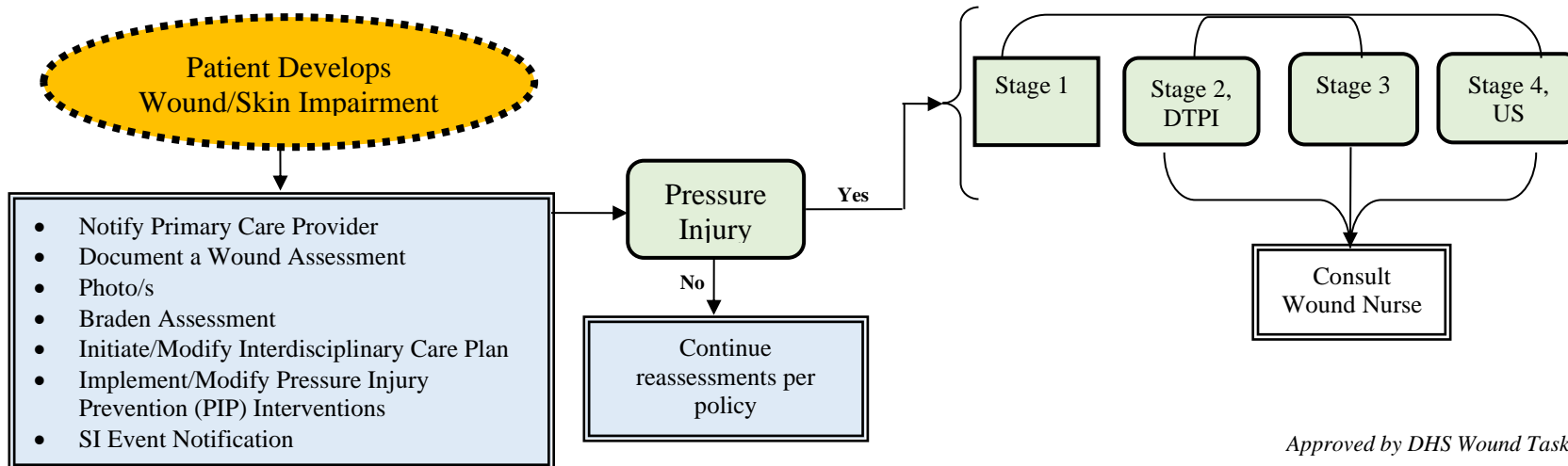
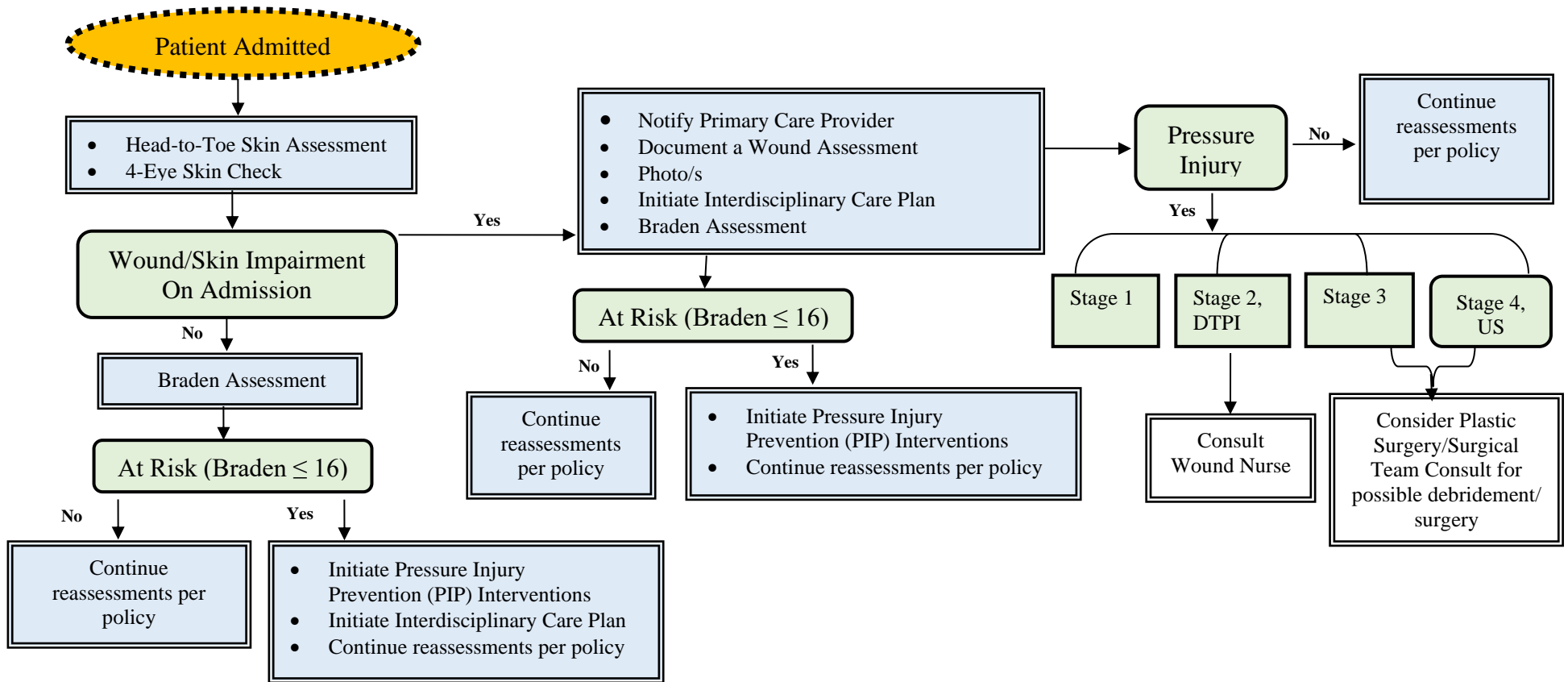


