PURPOSE

Nova Scotia Health is committed to promoting patient safety while delivering high-quality health care services. This policy provides direction in best practices for pressure injury prevention.

PRINCIPLES AND VALUES

People Centred Care: “As a foundation of the Nova Scotia Health Authority, we are working to place the dignity and respect of patients, families and communities at the heart of every decision. We seek to build trust-based relationships to achieve more genuine partnerships with those we serve.”

Prevention of pressure injuries requires an interdisciplinary approach. Every member of the health care team contributes by using their knowledge and expertise to plan care that addresses pressure injury risk factors.

POLICY STATEMENTS

1. The registered nurse (RN), licensed practical nurse (LPN), and advanced care paramedic (ACP) must assess and document the patient’s risk of developing a pressure injury using the Braden Scale Risk Assessment Tool for adults, and Braden QD Scale for Predicting Pediatric Pressure Ulcer Risk (premature-21 years) at the following intervals:
   - On initial assessment in the Emergency Department for patients assigned CTAS (Canadian Triage Acuity Scale) Level 1, 2 or 3, or
   - When the patient is admitted, and
   - When patient is transferred between units (internal and external to facility), and
   - At routine pre-determined intervals, and
● With any significant change in patient condition.

2. All patients identified as being at risk of developing pressure injury must have a plan of care developed and implemented.

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

4. Every pressure injury must be staged using Appendix B: National Pressure Injury Advisory Panel (NPIAP) Pressure Injury Stages©.

5. All Nova Scotia Health facility-acquired pressure injuries (PIs), and community-acquired PIs progressing to an advanced stage (any PI that worsens to a further stage), must be reported through NSHA AD-QR-015 Patient Safety Incident Management.

6. The Health Services Managers of inpatient units must ensure that monthly unit audits are completed.

7. The Nova Scotia Health Provincial Pressure Injury Prevention Committee must ensure the completion of a yearly Nova Scotia Health prevalence study.

PROCEDURE

Skin Assessment

1. RN/LPN/ACP Responsibilities

   1.1. Perform a skin assessment during initial assessment of patients in the emergency department with a CTAS level 1, 2 or 3

   1.2. Perform a skin assessment on all patients on admission* and as per Table 1 and document according to program/facility standards.

       Complete skin assessments on transfers to and from the unit (internal or external to the facility) and with changes in patient condition (including return to unit from an intervention, surgery and/or appointments).

   *Exceptions:

   Mental Health and Addictions Program: Skin assessments on admission are only conducted on those patients at risk for developing a PI (clinical presentation or Braden Scale 18 or less)

   Emergency Department: for patients in the ED with CTAS score 1, 2 or 3 a skin re-assessment is not required at admission if within 12-hours of initial assessment.
Table 1.

<table>
<thead>
<tr>
<th>Area</th>
<th>Frequency of Completing an Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department patients with CTAS levels 1, 2 &amp; 3 or ED admitted patients at risk for developing a PI (clinical presentation or Braden Scale 18 or less)</td>
<td>Every 12 hours</td>
</tr>
<tr>
<td>Critical Care (ICU/IMCU Units)</td>
<td>Per shift</td>
</tr>
<tr>
<td>Acute Care Units</td>
<td>Per Shift</td>
</tr>
<tr>
<td>Subacute Care Units (e.g. Restorative Care)</td>
<td>Daily</td>
</tr>
<tr>
<td>Long Term Care</td>
<td>With Braden Risk Assessment schedule and with bathing</td>
</tr>
<tr>
<td>Geriatric Long Stay Units</td>
<td>With Braden Risk Assessment schedule and with bathing</td>
</tr>
<tr>
<td>Identified high risk patient (Braden Scale 18 or less) in Mental Health and Addictions</td>
<td>Per shift</td>
</tr>
<tr>
<td>Continuing Care</td>
<td>With Braden Risk Assessment schedule and care plan</td>
</tr>
</tbody>
</table>

1.3. Assess skin around and over all boney prominences, and around and under any medical device using a trauma-informed care approach (Appendix C). Assess for:

