Local Guideline

Kaleidoscope
CHILDREN, YOUNG PEOPLE AND FAMILIES

Health
Hunter New England
Local Health District

Pressure Injury Screening in Outpatients and Community Settings

Sites where Local Guideline applies	John Hunter Children's Hospital (JHCH) and Community Partnerships and Integration (CPAIS).
This Local Guideline applies to:	
1. Adults	No
2. Children up to 16 years	Yes
3. Neonates – less than 29 days	Yes
Target audience	Clinical staff
Description	Screening for pressure injuries in Paediatric population in outpatient and community settings.

Hyperlink to Guideline

Keywords	Skin, skin management, pressure injury, pressure ulcer, Glamorgan scale, pressure injury prevention, JHCH, CPAIS
Document registration number	JHCH 16.3
Replaces existing document?	No

Related Legislation, Australian Standard, NSW Ministry of Health Policy Directive or Guideline, National Safety and Quality Health Service Standard (NSQHSS) and/or other, HNE Health Document, Professional Guideline, Code of Practice or Ethics:

- NSW Health PD2014_007 Pressure Injury prevention and management
- HNELHD Local Guideline GNAH_0433: Skin management Bundle- adult
- Pan Pacific Clinical practice guideline for the prevention and management of Pressure Injury
- HNELHD Policy HNEH 09_05:Pressure Injuries: Prediction, Prevention and Management
- HNELHD Local Guideline GNC_14_074: Wound Assessment: GNC
- NSW Health Policy Directive 2014_036: Clinical procedure safety
- NSW Health Policy PD 2005_406 Consent to medical treatment

Prerequisites (if required)	N/A
Local Guideline note	This document reflects what is currently regarded as safe and appropriate practice. The guideline section does not replace the need for the application of clinical judgment in respect to each individual patient but the procedure/s **requires mandatory compliance**. If staff believe that the procedure/s should not apply in a particular clinical situation they must seek advice from their unit manager/delegate and document the variance in the patient's health record.
Position responsible for the Local Guideline and authorised by	Pat Marks, General Manager, CYPFS
Contact person	Cathy Grahame
Contact details	cathy.grahame@hnehealth.nsw.gov.au
Date authorised	
This document contains advice on therapeutics	No
Issue date	October 2015
Review date	October 2018

Note: Over time links in this document may cease working. Where this occurs please source the document in the PPG Directory at: http://ppg.hne.health.nsw.gov.au/

RISK STATEMENT

This local guideline has been developed to provide guidance to staff and to ensure that the risks of harm to patients and staff associated with maintaining skin integrity are identified and managed.
Risk Category*:* Clinical Care & Patient Safety

GLOSSARY

Acronym or Term	Definition
Glamorgan scale	The Glamorgan scale is a specific Paediatric pressure ulcer risk assessment scale. It is weighted to give increased risk scores for immobility and pressure on the skin. It has proven predictive validity and high inter-rater reliability. See appendix four.

GUIDELINE

This Guideline does not replace the need for the application of clinical judgment in respect to each individual patient.

All patients attending outpatient services at John Hunter Children's Hospital and Community, Partnerships and Integration Service should be screened for potential pressure injury using the Glamorgan Paediatric Pressure ulcer risk assessment form (see Appendix- Glamorgan scale, flow chart). This will be documented in the diagnostics section of the DMR.

High risk patients such as those with oxygen, in seating such as wheelchairs, long term nasogastric feeding, PEG feeding, casts, splints or with spinal issues should be identified and parent fact sheets regarding skin integrity supplied to them.

For complex patients the treating team should be responsible for performing and documenting a Glamorgan risk assessment and recording the results in the patient medical record.

For non- complex patients the treating therapist should administer a Glamorgan risk assessment and record the results in the patient's medical record.

If patient is identified as At Risk, High Risk or Very High Risk on the Glamorgan scale, information and education about pressure area risk and prevention plan must be given to the family including approved handout. This must also be documented in the medical record. The three children's hospital fact sheet: Pressure Injuries.

IMPLEMENTATION AND MONITORING COMPLIANCE

1. All staff in Allied Health outpatient areas, ambulatory care outpatients and CPAIS Allied Health will be given education by an identified lead clinician within their service or team regarding the implementation of the Pressure Area guideline.
2. This will include: education in the use of the Glamorgan scale and flow chart, availability of appropriate approved handouts/ fact sheets for families regarding pressure injury, education regarding the importance of using the IIMs system to record any unsatisfactory outcomes and documentation requirements for recoding the screening process.
3. Compliance with pressure injury management will be done through the CYPF standardized auditing tool currently in final development and IIMS tracking and reporting.

