

BEEBE HEALTHCARE

Patient Care Manual

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| Skin Care: Pressure Injury Prevention & Treatment Plan | Date Issued: |
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PURPOSE

To provide guidelines for:

- Identification of patients at risk for development of pressure injuries
- Identification of interventions needed for prevention and treatment of pressure injuries

Goals:

- Initiate early prevention and treatment interventions.
- Maintain and/or improve tissue tolerance to prevent injury.
- Protect against the adverse effects of pressure, shear, friction, and moisture.
- Reduce the incidence of hospital-acquired pressure injuries.

SCOPE

The Registered Nurse (RN) is competent to perform pressure injury prevention and treatment. The RN may delegate care as appropriate to competent staff members. All members of the health care team must notify the primary RN of skin changes and/or breakdown.

PRESSURE INJURY PREVENTION PLAN

POLICY

1. The RN is responsible to complete a physical assessment daily on every patient upon admission, when there is a significant change in the patient’s status, or as per unit standard.
2. As part of the physical assessment, the RN is responsible for a complete head to toe skin assessment and completion of the Braden Scale. The skin and Braden assessment should be completed upon admission (within 4 hours of arrival to the patient care unit), every 12 hours (including day of discharge), and when there is a significant change in status.

3. The RN shall determine the patient's risk for development of pressure injuries using the Braden Risk Scale and additional risk factors listed below and implement interventions as per the numeric Braden score obtained.
4. All patients shall receive pressure injury prevention interventions based on the Braden Assessment Score and head to toe assessment.
5. All direct patient care givers are responsible for visually inspecting skin integrity during the provision of care and are expected to report and document any significant findings to the RN or physician.
6. The RN will initiate an interdisciplinary plan of care based on the individual needs of the patient and will communicate the plan of care with the patient care team.
7. It is the responsibility of the RN to implement, document, and evaluate the planned interventions. The RN will review the plan daily and update as needed.

A Braden Risk Assessment will be performed on all patients upon admission (within 4 hours of arrival to the patient care unit), every 12 hours (including day of discharge), and when there is a significant change in status and documented in Cerner assessment.

- Braden Risk Score = 15–23 = Low Risk
- Braden Risk Score = 6–14 = High Risk

|  | | Braden Scale For Predicting Pressure Injury Risk | | | |
|---|--|--|--|--|--|
| Patient Name | | | Evaluators Name | | |
| | | | Date of Assessment | | |
| 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 half 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. Very 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 non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair | 3. Walks occasionally Walks occasionally during the day, but very short distances, with or without assistance. Spends majority of each shift in bed or chair. | 4. Walk 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. | |

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| Nutrition: Usual food intake pattern. | 1. Very poor: Never eats a complete meal. Rarely eats more than half of any food offered. Eats 2 servings or less of protein (meat or dairy products) OR is NPO and/or maintained on clear liquids or IV's for more than 5 days. | 2. Probably inadequate: Rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement OR received 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 will refuse a meal, but will usually take a supplement if offered OR is on a tube feeding or TPN 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 & 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, contracture or agitation leads to almost constant friction. | 2. Potential problem: Moves freely or requires minimum assistance. During a move skin probably slides 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 overall at all times. | | |
| | | | | TOTAL SCORE | |

Major Risk Factors for the Development of Pressure Injuries

- Age
- Fever
- Poor dietary intake of protein
- Diastolic pressure < 60 mmHg and/or hemodynamic instability

If any of the above major risk factors are present after the total score is obtained, advance patients with a low risk score to high risk. All at-risk patients will receive prevention/treatment interventions as determined by the Braden Score and risk factors by utilizing the guidelines above.

PROCEDURE

If there is **EXISTING** skin breakdown on admission, a **Pressure Injury Treatment Plan** will be initiated in addition to the appropriate Prevention Interventions. Refer to the Pressure Injury Treatment Plan included in this policy for further details.

If the patient develops a pressure injury after admission, Prevention Interventions must be continued.

Based on the score obtained from Braden Risk Scale and additional risk factors above, implement interventions listed below.

Prevention Interventions for All Patients with Low Risk or High Risk:

1. **Initiate prevention interventions for patients with limited mobility:**
 - a. Increase patient's mobility:
 - Ambulate patient, if possible.
 - Consider Physical Therapy screen if indicated.
2. **Institute measures to redistribute pressure:**
 - a. **Do NOT use foam rings, donuts, and sheepskin.**

b. **Turning and Repositioning**

The frequency of repositioning is based on tissue tolerance, skin condition, mobility, medical condition and treatment goals.