- **Colour** - Blanching or non-blanching erythema, or dark purple color changes in areas of potential pressure compared to surrounding skin.
  - For **patients** with darkly pigmented skin: Colour changes may not be visible, or are very subtly different between areas of potential pressure and the surrounding skin. It is important to not rely on color changes but the complete skin assessment and consider any abnormalities assessed in an area of potential pressure to be considered indicative of a pressure injury

- **Tissue** consistency - Palpate both bony prominence and surrounding area to feel for any changes:
  - Edema: May appear taut and shiny, feels firm
  - Bogginess: Soft and “squishy” feeling

- **Temperature** difference - Compare area to surrounding skin for any difference:
■ Warmer: Inflammation happening in localized area
■ Cooler: Sign of Tissue Devitalization

□ Patient perception of sensation - Pain or itching over bony prominences or medical devices as compared to surrounding skin

2. Unregulated Care Provider (UCP) Responsibilities
   2.1. Inspect skin during assistance with activities of daily living (ADLs).
   2.2. Report any abnormalities or changes to RN/LPN.

Validated Risk Assessment

3. RN/LPN/ACP Responsibilities
   3.1. Perform a risk assessment during initial assessment of patients presenting to the emergency department with a CTAS level 1, 2 or 3 using the Braden Scale for Predicting Pressure Ulcer Risk for adults
   3.2. Within eight hours of admission*, complete the risk assessment using:
      □ The Braden Scale for Predicting Pressure Ulcer Risk for adults.
      □ The Braden QD Scale for Predicting Pediatric Pressure Ulcer Risk for premature infants until 21 years (or once transitioned from pediatric service to adult services if younger than 21 years)

*Exception: ED patients with CTAS score 1, 2 or 3: a risk re-assessment is not required upon admission

3.3. Score Braden scales according to physical assessment, interview and chart review.
3.4. Perform re-assessment of Braden or Braden QD Scale assessments on transfers, whenever patient condition changes, and routine as per Table 2.

Table 2.

<table>
<thead>
<tr>
<th>Area</th>
<th>Frequency of Completing an Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department admitted patients</td>
<td>Daily</td>
</tr>
<tr>
<td>awaiting transfer to in-patient unit</td>
<td></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 (e.g. Restorative Care)</td>
<td>Weekly</td>
</tr>
<tr>
<td>Long Term Care</td>
<td>Weekly x 4 and then monthly</td>
</tr>
<tr>
<td>Geriatric Long Stay Units</td>
<td>Weekly x 4 and then monthly</td>
</tr>
</tbody>
</table>
Patients with a risk assessment (Braden) of 18 or less for Mental Health and Addictions patients | Weekly x 4 and then monthly until risk factors have been alleviated
---|---
Continuing Care | Weekly x 4 and as determined by client presentation

**EXCLUSIONS:**
- Maternal/Labor and Delivery
- Operating Room

### Care Planning

4. **Regulated Care Provider (RCP) Responsibilities**

4.1. Develop an individualized care plan in collaboration with the patient and interdisciplinary team

4.1.1. For all patients with a Braden Scale Score of 18 or less, or a Braden QD score of 13 or higher (deemed at risk by the validated risk assessment tool)

4.1.2. To address individual Braden scale subscales that are 2 or less regardless of the overall Braden scale score.

- Use the subscales of the Braden or Braden QD Scale to identify appropriate interventions to prevent skin breakdown (Appendix D).

- Assess for the need for therapeutic supports using Nova Scotia Health algorithms:

  4.1.3. Heel Off Loading ([Appendix E](#))
  4.1.4. Therapeutic Support Surface ([Appendix F](#))
  4.1.5. Chair Support Surfaces ([Appendix G](#))

4.2. Use Nutrition algorithm ([Appendix H](#)) to identify appropriate interventions patients identified at risk

4.3. Monitor the effectiveness of the interventions on a regular, ongoing basis.

  4.3.1. Evaluate the care plan at minimum daily for the first seven (7) days, and then weekly

  4.3.2. Evaluate care and revise interventions as needed based on patient’s outcomes, and any changes in condition.

**Note:** in the MEDITECH™ System the Pressure Injury Prevention Care Plan is labelled a “Care Plan Problem” within the overall care plan.
Patient Education

