Pressure Injury Champions by Line

A. Kevin Browne-Getzinger
B. Sunyoung Jeong
C. Brynn Kemp
D. Christina Knechtel
E. Grace McLeod
F. Nathalie Smith
G. Michelle Vivian
H. Julie Whalen

Sacral-Border Dressing Application
All patients admitted to CCTC

1. **Clean area (soap, water and dry).**
2. **Assess (visual, palpate).**
3. **Open Sacral/Coccyx Grouper and document assessment/interventions.**
4. **Continue all pressure relief and pressure prevention/management strategies**

Contraindications to dressing?

- Unstageable or Stage III/IV coccyx/sacral ulcer
- Severe diarrhea with uncontained liquid stool.

Yes

No

Apply dressing per protocol as soon as possible following admission (before OR/Imaging).

Injury > Stage II

(Unstageable or Stage III/IV coccyx/sacral ulcer)

- Initiate wound specific Grouper and document
- Notify SWOT and initiate PI Treatment per LHSC protocols/orders
- Complete Speak

Frequent Liquid Stool

- Treat cause
- Consider FMS for C-Diff or unmanageable liquid stool
- Apply barrier cream to protect skin
- Reassess every shift and initiate preventative dressing when stool is contained or no longer liquid

No Pressure Injury

- Apply dressing; date the dressing with a Sharpie
- Record “P” for Prevention/Peak
- Document skin assessment with each dressing change
- Assess/document dressing appearance Q12H and prn
- Change dressing **Q5 Days and PRN**
- Dressing may be wiped off/worn in shower
- Add date and purpose to Situational Awareness

Stage I, II, Maceration or Sheer Injury

(upon admission or developed after application)

- Create a separate group for each wound and side; if a coccyx wound develops, continue to document sacrum assessment separately
- If dressing cannot be maintained over area (e.g. coccyx), use triad or Critc-Aid over area
- Consult with Pressure Injury Champion prn
- Apply dressing; date the dressing application with a Sharpie.
- Record “T” for Treatment
- Leave the dressing undisturbed for **Q5 days or PRN** if soiled/lifting
- Add date and purpose to Situational Awareness
- Document wound assessment with each dressing change in grouper
- If wound progresses to Stage III, IV or unstageable, remove and notify SWOT. Initiate treatment per LHSC protocol or orders.

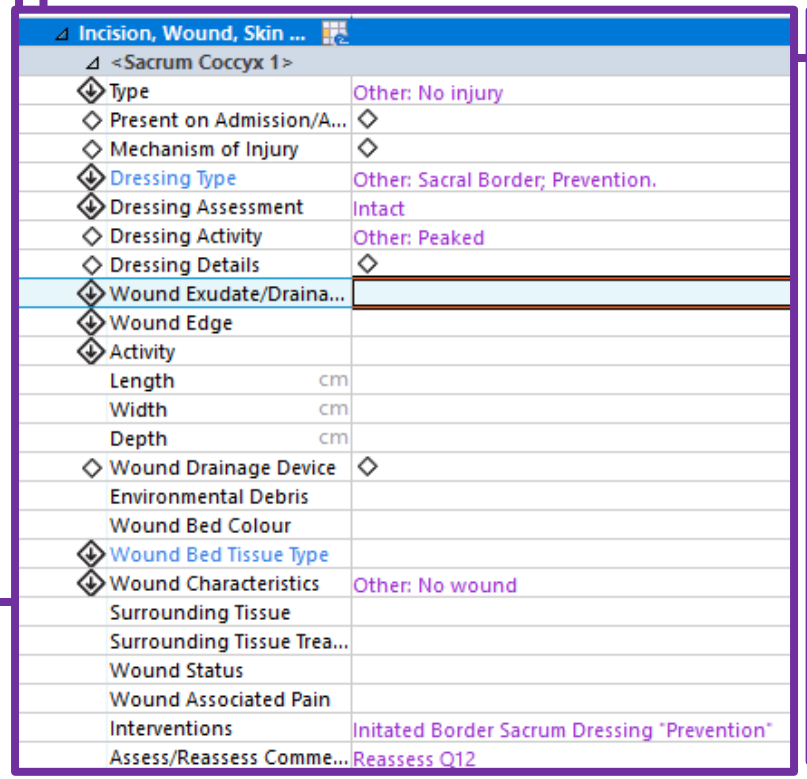
Protocol for Application of Mepilex Border Sacrum

- Clean sacrum and coccyx with gentle rain soap and water (do not use barrier creams, chlorhexidine or Sproam™).
- Assess the area carefully. Do not apply dressing if Stage III, IV or unstageable (notify SWOT and follow LHSC protocols/orders)
- Pat dry, ensuring skin is completely dry
- Do not apply any creams or skin protectants
- Ensure that you have sufficient manpower to position patient for correct dressing application
- Remove the centre release film by gently pulling on pink-lined edge
- Separate buttocks (second person). Fold the dressing in half towards the outside of dressing.
- Position the “base” or narrowest edge of the dressing to cover the coccyx. This is the most important aspect of the application for keep the dressing intact.
- Apply dressing to sacral area and into upper aspect of gluteal cleft.
- Remove side release films and gently smooth each edge into place.
- Press and smooth the dressing to ensure the entire dressing is in contact with the skin.
- Do not use Cavilon™ under the dressing. You can apply a small amount of ostomy paste or Cavilon™ over top of the base at the coccyx.
- See photos on reverse

