Purpose

An evidence based, inter-professional and person centered approach to care can decrease the incidence of pressure injuries in the hospital setting, thus reducing pain, suffering and cost within the healthcare system. At MAHC, all admitted patient will undergo routine risk assessment, have an individualized skin injury prevention care plan and consistent monitoring of skin surfaces to support safe skin practices.

Scope

The policy pertains to all staff members and physicians at Muskoka Algonquin Healthcare (MAHC).

Policy Statement

At MAHC, the primary goal is the prevention of pressure injuries, and/or preventing further tissue damage of pre- existing pressure injuries. Nurses will assess for risk of skin breakdown using the Braden Scale for predicting Pressure Sore Risk on all adult patients with the exception of maternity. A Braden Score of less than 18 indicates that a patient is at risk, requiring the nurse to establish, implement and document a plan of care. Ongoing evaluation of Braden Score and effectiveness of the plan of care must be documented. The patient and family are to be included in the prevention planning and intervention process. The Management of wounds will follow the Wound Assessment and Management Policy.

Definitions

Braden Scale: A validated risk assessment tool used to determine risk for developing pressure injuries. Six subscales are scored based upon patient presentation. A low score indicates high risk of developing skin injury. Subscale scores can be used to determine appropriate patient interventions.

National Pressure Injury Advisory Panel (NPIAP) Staging System: A staging system that describes the depth of tissue involvement in a unilateral dimension of deterioration created by the NPIAP. Appendix B outlines the NPIAP staging system.

Pressure Injury: Localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a device. The extent of damage is defined by the NPIAP staging guide (Appendix B)

Procedure

Risk Assessment:

1. All nurses working in patient areas will receive education on utilization of the Braden scoring tool. (Appendix A) Lanyard cards will be available for reference.
2. All patients admitted to MAHC will have a Braden score assessment completed and documented within 12 hours of admission, weekly, with the development of any pressure injury and with any major change in patient status.
3. Braden score values will be used to create the individualized patient care plan along with the interdisciplinary team as required.

Skin Assessment:

1. All patients admitted to hospital will have a complete skin assessment within the first 12 hours of admission.
2. A full skin assessment on admission will include all the bodily surfaces, with particular attention to bony prominences and areas of pressure. Any existing dressings or devices will be removed with the underlying tissue examined and documented.
3. A skin assessment will subsequently take place every shift, focusing on bony prominences. In subsequent assessments, any therapeutic dressings may remain intact and be documented as such. Any dressings used for prevention or medical devices must be lifted to examine the underlying tissue.
4. Staff will utilize the National Pressure Injury Advisory Panel staging guide for assessment of skin injuries. (Appendix B) It is important to consider previous skin assessments as pressure injury staging works in a unilateral direction (i.e. a stage 2 injury cannot recover and become a stage 1 injury). (Appendix B)

Documentation:

1. All suspected and established pressure injuries, including stage 1, are to be documented at the time they are initially noted and with each subsequent skin assessment. Documentation will take place on the 'Incision/Wound care' Power Form and include at minimum the location, stage and size of wound and a description of the wound bed and peri-wound area.
2. Wounds stage 2 or greater require photo documentation on initial assessment. All photos must be taken on a hospital owned camera, available in designated unit Medication Rooms. Refer to instructions for loading to patients Cerner chart in the Wound Care Binder and attached to all cameras.
3. Document utilization of any therapeutic surfaces on initiation or discontinuation. (Appendix D)
4. Document all patient and/or family education and instructions.

Reporting:

1. Any pressure injury first identified after 24 hours of admission are considered a Hospital Acquired Pressure Injury (HAPI).
2. HAPIs will be recorded in the patient chart followed by an IMRS incident report using the "Skin Tissue" incident category.
3. Any Pressure Injury that worsens (i.e.: stage 1 develops to a stage 2) will be reported through the IMRS.
4. HAPIs and worsening injuries will be reviewed quarterly by the Skin and Wound Care committee and forwarded to Nursing Leadership and Quality Council.
5. Braden Score Compliance will be reviewed quarterly by the Skin and Wound Care Committee.
6. Pressure Injury (PI) audits will be conducted at a minimum of monthly on a designated unit and results reported to staff and management.