5. RCP Responsibilities

5.1. Provide the patient, family member and care giver education on the following using the teach-back method:

5.1.1. What pressure injuries are,
5.1.2. Patient's individual risk factors of developing a PI
5.1.3. Individualized prevention strategies that will decrease their risk of developing a pressure injury

5.2. Provide the patient, family member and care giver with the NSHA Pressure Ulcer Prevention Patient Pamphlet

Documentation

6. RCP and UCP Responsibilities

6.1. Document the observation (UCP), assessment (RCP), interventions and outcomes in the patient’s health record.

6.2. If a pressure injury develops, document wound care plan and assessment as per CL-SW-015 Skin and Wound Assessment and Documentation.

6.3. For patients identified as being at Moderate Risk, High Risk or Very High Risk (Braden Scale score of 14 or less) place a Pressure Injury Sticker on the chart

EXCEPTION: Units that use computer documentation (PCS, MEDITECH™) are not required to use Pressure Injury Icon stickers

Monitoring of the Pressure Injury Prevention Program

7. RN/LPN Responsibilities

7.1. Report all facility acquired pressure injuries when they develop and any community acquired pressure injury that advances in stage through Safety Improvement and Management System (SIMS)).

8. Health Services Manager Responsibilities

8.1. Ensure unit audits are completed monthly to assess pressure injury prevention activities.
    □ Audits will be completed by designated personnel as determined by the unit Health services Manager.

9. Nova Scotia Health Pressure Injury Prevention Committee Responsibilities

9.1. Plan an annual prevalence study.
Each Nova Scotia Health facility will assist in completing the annual prevalence study.

REFERENCES


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RELATED DOCUMENTS

Policies
NSHA CL-SW-015 Skin and Wound Assessment and Documentation
CC 02-009 Care Team Assistant (CTA) Skills (formerly Patient Support Workers)
800.1045 1 Pressure Ulcer Management
NSHA AD-QR-015 Patient Safety Incident Management

Forms
Pressure Injury Risk Assessment and Documentation tool (Braden)
Pressure Injury Risk Assessment and Documentation tool (Braden QD)
Pressure Injury Prevention Care Plan
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

Resources
NSHA Skin and Wound Library Guide
Learning Management System (LMS): Pressure Injury Prevention Program Module
Pressure Injury Monthly Unit Audit

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Posters
NPIAP Staging Poster
Heel Offloading Algorithm
Therapeutic Surface Support Algorithm

Appendices
Appendix A: Definitions
Appendix B: National Pressure Injury Advisory Panel (NPIAP) Pressure Injury Stages©
Appendix C: Applying Principles of Trauma Informed Care during Skin Assessments
Appendix D: Braden Scale Subscale Interventions
Appendix E: Heel Offloading Algorithm
Appendix F: Inpatient Therapeutic Surface Support
Appendix G: Chair Support Surfaces
Appendix H: Nutrition Algorithm

