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¹ Pressure Injury: A localized injury to the skin and/or underlying tissue usually over a bony prominence or related to medical devices/other objects, as a result of pressure, or pressure in combination with shear and/or friction

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MDAnderson Pressure Injury (PI) Assessment and Management Cancer Center

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WOC nurse = wound ostomy and continence nurse

LDA = lines, drains, airways

EHR = electronic health record

¹ See Appendix A for Bony Prominences: Common Sites of Pressure Injury and Appendix B for Pressure Injury Staging System

² See Appendix C for Braden Scale (ages 9 years and older) or Appendix D for Braden O Scale (ages 8 years and younger)

³ Arrival/admission/transfer includes any movement between the following areas: inpatient units, pre-operative and TPACU (Transitional Post Anesthesia Care Unit), Acute Cancer Care Center, Pediatric

Acute Cancer Care Center, Clinical Decision Unit (CDU). If PI is identified at the time of admission from the outside facility or home, the PI is considered to be community-acquired. If identified at any other time during

hospital stay, the PI is considered to be hospital/unit acquired.

⁴ For Stage 1 and 2, activate the patient needs screening (PNS) request for WOC nurse

⁵ Also applies to tubes/wounds

⁶ Use institutionally approved mobile device to capture and upload photo - refer to Patient Photograph in the Electronic Health Record (EHR) System Policy (#ADM1134)

⁷ Refer to Pressure Injury Assessment and Prevention Policy (#CLN0686) and Inpatient Nursing Documentation of Care Policy (#CLN0647)

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STAGING

EVALUATION OF INJURY



DTPI = deep tissue pressure injury

¹ For Stage 1 and 2, activate Patient Needs Screening (PNS) request for WOC nurse

² All preventable stages 3, 4, and unstageable PIs are reportable adverse events. These are reported to the Texas Department of State Health Services (DSHS) through the Department of Patient Safety and Accreditation

³ Also applies to tubes/wounds

⁴ Use institutionally approved mobile device to capture and upload photo - refer to Patient Photograph in the Electronic Health Record (EHR) System Policy (#ADM1134)

INTERVENTIONS

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APPENDIX A: Bony Prominences: Common Sites of Pressure Injury

Impaired skin/tissue integrity over a bony prominence or under medical devices/objects

BONY PROMINENCES: COMMON SITES OF PRESSURE INJURY



Common sites of pressure injury when lying down



Common sites of pressure injury when sitting in a wheelchair



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Shear¹ effect





Images from MD Anderson resources

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¹ Shear occurs when skin and adjacent bony surface slide across one another ² Friction occurs when skin moves against support surfaces

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APPENDIX B: Pressure Injury Staging System

Stage 1: Non-blanchable erythema of intact skin

Intact skin with a localized area of non-blanchable erythema



MASD¹: Erythematous skin damage due to moisture

Etiology is moisture as opposed to pressure



Stage 2: Partial-thickness skin loss with exposed dermis

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

Stage 3: Full-thickness skin loss

Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible.

Stage 4: Full-thickness skin and tissue loss

Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occurs.



MASD = moisture associated skin damage

¹MASD is not considered to be a pressure injury. Description is added for the purpose of comparison.

Photos from MD Anderson WOC nursing resources

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APPENDIX B: Pressure Injury Staging System - continued

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Unstageable: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar Deep Tissue Pressure Injury: Persistent non-blanchable, deep red, maroon or purple discoloration Intact or non-intact skin with localized area of persistent non-blanchable, deep red, maroon, purple discoloration or epidermal separation 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. Medical Device Related Pressure Injury (MDRPI): Pressure injury as a result from the use of devices designed and applied for diagnostic or therapeutic purposes **Mucosal Membrane Pressure Injury:** 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.

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APPENDIX C: Braden Scale (ages 9 years and older)