In bed:

1. Turn and reposition patient every 2 hours or more frequently.
2. Post turning schedule in room when appropriate.
3. Position on side at no more than a 30° angle to prevent pressure to bony prominences.
4. Use pillows or wedges to support limbs and separate skin surfaces.
5. Use an appropriate product (such as turn and reposition (glide) sheet, draw sheet or incontinence pad) when moving patient to avoid friction and shear. ComfortGlide Repositioning Sheet Application: <https://www.beebenet.org/media/4238/download>
6. Use turn and reposition device as a system: obtain glide sheet and wedges from distribution. Individual patient use. Clean as needed. Do not discard unless badly soiled. A Drypad is **NOT** needed unless the patient is incontinent. See instructions below under incontinence for use of Drypad.

In chair:

1. Assist patient out of bed to chair for short periods throughout the day, if tolerated.
 2. Change position every 1 hour when in the chair. If the patient can reposition independently, instruct patient to reposition every 15 minutes.
 3. Limit time out of bed in chair and utilize pressure redistribution device (chair cushion) as needed on chair seat.
 4. For patients with pressure injuries to the sacrum, coccyx or ischial areas, limit time in chair to three times a day for 60 minutes or less.
- c. **Place at risk patients on a pressure redistribution surface** (Versacare P500, Centrella Smart + Bed or bariatric bed if required).
- d. **Layers of linen for chair or bed: maximum 3 including fitted sheet, turn and position (glide) sheet or draw sheet and incontinence pad.**
- e. **Off-load heels**
1. Elevate heels off the bed with pillow(s). If use of pillows is unsuccessful for sustaining pressure reduction obtain boots from distribution.
 2. Off-load heels with heel boots. HeelRaiser Pro Application: <https://www.beebenet.org/media/4239/download>
 3. Make sure 2 fingers can fit under strap on boot when applied.
 4. If using boot with antiembolism device, make sure tubing lays on top of foot going out the top of the boot.
 5. Remove and replace boots every shift for reassessment of skin/wound/or dressing.
 6. Remove boots for bathing and then reapply.
- f. **Off-load while in seated position**
1. Use **pillows** to assist with repositioning.
 2. Use **cushion for chair or wheelchair:** (regular (up to 300 lbs.) and bariatric (up to 700lbs.) from Distribution. Beebe Waffle Cushion Flyer: <https://www.beebenet.org/media/4237/download>
 3. Cover cushion with a pillow case.
 4. Clean and reuse cushion during patient's hospital stay.
 5. Send cushion home with patient.
- g. **Avoid** vigorous massage to bony prominences.
- h. **Prone Positioning:** PIP Tips for Proning: <https://www.beebenet.org/media/4241/download>

3. **Minimize friction and shear:**

- a. Maintain head of bed at a 30° angle or less to reduce friction and shear (unless medically necessary or at meal times).
- b. Use an appropriate product (such as turn and reposition (glide) sheet, draw sheet or incontinence pad)

when moving patient to avoid friction and shear.

- c. Apply skin barrier wipe and/or transparent dressing to bony prominences.

4. Prevent dry skin:

- a. Use lotion after bathing and for areas of dry skin.
- b. Maintain adequate hydration.

5. Prevent development of pressure injuries from incontinence:

- a. To prevent patients from developing pressure injuries, moisture associated skin damage (MASD), including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), **briefs should be used only when patients are ambulating or transferring off the nursing unit for diagnostic studies, therapies, or procedures.**
- b. Clean skin and gently pat dry as soon as possible after each incontinence episode.
 - Avoid hot water to avoid thermal injuries.
 - Use mild cleansing agents to minimize irritation and/or dryness.
- c. Use incontinence skin barrier PRN to protect and maintain skin integrity. Use **clear zinc** if patient is incontinent of urine, stool or has wound drainage. If severe, or if skin is broken, use **protective barrier**. Reapply after each episode of soiling and cleansing. Obtain from distribution or unit stock.3 Step Skin Care Tool: <https://www.beebenet.org/media/4236/download>
- d. Report any red, raised rash to the primary physician for identification and treatment of possible fungal infections.
- e. If using a **single** layer absorbent pad (**not associated with the turn and position system**) under the patient to absorb urine and stool, change as soon as soiling occurs.
- f. When using the **turn and position** (glide) sheet, use the associated Drypad if the patient is incontinent. **NOTE: Drypad absorbs up to 1000 ml and is usually changed once a shift and PRN if the patient's skin is wet or soiled with stool.**
- g. **Layers of linen for chair or bed: maximum 3 including fitted sheet, turn and position (glide) sheet and incontinence pad.**
- h. Consider a pouching system or collection device to contain urine or stool to protect the skin.
 - For severe fecal incontinence, use a fecal management device.