* * *
## Appendix A: Definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma Informed Care</td>
<td>A universal and systemic approach to service provision. It is based on an understanding of the prevalence of many forms of violence and trauma among children and adults – developmental, historical, simple/complex, weather-related, war-related, gender-based – and the wide range of adaptations people make to cope.</td>
</tr>
<tr>
<td>Bottoming Out</td>
<td>A term used to describe inadequate support from a mattress overlay or seat cushion as determined by a “hand check”. To perform a hand check, the caregiver places an outstretched hand (palm up) under the overlay or cushion below the pressure injury or that part of the body at risk for a pressure injury. If the caregiver feels less than an inch of support material, the patient has bottomed out and the support surface is therefore inadequate.</td>
</tr>
<tr>
<td>Tissue Devitalization</td>
<td>Injury progressing to deeper tissues or further tissue breakdown.</td>
</tr>
<tr>
<td>Unregulated Care Provider (UCP)</td>
<td>Continuing care assistant (CCA), personal support worker (PWS), Care team assistant (CTA), home support workers (HSW).</td>
</tr>
<tr>
<td>Regulated Care Provider (RCP)</td>
<td>Nurse practitioner, registered nurse, licensed practical nurse, occupational therapist, physiotherapist, dietitian, advanced care paramedic.</td>
</tr>
<tr>
<td>Teach-back Method</td>
<td>Teach-back is a way to confirm that the educator has explained to the patient what is important and in a manner that the patient understands. Patient understanding is confirmed when the patient explains it back in their own words to the educator. It can also help the clinician identify explanations and communication strategies that are most commonly misunderstood by patients.</td>
</tr>
<tr>
<td>MedPass Program</td>
<td>“MedPass” program is an oral supplement provided in small amounts to nutritionally high risk patients (with medications) to help meet nutrient requirements. The program supported by Nutrition and Food services and may be provincially site specific. If available, the suggested dosing of high calorie (2kcal/ml) high protein supplement is in 60ml portions ideally provided 4x/day when meds are given hence “medpass”.</td>
</tr>
</tbody>
</table>
Appendix B: National Pressure Injury Advisory Panel (NPIAP) 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/CATEGORY</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1 Pressure Injury</td>
<td>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.</td>
</tr>
<tr>
<td>Stage 2 Pressure Injury</td>
<td>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).</td>
</tr>
<tr>
<td>Stage 3 Pressure Injury</td>
<td>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.</td>
</tr>
<tr>
<td>Stage 4 Pressure Injury</td>
<td></td>
</tr>
<tr>
<td>-------------------------</td>
<td></td>
</tr>
<tr>
<td>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</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Unstageable Pressure Injury</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Deep Tissue Pressure Injury (DTPI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

**Medical Device Related Pressure Injury:** This describes an etiology. 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.

**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.

**Do not Reverse Stage:** NPIAP pressure injury staging describes the depth of tissue damage due to pressure. It does not describe healing tissue. Do not reverse stage using NPUAP pressure injury staging. (i.e., a Stage 4 pressure injury cannot become a Stage 3, Stage 2, and/or subsequently Stage 1. When a Stage 4 injury has healed it should be classified as a healed Stage 4 pressure injury.)
Appendix C: Applying Principles of Trauma Informed Care During Skin Assessments

Research shows that approximately 76% of Canadians have experienced some form of trauma in their lifetime (Van Ameringen et al., 2008). Procedures that require disrobing have potential to cause feelings of discomfort, distress and even retraumatization in some individuals. Health care professionals should apply the Principles of Trauma Informed Care in all interactions with patients, especially during activities that require disrobing, such as skin assessments, bathing, toileting, dressing, etc. Trauma Informed Care is a universal, systematic, strengths-based service delivery approach that is rooted in an understanding of and responsiveness to the impact of trauma that emphasizes physical, psychological, cultural and emotional safety for both providers and clients (Hopper, Bassuk, & Olivet, 2010, Fallot & Harris, 2009, IWK Health Center, 2019). The principles of Trauma informed care include safety, trustworthiness, choice, collaboration and empowerment.

SAFETY

Create physical, emotional and cultural safety by gaining consent from the patient before beginning the skin assessment. Respect the patient’s right to decline and/or respect the patient’s need for more time and more questions. Create a safe and secure environment that supports the sharing of information if the patient so chooses.

Examples include:

- Introduce self and role.
- Ensure privacy
- Advise the patient step by step what is going to happen and what is expected from them.
- Gain verbal consent
- Maintain the pace that is comfortable for the patient
- Ask “Before we begin, is there anything you would like me to know that would make this a more comfortable experience for you?”
- If the patient discloses a history of past discomfort, distress or trauma provide reassurance and empathy as needed. “I am sorry that happened to you”, “thank you for sharing that with me”, “At any time please let me know if we need to stop or slow down”, “Is there anything we can do to increase your sense of safety” etc.
- “Thank you for allowing the skin assessment, together we can use this assessment information to prioritize your health goals”

TRUSTWORTHINESS

Establish trustworthiness by clearly explaining tasks required for proper skin assessment and maintaining appropriate boundaries. Boundaries are the defining lines which separate the therapeutic behaviour of a practitioner from any behaviour which, well intentioned or not, could reduce the benefit of care to patients.

