Pressure Injury Assessment, Prevention, and Management Procedure

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Purpose

To provide best practice guidance for health professionals on pressure injury assessment, prevention, and management.

For all health professionals working for Health New Zealand Canterbury and West Coast must assess, prevent, and manage pressure injuries.

And these health professionals must adhere to the guidelines set by:

- Health New Zealand Canterbury and West Coast (organizational requirements)
- Ministry of Health (MOH)
- Accident Compensation Corporation (ACC)
- Health Quality and Safety Commission (HQSC)
- International Pressure Injury Prevention and Treatment Guidelines.

Applicability

All Health New Zealand Canterbury and West Coast staff and students working in these organisations.

Excluded: Canterbury and West Coast community providers e.g., NGO’s who will be directed by Community Health Pathways and their own organisational policies and procedures.

Pressure injury assessment, prevention, and management requires collaboration between the multidisciplinary team and the patient/whānau.

Health professionals are required to assess, document, and communicate patient risks to minimize harm from pressure injuries.

The entire multidisciplinary team must report skin integrity concerns to the patient's nurse/nurse in charge/key health professional.

Definitions

Pressure Injury is defined as localised damage to the skin and/or underlying tissue, as a result of pressure or pressure in combination with shear. Pressure injuries usually occur over a bony prominence but may also be related to a medical device or other object.

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.

Intertrigo (intertriginous dermatitis) is an inflammatory condition of skin folds, induced or aggravated by heat, moisture, maceration, friction, and lack of air circulation.

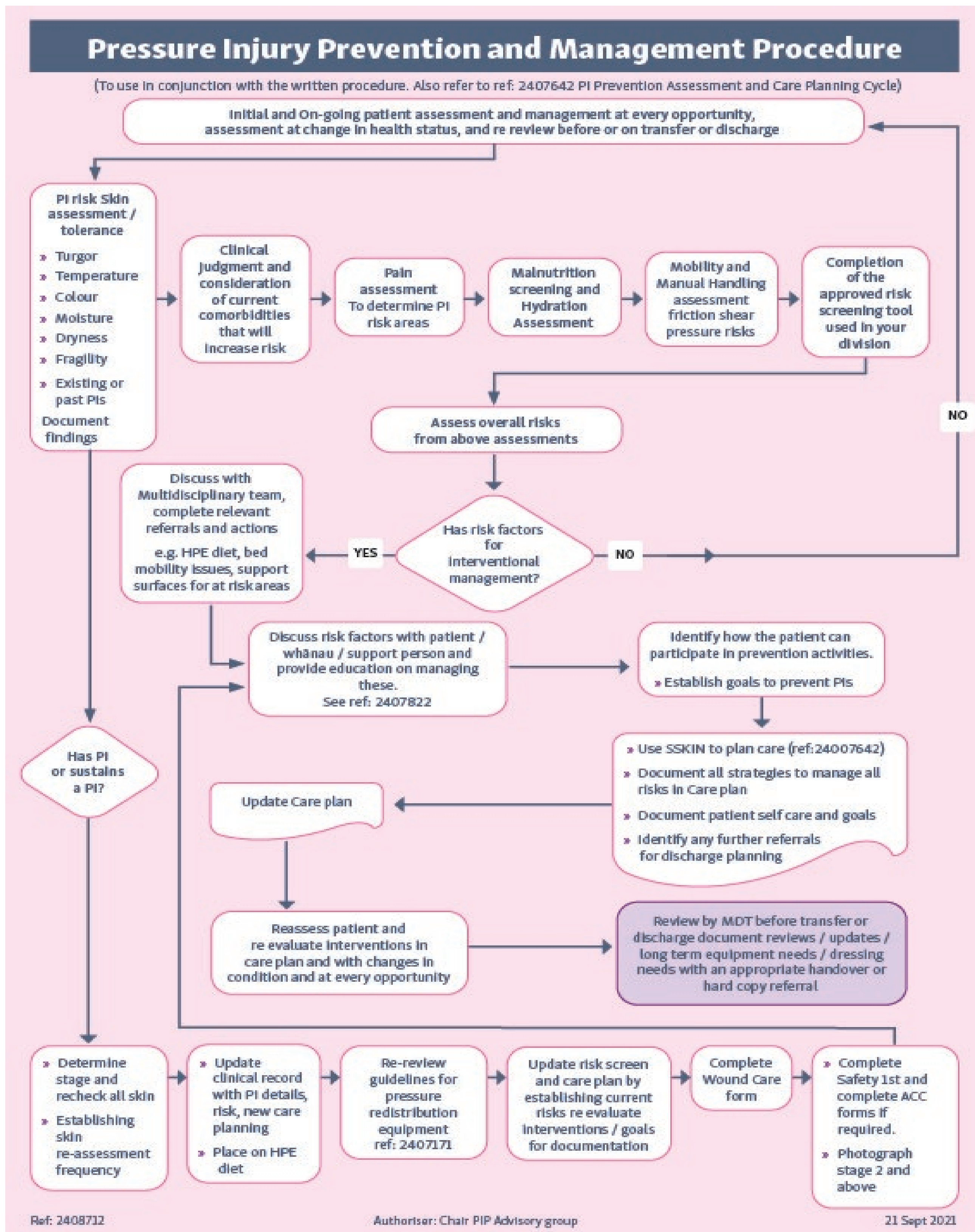
Incontinence-associated dermatitis (IAD) is a form of irritant contact dermatitis due to contact with urine and faeces in people who are incontinent of urine or faeces or both (dual incontinence).