Care Plan:

1. All patients receiving care at MAHC will have an individualized Braden Skin Assessment Care Plan documented in Power Chart. The MAHC Pressure Injury Prevention Protocol will be utilized. (Appendix C)
2. The Braden Skin Assessment Care Plan will be reviewed and updated with each instance of the Braden Scoring Tool.
3. Interventions will be selected considering the sub scoring values.
4. Dietician, physio and OT consults will be completed as required.

Education:

1. Education will be provided for care providers regarding utilization of the Braden Score, protocols and prevention strategies/ devices and recognition of pressure injuries in general orientation.
2. Strategies and algorithms will be available in the Wound Care Binder found in all clinical areas and on SharePoint.
3. All patients will receive a copy of the Patient Information on Bed Sores and Pressure Injury information sheet. (Appendix E)

Cross Reference

N/A

Notes

Standardized Statement:

References / Relevant Legislation

Accreditation Canada. Required Organizational Practices: Risk Assessment, Pressure Ulcer Prevention

Barbara Braden and Nancy Bergstrom (2008), “Braden Pressure Ulcer Risk Assessment”

Health Quality Ontario. Quality Standards; Pressure Injuries, Care for Patients in All Settings https://www.hqontario.ca/Evidence-to-Improve-Care/Quality-Standards/View-all-Quality-Standards/Pressure-Injuries

National Pressure Ulcer Advisory Panel. (2016). National Pressure Ulcer Advisory Panel (NPUAP) announces a change in terminology from pressure ulcer to pressure injury and updates the stages of pressure injury. Retrieved from: https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf

