# Wound Assessment Form (Complicating Clinical Factors)



**Facility:**

**Resident Name:**

**Health Care Insurance/Medicare:**

**Address:**

**Phone:**

**DOB:** _____/_____/_____

**Insurance/Medicare #**

**Braden Score:** **Braden Risk:**
**Advanced to next level of risk due other major risk factors:**
❑ **Yes** ❑ **No** **See page 2 Complicating Factors**

**Gender:** **M** **F**

**Physician Name**

**Date Wound ID'd:** [ ][ ][ ] ❑ New Wound
❑ Recurrence-Same etiology/same location
❑ Date of Last Recurrence:

**Etiology:**
❑ Pressure ❑ Venous
❑ Arterial ❑ Neuropathic
❑ Surgical ❑ Other:_____
Mixed (describe)_____

**Depth of Tissue Injury:**
**Non-PrU:** **PrU:**
❑ Partial ❑ Stg I ❑ Stg II ❑ Stg III ❑ Stg IV ❑ sDTI
❑ Full Thickness ❑ **Unstageable:** (check reason below)
❑ Non-removable dressing/device;
❑ Slough/eschar; ❑ Deep tissue injury

**LOCATION: (Describe anatomically: i.e. L-trochanter)**

**Measurements (cm)**
L _____cm W_____cm D_____cm
If utd, describe why:_____
Undermining or Tunneling (cm)
U / T _____cm @ _____o'clock
U / T _____cm @ _____o'clock

**Exudate**
Amount: ❑ None; ❑ Scant/Min; ❑ Mod; ❑ Hvy/Copious
Consistency: ❑ Serous
❑ Sanguineous/bleeding
❑ Serosanguineous
❑ Purulent
Odor*: ❑ None; ❑ Min.; ❑ Mod.; ❑ Strong/foul
**Assess after dressing removal & cleansing*

**Infection/Critical Colonization**
❑ None or n/a ❑ Yes, the following noted:
Localized s/s: Systemic s/s:
❑ **N**on-healing ❑ **S**ize↑
❑ **E**xudate↑ ❑ **T**emperature↑
❑ **R**ed-friable ❑ **O**steo (probes to bone)
❑ **D**ebris ❑ **N**ew breakdown
❑ **S**mell/Odor ❑ **E**xudate↑
❑ New onset of pain ❑ **E**rythema/Edema
❑ Pain > than expected ❑ **S**mell/Odor
❑ Culture: _____ ❑ Biopsy:_____
**Initiate localized or systemic Rx if 3 or more criteria noted per NERDS or STONEES lists.*

**Wound Bed**
Tissue Type/Color & percent
❑ Dermal Base (Pink/Red) *Partial or Stg II
❑ Granulation: _____%
❑ Pink, Red; Healthy
❑ Pale Pink/Red; hypogranular tissue
❑ Hypergranulation tissue
❑ Red, Friable (fragile/bleeds) and/or Dusky
❑ Necrotic: _____%
❑ Slough (white/yellow/gray)
❑ Eschar (intact/stable)
❑ Eschar (unstable/fluctuant/mushy/boggy)
❑ Other: (eg. tendon/muscle/bone)_____

**Wound Edges/Periwound**

**Wound Edges/Margins**
❑ Edge epithelializing
flush w/wound base
❑ Edge attached to base
❑ Edge not attached to base
❑ Well defined wound edges
❑ Irregular wound edges
❑ Epiboly/Rolled
❑ Hyperkeratotic (callous)
❑ Fibrotic, scarred
❑ Other

**Periwound Tissues**
❑ Intact/Uninvolved tissues
❑ Macerated
❑ Inflamed/Erythematic
❑ Indurated/Firm
❑ Fluctuance/Boggy tissue
❑ Excoriated/Denuded
❑ Deep red/purple hue (sDTI)
❑ Sclerotic tissue
❑ Other-eg weeping, dry, rash, blister

**Pain**
❑ None ❑ Yes: Intensity Rating (1-10)_____
Location: _____
Nature/Type Radiate/local_____
❑ Chronic wound pain
❑ Cyclical acute wound pain (eg. dressing change)
❑ Noncyclical wound pain (eg. debridement)
Frequency: _____
Local/systemic Rx? ❑ None
❑ Yes (Describe Rx)_____

