PURPOSE:
To identify participants at risk for development of altered skin integrity and ensure all participants will receive appropriate skin assessments and interventions as applicable.

APPLIES TO:
Catholic Health LIFE and contracted staff

GENERAL STATEMENT OF POLICY AND PROCEDURE:
All participants will receive appropriate skin assessments and interventions as applicable.

PROCEDURE:

Risk Assessment
All participants will have a full RN assessment at enrollment, 6 & 12 month assessments and with any significant change of condition as determined by IDT. This assessment will include completing a Pressure Injury Prevention Tool (See attachment 1) and a Braden Scale (See attachment 2). These assessments will enable the RN to determine the appropriate pressure relieving interventions to incorporate into the plan of care and plan future nursing visits for skin examinations and education to participants and/or caregivers.

Braden Scale:
The Braden Score will determine the frequency of home visits. Follow-up home visits should include a full skin examination, education for participant and/or caregiver on pressure injury prevention, ensuring an adequate treatment plan is in place including appropriate DME and documenting the interaction. The nurse may use LIFE Educational Tool “Preventing Pressure Injuries/Bed Sores” (See attachment 3) to assist in education.

- A score of 16 or greater- follow up visit will occur every 6 months
- Score of 15 or 14 - every 3 months
- Score of 13 or less and/or History of previous pressure injury– every month.

If the only risk factor is a history of a previous pressure injury and the participant has reached the 6 month reassessment without a reoccurrence, the frequency of revisits for teaching and ensuring an adequate treatment plan and DME can be re-evaluated. The RN must confer with the PCP staff.
**Pressure Injury Prevention Tool**: The Pressure Injury Prevention Tool can be used as an instrument to ensure the proper treatment plan and interventions are in place.

- **Hospital Admission**: The PCP will coordinate with the primary care nurse to complete the form and send to the hospital contact.
- **SAR/LTC Transfer**: LIFE informational sheet with contact information will be placed in the chart. If the nurse is unfamiliar with the participant, a call to the Primary nurse or the PCP will need to occur.
  - LIFE RN Completes case communication within 24-48hrs. Case communication is to include a full skin assessment and completion of the Pressure Injury Prevention Tool which then will be communicated to the facility RN. A copy will then be scanned into TruChart.
  - LIFE RN to follow up within 24hrs if recommended equipment is not readily available. If equipment is not provided the LIFE RN is to notify the Director of Home Health who in turn will contact the SNF DON for follow through. If equipment still is not provided the Director of Home Health will notify the LIFE Medical Director who will reach out to SNF Medical Director.
- **Respite Stay**: Prior to leaving for a respite stay a full skin assessment will be completed by a RN. A case communication will be completed by the primary RN or RN designee. This can be done over the phone for short (up to 3 overnight stays) uncomplicated respite stays. If the participant is more complicated or the respite stay is extended a face to face communication must be completed within 48 hrs of admission. A follow up skin assessment is completed upon the participants respite discharge by the RN.

**Interventions for participants without current breakdown, to be completed every 6 months**

- Full skin assessment by RN and PCP
- Barrier Cream initiated if incontinent
- Therapy assess for positioning devices as appropriate for pressure relief
- Therapy assess any participant that is admitted with a prosthesis (See policy # 3038)
- Nutritional assessment
- Update LIFEPLAN,HHA CarePlan by all disciplines

**Wound assessment/documentation**
Cleanse wound prior to assessment. Consider wound photo (See wound photo policy). Document wound description including:

- Body Location
- Measure in centimeters
- Length
- Width
- Depth
- Exudate
- Odor
- Tissue Type
- Wound Edges
- Periwound Skin
- Undermining and/or tunneling
**Staging** - Stage all pressure injuries

**Stage 1 Interventions:**
- Skin assessments should now be done weekly until healed, then monthly thereafter or more frequently as needed.
- Initiate off-loading of affected area.
- Initiate treatment of area as appropriate
- Update LifePlan/HHA CarePlan
- Educate with participant/caregiver LIFE Educational tool “Preventing Pressure Injury/Bed Sores” (See attachment 3), and document as such.
- Complete occurrence form
- Notify IDT

**Stage 2 Interventions:**
- Skin assessments should now be done weekly until healed, then monthly thereafter or more frequently as needed.
- Initiate off-loading of affected area. Consider pressure relieving mattress and/or specialty chair cushion.
- Initiate treatment as appropriate after discussion with PCP or WOCN. Possible treatments at this stage are: Gels, Foams, or Alginates
- Monitor for s/s infection
- Update LifePlan/HHA CarePlan
- Educate with participant/caregiver LIFE Educational tool “Preventing Pressure Injury/Bed Sores” (See attachment 3), and document as such.
- Complete occurrence form
- Notify IDT

