Pressure Injury Prevention

Policy

1. Clinical staff must take reasonable steps outlined in this document to have 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.
2. Only the validated pressure injury risk assessment tool/process listed within this policy are to be used. Any variance to this should be forwarded to the CDHB Pressure Injury Prevention Working Group.

3. The CDHB seeks to improve its services by supporting health care employees to have adequate knowledge, skills and materials to provide such prevention and management strategies, and to learn from pressure injury incidents.

Purpose

To outline:

- The assessment process:
  - to identify patient populations at risk of developing pressure injuries
  - to appropriately stage pressure injuries should they occur
- Pressure injury prevention strategies to be employed aligned with the level of risk identified.
- Development of a treatment/management plan should a patient develop a pressure injury.
- Documentation requirements around pressure injury prevention and management.

Scope/Audience

All CDHB clinical staff

Definitions

Medical device/object

An item used in the care of a patient which may rub or exert pressure on the skin when in consistent contact (with the skin) and therefore likely to cause skin/tissue damage.

Associated documents

- Initial Assessment Documentation
- Nursing Care Plan/Clinical Pathway/Treatment Plan
Objectives

- To identify “at risk” patients and the specific factors placing them at risk.
- To maintain and improve tissue tolerance to pressure in order to prevent injury.
- To protect against the adverse effects of external mechanical forces: pressure, friction, and shear.
- To provide an environment conducive to healing.
- To ensure regular review of patients to determine the effectiveness and necessity for the designated interventions.
- To maintain ongoing education of health professionals/carers/support staff/patient/family in the prevention/treatment of pressure injury/ulcers.

Personnel Authorised to Perform Procedure

- Registered Nurse/Midwife
- Enrolled Nurse under the supervision of a Registered Nurse/Midwife.
- Student Nurse/Midwife under the supervision of a Registered Nurse.
- Nursing carers/support staff under the supervision of a Registered Nurse/Midwife

Initial Skin and Pressure Injury Risk Assessment

Pressure risk of all patients is assessed using a pressure risk assessment tool and clinical judgement during the initial four to six hours of admission or at the initial visit with a community provider. If the patient is found to be “at risk”, a skin assessment should also be performed.

Assessment tools within CDHB facilities are:

- Adult Braden Scale for predicting pressure sore risk (Appendix One)
- Children Glamorgan Pressure Ulcer Risk Assessment Scale (Appendix Two)
- The National Pressure Ulcer Advisory Panel/ (NPUAP) European Pressure Ulcer Advisory Panel (EPUAP) pressure ulcer classification system (Appendix Three)

If a patient is admitted to a CDHB facility with an existing pressure injury, an Incident form must be completed with the stage of the
pressure injury documented on this report and the appropriate interventions implemented.

Prevention Strategies

The following prevention strategies should be considered during patient assessment and documented in patient clinical records if appropriate.

Maintenance of skin integrity

- Regular skin assessment as outlined above and when repositioning
- Prevent exposure to excessive moisture or dryness
- Toilet regularly and timely change of incontinence products.
  - Close observation of areas where medical devices/objects (e.g. ETT, nasogastric tubes, ECG dots) are in consistent contact with the skin
  - Promote optimal skin hygiene
- Promote optimal nutrition
- Elimination of pressure shear and friction
- Protect against the forces of shear and friction
- Reduce heel pressure
- Promote activity and mobility
- Optimise positioning and utilise appropriate safe handling techniques
  - Correct positioning of medical devices including appropriate fixation and stabilisation of the device

Pressure relieving positions – turn schedules and re-positioning intervals

- Individualised in collaboration with the patient and their individual circumstances with frequency documented in the patient’s plan of care.
- At least two hourly reminders of change of position for “at risk” patients’ dependant on skin assessment, skin response, support surfaces comfort, medical condition and whether they are able to reposition themselves.
- Pressure redistributing devices
- Constant low pressure devices such as gel-filled pads, foam wedges/pillows, overlays, mattresses
- Pressure redistributing alternating pressure devices.
Pressure redistributing mattress if indicated as per the Pressure Redistributing Mattress Guidelines (Appendix Four).

**Interventions**

Implement actions for patient’s level of risk as identified using either the Adult Braden Scale or Glamorgan Pressure Ulcer Risk Assessment Scale (children). Document actions undertaken in patient clinical record.