## DHS Pressure Injury Prevention & Wound Management Algorithm



## Braden Scale for Predicting Pressure Sore Risk

|   |   |   |   |   |
|---|---|---|---|---|
| <b>Sensory perception</b><br>Ability to respond meaningfully to pressure-related discomfort | <b>1. Completely limited:</b><br>Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation,<br>OR<br>limited ability to feel pain over most of body surface.  | <b>2. Very limited:</b><br>Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness,<br>OR<br>has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body.   | <b>3. Slightly limited:</b><br>Responds to verbal commands but cannot always communicate discomfort or need to be turned,<br>OR<br>has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.   | <b>4. No impairment:</b><br>Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.  |
| <b>Moisture</b><br>Degree to which skin is exposed to moisture                              | <b>1. Constantly moist:</b><br>Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.  | <b>2. Moist:</b> Skin is often but not always moist. Linen must be changed at least once a shift.   | <b>3. Occasionally moist:</b><br>Skin is occasionally moist, requiring an extra linen change approximately once a day.  | <b>4. Rarely moist:</b> Skin is usually dry; linen requires changing only at routine intervals.   |
| <b>Activity</b><br>Degree of physical activity  | <b>1. Bedfast:</b> Confined to bed.   | <b>2. Chairfast:</b> Ability to walk severely limited or nonexistent. Cannot bear own weight and/or must be assisted into chair or wheel chair.   | <b>3. Walks occasionally:</b><br>Walks occasionally during day but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.   | <b>4. Walks frequently:</b><br>Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.   |
| <b>Mobility</b><br>Ability to change and control body position                              | <b>1. Completely immobile:</b> Does not make even slight changes in body or extremity position without assistance.  | <b>2. Very limited:</b> Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.   | <b>3. Slightly limited:</b><br>Makes frequent though slight changes in body or extremity position independently.  | <b>4. No limitations:</b> Makes major and frequent changes in position without assistance.  |
| <b>Nutrition</b><br>Usual food intake pattern   | <b>1. Very poor:</b> Never eats a complete meal. Rarely eats more than 1/3 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,<br>OR<br>is NPO[1] and/or maintained on clear liquids or IV[2] for more than 5 days. | <b>2. Probably inadequate:</b><br>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,<br>OR<br>receives less than optimum amount of liquid diet or tube feeding. | <b>3. Adequate:</b> Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered,<br>OR<br>is on a tube feeding or TPN[3] regimen, which probably meets most of nutritional needs. | <b>4. Excellent:</b> 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. |
| <b>Friction and shear</b>   | <b>1. Problem:</b> 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.          | <b>2. Potential problem:</b><br>Moves feebly 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.                                   | <b>3. No apparent problem:</b> Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.  |   |
| <b>Total Score:</b>   |   |   |   |   |

