Australian Government
National Health and Medical Research Council

NHMRC

NHMRC Centre of Research Excellence (CRE) in Wiser Wound Care

2021 – 2025
$2.5 million

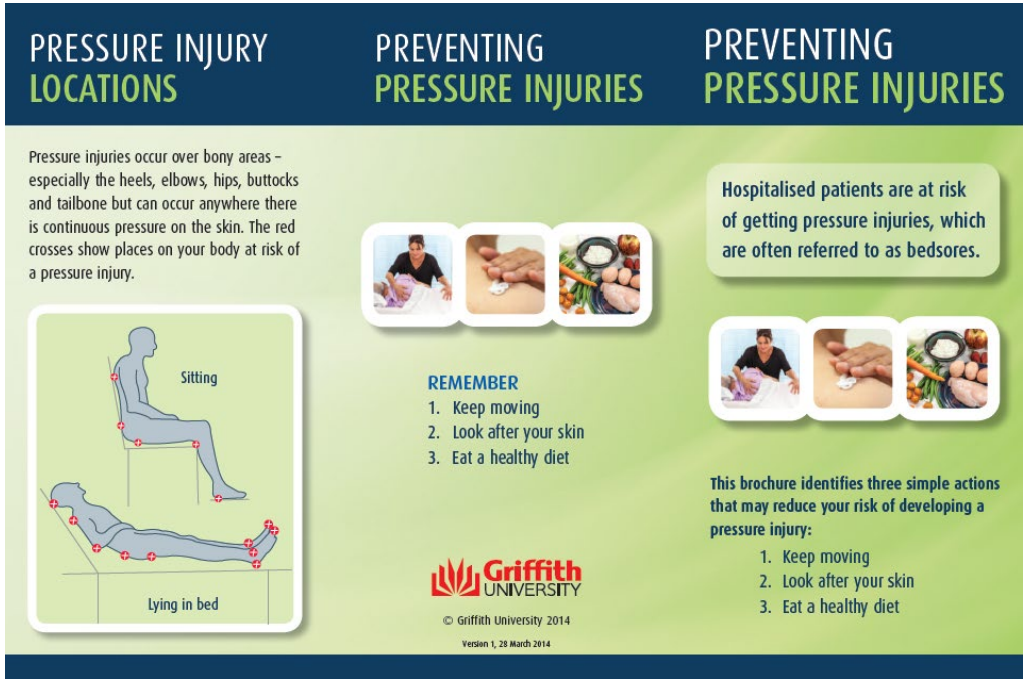
Griffith UNIVERSITY
Queensland, Australia

New Clinical Tools Developed (n=9)

- Pressure Injury Prevention Toolkit (DVD, poster and brochure in 8 languages) (Professor Wendy Chaboyer)
- Perioperative Perceived Competence Scale-Short Form (Professor Brigid Gillespie)
- Perioperative Perceived Competence Scale-Revised (in 8 languages) (Professor Brigid Gillespie)
- End-of-life Wound Assessment Tool (Dr Sharon Latimer)
- Surgical Wounds and Patient Participation Questionnaire (SWAPP-Q) (in English, Dutch & Swedish) (Georgia Tobiano)
- Translation and Testing of an ICU PI Risk Assessment Tool (in English, Spanish, Chinese & Turkish) (Dr Josie Lovegrove)
- I-DECIDED intravascular device assessment and decision tool (Professor Claire Rickard)
- IV Passport (Professor Amanda Ullman)
- miniMAGIC (Professor Amanda Ullman)

Pressure Injury Prevention Toolkit (DVD, poster and brochure in 8 languages) (Professor Wendy Chaboyer)

[Tool access link]



Griffith UNIVERSITY
Queensland, Australia

Perioperative Perceived Competence Scale-Revised (in 8 languages) (Professor Brigid Gillespie)

[Access link]

Perceived Perioperative Competence Scale

Revised

Perioperative Perceived Competence Scale-Short Form (Professor Brigid Gillespie)

