Pressure Injury Prevention

Corporate Policy & Procedures Manual

Number: VII-B-485
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Next Review: (3 years from Effective Date) September 2022

Approved by:
Chief Medical Officer; and
Chief Executive Officer

NOTE: The first appearance of terms in bold in the body of this document (except titles) are defined terms – please refer to the Definitions section.

Purpose
To minimize the development of pressure injuries by initiating early assessment, and evidence-based interventions for patients/residents\(^1\) in our care.

Policy Statement
All patients admitted to Covenant Health facilities shall be managed with appropriate pressure injury prevention strategies. This includes, but is not limited to:

- identifying patients who are at risk for pressure injury development on admission and at specific intervals;
- utilizing evidence informed pressure injury risk assessment tools pertinent to the program area/patient population;
- engaging the patient and their family to participate in pressure injury prevention strategies; and
- provision of education, training and resources to health care providers to support pressure injury prevention.

Applicability
This policy and procedure applies to all Covenant Health facilities, staff, medical staff, volunteers, students and any other persons acting on behalf of Covenant Health.

Responsibility
Health care professionals are responsible to work collaboratively to support a culture of pressure injury prevention.

Principles
Covenant Health is committed to improving patient safety and focusing on preventing and minimizing/avoiding harm. All patients are potentially at risk for the development of pressure injuries. Pressure injuries are considered an adverse event. Pressure injuries impact patients’ quality of life, can result in pain, hinder recovery, and increase risk of infection. Pressure injuries increase length of patient’s recovery, cost of health services and rates of mortality. The majority of pressure injuries are preventable or avoidable.

Policy Elements
1. Validated Risk Assessment on Admission
   1.1 On admission, assess patient for risk of developing pressure injuries using a validated risk/assessment tool; for example, Appendix 1 - Braden Scale for Predicting Pressure Sore (Ulcer) Risk.

\(^1\) Hereafter, all references to 'patients' includes residents.
2. Intervention

2.1 The health care team shall develop a care plan and implement specific individualized pressure injury prevention strategies based on level of risk as indicated in Appendix 3 – Pressure Injury Prevention Strategies for Adult Patients, and Appendix 4 – Acute Care: Initial Risk Assessment and Reassessment (Adults).

2.2 The level of prevention strategies will depend on the risk level, available resources, individual needs and the clinical judgment of the health care provider. The pressure injury prevention strategies may address one or more of the following, but are not limited to:

- minimizing pressure (including pressure caused from medical devices and in mucosal membranes)
- managing moisture
- enhancing mobility and activity
- optimizing nutrition and hydration
- minimizing friction and shear.

2.3 The above mentioned strategies may also be implemented in a standardized bundled approach to pressure injury prevention including the acronym SKIN (refer to Appendix 2). The SKIN bundle involves the initial and ongoing care planning for pressure injury prevention that can be updated by reviewing the additional interventions and strategies (Appendix 4) for pressure injury prevention that would contribute to an individualized, patient centered approach to care:

   S: Surface selection (assessment of surfaces (mattresses) or seated surfaces that have an impact on pressure).
   K: Keep moving (support for mobilization)
   I: Incontinence care (skin care and incontinence management to maintain skin integrity)
   N: Nutrition (assessment of nutritional status, support for nutrition and/or consultation to registered dietitian as available)

3. Re-Assessment

3.1 Reassess the patient at regular intervals for according to Appendix 4 and Appendix 5, Initial Risk Assessment and Reassessment, and when:

- their initial assessment identifies risk (i.e. Braden score of 18 or less)
- a significant change in the patient’s clinical status has occurred; or
- the patient is transferred from one care area to another.

3.2 Continuing Care risk reassessment is completed with the interRAI Pressure Ulcer Risk Score (PURS) on a quarterly basis.
4. **Reporting of Pressure Injury**

4.1 Use the Reporting and Learning System (RLS) to report any pressure injuries that develop while the patient is in a Covenant Health facility. Refer to Covenant Health policy #III-45, *Responding to Adverse Events, Close Calls and Hazards*.

