Pressure Injury Prevention and Management Policy

1. Background

This policy addresses the requirements for the prevention and management of pressure injuries for adult, maternity, newborn and paediatric inpatients and aged care residents within WA Country Health Service (WACHS) healthcare facilities.

A pressure injury is a localised injury to the skin and / or underlying tissue, usually over a bony prominence, as a result of pressure or pressure in combination with shear[1] (Appendix 1).

Pressure Injuries can occur to patients of any age who have one or more of the following risk factors: immobility, older age, lack of sensory perception, poor nutrition or hydration, excess moisture or dryness, poor skin integrity, reduced blood flow, limited alertness or muscle spasms[2].

2. Policy Statement

This policy is to be read in conjunction with the WA Department of Health (DoH) WA Pressure Injury Prevention and Management Clinical Guideline (Pressure Injury Guideline) which is mandated for use in WACHS healthcare facilities. The Pressure Injury Guideline identifies health service requirements addressing:

- prevention and management of pressure injuries
- partnering with patients and consumers
- reporting pressure injury clinical incidents

2.1 Clinical Practice – preventing and managing pressure injuries

WACHS clinical policy resources (e.g. forms, flowcharts, care plans) for specific patient groups supporting the requirements of the Pressure Injury Guideline are described in 2.1.1 – 2.1.4.

WACHS regions are paired to a Perth Metropolitan Health Service, known as their linked hospital. Advice regarding the management of complex pressure injuries is available by contacting the Clinical Nurse Specialists for wound care at the respective linked hospital.

Processes supporting effective clinical handover of pressure injury risk are described in the Inter-hospital Clinical Handover Form Procedure, Allied Health Clinical Handover Policy and associated MR184 Inter-hospital Clinical Handover and MR66 WACHS Clinical Handover (Allied Health) forms.

2.1.1 Adult patients

The MR111 Nursing Admission, Screening and Assessment Tool – Adults incorporates a skin integrity assessment that provides baseline documentation of any injuries/issues occurring prior to admission and an initial Braden scale assessment of pressure injury risk. All patients require completion and documentation of a Braden scale assessment and a comprehensive skin assessment within 8 hours of admission.

The MR120 Adult nursing Care Plan 'My Care Plan' enables the documentation of patient care regarding pressure injury assessment and management including when reassessment of pressure injury risk has occurred and the type of pressure relieving device(s) in use. The MR124 Braden Scale and Pressure Injury Risk Assessment is used to document additional assessment(s) and guides clinicians as to suggested pressure relieving equipment and practice based on risk. The MR122 Wound Assessment and Management Plan is used to document the management plan for any pressure injury present.

2.1.2 Residential Aged Care residents

The Residential Aged Care – Admission to Residential Facility flowchart describes the requirement for a completed assessment of pressure injury risk and a comprehensive skin assessment to occur within 8 hours of admission to a residential facility. Resources to support and guide pressure injury prevention and management for residential aged care residents comprise:

- RC5 Resident Admission Assessment
- RC7 Resident Care Plan
- MR124 Braden Scale and Pressure Injury Risk Assessment
- MR124B Comprehensive Skin Assessment

2.1.3 Maternity patients

WACHS endorses for use in clinical practice, the Women and Newborn Health Service King Edward Memorial Hospital Obstetrics and Gynaecology Pressure Injury Prevention and Management Clinical Guideline.

WACHS Midwifery/ Nursing staff are to undertake a pressure injury risk assessment using the MR80A WACHS Maternity Inpatient Risk Assessment Record on admission, post birth and on discharge as described in the:

- MR 80 Vaginal birth postnatal Care Plan
- MR 81 Caesarean Postnatal Care Plan
- MR 70A WACHS antenatal inpatient Care Plan

2.1.4 Paediatric patients

WACHS endorses for use in clinical practice the Princess Margaret Hospital Pressure Injury Prevention and Management Guideline.

Resources to support and guide pressure injury prevention and management for paediatric patients comprise:

- MR111P Paediatric Nursing Admission/Discharge Assessment
- WACHS MR124A Glamorgan Scale Paediatric and Neonatal Pressure Injury Risk Assessment form
- MR120P WACHS Paediatric Nursing Care Plan
- MR115 Paediatric Short Stay Medical Admission

2.1.5 Neonates

WACHS endorses for use in clinical practice the Women and Newborn Health Service Neonatal Directorate Skin Care Guideline (for use in WACHS Special Care Nurseries), utilising the MR124A Glamorgan Scale Paediatric and Neonatal Pressure Injury Risk Assessment form to document risk assessment and guide management actions .

