Pressure Injury Champions by Line

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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

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 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.

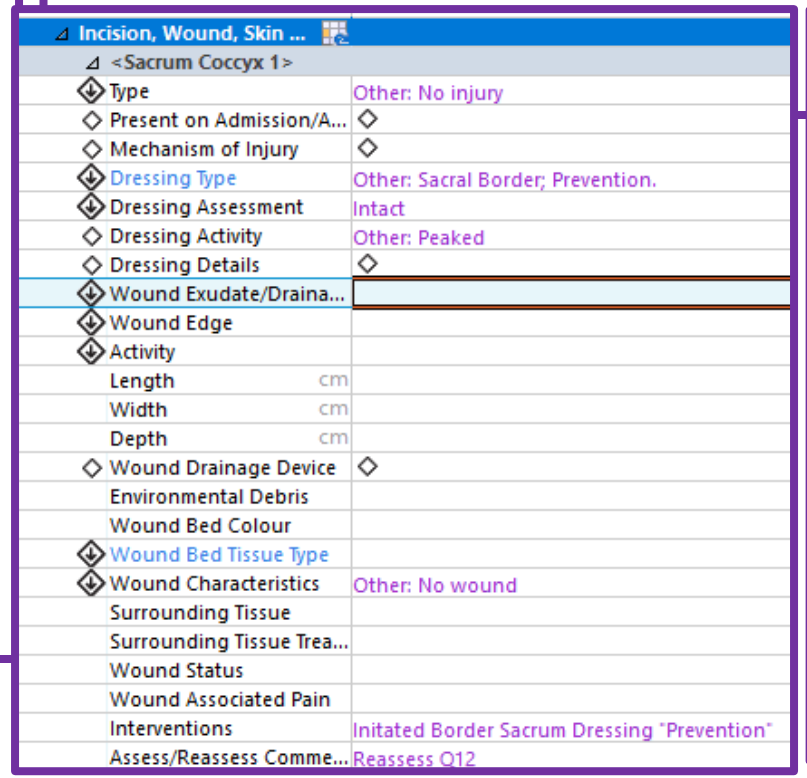
Protocol for Application of Mepilex Border Sacrum

- 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



Treatment