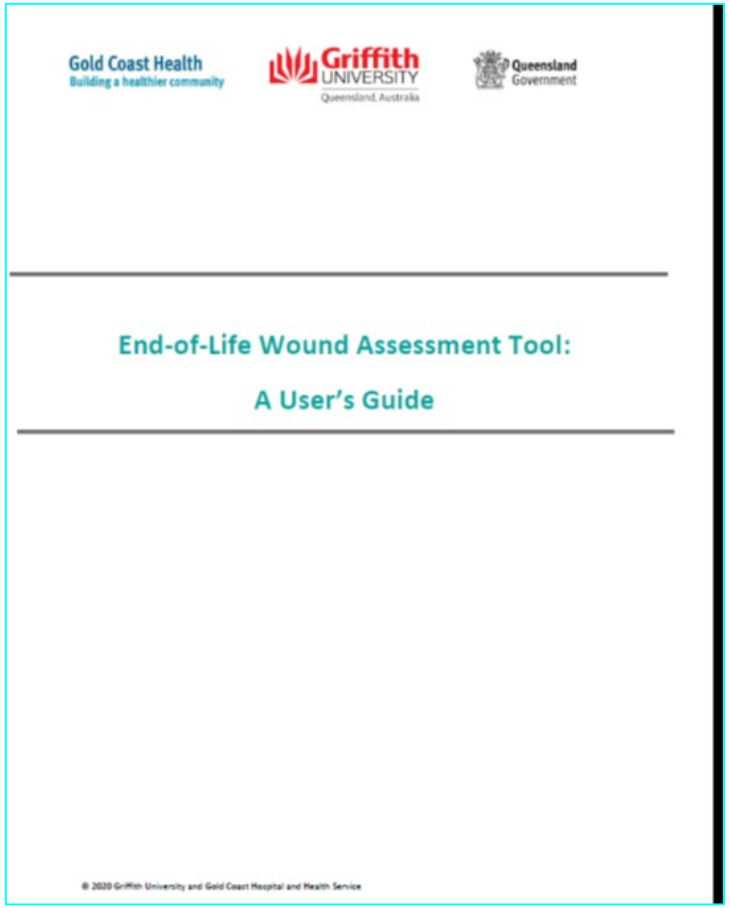
[Access link]

Perceived Perioperative Competence Scale

Short Form

End-of-life Wound Assessment Tool (Dr Sharon Latimer)

More information link (to access the tool, please contact Dr Latimer via email to: s.latimer@griffith.edu.au)



END-OF-LIFE WOUND ASSESSMENT TOOL

Patient Identification:

END-OF-LIFE WOUND DEFINITION: a sudden unavoidable skin injury that rapidly develops in some dying individuals. These include Skin Changes at Life's End (SCALE), Kennedy terminal ulcer and Trombley-Brennan terminal tissue injury.

Instructions:

Use this assessment tool if you suspect the skin injury is an end-of-life wound and *NOT* a pressure injury.

Section 1: SCREENING	**Yes**	**No**
1. Patient has been assessed by healthcare professional/s as ***dying or actively dying?*** 'Actively dying' or 'dying' is "the terminal phase of life, where death is imminent and likely to occur" in the following days, weeks, or months.		
2. Patient has been receiving *regular pressure injury prevention strategies (e.g. regular repositioning, support surfaces, nutrition, wheelchair cushions)?* 'Regular repositioning' is defined as patient body position changes (e.g. 1-4 hourly) as determined by healthcare professional/s in collaboration with the patient/family.		
3. Patient has ***suddenly developed*** skin discolouration / injury / blister in the previous 24 hours of this assessment?		

Proceed to Section 2 if you answer **'Yes' to ALL THREE** screening questions

Section 2: ASSESSMENT			
Wound characteristics	**Wound descriptors**	**Yes**	**No**
Location/s	Coccyx, sacrum or buttock (unilateral or bilateral), leg, heel, arm, shoulder, thoracic and lumbar spine or other body locations		
Appearance (any combination)	• Bruise-like appearance (skin intact) • *Similar to Stage II-IV pressure injury (skin not intact)		
Shape/s	Pear, horseshoe, butterfly shape, linear striations, or other shapes		
Colour (any combination)	Red, yellow or black. Deep darkening of the tissue (for dark skin tone individuals). Non-blanchable pink, purple or maroon. May have a white centre.		
Speed of change	Sudden and rapid development with increase in size of skin discolouration / injury / blister in the previous 24 hours of this assessment.		

