



COUNTY OF LOS ANGELES DEPARTMENT OF HEALTH SERVICES

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<b>Policy &amp; Procedure Title:</b>	DHS Pressure Injury Prevention & Wound Management Policy		
<b>Category:</b>	300-399 Operation Policy	<b>Policy No.:</b>	321.007
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<b>DHS Division/Unit of Origin:</b>	Office of Nursing Affairs		
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**PURPOSE:**

This policy and procedure establish guidelines for the assessment of risk, early detection, prevention, and identification of occurrence of skin breakdown in hospital patients. It also describes interventions, management and documentation of potential or actual cases of alteration in skin integrity during the patient’s hospital stay.

**POLICY:**

The Department of Health Services and its facilities are committed to providing quality care to all its patients.

Risk for pressure injury development will be evaluated upon admission to a nursing care unit as indicated using the age appropriate Braden scale, appropriate tool, or procedure. Based on assessment, a plan of care will be developed and implemented using appropriate prevention and treatment interventions (see appendices). The primary care provider shall be informed of patient skin integrity issues and documented in the patient’s medical record.

**PROCEDURE:**

1. Assessments/Reassessments:
  - a. Use age appropriate Braden Scale (Appendix A), on ALL patients, to assess pressure injury risk.
    - i. On Admission
    - ii. Daily
    - iii. Transfers
    - iv. PRN (example: decline in patient condition)
    - v. After prolonged procedures/surgeries

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*The mission of the Los Angeles County Department of Health Services is to advance the health of our patients and our communities by providing extraordinary care.*

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Department Head/Designee Approval: Approved by Hal F. Yee, M.D. 7/6/2021

- b. Skin assessment, on ALL patients, which includes a head-to-toe physical inspection of the skin
  - i. Frequency Minimum (May do more frequently based on patient condition)
    - Every 4-hours (ICUs)
      - a. Adult
      - b. Pediatric
      - c. Neonatal
    - Every 8-hours (Level 1 & 2 Nursery/Rooming-in/Ward/progressive Care)
      - a. Adult
      - b. Pediatric
      - c. Newborn/Infant
    - Daily (Behavior Health)
  - ii. On Admission and Transfer, “Four Eyes with licensed professionals” (Two RNs or One RN/One NP, MD, or PA)
  - iii. Preventive/Protective padding placed over intact, non-broken skin are temporarily removed when performing a skin inspection.
  - iv. Therapeutic/Immobilization devices, e.g. cervical collars, trach collar, boots, braces, halo vests, and thoracic lumbosacral orthoses (TLSOs), may require a physician’s order prior to removal. The device is still to be checked for tightness around skin and bony prominences, moisture, surrounding skin status, and patient comfort.
  - v. Return from prolonged procedures/surgeries
  - vi. When there is a decline in patient’s condition
  - vii. Per primary care provider order

#### **PLAN OF CARE:**

RNs initiate Interdisciplinary Plan of Care (IPOC), related to skin integrity, for patients with actual or at risk for (Braden Score of 16 or less) impaired skin integrity. LVNs, NA, RA, and SNWs are to collaborate with the RN ensuring the plan of care compliments the patient’s needs and interventions are carried out.

#### **PRESSURE INJURY PREVENTION INTERVENTIONS:**

- a. Braden Scale for Predicting Pressure Sore Risk © (Appendix A)
- b. DHS: SSKIN-MED Pressure Injury Prevention Bundle (Appendix B)
- c. DHS Heel Offloading Criteria (Appendix C)
- d. DHS Pressure Redistribution Cushion Criteria: WAFFLE® Cushion Usage (Appendix D)
- e. DHS Bed Criteria: WAFFLE® Overlay Usage (Appendix E)
- f. DHS Bed Criteria: WAFFLE® Overlay ED Usage (Appendix F)
- g. DHS Bed Criteria: Facility Owned (Appendix G)
- h. DHS Bed Criteria: Rentals (Appendix H)