**Wound Healing Status**
PuSH Score:_____
Clinically Presenting as:
❑ Acute *or* ❑ Chronic, *and:*
❑ Progressing well; as expected
❑ Stable wound bed maintained, per goal
❑ Plateau, stalled but healing expected
❑ ↑size noted s/p debridement activity
❑ ↑exudate noted s/p debridement activity
❑ ↑necrotic tissues as sDTI now declared
❑ Declining *(See Infection/Critical Colonization box)*

**Other related factors…**
❑ None
❑ Yes*-Clinically complicating factors noted
**Continue documentation onto pg 2 of wound assessment form. (Other considerations for tx.)*

**Noninvasive Vascular Tests for Lower Extremity**

**Pedal Pulses**:
❑ Dorsalis pedis: ❑ Present; ❑ Absent; ❑ Diminished; ❑ Bounding
❑ Posterior tibialis: ❑ Present; ❑ Absent; ❑ Diminished; ❑ Bounding

❑ Capillary Refill: ❑ < 3s; ❑ > 3s
❑ Rubor of Dependency: ❑ Negative; ❑ Positive
❑ Venous Filling Time Test: _____s

❑ ABI Screening Results: _____
❑ Other: _____
❑ N/A

**Wound Assessment - Evidence of wound improvement or deterioration includes measurable changes in the following:**

❑ ↓↑Drainage ❑ ↓↑Inflammation ❑ ↓↑Swelling/Edema ❑ ↓↑Pain/tenderness ❑ ↓↑Wound Size (LxWxD) ❑ ↓↑Size of Undermining/Tunneling
❑ ↓↑Granulation % ❑ ↓↑Necrotic %
❑ No improvement noted s/p 30 days; (NOTE: Consider new approach including MD reassessment of underlying infection, metabolic, nutritional, or vascular problems that may be inhibiting wound healing, or a new treatment approach including selection of dressing(s), dressing combination and/or FOC.

**Treatment Plan**

Debridement Type: ❑ n/a
❑ Autolytic ❑ Enzymatic
❑ Mechanical: (ex) wet-to dry _____
❑ Surgical ❑ Sharp ❑ Other_____

Topical Rx: ❑ None ❑ Yes, _____
Systemic Rx: ❑ None ❑ Yes, _____
Incontinence POC: ❑ n/a ❑ Yes
Pressure redistribution device: ❑ n/a ❑ Yes_____

Frequency: ❑ Daily ❑ 3X/wk
❑ 2X/day
❑ Other:_____

**Therapeutic Goals/Clinical Rationale**

**Dressing Change Protocol:**

**Referral Recommendations:**
❑ Vascular consult ❑ Nutrition consult;
❑ Infectious disease ❑ Psych/counseling-resident/family
❑ PT; ❑ OT; ❑ SLP; ❑ Other _____

