



**WOUND CARE:**  
ARE WE SPEAKING THE  
SAME LANGUAGE?



**WOUND PRACTICES AT  
UPLAND  
REHABILITATION &  
CARE CENTER**

NURSING HOME PERSPECTIVE



## Wound Measurement & Photo



•Right hip unstageable pressure ulcer site #1 **3.6 x 8.4 cm**

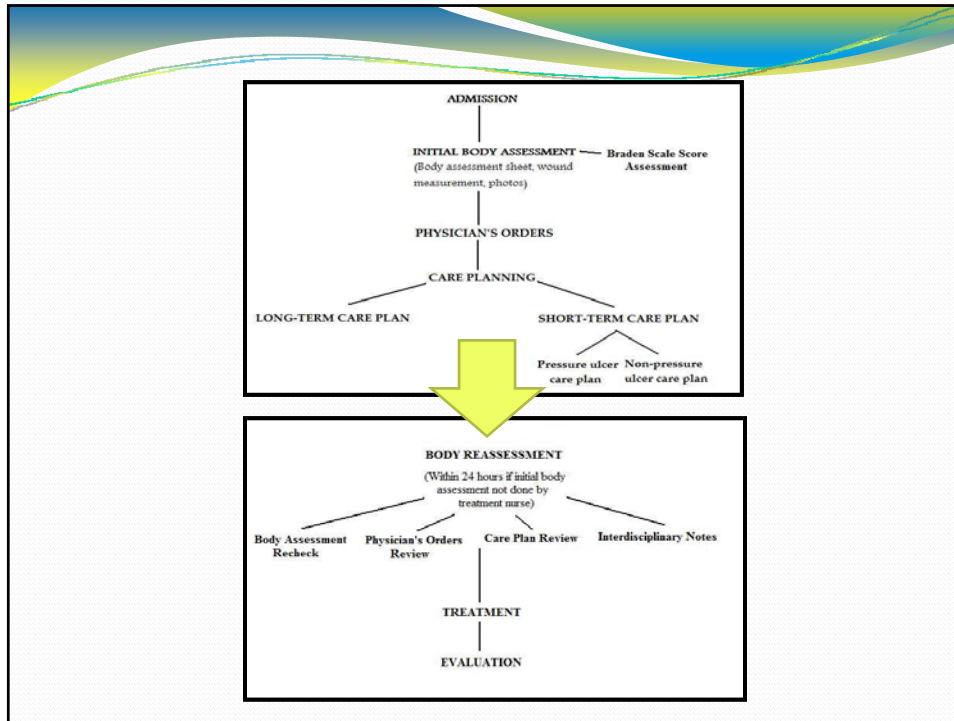
•Right hip unstageable pressure ulcer site #2 **1.3 x 1.3 cm**

## Braden Scale

BRADEN SCALE FOR PREDICTING PRELUDE SCORE RISK		ASSESSMENT DATE: 12/2/09			
RISK FACTOR	SCORE/DESCRIPTION	1	2	3	4
<b>SENSORY PERCEPTION</b> Ability to respond appropriately to pressure or other stimuli	1. COMPLETELY LOST: Unresponsive to pain, temperature, or other stimuli. 2. LIMITED: Responds to pain, temperature, or other stimuli, but not to light touch or vibration. 3. SOMEWHAT LIMITED: Responds to pain, temperature, or other stimuli, but not to light touch or vibration. 4. NO LIMITATION: Responds to pain, temperature, or other stimuli, and to light touch or vibration.	2	4	4	4
<b>MOISTURE</b> Degree to which skin is exposed to moisture	1. COMPLETELY WET: Skin is completely wet and moist. 2. APTLY WET: Skin is moist, but not completely wet. 3. OCCASIONALLY WET: Skin is moist, but not completely wet. 4. NEVER WET: Skin is never wet.	2	3	3	3
<b>ACTIVITY</b> Degree of physical activity	1. COMPLETELY BEDRIDDEN: Patient is completely bedridden. 2. SOMEWHAT BEDRIDDEN: Patient is somewhat bedridden. 3. MODERATELY ACTIVE: Patient is moderately active. 4. FULLY ACTIVE: Patient is fully active.	1	1	1	1
<b>MOBILITY</b> Ability to change and control body position	1. COMPLETELY IMMOBILE: Patient is completely immobile. 2. APTLY LIMITED: Patient is aptly limited. 3. MODERATELY LIMITED: Patient is moderately limited. 4. FULLY ACTIVE: Patient is fully active.	2	2	2	2
<b>NUTRITION</b> Amount and kind of food and fluid consumed	1. VERY POOR: Patient is very poor. 2. POOR: Patient is poor. 3. MODERATE: Patient is moderate. 4. EXCELLENT: Patient is excellent.	2	3	2	2
<b>FRICION AND SHEAR</b>	1. HIGH: High friction and shear. 2. MODERATE: Moderate friction and shear. 3. LOW: Low friction and shear.	1	1	1	1
<b>Total Score</b>	<b>VERY HIGH RISK: Total Score 9-12; HIGH RISK: Total Score 10-13; MODERATE RISK: Total Score 13-14; LOW RISK: Total Score 15-18</b>	2	4	3	1

- Sensory Perception
- Moisture
- Activity
- Mobility
- Nutrition
- Friction and Shear