2.2 Partnering with patients and /or carers

WACHS clinical resources listed in 2.1.1 - 2.1.4 encourage patient (and carer) participation in shared decision making with the clinician. DoH Patient First resources provide information to patients and carers on how they can 'stay safe in hospital' and reduce the risk of developing pressure injuries.

Discharge planning for patients with an existing pressure injury must include communication with all members of the healthcare team, the patient (and carer/s where appropriate) regarding ongoing management of the pressure injury.

2.3 Reporting pressure injury clinical incidents

As required in the DoH Clinical Incident Management Policy, clinical incidents are to be notified into the DATIX Clinical Incident Management System (Datix CIMS). Hospital acquired pressure injuries and pressure injuries that have significantly deteriorated (progressed to the next stage of pressure injury) since admission must be notified into DATIX CIMS.

To support identification and management of pressure injuries the WA Health Pressure Injury alert sticker is to be used.

3. Roles and Responsibilities

WACHS Health Service Executive members are responsible for ensuring clinical governance structures exist to enable ongoing monitoring of pressure injuries and implementation of quality improvement activities to prevent and reduce their occurrence.

All Staff are:

- required to work within their scope of practice
- responsible for adhering to processes identified in this policy to ensure the optimal prevention and management of pressure injuries in WACHS healthcare facilities.
- Required to notify hospital acquired pressure injuries and pressure injuries that have significantly deteriorated into DATIX CIMS.

4. Compliance

Failure to comply with this policy may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the Employment Policy Framework issued pursuant to section 26 of the *Health Services Act 2016* (HSA) and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies is mandatory.

5. Evaluation

Governance and evaluation of pressure injury prevention and management processes involves data collection and interpretation at a site, regional and WACHS level. This is to include:

- understanding compliance with processes to screen, assess, manage and prevent pressure injuries (for example by clinical audit)
- analysis of pressure injury data (Hospital Morbidity Data System) and clinical outcomes (Clinical Incident Management System information) at regional (Business Performance Meetings) and WACHS (Adverse Event Review Team and HealthCare Safety and Quality Executive Sub-Committee) governance committees.

6. Standards

National Safety and Quality Health Service (NHQHS) Standards Edition 1

- NSQHS Standard 8: Preventing and Managing Pressure Injuries: 8.1.1 and 8.1.2

National Safety and Quality Health Service (NHQHS) Standards Edition 2

- Comprehensive Care Standard: 5.21, 5.22 and 5.23

7. Legislation

(Accessible via: Government of Western Australia (State Law Publisher or ComLaw)

Health Service Act 2016
Carers Recognition Act 2004
Disability Services Act 1993
Guardianship and Administration Act 1990
Health Practitioner Regulation National Law (WA) Act 2010
Mental Health Act 2014
State Records Act 2000

8. References

1. National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan pacific Pressure Injury Alliance. Prevention and treatment of Pressure Ulcers: Clinical Practice Guideline. Cambridge Media: Perth, Australia; 2014.
2. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards. 2nd ed. Sydney: ACSQHC; 2017.

9. Related Forms

Datix Clinical Incident Management System (Datix CIMS) form
MR111 Nursing Admission, Screening and Assessment Tool – Adults
MR120 Adult Nursing Care Plan 'My Care Plan'
MR122 Wound Assessment and Management Plan
RC5 Resident Admission Assessment
RC7 Resident Care Plan
MR124 Braden Scale and Pressure Injury Risk Assessment
MR124A Glamorgan Scale Paediatric and Neonatal Pressure Injury Risk Assessment
MR124B Comprehensive Skin Assessment
MR80A WACHS Maternity Inpatient Risk Assessment Record
MR80 Vaginal Birth Postnatal Care Plan
MR81 Caesarean Postnatal Care Plan
MR70A WACHS antenatal inpatient Care Plan
MR120P WACHS Paediatric Nursing Care Plan
MR111P Paediatric Nursing Admission/Discharge Assessment
MR66 WACHS Clinical Handover (Allied Health)
MR184 Inter-hospital Clinical Handover
MR115 Paediatric Short Stay Medical Admission

10. Related Policy Documents

WACHS Allied Health Clinical Handover Policy
WACHS Inter-hospital Clinical Handover Form Procedure
WACHS Residential Aged Care – Admission to Residential Facility Flowchart
KEMH Pressure Injury Prevention and Management Clinical Guideline
KEMH Neonatal Directorate Skin Care Guideline
PMH Pressure Injury Prevention and Management Guideline

11. Related WA Health System Policies

Clinical Incident Management Policy (2015)
Clinical Handover Policy
WA Pressure Injury Prevention and Management Clinical Guideline

12. WA Health Policy Framework

Clinical Governance, Safety and Quality Policy Framework

13. Appendix 1: International NPUAP/EPUAP Pressure Injury Classification System

This document can be made available in alternative formats on request for a person with a disability