6. Apply pressure injury prevention dressing (adhesive foam sacral dressing) for any of the following criteria: PI Prevention Dressing Criteria: <https://www.beebenet.org/media/4240/download>

- Total Braden Score of < 15
- Low Braden score for mobility (very limited or completely immobile)
- Low Braden score for sensory perception (very limited or completely limited)
- Scarring from previous pressure injury
- BMI >40
- Excessive weight loss/malnutrition
- ALL Intensive Care Unit patients
- ALL Emergency Department holds
- Preoperatively for ALL Operating Room patients
- ALL diagnostic procedures with unknown duration and/or expected to last longer than 2 hours
For example: Diagnostic Cardiac Catheterization, Interventional Radiology
- **NOTE:** The adhesive foam sacral dressing has 2 sizes: regular and large.
Assess skin under dressing Q shift and reseal the dressing to the skin.

7. Prevent development of pressure injuries from medical devices:

- a. Choose the correct size of medical device(s) to fit the individual.
- b. Inspect the skin in contact with a medical device (e.g., CPAP mask, oxygen tubing, immobilizer, etc.) at least every shift (if not medically contraindicated).
- c. Cushion and protect the skin with adhesive foam dressings in high risk areas (e.g. nasal bridge, earlobes, etc.). **NOTE:** When inspecting the skin, lift and replace the foam dressing.
- d. Avoid placement of device(s) over sites of prior, or existing pressure injury.
- e. Reposition the patient and the device to help redistribute pressure and decrease shear.
- f. Be aware of edema under device(s) and potential for skin breakdown.
- g. Confirm that medical devices are not placed directly under an individual who is bedridden or immobile.

8. Prevent development of mucosal membrane pressure injuries:

NOTE: These injuries cannot be staged.

- a. Inspect the mucosa in contact with a medical device (e.g., endotracheal tube, etc.) at least every shift (if not medically contraindicated).
- b. Avoid placement of device(s) over sites of prior or existing mucosal pressure injury.
- c. Be aware of edema under device(s) and potential for mucosal pressure injury.

9. Maintain adequate nutrition:

- a. Perform a nutrition assessment upon admission and when there is a decline in the patient's condition.
- b. Monitor and encourage dietary intake and adequate fluid intake.
- c. Evaluate need for nutrition consult. Consult if:
 - Braden nutrition subscale is Probably Inadequate (2) or Very Poor (1) regardless of the total Braden Scale Score
 - Braden nutrition subscale is Adequate (3) if the total Braden Scale is less than or equal to 12
 - Patient has a stage 2, 3, 4, unstageable or DTI pressure injury

NOTE: A physician's order is **not** needed to request a consult with a Dietitian.

10. Assess skin every shift and document results.

11. Document all PREVENTION interventions and outcomes in the patient's permanent medical record.

12. Educate patient and significant other(s) on the causes of skin breakdown and prevention measures. Document teaching and comprehension in the medical record.

13. Evaluate effectiveness of prevention interventions, and make care plan changes daily as needed.

PRESSURE INJURY TREATMENT PLAN:

PURPOSE

To provide guidelines for:

- Assessment of patients with pressure injuries
- Identification of interventions needed for treatment of pressure injuries

Goals:

1. Maintain prevention measures.
2. Promote healing of pressure injuries.
3. Prevent infection or other wound complications.
4. Prevent the development of additional pressure injuries.
5. Maintain therapy beds as indicated. (See policy for Selection and Use of Therapy Beds).
6. Perform wound and skin care as per Wound Product Selection Protocol <https://www.beebenet.org/media/4243/download>, and Wound Product Crosswalk <https://www.beebenet.org/media/4242/download> (Unless otherwise specified by the Pressure Injury Treatment Power Plan).

SCOPE

The RN is competent to perform pressure injury prevention and treatment. The RN may delegate care as appropriate to competent staff members. All members of the health care team must notify the primary RN of wound deterioration and/or new breakdown.