**Principles:**
- Pressure must be relieved
- Risk of further pressure injury minimised
- Improvement of patient’s general condition
- Optimise wound healing

**Multidisciplinary team interventions**

- Patient assessment
- Pressure injury assessment and prevention
- Nutritional assessment and management
  - Appropriate positioning, fixation and stabilisation of the any required medical device/object in contact with the skin
- Control of infection and debridement
- Wound cleansing/product selection
- Consider consultation/surgical correction
  - Provision of appropriate pressure relieving device including barrier products/ protective dressings when medical devices/object are in contact with the skin if medically appropriate
- Discharge planning/patient and carer education
- Monitor progress of healing

**Reassessment**

Reassessment of skin integrity and pressure injury risk using the Adult Braden Scale or Glamorgan Pressure Ulcer Risk Assessment Scale (Children) and the NPUAP/EPUAP 2009 pressure ulcer classification system will occur for all patients in the following circumstances:

- If patient condition deteriorates
- If the patient develops a pressure injury
- If patient undergoes prolonged anaesthetic time
• Any significant event that would alter the patient’s ability to maintain skin integrity
• Upon transfer of the care of the patient within/from the CDHB
• As determined by nursing staff based on clinical judgement

Skin assessment should occur with every position change for all at risk patients.

For Adults in the acute setting the Braden Scale is to be used daily; any pressure injuries identified will be staged & documented using the NPUAP/EPUAP 2009 pressure ulcer classification system. Children who have been identified at risk during either their initial assessment or assessment as triggered above will have a reassessment conducted daily using the Glamorgan Pressure Ulcer Risk Assessment Scale; any pressure injuries identified will be staged & documented using the NPUAP/EPUAP 2009 pressure ulcer classification system.

In Specialist Mental health/Older Person’s Health/Rehabilitation patients with acute deterioration resulting in the use of pressure redistributing devices, require reassessment using the Braden Scale (Glamorgan Pressure Ulcer Risk Assessment Scale for children) and the NPUAP/EPUAP 2009 pressure ulcer classification system, daily. Patients with longer term needs, requiring the use of pressure redistributing devices, require reassessment using the Braden Scale (Glamorgan Pressure Ulcer Risk Assessment Scale for children) and the NPUAP/EPUAP 2009 pressure ulcer classification system, weekly for four weeks and then monthly if stable.

The patient/family/carer can also be taught by nursing staff to check skin integrity with a mirror if appropriate.

If a patient develops a pressure injury, an Incident Reporting Form must be completed documenting the stage of the pressure injury, and appropriate interventions implemented. Additionally an ACC Claim form and ACC2152 Treatment Injury Claim form should be completed.

**Documentation**

All risk assessment/reassessments, pressure injury staging and the patient’s plan of care should be clearly documented in the patient’s clinical record.

A patient’s plan of care should address:

• Skin assessment and care
• Individualised positioning/turning schedules
• Redistribution (support) surface systems

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• Nutritional interventions
• Management/product selection
• Referrals to Allied Health if required
• Evaluation of patient outcomes to interventions

Discharge planning

• Determine equipment already at home
• Identify deficits
• determine who is responsible to fund and organise equipment e.g. ACC, Long term Residential Facilities, hospital OT
• Equipment details need to be documented on discharge form

Measurement/Evaluation

• Nursing Department support & attendance at CPIT Pressure injury Courses and In-house Education attendance – evaluation in practice.
• Completion of On- line packages and evaluation in practice
• Monthly pressure injury coding audits.
• Annual prevalence study including a randomised selection of at least one extra ward in Med/Surg, maybe other divisions each year.
• Root Cause Analysis for Stage 3 & 4 pressure injuries developed within hospital.

References


<table>
<thead>
<tr>
<th>Policy Owner</th>
<th>Nurse Co-ordinator, Department of Nursing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Authoriser</td>
<td>Clinical Board</td>
</tr>
<tr>
<td>Date of Authorisation</td>
<td>August 2014</td>
</tr>
</tbody>
</table>
Appendices

1.1.1 Appendix One – Adult Braden score for predicting Pressure sore risk (Braden Scale)
1.1.2 Appendix Two – Glamorgan Pressure Ulcer Risk Assessment Scale
1.1.3 Appendix Three – CDHB Paediatric Pressure Redistributing Guidelines
1.1.4 Appendix Four – The National Pressure Ulcer Advisory Panel (NPUAP)/European Pressure Ulcer Advisory Panel (EPUAP) pressure ulcer classification system.
1.1.5 Appendix Five – CDHB Adult Pressure Redistributing Guidelines
1.1.1 - Adult Braden Score for Predicting Pressure Sore Risk

