

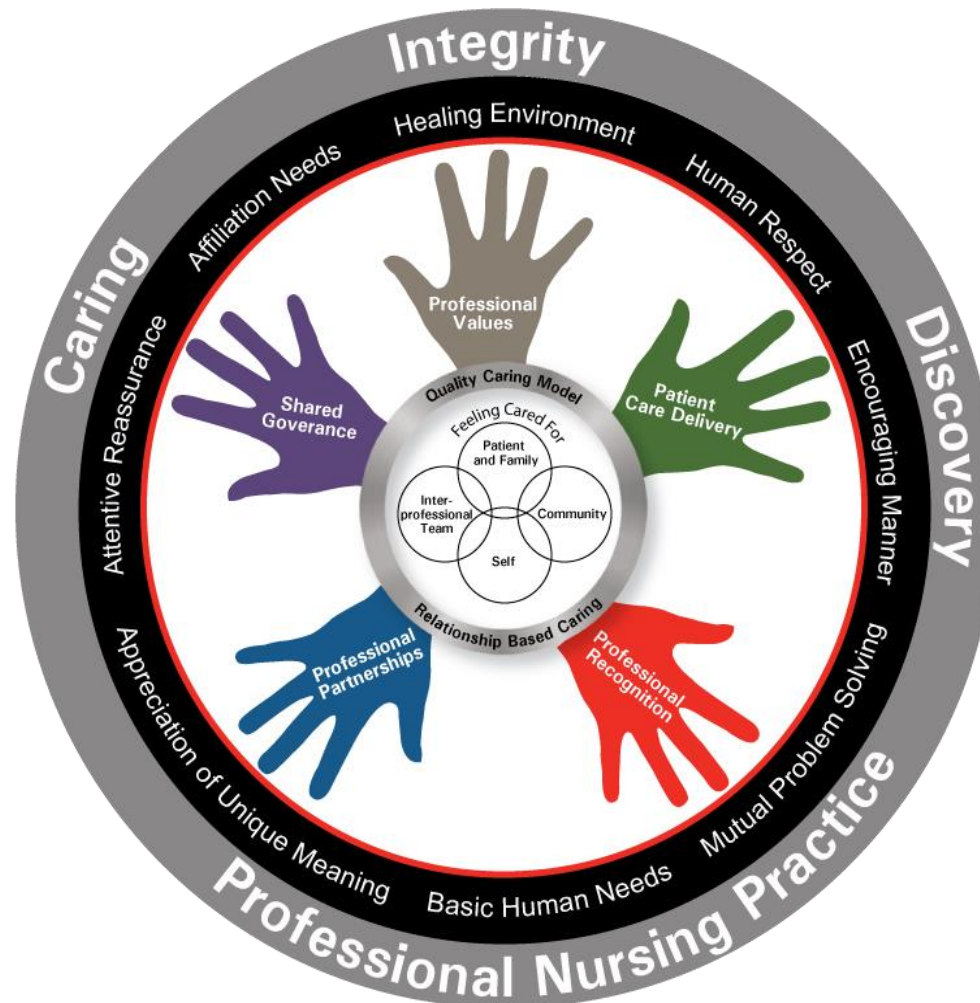
2017 Pressure Injury Prevention Competency for Nurses

A General Overview

In collaboration with the
Pressure Ulcer Prevention Workgroup



Professional Practice Model



Objectives

1. Discuss the different components of the Pressure Injury Prevention Bundle.
2. Describe the proper wound assessment and correct staging for pressure injuries.
3. Illustrate proper OneConnect documentation related to assessment and/or management of potential or actual pressure injury.

Pressure Injury Prevention Bundle

According to the Institute for Healthcare Improvement (IHI) and the National Pressure Ulcer Advisory Panel (NPUAP):

- Most pressure injuries are preventable
- Prevention includes:
 - Identifying patients at risk **AND**
 - Implementing prevention strategies for all at risk patients

Pressure Injury Prevention Bundle

- Conduct a pressure injury admission assessment for all patients
- Inspect skin and reassess risk for all patients every shift
- Manage moisture and promote skin care
- Optimize nutrition and hydration
- Reposition, mobilize, and minimize pressure, friction, and shear
- Engage, educate, and empower

Skin/Wound Assessment

Skin Assessment

- Head to toe skin assessment on admission **and** every shift
 - Inspect all of the skin upon admission/transfer (within 2 hours)
 - 2-RN cosign on admission/transfer
 - Inspect all of the skin every shift for signs of pressure injury
 - Assess **ALL** bony prominences and pressure points and give special attention to the following areas:
 - Sacrum, coccyx, buttocks, back, heels, ischium, trochanters, elbows, occiput
 - Areas beneath medical devices
 - e.g., trache collar, Foley catheter, nasal cannula, SCD/Teds

Skin Assessment

- Inspect body surfaces subject to pressure or pressure in combination with friction/shear
- Pay close attention to the following:
 - Skin folds especially for bariatric patients
 - Skin over the occiput for neonates/pediatric patients
- Palpate skin to assess temperature, moisture, and consistency
 - When inspecting darkly pigmented skin, look for changes in skin tone, skin temperature and tissue consistency compared to adjacent skin. Moistening the skin assists in identifying changes in color.

Skin Assessment

- Consider general risk factors including:
 - Age (elderly/pediatric patients)
 - Immobility
 - Incontinence
 - Inadequate nutrition
 - Sensory deficiency
 - Device-related pressure
 - Multiple co-morbidities
 - Circulatory abnormalities
 - Dehydration

Skin Assessment

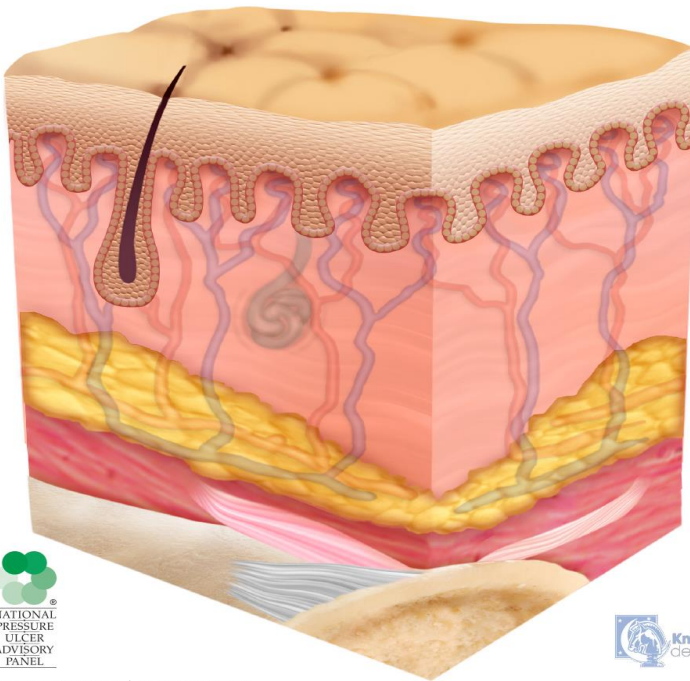
- Special considerations for oncology patients:
 - Nutritional status
 - Type of treatment
 - Skin-toxic chemotherapy/biotherapy agents
 - Radiation
 - Surgery
- Other considerations
 - Diminished perfusion/oxygenation
 - Spinal cord injury
 - History of previous pressure injury
 - Impairments in blood flow to the extremities from vascular disease, diabetes or tobacco use
 - Fragile skin

Skin Assessment

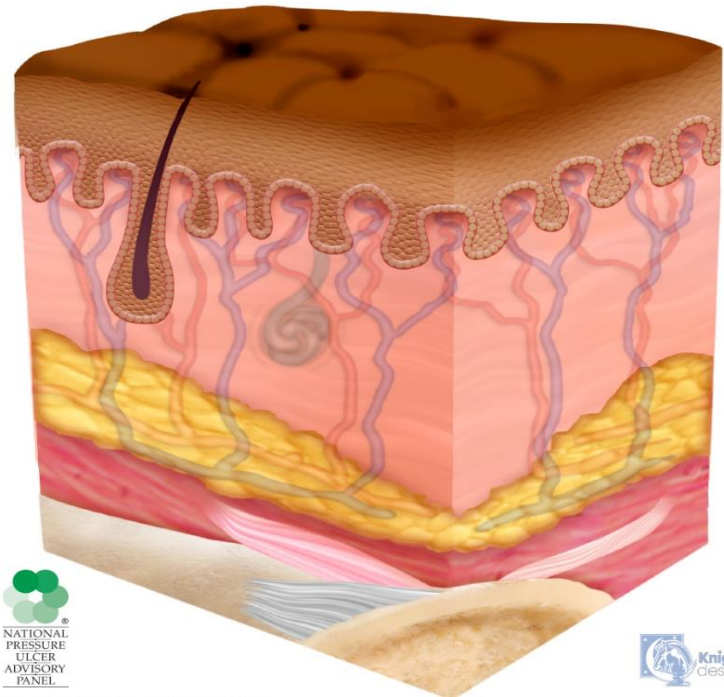
- Special considerations for pre/post-op patients:
 - Length of surgery (>4 hours)
 - Operating Room (OR) positioning
 - Lines/Drains/Airways
 - Medical Devices
 - SCDs
 - Compression stockings
 - Halo
 - Nutritional status
 - Functional capacity pre and post procedure
 - Number of hypotensive episodes intra-op
 - Low body temperature intra-op

Healthy Skin

Healthy Skin – Lightly Pigmented



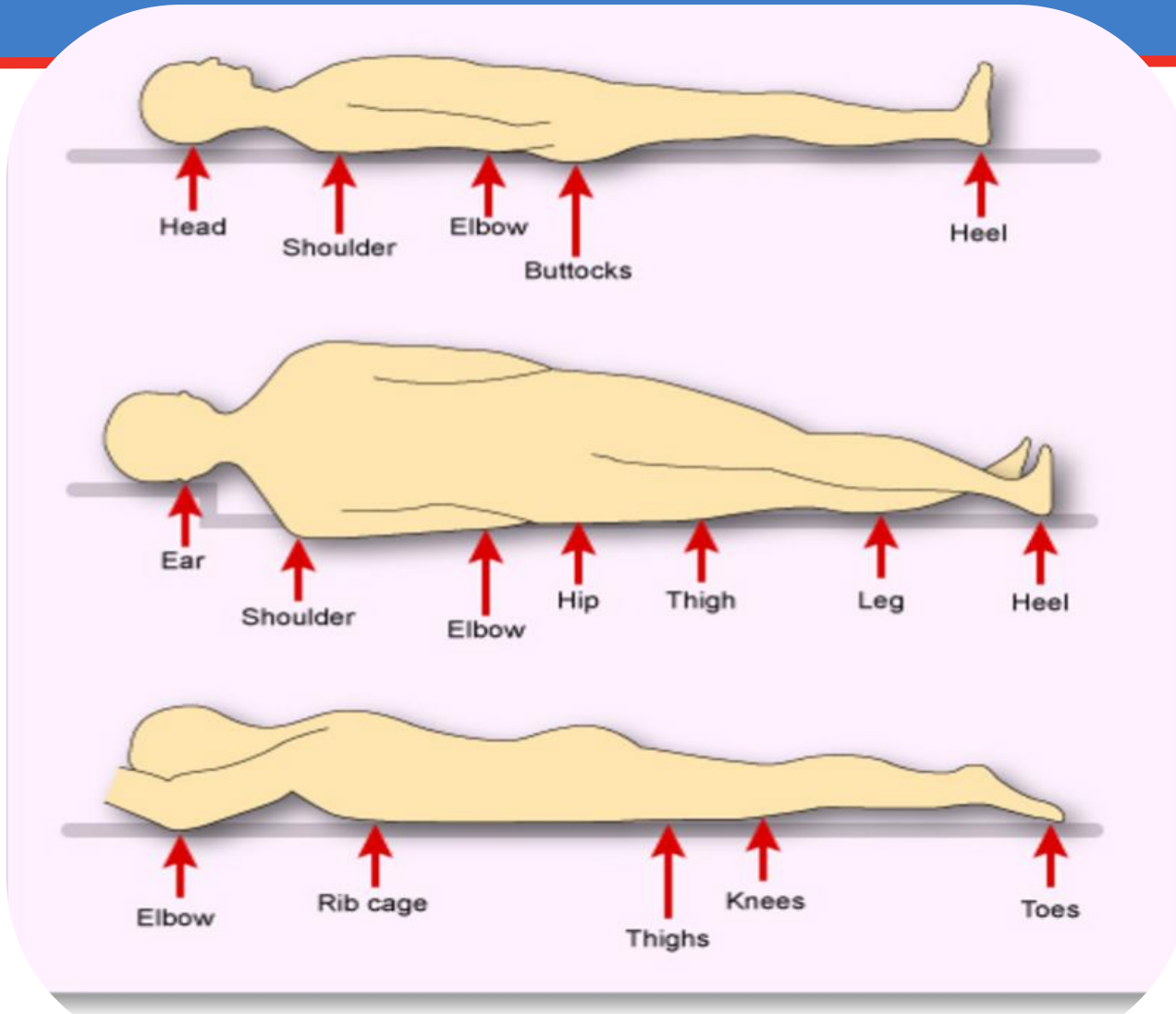
Healthy Skin – Darkly Pigmented



Wound Assessment

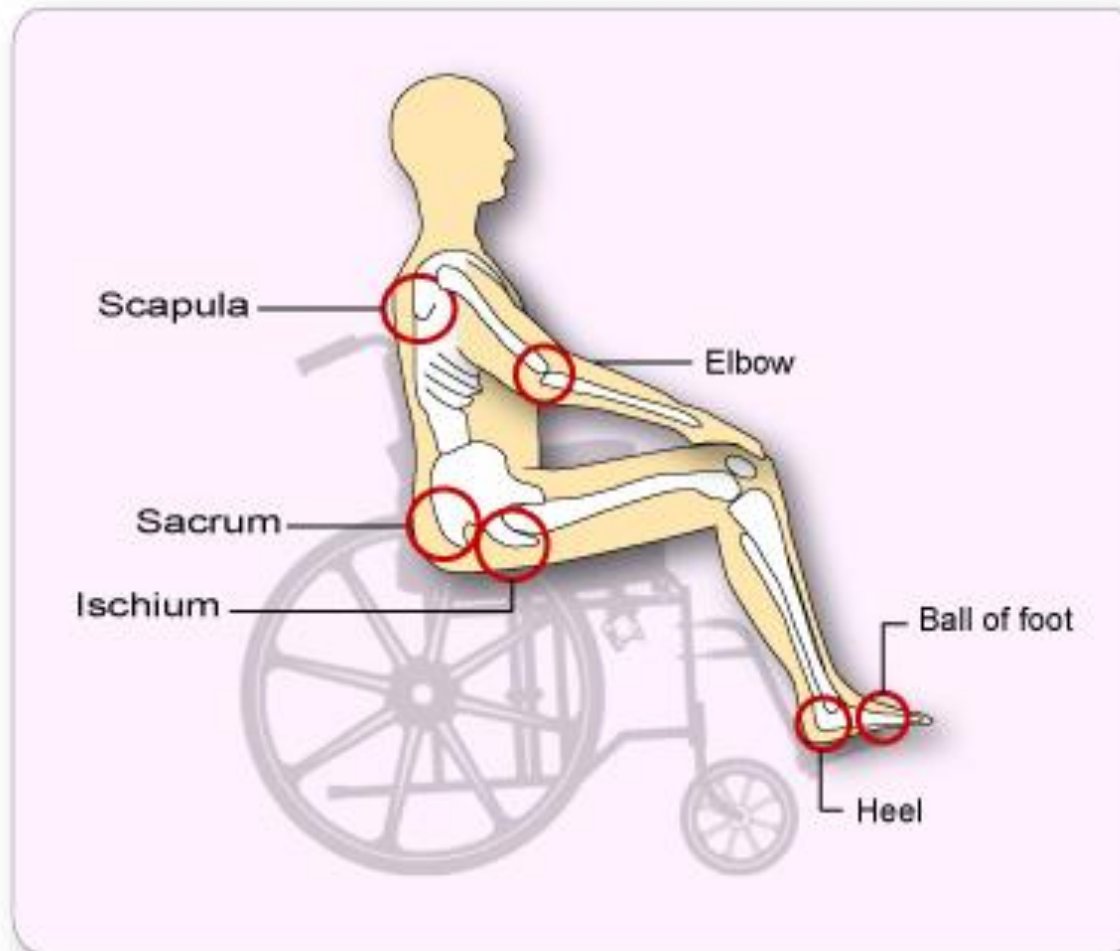
- Anatomical location
- Dimension
 - Length x Width x Depth (cm)
- Undermining/Tunneling/Sinus Tracts
- Extent of Tissue Loss
 - *Note that **staging** is used for pressure injury only*
- Wound Bed/Base
- Wound Edges/Wound Margins
- Surrounding skin
- Drainage
- Pain

