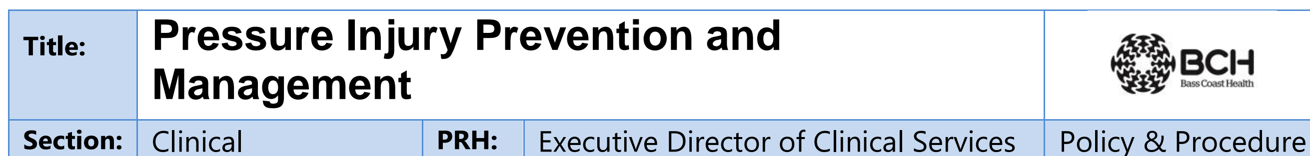

Title:	Pressure Injury Prevention and Management			
Section:	Clinical	PRH:	Executive Director of Clinical Services	Policy & Procedure

1.0 POLICY

Bass Coast Health is committed to the safety of consumers and staff. In accordance with the National Safety and Quality in Health Service Standard 8, Residential Aged Care Standards, Home Care Standards and the Coroner's Investigation recommendations, Bass Coast Health has developed processes to prevent, minimise and manage pressure injury.

Bass Coast Health has a process of integrating pressure injury prevention and management into routine work practice in all care settings. The Policy takes a 'whole of service' approach and embraces the concepts of partnering with consumers, interdisciplinary planning and management, unit-based ownership, multi-factorial interventions and quality improvement.

The principles that underpin Bass Coast Health's approach to pressure injury prevention and management in all settings are evidenced based and current best practice.

Bass Coast Health promotes:

- Informing consumers of the risk of pressure injury and involvement of prevention strategies
- Screening consumer's for the risk of pressure injury
- Conducting a comprehensive risk assessment for consumers
    - Identifying at risk of pressure injury
    - On identifying a pressure injury
    - After any clinical deterioration
    - Upon relocation to a different environment, e.g to a different ward within the health service or a transfer into BCH from another health service
- Implementation, documentation and communication of multi factorial pressure injury prevention plans with consent and partnership with consumers/carer's
- Referral of high risk consumers during admission and as part of the discharge process
- Development, implementation and regular review of policies and procedures to prevent pressure injury and associated harm based evidence based practice e.g. – Pan Pacific Clinical Practice Guidelines for the Prevention and Management of Pressure Injury 2012
- The use of pressure injury prevention equipment to prevent pressure injuries
- Appropriate response following the identification of a pressure injury including requirements for incident reporting in the VHIMs system
- A robust organisation wide system of evaluation of pressure injury prevention program – investigating, managing and monitoring pressure injury pressure injury incidents
- Participation in quality improvement activities to address safety risks and ensure effectiveness of pressure injury prevention systems
- Provision of appropriate information for consumers and/or carers about the risk of pressure injury and pressure injury prevention strategies

This policy is to be read in conjunction with:

Comprehensive Care – Assessment, Care Planning, Referral and Discharge Planning Policy
Partnering with Consumers Policy
Quality and Clinical Governance Policy and Framework
Risk Management Policy
Manual Handling Policy
Incident Management Policy
Negative Pressure Wound Therapy Clinical Guideline
Pressure Care Equipment Clinical Guideline
Wound - Skin Tear Management Clinical Guideline
Wound – Assessment Clinical Guideline
Wound – Swab Clinical Guideline
Wound – Cleansing Clinical Guideline

2.0 RESPONSIBILITY

Executive	• To oversee the presence of an effective Pressure Injury prevention program • Ensure that the processes and resources are available for a comprehensive pressure injury prevention and management program
Medical Officer	• To ensure that the appropriate documentation is completed • To provide timely and appropriate review and assessment post the finding of a pressure injury • To make appropriate and timely referrals for further assessment as identified
Nurse Unit Manager (NUM) **Allied Health Managers**	• To ensure staff are aware of pressure injury prevention program and resources • To ensure relevant staff complete pressure injury prevention competencies as per the BCH Education Framework • To monitor pressure injury incident data and facilitate quality improvement activities as required • To initiate timely review of pressure injuries with major harm and implement relevant recommendations arising from same • To report local pressure injury data at staff meetings • To oversee timely access to equipment