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Examples include:

- When entering patient spaces knock or announce yourself.
- “With your permission, I will look at and touch some areas on your body. I will wash my hands first and apply gloves. I will only expose small areas of skin at a time. If there are reddened areas or open skin, I will be touching the area to check circulation, temperature and firmness, as well as signs of swelling or infection.”
- Seek permission again if you need to stop and restart the assessment (i.e. you had to leave the room or you have to write down a lot of notes etc)
- Pay attention and be sensitive to cultural nuances. “Is there anything that is important for me to know about working together with you?” “Do you have any questions or concerns that you would like to share?” Follow diversity and inclusion guidelines.
- If patients are asked to lay down be aware that they are in a more vulnerable position.
- Pay attention to non-verbal behavior.

**CHOICE**

Provide patient **choice** and control throughout the assessment.

Examples include:

- Ask patient if they are ready to begin.
- “Please know you can withdraw consent or take breaks at any time”
- Ask patient at the end if they have any additional questions.

**COLLABORATION**

Maximize **collaboration** with patients. Include patients in the care planning process to ensure care is meeting their needs/goals. Ensure emotional/mental wellbeing is assessed and supported.

Examples include:

- “Would you prefer to have the assessment done in your room or in the treatment room?”
- “Would you like to have a family member or other staff member present?”
- “Would you prefer to be standing, sitting or lying down for the assessment?”
- If someone requires assistance with activities of daily living such as showering/toileting/dressing – “Would you like the assessment done during showering/toileting/dressing or would you like it done at another time in another setting?”
- “Please let me know if there is anything you would like done differently next time this assessment is required”
EMPOWERMENT

Prioritize patient empowerment and skill-building. Validate feelings experienced during the assessment.

Examples include:

- “With your permission, I would like to show you some ways that you can prevent soreness and skin breakdown. You may choose to use these techniques during your stay and when you get home.”

- Let the person know how they can provide feedback about their experience (i.e., they can give you information and feedback anytime during the procedure so you can adjust, later they can call the patient feedback line etc).

- If patient agrees and it is appropriate, increase family member presence in ongoing care plans.
**Appendix D: Braden Scale Subscale Interventions**

