Pressure Injury Prevention Procedure

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Purpose

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

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

Applicability

CDHB and West Coast DHB 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 prevention and management is a collaborative approach between the interdisciplinary team and the patient/ whānau.

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

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

Definitions

Pressure Injury:

A pressure injury is defined as a 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.

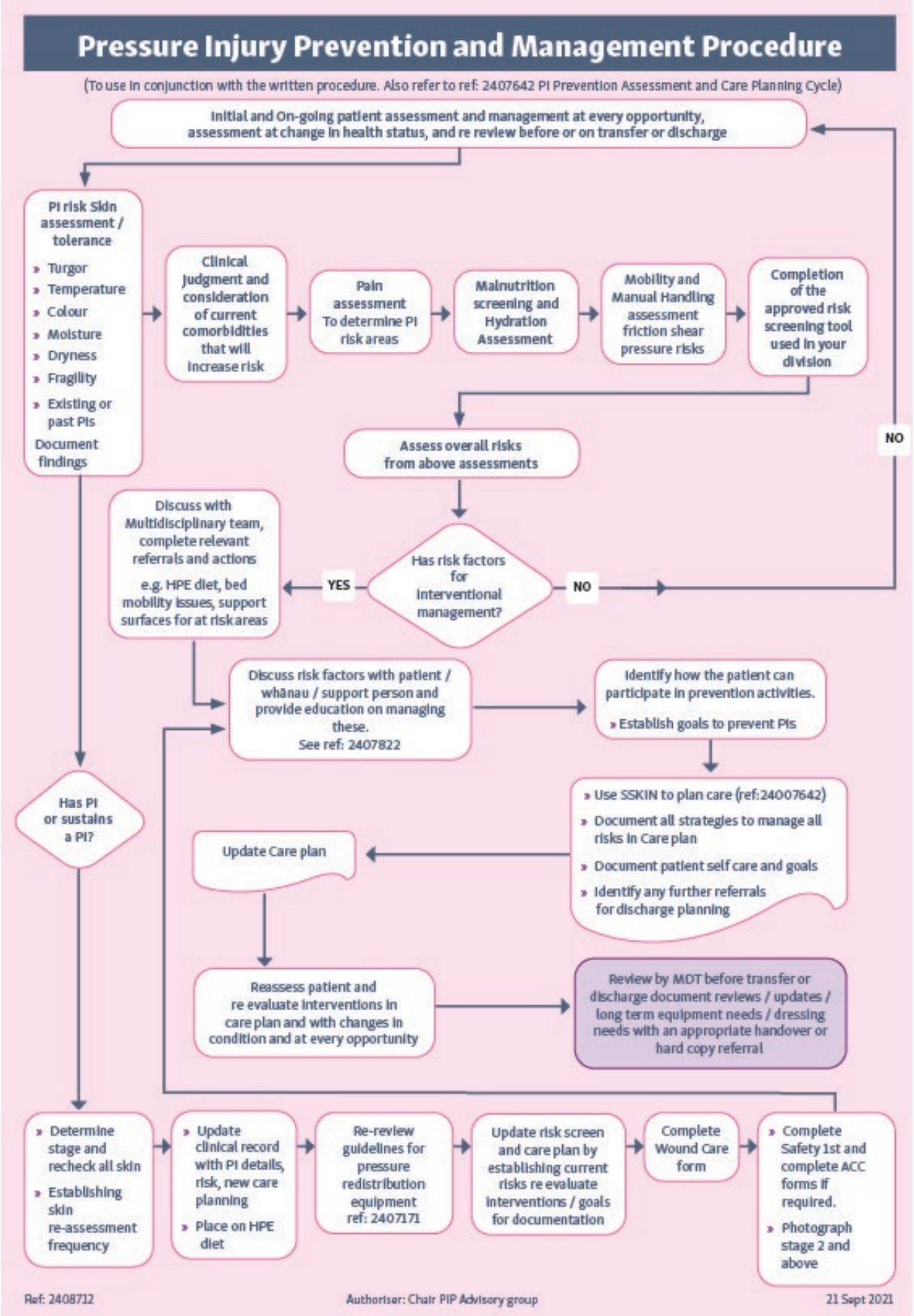
Intertriginous injuries:

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

IAD:

Incontinence-associated dermatitis 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).

Flowchart of Procedure



Education and training

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 modules or attend tertiary education.

Staff will complete the Pressure Injury Prevention Self Learning Package on healthLearn.

Staff have access to the Pressure Injury Prevention Community of Practice Forum on healthLearn where further education and resources are available.