Registered Nurse **Registered Midwife** **Endorsed Enrolled Nurse**	• To ensure that all consumers are screened for the risk of pressure injury as soon as possible and within 8 hours of admission, with a deterioration of clinical condition, with change in setting or every 48 hours as per NCP • To ensure all consumers have a minimum daily skin inspection • To ensure that all consumers and relatives are involved in the pressure injury prevention program • To ensure that all consumers/carer's are provided with information about the risks and management of pressure injuries • To ensure that appropriate documentation is completed (i.e. Risk Assessment, Care Plan, Incident Report) • To make appropriate referrals based on assessments • To consult with patients and their support team to develop, implement and evaluate an individualised plan of care to prevent pressure injury and harm for pressure injury
Allied Health Staff	• To conduct assessment on all new consumer referrals within two business days of notification that have been assessed as being at risk of pressure injury or have a pressure injury and reassess as necessary
All Staff	• Promote the importance of a pressure injury prevention culture to other staff, students, consumers and carers • Develop and maintain awareness of actions, environmental factors, other issues which may contribute to the development of a pressure injury • To report identified issues or concerns to Unit Manager • To complete pressure injury prevention competencies as required within the Education Framework
Engineering	• To ensure maintenance of pressure injury equipment

3.0 RECORDS

- MR/025 – Pressure Area Risk Assessment Tool
- MR/018 – Core Screening and Discharge Planning Tool
- MR/200 – Nursing Care Plan
- MR/240 – Wound Chart
- MR/240A – Lower Limb Wound Chart
- 'Move, Move, Move' (Department of Health, Victoria, 2014)

4.0 PROCEDURE

4.1 Definitions

Pressure Injury is a localised injury to the skin and/or underlying tissue usually over a bony prominence as a result of a pressure, shear and/or friction or a combination of these factors

Consumers for the purpose of this policy the term refers to patients, clients, residents

Best Practice Pressure Injury Prevention and Management refers to the recommended strategies for Pressure Injury Prevention and Management that are evidence based and supported by sound research

Pressure Injury with major harm refers to a pressure injury that is a stage 3 or 4 or death

Pressure Injury Risk Assessment is a process of identifying an individual's pressure injury risk factors and is used to develop a targeted pressure injury prevention plan

Pressure Injury Management Plan is an individualised pressure injury prevention/management plan with interventions developed with the consumer and multidisciplinary team to mitigate risk of pressure injury or to manage a pressure injury and promote healing

4.2 Assessment and Care Planning

- The purpose of a risk assessment tool is to identify those consumers at risk of developing pressure injuries. Professional judgement should always be used in conjunction with this tool
- All consumers must have an evidence based risk assessment tool completed on/or within 8 hours of admission
- Using the Braden scale, consumers will be classified as High (12 or less), Moderate (13 - 14) or Low (15 - 18)
- Consumers assessed as at risk are to be reassessed as per the approved risk assessment tool time frames and when there is a change in the condition of the consumer
- Document skin inspection as soon as possible after admission and within a maximum of 8 hours. Skin inspections should then be completed on a daily basis and whenever there is deterioration in the condition of the consumer or change in the setting. Indicators for pressure injury include;
  - erythema,
  - blanching response,
  - localised heat,
  - oedema,
  - induration, and
  - skin breakdown.
- Strategies to minimise risk (the pressure injury prevention and management plan) are described within the core screening tool relevant to the Braden scale score and also documented in the progress notes and ongoing implementation of the strategies to be evidenced in the progress notes

- Referral to Podiatry/Occupational Therapy/Dietetics/Physiotherapy is to be considered for all consumers classified as Moderate to High risk where relevant
- Healthcare staff to discuss strategies with consumers, family members or carer and provide information documentation such as 'Move Move Move' brochure or 'Making your stay safer' booklet
- For those consumers assessed as NOT being at risk of pressure injuries on general admission, daily skin inspection will occur. Consumers should be reassessed should their condition change. Note that clinical judgement can be considered to alter a consumer's risk level but this must be documented in the progress notes and risk assessment
- Education is provided at local ward orientation to new employees at BCH in conjunction with a mandatory on-line competency and regular in-services as per the Education Framework and calendar