Anatomical Location



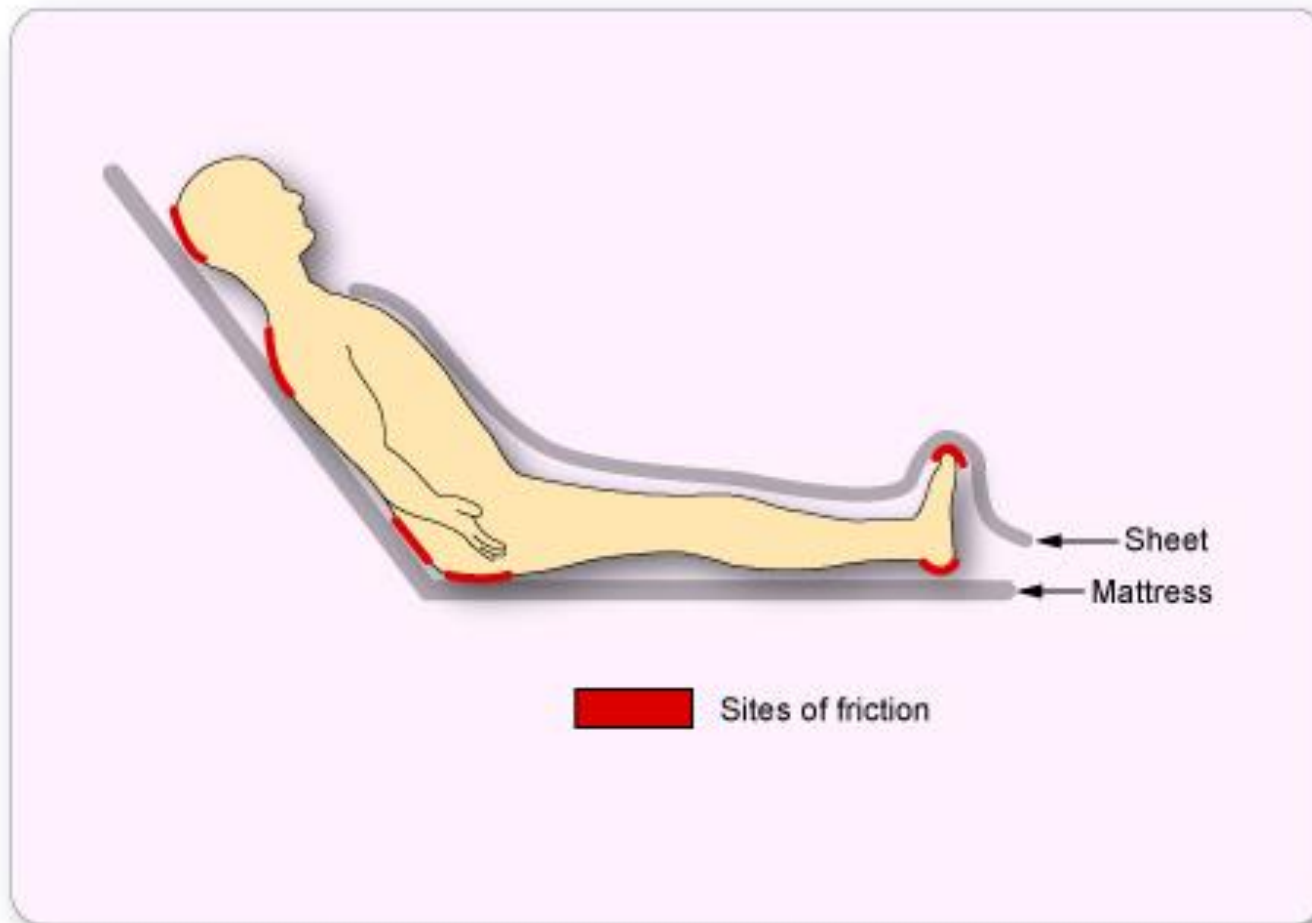
Common sites of pressure ulcers when lying down

Anatomical Location



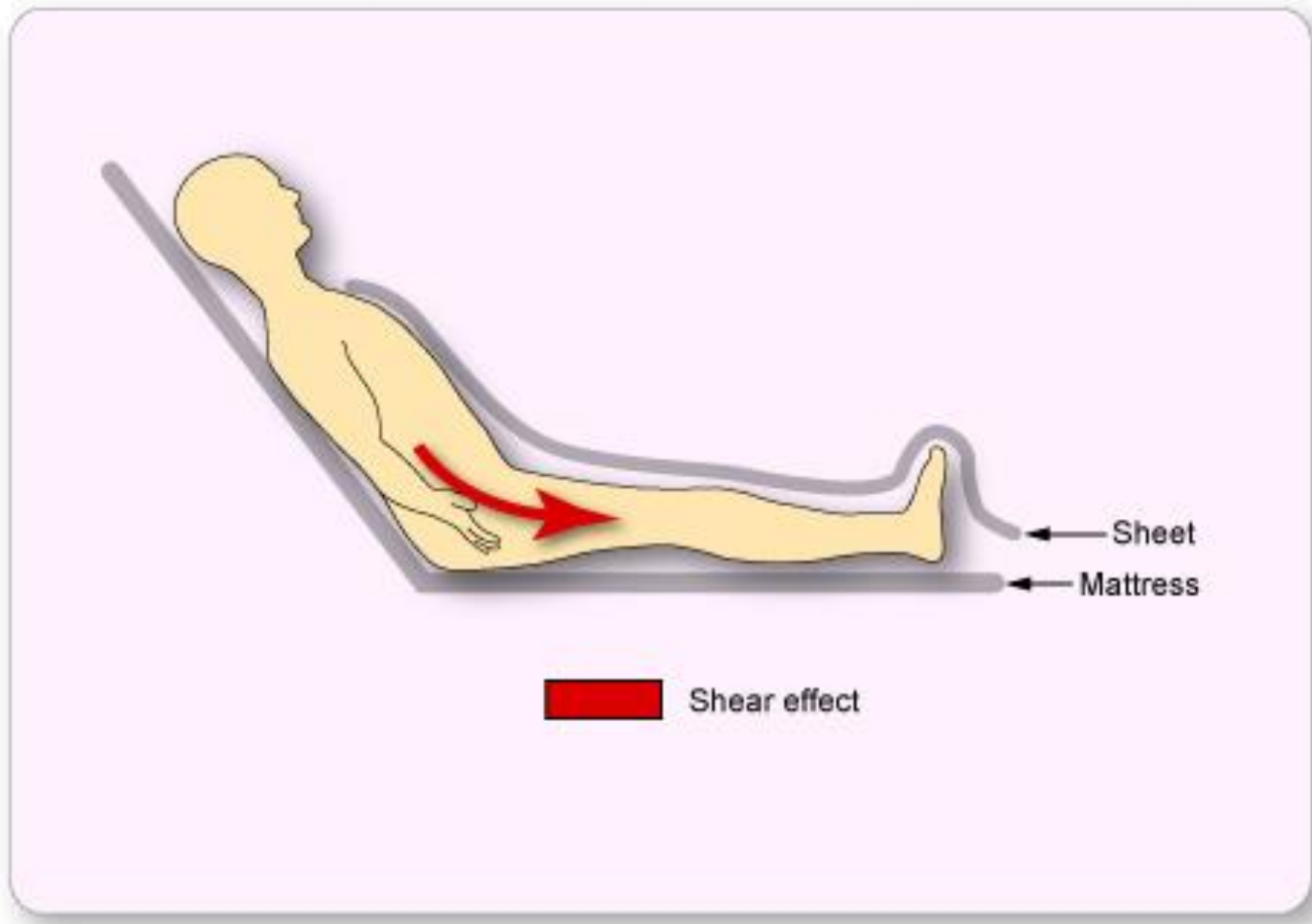
Common sites of pressure ulcers when sitting in a wheelchair

Anatomical Location



Effect of friction

Anatomical Location



Shear effect

Dimension:

Length x Width x Depth (cm)

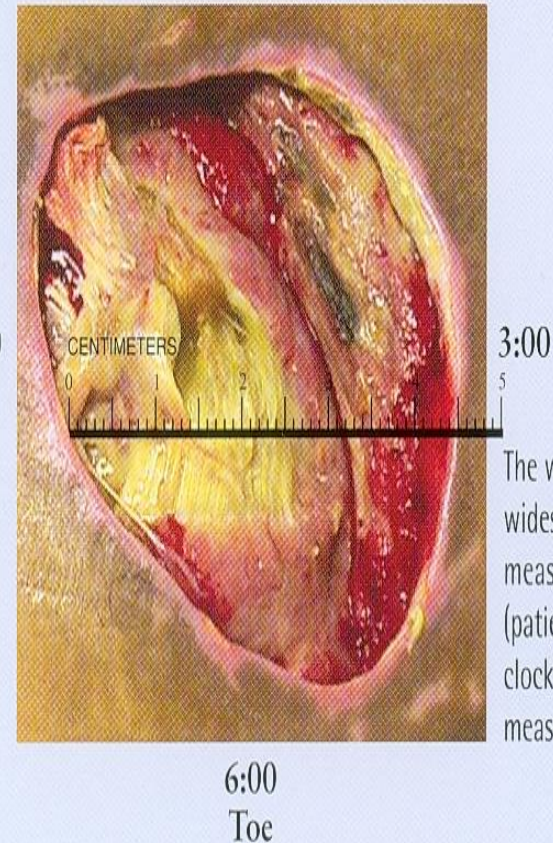
Length
Head
12:00



3:00 9:00

The length of a wound is the longest area of the wound measured head to toe (patient's) or if using the clock method, the length is measured from 12:00 to 6:00 (12:00 is at the patient's head).

Width
Head
12:00



3:00 9:00

The width of a wound is the widest area of the wound measured side to side (patient's) or if using the clock method, the width is measured from 3:00 to 9:00.

Dimension: Clock Method

Length x Width x Depth (cm)

Use the clock to guide wound measurement with the head of the body as the 12:00 reference position



Length:

- Place ruler over the longest length using the head to toe reference (head at 12:00 and feet at 6:00)
- Some wound may have a smaller length than width (i.e. the wound may be wider than it is long)

Width:

- Measure the widest aspect of the wound perpendicular to the length using the hip to hip direction (left hip at 3:00 and right hip at 9:00)

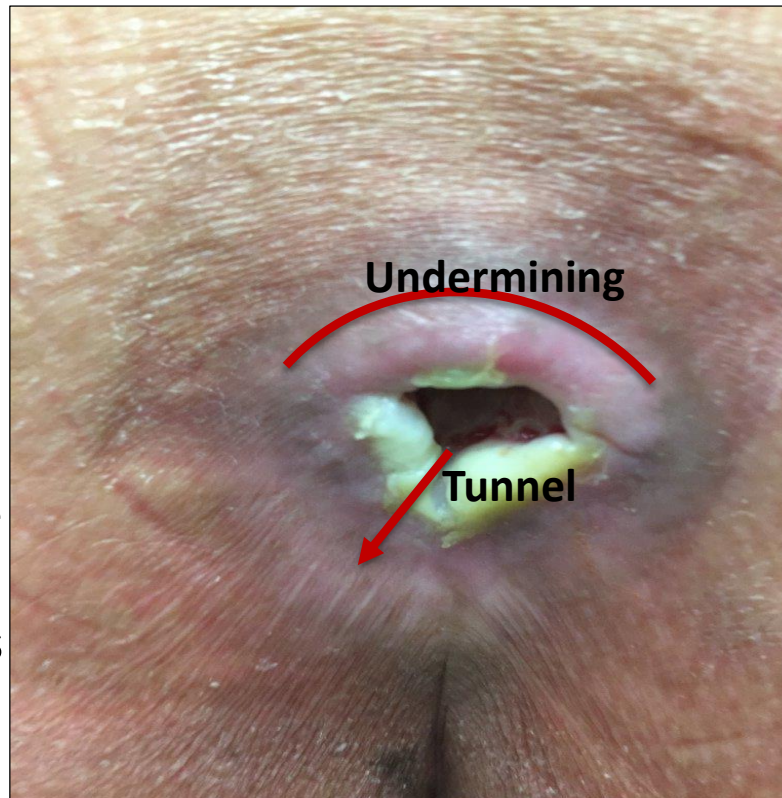
Depth:

- Gently insert a moistened cotton swab into the deepest part of the visible wound bed. Grasp the swab at the wound edge/margin and place against the ruler to measure

Note: When measuring wounds on the feet, the toes are at 6:00 and the heels are at 12:00.

Undermining/Tunneling

- **Undermining** refers to tissue destruction underneath intact skin at the wound edge.
- Wound edges are not attached to the wound base. Rather, skin edges overhang the periphery of the wound.



- A **tunnel** is a channel of tissue loss that can extend in any direction away from the wound through soft tissue and muscle.
- The tunnel or track may result in dead space which can delay wound healing.

Extent of Tissue Loss

Partial Tissue Loss

- involves loss of epidermis and dermis



Full Thickness Tissue Loss

- involves loss of tissue beyond the epidermis and dermis



Wound Bed/Base

Focus on the following:

- What is the **color**?
- Is it non-blanchable/non-viable OR blanchable/viable?

Non-Blanchable Erythema

- Area of persistent redness when pressure is applied with a fingertip (in darker skin tones, may appear with persistent red, blue, or purple hues)

Non-Viable

- Shows no signs of perfusion
- Think **no capillary refill**



Wound Bed/Base

Blanchable Erythema

- Reddened area that temporarily turns white or pale when pressure is applied with a fingertip.

Viable

- Shows signs of perfusion
- Think ***good capillary refill***



Wound Edges/Wound Margins

Focus on the following:

- Are the edges defined/distinct or diffused/irregular?
 - NOTE: Pressure injuries have defined/distinct edges whereas MASD have diffused/irregular edges
- Epibole = rolled/closed edges



Peri-Wound/Surrounding Skin Assessment

Describe in terms of:

- Color
- Texture
- Temperature
- Integrity
- Presence/Absence of lesions



Pain

- Note that pressure injuries can be very painful!
- Assess pain level at wound site using appropriate pain scale

Wong-Baker FACES® Pain Rating Scale

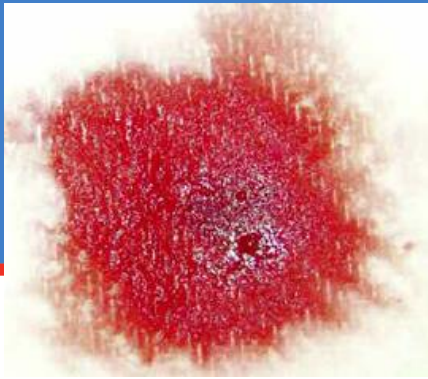


Drainage/Exudate

Describe:

- Type
 - Sanguineous, Serosanguineous, Serous, Purulent
- Color
- Odor
- Amount
 - **None** – Wound tissues are dry.
 - **Scant** – Wound tissues are moist, but there is no measurable drainage.
 - **Small or minimal** – Wound tissues are very moist or wet; the drainage covers less than 25% of the dressing.
 - **Moderate** – Wound tissues are wet; the drainage involves more than 25% to 75% of the dressing.
 - **Large or copious** – Wound tissues are filled with fluid that involves more than 75% of the dressing.

