

## Pressure Injury Prevention Procedure

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## Purpose

To provide best practice direction for health professionals on pressure injury prevention and management.

The CDHB will adhere to their organisational requirements and Ministry of Health (MOH) and the Accident Compensation Corporation (ACC) direction on pressure injury prevention and management, outlined in this procedure.

## Scope

CDHB staff. Students working in the CDHB.

Excluded: Community providers e.g. NGO's who will be directed by [Community Health Pathways](#) and their own organisational policies and procedures.

## Definition

**Pressure Injury:** Localised 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 and/or 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.

## Associated documents

[Graduated Compression Stockings \(TED's\)](#)

[Screening Tools and Management flipchart](#) ref: 3365

[Pressure Injury: Care planning guidance](#)

[Pressure Injury: management categories](#) ref: 2310840

Medical Illustrations photographing policy within the Informed Consent Policy

Agreement to clinical photography, digital imaging and video recording

(Clinical imaging) form Ref. 0947

General Photography / Video Filming Consent form Ref: 3228

New Zealand Wound Care Society Public resources

Preventing Pressure Injuries - Child Health resource

CDHB Malnutrition Guidelines

Chronic Spinal Cord Impairment Assessment form

Prescription Footwear procedure - Burwood

## Pressure Injury Prevention

### Roles, responsibilities and staff education

Pressure injury prevention and management is a fundamental element of health care provision.

Staff are required to update their knowledge and skills on pressure injury prevention and management i.e. by utilising organisational education such as HealthLearn module or attend tertiary education.

Pressure injury prevention and management is a collaborative approach between the interdisciplinary team and the patient/whanau.

It is the responsibility of all health professionals to document potential or actual risk to minimise harm from pressure injuries and communicate prevention strategies with the interdisciplinary team and patient whanau.

All members of the interdisciplinary team must document and report any risks or skin integrity concerns to the patient's nurse/key health professional.

### Initial assessment requirements (within 6-24hrs from presentation)

There are six components to the initial assessment of patients/clients

1. A Risk Prediction screen
2. Clinical judgement and relevant co-morbidities and their health status that will impact the person's pressure injury risk
3. Skin assessment
4. Pain assessment
5. Malnutrition risk screen
6. Mobility/Manual handling assessment

#### 1. Risk assessment prediction

All patients/clients must have a risk assessment completed on initial presentation/admission/transfer and if the person's health status changes.

This will include using a validated risk prediction tool for example the Braden, Waterlow, PURPOSE T (V2), Glamorgan, or InterRai tools as directed by the organisation

#### 2. Clinical Judgment of all relevant risk factors

Clinical judgement must be used in conjunction with a risk screening and will determine the 'real' risk of developing pressure injuries.

These co morbidities/clinical conditions would include, but are not exhaustive:

Diabetes	Frailty
Poor perfusion	Current or previous pressure injury
Peripheral Vascular Disease	Malnutrition and risk of malnutrition
Incontinence- Bowel or Bladder	Altered Level of Consciousness/anaesthetic/intubation
Motor/Sensory Impairment	Low Body Mass Index (BMI)

Autoimmune disorders	Fractured Neck of Femur
Immunosuppression	Acutely ill
Spinal injuries	Obesity
Anaemia	Cognitive impairment – dementia, delirium, intellectual disability
Motor agitation	Requiring enteral feeding
Single or multiple organ failure	Oedema
Amputees	Chronic Obstructive Respiratory Disease

### 3. Skin assessment

- On admission or transfer the patient or whanau must be asked if they have any skin integrity issues and a visual skin assessment completed.
- A full skin assessment must be performed on patients that are identified 'at risk' using the five components of a comprehensive skin assessment (temperature, turgor, colour, moisture and skin integrity)
- This skin assessment must be documented
- Any bandages, socks, or medical devices should be removed to assess the skin, ensuring appropriate and safe removal of braces and collars.
- Consider preventative dressings on 'at risk' areas – if these are used they must be reviewed on a daily basis and documented
- Subsequent skin assessment must occur according to the persons' skin integrity and pressure injury risk management plan
- Moderate and high risk patients must have skin assessments every 8hrs/every opportunity