4.3 Risk Factors

Risk factors for developing pressures include any factors that expose the skin to excessive pressure or diminishes its tolerance to pressure, such as:

- Immobility – including pain induced, extended procedures or positioning restrictions.
- Diminished activity.
- Impaired sensory perception.
- Moisture such as perspiration, urine, faeces and drainage from wounds or fistulae.
- Friction – rubbing or resistance to sliding movement.
- Shear – tearing of deep soft tissues under pressure, such as moving skeletal structures without lifting body weight.
- Poor nutrition such as weight loss, hypoalbuminemia, malnutrition, poor energy intake.
- Poor oxygen delivery such as anaemia, low blood pressure, circulatory abnormalities, smoking, spinal cord injury.
- High skin temperature.
- Chronic illness such as diabetes, lymphedema, metastatic carcinoma, renal impairment or failure.

4.4 Documentation & Reporting

- A risk assessment must be documented and readily accessible to all staff.
- All consumers 'at risk' should have the following recorded in their medical record on a regular, ongoing basis:
  - regular daily assessment of skin integrity
  - risk assessment status
  - risk factors
  - a detailed management plan and efficacy of current interventions.
- The management plan should include information such as what interventions are required, who is responsible for that care, frequency of position changes, equipment required, referrals, expected outcomes and evaluation

- In the event of a consumer being admitted with a pressure injury or developing one while in care, there must be documentation of the pressure injury in the progress notes. In addition all pressure injuries must be reported via the Riskman incident reporting system.
- **All developed stage 3 or 4 pressure injuries** must be formally reviewed via an in depth case review
- Pressure injuries are to be classified by the International NPUAP/EPUAP Pressure Ulcer Classification System as referenced in the Pan Pacific Clinical Practice Guidelines for the Prevention and Management of Pressure Injury 2012.

Stage I pressure injury: Non-blanchable Erythema
• Intact skin with non-blanchable redness of a localised area usually over a bony prominence. • Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area. • The area may be painful, firm, soft, warmer or cooler compared to adjacent tissue. • May be difficult to detect in individuals with dark skin tones. • May indicate “at risk” persons (a heralding sign of risk).
Stage II Pressure Injury: partial thickness skin loss
• Partial thickness loss of dermis presenting as a shallow, open wound with a red-pink wound bed, without slough. • May also present as an intact or open/ruptured serum-filled blister. • Presents as a shiny or dry, shallow ulcer without slough or bruising (NB bruising indicates suspected deep tissue injury). • Stage II PI should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.
Stage III pressure injury: full thickness skin loss
• Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunnelling. • The depth of a stage III PI varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage III PIs can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage III PIs. Bone or tendon is not visible or directly palpable.
Stage IV pressure injury: full thickness tissue loss
• Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. • The depth of a stage IV pressure injury varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these PIs can be shallow. Stage IV PIs can extend into muscle and/or supporting structures (e.g. fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone or tendon is visible or directly palpable.

Unstageable pressure injury: depth unknown
• Full thickness tissue loss in which the base of the PI is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the PI bed. • Until enough slough/eschar is removed to expose the base of the PI, the true depth, and therefore the stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as the body's natural biological cover and should not be removed.
Suspected deep tissue injury: depth unknown
• Purple or maroon localised area or discoloured, intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. • Deep tissue injury may be difficult to detect in individuals with dark skin tone. • Evolution may include a thin blister over a dark wound bed. The PI may further involve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.

- The management plan should be evaluated and continue in addition to appropriate wound care.

