MANAGEMENT OF PRESSURE INJURIES
HOW TO COMMUNICATE & DOCUMENT

DOCUMENTATION & COMMUNICATION OF PRESSURE INJURIES
All pressure injuries require careful documentation and communication. All of the following should occur upon recognition of a pressure injury:

1. Document pressure injury appearance, location, stage, measurement, and exudate in EMR progress note
2. Add pressure injury LDA in EMR (see below)
3. Notify medical staff and AUM on for shift
4. Notify patient, family/care-givers of pressure injury and management plan
5. Handover detailed description of pressure injury to nurse looking after the patient

VHIMS
Every pressure injury warrants a clinical incident form to be completed i.e. a VHIMS.
Follow the steps below when completing a VHIMS;

1. Primary incident type: adverse outcome/harm > injury > physical > wound > pressure injury

EMR DOCUMENTATION
How to keep track of a patient’s pressure injury if we don’t have adequate documentation about it?
The best way to track any wound including a pressure injury in EMR is by creating an LDA for that wound.
Currently, the most appropriate LDA for a pressure injury is an “ulcer”. If your patient is identified to have a pressure injury follow these steps to add an LDA;

1. Flowsheets > LDA tab > add LDA
2. Search for “WOUND” or “ULCER” to find “ULCER”
3. “Other Ulcer Type”
   • Our pressure injuries in PICU don’t fall into any of the categories
   • Create a comment: pressure injury
4. Select the location (e.g. nose, sacrum)
5. In “wound description” state what stage the pressure injury is and the cause (e.g. stage 1 pressure injury from ETT)
6. Complete LDA assessment at least once per shift and anytime the pressure injury is visualised.

DON’T FORGET TO TAKE A PHOTO OF THE PRESSURE INJURY USING A ROVER OR HAIKU APP ON YOUR PHONE!