Staff can access the *CDHB Pressure Injury Prevention SharePoint* site for access to resources for staff and patients.

Initial assessment (within 6 hrs) and ongoing assessment requirements

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

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
6. Mobility/Manual handling assessment

1. Risk assessment prediction

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

This will include using a validated risk prediction tool for example the Braden, , 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
Pallative care	

3. Skin assessment

On admission or transfer of the patient and with the patient's consent their, whānau 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, skin status – dry or frail, existing pressure injury, or healed pressure injury).

Please note: Natal cleft injuries will be entered into Safety 1st as intertriginous injuries (see definition above)

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

- A skin tolerance assessment will guide the assessor to establish frequency of position changes, appropriate utilisation of devices and rotation of these, appropriate sizing and use of incontinence aids and clinically appropriate pressure reduction equipment/devices.
- Skin tolerance issues will be identified by persistent blanching erythema and/or marking an upgrade in surfaces/mattress.
- Please refer to the PI Prevention assessment guidelines for equipment document 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.

Assessment guideline for Pressure redistribution equipment

PI Prevention support surface recommendations for 'at risk' areas

The 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 or as per facility/area protocol, and documented in the clinical record.

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 and or 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. Where patients have neuropathy special attention is required to pressure points as pain will not be a symptom.

Medical devices - recognise pain may be due to pressure and friction issues.

5. Malnutrition risk screen and Hydration monitoring

A validated malnutrition screening tool (MST) should be used within a pressure injury assessment to identify those at risk of malnutrition. For the CDHB use the *Malnutritional Screening tool.* West Coast inpatients have their MST completed in Trendcare and 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.

Nutritional status deteriorates during hospital stays and therefore rescreening for malnutrition should occur every 5 days.

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

Monitor oral intake and hydration by commencing a food and fluid chart and fluid balance chart.. For patients with a pressure injury additional protein and energy requirements are needed to assist healing.

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 assessment 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

Consider the use of air assisted transfer devices/other appropriate turning devices/ceiling hoists to reduce friction and shear on transfer.

Consider the risk to the heel friction risk when utilising overhead equipment e.g. monkey bars or when patients are performing bed based exercises where using socks and a sliding sheet could minimise friction and shear on the heels.

Consider a referral to the Occupational/Physiotherapist for special seating and or lying requirements and heel protection 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 discussed with the patient and the team to determine management of this risk.

Staff video on establishing the correct inflation for roho cushions

Patient and Whānau Health literacy education

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 their risks, may include:

- Their relevant co-morbidities e.g. poor perfusion, diabetes
- Their change in health state
- Lifestyle choices
- Educate the person and whānau on the individualised intervention strategies for pressure injury prevention
- Moisture management
- Their current skin status
- How to check their skin integrity themselves (and ask for checks if you have any discomfort)
- 24hr position change plan which includes frequency of repositioning , off loading plan, night versus day plan
- Regular movement and their 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 following resources are available to assist in education
Patient/whānau teaching cards ref: 2407822. These can be printed out as sections or as a whole for ongoing patient education and discussion

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

SSKIN and positioning video (10min)

Patient involvement in mimising their own risks

A patient centred approach is required in PI prevention. This ensures patients are aware of and understand their risk of PIs and can be involved with decisions in their care to minimise their risk.

Establish the patient's ability to assist themselves in managing their risk from your assessment of the patients individual risk factors, the education provided on these risk factors and discussion on what they can do to minimise risk.

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 re position himself every 20min in bed/chair while awake to minimise the risk of PIs. E.g. Mr Smith will drink the supplements provided to increase his protein and energy requirements to reduce his risk of PI.

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.

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

Utilise the *Skin Care Guide* ref: 2407277 to support appropriate cleansing , skin protection and enhance healing

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, intervention strategies should be applied to reduce pressure, friction and shear with an adequate replacement regime, documented in the care plan

Reassessment

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

AND

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

Care planning

The assessment care planning and evaluation pressure injury prevention cycle must be used in conjuncition with assessment, care planning and evaluation

In conjunction with the requirements for patient involvement in their care plan in shared decision making, staff are required to provide a detailed intervention plan to minimise the patients risk.

Care planning must address the **individual's** assessed risk and align with appropriate intervention strategies.

Refer to the guidance document on care planning for pressure injury prevention and management ref: 2404914 *Pressure injury Assessment Interventions Care planning and Evaluation Cycle*

The care plan should include direction on the rotation/re positioning of medical devices/securement if clinically safe to do so e.g. pulse oximeters, gastrostomy tubes, nasogastric tubes and urinary catheters

The plan needs to include checking the skin under and around medical devices and consider the use of a preventative dressing underneath medical devices as able, which cannot be rotate/re positioned e.g. CPAP masks, peripheral cannula, indwelling catheters

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

SSKIN lanyard Card (order from Med Ills)

Bedside board and communication

Identify the patients current risk factors and skin assessment frequency at bedside handover

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

It is the teams 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, Fon, head of bed less than 30 degrees, use knee brake when raising head of bed etc.

