OANHSS

LTCHA Implementation
MEMBER SUPPORT PROJECT

Skin and Wound Care Program

Policy, Procedures and Training Package

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ABOUT THIS DOCUMENT

The development and implementation of an interdisciplinary program for skin and wound care is a requirement of Regulation 79 of the *Long-Term Care Homes Act, 2007* (LTCHA). This document contains sample program objectives, policy, procedures and staff training materials and tools that meet the minimum requirements of the LTCHA and regulation.

This package is intended to be used as a resource for OANHSS member homes to modify and customize, as appropriate. This material can also be used by homes to review their current policies and procedures and compare content. Please note: The project team have compiled these materials during the fall of 2010, and as a result, the information is based on the guidance available at this time. Homes need to regularly review the Ministry of Health and Long-Term Care (MOHLTC) Quality Inspection Program Mandatory and Triggered Protocols to ensure that internal policies and procedures align to these compliance expectations.

Program Evaluation: As described in the regulation, the core clinical programs must be evaluated and updated at least annually by Long Term Care Homes, in accordance with evidence-based practices and if there are none, in accordance with prevailing practices. **Note: a program evaluation approach is not included in this document**. However, OANHSS is planning to develop resource materials on the topic of integrative program evaluation approaches for its members in the near future.

Acknowledgements

OANHSS gratefully acknowledges the contribution of written practices, resources and tools used in the development of this package from Belmont House and The Perley and Rideau Vetrans' Heath Centre (PRVHC). Please see page 11 for additional resources and reference materials.

SKIN AND WOUND CARE PROGRAM

Policy

Skin care, risk assessment and wound care treatment plans are based on resident focused goals of pressure relief, improved or sustained skin integrity, comfort and mobility, infection prevention, healing and/or palliation.

The home shall ensure that a skin and wound care program will be maintained to preserve skin integrity, prevent pressure ulcers, promote comfort and mobility and prevent infection.

The skin and wound care program will use screening protocols and assessment instruments to assess risk factors identified. The interdisciplinary team plays a significant role in skin care and pressure ulcer management, promoting open communication and monitoring resident outcomes and program outcomes.

(Please refer to related policies on topics such as foot care, bathing and infection control.)

Definitions

Altered skin integrity: Potential or actual disruption of epidermal or dermal tissue.

Pressure Ulcer: A lesion caused by unrelieved pressure that results in damage to underlying tissue. Pressure ulcers usually occur over a bony prominence and are staged to classify the degree of tissue damage observed.

Purpose/Goals

The purpose of skin care and wound management is to:

- Identify residents at risk for skin breakdown.
- Implement strategies to prevent and/or manage pressure ulcers and reduce pain and minimize infection.
- Reduce and mitigate the overall incidence of pressure ulcers.
- Reduce risk factors that contribute to the development of pressure ulcers.
- Monitor the incidence and severity of pressure ulcers.
- Promote an optimal level of resident function, comfort and quality of life.
- Monitor and evaluate resident outcomes.

Procedure

Skin Assessment and Identifying Residents at Risk for Altered Skin Integrity

Registered Staff:

1. Complete a Braden Scale (Appendix B) and a Skin Assessment (Appendix C) within 24 hours of admission to identify residents at risk for altered skin integrity.
2. Assess residents identified as being at risk of altered skin integrity by completing a Skin Assessment and Braden Scale:
   - Upon any return of the resident from hospital*
   - Upon any return of the resident from an absence of greater than 24 hours*
   - Quarterly as per the Resident Assessment Instrument Minimum Data Set 2.0 (RAI-MDS 2.0) schedule
   - When there is a change in health status.

   This assessment can be completed while assisting with other care such as dressing and undressing and bathing.
3. Initiate a plan of care within 24 hours of admission to reduce identified risks.
4. Identify the resident as being at risk of altered skin integrity (e.g. high/very high risk-red dot, at risk-green dot on resident chart).
5. Conduct RAI-MDS 2.0 assessment according to the RAI-MDS 2.0 schedule within 14 days of admission and quarterly thereafter according to the schedule and if there is a change in health status. The RAI-MDS 2.0 will generate a Pressure Ulcer Risk Scale score (PURS). A PURS score includes bed mobility, walk in room, bowel incontinence, weight loss, daily pain, shortness of breath and history of resolved pressure ulcer. A score of 6, 7, or 8 indicates high/very high risk of altered skin integrity.
6. Continue to update the care plan based on the RAI-MDS 2.0 assessment and complete the care plan within 21 days.
7. Place resident identified as being at high risk for altered skin integrity on the high risk rounds list.
8. Make referrals to interdisciplinary team members as required (e.g. registered dietitian, physiotherapist).
9. Ensure all staff can identify the residents who are at risk for actual or potential skin/wound breakdown, know whether, how and when the resident has been assessed, what the assessment results are, and the interventions and treatments being carried out.