**Stage 3 & 4 Interventions:**
- Skin assessments should now be done weekly until healed, then monthly thereafter or more frequently as needed.
- Initiate off-loading of affected area. Consider pressure relieving mattress and/or specialty chair cushion
• Initiate/ change treatment if appropriate after discussion with PCP or WOCN, consider the following based on wound bed appearance, drainage, slough, periwound skin integrity, and location.
  1. Silver dressing/gel
  2. Santyl
  3. Honey dressing/ gel
  4. Tenderwet
  5. Alginate
• Consider therapeutic wound debridement, E.Stim. pulsed lavage, wound center consultation, hyperbaric treatment, etc.
• Monitor for s/s infection/osteomyelitis
• Update LifePlan/HHA CarePlan
• Educate with participant/caregiver LIFE Educational tool “Preventing Pressure Injury/Bed Sores” (See attachment 3), and document as such.
• Complete occurrence form
• Notify IDT
• Notify LIFE clinical wound advisor for consultation.
• NOTIFY QA / PI COORDINATOR

Unstageable Pressure Injuries:
• A wound becomes unstageable when the wound bed is covered with greater than or equal to 50% slough.
• See stage 3 & 4 Interventions

❖ If a pressure injury becomes a stage III, IV, or unstageable notify the QA/PI Coordinator immediately and also bring back to the IDT as these qualify for a Level II under CMS guidelines.

Replaces the following P&P(s), if applicable:

<table>
<thead>
<tr>
<th>Origination/Effective Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
</tr>
<tr>
<td>Reviewed</td>
</tr>
<tr>
<td>Revised</td>
</tr>
</tbody>
</table>
# Pressure Injury Prevention Tool

(LIFE Communication Sheet) p.1-888-845-0247 f.819-5253

**Participant Name**

**Current Location**

**LIFE Clinician**

**FTF w/ PCN**

**Recommendations given to:**

**Date**

**Fax #**

### RISK FACTORS

<table>
<thead>
<tr>
<th>History of skin breakdown?</th>
<th>Yes</th>
<th>No</th>
<th>Type:</th>
<th>Location:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current breakdown?</td>
<td>Yes</td>
<td>No</td>
<td>Type:</td>
<td>Location:</td>
</tr>
<tr>
<td>Presence of medical device? (Foley, O2, etc)</td>
<td>Yes</td>
<td>No</td>
<td>Type:</td>
<td></td>
</tr>
<tr>
<td>Impaired or decline in mobility?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recent orthopedic procedure?</td>
<td>Yes</td>
<td>No</td>
<td>Type:</td>
<td></td>
</tr>
<tr>
<td>Neuropathy?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive impairment?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor nutritional status?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Requires assistance with management of incontinent care?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### PLEASE CIRCLE RECOMMENDATIONS

**Bed/Seating**

<table>
<thead>
<tr>
<th>Chair Cushion: Foam, Gel or Roho</th>
<th>Slip Sheet for positioning</th>
<th>Overlay: Air or Gel</th>
<th>Alternating Pressure Mattress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Repositioning in Chair Every 1 Hr./Repositioning in Bed Every 2 Hr.</td>
<td>Low Air Loss Mattress</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Bony Prominences**

<table>
<thead>
<tr>
<th>Heels: Skin Prep Daily</th>
<th>Heel Float Boots</th>
<th>Float Heels on Pillow</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Elbows: Skin Prep Daily</th>
<th>Elbow Protectors</th>
<th>Ankle Protectors</th>
</tr>
</thead>
</table>

| Spine: Skin Prep Daily | Foam Dressing | Ears: Skin Prep Daily | Pressure Relief Pillow |
|------------------------|---------------|-----------------------|

**Incontinent Care**

<table>
<thead>
<tr>
<th>Incontinent Care Every 2 Hours and as Needed</th>
<th>Toileting Schedule</th>
<th>Barrier Cream</th>
</tr>
</thead>
</table>

**Nutrition**

<table>
<thead>
<tr>
<th>Poor Appetite Assessment</th>
<th>Needs to be Fed</th>
<th>Recent Weight Loss</th>
<th>Swallowing Evaluation</th>
<th>Dietary</th>
</tr>
</thead>
</table>

*Reduce friction/shear by using lifts, slide sheet and do not elevate head of bed more than 30 degrees*

**Other Notes:**
Preventing Pressure Injuries/Bed Sores

The most common areas of the body for pressure injuries/bedsores to develop are the tailbone, buttocks, side of hip joint, back of the heel, ankle, knee, and elbow.