**TREATMENT/EQUIPMENT INTERVENTIONS:**

- a. Treat the underlying wound etiology.
- b. For Wounds: start initial treatment based on DHS Facility Wide Wound Care Quick Reference Guide (Appendix I)
- c. When “Do Not Turn” orders are in place:
  - i. Reassesses the patients’ stability to be turned, if patient tolerates, notify provider to discontinue “Do Not Turn” order.
  - ii. Attempt micro shifts or offloading of any bony prominences and/or any existing pressure injuries (PIs) while “Do Not Turn” order is in place, as patient’s condition allows.
- d. DHS Pressure Redistribution Cushion Criteria: WAFFLE® Cushion Usage (Appendix D)
- e. DHS Bed Criteria: WAFFLE® Overlay Usage (Appendix E)
- f. DHS Bed Criteria: WAFFLE® Overlay ED Usage (Appendix F)
- g. DHS Bed Criteria: Facility Owned (Appendix G)
- h. DHS Bed Criteria: Rentals (Appendix H)

**PHOTOS:**

- a. On admission when admitted with skin impairment, upon discovery of a new skin impairment, when significant changes occur and within a week of discharge or transfer to outside facility.
- b. Include Medical Record Number (MRN), Date and Time.

**NOTIFICATIONS:**

- a. Primary Care Provider (Not Limited To):
  - I. Wound/Skin abnormalities present on admission and upon discovery
  - II. Deterioration of existing wound/skin abnormality
  - III. Need for possible debridement
  - IV. Signs of infection
  - V. Orders for wound treatment

**CONSULTS:**

- a. Wound Nurse (WN) for Community Acquired Pressure Injuries (CAPI)
  - Stage 2 and Deep Tissue Pressure Injuries (DTPI)
- b. WN for Hospital Acquired Pressure Injuries (HAPI)
  - Stage 2 and Above

**COLLABORATE:** with providers for interdisciplinary consults, as appropriate.

**DOCUMENTATION:**

- a. In accordance with “Documentation” standards

- b. Interdisciplinary Plan or Care (IPOC)
- c. All pertinent information related to skin abnormalities
- d. Pressure injury prevention interventions
- e. Bed Type/Surface
- f. Photos taken
- g. Provider that was notified
- h. Patient/Care Giver/Family Education

**ATTACHMENTS/FORMS:**

DHS PIP & Wound Management Algorithm (Attachment I)  
Braden Scale for Predicting Pressure Sore Risk © (Appendix A)  
DHS: SSKIN-MED Pressure Injury Prevention Bundle (Appendix B)  
DHS Heel Offloading Criteria (Appendix C)  
DHS Pressure Redistribution Cushion Criteria: WAFFLE® Cushion Usage (Appendix D)  
DHS Bed Criteria: WAFFLE® Overlay Usage (Appendix E)  
DHS Bed Criteria: WAFFLE® Overlay ED Usage (Appendix F)  
DHS Bed Criteria: Facility Owned (Appendix G)  
DHS Bed Criteria: Rentals (Appendix H)  
DHS Facility Wide Wound Care Quick Reference Guide (Appendix I)

**REFERENCE(S)/AUTHORITY:**

Aderibigbe, B.A. & Buyana, B. (2018). Alginate in wound dressings. *Pharmaceutics*, 10(2), 1-19.

Agency for Healthcare Research and Quality (AHRQ) (2017). Preventing pressure injuries in hospitals: Module 1-understanding why change is needed. Preventing Pressure Ulcers in Hospitals Toolkit. Retrieved on 6/30/21 from: <https://www.ahrq.gov/patient-safety/settings/hospital/resource/pressure-injury/index.html>

Braden, B. & Bergstrom, N. (1988). The Braden scale for predicting pressure sore risk. Reprinted with permission. All rights reserved. 2019.