POLICY

1. The RN is responsible to follow the policy for prevention of pressure injuries.
2. A wound nurse will assist the patient's primary nurse (RN) with recommendations for appropriate interventions when a pressure injury is identified on admission or when a pressure injury develops during hospitalization. When needed, a physician's order will be obtained. A wound consult is triggered in Cerner for Stage 2, 3, or 4 pressure injuries, unstageable pressure injuries, deep tissue pressure injuries, medical device related injuries and mucosal membrane pressure injuries.
3. RN will evaluate all pressure injuries at dressing change and document any changes in wound status and/or interventions. Status of wound dressing should be documented daily.
4. Notify the physician of pressure injuries including Stage 1, Stage 2, Stage 3, Stage 4, unstageable pressure injuries, deep tissue pressure injury, medical device related pressure injuries, or mucosal membrane pressure injuries.
5. Signs and symptoms of infection will be reported to the physician immediately.
6. Wound assessments are to be obtained **on admission, weekly, with any significant change, and on day of discharge.**

The RN will document the following wound characteristics:

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| a. location | i. exudate (amount, type, character) |
| b. stage | j. odor |
| c. length (cm) | k. surrounding skin (e.g., erythema, induration, edema) |
| d. width (cm) | l. presence or absence of infection |
| e. depth (cm) | m. wound edges |
| f. undermining (cm) | n. pain at pressure injury site |
| g. tunneling (cm) | o. patient/caregiver's ability and willingness to adhere to the prevention and treatment program |
| h. tissue type (e.g., granulation, epithelial tissue, necrosis, eschar, slough) | |

HOW TO MEASURE WOUNDS:

- Take measurements in centimeters using disposable wound measurement ruler (available on every unit and are supplied by Distribution).
 - Measure the length of the wound as the greatest length from wound edge to wound edge.
 - Measure the width of the wound as the greatest width from wound edge to wound edge.
 - Measure the depth of the wound (the distance from the wound bed to the visible skin surface) by gently inserting a cotton-tipped applicator into the deepest point in the base of the wound.
 - Holding this position on the applicator, place the applicator along the measurement guide to determine the depth.
 - Measure undermining edges by gently inserting a cotton-tipped applicator under the intact skin along the periphery of the wound. Use a clock to describe the location of the undermining edge. (e.g.: 4 cm at 12 o'clock to 2 o'clock).
 - Measure tunneling by gently inserting a cotton-tipped applicator into the dead space in the base or the edge of the wound.
7. Dressings must be dated, timed, and initialed when applied.
 8. Dressings/interventions shall be initiated upon admission based on the wound assessment.
 9. The type of dressing may change over time as the wound heals or deteriorates. Wounds shall be monitored at every dressing change, assessed on admission and reassessed at least weekly, if the wound worsens, and day of discharge to determine if modifications are needed in the treatment plan.
 10. Assess pain and provide analgesics (as ordered), and document effectiveness of medication.
 11. The need for pressure redistribution surfaces will be assessed and implemented by the RN.
(See policy for Selection and Use of Therapy Beds).

All pre-existing pressure injury(s) will be documented on admission. If a pressure injury exists, or develops during hospitalization, the appropriate treatment plan will be selected and implemented based on the staging of the pressure injury as defined below. **The Wound Product Selection Protocol**

<https://www.beebenet.org/media/4243/download> or a physician order utilizing the **Pressure Injury Treatment Power Plan in Cerner is required for treatment.**

DEFINITIONS

Pressure Injury:

A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, comorbidities and condition of the soft tissue.

| STAGE | DEFINITION |
|----------------------------|--|
| Stage 1 Pressure Injury | Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury. |
| Stage 2 Pressure Injury | Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled |

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| | <p>blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARS), or traumatic wounds (skin tears, burns, abrasions).</p> |
| <p>Stage 3 Pressure Injury</p> | <p>Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.</p> |
| <p>Stage 4 Pressure Injury</p> | <p>Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.</p> |
| <p>Unstageable Pressure Injury</p> | <p>Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, and intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.</p> |

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| <p>Deep Tissue Pressure Injury (DTPI)</p> | <p>Persistent non-blanchable deep red, maroon or purple discoloration Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.</p> |
| <p>Medical Device Related Pressure Injury This describes an etiology.</p> | <p>Medical device related pressure injuries result from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure injury generally conforms to the pattern or shape of the device. The injury should be staged using the staging system.</p> |
| <p>Mucosal Membrane Pressure Injury</p> | <p>Mucosal membrane pressure injury is found on mucous membranes with a history of a medical device in use at the location of the injury. Due to the anatomy of the tissue these ulcers cannot be staged.</p> |

* **NOTE:** Wounds that are not over a bony prominence and/or, not related to pressure from a device, are **NOT** staged. They are classified as full thickness or partial thickness.