APPENDICES

1. JHCH Process for assessment of pressure area risk in Paediatric Clinics
2. Process for assessment of pressure area risk in JHCH Allied Health Department
3. Process for assessment of pressure area risk in Community, Partnerships and Intergration Service (CPAIS)
4. Glamorgan scale: Paediatric Pressure Ulcer Risk Assessment form
5. Pressure Injury prevention plan- in development

REFERENCES

Pan Pacific Clinical practice guideline for the prevention and management of Pressure Injury
http://www.awma.com.au/publications/publications.php#pipm
JHCH_NICU_3.05 Skincare guidelines for babies in NICU
http://intranet.hne.health.nsw.gov.au/__data/assets/pdf_file/0010/120214/SkinDec2013newNo.pdf
ACI 2014 State Spinal Cord Injury Service Model of Care for Prevention and Integrated Management of Pressure Injuries in people with SCI and Spina Bifida
http://www.aci.health.nsw.gov.au/resources/spinal-cord-injury/pressure_injuries_in_people_with_spinal_cord_injury_and_spina_bifida/scis-pressure-injury-moc

USEFUL LINKS

1. HNELHD PD2005_257:PCP 1 Pressure Injuries: Prediction, Prevention and Management PD2005_257:PCP 1
   http://intranet.hne.health.nsw.gov.au/__data/assets/pdf_file/0008/115928/PD2005_257_PCP_1_Pressure_Injuries.pdf

Parent Fact Sheets can be found on the Kaleidoscope Webpage:

- Pressure Relief Technique (weight shifts) and Spina Bifida

  http://www.schn.health.nsw.gov.au/files/factsheets/pressure_relief_technique_weight_shifts_and_spina_bifida-en.pdf
- Protecting your skin and Spina Bifida

  http://www.schn.health.nsw.gov.au/files/factsheets/spina_bifida_-_protecting_your_skin_-en.pdf
- Pressure Injuries

  http://www.schn.health.nsw.gov.au/files/factsheets/pressure_injuries-en.pdf
- Foot care and Spina Bifida

  http://www.schn.health.nsw.gov.au/files/factsheets/spina_bifida_-_foot_care_-en.pdf

CONSULTATION

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APPROVAL

CPGAG – 20th July 2015.

JHCH CQ&PCC – 24th November 2015

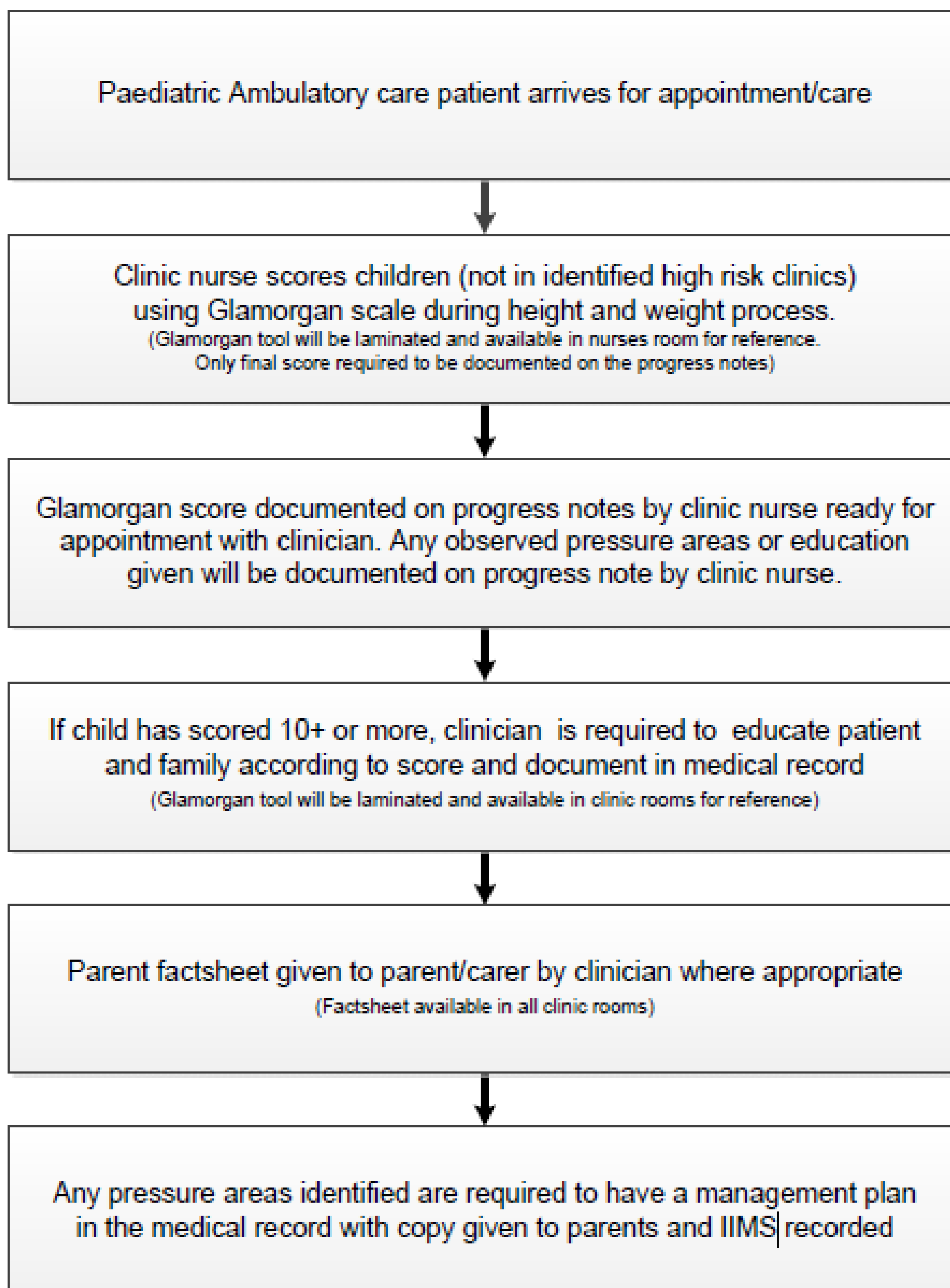
CPAIS CQ&PCC - 26th November 2015.

