Daily Bedside Screens: Skin, Falls, Swallow and Withdrawal

Pressure injury risk, fall risk, the post-extubation swallow screen and CIWA-Ar, and what to do with each result

ICU Basics
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WHAT YOU WILL DO

- Score pressure injury risk and fall risk on admission and at the interval your unit sets, and again after any big change (surgery, new sedation, new delirium).
- Check the skin head to toe, including under every device.
- Screen swallowing before anything goes by mouth after extubation, even pills or ice chips.
- Screen every admission for alcohol withdrawal risk; score withdrawal when ordered.
- Turn each result into actions, chart them and hand them off. A score with no plan helps no one.

SKIN: PRESSURE INJURY RISK

The Braden Scale is the common tool. It scores six areas: how well the patient senses and responds to pressure discomfort, skin moisture, activity, ability to change position, nutrition, and friction and shear. Totals run 6 to 23; lower means higher risk.

The score adds to judgment. Low perfusion, vasopressors, edema and long cases raise risk in the ICU even with a fair score.

TOTAL	RISK
19 to 23	Not at risk by score
15 to 18	Mild
13 to 14	Moderate
10 to 12	High
9 or less	Very high

- Prevention (NPIAP 2019): turn on a plan, 30° side tilt, small shifts if unstable; float heels; head of bed as low as allowed; pressure-redistributing surface; silicone foam dressing on sacrum and heels if at risk; prompt incontinence care; nutrition consult.
- Devices (ETT, NG, NIV mask, collar, SpO_2 probe, tubing): pad, move or rotate, and look under them every shift, more often with edema.
- Staging and wound care: see Pressure Injury Staging and Wound Care.

FALLS: MORSE FALL SCALE

Six items: a recent fall, a second diagnosis, use of a walking aid or furniture, an IV or saline lock, gait, and whether the patient forgets their limits. Totals run 0 to 125. Common bands: 0 to 24 low, 25 to 44 moderate, 45 or more high.

- ICU risks the score misses: delirium, sedatives and opioids, ICU-acquired weakness, low BP on standing, diuretics and urgency, lines and tubes, and the first time up.
- Actions: bed low and locked, alarm on per policy, call light and urinal in reach, toileting plan, nonslip socks, gait belt and enough staff for the first mobility session.

SWALLOW: AFTER EXTUBATION

1. Hold the screen and call SLP if the patient cannot stay alert, must stay below 30°, has a tracheostomy tube, or was on a modified diet for dysphagia before admission.
2. Sit upright, 80 to 90° or as high as allowed.
3. Yale screen: the patient drinks 3 oz (90 mL) of water from a cup or straw without stopping.
4. Pass: drinks it all with no cough or choke during or right after. Diet per protocol.
5. Fail: cannot finish, stops, or coughs or chokes. Keep NPO (meds by another route), tell the provider, refer to SLP; rescreen in 24 h or instrumental test per SLP.

Aspiration precautions: fully upright to eat, small sips, supervise early meals, oral care. Stop and report coughing at meals, a wet voice, new fever or falling SpO_2.

ALCOHOL WITHDRAWAL: CIWA-AR

Ten items: nausea or vomiting, tremor, sweats, anxiety, agitation, touch, hearing and visual disturbances, headache, and orientation. Maximum 67. Score it when the patient can talk with you; protocols give medication by score (symptom-triggered).

CIWA-AR	SEVERITY (ASAM 2020)
Under 10	Mild; many protocols start dosing at 8 or 10
10 to 18	Moderate
19 or more	Severe; close monitoring

SAFETY CIWA-Ar depends on the patient's answers. It is not valid if they are intubated, deeply sedated or delirious. Use your unit's alternative (for example RASS with CAM-ICU, the Minnesota Detoxification Scale, or a phenobarbital protocol).

Give thiamine as ordered; ASAM 2020 says thiamine and glucose can go in any order, so never hold glucose for a low sugar.

CALL FOR HELP WHEN

- Any new pressure injury, a purple or maroon area, or skin damage under a device.
- Any fall, even without injury; a head strike or anticoagulant needs urgent review.
- A failed swallow screen, or coughing, a wet voice, fever or hypoxia after eating.
- CIWA-Ar 19 or more or rising despite doses, a seizure, hallucinations, new confusion, rising HR or BP, or doses climbing fast.
- RASS –3 or deeper or slow breathing after withdrawal doses.

CHECK YOUR UNIT'S POLICY

Check your unit's policy for which risk tools it uses and how often, bed alarm and sitter rules, who may do the swallow screen and how long to wait after extubation, and the withdrawal protocol, its dosing thresholds and its scale for patients who cannot talk.

Sources (12) are listed with links at icubasics.com/sheets/bedside-screens.html. For education and exam preparation only. Not medical advice; follow current guidelines and your institution's protocols. ICU Basics is an independent study aid not affiliated with any certifying body.