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IMPROVING THE ACCURACY OF PATIENT ASSESSMENT USING THE BRADEN SCALE & CHOICE OF WOUND PRODUCTS BY WARD NURSES

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INTRODUCTION & BACKGROUND

Pressure ulcer is known as one of the contributors to increased patient's length of stay, increased hospital cost & increased disability and suffering to patients. Accurate & timely assessment towards prevention is critical to avoid patient discomfort as a result of the presence of pressure ulcers. Some problems nurses face while using the old Braden Scale chart are:

1. Unable to remember risk indicators
2. Too wordy and lengthy
3. Difficult to understand
4. Time consuming

OBJECTIVES

- To improve the quality of patient's care
- To save time and improve nurses' knowledge in assessing patients using the Braden Scale criteria
- To increase nurses' knowledge in choosing the correct product for patient

METHODOLOGY

*To use as case notes divider (double sided)

PREDICTING PRESSURE ULCER RISK

SENSORY

1. Completely limited — Unresponsive OR limited ability to feel pain
2. Very Limited — Responds only to painful stimuli Eg: moaning/restlessness
3. Slightly Limited — Responds to verbal commands
4. No Impairment — No sensory deficit that limit ability to feel/voice pain/discomfort

MOISTURE

1. Constantly Moist — Dampness always present whenever patient is moved/turned (perspire/urine)
2. Very Moist — Linen must be changed x1/shift
3. Occasionally Moist — Linen changed approx. x1/day
4. Rarely Moist — Linen changed routinely

ACTIVITY

1. Bedfast — Confined to bed
2. Chairfast — Must be assisted into chair or w/c
3. Walks Occasionally — Able to walk short distances
4. Walks Frequently — Walk x2/day, once every 2hrs

MOBILITY

1. Completely Immobile — Unable to position w/o assistance
2. Very Limited — Makes occasional slight changes in positioning
3. Slightly Limited — Able to do frequent but slight repositioning independently
4. No Limitation — Able to make major and frequent positioning w/o assistance

NUTRITION

1. Very Poor — <1/2 share of food OR NBM and/or on clear fluids/IVs for >5 days
2. Probably Inadequate — Rarely eats a complete meal (=1/2 share) OR less than the ideal amount of clear fluids/NGT
3. Adequate — >1/2 share of food and takes supplements when offered
4. Excellent — Never refuses a meal/no supplement required.

FRICTION & SHEAR

1. Problem — Needs mod to max assist in moving, frequently slides down in bed/chair OR has spasticity/contractures
2. Potential Problem — Mostly good position in chair/bed BUT occasionally slides down.
3. No Apparent Problem — Maintains good position in bed/chair, move in bed and chair independently

STAGES OF PRESSURE ULCERS

STAGE 1

>Intact skin with **non-blanchable redness (erythema)** of a localized area, usually over **a bony prominence**

>Darkly pigmented skin that may not have visible blanching, **its colour may differ from the surrounding area**

STAGE 2

>**Partial thickness loss** of dermis presenting as a shallow open ulcer with a **red pink wound bed w/o slough**

>may present as **an intact OR open/ruptured** serum filled or blood filled blister

>**Shiny or dry** shallow ulcer **w/o slough or bruising.**

STAGE 3

>**Full thickness loss**, subcutaneous fat may be exposed but **NO** exposed bone, tendon or muscle

>Some slough, undermining and tunnelling **MAY** be present

STAGE 4

>**Full thickness loss WITH** exposed tendon, bone, muscle

>Slough/eschar **MAY** be present & often include undermining and tunnelling.

UNSTAGEABLE

>**Full thickness tissue loss** in which the **base of the ulcer is completely covered** by slough (yellow/tan/grey/green) and/or eschar (tan,brown,black)

DEEP TISSUE INJURY (DTI)

