| Catholic Charities Disabilities Services | |
|---|---|
| **Agency Standard and Procedure** | |
| **Standard Category** | Residential |
| **Standard Title** | Wound Care |
| **Regulations** | |
| **Original Issue Date** | 07/12/2023 |
| **Latest Revision Date** | 01/18/2024<br>08/18/2026 |
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| **Attachments** | Braden Scale |
| **Approved by:**<br>Paula Warika, Executive Director | Paula Warika |

**Standard:**
Catholic Charities Disabilities Services will evaluate skin integrity risk using the Braden Scale forms on every individual that is at risk for skin breakdown. This includes individuals that have reduced ability to ambulate and/or turn themselves in bed and those that are completely unable to ambulate and/or turn themselves in bed.

Wounds are more prevalent of a concern when working with people with intellectual or developmental disabilities that are either wheelchair bound, or unable to express themselves verbally. This is also true with individuals with a secondary diagnosis of Diabetes. Wounds can lead to infection and decrease quality of life; and severe enough can lead to much more significant medical complications.

**Procedure**:

1. Every individual admitted to an OPWDD Certified Site that has reduced capacity or no capacity to ambulate and/or turn themselves in bed, will have a Skin Integrity Assessment upon admission and annually thereafter. This will consist of the Braden Scale Form that is appropriate for assessing the individuals we serve. This will be included in the individual's Life Plan, Plans of Nursing Services (PONS), Treatment and Hygiene documents, and Staff Action Plans as necessary.

2. All staff will be responsible for daily skin checks and report to the Program Nurse, Nursing Manager, or On-Call Nursing, any and all changes that are noted including approximate size, color and location of skin integrity concerns.

3. For any individual that develops a wound:
    a) The Program RN, or Nursing Manager will assess the wound within 24 hours of or next business day from report. The wound will be measured and staged and documented in Therap. Instructions for staff to care for the wound (stage 2 or lower) will be documented on the MAR and in Therap. The Program RN, or Nursing Manager will also document initial findings in Therap.
    b) Any individual that has a change in status will have an updated Plan of Nursing Services (PONS) to assist staff with knowing how to treat the wound.
    c) The Program RN, or Nursing Manager will then re-assess the wound at least weekly, including measure and stage, and document in Therap. This will continue until the wound is fully healed. If the wound does not improve within a month, or becomes

worse than a stage 2, or show signs or symptoms of infection, the individual will be sent to be seen by provider (either ER or PCP) immediately.

d) Any individual with a wound beyond stage 2, a licensed medical professional (RN, LPN, etc.) will treat the wound as order by provider.
e) All active wounds will be discussed at regularly scheduled Supportive Health Services Team meetings and documented in meeting notes.

# BRADEN SCALE – For Predicting Pressure Sore Risk

**SEVERE RISK**: Total score ≤ 9 **HIGH RISK**: Total score 10-12
**MODERATE RISK**: Total score 13-14 **MILD RISK**: Total score 15-18

| RISK FACTOR | SCORE/DESCRIPTION | | | | DATE OF ASSESS ➡ 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|---|---|---|
| **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 surface. | **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 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. **OFTEN 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 nonexistent. 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 the room at least twice a day and inside room at least once every 2 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 LIMITATIONS** – Makes major and frequent changes in position without assistance. | | | | |
| **NUTRITION** Usual food intake pattern<br>[1]NPO: Nothing by mouth.<br>[2]IV: Intravenously.<br>[3]TPN: Total parenteral nutrition. | **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 NPO[1] and/or maintained on clear liquids or IV[2] 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) each day. Occasionally refuses a meal, but will usually take a supplement if offered, **OR** is on a tube feeding or TPN[3] 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 AND 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 at all times. | | | | | |
| **TOTAL SCORE** | **Total score of 12 or less represents HIGH RISK** | | | | | | | |

| ASSESS | DATE | EVALUATOR SIGNATURE/TITLE | ASSESS. | DATE | EVALUATOR SIGNATURE/TITLE |
|---|---|---|---|---|---|
| 1 | / / | | 3 | / / | |
| 2 | / / | | 4 | / / | |

| NAME-Last | First | Middle | Attending Physician | Record No. | Room/Bed |
|---|---|---|---|---|---|
| | | | | | |

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**BRADEN SCALE**

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