Drainage/Exudate



Sanguineous

- Bloody drainage (fresh bleeding) seen in deep wounds, partial or full thickness wounds



Illustration retrieved from
<https://caringforwounds.woundcareadvisor.com/how-to-assess-wound-exudate/>

Photo from MDA WOCN Resources

Drainage/Exudate



Serosanguineous

- *Thin, watery, pale red to pink plasma with red blood cells*

Drainage/Exudate



Serous

- Thin, clear, watery plasma seen in partial thickness wounds and venous ulceration



Illustration retrieved from
<https://caringforwounds.woundcareadvisor.com/how-to-assess-wound-exudate/>

Photo from MDA WOCN Resources

Drainage/Exudate



Purulent

- Thick, opaque drainage that is tan, yellow, green, or brown

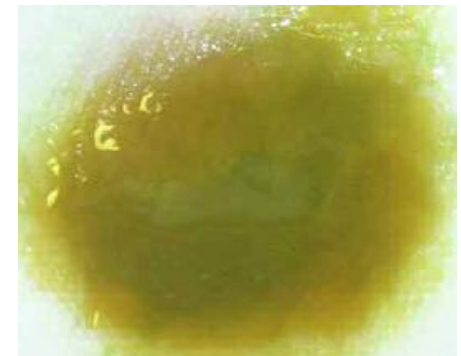


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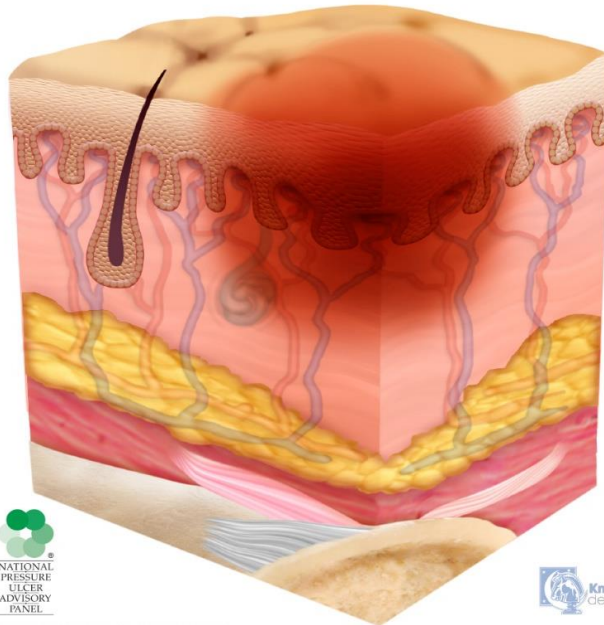
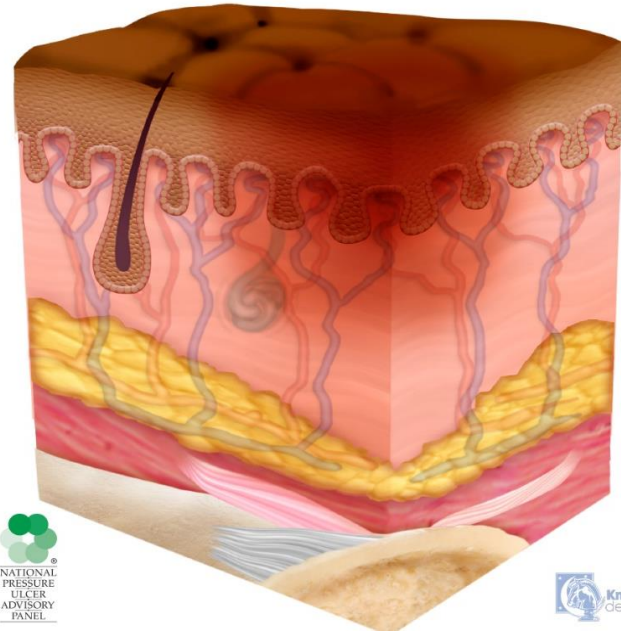
Assessing & Staging Pressure Injury

Stage I Pressure Injury

- ***Non-blanchable*** erythema of ***intact*** skin
- 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 (may indicate deep tissue pressure injury)

Stage I Pressure Injury

Stage 1 Pressure Injury - Lightly Pigmented Stage 1 Pressure Injury – Darkly Pigmented



Note: Consult with SKIN Champion

Illustrations from NPAUP Educational and Clinical Resources

Stage I Pressure Injury

Think
“tomato”!

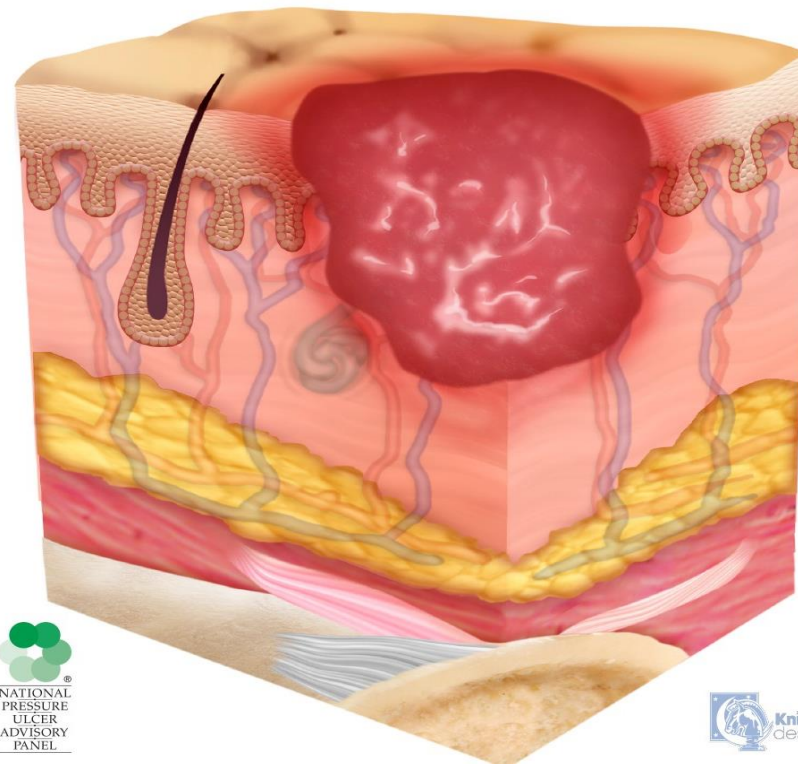


Stage II Pressure Injury

- Partial-thickness loss of skin with ***exposed dermis***
- Wound bed is ***viable***, pink or red, moist
- May also present as ***intact or ruptured serum-filled blister***
- Adipose (fat) and deeper tissues are not visible
- Granulation tissue, slough and eschar **not present**

Stage II Pressure Injury

Stage 2 Pressure Injury



Note: Consult with SKIN Champion

Stage II Pressure Injury

Think
“potato peel”!



Note:

May present as an intact
or ruptured **serum-filled**
blister

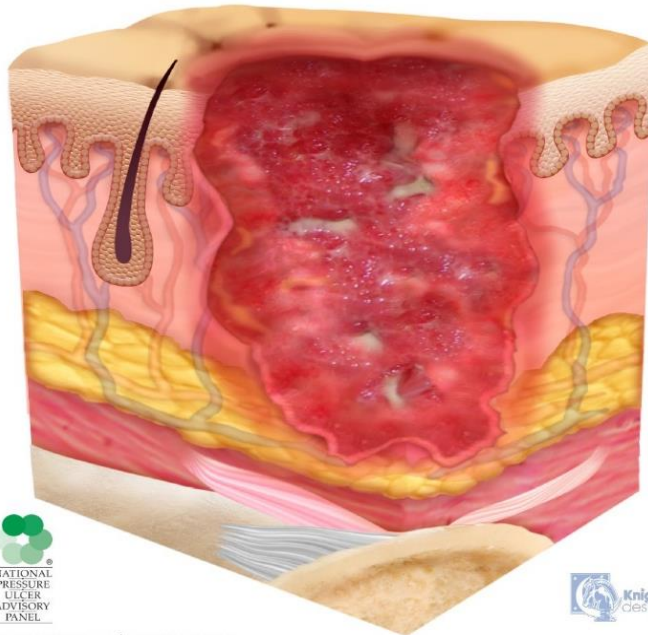


Stage III Pressure Injury

- Full-thickness loss of skin
- Adipose (fat) may be visible in the ulcer
- Granulation tissue and epibole (rolled wound edges) are often present
- Slough and/or eschar may be visible (*should not obscure extent of tissue loss*)
- Depth of tissue damage varies by anatomical location
- Undermining and tunneling may occur
- Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed

Stage III Pressure Injury

Stage 3 Pressure Injury

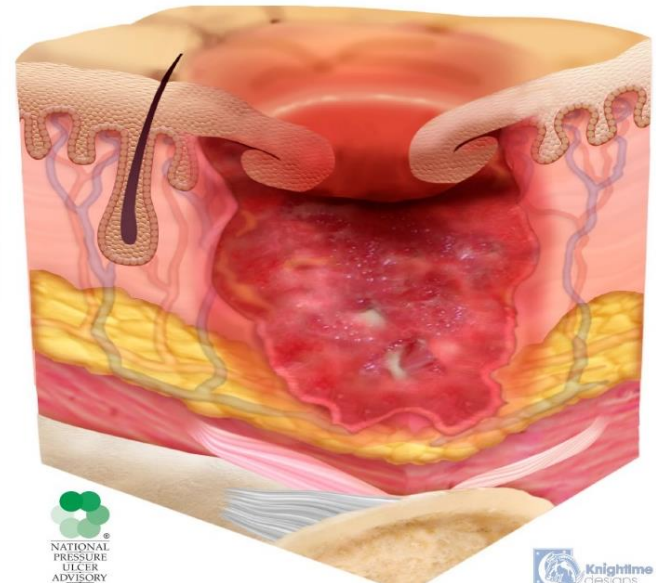


Note: Consult WOCN

Stage 3 Pressure Injury with Epibole



Area of Focus



Stage III Pressure Injury

Think
“apple bite”!

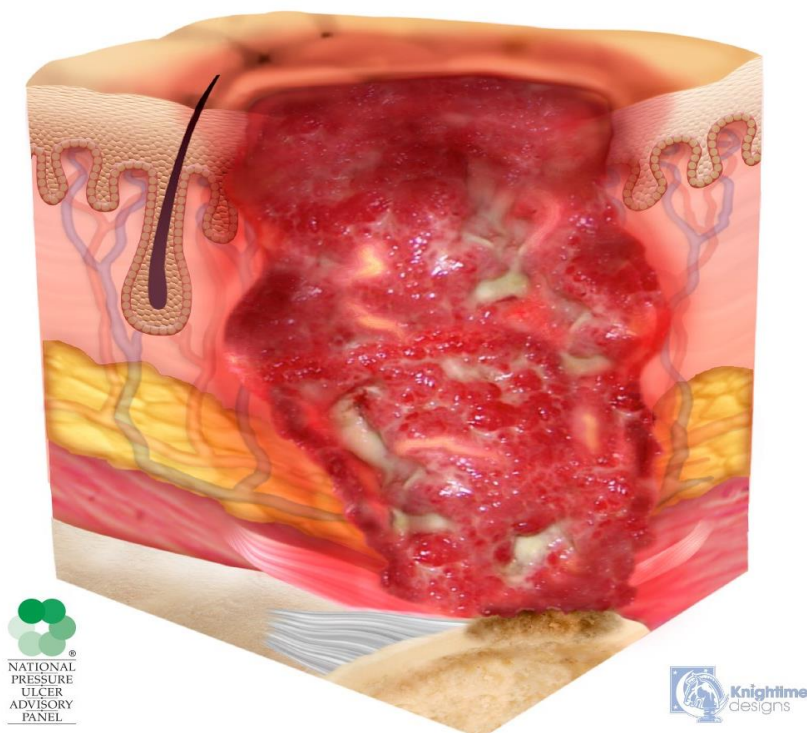


Stage IV Pressure Injury

- Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer
- Slough and/or eschar may be visible (***should not obscure extent of tissue loss***)
- Epibole (rolled edges), undermining and/or tunneling often occur
- Depth varies by anatomical location

Stage IV Pressure Injury

Stage 4 Pressure Injury



Note: Consult WOCN

Stage IV Pressure Injury

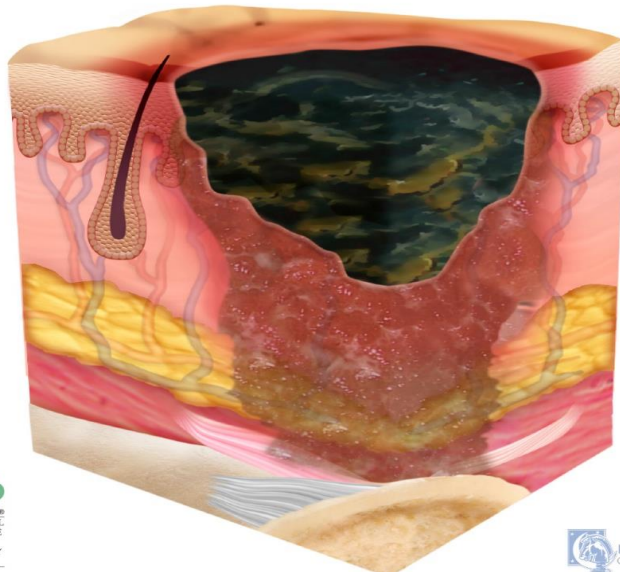
Think
“peach pit”!



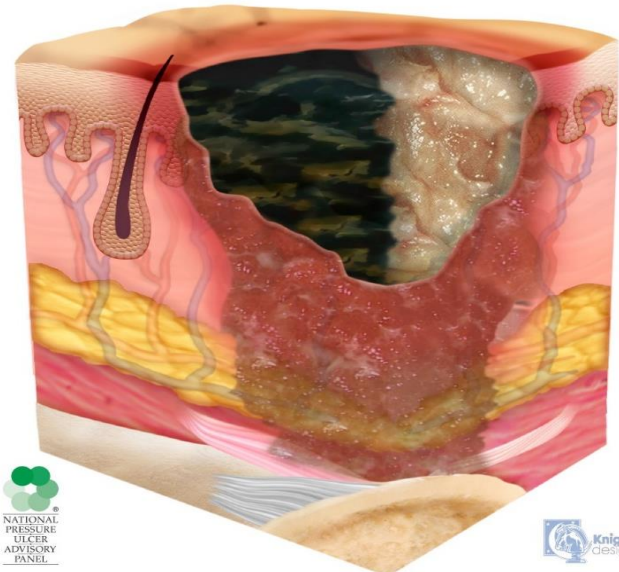
Unstageable Pressure Injury

- Full-thickness skin and tissue loss
- Extent of tissue damage within the ulcer cannot be confirmed because it is **obscured by slough or eschar**.

Unstageable Pressure Injury - Dark Eschar



Unstageable Pressure Injury - Slough and Eschar



Note: Consult WOCN

Unstageable Pressure Injury

Think “rotten fruit”!

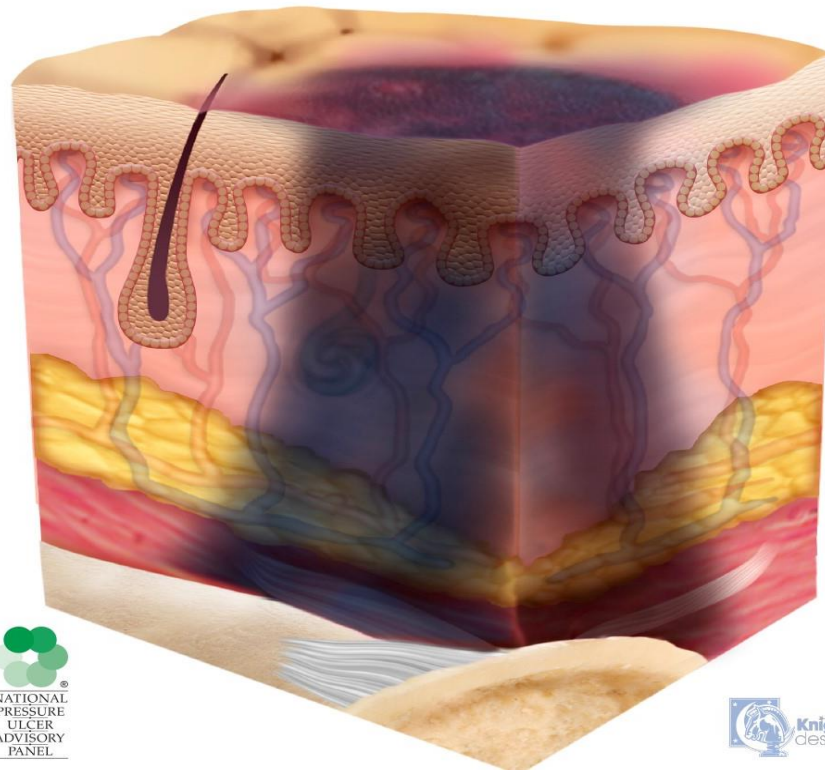


Deep Tissue Injury

- ***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.

Deep Tissue Injury

Deep Tissue Pressure Injury



Note: Consult WOCN

Deep Tissue Injury



Think
purple
“eggplant” or
maroon “plum”



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.

Mucosal Membrane Pressure Injury and Invisible 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.
- Example: Pressure injury inside the nose, mouth or throat from NGT tube

- Invisible pressure injury is a known pressure injury located under a non-removal dressing or device that cannot be visualized at the time of the skin inspection and the stage is not documented in the patient's record.

NOTE: Non-removable devices include all devices that are not normally removed in the course of patient care (e.g., casts, endotracheal tubes, and pressure dressings) and any dressing or device with a physician order to not remove.

