Departmental	**Nursing**
Section 100 – Patient Bedside Care	
SUBJECT:	**110:010 PRESSURE INJURY (ULCER) PREVENTION AND INTERVENTION / SKIN MANAGEMENT**
Revised:	1/01, 4/01, 4/02, 6/02, 11/03, 6/05, 10/06, 10/07, 4/09, 4/11, 8/12, 4/13, 6/13, 10/13, 2/17, 6/19, 2/20, 3/21
Approved:	Nursing Executive Committee 8/05, 11/06, 11/07 Practice Council 5/09, 4/11, 8/12, 4/13, 6/13, 10/13, 2/17, 6/19, 2/20, 3/21

I. Policy

The purpose of the policy is to identify patients at risk for pressure injuries and to implement interventions for the prevention of pressure injuries.

- Registered nurses, licensed practical nurses, physician's assistants, and nursing technicians implement pressure injury prevention for all patients, as appropriate.
- Most dynamic therapeutic surfaces (air mattress) are not recommended for patients with unstable spinal cord injury that has not been stabilized.
- If patient > 500 lbs and/or bed not wide enough for patient to turn, order bariatric bed – refer to Therapeutic Bed Guidelines.
- Consult wound care specialist (beeper #1333) for rental beds used for skin care management or questions. If unavailable, contact Nursing Supervisor. Consult team leader for rental beds used for pulmonary management (RotoRest or RotoProne).
- Evaluate daily for continued need of specialty bed.
- The transferring unit is responsible for re-evaluating the continuing need for a specialty bed at time of transfer.

II. Definitions

Term	Definition
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, co-morbidities and condition of the soft tissue.

III. Procedure

Lippincott Nursing Procedures – Pressure injury prevention

A. Assessment

1. Braden Scale and presence of pressure ulcers will be documented on admission. Reassessment of Braden Scale will be repeated at least every 24 hours.
   - No risk – Braden Scale 23-19
   - Low risk – Braden Scale 18-15
   - Moderate risk – Braden Scale 14-13
   - High risk – Braden Scale 12-10
   - Very high risk – Braden Scale 9 or less

2. Routine ambulatory obstetrical patients will be excluded from Braden Scale assessment and documentation.

B. Pressure Injury Preventions Measures

1. Patients who are unable to turn themselves will be turned or repositioned at least every 1-2 hours.

2. Beds with Turn Assist do not eliminate the need for every 2 hour turning and repositioning. Patients on beds with Turn Assist must be turned and repositioned at least every 2 hours and lower body supported with pillows. With each turn, the patient's skin should be assessed for signs of redness or skin breakdown.

3. Stable spinal cord injuries (paraplegics or quadriplegics) should be repositioned every 30 minutes when in chair.

4. Heels of immobile patients will be suspended off mattress using pillows under the full length of the calves to decrease heel interface pressure.

5. Turning sheets, trapeze bar and/or application of lotion will be used to reduce friction and shear.

6. Unless contraindicated, the head of bed will be at a maximum elevation of 30 degrees during sitting or inactivity to reduce the potential for shearing.

7. Attempts will be made to control skin exposure to moisture from incontinence, drainage, and diaphoresis. Frequent cleaning with chlorhexidine soap and water (15 ml CHG in 2 liters water) or hospital approved perineal wash with application of hospital approved moisture barrier product, Dry Flow chux, and frequent linen change are indicated with diaphoresis and incontinence of stool or urine.

8. Discourage use of diapers/disposable briefs when patient is in bed.

9. For patients placed on Rotorest or Rotoprone surfaces with emaciated skin or on palliative care, apply adhesive foam dressings to at risk bony prominences. Roll back dressing and check site every shift.

C. Treatment

1. No Pressure Injury

Skin free of an injury caused by pressure.
a. High or Very High Risk (Braden Scale 12 or less) – consult nutrition.

2. **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.
   a. Off load pressure and recheck in 30 minutes.

3. **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 open/ruptured serum-filled 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 (MARSI), or traumatic wounds (skin tears, burns, abrasions).
   a. If injury is dry – apply hydrocolloid dressing; change every 3-5 days (in Omnicell or from CSR). Other products or treatments may be specified by the physician, nurse practitioner, physician's assistant, or wound care specialist.
   b. If injury is wet – apply adhesive foam dressing or foam dressing; change every 3-5 days (in Omnicell or from CSR). Other products or treatments may be specified by the physician, nurse practitioner, physician's assistant, or wound care specialist.
   c. Hospital approved moisture barrier product (in Omnicell) if dressings above are not suitable.
   d. Consult wound care specialist PRN (beeper #1333).
   e. Consult Nutrition & Food Services PRN.

4. **Stage 3 Pressure Injury: Full-thickness skin loss**
   Full thickness tissue loss, 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.
   a. Consult Nutrition & Food Services.
   b. Place foam dressing or ABD and tape (if allergic to adhesive) until seen by wound care specialist or physician.
   c. Consult wound care specialist (beeper #1333).

5. **Stage 4 Pressure Injury: Full-thickness skin and tissue loss**
   Full thickness 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.

a. Consult Nutrition & Food Services.
b. Wet to dry Normal Saline until seen by wound care specialist or physician.
c. Consult wound care specialist (beeper #1333).