Opportunities to assess skin include:

- Hygiene cares
- Toileting
- Before applying medical devices
- At Intentional rounding
- With position changes
- Observation monitoring
- Treatments such as dressing changes
- Post-operatively (particularly following long surgeries)

Medical devices where skin assessment is required include, but are not exhaustive to:

- TEDs/venous embolism stockings
- Casts
- Splints

- Collars
- Catheters – urethral and suprapubic
- Intravenous cannulas
- Oxygen tubing and masks
- CPAP masks
- Endotracheal tubing
- Enteral feeding tubes
- Negative Pressure Wound Therapy devices and tubing
- Pulse oximeters and Blood Pressure cuffs
- Wheelchairs
- Prosthesis/Orthotics/and or general footwear

#### **4. Pain assessment**

A pain assessment must be completed concurrently with the skin assessment to determine skin integrity issues

Medical devices – identify pressure and friction issues

#### **5. Malnutrition risk screen and Hydration monitoring**

A validated malnutrition risk screening tool (MST) should be used within a pressure injury assessment to identify those at risk malnutrition.

If a patient has an MST score of  $\geq 3$  a referral to the dietitian should be made for an assessment and nutrition intervention as per CDHB malnutrition policy

If a patient has an MST score of  $\leq 2$ , staff must follow the malnutrition screening tool action flow chart and implement the appropriate nutrition plan based on the malnutrition risk score.

Nutritional status deteriorates during hospital stays and therefore rescreening for malnutrition should occur every 5 days for those with an initial MST score of  $\leq 2$ .

Fluid balance assessment and ongoing monitoring where patient is at risk of dehydration e.g. Diarrhoea, fever, specific treatments.

Achieved by commencing a food and fluid chart or fluid balance chart depending on clinical judgement.

#### **6. Mobility/Manual Handling**

This assessment must include a review of their bed mobility, the use of any manual handling equipment and the patient's general mobility to determine a mobility plan, or turning plan. For example motor agitation that may increase their risk of friction and shear, their ability to mobilise in and out of bed without compromising their skin, the safe use of equipment to promote mobilisation

Consider a referral to the Occupational/Physio Therapist for special seating particularly if using a wheelchair or if the patient has a neurological condition.

If the patient has any deeper pressure injuries with bone involvement the patient's weight bearing status must be recorded by the Medical Officer.

### **Health literacy and education**

If the patient is at risk of pressure injuries a discussion must occur with the patient on their individual risk/s and management strategies, where possible include the whanau/carer in this discussion. A discussion of their risks, may include:

- Their relevant co-morbidities e.g. poor perfusion, diabetes
- Their change in health state
- Lifestyle choices

Educate the patient on the following strategies as appropriate

- Moisture management
- Regular Mobilising
- Their current skin status
- How to check their skin integrity themselves
- Position changes – frequency and length of time
- Mobility plan – frequency and length of time between bed to chair, and walking frequency
- Friction and shear risks, safe mobility and manual handling
- Hydration
- Nutrition
- Device use
- Inform the patient to tell staff if they have any pain/discomfort or numbness anywhere

The New Zealand Wound Care Society Public resources/ Preventing Pressure Injuries - Child Health resource are to be utilised as part of the resources required to educate the patient and their family on pressure injury prevention.