STAGE 1 AND 2 PRESSURE INJURIES (PI) AND INCONTINENCE ASSOCIATED SKIN DAMAGE (IAD)

Stage 1 and Stage 2 PI's are often confused with IAD.

Incontinent patients who cannot reposition themselves may have **BOTH** Stage 1 or Stage 2 PI and IAD.

Below is a guide to distinguish between Stage 1 and Stage 2 PI's and IAD.

| | INCONTINENCE ASSOCIATED DERMATITIS (IAD) | PRESSURE INJURY STAGE 1 OR 2 |
|--------------------|--|---|
| HISTORY | Urinary and/or fecal incontinence | Exposure to pressure/shear |
| SYMPTOMS | Pain, burning, itching, tingling | Pain may or may not be present |
| LOCATION | Diffusely distributed in perineum, genital area, buttocks, gluteal fold, inner and posterior aspects of upper thighs, groin, lower abdominal folds, lower back, any areas exposed to urine or feces. | Usually over a bony prominence or associated with a medical device |
| COLOR | Pink or red | Red |
| SHAPE/EDGES | Diffuse with poorly defined edges/may be blotchy | Distinct edges or margins |
| DEPTH | Intact skin with blanchable erythema or partial-thickness skin loss | Intact skin with non-blanchable erythema and/or partial-thickness skin loss |

PROCEDURE

Interventions

A. Stage 1 Pressure Injury:

1. Implement Pressure Injury Prevention Interventions.
2. Record patient weight.
3. Document I&O/dietary intake every shift.
4. Obtain order for multivitamin po daily if approved by physician.
5. Consult Dietitian.
6. If patient is incontinent, consider external catheter or fecal incontinence management device.
7. Cleanse skin with bath wipes or mild soap and water.
8. Follow Wound Product Selection Protocol <https://www.beebenet.org/media/4243/download> and Wound Product Crosswalk <https://www.beebenet.org/media/4242/download>
9. Place patient on pressure redistribution surface (Versacare P500, Centrella Smart + Bed or bariatric bed if required).
10. Order chair cushion if OOB, off-loading heel boots if needed.
11. Educate patient/family/caregiver about skin care and prevention techniques.

B. Stage 2 Pressure Injury:

1. Implement Pressure Injury Prevention Interventions.
2. Record patient weight.
3. Document I&O/dietary intake every shift.
4. Obtain order for multivitamin po daily if approved by physician.
5. Consult Dietitian.
6. If patient is incontinent, consider external catheter or fecal incontinence management device.
7. Wound Care consult will be triggered by Cerner.
8. Cleanse wound with normal saline or non-cytotoxic wound cleanser.
9. Apply skin barrier wipe to peri-wound skin to protect as needed.
10. Follow Wound Product Selection Protocol <https://www.beebenet.org/media/4243/download> and Wound Product Crosswalk <https://www.beebenet.org/media/4242/download>
11. Use only paper or gentle tape such as silicone or self-adhesive, non-woven fabric sheet tape on skin, if required. For an extremity, wrap with soft gauze wrap to avoid use of tape.
12. Place patient on pressure redistribution surface (Versacare P500, Centrella Smart + Bed or bariatric bed if required).
13. Order chair cushion if OOB, off-loading heel boots if needed.
14. Educate patient/family/caregiver about plan of care and prevention techniques.

C. Stage 3 Pressure Injury:

1. Implement Pressure Injury Prevention Interventions.
2. Record patient weight.
3. Document I&O/dietary intake every shift.
4. Obtain order for multivitamin/po daily if approved by physician.
5. Consult Dietitian.
6. If patient is incontinent, consider external catheter or fecal incontinence management device.
7. Place patient on pressure redistribution surface (Versacare P500, Centrella Smart + Bed or bariatric bed if required).
8. Wound Care consult will be triggered by Cerner.
9. Cleanse wound with normal saline or non-cytotoxic wound cleanser.
10. Apply skin barrier wipe to peri-wound skin to protect as needed.
11. Follow Wound Product Selection Protocol <https://www.beebenet.org/media/4243/download> and Wound Product Crosswalk <https://www.beebenet.org/media/4242/download>
12. Use only paper or gentle tape such as silicone or self-adhesive, non-woven fabric sheet to skin if required. For an extremity, wrap with soft gauze wrap to avoid the use of tape.
13. Order chair cushion if OOB, off-loading heel boots if needed.
14. Educate patient/family/caregiver about skin care and prevention techniques and document.