It may also be referred to as excoriation.

Multidisciplinary Team (MDT) will be used throughout this document and covers the interdisciplinary team.

Procedure Flowchart

Refer to Pressure Injury Prevention Procedure Flowchart Ref: 2408712.



Education and Training

Pressure Injury Assessment, 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 e.g., by utilising organisational education such as HealthLearn modules or attend tertiary education.
- Staff must complete the Pressure Injury Prevention Self Learning Package on HealthLearn as part of the clinical orientation programme, to complete within 6 months of starting.
  - ✓ Pressure Injury Prevention RGMD007
  - ✓ Pressure Injury Prevention – the SSKIN Model RGCL003
- Staff can learn more and find helpful resources about preventing pressure injuries through the Pressure Injury Prevention Community of Practice FMMS0014 on HealthLearn.
- Staff can access resources for themselves and their patients on the *Pressure Injury Prevention SharePoint* site

ASSESSMENT REQUIREMENTS

There are six components to the assessment of patients/clients/consumers as follows:

1. Pressure Injury Risk Screen
2. Clinical judgment, co-morbidities, and health status influence pressure injury risk.
3. Skin Assessment
4. Pain Assessment
5. Malnutrition Risk Screen and Hydration Monitoring
6. Mobility and Manual Handling Assessment

Below are detailed requirements for components in the Initial Assessment (within 6 hours of admission to hospital or sooner if clinically indicated) and Ongoing Assessment, as follows:

1. Pressure Injury Risk Screen

All patients/clients must have a risk screen completed on initial presentation/admission/transfer from any area within or from outside the hospital and if the person's health status changes or they develop a pressure injury.

This will include using a validated risk screening tool for Pressure Injury such as: Braden Scale, 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 tool and will determine the 'real' risk of developing pressure injuries.

Examples of these *clinical conditions* include, but are not limited to:		
Current or previous pressure injury	Incontinence – Bowel or Bladder	Malnutrition or risk of malnutrition
Motor/ Sensory Impairment	Fractured Neck of Femur	Requiring Enteral Feeding
Spinal Injuries	Motor Agitation	Low Body Mass Index (BMI)
Peripheral Vascular Disease	Acutely ill	Obesity
Poor Perfusion	Frailty	Diabetes

Amputees	Palliative Care	Anaemia
Oedema	Single or multiple organ failure	Autoimmune disorders
Chronic Obstructive Pulmonary Disease	Cognitive Impairment (dementia, delirium, intellectual disability)	Immunosuppression
Altered Level of Consciousness/Anaesthetic/Intubation		

3. Skin Assessment

Upon admission or transfer, with patient consent, inquire about skin integrity and seek permission to visualise skin. As appropriate, involve family and whānau in discussions.

A full skin assessment must be performed as part of determining the risk, using the five components of a comprehensive skin assessment as follows:

✓ Temperature	✓ Moisture and Skin Integrity	✓ Colour which includes circulation to lower limbs
✓ Turgor	✓ All Pressure points (bony prominence) and skin under devices/dressings	✓ Skin status – dry or frail, existing pressure injury, or healed pressure injury

All the above facets of skin assessment will identify the person's skin tolerance to pressure, friction, and shear.

A **skin tolerance assessment** guides the assessor in determining position change frequency, proper device usage and rotation, correct sizing and use of incontinence aids, and clinically suitable pressure redistribution equipment/devices.

- Skin intolerance issues will be identified by persistent blanching erythema and/or marking, if this occurs, a review for upgrade in surfaces/mattress is required.
- Refer to the PI Prevention Assessment Guidelines for Equipment Ref: 2407171 on assessment of skin tolerance and equipment guidance, and the Support Surface Recommendations for At Risk Areas Ref: 2408710 for further care direction/support options.

NB: Skin Assessment **must be documented each shift,** and subsequent skin assessment must occur according to the patient's risk management plan for skin integrity and pressure injury.

Opportunities to assess skin include:			
✓ Hygiene cares	✓ At Intentional rounding	✓ Observation monitoring	✓ Post-operatively (particularly following long surgeries)
✓ Toileting	✓ Position changes	✓ Before applying medical devices	✓ Treatments such as dressing changes

Wound Dressings that have been reviewed should remain intact until the planned review date and documented in the clinical record. e.g., Negative Pressure Wound Therapy (NPWT) dressings should remain undisturbed to prevent patient distress and wound dressing disruption.		
Wound Dressings include, but are not limited to:		
✓ Absorbent Pad	✓ Gelling Fibers	✓ Negative Pressure Wound Therapy (NPWT) dressing
✓ Island dressings	✓ Self-Adherent Soft Silicone Foam	✓ Non-silicone low adherent mesh

Consider ***preventative dressings*** on 'At Risk' areas – if these are used, it must be reviewed on a daily basis or as per facility/area protocol and documented in the clinical record. **NB:** This includes looking under the preventative dressing each shift. Moderate and High-Risk patients must have skin assessments every 8hrs and or every opportunity. **NB**: Natal cleft injuries will be entered into Safety 1st as intertriginous injuries (see definition above)
Preventative Dressings include, but are not limited to: Multi-layered silicone dressing

Assess the skin under and around ***medical devices*** for signs of pressure related injury as part of routine skin assessment. **NB:** Only remove medical devices if it is clinically safe to do so and does not interfere with medical treatment.		
Medical Devices include, but are not limited to:		
✓ Splints	✓ Casts	✓ TEDs/venous embolism stockings /foot pumps
✓ Collars	✓ Braces	✓ Prosthesis/Orthotics and or general footwear
✓ CPAP masks	✓ Endotracheal tubing	✓ Oxygen tubing and masks
✓ Wheelchairs	✓ Intravenous cannulas	✓ Catheters – urethral and suprapubic
✓ Eye Glasses	✓ Enteral feeding tubes	✓ Pulse oximeters and Blood Pressure cuffs

Incontinence Associated Dermatitis (IAD)

Refer to the Skin Care Guide Ref: 2407277 to support appropriate cleansing , skin protection and enhance healing.

