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OP3PO150710
POLICY

1. The assessment and documentation of all patients' risk of developing pressure injury are to be performed by an RN/LPN using the Braden Scale Risk Assessment Tool for adults and Braden Q Scale for Predicting Pediatric Pressure Ulcer Risk (under age 5 years) within the first 24 hours of being admitted.

2. The assessment of skin must be performed for each patient on admission, every shift, and when there is a significant change in patient's status.

3. Every pressure injury will be staged using the National Pressure Ulcer Advisory Panel (NPUAP) staging system (Appendix A).

4. All patients identified at risk of developing pressure injury (i.e. Braden score of 18 or less) will have a plan of care implemented.

5. Patients, family members and caregivers will be provided with education and prevention strategies on pressure injury risk factors.

6. Taking into consideration their scope of practice and employment, all health care team members are required to maintain their competency for best practice in pressure injury prevention.

7. Facility acquired pressure injury (FAPI) Stage 3, Stage 4, Unstageable and Deep Tissue Pressure Injury (DTPI) will be reported using the facility-specific reporting system (e.g. Safety Improvement and Management System (SIMS)). Note: Preexisting pressure injury progressing to an advanced stage (i.e. Stage 3, Stage 4, Unstageable) will be reported.

8. Written informed consent will be obtained in writing and documented in the patient chart prior to a photograph being taken of any wound.

9. The success of the pressure injury prevention program will be measured by NSHA quarterly audits and yearly prevalence/incidence study.

GUIDING PRINCIPLES AND VALUES

Pressure Injury (Ulcer) Prevention is a Required Organizational Practice (ROP) within the Accreditation Canada Standards. This policy supports compliance with the Accreditation Standards. This information is based on the Required Organizational Practice (ROP) Handbook 2017.

PROTOCOLS

1. Skin Assessment (RN/LPN Responsibilities)
   1.1 Perform skin assessment on all patients on admission and at least once every shift, and document according to facility standards. Refer to current Perry and Potter for details of skin assessment.

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2. **Risk Assessment** (RN/LPN Responsibilities)

2.1 Assess all admitted patients, within 24 hrs, for their level of risk for skin breakdown using:

- **2.1.1** the Braden Scale for Predicting Pressure Ulcer Risk for adults.
- **2.1.2** the Braden Q Scale for Predicting Pediatric Pressure Ulcer Risk for age less than 5 years.

2.2 Braden scales are scored according to physical assessment, interview and chart review.

2.3 Patients will be reassessed on transfer to the nursing unit, and whenever their condition changes.

2.4 Perform routine Braden or Braden Q Scale assessments as follows:

<table>
<thead>
<tr>
<th>Setting</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department</td>
<td>Within 24 hour of admission, and Daily</td>
</tr>
<tr>
<td>Critical Care (ICU/ IMCU) units</td>
<td>Daily</td>
</tr>
<tr>
<td>Acute Care units</td>
<td>Daily</td>
</tr>
<tr>
<td>Subacute Care units</td>
<td>Weekly (e.g. Restorative Care)</td>
</tr>
<tr>
<td>Long Term Care/Nursing Home Unit within NSHA</td>
<td>Weekly x 4 and then Monthly</td>
</tr>
<tr>
<td>Geriatric long stay</td>
<td>Weekly x 4 and then monthly</td>
</tr>
<tr>
<td>Identified high risk patients in Mental Health and Addictions</td>
<td>Weekly x 4 and then monthly</td>
</tr>
</tbody>
</table>

**EXCLUSIONS:**

- Maternal/Labor and Delivery/Operating Room
- Neonatal Intensive Care Unit (NICU)
- Patient visits less than 24 hours

3. **Interventions/ Plan of Care based on Braden Scale/Braden Q**

3.1 An individualized care plan must be developed for the patient.
3.2 The subscales of the Braden or Braden Q Scale should be used to identify appropriate interventions to prevent skin breakdown (standardized plans of care are available on NSHA facility websites).

<table>
<thead>
<tr>
<th>If Braden Score 18 or Braden Q Score 16 the RN/LPN must:</th>
</tr>
</thead>
<tbody>
<tr>
<td>● have an individualized patient plan of care</td>
</tr>
<tr>
<td>● have interventions to address identified Braden subscale areas of risk (e.g. sensory perception, moisture, etc)</td>
</tr>
<tr>
<td>● develop a turning schedule</td>
</tr>
<tr>
<td>● assess for Heel Off Loading (Appendix B)</td>
</tr>
<tr>
<td>● assess for Therapeutic Support Surface (Appendix C)</td>
</tr>
<tr>
<td>● assess for Chair Support Surfaces (Appendix D)</td>
</tr>
<tr>
<td>● assess for device related injury (bedpan, braces, etc)</td>
</tr>
<tr>
<td>● collaborate with the health care team to promote patient goals</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If Braden Score 14 or less the RN/LPN must:</th>
</tr>
</thead>
<tbody>
<tr>
<td>● perform above activities and</td>
</tr>
<tr>
<td>● place a pressure ulcer icon sticker on plan of care</td>
</tr>
<tr>
<td>● revise interventions as necessary</td>
</tr>
</tbody>
</table>

Braden Q- for subscale Tissue Perfusion and Oxygenation patient must be:

- monitored for oxygen saturation OR
- serum hemoglobin and serum pH OR
- capillary refill

For extremely compromised: Hypotensive (mean arterial pressure (MAP) of less than 50mmHg; less than 40 in a newborn) OR the patient does not physiologically tolerate position changes.