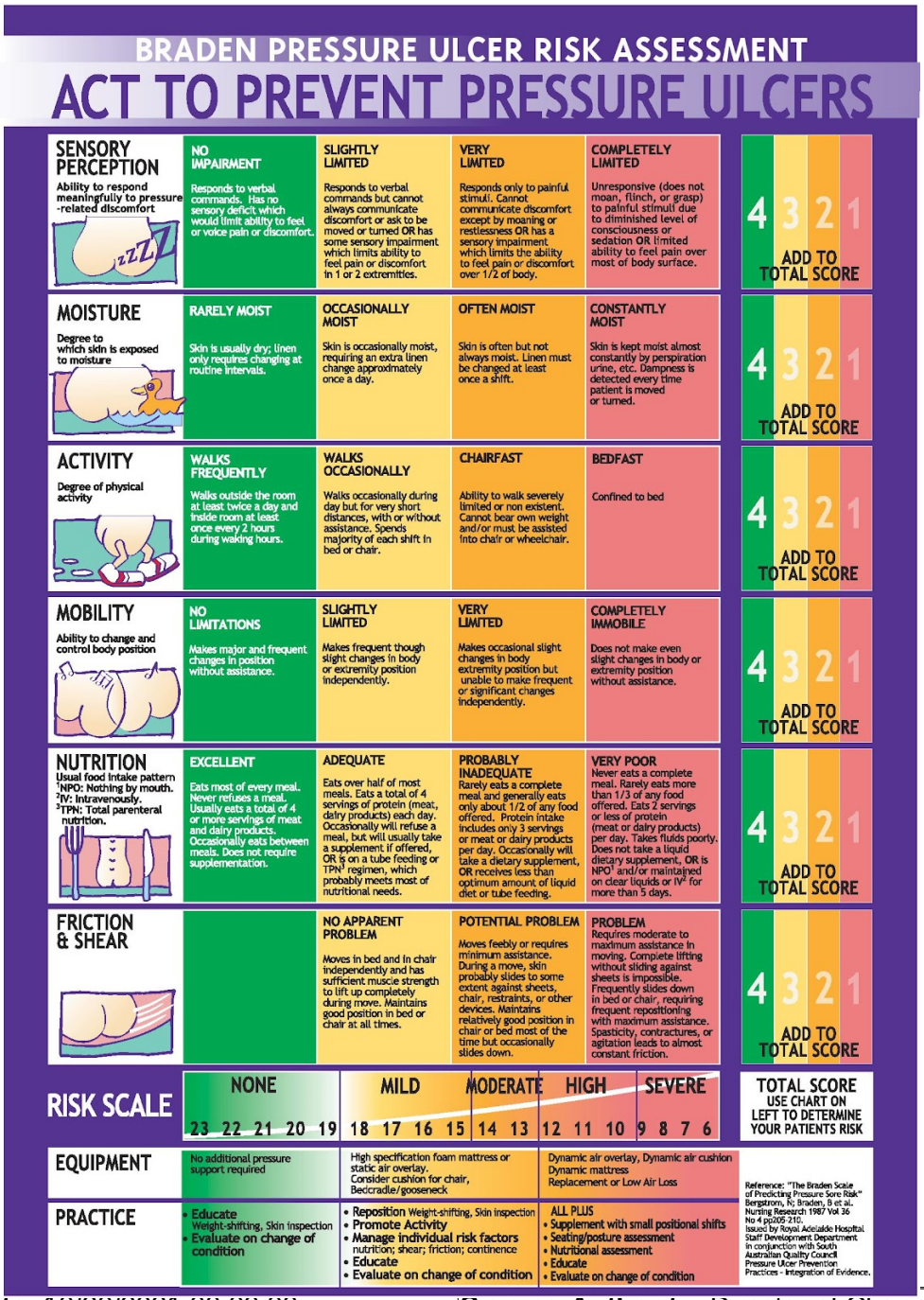
Registered Nurses’ Association of Ontario. (2016). Assessment and Management of Pressure Injuries for the Interprofessional Team (Third Edition). Toronto, Canada: Registered Nurses’ Association of Ontario: https://rnao.ca/bpg/guidelines/pressure-injuries

Wounds Canada. Best Practice Recommendations for Prevention and Management of Wounds. https://www.woundscanada.ca/docman/public/health-care-professional/bpr-workshop/165-wc-bpr-prevention-and-management-of-wounds/file

Appendices

Appendix A - Braden Score
Appendix B - National Pressure Injury Advisory Panel Staging Guide
Appendix C - MAHC Pressure Injury Prevention Protocol
Appendix D - Surface Selection for Braden Score and Pressure Injury
Appendix E - Patient Information: Bed sore and Pressure Injury Prevention
Appendix F – Document Consultation and Approval Tracking Form

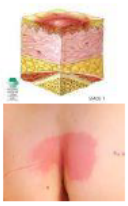
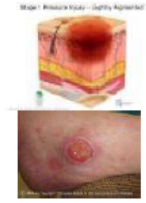
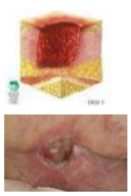
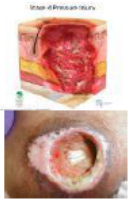
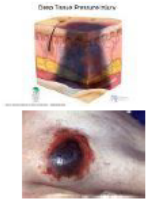
Appendix A: Braden Score



Appendix B- National Pressure Injury Advisory Panel Staging Guide

MUSKOKA ALGONQUIN HEALTHCARE

Pressure Injury Staging

Stage I Pressure Injury	Stage II Pressure Injury	Stage III Pressure Injury	Stage IV Pressure Injury	Deep Tissue Pressure Injury	Unstageable Pressure Injury
Non-blanchable erythema of intact skin Intact skin with 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. Colour changes do not incluce purple or mar0on discoloration; thes may indicate deep tissue 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 blister. Adipose (fat) is not visable and deeper tissues are not viable. 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-assosicated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive-related skin injury (MARSI), or taumatic wounds (skin tears, burns, abrasions).	**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 or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury	**Full-thickness loss of skin and tissue** 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 sough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.	**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 colour 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 dematologic conditions.	**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, intact without erythema or fluctuance) on an ischemic limb or the heels(s) should not be softened or removed.
					

