

IV AND FLUSH SOLUTIONS	RATE (cc/hr)	<input type="checkbox"/> STRICT I&O ORDERED
#A		
#B		
#C		
#D		
IVPB		

INTAKE													OUTPUT					
HOUR	ORAL	FEEDING TUBE		IV - #A		IV - #B		IV - #C		IV - #D		IVPB AMT. UP	12 HR TOTAL	URINE	STOOL			12 HR TOTAL
		AMT. UP	AMT. ABS.	AMT. UP	AMT. ABS.	AMT. UP	AMT. ABS.	AMT. UP	AMT. ABS.	AMT. UP	AMT. ABS.							
0700																		
0800																		
0900																		
1000																		
1100																		
1200																		
1300																		
1400																		
1500																		
1600																		
1700																		
1800																		
12 HR TOTAL																		
1900																		
2000																		
2100																		
2200																		
2300																		
2400																		
0100																		
0200																		
0300																		
0400																		
0500																		
0600																		
12 HR TOTAL																		
24 HR TOTAL																		

COMBINED 24 HOUR TOTAL (Document on Graphic Record)	INTAKE >	OUTPUT >
--	--------------------	--------------------

Date: _____ Time of Assessment: _____ (To be done on Admission & Daily on Day Shift)

Admission Braden Score: _____ Previous Day Braden Score: _____ (Night shift to carry-over)

BRADEN SKIN-RISK ASSESSMENT SOURCE: Barbara Braden and Nancy Bergstrom. Copyright, 1988. Reprinted with permission.

Sub-Score

<p>Sensory Perception Ability to respond meaningfully to pressure-related discomfort</p>	<p>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 surface.</p>	<p>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 1/2 of body.</p>	<p>3. Slightly limited: Responds to verbal commands but cannot always communicate discomfort or need to be turned. OR Has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.</p>	<p>4. No impairment: Responds to verbal commands. Has no sensory deficit would limit ability to feel or voice pain or discomfort.</p>	
<p>Moisture Degree to which skin is exposed to moisture</p>	<p>1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.</p>	<p>2. Very moist: Skin is often but not always moist. Linen must be changed at least once a shift.</p>	<p>3. Occasionally moist: Skin is occasionally moist, requiring an extra linen change approximately once a day.</p>	<p>4. Rarely moist: Skin is usually dry; linen requires changing only at routine intervals.</p>	
<p>Activity Degree of physical activity</p>	<p>1. Bedfast: Confined to bed.</p>	<p>2. Chairfast: Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.</p>	<p>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.</p>	<p>4. Walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.</p>	
<p>Mobility Ability to change and control body position</p>	<p>1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.</p>	<p>2. Very limited: Makes occasional slight changes in body and extremity position but unable to make frequent or significant changes independently.</p>	<p>3. Slightly limited: Makes frequent though slight changes in body extremity position independently.</p>	<p>4. No limitations: Makes major and frequent changes in position without assistance.</p>	
<p>Nutrition Usual food intake pattern</p>	<p>1. Very poor: Never eats a complete meal. Rarely eats more than 1/3 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 NPO¹ and/or maintained on clear liquids or IV² for more than 5 days.</p>	<p>2. Probably inadequate: Rarely eats a complete meal and generally eats only about 1/2 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.</p>	<p>3. Adequate: Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement of offered, OR Is on a tube feeding or TPN³ regimen, which probably meets most of nutritional needs.</p>	<p>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.</p>	
<p>Friction and Shear</p>	<p>1. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequent slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures, or agitation leads to almost constant friction.</p>	<p>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.</p>	<p>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 at all times.</p>		
<p>Note: Advance to next level of risk if any of the following conditions are present: Diabetes; PVD; Renal Disease or Dialysis; Significant Thinness or Obesity; Edema</p>					<p>TOTAL SCORE: _____</p>

HIGH RISK (6-12) AT RISK (13-18) LOW RISK (19-23)

Patients with total score of 18 or less are considered to be at risk for developing pressure ulcers. Interventions are indicated.

PRESSURE ULCER PREVENTION & INTERVENTIONS

Subscale scores of 1-2 in "Nutrition" and "Friction Shear" and subscale scores of 1-3 in any other subscale (regardless of Total Score) requires implementation of interventions that address the issue.