Report IAD as a skin injury, not a Stage 2 pressure injury, due to frequent misdiagnosis in patients with IAD.

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 necessitate intervention strategies to mitigate pressure, friction, and shear. These strategies should be documented in the care plan and include appropriate replacement scheduling.

4. Pain Assessment

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

Patients with localised or general neuropathy will not report pain as a symptom.

For medical devices, recognize that pain may result from pressure and friction issues.

5. Malnutrition Risk Screen and Hydration Monitoring

Refer to Identification and Management of Malnutrition in the Hospitalised Adult and Paediatric Patients Policy Ref: 2400321 and Malnutritional Screening Tool Ref: 2407654.

A validated Malnutrition Screening Tool (MST) (to be completed within the first 24 hours) must compliment pressure injury assessment to identify those at risk of malnutrition.

Re-screening of all inpatients should occur every 5 days in an acute hospital and 7 days in a non-acute setting as nutritional status has been shown to deteriorate during hospital stays.

NB: West Coast inpatients have their MST completed in TrendCare and a hardcopy version is completed in the community.

All patients at risk of malnutrition with an MST score of ≥ 2 should be placed on a high protein, high energy diet, if appropriate.

For patients with a pressure injury, additional protein and energy requirements are needed to assist healing and should be placed on the Pressure Injury Protein Energy (PIPE) diet, if appropriate or available.

Monitor hydration with a ***Fluid Balance Chart***, where the input and output must be documented as accurately as possible.

Fluid balance assessment and ongoing monitoring is required where patients are at an increased risk of dehydration e.g., diarrhoea, fever, and/or specific treatments.

Monitor food and fluid intake with a food and fluid chart.

6. Mobility/Manual Handling

This assessment must include a review of their bed mobility, the appropriate use of any manual handling equipment and the patient's general mobility. This is to determine a mobility or repositioning plan.

For example, motor agitation 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.

Do not leave equipment such as slings or air-pals under patients unless clinically warranted. The pressure re-distribution properties of mattresses and cushions is reduced with every extra layer and bunching of the material could cause pressure injuries. Use of pillows or specialist products to redistribute weight onto the calf muscles is recommended to enable heels to "float".

Utilize transfer devices like air-assisted systems, turning aids, or ceiling hoists to prevent friction and shear during transfers.

When sitting someone up in bed at greater than **30 degrees** consider risk to sacrum and heels. Ensure that the **knee break** technique is utilised.

Consider the risk for heel friction when utilising overhead equipment e.g., overhead bed poles or when patients are performing repetitive bed-based exercises. Consider having heels on slide sheets, otherwise they can be dragged up the bed i.e., mitigate friction to all body parts not just under trunk. Lift heels after repositioning to relieve tension.

Consider Occupational Therapist or Physiotherapist referral to support pressure injury assessment, prevention, and management. This includes patient's sitting and/or lying requirements.

Discuss bed/sitting restrictions and/or weight-bearing status with the patient and work with the multidisciplinary team to appropriately manage the risk of the Pressure Injury classification.

Education Videos for Staff, Patient, and Whānau:

SSKIN and Positioning Video (10min) includes chair positioning, knee break, and how to correctly "float" heels.

Staff video on establishing the correct inflation for roho cushions (link)

INTERNAL REFERRALS

All referrals should be based on clinical judgement, risk assessment, and skin assessment.

Referrals for pressure redistribution mattresses and devices should be based on individual need, following skin assessment and clinical judgment.

Specialist support surfaces and devices may not always align with risk prediction levels. For instance, mobile and cognitively intact individuals may need a mobility and positioning plan rather than a pressure redistribution mattress. They might only require a pressure redistribution cushion due to more time spent sitting than lying in bed.

Surgical Referral:

As per Hospital HealthPathways: Pressure Injuries

- If limb ischaemia, request acute vascular surgery review.
- If pressure area with deep cavity, or bone tendon visible, request acute plastic surgery review.
- If the patient has a spinal cord injury, consider requesting spinal cord impairment specialised review.

Wound Care Specialist Referral:

Contact your Wound Care specialists or charge nurse manager to advise on skin issues that have the potential of developing into pressure injuries

- If stage 3 and above pressure injuries are **not improving,** request wound care clinical nurse consultant or clinical nurse specialist assistance or plastic surgery review.

Dietitian Referral:

All patients should be screened for malnutrition.

A referral to a dietitian should be made if malnutrition risk is high:

- MST ≥3 in adult patients in Christchurch Campus, Burwood, and Ashburton Hospitals
- MST ≥2 in adult patients on the West Coast
- PNST ≥ 2 in paediatrics

Also, refer to Hospital HealthPathways Acute Adult Nutrition and Dietetics Assessment for clinical conditions that warrant an acute referral to a Dietitian.

