Using Pressure Ulcer Risk Assessment Tools in Care Planning

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Welcome!

Thank you for joining this webinar about how to use pressure ulcer risk assessment tools in care planning.

A Little About Myself…

- Board certified wound and ostomy nurse
- Clinical editor of the journal *Advances in Skin and Wound Care*
- Vice president of the World Council of Enterostomal Therapists (WCET)
- Faculty member of Excelsior College School of Nursing
- Author of numerous articles and two books on wound care
- Past president of the National Pressure Ulcer Advisory Panel
- Former consultant to CMS on some skin conditions

Today We Will Talk About

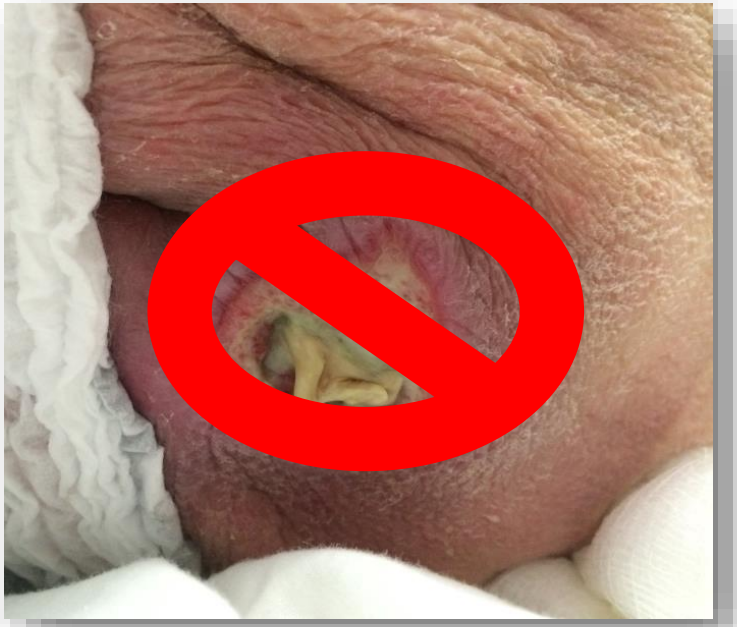
- Pressure ulcer risk factor assessment
- Pressure ulcer risk assessment tools
- Using pressure ulcer risk assessment tools in care planning

These topics were introduced in your 1-day training. Today, we will revisit them in depth.

Please make a note of your questions. Your Quality Improvement (QI) Specialists will follow up with you after this webinar to address them.

Attributes of Risk Factor Assessment

- Multifaceted
- Ongoing
- Standardized



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Standardized risk assessment is a prerequisite to implementing an evidence-based pressure ulcer prevention protocol.

Purpose of Risk Factor Assessment

Risk factor assessment facilitates—

- Clinical decisionmaking
- Selective targeting of preventive interventions
- Care planning
- Communication between health care workers and care settings

Purpose of Risk Factor Assessment

Risk factor assessment identifies—

- Patients who are more likely to develop pressure ulcers
- Different components of risk for pressure ulcers

When To Do Risk Assessment

- On admission
  - Within 8 hours
- Reassessment frequency
  - Based on patient's acuity
- Significant change in patient's condition

Risk Assessment Tools

Adult tools used in the United States include—

- Norton Scale

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- Braden Scale

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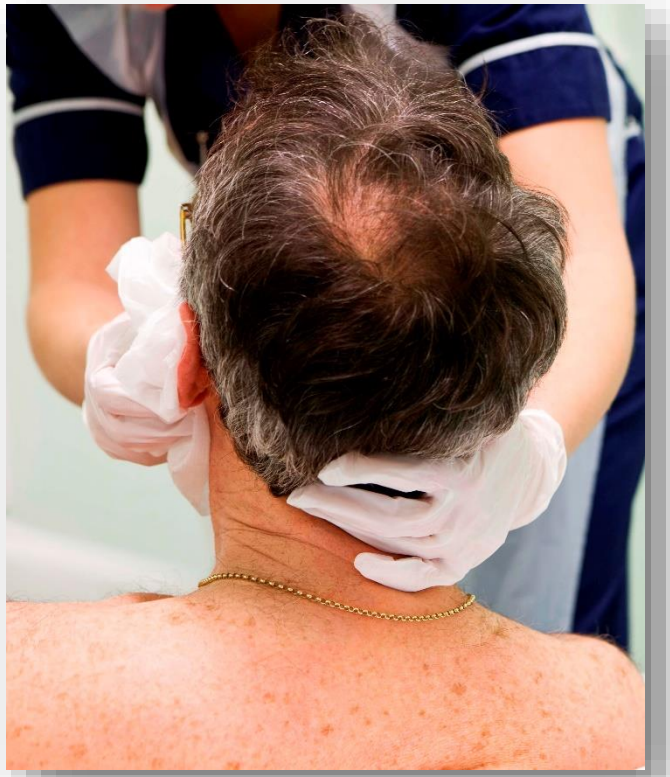
Today, we will focus on the Braden Scale.