Moisture-Associated Skin Damage (MASD)

- MASD is defined as an inflammation and erosion of the skin caused by prolonged exposure to moistures, such as urine, stool, perspiration, wound drainage, mucus or saliva
- May progress to pressure injury
- **Should NOT be described as Stage II**



Photo retrieved from <https://www.uniklinikum-dresden.de/de/das-klinikum/universitaetscentren/zegv/cousin/meet-the-teams/project-groups/developing-a-core-outcome-set-for-incontinence-associated-dermatitis-iad-research>

Pressure Injury Risk Assessment

Pressure Injury Risk Assessment

- Consider bedfast and chairfast patients to be at risk for development of pressure injury.
- Use a structured risk assessment, such as the Braden Scale, to identify patient at risk for pressure injury
- Develop a plan of care based on the areas of risk, rather than on the total risk assessment score

Pressure Ulcer Prevention Policy

#CLN0686

- Use age-appropriate Braden Scale to assess for risk of pressure ulcer development
- RN is responsible for:
 - assessing the patients and determining the Braden Score
 - implementing interventions based on the subscale score of the Braden Scale

Pressure Ulcer Prevention Policy

#CLN0686

The Braden Scale for Predicting Pressure Ulcer Risk should be used on the following units:

- ***Inpatient Units***
 - Within 2 hours of admission/transfer
 - Every shift
 - Then, implement plan of care to prevent PU
- ***Pre-Operative/Holding***
 - Prior to or upon arrival to Holding area
- ***Operating Room (OR)***
 - Part of the review of patient's record before surgery
- ***Post Anesthesia Care Unit (PACU)***
 - Upon arrival to PACU
- ***Emergency Center (EC)***
 - Within 2 hours of arrival
- ***Clinical Decision Unit (CDU)***
 - Within 2 hours of arrival

Braden Scale for Predicting Pressure Injury Risk: Adult

- Six (6) Categories:
 - Sensory perception
 - Moisture
 - Activity
 - Mobility
 - Nutrition
 - Friction/Shear

- Level of risk based on Braden Score:
 - At risk (15 – 18)
 - Moderate risk (13 – 14)
 - High risk (10 – 12)
 - Very high risk (9 or below)

Braden Scale for Predicting Pressure Injury Risk: Adult

Sensory Perception (SEN) Ability to respond in a developmentally appropriate way to pressure related discomfort	1. Completely Limited Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body surface.	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body.	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.
MOISTURE (MOI) Degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift.	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day.	4. Rarely Moist Skin is usually dry, linen only requires changing at routine intervals.
ACTIVITY (ACT) Degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances with or without assistance. Spend majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours
MOBILITY (MOB) Ability to change and control body positions	1. Completely Immobile Does not make even slight changes in body or extremity position without assistance.	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	3. Slightly Limited Makes frequent though slight changes in body or extremity position independently.	4. No Limitation Makes major and frequent changes in position without assistance.
NUTRITION (NU) Usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than 1/8 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and/or maintained on clear liquids or IVFs for more than 5 days.	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement OR receives less than optimum amount of liquid diet or tube feeding.	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products per day). Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs.	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.
FRICTION & SHEAR (FRI) Friction occurs when skin moves against another object. Shear occurs when skin and adjacent body surface slide across one another.	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction.	2. Potential Problem Moves freely or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	3. No Apparent Problem Moved in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair.	

Braden Q Scale for Predicting Pressure Injury Risk: Pedi

- Seven (7) Categories:

- Mobility
- Activity
- Sensory Perception
- Moisture
- Friction/Shear
- Nutrition
- Tissue Perfusion & Oxygenation

- Level of risk based on Braden Score:

- At risk (16 – 23)
- Moderate risk (13 – 15)
- High risk (10 – 12)
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Braden Q Scale for Predicting Pressure Injury Risk: Pedi

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TISSUE PERFUSION & OXYGENATIION (TPO)	1. Extremely Compromised Hypotensive (MAP <50 mmHg: <40 in a newborn) OR the patient does not physiologically tolerate position changed.	2. Compromised Normotensive; Oxygen saturation may be <95% OR hemoglobin may be <10 mg/d OR capillary refill may be >2 seconds: Serum pH is <7.40	3. Adequate Normotensive; Oxygen saturation may be <95% OR hemoglobin may be <10 mg/d OR capillary refill may be >2 seconds: Serum pH is normal	4. Excellent Normotensive; Oxygen saturation may be >95% Normal hemoglobin; capillary refill may be <2 seconds

**Manage
Moisture and
Promote
Skin Care**

Pressure Injury Prevention Bundle: Manage Moisture and Promote Skin Care

- Keep skin/skin folds clean and dry
- Cleanse skin promptly after episodes of incontinence
 - No diaper unless indicated
 - Apply appropriate moisture barrier cream
 - Establish a toileting schedule
 - Bowel management system (if indicated)
- Use mild/pH-balanced cleanser and apply moisturizer to dry, intact skin

Pressure Injury Prevention Bundle: Manage Moisture and Promote Skin Care

- Limit to 2 layers of linen (not more than 3 layers if additional layers indicated)
 - 2 layers: fitted sheet and draw sheet
 - Use breathable incontinence pads (e.g., Covidien pads, Ultrasorb pads)
- Apply appropriate moisture or protective skin barrier
- Apply appropriate silicone foam barrier

MDA Skin Care Formulary



Order from
PSPD/
available in
unit PAR

Requires MD
order



SKIN CARE FORMULARY

The Skin You're In: Protecting Your First Line of Defense

			Normal Intact Skin	Moderate to Severely Dry Skin	Fecal or Urinary Incontinence	Broken Skin	Wet Weeping Skin	Itchy Burning Skin	Common Fungal	Anal Fissures
	Cleanser	Remedy Foaming Body Cleanser (PSPD #5214) No-Rinse Foam for cleaning head-to-toe. Indicated for hair, body, perineal and peristomal areas. Tear-free and suitable for the most sensitive skin.	●	●	●	●	●	●	●	
	Cleanser	Soothe & Cool No-Rinse Perineal Wash (PSPD #5212) No-rinse formula makes patient clean-up easy. Simply spray and wipe clean.	●		●	●			●	●
	Protection	Remedy Nutrashield (PSPD #5213) Provides a long-lasting moisture barrier. Can be used on entire body, lasts after repeated washings, and is CHG compatible. Ideal for daily use to prevent dry skin and treatment of dry skin.	●	1				2		
	Barrier – Protection	Remedy Calazime Skin Protectant (PSPD #6337) Zinc Oxide based barrier for skin protection against moisture and irritation. Indicated for the relief of painful, itchy skin and discomfort caused by wetness, urine, stool or other macerated skin conditions.			2	2	2	1		
	Barrier – Protection	Remedy Clear-Aid Skin Protectant (PSPD #6338) Clear protective moisture barrier that adheres to wet, macerated skin and allows for easy monitoring.		2	1	1	1			
	Barrier – Protection	Soothe & Cool Paste (PSPD #5210) Zinc oxide and petrolatum create a thick protective formula that protects and absorbs excess exudate.								●
	Antifungal	Soothe & Cool Antifungal INZO (PSPD #5211) Contains 2% micronazole nitrate to protect skin from most common fungal infections. Adheres well to wet or damaged skin.							●	
	Protect	Ultrasorb (PSPD #98680) Air-Permeable, provides superior skin dryness and comfort. Wicks moisture away from the skin and locks fluid away for increased patient dignity and better skin care. Super absorbent. Exceptional odor control.			●	●	●	●	●	●

FOR MORE CLINICAL INFORMATION CALL
THE EDUCARE® HOTLINE AT: 1-888-701-SKIN (7546)

Please obtain a physician's order for WOCN consult if a positive outcome is not achieved.

> inside.mdanderson.org/departments/nursing/wocn-wound-ostomy-contingence

Medline sales specialist

Katie Johnson
Medline Industries
832-370-0802

1 = First Option
2 = Second Option



www.medline.com/Woundcare

Poster with permission to use from Medline

Optimize Nutrition and Hydration

Pressure Injury Prevention Bundle

Optimize Nutrition and Hydration

- Consider hospitalized patients to be at risk for under nutrition and malnutrition from their illness or being NPO for diagnostic testing.
- Review nutritional factors and assess hydration status
 - Observe for muscle mass loss and weight loss
 - Results in more prominent bones
 - Impacts mobility
 - Observe for edema and signs of reduced blood flow
 - Increases risk for skin breakdown

Pressure Injury Prevention Bundle

Optimize Nutrition and Hydration

- Monitor patient's weight for significant changes
 - $\geq 2\%$ in 1 week
 - $\geq 7.5\%$ in 3 months
 - $\geq 10\%$ in 6 month
 - $\geq 20\%$ in 12 months
- Monitor associated signs/symptoms that impact patient's nutritional status (e.g., N/V, diarrhea, anorexia, cachexia)
- Consult Nutrition Services
 - Uses a valid and reliable screening tool to determine risk of malnutrition

Pressure Injury Prevention Bundle

Optimize Nutrition and Hydration

- Assist patients at mealtimes to increase oral intake.
- Assess adequacy of oral, enteral and parenteral intake.
- Evaluate change in dietary pattern and monitor oral intake
 - e.g., <75% of estimated energy requirement for > 7 days)
- Provide nutritional supplements between meals and with oral medications, unless contraindicated.

**Reposition,
Mobilize, and
Minimize Pressure
Friction, or
Shear**

Pressure Injury Prevention Bundle

Minimize Pressure

Pressure redistribution over bony prominences is a primary concern

- Turn/reposition patients every two hours (while on bed)
 - May use pillows/wedges
- Instruct patient to shift position every one hour (while up on chair)
- Use pressure-redistribution surfaces
 - Use specialized support surfaces (such as mattresses, beds, and cushions)
 - Order air loss specialty mattress/bed for Braden score of <14
 - Consider the level of immobility, exposure to shear, skin moisture, perfusion, body size and weight of the patients when choosing a support surface.
 - Use breathable incontinence pads when using microclimate management surfaces.

Pressure Injury Prevention Bundle

Minimize Pressure

- Keep head of bed <30 angle (unless contraindicated)
- Ensure linen is free of wrinkles and bed is free of objects that may cause pressure (e.g., needle cap, call light, etc.)
- Ensure right size of bed linen (i.e., fitted sheet)
- Use a pressure redistributing chair cushion for patients sitting in chairs or wheelchairs.
 - e.g., EHOB Waffle Seat Cushion or ROHO Seat Cushion
- Float heels off the bed using pillows or heel off-loading device
 - e.g., Multi-podus boots – Prevalon
- Ensure right size of antiembolic stockings and remove every 8-12 hours

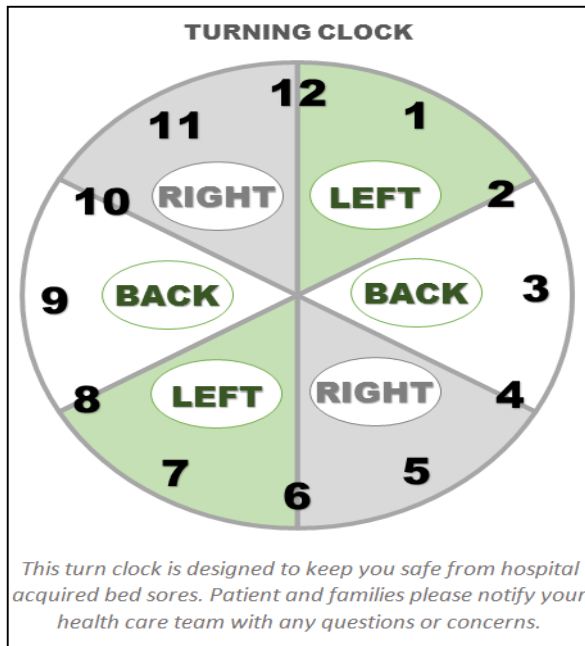
Pressure Injury Prevention Bundle

Minimize Pressure

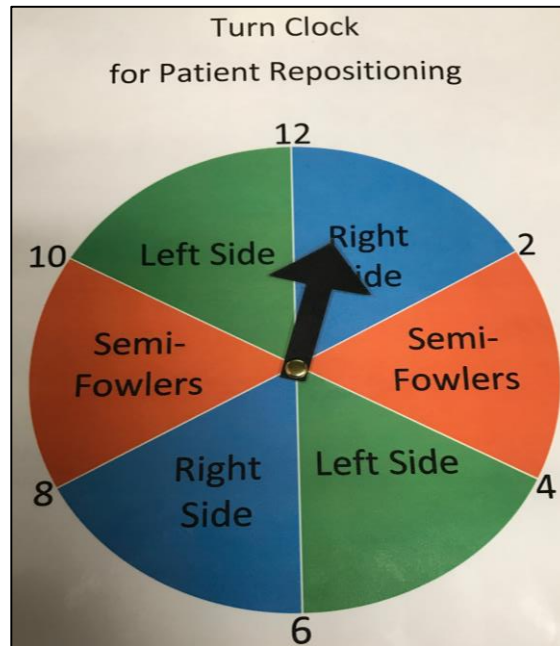
- Use appropriate silicone foam barrier
 - e.g., Mepilex or KerraFoam
- Place thin foam or breathable dressings under medical devices.
 - e.g., Mepitac, Mepilex lite
- Lift patient or use transfer aids
 - e.g., slide board – MaxiSlide; mechanical lifts – Hoyer lift
- Avoid positioning an patients on an area of erythema or pressure injury.
- Consult Rehabilitation Medicine Services
 - Occupational Therapy (sensory deficits and ADLs)
 - Physical Therapy (mobility and exercise)

Repositioning

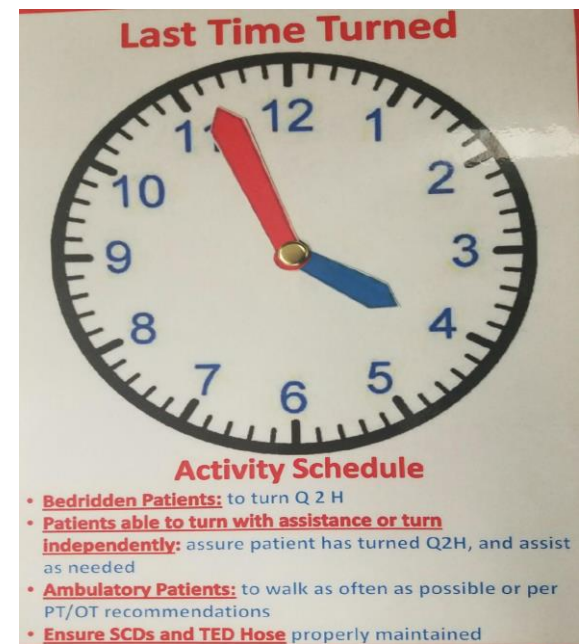
A turning schedule (e.g., turn clocks) can be an effective tool in ensuring patient repositioning every 2 hours.



G7 (ICU)



G16 (Leukemia)



P12 (Medical Oncology)

Pressure-Redistribution Surface



Hill-Rom VersaCare®

- Standard bed in MDA (except ICU)
- Pressure redistribution bed
- Max wt. 500 lbs. or 277.27 kg
- Prevention & treatment of Stage I & II and Braden Score >15

AccuMax Quantum™ VPC Surface

- Standard mattress used in MDA (except ICU)
- For patients at moderate risk of skin breakdown
- Controlled Release™ valve technology automatically adjusts during patient movement to deliver consistent pressure redistribution surface
- Patented Heel Pillow™ is designed to reduce interface pressure in the sensitive heel area



Photo with permission to use from Hill-Rom

Pressure-Redistribution Surface

Standard for all MDA ICU rooms



Progressa® Bed System

- Provides features and functions that help support early mobility (continuous lateral rotation therapy)
- StayInPlace™ Technology extends the head section of the frame and surface, in unison, to accommodate the natural elongation of the body as the patient sits up and also helps address patient migration to the footend of the bed

Pressure-Redistribution Surface (Rental Beds available at MDA)

Envision® E700 Therapeutic Surface

- Addresses 5 key physical factors affecting pressure healing:
 - Pressure, shear, friction, patient mobility, & microclimate control
- Prevention & treatment of Stage I & II and Braden Score >15



Total Care SpO2RT®

- Same features as VersaCare with added features:
 - Customizable continuous lateral rotation
 - Percussion/Vibration Therapy and turn assist for Pulmonary therapy
- Max wt. 400 lbs.
- Manually turn Q2H or PRN

Pressure-Redistribution Surface (Beds available at MDA)

Clinitron® Rite-Hite® Air Fluidized

- Provides combined air fluidized and low air loss therapies
- Adjustable, low-height frame for easier egress and HOB articulation for easier positioning
- Aids in prevention/treatment of Stage IV/eschar, flaps, grafts, and lower trunk wounds
- Max wt. 350 lbs.



TotalCare® Bariatric Plus

- Extra wide, 40" pressure redistribution
- Optional Pulmonary Therapy
- Full chair position
- Max wt. 500 lbs.
- Manually turn Q2H or PRN

Pressure-Redistribution Surface (Beds available at MDA)

Excel Care® ES Bariatric

- Integrated expandable frame and surface
- 40-50" width pressure distribution
- Available with foam or low airflow
- Max wt. 500 lbs.



Tru-Flex II™ Bariatric Bed

- Expandable 37-48" width frame
- Drop down foot rails
- Foam surface with optional low air loss surface
- Max wt. 1000 lbs.