FEEDBACK

Any feedback on this document should be sent to the Contact Officer listed on the front page.

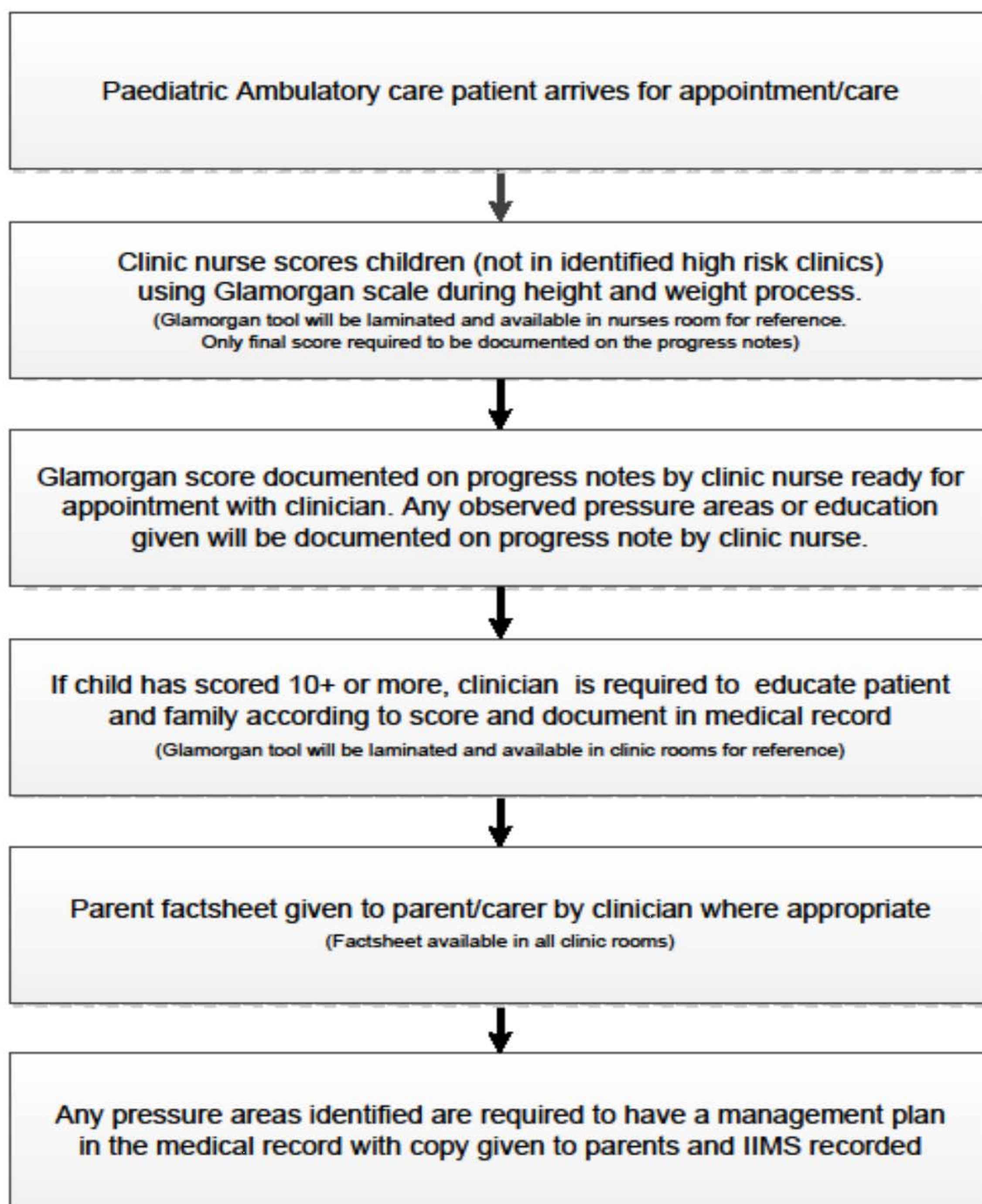
Appendix One