Bergstrom, N., Braden, B., Laguzza, A., & Holman, V. (1987). The Braden scale for predicting pressure sore risk, *Nursing Research*, 36(4), 205-208.

Bergstrom, N., Braden, B., Kemp, M., Champagne, M., & Ruby, E. (1998). Predicting pressure ulcer risk: A multisite study of the predictive validity of the Braden scale. *Nursing Research*, 47(5), 261-269.

Black, J., Berke, C., & Urzendowski, G. (2012). Pressure ulcer incidence and progression in critically ill subjects. *Journal of Wound Ostomy Continence Nurses*. 39(3), pp. 267-273.

Braden, B. (2012). The Braden Scale for predicting pressure sore risk: reflections after 25 years. *Advances in Skin & Wound Care*, 61.

Brett, D.W. (2006). A review of moisture-control dressings in wound care. *Journal of Wound Ostomy Continence Nursing*, 33(65), 53-58.

Brett, D. W. (2006). Impact on exudate management, maintenance of a moist wound environment, and prevention of infection. *Journal of Wound Ostomy Continence Nursing*, 33(65), 59-S14.

Brindle, C.T., Malhotra, R., O'Rourke, S., Currie, L., Chadwik, D., et al. (2013). Turning and repositioning the critically ill patient with hemodynamic instability: a literature review and consensus recommendations. *Journal Wound Ostomy Continence Nursing*. 40(3), 254-267.

Britto, E.J., Nezwek, T.A., & Robins, M. (2020). Wound dressings. *In StatPearls [Internet]*. Treasure Island (FL): StatPearls Publishing; 2020 Jan-. Retrieved on 6/30/21 from: <https://www.ncbi.nlm.nih.gov/books/NBK470199>

Brotherton, A. (2020). BAPEN meets NHS Midlands and East for a focus on nutrition and hydration. British Association for Parenteral and Enteral Nutrition. Retrieved on 6/30/21 from: <https://www.bapen.org.uk/nutrition-support/good-practice-in-nutritional-care/examples-of-good-practice-in-nutritional-care/regional-settings/sskin-a-five-step-model-for-pressure-ulcer-prevention>

Campbell, N. (2016). Electronic SSKIN pathway. Reducing device-related pressure ulcers. *British Journal of Nursing*, 25(15), pp.S14-S26.

Edsberg, L.E., Black, J.M., Goldberg, M., McNichol, L., Moore, L., et al. (2016). Revised National Pressure Ulcer Advisory Panel pressure injury staging system. *Journal of Wound Ostomy Continence Nursing*, 43(6), 585-597.

EHOB (2015). Call out images and product references. Provided with permission for educational purposes to County of Los Angeles Department of Health Services. All rights reserved. 2020.

European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance (2019). *Prevention and Treatment of Pressure Ulcers/Injuries: Quick Reference Guide 2019*. Emily Haesler (Ed.). Cambridge Media: Osborne Park, Australia.

Gadd, M.M. (2014). Braden scale cumulative score versus subscale scores: are we missing opportunities for pressure ulcer prevention? *Journal of Wound Ostomy Continence Nurses*, 41(1), 86-89.

Gadd, M.M. & Morris, S.M. (2014). Use of the Braden scale for pressure ulcer risk assessment in a community hospital setting: the role of total score and individual subscale scores in triggering preventive interventions. *Journal of Wound Ostomy Continence Nurses*, 41(6), 535-538.

Hill-Rom (2017). Hill-Rom rental therapy.

Hill-Rom (2016). Solutions for your patient's needs.

Hill-Rom (2012). Science of surfaces: The science behind therapeutically effective surfaces.

Lisco, C.M. (2014). Understanding static air from: patient care to patient spend. EHOB.