Patients with a diagnosed pressure injury should be referred to a Dietitian as follows:

- ✓ Pressure Injury Stage 3 or 4: Refer to Dietitian in Ashburton, Burwood, and West Coast.
- ✓ Pressure Injury Stage 4 or Unstageable: Refer to Dietitian in Christchurch Campus.
- ✓ If appropriate, the patient may be referred onto community dietitians for ongoing monitoring.

Physiotherapist and/or Occupational Therapist Referral:

Consider consulting a Physiotherapist and/or Occupational Therapist for advice, if having any difficulty developing a 24-hour mobility, safe handling and/or positioning plan.

An Occupational Therapist must be involved where the person requires assistance to improve independence with activities of daily living (ADLs) and/or where pressure redistribution devices are required for use in their home setting.

NB: A 24-hour safe mobility and positioning plan is an essential component in prevention and reduction of friction and shear.

Patient and Whānau Partnership

If the person is at risk of pressure injuries a documented discussion must occur with them on their individual risk/s and intervention strategies, where possible include the whānau/carer in this discussion.

A discussion of risks may include:

- Change in health status
- Relevant co-morbidities (e.g., poor perfusion, diabetes)
- 24hr position change plan, including repositioning frequency, off-loading plan, night versus day plan
- Regular movement and mobility plan (frequency and time between bed to chair, walking)
- Friction and shear risks, safe mobility, and manual handling
- Moisture management
- Device use
- Hydration
- Nutrition
- Lifestyle choices
- Educate the person and whānau on individualized intervention strategies for pressure injury prevention
- Current skin status
- How to self-check skin integrity (and request checks for discomfort)

NB: Inform and encourage the patient to report to staff if they have any pain/discomfort or numbness anywhere.

The following resources are available to assist with patient and whānau education which can be printed out as sections for ongoing education and discussion:

- ✓ ACC PI prevention pamphlets available in multiple languages - order hardcopies *here*

  Click the “Pressure Injury” tile to access and order pamphlets from the ACC webpage.

RESOURCES for PI IDENTIFICATION and MANAGEMENT

Refer to the link for the Pan Pacific Pressure Injury Alliance Resource Manuals for identification and management of Pressure Injury as per skin type and age.

Pressure Injuries must be staged according to the National Pressure Ulcer Advisory Panel (NPUAP, American), the European Pressure Ulcer Advisory Panel (EPUAP), and the Pan Pacific Pressure Injury Alliance (PPPIA) CLASSIFICATION SYSTEM at identification of a suspected pressure injury.

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

MANAGEMENT of PRESSURE INJURIES (At Risk and Existing PI)

NB: Patients at End of Life are at high risk for pressure injuries; staff must ensure that intervention strategies are in place that align with the patient's specific needs.

Interventions:

Interventions in the care plan should be continued and adjusted according to the patient's condition. Interventions should be discussed and agreed upon with the patient/whānau involvement.

Re-Assessment Guidelines:

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.

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

AND

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

AND

On transfer between clinical areas and prior to discharge.

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

Managing Specific Classifications Guidance

Follow the Pressure Injuries: Management Categories Ref: 2405337

Contact your local link staff/wound care nurse specialist/consultant for any advice on management.

Encourage the involvement of the multidisciplinary team which include the medical and allied health teams.

Dressing and Equipment:

Refer to the Dressing Selection Guidelines for Pressure Injuries Ref: 2407278 and PI Prevention Assessment Guideline for Equipment Ref: 2407171 when considering management options

Images:

Staff must adhere to the Clinical Photography Policy Ref: 2406564 when taking pressure injury images.

An approved device or medical photographer must be utilized to capture a photographic image for all pressure injury stages, excluding stage 1. Prior to obtaining an image, a written consent from the patient is mandatory, and it should be documented using the Agreement to Clinical Imaging Form Ref: 2401616.

The image must then be uploaded into the designated secure site, refer to Procedure for uploading photos to HCS via CELO Ref: 2410275.

Place a copy into their clinical documents and add image to the incident management system as able (i.e., Safety 1st).

Bedside Board and Communication:

The bedside board is a method to alert the multidisciplinary team and support services of the interventions they can assist with to reduce patient risk.

a. It is the team's responsibility to update the board on PI risk and use the special intervention notes section of the bedside board as the needs of the patient change.

   For example: Prompts on handling, positioning, head of bed less than 30 degrees, use knee brake when raising head of bed etc.

b. At bedside handover, staff must identify the patient's current risk factors and skin assessment frequency.

CARE PLANNING

Refer to:
Guidance Document on Care Planning for Pressure Injury Prevention and Management Ref: 2404914, and
Pressure Injury Assessment Interventions Care Planning and Evaluation Cycle Ref: 2407642

Utilise the pressure injury prevention cycle alongside assessment, care planning, and evaluation.

Staff must provide a detailed risk reduction plan, aligned with patient and whānau involvement in shared decision-making and addressing individual assessed risks.

The care plan should include but is not limited to:

- ✓ Assessing the skin under and around ***medical devices*** for signs of pressure related injury as part of routine skin assessment. **NB:** Remove medical devices only if clinically safe and provide guidance on securement and repositioning when applicable (e.g., pulse oximeters, gastrostomy tubes, nasogastric tubes, urinary catheters).

- ✓ Use ***preventative dressings*** on 'At Risk' areas which includes the skin where non-rotatable medical devices like CPAP masks, peripheral IV cannulas, and indwelling catheters are attached. If these are used, it must be reviewed on a daily basis or as per facility/area protocol and documented in the clinical record.

