|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|

|  |
| --- |
| **Huron Perth Healthcare Alliance** |
| **1. Clinical Policies and Procedures** | Original Issue Date:  | June 16, 2008 |
| **Pressure Injury Prevention and Management Protocol** | Review/Effective Date:  | March 16, 2018 |
| **Approved By: VP People & Chief Quality Executive** | Next Review Date:  | March 16, 2020 |

 |
| https://intranet.hpha.ca/myalliance/imgs/spacer.gif |
| This is a CONTROLLED document for internal use only.Any documents appearing in paper form are not controlled and should be checked against the document (titled as above) on the file server prior to use.  |
| **Scope:**This policy applies to Registered Nurse, Registered Practical Nurse, Personal Support Worker, Registered Dietician, Physiotherapists and Occupational Therapists across Huron Perth Healthcare Alliance.**Policy Statement:** Pressure injury risk screening and assessment processes to reduce the incidence and prevalence of pressure injuries and to prevent or delay complications arising from them is the responsibility of clinical staff. HPHA seeks to improve its services by supporting healthcare providers to have the knowledge and skills to provide prevention and management strategies.**Purpose Statement:**This policy outlines:1. Early and ongoing assessment, prevention and intervention;
2. Promote an interprofessional team approach with timely referrals to Occupational Therapist, Physiotherapist, Dietitian and Home and Community;
3. Improved clinical outcomes for those with skin/wound concerns;
4. Protection against the forces of pressure, friction, shear and moisture;
5. Reduction of the incidence of pressure injuries through educational for healthcare providers, patients and families;
6. Timely diagnosis of pressure injuries, with accurate staging and appropriate interventions based on evidence-informed wound care practices;
7. Optimal patient experience;
8. Performance monitoring and quality reporting.

**Indications:**Inpatients, including patients in the Emergency Department awaiting admission using the Braden scale to prevent/reduce the development of facility-acquired pressure injuries and/or to improve the care of compromised skin integrity. Outpatients (Chemo, Dialysis, Day Surgery (Pre-op) Recovery Room):To be completed at first appointment (as per instructions above), and repeated with any significant change in patient's condition.**Pressure Injury Prevention and Management Protocol:****a) Description of Procedure:**Implement the pressure injury prevention/management protocol for protecting, maintaining, and improving skin integrity in 'at risk' patients, by using the algorithm to guide interventions and treatments. (See: HPHA Pressure Ulcer Algorithm). **Authorized To:**The pressure injury prevention/treatment protocol gives authorization to Registered Nurses and Registered Practical Nurses in the Huron Perth Healthcare Alliance, who have completed the required education, to implement this protocol. The nurse is accountable and responsible for using professional judgment regarding the implementation of the Protocol.**b) Contraindications:**Pressure ulcers that are Stage 3 or greater require physician assessment and intervention.**c) Reasons to seek immediate medical consultation:**No improvements noted after 10 days of treatment, consider assessing for infection/sepsis**Education:****1.** Annual mandatory e-learning module including quiz.**2.** Skin assessment is included in nursing orientation as part of the head to toe assessment.**Performance Monitoring and Quality Reporting:****1.** The clinical manager is responsible for ensuring the completion of e-learning.**2.** RL-6 tracking and trending**3.** A report has been created in Meditech that can be run daily to provide Braden Scores and risk levels for each patient on a unit, so that the Team Leader can follow-up with the nursing staff to ensure that all appropriate interventions have been implemented.