5. **Disclosure of Harm**

5.1 Disclosure of any patient harm from development of in-facility pressure injuries shall be in compliance with Covenant Health policy #III-40, *Disclosure of Adverse Events, Close Calls and Hazards*.

6. **Audits/Evaluation**

6.1 Audits to determine prevalence/incidence rates and assessment of preventative strategies (processes and care) shall be conducted regularly.

7. **Patient/Family/Alternate Decision-Maker Engagement**

7.1 Patients and/or families will be provided with information on the identification of risk factors and suggested strategies to engage them in care activities when possible to prevent pressure injuries.

8. **Training and Education**

8.1 Health care providers will be provided education to support the adoption of pressure injury prevention strategies including application of the approved validated risk assessment tool and implement prevention strategies applicable to their practice setting. These tools, processes, and strategies are available on CompassionNet @ https://www.compassionnet.ca/Page913.aspx. CLiC learning modules are in development.

9. **Documentation and Communication**

9.1 Documentation will align with corporate policy #III-120, *Clinical Documentation*.

9.2 Minimum documentation requirements shall include:

- risk and skin assessment
- corresponding interventions
- evaluation of interventions
- patient/family education as applicable

9.3 It is recommended that pressure injuries present on admission to a care facility be documented as “present on admission”, and upon transfer or discharge as “present on departure.”
9.4 Health care providers shall communicate the risk level and the plan of care to the team, patient and patient’s family.

Definitions

Alternate decision-maker means a person who is authorized to make decisions with or on behalf of the patient. These may include, specific decision-maker, a minor’s legal representative, a guardian, a ‘nearest relative’ in accordance with the Mental Health Act [Alberta], an agent in accordance with a Personal Directive, or a person designated in accordance with the Human Tissue and Organ Donation Act [Alberta].

Health care professional means an individual who is a member of a regulated health discipline, as defined by the Health Disciplines Act (Alberta) or the Health Professions Act (Alberta), and who practices within a defined scope and role.

Pressure Injury: Localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense pressure, prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue.

Related Documents

Appendix 1 - Braden Scale for Predicting Pressure Sore (Ulcer) Risk
Appendix 2 - SKIN Bundle
Appendix 3 – Pressure Injury Prevention Strategies for Adult Patients
Appendix 4 – Acute Care: Initial Risk Assessment and Reassessment Frequency
Appendix 5 – Continuing Care Edmonton Zone (CCEZ) Pressure Injury Prevention Risk Assessment Recommendations

References


Canadian Patient Safety Institute. Never Events for Hospital Care in Canada. Safer Care for Patients, September 2015.


Revision Date(s) N/A
## Braden Scale for Predicting Pressure Sore (Ulcer) Risk

**For Assessment and Reassessment of Pressure Ulcer Prevention**

### Sensory Perception
- **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 sensory impairment which limits the ability to feel pain or discomfort over 1/2 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
- **1. Constantly Moist**
  - Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected everytime 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 occationally moist, requiring extra linen change approximately once a day
- **4. Rarely Moist**
  - Skin is usually dry, linen only requires changing at routine intervals

### 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 room at least twice a day and inside room at least once every two hours during waking hours

### Mobility
- **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
- **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 and/or maintained on clear liquids or IV’s for more than 5 days
- **2. Probably Inadequate**
  - Rarely eats a complete meal and generally eats only about 1/2 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) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN 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 & 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.

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For Assessment and Reassessment of Pressure Ulcer Prevention

**Total Score**

**Initials**

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Instructions for Completing the Braden Scale

The Braden Scale is used to assess the patient’s level of risk for developing pressure ulcers. The assessment consists of six (6) indicators: sensory perception; moisture; activity; mobility; nutrition; and friction and shear.