Complete Section 3 if you answer **'Yes' to TWO OR MORE** assessment questions

Section 3: CONFIRMATION and MANAGEMENT

In your assessment, is this an end-of-life wound? (circle one): **Yes** **No***

End-of-life wound management plan developed? (circle one): **Yes*** **No***

Consider:
1. Wound: manage wound infection, pain, odour, exudate
2. Patient and family involvement in care and education (wound management and end-of-life care)
3. Quality of life and psychosocial support
4. Clinical specialist referral
5. Documentation as per facility requirements

Completed by: Name: _____ Signature: _____

Date: _____ Time: _____

* refer to European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel, and Pan Pacific Pressure Injury Alliance, *Prevention and treatment of pressure ulcers/injuries: Clinical practice guideline*, in *The International Guideline*, E. Hasler, Editor. 2019, EPUAP/NPIAP/PPPIA. p. 1-408.

Surgical Wounds and Patient Participation Questionnaire (SWAPP-Q) (in English, Dutch & Swedish) (Dr Georgia Tobiano)

Access link

SURGICAL PATIENT SURVEY

Translation and Testing of an ICU PI Risk Assessment Tool (Dr Josie Lovegrove)

[Access link]

The COMHON Index (RASS = Richmond Agitation Sedation Scale)

Please circle the most appropriate sections of the chart below:

Score	Level of consciousness	Mobility	Haemodynamic	Oxygenation	Nutrition
1	Awake and alert (RASS 0, + 1) (Glasgow 15)	Independent, walking with help	No haemodynamic support	Spontaneous breathing and FiO_2 < 0.4	Full oral diet
2	Agitated, restless, confused (RASS > 1) (Glasgow 13 - 14)	Limited, bed-chair activity	Volume expanders	Spontaneous breathing and FiO_2 ≥ 0.4	Enteral or parenteral feeding
3	Sedated but responsive (RASS -1 to -3) (Glasgow 9 - 12)	Very limited but tolerates position change	Dopamine or norepinephrine or adrenaline. Mechanical support	Non-invasive mechanical ventilation	Oral fluids. Incomplete oral feeding
4	Coma, sedated and unresponsive (RASS < -3) (Glasgow < 9)	Unable to change position; lying prone	Needing two of the above	Invasive mechanical ventilation	No feeding

LOW RISK: 5-9, MODERATE RISK: 10-13, HIGH RISK: 14-20

TOTAL PATIENT SCORE = ☐ **RISK LEVEL =** ☐

SUBSCALE DEFINITIONS

Level of consciousness

1. ***Awake and alert: RASS 0 to + 1***
   The patient is conscious and orientated to time and space, obeys commands and recognises and responds to any stimulus in their environment. Glasgow Coma Score 15.
2. ***Agitated/restless/confused: RASS > 1***
   The patient is aware but is partially or intermittently disorientated to time and/or space and responds inadequately to stimuli. Glasgow Coma Score 13 to 14.
3. ***Sedated but responsive: RASS -1 to -3***
   The patient has a Glasgow Coma Score of 9 to 12 or is sedated with RASS -1 to -3.
4. ***Coma, sedated and unresponsive: RASS -4 to -5***
   The patient is comatose with Glasgow Coma Score < 9 or sedated with RASS -4 to -5.

Mobility

1. ***Independent/walking with help***
   The patient walks alone or needs a support system to maintain balance.
2. ***Limited/bed-armchair activity***
   The patient is in bed and can move on their own. The patient has alternating periods of bed rest with periods of rest in a chair. The patient can stand up with or without assistance.
3. ***Very limited but tolerates change in position***
   The patient is in bed and cannot move without assistance but can be moved without affecting haemodynamic or respiratory status.
4. ***Unable to change position or lying prone***
   The patient is in bed and must not be moved due to haemodynamic or respiratory instability or the patient is lying in the prone position.