## DHS: SSKIN-MED Pressure Injury Prevention Bundle

### S

#### S - Skin Inspection and Risk Assessment (Braden)

- Perform a thorough head-to-toe skin inspection.
  - Check skin under hair, on bony prominences and under medical devices.
  - Use proper lighting.
  - Separate skin folds.
  - Palpate for moisture and induration.
- Perform risk assessment scale (Braden) to identify risk fact.

### S

#### S – Support Surfaces

- Include mattresses, wheelchair cushions and any therapeutic surfaces.
- Minimize layers of linen under patient – less is best!

### K

#### K - Keep Moving/Turning

- Turn/reposition every 2 hours while in bed, gurneys, etc.
- For independent patients, encourage them to perform pressure relief every 15 to 20 minutes when in chair. For dependent patients, assist them to perform pressure relief every hour for 2 full minutes.
- Offload bony prominences or pressure areas (e.g. heels, sacrum-coccyx).
- Attempt micro shifts for patients with “Do Not Turn” order as condition allows.

### I

#### I – Incontinent and Moisture Management

- Keep skin clean and protected from stool, urine, and wound drainage.
- Apply skin barrier creams/paste/film to incontinent patients.
- Keep skin moisturized to avoid very dry skin.
- Do NOT use diapers when patient is in bed.

### N

#### N – Nutrition and Hydration

- Encourage and monitor food and fluid intake: protein, supplements, and water.
- Consult dietician as needed

### M

#### M – Medical Devices and Devices

- Check for tightness under straps.
- Stabilize tubes/devices.
- Pad under devices.
- Assess skin under and around medical devices every shift (Remove devices to assess if appropriate).
- Ensure correct fit/size.
- Question use of device and if still medically needed.
- Ensure skin is in optimal condition (e.g. moisturized).

### E

#### E – Educate Patient and Caregiver

- Provide teaching and hands-on materials to both patient and caregivers.

### D

#### D – Documentation

- Assessments, individualized interventions, patient non-adherence and patient/caregiver response to be documented in electronic health record (EHR) and plan of care as appropriate.

# DHS Heel Offloading Criteria

If Patient NOT able to lift foot  
AND

**Presents with one of the following:**

- At risk for foot drop
- Mild to moderate foot drop
- On vasopressors (hemodynamically unstable)
- Current pressure injuries on heel

**Use TruVue® Boot**



| SIZES                     |                          |                              |
|---------------------------|--------------------------|------------------------------|
| <b>Petite</b>             | <b>Standard</b>          | <b>X-Large</b>               |
| Calf measures<br>7"-12.5" | Calf measures<br>13"-18" | Calf measures<br>18.5"-25.5" |
| TRUVUEPW060               | TRUVUESW060              | TRUVUEXL060                  |

- Remove TruVue® boot for skin inspection every shift.
- Discontinue when no longer medically needed.

If Patient ABLE to lift foot  
OR

**Presents with one of the following:**

- Lower extremity contracture/s
- Severe foot drop
- Severe spasticity
- Peripheral Vascular Disease

**Use Pillow**



## WAFFLE® Cushion Usage

Use to Provide Comfort, Prevention and Healing of Pressure Injuries in **At-Risk** Patients

### Some Indications for Use

- **At Risk** patients or a history of pressure injury (PI) on sacrum, coccyx or ischial tuberosities
- Prevention of pressure injuries and comfort for seated patients
- For patients during chemotherapy, hemodialysis or other procedures requiring patients to sit for prolonged periods of time
- For patients with but not limited to: Post perineal, Gynecological, Colorectal and Urological surgeries
- Behind the back of patients with spinal abnormalities (e.g. kyphosis, cachexia)
- Can be used for prevention and healing of all pressure injuries and wounds in various locations (e.g. behind head, elbows)

### Sitting Precautions

Patient should shift or lift their body weight every 15-20 minutes; however, patients should not sit longer than 2 hour intervals

### Proper Inflation

Before use test for accurate inflation: roll the cushion past the first set of holes, stopping before the second set of holes.