Note:

- Use the "Adult Therapeutic Bed Order Set" to order specialty beds
- A Hill-Rom representative is on-site for in-service upon bed delivery (contact via PSPD)



Linens

- Ensure right size of bed linen (fitted sheet) that is free of wrinkles and objects that may cause pressure (e.g., needle cap, call light, etc.)
- Limit to **2 layers** of linen (not more than 3 layers if additional layers indicated)



Pressure-Redistribution Surface (Seat Cushions available at MDA)

Note:

- May be used for comfort and treating and preventing pressure ulcers
- Recommended for Stage I-IV pressure injuries and sDTI
- Single use; may send home with patient upon discharge



EHOB WAFFLE Seat Cushion



EHOB WAFFLE Bariatric Cushion

Pressure-Redistribution Surface (Seat Cushions available at MDA)



Note:

- The ROHO pressure redistribution surface comes from OT as a loaner
- Patient who are eligible may have this prescribed upon discharge (DME)

Reduce Friction/Shear

Lift/Transfer Aids available at MDA



MaxiSlide

Photo <http://www.arjohuntleigh.com>



Mechanical Lift

Photo with permission to use from Hill-Rom

Heel Off-loading Device Specialty Boots: Prevalon

Prevalon®
STANDARD SIZE

Pressure-Relieving Heel Protector
with Integrated Foot & Leg Stabilizer Wedge

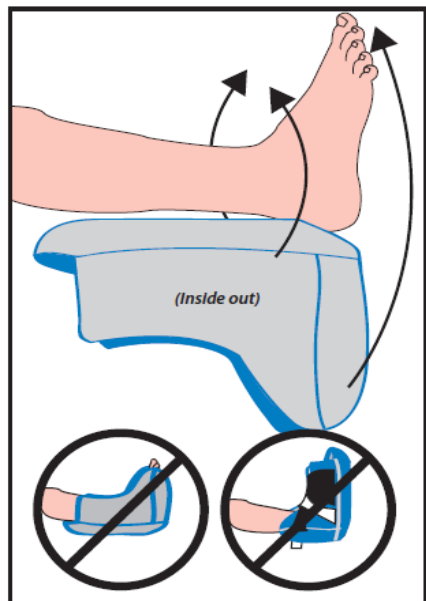
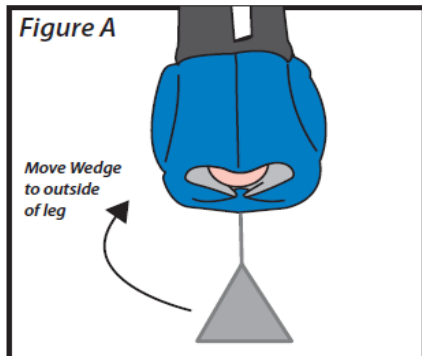
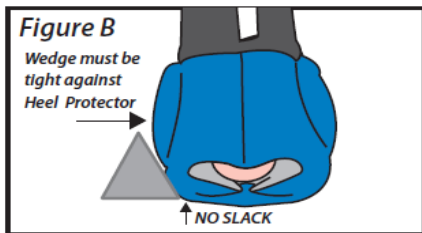
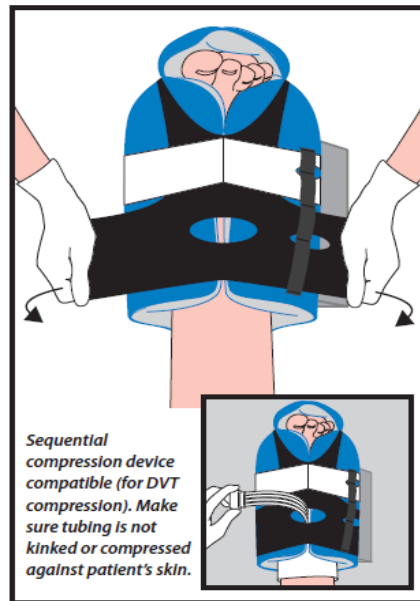
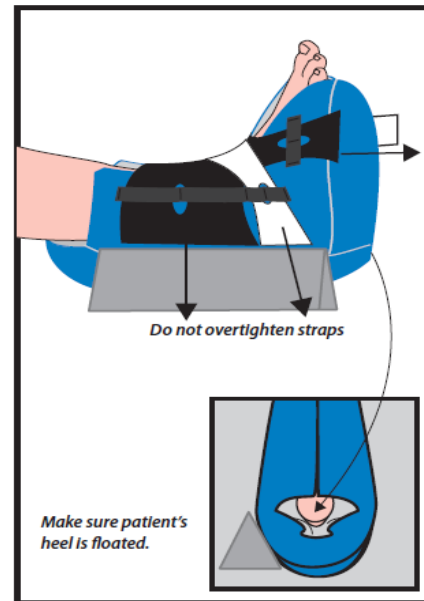
Instructions for Use:

- 1 Position heel over opening. Pull Heel Protector up around foot. Pull front of Heel Protector up around toes.

- 2 Position Integrated Wedge on outside of leg (lateral side). Apply pressure to affix to side of Heel Protector. Reposition as appropriate.

- 3 Wrap stretch panels around boot.

- 4 Adjust straps. **DO NOT** overtighten.



Manufactured in the U.S.A. for:

Heel Off-loading Device

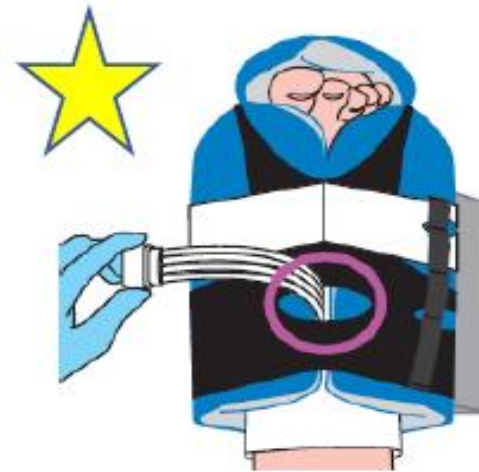
Multi-Podus Boots: Prevalon

PREVALON BOOT PLACEMENT

CORRECT PREVALON BOOT PLACEMENT



CORRECT SCD TUBING PLACEMENT



[Video: Proper Prevalon Application](#)

*****View video by opening link in Google Chrome*****

DO NOT EXIT SCD TUBING BY THE HEEL.

MDA Foam Barrier Availability Guide

Mepilex® Border

- Moderate to highly exuding wounds
- Pressure ulcers, leg/foot ulcers
- Traumatic wounds (e.g., skin tears and secondary healing wounds)
- Wear Time: Up to 7 days



Mepilex® Border Sacrum

- Sacral wounds caused from pressure, friction or shear
- Wear Time: Up to 7 days

MDA Foam Barrier Availability Guide

Mepilex® Lite

- Minimizes the risk of maceration
- Skin protection when used under devices (e.g., tubes)
- Can easily be cut to size



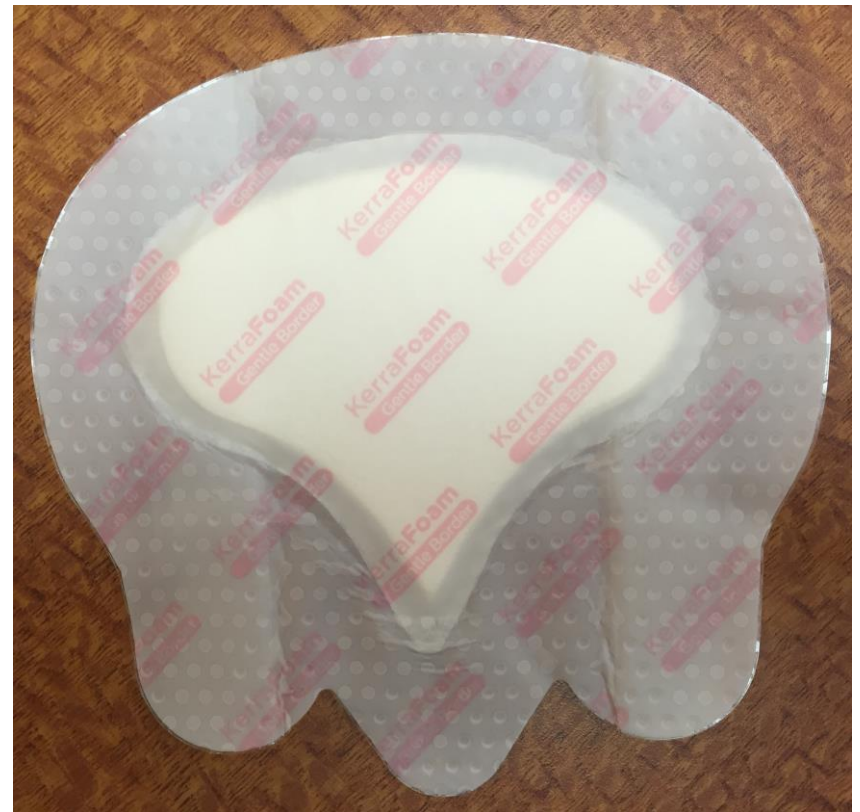
Mepitac®

- Fixation of medical devices such as drains, tubes, probes, electrodes, IV cannula, and dressings
- Silicone tape for skin protection, used to secure devices (e.g., tubes)

MDA Foam Barrier Availability Guide

KerraFoam® Gentle Border – Sacrum

- Sacral wounds caused from pressure, friction or shear
- Designed to absorb exudate, fluid and help wound healing
- Use on moderate to heavily exuding wounds such as pressure ulcers
- Ease of peeling and smoothing back into place



Best Practices for *Prevention* of *Medical Device-Related* Pressure Injuries

- ✓ **Choose** the correct size of medical devices to fit the individual
- ✓ **Cushion** and protect the skin with dressings in high risk areas (e.g., nasal bridge)
- ✓ **Remove** or move the device daily to assess skin
- ✓ **Avoid** placement of device(s) over sites of prior, or existing pressure injury
- ✓ **Educate** staff on correct use of devices and prevention of pressure injury
- ✓ **Be aware** of edema under device(s) and potential for pressure injury
- ✓ **Confirm** that devices are not placed directly under an individual who is bedridden or immobile



ET Tube



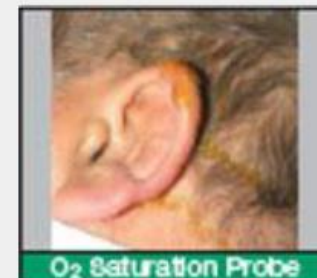
Trach Ties



Retention Sutures



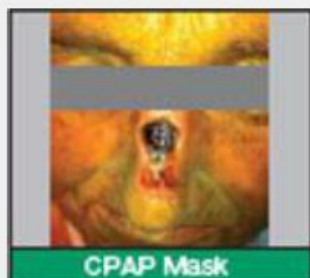
NG Tube



O₂ Saturation Probe



Oxygen Tubing



CPAP Mask



Bedpan



Arterial Line



Wrist Splint

Antiembolic Stockings

METHOD - STANDARD



STEP 1 Gather length of stocking down to heel



STEP 2 Stretch stocking open and fit over foot and heel

METHOD - REVERSE FOLD



STEP 1 Place stocking on outstretched arm



STEP 2 Fold top of stocking down toward fingertips



STEP 3 Gather stocking to toe



STEP 4 Pull stocking over foot

See back for final fitting instructions.

METHOD - PACKAGE ASSIST



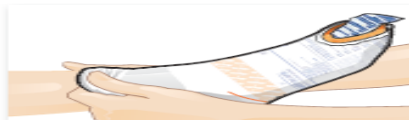
STEP 1 Open package at perforation



STEP 2 Place package over foot



STEP 3 Gather stocking to toe



STEP 4 Put stocking over package/foot and draw over heel



STEP 5 Pull package through toe port to remove

See back for final fitting instructions.

[You Tube: How to Apply Teds](#)

View video on how to apply TEDs by opening link in Google Chrome

Antiembolic Stockings and Sequential Compression Devices

Mosby's Nursing Skills - Review video and extended text on how to apply antiembolic stockings and sequential compression devices [Click to view "Antiembolic Stockings and Sequential Compression Devices"](#)

Clinical Skills

THE UNIVERSITY OF TEXAS
MDAnderson
Cancer Center

UT MD Anderson Cancer Cent

Logir

Skills

Patient Education

Search Skills for [Advanced Search](#)

Browse Skills By

Index

Specialty

Category

A B C D E F G H I J K L M
N O P Q R S T U V W X Y Z
Other

Also of Interest

RELATED SKILLS

- Assessment: Cardiovascular
- Isometric Exercises
- more....

REFERENCES

- References

RELATED BOOK CHAPTER

Skill Content

Search: "antiembolic" > Skill - Antiembolic Stockings and Sequential Compression Devices

Antiembolic Stockings and Sequential Compression Devices

 Quick Sheet

 Extended Text

 Supplies

 Demos

 Illustrations

 Test

 Checklist

Extended Text

ALERT

Recognize that antiembolic stockings and sequential compression devices (SCDs) are for venous thromboembolism (VTE) prevention only and should not be applied if VTE is suspected. Signs and symptoms of VTE include a swollen extremity; pain; warm, discolored skin; and elevated temperature.

Be aware that the use of antiembolic stockings increases the risk of disruption to a patient's skin integrity.¹

Engage, Educate & Empower



Visual Art © 2012 The University of Texas MD Anderson Cancer Center

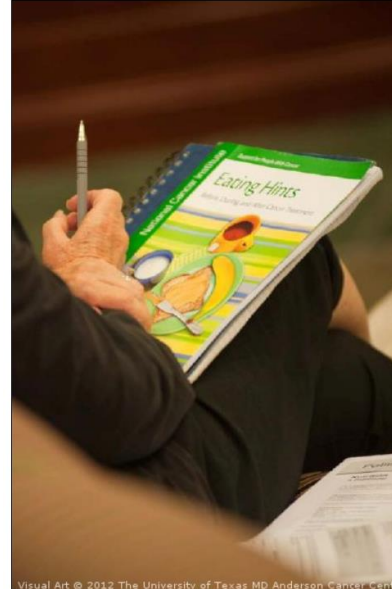
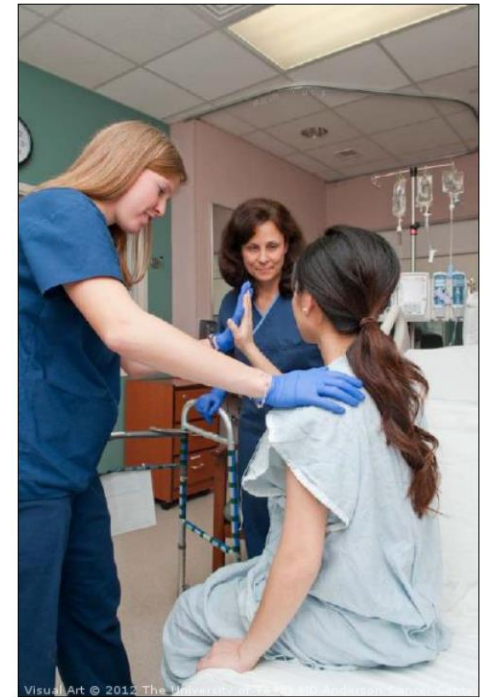
Interdisciplinary and Multidisciplinary Approach

- Engage all healthcare professionals/staff
 - Notify physician upon discovery of pressure injury
 - Discuss at risk and patients with active pressure injury during pod briefs, physician rounding, interdisciplinary care conferences, family care conferences
 - Utilize the CPG in developing actions plans for education and intervention



Interdisciplinary and Multidisciplinary Approach

- Educate all nursing staff
 - Utilize the CPG in developing actions plans for education and intervention
 - Update the Patient Needs Assessment throughout the inpatient stay
 - Ensure timely consults with Nutrition, PT/OT, and WOCN as appropriate



Visual Art © 2012 The University of Texas MD Anderson Cancer Center

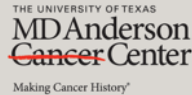
Patient-Centered Care Approach

- Empower all patients and family members
 - Educate at risk patients and family members about risk factors and prevention bundle
 - Educate patients with active pressure injury and family members about management and prevention of wound progression
 - Provide educational materials and resources



Patient-Centered Care Approach

Patient Education



Bedsore Prevention

Bedsore can develop when you stay in the same position too long. The pressure between your skin, especially over a bony area, and a hard surface or object such as the bed, a wheelchair, or a medical device like an oxygen tube can cause a decrease in the blood flow to that area. Without good blood flow, the skin and the soft tissue just under the skin can become damaged or die and cause a bedsore to develop.

Bedsore are also called pressure ulcers or pressure injuries. They can be very painful, put you at risk for infections, prolong hospital stays, and decrease your quality of life. It is important to know the risks for developing them and what you can do to prevent them.

Risk Factors

You are at high risk for developing a bedsore if you:

- Have a decrease in physical movement
- Spend most of your day in a bed, a chair or wheelchair
- Have nerve damage (neuropathy) or a decrease of feeling in an area of your body
- Have poor bowel or bladder control (incontinence)
- Are not getting enough good nutrition
- Are overweight or underweight

Self-Care

Skin

You or your caregiver should check the bony areas of your body and any areas with a decrease of feeling, such as tingling or numbness, daily for pressure-related problems. Be sure to include the heels, ankles, hips, spine, tailbone, shoulders, elbows, back of the head and ears.

