

Best Practice for Risk Assessment and Capturing Present on Admission

Presented by:

Bronwynne Carpico RN, MSN, CCRN



Identify Issues

- NDNQI and PPUP Portal for Benchmarking
- WOCN for Standards of Care
- Staff Survey
- Review St Clair Policy
- Braden Scale Frequency

Develop Tools for Patient Care

Toyota Principles:

Make Workplace Visual:

Badge Cards

Body Maps

Turning Clocks

Placing Tools at Point of Care:

Measuring Tapes in Nurse Server

Skin Care Box with Guide

Skin Care Binder for Reference

Documentation Tools to Support Practice

Documentation Flowsheets

- Risk Assessments/Screenings			
<input type="checkbox"/> Fall / Harm Risk Assessment (every shift)			
<p style="text-align: right;">Fall Risk Indicators</p> <p style="text-align: right;">Fall Risk Score (if 31 or greater, activate Trauma/Injury Risk guideline)</p> <p style="text-align: right;">Harm Risk Indicators</p> <p style="text-align: right;">Risk of Harm Score (if 1 or greater, activate Trauma/Injury Risk guideline)</p>	<p style="text-align: right;">age greater than 65 years; 75</p> <p style="text-align: right;">Post op major chest / abd s 1</p>	<p style="text-align: right;">age greater than 65 years; 75</p> <p style="text-align: right;">Post op major chest / abd s 1</p>	
Safety Interventions			
<p style="text-align: right;">Risk of Harm Interventions (1-5)</p> <p style="text-align: right;">Fall Interventions Level 1 (0-30)</p> <p style="text-align: right;">Fall Interventions Level 2 (31-64)</p> <p style="text-align: right;">Fall Interventions Level 3 (65 or greater)</p> <p style="text-align: right;">Alarms</p> <p style="text-align: right;">Elopement Precautions</p> <p style="text-align: right;">Medical Device Protection</p>	<p style="text-align: right;">low bed recommended;</p> <p style="text-align: right;">bed in lowest position;</p> <p style="text-align: right;">none present</p>	<p style="text-align: right;">low bed recommended;</p> <p style="text-align: right;">bed in lowest position;</p> <p style="text-align: right;">none present</p>	
<input type="checkbox"/> Braden Risk Assessment (every day)			
<p style="text-align: right;">Sensory Perception (response to environment)</p> <p style="text-align: right;">Moisture (degree skin exposed to moisture)</p> <p style="text-align: right;">Activity (ability to walk)</p>		<p style="text-align: right;">(4) no impairment</p> <p style="text-align: right;">(3) occasionally moist</p> <p style="text-align: right;">(4) walks frequently</p>	

Change of Shift Report

View: Professional Exchange Report				Start of chart	Start of Chart To 04-27
D5 1/2 NS 1000 ml					
D5 Lactated Ringers	ml/hr		active		
D5 Lactated Ringers...					
D5w Normal Saline	ml/hr		active		
D5 Normal Saline 1000...					
Diltiazem in D5w	ml/hr		active		
Diltiazem. 125 mg 25 ml					
D5w 100 ml					
Drugs	ml/hr	Heparin	dc'd		
Risk Screens and Assessment Tools					
Item	Item Info	Value	Last Date		
Fall Risk	Fall Risk Score (if...	60	04-27-2010 00:43		
	Risk of Harm Score...	2	04-27-2010 00:43		
Braden	Sensory Perception...	(4) no impairment	04-27-2010 00:43		
Braden	Moisture (degree...	(4) rarely moist	04-27-2010 00:43		
Braden	Activity (ability to...	(3) walks...	04-27-2010 00:43		
Braden	Mobility...	(4) no limitation	04-27-2010 00:43		
Braden	Nutrition (quality of...	(3) adequate	04-27-2010 00:43		
Braden	Friction and Shear	(3) no apparent...	04-27-2010 00:43		
Braden	Score (if 18 or less...	21	04-27-2010 00:43		
VTE	Age	over 60 (2)	04-21-2010 19:40		
VTE	BMI	30 or less (0)	04-21-2010 19:40		
VTE	History	Superficial Vein...	04-21-2010 19:40		

Admission Screening



Adult Patient Profile [04-22-2010 12:10], Visit:

! REVIEW OF SYSTEMS (Prior to Admission):

! PRESSURE ULCER:

- Pressure Ulcer in Past no
- Pressure Ulcer Present at Time of Admission no

Daily PI Monitor

Results

Patient Info

Summary

Documents

Flowsheets

Clinical Summary

PI Monitor

Discharge Planning

Inpatient

Admitted

Thursday, April 22, 2010 11:04 AM

IV Charting Issues

Issue	Date	IV
		

Patient Profile Issues

Section	Unaddressed Item
	

Tools for ET Nurse

St. Clair Hospital

Pittsburgh, PA 15243

Enterstomal Therapy Progress Notes

Wound and Skin
Check all that apply

Wound #1

Present on Admission

Nosocomial

Wound #2

Present on Admission

Nosocomial

Wound #3

Present on Admission

Nosocomial

Wound type

Pressure Ulcer

Trauma

Diabetic –Neuropathic Ulcer

Venous Stasis Ulcer

Surgical

Burn/Trauma

Pressure Ulcer

Trauma

Diabetic –Neuropathic Ulcer

Venous Stasis Ulcer

Surgical

Burn/Trauma

Pressure Ulcer

Trauma

Diabetic –Neuropathic Ulcer

Venous Stasis Ulcer

Surgical

Burn/Trauma

Tools for ET Nurse

St Clair Hospital
Pittsburgh, PA 15243
Skin/Wound Care
Physician Orders
Page 1 of 1

Date: _____ Time: _____ Allergies: _____

This Wound is a Pressure Ulcer:

Yes

No

Present on Admission

Hospital Acquired

Unknown

Location: _____

If multiple wounds require different treatment, circle Wound # for this order: 1 2 3 4 5 6

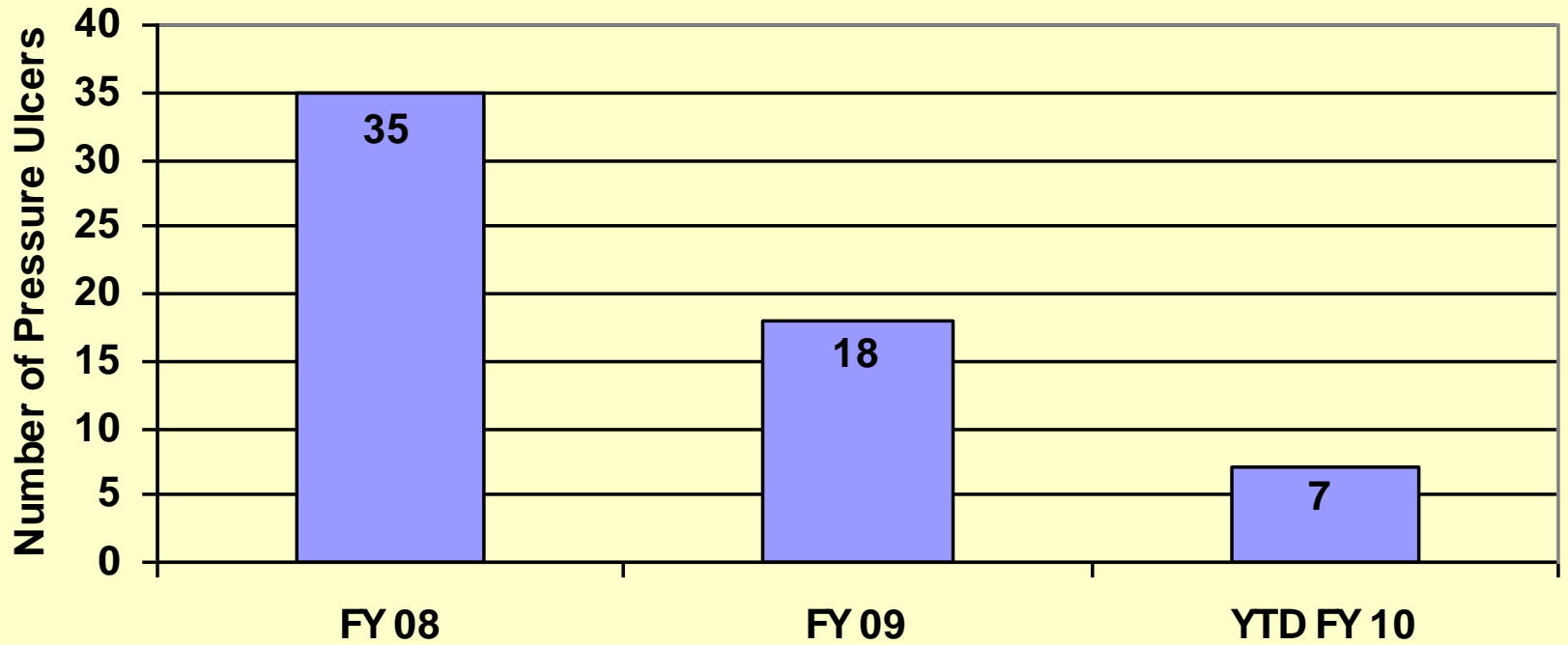
DRESSING CHANGES:

Cleanse wound with each dressing change using: Dove soap Normal saline Sterile water

Approximate skin tear, steri strip epidermal flap if present

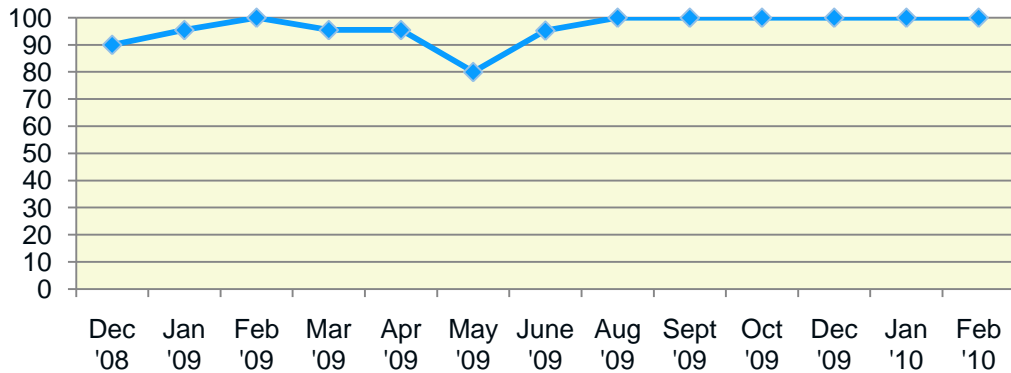
Results

HAC Pressure Ulcers Reported to NDNQI

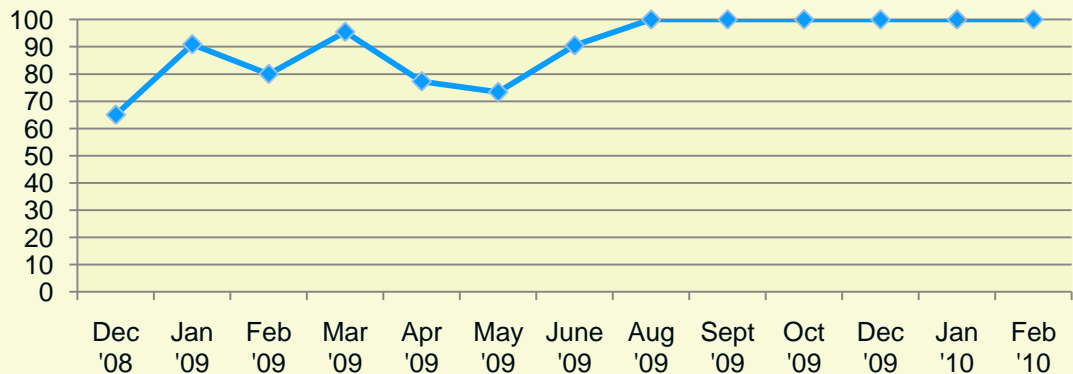


Results

Pressure Ulcer Risk Assessment On Admission

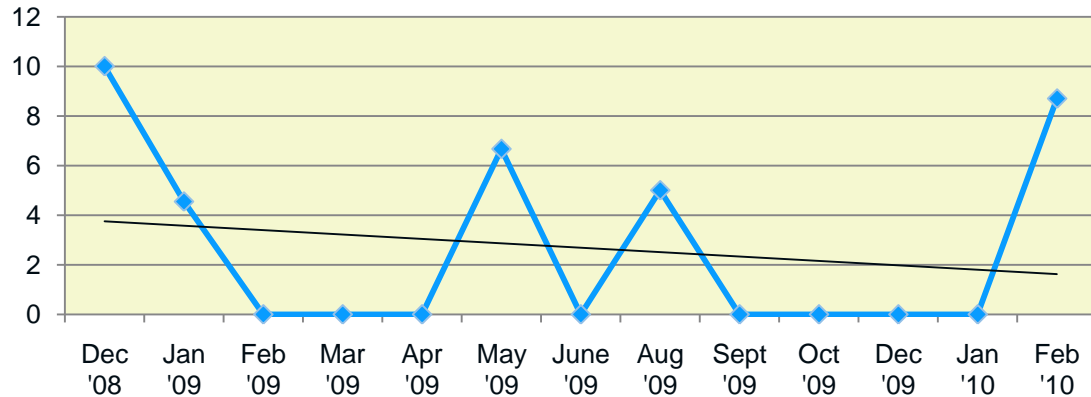


On-going Pressure Ulcer Risk Assessments

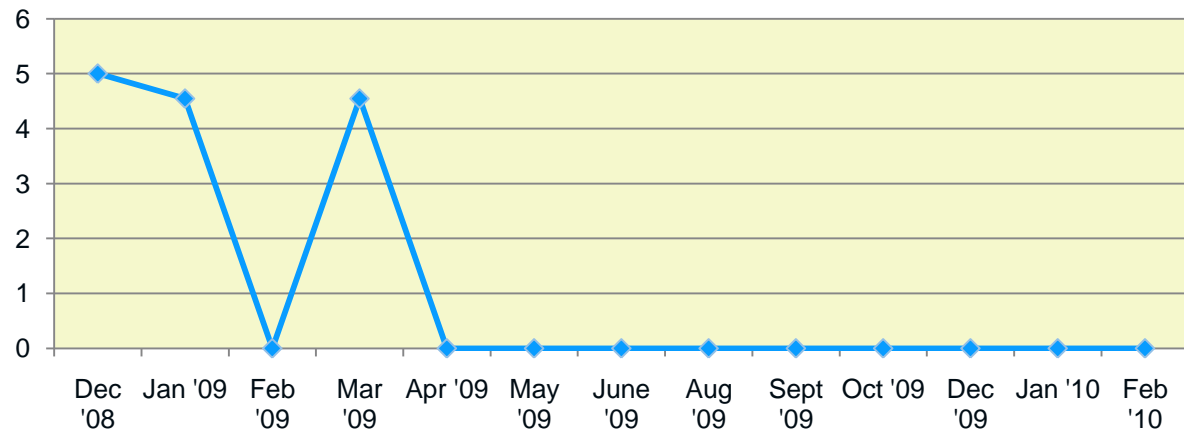


Results

Developed Pressure Ulcer During Hospital Stay



Pressure Ulcer Progressed During Hospital Stay





Questions?



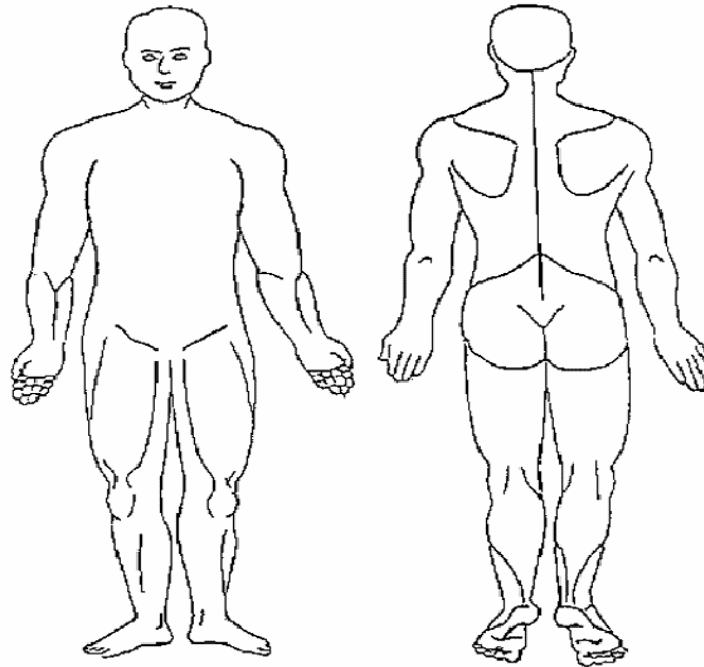
References

1. Nutrition Screening Initiative. (2002). Nutrition Statement of Principle. Retrieved September 1, 2005 at [http://www.eatright.org/Public/Files/nutrition\(1\).pdf](http://www.eatright.org/Public/Files/nutrition(1).pdf).
2. Pokorny M, Kodjeski D, Swanson M, Skin Care Interventions for Patient Having Cardiac Surgery. American Journal of Critical Care. Nov. 03; 535-544.
3. Frantz Rita. Evidence Based Protocol. Journal of Gerontological Nursing. Feb. 04; 4-11.
4. Brown, Sarah Jo. The Braden Scale: A Review of the Research Evidence. Orthopedic Nursing. Jan. 04; 30-38.
5. Doughty, Dorothy B. Current Management Concepts Urinary and Fecal Incontinence 3rd Edition pages 318-323.

Appendix

Name: _____ Room: _____

Indicate Ulcer Sites:



If this patient has a pressure ulcer or is at risk [Braden <18]:

Turn and position every two hours utilizing **turning clock**

Heel protectors or pillows to elevate

For incontinence use Wipes and Protective Cream OR Barrier Ointment

BID and PRN

Appendix