**Cushions should appear to be 60% full**



### Alternate Uses



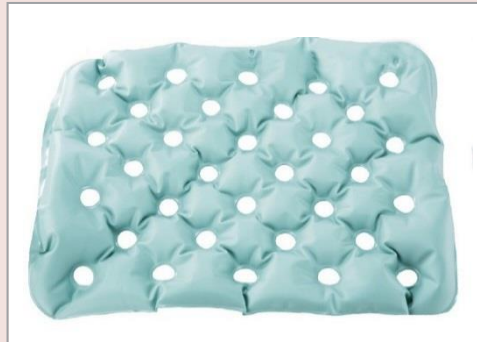
**For Rancho Spinal Cord Injuries (SCI):** Follow SCI wheelchair sitting program

### Single patient use



#### **WAFFLE® Cushion, 2200WCI:**

Weight capacity: 300 lbs.  
Flame retardant.  
Antimicrobial/Antifungal



#### **WAFFLE® Bariatric Cushion, 2400WCV:**

Weight capacity: 700 lbs.  
Flame retardant • Antimicrobial/Antifungal

Cushions come pre-inflated and can be wiped clean with approved facility germicidals.

Cover the cushion with a pillowcase for added patient comfort. Label cushion with patient's name.

**Cushions should stay with the patient throughout the hospital and be sent home upon discharge. At home patient may clean with soap and water.**



Use to Provide Comfort, Prevention and Healing of Pressure Injuries in **At-Risk** Patients

### Some Indications for Use

- Pressure injuries of any stage
- Complex wounds
- Unable to reposition self due to cognitive or physical impairment
- Elderly/Frail
- Hemodynamically unstable
- Multisystem trauma
- Cachexia or Obesity
- Intractable pain
- **Stable Spinal Cord Injury / Fracture**

### Considerations

- Can be used for safe patient handling and transfers
- Can be used during CT Scans, MRIs and is radiolucent for X-ray
- Can be placed on most surfaces (e.g. beds, gurneys, OR tables)

### Proper Inflation

Place patient on noninflated overlay then add air and perform a hand check. Perform a hand check each shift and after every adjustment of air to check for over inflation or “bottoming out”. Place hand, palm side up, under overlay. Use fingers to tap upward to feel approximately ¼ inch air inflated within the cushion directly under the patient’s sacrum/tailbone.

### Single patient use



**WAFFLE® Overlay,  
1005ECP:**  
Weight capacity: 600 lbs.



**WAFFLE® Overlay,  
1076BMPX020:**  
Weight capacity: 800 lbs.

Antimicrobial • Antifungal • Flame Retardant

### Single patient use:

- Label overlay and pump with patient’s name
- Both overlay and pump should stay with the patient throughout the hospital and be sent home upon discharge

### Cleaning:

- Can be cleaned with any hospital germicidal wipes
- Operating Room/Special Procedures: if heavily soiled with body fluids after initial cleaning, discard and replace
- At home patient may clean with soap and water