Haemodynamic

1. ***No haemodynamic support***
   The patient does not require vasopressor drugs or plasma expanders or mechanical haemodynamic support (e.g. intra-aortic balloon pump).
2. ***Volume expanders***
   The patient requires use of blood products, colloid or crystalloid to maintain haemodynamic status.
3. ***Dopamine or norepinephrine or adrenaline or cardiopulmonary mechanical support***
   The patient requires one or more of the above drugs by continuous infusion or cardiopulmonary mechanical assistance e.g. intra-aortic balloon pump, extra-corporeal membrane oxygenation, ventricular assist device, to maintain haemodynamic stability.
4. ***Needing two of the above***
   The patient requires two or more of the above supports to maintain haemodynamic stability.

Oxygenation

1. ***Spontaneous breathing and low FiO_2 (< .4)***
   The patient is breathing by themself and requires no extra oxygen or less then 40%.
2. ***Spontaneous breathing and high FiO_2 (≥ .4)***
   The patient is breathing by themself and requires supplementary oxygen greater than 40%.
3. ***Non-invasive mechanical ventilation***
   The patient requires non-invasive mechanical ventilation.
4. ***Invasive mechanical ventilation***
   The patient requires invasive mechanical ventilation.

Nutrition

1. ***Full oral diet***
   The patient tolerates liquids and solids and is eating enough food to meet their needs.
2. ***Enteral nutrition / parenteral feeding***
   The patient is being fed with parenteral nutrition, enteral nutrition or both and may also be partially eating orally or not eating at all.
3. ***Oral fluids. Incomplete oral feeding***
   The patient has an inadequate or reduced diet that does not meet their needs and is not being enterally or parentally fed.
4. ***No feeding***
   The patient is not being fed at all.

Version 2.1, 2021

Yoğun Bakıma Özgü Basınç Yaralanması Risk Değerlendirme (COMHON) Aracı
(RASS = Richmond Ajitasyon Sedasyon Skalası)

Lütfen aşağıdaki tabloda en uygun bölümleri daire içine alınız:

Puan	Bilinç Düzeyi	Hareketlilik	Hemodinamik	Oksijenizasyon	Beslenme
1	Uyanık ve alert (RASS 0, + 1) (Glasgow 15)	Bağımsız, yardımla yürür	Hemodinamik destek yok	Spontan solunum ve FiO2 < 0,4	Tam oral beslenme
2	Ajite, huzursuz, konfüze (RASS > 1) (Glasgow 13 - 14)	Sınırlı, yatak-sandalye aktivitesi	Volüm genişleticiler	Spontan solunum ve FiO2 ≥0.4	Enteral veya parenteral beslenme
3	Sedatize ancak tepkili (RASS -1 ila -3) (Glasgow 9 - 12)	Çok sınırlı ancak pozisyon değişikliğini tolere eder	Dopamin veya norepinefrin veya adrenalin. Mekanik ventilasyon	Non-invaziv Mekanik ventilasyon	Oral sıvı alımı. Oral beslenmede yetersizlik
4	Koma, sedatize ve tepkisiz (RASS < -3) (Glasgow < 9)	Pozisyon değiştirmez; prone pozisyonda yatar	Yukarıdakilerden ikisine ihtiyaç duyar	İnvaziv mekanik ventilasyon	Beslenme yok

Düşük Risk: 5-9, Orta Risk: 10-13, Yüksek Risk: 14-20

TOPLAM HASTA PUANI: ☐ **RİSK DÜZEYİ:** ☐

ALT ÖLÇEK TANIMLARI

BİLİNÇ DÜZEYİ

1. Uyanık ve alert: RASS 0 ila + 1
Hastanın bilinci açık, zaman ve yer oryantasyonu vardır, komutlara uyar ve çevresindeki herhangi bir uyaranı tanır ve yanıt verir. Glasgow Koma Skoru 15.

2. Ajite/ huzursuz/ konfüze: RASS> 1
Hasta farkındadır ancak kısmen ya da aralıklı olarak zaman ve/veya yere disoryantasyontedir ve uyaranlara yetersiz yanıt verir. Glasgow Koma Skoru 13-14.

3. Sedatize ancak tepkili: RASS -1 ila -3
Hastanın Glasgow Koma Skoru 9-12'dir veya RASS -1 ila -3 ile sedatize edilmiştir.

