SESLHD PROCEDURE COVER SHEET

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FUNCTIONAL GROUP(S)	Women's and Babies Health
KEY TERMS	Pressure Injury (PI), P.I. Prevention, P.I. Management, P.I. Risk, P.I. Assessment, P.I. Examination.
SUMMARY	This policy outlines the processes to identify women receiving maternity care, at risk of pressure injury or who have an existing pressure injury.

Pressure injury screening, prevention and management in maternity services

SESLHDPR/740

1. POLICY STATEMENT

This procedure provides guidance on pressure injury screening, prevention, and management for women in SESLHD maternity services. Pressure Injuries (PI) can affect anyone of any age, including women receiving care from a maternity service.

For further information on pressure injuries refer to:

- NSW Health Policy Directive PD2021_023 – Pressure Injury Prevention and Management
- SESLHDPD/326 - Pressure Injuries – screening, preventing and managing

Aboriginal people have been considered and engagement with the Aboriginal Health Unit has occurred in the development of this policy. Aboriginal Hospital Liaison Officers and /or Aboriginal Health Workers can be contacted as required.

2. BACKGROUND

The reported incidence of pressure injuries amongst women in a maternity setting is low, however, there are factors placing maternity inpatient women at increased risk of developing a pressure injury. This procedure is:

- To identify women during pregnancy, childbirth and postnatally at risk of developing a pressure injury
- To minimise risks of pressure injuries using preventative measures
- To improve staff awareness of resources and management pathways if a pressure injury is identified

3. RESPONSIBILITIES

All maternity staff in SESLHD maternity services are responsible for PI prevention and management including medical, midwifery, nursing, and allied health staff.

3.1 Employees will:

Support and practice, PI screening, prevention, and management strategies for women in maternity services. When appropriate, use risk assessment tools, clinical pathways, safety huddles, and reporting templates.

3.2 Line Managers will:

Ensure clinical staff are supported with resources to work within their clinical scope of practice including education. Identify clinical practice gaps and manage risks in a timely manner.

3.3 Medical officers will:

Manage and investigate pressure injuries as required and communicate and document appropriately in the woman's own care plan and electronic medical notes. Conduct

regular reviews, referring as required, using appropriate referral pathways to services such as, surgical team, wound Clinical Nurse Specialist or GP.

4. DEFINITIONS

Blanching erythema	Reddened skin that blanches white under light pressure. May be difficult to visualise in darker skin tones.
Erythema	Redness of the skin caused by dilatation and congestion of the capillaries, often a sign of inflammation or infection. May be difficult to visualise in darker skin tones.
Friction	A mechanical force that occurs when two surfaces move across one another, creating resistance between skin and contact surface.
Pressure Injury (PI)	A localised damage to the skin and /or underlying tissue, as a result of pressure or pressure in combination with shear. Pressure injuries usually occur over a bony prominence but may also be related to a medical device or other object.
Pressure Injury Risk Assessment	A formal patient assessment process involving factors known to predispose to PI development to help determine the presence and degree of PI risk. Usually includes or comprises a recognised scale validated for this purpose. For example, Waterlow Pressure Ulcer Prevention Assessment.
Risk Screening	A process to support identification of an individual's risk of developing a PI.
Shearing	When layers of skin slide over another surface.
Skin Examination	A visual examination of the skin surface to check integrity and identify any characteristics indicative of pressure damage.

5. PROCEDURE

5.1 Risk Screening

Risk screening needs to occur on every admission during initial assessment or within 8 hours of presentation to the maternity service. Women require screening for their individual risk factors relating to the predictors of pressure injury development: *mobility, perfusion and skin integrity.*

- NSW Health PD2021_023 - Pressure Injury Prevention and Management
- SESLHDPD/326 - Pressure Injuries - screening, preventing and managing

5.2 Risk factors for Pressure Injury

Mobility

- BMI ≥35
- Chronic immobility for example, multiple sclerosis, paraplegia
- Changes to mobility - acute immobility. If a woman is affected by,
    - **dense** spinal, epidural or patient controlled epidural analgesia,
    - is unable to change position by herself
    - received epidural pain relief for ≥ 10 hours

Perfusion

- Pre-existing (Type 1 or Type 2) Diabetes
- Haemoglobin <80g/L
- Significant nutritional compromise, BMI≤18.5
- Peripheral artery disease/venous insufficiency

Skin Status

- Impaired skin integrity, such as, severely oedematous, dry, clammy, discoloured or damaged skin
- Chronic disability affecting skin condition
- Pre-existing pressure injury

5.3 Management of risk factors

5.3.1 Women with no risk factors

- Women are *low risk* if there are no risk factors identified on admission
- Skin assessment and extra documentation is not required unless there are any changes to their health status or mobility.

5.3.2 Women with one to three risk factors require

- Skin examination and PI prevention for skin hygiene and protection
- At least second hourly position change, (if they are unable to change position by themselves)
- Encouragement and assistance to mobilise early post birth
- Documented skin assessment utilising a Waterlow Score if there are any changes to their health status or mobility.