**Other Interventions:**
❑ NPWT; ❑ E-stim; ❑ Other modalities/interventions:_____

# Wound Assessment Form (Complicating Clinical Factors)

| Resident Name: | |
|---|---|
| **Complicating Clinical Factors** | **Details - Identify variables/factors impacting resident's condition or ability to progress towards wound closure** |
| □ Age | □ > 65 years of age |
| □ Chronicity | □ Stage II or Partial Thickness Wound w/o evidence of expected healing by 1-2 weeks<br>□ Stage III, IV or Full Thickness Wound w/o expected reduction in size following 2-4 weeks of therapy |
| □ Cognitive status | □ Dementia □ Other Cognitive Impairment: |
| □ Comorbidities | □ Diabetes □ PAD □ ESRD □ Malignancy □ Anemia □ Other:<br>□ Thyroid Disease □ CHF □ Immune Deficiency Dx: |
| □ Incontinence | □ Urinary □ Fecal □ Both □ Other Condition (ie, Cdiff): |
| □ Location | □ Pelvic/sacral region; prone to urine/feces contamination; □ Atypical wound location<br>□ Difficult to dress location<br>□ At vulnerable pressure point (sacrum, heels, coccyx, trochanters, ischial tuberosity, occiput) |
| □ Medications | □ Rx affecting immune system, host defenses and/or skin integrity (Corticosteroids, immunosuppressives, sedatives, anticancer Rx, antiembolic/anticoagulant Rx)<br>□ Other: |
| □ Mobility Impairment/ Repositioning & increased risk for friction/shear | □ Impaired Mobility and/or decreased functional ability due to:<br>□ Condition(s) preventing repositioning/pressure redistribution (contractures, severe arthritis) |
| □ Sensory deficits/ neurosensory conditions | □ Reduced Braden Sensation Perception Score □ Neurological Disease/Condition: (ie Parkinson's disease, Peripheral Neuropathy, Spasticity, Multiple Sclerosis, CVA)<br>□ Other similar neurologic conditions: |
| □ Nutrition/hydration deficits | □ Presence of Malnutrition □ Presence of Dehydration □ Skin Turgor _____<br>□ Lab Values if available:<br>Albumin_____ Prealbumin_____; Creatinine_____; BUN_____ |
| □ Pain | □ Presence of wound related Pain □ Pain Rating/Intensity: Pain Type: □ Intermittent □ Constant |
| □ Poor Prognosis | □ Terminal Disease □ Systemic Infection □ Other: □ Maintenance Goal Appropriate to Implement |
| □ Psychosocial/ Behavioral Issues | □ Refusal of care and/or treatment □ Poor adherence to interventions □ Behavior r/t dementia, delirium or psychosis, **depression;** fear of falling |
| □ Skin-Integrity impairment | □ Advanced Age related skin changes □ Other skin condition or alterations (ie, dermatitis, skin tear, moisture associated skin damage): □ h/o wound at same location; Include Dates of Recurrences if known : |
| □ Vascular/ Cardiovascular condition | □ Impaired diffuse/systemic blood flow (Cardiovascular disease/condition, CHF, DM, general atherosclerosis):<br>□ Impaired localized blood flow (PVD: ie LE arterial/venous insufficiency, or edema)<br>□ Other: |
| □ Wound decline/ complications | □ h/o or currently presenting with Cellulitis or Osteomyelitis □ Other s/s of decline: |
| □ Other barriers to examination, healing, or altered tissue tolerance or integrity. | □ Non-removable dressing/device limits monitoring of wound status/progress<br>□ Identified at Mod or High Risk (Braden/Norton) □ ↑Bioburden/Critical Colonization □ Infection<br>□ Other unmodifiable factors that impair wound healing: |

