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|  | **Pressure Injury and Prevention Policy and Procedure** | |
| Program/Dept.: Professional Practice | Document Category: Patient Care |
| Developed by: Professional Practice Clinicians,  Skin and Wound, Surgery, Corporate | Original Approval February 2010 Date: |
| Approved by: Director Professional Practice  Senior Vice President Patient Engagement and Chief Nurse Executive | Reviewed Date: March 2018  January 2023 |
| Review Frequency: 3 years | Revised Date: March 2018,  January 2023 |

# 1.0 Purpose

To outline the standard of practice for the identification of risk, prevention and management of pressure injuries.

# 2.0 Scope

All staff and credentialed staff providing patient care.

# 3.0 Policy

3.1 The Braden Scale for Predicting Pressure Sore Risk is the standardized tool used at Halton Healthcare to identify patients who are at risk of developing a pressure injury. It is evidence-based and measures elements of risk that contribute to potential pressure injury.

3.2 The Braden Scale will be completed, documented, and repeated regularly on all admitted adult patients, according to the schedule defined in 4.1 below, with the exception of patients admitted to the Birthing Suite, Postpartum and Mental Health.

3.3 A consult for Wound Care must be order entered using the ‘Wound Care Referral’ order for patients with unstageable, deep tissue injury, stage 3 or stage 4 pressure injuries as soon as the pressure injury is identified.

3.4 Patients who are identified as at risk of developing a pressure injury, based on a Braden Score of less than 18 require daily skin assessments with implementation and documentation of a plan of care for prevention of pressure injury.

3.5 The most responsible physician shall be notified of a pressure injury found on admission and at any time a skin assessment is done.

3.6 The patient and family are to be included in the pressure injury prevention planning and intervention process.

3.7 All identified facility acquired pressure injuries stage 2 or greater must be reported in the electronic Incident Reporting System (IRS).

# 4.0 Procedure

1. The Braden Scale for Predicting Pressure Sore Risk will be completed on admitted adult patients according to the following schedule, based on care area:
2. On admission to hospital: within 24 hours of admission
3. At transfer between units’ and hospital sites
4. In ICU: every day
5. In Medical/Surgical units: Monday/ Wednesday /Friday
6. In Complex Transitional Care and Rehab units: Weekly
   1. When a pressure injury is identified, it will be staged according to the National Pressure Ulcer Advisory Panel’s pressure injury staging system as outlined in Appendix B.
   2. Patients with a pressure injury on arrival to hospital should follow a plan of care based on the risk assessment to address problems with pressure related skin breakdown and prevent worsening pressure injuries.

4.4 When a Wound Care Referral is order entered, information should be included with the details of the wound to assist with priorization of care. Select ‘Scope of Practice/Policy’ as the order source when placing the order.

* 1. When taking a photograph of a pressure injury to upload to the patient health record, a hospital approved device must be used (i.e. SpectraLink) and the photo must be deleted off the device once uploaded to the patient record. Verbal consent for photos shall be obtained. Photos should not include any patient identifying information. Photos should be uploaded into the ‘Wound Care Consultation Note’.
  2. The health care team shall begin development of patient specific care plan while waiting for wound care consult.

# Procedure for Documentation

# 5.1 All 6 subscales of the Braden Scale for Predicting Pressure Sore Risk must be documented in order to generate a total score for the Braden Scale.

* 1. The ‘Braden Scale Assessment’ shall include the admission and subsequent Braden Scale risk assessments, pressure injury prevention, and treatment interventions.
  2. Ongoing skin assessments will be documented in the following interventions:
     1. Inpatients: ‘PHYS-Integumentary’
     2. REG ER Patients: ‘Physical Assessment’ intervention under the ‘Integumentary/Musculoskeletal Assessment’ document section

# Procedure to Establish the Plan of Care

* 1. Select appropriate intervention(s) for subscales of the Braden Scale located within the Braden Scale Assessment under the ‘Plan of Care/Intervention’ document section.

6.2 Nurses will order enter a consult for a Registered Dietitian assessment for patients with a Braden Scale nutritional subscale of 1. Very Poor or 2. Probably Inadequate, or those patients who answer YES to either of the two Canadian Nutritional Screening Questions and for all patients with a pressure injury. Nurses should select ‘Scope of Practice/Policy’ as the order source when placing the order.

6.3 Nurses are to request for the Provider to order a referral for Physiotherapy for patients with Braden Scale mobility sub scale of 1. Completely Immobile or 2. Very Limited.