NB: The plan must be evaluated each shift to determine if the interventions are still appropriate and don't need revising.

Ensure the rationale for any changes made to interventions is recorded and care plan is updated.

Patient Engagement in Risk Reduction:

Engaging patients and whānau in co-designing care are essential. This ensures patients and whānau are aware of and understand the risk of PIs and can be involved with decisions to minimise their risk. It is important to determine the patient's ability to assist in risk reduction. Document patient and/or whānau goals in the patients care plan.

NB: Ensure that documentation reflects discussion and education interventions as well as any barriers to engagement/participation.

These interventions are to be **written as goals** in the patients **care plan** and identified as the activities the patient/whānau will do to help reduce their risk.

e.g., *"Mr. Smith will reposition himself every 20min in bed/chair while awake to minimise the risk of Pressure Injuries"* another example would be *"Mr. Smith will drink the supplements provided to increase his protein and energy requirements to reduce his risk of Pressure Injury".*

Where patients are cognitively impaired, **write the goals** (in conjunction with their whānau) to establish a "reminder schedule" so patients can still participate with prompting from staff.

e.g., "*Staff will remind Mr. Smith to change his position every 2 hours and remind him this helps him to prevent pressure injuries."*

PRESSURE INJURY DOCUMENTATION

Refer to the link for the PI staging lanyard card (order from Med Ills) Ref: 2404648

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

The following terminology must be used in documentation as per below:

Classification/Stage

Stage 1 pressure injury - is recognised as NON blanchable skin and must be documented as NON BLANCHABLE ERYTHEMA

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

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 (SDTI)** is usually a BLOOD-filled blister or skin that is maroon or purple in colour and must be documented as a SUSPECTED DEEP TISSUE PRESSURE INJURY.

NB: Document the discovery of PI/s using appropriate clinical notes (paper or electronic). Use the PI alert sticker in the patients record.

Mucosal injury - moist membranes that line the respiratory, gastrointestinal, and genitourinary tract. Mucosal membrane pressure injuries are primarily caused by medical devices (generally tubing and stabilisation equipment) exerting sustained compressive and shear forces on the mucosa that affect

the moist membranes that line the respiratory, gastrointestinal, and genitourinary tract. These cannot be staged.

Forms

All pressure injuries, regardless of classification or stage, must be documented on a dedicated assessment and management form (paper or electronic).

Staff must ensure that pressure injury prevention interventions are documented in the patient's care plan and management form, with particular attention to Stage 1 pressure injuries.

The assessment form should include the following information:

- ✓ *Classification and location(s) of the pressure injury*
- ✓ *Size or dimensions of the wound*
- ✓ *Tissue type*
- ✓ *Exudate and odour*
- ✓ *Depth of the wound*
- ✓ *Duration of the injury*
- ✓ *Assessment of the wound bed and surrounding skin (including pain)*
- ✓ *Protective or dressing requirements and frequency of review*

Staff from the outgoing shift must communicate the pressure injury assessment and care requirements of the patient to the incoming staff during handover. This will enable staff to effectively monitor the improvement or deterioration of the pressure injury over time.

Retrograde Staging

Staff must document a healing pressure injury as its healing stage (e.g., Healing Stage 4) without downgrading it (e.g., from Stage 4 to 3).

PRESSURE INJURY REPORTING REQUIREMENTS

All stages of pressure injuries and IAD must be reported through the organisation's incident management system (Safety 1st).

Learnings from pressure injury event reviews are shared locally.

SAC 3 and 4 aggregated local reviews

SAC 1 and 2 independent reviews.

For all identified pressure injury events, an immediate review takes place.

This must include:

- ✓ Identify causal factors of the Pressure Injury to manage and minimise the risk of deterioration or further injuries.
- ✓ A reassessment of the patients contributing factors, health status and comorbidities is undertaken utilising the assessment components as per Pressure Injury Prevention Procedure Flowchart Ref: 2408712 and move the patient to the highest risk category.

- ✓ For a patient that comes into hospital with a known pressure injury and deteriorates to a higher stage of pressure injury during their hospital stay, these events should be recorded as Hospital Acquired Pressure Injury (HAPI).
- ✓ To notify that a pressure injury has been identified, use the pressure injury alert sticker for paper form clinical notes or an electronic clinical note equivalent (e.g., Cortex).
- ✓ Wound Care Assessment Chart to document baseline and be a tool to communicate progress for all clinicians to see in one place
- ✓ Follow the PI Prevention Assessment Guideline for Equipment Ref: 2407171.

ACC REPORTING REQUIREMENTS

Refer to ACC45 Sample – Pressure Injury Ref: 2404919 or ACC2152 Example -Pressure Injury Ref: 2404920

- ✓ Ensure that the consent section of the **ACC45** must be signed by the patient or their EPOA.

Use an ACC45 and ACC2152 for Stage 2 and above Pressure Injuries that have occurred as a result of a **Treatment Injury.**

This is where the person is under the 24-hour care or direction of a Registered Health Professional.

For example, a Stage 4 sacral pressure injury as a result of inconsistent care during an inpatient stay.

These forms can be completed by a Registered Nurse or Physio, Medical or Nurse Practitioner

Please note: If the patient will need time off work the forms MUST BE SIGNED by a Medical or Nurse Practitioner

Use an ACC45 for a Stage 2 and above PIs for a **Personal Injury/Accident.**

This is where the PI was sustained as the result of a personal accident e.g., where the patient fell while taking themselves to the bathroom and they sustained a PI from a long lie.