| **Other Clinically Complicating Factors / Other Comments** | |
|---|---|
| | |

**Medical Professional's Signature:** _____ **Date:** _____

**Print Name and Title:** _____

**Physician's Signature:** _____ **NPI #:** _____

**Physician's Name (Print):** _____ **Phone:** _____

**Physicians Address:** _____ **Fax:** _____

# Protocols by Level of Risk

| | |
|---|---|
| **AT RISK (15-18)*** | **MANAGE MOISTURE** |
| **FREQUENT TURNING**<br>**MAXIMAL REMOBILIZATION**<br>**PROTECT HEELS**<br>**MANAGE MOISTURE, NUTRITION AND FRICTION AND SHEAR**<br>**PRESSURE-REDUCTION SUPPORT SURFACE IF**<br>**BED- OR CHAIR-BOUND**<br>*** If other major risk factors are present** ***(advanced age, fever, poor dietary intake of protein, diastolic pressure below 60, hemodynamic instability*****)**<br>**advance to next level of risk** | **USE COMMERCIAL MOISTURE BARRIER**<br>**USE ABSORBANT PADS OR DIAPERS THAT WICK & HOLD MOISTURE**<br>**ADDRESS CAUSE IF POSIBLE**<br>**OFFER BEDPAN/URINAL AND GLASS OF WATER IN CONJUNCTION WITH TURNING SCHEDULES** |
| **MODERATE RISK (13-14)*** | **MANAGE NUTRITION** |
| **TURNING SCHEDULE**<br>**USE FOAM WEDGES FOR 30! LATERAL POSITIONING**<br>**PRESSURE-REDUCTION SUPPORT SURFACE**<br>**MAXIMAL REMOBILIZATION**<br>**PROTECT HEELS**<br>**MANAGE MOISTURE, NUTRITION AND FRICTION AND SHEAR**<br>*** If other major risk factors present, advance to next level of risk** | **INCREASE PROTEIN INTAKE**<br>**INCREASE CALORIE INTAKE TO SPARE PROTEINS.**<br>**SUPPLEMENT WITH MULTI-VITAMIN (SHOULD HAVE VIT A, C & E)**<br>**ACT QUICKLY TO ALLEVIATE DEFICITS**<br>**CONSULT DIETITIAN** |
| **HIGH RISK (10-12)** | **MANAGE FRICTION & SHEAR** |
| **INCREASE FREQUENCY OF TURNING**<br>**SUPPLEMENT WITH SMALL SHIFTS**<br>**PRESSURE REDUCTION SUPPORT SURFACE**<br>**USE FOAM WEDGES FOR 30! LATERAL POSITIONIING**<br>**MAXIMAL REMOBILIZATION**<br>**PROTECT HEELS**<br>**MANAGE MOISTURE, NUTRITION AND FRICTION AND SHEAR** | **ELEVATE HOB NO MORE THAN 30!**<br>**USE TRAPEZE WHEN INDICATED**<br>**USE LIFT SHEET TO MOVE PATIENT**<br>**PROTECT ELBOWS & HEELS IF BEING EXPOSED TO FRICTION** |
| **VERY HIGH RISK (9 or below)** | **OTHER GENERAL CARE ISSUES** |
| **ALL OF THE ABOVE**<br>**+**<br>**USE PRESSURE-RELIEVING SURFACE IF PATIENT HAS INTRACTABLE PAIN**<br>**OR**<br>**SEVERE PAIN EXACERBATED BY TURNING**<br>**OR**<br>**ADDITIONAL RISK FACTORS**<br>***low air loss beds do not substitute for turning schedules** | **NO MASSAGE OF REDDENED BONY PROMINENCES**<br>**NO DO-NUT TYPE DEVICES**<br>**MAINTAIN GOOD HYDRATION**<br>**AVOID DRYING THE SKIN** |

# BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK

Patient's Name _____ Evaluator's Name_____ Date of Assessment

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **SENSORY PERCEPTION**<br><br>ability to respond meaningfully to pressure-related discomfort | **1. Completely Limited**<br>Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation.<br>OR<br>limited ability to feel pain over most of body | **2. Very Limited**<br>Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness<br>OR<br>has a sensory impairment which limits the ability to feel pain or discomfort over ½ of body. | **3. Slightly Limited**<br>Responds to verbal commands, but cannot always communicate discomfort or the need to be turned.<br>OR<br>has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities. | **4. No Impairment**<br>Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.. | | | | |
| **MOISTURE**<br><br>degree to which skin is exposed to moisture | **1. Constantly Moist**<br>Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned. | **2. Very Moist**<br>Skin is often, but not always moist. Linen must be changed at least once a shift. | **3. Occasionally Moist:**<br>Skin is occasionally moist, requiring an extra linen change approximately once a day. | **4. Rarely Moist**<br>Skin is usually dry, linen only requires changing at routine intervals. | | | | |
| **ACTIVITY**<br><br>degree of physical activity | **1. Bedfast**<br>Confined to bed. | **2. Chairfast**<br>Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair. | **3. Walks Occasionally**<br>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**<br>Walks outside room at least twice a day and inside room at least once every two hours during waking hours | | | | |
| **MOBILITY**<br><br>ability to change and control body position | **1. Completely Immobile**<br>Does not make even slight changes in body or extremity position without assistance | **2. Very Limited**<br>Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently. | **3. Slightly Limited**<br>Makes frequent though slight changes in body or extremity position independently. | **4. No Limitation**<br>Makes major and frequent changes in position without assistance. | | | | |
| **NUTRITION**<br><br><u>usual</u> food intake pattern | **1. Very Poor**<br>Never eats a complete meal. Rarely eats more than ⅓ 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<br>OR<br>is NPO and/or maintained on clear liquids or IV's for more than 5 days. | **2. Probably Inadequate**<br>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.<br>OR<br>receives less than optimum amount of liquid diet or tube feeding | **3. Adequate**<br>Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products per day. Occasionally will refuse a meal, but will usually take a supplement when offered<br>OR<br>is on a tube feeding or TPN regimen which probably meets most of nutritional needs | **4. Excellent**<br>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 & SHEAR** | **1. Problem**<br>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**<br>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**<br>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. | | | | | |
| | | | | Total Score | | | | |