It is much better to prevent pressure ulcers than to treat them. Ways to reduce the risk of pressure injuries include:

**Take care of your skin**
- Do skin checks daily. Look for redness, dark areas, cracks, bruises, and blisters.
  - Watch for red, tender, or swollen areas on the skin. Pay special attention to any areas that stay red after the pressure has been relieved. The goal is to find and correct problems before skin breakdown occurs.
- Clean your skin when you have become wet or soiled.
- Keep your skin moisturized.

**Change positions often**
- Limit pressure over bony parts by changing positions.
  - If in bed, change position at least every 2 hours.
  - If in a chair/wheelchair, make small position changes every 15 minutes and if able, stand up every hour.
- Be careful when changing positions or standing. Do not slide or scoot.
- Relieve pressure by shifting weight while in a seated position or in bed

**Use devices to relieve pressure**
- Devices may be given to you by the LIFE program to relieve pressure.
- The LIFE staff will instruct you on your proper body positioning while in bed.

**Eat well**
- Eat a balanced diet and drink plenty of fluids. Healthy skin is less likely to be damaged. If unable to eat a balanced diet, talk to your LIFE staff members about supplements.
Pressure Injuries

You have a sore_____________________. (Specify body area)
This is considered a Pressure Injury / Bed Sore.

What are pressure injuries/ bed sores?
A pressure injury is a breakdown of skin and underlying tissue that develops when you are bedridden or have to stay in one position for a long time. Pressure injuries can occur if you lie in bed or sit in a chair for long periods of time without shifting your weight. They may also be caused by rubbing or friction on the skin.
Pressure injuries used to be called bedsores.

How do they occur?
Pressure injuries are caused by pressure or rubbing of weight-bearing parts of the body. Areas where bones are close to the skin are especially prone to such injuries. The common areas that these injuries can occur are on the buttocks, hips, ankle, heels, and elbows.
The following risk factors increase your chance of getting pressure injuries:
• Previous injuries make you more at risk for future ones.
• Inability to move without help while in a bed or a chair.
• Loss of bowel or bladder control (the moisture from stool or urine may irritate the skin)
• Poor diet and eating habits, result in unhealthy skin
• Low body weight or recent weight loss resulting in a lack of fat tissue over bony areas such as the hips, heels, and ankles
• Decreased alertness, possibly from health problems, medicines, or anesthesia

What are the symptoms?
Pressure injuries appear over bony parts of the body where there is irritation or pressure. These symptoms can be:
• Redness
• Pain
• Swelling or blister formation
• Cracks or peeling of the skin
• Drainage / odor
• Skin color changes
**How are they treated?**

Treatment depends on the severity of the condition. Pressure injuries need prompt and ongoing care in the early stages to try to avoid tissue damage and infection.

If you have any of the symptoms listed above, you should:

- Tell your LIFE Nurse
- Keep pressure off the area. For example, if the area is on your back, try to lie on your stomach or side.
- Keep the area clean and protect it from urine and stool.
- Do not massage the area.
- Turn or change your position every 1 to 2 hours. See the attached positioning schedule.
- Eat a healthy diet.
- Tell your LIFE nurse right away if you develop a fever, notice an odor or change in the color of drainage from the area, or develop redness around it.
- Sleep in a bed NOT a recliner chair.
- Try not to raise the head of the bed

**How long will the effects last?**

Pressure injuries can take a long time to heal if they are completely through the skin. The rate at which the broken skin heals depends on your general health, diet, and home care. It is best to try to prevent pressure injuries.
Complete PIPT

Calculate Braden score

16 or greater

14 or 15

13 or less or previous history of pressure injury

Ensure proper interventions are in place and listed on care plan under “At risk for skin breakdown.”

Full RN assessment at least EVERY 6 MONTHS (No deviation from current procedure)

RN home visit at least once every 3 MONTHS in addition to the 6 month assessments

RN home visit at least once EVERY MONTH in addition to the 6 month assessments

At 6 MONTH assessment complete the following:
- Full skin assessment
- Re-educate Family/CG on pressure injury prevention and care
- Update LIFEPLAN, HHA care plan
- Therapy assess positioning/prosthesis
- Nutritional assessment

At 3 MONTH home visit complete the following:
- Full skin assessment
- Re-educate family/CG on pressure injury prevention and care

At MONTHLY home visit complete the following:
- Full skin assessment
- Re-educate family/CG on pressure injury prevention and care

RN assessment (enrollment, annual, semi-annual) and for change in condition identified by IDT