Initial all interventions completed or implemented:	INITIALS	
	7A-P	7P-A
<input type="checkbox"/> PRESSURE REDUCTION INTERVENTIONS		
Encourage / Turn and reposition at least every 2 hours		
Use 30-degree side-lying to avoid direct pressure on hip / sacrum		
Use of Waffle Bed Mattress (Hand Check done q shift)		
Use of dynamic (powered) overlay / replacement or specialty bed:		
Type of bed: _____		
Use of Waffle Seat Cushion when in chair		
Encourage to weight shift and lift buttock periodically when in chair		
Use of heel elevator product.....		
Use pillows or rolled blanket/towel to elevate heels off surface		
Use pillows to separate bony prominences such as knees & ankles		
Check to see pt not lying on tubes, drains, catheters causing pressure		
ACE wraps, AE hose and SCDs removed q shift for skin inspection		
<input type="checkbox"/> FRICION / SHEAR PREVENTION		
HOB no more than 30 degrees or lowest angle based on pt condition		
Use lift sheet to move patient up in bed.....		
Use trapeze if patient can assist to lift up body to prevent skin drag		
Protect elbows & heels if exposed to friction (heel & elbow protectors)		
Use thin hydrocolloid or transparent dressing to shear prone areas		
Apply skin protectant to serve as "second" skin to heels, coccyx		
Apply padding to casts, splints & braces as applicable		
<input type="checkbox"/> MOISTURE PREVENTION		
Offer Toileting (bedpan, urinal) frequently		
Frequent check of linen for soiling with prompt changing of linen		
Use spray incontinence cleanser		
Use protective moisture barrier cream and ointment (thick layer)		
Use fecal collector for frequent or continuous, liquid stooling		
Avoid diapers (they entrap moisture). If used, change when soiled		
Insert urine catheter if okay with physician		
Apply condom urine catheter		
<input type="checkbox"/> NUTRITION-RELATED INTERVENTIONS		
Encourage patient to eat and drink		
Monitor food intake		
Notify Dietician to evaluate protein, calorie intake		
Notify MD of poor intake (may benefit from supplements, vitamin, TPN)		
<input type="checkbox"/> GENERAL CARE ISSUES		
Avoid massaging reddened bony prominences (causes tissue injury)		
Avoid doughnut type devices (impairs capillary perfusion around area)		

SKIN BREAKDOWN IS PRESENT. Refer to the Altered Skin Integrity Form.

FALL RISK ASSESSMENT

Admission Fall Score: _____ Previous Day - Highest Fall Score: _____

Circle appropriate risk factors and add for TOTAL SCORE

	7A	7P
GENDER		
Female	0	0
Male	1	1
AGE > 65	2	2
HISTORY OF FALLS (In Past Year)	3	3
MENTAL STATUS		
Not Impaired (Uses Phone, Call Light)	0	0
Poor Insight into Self-Care Abilities	2	2
Impaired/Confused	3	3

ALTERATION IN ELIMINATION

Urgency, Frequency, Incontinence of Bowel or Bladder
Foley Removed (Within Last 24-Hours)

7A	7P
1	1
1	1

GAIT / TRANSFERS

No Problems
Weakness / Contact Guard / Supervision
Impaired Mod - Max Assist

7A	7P
0	0
1	1
2	2

MEDICATIONS (Within Last 24-Hours)

Anti-Anxiety Agents
Narcotics / Pain Medication
Sleepers / Sedatives

7A	7P
1	1
1	1
1	1

TOTAL SCORE		
--------------------	--	--

AT RISK (greater than 6) **LOW RISK** (6 or less)

For Score > 6, Implement Fall Risk Protocol and ALL Interventions Below. (✓)

Fall Prevention Interventions	7A	8A	9A	10A	11A	12P	1P	2P	3P	4P	5P	6P	7P	8P	9P	10P	11P	12A	1A	2A	3A	4A	5A	6A
Q1 Hour Patient Checks																								
Bed in Low Position																								
Phone, Urinal, Call/TV Control Handy																								
Evaluate/Monitor Medication Effect																								
Elimination Assist Offered																								
Hydration Needs Attended																								
Safety Alarm On (if applicable)																								

PATIENT SAFETY ALTERNATIVES - (Check all that apply):

Alternatives/asures in use to prevent falls and injury:

- Reality Orientation
 Bed Alarm
 Side Rails
 Skin Sleeve
 Conceal Tubes/Drains with Kerlix
 Peek-a-Boo Mittens
 Use Diversional Activities - Music, Puzzles
 Frequent Rounds
 Re-Assess/Treat Pain
 Move Closer to Nursing Station
 Assess Medication/Drug Interactions
 Sitter
 Involve Family/Significant Others to Sit/Stay with Patient
 Non-Skid Slippers
 Other: _____

PATIENT RESTRAINT APPLIED AS ALTERNATIVES ALONE ARE UNSUCCESSFUL

See Patient Restraint Monitoring Flowsheet

