SESLHD POLICY COVER SHEET

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EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Director, Nursing and Midwifery Services
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FUNCTIONAL GROUP(S)	Aged Care and Rehabilitation Nursing and Midwifery
KEY TERMS	Pressure Injury, Pressure Injury Prevention, Pressure Injury Management, Pressure Injury Risk
SUMMARY	This policy sets out the processes to identify patients at risk of pressure injury or who have an existing pressure injury, and health care professionals' management of this in addition to pressure injury preventative strategies risk.

COMPLIANCE WITH THIS DOCUMENT IS MANDATORY

Feedback about this document can be sent to SESLHD-Policy@health.nsw.gov.au

Pressure Injury – screening, preventing and managing

SESLHDPD/326

1. POLICY STATEMENT

This policy outlines strategies to reduce the risk of pressure injury (PI) development and minimise the occurrence and severity (stage) of skin and tissue damage to patients receiving treatment or care at South Eastern Sydney Local Health District (SESLHD) Services.

Aboriginal people have been considered and engaged with the Aboriginal Health Unit in the development of this policy.

2. AIMS

The aim of this policy is to identify those at risk of PI and initiate intervention strategies to prevent and manage PI in patients deemed to be 'at risk' who are admitted to SESLHD hospitals and/ or provided care by staff of SESLHD organisations, including those providing care in community settings. This policy extends to all patients (adult or children) admitted or presented to SESLHD facilities including Emergency Departments (EDs), Operating Theatres (OT), ward areas, out-patient clinics and community settings. The information provided must be used in conjunction with the clinical judgement of clinicians and the patients' preferences, and Aboriginal Hospital Liaison Officer can be contacted if required.

Wound management of pressure injuries is outside the scope of this business rule. For information on wound management refer to SESLHD Wound policies:

SESLHDPD/146 - Wound-Antiseptic Dressing Policy
SESLHDPR/297 - Wound – Wound Assessment and Management
Wound Product Catalogue
SESLHDPR/285 - Wound - Clinical Digital photography
SESLHDPR/205 - Wound - Incontinence Associated Dermatitis (IAD)
SESLHDPR/437 - Wound - Managing Pain at Dressing Change
SESLHDPD/136 - Wound - Negative Pressure Wound Therapy (NPWT)
SESLHDPR/398 - Wound – Graduated Compression Therapy (GCT) in Venous Disease
SESLHDPR/348 - Wound Debridement

3. TARGET AUDIENCE

SESLHD Medical, Nursing and Allied Health staff.

4. RESPONSIBILITIES

SESLHD Director Nursing and Midwifery Services, SESLHD Clinical Stream Director, Directors of Operations, Clinical Stream Directors and all staff who work in SESLHD regardless of location and position are responsible for preventing pressure injuries [(1)].

An executive manager and/or a governance group in SESLHD facilities are responsible for monitoring compliance with the health service pressure injury policies, procedures and protocols, and ensuring there are systems in place to monitor and analyse pressure injury data and conduct relevant quality improvement activities [(1)].

4.1 Chief Executive of Local Health District/Network (LHD/N) is responsible for:

Implementing best practice guidelines for the prevention and management of PI.
Allocating resources to enable effective prevention and management of PI, including:

- Delegating the day-to-day responsibility of establishing and monitoring the implementation of this policy to the relevant senior managers and/or governance group/committee.
- Making appropriate education and training available to all clinical and support staff.

4.2 Senior Health Management is responsible for:

- Establishing local clinical practice which follows best practice guidelines, to support safe and effective prevention and management of PI.
- Making appropriate education and training in PI prevention and management available to staff. Encouraging a culture of harm prevention and patient participation in their own care.
- The availability and accessibility of necessary products and equipment to ensure safe and effective patient care for PI prevention and management.
- Developing, implementing and monitoring the product and equipment strategies for the prevention and management of PI.

4.3 LHD/N Clinical Governance Unit is responsible for:

- Supporting and monitoring this policy in line with best practice guidelines for the prevention and management of PI.
- Collecting, collating, analysing and evaluating relevant data to improve patient safety and supporting quality improvement activities.
- Providing feedback to the relevant clinical unit/s validated information on outcomes in relation to this policy.
- Supporting the audit tools (such as QARS) to assess compliance with the policy.

4.4 Executive Sponsor is responsible for:

- Promote a positive culture that supports PI prevention and management strategies in their facilities.
- Provide support to Managers and PI committee to ensure that PI prevention and management strategies are embedded within their facilities.
- Ensure that identified risks appropriately mitigated in a timely manner.

4.5 Line Manager or Delegate is responsible for:

- Promote a positive culture that supports PI prevention and management strategies in their clinical areas.
- Ensure that any identified gaps in clinical practice communicated, reported and managed as per NSW Minister of Health policies [1, 2, 3]
- Ensure that all clinical staff are compliant with mandatory education attendance.
- Ensure that all clinical staff work within clinical practice.
- Ensure that all clinical staff have access to appropriate resources.
- Ensure that identified risks are appropriately mitigated in a timely manner.

4.6 Clinical staff who involves in PI prevention and management is responsible for:

- Promote a positive culture that support PI prevention and management strategies.
- Complete PI risk screening and assessment of a patient presented to a SESLHD facility and identify staging of PI if any (Appendix A). Risk assessment tools used at SESLHD are Waterlow, Braden, Glamorgan Scale (Appendix B, C and D).

- Document risk assessment and management plans into the Electronic Medical Record (eMR), Electronic Record Intensive Care (eRIC), Surginet and FirsNet or equivalent in non-inpatient settings (Community nursing services, ambulatory facilities or clinics).
- Conduction a Post Incident Bedside Safety Huddle with 24hours for all Hospital Acquired Pressure Injuries (Stages 1,2,3,4, Unstageable and Suspected Deep Tissue Injuries)[4].
- Conduct PI risk assessment regularly based on identified risk on admission/presentation.
- Commence PI management strategies based on identified risk.
- Communicate PI risk assessment and management with patient/carer and multidisciplinary team members who involve in patient's care regularly.
- Mandatory completion of My Health Learning on-line learning pathway. The learning pathway includes three modules as;
    - Pressure Injury Risk Assessment (course code 115610702)
    - Pressure Injury Risk Management (course code 115610919)
    - Wound Assessment (course code 40063891)
- Completion of hospital orientation sessions.
- Maintain knowledge and skills through attendance at regular training sessions identified by each facility.
- Participate PI related audits as communicated via line managers. Examples of PI audits are; documentation, equipment, risk assessment, risk management or point prevalence audits.
- Communicate any faulty equipment with line managers and/or in-charge for maintenance and/or replacement for prevention of risk in a timely manner.
- Ensure that PI related equipment usage according to manufacturer guideline.
- Ensure that identified risk communicated, reported and managed as per policies [1, 2, 3]

5. DEFINITIONS

Active Support Surface	A powered support surface that produces alternating pressure through mechanical means, providing the capacity to change its load distribution properties with or without an applied load. This generally occurs through alternating of air pressure in air cells on a programmed cycle time. Also called an alternating pressure support surface or a dynamic support surface [5].
Bony prominence	An anatomical projection of bone [5].
Carers	People who provide care and support to family members and friends who have a disability, mental illness, chronic condition, terminal illness, an alcohol or other drug issue or who are frail aged. Carers provide emotional, social or financial support [6]. Carers provide support for activities of daily living and include parents and guardians caring for children [6].
Classification of pressure injuries	Pressure injuries are classified using the National Pressure Ulcer Advisory Panel (NPUAP) and European Pressure Ulcer Advisory Panel (EPUAP) 2009/2014 classification system cited in the Australian Wound Management Association Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure Injury, 2012[7]. Classification of PI (Appendix A)

Community Services	Services provided in the community setting and include but not limited to, Generalist Community Health Services, Palliative Care Services, Hospital in the Home, Child and Family Health Services, Chronic Care Services, Continence Services, Ostomy Services, Diabetes Services and Podiatry Services.
Mucosal pressure injury	Mucosal membrane pressure injuries are pressure injuries of the moist membranes that line the respiratory, gastrointestinal and genitourinary tracts. Mucosal pressure injuries are primarily caused by medical devices exerting sustained compression and shear forces on the mucosa. Classification systems for pressure injuries of the skin and underlying tissue cannot be used to categorize mucosal pressure injuries [(5).]
NSW public health facility	Any clinical unit or service that delivers public healthcare services. Health facilities include hospitals, multi-purpose services, emergency services, ambulatory care services, Aboriginal Medical Services and community health services and clinics.
Plan of care	Outlines the types and frequency of services required and the service provider details to meet care needs and mitigate identified risk factors.
Pressure Injury (PI)	Localised damage to the skin and/or underlying tissue, as a result of pressure or pressure in combination with shear and friction. Pressure injuries usually occur over a bony prominence but may also be related to a medical device or other object [(5, 8).]
Pressure injury risk identification	A process to support identification of an individual's risk of developing a pressure injury. **Risk screening must consider** the three primary predictors of PI development: 1) **Mobility/activity and neurological status** - which can be restricted by the following but is not limited to physical limitations, over/under weight, sensory deficits, impaired cognition, low affect, demotivation, medication/anaesthetic or pain. 2) **Perfusion** – related to diabetes, peripheral artery disease, venous insufficiency, respiratory disease, organ failure, medication. 3) **Skin status** (as reported by the patient or the carer): a) General skin status relating to factors which may make the skin more vulnerable to pressure injury, e.g., redness, moisture, dryness, oedema b) Skin integrity including current and previous pressure injuries [(9).] Patients with a history of or if a current pressure injury exists may be at risk of developing further pressure injuries [(1).]
Primary Care Provider	Primary healthcare providers include but are not limited to – General Practitioners, nurses (including general practice nurses, community nurses and nurse practitioners), allied health professionals, midwives, pharmacists, dentists, and Aboriginal Health Workers.
Risk screening	A process to support identification of an individual's risk of developing a PI [(5).]