Developed by MAHC Wound Care Team referencing from www.npuap.org April 2020

Appendix C- MAHC Pressure Injury Prevention Protocol

Appendix D – Surface Selection for Braden Score and Pressure Injury

MUSKOKA ALGONQUIN HEALTHCARE

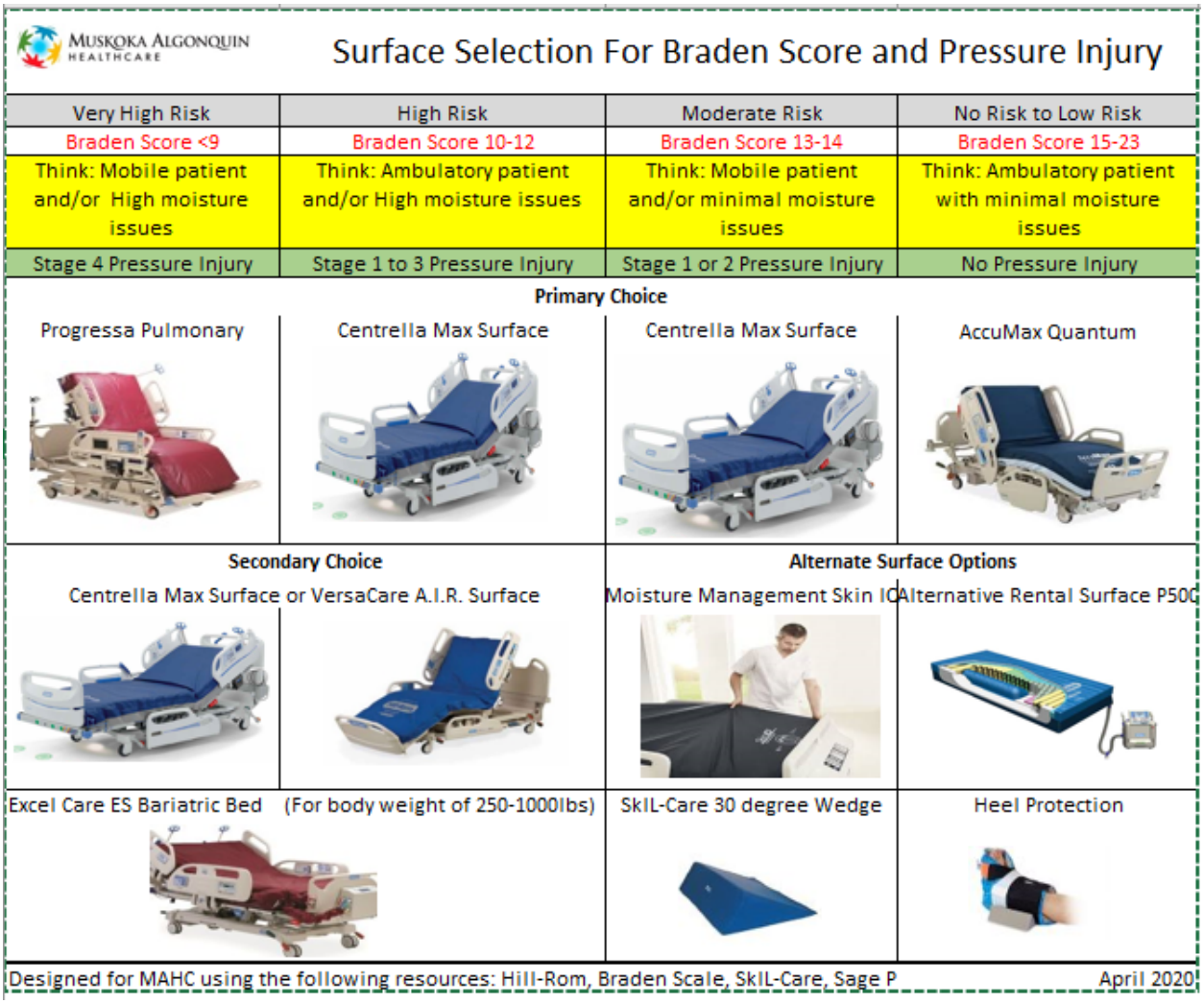
Muskoka Algonquin Healthcare Pressure Injury Prevention Protocol