5.3.3 Women with four or more risk factors are *higher risk* and require

- Documented skin risk assessment utilising Waterlow Score
- If the Waterlow Score is ≥10, complete a PI Plan of Care
- Documentation in clinical care plan
- At least second hourly position change (if they are unable to move themselves)
- Surveillance for blanching erythema and/or areas of concern
- Repeat skin assessments if there are any changes to their health status or mobility

5.4 Examples of four possible maternity scenarios requiring extra clinical assessments:

- Regular skin assessments
- Waterlow Pressure Ulcer Prevention Assessment
- PI Skin Assessment
- PI Plan of Care (If a PI has been identified)
- Pressure injury notification (If a PI has been identified)

Example 1
A woman with BMI≥35 has a prolonged period of immobility following regional anaesthesia for a caesarean section; complains of pain, some numbness, and swelling in the sacral region. Staff notice a pressure injury on the sacrum.

Example 2
A woman presents to birthing services in early labour with a history using a hot pack at home for pain relief for the last few hours, midwives notice a weeping burn on her lower abdomen.

Example 3
A nutritionally compromised woman has a long labour, instrumental delivery, and a severe tear. The woman has patient controlled epidural analgesia (PCEA) continued postpartum. A heel pressure injury develops on day one postpartum.

Example 4
A woman with a dense epidural was used leg supports to push during the second stage of labour and developed a small pressure injury on her ankle.

5.5 Educating women on preventative measures

Clinicians will work in partnership with women, providing antenatal education on:

- Individual risk factors associated with PI
- Inspecting and recognising skin changes
- Self-checking skin status and self-reporting
- Skin care, managing wet skin; hygiene/removal of wet pads
- Regional anaesthesia e.g., epidurals, the importance of frequent position change, assessing density of block using Bromage score refer to Clinical Business Rule/ Local Operating Procedure:
    - *Epidural Pain Management in Labour - SGH*
    - *Epidural Analgesia for Labour and Birth - TSH*
    - *Epidural Analgesia (maternity) RHW*
- Safely encourage early mobilisation post birth
- Provide Pressure Injury Prevention Information for Patients and Families and Information for People at Risk - Clinical Excellence Commission *Information for patients - Clinical Excellence Commission*

6. CULTURAL SUPPORT

- When clinical risks are identified for an Aboriginal woman, she may require additional supports. This may include Aboriginal health professionals such as Aboriginal liaison officers, health workers or other culturally specific services.
- For a Culturally and Linguistically Diverse (CALD) woman, notify the Cross Cultural workers attached to each service.
- If the woman is from a non-English speaking background, call the interpreter service: NSW Ministry of Health Policy Directive PD2017_044 – Interpreters – Standard Procedures for Working with Health Care Interpreters.

7. DOCUMENTATION

If the skin integrity looks impaired (including in the absence of risk factors), or a pressure injury develops, a formal skin assessment (Waterlow Score) should be completed, reported, and documented in the following electronic medical records/databases:

- Progress notes
- Waterlow Score
- Individualised pressure injury care plan developed in consultation with the woman
- Pressure Injury Notification
- Huddle-up Form (in consultation with wound CNC)
- IMS+ notification

8. COMMUNICATION

Any changes in skin condition, pre-existing pressure injuries and new pressure injuries must be reported to the medical team, multidisciplinary teams, and fellow clinicians at clinical handover and safety huddles. Development of a pressure injury treatment plan, including updates and goals and referrals to respective surgical teams, wound CNC, Dietician and Physiotherapist should occur and be included in all communications.

8. AUDIT

Compliance can be measured using QARS audits, at the Line manager's discretion.

9. EDUCATION / TRAINING

Clinical staff providing care to women are strongly encouraged to complete PI training in PI prevention and management. Modules are available on My Health Learning on-line learning pathway.
The learning pathway include:

- Pressure Injury Risk Assessment (course code 115610702)
- Pressure Injury Risk Management (course code 115610919)
- Wound Assessment (course code 40063891)

Recording of training sessions on PI prevention and management can be entered to HETI under relevant training codes and monitored by line managers.

Staff can access further PI information at Clinical Excellence Commission Resources for clinicians.

A Waterlow Pressure Injury risk assessment template can be found *here*.

10. REFERENCES

1. Australian Commission on Safety and Quality in Health Care Preventing and Managing Pressure Injuries
2. NSW Health Policy Directive PD2021_023 - Pressure Injury Prevention and Management
3. NSW Health Policy Directive PD2017_044 - Interpreters - Standard Procedures for working with Health Care Interpreters
4. Royal Hospital for Women LOP – Epidural Analgesia (Maternity)
5. SESLHDPD/326 - Pressure Injuries – screening, preventing and managing
6. SGH-TSHCLIN163 - Epidural Pain Management in Labour SGH
7. SLHD- Canterbury Hospital Policy Compliance procedure – CANT_PC2018_MP305 Pressure Injury: Assessment and Management in Maternity
8. TSHLIN013 Epidural Analgesia for Labour and Birth – TSH

11. REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
June 2022	DRAFT	Initial draft by SESLHD Maternity Services working party. Draft for comment period.
July 2022	DRAFT	Draft for comment period
October 2022	DRAFT	Approved by Executive Sponsor. To be tabled at Clinical and Quality Council for approval.
December 2022	1	Approved at November 2022 Clinical and Quality Council meeting. Processed and published.