Reactive Support Surface	Powered or non-powered support surface with the capability to change its load distribution properties in response to an applied load [10].
Skin assessment	Examination of the entire skin surface from head to toe to check integrity and identify any characteristics indicative of pressure damage/injury. This entails assessment for erythema, blanching response, localised temperature changes compared to surrounding skin, oedema, induration and skin breakdown. Consider different skin tones. The skin beneath devices, prosthesis and dressings are to be checked when practical and safe to do so [5].
Staff	Any person working within the NSW Health system including clinicians, contractors, students and volunteers.
Unavoidable Pressure Injuries	Pressure injuries which occur despite consistent application of PI prevention interventions. The implemented interventions were consistent with the patient's needs, goals, and recognised standards of practice, and there is evidence of monitoring and evaluation/revision of the interventions [11].
Wound-related pain	An unpleasant sensory and emotional experience associated with a PI. Patients may use different words to describe pain including discomfort, distress and agony [12]. Patients with cognitive impairment or expressive dysfunction may be unable to communicate their pain.

6. PRESSURE INJURY PREVENTION AND MANAGEMENT

6.1 Pressure Injury Risk Screening and Assessment

All inpatients, including paediatric patients under the age of 16 years, must be screened for PI risk as early as possible to SESLHD presentation/admission as:

- Within 8 hours of presentation to inpatient and Multi-Purpose Service (MPS) long stay and Residential Aged Care (RAC) facilities
- At the first home visit or presentation to non-inpatient (community services, ambulatory facilities or clinics with clients at high risk) services.

Risk screening must consider the three primary predictors of PI development:

1) Mobility/activity and neurological status - which can be restricted by the following but is not limited to physical limitations, over/under weight, sensory deficits, impaired cognition, low affect, demotivation, medication/anaesthetic or pain.

2) Perfusion – related to diabetes, peripheral artery disease, venous insufficiency, respiratory disease, organ failure, medication.

3) Skin status (as reported by the patient or the carer):

a) General skin status relating to factors which may make the skin more vulnerable to PI, e.g., redness, moisture, dryness, oedema.

b) Skin integrity including current and previous pressure injuries [9].

Patients with a history of or if a current pressure injury exists may be at risk of developing further pressure injuries [1].

The PI risk assessment tools assist with identifying the level of PI risk. The PI risk assessment tools are used at SESLHD facilities are, for adult patients/clients Waterlow and Braden scale (Appendix B, C) and for paediatric patients/clients adapted 'Glamorgan Scale' assessment tool (Appendix D), for outpatient settings Modified Anderson tool or clinical judgement (Appendix E).

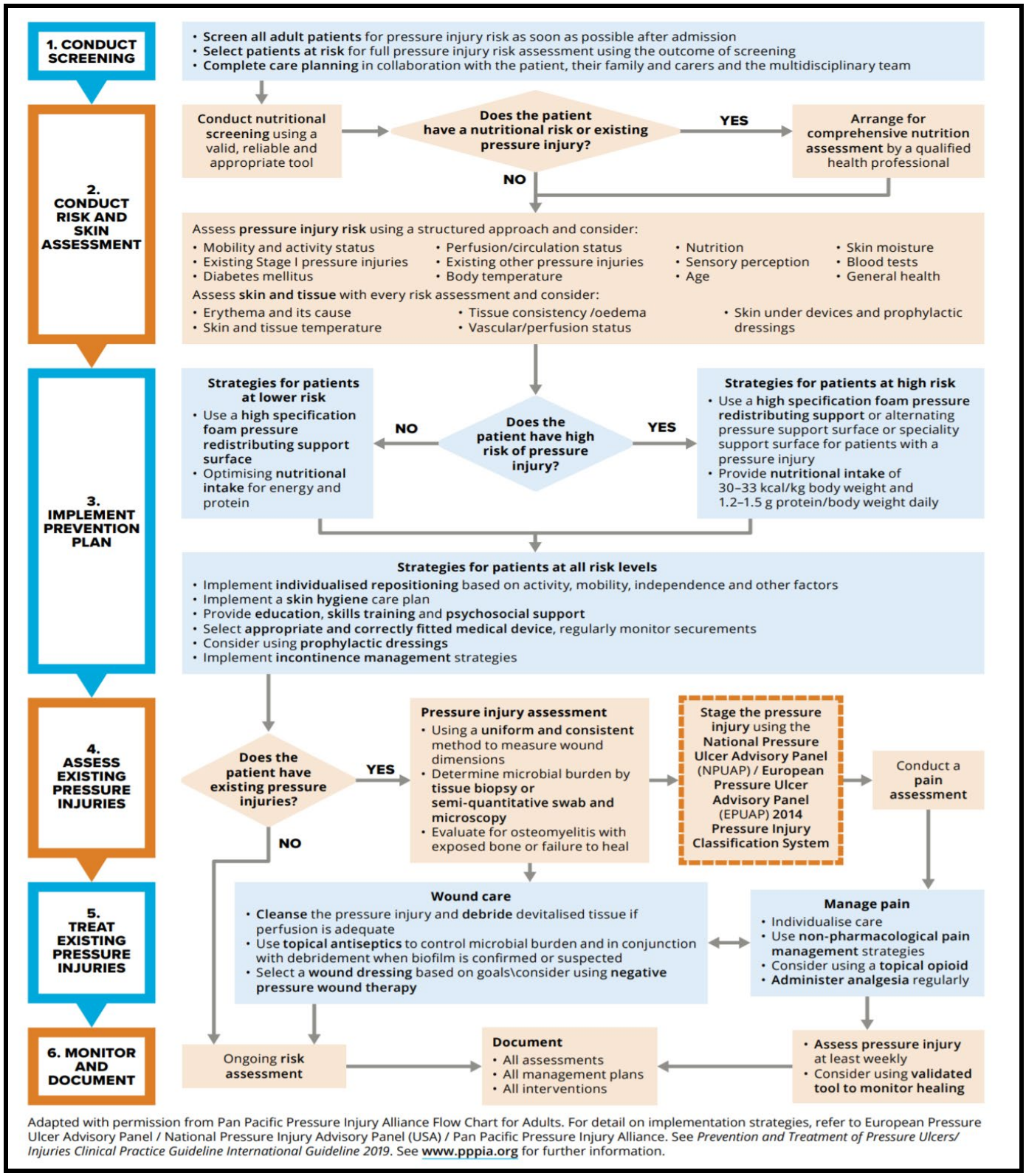
The following (Table 1) outlines PI screening and skin assessment requirements based on patient care setting as per NSW Health Policy [1].

Table 1: PI screening and skin assessment based on patient care settings

	Inpatients	Multi-Purpose Service (MPS) long stay facility residents and NSW Health Residential Aged Care (RAC) facility residents	Non-inpatients (community services, ambulatory care or clinics with clients at high risk)
First pressure injury screening and skin assessment to guide clinical decision making	1. Screened as soon as possible - no later than 8 hours of presentation 2. Skin assessment on identification of risk factors	1. Screened within 8 hours of presentation 2. Skin assessment on identification of risk factors	1. Screened at the first home visit or presentation 2. Skin assessment (if practicable) on identification of risk factors
Identified risk factor/s	Skin assessment and plan of care reviewed daily, and: • Change in health status or mobility • Pre-operatively, and as soon as feasible after surgery • Postnatally, prior to leaving the birthing setting • Transition of care • Prior to discharge • If a pressure injury develops • Based on clinical judgement	Skin assessment daily and plan of care reviewed regularly (on agreed review date), and: • Change in health status or mobility • Clinical change impacts on the needs, goals or preferences of the consumer • Transition of care • If a pressure injury develops • Based on clinical judgement	Skin assessment and review of plan of care monthly (as a minimum) and: • Change in health status or mobility • Transition of care • If a pressure injury develops • Based on clinical judgement
No identified risk factor/s	Reassess: • Change in health status or mobility • Post operatively • Postnatally, prior to leaving the birthing setting • Transition of care • Prior to discharge • If a pressure injury develops • Based on clinical judgement	Reassess: • Change in health status or mobility • Transition of care • If a pressure injury develops • Based on clinical judgement	Reassess: • Change in health status or mobility • Transition of care • If a pressure injury develops • Based on clinical judgement
Pressure injury/ies - skin assessment and pain assessment completed and documented	During each shift as a minimum	During each shift as a minimum	At each home visit/appointment
NB. Community services who are not the primary care provider for clients/consumers identified at risk for pressure injury are to provide education to the client/consumer and/or carer and primary provider. This will increase awareness and understanding of risk factors and their role in ongoing monitoring of skin integrity and the plan of care. People with spinal cord injury and other neurological disorders are at life-long high risk for pressure injuries. The plan of care is to be reviewed regularly, particularly if there is a change in health status or mobility.			

After PI risk screening and assessment, PI prevention and management strategies must be implemented based on identified risk level and individualised care plan within two hours [1].

Figure 1: PI Prevention and Management for adult hospital admissions [13]



Adapted with permission from Pan Pacific Pressure Injury Alliance Flow Chart for Adults. For detail on implementation strategies, refer to European Pressure Ulcer Advisory Panel / National Pressure Injury Advisory Panel (USA) / Pan Pacific Pressure Injury Alliance. See *Prevention and Treatment of Pressure Ulcers/ Injuries Clinical Practice Guideline International Guideline 2019*. See www.pppia.org for further information.

6.1 Conduct skin assessment

PI risk factor/s must be identified through the initial screening process and comprehensive skin assessment documented in clinical notes. If a skin assessment is outside of the clinician's scope of practice, referral for skin assessment may be required. Ongoing regular skin assessment based on care setting (Table 1).

In some situations, the patient may not give consent or is unsuitable to undergo a full skin assessment. The clinician must record in the medical record the reason why the skin assessment was not undertaken.

In clinical situations when the risk of doing a skin assessment is outweighed by other risks to the patient or staff, the assessment is to take place as soon as practical after the risk is mitigated. Risks include:

- Clinical instability e.g. acute spinal cord injury, unstable fractures, active bleeding
- Medical device patency e.g. extracorporeal membrane oxygenation (ECMO), intraarterial lines/sheaths
- Dressing wear time e.g. severe burn injury, negative pressure wound therapy.
- Potential for physical harm to the patient or staff e.g. delirium, behavioural disturbance, psychological trauma, cultural sensitivity
- Imminent death.

Comprehensive skin assessment include a head to toe assessment especially over bony prominences, such as occiput, shoulder, sacrum, coccyx or great trochanter, and under and/or around a device such as endotracheal tubes, intravenous lines or cast.