	1	2	3	4
Sensory Perceptions Ability to respond meaningfully to pressure-related discomfort	Completely Limited: Unresponsive (does not moan, flinch, or grasp) to painful stimuli because of diminished level of consciousness or sedation <u>Or</u> Limited ability to feel pain over most of the body	 Very Limited: Responds only to painful stimuli Cannot communicate discomfort except by moaning or restlessness <u>Or</u> Has a sensory impairment which limits the ability to feel pain or discomfort over half of the body 	Slightly Limited: Responds to verbal commands but cannot always communicate discomfort or need to be turned <u>Or</u> Has some sensory impairment, which limits ability to feel pain or discomfort in one or two extremities	 No Impairment: Responds to verbal commands Has no sensory deficit that would limit ability to feel or voice pain or discomfort
Moisture Degree to which skin is exposed to moisture	 Constantly Moist: Skin is kept moist almost constantly by perspiration, urine, <i>etc</i>. Dampness detected every time patient is moved or turned 	 Very Moist: Skin is often but not always moist Linen must be changed at least once a shift 	Occasionally Moist: Skin is occasionally moist, requiring extra linen change approximately once a day	Rarely Moist: Skin is usually dry; linen requires changing only at routine intervals
Activity Degree of physical activity	Bedfast: Confined to bed	 Chairfast: Ability to walk severely limited or non-existent Cannot bear own weight, must be assisted into chair or wheelchair, or both 	 Walks Occasionally: Walks occasionally during day but for very short distances with or without assistance Spends most of each shift in bed or chair 	Walks Frequently: Walks outside room at least twice a day and inside room at least once every 2 hours during waking hours
Mobility Ability to change and control body position	Completely Immobile: Does not make even slight changes in body or extremity position without assistance	Very Limited: Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	Slightly Limited: Makes frequent though slight changes in body or extremity position independently	No Limitation: Makes major and frequent changes in position without assistance

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APPENDIX C: Braden Scale (ages 9 years and older) - continued

	1	2	3	4
Nutrition Usual food intake pattern	 Very Poor: Never eats a meal Rarely eats more than ⅓ of any food offered Eats ≤ 2 servings of protein (meat or dairy products) per day Takes fluids poorly; does not take a liquid dietary supplement Or Takes nothing by mouth, is maintained on clear liquids or IV infusions for > 5 days, or both 	 Probably Inadequate: Rarely eats a complete meal and generally eats only about ½ of any food offered Protein intake includes only 3 servings of meat or dairy products per day Occasionally takes a dietary supplement <u>Or</u> Receives less than optimum amount of liquid diet or tube feeding 	 Adequate: Eats over ½ of most meals Eats a total of 4 servings of protein (meat, dairy products) each day Occasionally refuses a meal but usually takes a supplement when offered <u>Or</u> Is on tube feeding or TPN regimen that probably meets most of nutritional needs 	 Excellent: Eats most of every meal Never refuses a meal Usually eats ≥ 4 servings of meat and dairy products Occasionally eats between meals Does not require supplementation
Friction and Shear Friction is the resistance to motion of one object moving against another. Shear is the unaligned force of two different parts of the body moving in opposite directions.	 Problem: Requires moderate to maximum assistance in moving Complete lifting without sliding against sheets impossible Frequently slides down in bed or chair; repositioning with maximal assistance Spasticity, contractions, or agitation leads to almost constant friction 	 Potential Problem: Moves feebly or requires minimum assistance During a move the 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 	 No Apparent Problem: Moves in bed and in chair independently and has sufficient muscle strength to sit up completely during move Maintains good position in bed or chair 	N/A

Note: See Appendix E for Pressure Injury Prevention/Progression Bundle based on Braden Scale score

IV = intravenous

TPN = total parenteral nutrition

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APPENDIX D: Braden Q Scale (ages 8 years and younger)

	1	2	3	4
Mobility The ability to change and control body position	Completely Immobile: Does not make even slight changes in body or extremity position without assistance	Very Limited: Makes occasional slight changes in body or extremity position but is unable to completely turn self independently	Slightly Limited: Makes frequent although slight changes in body or extremity position independently	No Limitations: Makes major and frequent changes in position without assistance
Activity The degree of physical activity	Bedfast: Confined to bed	 Chair Fast: Ability to walk severely limited or non-existent Cannot bear own weight or must be assisted into chair or wheelchair 	 Walks Occasionally: Walks occasionally during day but for very short distances, with or without assistance Spends most of each shift in bed or chair 	All patients too young to ambulate or walks frequently: Walks outside room at least twice a day and inside room at least once every 2 hours during waking hours
Sensory Perception The ability to respond in a <u>developmentally</u> appropriate way to pressure related discomfort	Completely Limited: Unresponsive (does not moan, flinch, or grasp) to painful stimuli because of diminished level of consciousness or sedation <u>or</u> limited ability to feel pain over most of body surface	 Very Limited: Responds only to painful stimuli Cannot communicate discomfort except by moaning or restlessness or has sensory impairment that limits the ability to feel pain or discomfort over half of body 	Slightly Limited: Responds to verbal commands but cannot always communicate discomfort or need to be turned <u>or</u> has some sensory impairment that limits ability to feel pain in 1 or 2 extremities	 No Impairment: Responds to verbal commands Has no sensory deficit that limits ability to feel or communicate pain or discomfort
Moisture Degree to which skin is exposed to moisture	 Constantly Moist: Skin is kept moist almost constantly with perspiration, urine, drainage, <i>etc</i>. Dampness is detected every time the patient is moved or turned 	 Very Moist: Skin is often but not always moist Linen must be changed at least every 8 hours 	Occasionally Moist: Skin is occasionally moist, necessitating linen change every 12 hours	Rarely Moist: Skin is usually dry; routine diaper changes; linen needs changing only every 24 hours