Scoring

Each row lists an indicator, as well as a corresponding scale of one (1) to four (4) with “1” representing the highest risk and “4” representing the lowest risk. **Exception:** Friction and Shear are ranked on a scale of one (1) to three (3).

For each row, select a score that best describes the patient. The score should consist of a whole number only and is documented clearly in the corresponding box in the same row. Add the six (6) sub scores together and enter the total score at the bottom.

Who Should Complete the Braden Scale?

The Braden Scale should be completed by a health care professional.

Conduct initial assessments and re-assessments as per Appendix 1: *Conducting Pressure Ulcer Risk Assessment and Reassessment.* Place the completed form into the patient’s chart.

The assessor must score, initial, and date where indicated.

Implementing Pressure Ulcer Prevention Strategies

Based on the Braden Scale score, reassess the level of risk by repeating the Braden Scale (see Appendix 1) and determine and implement appropriate pressure ulcer prevention strategies (see Appendix 2).

<table>
<thead>
<tr>
<th>Score</th>
<th>Risk</th>
<th>Repeat Braden Scale and Implement Prevention Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>9 or lower</td>
<td>Very High Risk</td>
<td>Yes, see Appendices 1 &amp; 2</td>
</tr>
<tr>
<td>10-12</td>
<td>High Risk</td>
<td></td>
</tr>
<tr>
<td>13 – 14</td>
<td>Moderate Risk</td>
<td></td>
</tr>
<tr>
<td>15-18</td>
<td>Mild Risk</td>
<td></td>
</tr>
</tbody>
</table>
The SKIN bundle is meant for use across all areas of care in the organization and will be implemented where a patient/client is deemed at risk of pressure injuries as indicated by use of an assessment tool or by clinical judgement. Start with the SKIN bundle which prompts consideration of all the health factors involved in maintaining skin integrity then reassess further preventative interventions that may be required for an individualized patient of care.

**Risk and skin assessment and clinical judgment followed by SKIN!**

**Surface Selection:** Pressure Injuries are typically caused by sitting or lying in one position for too long. Assess the need for a therapeutic surface. Refer to the therapeutic surface algorithm to choose the appropriate surface for your patient. Surfaces do not replace the need for turning and repositioning or heel off-loading. Assess the seated surface and consider implementing cushions for redistribution of pressure.

**Keep Moving:** Whether you can walk independently, are dependent on others to move you, or a combination of both- regular movement can greatly reduce your risk of developing a pressure injury. Healthcare professionals will assist you if you are unable to do this and may ask you to walk with them if you are able.

**Incontinence:** Being incontinent is a well-known risk factor in the development of pressure injuries. Your healthcare professional will assist you in managing incontinence and will provide skin barriers to protect your skin. The goal is to clean and protect your skin from the damage from incontinence, moisture, heat and humidity.

**Nutrition and Hydration:** Your risk of developing a pressure injury is far greater if you are not eating and drinking well, and the chances of it healing quickly are much reduced if you have a pressure injury. Your healthcare professional will assess you for this and will ensure that a Nutritional Assessment/Consult is provided.

Designed to help everyone think about the key elements of pressure injury prevention: Assess (Risk and Skin), then SKIN: Surface, Keep Moving, Incontinence and Nutrition. These components routinely form the core aspects upon which educational interventions in pressure injury preventative care practices are based.
### Appendix 3: Pressure Injury Prevention Strategies for Adult Patients