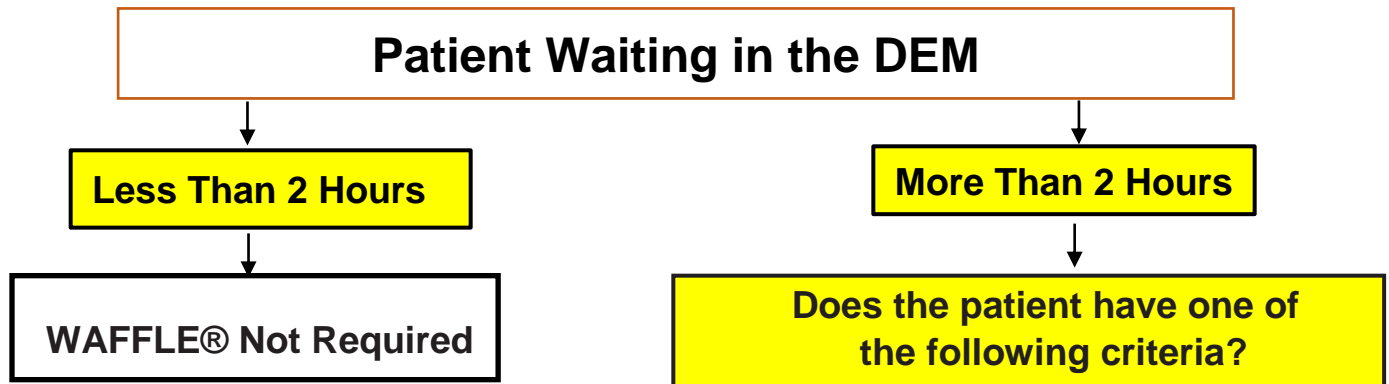
**Contraindications:** Do not use for patients with unstable spines

# DHS Bed Criteria

## Department of Emergency Management

### WAFFLE® Overlay Usage

Use to Provide Comfort, Prevention and Healing of Pressure Injuries in **At-Risk** Patients



**Considerations:**

- Can be used for safe patient handling and transfers
- Can be used during CT Scans, MRIs and is radiolucent for X-ray
- Can be placed on most surfaces (e.g. beds, gurneys, OR tables)

**Proper Inflation:**

- Perform a hand check each shift and after every adjustment of air. To check for “bottoming out”, place hand palm side up, under overlay beneath patient’s sacrum/tailbone. Use fingers to tap upward to feel approximately ¼ inch air inflated within the cushion directly under the patient’s sacrum/tailbone

**Single patient use:**

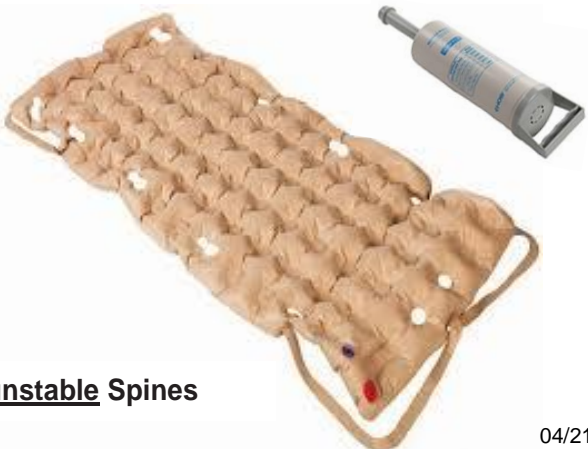
- Label overlay and pump with patient’s name
- Both overlay and pump should stay with the patient throughout the hospital and be sent home upon discharge. At home patient may clean with soap and water.

**Cleaning:**

- Can be cleaned with any hospital germicidal wipes
- Operating Room/Special Procedures: if heavily soiled with body fluids after initial cleaning, discard and replace

- Pressure injury of any stage
- Unable to reposition due to cognitive or physical impairment
- Stable spinal cord injury / Fractures
- Came in with one of the following:
  - ✓ Elderly/Frail/Malnourished
  - ✓ Unresponsive
  - ✓ Unable to breathe without assistance
  - ✓ Found down
  - ✓ Hemodynamic instability
  - ✓ Multisystem trauma
  - ✓ Dehydration
  - ✓ Decreased pain awareness
  - ✓ Obesity/Cachexia

**Place patient on a WAFFLE® Overlay**





**Contraindications:** Do not use for patients with unstable Spines

# DHS BED CRITERIA: (Facility Owned)

- If beds owned by the facility are being used in conjunction with WAFFLE<sup>®</sup> Overlay and are still not meeting patient goals, refer to “DHS Bed Criteria: (Rentals)” Appendix H.
- **For patients with unstable spine/fractures follow facility protocols.**