### Sensory Perception:

<table>
<thead>
<tr>
<th>SCORE</th>
<th>Moiety</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td></td>
<td>No Impairment</td>
</tr>
<tr>
<td>3</td>
<td>Gently</td>
<td>Slightly Limited</td>
</tr>
<tr>
<td>2</td>
<td>Moderately</td>
<td>Very Limited</td>
</tr>
<tr>
<td>1</td>
<td>Heavily</td>
<td>Completely Limited</td>
</tr>
</tbody>
</table>

- **Sensory Perception:**
  - Able to respond meaningfully to pressure related discomfort
- **SCORE**
  - 4: No Impairment
  - 3: Slightly Limited
  - 2: Very Limited
  - 1: Completely Limited

### Moisture:

<table>
<thead>
<tr>
<th>SCORE</th>
<th>Moiety</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td></td>
<td>Rarely Moist</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>Occasionally Moist</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Very Moist</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>Constantly Moist</td>
</tr>
</tbody>
</table>

- **Moisture:**
  - Degree to which skin is exposed to moisture
- **SCORE**
  - 4: Rarely Moist
  - 3: Occasionally Moist
  - 2: Very Moist
  - 1: Constantly Moist

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### Activity:
Degree of physical activity

<table>
<thead>
<tr>
<th>SCORE</th>
<th>Activity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Bedfast</td>
<td>Confined to bed.</td>
</tr>
<tr>
<td>2</td>
<td>Chair fast</td>
<td>Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.</td>
</tr>
<tr>
<td>3</td>
<td>Walks Occasionally</td>
<td>Walks occasionally during day but for very short distances with or without any assistance. Spends majority of each shift in bed or chair.</td>
</tr>
<tr>
<td>4</td>
<td>Walks Frequently</td>
<td>Walks outside the room at least twice per day and inside room at least once every two hours during waking hours.</td>
</tr>
</tbody>
</table>

### Mobility:
Ability to change and control body position

<table>
<thead>
<tr>
<th>SCORE</th>
<th>Mobility</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Completely Immobile</td>
<td>Does not make even slight changes in body or extremity position without assistance.</td>
</tr>
<tr>
<td>2</td>
<td>Very Limited</td>
<td>Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.</td>
</tr>
<tr>
<td>3</td>
<td>Slightly Limited</td>
<td>Makes frequent though slight changes in body or extremity position independently.</td>
</tr>
<tr>
<td>4</td>
<td>No Limitations</td>
<td>Makes major and frequent changes in position without assistance.</td>
</tr>
</tbody>
</table>

### Nutrition:
Usual food intake pattern

<table>
<thead>
<tr>
<th>SCORE</th>
<th>Nutrition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Very Poor</td>
<td>Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats two servings or less of protein (meat or dairy products), per day. Takes fluids poorly.</td>
</tr>
<tr>
<td>2</td>
<td>Probably Inadequate</td>
<td>Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only three services of meat or dairy products per day.</td>
</tr>
<tr>
<td>3</td>
<td>Adequate</td>
<td>Eats over half of most meals. Eats a total of four servings of protein (meat or dairy products) each day.</td>
</tr>
<tr>
<td>4</td>
<td>Excellent</td>
<td>Eats most of every meal. Never refuses a meal. Usually eats a total of four or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation</td>
</tr>
</tbody>
</table>
### Clinical Pressure Injury Prevention

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**Authorised by:** Clinical Board  
**Be reviewed by:** August 2017

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Very Poor</strong></td>
<td><strong>Probably Inadequate</strong></td>
<td><strong>Adequate</strong></td>
<td><strong>Excellent</strong></td>
</tr>
<tr>
<td>Does not take a liquid dietary supplement OR is NPO and/or maintained on clear liquids or IVs for more than five days</td>
<td>Occasionally will take a dietary supplement OR receives less than optimum amount of liquid diet or tube feeding.</td>
<td>Occasionally will refuse a meal but will usually take a supplement if offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs.</td>
<td></td>
</tr>
</tbody>
</table>

**Friction and Shear:**

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Problem</strong></td>
<td><strong>Potential Problem</strong></td>
<td><strong>No Apparent Problem</strong></td>
</tr>
<tr>
<td>Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair requiring frequent repositioning with maximum assistance. Spasticity contractures or agitation lead to almost constant friction.</td>
<td>Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.</td>
<td>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 at all times.</td>
</tr>
</tbody>
</table>

**TOTAL SCORE**

A lower score indicates a higher level of risk

- 9 or less = Very high risk
- 10 - 12 = High Risk
- 13 – 14 = Moderate risk
- 15 – 18 = Mild risk
- 19 – 23 = Generally not a risk

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1.1.2 - Adapted Glamorgan Pressure Ulcer Risk Assessment Scale for Children

Suitable for use from Birth – 18 years

**Note:** This tool should be used to support **not replace** clinical judgement as to whether the child is at risk of pressure injury development.