3. Koma, sedatize ve tepkisiz: RASS - 4 ila -5
Hasta Glasgow Koma Skoru <9 komada veya RASS -4 ila -5 ile sedatize.

HAREKETLİLİK

1. Bağımsız/yardımla yürür
Hasta tek başına yürür veya dengesini korumak için bir destek sistemine ihtiyaç duyar.

2. Sınırlı/yatak-sandalye aktivitesi
Hasta yataktadır ve kendi başına hareket edebilir. Hasta, dönüşümlü olarak yatak ve sandalyede dinlenme sürelerine sahiptir. Hasta yardımlı veya yardımsız ayağa kalkabilir.

3. Çok sınırlı ancak pozisyon değişikliğini tolere eder
Hasta yataktadır ve yardım olmadan hareket edemez ancak hemodinamik veya solunum durumunu etkilemeden hareket ettirilebilir.

4. Pozisyon değiştirmez veya prone pozisyonda yatar
Hasta yataktadır ve hemodinamik veya solunumsal dengesizlik nedeniyle hareket ettirilmez veya hasta prone pozisyonda yatar.

HEMODİNAMİK

1. Hemodinamik destek yok
Hastanın vazopressör ilaçlara /plazma genişleticilere /mekanik hemodinamik desteğe (örn. intraaortik balon pompası) ihtiyacı yoktur.

2. Volüm genişleticiler
Hastanın hemodinamik durumunu korumak için kan ürünleri, kolloid veya kristalloid kullanılması gerekir.

3. Dopamin veya norepinefrin veya adrenalin veya kardiyopulmoner mekanik destek
Hasta, hemodinamik dengeyi korumak için sürekli infüzyon veya kardiyopulmoner mekanik destek (örn. intra-aortik balon pompası, ekstra-korporeal membran oksijenasyonu, ventriküler destek cihazı) yoluyla yukarıdaki ilaçlardan bir veya daha fazlasına ihtiyaç duyar.

4. Yukarıdakilerden ikisine ihtiyaç duyar
Hasta hemodinamik dengeyi korumak için yukarıdaki desteklerden iki veya daha fazlasına ihtiyaç duyar.

OKSİJENİZASYON

1. Spontan solunum ve düşük FiO2 (< .4)
Hasta kendi kendine nefes alır ve fazladan oksijene ihtiyaç duymaz veya %40'tan az ihtiyaç duyar.

2. Spontan solunum ve yüksek FiO2 (≥.4)
Hasta kendi kendine nefes alır ve %40'tan daha fazla ek oksijene ihtiyaç duyar.

3. Non-invaziv mekanik ventilasyon
Hasta non-invaziv mekanik ventilasyona ihtiyaç duyar.

4. İnvaziv mekanik ventilasyon
Hasta invaziv mekanik ventilasyona ihtiyaç duyar.

BESLENME

1. Tam oral beslenme
Hasta katı ve sıvı gıdaları tolere eder ve ihtiyaçlarını karşılayacak kadar yemek yer.

2. Enteral besleme / parenteral beslenme
Hasta parenteral beslenme, enteral beslenme veya her ikisi ile beslenir ve ayrıca kısmen ağızdan alabilir veya hiç alamaz.