Forward forms in Canterbury to the Patient Information Office, Christchurch Hospital.

Forward forms in the West Coast SHB ACC Revenue Coordinator, Te Nikau Hospital and Health Centre

NB: Examples of completed ACC forms are in Appendix 1 of this document (refer below).

DISCHARGE PLANNING

Discharge Planning starts on presentation.

Discharge Plan as per risk and/or identified pressure injury.

- Ensure that the appropriate ACC Forms (ACC45 and ACC2152) are completed prior to discharge.

- Ensure that the consent section of the ACC45 must be signed by the patient or their EPOA.
- Send 2 days of protective dressing equipment with the patient for the community nursing service.
- Report ‘at risk’ skin, any protective dressings being utilised, risk of malnutrition, mobility or incontinence issues, and discharge plan to the relevant receiving health care professional or primary health care providers e.g., nursing service, palliative care team, GP, dietitian, physiotherapist.
- If the patient requires ongoing wound management after discharge, request Specialist Wound Management Nursing (link).
- Ensure a skin inspection is completed immediately before discharge to ensure that the patient’s current state is addressed before discharge or transfer. The findings and any actions need to be detailed in the clinical record and care plan updated.
- Involve a community dietitian service where ongoing nutritional support is required.
- Occupational Therapist must be aware of any need for Pressure Redistribution Equipment for discharge and ensure referral sent to the community occupational therapist (via Acute Home visit team or community teams).
- Consult Occupational Therapist/Physiotherapist for specialist equipment continuity.
- Ensure that all devices for use to prevent pressure injuries are available before discharge, these could include specialised pressure redistribution equipment, orthotics etc.
- Contact the ARC facility early to ensure the facility can organise pressure redistribution equipment in a timely manner.
- Patients with diabetes with ‘at risk feet’ can be referred to the Community high risk foot scheme for 4 free consultations via their GP. Request this service on the discharge summary or request through the patient’s medical team.

KEY PERFORMANCE INDICATORS

Outcome Measures:

The key outcome measures are:

a. Total inpatient pressure injuries, hospital-acquired pressure injuries (HAPI), and SAC 1 & 2 Pressure Injuries are monitored by the Canterbury and West Coast PI Advisory Group, other divisional PI Groups such as the Christchurch Campus Skin Integrity Working Group, Clinical Governance Committees, or equivalent bodies, and management teams on an ongoing basis.
b. The HQSC Quality and Safety Marker outcome measure continues to be monitored and reported by the HQSC quarterly.
c. All SAC 1 and Pressure Injury events are reported to the HQSC.

Process Measures:

A monthly hospital-wide pressure injury audit is conducted to measure adherence to the pressure injury assessment, prevention, and management procedure. Pressure Injuries - Power BI (link)

- The frequency of reviewing the findings and ongoing monitoring is the responsibility of the Divisional PI group or equivalent.
- Canterbury Inpatient Experience Survey results for Bedside Board questions.
- Staff education on PI assessment, prevention, and management.

Supporting Material

Controlled Documents

Prevention:

ACC PI prevention pamphlets available in multiple languages

Air-Assisted Transfer Device Procedure Ref: 2408381

Bedside Board Guideline Ref: 2406251

Braden Scale Ref: 2403638

Braden Scale (Ashburton and Rural Health) Ref: 2402469

Malnutrition Identification Management - Adult Paediatric Policy Ref: 2400321

Malnutrition Screening Tool (MST) Ref: 2407654

PI Assessment, Implementation, & Documentation Guidelines Child Health Ref: 2410986

PI Prevention Assessment and Care Planning Cycle Ref: 2407642

PI Prevention Assessment Guideline for Equipment Ref: 2407171

PI Prevention Support Surface Recommendations Ref: 2408710

Preventing Pressure Injuries Caregiver Information Child Health Ref: 2407653

Purpose T (V2) Tool and Pathways Ref: 2405833

Purpose T PIP Individual Plan Ref: 2405832

Purpose T PIP Individual Plan Surgical Services Ref: 2408682

Risk Screening Resources & Assessment Tools (p.12-14) Ref: 2400597

Skin Care Guide Ref: 2407277

SSKIN and Positioning video

Staff video on establishing the correct inflation for Roho cushions

Management:

ACC45 Sample – Pressure Injury Ref: 2404919

ACC2152 Example -Pressure Injury Ref: 2404920

ACC General Information Ref: 2404666

Agreement to Clinical Imaging Form Ref: 2401616

Change or Decline in Health Status PIP Community of Practice Ref: 2406457

Chronic Spinal Impairment Ref: 2400376

Clinical Photography Policy Ref: 2406564

Covid-19 Prone Positioning of conscious patients Ref: 2408957

Dressing Selection Guidelines for Pressure Injuries Ref: 2407278

General Wound Care Ref: 2402984 (Ashburton)

Graduated Compression Stockings Ref: 2400656

Guidance Document on Care Planning for Pressure Injury Prevention and Management Ref: 2404914

Hamilton Russell Traction Ref: 2408657

Initial Wound Assessent and Management Form Ref: 2400271 (Christchurch Campus)