Bathe or clean your skin on a regular basis. Use mild soap and clean well under the breasts, in the groin area and between the skin folds. Do not scrub your skin hard. Use creams with moisturizer and skin protection products every day. Do not use powder and strong soaps. These can irritate and dry the skin.

Tell your doctor if you see skin changes, such as:

- skin redness that does not lighten in color when pressed,
- areas that are warm to the touch or that feel spongy or hard, or
- areas with visible skin damage (breakdown) or sores.

Nutrition

Make sure to eat the recommended amount of calories and protein to stay healthy. Drink at least eight 8-ounce glasses of water daily. Dietitians are available to help you with your nutritional needs. Ask your doctor to refer you for a consult.

Physical and Occupational Therapy

Physical and occupational therapists can help if you have concerns about fatigue, weakness, movement (mobility), activities of daily living, such as bathing, or sensory problems like peripheral neuropathy. Ask your doctor to refer you for a consult.

Clothing

Wear loose, comfortable clothing. Make sure that your clothing is not bunched up under you when sitting in a chair or lying in bed.

Wheelchair

Proper Fit

Ensure that your wheelchair is the right size for you. You can have your doctor or physical therapist check the fit once per year.

Seat Cushion

Use a foam or gel seat cushion that fits your chair. **Do not** use a donut-shaped cushion. It increases pressure and can cause a bedsore.

Shift Your Weight

Try to shift your weight every 15 to 20 minutes while in the wheelchair. Change positions every hour to prevent too much pressure in one area.

Bedsore Prevention Tips

1. **Support bony areas.** Use a pillow or foam to support bony areas, such as between your knees and ankles, or between your elbows and the bed rails. When laying on your back, prop your feet up so that your heels are not touching the bed or pillow.
2. **Do not drag your body.** When getting in and out of bed, ask for help if you are unable to lift yourself. If you drag your body on a surface, it can cause friction and skin damage and also lead to bedsores.
3. **Change position.** Change your position at least every 2 hours to shift your weight. Unless you are instructed not to, keep the head of the bed at a 30° degree angle or lower so you do not slide down in the bed.
4. **Smooth out bed linens.** Make sure that the sheets under you are smoothed out with no wrinkles. Remove any objects that may be in the bed, such as coins or pens.

Documentation



OneConnect Documentation: Braden Scale (Adult)

Flowsheets (completed rows are filtered out)

File Selected | Add Rows | Add LDA | Cascade | Add Col | Insert Col | Hide Device Data | Hide Comp'd

Vital Signs | Pa **2** Assessment | Intake/Output | Nutrition/Tube Feed | IV Assessment | Daily Cares

Head ☒ | Jump to where I left off | Mode: Accordion | Expanded | View All

HEENT ☒

Chest ☒

Cardiac ☒

Extremities ☒

Skin ☒

Patch Assessment ☒

Braden Scale **3** ☒

Braden Scale ☒

Wound ☒

Musculoskeletal ☒

Gastrointestinal ☒

Genitourinary ☒

1/16/17
1915

Braden Scale

Braden Scale Used | Braden

Braden Scale

Sensory Perceptions	4
Moisture	4
Activity	2
Mobility	3
Nutrition	2
Friction and Shear	3
Braden Scale Score	18

OneConnect Documentation: Braden Q Scale (Pedi)

Flowsheets (completed rows are filtered out)

File | Add Rows | Add LDA | Cascade | Add Col | Insert Col | Hide Device Data | Hide Comp'd | Last Filed | Reg Doc | Graph

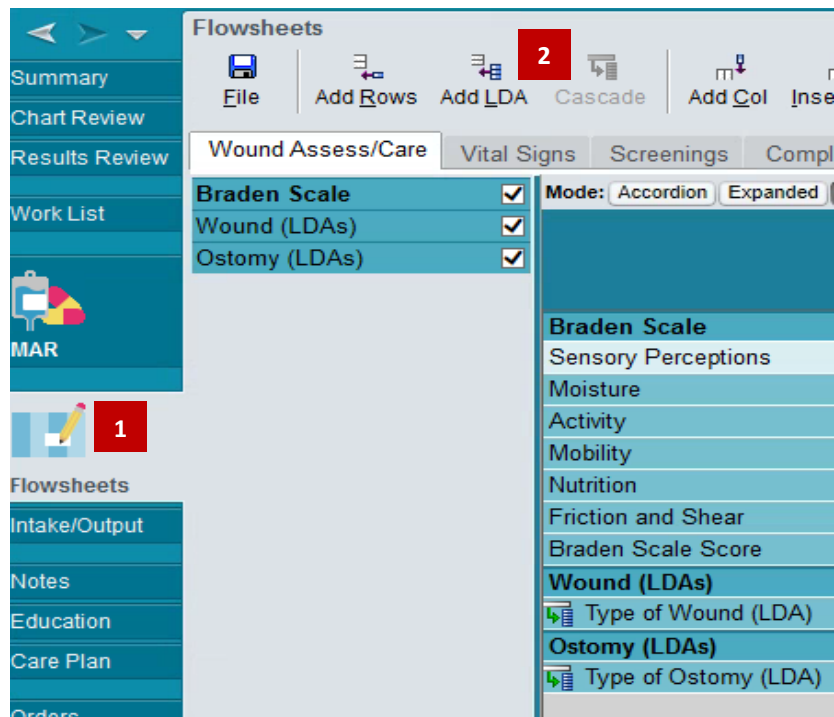
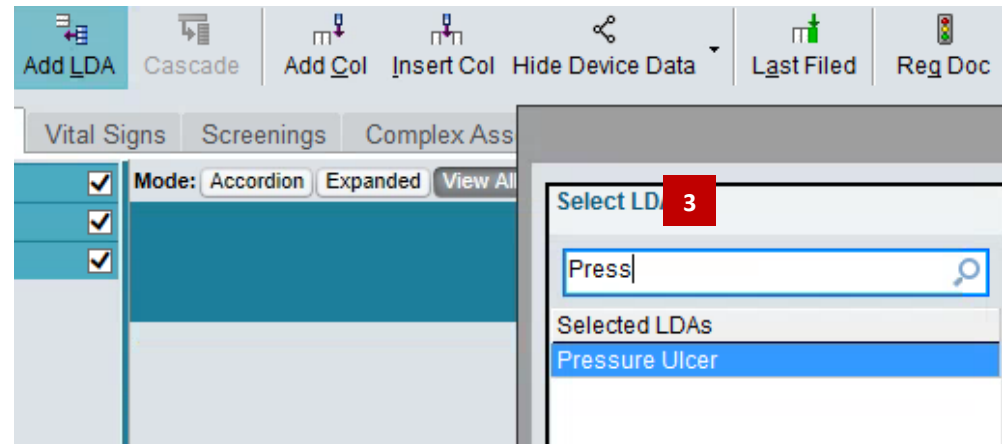
Vital Signs | **2** Assessment | Intake/Output | Nutrition/Tube Feed | IV Assessment | Daily Cares/Safety | Blood Admin

Head ☒ | HEENT ☒ | Chest ☒ | Cardiac ☒ | Extremities ☒ | Skin ☒ | Integumentary ☒ | **3** Braden Scale ☒ | Braden Scale ☒ | Braden Q Scale ☒ | Wound ☒ | Musculoskeletal ☒ | Gastrointestinal ☒ | Genitourinary ☒ | Psychosocial ☒ | Provider Notification ☒

Mode: Accordion | Expanded | View All

	1106	1218
Braden Scale		
Braden Scale Used		Braden Q
Braden Scale		
Braden Scale Score		
Braden Q Scale		
Mobility		3
Activity		1
Sensory Perception		3
Moisture		3
Friction and Shear		3
Nutrition		3
Tissue Perfusion and Oxygenation		3
Braden Q Score		19

OneConnect Documentation: Adding an LDA



Note:

- Each pressure injury site/location requires a separate LDA!
- Other skin impairments that require intervention needs a separate LDA

OneConnect Documentation: Initial Pressure Injury Assessment

Note:

- Date/Time First Assessed will be the **actual** date and time assessed (**NOT** the recording date/time).
- Pre-Existing Wound = Present on Admission

The screenshot displays the 'Define Properties' window for a 'Pressure Ulcer' assessment. The 'Date First Assessed' and 'Time First Assessed' fields are circled in red. A 'Date Entry' dialog box is open, showing the date 12/22/2016 and a calendar view for December 2016 with the 22nd highlighted.

Define Properties

Pressure Ulcer

Shows New Info All Choices

Date First Assessed

Time First Assessed

Pre-Existing Wound ☐ Yes ☐ No

Location Abdomen

Orientation Anterior

Staging (RETIRED)

Value	Comment	Time Recd

Next

Date Entry

12/22/2016

January February March April May June July August September October November December

2011 2012 2013 2014 2015 2016 2017 2018 2019 2020

Accept Cancel

OneConnect Documentation: Initial Pressure Injury Assessment

Lines, Drains, Airways, Tubes, and Wounds Properties

Select LDAs

Selected LDAs

Pressure Ulcer

Pick an Existing Pressure Ulcer

☒ Only Active

Date First Assessed	Time First Assessed	Pre-Existing Wound	Location	Orientation	Staging (RE
** New **					

Define Properties

Pressure Ulcer

Location

Heel

Abdomen	Ankle	Antecubital	Arm	Axilla	Back	Breast
Buttocks	Calf	Cheek	Chest	Chin	Coccyx	Ear
Face	Finger (Comment which one)	Flank	Foot	Generalized		
Gluteal Fold	Groin	Hand	Head	Heel	Hip	Ileac Crest
Ischium	Jaw	Knee	Leg	Malleolus	Mons Pubis	Mouth
Natal Cleft	Neck	Nose	Occiput	Pedal	Pelvis	Penis
Perineum	Pretibial	Rectum	Rib cage	Sacrum	Scalp	Scapula
Scleral	Scrotum	Shoulder	Spinous Processes	Sternum		
Thigh	Throat	Thorax	Tibial	Toe (Comment which one)		

Value	Comment	Time Recd	User Taken	User Recd	Show Audit
Heel			Faith S. Pattavana, RN		

Next Accept & Stay Accept Close

Note:

- For **LOCATION**, choose from the alphabetized list.
- If location is not found, choose **Other** and enter location in the **Comment** box.
- DO NOT** pick multiple locations or add other locations in the Comment box

OneConnect Documentation: Initial Pressure Injury Assessment

Lines, Drains, Airways, Tubes, and Wounds Properties

Select LDAs

Selected LDAs

Pressure Ulcer

Pick an Existing Pressure Ulcer

☒ Only Active

Date First Assessed	Time First Assessed	Pre-Existing Wound	Location	Orientation	Staging (RE
** New **					

Define Properties

Pressure Ulcer

Other (Comment)

☐ Left;Posterior;

Anterior	Distal	Dorsal	Inner	Lateral
Left	Lower	Medial	Mid	Outer
Palmer	Plantar	Posterior	Proximal	Right
Upper	Other (C...			

Staging (RETIRED)

Stage I Stage II Stage III

Not applicable (non-pressure related)
Stage I = Intact skin with non-blanchable redness of a localized area usually over a

Value	Comment	Time Recd	User Taken	User Recd	Show Audit
Left; Posterior			Faith S. Pattavana, RN		

Add New Edit

Next Accept & Stay Accept Close

Note:

- For **ORIENTATION**, you can pick more than 1 descriptor
- Choose **Other** to enter missing description in the **Comment** box.

OneConnect Documentation: Initial Pressure Injury Assessment

Pick an Existing Pressure Ulcer

☒ Only Active

Date First Assessed	Time First Assessed	Pre-Existing Wound	Location	Orientation	Staging (R)
---------------------	---------------------	--------------------	----------	-------------	-------------

** New **

< ||| >

Define Properties

Pressure Ulcer

and tunneling.
Unstageable = Full thickness tissue loss. The base of the ulcer is not visible due to slough and/or eschar.
Suspected Deep Tissue Injury = Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

Wound Description

☐ Blanchable ☐ Denuded ☐ Friction ☐ Non-Blanchable ☐ Sheer

Enter any additional wound information desired.

Final Assessment Date

Final Assessment Time

Value
Blanchable; Denuded; Friction; Sheer

Comment

Time Recd

User Taken

Faith S. Pattavana, RN

User Recd

Show
Audit

Add New

Edit

Next

Accept & Stay

Accept

Close

Note:

- For **WOUND DESCRIPTION**, you can pick more than 1 descriptor
- Choose **Other** to enter missing description in the **Comment** box.

OneConnect Documentation: Daily Pressure Injury Assessment

Flowsheets (completed rows are filtered out)

File Add Rows Add LDA Cascade Add Col Insert Col Hide Device Data Hide Comp'd Last Filed Reg Doc Graph Go to Date Responsible Refresh Legend Link Lines

Head to Toe Assessment IP Scoring Batch Jobs Vital Signs Procedure Lab Notifications Care Handoff IV Assessment

Mode: Accordion Expanded View All 1m 5m 10

ED to Hosp-Admission (Current) from 8/21 1/5/17

0900 0952

Wound (LDAs)

Type of Wound (LDA) Pressure ulcer

Pressure Ulcer 12/13/16 Sacrum Left

Pressure Ulcer Properties

Staging

State of Healing

Dressing Status

Wound Length (cm)

Wound Width (cm)

Wound Depth (cm)

Tunneling

Undermining

Calculated Wound Size (cm*2)

Change in Wound Size %

Wound Bed

Drainage Amount

Drainage Description

Odor

Edges

Peri-wound Assessment

Dressing Intervention

Treatment

Dressing

Selection Form

Stage I

Stage II

Stage III

Stage IV

Suspected Deep Tissue Injury

Unstageable

Not applicable

Resolved

Accept Cancel

Attached edges;Defi...

Clean;Dry;Intact

Foam

Note:

- Complete entries by choosing the appropriate descriptors from the **Selection Form**
- Pressure injuries should be assessed every shift (**remove dressing every shift to note for progression**)
- Do not document UTA just because a foam barrier is in place!**

OneConnect Documentation: Daily Pressure Injury Assessment

Flowsheets (completed rows are filtered out)

File Add Rows Add LDA Cascade Add Col Insert Col Hide Device Data Hide Comp'd Last Filed Reg Doc Graph Go to Date Responsible Refresh Legend Link Lines

Head to Toe Assessment IP Scoring Batch Jobs Vital Signs Procedure Lab Notifications Care Handoff IV Assessment Departure Condition VS, I/O Patient Needs Screen Wo

Mode: Accordion Expanded View All 1m 5m 10m 15m 30m 1h 2h 4h 8h 24h Based On: 0700 Reset Now

ED to Hosp-Admission (Current) from 8/21/2016 in MAIN 15NE

1/5/17

0900 0952 1321 1323

Wound (LDAs)

Type of Wound (LDA) Pressure ulcer

Pressure Ulcer 12/13/16 Sacrum Left

Date First Assessed/Time First Assessed: 12/13/16 1400 Pre-Existing Wound: No Location: (c) Sacrum

Pressure Ulcer Properties

Staging

Unstageable

State of Healing

Dressing Status

Wound Length (cm)

Wound Width (cm)

Wound Depth (cm)

Tunneling

Undermining

Calculated Wound Size (cm²)

Change in Wound Size %

Wound Bed

Drainage Amount

Drainage Description

Odor

Edges

Peri-wound Assessment

Dressing Intervention

Treatment

Dressing

Foam

Note:

- **State of Healing** should only be updated by the **WOCN**
- **Wound length, width, and depth** should be measured on **initial assessment** and then **weekly thereafter**.

