Pressure Injury Documentation – Comprehensive Care Standard
Brighton Subacute Services
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Learning outcomes

- Describe how to document pressure injuries using correct anatomical terms
- Discuss correct communication of pressure injuries within the multidisciplinary team
- Identify potential errors in documenting pressure injuries and wounds
- Identify sources of further information
Common sites

1. Occiput
2. Dorsum of neck
3. R + L ears
4. Acromion process R + L
5. Scapulae
6. Spiny process
7. Elbows
8. Greater trochanter
9. Iliac tuberosities
10. Sacrum
11. Lateral condyle
12. Medial condyle
13. Calves
14. Medial malleolus
15. Lateral malleolus
16. Heels

Cancer Research UK
Original diagram by the Tissue Viability Society
Visualize the bones

Sitting
- Shoulder blade
- Buttocks
- Ball of foot

On the back
- Heel
- Sacrum
- Elbow
- Shoulder
- Back of head
Friction and shear

As you may have observed, most pressure sores occur over a bony prominence.
Anatomical terms

Elements of Wound Documentation

LOCATION OF WOUND

- Sacral Region
- Coccyx Region
- Ischial Tuberosity
- Posterior Thigh
- Hip
- Thigh
- Buttock
- Sacroiliac Region
Documenting Pressure Injuries

What NOT to write:

- PAC +++
- OR PAC attended
- OR PAC √
- OR Sacrum red, dressing applied.

Why?
Example One - Intact skin on admission:

05/06/2018 1330hours Skin assessment performed on admission to ward. Skin is intact with no reddened areas or abnormalities. Patient is independently mobile and self-toileting...

Why does it matter?
Example Two – new pressure injury found:

05/06/2018 1430 hours: Routine skin assessment performed during shower. Non blanching red area noted 5x2cm with 2x1cm broken blister on L hip. Stage 2 pressure injury. Patient placed on Quattro mattress. 2/24 repositioning and toileting regime implemented – and documented on Repositioning Chart. Do not position on left hip until further assessment. Referred to Dietitian. Patient provided with brochure and education about pressure ulcer and understands need to keep off left hip. Riskman completed (no 125896) and MO notified.

• [use PI Communication sticker]
The orange sticker

Pressure Injury Incident

Present on admission □

Incident report □

STAGE 1 □ 2 □ 3 □ 4 □

Suspected Deep Tissue Injury □

Mucosal PI □

Unstageable □

Hospital Acquired □

Date ______________

Signature ____________________________________________
Example Three: Stage 3 Pressure injury found on admission

08/06/18 1000hrs: Patient admitted to ward. Skin inspected. Stage 3 pressure injury noted on sacrum (4cm x 2.5cm x 1cm in depth). The wound is moist with small amount of yellow slough. Minimal amount of purulent exudate noted when dressing removed. Surrounding skin is warm, dry and clean. Clinical Photography completed. Riskman completed (no. 12456) Referred to Wound CNC. Air mattress requested from CELS. Patient c/- lower back pain 8/10 and is unwilling to move. Given 5mg of Endone with good effect. Patient severely malnourished – referred to dietitian. Patient’s wife given brochure and education about the pressure injury. Aware of need to reposition hourly – commenced on repositioning chart. Referred to OT.
Documentation re non-adherence

- Document client factors (such as evidence that the client had been advised and reminded of strategies for pressure injury prevention), has been provided with appropriate and timely risk assessment and intervention.
- Document a description of behaviours that the client is demonstrating (such as refusal for cares etc). This documentation should not only be evident in the client record and demonstrated throughout as the episode of care (therefore telling a story of e.g. pressure injury progression and client factors) but should also been documented in the original RiskMan incident.
- As a minimum documentation of patient understanding of the recommended treatment, non-adherence, awareness of consequences (& referral to COHD Wound Stoma for a pressure injury) may not prevent the incurring of financial penalty, however, we should be following sound clinical practice for all our clients in particular those who are high risk for PI.
- Caution of documentation wording e.g. non-adherence, non-compliant. Remember legal implications and demonstration of empathy for the patient.