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Braden Score 1</th>
<th>Braden Score 2</th>
<th>Braden Score 3</th>
<th>Braden Score 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sensory Perception</strong></td>
<td>- Skin assessment per shift/schedule. Pay special attention to heels&lt;br&gt;- Elevate heels, consider a offloading devise&lt;br&gt;- Consider a therapeutic surface&lt;br&gt;- Encourage/assist with turning and repositioning every 2-hours, or based on patients skin tolerance&lt;br&gt;- When in wheelchair, encourage/assist shifting weight every 15-min&lt;br&gt;- Assess under medical devices frequently&lt;br&gt;- Use appropriate footwear when ambulating (high risk feet should not be in socks/booties or bare feet)</td>
<td>- Skin assessment per shift Pay special attention to heels&lt;br&gt;- Elevate heels, consider a offloading devise&lt;br&gt;- Consider a therapeutic surface (mattress, chair cushion)&lt;br&gt;- Encourage/assist with turning and repositioning every 2-hours, or based on patients skin tolerance&lt;br&gt;- When in wheelchair, encourage/assist with position changes at least every hour&lt;br&gt;- Assess under medical devices frequently&lt;br&gt;- Use appropriate footwear when ambulating (high risk feet should not be in socks/booties or bare feet)</td>
<td>- Skin assessment per shift&lt;br&gt;- Elevate heels, consider a offloading devise&lt;br&gt;- Encourage/assist with turning and repositioning every 2-hours, or based on patients skin tolerance&lt;br&gt;- When in wheelchair, encourage/assist with position changes at least every hour&lt;br&gt;- Assess under medical devices frequently&lt;br&gt;- Use appropriate footwear when ambulating (high risk feet should not be in socks/booties or bare feet)</td>
<td>- Routine skin care&lt;br&gt;- Encourage patient to report any pain over boney prominences&lt;br&gt;- Check heels daily</td>
</tr>
<tr>
<td>Moisture</td>
<td>Constantly moist</td>
<td>Often moist</td>
<td>Occasionally moist</td>
<td>Rarely moist</td>
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<td>---------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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<tr>
<td></td>
<td>- Assess skin per shift; pay attention to skin folds</td>
<td>- Assess skin per shift; pay attention to skin folds</td>
<td>- Skin assessment per shift</td>
<td>- Routine skin care</td>
</tr>
<tr>
<td></td>
<td>- Use moisture barrier ointments (protective skin barriers).</td>
<td>- Use moisture barrier ointments (protective skin barriers).</td>
<td>- Use moisture barrier ointments (protective skin barriers).</td>
<td>- Encourage patient to report any skin changes noted</td>
</tr>
<tr>
<td></td>
<td>- Moisturize dry unbroken skin.</td>
<td>- Moisturize dry unbroken skin.</td>
<td>- Moisturize dry unbroken skin.</td>
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<tr>
<td></td>
<td>- Avoid hot water.</td>
<td>- Avoid hot water.</td>
<td>- Avoid hot water.</td>
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</tr>
<tr>
<td></td>
<td>- Cleanse skin with pH-balanced no-rinse soap, pat skin dry</td>
<td>- Cleanse skin with pH-balanced no-rinse soap, pat skin dry</td>
<td>- Cleanse skin with pH-balanced no-rinse soap, pat skin dry.</td>
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<tr>
<td></td>
<td>- Avoid powder/talc</td>
<td>- Avoid powder/talc</td>
<td>- Avoid powder/talc</td>
<td></td>
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<tr>
<td></td>
<td>- Use wicking material or moisture transfer dressing between skin folds to wick away moisture</td>
<td>- Use wicking material or moisture transfer dressing between skin folds to wick away moisture</td>
<td>- Use wicking material or moisture transfer dressing between skin folds to wick away moisture</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Check incontinence pads frequently (Q 2-3 hours)</td>
<td>- Check incontinence pads frequently (Q 2-3 hours)</td>
<td>- Check incontinence pads frequently (Q 2-3 hours)</td>
<td></td>
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<tr>
<td></td>
<td>- Establish toileting schedule</td>
<td>- Establish toileting schedule</td>
<td>- Establish toileting schedule</td>
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<tr>
<td></td>
<td>- Consider a low-air-loss mattress</td>
<td>- Consider a low-air-loss mattress</td>
<td>- Consider a low-air-loss mattress</td>
<td></td>
</tr>
<tr>
<td>Activity</td>
<td>Bedfast</td>
<td>Chairfast</td>
<td>Walks occasionally</td>
<td>Walks frequently</td>
</tr>
<tr>
<td>----------</td>
<td>---------</td>
<td>-----------</td>
<td>-------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Mobility</td>
<td>Completely immobile</td>
<td>Very limited</td>
<td>Slightly limited</td>
<td>No limitations</td>
</tr>
<tr>
<td></td>
<td>• OT consult</td>
<td>• OT consult</td>
<td>• Consider OT consult</td>
<td>• Encourage frequent position changes</td>
</tr>
<tr>
<td></td>
<td>• PT consult (Rehab Services)</td>
<td>• PT consult (Rehab services)</td>
<td>• Encourage/assist in turning and repositioning Q-hours</td>
<td>• Routine skin care</td>
</tr>
<tr>
<td></td>
<td>• Encourage/assist in turning and repositioning Q-2 hours</td>
<td>• Encourage/assist in turning and repositioning Q-hours</td>
<td>• Consider use of turning and positioning devises (wedges, pillows)</td>
<td>• In chair, encourage frequent repositioning</td>
</tr>
<tr>
<td></td>
<td>• Consider use of turning and positioning devises (wedges, pillows)</td>
