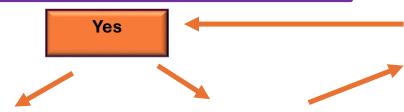
Pressure Injury Champions by Line

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



Injury > Stage II

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

- Initiate Grouper and document
- Notify SWOT and initiate PI Treatment per LHSC protocols/orders

Frequent Liquid Stool

- Treat cause
- Consider FMS for C-Diff or unmanageable liquid stool
- Reassess readiness for preventative dressing application every shift and initiate when stool is contained, or is no longer liquid

All patients admitted to CCTC *after*October 1, 2024

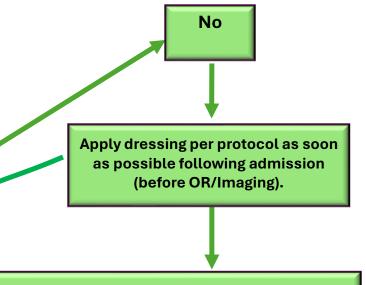
Clean, Assess and Document Sacrum/Coccyx upon admission

Any Contraindications to dressing?

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

No Pressure Injury

- Date the dressing with a Sharpie
- Record "P" for Prevention/Peak
- Initiate a Coccyx Grouper in One Chart
- Assess skin Q12H per protocol and document in grouper
- Change dressing Q7Days and PRN
- Dressing may be wiped off if soiled and may be worn in shower.



Stage I, II, Maceration or Sheer Injury (upon admission or developed after application)

- Notify Pressure Injury Champion to assess wound
- Date the dressing with a Sharpie.
- If "P" dressing has been on for less than 2 days and is intact, you do not need to change it
- Record "T" for Treatment
- Leave the dressing undisturbed for 5 days or PRN if soiled; update the Situation Awareness on dressing purpose and date due for dressing change
- Dressing may be wiped off if soiled and may be worn in shower
- If wound progresses to Stage III, IV or unstageable, remove and notify SWOT. Initiate treatment per LHSC protocol or orders.

Application of Mepilex Border Sacrum

- Clean sacrum and coccyx with soap and water (do not use barrier creams 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 (Peeking) or dressing status (Treatment) **every 12 hours.**
- Use a sharpie to place the date of application on the dressing along with "P" (Prevention/Peeking) or "T" (Treatment) to indicate purpose/intervention.
- Use "P" Prevention/Peeking for patient without any skin breakdown. Perform a skin assessment and document in the Sacrum/Coccyx grouper every 12 Hours.
- "T" Treatment upon identification of a Stage 1, 2, maceration or sheer injury. Leave in place for up to 5 days if intact.
- Update the Situation Awareness for dressing change date.

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 ♦ Wound Drainage Device **Environmental Debris** Wound Bed Colour ◆ Wound Bed Tissue Type ◆ Wound Characteristics Other: No wound Surrounding Tissue Surrounding Tissue Trea...

Initated Border Sacrum Dressing "Prevention"

Wound Status Wound Associated Pain

Interventions

Assess/Reassess Comme... Reassess O12

Treatment

W.	2024/00/20
	2024/09/30 14:48
△ <sacrum 1="" coccyx=""></sacrum>	14:40
◆ Type	E-th-ora Boson Internation
Present on Admission/A	Erythema, Pressure Injury
♦ Present on Admission/A ♦ Mechanism of Injury	
Pressure Injury, Date Ac	Pressure over sacrum
◇ Pressure Injury, Date Ac ◇ Pressure Injury Stage	2024/10/01
	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
	None
	Other: Intact, red
Length cm	
Width cm	_
Area cm2	6
Depth cm	-
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