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APPENDIX D: Braden Q Scale (ages 8 years and younger) - continued

	1	2	3	4
Friction – Shear Friction: occurs when skin moves against support surfaces Shear: occurs when skin and adjacent bony surface slide across one another	Significant Problem: Spasticity, contracture, itching or agitation leads to almost constant thrashing and friction	 Problem: Needs moderate to maximum assistance in moving Complete lifting without sliding against the sheets is impossible Frequently slides down in bed or chair, necessitating frequent repositioning with maximum assistance 	 Potential Problem: Moves freely or needs 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 	 No Apparent Problem: Able to completely lift patient during a position change; moves in bed and chair independently and has sufficient muscle strength to lift up completely during move Maintains good position in bed or chair at all times
Nutrition Usual food intake pattern	 Very Poor: NPO or maintained on clear liquids, or IV lines for > 5 days or albumin < 2.5 mg/dl or never eats a complete meal Rarely eats more than ½ of any food offered Protein intake includes only 2 servings of meat or dairy products per day Takes fluids poorly Does not take a liquid dietary supplement 	 Inadequate: Is on liquid diet or tube feedings or TPN that provide inadequate calories or minerals for age or albumin < 3 mg/dl <u>or</u> rarely eats a complete meal and generally eats only about ½ of any food offered Protein intake includes only 3 servings of meat or dairy products per day Occasionally takes a dietary supplement 	 Adequate: Is on tube feedings or TPN that provides adequate calories and minerals for age <u>or</u> eats over ½ of most meals Eats a total of 4 servings of protein (meat, dairy products) each day Occasionally will refuse a meal but usually take a supplement if offered 	 Excellent: Is on a normal diet that provides adequate calories for age. For example: Eats or drinks most of every meal or feeding. Never refuses a meal Usually eats a total of 4 or more servings of meat and diary products Occasionally eats between meals Does not need supplementation
Tissue Perfusion and Oxygenation	Extremely Compromised: Hypotensive (MAP < 50 mmHg or < 40 mmHg in a newborn) <u>or</u> the patient does not physiologically tolerate position changes	Compromised: Normotensive; oxygen saturation may be < 95% <u>or</u> hemoglobin may be < 10 mg/dL <u>or</u> capillary refill may be > 2 seconds; serum pH < 7.4	Adequate: Normotensive; oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dL <u>or</u> capillary refill may be > 2 seconds; serum pH is normal	Excellent: Normotensive; oxygen saturation > 95%; normal hemoglobin; capillary refill < 2 seconds

IV = intravenous MAP = mean arterial pressure

NPO = nothing by mouth TPN = total parenteral nutrition Note: See Appendix E for Pressure Injury Prevention/Progression Bundle based on Braden Q Scale score

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APPENDIX E: Pressure Injury Prevention/Progression Bundle

Conduct a pre	ssure injury admission assessment for a	ll patients		
 Use a structured risk assessment, such as the Braden Scale to identify patients at risk for pressure injury Braden Scale for patients age 9 years and older (see Appendix C) Braden Q Scale for patients age 8 years and younger (see Appendix D) Conduct a head-to-toe assessment on admission 				
• Inspect all of the skin upon admission or trans	ster (within 2 hours)			
• Consider general risk factors including:	ssion of transfer			
• Age (elderly/pediatric patients)	• Inadequate nutrition	• Multiple comorbidities		
∘ Immobility	• Sensory deficiency	• Circulatory abnormalities		
∘ Incontinence	 Device-related pressure 	• Dehydration		
• Special considerations for oncology patients:				
• Nutritional status	• Radiation	 Skin-toxic chemotherapy/biotherapy agents 		
• Type of treatment	• Surgery			
• Other considerations:				
 Diminished perfusion/oxygenation 	 Spinal cord injury 			
 History of previous pressure injury 	 Fragile skin 			
 Impairments in blood flow to the extremitie 	s from vascular disease, diabetes or tobacco use			
• Special considerations for pre/post-operative	patients:			
\circ Length of surgery (> 3 hours)	 Medical devices (see Appendix G) 			
 Operating room (OR) positioning 	 Nutritional status 			
 Lines/Drains/Airways 	 Functional capacity pre and post procedure 			
 Number of intra-operative hypotensive epise 	odes			
• Duration of intra-operative low body temper	rature			