<td>• Consider use of turning and positioning devises (wedges, pillows)</td>
<td>• Consider heel offloading devise</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Consider use of therapeutic support surface (mattress and/or cushion)</td>
<td>• Consider use of therapeutic support surface (mattress and/or cushion)</td>
<td>• In chair encourage/assist in frequent repositioning</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Consider Heel offloading devise</td>
<td>• Consider heel offloading devise</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>• Assess skin frequently</td>
<td>• Assess skin frequently</td>
<td>• Assess skin frequently</td>
<td>• Encourage activity as tolerated</td>
</tr>
<tr>
<td></td>
<td>• PT/OT consult</td>
<td>• PT/OT consult</td>
<td>• Encourage/assist in ambulation as tolerated</td>
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<tr>
<td></td>
<td>• Avoid multiple layers of bedding or padding, keep linens smooth</td>
<td>• Avoid multiple layers of bedding or padding, keep linens smooth</td>
<td>• Consider PT consult</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Consider OT consult</td>
<td>• Consider OT consult</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Consider use of therapeutic support surface (mattress &amp;/or chair cushion)</td>
<td>• Consider use of therapeutic support surface (mattress &amp;/or chair cushion)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Consider use of therapeutic support surface (mattress &amp;/or chair cushion)</td>
<td>• Consider heel offloading devise</td>
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This is a CONTROLLED document for internal use only. Any documents appearing in paper form are not controlled and should be checked against the electronic file version prior to use.
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<tr>
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<td>• Keep head of bed (HOB) less than 30°</td>
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<tr>
<td></td>
<td>• Nutrition consult</td>
</tr>
<tr>
<td></td>
<td>• Consider MedPass program</td>
</tr>
<tr>
<td></td>
<td>• Encourage meal intake and assist with set up</td>
</tr>
<tr>
<td></td>
<td>• Consider high calorie and high protein options</td>
</tr>
<tr>
<td></td>
<td>• Offer patient food choices</td>
</tr>
<tr>
<td></td>
<td>• Offer fluids and snacks throughout day</td>
</tr>
<tr>
<td></td>
<td>• Record ins &amp; outs</td>
</tr>
<tr>
<td></td>
<td>• Monitor weight weekly</td>
</tr>
<tr>
<td></td>
<td>• Monitor and document nutritional intake</td>
</tr>
<tr>
<td>Potential Problem</td>
<td>Probably Inadequate</td>
</tr>
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<td></td>
<td>• Keep head of bed (HOB) less than 30°</td>
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<tr>
<td></td>
<td>• Nutrition consult</td>
</tr>
<tr>
<td></td>
<td>• Consider MedPass program</td>
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<tr>
<td></td>
<td>• Record ins &amp; outs</td>
</tr>
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<td></td>
<td>• Monitor weight weekly</td>
</tr>
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<td>• Monitor and document nutritional intake</td>
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<td>Adequate</td>
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<td>• Keep head of bed (HOB) less than 30°</td>
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<td></td>
<td>• Encourage meal intake and assist with set up</td>
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<td>• Offer patient food choices</td>
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<td>• Offer fluids and snacks throughout day</td>
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<td></td>
<td>• Record ins &amp; outs</td>
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<td></td>
<td>• Monitor weight weekly</td>
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<td>• Monitor and document nutritional intake</td>
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<td>Excellent</td>
<td>Excellent</td>
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<td></td>
<td>• Keep head of bed (HOB) less than 30°</td>
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<tr>
<td></td>
<td>• Encourage fluid and food intake</td>
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<td></td>
<td>• Monitor and document nutritional intake</td>
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<table>
<thead>
<tr>
<th>Unless for meal time or as per client condition:</th>
<th>Consider use of prophylactic foam dressing over boney prominences and under medical devises:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Lift patient, do not drag</td>
<td>• Consider use of transfer aids/devises (transfer boards, slider sheets)</td>
</tr>
<tr>
<td>• Consider use of prophylactic foam dressing over boney prominences and under medical devises:</td>
<td>• Consider use of prophylactic foam dressing over boney prominences and under medical devises:</td>
</tr>
<tr>
<td>• Use wheelchair tilt feature</td>
<td>• Use wheelchair tilt feature</td>
</tr>
<tr>
<td>• Raise knees of bed prior to raising head of bed</td>
<td>• Raise knees of bed prior to raising head of bed</td>
</tr>
<tr>
<td>• Protect elbows and heels during repositioning or transfers</td>
<td>• Protect elbows and heels during repositioning or transfers</td>
</tr>
</tbody>
</table>
Appendix E: Heel Offloading Algorithm