Prevention of Pressure Ulcers

For residents in bed or chair:

1. Use devices to enable positioning, lifting and transfers, e.g. trapeze, transfer board, bed rails, glide sheet.

2. Reposition dependent resident a minimum of every 2 hours depending on the resident's condition and the tolerance of tissue load during waking, including chair positioning and a minimum of 2 times per night if clinically indicated. (Note: minimize waking a resident if possible.)
3. Relieve pressure from bony prominences:
    - Use devices (e.g. pillows, foam wedges, gel pads, roho cushions, heel boots).
    - Turn to either side at small increments. Avoid positioning at 90 degrees over the trochanter.
    - Maintain the head of the bed less than 30 degrees.
    - Change angle of reclining chair a minimum of every 2 hours.
4. Manage risk factors such as moisture control, pressure reduction, positioning, mobility and nutrition.
5. Use low air loss surface for very high-risk residents.
6. Avoid layers of padding between resident's skin and relief surface.
7. Maintain proper body alignment and position of comfort.
8. Refer to Physiotherapist for seating assessment and seating devices for special needs.
9. Develop, implement and update an interdisciplinary plan of care.

<u>Residents with Pressure Ulcers</u>

Registered Staff:

1. Upon discovery of a pressure ulcer, initiate a baseline assessment using a clinically appropriate assessment instrument (e.g. Appendix D: Pressure Ulcer/Wound Assessment Record) from the Registered Nurses' Association of Ontario (RNAO) Toronto Best Practice Implementation Steering Committee. Also refer to the Pressure Ulcer Awareness Program of The Canadian Wound Care Association. Insert appendix form if available.
2. Stage the pressure ulcer using the staging guidelines (see Appendix E: Staging of Wounds).
3. Communicate findings and recommendations to resident or Substitute Decision Maker (SDM).
4. Ensure the plan of care is established outlining interventions and treatments; the resident is reassessed weekly if indicated and the care plan is revised accordingly.
5. Ensure that the resident is on a turning and positioning schedule.
6. Ensure the resident is provided with a pressure relief therapeutic surface.
7. Obtain a seating assessment if the resident has an ulcer on a sitting surface.
8. Minimize the risk of infections by utilizing routine and aseptic practices as appropriate.
9. Make referral to Enterostomal Therapist (ET) nurse or Wound Care Specialist if available (for Stage 3, 4 and unstageable ulcers only).
10. Contact the physician once the ET nurse or Wound Care Specialist has provided recommendations; obtain physician order for treatment recommendations. The ET nurse or Wound Care Specialist will order appropriate supplies through the wound supply company.

11. Implement interventions for the prevention of further skin breakdown including recommendations from the ET nurse or Wound Care Specialist.
12. Complete a pain assessment and refer to physician for effective management.
13. Participate in the weekly high risk rounds and take photographs of the wound as needed.
14. After a dressing change, complete the Pressure Ulcer/Wound Assessment Record (weekly) including size (circumference and depth) of the wound, discharge from the wound, appearance, progression, pain, nutrition, equipment being used, etc.
15. Communicate with resident, SDM and the team (on the development and monitoring of plan of care, evaluation of progress, and reporting of the outcome).
16. Evaluate and document resident outcomes (e.g. using PURS score).

The Assistant Director of Care/designate:

1. Coordinate the submission for high intensity needs funding in keeping with MOHLTC High Intensity Needs Funds (HINF) Program.
2. Participate in weekly high risk rounds and best practice meetings.
3. Facilitate education for new employees and ongoing education for current employees as needed.