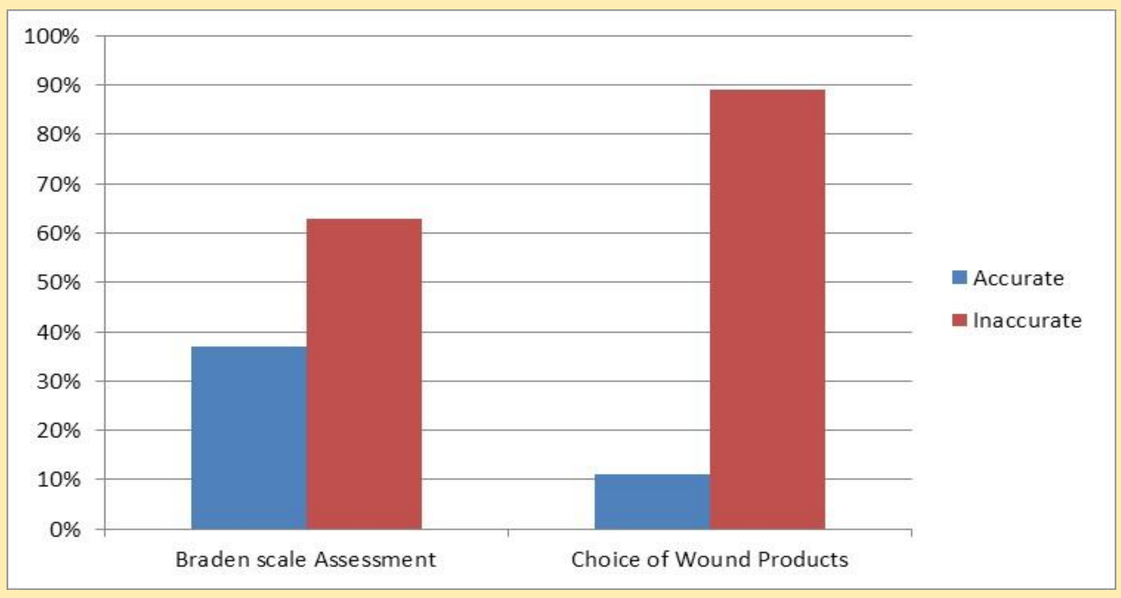
>**Purple or maroon** localized area of discoloured intact skin **OR** blood filled blister due to damage of underlying soft tissue.

>Area of tissue may be painful, firm, mushy, warmer/cooler as compared to adjacent tissue

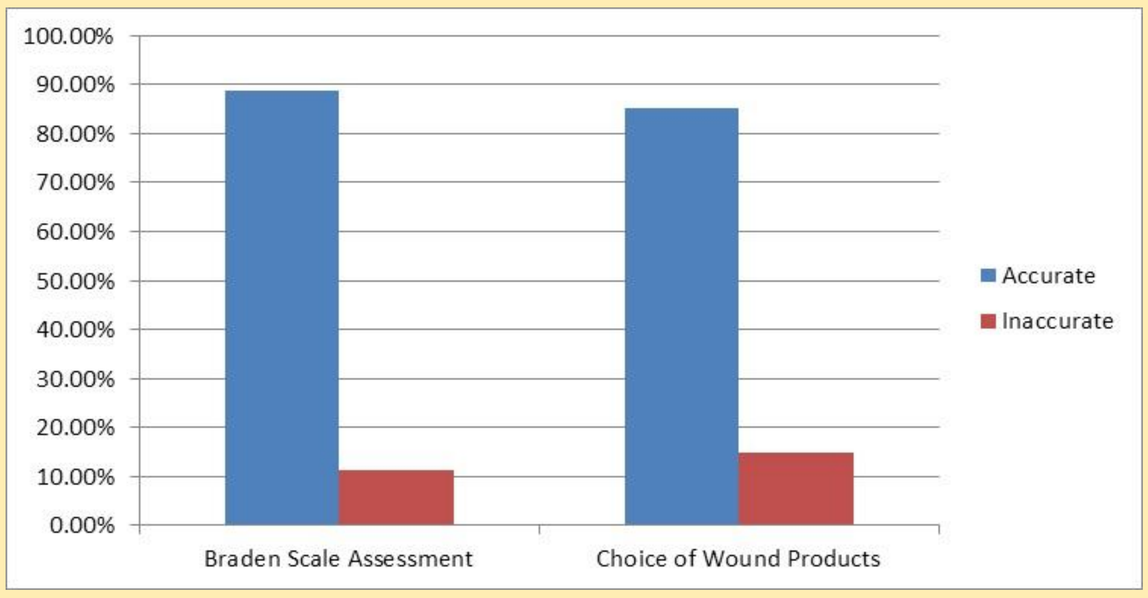
PRODUCTS/DEVICES
SANYRENE SPRAY
MEPILEX BORDER/FOAM
AIR MATTRESS
OFFLOAD
MEPILEX FOAM
MEPITEL ONE
URGOTUL
AQUCEL /MEPILEX AG
AQUACEL /MEPILEX FOAM
INADINE
KALTOSTAT
REFER WOUND NURSE
REFER WOUND NURSE
IODINE SOAKED GAUZE/INADINE
PURILON GEL, URGOTUL
MEPILEX/AQUACEL FOAM
MEPILEX/URGOTUL AG
OFFLOAD
SANYRENE SPRAY
MEPILEX FOAM

****REMEMBER! **Consent for photo-taking & PFER**

RESULT



PRE-SURVEY ASSESSMENT



POST SURVEY ASSESSMENT

CONCLUSION

By standardizing this project to the whole organization, it can contribute to an increased nurse's satisfaction and accuracy when using the Braden scale to assess for patients at risk for pressure ulcers. This can promote quality care for all our patients.