4. Patient Education

4.1 Patients, family members and caregivers are provided with education on risk factors and prevention strategies related to their care.

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4.2 Provide patient and family with pamphlet on pressure ulcer prevention.

5. **Documentation**

   5.1 Document the assessment, interventions and outcomes in the patient’s health care record.

6. **Quality/Reporting**

   Facility acquired pressure injury (FAPI) Stage 3, Stage 4, Unstageable and Deep Tissue Injury (DTI) will be reported using the facility-specific reporting system. **Note:** Preexisting pressure injury progressing to an advanced stage (i.e. Stage 3, Stage 4, Unstageable) must also be reported.

   6.1 Unit audits will be performed quarterly (every 3 months) to assess pressure ulcer prevention activities.

   6.2 Prevalence and Incidence will be performed on a yearly basis for NSHA.

**REFERENCES**


Braden, B.; Bergstrom, N. (2004) Permission to Use Braden Scale in CDHA; Prevention Plus Omaha, NE. (obtained for NSHA)


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OP3PO150710
January/February 2003. [http://www.marthaaqcurley.com/braden-q.html](http://www.marthaaqcurley.com/braden-q.html) (Permission for NSHA to use Braden Q Jan 26, 3016)


National Pressure Ulcer Advisory Panel (NPUAP) website. [www.npuap.org](http://www.npuap.org); Accessed April 22, 2016.


http://www.bradenscale.com

RELATED DOCUMENTS

Policies
CC 02-009 Care Team Assistant Skills
CDHA CC 55-045 Skin and Wound Assessment
SWH 800.1045 1 Pressure Ulcer Management

Forms
See forms for each Zone at present
Braden Scale
Braden Q Scale
PrinA1513 (Dal Print) Pressure Ulcer Prevention Sticker
PrinA1514 (Dal Print) Pressure Ulcer Prevention bedside Poster (5” x 5”)

Brochures
Central Zone: Pressure ulcer (bed sore) prevention (print # WE85-1582 Dal printing)
South Shore: Pressure Ulcer Pamphlet

Appendices
Appendix A - NPUAP Pressure Injury Stages (2016)
Appendix B - Heel Offloading Algorithm
Appendix C - Therapeutic Surface Support
Appendix D – Chair Support Services

Click here to get to the LIBRARY for more resources

Replacing the Following District Health Authority/Version History

***

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APPENDIX A National Pressure Ulcer Advisory Panel (NPUAP)
Pressure Injury Stages

Pressure Injury Definition:
A pressure injury is localized damage to the skin and/or 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.

<table>
<thead>
<tr>
<th>STAGE PICTURE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
</table>
| ![Stage 1 Picture](image1.png) | **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 Picture](image2.png) | **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 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). |
### Stage 3 Pressure Injury: 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.

### Stage 4 Pressure Injury: 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 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.

### 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 an ischemic limb or the heel(s) should not be removed.
| Deep Tissue Pressure Injury (DTPI): 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. |

It is recommended that reverse staging of pressure ulcers NOT be used to describe the healing process of a wound as this does not accurately reflect what is physiologically occurring in the ulcer (NPUAP, 2000). NPUAP 2016© [www.npuap.org](http://www.npuap.org)
APPENDIX B Heel Offloading

Assessing the Patient who is at Risk for Heel Pressure Injury (Complete Braden Scale)

Braden 19-23

Do the following:
- Frequent position changes
- Early mobilization
- Assess skin integrity every shift

Braden 18 or less

Pressure Ulcer Prevention Basic Strategies:
- Reposition every 2 hours (even when on a therapeutic surface)
- Elevate/float heels off the surface of the bed
- Use pillows lengthwise
- Assess skin integrity every shift for red areas

IS PATIENT AMBULATORY?
2 person assist will be considered “NOT AMBULATORY”

CONTINUED VISIBLE SIGNS OF PRESSURE?
(blanchable and/or non-blanchable redness)

Return to Pressure Injury Prevention Strategies

- Apply and monitor off-loading device
- Perform skin check q2h once device applied
- Refer to appropriate team members
- Consider therapeutic surface

If continues skin breakdown, consider consult:
- Occupational Therapy
- Orthotics & Prosthetics

Establish if patient is appropriate for heel device:
1. Visible signs of pressure? And/or
2. Have ONE of the risk factors for pressure