6.4 Nurses are to request for the Provider to order a referral for Occupational Therapy to optimize patient positioning.

# 7.0 Procedure for Reporting Facility Acquired Pressure Injuries

7.1 Information required for reporting a facility acquired pressure injury stage 2 or greater includes

wound location, appearance, dimensions, drainage and odour. Once reported in the IRS, this information is documented in the patients Electronic Medical Record (EMR) recording the date filed.

# Definitions

# 8.1 Credentialed Staff: Physicians, dentists, midwives or extended class nursing staff who are appointed by the Halton Healthcare Board of Directors and who are granted specific privileges to practice medicine, dentistry, midwifery or extended class nursing, respectively, in one or more Halton Healthcare hospital sites.

# 8.2 Facility Acquired Pressure Injury: A pressure injury that develops after admission while under the care of the hospital.

8.3 **Pressure Injury:** Pressure injuries are characterized as damage to the skin and/or underlying soft tissue, usually over a bony prominence or related to a medical or other device. They occur as a result of intense and/or prolonged pressure and/or shear (in the past referred to as bed sore, pressure sore, pressure ulcer).

# 9.0 Key Words

Pressure injury, Braden scale, wound, skin integrity, skin assessment

# 10.0 Appendices

**Appendix A:** Pressure Injury Prevention Interventions related to the Braden Scale for Predicting Pressure Sore Risk

**Appendix B:** National Pressure Ulcer Advisory Panel Pressure Ulcer Staging

# 11.0 References

Barbara Braden and Nancy Bergstrom (2008), have provided copyright approval for use of the “Braden Scale for Predicting Pressure Sore Risk” and protocols. Wording and scoring of the tool may not be changed.

Best Practice Recommendations. Canadian Association of Wound Care. Toronto, ON.

Health Quality Ontario (2017). Quality Standards: Pressure injuries and Care for patients in all settings. [http://www.hqontario.ca/Portals/0/documents/evidence/qualitystandards/QS\_ENG\_PI\_CPG\_v5](http://www.hqontario.ca/Portals/0/documents/evidence/qualitystandards/QS_ENG_PI_CPG_v)

[\_AODA.pdf](http://www.hqontario.ca/Portals/0/documents/evidence/qualitystandards/QS_ENG_PI_CPG_v)

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[Norton L, Parslow N, Johnston D, Ho C, Afalavi A, Mark M et al. Best practice recommendations for the](http://www.hqontario.ca/Portals/0/documents/evidence/qualitystandards/QS_ENG_PI_CPG_v) [prevention and management of pressure injuries.](http://www.hqontario.ca/Portals/0/documents/evidence/qualitystandards/QS_ENG_PI_CPG_v) <https://www.woundscanada.ca/health-care-> professional/education-health-care-professional/advanced-education/12-healthcare- professional/110-supplements.

Registered Nurses’ Association of Ontario (2016). Assessment and Management of Pressure Injuries for the Interprofessional Team, Third Edition. Toronto, ON: Registered Nurses’ Association of Ontario

# Appendix A Pressure Injury Prevention Interventions related to the Braden Scale for Predicting Pressure Sore Risk

The patient and family are to be included in the prevention planning and interventions. Provide patient/family education *Working Together to Prevent Pressure Injuries* available on Form Fast Form# H3784, on Connections Wound Care Resources

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| **SENSORY PERCEPTION** | - If patient is not able to meaningfully respond to pressure related discomfort then the nurse is to increase frequency of monitoring skin over boney prominences. |
| **NUTRITION** | * Consult with the Dietitian when there is a nutritional deficit noted and/or patient has an existing pressure ulcer * Offer individual support with oral intake as needed |
| **MOISTURE** | * Address cause of incontinence * If patient develops diarrhea: Inform Physician and Dietician; investigate and treat cause * Schedule toileting or offer bed pan with scheduled repositioning. * Use protective barrier cream * Apply liquid barrier film |
| **ACTIVITY/MOBILITY** | **Patients Confined to bed:**  **-** Do not use donut type devices or products that will localize pressure (i.e. IV bags,  *rolled* towels/blankets)   * Individualize repositioning schedule with Q 2-hour frequency for the high risk patient * Use 30 degree rule: 30 degree side to side position keeping the head-of –bed elevation below 30 degrees unless contraindicated * Place patient on an advanced air bed identified with a “Skin” tag found at the foot of the bed.   **Protect heels:**   * Heels must be completely suspended off the mattress in all positions. If this cannot be accomplished document reasons and other prevention strategies.   **Patients Restricted to Chair:**  **-** Patient should not be in chair > 1 hour at a time if unable to reposition self or are not in a manual tilt chair   * Have patient make minor position shifts every 15 minutes * Request physician order for OT consult to optimize positioning for high risk patients |
| **SHEAR** | * Consider consultation with OT/PT   - Follow the [Safe Patient Handling Policy and Procedure](https://est.omni-assistant.net/hhs/Document/DocumentDownloader.aspx?Df_Guid=71eca56e-0f5b-4590-840e-5e3fee1e5370) for repositioning and transferring patients   * Lift patients, DO NOT DRAG * Position the head of the bed at 30 degrees or less if not contraindicated * Use ceiling lifts, transfer lifts when transferring patient or when patient’s weight may contribute to dragging when repositioning patient in bed * To protect skin apply skin transparent films, skin barriers, heel lift devices as required |