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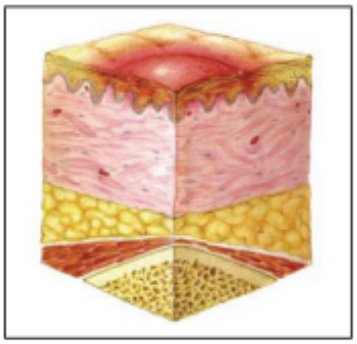
Appendix 1 - International NPUAP/EPUAP Pressure Injury Classification System[1]

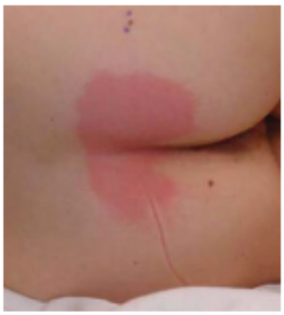
A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated.

Category/Stage I: Nonblanchable Erythema

Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.

The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category/Stage I may be difficult to detect in individuals with dark skin tones. May indicate "at risk" individuals (a heralding sign of risk).



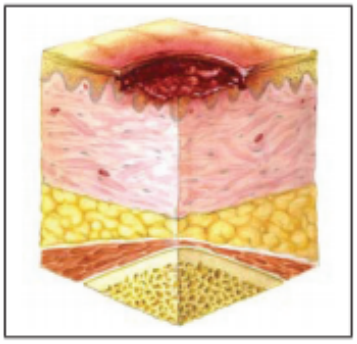


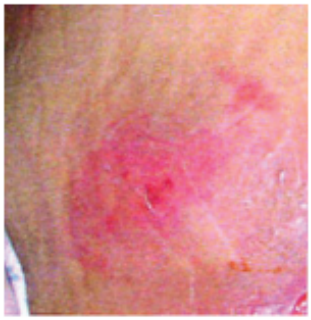
Category/Stage II: Partial Thickness Skin Loss

Partial thickness loss of dermis presenting as a shallow open ulcer 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.* This Category/Stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.

**Bruising indicates suspected deep tissue injury.*

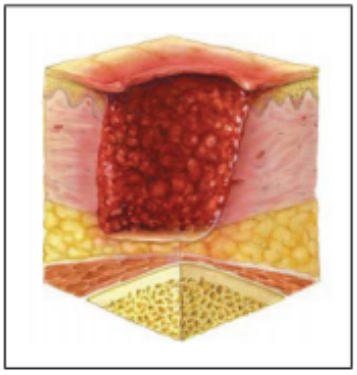


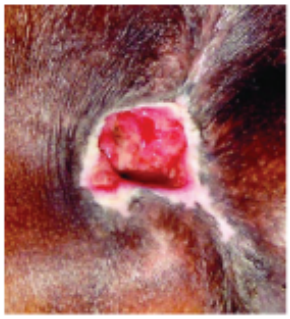


Category/Stage III: Full Thickness Skin Loss

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 tunneling.

The depth of a Category/Stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category/Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage III pressure ulcers. Bone/tendon is not visible or directly palpable.





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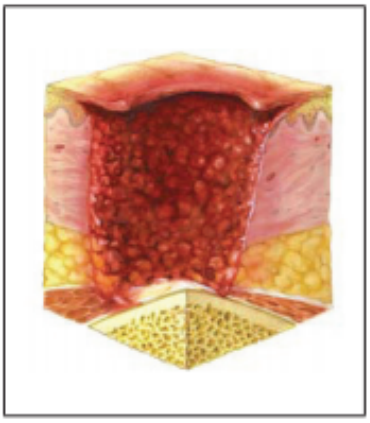
Category/Stage IV: Full Thickness Tissue Loss

Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.

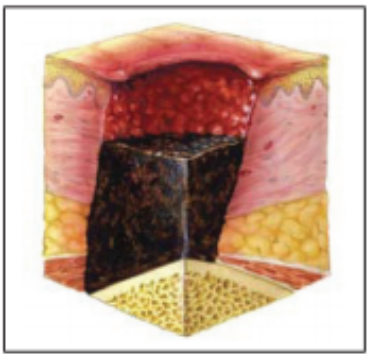
The depth of a Category/Stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category/Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.

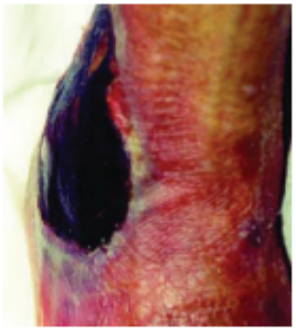


Unstageable: Depth Unknown

Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/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 localized area of discolored 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 tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.