Internal referrals for pressure injury prevention

Referrals for pressure re distribution mattresses and other devices should be requested on individual need and after skin assessment and clinical judgement. The requirement for specialist support surfaces and devices may not be in relation to their risk prediction level e.g. not all people that are at a high risk require a pressure re distribution mattress/devices. For example, a person who is mobile and cognitively intact may require a mobility and positioning plan rather than a pressure re distribution mattress. They may just require a pressure re distribution cushion as they are sitting up more than lying in bed.

All patients at risk of developing pressure injuries should be screened for malnutrition. A dietitian referral should be considered for those with an MST score of 2 or 3, depending on direction of local policy.

Patients who have a stage 4 or unstageable pressure injury must be referred to the dietitian. If appropriate the patient may then be referred onto the community dietitians for ongoing monitioing.

A safe mobility plan is an essential component in prevention and reduction of friction and shear. Consider consulting a physiotherapist/occupational therapist for advice if having any difficulty developing a mobility, safe handling or positioning plan.

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 re distribution 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 a potential pressure injury risk

Discharge Planning starts on presentation.

Involve the Occupational Therapist/Physiotherapist early where the patient requires short or long-term pressure redistribution equipment, a home or ARC visit may be required.

Patients with diabetes with 'at risk feet' can be referred to the Community high risk foot scheme for 4 free consulations via their GP. Request this service on the discharge summary or request through the patients medical team.

Ensure if specialist equipment has been used in hospital, that the Occupational Therapist/Physiotherapist is consulted as soon as possible for continuity of care for pressure redistribution devices on transfer/device.

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. Importance of pressure reldistribution needs to documented in any transfer information and verbally handed over to the person's responsible for transferring the patient and those receiving the patient.

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 re distrubution equipment, orthotics etc.

Send 2 days of protective dressing equipment with the patient for the community nursing service.

Involve a community dietitian service where ongoing nutritional support is required.

Contact the ARC facility early to ensure the facility can organise pressure redistribution 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

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

Please note: refer to the documentation section below

DHB reporting requirements and learnings

Immediate review takes place for all identified pressure injury events. This must include

- Identification of the causal factors of the PI so interventions to minimise risk of deterioration or further injuries can be identified and managed.
- A reassessment of the patients contributing factors, health status and comorbidities is undertaken utilising the assessment components on page 3 of this procedure and move the patient to the highest risk category
- Follow the direction on the assessment guidelines for equipment ref: 2407171
- Complete pressure injury alert sticker or similar available in Cortex is required to be completed on identification of an injury.

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

Learnings from pressure event reviews are shared locally

SAC 3 and 4 aggregated local reviews

SAC 1 and 2 independent review

ACC reporting requirements

Use an ACC45 and ACC2152 for Stage 2 and above PI's 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

Please note: Examples of completed ACC forms are in the Appendix of this document

Retrograde staging

As a pressure injury heals it should be documented as a healing stage (e.g. 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 *Staging resource*

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** (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

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.

Please note: Document the discovery of PI/s using Cortex or use the PI alert sticker in the patients record.

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.

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

Using an approved device or medical photographer, a photographic image must be obtained for all pressure injury stages except stage 1, with the patients written consent using the Agreement to Clinical Imaging form ref: 2401616. The image must be uploaded into the designated secure site. Place a copy into their clinical documents and add image to the incident management system as able (i.e. Safety 1st).

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.

A wound management form, paper or electronic must be utilised for all stages, with information on prevention interventions with Stage 1 PIs

Refer to the *Dressing selection guidelines for pressure injuries* (ref. 2407171) when considering management options.

Guidance for managing specific classifications

Follow the Guidance document on management of pressure injuries Ref: 2405337 and the Dressing Selection Guide for PIs Ref: 2407278

Contact your local link staff/wound care nurse specialist/consultant 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

Involve the Occupational Therapist early where the patient requires short or long term pressure re distribution equipment, a home or ARC visit may be required.

Involve the hospital dietitian in the consideration of ongoing education and monitoring in the community before discharge.

Ensure that a patient using any pressure re distribution devices/equipment or orthotics are available on discharge

Contact the ARC facility early to ensure the facility can organise pressure re distribution equipment in a timely manner.