Additionally, please utilise local/hospital resources

### **Care planning roles and responsibilities**

- Care planning is to occur with the patient and, where possible, whanau
- Care planning must address the individual's assessed risk and align with appropriate management strategies
- Refer to the Guidance document on care planning for pressure injury prevention and management
- If possible the care plan should include direction on the rotation of medical devices e.g. pulse oximeters, gastrostomy tubes

- A plan must include a preventative dressing underneath a medical device on devices that cannot be rotated e.g. CPAP masks, peripheral cannula, indwelling catheters
- A plan must include frequency of skin checks according to the patients risk and use of medical devices

### **Incontinence associated dermatitis (IAD)**

- A significant number of patients with IAD are often mistaken for Stage 2 Pressure Injuries.
- Report IAD as a skin injury not a Stage 2 pressure injury
- Management of IAD
- Use non perfumed skin products and skin barriers
- Ensure the care plan identifies how to appropriately manage the patient's incontinence e.g. utilise appropriately sized male external catheters where possible
- Incontinence products are medical devices, therefore strategies should be applied for the care plan for changing these regularly

### **Reassessments**

- Ongoing assessments will include skin, pain and device review at least every 8 hrs

And

- If the patient's condition/ mobility deteriorates, or they experience altered sensation e.g. oedema, regional anaesthesia

Reassessments will include an evaluation of the prevention plan. This could include a change in plan according to deterioration or improvement

### **Internal referrals for pressure injury prevention**

Referrals for pressure relieving mattresses should be ordered on individual need and may not necessarily be required in relation to their risk screen e.g. not all people that are at a high risk require a pressure relieving mattress. For example a person who is mobile and cognitively intact may require a mobility and positioning plan rather than a pressure relieving mattress. They may just require a pressure relieving cushion as they are sitting up more than lying in bed.

- A referral to the dietitian should be made if the person has poor wound healing or if the patient has been identified as having malnutrition or being at risk of malnutrition when screened
- A safe mobility plan is an essential component in prevention and reduction of friction and shear. Consider consulting a physiotherapist for advice if having any difficulty developing a mobility, safe handling or positioning plan.
- Where feet/ footwear is an ongoing issue consider a referral to orthotics/diabetes podiatrist. In Burwood Hospital follow your specific policy on Prescription footwear ref 2310243.

- An Occupational Therapist must be involved where the person requires assistance to improve independence with activities of daily living (ADLs) and/or where relieving devices are required in facility or domiciliary circumstances.
- Contact your Link Staff/Wound specialists or manager to advice on skin issues that have the potential of developing into pressure injuries

### **Discharge planning with pressure injury risk**

- Ensure a skin inspection is completed immediately before discharge to ensure that the patient's current state is addressed before discharge or transfer.
- Report 'at risk' skin, any protective dressings being utilised, and risk of malnutrition and mobility or incontinence issues to the primary health care provider's e.g. nursing service, palliative care team, GP, dietitian, physiotherapist
- Ensure that all devices for use to prevent pressure injuries are available before discharge, these could include specialised pressure relieving equipment, orthotics etc.
- Send 2 days of protective dressing equipment with the patient for the community nursing service.
- Involve the Occupational Therapist early where the patient requires short or long term pressure relieving equipment, a home or ARC visit may be required.
- Involve the Nurse Maude dietitian service where ongoing nutritional support is required.
- Contact the ARC facility early to ensure the facility can organise pressure relieving equipment in a timely manner.

## **Pressure Injury Management**

### **Identification and reporting of Pressure injuries**

Pressure injuries must be staged according to the National Pressure Ulcer Advisory Panel (America) and the European Pressure Ulcer Advisory Panel CLASSIFICATION SYSTEM at identification of a suspected pressure injury

[Stages](#)

[Staging Illustrations](#)

Where staging requires expert clarification, refer to wound nurse consultant/specialist for confirmation and management plan.

### **CDHB reporting requirements**

All pressure injuries and IAD must be reported through the organisation's incident management system (Safety 1<sup>st</sup>)



## ACC reporting requirements

Pressure injuries that occur as a result of an accident or treatment injury of Stage 2 and above, need an ACC claim to be lodged by the DHB (even if the PI occurred at another facility or the patients 'home', and a claim has not been lodged).

If the pressure injury occurred as the result of an accident e.g. a personal accident where the patient fell while taking themselves to the bathroom and a PI occurred from a long lie.