Guidelines adopted from the National Pressure Advisory Panel (NPIAP) and National Institute of Health (NIH)

Note: Clinical judgment must be used to determine patient needs. Interventions may be initiated at any time, even if patient's Braden/Braden Q Score are above the recommendation herein.

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APPENDIX E: Pressure Injury Prevention/Progression Bundle - continued

Inspect skin and reassess risk for all patients every shift • Perform head-to-toe skin assessment every shift for signs of pressure injury	Manage Moisture and Promote Skin Care: (see Appendix H for MASD prevention/treatment) (Implement interventions for Moisture subset score ≤ 3)
 Assess ALL bony prominences and pressure points (see Appendix A) and give special attention to the following areas: Sacrum, coccyx, buttocks, back, heels, ischium, trochanters, elbows, occiput Areas beneath medical devices (<i>e.g.</i>, tracheostomy collar, Foley catheter, nasal cannula, SCD/AES) 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 Consider bedfast and chairfast patients to be at risk for development of pressure injury Use age-appropriate Braden Scale to assess for risk of pressure injury development. The RN is responsible for: Assessing the patients and determining the Braden/Braden Q Score For patients with a total Braden Score/Braden Q Score ≤ 14, order a low air bed/mattress Implementing interventions based on the areas of risk, rather than on the total risk assessment score 	 Perform head-to-toe skin assessment every shift for signs of pressure injury Assess ALL bony prominences and pressure points (see Appendix A) and give special attention to the following areas: Sacrum, coccyx, buttocks, back, heels, ischium, trochanters, elbows, occiput Areas beneath medical devices (<i>e.g.</i>, tracheostomy collar, Foley catheter, nasal cannula, SCD/AES) 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 Limit to 2 layers of linen (no more than 3 layers if additional layers indicated) 2 layers: fitted sheet and draw sheet Use breathable incontinence pads (<i>e.g.</i>, CovidienTM pads, UltrasorbTM pads) If patient is on low air loss mattress, limit 2 layers (draw sheet <u>or</u> loose fitted sheet with incontinence pad)
uidelines adopted from the National Pressure Advisory Panel (NPIAP) and National Institute of Health (NIH)	 Remedy NutrashieldTM) Order appropriate specialty pressure redistribution surface (bed/mattress) if

Note: Clinical judgment must be used to determine patient needs. Interventions may be initiated at any time, even if patient's Braden/Braden Q Score are above the recommendation herein.

AES = anti-embolic stockings

SCD = sequential compression device

Continued on next page

Braden/Braden Q Moisture subset scores are ≤ 2 (see Appendix F)

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APPENDIX E: Pressure Injury Prevention/Progression Bundle - continued