JHCH Process for assessment of pressure area risk in Paediatric Clinics



Appendix Two

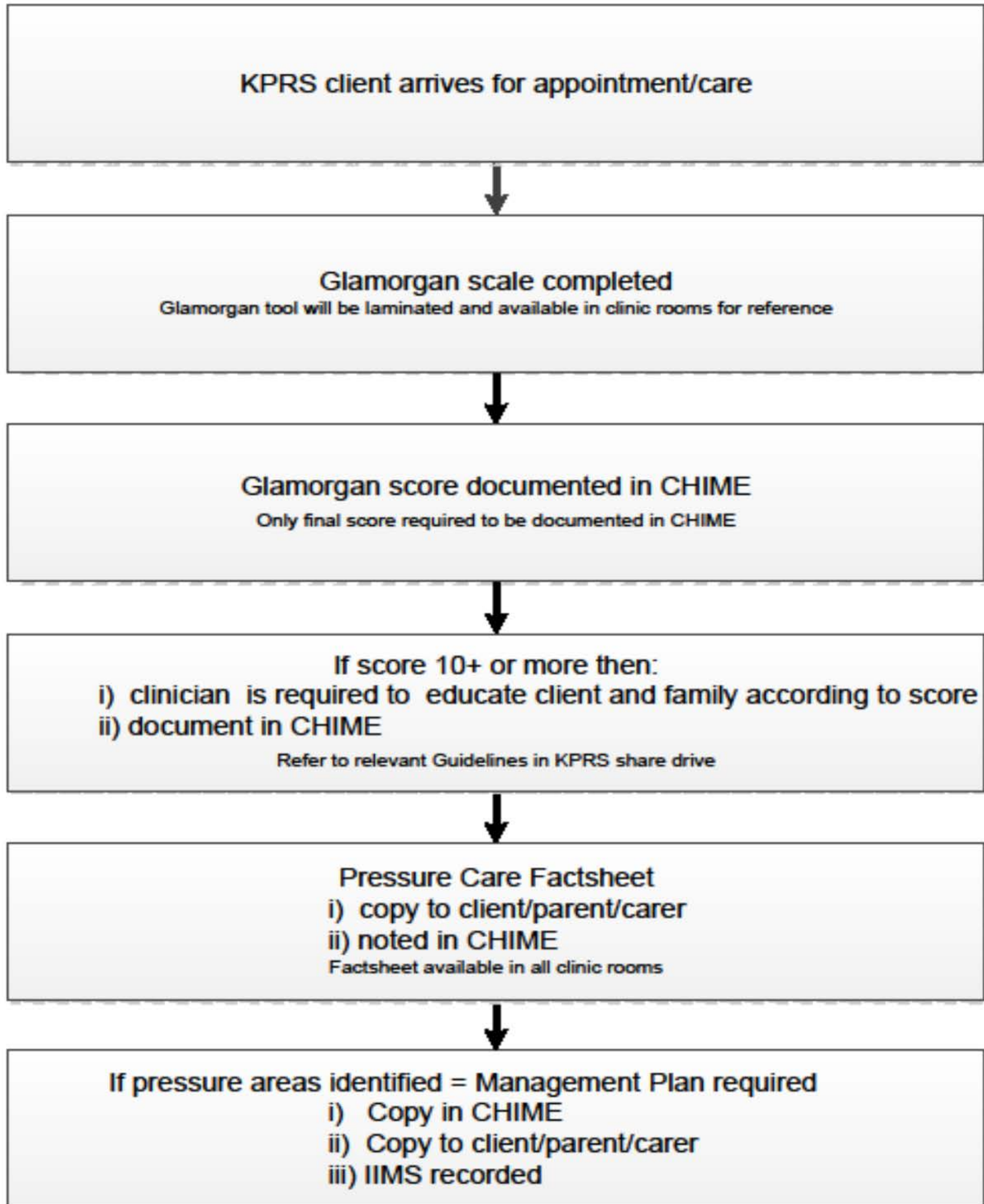
Process for assessment of pressure area risk in JHCH Allied Health Department



