Policy Applies to: All Mercy Hospital Clinical Staff and Credentialled Specialists

Related Standards:

Ngā paerewa health and disability service standard.

Cultural Considerations:
Māori patients will be cared for following the principles outlined in the Te Whare Tapa Whā model of Māori wellbeing. Specifically, this involves addressing not only the physical (taha tinana) aspects of pressure injury prevention and care, but considering family and social (taha whānau), spiritual (taha wairua), and mental and emotional (taha hinengaro) dimensions to pressure injury prevention and management.

Information regarding pressure area prevention, signs and symptoms and care will be provided to each individual patient in a way that they can understand, and that is acceptable and accessible to them.

If requested, local Māori healthcare providers will be consulted, via liaison with Mission Coordinator, to help with the ongoing care of patients who develop pressure areas.

Rationale:
Pressure Injuries cause pain, disability, hospitalisation, and sometimes even death for those affected. Preventing pressure injuries before they develop or progress is a high priority for Mercy Hospital staff and credentialed specialists.

This policy has been written to reflect the six guiding principles of Pressure Injury Prevention and Management in New Zealand, described by ACC (ACC, 2017). *https://www.acc.co.nz/assets/provider/pressure-injury-prevention-acc7758.pdf*

Definitions:

- **Medical Device/Object:** Medical equipment that has the potential to exert pressure or rub over an area of skin when in contact with a patient.

- **Pressure Injury:** An area of tissue compromised by direct compression or pressure as a direct consequence from sustained unrelieved positioning. Pressure Injuries can occur in any body area, but most often is found on bony prominences such as the sacrum, hips, buttocks, heels, or elbow.

  The Pressure Injury classification system (PI Classification) is a standardised system that uses a pictorial guide to stage the severity of a pressure injury and provides a consistent and accurate means by which the pressure injury can be communicated and documented. The system has been developed by the National Pressure Ulcer Advisory Panel (NPUAP) and European Pressure Ulcer Advisory Panel (EPUAP). Pressure Injuries are often also called “Pressure Ulcers”.

- **Pressure Relieving:** Refers to both pressure reducing and pressure re-distributing equipment that either remove pressure from different areas of the body at regular intervals, or moulds or contours around the body, spreading the load and relieving bony prominences. These can be pressure relieving mattresses, gels or overlays.

Objectives:

- To identify patients "at risk" of developing pressure injuries.
- Reduce harm to patients by putting a plan of care in place to prevent pressure injuries.
- To promote ongoing education of health professionals/carers/support staff/patients and whānau in the prevention and treatment of pressure injury.
- Monitor the prevalence of pressure injuries at Mercy Hospital.

Implementation:

- All patients will be screened on admission using a Mercy approved Pressure Injury Risk Assessment Tool. Staff are to utilise critical thinking and clinical reasoning in viewing each patient holistically regarding their risk, regardless of whether they fit the usual triggering criteria. Staff are to implement and document interventions as required.
- Patients identified as at risk through this screening will have a Waterlow Pressure Injury Risk Assessment completed.
- If a patient is categorised as 'at risk', 'high risk' or 'very high risk', a Waterlow Assessment will be re-done daily.
- A plan of care will be put in place to reduce the risk of pressure injury using the SSKIN principles and tools (Surface, Skin inspection, Keep moving, Incontinence/moisture, and Nutrition/hydration). The SSKIN assessment will then be recorded on Trak every shift until either the Waterlow score drops, or the patient is discharged.
- SSKIN includes consideration of surface, skin inspection, keep moving, incontinence / moisture and nutrition / hydration.
- If a patient goes on to develop a pressure injury, a wound care assessment will be completed on TRAK. This will include the documentation of the management plan of care to ensure the pressure injury heals as quickly as possible.
- An ACC form will be completed by the Credentialled Specialist (treatment injury form) if a pressure injury is identified.
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- An incident report will be completed and if the patient consents, this will include a photo of the pressure area, stored on the clinical record in TRAK.
- Where a patient has developed a pressure injury at Mercy, they will be phoned after discharge to ensure appropriate care is in place. This follow-up will be recorded in the Incident Report.
- Incidental findings of any existing injury are to be recorded, photographed, managed and reported to credentialed specialist.
- Education of staff on Pressure Injuries (PI) will occur within three months of starting and will include:
    1. Tautoko PI course completion
    2. Education on PI prevention and management discussed during the Clinical Orientation Study Day (discuss skin assessment specifically blanching/non

blanching skin, explain need for incident form and ACC form if stage 1 pressure injury is identified)

3. A meeting with the risk mitigation committee area representative will be held as part of area orientation which includes familiarisation with area process, documentation and hospital process document.
4. Ongoing updates arranged via area representative and Area Manager/Associate Charge Nurse (ACN)/Clinical Learning and Development Coordinator (CLD)
5. IT orientation for clinical staff involving use of TRAK care relevant to PIs.

- See the Pressure Injury Prevention and Management Process (in clinical work manual) for further information regarding Mercy Hospital's assessment, prevention and management strategy.

Evaluation:

- Use the Incident Management system to track the incidence of pressure injury at Mercy, and to review cases to guide practice direction
- Care plan will reflect the effectiveness of the actions / strategies

Associated Documents

- **External**
  - Prevention and treatment of Pressure Ulcers: Clinical Practice Guideline
  - Prevention and treatment of Pressure Ulcers: Classification, Assessment and Monitoring
  - *Guiding Principles for pressure injury Prevention & Management, NZ, May 2017*

- **Internal**
  - Day case form – pressure injury screening tool (Waterlow score)
  - Epidural package
  - Incident Policy
  - Area specific orientation
  - Nursing Assessment form – pressure injury screening tool
  - Nursing care paths
  - PACU to ward nurse handover - Clinical Services Work Manual.
  - PACU post-operative nursing care guidelines (pg. 22)
  - Patient admission form
  - Patient Assessment Policy
  - Safe patient Handling – Theatre and PACU competencies
  - Work Manual Pressure Injury Prevention and Management Process
  - Work Manual Appendices Pressure Injury Prevention Resources

Acknowledgements

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