<table>
<thead>
<tr>
<th>Table A: Strategies for Adult Patients at High, Moderate, and Low Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>VERY HIGH RISK Braden 9 or less</strong>&lt;br&gt;High Risk Score 10-12&lt;br&gt;interRAI PURS score</td>
</tr>
<tr>
<td><strong>Minimize or Eliminate, Pressure, Shear, Friction and Moisture</strong></td>
</tr>
<tr>
<td>o Mobilize patients/clients as often as possible;</td>
</tr>
<tr>
<td>o Use a pressure redistribution surface decision algorithm (if available) OR refer to an OT, PT or local wound expert to determine the need for pressure redistribution surface;</td>
</tr>
<tr>
<td><strong>AND follow the strategies below:</strong></td>
</tr>
<tr>
<td>o Offer toileting assist as necessary to maintain continence or check for incontinence every 2-4 hours and change incontinence product if soiled or wet. Evaluate contributing factors for urinary and/or fecal incontinence; assess, prevent or manage Incontinence Associated Dermatitis (IAD).</td>
</tr>
<tr>
<td>o Use trapeze when not contraindicated.</td>
</tr>
<tr>
<td>o Protect sacral / perineal wounds from feces and urine.</td>
</tr>
<tr>
<td>o Do lateral transfers / bed repositioning with a transfer sheet (such as TAP or Air Tap/ lift, Be-Lite or positioning sling).</td>
</tr>
<tr>
<td>o Consider using prophylactic foam dressings to bony prominences or under medical devices.</td>
</tr>
<tr>
<td>o Select non-plastic-backed underpads or briefs to wick incontinence moisture away from the skin versus trapping moisture against the skin, which causes maceration.</td>
</tr>
<tr>
<td><strong>Moderate Risk 13-14</strong></td>
</tr>
<tr>
<td><strong>At Risk 15-18</strong></td>
</tr>
<tr>
<td><strong>Scores of 18 or less are considered to be at risk</strong></td>
</tr>
<tr>
<td><strong>interRAI PURS score 1-3</strong></td>
</tr>
<tr>
<td><strong>Re distribute &amp; Minimize Pressure</strong></td>
</tr>
<tr>
<td>o Reposition every 2 hours (as a starting point) if patient/client unable to get up and mobilize.</td>
</tr>
<tr>
<td>o If on a pressure redistribution surface, reposition every 2-4 hours depending on individual patient’s intensity of tissue loading, illness severity and surface type.</td>
</tr>
<tr>
<td>o Suspend heels above the mattress, using pillows or pressure relief boots, even if a pressure redistribution surface is used.</td>
</tr>
<tr>
<td>o Consider patient’s height and weight in bed selection. (For patients over 300 pounds, evaluate need for bariatric bed or appropriate size support surface.)</td>
</tr>
<tr>
<td>o Maintain or enhance patient’s level of activity. (Consult PT to collaborate with Nursing.)</td>
</tr>
<tr>
<td>o Keep linen clean, smooth and dry; minimize layers of linen between the support surface and patient’s skin, avoid tucking in sheets or blankets to allow patient to move freely to avoid shear.</td>
</tr>
<tr>
<td>o Use pillows / foam slabs to avoid contact between bony prominences; consider prophylactic foam dressings to sacrum or heels.</td>
</tr>
<tr>
<td>o Keep skin clean and dry. Provide routine skin care and moisturize skin daily.</td>
</tr>
<tr>
<td>o Develop and document individualized care plan.</td>
</tr>
<tr>
<td>o Minimize or eliminate pressure from medical devices such as oxygen masks, tubing, restraints, splints, etc.</td>
</tr>
<tr>
<td><strong>Patients in bed</strong></td>
</tr>
<tr>
<td>o Use devices to optimize independent repositioning and transfers.</td>
</tr>
<tr>
<td>o Inspect skin when repositioning, toileting and assisting with Activities of Daily Living (ADL).</td>
</tr>
<tr>
<td>o Elevate head of bed (HOB) 30° or less for short periods only for bedfast patients, unless contraindicated.</td>
</tr>
<tr>
<td>o Do not position patient directly on the greater trochanter (bony prominence of the hip).</td>
</tr>
<tr>
<td><strong>Patients in sitting position</strong></td>
</tr>
<tr>
<td>o Use elbow and heel protectors (do not use white heel covers with straps).</td>
</tr>
<tr>
<td>o Use foam wedges or pillows to support lateral 15-30° tilt.</td>
</tr>
<tr>
<td>o Reposition every 1-2 hours / incorporate frequent small shifts in position between turns - regardless of support surface.</td>
</tr>
<tr>
<td>o Reposition chair bound immobile patient every hour, use support surfaces on chair and limit sitting to 1-2 hours intervals.</td>
</tr>
<tr>
<td>o Remove slings and transfer or therapeutic aids from under the patient.</td>
</tr>
<tr>
<td>Sensory Perception Sub-scale equals 3 or less</td>
</tr>
<tr>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>Consider a pressure redistribution surface if mobility and sensory sub scales both score 1. Minimize, or eliminate when possible, pressure from bony prominences or extremities. Collaborate with OT and PT. Consider pressure redistribution surface for OR table for surgeries greater than 90 minutes.</td>
</tr>
</tbody>
</table>