D. Stage 4 Pressure Injury:

1. Implement Pressure Injury Prevention Interventions.
2. Record patient weight.
3. Document I&O/dietary intake Q shift.
4. Obtain order for multivitamin/po daily if approved by physician.
5. Consult Dietitian.
6. If patient is incontinent, consider external catheter or fecal incontinence management device.

7. Place patient on pressure redistribution surface (Versacare P500, Centrella Smart + Bed or bariatric bed if required).
8. Wound Care consult will be triggered by Cerner.
9. Cleanse wound with normal saline or non-cytotoxic wound cleanser.
10. Apply skin barrier wipe to peri-wound skin to protect as needed.
11. Follow Wound Product Selection Protocol <https://www.beebenet.org/media/4243/download> and Wound Product Crosswalk <https://www.beebenet.org/media/4242/download>
12. Use only paper or gentle tape such as silicone or self-adhesive, non-woven fabric sheet to skin if required. For an extremity, wrap with soft gauze wrap to avoid the use of tape.
13. Order chair cushion if OOB, off-loading heel boots if needed.
14. Educate patient/family/caregiver about skin care and prevention techniques and document.

E. Unstageable Pressure Injury:

1. Implement Pressure Injury Prevention Interventions.
2. Record patient weight.
3. Document I&O/dietary intake every shift.
4. Obtain order for multivitamin po daily if approved by physician.
5. Consult Dietitian.
6. If patient is incontinent, consider external catheter or fecal incontinence management device.
7. Place patient on pressure redistribution surface (Versacare P500, Centrella Smart + Bed or bariatric bed if required).
8. Wound Care consult will be triggered by Cerner.
9. Cleanse wound with normal saline or non-cytotoxic wound cleanser.
10. Apply skin barrier wipe to peri-wound skin to protect as needed.
11. Follow Wound Product Selection Protocol <https://www.beebenet.org/media/4243/download> and Wound Product Crosswalk <https://www.beebenet.org/media/4242/download>
12. Use only paper or gentle tape such as silicone or self-adhesive, non-woven fabric sheet to skin if required. For an extremity, wrap with soft gauze wrap to avoid the use of tape.
13. Order chair cushion if OOB, off-loading heel boots if needed.
14. Educate patient/family/caregiver about plan of care, need for debridement and prevention techniques and document.

F. Deep Tissue Pressure Injury:

1. Implement Pressure Injury Prevention Interventions.
2. Record patient weight.
3. Document I&O/dietary intake every shift.
4. Obtain order for multivitamin po daily if approved by physician.
5. Consult Dietitian.
6. If patient is incontinent, consider external catheter or fecal incontinence management device.
7. Place patient on pressure redistribution surface (Versacare P500, Centrella Smart + Bed or bariatric bed if required). Order Envella bed if not contraindicated.
8. Cleanse wound with normal saline or non-cytotoxic wound cleanser.
9. Follow Wound Product Selection Protocol <https://www.beebenet.org/media/4243/download> and Wound Product Crosswalk <https://www.beebenet.org/media/4242/download>
10. Order chair cushion if OOB, off-loading heel boots if needed.
11. Educate patient/family/caregiver about skin care and prevention techniques.

G. Medical Device Related Pressure Injury

1. Choose the correct size of medical device(s) to fit the individual.
2. Cushion and protect the skin with dressings in high risk areas (eg. nasal bridge, earlobes, etc.).
3. Inspect the skin in contact with a medical device (e.g., CPAP mask, oxygen tubing, immobilizer, etc.) at least daily (if not medically contraindicated).
4. Avoid placement of device(s) over sites of prior, or existing pressure injury.
5. Reposition the patient and the device to help redistribute pressure and decrease shear.
6. Be aware of edema under device(s) and potential for skin breakdown.
7. Confirm that devices are not placed directly under an individual who is bedridden or immobile.
8. Cleanse wound with normal saline or non-cytotoxic wound cleanser.
9. Apply skin barrier wipe to peri-wound skin to protect as needed.
10. Follow treatment for pressure injury as assessed and staged as outlined above.
11. Educate patient/family/caregiver about skin care and prevention techniques.