Documentation

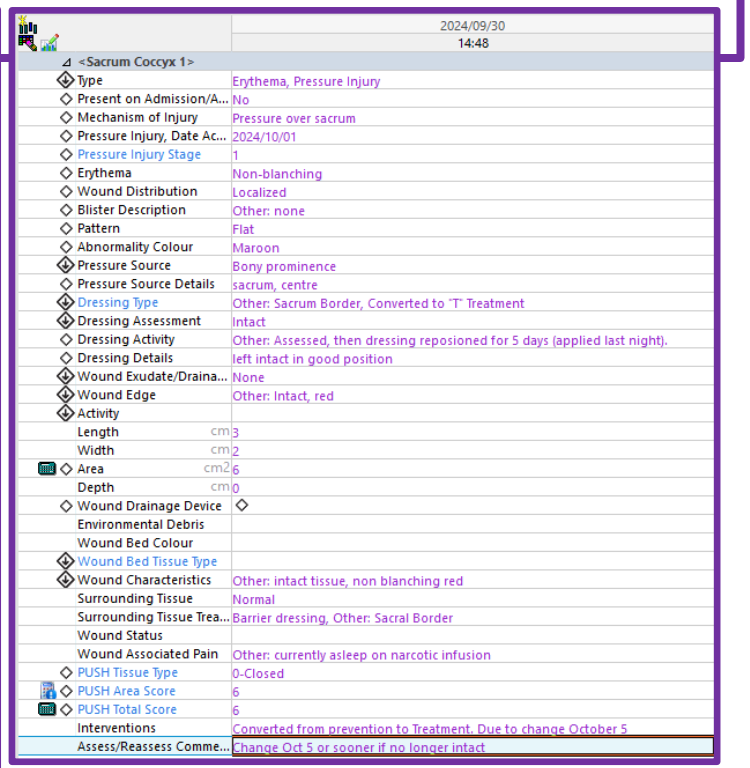
- Open up a Sacrum/Coccyx Grouper and document skin assessment prior to each application or dressing change
- Use a sharpie to place the date of application on the dressing along with “P” (Prevention) or “T” (Treatment) to indicate purpose/intervention.
- Use “P” without any skin breakdown. Assess/document dressing integrity Q12H and PRN.
- Use “T” Treatment upon identification of a Stage 1, 2, maceration or sheer injury. Leave in place for up to 5 days if intact.
- Create a unique Grouper for each wound (each location and each side of body)
- Update the Situation Awareness for dressing change date.
- Use “Push” Tool to describe wounds

Prevention/Assessment



Incision, Wound, Skin ...	
<Sacrum Coccyx 1>	
Type	Other: No injury
Present on Admission/A...	
Mechanism of Injury	
Dressing Type	Other: Sacral Border; Prevention.
Dressing Assessment	Intact
Dressing Activity	Other: Peaked
Dressing Details	
Wound Exudate/Draina...	
Wound Edge	
Activity	
Length cm	
Width cm	
Depth cm	
Wound Drainage Device	
Environmental Debris	
Wound Bed Colour	
Wound Bed Tissue Type	
Wound Characteristics	Other: No wound
Surrounding Tissue	
Surrounding Tissue Trea...	
Wound Status	
Wound Associated Pain	
Interventions	Initated Border Sacrum Dressing "Prevention"
Assess/Reassess Comme...	Reassess Q12

Treatment



	2024/09/30 14:48
<Sacrum Coccyx 1>	
Type	Erythema, Pressure Injury
Present on Admission/A...	No
Mechanism of Injury	Pressure over sacrum
Pressure Injury, Date Ac...	2024/10/01
Pressure Injury Stage	1
Erythema	Non-blanching
Wound Distribution	Localized
Blister Description	Other: none
Pattern	Flat
Abnormality Colour	Maroon
Pressure Source	Bony prominence
Pressure Source Details	sacrum, centre
Dressing Type	Other: Sacrum Border, Converted to 'T' Treatment
Dressing Assessment	Intact
Dressing Activity	Other: Assessed, then dressing reposioned for 5 days (applied last night).
Dressing Details	left intact in good position
Wound Exudate/Draina...	None
Wound Edge	Other: Intact, red
Activity	
Length cm	3
Width cm	2
Area cm2	6
Depth cm	0
Wound Drainage Device	
Environmental Debris	
Wound Bed Colour	
Wound Bed Tissue Type	
Wound Characteristics	Other: intact tissue, non blanching red
Surrounding Tissue	Normal
Surrounding Tissue Trea...	Barrier dressing, Other: Sacral Border
Wound Status	
Wound Associated Pain	Other: currently asleep on narcotic infusion
PUSH Tissue Type	0-Closed
PUSH Area Score	6
PUSH Total Score	6
Interventions	Converted from prevention to Treatment. Due to change October 5
Assess/Reassess Comme...	Change Oct 5 or sooner if no longer intact