Braden Scale Risk Factors

1. Sensory/perception
2. Moisture
3. Activity
4. Mobility
5. Nutrition
6. Friction/shear



Braden Scale

BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK

Patient's Name _____ Evaluator's Name_____ Date of Assessment

SENSORY PERCEPTION ability to respond meaningfully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation. OR limited ability to feel pain over most of body	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over ½ of body.	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned. OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort..				
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift.	**3. Occasionally Moist:** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals.				
ACTIVITY degree of physical activity	**1. Bedfast** Confined to bed.	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours				
MOBILITY ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. Slightly Limited** Makes frequent though slight changes in body or extremity position independently.	**4. No Limitation** Makes major and frequent changes in position without assistance.				
NUTRITION usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than ⅓ of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and/or maintained on clear liquids or IV's for more than 5 days.	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. OR receives less than optimum amount of liquid diet or tube feeding	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.				
FRICTION & SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair.					
					Total Score			

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How To Score Risk Factors

- Score risk factors from **1 to 4** except—
  - Score **friction/shear** from **1 to 3**.
- Risk factor score of 1 is the **lowest** level of functioning.
- If a category falls **between two numbers**, choose the **lower** score.

How To Interpret Braden Score

- **Total score** ranges from **6 to 23**.
- **Lower Braden score** indicates **higher** level of risk for pressure ulcer development.
- In most cases, a score of **18 or less** indicates at-risk status. Tailor this number to fit your hospital or unit.
- **Low subscale score** indicates risk from that factor. Address all deficits in care planning.

Do not rely on the total score alone.

REMEMBER

With the Braden Scale

Limits of Risk Scores

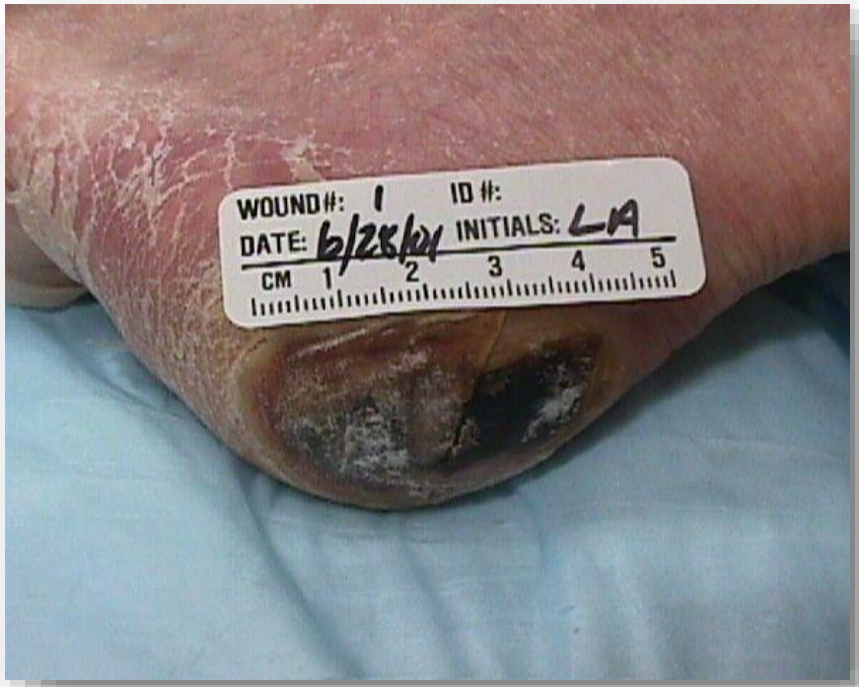
- Some assessment tools include a scoring system to predict pressure ulcer risk:
  - No tool has **perfect** predictability.
  - Even patients with a **low risk score** may need intervention.
  - If you base a patient's individualized care plan on the risk score alone, the care plan will not be tailored to all of his or her risk factors.
  - Instead, use a comprehensive approach to risk assessment to identify pressure ulcer risk factors.

