

Blueprint for Individual Risk Care Plans

I. Create and maintain awareness

- a. Education
- b. Place at a higher priority
- c. Easy to use visual reminders

II. Identify patients at risk

- a. Timely (1)
- b. Cumulative scale
- c. Specific risk factor at all levels of care (See chart, 2-3)

III. Skin and soft tissue evaluation

- a. Visual, palpation, temperature and sensation (4)
- b. Proper diagnosis if wound is present
 - i. Pressure ulcer
 - ii. Vascular
 - 1. Arterial
 - 2. Venous
 - iii. Neuropathic
 - iv. Trauma
 - v. Misc.

IV. Define and implement intervention consistent with patient's needs and goals based on medical standards of care

- a. Create an individualized care plan at first level of contact (5)
- b. Define goals and expectations
- c. Monitor care plan on a defined scheduled time frame (6)
- d. Modify care plan if no improvement occurs, risk factor changes in type or severity, conditions worsen and/or change in a clinical setting(7)
- e. Document in real time (8)

References

1. Pressure ulcers can develop in as little as 2-6 hours (Tag 314)
2. Each individual risk factor needs to be addressed (Tag 314, Discharge Planning Regulations)
3. Seamless Continuum of Care (Discharge Planning)
4. Recognition of deep tissue injury (Tag 314, NPUAP white paper, literature)
5. Pressure ulcer protocols need to address all levels of care, on all surfaces and by all caregivers in a seamless fashion. (Discharge Planning).
6. Monitor care plane on a scheduled basis (Tag 314, Discharge Planning Regulations)
7. Modify care plan if needed. (Tag 314, Discharge Planning Regulations, Standards of Care)
8. Medical records are legal documents.