## Pressure Redistribution





|  |   |  |
|--|---|--|
| <p><b>AccuMax</b><br/>(500lbs max)</p>       |  | <p><b>Criteria For Use</b></p> <ul style="list-style-type: none"> <li>• Non-powered mattresses</li> <li>• Prevention of pressure injuries</li> <li>• Treatment of Stage 1-2 (on extremities)</li> <li>• Non-complex and conservative pressure injury management</li> </ul> |
| <p><b>Centrella Pro</b><br/>(500lbs max)</p> |  |  |



### WAFFLE<sup>®</sup> Mattress Overlay

- Prevention for increased risk
- Treatment of multiple Stage 1-4, DTPI, & unstageable on torso (e.g. back, trochanter, sacrococcyx)
- Elderly, cachectic, malnourished, frail
- Unable to self-turn
- HOB consistently greater than 30 degrees
- **STABLE** spinal injury / fractures

## Pressure Redistribution & Advanced Microclimate



|   |  |  |
|---|--|--|
| <p><b>P500</b><br/>(Max Length: 84")</p>            |   | <p><b>Criteria For Use</b></p> <ul style="list-style-type: none"> <li>• Low air loss integrated mattresses</li> <li>• May be used on high risk patients</li> <li>• Used for single/multiple Stage 3-4</li> <li>• Excessive unresolved perspiration/incontinence issues</li> <li>• Total Care Sport &amp; Progressa have pulmonary features</li> <li>• Progressa are used primarily in ICU and may also be used in other units as directed by each hospital protocol</li> <li>• Maximum weight of 500 pounds</li> </ul> |
| <p><b>Centrella MAX</b><br/>(Max Length: 98.7")</p> |   |  |
| <p><b>TotalCare Sport</b><br/>(Max Length: 93")</p> |   |  |
| <p><b>Progressa</b><br/>(Max Length: 88")</p>       |  |  |



### WAFFLE<sup>®</sup> Mattress Overlay

- When mattress is not meeting patient goals
- Treatment multiple Stage 1-4, DTPI, & unstageable.
- HOB consistently greater than 30 degrees
- Multisystem Trauma
- **STABLE** spinal injury / fractures

## Bariatric Pressure Redistribution & Advanced Microclimate

|   |  |   |
|---|--|---|
| <p><b>TotalCare Bariatric</b><br/>(500lbs max)</p>  | <p><b>Compella</b><br/>(1000lbs max)</p>  | <p><b>Criteria For Use</b></p> <ul style="list-style-type: none"> <li>• Obese or wide girth</li> <li>• TotalCare Bariatric (Width expands to 40")</li> <li>• Compella (Width expands to 50")</li> </ul> |
|---|--|---|



### WAFFLE<sup>®</sup> Bariatric Mattress Overlay

- When mattress is not meeting patient goals
- 800 lbs. max
- **STABLE** spinal injury / fractures



# DHS BED CRITERIA: (Rentals)

Rent one of these: **If facility owned bed with WAFFLE® Overlay is not meeting patient goals.**

## Pressure Redistribution & Advanced Microclimate

### Envision

(400 lbs max)



#### Criteria For Use

- Mattress fits VersaCare and flat deck bed frames
- Treatment of multiple/complex stage 3 & 4, extensive Unstageable and DTPI

#### Criteria For Use

- Extensive Stage 3, 4, Unstageable and DTPIs
- Immediate post flap/grafts of major turning surface
- Very contracted with intractable pain
- Burns management by BURN Unit physician criteria
- Max length 74"

### Envella

Air Fluidized Therapy  
(350 lbs max)



## Bariatric

## Pressure Redistribution & Advanced Microclimate

### TotalCare Bariatric

(500 lbs max)



#### Criteria For Use

- Prevention & treatment of pressure injuries
- Turn assist
- **Full Chair position**
- Continuous Lateral Rotation Therapy (CLRT) & Trapeze (optional when ordering)
- Adjustable length to 72-84"
- Width expands to 40"

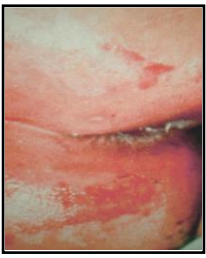




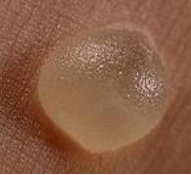




### Compella Bariatric

(1000 lbs max)