- Repeat Wound Assessment and Management Form Ref: 2400380

Mosaic Cushion Use Ref: 2409893

Nursing Care of a Patient in a Back-slab Ref: 2411078

Nursing Care of a Patient with a Cast Ref: 2409087

Nursing Care of a Patient with a Moonboot Ref: 2409086

Pan Pacific Pressure Injury Alliance Resource Manuals

Paediatric Wheelchair Guideline Ref: 2408943

Physiotherapy Wheelchair Protocol Ref: 2407681

PIPE Diet Ref: 2407228

PI staging lanyard card (order from Med Ills) Ref: 2404648

PI alert sticker (for clinical record identification) Ref: 2406223 (order from FujiXerox - rolls of 50)

Pressure Injuries: Management Categories Ref: 2405337

Procedure for uploading photos to HCS via CELO Ref: 2410275

Skin/Wound Care Spinal Unit Ref: 2403392

Straight Pull Skin Traction Ref: 2406712

Wound Assessment Chart BSU Ref: 2403134 (Burwood)

Hospital HealthPathways:

Acute Adult Nutrition and Dietetics Assessment

Medical Imaging

Pressure Injuries

SharePoint Sites:

Air-Assisted Devices SharePoint

Patient Assessment and Care Planning SharePoint

Pressure Injury Prevention SharePoint

Lippincott:

Care plan preparation

Pressure injury prevention, neonate

Pressure ulcer management

Pressure injury prevention, paediatric

Pressure ulcer prevention

Skin assessment

Supplemental bed equipment use

Wound Care

References

Accident Compensation Corporation. (2017). Guiding principles for pressure injury prevention and management in New Zealand. Retrieved from https://www.acc.co.nz/assets/provider/pressure-injury-prevention-acc7758.pdf

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Latimer, et al. (2021). Feasibility and acceptability of implementing a patient education pressure injury prevention care bundle in acute care: An interview study. Wound Practice & Research, 29, 163-170. https://doi.org/10.33235/wpr.29.3.163-170

New Zealand Wound Care Society. (n.d.). Pressure Injury Clinical Resources.
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Appendix 1 - ACC Form Completion Examples (ACC45 and ACC2152)

ACC 45 **ACC Injury Claim Form**
Patient to complete

ACC PREVENTION. CARE. RECOVERY.
Te Kaporeihana Āwhina Hunga Whara

PART A: PERSONAL DETAILS

Family name: SMITH (SURNAME)
First name(s): JOHN
Date of birth: 15 06 1947 (DAY MONTH YEAR) Male ✓ Female ○
Home/postal address: 123 SMITH ST (NUMBER, STREET NAME)
CASEBROOK CHRISTCHURCH (SUBURB, TOWN/CITY)
Telephone WORK: 012345 (CODE) HOME: 0 (CODE)

What is your ethnic background? *This information is collected for statistical reasons only, to help ACC develop services that are culturally appropriate.*

✓ NZ European/Pakeha ○ Cook Island Maori ○ Fijian ○ Indian ○ Samoan ○ Other ethnic group – *please specify*
○ Other European ○ Tongan ○ Other Pacific ○ Other Asian ○ Tokelauan
○ NZ Maori ○ Niuean ○ South East Asian ○ Chinese ○ I'd prefer not to say

PART B: ACCIDENT AND EMPLOYMENT DETAILS *If required you can provide further information in answer to the following questions on a separate piece of paper.*

When did the accident happen? 24 04 2021 (DAY MONTH YEAR) at 15.00 (TIME) ✓ am ○ pm
Accident scene (*eg. home, place of work, road*): ICU, Christchurch Hospital.
Accident location (*eg. Taupo*):
Did the accident occur in New Zealand? ○ Yes ○ No
What were you doing – what happened – how was the injury caused? (*eg. cleaning kitchen, slipped on wet floor and hit head on table*)
Developed Pressure Injury while being treated for pneumonia
Did the accident involve a moving motor vehicle on a public road, driveway or beach? ○ Yes ✓ No
If sporting injury, name sport (*eg. rugby union*):
Occupation: Retired
Please tick those that apply: ○ I am in paid employment (*part time or full time*) ○ I own/part own the company in which I work ○ I am self-employed ✓ I am not in paid employment
What type of work do you do? (Tick one box only) ○ Sedentary (*brief standing and walking*) ○ Light (*mainly standing and walking*) ○ Medium (*often lift 5kg plus*) ○ Heavy (*often lift 9kg plus*) ○ Very heavy (*often lift 22kg plus*)
Did the accident occur at work? ○ Yes ○ No
What is the name of the business you are employed by/own? What is the address of the business you are employed by/own?
If patient can't sign Part C: must write 'Verbal Consent Received'
EMPLOYER NAME AND ADDRESS

PART C: PATIENT AUTHORISATION AND DECLARATION

I have read and understood the Important Information and the Patient Authorisation and Declaration on the reverse of the patient copy of this form

Patient to sign here or legal guardian or representative: x J Smith Date: 25 04 2021 (DAY MONTH YEAR)
Authorised representative's name:
Authorised representative's relationship to patient:

CF71464

Treatment Provider to complete CF71464
Note: ACC does not provide cover for illness or sickness.