Optimize Nutrition and Hydration (Implement interventions for Nutrition subset score ≤ 2)• Consider hospitalized patients to be at risk for under nutrition and	Reposition, Mobilize, and Minimize Pressure, Friction, or Shear (Implement interventions for Sensory Perception Subset Score ≤ 3 , Mobility Subset Score ≤ 3 , Activity Subset Score ≤ 3 , Friction/Shear Subset Score ≤ 2 , Tissue Perfusion Subset Score ≤ 2) Note: Pressure redistribution over bony prominences is a primary concern
 malnutrition from their illness or from being on prolonged NPO and/or clear liquid diet for > 3 days 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 Monitor patient's weight for significant changes ≥ 2 % in 1 week ≥ 10% in 6 months ≥ 5 % in 1 month ≥ 20% in 12 months ≥ 7.5% in 3 months Monitor associated signs/symptoms that impact patient's nutritional status (<i>e.g.</i>, nausea, vomiting, diarrhea, anorexia, cachexia) Request for Nutrition Services consult Use a valid and reliable screening tool to determine risk of malnutrition Assist patients at mealtimes to increase oral intake Evaluate change in dietary pattern and monitor oral intake Encourage intake of nutritional supplements if ordered Guidelines adopted from the National Pressure Injury Advisory Panel (NPIAP) and National Institute of Health (NIH) 	 Turn/reposition¹ patients every 2 hours while in bed and every 1 hour when up in chair to optimally offload bony prominences and/or relieve pressure Use wedge or fluidized positioner (<i>e.g.</i>, Z-Flo) for positioning Utilize a turning schedule (<i>e.g.</i>, turn clocks) When patient is up in chair, instruct patient to shift position every 15 minutes and assist with full relief of weight every hour Use specialized support surfaces Use specialized support surfaces (such as mattresses, beds, and cushions), see Appendix F (Nurse to place order for specialty bed^{2.3} with "Patient supplies: No Cosign Required" order mode) Consider the level of immobility, exposure to shear, skin moisture, perfusion, body size and weight of the patient when choosing a support surface Use breathable incontinence pads when using microclimate management surfaces Keep the head of bed at ≤ 30 degree angle (unless contraindicated) Ensure right size of bed linen (<i>e.g.</i>, fitted sheet) Use a pressure redistributing chair cushion for patients sitting in chairs or wheelchairs (<i>e.g.</i>, EHOBTM Waffle Seat Cushion or ROHO[®] Seat Cushion) Float heels off the bed using pillows or heel off-loading device (<i>e.g.</i>, Multi-podus boots – Prevalon[®]) Ensure right size of antiembolic stockings and remove every 8-12 hours Use appropriate silicone foam barrier (<i>e.g.</i>, Biatain[®] or KerraFoamTM) Place thin foam or breathable dressings under medical devices (<i>e.g.</i>, Mepilex[®] lite), see Appendix G Lift patient or use transfer aids. Take measures to prevent dragging patient during repositioning and transfer. (<i>e.g.</i>, slide board; slide sheet – MaxiSlide; mechanical lifts – Ultralift; AirTAP)
¹ Incremental weight shifts may be performed for the hemodynamically unstable patients ² Screen for contraindications and discuss with WOC nurse/Physical Therapy/Rehab Services ³ Request for Envella TM bed requires a physician's order Note: Clinical judgment must be used to determine patient needs. Interventions may be initiated at any time, even if patient's Braden/Braden O Score is above the recommendation be	 Avoid positioning patients on an area of erythema or pressure injury Request a Rehabilitation Services consult Occupational therapy for sensory deficits and activities of daily living (ADL) Physical therapy for mobility and exercise

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APPENDIX E: Pressure Injury Prevention/Progression Bundle - continued

Educate Note: Utilize an interdisciplinary and patient-centered care approach • Engage all healthcare professionals/staff • Notify physician upon discovery of pressure injury • Discuss patients at risk and patients with active pressure injury during hand-off, pod brief, physician rounding, interdisciplinary or family care conferences • Utilize the Clinical Practice Guidelines (CPG) in developing action plans for education and intervention • Educate all nursing staff • Utilize the CPG in developing action plans for education and intervention • Update the Patient Needs Screening (PNS) assessment throughout the inpatient stay • Ensure timely consults with Nutrition, PT/OT, and WOC nurse as appropriate • Ensure physician and caregiver notification upon discovery of pressure injury • Ensure Escalation and documentation of patient's declination of care¹ • Educate and engage patient and caregiver • Patients at risk of PI: educate patient and caregivers about PI risk factors and PI prevention bundle • Patients with active PI: educate patient and caregivers about management and prevention of wound progression • Provide educational materials and resources - Pressure Injury Prevention Patient Education Online - Pressure Injury Prevention Patient Education Video

¹ Refer to the institutional policy attachment Inpatient Declination of Care Escalation Process (#ATT3479)

Guidelines adopted from the National Pressure Injury Advisory Panel (NPIAP) and National Institute of Health (NIH)

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APPENDIX F: Low Air Loss/Pressure Redistribution Surface (Bed/Mattress)