Patients must be reviewed if

- There is a change in patient's health status or mobility
- Pre-operatively
- Post-operatively (as soon as feasible after surgery)
- Postnatally prior leaving the birthing setting
- At transition of care
- Prior to discharge
- If a pressure injury develops

If a PI risk identified, the risk, skin assessment and plan of care must be reviewed and ongoing comprehensive skin assessment must be undertaken [(1).]

PI prevention and management for inpatients, non-inpatients and Multi-Purpose Service Long Stay (MPSLS) Facility residents and NSW Health Residential Aged Care Facility as outlined in figures 2, 3 and 4 [(14).]

Figure 2: PI Prevention and Management for Inpatients

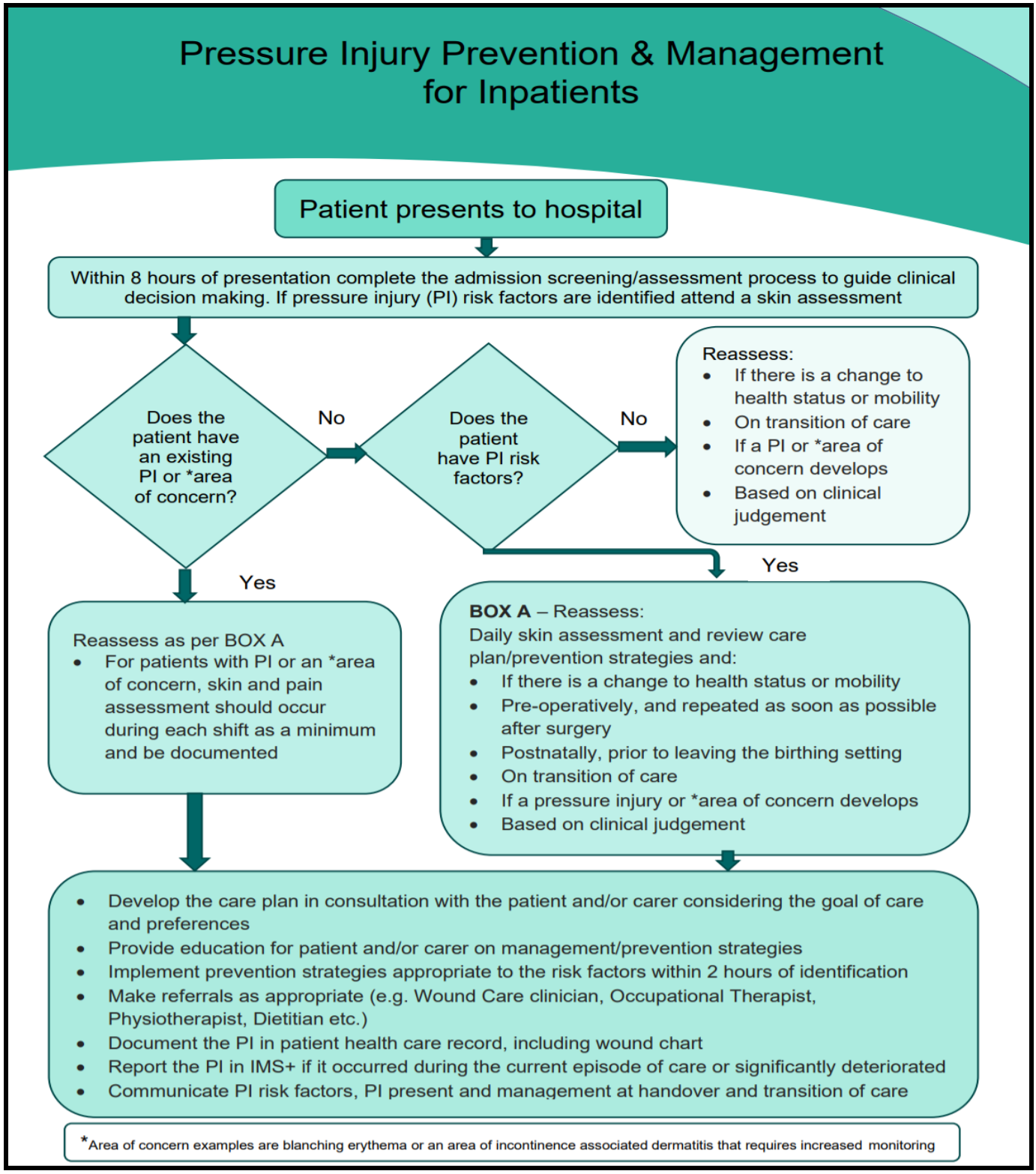


Figure 3: PI Prevention and Management for Non-Inpatient

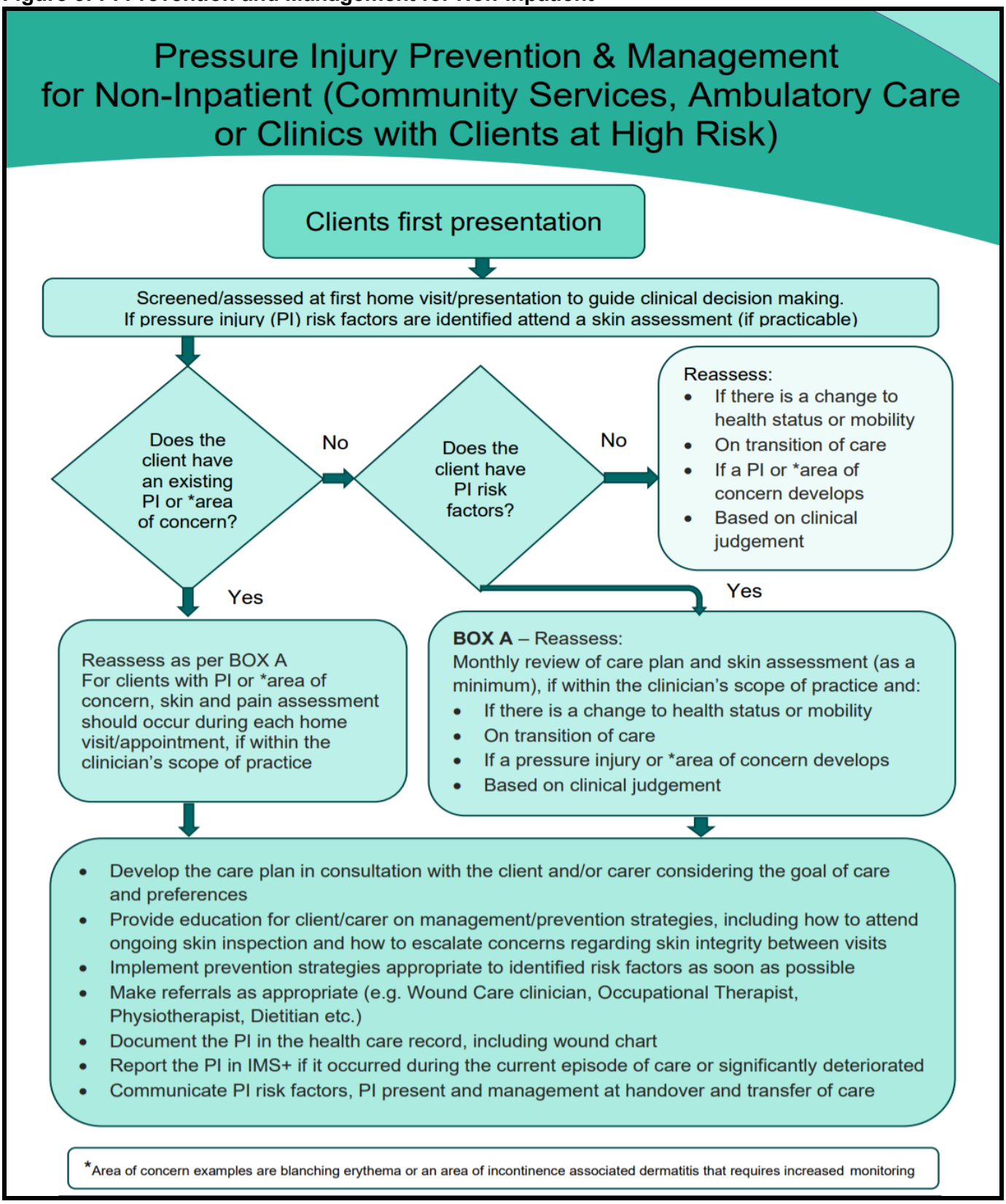
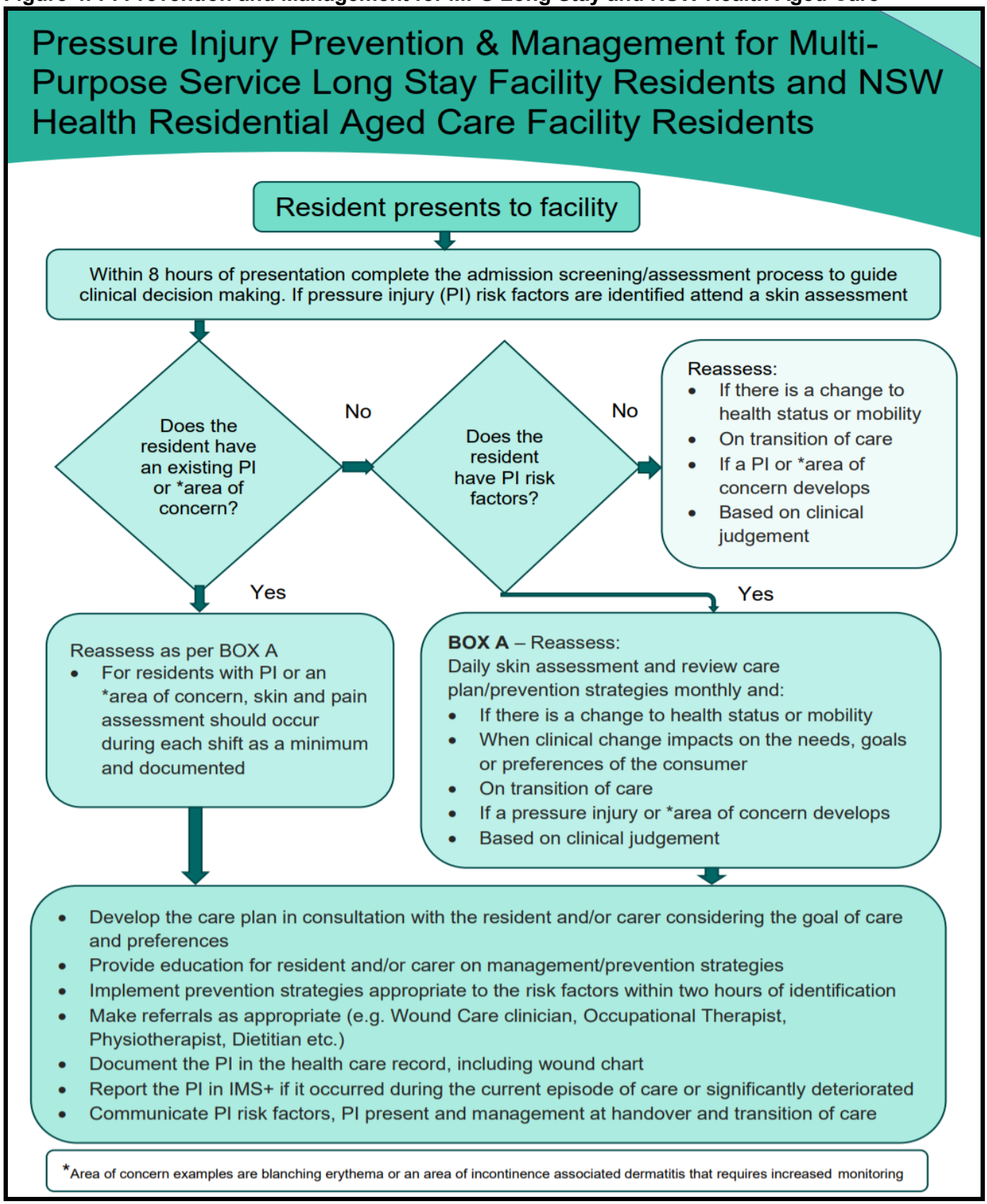