- Complete an ACC45 to register the claim and send to ACC
- If the Pressure Injury occurred as a result of a Treatment Injury (under the care or direction of a Registered Health Professional) e.g. Stage 4 sacral pressure injury as a result of inconsistent assessment during an inpatient stay
- Complete an ACC45 to register the claim

### AND

- Complete an ACC2152 Treatment Injury form
- Forward completed forms to Katrina Logan, Patient Information Office, Christchurch Hospital

[Click here](#) for a sample ACC45 form

[Click here](#) for a sample ACC2152 form

## Retrograde staging

- As a pressure injury heals it should be documented as a healing stage (eg. Healing stage 4) i.e. that the pressure injury is not downgraded e.g. from stage 4 to 3.

## Documentation of pressure injuries

The correct terminology used in documentation is essential for management and coding purposes

The following terminology must be used in documentation:

- A stage 1 pressure injury is recognised as NON blanchable skin and must be documented as NON BLANCHABLE ERYTHEMA
- A stage 2 pressure injury is recognised as a CLEAR fluid filled blister or as a partial thickness skin loss which must be documented as a PRESSURE INJURY blister or PRESSURE INJURY partial thickness skin loss
- A Stage 3 pressure injury is recognised by full thickness skin loss that doesn't include fascia, tendon, joint or bone and must be documented as PRESSURE INJURY full thickness loss
- Stage 4 pressure injury is recognised by full thickness WITH fascia, tendon, joint or bone involvement and must be documented as PRESSURE INJURY full thickness with deep structure involvement
- An Unstageable pressure injury is where the depth is unknown because you cannot see the wound bed. It may be covered by slough and/or

eschar. This must be documented as an UNSTAGEABLE PRESSURE INJURY.

- A suspected deep tissue injury is usually a BLOOD filled blister or skin that is maroon or purple in colour and must be documented as a SUPECTED DEEP TISSUE PRESSURE INJURY

### **Management of pressure injuries**

- There is an increased risk of further pressure injuries where a patient has already developed them.
- The 6 components of pressure injury assessment should be undertaken at least 8 hourly/each shift and reviewed at every possible opportunity
- Prevention strategies in the care plan should be continued and adjusted according to the patient's condition
- A legal photographic image must be obtained for all pressure injury stages, with the patient's written consent (ref 0947). Place a colour photograph in clinical notes and add image to the incident management system as able (i.e. Safety 1<sup>st</sup>).
- Pressure injuries must be identified using a management form that covers their location/s, size, depth, duration, wound bed assessment, assessment of surrounding skin and protective or dressing requirements, with a frequency for review

### **Guidance for managing specific classifications**

- Follow the Guidance document on management of pressure injuries
- Contact your local link staff/wound care specialist for any advice on management
- Encourage the involvement of the multidisciplinary team who include the medical and allied health teams.

### **Discharge Planning for Pressure injury Management**

- Ensure a skin inspection is completed immediately before discharge to ensure that the patient's current state is addressed before discharge or transfer.
- Report 'at risk' skin, any protective dressings being utilised, and risk of malnutrition and mobility or incontinence issues to the primary health care provider's e.g. nursing service, palliative care team, GP, dietitian, physiotherapist
- Send 2 days of protective dressing equipment with the patient for the nursing service.
- Involve the Occupational Therapist early where the patient requires short or long term pressure relieving equipment, a home or ARC visit may be required.
- Involve the Nurse Maude dietitian service where ongoing nutritional support is required.

- Ensure that a patient using any pressure relieving devices/equipment or orthotics are available on discharge
- Contact the ARC facility early to ensure the facility can organise pressure relieving equipment in a timely manner.

### **Measurement or Evaluation**

Canterbury and West Coast sector audit programmes with regular governance reviews.

Health Quality and Safety Commission Quality Safety Marker benchmarking with other regions.

Incident Management reviews.

### **References**

Guiding principles for pressure injury prevention and management in New Zealand May 2017 retrieved 29.8.2018

National Pressure Ulcer Advisory Panel Pressure Injury Stages retrieved 29.8.2018

Prevention and Treatment of Pressure Ulcers: Quick Reference Guide retrieved 20.9.2018