Refer to local wound expert for:
- New or deteriorating wound
- Yeast/bacterial infection
- Unresolved moisture associated skin damage
- Assistance with precaution planning
Appendix 4

Acute Care: Initial Risk Assessment and Reassessment Frequency

Minimum Requirements for Pressure Injury Prevention Pathway of Risk Assessment

<table>
<thead>
<tr>
<th>Patient Population</th>
<th>Risk Assessment Tool</th>
<th>Initial Risk Assessment Standard</th>
<th>Reassessment Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute (including those assessed for “Alternate Levels of Care” /Sub-acute (In the acute care setting))</td>
<td>Braden Scale</td>
<td>Within 8 hours of Emergency Inpatient Status (EIP)</td>
<td>ER/Critical Care: Reassess q12h</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Within 8 hours of ICU admission</td>
<td>Acute/Sub-acute, Rehabilitation: Daily</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Upon transfer to unit</td>
<td>Pre-operatively and post-operatively</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mental Health: Weekly</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ambulatory: Weekly</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Alternative Level of Care: Weekly</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Hospice/Palliative Care: Monthly Palliative Performance Scale to trigger more frequent reassessments</td>
</tr>
</tbody>
</table>

Receiving unit to complete a risk assessment with any new transfer.

Reassess risk assessment when a major change that is not self-limited affects patient’s health status.

Members of the Provincial Injury/Ulcer Prevention team are available to support health care providers in determining alternative best practice risk assessment frequencies that reflect characteristics of the patients/populations they serve. Contact Marlene.varga@covenanthealth.ca

Revised December 2018
### Initial Assessment on Admission

**ROP requires a PURS or Braden Scale screen during initial visit**

<table>
<thead>
<tr>
<th>Home Living</th>
<th>Supportive Living</th>
<th>Home and Private Supportive Living</th>
<th>Facility Living</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LT Supp/Maintenance Client Groups</strong></td>
<td><strong>LT Supp/Maintenance Client Groups</strong></td>
<td><strong>Acute, Rehab, End of Life, and Pediatric Client Groups</strong></td>
<td><strong>Wellness Client Group</strong></td>
</tr>
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<td><strong>Home Living</strong></td>
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<td><strong>Wellness Client Group</strong></td>
</tr>
</tbody>
</table>

All clients will have a pressure injury risk assessment completed upon admission to a Continuing Care program. Discuss Pressure Injury risk score and any recommended interventions with resident/family for care plan development. Provide education to the client/family/caregivers on the risk factors and strategies for prevention of pressure injury.

RAI-HC is completed upon admission which will generate a PURS score. Recommend to do a Braden on clients with a PURS score 2+. Initiate interventions for Braden 18 or less.

RAI-HC is completed within 14 days of admission which will generate a PURS score. Recommend to do a Braden on clients with a PURS score 2+. Initiate interventions for Braden 18 or less.

Note: Alternate recommendation: Complete Braden upon admission. Initiate interventions for Braden 18 or less. If PURS 2+, review interventions and adjust as needed.

Recommend including pressure injury screening questions as part of the initial comprehensive assessment.