OneConnect Documentation: Physician Notification

Flowsheets (completed rows are filtered out)

File Add Rows Add LDA Cascade Add Col Insert Col Hide Device Data

Vital Signs Pain Assessment Intake/Output Nutrition/Tube Feed IV A

Mode: Accordion Expanded View All

Head ☒ Neurological ☒ Sedation Scales ☒ Glasgow Coma Scale ☒ Delirium Assessment T... ☒ HEENT ☒ Chest ☒ Cardiac ☒ Extremities ☒ Skin ☒ Wound ☒ Musculoskeletal ☒ Gastrointestinal ☒ Genitourinary ☒ Psychosocial ☒ Provider Notification ☒ Language Assistance ☒ Handoff Communication ☒ Charting Type ☒

Urine Odor
Bladder Scan Volume (mL)
Post Void Cath Residual (mL)
Intermittent/Straight Cath (mL)
Female Genitalia
Genitourinary Symptoms
Genitourinary Additional Assessments
Afterloading Tandem Ovoid (ALTO)
Head of Bed Elevated
Psychosocial
Psychosocial (WDL)
Patient Behaviors/Mood
Needs Expressed
Psychosocial Additional Assessments
Ability to Express Feelings
Ability to Express Needs
Ability to Express Thoughts
Ability to Understand Others
Length of Time/Family Visitation

Provider Notification

Reason for Communication		Other (Comment)
Provider Name		Dr Wound
Provider Role		Attending physician
Method of Communication		By Phone
Response		See orders
Notification Time		0700
Shift Event		

Note:

- Notify the primary/attending physician upon discovery of **any** pressure injury so that it can be confirmed and added to the problem list/diagnosis

OneConnect Documentation: Care Plan Guidelines (CPG)

Care Plan

Summary
Chart Review
Care Everywhere...
Results Review
Work List
MAR
Flowsheets
Intake/Output
Notes
Care Plan
Orders
Navigators
FYI

Back Forward Document Modify Problem Apply Template Bring Forward Resolve Problems Delete Problem Clear All Filters Filters Reviewed Legend

Care Plan

- Overview
- Care Plan Progress Notes
- Event Log
- Patient Care Overview (Adult)
- Patient Care Overview (Adult)
- Fall/Trauma/Injury Risk (Adult)
- Fall/Trauma/Injury Risk (Adult)
- Constipation (Adult)
- Constipation (Adult)
- Pain, Chronic (Adult)
- Pain, Chronic (Adult)
- Oncology Care (Adult)
- Oncology Care (Adult)
- Pressure Ulcer Risk (Using Braden Scale) (Adult, Obstetrics, Pediatric)
- Neutropenia (Adult)
- Neutropenia (Adult)
- Chemotherapy Effects (Adult)
- Chemotherapy Effects (Adult)
- Mobility, Physical Impaired (Adult)
- Mobility, Physical Impaired (Adult)
- Restraint, Medical Surgical
- Restraint, Medical Surgical
- Mechanical Vent/Discontinuation
- Mechanical Vent/Discontinuation
- Skin Integrity Impairment, Risk
- Skin Integrity Impairment, Risk

Display: Description

Pressure Ulcer Risk (Using Braden Scale) (Adult, Obstetrics, Pediatric)

Pressure Ulcer Risk (Using Braden Scale) (Adult, Obstetrics, Pediatric)

Web Links

View CPG: Press_Risk_Braden_Adult_Spring2014

Goal: Identify Related Risk Factors and Signs and Symptoms

Completed (Date: 09/21/16)

Related risk factors and signs and symptoms are identified upon initiation of Human Response Clinical Practice Guideline (CPG)

Goal: Skin Integrity

Ongoing (interventions implemented as appropriate)

Patient will demonstrate the desired outcomes by discharge/transition of care.

Problem Interventions

1. Pressure Reduction Devices (PER CPG)
*** Pressure Reduction Devices ***
 1. elbow protectors utilized
 2. foam padding utilized (specify)
 3. heel offloading device utilized
 4. positioning supports utilized
 5. pressure-redistributing mattress utilized
 6. specialty bed utilized
 7. other (see comments)
2. Pressure Reduction Techniques (PER CPG)
*** Pressure Reduction Techniques ***
 1. heels elevated off bed
 2. log rolled
 3. mechanical lift used
 4. positioned off wounds
 5. pressure points protected
 6. skin to skin areas padded
 7. skin to device areas padded
 8. tubing/devices free from under/on patient
 9. transfer board used
 10. trapeze bar used
 11. turn sheet used
 12. turned/repositioned
 13. other (see comments)
3. Pressure Reduction Chair (PER CPG)
*** Pressure Reduction Chair ***
 1. feet on footrest/footstool
 2. one hour rest between sit times provided

Showing all problems, goals, and interventions.

Expand All Collapse All Problems Goals

Note:

- The Pressure Ulcer Risk CPG **automatically** populates if the patient has a moderate or higher risk score.
- Activate the Pressure Ulcer Risk CPG for patients who are **At Risk** (<18 for adults and <16 for pedi) based on every shift assessment

OneConnect Documentation: Care Plan Guidelines (CPG)

Care Plan

Back Forward Document Modify Problem Apply Template Bring Forward Resolve Problems Delete Problem Clear All Filters Filters Reviewed Legend CPM Guidelines

Care Plan

Overview
Care Plan Progress Notes
Event Log
Patient Care Overview (Adult)
Patient Care Overview (Adult)
Fall/Trauma/Injury Risk (Adult)
Fall/Trauma/Injury Risk (Adult)
Constipation (Adult)
Constipation (Adult)

Display: ☒ Description

Pressure Ulcer (Adult)

Pressure Ulcer (Adult)
Prevent and manage potential problems including: 1. acute pain 2. delayed wound healing 3. infection 4. wound progression/extension

Web Links

View CPG: Pressure_Ulcer_Adult_Spring2014

Note:

- Activate the Pressure Ulcer CPG ***NOT*** Skin Integrity Impairment CPG for patients with **active pressure injuries**
- Adult and Pedi available
- PACU RNs – continue to use ***“PACU Assessment/Nursing Diagnosis”***

Care Plan

Back Forward Document Modify Problem Apply Template Bring Forward Resolve Problems Delete Problem

Care Plan

Overview
Care Plan Progress Notes
Event Log
Patient Care Overview (Adult)
Patient Care Overview (Adult)
Fall/Trauma/Injury Risk (Adult)
Fall/Trauma/Injury Risk (Adult)
Constipation (Adult)

Display: ☒ Description ☒ Web Links ☐ Detail ☒ Goals ☒ Interventions

Skin Integrity Impairment, Risk/Actual (Adult)

Resolve Modify Problem

Web Links

View CPG: Skin_Integrity_Spring2014

OneConnect Documentation: Care Plan Guidelines (CPG)

The screenshot displays the OneConnect Care Plan interface. The top toolbar includes buttons for Back, Forward, Document, Modify Problem, Apply Template, Bring Forward, Resolve Problems, Delete Problem, Clear All Filters, Filters, Reviewed, Legend, and CPM Guidelines. The left sidebar shows a tree view of the Care Plan, with 'Pressure Ulcer (Adult)' selected. The main content area is divided into two panels. The left panel shows the 'Pressure Ulcer (Adult)' section with a 'Display' dropdown set to 'Description'. It includes a 'Web Links' section with a link to 'View CPG: Pressure_Ulcer_Adult_S' and a 'Problem Interventions' section with a list of interventions. The right panel shows the 'Pressure Reduction Chair' section with a 'Display' dropdown set to 'Description'. It includes a 'Document' button, a 'Discontinue' button, and an 'Edit Intervention' button. The 'Pressure Reduction Chair' section also has a 'Display' dropdown with options for Description, Detail, and Notes. The 'Problem Interventions' section lists the following interventions:

- 1. Pressure Reduction Chair (*** Pressure Reduction Chair ***)
- 1. feet on footrest/footstool
- 2. one hour rest between sit times provided
- 3. pressure-redistributing chair cushion utilized
- 4. sit time 1 hour maximum maintained
- 5. sit time 2 hour maximum maintained
- 6. weight shift assistance provided
- 7. weight shift every 15 minutes promoted
- 8. other (see comments)

The 'Pressure Reduction Chair' section lists the following interventions:

- *** Pressure Reduction Chair ***
- 1. feet on footrest/footstool
- 2. one hour rest between sit times provided
- 3. pressure-redistributing chair cushion utilized
- 4. sit time 1 hour maximum maintained
- 5. sit time 2 hour maximum maintained
- 6. weight shift assistance provided
- 7. weight shift every 15 minutes promoted
- 8. other (see comments)

Note:

- Document Problem Interventions every shift

OneConnect Documentation: Education Assessment

Summary

Chart Review

Results Review

Work List

MAR

Flowsheets

Intake/Output

Notes

Education

Care Plan

Orders

Navigators

Education

Assessment

Education

Assessments

12/31/16 2036

12/23/16 1817

12/12/16 0659

12/01/16 1222

11/26/16 1420

12/31/2016 2036 MAIN

Created by Lauren Berk

PRIMARY LEARNER

Primary Learner Name:

Relationship: Patient

Does the primary learner have any barriers to learning?

What is the preferred language of the primary learner for medical teaching?

Is an interpreter required?

How does the primary learner prefer to learn new concepts?

CO-LEARNER #1

No question answered

CO-LEARNER #2

No question answered

SPECIAL TOPICS

No question answered

ANSWERED BY:

No question answered

Edit History

Assessment

LEARNING ASSESSMENT

PRIMARY LEARNER

Primary Learner Name

Relationship

Does the primary learner have any barriers to learning?

What is the preferred language of the primary learner for medical teaching?

Is an interpreter required?

How does the primary learner prefer to learn new concepts?

CO-LEARNER #1

Co-Learner Name (if applicable)

Relationship

Does the co-learner have any barriers to learning?

What is the preferred language of the co-learner for medical teaching?

Is an interpreter required?

How does the co-learner prefer to learn new concepts?

File

File Incomplete

Cancel

Note:

- Call Language Assistance as appropriate and document accordingly

OneConnect Documentation: Patient Education

The image displays two screenshots of the OneConnect Patient Education interface. The top screenshot shows the 'Pressure Ulcer Risk (Using Braden Scale) (Adult,Obstetrics,Pediatric)' CPG selected in the left sidebar, with its corresponding education content displayed on the right. The bottom screenshot shows the 'Pressure Ulcer (Adult)' CPG selected, with its education content displayed. Red boxes highlight the CPG titles in both screenshots. The left sidebar in both images has 'Education' and 'Notes' highlighted with red circles.

Pressure Ulcer Risk (Using Braden Scale) (Adult,Obstetrics,Pediatric)
Title Points for Pressure Ulcer Risk (Using Braden Scale) (Adult,Obstetrics,Pediatric)

Personal Risk Factors And Signs/Symptoms Related To Pressure Ulcers
Personal Risk Factors And Signs/Symptoms Related To Pressure Ulcers

Category	Acceptance, Explanation, Teach Back	Needs Reinforcement
Patient	Acceptance, Explanation, Teach Back Miklyne A Wren, RN at 1/18/2017 1402	
Family	Eager, Explanation, Needs Reinforcement Kimberly M Whitford, RN at 1/17/2017 2006	
Significant Other	Acceptance, Explanation, Teach Back Julio Arthunton Cruz, RN at 1/6/2017 2107	
Caregiver	Acceptance, Explanation, Teach Back Julio Arthunton Cruz, RN at 1/6/2017 2107	
Other	Acceptance, Explanation, Teach Back Julio Arthunton Cruz, RN at 1/6/2017 2107	

Pressure Ulcer (Adult)
Title Points for Pressure Ulcer (Adult)

Pressure Ulcer Overview
Pressure Ulcer Overview [e.g., description, anatomy, physiology, cause(s)]

Category	Acceptance, Explanation, Teach Back	Needs Reinforcement
Patient	Acceptance, Explanation, Teach Back Miklyne A Wren, RN at 1/18/2017 1402	
Family	Acceptance, Explanation, Needs Reinforcement Jocelene Isidoro, RN at 1/17/2017 0548	

Signs/Symptoms
Signs/Symptoms [e.g., localized non-blanching redness, change in temperature, change in characteristics (firm, soft, boggy); open areas; drainage; bleeding]

Category	Acceptance, Explanation, Teach Back	Needs Reinforcement
Patient	Acceptance, Explanation, Teach Back Miklyne A Wren, RN at 1/18/2017 1402	
Family	Acceptance, Explanation, Needs Reinforcement Jocelene Isidoro, RN at 1/17/2017 0548	

Treatment Plan
Treatment Plan [e.g., MEDICATIONS: antibiotics, analgesics, antispasmodics; DIET: adequate protein, calories, fluids and vitamins/minerals. ACTIVITY: frequent position changes, friction and shear reduction, pressure redistribution surfaces, avoidance of restraint (due to pressure redistribution devices), adequate sleep/rest. TREATMENTS: skin care, excessive moisture management (e.g., urine, stool)]

Note:

- Activating the Pressure Ulcer Risk and Pressure Ulcer CPGs will automatically activate the Pressure Ulcer Risk and Pressure Ulcer Education

OneConnect Documentation: Interventions in Daily Cares/Safety

Flowsheets

File Add Rows Add LDA Cascade Add Col Insert Col Hide Device Data

Intake/Output Data IV Assessment Lab Notifications Vital Signs VS, I/O

Precautions	☒	Mode: Accordion Expanded View All
Call Light Usage	☒	
Safe Environment	☒	
Telemetry	☒	
Communication	☒	
Fall Risk	☒	
Activity	☒	
Mobility	☒	Mobility Activity Level of Assistance Assistive Device Distance Ambulated (ft) Ambulation Response Repositioned Positioning Frequency Head of Bed Elevated Heels/Feet Range of Motion Transport Method
Lower Extremities	☒	
ADLs	☒	
Hygiene	☒	
Comfort/Environment In...	☒	
Miscellaneous Devices	☒	
Safety Equipment at Be...	☒	
Entertainment	☒	

Positioning Frequency

Previous: [Able to turn self](#)

Select Single Option: (F5)

[Able to turn self](#)

Every 2 hours

Per order (comment)

Head of Bed Elevated

Previous: [Self regulated](#)

Select Single Option: (F5)

Self regulated

HOB Flat

HOB 10

HOB 20

HOB 30

HOB 45

HOB 60

HOB 90

Other (Comment)

HOB not > 30 unless contraindicated

Heels/Feet

Previous: [Heels elevated off bed](#)

Select Multiple Options: (F5)

Bilateral heel protectors

Right heel protector

Left heel protector

Heels elevated off bed

Foot of bed elevated

Bilateral multi-podus boots

Right multi-podus boot

Left multi-podus boot

Other (Comment)

Prevalon = multi-podus boots

Mobility:

- Assess and document patient's level of independence
- Document assistive devices
- Ensure appropriate positioning frequency
- Ensure HOB not >30 degrees unless contraindicated

OneConnect Documentation: Interventions in Daily Cares/Safety

The screenshot displays the OneConnect software interface. On the left is a vertical navigation menu with options: Summary, Chart Review, Results Review, Work List, MAR, Flowsheets (selected), Intake/Output, Notes, Education, Care Plan, Orders, Navigators, and FYI. The main area is titled 'Flowsheets' and contains a toolbar with icons for File, Add Rows, Add LDA, Cascade, Add Col, Insert Col, and Hide Device Data. Below the toolbar are tabs for Intake/Output, Data, IV Assessment, Lab Notifications, Vital Signs, and VS, I/O. The 'Intake/Output' tab is active, showing a list of categories with checkboxes: Precautions, Call Light Usage, Safe Environment, Telemetry, Communication, Fall Risk, Activity, Mobility (selected), Lower Extremities, ADLs, Hygiene, Comfort/Environment In..., Miscellaneous Devices, Safety Equipment at Be..., Entertainment, Schoolwork, Sitter, and Visitation. To the right of this list is a detailed view of the 'Mobility' category, showing sub-items like Activity, Level of Assistance, Assistive Device, Distance Ambulated (ft), Ambulation Response, Repositioned, Positioning Frequency, Head of Bed Elevated, Heels/Feet, Range of Motion, and Transport Method. The 'Anti-Embolism Devices' sub-category is highlighted with a red box, showing items: Anti-Embolism Devices, Anti-Embolism Intervention, Lower Extremities, L Calf Circumference (cm), R Calf Circumference (cm), L Thigh Circumference (cm), R Thigh Circumference (cm), and Antiembolism Stockings Size.