H. Mucosal Membrane Pressure Injury

1. Choose the correct size of medical device(s) to fit the individual.
2. Inspect the mucous membrane in contact with a medical device (e.g., ET tube, etc.) at least daily (if not medically contraindicated).
3. Avoid placement of device(s) over sites of prior, or existing pressure injury.
4. Cleanse wound with normal saline.
5. Educate patient/family/caregiver about mucosal care and prevention techniques.

Patient/Caregiver Education

Educate patients, caregivers, and healthcare providers involved in the continuum of care about prevention, treatment and factors contributing to recurrence of pressure injuries.

Evaluate patient/caregiver learning as evidenced by their ability to describe the disease process and prevention/treatment plans, correct demonstration of care, and active participation in the treatment plan.

DOCUMENTATION

Prevention Interventions:

In Cerner, under Adult System Assessment

- Braden score on admission (within 4 hours of arrival to patient care unit) and then every 12 hours and when there is a significant change in the patient's condition

In Cerner, under Integumentary

- Skin assessment every shift

In Cerner, under Patient Status Rounding in Skin Integrity or ADL's

- Check boxes for:
 - Prevention measures
 - Friction/shear prevention dressing
 - Skin barrier film
 - Transparent dressing
 - Lotion
 - Turning Q 2 hours (left, right, supine)
 - OOB to chair
 - Time up in chair

- Ambulatory with distance in feet
- HOB elevation
- Specialty bed
- Position/Pressure Reduction Device
 - Cushion
 - Wedge
 - Heel off-loading device
 - Elbow protectors
 - Pillow
 - Turn & reposition system

In Cerner, under Genitourinary

- Drop down menu
 - Incontinent if skin is intact
 - Urinary catheter
 - Elimination
 - Brief
 - Pad

In Cerner, under Drains/Tubes

- Fecal management system

In Cerner, under Nutrition

- Intake and output

In Cerner, under patient education

- Patient education

Prevention/Treatment Interventions if patient has a wound:

- See above for prevention interventions.
- Under Assessment: Wound Skin Abnormality: document Stage 1, 2 3, 4 pressure injuries, deep tissue pressure injury, medical device related injury (stage of pressure injury, type of device), mucosal membrane injury (do not stage), wounds from incontinence (do not stage), wound measurements and characteristics and type of dressing. Wound assessments are to be obtained **on admission, weekly, with any significant change, and on day of discharge.**
- Under orders in Power Plan
 - Consult Dietitian
 - Consult Wound Nurse
 - Consult Physical Therapy

Patient Education:

- Under patient education section in Cerner

REFERENCES

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National Pressure Injury Advisory Panel Pressure Injury Stages
<https://npiap.com/page/PressureInjuryStages>

National Pressure Ulcer Advisory Panel Best Practices for Prevention of Medical Device-Related Injuries
<https://npiap.com/page/MDRPI-Posters?&hhsearchterms=%22best+and+practices+and+prevention+and+medical+and+device-re%22>

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<https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/quick-safety/quick-safety-43-managing-medical-devicerelated-pressure-injuries/>

World Union of Wound Healing Societies (WUWHS) (2016). Consensus Document. *Role of dressings in pressure ulcer prevention*. <https://www.wuwhs.org/position-documents/>

Wound Ostomy and Continence Nurses Society. (2016). *Guideline for prevention and management of pressure ulcers*. Wound Ostomy and Continence Nurses Society.

REFERENCE TEXT

ComfortGlide Instructions: <https://www.beebenet.org/media/4238/download>

How to Apply HeelRaiser: <https://www.beebenet.org/media/4239/download>

Waffle Seat Cushion: <https://www.beebenet.org/media/4237/download>

PIP Tips for Prone Positioning: <https://www.beebenet.org/media/4241/download>

3 Step Skin Management: <https://www.beebenet.org/media/4236/download>

Pressure Injury Prevention Dressing: <https://www.beebenet.org/media/4240/download>

Wound Product Selection Protocol: <https://www.beebenet.org/media/4243/download>

Wound Product Crosswalk: <https://www.beebenet.org/media/4242/download>