Recommend to do a Braden (Braden Q for Peds) when a concern is identified and client is unable to self-manage their care.

Initiate interventions for Braden score of 18 or less.

Recommend a Braden upon admission. If they have a score of 18 or less, and are unable to self-manage their care, the client may have needs that would indicate they no longer qualify for the wellness client group. Initiate interventions for Braden score of 18 or less.

Recommend no screening as support with STAC clients is focused and short term.

Recommend Braden or paper PURS completed upon admission. Must be RAI trained to complete PURS.

RAI 2.0 completed within 14 days of admission.

Initiate interventions for Braden 18 or less or a PURS 1+. Recommend completing a Braden upon admission. Initiate interventions for Braden score of 18 or less.

Recommend completing a Braden upon admission. Initiate interventions for Braden score of 18 or less.
### Reassessment:

<table>
<thead>
<tr>
<th>Home Living</th>
<th>Supportive Living</th>
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<th>Facility Living</th>
</tr>
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<tr>
<td>LT Supp/Maintenance</td>
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<td>Acute, Rehab, End of Life, Pediatric, Wellness</td>
<td>Short Term Acute Client (STAC)</td>
</tr>
<tr>
<td>Long Term Care</td>
<td>Sub-acute and Restorative Care</td>
<td>Hospice</td>
<td></td>
</tr>
</tbody>
</table>

**Evaluate the effectiveness of interventions at regular intervals, as clinically appropriate for that intervention.** Interventions may or may not impact the PIP risk score when effective, but should be adjusted if they are not meeting the identified need.

**Repeat the appropriate pressure injury risk assessment at routine reassessment intervals.**

**Provide education to the client/family/caregivers on the risk factors and strategies for prevention of pressure injury.**

- When a Braden score is 18 or less:
  - Reassess quarterly using Braden
  - Reassess and/or initiate interventions for pressure injury prevention
- When a Braden score is 18 or less:
  - Reassess quarterly using Braden
  - Reassess and/or initiate interventions for pressure injury prevention
- When a major change that is not self-limited affects client's health status, complete a full RAI-HC reassessment.

**RAI-HC completed annually which will generate a PURS score. Complete Braden on clients with a PURS score ≥2.**

- Complete Braden following an acute care admission that resulted in change in client status - short term or long term. Reassess interventions and equipment as required.
- When a major change that is not self-limited affects client's health status, complete a full RAI-HC reassessment.

- When a Braden score is 18 or less:
  - Reassess monthly using Braden
  - Reassess and/or initiate interventions for pressure injury prevention
- When a major change that is not self-limited affects client's health status, complete a full RAI-HC reassessment.

- When a Braden score is 18 or less:
  - *Reassess monthly using Braden
  - Reassess and/or initiate interventions for pressure injury prevention
- When a major change that is not self-limited affects client's health status, complete a full RAI-HC reassessment.

- When a Braden score is 18 or less:
  - *Reassess monthly using Braden
  - Reassess and/or initiate interventions for pressure injury prevention
- When a major change that is not self-limited affects client's health status, complete a full RAI-HC reassessment.

**RAI 2.0 completed quarterly which will generate a PURS score. Initiate interventions for a PURS score of 1+ when a major change that is not self-limited affects client's health status, complete a full RAI 2.0 reassessment.**

**Optional:**
- Complete Braden/paper PURS following an acute care admission that resulted in significant change in client status - short term or long term. Reassess interventions and equipment as required.

- When a Braden score is 18 or less:
  - *Reassess monthly using Braden
  - Reassess and/or initiate interventions for pressure injury prevention

- When a Braden score is 18 or less:
  - *Reassess monthly using Braden
  - Reassess and/or initiate interventions for pressure injury prevention

**Note:** more frequent reassessments (ie less than monthly) may be completed using available palliative tools.

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*Recommendation: Most recent Braden completed in acute care to be forwarded to receiving site in order to assist with transition and act as a point of reference.*