Risk Assessment	General Care Issues
• Braden Score to be done on admission, every 7 days and with acute change in patient status • Patient care plan interventions to be reevaluated with each Braden Score • Consider implementing additional interventions if patient has additional risk factors: ○ Age >75, Mobility limiting fracture, stroke, multiple co-morbidities (CKD, Diabetes, heart failure, dialysis, PVD), delirium, poor dietary protein intake, fever	• Do not massage reddened bony prominence • Do not use donut type devices • Educate all patients regarding skin health and monitoring • Avoid using rolled blankets as positioning devices on bony surfaces • Advanced surfaces do not substitute for turning schedules • Encourage maximal activity for all patients

Braden Score	Risk Level	Protocol
>or = 15	Low Risk	Patient family education Frequent repositioning Protect heels: elevate using a pillow, apply advanced dressing Manage Moisture, Nutrition, Friction and Shear Pressure redistribution support surface IF patient is bed or chair bound Advance to next level of risk if other major risk factors present or with clinical nursing judgment
Sue 13-14	Moderate Risk	*Includes the above strategies PLUS:* Ensure patient repositioning q 2-4 hours. In bed ensure 30 degree lateral positioning Pressure redistribution support surface Advance to next level of risk if other major risk factors present or with clinical nursing judgment
<or=12	High Risk	*Includes the above strategies PLUS:* Q 2 hour repositioning. In bed ensure 30 degree lateral positioning Required PT OT RD consult

Strategies to Manage

Moisture	Nutrition
• Address cause if possible (fever, incontinence, wound drainage) • Use Cavilon Barrier cream • Cleanse skin after each episode of incontinence • Use absorbent pads or diapers only if incontinence persists • Use *Interdry* between moist skin folds • Offer bedpan/urinal and glass of water in conjunction with turning schedule • Use fragrance free moisturizing products or skin emollients with bath when appropriate • Use warm (not hot water for bathing)	• Monitor nutritional intake • Encourage protein intake • Dietary consult
Friction and Shear	**Pressure**
• Maintain the head of the bed at the lowest degree of elevation consistent with medical conditions (assess patients with swallowing, and airway considerations independently) • Use lift sheets to move patient • Utilize Versacare cloths for cleansing at risk skin • Use air mattress as appropriate • Protect elbows and heels from friction: Use long sleeves and prevalex heel where appropriate • Mepilex sacrum for protection if patient bed bound • Consult PT/OT for positioning/ transfer/ mobility considerations	• Encourage, educate and assist with frequent repositioning q 2-4hours. • If patients cannot self-reposition, use foam wedges to achieve lateral turn of 30 degrees • Air mattress if patient bed bound or moderate/high risk (continue to use wedge) • OT consult for seating assessment



MUSKOKA ALGONQUIN HEALTHCARE

Surface Selection For Braden Score and Pressure Injury

Very High Risk	High Risk	Moderate Risk	No Risk to Low Risk
Braden Score <9	Braden Score 10-12	Braden Score 13-14	Braden Score 15-23
Think: Mobile patient and/or High moisture issues	Think: Ambulatory patient and/or High moisture issues	Think: Mobile patient and/or minimal moisture issues	Think: Ambulatory patient with minimal moisture issues
Stage 4 Pressure Injury	Stage 1 to 3 Pressure Injury	Stage 1 or 2 Pressure Injury	No Pressure Injury