#### Criteria For Use

- Prevention & treatment of pressure injuries
- Turn assist
- Continuous Lateral Rotation Therapy (CLRT) & Trapeze (optional when ordering)
- Adjustable length to 88"
- Width expands to 40-50"

| Incontinence Assoc Dermatitis (IAD)  | Fungal Dermatitis   | Skin Tear   | Intact Skin   | Partial Thickness Wounds   |  |   | Full Thickness Wounds   |   |   | Deep Tissue Pressure Injuries (DTPJ) |
|--|---|---|---|--|--|---|---|---|---|--------------------------------------|
|  |  |  | <b>Stage 1 Pressure Injury</b><br> | <b>Stage 2 Pressure Injury</b><br> | <b>Bulla (Serous Blister)</b><br> | <b>Stage 3 Pressure Injury</b><br> | <b>Stage 4 Pressure Injury</b><br> | <b>Unstageable Pressure Injury</b><br> |  |                                      |

**Treatment Objectives: If it's wet, absorb it. If it's dry, moisten it but protect the wound.**

|   |   |   |  |  |  |  |  |
|---|---|---|--|--|--|--|--|
| Protect<br>Treat cause<br>Turn schedule | Protect<br>Treat cause<br>Separate skin folds | Protect<br>Treat cause<br>Maintain drainage | Offload pressure<br>Turn schedule<br>Moisturize skin | Offload pressure<br>Manage drainage<br>Turn schedule | Offload pressure<br>Manage drainage<br>Turn schedule | Offload pressure<br>Manage drainage<br>Turn schedule | Offload pressure<br>Protect<br>Turn schedule |
|---|---|---|--|--|--|--|--|