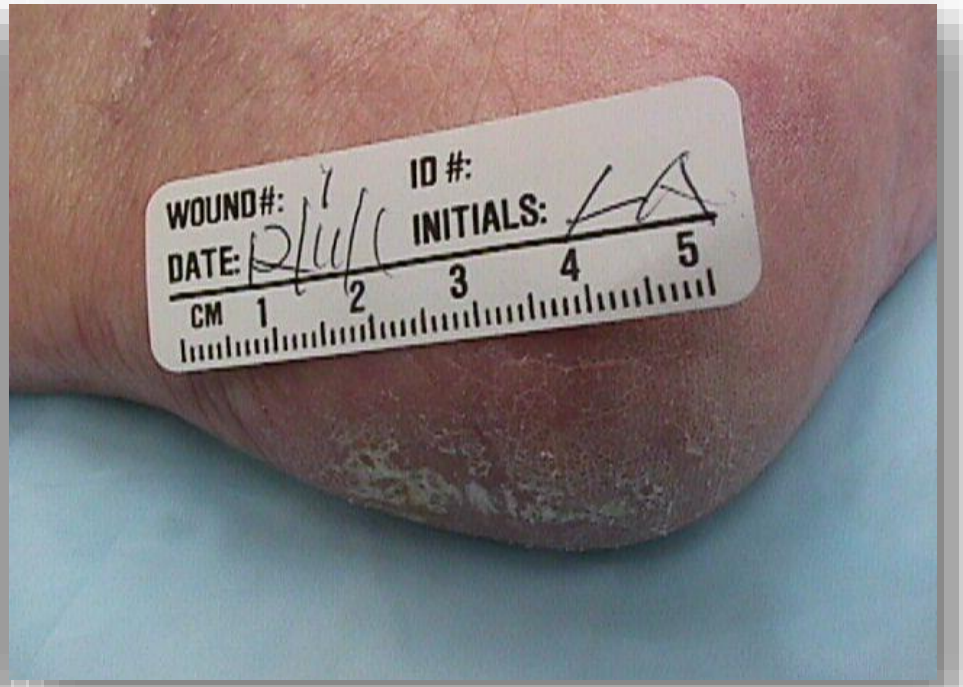
Don't rely on scores alone.

Comprehensive Pressure Ulcer Risk Assessment

- **H**istory.
- **A**ssess co-morbidities, medications.
- **L**ook at the skin.
- **T**ouch the skin.