6. **Unstageable Pressure Injury: 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 the heel or ischemic limb should not be softened or removed.
   a. Consult Nutrition & Food Services PRN.
   b. Until seen by wound care specialist or physician, apply Normal Saline wet to dry gauze dressing except for stable heel eschar which should be left dry, intact, and pressure off-loaded.
   c. Consult wound care specialist (beeper #1333).

7. **Deep Tissue 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 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.
   a. Consult Nutrition & Food Services.
   b. Keep dry and off-load pressure.
   c. Consult wound care specialist (beeper #1333).
   d. Do not use any dressings.

8. **Medical Device Related Pressure Injury**
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.

9. **Mucosal Membrane Pressure Injury**
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.
   a. Notify physician.

10. **Moisture Associated Skin Damage (MASD)**
   - **Incontinent Associated Dermatitis** (IAD)
     a. Incontinence without a break in the skin – Cleanse soiled area with chlorhexidine soap and water (15 ml CHG in 2 liters water) or hospital approved perineal wash, then apply hospital approved moisture barrier product after each episode.

b. Incontinence with partial thickness skin loss – Cleanse soiled area with chlorhexidine soap and water (15 ml CHG in 2 liters water) or hospital approved perineal wash, then apply hospital approved moisture barrier product after each episode (in Omnicell or from CSR).
c. Keep patient clean and dry.
d. Avoid diapers or briefs.
e. Use Dry Flow chux on bed.
f. Consult wound care specialist PRN (beeper #1333).

- **Fungal Rash**
  a. Keep patient clean and dry.
  b. If wet fungal rash, apply antifungal (microguard) powder with no sting spray.
  c. If dry fungal rash, apply Barb's Magic Butt Paste (provider order required – comes from Pharmacy).
  d. Avoid diapers or briefs.
  e. Consult wound care specialist PRN (beeper #1333).

- **Skin Tears**
  a. Be gentle when repositioning or transferring the patient.
  b. Dry skin tears. Contact physician for order for antibiotic ointment, then apply with adaptic and cover with ABD, Kerlix, and gentle tape.
  c. Wet fragile skin with skin tear: Apply non-adherent dressing and wrap with Kerlix. Change dressing daily and PRN; observe.
  d. Consult Wound Care Specialist PRN (beeper #1333).
  e. Do not use Tegasorb dressing on this skin.

- **Skin Fold Tears**
  a. Keep patient clean and dry.
  b. Place ABD between folds to help with moisture control.
  c. Consult wound care specialist PRN (beeper #1333).

IV. References

National Pressure Ulcer Advisory Panel (revised April 2016)

THE UNIVERSITY OF TENNESSEE MEDICAL CENTER

Therapeutic Bed Guidelines

	Acute Care		Critical Care		Nonrental	Hill-Rom Rental			Arjo Rental	
	HR VersaCare, Centrella 500 lbs	HR VersaCare, Centrella P500 500 lbs	HR Total Care 500 lbs	HR Sport 2, Progressa 500 lbs	HR Excel Care ES[1], BariMaxx II Bariatric Beds 1000 lbs	Compella w CLR turning[2] 1000 lbs, Pt Ht. 7'3"	Progressa 500 lbs	HR Envella, air fluidized therapy[5] 70 to 350 lbs	RotoRest[3, 4] 300 lbs	RotoProne[4] 350 lbs
Stage 1	✓	✓	✓	✓						
Stage 2	✓	✓	✓	✓						
Stage 3		✓		✓	1st choice	✓				
Stage 4		✓		✓	1st choice	✓				
Deep Tissue Pressure Injury		✓		✓	1st choice	✓				
Unstageable Pressure Injury		✓		✓	1st choice	✓				
Flap/Graft to Posterior Surface								✓		
Respiratory Failure (P/F ratio < 200-300)				✓			if no Sport 2		✓	✓
Unstable spinal injury									✓	
Traumatic brain injury				✓			✓			
Moisture Associated Dermatitis	Mild	Severe	Mild	Severe	Severe	Severe				

Consult wound care specialist (beeper #1333) for rental beds used for skin care management or questions. If unavailable, contact Nursing Supervisor.
Consult team leader for rental beds used for pulmonary management (RotoRest or RotoProne).

- Order for specialty beds must be placed in Cerner. When specialty bed is discontinued, the order to discontinue the bed must be placed in Cerner.
- The transferring unit is responsible for re-evaluating the continuing need for a specialty bed.

1 **HR Excel Care ES / BariMaxx II** – 1st choice for bariatric patient: non-rental. Place order in Cerner. If non-rental Bariatric bed is available, CSR will ask Maintenance to deliver. If not available, CSR will order a rental Compella bed. If a bed is needed for a tall patient up to 7'3", order a Compella bed.

2 **Compella with CLR turning mattress** – if immobile or has pressure ulcer; no cardiac chair position

3 For **unstable** spinal injury requiring rotational therapy, use only RotoRest

4 RotoRest or RotoProne – consider aggressive therapy if P/F < 200. Use of these beds, increases risk of pressure ulcers. Must be vigilant with skin care.

5 **HR Envella, air fluidized therapy** – must have MD order

If Sport 2 is unavailable on critical care, may consider renting Hill-Rom Progressa bed.