Figure 4: PI Prevention and Management for MPS Long Stay and NSW Health Aged Care



6.2 Developing plan of care

For patients/clients who are at risk of, or have an existing PI, the plan of care must:

- Be developed with the person, and/or their carer (when able) and documented in their medical record.
- Include strategies aimed at preventing PI and optimising healing and preventing complications of current PI.
- Document how the patient and/or carer are involved in the PI prevention and management care planning process.
- Have input from the interdisciplinary team about additional assessment, recommendations and treatment.
- Be communicated via documentation in the medical record.
- Be communicated during handover at the end of every shift in an acute, MPS long stay facility or NSW Health RAC facility, and within twenty-four hours of initial home visit for community services.
- Have risk communicated, e.g. through the use of patient journey boards and care boards
- Be verbally communicated during bedside handover, intentional-rounding, safety huddles, journey board meetings and at transition of care.

6.3 Prevention Strategies

Patients with PI risk factors, either with or without pressure injury, must have:

- Evidence based prevention strategies implemented as a priority within two hours of risk identification.
- Targeted interventions/strategies based on the risk factor(s) identified and reviewed regularly for their effectiveness.
- Repositioning and/or early mobilisation schedule to prompt or assist repositioning as clinically indicated and using appropriate manual handling techniques and equipment.
- Patients are to be educated and encouraged to perform independent, pressure relieving manoeuvres when able.
- A 30-degree side lying position is to be used when repositioning individuals in bed. Keep the head of the bed as flat as possible at no greater than 30-degrees elevation unless clinically necessary to facilitate breathing and/or prevent aspiration and ventilator-associated pneumonia [(5).]
- The knee break function is to be used to prevent the patient from sliding down the bed to reduce shear forces. The torso to thigh angle is to be no greater than 30-degrees [(5).]

Pressure redistribution:

- Mattress support surfaces which meet individualised requirements (i.e. weight, moisture, temperature, width, static or active surface types) are to be considered and regularly reviewed.
- Support surfaces (such as active and reactive) are to be used during care, including emergency departments, operating room, intensive care, dialysis units, and during transportation when clinically indicated and appropriate.

NB: In unstable spinal or pelvic fracture, active support surfaces are contra-indicated. This is regardless of the patient having identified risk factors for PI or an existing PI. Patients with unstable spinal or pelvic fracture are to stay on the appropriate non-powered support surface and receive regular pressure relief through lifting, as per spinal and pelvic fracture protocols.

- Seating support surfaces which meet the individualised requirements are to be considered and regularly reviewed.
- Other pressure redistribution and offloading equipment (e.g. repositioning devices or aids) are to be used according to individualised requirements and goals of care.
- Heels, Achilles tendon and popliteal vein are to be offloaded completely to distribute the weight of the leg along the calf [5].

Medical devices:

- Devices/orthoses, compression therapy/stockings, casts/splint and other devices are to be correctly fitted, repositioned or removed regularly to have underlying skin inspected.
- Devices and orthosis need to be checked within 1-2 hours of first application to ensure there is no pressure [8]
- The paediatric population is at increased risk of device related pressure injury.

Reduction of shear and friction:

- Prophylactic dressings - note dressing products do not reduce pressure.
- Appropriate manual handling techniques and equipment

Pain Management:

- Ensure patients have adequate pain management to support early mobilisation and repositioning.

Education of patients/carers:

- On risk factors, prevention strategies and the importance of regular repositioning. Patient education brochures are (Appendix G, H and I) and translated version of patient education brochures can be found at Clinical Excellence Website [14] https://www.cec.health.nsw.gov.au/keep-patients-safe/older-persons-patient-safety-program/pressure-injury/information-for-patients
- Patient education brochures on paediatric population (Appendix J)

Skin protection and moisture balance:

- Skin is cleaned and hydrate.
- Skin is protected from excessive moisture with a barrier product.
- Vigorous massage or rubbing of the skin is to be avoided as this can cause damage from shear and friction.

Continence management for persons with incontinence:

- A continence management plan is to be developed that facilitates individualised toileting, change of continence aids, and regular skin care.
- Highly absorbent continence products to protect the skin in individuals with or at risk of PI who have urinary and/or faecal incontinence. These need to be checked and changed regularly.
- Skin is to be cleansed after each episode of incontinence.

Adequate nutrition and hydration, is to be provided, including:

- Consideration of adequacy of total energy (calorie), protein, fluid, vitamin and mineral intake.
- Screening for nutritional deficiencies.

- Nutrition assessment by a Dietitian (where available) if with or at risk of malnutrition or for those with severe pressure injuries (stage 3, stage 4, Unstageable and Suspected Deep Tissue). Risk factors for malnutrition may include unintentional weight loss, poor appetite, reduced oral intake, and increased gastrointestinal losses (e.g. diarrhoea, vomiting).
- Consideration of high energy high protein supplements, and/or arginine if recommended by a Dietitian or Medical Officer.
- Feeding assistance, if required.

Referral to health disciplines are to be made as clinically indicated for additional assessment and treatment.

6.4 Assess existing pressure injuries

Pressure injuries are classified using the EPUAP/NPUAP 2009/2014 classification system (Appendix A).

Classification and assessment of PI must occur,

- when a PI is identified,
- during serial wound management and
- on transfer of care.

Pain assessments are to be conducted to include pain management in the plan of care.

6.5 Managing existing pressure injuries

Management of pressure injuries when a PI is identified, plan of care should address risk factors and includes wound and pain assessment and management. The plan of care is to be reviewed by the multidisciplinary team within twenty-four hours of PI identification wherever possible.

If a PI develops or an existing PI significantly deteriorates (progresses to a more severe stage) the patient is to be reviewed.

Wound Management is to be provided or supervised by clinicians with knowledge, skills, and resources to provide treatment in accordance with best practice.

6.6 Monitor and document

The risk, skin assessment and plan of care should be documented on eMR, eRIC or relevant forms. Documentation as [17]

- Immediate pre-admission history e.g. risk factors such as length of time on the floor, tissue damage present on admission to hospital
- Results of risk screening and assessments on admission and regular bases
- Details of interventions for patient /client identified at risk of PI
- The type of mattress/cushion selected
- Document whether equipment, e.g. mattress or cushion, is functioning correctly
- Any healthcare professional consulted to manage PI prevention
- Consultation with patient/ carer.
- Monitoring of progress and review/ reassessment, as required.
- Community nursing will record PI details in the Wound Assessment Treatment Evaluation Plan (WATEP) form on eMR.
- PI care and end of life care pathway as per MDT goal of care.

Monitor and document pressure injuries;

- in the medical record and complete wound chart(s) for PI, including if they were present on presentation or developed during the episode of care.
- Documentation is to include a PI classification, anatomical location and dimensions.
- PI reassessment is to occur as frequently as required, but at least weekly. Severe or a PI that is not healing as anticipated, i.e. 25% reduction in four weeks3 are to be reviewed by a clinician with expertise in wounds.
- Capture and upload an image of the PI after gaining consent from a patient as part of the documentation to monitor outcomes.
- Notify through the incident management system, IMS+, if the injury was acquired during the current episode of care [(2).]

Consultations are to occur in a timely fashion with clinicians with expertise in wounds, medical or other health disciplines for their assessment, management and interventions. The use of virtual health to facilitate the consultation and reduce the need for patient or clinicians to travel is to be considered.

Pain is to be assessed and managed using best practice guidelines (using a validated pain tool) and documented.

Nutritional support is to be provided in accordance with NSW Health Nutrition Care Policy [(18)]

Prevention of additional pressure injuries as patients with a pressure injury are at a high risk of the injury worsening or developing other pressure injuries (Refer section 6.3).

6.7 Transition of Care

Transition of care for a patient at risk or with a PI requires timely communication with health care providers taking over/resuming care, the patient and/or their carers, other community or residential services, equipment suppliers, and allied health clinicians.
Communication of care is to occur:

- In the medical record and complete wound chart(s) for PI, including if they were present on presentation or developed during the episode of care.
- Goals of care (healing, maintenance, or palliation)
- Classification, anatomical location and dimensions of the PI
- Wound management
- Ongoing prevention/management strategies
- Follow-up care.

Prevention strategies are to be used during transportation or transition of care for patients at risk or with an existing pressure injury [(5).]