History: It's Not Just About Score

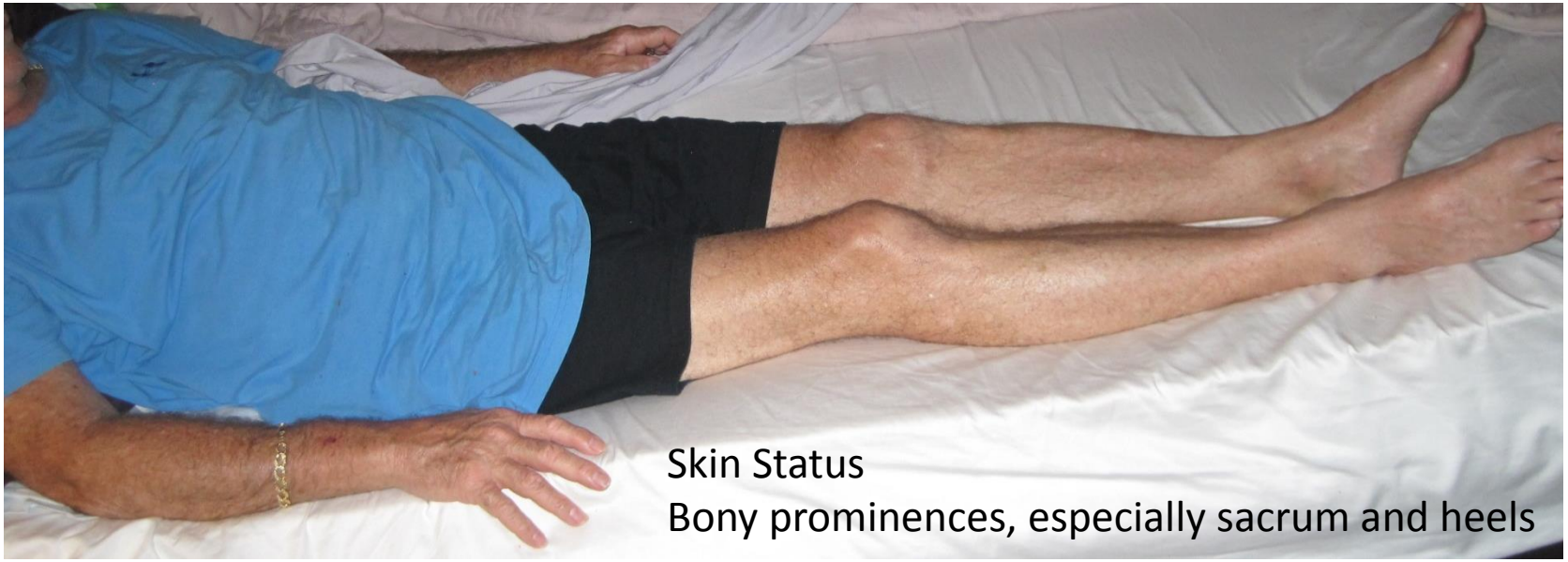


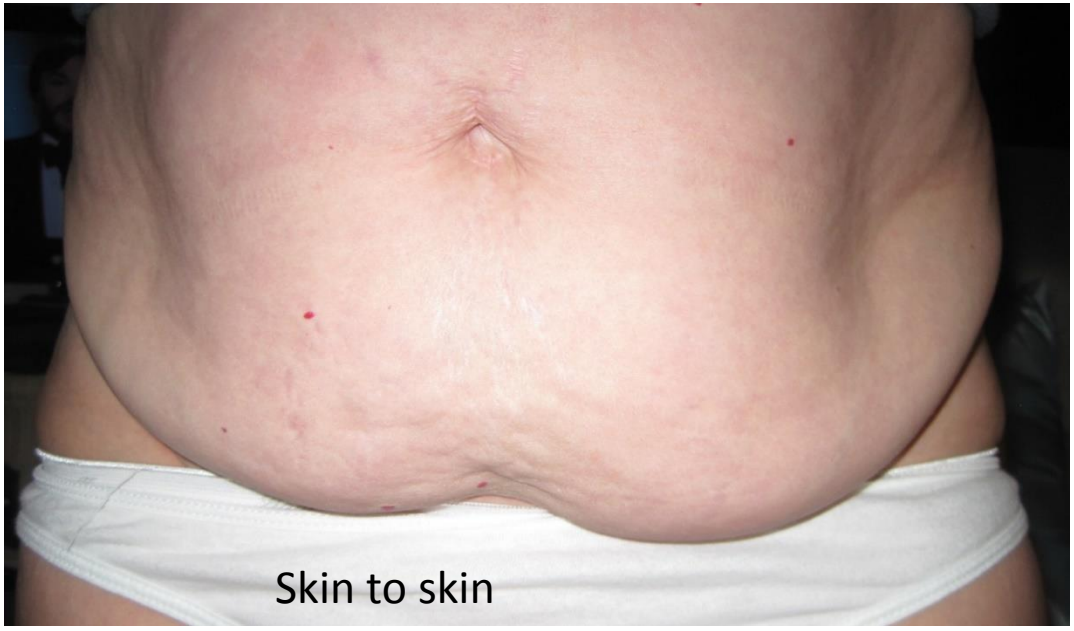


Assess Co-Morbidities & Medications

- Perfusion and oxygenation
- Nutritional deficits
- **Higher rates of PU**
  - Corticosteroid use
  - CHF
  - COPD
  - PVD
  - DM
  - Obesity