# ALGORITHM FOR PREVENTION OF PRESSURE ULCERS: NUTRITION GUIDELINES†

## Trigger Condition:

- Unintended wt. loss ≥5% in 30 days; ≥10% in 180 days
- BMI[§]< 18.5 (weight (lb) / (height (in) x height (in)) x 703 **or** weight (kg) / (height (m) x height (m))
- Swallowing Problems/dysphagia
- Receiving enteral or parenteral nutrition
- Poor oral intake
- At risk of developing pressure ulcer (i.e., low score on Braden Scale[Δ])
- Immobility
- Infections (i.e., respiratory, urinary tract, gastrointestinal)
- Decline in ADLs (activities of daily living)
- Other selected conditions per facility

§ Body Mass Index

Δ Braden BJ & Bergstrom N. *Decubitus* 1989;2(3):44

**Refer to dietitian to Assess & Document: RD follows the Nutrition Care Process**

**At Nutrition Risk?**

**No**

**Monitor Status as needed or following a change in condition**

**Yes**

**Provide Nutrition Therapy**

**Re-assess & Document as needed**

## Dietitian Assessment:[1]

- Current weight/height
- Determine deviation from Usual Body Weight
- Body Mass Index (BMI)
- Interview for Food Preferences/Intolerances
- Determine nutritional needs
  1. Calories (30-35 kcal/kg body wt (BW)s
  2. Protein (1.25-1.5 g/kg)
  3. Fluid (1 mL fluid per calorie intake/d or minimum of 1500 mL/day or per medical condition)
- Compare nutrient intake with nutritional needs: assess adequacy
- Laboratory values (within 30 days)
  1. Serum protein levels may be affected by inflammation, renal function, hydration and other factors and do not reflect nutritional status
  2. Consider lab values as one aspect of the assessment process. Refer to facility policy for specific labs
- Risk factors for pressure ulcer development
  1. Medical history
  2. Validated risk assessment (i.e., Braden Scale)
  3. Malnutrition (use screening tool, e.g., Mini Nutritional Assessment (MNA® for ≥ 65 years located at www.mna-elderly.com)
  4. Medical Treatments
  5. Medications (review type of medications)
  6. Ability to meet nutritional needs orally (if inadequate, consider alternative method of feeding) consistent with individual's wishes
  7. Oral Problems (e.g. chewing, swallowing) EAT-10: A Swallowing Screening Tool available at Nestlé Nutrition Institute (www.nestlenutrition-institute.org)

## Considerations:

- Incorporate fortified foods at meals for weight gain
- Provide supplements between meals as needed
- Vary the type of supplements offered to prevent taste fatigue
- Provide preferred food/food substitutions
- At admission weigh weekly x 30 days and then monthly
- Monitor acceptance of food and/or supplements offered
- Monitor tolerance of oral nutritional supplements, e.g., diarrhea
- Provide a vitamin/mineral supplement, if intake is poor
- Provide assistance at meal time, if needed
- Encourage family involvement
- Offer food/fluid at appropriate texture for condition
- Liberalize restrictive diets
- Consult with Pharmacist and provide food and drugs at appropriate times and amounts
- Consider alternative method of feeding and if consistent with individual's wishes and goals of therapy:
  1. Provide tube feeding to meet needs per assessment
  2. Monitor tolerance, if needed recommend a specialty formula
  3. Provide parenteral nutrition when gut is non-functioning

[1] National Pressure Ulcer Advisory Panel and European Pressure Ulcer Advisory Panel. Prevention and treatment of pressure ulcers: clinical practice guideline. Washington DC: National Pressure Ulcer Advisory Panel; 2009.