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 dressing changes of protective dressing equipment with the patient for the nursing service.

At discharge ensure information regarding the patients interventional strategies and equipment is relayed to the ongoing service

Associated material

Prevention

CDHB Pressure Injury Prevention SharePoint site

PI prevention Assessment, intervention and evauation cycle Ref: 2407642

Assessment guideines for the use of pressure redistribution equipment Ref: 2407171

PI Prevention support surface recommendations Ref: 24087190

CDHB Malnutrition Identification Management - Adult Paediatric Policy Ref 2400321

Manutrition in Hospitals RGCL006 HealthLearn package

CDHB Malnutrition Screening Tool (MST) Ref: 2407654

Skin Care Guide Ref: 2407277

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

Staff education teaching card resource Ref 2406453

Patient teaching card resource Ref: 2407822

Manual Handling SharePoint site - Air assisted devices

Air assisted transfer device procedure Ref: 2408381

Staff video on establishing the correct inflation for roho cushions

SSKIN and positioning video

Bedside board guideline Ref: 2406251

Management

Staging/Classification

PI staging lanyard card (order from Med Ills)

PI alert sticker (for clinical record identification) Ref: 2311272 (order from FujiXerox - rolls of 50)

Dressing selection guideline for pressure injuries Ref: 2407278

Pressure injuries: Management for stages/categories Ref: 2405337

Initial Wound Assessent and Management form Ref: 2400271

Clinical photography Policy Ref: 2406564

Agreement to Clinical Imaging form Ref: 2401616.

Patient Assessment and Care planning resource site

Supporting material and 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/a5db7f3136/acc7758-pressure-injury-prevention.pdf*

Australian Commission on Safety and Quality in Health Care (2011), Patient centred care: Improving quality and safety through partnerships with patients and consumers. Retrieved from *https://www.safetyandquality.gov.au/sites/default/files/migrated/PCC_Paper_August.pdf*

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Chaboyer et al. (2015). INTroducing A Care bundle To prevent pressure injury (INTACT) in at-risk patients: A protocol for a cluster randomised trial. *International Journal of Nursing Studies*, *52*(11), 1659-1668. https://doi.org/10.1016/j.ijnurstu.2015.04.018

European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel, and Pan Pacific Pressure Injury Alliance (2019). *Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline*. Haesler, E. (Ed.). EPUAP/NPIAP/PPPIA

Gruden et al. (2021). Impact of Person-Centered Interventions on Patient Outcomes in Acute Care Settings: A Systematic Review. Journal of Nursing Care Quality, 36(1), E14-E21. *https://doi.org/10.1097/ncq.0000000000000471*

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/https://doi.org/10.33235/wpr.29.3.163-170

Longtin, Y., Sax, H., Leape, L. L., Sheridan, S. E., Donaldson, L., & Pittet, D. (2010). Patient participation: current knowledge and applicability to patient safety. Mayo Clinic Proceedings, 85(1), 53+. Retrieved from *https://link.gale.com/apps/doc/A216442334/AONE?u=polytechnic&sid=AONE&xid=8091bf50*

McInnes, E., Chaboyer, W., Murray, E., Allen, T., & Jones, P. (2014). The role of patients in pressure injury prevention: a survey of acute care patients. BMC Nursing, 13(1), 1-15. *https://doi.org/10.1186/s12912-014-0041-y =*