The Health Care Aide/Personal Support Worker:

1. Refer to kardex and/or care plan for specific care interventions.
2. Reposition any resident who is dependent on staff for repositioning every 2 hours and document same.
3. Participate in the weekly high-risk rounds.
4. Observe the resident's skin, specifically bony prominences daily and report any areas of redness to the registered staff. Do a visual head to toe skin assessment on bath days.
5. Report any changes in appetite and nutrition.
6. Provide skin care (e.g. pat vs. rubbing to dry skin, do not massage over reddened bony prominences, keep skin lubricated, lift rather than slide a resident in a manner that creates abrasions).
7. Ensure adequate intake of fluid (1500 mls per 24 hours). Report to registered staff if resident's 24 hour intake is less than 1000 mls per 24 hours.
8. Minimize shearing and friction on the skin when cleansing, providing care, or moving the resident.
9. Manage moisture, e.g. urine, feces, perspiration, wound exudates, saliva. Use protective barrier products, change linens and clothing when damp.
10. Do not use donut type devices or products that localize pressure to other areas.
11. Ensure that wheelchair cushions (e.g. ROHO) are properly inflated.
12. Report any evidence of pain (e.g. verbal, facial grimace) to the registered staff.

Registered Dietitian:

1. Complete nutritional and hydration risk assessment within 7 days.

2. Recommend / order appropriate diet, supplements and hydration strategies.
3. Make recommendations to physicians including: albumin, blood monitoring, and vitamins/minerals.

Enterostomal Therapist (ET) / Wound Care Specialist:

1. Complete and document assessment based on nursing or physician referral. (Note: ET nurse and Wound Care Specialist will use his/her own forms.)
2. Identify potential underlying causative factors contributing to pressure ulcer development.
3. Recommend treatment options.
4. Monitor and document effectiveness of treatment.
5. Provide staff education.

Physiotherapist (PT)/Rehab Assistant (RA):

1. Assess and advise on positioning and seating options.
2. Advise staff on bed mobility and transferring techniques to prevent shearing.
3. Assess and develop treatment plan for restorative/maintenance of mobility program and communicate plan to interdisciplinary team.
4. Provide and use therapeutic modalities (e.g. ultrasound).
5. Communicate with the resident or Power of Attorney (POA) for Property/ Guardian/Trustee on equipment purchases and seek authorization where payment is required.

Activation/Recreation:

1. Involve the resident in group or one-to-one exercise, range of motion, social programs as desired by the resident.
2. Ensure the resident is positioned according to the plan of care.
3. Recognize and report resident verbalizations; observe for signs and behaviours indicative of discomfort.

Foot Care/*Chiropodist/Podiatrist:

1. Complete assessment and treatment of the toenails and feet.

*where fees charged resident needs to agree to this intervention.

Physician:

1. Complete assessment within 7 days of admission.
2. Complete medical orders for wound treatment based on current evidence, best practice and ET / Wound Care Specialist recommendations.
3. Participate/consult with registered staff weekly regarding outcomes of weekly Pressure Ulcer Awareness and Prevention rounds.
4. Refer to specialized consultation services as needed (e.g. ET Nurse / Wound Care Specialist).
5. Monitor, evaluate and document outcomes of treatment.
6. Communicate and provide updates to families.

Pharmacist:

1. Assess resident's medications.
2. Make recommendations to physicians as appropriate.
3. Provide consultation services.
4. Provide education.
5. Evaluate and document preventative interventions and resident outcomes quarterly.

Program Evaluation

The following indicators will be tracked monthly, analyzed and trended and reported to an appropriate internal committee (e.g. Quality Improvement, Best Practice, Clinical Advisory) or responsible task group:

- Prevalence of internally acquired pressure ulcers.
- Prevalence of externally acquired pressure ulcers.
- Prevalence of stage 1-4 pressure ulcers (from RAI-MDS 2.0 Canadian Institute for Health Information (CIHI) report).
- Prevalence of worsening pressure ulcers.

Pressure ulcer data can be obtained from CIHI reports derived from RAI-MDS 2.0, internal quality improvement reports from the home's care software program internal tracking systems (e.g. Appendix F: Pressure Ulcer Tracking Form) to assist in the identification, analysis and trends that may impact on the skin and wound care program.

Skin and pressure ulcer audits will be conducted quarterly to ensure that the assessment and tracking tools are being utilized appropriately and the strategies have been successful in reducing the number and severity of pressure ulcers.

Staff Training and Education

New staff (including agency staff and direct care contracted staff), registered nursing staff and health care aides (full and part time) will receive skin and wound care education and information during orientation. (Sample education tools include*: Education Workshop for Unregulated Care Providers-Assessment and Management of Pressure Ulcers* (RNAO) and *Education Workshop for RNs and RPNs –Assessment and Management of Pressure Ulcers* (RNAO), and Skin and Wound Care Program Training Presentations (Appendix G and H) (OANHSS).