†These are general guidelines based on various clinical references and are not intended as a substitute for medical advice or existing facility guidelines. An individual assessment is recommended.



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# ALGORITHM FOR TREATMENT OF PRESSURE ULCERS: NUTRITION GUIDELINES†

## Trigger Condition:

Medical records confirm presence of *Pressure Ulcer/s*

## Assess:[1]

- Caloric needs ..... 30-35 kcal/kg body wt (BW)
- Protein needs..... 1.25 g -1.5 g/kg BW
- Fluid needs..... 1 mL/kcal or minimum of 1500 mL/day (unless medically contraindicated)
- Evaluate current dietary intake
- Evaluate amount and quality of protein provided

**Document: RD follows the Nutrition Care Process (NCP)**

## Dietitian Assessment:[1]

- Current weight/height
- Determine deviation from Usual Body Weight
- Body Mass Index (BMI)
- Interview for Food Preferences/Intolerances
- Determine nutritional needs
- Laboratory values
  1. Serum protein levels may be affected by inflammation, renal function, hydration and other factors and do not reflect nutritional status
  2. Consider lab values as one aspect of the assessment process. Refer to facility policy for specific labs
- Risk factors for pressure ulcer development
  1. Medical history
  2. Validated risk assessment (i.e. Braden Scale)
  3. Malnutrition (screening tool i.e., Mini Nutritional Assessment (MNA® for >65 years located at www.mna-elderly.com)
  4. Medical treatments
  5. Medications (type of medications)
  6. Ability to meet nutritional needs orally (if inadequate, consider alternative method of feeding) consistent with individual's wishes
  7. Oral Problems (i.e. chewing, swallowing) EAT-10: A Swallowing Screening Tool, available at Nestlé Nutrition Institute (www.nestlenutrition-institute.org)

**Is Weight stable?**

No — Yes

## Document Plan for Fluid/Protein Intake

- Consider hydration pass between meals
- Provide preferred fluids with meds
- Protein supplements

**Poor intake; not a tube feeding candidate**

## Consult Prevention Plan plus

- é Calories, Protein & fluid
- MVI* to meet Dietary Recommended Intakes
- Fortified Foods
- Weekly weights

**Consider Oral Supplements**

**Document Plan: RD follows NCP**

*vitamin/mineral supplement

**See Considerations**

**Reassess as needed & document**

**Outcome**
If goal of therapy is complete healing, monitor with PUSH Tool.
Document as needed

**Poor intake; candidate for tube feeding**
Consistent with goals of therapy and individual's wishes

- Requires additional protein — Yes → Consider: High protein formula
- NO
- Poorly controlled diabetes — Yes → Consider: Lower carbohydrate formula
- NO
- Malabsorption — Yes → Consider: Peptide-based, high MCT formula
- NO
- Renal failure — Yes → Consider: Lower electrolyte formula

**Reassess weekly. Document:**
Formula tolerance; meeting 100% of estimated nutritional needs from TF formula and modular/s as needed

## Considerations:

- Incorporate fortified foods at meals for weight gain
- Provide supplements between meals as needed
- Vary the type of supplements offered to prevent taste fatigue
- Provide preferred food/food substitutions
- At admission weigh weekly x 30 days and then per policy
- Monitor acceptance of food and/or supplements offered
- Monitor tolerance of supplements, e.g. diarrhea
- Evaluate lab values when available
- Provide assistance at meal time if needed
- Encourage family involvement
- Offer food/fluid at appropriate texture for condition
- Liberalize restrictive diets
- Consult with pharmacist and provide food and drugs at appropriate times and amounts
- Consider alternative method of feeding and if consistent with individual's wishes and goals of therapy:
  — Provide parenteral nutrition for non-functioning GI tract

[1] National Pressure Ulcer Advisory Panel and European Pressure Ulcer Advisory Panel. Prevention and treatment of pressure ulcers: clinical practice guideline. Washington DC: National Pressure Ulcer Advisory Panel; 2009.

†These are general guidelines based on various clinical references and are not intended as a substitute for medical advice or existing facility guidelines. An individual assessment is recommended.



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