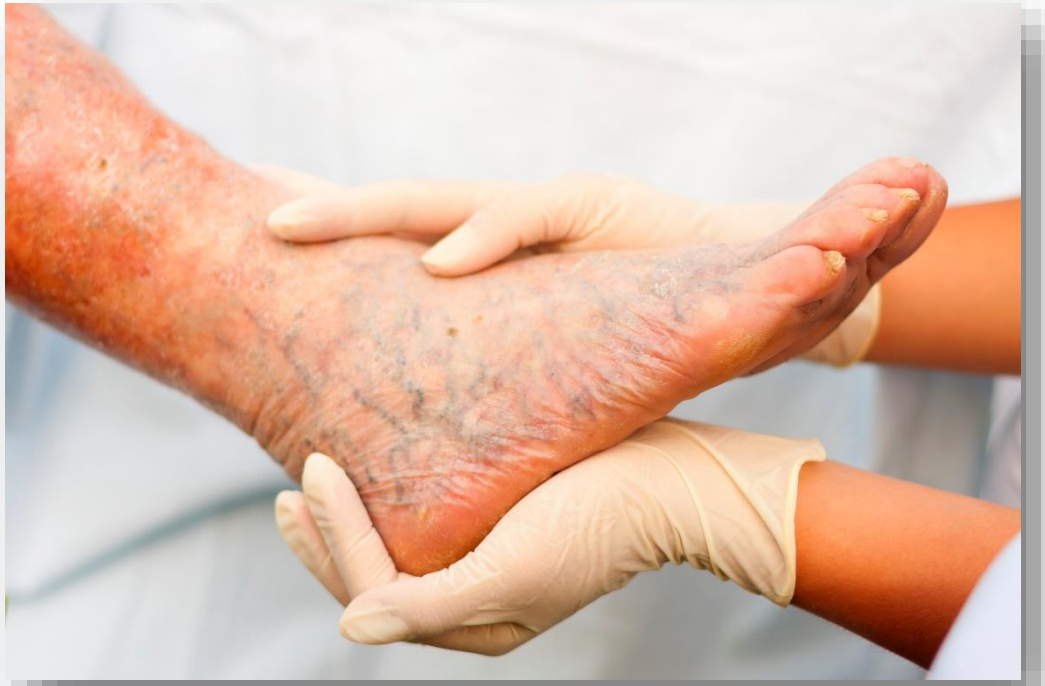
Look at Skin





Touch Skin

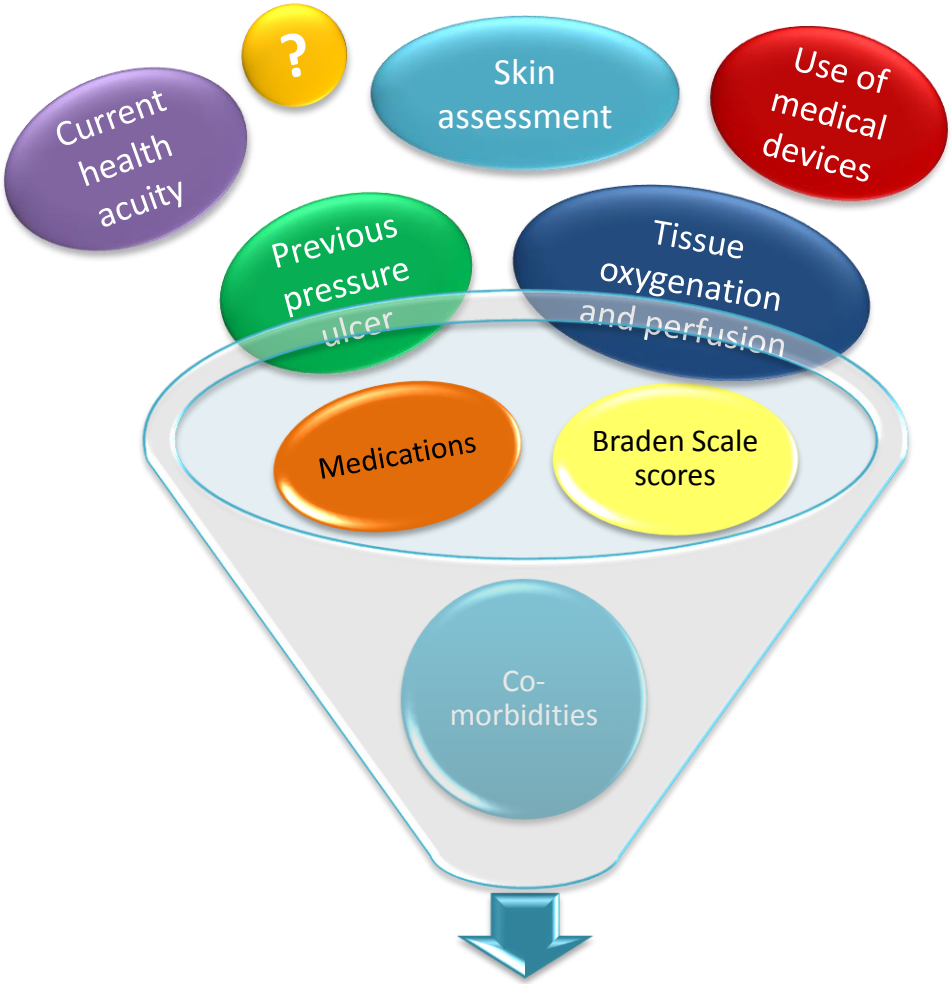
Skin temperature may predict pressure ulcer risk.



Risk Assessment

- Critically ill patients
  - Number of hypotensive episodes, hemodynamic instability
  - Medical devices
- Perioperative patients
  - Length of surgery
  - Number of hypotensive episodes during surgery
  - Low core temperatures during surgery
  - Amount of time immobilized before and after surgery

Clinical Decision making Based on Pressure Ulcer Risk



Is my patient at risk for a pressure ulcer?
What is the plan of care?

Using Assessment Tools

Assessment tools should be used—

- By trained staff
- In conjunction with clinical judgment and review of other risk factors
- To identify a patient's risk factors
- To plan care that addresses these factors
  - Prevention strategies should be consistent with the patient's preferences and care goals.

If your hospital has an electronic health record system, integrate assessment tools into the system.

Strategies for Using Risk Assessment Tools

- Use valid and reliable tools.
- Train staff in how to properly use risk assessment tools.
- Assess all patients.
- Tailor interventions based on patient-specific areas of risk.

Patients who previously had pressure ulcers are at risk for getting them again, especially under similar circumstances. Plan appropriately.

Using Risk Assessment Tools in Care Planning

Take these steps:

1. Review areas of risk identified by the Braden Scale for a specific patient and other risk factors included as part of a structured comprehensive risk assessment.
2. Select interventions to address each area of risk that are consistent with patient preference and care goals.
3. Communicate a tailored pressure ulcer prevention plan to all staff who interact with the patient. Also share it with the patient and their family members.