4.5 Nursing Interventions

4.5.1 Skin Care

- Daily skin inspection for signs of pressure areas particularly all pressure points, including natal skin folds and heels for those patients/residents deemed to be at risk.
- Localised skin checks with each repositioning or turn.
- Skin should be kept clean and dry, without excessive dryness.
- Minimise excessive washing and use of soaps or detergents.
- Employ measures to promote continence such as training, toileting, and continence products.
- Apply moisture barrier ointments.
- Remove warming blankets as soon as the patient's temperature is normalised.
- Ensure a balanced diet with adequate caloric intake. Consult a Dietitian.

4.5.2 Pain

- All consumers with a pressure injury must be assessed for the presence of pain regularly and routinely
- A individualised pain management plan is to be developed

4.5.3 Positioning & Lifting

- Reposition the consumer as frequently as the consumers' tolerance to pressure dictates e.g. 1 – 2 hourly.
- To avoid friction ensure correct lifting and transferring techniques.

- Skin that is constantly exposed to friction should be protected with padding or protective dressings such as hydrocolloids or films.
- Do not rub or massage the skin.
- Minimise sitting if the consumer slides when in this position
- When sitting in a chair or wheelchair reposition or shift pressure points frequently as appropriate. Foot placement should be below the level of the hips.
- Implement the use of appropriate pressure relieving cushions as assessed by an Occupational Therapist. Occupational Therapist to liaise with nursing staff to ensure access to manufacturer's instructions and are aware of correct setup.
- When positioning in bed, complete regular side to side position changes with the bed in 30 degree inclination or a 30 degree inclined recumbent position. If the consumers medical condition precludes other options, use the prone position if appropriate.
- Consider use of an Alternating Air Mattress for those at high risk of pressure injury. Ensure these are installed to manufacturer's instructions.
- Monitor the positioning of heels and bony prominences in bed. Consider the use of the following to completely elevate the heel off the surface of the bed;
    - Bed cradles
    - Heel Wedges
    - Pillows under the full length of the lower leg

4.5.4 Activity and Mobilisation

- Encourage early and maximum activity and mobilisation following surgery or major illness with the assistance of appropriate equipment when required. In addition ensure adequate pain relief.
- Refer to a Physiotherapist or Occupational Therapist. where applicable to optimise mobility

4.5.5 Diet

- Consult a dietician for those assessed with poor/at risk nutritional status
- Optimise nutritional status

4.6 Maintenance of equipment

- Pressure injury prevention equipment is detailed in an inventory. All new equipment must be added to this list
- Regular inspection of the equipment is to occur to ensure optimal functioning and consumer comfort
- Education will be provided on a regular basis from the Occupational Therapy department. Where possible, Occupational Therapy should be consulted prior to initiating pressure relieving devices to ensure correct set up

EVALUATION AND MONITORING

- Preventing Pressure injuries and harm from pressure injuries is monitored at an organisation level through the Best Care Committee which monitors overall trends in pressure injury incidents and oversees quality improvement activities. The Best Care Committee reports to the Quality & Clinical

Risk Management Committee which in turn reports to the Board Quality & Clinical Governance Committee.

- Service / Program based Quality Committees review and monitor pressure injury incident data, approve and monitor recommendations from reviews of pressure injuries with major harm and facilitate quality improvement activities.
- Reports regarding pressure injury incidents are tabled at local ward meetings and recommendations from pressure injuries with harm review are reported.
- A suite of Pressure injury KPIs are reported to the Board Quality & Clinical Governance Committee and are reviewed at Quality and Clinical Risk and the Best Care Committee.

5.0 REFERENCES

Barwon Health, 13th November 2012 *Pressure Injury Prevention and Management*, Clinical Practice, Version 8, PROMPT Doc No: BAH0004397

Australian Wound Management Association Inc., 2012 *Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure Injury*, Cambridge Publishing, Osborne Park, WA, accessed from; http://www.awma.com.au/publications/2012_AWMA_Pan_Pacific_Abridged_Guideline.pdf

Wounds Australia (2016) *Standards for Wound Prevention and Management*. 3rd edition. Cambridge Media, Osborne Park, WA, accessed from http://www.woundsaustralia.com.au/2016/standards-for-wound-prevention-and-management-2016.pdf