Refer to the attached notes for guidance on how to score each category and how often to calculate the score.

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mobility</strong></td>
<td></td>
</tr>
<tr>
<td>Child cannot be moved without great difficulty or deterioration in condition under general anaesthesia &gt; 2 hours</td>
<td>20</td>
</tr>
<tr>
<td>Unable to change his/her position without assistance/cannot control body movement</td>
<td>15</td>
</tr>
<tr>
<td>Some mobility, but reduced for age</td>
<td>10</td>
</tr>
<tr>
<td>Normal mobility for age</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Score for section</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Objects</strong></td>
<td></td>
</tr>
<tr>
<td>Equipment/ medical devices / objects / hard surface pressing or rubbing on skin. E.g. pulse oximeter probes, ET tubes, masks, tubing/wires, tight clothing (anti-embolic stockings), plaster casts/splints</td>
<td>15</td>
</tr>
<tr>
<td><strong>Total Score for section</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td></td>
</tr>
<tr>
<td>Significant anaemia (Hb &lt; 90 g/L)</td>
<td>1</td>
</tr>
<tr>
<td>Persistent pyrexia (temperature &gt; 38.0 ºC for &gt; 4 hours)</td>
<td>1</td>
</tr>
<tr>
<td>Poor peripheral perfusion (cold extremities/ capillary refill &gt; 2 seconds / cool mottled skin)</td>
<td>1</td>
</tr>
<tr>
<td>Inadequate nutrition (discuss with dietician if in doubt)</td>
<td>1</td>
</tr>
<tr>
<td>Low serum albumin (&lt; 35 g/L)</td>
<td>1</td>
</tr>
<tr>
<td>Incontinence (inappropriate for age)</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total Score for section</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Total Score: Mobility</strong></td>
<td>+ <strong>Objects</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Glamorgan Score</th>
<th>Risk Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 10</td>
<td>Not at risk</td>
</tr>
<tr>
<td>10 - 15</td>
<td>At risk</td>
</tr>
<tr>
<td>15 - 20</td>
<td>High risk</td>
</tr>
<tr>
<td>20+</td>
<td>Very high risk</td>
</tr>
</tbody>
</table>

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Guidance on Using the Glamorgan Scale

A child’s risk of developing a pressure injury should be assessed

- Within 6 hours of admission
- Re-assessed daily
- Whenever a child changes unit/area
- Every time there are significant changes in his/her condition

**Mobility** - Include the total of ALL relevant scores in this section

**Child cannot be moved without great difficulty or deterioration in condition** – add 20 to total score for this section.
E.g. ventilated child who de-saturates with position changes, a child who becomes hypotensive in a certain position.
Children with cervical spine injuries are limited in the positions they can lie in.
Some children with contracture deformities are only comfortable in limited positions.
General anaesthetic >2hours – add 20 to total score for this section only on day of surgery
E.g. a child who is on the theatre table may not have their position changed during an operation for a prolonged period and is placed on a firm surface for stability during the operation.

**Unable to change his/her position without assistance** – add 15 to total score for this section.
E.g. a child may be unable to move themselves, but carers can move the child and change his/her position.
Cannot control body movement – add 15 to total score for this section.
E.g. the child can make movements but these may not be purposeful (repetitive dyskinetic movements), the child is unable to consciously change his/her own position.

**Some mobility but reduced for age** – add 10 to total score for this section.
The child may have the ability to change their own position but this is limited / restricted.
E.g. a child with developmental delay, a child in traction who is able to make limited movements, or a child on bed rest.

**Normal mobility for age** – score 0 for this section.
Mobility is appropriate for developmental stage.
E.g. a new born baby is able to move his/her limbs but is not able to roll over; a 1 year old is able to roll over, bottom shuffle or crawl, sit up and pull up to standing.

**Equipment / objects / hard surface pressing or rubbing on the skin** – add 15 to total score.
Any object pressing or rubbing on the skin for long enough or with enough force can cause pressure damage. (These areas must be observed closely). E.g. Pulse oximeter probes, ET tubes, masks, tubing/wires, tight clothing (anti-embolic stockings), plaster casts/splints.