COHD Pressure Injury Prevention & Management Sub-Committee (2018)
APIRA

• Adult pressure injury risk assessment
• Please ensure it is complete
• It is a requirement to calculate the BMI
• MST score must be complete – in-service next week
• Tissue malnutrition section – look up in chart if you are not sure
• Neurological deficit – look up if you are not sure
• Major surgery section – read carefully
The wound care plan

• Provides a wholistic and comprehensive assessment on wounds for continuity of care
• Please make sure you fill in all applicable items or the information will not be useful to the next person
• Pain score very important
Wound information

- Wound type – PI, skin tear, malignant, burn
- Location
- Initial assessment date
- Photo taken
- Referrals
- Diabetes?
- Swab taken?

Assessment
- PI/skin tear – stage/cat
- Riskman
- Date
- Riskman

Wound dimensions
- Width
- Length
- Depth

Clinical appearance (%)
- Granulating
- Epitheliasing
- Sloughy
- Necrotic
- Hypergranulation
Wound assessment (cont)

Exudate
- Amount – nil, moist, wet, saturated
- Type – serous, haemoserous, sanguineous, purulent

Odour
- Nil
- Malodour

Surrounding skin
- Healthy
- Erythema
- Oedema
- Macerated
- Fragile
- Dry
Silhouette Wound Assessment

1. Capture
   Photograph wounds using SilhouetteStar

2. Measure
   Review images, draw wound boundaries, generate measurements using SilhouetteConnect, including area, depth, volume and % area reduction

3. Record
   Enter clinical notes

4. Results
   View wound progress graph and wound assessment report
Pain Severity Score

• Why do we need to do this?

<table>
<thead>
<tr>
<th>COMPARATIVE PAIN SCALE CHART (Pain Assessment Tool)</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="" alt="Comparative Pain Scale Chart" /></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pain Free</th>
<th>Very Mild</th>
<th>Discomforting</th>
<th>Tolerable</th>
<th>Distressing</th>
<th>Very Distressing</th>
<th>Intense</th>
<th>Very Intense</th>
<th>Utterly Horrible</th>
<th>Excruciating Unbearable</th>
<th>Unimaginable Unspeakable</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No Pain</th>
<th>Minor Pain</th>
<th>Moderate Pain</th>
<th>Severe Pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling perfectly normal</td>
<td>Nagging, annoying, but doesn't interfere with most daily living activities. Patient able to adapt to pain psychologically and with medication or devices such as cushions.</td>
<td>Interferes significantly with daily living activities. Requires lifestyle changes but patient remains independent. Patient unable to adapt pain.</td>
<td>Disabling; unable to perform daily living activities. Unable to engage in normal activities. Patient is disabled and unable to function independently.</td>
</tr>
</tbody>
</table>
Detail

- Ensure you have filled in your name, designation, signature and date

**Dressing Regime**

- Frequency
- When
- Cleansing agent
- Primary dressing
- Secondary dressing
- Dressing availability
- Extra instructions

Don’t forget to write a comprehensive note in patient’s chart to ensure continuity of care
Referrals

• How do you refer to:
  - Dietitian
  - Occupational therapist
  - Podiatry
  - Wound CNC
  - Medical officer
Any questions?

One full-thickness pressure ulcer can cost up to $70,000 to treat.
• Australian Commission on Safety and Quality in Health Care (ACSQHC) National Safety and Quality Health Services Standards (NSQHSS), Comprehensive Care Standard.

• http://www.npuap.org/resources/educational-and-clinical-resources/


Compare the pair

Stage 1 pressure injury

Stage 2 pressure injury
Compare the pair

Stage 3 pressure injury

Stage 4 pressure injury
Compare the pair

Suspected deep tissue injury

Unstageable pressure injury