Assessing the Patient Who is at Risk for Heel Pressure Injury

Complete Braden Scale

**BRADEN 19-23**

- Follow Pressure Injury Prevention Strategies which include:
  - Frequent position changes
  - Early mobilization
  - Assess skin integrity **EVERY SHIFT**

**BRADEN 18 OR LESS**

- Follow Pressure Injury Prevention Strategies which include:
  - Reposition every 2-4 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)

- 1 person assist for transfers and mobility

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

- Return to Pressure Injury Prevention Strategies

**NO**

- Apply and monitor off-loading device (heel boot or pillow)
- Perform skin check q2h once device applied

**YES**

If continued skin breakdown, consider consult:
- Occupational Therapist
- Professions of Orthotics or Prosthetics or Pedorthist

Establish if patient is appropriate for heel device:

- Visible signs of pressure?
  - AND/OR
    - Braden - Mobility ≤ 2 and Activity ≤ 2
    - Fractured hip or lower extremity fracture
    - Ischemia of the lower limb
    - Remaining lower limb amputee
    - Peripheral neuropathy - Diabetes mellitus
    - Leg spasms/inadequately controlled pain
    - Mental confusion
    - Skin grafts to the lower leg or foot
    - Paralysis of the lower leg or foot
    - Unconscious
    - Slings and springs
    - Bucks traction

- Apply and monitor off-loading device
  - Perform skin check q2h once device applied
  - Refer to appropriate team members
  - Consider therapeutic surface
Appendix F: Inpatient Therapeutic Surface Support

Surface Support Decision Tree

Braden Score 18 or less and/or Clinical Signs of Pressure (Blanchable or Non-blanchable Redness)

**NO**
- 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 q2-4 hours
  - Off-load heels

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

**YES**
- 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/q-shift
- Consult OT/PT to address mobility, activity and or surface support challenges

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

Patients at risk must be on a turning schedule. Mattresses should fit the beds to reduce risk of entrapment.

**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
  - Gore-Tex cover sheet
  - Microclimate

- **Pressure Redistribution, Compromised Pulmonary, or Circulatory System**
  - Low air loss mattress
  - Percussion/pulsion
  - Rotation
  - Alternating pressure

---

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Appendix G: 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 patients 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>

**NOTE:** Bottoming out 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.
Appendix H: Nutrition Algorithm: Supporting the Nutritional Needs of Patients at Risk of Developing a Pressure Injury

**BRADEN 19-23**

- Maintain nutrition status and minimize loss of lean body mass by:
  - Encouraging intake of high calorie, high protein foods
  - Ensuring easy access to meals and snacks
  - Encouraging intake of nutritionally sound fluids (water, milk) if able
  - Monitoring and documenting intake daily. If intake less than 50% of meals provided, consult clinical dietitian for an individualized assessment and plan of care.

**BRADEN 18 OR LESS**

- Consult clinical dietitian for individualized assessment and plan of care.
- Start MedPass program if available at facility and patient able to tolerate
- Encourage intake of high calorie, high protein foods.
- Offer main entrée first at every meal.
- Ensure easy access to meals and supplements via tray set up, mealtime support and assistance
- Encourage intake of nutritionally sound fluids (water, milk) if able
- Monitor and document oral intake daily.
- If oral intake remains consistently poor, consider nutrition support via enteral nutrition or TPN if within goals of care.

**Nutrition Facts and Things to Consider**

- 45% of hospitalized patients are malnourished upon admission to the hospital
- Consulting clinical dietitians early can make a difference in hospital length of stay and readmission rates
- In some instances where texture modified diets are in use and thickened liquids required, MedPass and the use of supplements and high protein foods will require the assistance of a clinical dietitian to optimize nutrition status
- If patient NPO and/or are nourished via enteral or parenteral nutrition, the use of MedPass may not be feasible. Confirm with clinical dietitian and interdisciplinary team if option to include.
VERSION HISTORY

<table>
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<th>Version:</th>
<th>Effective:</th>
<th>Approved by:</th>
<th>What’s changed:</th>
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<td>2016-06-03</td>
<td>Vice-President, Research and Innovation</td>
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<td>Revised</td>
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<td>Standard review – minor revision</td>
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<td>2021-02-05</td>
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<td>Clarification for Emerg:</td>
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<td>2021-11-05</td>
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<td>• Included initial risk assessment of patients with CTAS levels 1-3</td>
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<td>• Frequency of risk assessment and skin assessment</td>
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<td>Added ACP to “applies to” section</td>
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