Staff education sessions regarding skin and wound care will be provided annually and additionally as required.

References

Long-Term Care Homes Act, 2007 and Regulation 79/2010. Section 50

Registered Nurses' Association of Ontario (2005). *Risk Assessment and Prevention of Pressure Ulcers. (Revised).* Toronto, Canada: Registered Nurses' Association of Ontario. [On-line]. Available: www.rnao.org/bestpractices

Additional Resources

1) Canadian Association of Enterostomal Therapists (CAET): www.caet.ca

CAET is a professional organization founded to represent Enterostomal Therapy nursing.

The CAET believes that all persons with the following conditions are entitled to the comprehensive services of an Enterostomal Therapy nurse: abdominal stomata (opening), fistulae, draining wounds, and selected disorders of the integumentary (skin), gastrointestinal, and genitourinary systems.

2) Canadian Association of Wound Care (CAWC): *Pressure Ulcer Awareness Program* www.cawc.net

The CAWC is a non-profit organization of healthcare professionals, industry participants, patients and caregivers dedicated to the advancement of wound care in Canada.

3) OANHSS *A Resource Guide – Skin and Wound Care*.

Glossary of Terms

Cellulitis
Inflammation of cellular connective tissue. Inflammation may be diminished or absent in immunosuppressed individuals.

Colonized
The presence of bacteria on the surface or in the tissue of a wound without indications of infection such as purulent exudate, foul odour, or surrounding inflammation. All Stage II, III, and IV pressure ulcers are colonized.

Contaminated
Containing bacteria, other microorganisms, or foreign material. The term usually refers to bacterial contamination and in this context is synonymous with colonized. Wounds with bacterial counts of 10^5 organisms per gram of tissue or less are generally considered contaminated; those with higher counts are generally considered infected.

Debridement
Removal of devitalized tissue and foreign matter from a wound. Various methods can be used for this purpose:

> Autolytic Debridement: The use of synthetic dressings to cover a wound and allow eschar to self-digest by the action of enzymes present in wound fluids.
>
> Enzymatic (Chemical) Debridement: The topical application of proteolytic substance (enzymes) to breakdown devitalized tissue.
>
> Mechanical Debridement: Removal of foreign material and devitalized or contaminated tissue from a wound by physical forces rather than by chemical (enzymatic) or natural (autolytic) forces. Examples are wet-to-dry dressings, wound irrigations, whirlpool, and dextranomers.
>
> Sharp Debridement: Removal of foreign material or devitalized tissue by a sharp instrument such as a scalpel. Laser debridement is also considered a type of sharp debridement.

Epithelialization
The stage of tissue healing in which epithelial cells migrate (move) across the surface of a wound. During this stage of healing, the epithelium appears the colour of “ground glass” to pink.

Erythema
Redness of the skin.

Eschar
Thick, hard, black, leathery, necrotic, devitalized tissue.

Friction
Mechanical force exerted when skin is dragged across a coarse surface such as bed linens.

Granulation Tissue
Pink/red, moist tissue that contains new blood vessels, collagen, fibroblasts, and inflammatory cells, which fills an open, previously deep wound when it starts to heal.

Hypergranulation
Hypergranulation (proud flesh) may occur in wounds that are healing by second intention. This aberrant response represents overgrowth of fibroblasts and endothelial cells, and it is clinically recognized by its beefy, friable, red appearance. These highly vascular lesions resemble pyogenic granuloma on histologic analysis, and they bleed easily. The presence of this tissue results in the inhibition of fibroblast proliferation and prevents wound healing. Treatment consists of destruction of the hypergranulation tissue by cautery, shave excision, aluminum chloride, or curettage.

Maceration
Softening of tissue by soaking in fluids. In this context, it refers to degenerative changes and disintegration of skin when it has been kept too moist.

Necrosis/Necrotic Tissue
Describes devitalized (dead) tissue, e.g. eschar and slough.

Pressure Ulcers
Any lesions caused by unrelieved pressure that results in damage to underlying tissue. Pressure ulcers usually occur over a bony prominence and are staged to classify the degree of tissue damaged observed.

Shear
Mechanical force that acts on a unit area of skin in a direction parallel to the body's surface. Shear is affected by the amount of pressure exerted, the coefficient of friction between the materials contacting each other, and the extent to which the body makes contact with the support surface.