McCoulough, S. (2016), Adapting a SSKIN bundle for carers to aid identification of pressure damage and ulcer risks in the community. Community Wound Care, S19, pp.S18-25

McNichol, L., Watts, C., Mackey, D., Beitz, J.M., & Gray, M. (2015). Identifying the right surface for the right patient at the right time: generation and content validation of an algorithm for support surface selection. Journal of Wound Ostomy Continence Nurses. 42(1), pp.19-37.

Medline Industries (2012). Remedy advanced skin care system. MKT1220971.

Moore, A. (2012). Reduce the pressure. Nursing Standard, 27(9), pp.18-20

National Pressure Injury Advisory Panel (NPIAP) (2020). Pressure Injury Prevention Points. Retrieved on 6/30/21 from

[https://cdn.ymaws.com/npiap.com/resource/resmgr/online\\_store/1a.\\_pressure-injury-preventi.pdf](https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/1a._pressure-injury-preventi.pdf)

National Pressure Injury Advisory Panel (NPUAP) (2016). NPIAP Pressure Injury Stages. Retrieved on 6/30/21 from

[https://cdn.ymaws.com/npiap.com/resource/resmgr/online\\_store/npiap\\_pressure\\_injury\\_stages.pdf](https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf)

National Pressure Injury Advisory Panel (NPIAP) (2020). Best Practices for Prevention of Medical Device-Related Pressure Injuries. Retrieved on 6/30/21 from

<https://npiap.com/page/MDRPI-Posters>

National Pressure Injury Advisory Panel Support Surface Standards Initiative (S3I) (2019). Terms and definitions related to support surfaces. Retrieved on 6/30/21 from:

[https://cdn.ymaws.com/npiap.com/resource/resmgr/s3i/10-23\\_Terms\\_and\\_Defs\\_2019\\_We.pdf](https://cdn.ymaws.com/npiap.com/resource/resmgr/s3i/10-23_Terms_and_Defs_2019_We.pdf)

Roberts, M.J. (2007). Preventing and managing skin tears: a review. Journal of Wound Ostomy Continence Nursing, 34(3), 256-259.

Noonan, C. Quigley, S., & Curely, M. (2011). Using the Braden Q scale to predict pressure ulcer risk in pediatric patients. Journal of Pediatric Nursing. 26(6), 566-575.

Tescher, A.N., Branda, M.E., Byrne, T.J.O., & Naessens, J.M. (2012). All At-Risk Patients Are Not Created Equal. Journal of Wound Ostomy Continence Nurses, 39(3), 282-291.

The Joint Commission (2016). Preventing pressure injuries. Quick Safety: And advisory on safety and quality issues, 55, 1-4. Retrieved on 6/30/21 from [https://www.jointcommission.org/assets/1/23/Quick\\_Safety\\_Issue\\_25\\_July\\_20161.PDF](https://www.jointcommission.org/assets/1/23/Quick_Safety_Issue_25_July_20161.PDF)

Whitlock, J. (2013). SSKIN bundle: preventing pressure damage across the health-care community. Wound Care, pp32-S39

Wound Ostomy and Continence Nursing Society. (2017). Position Paper: Avoidable versus Unavoidable Pressure Ulcers (Injuries). Retrieved on 6/30/21 from [https://cdn.ymaws.com/member.wocn.org/resource/resmgr/document\\_library/Avoidable\\_vs.\\_Unavoidable\\_Pr.pdf](https://cdn.ymaws.com/member.wocn.org/resource/resmgr/document_library/Avoidable_vs._Unavoidable_Pr.pdf)

Wound, Ostomy, and Continence Nurses Society. (2016). Guideline for prevention and management of pressure ulcers (injuries). WOCN Clinical Practice Guideline series 2. Mt. Laurel, NJ: Author.

Zhang, L., Yin, H., Lei, X., Lau, J.N.Y, Mingzhou, Y., et al. (2019). A systematic review and meta-analysis of clinical effectiveness and safety of hydrogel dressings in the management of skin wounds. Frontiers in Bioengineering and Biotechnology, 21(7), 1-16.