7 RESOURCES

PI prevention products, devices and equipment are to be purchased/rented in accordance with NSW Health Procurement Guidelines and SESLHD Pressure Relieving Mattresses and Cushions Rentals guidelines [(15)] and used in accordance with:

- The manufacturers' instructions
- NSW Health Infection Control Policies
- NSW Health Workplace Health & Safety Policy.

8 EDUCATION AND TRAINING

Clinical staff providing care to patients at risk of or with PI are to undertake training in PI prevention and management, modules are available on My Health Learning on-line learning pathway.

The learning pathway includes three modules as:

- Pressure Injury Risk Assessment (course code 115610702)
- Pressure Injury Risk Management (course code 115610919)
- Wound Assessment (course code 40063891)

Targeted education for:

- Follow-up care
- Orientation and ongoing training programs related to PI prevention and management
- Clinical coders on PI classification and condition onset
- Auditors who conduct audits related to pressure injuries

Recording of training sessions on PI prevention and management should be entered to HETI under relevant training codes and monitored by line managers.

9 REPORTING

9.1 PI Incidents Notification

Incident notification in the incident management system (IMS+) must occur for

- Hospital/health service-acquired PI, which have developed after eight hours of presentation and communicated to the admitting medical team or primary care provider.
- PI that have deteriorated (progressed to a more severe PI) since admission.

Unstageable pressure injuries and suspected deep tissue injuries require review for definitive staging [(1).] Where definitive staging is likely to occur after the transition of care, the health service is to communicate with the ongoing care provider to confirm staging. Definitive staging is to be entered into the medical record and the IMS+ particularly for unstageable pressure injuries or suspected deep tissue injuries that are staged as a stage 3 or stage 4.

Stage 3, stage 4, unstageable and suspected deep tissue pressure injuries which are hospital/health service-acquired are to have a clinician with expertise in PI prevention and management or wound management on the Incident Review Team, where possible.

Hospital/Health Service-acquired PI are reviewed and recommendations reported and monitored in accordance with the NSW Health Policy Directive Incident Management (PD2020_047) [(2).]

When a PI occurs or deteriorates to a more severe injury during an episode of care, the patient and/or carer are informed in accordance with the NSW Health Policy Directive Open Disclosure Policy (PD2014_028) [(16).]

Pre-existing PI do not require notification in the IMS+. These are to be documented in the medical record and wound chart.

9.2 Monitoring

Health services are to have systems in place to:

- Identify PI that develop during the episode of care.

- Review PI data regularly, at a minimum quarterly
- Ensure PI data is communicated to the health service executive and those responsible for governance of clinical care
- Analyse PI data to inform care, quality improvement activities and monitor progress.
- Conduct PI Point Prevalence Audit annually or as required.

10. REFERENCES

Reference number	Reference citation
1	NSW Health Policy Directive PD2021_023 - Pressure Injury Prevention and Management
2	NSW Health Policy Directive PD2020_047 - Incident Management
3	NSW Health Policy Directive PD2020_013 - Complaints Management
4	SESLHDGL/072 - Post Incident Bedside Safety Huddles and Effective use of the HUDDLE UP tool
5	European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline. The International Guideline. Emily Haesler (Ed). EPUAP/NPIAP/PPPIA: 2019
6	Carers Australia. About Carers. https://www.carersaustralia.com.au/about-carers/who-is-a-carer/
7	Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure Injury, 2012. Australian Wound Management Association, Cambridge Media Osborne Park, WA
8	Gefen A, Alves P, Ciprandi G et al. Device related pressure ulcers: SECURE prevention. J Wound Care 2020; 29(Sup2a): S1–S52 https://doi.org/10.12968/jowc.2020.29.Sup2a.S1
9	Coleman S, Gorecki, C., Nelson, EA., Closs, SJ, Defloor, T., Halfens, R., Farrin, A., Brown, J., Schoonhoven, L., and Nixon, J. Patient risk factors for pressure ulcer development: Systematic review. International journal of Nursing Studies. 2013, 974-1003.
10	National Pressure Injury Advisory Panel. (2020). Support Surface Standards Initiative. American National Standards Institute / Rehabilitation Engineering Society of North America (ANSI/RESNA). https://cdn.ymaws.com/npiap.com/resource/resmgr/s3i/10-23_Terms_and_Defs_2019_We.pdf
11	Black, J., Cuddigan, J., Capasso, V., Cox, J., Delmore, B., Munoz, N., & Pittman, J. on behalf of the National Pressure Injury Advisory Panel (2020). Unavoidable Pressure Injury during COVID-19 Crisis: A Position Paper from the National Pressure Injury Advisory Panel. www.npiap.com
12	International Association for the study of pain. Accessed March 2020. https://www.iasp-pain.org/Education/Content.aspx?ItemNumber=1698
13	Australian Commission on Safety and Quality in Health Care https://www.safetyandquality.gov.au/standards/nsqhs-standards/comprehensive-care-standard/minimising-patient-harm
14	Clinical Excellence Commission Pressure Injury Prevention https://www.cec.health.nsw.gov.au/keep-patients-safe/older-persons-patient-safety-

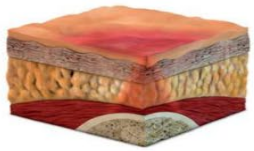
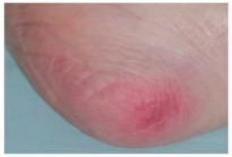
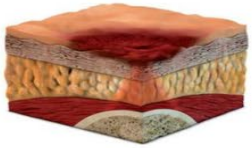
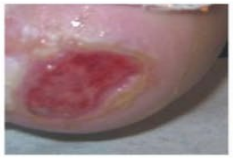
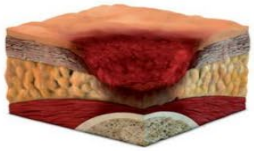
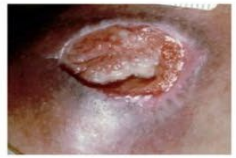
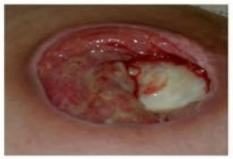
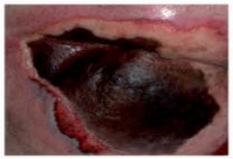
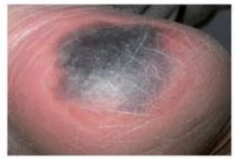
	program/pressure-injury
15	SESLHD Procurement Pressure Relieving Mattresses and Cushions Rentals http://seslhdweb.seslhd.health.nsw.gov.au/SESLHD_Procurement/Clincal_Products/mattresses.asp
16	NSW Health Policy Directive PD2014_028 - Open Disclosure Policy
17	SESLHDPR/336 - Documentation in the Health Care Record
18	NSW Health Policy Directive PD2017_041 - Nutrition Care

11. REVISION & APPROVAL HISTORY

Date	Revision No.	Author and Approval
August 2020	DRAFT	Author: Emine Tetik, POWHCH CNC Pressure Injury Prevention and Management in collaboration with the SESLHD Pressure Injury Committee.
August 2020	DRAFT	Draft for comment period.
December 2020	DRAFT	Approved by Executive Sponsor.
December 2020	DRAFT	To SESLHD Clinical and Quality Council for endorsement
January 2021	1	Approved by SESLHD Clinical and Quality Council. Published by Executive Services.
January 2022	2	Minor review based on *NSW Health Policy Directive PD2021_023 - Pressure Injury Prevention and Management Policy* by Emine Tetik, POWHCH CNC Pressure Injury Prevention and Management in collaboration with the SESLHD Pressure Injury Committee. Approved by Executive Sponsor.

Appendix A: Pressure Injury Classification System

Pressure injury classification system

Stage I pressure injury: non-blanchable erythema	Stage II pressure injury: partial thickness skin loss	Stage III pressure injury: full thickness skin loss
• 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).	• 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.	• 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	**Unstageable pressure injury: depth unknown**	**Suspected deep tissue injury: depth unknown**
• 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.	• 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.	• 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.
 	 	 

All 3D graphics designed by Jarrad Gittos, Gear Interactive, http://www.gearinteractive.com.au
Photos stage, I,IV, unstageable and suspected deep tissue injury courtesy C. Young, Launceston General Hospital. Photos stage II and III courtesy K. Carville, Silver Chain. Used with permission.

Based on National Pressure Ulcer Advisory Panel (NPUAP), European Pressure Ulcer Advisory Panel (EPUAP). Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline. 2009, Washington DC: NPUAP cited in Australian Wound Management Association. Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure Injury. Abridged Version, AWMA; March 2012. Published by Cambridge Publishing, Osborne Park, WA.

Appendix B: Waterlow pressure injury risk assessment

WATERLOW PRESSURE ULCER PREVENTION/TREATMENT POLICY

RING SCORES IN TABLE, ADD TOTAL. MORE THAN 1 SCORE/CATEGORY CAN BE USED

BUILD/WEIGHT FOR HEIGHT		SKIN TYPE VISUAL RISK AREAS		SEX AGE		MALNUTRITION SCREENING TOOL (MST) (Nutrition Vol.15, No.6 1999 - Australia)	
AVERAGE		HEALTHY	0	MALE	1	A - HAS PATIENT LOST WEIGHT RECENTLY	B - WEIGHT LOSS SCORE
BMI = 20-24.9	0	TISSUE PAPER	1	FEMALE	2	YES - GO TO B	0.5 - 5kg = 1
ABOVE AVERAGE		DRY	1	14 - 49	1	NO - GO TO C	5 - 10kg = 2
BMI = 25-29.9	1	OEDEMATOUS	1	50 - 64	2	UNSURE - GO TO C AND SCORE 2	10 - 15kg = 3
OBESE		CLAMMY, PYREXIA	1	65 - 74	3		> 15kg = 4
BMI > 30	2	DISCOLOURED GRADE 1	2	75 - 80	4		unsure = 2
BELOW AVERAGE		BROKEN/SPOTS		81 +	5	C - PATIENT EATING POORLY OR LACK OF APPETITE 'NO' = 0; 'YES' SCORE = 1	NUTRITION SCORE If > 2 refer for nutrition assessment / intervention
BMI < 20	3	GRADE 2-4	3				
BMI=Wt(Kg)/Ht (m)^2							

