

- 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

**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.

**Yes**

**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

**No Pressure Injury**

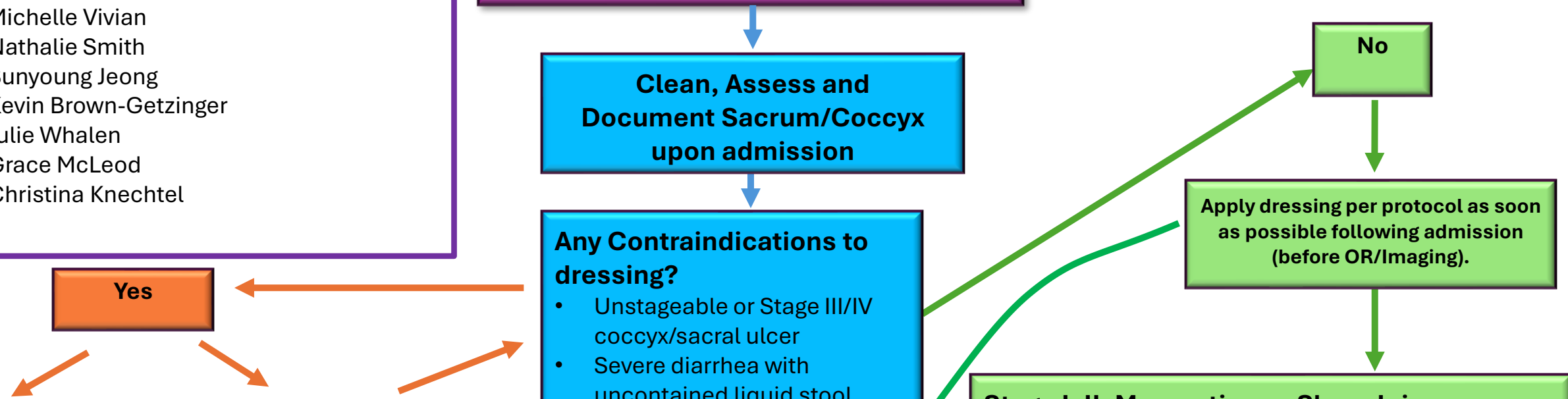
- Date the dressing with a Sharpie
- Record "P" for Prevention/Peak
- Initiate a Coccyx Grouper in One Chart
- Assess skin Q12H per protocol and document in grouper
- Change dressing Q7Days and PRN
- Dressing may be wiped off if soiled and may be worn in shower.

**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.

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

**No**



# Protocol for Application of Mepilex Border Sacrum

- Clean sacrum and coccyx with 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 (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	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 repositioned 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	cm 2 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