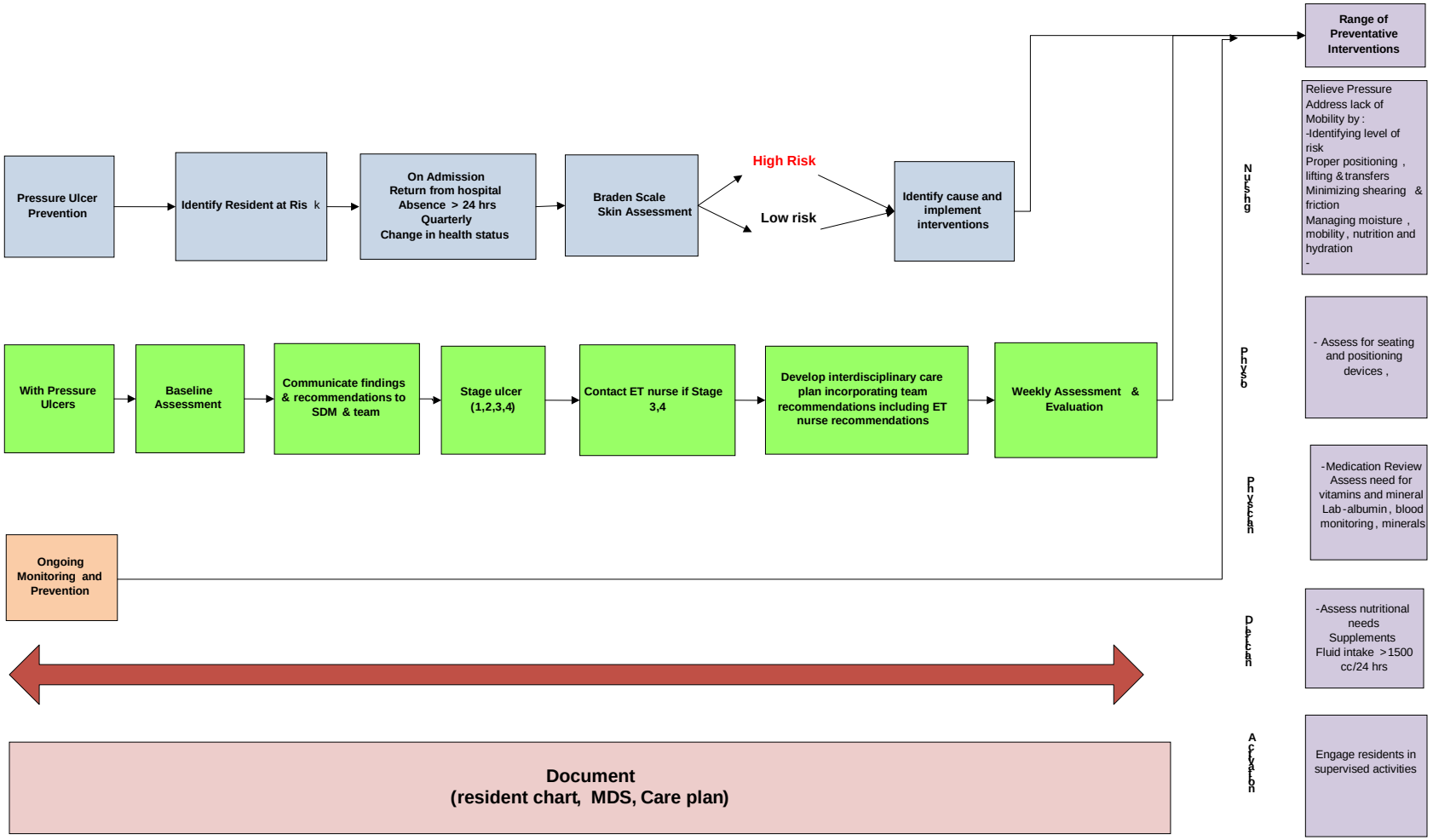
Sinus Tract
A cavity or channel underlying a wound that involves an area larger than the visible surface of the wound. It is a pathway that can extend in any direction from the wound surface, which results in dead space with potential for abscess formation.

Slough
Necrotic (dead) tissue in the process of separating from viable portions of the body. It is seen as the accumulation of dead cellular debris on the wound surface, and tends to be yellow in colour due to the large amounts of leukocytes present. However, yellow tissue is not always indicative of slough but may be subcutaneous tissue, tendon, or bone instead.