John Hunter Children's Hospital
CHILDREN, YOUNG PEOPLE AND FAMILIES

Appendix Three

Process for assessment of pressure area risk in Kaleidoscope Paediatric Rehabilitation Service (KPRS)



Appendix Four

HUNTER NEW ENGLAND AREA HEALTH SERVICE

Facility: ______________________________

THE GLAMORGAN SCALE – PAEDIATRIC PRESSURE ULCER RISK ASSESSMENT FORM

PLEASE USE GUMMED LABEL IF AVAILABLE

SURNAME		UNIT NUMBER
OTHER NAMES		
ADDRESS		
DATE OF BIRTH	M.O.	

HNEMR43

BINDING MARGIN – DO NOT WRITE

Risk Factor	Score	Date and Time of Assessments (reassess at least daily and every time condition changes)						
(If data such as serum albumin or haemoglobin is not available, write NK – not known and score 0)								
Mobility and Movement								
Child cannot be moved without great difficulty or deterioration in condition / under general anaesthetic	20							
Child unable to change position without assistance /cannot control body movement	15							
Some mobility, but reduced for age	10							
Normal mobility for age	0							
External Factors								
Equipment / objects / hard surface pressing or rubbing on skin	15							
Physiological Factors								
Significant anaemia (Hb <90g/L)	1							
Persistent pyrexia (temperature > 38.0°C for more than 4 hours)	1							
Poor peripheral perfusion (cold extremities/ capillary refill > 2 seconds / cool mottled skin)	1							
Inadequate nutrition (discuss with dietician if in doubt)	1							
Low serum albumin (< 35g/l)	1							
Weight less than 10th centile	1							
Incontinence (inappropriate for age)	1							
Total Score								
Action Taken (Yes or no – document in child's medical record)								
Name								
Signature								
Designation								

Risk Score	Category	Suggested Action
10+	At risk	Inspect skin at least twice a day. Relieve pressure by helping child to move at least every 2 hours. Use an age and weight appropriate pressure redistribution surface for sitting on/ sleeping on.
15+	High risk	Inspect skin with each positioning. Reposition child / equipment/ devices at least every 2 hours. Relieve pressure before any skin redness develops. Use an age and weight appropriate pressure redistribution surface for sitting on/ sleeping on.
20+	Very high risk	Inspect skin at least hourly. Move or turn if possible, before skin becomes red. Ensure equipment / objects are not pressing on the skin. Consider using specialised pressure relieving equipment.