CONTINENCE		MOBILITY	
COMPLETE/ CATHETERISED	0	FULLY	0
URINE INCONT.	1	RESTLESS/FIDGETY	1
FAECAL INCONT.	2	APATHETIC	2
URINARY + FAECAL INCONTINENCE	3	RESTRICTED	3
		BEDBOUND e.g. TRACTION	4
		CHAIRBOUND e.g. WHEELCHAIR	5

SCORE
10+ AT RISK
15+ HIGH RISK
20+ VERY HIGH RISK

SPECIAL RISKS

TISSUE MALNUTRITION		NEUROLOGICAL DEFICIT	
TERMINAL CACHEXIA	8	DIABETES, MS, CVA	4-6
MULTIPLE ORGAN FAILURE	8	MOTOR/SENSORY	4-6
SINGLE ORGAN FAILURE (RESP, RENAL, CARDIAC,)	5	PARAPLEGIA (MAX OF 6)	4-6
PERIPHERAL VASCULAR DISEASE	5	**MAJOR SURGERY or TRAUMA**	
ANAEMIA (Hb < 8)	2	ORTHOPAEDIC/SPINAL	5
SMOKING	1	ON TABLE > 2 HR#	5
		ON TABLE > 6 HR#	8

MEDICATION - CYTOTOXICS, LONG TERM/HIGH DOSE STEROIDS, ANTI-INFLAMMATORY MAX OF 4

Scores can be discounted after 48 hours provided patient is recovering normally

Obtainable from the Nook, Stoke Road, Henlade TAUNTON TA3 5LX

* The 2005 revision incorporates the research undertaken by Queensland Health.

www.judy-waterlow.co.uk

Appendix C: Braden Scale

Risk assessment tools

Table 6: Braden Scale for Predicting Pressure Sore Risk

	1	2	3	4
SENSORY PERCEPTION Ability to respond meaningfully to pressure-related discomfort	Completely limited Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR Limited ability to feel pin over most of body	Very limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR Has sensory impairment which limits the ability to feel pain or discomfort over ½ of body.	Slightly limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR Has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	No impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort
MOISTURE Degree to which skin is exposed to moisture	Constantly moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	Very moist Skin is often, but not always moist. linen must be changed at least once a shift	Occasionally moist Skin is occasionally moist, requiring an extra linen change approximately once per day	Rarely moist Skin is usually dry, linen only requires changing at routine intervals.
ACTIVITY Degree of physical activity	Bedfast Confined to bed	Chair fast Ability to walk is severely limited or non-existent. Cannot bear own weight &/or must be assisted into chair or wheelchair	Walks occasionally Walks occasionally during day, but for very short distances with or without assistance. Spends majority of each shift in bed or chair	Walks frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours
MOBILITY Ability to change and control body position	Completely immobile Does not make even slight changes in body or extremity position without assistance	Very limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	Slightly limited Makes frequent though slight changes in body or extremity position independently	No limitation Makes major and frequent changes in position without assistance
NUTRITION Usual food intake pattern	Very poor Never eats a complete meal. Rarely eats more than ½ of any food offered. Eats 2 servings or less of protein (meat or dairy) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR Is NPO &/or maintained on clear liquids or IVs for more than 5 days	Probably inadequate Rarely eats a complete meant and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement OR Receives less than optimum amount of liquid diet or tube feeding	Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat or dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered	Excellent East most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation
FRICTION & SHEAR	Problem Requires moderate to maximum assistance in moving. Complete lifting without siding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	Potential problem Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relativity good position in chair or bed most of the time but occasionally slides down	No apparent problem Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair	

RISK RATING	SEVERE RISK	HIGH RISK	MODERATE RISK	MILD RISK	NO RISK
	≤ 9	10-12	13-14	15-18	19-23

Braden & Bergstrom (1987) [68]

23 Pressure Injury Prevention for Critically Ill Adults, 2014

APPENDIX D: Paediatrics - Glamorgan Pressure Ulcer Risk Assessment Scale

Adapted Glamorgan Pressure Ulcer Risk Assessment Scale

Mobility

- ☐ Normal mobility for age
- ☐ Child cannot be moved without great difficulty OR deterioration in condition / under general anaesthetic >2 hours
- ☐ Unable to change his/her position without assistance / cannot control body movement
- ☐ Some mobility but reduced for age

Other Risk Factors

- ☐ Not applicable
- ☐ Significant anaemia (Hb <9g/dl)
- ☐ Persistent fever (>38 for more than 4 hours)
- ☐ Poor peripheral perfusion
- ☐ Inadequate nutrition
- ☐ Low serum albumin (<35g/L)
- ☐ Weight < 10th centile
- ☐ Incontinence (inappropriate for age)

Eg. Cold extremities / cap refill < 3 secs/ cool mottled skin. Inadequate nutrition includes any of the following: not eating or decreased intake, vomiting NG aspirates > 10ml/kg or > 200mls. If data not avaliable (eg HB or serum albumin) select N/A.

Mobility and Other Risk Factors Assessment Score [ ]

Score > or = 20 VERY HIGH RISK OF PRESSURE INJURY

Devices- e.g. objects on the skin

- ○ Not applicable
- ○ Equipment/objects/hard surface pressing or rubbing on skin

Device Assessment Score [ ]

Management Plan

- ☐ Risks have been discussed with the family
- ☐ Pressure Injury Management Plan
- ☐ Actions based on risk score have been considered
- ☐ Pressure relieving device implemented
- ☐ IIMS completed
- ☐ Referral to Wound/Stoma Therapist
- ☐ Referral to Nutrition & Dietetics
- ☐ Other:

Risk Score	Category	Suggested Action
10+	At risk	Inspect skin at least twice a day. Relieve pressure by helping child to move at least every 2 hours. Use an age and weight appropriate pressure redistribution surface for sitting on/ sleeping on. Reposition equipment/ devices every 2 hours.
15+	High risk	Inspect skin with each positioning. Reposition equipment and devices at least every two hours. Relieve pressure before any skin redness develops. Use an age and weight appropriate pressure redistribution surface for sitting on/ sleeping on.
20+	Very high risk	Inspect skin at least hourly. Move or turn if possible, before skin becomes red. Ensure equipment/ objects are not pressing on the skin.Consider using specialised pressure relieving equipment.

Modified from the Glamorgan Paediatric Pressure Ulcer Risk Assessment Scale 2012 and used with permission of The Children's Hospital at Westmead

Appendix E : Pressure Injury Screening for Outpatient Departments & Clinics

Stock code Product code - NHSIS1117 (Sticker) - ordered through Stream solutions

Pressure Injury Screening for Outpatients Department & Clinics

Pressure Injury Risk Rating

Absolute Risk: Score 2 for each

- Trauma/Major Surgery ☐
- Rehydration Necessary ☐
- Paralysis ☐
- Having difficulty/won't move ☐

Relative Risk: Score 1 for each

- Limb mobility restricted ☐
- Incontinent ☐
- Emaciated/Obese ☐
- Discoloured over bony prominences ☐
- 70+ years of age ☐
- Diabetes (Type 1 or 2) ☐
- Single or multi organ failure ☐

Total Risk Score:

If the score is **greater than 2** please follow the Pressure Injury Risk Management Plan for patients now deemed at risk of a pressure injury

Completed by: _____ Date: _____

Pressure Injury Risk Management Plan

Skin Inspection: Consent ☐ Y ☐ N

If N: Is a self-assessment given & documented ☐ Y ☐ N

Pressure Injury (PI) detected ☐ Y ☐ N

IIMS/ims+ entered ☐ Y ☐ N IIMS/ims+ Number: _____

Patient Information given and explained ☐ Y ☐ N

Patient reposition education received ☐ Y ☐ N

Air Mattress / Cushion supplied if treatment 4 hrs or > ☐ Y ☐ N

Wound Care review if stage 2 or > PI observed ☐ Y ☐ N

GP / Nursing Home notification made ☐ Y ☐ N

Completed by: _____

Date: _____

Adapted from the Anderson Tool NHSIS1117 290720

Pressure Injury Screening

Fold over edge and affix to the edge of the progress notes for easy identification.

If the patient scores 2 or greater on the initial pressure risk screening tool, the 'Pressure Injury Risk Management Plan' section of the tool must be completed

Appendix F: Skin Assessment

Stock code NHSIS0812 (sticker) – ordered through Stream solutions

Patient Given Name and Family Name: _____

MRN: _____

SKIN ASSESSMENT

Conduct skin assessment and tick relevant section.

Erythema (redness):	☐ **No**	☐ **Yes: Location** _____
Blanching response:	☐ **No**	☐ **Yes: Location** _____
Localised Heat:	☐ **No**	☐ **Yes: Location** _____
Induration (Hardness):	☐ **No**	☐ **Yes: Location** _____
Skin Breakdown:	☐ **No**	☐ **Yes: Location** _____
☐ **Patient reported**	☐ **Visual inspection**	

Name and Designation: _____

Signature: _____

Date: _____

S0812 230915

Appendix G: Pressure Injury Prevention: Information for Patients and Families in Hospital

Pressure Injury Prevention
Information for Patients & Families

Pressure Injury

A pressure injury, also referred to as a pressure ulcer or bed sore, is an injury to the skin caused by unrelieved pressure and may occur when you are unable to move due to illness, injury, or surgery.

Pressure injuries can happen quickly, from lying or sitting in the same position for too long. They can be painful, take a long time to heal, and may lead to other complications.

Pressure injuries may develop under plasters, splints or braces, and around medical equipment such as tubes, masks or drains.

The diagrams below show the areas of the body at risk of pressure injury when lying and sitting.