PART D: INJURY DIAGNOSIS AND ASSISTANCE

Patient's NHI no.: ADC1234
Diagnosis coding used if not READ CODES ○ ICD9 ○ ICD10
Diagnosis 1 — Side: ○ Left ○ Right
Diagnosis 2 — Side: ○ Left ○ Right
Diagnosis 3 — Side: ○ Left ○ Right
Is this a work related gradual process, disease or infection claim? ○ Yes ○ No
Additional injury comments to injury code entered above: Left heel pressure Injury.
Has the patient been admitted to hospital? ○ Yes ✓ No
Is this claim for treatment injury? ✓ Yes ○ No (*If Yes, also fill in ACC2152*)
Referral information (*type of Treatment Provider referred to*)
REHABILITATION/ASSISTANCE REQUIRED (*eg. case management or home help*) ○ Yes ○ No
ACC should call me? ○ Yes ✓ No

PART E: ABILITY TO WORK *Registered Medical Practitioner only to complete this part*

IS THE PATIENT ABLE TO CONTINUE NORMAL WORK? ○ Yes (*go to part F*) ○ No (*continue*)
RESTRICTED DUTIES: The patient is able to undertake restricted duties for ___ days, from ___ (DAY MONTH YEAR) of the following type:
○ Sedentary (*brief standing and walking*) ○ Light (*mainly standing and walking*) ○ Medium (*often lift 5kg plus*) ○ Heavy (*often lift 9kg plus*)
Additional restrictions (*eg. up to four hours per day; no lifting*)
FULLY UNFIT: The patient is unfit for work for ___ days, from ___ (DAY MONTH YEAR) (Maximum 14 days using this form)
REVIEW/RETURN TO WORK: Based on this medical assessment
○ a review is required on, or
○ the patient should be fit to return to normal work on: (DAY MONTH YEAR)

PART F: TREATMENT PROVIDER DECLARATION

I certify that, on the date shown, I have personally examined the patient and that in my opinion the condition is the result of an accident. I also certify that the patient (or their representative) has signed the Patient Authorisation and Declaration and has authorised me to lodge the claim on their behalf.

ACC PROVIDER NUMBER: K21882
HEALTH PRACTITIONER INDEX: PERSON (CPN) G ORGANISATION F FACILITY
Treatment provider name (print) or stamp:
Treatment provider signature: x [signature] Date: 24 04 2021 (DAY MONTH YEAR)

ACC or Accredited Employer copy: please return this form when completed to your ACC Service Centre or to the Accredited Employer (check www.acc.co.nz). 08/201

ACC2152

Treatment Injury Claim

Treatment providers use this form in addition to an ACC claim lodgement form eg ACC45, ACC46, ACC42, when lodging a claim for injuries which occur in the context of treatment.

1. Patient details		
Family name: [Client family name auto]	First names(s): [Client first names auto]	
Date of birth: [DOB auto]	NHI number: [NHI auto]	Claim number: [ACC45/ACC42 auto]

2. Treatment injury details
List the injury(s) caused by the treatment:
List the signs and symptoms of the injury:
Diagnosis coding: ☐ ICD10 ☐ Read Code ☐ And reason (Dental) Diagnosis code(s) (if available):
Date which the patient first sought or received treatment for the injury: This is when you first noticed the injury, not necessarily when it occurred
How does the injury affect the patient's daily activities?

3. Treatment claimed to have caused the injury			
What treatment gave rise to the injury? (If the claimed injury resulted from failure to treat, please note.) How did the pressure injury occur eg Patient was in ICU for 48 hours			
Describe the events or circumstances which led to the injury. Include details of any medications and dates prescribed. (Please attach additional information if required.)			
Where was treatment provided?			
☐ Specialist rooms	☐ GP/medical centre	☐ Operating theatre	☐ Emergency department
X Ward/special unit	☐ Pharmacy	☐ Community clinic	☐ Hospital outpatient clinic
☐ Rest home/aged care	☐ Home	☐ Laboratory	☐ Radiology
☐ Other diagnostic/treatment area	☐ Other – please specify:		
Name of the facility (if relevant): Where the injury occurred – eg Christchurch Hospital			
Outline the condition(s) being treated (with dates): That is - What the patient was admitted for e.g. Admitted with severe community acquired pneumonia 2 – 7 January 2018			
Outline all underlying health conditions and other relevant factors/treatment. (If the injury is a worsening of an existing condition, please note.) List current health conditions (medical included) e.g.			

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ACC2152 Treatment Injury Claim

Type 2 diabetes Pneumonia
Name and occupation of the health professional(s) who provided or directed treatment. (ACC may need to contact these people for more information.)
Other information which may be relevant to this claim. (If there are any related ACC claims, please note.)

4. Treatment provider declaration		
To be signed by the health professional completing this claim form. I certify that the information provided is accurate, to the best of my knowledge.		
Treatment provider name:		Or treatment provider stamp:
Occupation:		
Address:		
ACC Provider ID: K21882	ACC Vendor ID:	ACC Facility ID:
Treatment provider signature:		**Date:**

Attach relevant documents, for example copies of clinical records such as discharge summaries, clinic letters, operative report, radiology report, incident form. Don't delay lodging this claim if these documents are not immediately available.

Lodging a treatment injury claim

- The ACC45 or ACC42 form can be lodged electronically or manually.
- ~~Please email or post this ACC2152 form and clinical notes to: ACC Treatment Injury Centre, PO Box 430, Dunedin 9054, email clinical.notes@acc.co.nz~~ Send to Katrina Logan, Patient Information, Christchurch Hospital
- Send your invoice to your ACC Service Centre (check www.acc.co.nz for contact and invoicing details)

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When we collect, use and store information, we comply with the Privacy Act 1993 and the Health Information Privacy Code 1994. For further details see ACC's privacy policy, available at www.acc.co.nz. We use the information collected on this form to fulfil the requirements of the Accident Compensation Act 2001.