Bed	Indication	Weight Capacity	Bed	Indication	Weight Capacity
Centrella [®] max	 First line for at risk patients: Braden Score ≤ 14 Moisture Subset Score ≤ 2 	32-227 kg (70-499 lbs)	Progressa [®] Smart+ Bed	 First line for at risk patients: Braden Score ≤ 14 Moisture Subset Score ≤ 2 Note: Equipped with CLRT and Percussion and Vibration therapy 	30-225 kg (66-495 lbs)
Envision [®] E700	Second line for at risk patients: • Braden Score ≤ 14 • Moisture Subset Score ≤ 2	32-180 kg (70-396 lbs)	Envella [™] Air Fluidized Bed ^{1,2}	 First line for at risk patients Braden Score ≤ 14 and At least of one the following conditions: Fresh flap or graft Intractable pain Burns Limited turning surfaces Patients not improving on low air loss 	32-160 kg (70-350 lbs)
TotalCare [®] Bariatric Plus Pulmonary	 First line for at risk patients: Braden Score ≤ 14 Moisture Subset Score ≤ 2 Note: Equipped with Continuous Lateral Rotation Therapy (CLRT) and Percussion and Vibration therapy 	90-225 kg (198-495 lbs)	Compella [™] Bariatric Bed CLRT	 First line for at risk patients: Braden Score ≤ 14 Moisture Subset Score ≤ 2 Note: Equipped with CLRT and Percussion and Vibration therapy 	113-454 kg (248-998 lbs)

¹ Screen for contraindications and discuss with WOC nurse/Physical Therapy/Rehab Services. Not recommended for a patient with an unstable spine or pulmonary disease. The fluid-like surface doesn't provide sufficient support for a patient with an unstable spine and the lack of firm support makes it difficult for patients to cough effectively for patients with pulmonary disease.

² Request for EnvellaTM bed requires a physician's order

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APPENDIX G: Medical Device Related Pressure Injury (MDRPI) Prevention

Standard interventions for ALL devices:

- Assess site and surrounding skin every shift and as needed
- Replace protective or securement device per standards and when visibly soiled (*e.g.*, spinal brace)
- Consult appropriate discipline for concerns regarding device that is not routinely removed

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- Pad, secure or reposition/rotate devices to minimize pressure, tension, and/or discomfort
- Provide appropriate routine care associated with type of medical device

Location	Device		Intervention
Face	BiPAP & CPAP masks	Gel barrier	 Place gel skin barrier¹ on the bridge of the nose and where the mask rests on the face The gel skin barrier¹ is to be used in conjunction with a face mask BiPAP/CPAP mask
		Foam barrier	 Foam barrier may be utilized on the bridge of the nose or side of the mouth when using an under the nose BiPAP/CPAP mask, full face mask (mask above the eyebrows and under the chin) or a nasal BiPAP/CPAP mask Do not layer gel barrier¹ and foam barrier together. These barriers are to be used independently of one another.
		Practice	 Avoid overtightening the straps when using any of the BiPAP/CPAP mask devices Under the nose mask shouldn't sit on the apex of the nose. The mask should rest directly under the nose and below the lower lip. Ensure proper placement of mask to avoid slipping of mask and skin/mask friction RT to evaluate the patient for intubation criteria (work of breathing, post NIPPV initiation ABG, <i>etc.</i>). RT or RN to report to provider if the patient meets intubation criteria.
Face/Ears	Oxygen Devices: nasal cannula ² , simple mask, venturi mask, and non-rebreather mask	Foam barrier	Evaluate the patient's skin for skin irritation/discoloration or indentations at the bridge of the nose, cheeks, around the mouth, behind the ears, and the outside area of the ears
		Practice	 Apply thin foam padding between the oxygen device and affected area if applicable Avoid overtightening of mask strap or nasal cannula
	High flow nasal cannula (HFNC)	Foam barrier	 Apply thin foam padding on the cheeks between the skin and HFNC pads where the device rests on the patient's face Place thin foam padding behind the ears if applicable
		Practice	 HFNC headgear/harness is to be opened/separated apart and anchored around the crown of the head. HFNC straps must remain around the crown of the head, off and above the ears. HFNC tubing should be pointed to the same side as where the high flow machine is placed. This will prevent pulling of the nasal cannula and prevent tension friction to the surrounding areas. Ensure that the tubing is clipped to the patient's gown utilizing the provided circuit clip Avoid overtightening of the HFNC's strap
	Forehead SpO2 probe	Practice	 Rotate site at least once every shift and as needed Keep probe wire away from the patient
BiPAP = bilevel RT = Respiratory	positive airway pressure CPAP = o v Therapy NIPPV =	continuous positive a	airway pressure ¹ RT provides gel skin barrier and assists in securing BiPAP/CPAP mask with gel barrier ² Use a soft nasal cannula pepartment of Clinical Effectiveness ²

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APPENDIX G: MDRPI Prevention - continued

Standard interventions for ALL devices:

- Assess site and surrounding skin every shift and as needed
- Replace protective or securement device per standards and when visibly soiled (e.g., spinal brace)
- Consult appropriate discipline for concerns regarding device that is not routinely removed
- Pad, secure or reposition devices to minimize pressure, tension, and/or discomfort
- Provide appropriate routine care associated with type of medical device

Location	Device	Intervention	
Neck	Endotracheal tube (ETT)	Practice	 RT to reposition the ETT every 4 hours unless otherwise ordered by provider Breathing tube will not be repositioned if the patient is nasally intubated or other contraindications apply If using a commercial ETT holder or tape, allow two fingers' width between the strap and the patient's neck Ensure ETT holder/bumper is positioned correctly (above the upper lip, bumper not in the eye area, <i>etc.</i>) Ventilator circuit should be placed on the ventilator's circuit holder in effort to avoid pulling on the face and ETT/Trach Change ETT holder as appropriate (<i>e.g.</i>, when soiled, when adhesive is holding device in place, <i>etc.</i>)
	Trach flange	Foam barrier Practice	If applicable, place appropriate dressing (<i>e.g.</i> , gauze/drain sponge) or foam padding (cut to size) between the edge of the trach flange and patient's skin Allow two fingers' width between the strap and the patient's neck

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APPENDIX G: MDRPI Prevention - continued

Location	Device	Intervention	
	Arterial line	Use soft splint to position wrist as needed	
Upper Extremities	O ₂ saturation probe	 Rotate site daily and as needed Keep probe wire away from the patient For pediatric patients, use pediatric probe 	
	Arm sling	Readjust every 2 hours when in useMonitor for increasing edema	
	SCD	 Remove SCD and assess skin every shift and as needed Monitor for increasing edema 	
Lower Extremities	AES/lymphedema wrap	 Remove AES and assess skin every shift and as needed Ensure correct size; no wrinkles Monitor for increasing edema 	
	Knee immobilizer	 Check every 2 hours for proper alignment and pressure point checks Monitor for increasing edema 	
	Shrinker (for below the knee amputation)	Release for 1 hour daily	
Heels/Feet	Heel offloading device	 Ensure correct application Adjust stabilizer as appropriate Monitor for increasing edema 	
	Orthopedic boots	 Ensure correct size and application Monitor for increasing edema 	
Abdomen	Feeding tube (e.g., J-tube, G-tube)	 Place foam padding between the tube bumper and the patient's skin Use silicone tape for additional securement 	
	Abdominal binder	 Remove binder every shift to assess skin Ensure correct size; no folded areas 	
Thigh/Penis	Indwelling urinary catheter, three-way urinary catheter/continuous bladder irrigation, external urinary catheter (condom catheter/external female catheter)	 Ensure correct size of catheter Use appropriate securement device to secure catheter (with enough slack) Use silicone tape for additional securement Rotate thighs (where tubing is taped/secured) 	
AES = anti-embolic stockings	J-tube = jejunostomy tube G-tube = gastrostomy tube	SCD = sequential compression device	Depa

AES = anti-embolic stockings J-tube = jejunostomy tube G-tube = gastrostomy tube

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APPENDIX G: MDRPI Prevention - continued

Location	Device	Intervention	
Other	Cast	 Place appropriate gauze dressing/abdominal pad/foam padding beneath the cast's edge/brim Assess for allowance of 2 finger breadth under the cast Monitor for increasing edema 	
	Braces/Collar (<i>e.g.</i> , spinal brace, cervical collar, hip abduction brace, knee brace, <i>etc.</i>)	 Remove brace/collar and assess skin every shift and as needed Place appropriate guaze dressing/abdominal pad/foam padding under the device Monitor for increasing edema 	
	Drains (<i>e.g.</i> , JP-drain, nephrostomy tube, <i>etc.</i>)	 Place foam padding between the tube bumper and the patient's skin Use silicone tape for additional securement Change dressing every other day and as needed 	
Tubes (e.g., rectal tube) $\bullet D$ $\bullet U$		Direct tubing away from the patientUse silicone tape for additional securement	
	Other tubing (e.g., IV tubing)	 Direct tubing away from the patient Apply small foam padding under the tubing as appropriate Use silicone tape for additional securement 	
	Pads and wires (<i>e.g.</i> , cardiac monitor device, EEG, <i>etc.</i>)	Direct wires away from the patientRotate pad placement (as appropriate)	
	Other potential objects (<i>e.g.</i> , call light, needle cap, <i>etc.</i>)	 Ensure linens are free of wrinkles (smooth wrinkles every two hours when turning) Ensure there are no objects caught under the patient's skin 	