People at increased risk

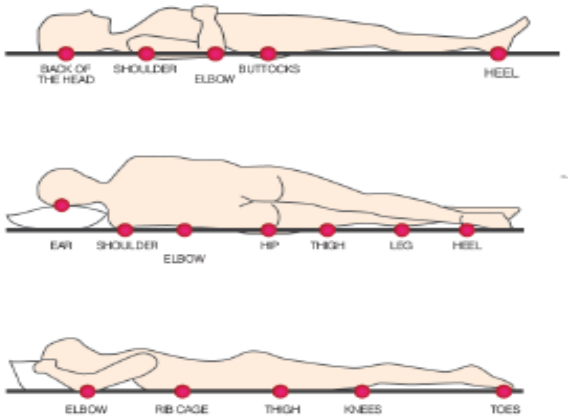
You have an increased risk of developing a pressure injury if you are:

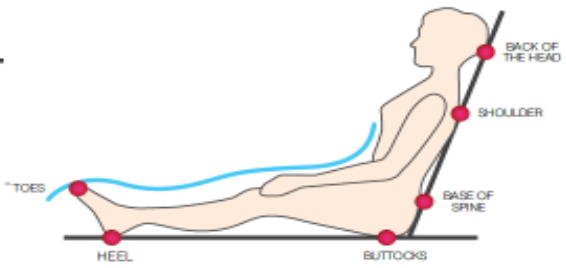
- Older or very young
- Immobile or having an operation
- Underweight, eating poorly or have experienced recent weight loss
- Overweight
- Incontinent

Signs of a pressure injury

Check your skin and look for the warning signs:

- Redness/skin discoloration
- Tenderness, pain, or itching in affected areas
- Blistering
- Broken Skin





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Pressure Injury Prevention
Information for Patients & Families

Reducing the risk of pressure injury

Patients, family, care givers and staff can all help to reduce the risk of a pressure injury.

- Staff will assess your level of risk of developing a pressure injury.
- If you are able to move yourself, involve your carers by asking them to remind you to change your position regularly. If you are unable to move yourself, staff will help you change your position frequently.
- Let staff know if your clothes or bedding are damp. Ask for help if you have a weak bladder or bowel.
- Let staff know if you are experiencing any warning signs (check over page).
- Drink fluids regularly, unless you are on a fluid restriction. You may be offered nutritional supplements if you are underweight, have recently lost weight, or have been eating poorly.
- Keep your skin clean and dry, use a 'skin-friendly' cleanser and moisturiser if appropriate.
- Be aware of the risk of a pressure injury under plasters, splints or braces, and around tubes, masks or drains.
- Specialised pressure-relieving equipment such as cushions and mattresses are available in hospital.

Managing a pressure injury

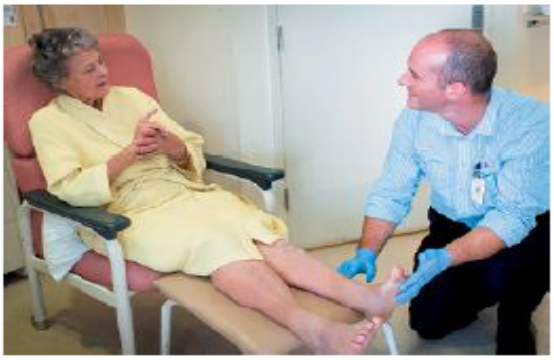
If you get a pressure injury:

- Staff will discuss how best to manage your pressure injury with you and your care giver. This may be called a 'care plan'.
- Use the prescribed equipment recommended at all times.
- Move frequently (where possible) to relieve pressure.

Heading home

When you go home from hospital with a pressure injury:

- Continue the care plan at home.
- Staff will organise ongoing care, which may include your GP or community nurse.
- Staff will advise you on how to obtain specialised equipment.



Acknowledgements

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

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Appendix H: Information for People at risk

Pressure Injury Prevention
Information for people at risk

Pressure Injury

A pressure injury, also referred to as a pressure ulcer or bed sore, is an injury to the skin caused by unrelieved pressure. It may occur when you are unable to move due to illness, injury or surgery. A pressure injury can develop at home or in a hospital.

They may develop from poorly-fitted shoes, under plasters, splints or braces, and around medical equipment such as tubes, masks or drains.

Pressure injuries can happen quickly, from lying or sitting in the same position for too long. They can be painful, take a long time to heal, and may lead to other complications.

People at increased risk

You have an increased risk of developing a pressure injury if you are:

- Older or very young
- Immobile or unable to reposition yourself
- Underweight, eating poorly or have experience recent weight loss
- Overweight
- Incontinent (bladder and/or bowel)
- Experiencing reduced sensation/feeling

Warning signs of pressure injury

Check your skin and look for the warning signs:

- Redness/skin discoloration
- Tenderness, pain, or itching in affected areas
- Blistering
- Broken skin
-

Reducing your risk of pressure injury

There are a number of simple things you can do to help reduce your risk of developing a pressure injury.

Move frequently to relieve pressure

Reposition yourself, or ask your carers to assist you to change your position. You can also ask them to regularly remind you to change position.

Eat a healthy diet and drink fluids regularly unless you are on fluid restriction

You may benefit from nutritional supplements if you are underweight, have recently lost weight, or have been eating poorly. Speak to a health care professional for advice.

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Pressure Injury Prevention
Information for people at risk

Keep your skin clean and dry

Regularly change incontinence pads. Use a soap-free cleanser and moisturiser, if appropriate.

Look after your feet

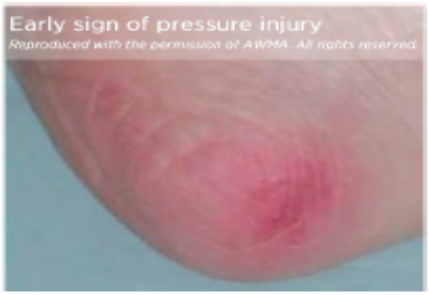
Check for signs of pressure injury on your feet. If you have diabetes or reduced sensation, check your feet regularly. Wear comfortable, well-fitted shoes.

Use appropriate equipment

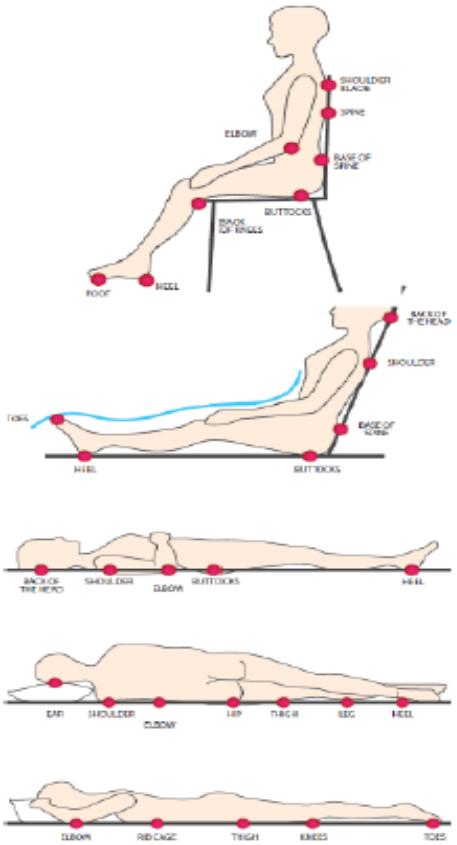
Ensure any equipment you are using is on good working order and regularly maintained. Specialised pressure-relieving equipment, such as cushions and mattresses, may be required if you are identified as being at risk of developing a pressure injury, or currently have a pressure injury.

Check your skin

Where possible, check your skin at least daily for signs of a pressure injury. If you are experience any warning signs speak to a healthcare professional for advice.



The diagrams below show the areas of body at risk of pressure injury when lying and sitting



Acknowledgements

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

Pressure Injury Prevention: Information for Patients and Families
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Appendix I: Caring for your skin

Caring for your skin

Our skin is our largest organ and a barrier to germs. It protects and maintains body temperature. It is the protective layer that guards us from the environment and stops our body losing fluids. As we age, skin becomes thinner and may become drier.

How to keep skin healthy

- Drink plenty of water to hydrate your skin, unless you have been advised otherwise by a health professional.
- Eat a well-balanced diet which includes fruit and grains, vegetables, meat and dairy.
- Avoid adding fabric softeners to your laundry as these are strongly perfumed and may irritate your skin.

Keeping your skin clean

- Use pH-neutral, non-perfumed, soap-free body wash
- Avoid bar soaps, as they remove the natural oils from the skin causing dryness
- Have shorter, warm showers rather than hot showers
- Use a soft washcloth or shower puff to cleanse your skin
- Rinse your skin and dry gently with a soft towel after showering. Do not rub
- Dry well between your toes and in skin folds
- Products that are plant based (pawpaw ointment) or animal-based (goat's milk soap) may cause allergies in some people.

Moisturising and barrier protection

- Applying moisturiser and barrier cream or barrier cloth to the skin helps maintain the skin's physical barrier, providing protection from irritants and preventing the skin from drying out. Use a non-perfumed moisturiser right after your shower
- Moisturise areas that get frequent exposure to the sun, such as the face, neck, arms and lower legs
- Use a barrier cream or barrier cloths to protect skin in your groin/buttocks from moisture damage caused by sweat or urine and/or faecal leakage.

Sun protection

- Long-term exposure to the sun increases your risk of skin damage and skin cancers. Some skin cancers can spread to other parts of your body if not treated promptly.

To protect your skin:

- Seek shade when outdoors. Use tree shade or umbrellas. Wear a hat with a broad brim or legionnaire style cap
- Use a Sun Protection Factor (SPF) 30+ broad spectrum sunscreen. Water-resistant sunscreens should be used if you are very active or are swimming
- Apply sunscreen 15 minutes before going outdoors and every 2 hours even when cloudy
- Wear wrap-around sunglasses with an Eye Protection Factor (EPF) of 10
- Wear wet-suits and rash shirts with an Ultraviolet Protection Factor (UPF) of 40+ to increase sun protection
- Avoid or minimise your time in the sun between 10 a.m. to 2 p.m. as the ultraviolet (UV) light is strongest during this time.

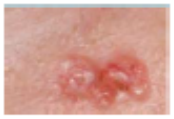
Caring for your skin

Check your skin regularly

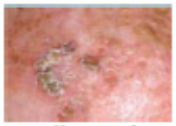
Any new, changed or bleeding moles, discoloured skin or wounds that won't heal. Ask a family member or your GP to check areas you cannot see, such as your back.

See your GP or Skin Specialist if you notice any changes or are worried or you have fair skin, lots of moles, freckles, sunburn easily or have had skin cancers.

Non-melanoma skin cancers



Basal cell carcinoma (BCC)



Squamous cell carcinoma (SCC)

Melanoma

Melanoma

Photos used with permission Professor Peter Soyer

Looking out for skin tears

As we age, skin is damaged more easily. Some medications can also make the skin thinner, such as long-term steroids. Skin tears can happen by bumping into furniture falling, or someone gripping your arm or hand.

