Vermont Psychiatric Care Hospital Policy and Procedure		
Skin Integrity and Pressure Injury Prevention		
Effective: March 2024	Revised: September 2024	Due to Review: September 2026

POLICY

The Vermont Psychiatric Care Hospital (VPCH) multidisciplinary treatment teams recognize that maintaining skin integrity is an integral factor in overall health maintenance and will promote skin integrity and prevention of pressure injury for hospitalized individuals.

DEFINITIONS

Pressure Injury: A pressure injury is localized damage to the skin and/or soft tissue. It usually occurs over bony prominences such as heels, ankles, hips, and coccyx. It can also occur anywhere on the body because of sustained pressure, or shear. Nutritional status and medical co-morbidities may affect skin integrity. Pressure injuries may appear as intact skin, or open ulcers. Pressure injuries may or may not be painful.

Skin Assessment: An inspection conducted as a head-to-toe assessment of an individual's bony prominences, skin folds and creases that may be at risk of skin breakdown.

Skin Tear: A skin tear is a wound caused by shear, friction, or force that results in separation of the skin layers. A skin tear may involve a separation of the epidermis and the dermis (partial thickness) or a separation of the epidermis and dermis from underlying structures (full thickness).

Risk Assessment: An assessment that identifies the potential risk that a hospitalized individual will develop skin breakdown.

PROCEDURE

Risk Assessment

- At the time of admission, and at least once per shift thereafter, the assigned Registered Nurse (RN) will perform a risk assessment using an evidence based risk assessment tool.
- As part of this assessment, at least once per shift the RN shall observe the visible aspects of the skin and notify a provider of any skin abnormalities or concerns regardless of the outcome of the risk assessment.
- Individuals with an existing pressure ulcer shall be considered at-risk for an additional ulcer regardless of routine risk assessment indicators.
- Provider notification shall occur each time an individual is assessed to be at a moderate-severe risk for skin breakdown.
- When moderate-severe risk is determined, risk for skin breakdown shall be noted as a problem to be addressed in the individual's treatment plan. Corresponding interventions and progress shall be documented in the treatment plan in accordance with VPCH policy.

Skin Assessment

- Any individual providing care at VPCH shall monitor visible skin areas for the skin condition of hospitalized individuals and notify the assigned RN of any observed new or abnormal condition so the RN can perform an assessment of the skin.
- Upon admission the admitting RN will complete a skin assessment and document this in the Skin Integrity section of the Nursing Assessment Flow Chart.
- Skin assessment shall then be conducted and documented by an assigned RN at a frequency dictated by provider order.
- If the individual refuses a skin assessment, the assessing RN shall assess and document the parts of the skin that are visible and the refusal must be documented specifying the skin areas not assessed.
- Upon identification of skin breakdown or abnormal skin appearance (abrasion, blister, bruising, erythema, laceration, rash, skin tear, wound), a provider shall be notified and a wound assessment shall be completed. This wound assessment shall be documented in the Wound Flow Chart along with corresponding interventions and provider notification.
- A VPCH event report and High-Risk Note shall also be completed in accordance with VPCH policy.

1.

Attachments

Attachment A: The Braden Scale

1. Attachment B: Treatment Plan Considerations

References

AHRQ's Safety Program for Preventing Pressure Ulcers in Hospitals retrieved from: link.
National Pressure Ulcer Advisory Panel (NPIAP) Pressure Injury Stages retrieved from: link.

Approved by	Signature	Date
Emily Hawes, Commissioner, Vermont Department of Mental Health	DocuSigned by: Emily Hawes C50275615A62462...	9/25/2024

Appendix A: The Braden Scale

BRADEN SCALE – For Predicting Pressure Sore Risk

SEVERE RISK: Total score ≤ 9 **HIGH RISK**: Total score 10-12
MODERATE RISK: Total score 13-14 **MILD RISK**: Total score 15-18

RISK FACTOR	SCORE/DESCRIPTION				DATE OF ASSESS ➡ 1	2	3	4
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 surface.	**2. VERY LIMITED** – Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness, **OR** has a sensory impairment which 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 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. OFTEN 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 nonexistent. 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 once 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 LIMITATIONS** – Makes major and frequent changes in position without assistance.				
NUTRITION Usual food intake pattern [1]NPO: Nothing by mouth. [2]IV: Intravenously. [3]TPN: Total parenteral nutrition.	**1. VERY POOR** – Never eats a complete meal. Rarely eats more than 1/3 of any food 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[1] and/or maintained on clear liquids or IV[2] for more than 5 days.	**2. PROBABLY INADEQUATE** – Rarely eats a complete meal and generally eats only about ½ of any food 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.	**3. ADEQUATE** – Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally refuses a meal, but will usually take a supplement if offered, **OR** is on a tube feeding or TPN[3] regimen, which probably meets most of nutritional needs.	**4. EXCELLENT** – Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or 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 leads to almost constant friction.	**2. POTENTIAL PROBLEM**– 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 in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.					
TOTAL SCORE	**Total score of 12 or less represents HIGH RISK**							

ASSESS	DATE	EVALUATOR SIGNATURE/TITLE	ASSESS.	DATE	EVALUATOR SIGNATURE/TITLE
1	/ /		3	/ /	
2	/ /		4	/ /	

NAME-Last	First	Middle	Attending Physician	Record No.	Room/Bed

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Appendix B: Treatment Plan Considerations

The attending provider, in collaboration with the medical consultant, will direct care, facilitate communication and treatment planning, order assessments, interventions, and treatments, and reviews results.

In developing the Treatment Plan, consider:

- Medical and psychiatric symptoms being experienced.
- Current state of skin integrity
- Cultural practices that impact the health or integrity of the skin
- Risk for pressure ulcer development / skin breakdown.

Plans for maintenance of skin integrity may include:

- Frequency of cleansing and moisture management
- Recommended movement and activity focused on pressure redistribution of bony prominences that may lead to tissue break down.
- Identification of risk factors that compromise skin integrity (medication, nutritional status, pre-existing skin wounds)
- Evidence based interventions to improve the overall integrity of the skin such as protective creams, barriers, coverings, or pressure reduction devices

Interventions for hospitalized individuals with identified risks may include:

- Frequent turning / repositioning schedules
- Keeping the head of the bed at (or below) 30 degrees to reduce friction and sheer
- Strategies to maximize the hospitalized person's mobility
- Using pressure reducing support surfaces if the individual is restricted to bed or chair
- Providing foam wedges for positioning support of bony prominences and extremities
- Minimizing nutrition deficits

Additional considerations:

- A referral to a wound care specialist for consultation may be considered as part of the treatment plan.
- The results of the medical consultant's clinical analysis and recommended treatments shall be documented/ordered in the hospitalized person's medical record.
- Registered Dietician: Adequate dietary intake is vital to ensure healing. A nutritional assessment, plan and interventions will be ordered and included in the treatment plan.
- Treatment plan: The treatment plan will be updated to the presence of pressure injury, interventions, and response.