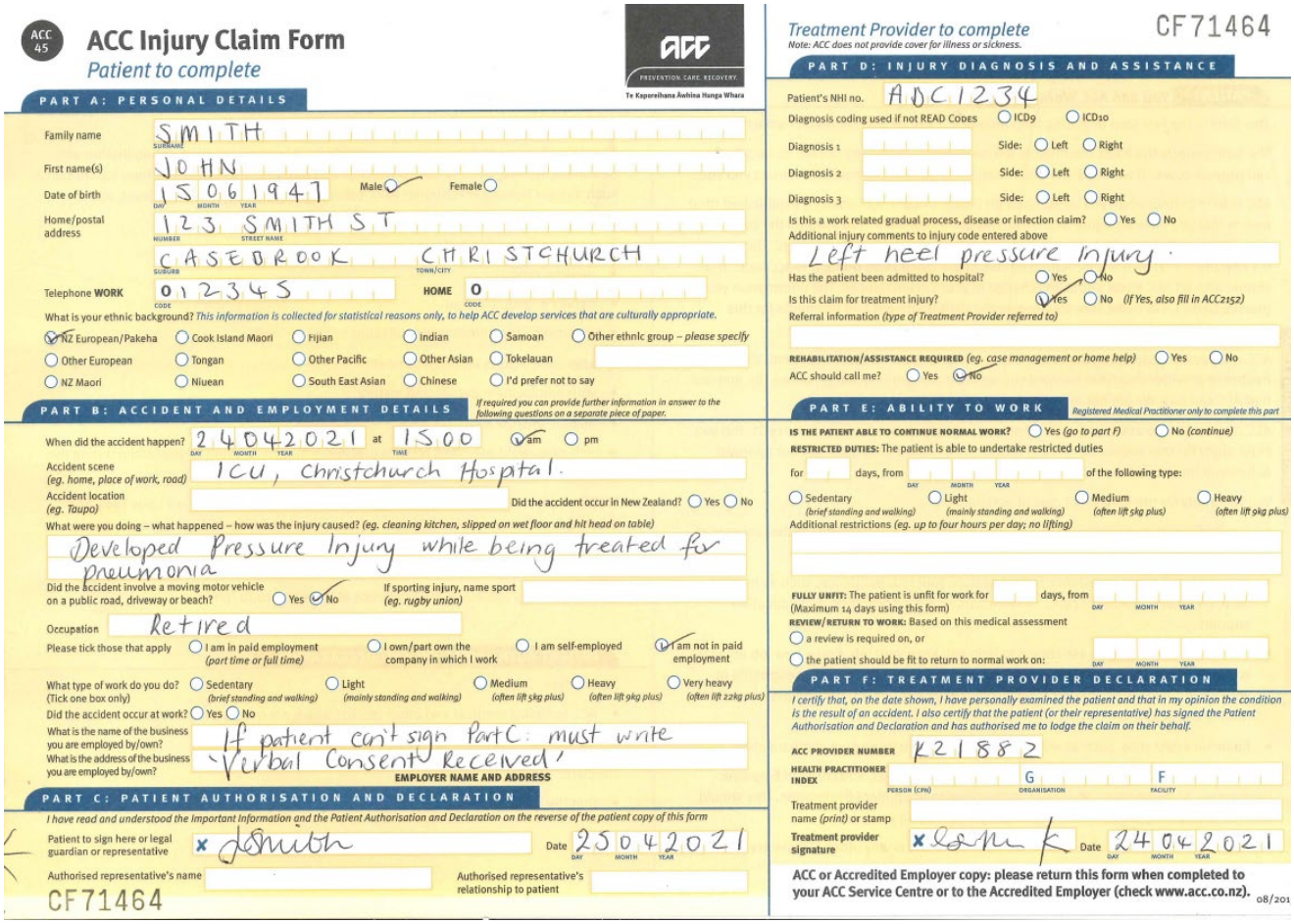
McCormack, B., & McCance, T. (2010). Person-Centred Processes. In McCormack, B., & McCance, T. (Eds.) pp. 89-109. Person-centred nursing : Theory and practice. ProQuest Ebook Central *https://ebookcentral.proquest.com*

New Zealand Wound Care Society resource "*How to identify and classify pressure injuries*"

Tobiano et al. (2015). Patient participation in nursing care on medical wards: An integrative review. International Journal of Nursing Studies, 52(6), 1107-1120. *https://doi.org/10.1016/j.ijnurstu.2015.02.010*

Weingart et al. (2011). Hospitalized patients' participation and its impact on quality of care and patient safety. International Journal for Quality in Health Care, 23(3), 269-277. https://academic.oup.com/intqhc/article/23/3/269/1792183

Appendix 1 - ACC form completion examples (ACC45 and ACC2512)



ACC 45

ACC Injury Claim Form

Patient to complete

ACC — PREVENTION. CARE. RECOVERY. Te Kaporeihana Awhina Hunga Whara

PART A: PERSONAL DETAILS

Family name (SURNAME): SMITH

First name(s): JOHN

Date of birth (DAY MONTH YEAR): 15 06 1947 — Male ✓ Female ○

Home/postal address: 123 (NUMBER) SMITH ST (STREET NAME)

CASEBROOK (SUBURB) CHRISTCHURCH (TOWN/CITY)

Telephone WORK (CODE): 012345 HOME (CODE): 0

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? (DAY MONTH YEAR) 24042021 at (TIME) 1500 ✓ 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? If patient can't sign Part C: must write 'Verbal Consent Received'

What is the address of the business you are employed by/own?

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: ✗ JSmith Date (DAY MONTH YEAR) 25042021

Authorised representative's name: CF71464 Authorised representative's relationship to patient:

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: ✗ [signature] Date (DAY MONTH YEAR) 24042021

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)

FOR HOSPITAL ADMINISTRATION USE ONLY

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.