Planning Care for Each Category

Assessment and Care planning

Braden Category	Braden Score: 1	Braden Score: 2	Braden Score: 3	Braden Score: 4
Sensory Perception	**Completely limited** *Skin assessment and inspection q shift. Pay attention to heels *Elevate heels and use protectors *Consider specialty mattress or bed *Use pillows between knees and boney prominences to avoid direct contact.	**Very limited** *Skin assessment and inspection q shift. Pay attention to heels *Elevate heels and use protectors *Consider specialty mattress or bed.	**Slightly limited** *Skin assessment and inspection q shift. Pay attention to heels *Elevate heels and use protectors	**No limitation** *Encourage patient to report pain over boney prominences. *Check heels daily.
Moisture	**Constantly Moist** *Skin assessment and inspection q shift. *Use moisture barrier ointments (Protective skin barriers) *Moisturize dry unbroken skin. *Avoid hot water. Use mild soap and soft cloths or package cleanser wipes. *Check incontinence pads frequently (q2-3h) and change as needed *Apply condom catheter if appropriate. *If stool incontinence consider bowel training and toileting after meals or Rectal tubes if appropriate *Consider low air loss bed	**Moist** *Use moisture barrier ointments (Protective barriers) *Moisturize dry unbroken skin. *Avoid hot water. Use mild soap and soft cloths or package cleanser wipes. *Check incontinence pads frequently (q2-3h) *Avoid use of diapers but if necessary check frequently (q2-3h)and change as needed *If stool incontinence consider bowel training and toileting after meals *Consider low air loss bed	**Occasionally Moist** *Use moisture barrier ointments (Protective skin barriers) *Moisturize dry unbroken skin. *Avoid hot water. Use mild soap and soft cloths or package cleanser wipes. *Check incontinence pads frequently *Avoid use of diapers but if necessary check frequently (q2-3h) and change as needed *Encourage patient to report any other moisture problem (such as under breasts.) *If stool incontinence consider bowel training and toileting after meals	**Rarely Moist** *Encourage patient to use lotion to prevent skin cracks. *Encourage patient to report any moisture problem (such as under breasts.)
Activity	**Bedfast** *Skin assessment and inspection q shift. *Position prone if appropriate or elevate HOB no more than 30 degrees *Position with pillows to elevate pressure points off of the bed. *Consider specialty bed *Elevate heels off bed and/or heel protectors *Consider physical therapy consult for conditioning and W/C assessment *Turn/reposition q 1-2 hours. *Post turning schedule. *Teach or do frequent small shifts of body weight	**Chairfast** *Consider specialty chair pad *Consider postural alignment, weight distribution, balance, stability, and pressure relief when positioning individuals in chair or wheelchair. *Instruct patient to reposition q 15 minutes when in chair. *Stand every hour *Pad boney prominences with foam wedges, rolled blankets or towels. *Consider physical therapy consult for conditioning and W/C assessment	**Walks Occasionally** *Provide structured mobility plan. *Consider chair cushion *Consider physical therapy consult	**Walks Frequently** *Encourage ambulating outside the room at least bid. *Check skin daily *Monitor balance and endurance
Mobility	**Completely Immobile** *Skin assessment and inspection q shift. *Turn/reposition q 1-2 hours. *Post turning schedule. *Teach or do frequent small shifts of body weight. *Elevate heels *Consider specialty bed	**Very Limited** *Skin assessment and inspection q shift. *Turn/reposition 1-2 hours. *Post turning schedule. *Teach or do frequent small shifts of body weigh *Elevate heels *Consider specialty bed	**Slightly Limited** *Check skin daily *Turn/reposition frequently *Teach frequent small shifts of body weigh *PT consult for strengthening/conditioning *Gait belt for assistance.	**No Limitations** *Check skin daily *Encourage ambulating outside the room at least bid. *No interventions required.
Nutrition	**Very Poor** *Nutrition Consult *Skin assessment and inspection q shift. *Offer Nutrition Supplements and water *Encourage family to bring favorite foods *Monitor Nutritional Intake *If NPO for > 24 hours, discuss plan with MD *Record dietary intake and I & O if appropriate	**Probably Inadequate** *Nutrition Consult *Offer Nutrition Supplements and water *Encourage family to bring favorite foods *Monitor Nutritional Intake *Small frequent meals *If NPO for > 24 hours, discuss plan with MD *Record dietary intake and I & O if appropriate	**Adequate** *Monitor nutritional intake *If NPO for > 24 hours, discuss plan with MD *Record dietary intake and I&O if appropriate	**Excellent** *Out of bed for all meals. *Provide food choices. *Offer Nutrition Supplements If NPO for > 24 hours, discuss plan with MD *Record dietary intake
Friction & Shear	**Problem** *Skin assessment and inspection q shift. *Minimum of 2 people + draw sheet to pull patient up in bed. *Keep bed linens clean, dry, and wrinkle-free. *Apply or elbow/heel protectors to intact skin over elbows and heels. *Elevate head of bed 30 degree or less	**Potential Problem** *Keep bed linens clean, dry, and wrinkle-free. *Avoid massaging pressure points. *Apply transparent dressing or elbow/heel protectors to intact skin over elbows and heels.	**No apparent problem** *Keep bed linens clean, dry, and wrinkle-free.	