# Appendix B

**National Pressure Ulcer Advisory Panel Pressure Ulcer Staging**

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| **Stage 1 Pressure Injury: Non-blanchable erythema, intact skin** | Non-blanchable erythema intact skin with a localized area of non- blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may  indicate deep tissue pressure injury. |  |
| **Stage 2 Pressure Injury:**  **Partial-thickness skin loss with exposed dermis** | Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds  (skin tears, burns, abrasions). |  |
| **Stage 3 Pressure Injury**:  **Full-thickness skin loss** | Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present.  Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. |  |

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| **Stage 4 Pressure Injury**:  **Full-thickness skin and tissue loss** | Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. |  |
| **Unstageable Pressure Injury**:  **Obscured full-thickness skin and tissue loss** | Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. |  |
| **Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration** | Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes.  Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions. |  |

**Engagement/Stakeholders/Approvals**

Please document participants, expert groups, and others consulted/engaged for the purpose of content expertise to support development, changes and/or approval.

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| Stakeholders/  Expert group | Program | Name(s)/  Committee/Designation | Consultation Only | Approval Obtained | Date |
| Professional Practice Clinician | Professional Practice | Skin and Wound Care | X |  | Sept-Dec 2022 |
| Professional Practice Clinicians | Professional Practice | Allied Health, Corporate, Surgery | X |  | Sept-Dec 2022 |
| Quality Specialist | Quality and Patient Relations | Corporate | X |  | Jan 2023 |
| Director(s)  COO(s) | Program | Name(s) | Consultation Only | Approval Obtained | Date |
| Director | Professional Practice | Co-lead Accreditation Required Organizational Practice (ROP) |  | X | Jan 17, 2023 |
| Physician Lead/Chief | Program | Name(s) | Consultation Only | Approval Obtained | Date |
| Quality and Patient Safety Medical Lead | Corporate | Co-lead Accreditation Required Organizational Practice (ROP) |  | X | Jan 13, 2023 |
| SVP Patient Engagement & Chief Nursing Executive | Corporate |  |  | X | Jan 17, 2023 |
| SVP, Clinical Operations | N/A |  |  |  |  |
| Quality Council | N/A |  |  |  |  |
| MAC | N/A |  |  |  |  |
| Other | N/A |  |  |  |  |

**Education and Implementation Plan**

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| *Purpose of the Education Plan e.g. the end goal – the “why”* |
| Minimal changes - revisions include updated documentation for Meditech Expanse which was taught as part of the training prior to Go-Live. Reinforcement required.  The revised policy and procedure reflects current practice already in place. |

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| **Action**  “How” the education will be accomplished e.g. staff meetings, huddles, workshops, in-services etc. | **Tools**  “What” tools used to accomplish goals and  outcomes e.g. policy, review, e-learning, posters, e-signatures | **Target Audience**  The “who” | **Date**  The “when”  Communication, education and implementation of the policy and procedure must occur within three months of the final approval date, preferably as soon as possible. |
| Staff meetings and huddles | Direct staff to EPPIC for revised policy and procedure document | Front line nurses | January 2023 |

**Communication Plan**

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| Target Audience  (who is impacted) | Objectives  (to explain change or need for change) | Key Messages  (what you need to communicate) | Delivery Method/Venue  Huddles, SBAR, Email, Quality Board  (how you share the message) | Timeline  Communication, education and implementation of the policy and procedure must occur within three months of the final approval date, preferably as soon as possible. |
| Front line nurses,  clinical managers and directors | Minor changes only | Revised policy and procedure now aligns with current practice. Reinforcement of practice. | Revised policy and procedure highlighted as part of the ROP tip sheet in preparation for Accreditation. | January 2023 |

**EPPIC Publishing Request**

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| Merging of document with another document – include all document titles | N/A |
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**Date: January 18, 2023**