Primary Choice

Progressa Pulmonary

Centrella Max Surface

Centrella Max Surface

AccuMax Quantum

Secondary Choice

Centrella Max Surface or VersaCare A.I.R. Surface

Alternate Surface Options

Moisture Management Skin IC

Alternative Rental Surface P50

Excel Care ES Bariatric Bed (For body weight of 250-1000lbs)

SkIL-Care 30 degree Wedge

Heel Protection

Designed for MAHC using the following resources: Hill-Rom, Braden Scale, SkIL-Care, Sage P April 2020

Appendix E – Patient Information: Bed sore and Pressure Injury Prevention

Appendix 1 – Document Consultation & Approval Tracking Record

TIPS FOR PREVENTING PRESSURE INJURIES

IF YOU ARE IN BED FOR A LONG TIME:

1. **Reposition in bed and move as often as you can:** turn your body at least every two to four hours. If you cannot move on your own, have someone help you.
2. **Keep pressure off your skin:** Use pillows or special cushions such as foam wedges so that bony areas do not touch each other. Elevate your heels so that they do not touch the surface of the bed. You can also use heel protectors to reduce pressure on your heels and ankles.

IF YOU ARE IN A CHAIR OR WHEELCHAIR FOR A LONG TIME:

1. **Shift your weight every 15 minutes.** If you cannot shift your weight on your own, have someone reposition you at least every hour.
2. **Do not create your own cushion.** Creating your own cushion, e.g. a donut, will likely just move pressure to a new area of your body. Instead, use special cushions called pressure-reducing devices. An occupational therapist or a physical therapist can suggest the best seating device or special cushion based on your needs.

Adapted from: OSI(H Bedsore and Pressure Injury Prevention (2012); RNAO.CA Health Education and Prevention Fact Sheet Pressure Injury Prevention (2016); UHN How to Keep Your Skin Healthy and Prevent Pressure Injuries (Form: D-5455)

MAHC Version: January 2020

MUSKOKA ALGONQUIN HEALTHCARE

Patient Information

Bed Sore and Pressure Injury Prevention

Pressure injuries, also known as bed sores or pressure ulcers, develop when your skin and the tissue under the skin is damaged by pressure. They can develop in a very short time and take a long time to heal. This can happen if you spend most of your day in a chair or bed. Pressure sores can be painful, hard to heal, and may lead to serious infections or affect your ability to perform day-to-day activities.

Pressure injuries can be prevented. While you are in hospital, your care team will work with you to keep your skin healthy. This brochure will provide tips on how to keep your skin healthy and prevent pressure injuries.

HUNTSVILLE DISTRICT MEMORIAL HOSPITAL SITE	SOUTH MUSKOKA MEMORIAL HOSPITAL SITE
100 FRANK MILLER DRIVE HUNTSVILLE, ON, P1H 1H7 PHONE (705) 789-2311	75 ANN STREET BRACEBRIDGE, ON, P1L 2E4 PHONE (705) 645-4404

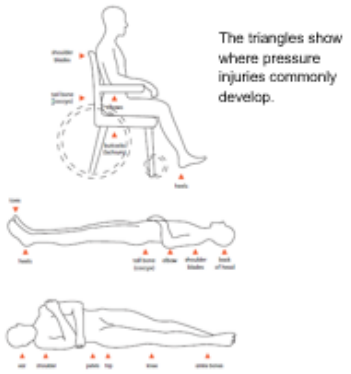
www.mahc.ca

WHAT CAUSES PRESSURE INJURIES?