## POST ADMISSION REASSESSMENT

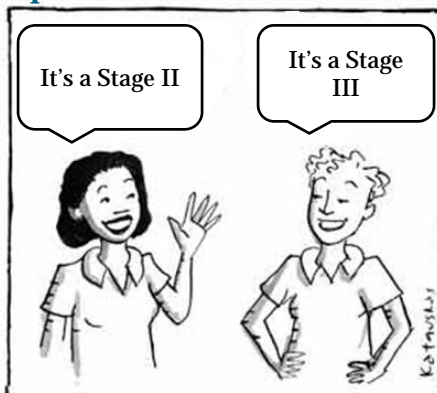
### First 24 hours

- Head to toe reassessment
- Evaluated: Current orders
- Re-clarify orders as needed
- Update care plan as needed
- Interdisciplinary notes

12/2/09 80 yo Caucasian female admitted on 12/1/09 2nd stage multiple sclerosis renal failure & fits the small bowel obstruction under care alternative hospice. Body assessment - rechecked notes E hip VTD pressure ulcer site #1 measuring 1.2 x 0.4cm (LW) I serosanguinous drainage; P hip VTD pressure ulcer site #2 superior to P hip pressure ulcer site #1 measuring 1.3 x 1.0cm (LW); O outer buttock stage II pressure ulcer measuring 1.1 x 0.8cm (LW) I low granulation tissue; W inner buttock stage II pressure ulcer measuring 0.5 x 0.5cm (LW); W buttock stage II pressure ulcer measuring 0.8 x 0.5cm (LW); W leg stage II pressure ulcer site #1 measuring 0.5 x 0.5cm (LW); C stage pressure ulcer stage I site #2 measuring 1.3 x 1.1cm (LW); C stage pressure ulcer stage I site #2 measuring 1.2 x 0.9cm (LW). All edema to bilateral & extensorities. P/C 10fr/sec & urine yellow & clear. C/d surgical team to do exploration. W inner heel threshold reflexes. D collaboration to P & C and been noted on nurse's admission record reclassified as echymosis to P & C and been noted on turn & repetition & limited cannot contain low air loss mattress. To do orders.

**Question?** Are we speaking the same language in URCC?

*Challenge:* Inconsistency between LVN initial admission assessment & the treatment nurse's 24 hr post admission assessment





**Transfer Communications Guidelines for Pressure Ulcers**

**S: Situation:**  
Patient Name \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

**B: Background:**  
Last Braden Score at Nursing Home: \_\_\_\_\_  
Additional pressure ulcer risk factors (list): \_\_\_\_\_  
Specialty bed or mattress type used at Nursing Home: \_\_\_\_\_

**A: Assessment:**

Location	Stage	Treatment

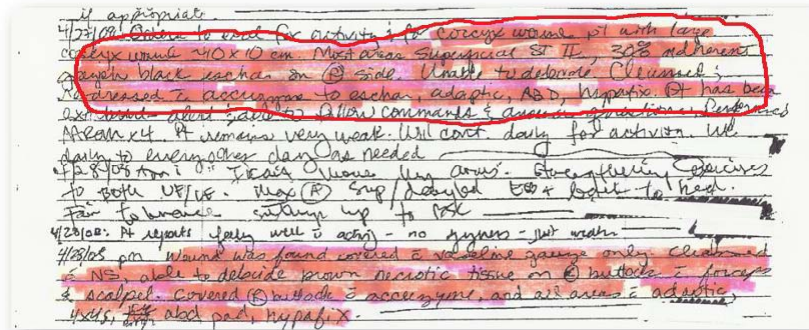
**R: Recommendations:**  
Wound Care Consult: CWOCN \_\_\_ Surgical \_\_\_ Podiatry \_\_\_  
Specialty Bed/Mattress: \_\_\_\_\_  
Other: \_\_\_\_\_

Source: Developed by Deborah Greener-Orr, PhD, RN. ♦

**ARE WE SPEAKING  
THE SAME  
LANGUAGE?**

# Case #1

This was an admission where in the transfer notes describe wound site as.....



This is a picture of the wound upon admission with us.





# ARE WE SPEAKING THE SAME LANGUAGE?

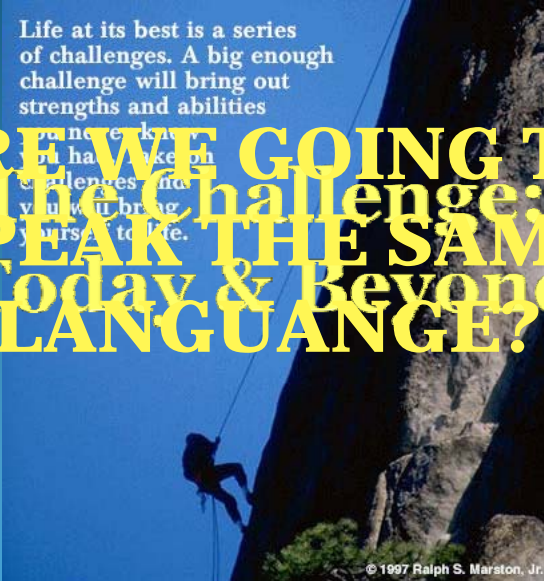
## Pre-admission Screening

- **Review of clinicals**
- **Wound notes – stage, measurements, & current treatments**
- **On-site visits**

Life at its best is a series of challenges. A big enough challenge will bring out strengths and abilities you never knew you had. Take on challenges and you will bring yourself to life.


# ARE WE GOING TO SPEAK THE SAME LANGUAGE?

*The Challenge:*



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Biele

"It's a message of hope."