JP drain = Jackson-Pratt drain IV = intravenous EEG = Electroencephalography Page 19 of 23

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APPENDIX H: Moisture-Associated Skin Damage (MASD) Prevention/Treatment

MASD is inflammation and erosion of the skin caused by prolonged exposure to urine, stool, saliva, mucus, perspiration, wound exudate, or any other type of drainage (any substance which causes "irritation" to the skin). Gluteal, abdominal, and groin skin folds are high moisture areas. <u>Note: MASD *may* progress to Pressure Injury</u>

Problem		Risk Factors	Prevention	Treatment
Intertriginous Dermatitis (ITD)	 Inflammatory skin condition of opposing skin surfaces caused by moisture Linear breaks in the skin at the base of skin folds caused by overhydration of the skin due to trapped moisture and friction exerted by opposing skin folds Most commonly occurs in the inframammary, axillary and inguinal skin folds Alkaline pH of the skin in these areas support the growth of bacteria and fungus "Mirror-image" appearance on each side of the skin fold Skin can be erythematous, macerated, oozing, or draining Patients report itching, pain, burning, and odor 	 Diaphoresis Diabetes Broad spectrum antibiotic therapy Obesity Steroids Poor hygiene Chemotherapy 	 Use non-perfumed cleansers Use non-talc powders Avoid use of lotions or ointments under skin folds Ensure skin folds are dry at all times Reduce heat and moisture Reduce skin to skin friction Contain or divert urine/stool as appropriate (<i>e.g.</i>, condom catheter, rectal pouch) Use absorptive/wicking products between skin folds (<i>e.g.</i>, moisture-wicking fabric - InterDry[®]Ag, pillowcase, <i>etc.</i>) Apply moisture barrier cream if indicated (<i>dimethicone-based only</i>) 	 Apply moisture-wicking fabric (<i>e.g.</i>, InterDry[®]Ag) Leave 2 inch area of strip exposed to air to allow for wicking of moisture Apply antifungal powder <i>only</i> if candidiasis Apply lightly after cleaning and pat dry the area
Periwound MASD	 Damage due to prolonged contact between periwound skin and wound exudate Mechanisms of injury include maceration and inflammation 	Pre-existing wound	 Use appropriate dressing to manage exudate (<i>i.e.</i>, pouch or dressing) Change dressing if saturated Change pouch weekly or as needed (<i>e.g.</i>, leaking) Apply non-alcohol liquid barrier film if indicated Apply cream based barrier products in areas where adhesion is not required 	
Peristomal MASD	Prolonged or recurrent exposure of peristomal skin to drainage from urinary or fecal stoma, tracheostomy, or gastrostomy	Stoma	 Establish secure pouching system Ensure correctly sized pouch opening (protection of all peristomal skin) Ensure appropriate pouch change frequency Correct causative factors (<i>e.g.</i>, diarrhea, peristomal hernia) 	

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APPENDIX H: MASD Prevention/Treatment - continued

Problem		Risk factors	Prevention	Treatment
Incontinence-Associated Dermatitis (IAD)	 Skin damage caused by prolonged or repetitive exposure to stool and/or urine Typically superficial, appears erythematous with patchy areas of skin loss and/or with candidiasis Source of moisture is external 	 Urinary and/or fecal incontinence Altered mental status Loss of normal "gut" flora Poor skin condition Diapers usage 	 Identify "at risk" patients Early use of protective barrier products Contain or divert urine/stool as appropriate (<i>e.g.</i>, condom catheter, rectal pouch) "Wick" urine and liquid stool away from skin ("Wick" means to absorb and draw off) Use only breathable, absorptive pads Limit diaper use Routine skin care for patients on diaper Cleanse the skin promptly following episodes of incontinence Use appropriate perineal cleansers/perineal wipes Apply moisture barrier products 	 Intact Skin: Routine skin assessment and care Routine application of moisture barrier products Wet, Denuded Skin: Create "crusting" over denuded skin ("crusting" creates a "dry" surface and allows for easier application of barrier ointment) Steps of "Crusting": Apply pectin powder to denuded area then brush excess powder off Spray a layer of non-alcohol barrier film to seal the powder

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MD Anderson Institutional Policy # ADM1134 - Patient Photograph in the Electronic Health Record (EHR) System Policy

- MD Anderson Institutional Policy # CLN0686 Pressure Injury Assessment and Prevention Policy
- MD Anderson Institutional Policy # CLN0647 Inpatient Nursing Documentation of Care Policy

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