Tunnelling
A passageway under the surface of the skin that is generally open at the skin level; however, most tunneling is not visible.

Undermining
A closed passageway under the surface of the skin that is open only at the skin surface. Generally, it appears as an area of skin ulceration at the margins of the ulcer with skin overlaying the area. The undermining often develops from shearing forces.

APPENDIX A: SKIN AND WOUND CARE - OVERVIEW



APPENDIX B: BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK AT ADMISSION

Resident's Name _____ Evaluator's Name _____

				Date of Assessment				
SENSORY PERCEPTION Ability to respond meaningfully to pressure-related discomfort.	**1. Completely Limited** Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminished level of consciousness or sedation, *OR* limited ability to feel pain over most of body.	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness, *OR* has a sensor impairment that limits the ability to feel pain or discomfort over ½ of body.	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned, *OR* has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.				
MOISTURE Degree to which skin is exposed to moisture.	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	**2. Very Moist** Skin is often, but not always, moist. Linen must be changed at least once a shift.	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals.				
ACTIVITY Degree of physical activity.	**1. Bedfast** Confined to bed.	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**3. Walks Occasionally** Walks occasionally during day, but for very short distances with or without assistance. Spends majority of each shift in bed or chair.	**4. Walks Frequently** Walks outside the room at least twice a day and inside room at least every 2 hours during waking hours.				
MOBILITY Ability to change and control body position.	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance.	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. Slightly Limited** Makes frequent though slight changes in body or extremity position independently.	**4. No Limitation** Makes major and frequent changes in position without assistance.				
NUTRITION Usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than 1/3 of any food	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about ½ of any food	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or				

	offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement *OR* is NPO and/or maintained on clear liquids of IVs for more than 5 days.	offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement *OR* receives less than optimum amount of liquid diet or tube feeding.	or dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered *OR* is on tube feeding or TPN regimen, which meets most of nutritional needs.	more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.				
FRICTION AND SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation lead to almost constant friction.	**2. Potential Problems** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair restraints, or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3. No Apparent Problem** Moves in bed and chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair.					
				TOTAL SCORE				

Note: (Braden, 2001)
15 to 18 = At Risk
13 to 14 = Moderate Risk
10 to 12 = High Risk
≤ 9 = Very High Risk

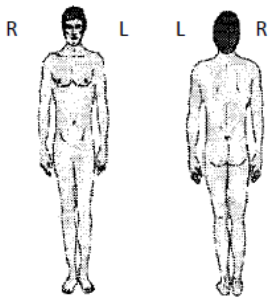
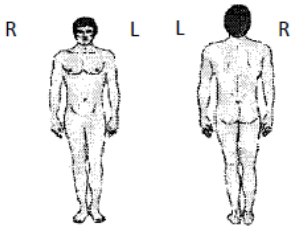
Assessment Schedule:
Very High to High Risk = minimum monthly
Moderate Risk = q3months
Low/No Risk = q6months

Consider other resident factors that will also increase risks e.g., advanced age, uncontrolled pain, underlying disease conditions, low albumin and HGB.