**Significant anaemia (Hb <90 g/l)**
- If the haemoglobin has been measured during this admission and is below 90g/l – score 1.
- If the haemoglobin is 90 g/l or above score 0.
- If the haemoglobin is unknown, write NK and score 0.

**Persistent pyrexia (temperature >38.0 ºC for more than 4 hours)**
- If temperature is 38.0 ºC and above for more than 4 hours - score 1.
- If temperature is less than 38ºC and/or pyrexia lasts less than 4 hours - score 0.

**Inadequate nutrition (discuss with a dietician if in doubt)**
- If a child is identified as being malnourished (exclude pre-op fasting) - score 1.
- A child who has a normal nutritional intake - score 0.

**Low serum albumin (<35 g/L)**
- If serum albumin is less than 35 g/L - score 1.
- If serum albumin is 35 g/L or above – score 0.
- If serum albumin has not been measured write NK and score 0.

**Incontinence (inappropriate for age)**
- Inappropriate incontinence - score 1
  - E.g. A 4 year old child who needs to wear nappies during the day and night.
  - Include children with special needs in this category.
  - Normal continence – score 0
  - E.g. A 5 year old who is dry during the day but may be occasionally incontinent during the night, a 12 month old who needs to wear nappies during the day and night.
  - Moisture lesions should not be confused with pressure ulcers.

**Risk Score**

Document total score, however scores for individual risk factors should be acted on i.e. optimise nutrition and mobility.

If the child scores 10 or higher, he/she is at risk of developing a pressure injury unless action is taken to prevent it. This action may include normal nursing care, such as frequent changes of position (document how often position is changed), encouraging mobilisation, lying the child on a standard foam pressure reducing hospital mattress or on an air-filled overlay or mattress, changing the position of pulse oximeter probes regularly, ensuring the child is not lying on objects in the bed such as tubing or hard toys.
**Suggested action** is indicated in the following strategies for nursing care; however nurses should also use their own discretion and expertise, and order a pressure-redistributing surface if it is considered necessary. Document action taken in child’s records.

**Pressure Injury Record**

The diagram of the child on the Nursing Initial Assessment Form can be used to indicate the position of any skin lesions.

If lesions are near to, or associated with any equipment such as BIPAP mask, nasogastric tube or splint, these should also be indicated. The skin lesions indicated in the diagram should be numbered so that they can be referred to in the table beside the diagram. Any existing or new pressure injuries should be documented, staged, incident reported and photographed by medical illustrations.

**Stage any Pressure Injuries**

Please use the following NPUAP/EPUAP 2009 pressure ulcer classification system to stage lesions, no other grading tool should be used.

Stage I. II, III, IV, un-stage able or suspected deep tissue injury.

Adapted from the Glamorgan Risk Assessment Scale from the United Kingdom
1.1.3 - CDHB Paediatric Pressure Redistributing Guidelines

CDHB PRESSURE RELIEVING PRODUCTS GUIDELINES FOR PAEDIATRIC PATIENTS

Clinical judgement in conjunction with the Glamorgan Pressure Injury Risk Score assessment must be used to determine level of risk

- At risk patients must have an individualised turning regime and mobilisation plan (e.g. 2nd during day and 3rd overnight).
- Reassess patient for PI risk daily or more frequently if patient condition changes or a pressure injury develops. Remember to fill out patient’s care plan.
- If heels are only at risk then order Mepilex® Heel Dressings and secure in place with Tubifast®. Oracle number: 144159 (for a box of 5).

NOT AT RISK
(Glamorgan Score of 0 – 10).
No skin marking.

AT RISK
(Glamorgan Score of 10 – 15).
With skin marking on hospital standard mattress.

OR
HIGH RISK
(Glamorgan Score of 15 – 20).
With no pressure injury and patient can self-position.

VERY HIGH RISK
(Glamorgan Score 20+)
Patient has difficulty changing/ maintaining position, or;
Patient has pre-existing history or existing Pressure Injury.

HOSPITAL STANDARD PRESSURE REDUCTION MATTRESS

ROHO® CUSHION AND COT OR BED OVERLAY (NO WEIGHT RESTRICTIONS)

ORDER

ROHO® MATTRESS AND CUSHION OR CIRROCELL CIRRUS® MATTRESS AND ALOVA® CUSHION (PATIENT MUST BE >20KGS)

ORDER EITHER

To request the rental of these products, please ring the company below and write out a requisition form. Suppliers are available 24/7.