- Pressure injuries can happen anywhere there is constant pressure on the skin. A very sick person may develop a pressure injury quickly.
- People who lay in bed for long periods of time may develop pressure injuries on bony parts of the body where they rest their weight, such as the tailbone, buttocks, heels, hips, ankles, shoulder blades, back of the head, ears, elbows and knees.
- People who sit in a chair or wheelchair for long periods of time may develop a pressure injury on the buttocks.
- Pressure injuries may also develop because of long-term pressure on a person's skin from medical devices.
- They can occur because you have difficulty moving by yourself, perhaps because of surgery or a short- or long-term illness.
- Not eating well or drinking enough can contribute to causing pressure injuries.
- Lack of control over your bowels and/or bladder can lead to sores if the skin becomes wet and/or soiled.

WHAT ARE SIGNS OF PRESSURE INJURIES?

- If you have light skin, the first sign of a pressure injury is reddened skin. If your skin tone is darker, the skin may appear purplish or blue.
- Blisters are also a sign of a pressure injury.



The triangles show where pressure injuries commonly develop.

CARING FOR YOUR SKIN

- Check your all areas of your skin regularly. Tell your nurse if you notice any signs of a pressure injury, like pain or change in colour or blisters.
- Use products that are gentle on the skin when bathing and after instances of incontinence. Use moisturizer on dry skin.
- Do not massage bony areas of the body.
- Eat healthy meals, snacks and drinks. Eat fruits, vegetables and foods high in protein and energy. Drink plenty of water and other fluids. Ask your care team about supplements if you have diabetes or cannot eat a balanced diet.

MUSKOKA ALGONQUIN HEALTHCARE	**Policy/Procedure Name:**	**Pressure Injury Prevention Policy**
Manual: Nursing	**Number:**	
Section: General	**Effective Date:**	07 Jan 2021
Pages: 11 of 12	**Revision Date:**	20 OCT 2021

Document Title: **Pressure Injury Prevention**

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- ☐ New
- ☒ Revision of Existing
- ☐ Reviewed, no edits required

Document Type:
- ☒ Policy/Procedure
- ☐ Protocol/Guideline
- ☐ Standard Operating Procedure
- ☐ Medical Directive
- ☐ Order Set
- ☐ Other: _____
- ☐ Clinical Pathway
- ☐ Order Set
- ☐ Standard of Care
- ☐ Rules & Regulations
- ☐ Form

Development Team (list the names and designations of those involved in the development/review of the document)**:**

Name	Designation
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Kim Schmitz	Clinical Educator

Scope of Document:
☒ Department specific ☐ Two or more departments/services ☐ Corporate/Hospital-wide

Groups Impacted by Document:
- ☒ Nursing
- ☐ Credentialed Staff
- ☐ Clerical/Support Staff
- ☐ Administration
- ☐ All Staff/Credentialed Staff
- ☐ Allied Health (specify):
- ☐ Support Staff (specify):
- ☐ Other (specify):

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Stakeholder/Committee	Date Consulted	Feedback/Comments	Development Team Response
Patient Services, Quality & Nursing Leadership Team			

Education & Communication Plan: (select all that apply)

Tool(s) / Method(s)	*Timeline for Completion*	*Lead Responsible*
☐ Huddles/Staff meetings		
☐ Education Blitzes		
☐ Learning Management System (LMS) Module		
☐ Posters		
☐ Electronic Mail		
☐ Communication Binder		
☐ Department Meetings		
☐ Frequently Asked Questions (FAQ)		
☐ Memo		
☐ MAHC Matters		
☐ Other:		

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Manual:	Nursing	**Number:**	
Section:	General	**Effective Date:**	07 Jan 2021
Pages:	12 of 12	**Revision Date:**	20 OCT 2021

Approval Phase (for list of Signing Authorities, view the "Policy, Procedure and Guideline Development" policy)**:**

Signing Authority:	**Date Review:**		
Director of Nursing & Clinical Services	**Oct. 20/21**	☒ **Approved**	☐ **Not Approved**

Comments: _____

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