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PAEDIATRIC PRESSURE ULCER RISK ASSESSMENT FORM

Paediatrics

SAMPLE - DO NOT PRINT

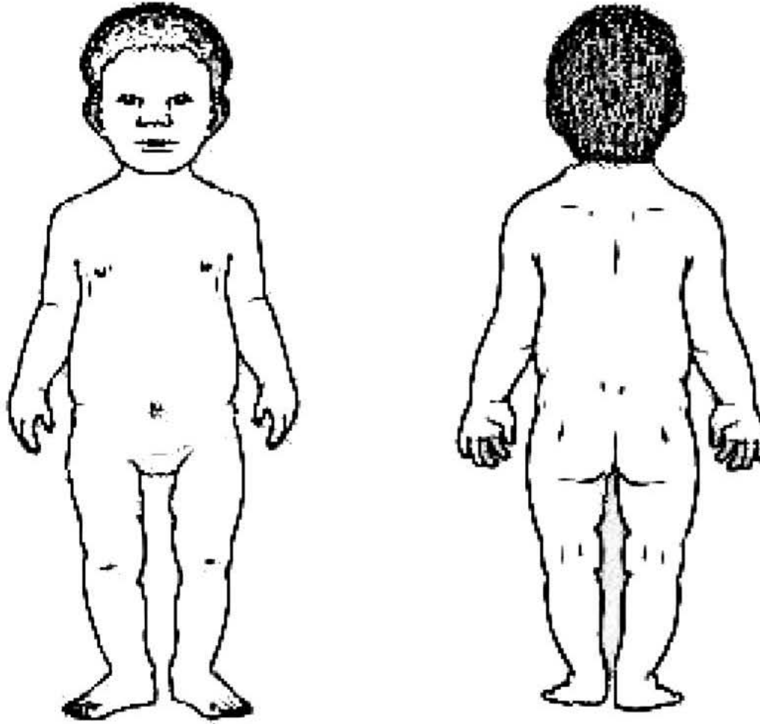
HUNTER NEW ENGLAND AREA HEALTH SERVICE

Facility: ______________________________

THE GLAMORGAN SCALE – PAEDIATRIC PRESSURE ULCER RISK ASSESSMENT FORM

PLEASE USE GUMMED LABEL IF AVAILABLE

SURNAME		UNIT NUMBER
OTHER NAMES		
ADDRESS		
DATE OF BIRTH	M.O.	



BINDING MARGIN – DO NOT WRITE

Using numbers, indicate on the diagram above any red areas or pressure ulcers, then using the box below describe the pressure area, the date it was first observed, and the outcome (resolved or not resolved) on resolution, completion of this form, transfer or discharge (whichever comes first).

Pressure Area Number	Date Pressure Area First Observed	Brief Description of Pressure Area (also document in child's medical record)	Outcome (Resolved / Not Resolved)	Date of Reassessment	Sign, Print and Designate

HNEMR43 – March 2009

SAMPLE - DO NOT PRINT

Appendix Five

Pressure injury prevention plan

Affix Patient Label Here
MRN ____________
SURNAME ____________
GIVEN NAME(S) ____________
DATE OF BIRTH: ________ SEX: _____

Form required for patients identified At Risk to Very High Risk on the Glamorgan Risk Assessment
Tick box for management strategies relevant to individual patient

Risk Assessment Score: ____________ Date: ____________

Referrals
(Before referral please check that the child is not actively involved with this discipline)
☐Occupational Therapy (*advice on appropriate pressure relieving devices*)
☐Physiotherapy (*assistance/advice on transferring and repositioning*)
☐Orthotics (*correct fitting of braces/splints/collars*)
☐Nursing
☐Dietetics

Prevent friction and shearing forces
☐Application of a barrier dressing
Dressing Used: ____________ Anatomical location: ____________
☐Observe patient closely for signs of friction eg splints/seating
☐Advice regarding transfers
☐Other: ____________

Reducing Moisture
☐Application of barrier cream
Cream Used: ____________ Anatomical location: ____________
☐Use of absorbent sheets (such as Kylie's)
☐Advice/management regarding cause of incontinence (bowel and bladder)
☐Consideration of appropriate equipment e.g wheelchair cushion
☐Other: ____________

Relieving pressure
☐Suspend heels off the bed using pillows or gel pads
☐Demonstrated pressure relieving techniques and time frames eg side lying, support under knees
☐Consideration of appropriate pressure relieving equipment e.g pressure relieving mattress
☐Other: ____________

Skin Inspection
Inspect:
☐Sacrum ☐Heels ☐Elbows ☐Shoulders ☐Legs
☐Hands if splints/casting
☐Toes ☐Around tubes ☐Back of Head especially in infants less than 36 months of age
☐Circulatory observations for children with plaster casts, orthosis and bandages note signs of irritation

Advice on positioning and repositioning
Reposition:
☐Tubing ☐Catheters ☐Face masks ☐Electrode
☐Check the positioning of heels and other bony prominences
☐If required to sit with bed head elevated, use aids such as pillows that support the upper body

☐Other preventative measures ____________
☐Individual variations ____________
☐Family/carer specific requests ____________
Health Professional Name: ____________ Signature: ____________
☐Prevention plan discussed with parent/carer ☐Pressure injury factsheet received
Parent Name: ____________ Signature: ____________
Date: ____________

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Pressure injury prevention plan

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