APPENDIX C: SKIN ASSESSMENT

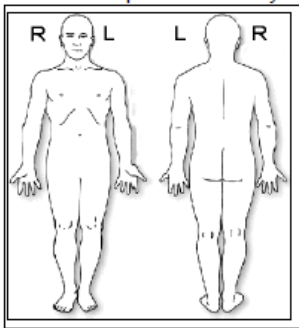
For use by Registered Staff

Resident Name (last/first) _____ Room Number: _____

☐ on Admission ☐ any return from hospital ☐ post LOA, return from hospital, greater than 24 hours ☐ quarterly (as per MDS) ☐ significant change in status  Date (y/m/d) _____ Signature: _____	**HEAD TO TOE** (Including scalp, extremities and trunk) ☐ Skin clear & intact ☐ Poor skin turgor ☐ Dry Skin ☐ Blisters ☐ Rash/reddened areas ☐ Bruising ☐ Open area	☐ Fingernails clean ☐ Fingernails unkempt ☐ Fingernails dirty ☐ Toenails unkempt ☐ Toenails dirty Other: _____ _____ _____ _____ _____ _____ _____	**DENTITION** ☐ Chipped or broken teeth ☐ Bleeding gums ☐ Ulcerated gums ☐ Inflamed mucous membranes ☐ Blisters (lips and gums) ☐ Beefy tongue ☐ Coated tongue Other: _____ _____ _____ _____ _____ _____ _____
☐ on Admission ☐ any return from hospital ☐ post LOA, return from hospital, greater than 24 hours ☐ quarterly (as per MDS) ☐ significant change in status  Date (y/m/d) _____ Signature: _____	**HEAD TO TOE** (Including scalp, extremities and trunk) ☐ Skin clear & intact ☐ Poor skin turgor ☐ Dry Skin ☐ Blisters ☐ Rash/reddened areas ☐ Bruising ☐ Open area	☐ Fingernails clean ☐ Fingernails unkempt ☐ Fingernails dirty ☐ Toenails unkempt ☐ Toenails dirty Other: _____ _____ _____ _____ _____ _____ _____	**DENTITION** ☐ Chipped or broken teeth ☐ Bleeding gums ☐ Ulcerated gums ☐ Inflamed mucous membranes ☐ Blisters (lips and gums) ☐ Beefy tongue ☐ Coated tongue Other: _____ _____ _____ _____ _____ _____ _____

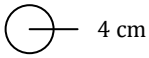
APPENDIX D: PRESSURE ULCER/WOUND ASSESSMENT RECORD

To be used for Pressure Ulcers ONLY
To be completed weekly / at dressing change

	**Diagram of wound**	**Pressure Ulcers or bedsores are caused by constant pressure that damages the skin and underlying tissue.**			
Date (y/m/d)	**Initial Assessment**	**Date (y/m/d)**	**Date (y/m/d)**	**Date (y/m/d)**	**Date (y/m/d)**
Braden Score-Date, interventions					
PURS Score					
Location of wound					
Stage (1,2,3,4, unstageable) DTI (deep tissue injury)					
Length /width (cm)					
Depth (cm)					
Undermining/Tunnelling (cm) (Use clock to describe)	◯	◯	◯	◯	◯
Wound Base (**Pink**-epithelialization: **Red**-granulating; **Yellow**-slough; **Black**-necrotic, eschar; **Green**-infected; hypergranulation) % of each	Pink ☐ Red ☐ Yellow ☐ Black ☐ Green ☐	Pink ☐ Red ☐ Yellow ☐ Black ☐ Green ☐	Pink ☐ Red ☐ Yellow ☐ Black ☐ Green ☐	Pink ☐ Red ☐ Yellow ☐ Black ☐ Green ☐	Pink ☐ Red ☐ Yellow ☐ Black ☐ Green ☐
Ulcer margins					
Exudate (serous, Blood, Purulent)					
Odour (none, mild, foul, other)					
Culture(date)					
Periwound skin (Normal, Macerated, Dry, Exzema, Cellulite, Edematours, Other)					
Pain Assessment (scale of 1-5 (5 is severe)					
Interventions (e.g. mattress, overlay cushion)					
Debridement Yes/No					
Referrals (RD/ET Wound specialist, PT etc.)					
Treatment:	see TAR	see TAR	see TAR	see TAR	see TAR
Treatment Appropriate Yes/No					
Changes in treatment/Care plan					
Nurse's signature					

Guidelines for Use of the Pressure Ulcer/Wound Assessment Record

1. Use the Pressure Ulcer/Wound Assessment Record for the initial assessment of a pressure ulcer and for the ongoing assessment and treatment.
2. The form can be completed by a Registered Nurse (RN) or Registered Practical Nurse (RPN).
3. Use the form **only** for **pressure ulcers**. Skin tears and stasis ulcers should be documented on the progress notes.
4. Use a separate Pressure Ulcer/Wound Assessment Record for each pressure ulcer.
5. **Braden Scale**: enter the Braden Score if the resident is a new admission. If the resident has had a RAI-MDS 2.0 assessment completed, enter the PURS outcome score.
6. **Wound Location**: circle location on the body diagram and write the site location in the area identified.
7. **Stage**: enter the stage of the wound based on the staging guidelines.
8. **Length of the wound**: use a ruler to measure the longest aspect of the wound or use the Visitrak to obtain this data. Write the length in cm in the space provided.
9. **Width**: use a ruler to measure the widest aspect of the wound or use the Visitrak to obtain this data. Write the width in cm in the space provided.
10. **Depth:** measure the depth of the wound with a q-tip or use the Visitrak to obtain this data. Write the depth in cm in the space provided.
11. **Undermining:** measure any undermining using the wooden side of a cotton swab. Advance it as far as it will go without using force. Mark the edge with a pen. Measure from the edge of the swab to the pen line. Continue this process around the wound and mark the areas and measurements in cm on the circle diagram (draw a line in the circle to indicate where the undermining is located (e.g. 3 o'clock-4 cm).