|  |  |
| --- | --- |
| **Risk Assessment Prevention Procedures**  | **Rationale**  |
| **a)      Braden Scale** Inpatients, including patients in the Emergency Department awaiting admission: To be completed as part of the admission assessment and daily thereafter. The risk categories are determined as follows: 19-23 No Risk 15-18 Low Risk 13-14 Moderate Risk 10-12 High Risk <9 Very High Risk Outpatients (Chemo, Dialysis, Day Surgery (Pre-op) Recovery Room): To be completed at first appointment (as per instructions above), and repeated with any significant change in patient's condition.  |    The Braden Scale is a validated, reliable tool and it is critical that the score and level of risk are linked to interventions to prevent the development of pressure ulcers. It is important that the scoring is completed accurately, in accordance with the descriptions provided with the [Braden Scale](https://intranet.hpha.ca/myalliance/doc.aspx?id=4652)  |
| **b)     Skin Assessment** To be completed as part of the admission assessment and thereafter every 12 hours. Any wound not documented as being present on admission, is considered to have developed under our care, and is therefore considered a harmful incident, and must be entered in RL-6 reporting system. All pressure injury assessments and treatments are to be documented under Wound Assessment. Any preventative measures put into place are also required to be documented on. |   |
| **c)      Nutrition Risk Screening** The [Canadian Malnutrition Task Force (CMTF) Nutrition Risk Screening Tool](https://intranet.hpha.ca/myalliance/doc.aspx?id=4395) is to be completed on admission and every 7 days, and with changes in patient's condition.  |   |
| **d)     Order Set** [HPHA Pressure Injury Prevention and Management Order Set](https://intranet.hpha.ca/myalliance/doc.aspx?id=4752) is to be initiated by the patient's nurse when Braden Score is 18 or less, or when pressure injury is identified. |   |
| **e)      Prevention Protocols by level of risk:** [HPHA Pressure Ulcer Prevention - Nursing Procedures](https://intranet.hpha.ca/myalliance/doc.aspx?id=4751) [HPHA Pressure Ulcer Prevention Teaching Tool](https://intranet.hpha.ca/myalliance/doc.aspx?id=4759) |   |
| **Pressure Ulcer Management Procedures**  | **Rationale**  |
| **a)      Wound Assessment** Proper wound assessment will: Guide nurse to the appropriate intervention for the wound Keep care focused on the clinical status of the wound Indicate that if there is no improvement in wound status within 10 days, you have to reassess/alter the treatment plan and consult the physician Monitor and evaluate overall patient outcomes Determine the effectiveness of treatment **Refer to:** [NPUAP Staging System for Pressure Ulcers](https://intranet.hpha.ca/myalliance/doc.aspx?id=4653) ·  [South West Regional Wound Care Program Wound Cleansing Assessment Guide](https://intranet.hpha.ca/myalliance/doc.aspx?id=4399)  |   |
| **b)     Documentation** Weekly the location, size and description of pressure ulcer and include the following: Size (length x width x diameter). Undermining * Sinuses:

Wound Bed (i.e. 50% yellow, 25% black) Wound Edge Peri-wound Skin Drainage (amount and type) * Odour
 |   |
| **c)      Treatment** Be prepared to make a decision on treatment based on the assessment. Utilize the following tools when planning your treatment: [HPHA Pressure Ulcer Algorithm](https://intranet.hpha.ca/myalliance/doc.aspx?id=4655) [South West Regional Wound Care Program Dressing Selection and Cleansing Enabler (Healable Wounds)](https://intranet.hpha.ca/myalliance/doc.aspx?id=4401) [South West Regional Wound Care Program Dressing Selection and Cleansing Enabler (Maintenance/Non-Healable Wounds)](https://intranet.hpha.ca/myalliance/doc.aspx?id=4402) [HPHA Stage 1 Pressure Ulcer Algorithm](https://intranet.hpha.ca/myalliance/doc.aspx?id=4656) [HPHA Stage II, III, IV Pressure Ulcer Algorithm](https://intranet.hpha.ca/myalliance/doc.aspx?id=4657) [South West Regional Wound Care Program Product Comparison Chart](https://intranet.hpha.ca/myalliance/doc.aspx?id=4405) [HPHA Pressure Ulcer Protocol Glossary of Terms](https://intranet.hpha.ca/myalliance/doc.aspx?id=4406) **OR** [Ask the Expert at the South West Regional Wound Care Program](http://www.swrwoundcareprogram.ca/AskExpert)  |   |

**REFERENCES:**RNAO Best Practice Guidelines:Risk Assessment and Prevention of Pressure Ulcers, Rev 2011Assessment and Management of Stage I to IV Pressure Ulcers, Rev 2007Department of Health – Community Care, Government of Nova Scotia. “Evidence Based Wound Management Protocol”, 2000Bluestein D, Javaheri A. “Pressure Ulcers: Prevention, Evaluation and Management”, Am Fam Physician. 2008; 78(10): 1186-1194.Dorner B, Posthauer ME, Thomas D. “The Role of Nutrition in Pressure Ulcer Prevention and Treatment: National Pressure Ulcer Advisory Panel White Paper, 2009 National Pressure Ulcer Advisory PanelKeast D, Parslow N, Houghton P, Fraser C. Best Practice Recommendations for the Prevention and Treatment of Pressure Ulcers: Update 2006. Wound Care Canada; 4 (1): 31-43Jones KR. “Identifying Best Practices for Pressure Ulcer Management” 2009. JCOM, 16(8): 375-381Gracia-Fernandez FP, Agreda J, Verdu J, Pancorbo-Hidalgo P. “A New Theoretical Model for the Development of Pressure Ulcers and other Dependence-Related Lesions: Jour Nurs Scholarship 2014; 46(1): 28-39Gillespie BM, Chaboyer W, Sykes M, O'Brien J, Brandis S. “Development and Pilot Testing of a Patient-Participatory Pressure Ulcer Prevention Care Bundle”. 2014. J Nurs Care Qual; 29(1): 74-82[South West Regional Wound Care](http://www.swrwoundcareprogram.ca/) |