You can reduce skin tears by:

- using soap free, pH neutral cleanser and moisturiser
- wearing long sleeves and long pants
- keeping your home clutter-free and using a night light when mobilising at night
- padding sharp edges of furniture
- carers avoiding long fingernails and jewellery
- wearing prescribed glasses.

Pressure Injuries

Pressure Injuries are caused by lying or sitting in the same position for too long. The skin may appear red or purple, or blistered or broken. You are at risk of getting pressure injuries if you are older, can't move well, have poor bladder or bowel control, or have recently been in hospital or unwell. Avoid pressure injuries by checking your skin regularly, change your position frequently and keep your skin clean and dry.

Take home points for healthy skin

- Check your skin often for changes
- Eat a healthy diet and drink plenty of water, unless advised otherwise by a health professional
- Use a non-perfumed soap free, pH neutral cleanser and moisturiser
- If outdoors, wear sunscreen, wrap-around sunglasses, a broad brim hat and long sleeves
- Talk to a Nurse, GP or Occupational Therapist if you have any concerns.

Where can I find more information?

Cancer Council Australia: Understanding Skin Cancer and Eatforhealth.gov: Australian Dietary Guidelines

Caring for your skin. Released May 2021, © Clinical Excellence Commission 2021. SHPN (CEC) 21043. This flyer is based on a brochure developed by Western Sydney Local Health District Wound Specialist Group. Used with permission

Appendix J: PI Prevention Information for Parents and Carers

PRESSURE INJURY PREVENTION FOR CHILDREN IN HOSPITAL

INFORMATION FOR PARENTS AND CARERS

A pressure injury is an injury to the skin, caused by unrelieved pressure. They can happen quickly, be painful and take a long time to heal.

Pressure injuries may develop around medical equipment such as tubes, masks, drains and cannulas and under plasters, splints or braces.

They can also develop around the back of the head, on the ears or nose, on the spine, shoulder blades and tailbone, and on the heels.

Children at increased risk

Children have an increased risk of developing a pressure injury in hospital if they have:

- a plaster cast, splint or brace
- equipment and other things pressing on their skin
- limited movement, or are restricted to bed
- reduced feeling
- been very unwell
- not been eating or drinking enough.

Signs of a pressure injury

A pressure injury may be developing if your child has any of the following signs:

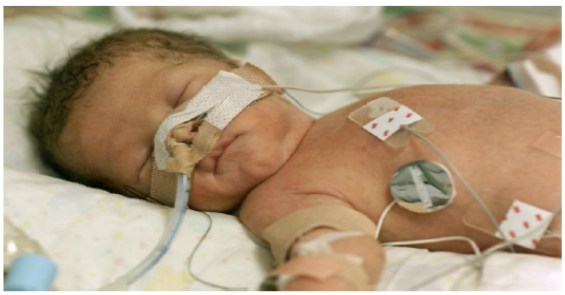
- Redness of the skin, or changes in skin colour
- Tenderness, pain, or itching in affected areas
- Blistering
- Broken skin
- There is an unpleasant smell coming from the area under a plaster, splint or brace, or it is leaking fluid.

If you notice any signs of a pressure injury, notify a nurse or other care team member.

Reducing the risk of a pressure injury in hospital

Speak with the doctors, nurses and other care team members and ask how you can help prevent a pressure injury. You can also:

- Check your child's skin regularly for any signs of a pressure injury, especially under medical devices
- Where possible, encourage your child to move or change their position regularly
- Speak with the staff who are caring for your child about your child's diet and how much they are drinking
- If your child wears a nappy, ensure it is changed as soon as possible when it becomes wet or dirty
- Keep your child's skin clean and dry, and use a 'skin friendly' cleanser and moisturiser daily.



About the Pressure Injury Prevention Project

The Pressure Injury Prevention Project is a project run by the Clinical Excellence Commission. It promotes best practice for the prevention and management of pressure injuries. For further information, please visit www.cec.health.nsw.gov.au/programs/pressure-injury-prevention-project

Acknowledgement

National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers: Quick Reference Guide. Emily Haesler (Ed.). Cambridge Media: Osborne Park, Australia; 2014.

PRESSURE INJURY PREVENTION PROJECT

CLINICAL EXCELLENCE COMMISSION

Appendix K: Paediatric Pressure Injury Prevention and Management Plan

Health
South Eastern Sydney Local Health District
Sydney Children's Hospital Randwick

Facility:

FAMILY NAME | MRN
GIVEN NAME | ☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____ | M.O.
ADDRESS
LOCATION / WARD
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

PAEDIATRIC PRESSURE INJURY PREVENTION AND MANAGEMENT PLAN

For all patients who have a Glamorgan Score 10+ or those with an existing pressure injury.

Assessment	Glamorgan Score	Date	Comments
Mobility and Other Risk Factors Score			
Devices in situ			

Skin inspection: Patients *at risk* and if there is a change to health status or mobility should have a skin inspection daily.

Results of Skin Assessments must be clearly documented in the patient's clinical progress notes. If more frequent skin inspections are required, document in patient's clinical progress notes.

Date							
Initials							

Interventions Strategy Plan

Pressure Relieving Support	*Describe and Document Interventions*	*Date and Initials*
Patient Positioning (e.g. supine; side lying; sit in bed/chair)		
Patient Repositioning	Repositioning Frequency:	
	Manual Handling Equipment:	
Pressure Relieving Devices (e.g. Alternating pressure mattresses/wedges/ foam/gel pads/cushions)		
Referrals (e.g. Physio/OT/Plastics/Dietician/Orthotics)		
Medical Devices	Devices in-situ:	
	Skin Inspection Frequency:	
	Repositioning Device Frequency (if applicable):	
Family/Carer Specific Requests *Risks must be discussed		
Prevention plan discussed with parent/carer	☐ Yes ☐ No (If No please state why)	
Pressure injury prevention factsheet provided to parent/ carer	☐ Yes ☐ No (If No please state why)	

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PAEDIATRIC PRESSURE INJURY PREVENTION AND MANAGEMENT PLAN
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Page 1 of 2

Health
South Eastern Sydney Local Health District
Sydney Children's Hospital Randwick

Facility:

PAEDIATRIC PRESSURE INJURY PREVENTION AND MANAGEMENT PLAN

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. _____/_____/_____ | M.O.

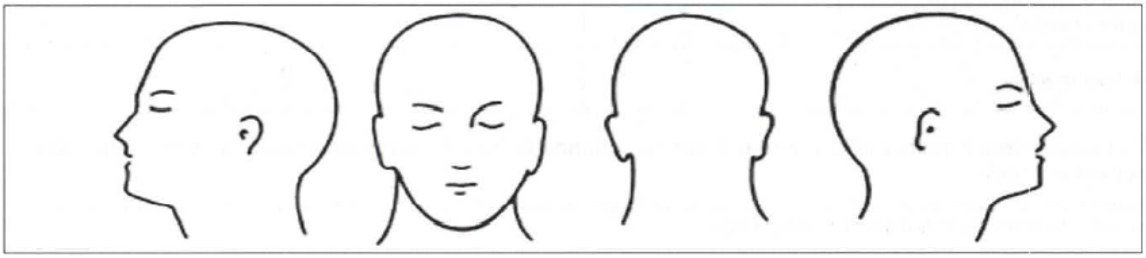
ADDRESS

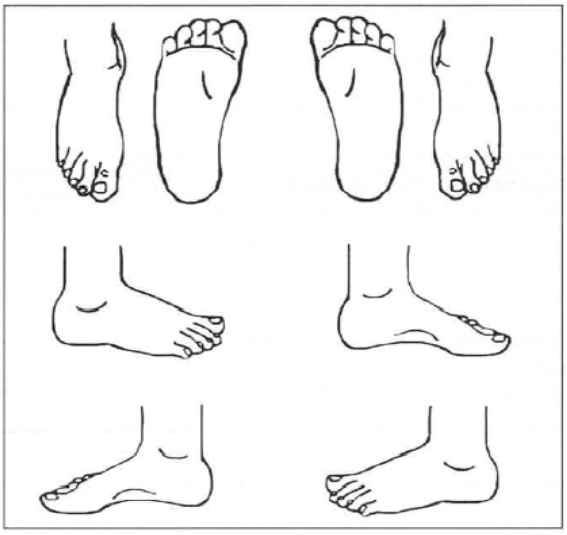
LOCATION / WARD

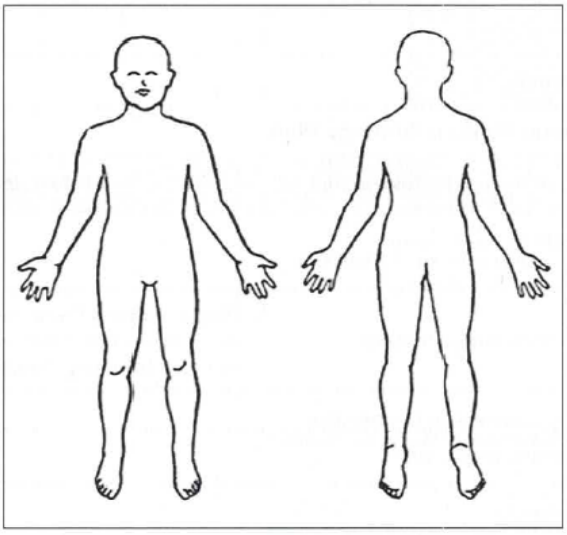
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

If patient has a pre-existing pressure injury, a Wound Assessment Form MUST also be completed to monitor the wound breakdown.

Indicate on the below diagrams any red areas or pressure injuries of concern.







Stage of injury	*Definition of Injury*
Stage I	Intact skin; reddened area that is fixed and does not blanch under pressure.
Stage II	Partial thickness loss of skin; may be a shallow open wound or intact serous blister.
Stage III	Full thickness tissue loss; Subcutaneous fat may be visible but bone tendon or muscle not exposed.
Stage IV	Full thickness tissue loss, exposed tendon, muscle and/or bone.
Unstageable Pressure Injury	Depth unknown. Full thickness tissue loss with the base covered by slough and/or eschar.
Suspected Deep Tissue Pressure Injury	Depth unknown. Purple or maroon area, or discoloured intact skin or blood filled blister.

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