Anti-Embolism Devices:

- Ensure correct measurement of extremities and size of antiembolism stockings

OneConnect Documentation: Interventions in Daily Cares/Safety

Flowsheets

File | Add Rows | Add LDA | Cascade | Add Col | Insert Col | Hide Device Data

IP Scoring Batch Jobs | Intake/Output | Travel and Exposure S... | Vaccinat

Precautions	☒	Mode: Accordion Expanded View All
Call Light Usage	☒	
Safe Environment	☒	
Telemetry	☒	
Communication	☒	
Fall Risk	☒	
Activity	☒	
Mobility	☒	ADL Screening
Lower Extremities	☒	Patient's Vision Adequate to Safely Complete Daily
ADLs	☒	Patient's Judgement Adequate to Safely Complete
Hygiene	☒	Patient's Memory Adequate to Safely Complete Daily
Comfort/Environment In...	☒	Patient Able to Express Needs/Desires
Miscellaneous Devices	☒	Which is your dominant hand?
Safety Equipment at Be...	☒	Dressing
Entertainment	☒	Grooming
Schoolwork	☒	Feeding
Sitter	☒	Bathing
Visitation	☒	Toileting
OTHER	☒	In/Out Bed
		Walks in Home
		Weakness of Legs
		Weakness of Arms/Hands
		Hearing - Right Ear
		Hearing - Left Ear

ADL Screening:

- Assess and document patient's degree of independence to complete ADL
- Assess for possible sensory deficits/ weakness

OneConnect Documentation: Interventions in Daily Cares/Safety

Comfort and Environment Interventions

Comfort

Patient Preference 01/11/17 1905

Additional Information

Special Matter

Comfort

Select Multiple Options: (F5)

- Repositioned
- Pain medication (see MAR)
- Bed pad changed
- Complete linen change
- Diaper changed
- Draw sheet changed
- Gown changed
- Lotion (Comment)
- Low light
- Music
- Partial linen change
- Powder (Comment)
- Other (Comment)

Hygiene

Hygiene

Oral Care

Skin Care

Level of Care 01/11/17 1905

Skin Care

Select Multiple Options: (F5)

- Chlorhexidine
- Foam skin cleanser
- Incontinent cleanser
- Moisture barrier
- Protective barrier
- Soap
- Soap (Antibacterial)
- Wound cleanser
- Other (Comment)

Other: Indicate type of cream used, e.g., Calazime

OneConnect Documentation: Interventions in Daily Cares/Safety

Comfort and Environment Interventions

Comfort

Patient Preferences

Additional Comfort/Environmental Interventions

01/11/17 1905

Additional Comfort/Environmental Interventi... ↑ ↓

Previous: 44 [Pillows/Foam Wedges](#)

Select Multiple Options: (F5)

Special mattress

Cold therapy

Heat therapy

Elevated

Cooling blanket

Pillows/Foam Wedges

Warming blanket

Other (Comment)

Comment (F6)

Comfort and Environment Interventions

Comfort

Patient Preferences

Additional Comfort/Environmental Interventions

Special Mattress

01/11/17 2010

Special Mattress ↑ ↓

Previous: 44 [Other \(Comment\)](#)

Select Single Option: (F5)

Alternating pressure relief

Bariatric alternating pressure relief

Bariatric alternating pressure relief with low air loss

Bariatric low air loss

Foam

Gel overlay

Low air loss

Low air loss and alternating pressure relief

Pressure relief overlay

Rotation alternating pressure relief

Rotation and low air loss

Rotation with alternating pressure relief and low air loss

Tempur-pedic

Other (Comment)

OneConnect Documentation: Interventions in Daily Cares/Safety

The screenshot displays two dropdown menus from the OneConnect software interface. The top menu, titled 'Miscellaneous Devices', is open and shows a list of items including 'Abdominal binder', 'ABductor pillow', 'Ace wrap', 'Brace', 'Collar', 'Immobilizer', 'Ortho boot', 'Orthotics', 'Prosthesis', 'Scrotal support', 'Sling', 'Splint', 'Trapeze', and 'Other (Comment)'. The bottom menu, titled 'Level of Mobility', is also open and shows a list of options including 'Level 1=Total Assist', 'Level 2=Max to Mod Assist', and 'Level 3=Mod Assist to Supervision'. Red circles and rectangles highlight specific elements in both menus.

Miscellaneous Devices

Select Multiple Options: (F5)

- Abdominal binder
- ABductor pillow
- Ace wrap
- Brace
- Collar
- Immobilizer
- Ortho boot
- Orthotics
- Prosthesis
- Scrotal support
- Sling
- Splint
- Trapeze
- Other (Comment)

OTHER

Level of Mobility

Select Single Option: (F5)

- Level 1=Total Assist
- Level 2=Max to Mod Assist
- Level 3=Mod Assist to Supervision

OneConnect Documentation:

Nutrition

Summary

Chart Review

Results Review

Work List

MAR

1

Flowsheets

Intake/Output

Notes

Education

Care Plan

Orders

Navigators

Flowsheets

File

Add Rows

Add LDA

Cascade

Add Col

Insert Col

Hide Device Data

Last Filed

Reg Doc

Graph

Go to D

Vital Signs

Pain

Assessment

Intake/Output

2 Nutrition/Tube Feed

IV Assessment

Daily Cares/Safety

Blood Admin

Weight

Weight

Nutrition

Tube Feeding

Mode: Expanded

View All

ED to Hosp-Admission (Current)

1/22/17

03:12:59

0505

Weight

Weight

Nutrition

Appetite

Feeding

Percent Meals Eaten (%)

Diet Type

Fluid Restrictions

Diet Supplements & Modular Products

Enteral Tube Feeding

Feeding Status

Tube Feeding Frequency

Feeding Formula

Feeding Route

Number of Cans Given

Feeding (rate/schedule)

Tube Feeding Bag Changed

Head of Bed Elevated

Residual (mL)

Residual Returned to Patient (mL)

Residual Discarded (mL)

Intake: Free Water (mL)

Intake: Amount of Feeding Received (mL)

61.8 kg

63.8 kg

OneConnect Documentation: Patient Needs Screening (PNS)

OneConnect interface showing the left sidebar with navigation options: Summary, Chart Review, Results Review, Work List, MAR, Flowsheets, Intake/Output, Notes, Education, Care Plan, Orders, Navigators, FYI.

The main area displays the 'Admission' tab under 'Navigators'. It shows 'Active Home Meds (0): None' and 'SIGNED/HELD ORDERS' section with 'Signed/Held Orders' and 'Release Orders'.

The 'OVERVIEW' section includes 'Care Everywhere', 'Travel/Exposure', 'History', 'OB History', 'OB/Gyn Status', 'Preg Screen', 'Vaccination', 'Immunizations', 'Allergies', 'Home Meds', 'Implants', 'LDAs', 'Filed Documents', 'Patient Belongings', 'E-Sign Patient Bel...', and 'Handoff Communi...'.

Note:

- Complete a PNS on admission
- Update the PNS throughout the inpatient stay based on patient's need or change in condition

PNS

+ New Reading

Required Documentation

ADL Screen

ADL Needs/Assistance

None	Equipment at home (whee...	Lymphedema or wounds	Getting off the commode	Getting out of bed/chair	Walking
Bathing	Dressing	Feeding	Toileting	Other (comment)	

PT/OT Assessment

Nutrition Screen

Nutrition Problem/Concerns

None	Tube Feeding or TPN	Unintentional weight loss of at least 10 lbs in the past month
Less than 50% of usual intake for more than 7 days		

Nutrition Assessment

Speech/Audiology Screen

Speech/Audiology Problems

None	Change in voice	Coughing while eating/drinking	Hearing	Hoarseness for more than two weeks	Speaking	Swallowing	Remembering	Understanding	Other (comment)
------	-----------------	--------------------------------	---------	------------------------------------	----------	------------	-------------	---------------	-----------------

Speech/Audiology Assessment

Case Management Screen

Case Management Requests/Needs

None	Nursing Care at Home	Home Oxygen	Hospice	Wound or Drain Care at Home	Home PT/OT
Placement in Outside Facility	Other (comment)				

Case Management Screen

WOCN Screen

WOC Problems/Concerns

None	Stage III, IV, Deep Tissue Injury, or Unstable Pressure Ulcer	Non-Healing Surgical Wound
Chronic Wound		

Wound Ostomy Assessment

OneConnect Documentation: Final Pressure Injury Assessment

Note:

- Complete entries for Final Assessment Date/Time **ONLY** for 2 instances:
 - **Wrong** LDA entry **OR**
 - Wound has **healed**
- ALWAYS add an appropriate comment when closing an LDA.
- **DO NOT** complete LDA on discharge if wound is **NOT** healed

[REMOVED] Pressure Ulcer 12/21/16 Heel Left;Posterior

Date First Assessment: 12/22/16 Time First Assessment: 10:34 AM

Pre-Existing Wound ☐ Yes ☒ No

Location ☒ Heel
Abdomen Ankle Antecubital Arm Axilla Back Breast Buttocks Calf Cheek Chest Chin

Orientation ☒ Left;Posterior;
Anterior Distal Dorsal Inner Lateral **Left** Lower Medial

Staging (RETIRED)
Stage I Stage II Stage III Stage IV Suspected De... Unstageable
☒ Not applicable

Not applicable (non-pressure related)
Stage I = Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.
Stage II = Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.
Stage III = Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are NOT exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.
Stage IV = Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.
Unstageable = Full thickness tissue loss. The base of the ulcer is not visible due to slough and/or eschar.
Suspected Deep Tissue Injury = Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler than adjacent tissue.

Comments for Final Assessment Date

Wound Description ☒ wound healed ☒ Stable ☒ Shear ☐ Other (comment)

Final Assessment Date ☒ 12/22/16 Final Assessment Time ☒ 1034

Value	Comment	Time Recd	User Taken	User Recd
12/22/2016		12/22/16 10:34	Faith S. Pattavana, RN	FP

Show Audit

Edit Accept Close

OneConnect Reports: IP Patients with Active Pressure Ulcer

IP Patients with Active Pressure Ulcers [5089624] as of Wed 2/22/2017 11:05 AM											
Filters Options Hospital Chart Add Current Chart to List Flowsheets Tx Team Patient List Membership											
MRN	Patient Name	Age/Sex	Admit Date/Time	Department	Bed	Line Name	Site				
69 y.o. / F		02/20/2017 1307	MAIN 17SE	G1781	Pressure Ulcer 02/20/17 Buttocks Left,Medial	Buttocks					
69 y.o. / F		02/20/2017 1307	MAIN 17SE	G1781	Pressure Ulcer 02/20/17 Sacrum Left	Sacrum					
67 y.o. / F		02/02/2017 0939	MAIN 12NW	G1255	Pressure Ulcer 02/16/17 Back Right,Lower	Back	No	02/22/17 0902	Suspected Deep Tissue Injury	Location: Sacrum Orientation: Left Wound Description: Non-Blanchable	
67 y.o. / F		02/02/2017 0939	MAIN 12NW	G1255	Pressure Ulcer 02/16/17 Sacrum	Sacrum	No	02/22/17 0902	Suspected Deep Tissue Injury	Date First Assessed/Time First Assessed: 02/16/17 1212 Pre-Existing Wound: No Location: Back Orientation: Right,Lower	
73 y.o. / M		02/15/2017 1403	MAIN P08A	P0826	Pressure Ulcer 02/15/17 Foot Lateral,Left	Foot	Yes	02/22/17 0000	Stage III	Date First Assessed/Time First Assessed: 02/15/17 2058 Pre-Existing Wound: Yes Location: Foot Orientation: Lateral,Left Wound Description: Blanchable	
70 y.o. / F		08/21/2016 1515	MAIN ICUE	G0742	Pressure Ulcer 12/13/16 Sacrum	Sacrum	No	02/22/17 0800	Unstagable	Date First Assessed/Time First Assessed: 12/13/16 1400 Pre-Existing Wound: No Location: (c) Sacrum Wound Description: Other (comment)	
70 y.o. / F		08/21/2016 1515	MAIN ICUE	G0742	Pressure Ulcer 12/13/16 Buttocks Right,Upper	Buttocks	No	02/22/17 0800	Stage III	Date First Assessed/Time First Assessed: 12/13/16 1400 Pre-Existing Wound: No Location: Buttocks Orientation: Right,Upper	
70 y.o. / F		08/21/2016 1515	MAIN ICUE	G0742	Pressure Ulcer 01/24/17 Buttocks Left,Lower	Buttocks	No	02/22/17 0800	Stage III	Date First Assessed/Time First Assessed: 01/24/17 1100 Pre-Existing Wound: No Location: Buttocks Orientation: Left,Lower Wound Description: Non-Blanchable	
70 y.o. / F		08/21/2016 1515	MAIN ICUE	G0742	Pressure Ulcer 01/24/17 Buttocks Lower,Right	Buttocks	No	02/22/17 0800	Unstagable	Date First Assessed/Time First Assessed: 01/24/17 1100 Pre-Existing Wound: No Location: Buttocks Orientation: Lower,Right Wound Description: Non-Blanchable	
82 y.o. / M		01/26/2017 2237	MAIN ICUF	G0750	Pressure Ulcer 02/16/17 Ankle Anterior,Right	Ankle		02/22/17 0702	Suspected Deep Tissue Injury	Date First Assessed/Time First Assessed: 02/16/17 0800 Location: Ankle Orientation: Anterior,Right Wound Description: Non-Blanchable	

Note:

- Real-time report that captures patient with active pressure ulcers on each unit

OneConnect Reports: IP Patients with Low Braden Score

Epic Patient Lookup In Basket OR Cases Non-Patient Transport Patient Education Link Cerner Bridge My Reports Track Board

Cuellar,Ricardo Reports

IP Patients with Low Braden Score: In House Dashboard [5089680] as of Wed 2/22/2017 11:07 AM

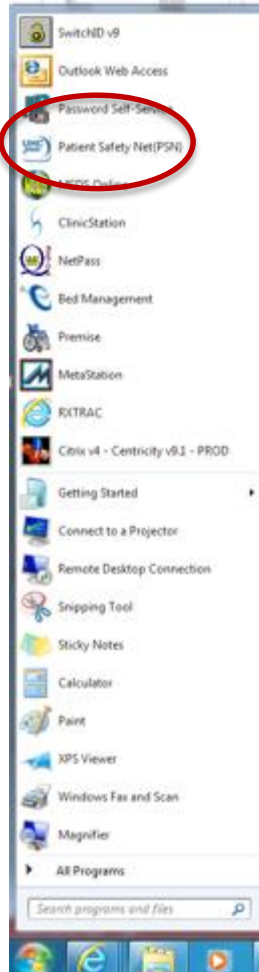
Filters Options Hospital Chart Add to List Ix Team Patient List Membership

Note:

- Real-time report that captures patient with low Braden score

MRN	Patient	Age/Sex	Department	Bed	Braden Score	ince B		
		75 y.o. / M	MAIN 15SE	G1581	16			
		67 y.o. / M	MAIN 12NW	G1258	14	0d 3h 12m	No	28d 21h
		69 y.o. / F	MAIN 17SE	G1781	12	0d 3h 37m	Yes	1d 16h
		76 y.o. / M	MAIN P08B	P0804	17	0d 15h 22m	No	11d 17h
		67 y.o. / F	MAIN 12NW	G1255	9	0d 2h 5m	Yes	19d 23h
		60 y.o. / F	MAIN 16NW	G1654	17	0d 2h 26m	No	1d 20h
		66 y.o. / M	MAIN ICUA	G0706	(P) 14	(P) 0d 3h 7m	No	32d 13h
		73 y.o. / M	MAIN P08A	P0828	16	0d 2h 37m	Yes	6d 17h
		70 y.o. / F	MAIN ICUE	G0742	12	0d 3h 7m	18	3d 15h 7m Yes 184d 16h
		69 y.o. / M	MAIN 17SW	G1740	17	0d 14h 7m	No	13d 7h
		67 y.o. / F	MAIN ICUF	G0747	15	0d 3h 47m	No	22d 21h
		59 y.o. / M	MAIN 12NW	G1248	7	0d 2h 7m	No	19d 18h
		69 y.o. / F	MAIN ICUE	G0739	16	0d 3h 37m	21	0d 3h 37m No 5d 8h
		75 y.o. / M	MAIN 19SW	G1942	16	0d 3h 22m	No	16h
		79 y.o. / F	MAIN P09B	P0905	17	0d 15h 56m	No	31d 12h
		82 y.o. / M	MAIN ICUF	G0750	8	0d 4h 5m	Yes	26d 10h
		54 y.o. / M	MAIN 16NW	G1649	17	0d 8h 7m	No	16h

Safety Intelligence



New Form | Login |

UHC Safety Intelligence: Event Report

Welcome to the UHC Safety Intelligence Front Line Reporter Form.

- A ★ indicates a mandatory field.
- Click the ⓘ icon for help with a particular field.
- Click the ▼ button to view and select from the list of available options for that field.
- Click the ✖ button to remove values from a field.

If you have any questions or concerns, contact your on-site administrators via email at eventreports@mdanderson.org

Start

★ Who was affected by the event? Patient ▼

Date of admission or ambulatory encounter ⓘ

People affected by the event

★ Type Patient ▼

For the first person affected: please respond to this question with the same answer you gave above to the question "Who was affected by the event?"

★ MRN Search

★ Inpatient/Outpatient? ▼

Last name

First name

Middle initials

★ Date of birth (MM/dd/yyyy) ⓘ

Age

★ Gender ▼

Add another

Note:

- Complete a safety event report for ALL suspected and active pressure injuries/deep tissue injuries via Safety Intelligence

Resources

Click on the link to open the site:

[Institute for Health Improvement: Pressure Ulcers](#)

[National Pressure Ulcer Advisory Panel](#)

[NDNQI Pressure Injury Training](#)

[Wound, Ostomy and Continence Nursing \(WOCN\) Resources at MDA](#)

[You Tube Video: How to Apply Antiembolism Stockings](#)

[You Tube Video: Proper Prevalon Application](#)

Resources

Other: Unit/Service-based PowerPoint Presentations

- ICU: Pressure Injury Bundle
- G16: 2 RN Skin Assessment
- G10E: Let us Check the Pressure Ulcer Out
- P12: Wound Assessment and Appropriate Documentation
- Perioperative Skin Impairment Initiative
- WOCN: Overview of Basic Wound, Ostomy, and Continence Care
- WOCN: Pressure Ulcers

OneConnect