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Select Interventions

- Bariatric patients
  - Appropriate size and weight of equipment, including pressure redistribution support surfaces.
  - Are staff trained to care for these patients?
- Critically ill patients
  - Choose pressure redistribution support surfaces based on individual's perfusion and ability to be turned.
  - "Slow, gradual turns"; allow time for hemodynamic and oxygenation stabilization.
- Perioperative patients
  - Facial pads for prone position.
  - Operating room support surfaces on table.
  - Heel suspension devices.

Case Study

Your hospitalized patient—

- Responds to verbal commands
- Reports no pain
- Can turn and reposition without assistance but needs frequent reminders
- Needs encouragement to walk more than twice a day outside his/her room
- Eats some of the food on his/her tray
- Has not suffered any recent weight loss
- Has moist skin from urinary and fecal incontinence

What is the total Braden Scale score for this patient, and is he/she at risk for a pressure ulcer?

Case Study Braden Scale Scores

BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK

Patient's Name _____ Evaluator's Name_____ Date of Assessment

SENSORY PERCEPTION ability to respond meaningfully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation. OR limited ability to feel pain over most of body	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over ½ of body.	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned. OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort..	4				
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift.	**3. Occasionally Moist:** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals.	2				
ACTIVITY degree of physical activity	**1. Bedfast** Confined to bed.	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours	4				
MOBILITY ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. Slightly Limited** Makes frequent though slight changes in body or extremity position independently.	**4. No Limitation** Makes major and frequent changes in position without assistance.	3				
NUTRITION usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than ⅓ of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and/or maintained on clear liquids or IV's for more than 5 days.	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. OR receives less than optimum amount of liquid diet or tube feeding	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	3				
FRICTION & SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair.		3				
				Total Score	19				

Selected Care Planning Examples

Plan care for **pain**.

- Assess using validated and reliable pain assessment scales; use specific tools or observe body language or other cues for nonverbal patients.
- Prevent and manage pain.
  - Do this when lifting or transferring patient.
  - Coordinate pain medication administration with care.

Sensory Perception	**Completely limited** *Skin assessment and inspection q shift. Pay attention to heels *Elevate heels and use protectors *Consider specialty mattress or bed *Use pillows between knees and boney prominences to avoid direct contact.	**Very limited** *Skin assessment and inspection q shift. Pay attention to heels *Elevate heels and use protectors *Consider specialty mattress or bed.	**Slightly limited** *Skin assessment and inspection q shift. Pay attention to heels *Elevate heels and use protectors	**No limitation** *Encourage patient to report pain over boney prominences. *Check heels daily.

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Selected Care Planning Examples

- Plan care for moisture problems.
- Use pH balanced skin cleaning products.
- Don't massage or vigorously rub skin at risk for pressure ulcers.
- Cope with dry skin.
  - Apply moisturizing products such as lotions and creams.
- Cope with wet skin (incontinence, perspiration).
  - Clean skin promptly.
  - Protect skin with products such as skin sealants, lotions, and creams.

Moisture	Constantly Moist	Moist	Occasionally Moist	Rarely Moist
	*Skin assessment and inspection q shift. *Use moisture barrier ointments (Protective skin barriers) *Moisturize dry unbroken skin. *Avoid hot water. Use mild soap and soft cloths or package cleanser wipes. *Check incontinence pads frequently (q2-3h) and change as needed *Apply condom catheter if appropriate. *If stool incontinence consider bowel training and toileting after meals or Rectal tubes if appropriate *Consider low air loss bed	*Use moisture barrier ointments (Protective barriers) *Moisturize dry unbroken skin. *Avoid hot water. Use mild soap and soft cloths or package cleanser wipes. *Check incontinence pads frequently (q2-3h) *Avoid use of diapers but if necessary check frequently (q2-3h)and change as needed *If stool incontinence consider bowel training and toileting after meals *Consider low air loss bed	*Use moisture barrier ointments (Protective skin barriers) *Moisturize dry unbroken skin. *Avoid hot water. Use mild soap and soft cloths or package cleanser wipes. *Check incontinence pads frequently *Avoid use of diapers but if necessary check frequently (q2-3h) and change as needed *Encourage patient to report any other moisture problem (such as under breasts.) *If stool incontinence consider bowel training and toileting after meals	*Encourage patient to use lotion to prevent skin cracks. *Encourage patient to report any moisture problem (such as under breasts.)

Selected Care Planning Examples

Plan care for **activity** problems.

- Inability to move while sitting in a wheelchair
  - Use support cushion in properly fitted wheelchair.
  - Consider PT/OT referrals for evaluation.