12. **Wound Base**: write the colour that best describes the predominant colour present in the wound base.
13. **Exudate:** write the type of drainage none= no drainage, bleeding=thin, bright red, serosanguinous=thin, watery pale red to pink, serous=thin, watery, clear purulent=opaque tan to yellow to green.
14. **Odour:** indicate if none, mild, foul, other.
15. **Culture:** indicate the date a culture was sent.
16. **Periwound skin:** indicate the condition of the skin around the wound (Normal, Macerated, Dry, Eczema, Cellulitc, Edematours, Other).
17. **Pain assessment**: indicate the severity of pain (scale 1-5 with 5 being severe).
18. **Interventions**: indicate what interventions are being used (therapeutic mattress, ROHO cushion, repositioning, etc.).
19. **Debridement:** was wound debrided (Yes, No).
20. **Referrals:** indicate what discipline was referred.

21. **Treatment:** record the treatment you provided today. Additional detail must be charted in the progress notes.
22. **Treatment Appropriate:** Is the wound healing or should a change of treatment be recommended? Indicate yes or no.
23. **Changes in Treatment/Care Plan**: indicate whether the treatment plan has changed. If yes, indicate the change.
24. **Nurse's Signature**: the RN/RPN completing the dressing change to write their name and designation in the space provided.

APPENDIX E: STAGING OF WOUNDS

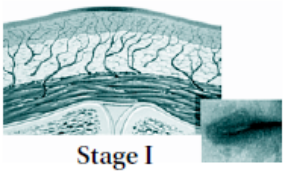
(From *Assessment and Management of Stage I to IV Pressure Ulcers*, Registerd Nurses Association of Ontario.)

Stages of Pressure Ulcers

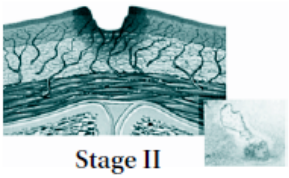
(NPUAP, 2007)

Suspected Deep Tissue Injury: Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones.

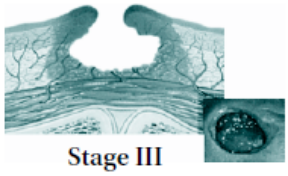
Stage I: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.


Stage I

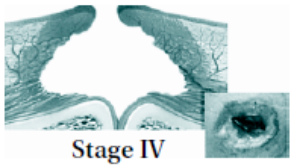
Stage II: Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.


Stage II

Stage III: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.


Stage III

Stage IV: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.


Stage IV

Unstageable: Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

It is recommended that reverse staging of pressure ulcers NOT be used to describe the healing process of a wound as this does not accurately reflect what is physiologically occurring in the ulcer (NPUAP, 2000). Please also refer to definition of **Reverse Staging of Pressure Ulcers**. Descriptive characteristics or a validated tool for measuring pressure ulcer healing, such as the PUSH tool, can be used to describe healing (NPUAP, 2000; Thomas et al., 1997).

Pictures courtesy of KCI Medical Canada, Inc.

APPENDIX F: PRESSURE ULCER TRACKING FORM

Floor/Unit: _____ Month/Year: _____

Date (d/m/y)	**Resident Name** (last/first)	**Rm #**	**Site** (use separate line for each site)	**Stage** 1 2 3 4 Unstageable	**Internally Acquired** (I) **Externally Acquired** (E)	**Improving** (I) **Worsening** (W) **No Improvement** (NI) **Resolved** (R)	**Action Taken**	**Staff Initials**

APPENDIX G: SKIN AND WOUND CARE PROGRAM TRAINING PRESENTATION – CLINICAL STAFF

For Skin and Wound Care Program Training Presentation for Clinical Staff, see attached presentation (Microsoft PowerPoint file) included in this package.

APPENDIX H: SKIN AND WOUND CARE PROGRAM TRAINING PRESENTATION – FRONT LINE STAFF AND FAMILIES

For Skin and Wound Care Program Training Presentation for Front Line Staff and Families, see attached presentation (Microsoft PowerPoint file) included in this package.