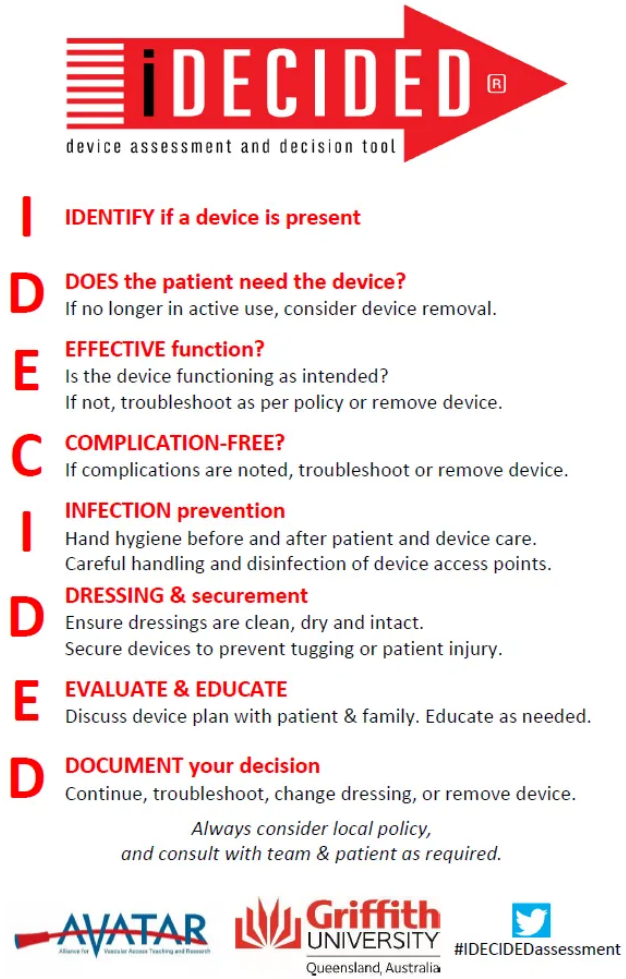
3. Oral sıvı alımı. Oral beslenmede yetersizlik
Hasta, ihtiyaçlarını karşılamayan yetersiz veya azaltılmış bir diyete sahiptir ve enteral veya parenteral olarak beslenmez.

4. Beslenme yok
Hasta hiç beslenmez.

Griffith UNIVERSITY
Queensland, Australia

I-DECIDED Intravascular Device Assessment and Decision Tool (in numerous languages)(Professor Claire Rickard)

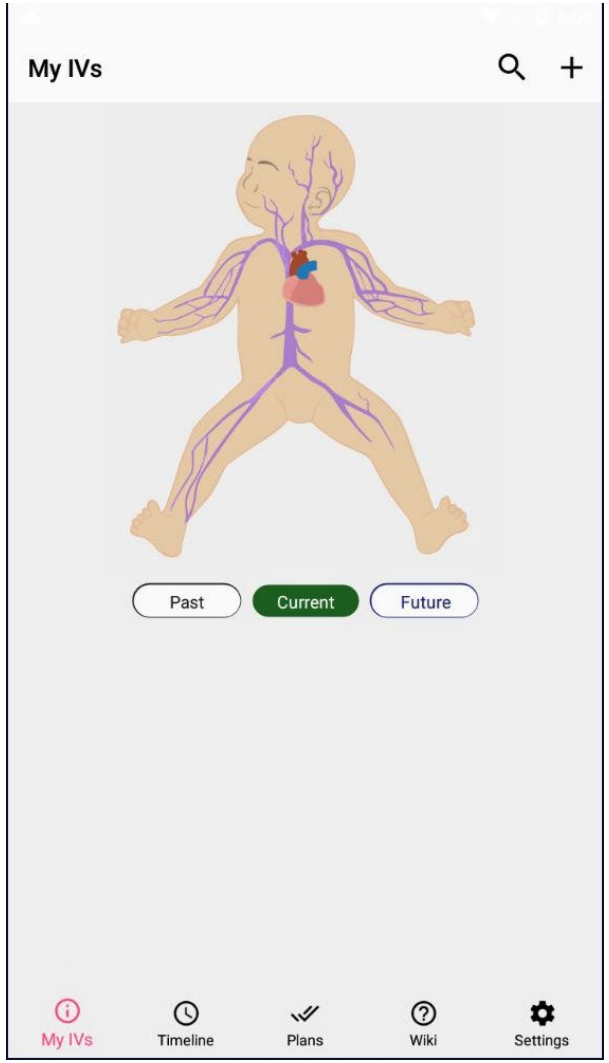
https://www.avatargroup.org.au/i-decided.html



Griffith UNIVERSITY
Queensland, Australia

IV Passport (Professor Amanda Ullman)

https://www.avatargroup.org.au/iv-passport.html



miniMAGIC (Professor Amanda Ullman)

https://www.avatargroup.org.au/minimagic.html

Griffith UNIVERSITY
Queensland, Australia