Activity	Bedfast	Chairfast	Walks Occasionally	Walks Frequently
.	*Skin assessment and inspection q shift. *Position prone if appropriate or elevate HOB no more than 30 degrees *Position with pillows to elevate pressure points off of the bed. *Consider specialty bed *Elevate heels off bed and/or heel protectors *Consider physical therapy consult for conditioning and W/C assessment *Turn/reposition q 1-2 hours. *Post turning schedule. *Teach or do frequent small shifts of body weight	*Consider specialty chair pad *Consider postural alignment, weight distribution, balance, stability, and pressure relief when positioning individuals in chair or wheelchair. *Instruct patient to reposition q 15 minutes when in chair. *Stand every hour *Pad boney prominences with foam wedges, rolled blankets or towels. *Consider physical therapy consult for conditioning and W/C assessment	*Provide structured mobility plan. *Consider chair cushion *Consider physical therapy consult	*Encourage ambulating outside the room at least bid. *Check skin daily *Monitor balance and endurance

Selected Care Planning Examples

Plan care for **mobility** problems.

- Heels on the mattress
  - Use heel suspension devices.

Mobility	**Completely Immobile** *Skin assessment and inspection q shift. *Turn/reposition q 1-2 hours. *Post turning schedule. *Teach or do frequent small shifts of body weight. *Elevate heels *Consider specialty bed	**Very Limited** *Skin assessment and inspection q shift. *Turn/reposition 1-2 hours. *Post turning schedule. *Teach or do frequent small shifts of body weigh *Elevate heels *Consider specialty bed	**Slightly Limited** *Check skin daily *Turn/reposition frequently *Teach frequent small shifts of body weigh *PT consult for strengthening/conditioning *Gait belt for assistance.	**No Limitations** *Check skin daily *Encourage ambulating outside the room at least bid. *No interventions required.

Selected Care Planning Examples

Plan care for **nutrition** problems.

- Encourage family to bring favorite foods.
- Offer nutrition supplements and water.

Nutrition	**Very Poor** *Nutrition Consult *Skin assessment and inspection q shift. *Offer Nutrition Supplements and water *Encourage family to bring favorite foods *Monitor Nutritional Intake *If NPO for > 24 hours, discuss plan with MD *Record dietary intake and I & O if appropriate	**Probably Inadequate** *Nutrition Consult *Offer Nutrition Supplements and water *Encourage family to bring favorite foods *Monitor Nutritional Intake *Small frequent meals *If NPO for > 24 hours, discuss plan with MD *Record dietary intake and I & O if appropriate	**Adequate** *Monitor nutritional intake *If NPO for > 24 hours, discuss plan with MD *Record dietary intake and I&O if appropriate	**Excellent** *Out of bed for all meals. *Provide food choices. *Offer Nutrition Supplements If NPO for > 24 hours, discuss plan with MD *Record dietary intake

Selected Care Planning Examples

Plan care for **friction and shear**.

- Protect bony prominences prophylactically by applying a polyurethane foam dressing.
- Use silk-like fabrics rather than cotton or cotton blend fabrics.

Friction & Shear .	**Problem** *Skin assessment and inspection q shift. *Minimum of 2 people + draw sheet to pull patient up in bed. *Keep bed linens clean, dry, and wrinkle-free. *Apply or elbow/heel protectors to intact skin over elbows and heels. *Elevate head of bed 30 degree or less	**Potential Problem** *Keep bed linens clean, dry, and wrinkle-free. *Avoid massaging pressure points. *Apply transparent dressing or elbow/heel protectors to intact skin over elbows and heels.	**No apparent problem** *Keep bed linens clean, dry, and wrinkle-free.	

Today We Talked About

- Pressure ulcer risk factor assessment
- Pressure ulcer risk assessment tools
- Using pressure ulcer risk assessment tools in care planning

Any Questions?

Thank you for being such great listeners. Please refer any questions you have to your QI Specialists.

Resources

- Berlowitz D, VanDeusen C, Parker V, et al. Preventing pressure ulcers in hospitals: a toolkit for improving quality of care. (Prepared by Boston University School of Public Health under Contract No. HHSA 290200600012 TO #5 and Grant No. RRP 09-112.) Rockville, MD: Agency for Healthcare Research and Quality; April 2011. AHRQ Publication No. 11-0053-EF.
  - Tool 3D: The Braden Scale for Predicting Pressure Sore Risk
  - Tool 3E: Norton Scale
  - Tool 3F: Care Plan
- Sprigle S, Linden, M, McKenna D, et al. Clinical skin temperature measurement to predict incipient pressure ulcers. *Adv Skin Wound Care* 2001;14(3):133-7.

Resources

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- National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel, Pan Pacific Pressure Injury Alliance. Prevention and treatment of pressure ulcers: clinical practice guideline. Perth, Australia: Cambridge Media; 2014.
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