Durable Medical Equipment (DME):
(03) 354 9239
Roho mattress and Roho cushion.

Active HealthCare:
0800 80 75 74
CoroCell Corros mattress and Alova Cushion.

For patients whose needs cannot be met by the above options or if the patient’s Pressure Injury is deteriorating and further advice and authorisation of other available products is needed contact:

Christchurch Hospital Campus, Wound Care and Pressure Management: Link nurse,
Wound Care Nurse Consultant, Clinical Nurse Specialists, Nurse Educators
Adele Barton, Wound Care CNS, Tissue Viability Nurse, Duty Managers (after hours)
BWNZ, Duty Nurses Managers
TPMH, Wound Care CNS, Duty Manager (after hours)
Hillsmorton, Utilise staff listed for TPWH or Christchurch Hospital campus

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1.1.4 - The National Pressure Ulcer Advisory Panel and European Pressure Ulcer Advisory Panel (NPUAP/EPUAP) pressure Injury classification system.

<table>
<thead>
<tr>
<th>Stage</th>
<th>Pressure Injury</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage I</td>
<td>non-blanchable erythema</td>
<td>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 &quot;at risk&quot; persons (a heralding sign of risk).</td>
</tr>
</tbody>
</table>

![Stage I Image](image1)

| Stage II | partial thickness skin loss | 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. |

![Stage II Image](image2)

| Stage III | full thickness skin loss | Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and 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 III Image](image3)
Stage IV pressure injury: full thickness tissue loss

- Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed.
- 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 PIIs can be shallow. Stage IV PIIs 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.

Unstageable pressure injury: depth unknown

- 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.

Suspected deep tissue injury: depth unknown

- Purple or maroon localised area or discouloured, 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 Jamad Gillo, Gear Interactive. 
http://www.gearinteractive.com.au

Photos anatomy, stage, IV, unstageable and suspected deep tissue injury courtesy C. Young, Lawrenceston General Hospital. Photos stage III and IV courtesy K. Carville, Silver Chain. Used with permission.
1.1.5 - CDHB Pressure Redistributing Guidelines

CDHB PRESSURE RELIEVING PRODUCTS GUIDELINES
FOR ADULT PATIENTS (excludes ICU)
Clinical judgement in conjunction with the Braden Scale assessment must be used to determine level of risk

- At risk patients must have an individualised turning regime and mobilisation plan
- Check heels - initiate preventative strategies if required
- Reassess patient for PI risk (Daily - Med/Surg, Weekly - other areas or more frequently if patient condition changes or a pressure injury develops)

LOW OR MODERATE RISK
(Braden Score of 13 – 18)
- no skin marking

Hospital standard pressure reduction mattress

LOW OR MODERATE RISK
(Braden Score of 13 – 18)
- with skin marking on hospital standard mattress

Curo Cell Area mattress and Alova cushion from Accurate Health Care (weight restricted to 30 - 230kg)

(MODERATE/HIGH/VERY HIGH RISK
(Braden Score 14 or below)
- with no pressure injury and patient can self position

(TPMH would use their purchased Atomsair for this patient group)

MODERATE/HIGH/VERY HIGH RISK
(Braden Score 14 or below)
- patient has difficulty changing/maintaining position

Modular Therapy mattress and Roho cushion from DME (no weight restrictions) – ideal for patients who sit elevated, ideal for heel pressure injuries

To request the rental of these products: raise a requisition via iproc using the following oracle numbers then call the Suppliers and provide them with the iproc Requisition no. and Oracle Numbers. Suppliers are available 24/7.

ActiveHealth Care: 0800 80 75 74 - Curo Cell Area mattress 156699 Alova Cushion
Durable medical equipment (DME): (03) 354 9239 - Modular Therapy mattress 181912 Roho cushion 156626, Heel Lift 156697

For patients whose needs cannot be met by the above options, or if the patient’s pressure injury is deteriorating, and further advice and authorisation of other available products is required, contact:

Christchurch Hospital Campus - Wound Care and Pressure Management Link Nurse: Wound Care Nurse Consultant; Clinical Nurse Specialist, Nurse Educations.
Ashburton - Wound Care OIC, Research Nurse, Duty Manager (after hours)
BIRD - Duty Nurse Manager
TPMH - Wound Care OIC, Duty Manager (after hours)
Millburnton - clinical staff listed for TPMH on Christchurch Hospital campus

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