RISK FACTORS:
- a) Braden-Mobility ≤ 2 and Activity ≤ 2
- b) Fractured hip or lower extremity fracture
- c) Ischemia of the lower limb
- d) Remaining lower limb amputee
- e) Peripheral neuropathy-Diabetes mellitus
- f) Leg spasms/inadequately controlled pain
- g) Mental confusion
- h) Skin grafts to the lower leg or foot
- i) Paralysis of the lower leg or foot
- j) Unconscious
- k) Slings and springs
- l) Bucks Traction

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APPENDIX C Therapeutic Surface Support

**BRADEEN SCORE 18 or less**

**AND / OR**

**CLINICAL SIGNS OF PRESSURE (BLANCHABLE OR NON-BLANCHABLE REDNESS)**

- Use a standard hospital foam mattress (consider weight limit of mattress)
- Implement basic prevention strategies for skin breakdown:
  - head to toe skin assessment daily
  - head of bed below 30°
  - turn q2hours
  - off-load heels

**NO**

**YES**

Develops signs of pressure (blanchable or non-blanchable redness)

Assess patient for additional concerns contributing to potential or actual skin breakdown:
- mattress unable to support weight (bottoming out)
- edema
- pressure points (i.e. coccyx, heels)
- poor nutrition and dehydration
- moisture (incontinence or excessive sweating or wound drainage)
- friction/shear
- head of bed greater than 30° over long periods of time (COPD, tube feeds, ventilation, TV, etc)
- pain (uncontrolled)
- limited options for repositioning (i.e. broken hip)

**YES**

- Increase prevention strategies regarding additional concerns identified above.
- Monitor skin integrity qshift
- Consult OT/PT to address mobility, activity and/or surface support challenges

CONTINUED VISIBLE SIGNS OF PRESSURE? (blanchable or non-blanchable redness)

Consider a therapeutic surface for patient/resident

**Pressure Redistribution**
- Therapeutic pressure redistribution mattress
- Provide appropriate mattress for patients for weight

**Pressure Redistribution, Moisture, Friction, and/or Shear**
- Air mattress
- Low air loss mattress or overlay
- GOR-TEX cover sheet
- Microclimate

**Pressure redistribution, pulmonary, and/or circulatory**
- Low air loss mattress
- Percussion/pulsation
- Rotation
- Alternating pressure

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APPENDIX D: Chair Support Surfaces

Regardless of the materials used no cushion relieves pressure from all aspects of the seated surface, so frequent (q 15min) repositioning is required.

Incontinence and incontinence briefs should be considered when choosing a cushion.

<table>
<thead>
<tr>
<th>Support Surface</th>
<th>Characteristic</th>
<th>Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foam Cushion (Solid)</td>
<td>Provides some pressure redistribution, depending on types of foam used and contours of the cushion. Patient still requires repositioning q15 min-1h</td>
<td>Condition of foam must be checked for deterioration. The more contoured the cushion, the more critical the patient’s placement is while sitting needs to be to prevent skin breakdown.</td>
</tr>
<tr>
<td>Gel Cushion (Semi-solid)</td>
<td>Redistributes pressure by allowing the pelvis to immerse into the gel. May be used with clients with problems with friction and shear. Patient still requires repositioning q15 min- q1h</td>
<td>Some gel cushions require the gel to be redistributed or kneaded every time before the patient sits on it. For cushions with thick gel sliding can be a problem.</td>
</tr>
<tr>
<td>Air-filled Cushion (Fluid)</td>
<td>Redistributes pressure by allowing the pelvis to immerse into the air cells. Patient still requires repositioning q 15 min- q1h</td>
<td>Under inflation or over inflation render the cushion ineffective. The cushion requires daily monitoring to ensure proper inflation (check for bottoming out). The cushion can be recalibrated when inappropriate air pressure is discovered. If a puncture in the cushion is found, repairs are in order.</td>
</tr>
</tbody>
</table>

Bottoming out (see definition in Learning Module) should be tested on air-filled cushions to ensure the air is supporting the patient and does not need to be replaced.

To establish recommended sitting time perform skin assessment when patients return to bed.
District Health Authority/IWK Policies Being Replaced

AVH Preventing Heel Pressure Ulcers and Plantar Flexion in the Non-ambulatory Patient Protocol
CEHHA 311-060 Pressure Ulcer Guidelines
CBDHA N-16-50 Pressure Ulcer Prevention and Braden Scale
CHA DW-012.034 Pressure Ulcer Prevention
GASHA 1-525 Pressure Ulcer Prevention & Management
SSH-NU-100-921 Pressure Ulcer Prevention in Long Term Care
SSH-NU-100-921.1 Pressure Ulcer Prediction, Prevention and Treatment Pathway
SWH 800.1044,1 Pressure Ulcer Prevention

Version History
(To Be Completed by the Policy Office)

<table>
<thead>
<tr>
<th>Major Revisions (e.g. Standard 4 year review)</th>
<th>Minor Revisions (e.g. spelling correction, wording changes, etc.)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>2017-12-12 Title changed to Pressure Injury (Ulcer) Prevention</td>
</tr>
<tr>
<td></td>
<td>2018-07-18 Title changed to Pressure Injury Prevention</td>
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