**Topical Treatments & Dressing Change Frequency**

| Intact or Non-Intact   | Intact or Non-Intact   | Tear with Flap  | Dry Skin  | Light Drainage   | Intact Blister  | Wound Drainage  | Unstageable Pressure Injury   | Intact Blood Blister   |
|--|--|---|---|--|---|---|---|--|
| <p>Apply a <b>protective skin barrier</b> when incontinence first identified. Gently cleanse and apply <b>protective skin barrier</b> every episode</p> <p><b>Examples:</b></p> <ul style="list-style-type: none"> <li>• Calazime</li> <li>• Nutrashield</li> <li>• Calmoseptine</li> <li>• Cavilon</li> <li>• Clear Aide</li> <li>• Touchless Care</li> <li>• Zinc Oxide</li> <li>• A&amp;D ointment</li> </ul> | <p>Cleanse the skin prior to each application. Apply <b>antifungal cream, ointment or antifungal powder</b> BID and PRN. <u>Requires provider's order</u></p> <p><b>Separate skin folds to decrease moisture</b></p> <p>Decrease skin to skin contact with a barrier such as non-adherent or soft woven gauze.</p> | <p>Approximate flap, cover with a <b>contact layer</b> then cover with secondary dressing. Change daily and PRN.</p> <p><b>Contact Layers:</b></p> <ul style="list-style-type: none"> <li>• Adaptic</li> <li>• Xeroform</li> <li>• Vaseline</li> </ul> <p><b>Tear Without Flap</b><br/>Cover with:</p> <ul style="list-style-type: none"> <li>• <b>Foam</b> if drainage. Change q 3 days and PRN.</li> <li>• <b>Transparent film</b> if no drainage &amp; non-fragile skin. Allow to fall off naturally</li> </ul> <p>If fragile skin use <b>contact layer</b> with secondary dressing.</p> | <p>Apply <b>moisturizing cream</b> daily and PRN</p> <p><b>Examples:</b></p> <ul style="list-style-type: none"> <li>• Remedy Skin Cream</li> </ul> <p><b>Moist Skin</b><br/>Apply <b>protective skin barrier</b> PRN</p> <p><b>Friction Areas</b><br/>Apply <b>barrier film</b> daily and PRN.</p> <p><b>Examples:</b></p> <ul style="list-style-type: none"> <li>• Cavilon</li> </ul> <p>Or</p> <p>Apply <b>transparent film</b> to non-fragile skin q 3 days and PRN</p> <p><b>Device Related erythema</b><br/>Apply <b>barrier film</b> and protective padding daily and PRN</p> | <p>Apply <b>hydrocolloid or foam</b>. Change q 3 days and PRN</p> <p><b>Hydrocolloids:</b></p> <ul style="list-style-type: none"> <li>• RepliCare</li> <li>• CombiDERM</li> <li>• Duoderm</li> <li>• Restore</li> <li>• 3M Tegaderm</li> <li>• Nu-Derm</li> </ul> <p><b>Moderate-Heavy Drainage</b><br/>Apply <b>non-adhesive or adhesive foam</b>. Change q 3 days and PRN</p> <p><b>Areas Exposed to Stool/Urine</b><br/>(Intact &amp; Non-Intact)<br/>Apply <b>protective skin barrier</b> every episode.</p> | <p>Apply <b>Cavilon barrier film</b> daily and leave open to air</p> <p>or</p> <p>Apply a <b>Contact Layer</b> (unfold to a single layer and cut to size) cover with gauze. Change daily &amp; PRN</p> <p><b>Drainage</b><br/>Apply <b>contact layer</b> with secondary dressing. Change daily and PRN.</p> | <p><b>None – Minimal Drainage</b><br/>Apply <b>hydrogel and contact layer</b> then cover with gauze. If cavity is present, impregnate filler (e.g. gauze roll, packing strip) with the hydrogel. Change daily and PRN.</p> <p><b>Examples:</b></p> <ul style="list-style-type: none"> <li>• SoloSite • IntraSite • NuGel</li> </ul> <p><b>Moderate – Heavy Drainage</b><br/>Apply <b>calcium alginate</b> and cover with <b>foam (q3 days &amp; PRN) or gauze/ABD pad (daily &amp; PRN)</b>. If cavity is present and filler is needed select appropriate calcium alginate form (e.g. rope, roll, ribbon).</p> <p><b>Calcium Alginate examples:</b></p> <ul style="list-style-type: none"> <li>• Algisite M</li> <li>• KaltoSTAT</li> <li>• 3M Tegaderm</li> <li>• Nu-Derm</li> </ul> | <p><b>Stable Eschar (non-infected)</b><br/>Apply <b>Cavilon barrier film</b> daily and leave open to air</p> <ul style="list-style-type: none"> <li>• <b>Do Not</b> Remove eschar</li> <li>• <b>Do Not</b> moisten</li> <li>• <b>Do Not</b> apply foam</li> </ul> <p><b>Unstable Eschar/Slough (non-infected)</b><br/>Apply <b>transparent film (q3 days) or Hydrogel</b> covered with gauze dressing (daily &amp; PRN)</p> <p><b>Consult Primary Provider:</b><br/>For consideration of sharp debridement if indicated</p> | <p>Apply <b>Cavilon barrier film</b> daily and leave open to air</p> <p>or</p> <p>Apply a <b>Contact Layer</b> (unfold to a single layer and cut to size) cover with gauze. Change daily &amp; PRN</p> <p><b>Intact Skin (over dry areas)</b><br/>Apply <b>moisturizing cream</b> daily &amp; PRN</p> <p><b>Intact or Non-Intact Skin</b><br/>Apply <b>barrier film</b> daily and leave open to air</p> <p><b>Areas Exposed to Stool/Urine</b><br/>(Intact &amp; Non-Intact)<br/>Apply <b>protective skin barrier</b> every episode.</p> |

**Assess** Braden scores & need for specialty bed per protocol. Assess for signs and symptoms of wound infection, if identified notify primary provider. Inspect integrity of dressing to verify that the wound has not been exposed to stool or urine.

**Perform** Cleanse all wounds before application of new dressings/treatments. Label dressings with the date and time applied.

**Please Note:** This reference is to serve only as a guideline to assist in choosing the appropriate treatment/dressing. It is not all inclusive to the skin/wound care available. Clinics and Home Health wound care frequency may be different. Revised 1.23.20