Developed in collaboration with the Wound Care Champions, Wound Care Specialists, Enterostomal Nurses, and South West Regional Wound Care Program (SWRWCP) members from Long Term Care Homes, Hospitals, and South West Community Care Access Centre contracted Community Nursing Agencies in the South West Local Health Integration Network.

Title

Procedure: Interdisciplinary Pressure Injury Contributing Factors Assessment Tool

Background

- The "Interdisciplinary Pressure Injury Contributing Factors Assessment Tool" was developed by members of the SWRWCP, and is an interdisciplinary assessment tool to be used to assess individuals with pressure injuries in order to identify contributing factors in the development of their pressure injuries. The form is intended:
  - To be completed at the point of entry to the health care system for individuals with a pressure Injury or when a pressure Injury is identified on an individual already within the system;
  - To be completed by a generalist health care provider such as an Registered Nurse, Registered Practical Nurse, Occupational Therapist (OT), Physiotherapist (PT), etc. or by a Wound Care Specialist or Enterostomal Nurse if they are the first person to assess the wound at time of admission into the health care system or discovery, and;
  - To follow the individual as they move through the health care system, providing all subsequent health care providers access to the assessment information
  - Legend of abbreviations used in the assessment tool:

Term	Abbreviation
Ind	Independent
Sup	Supervised
Ax1	Physical assist by one person
Ax2	Physical assist by two persons
FWB	Full weight bear
WBAT	Weight bearing as tolerated
PWB	Partial weight bearing
FeWB	Feather weight bearing
NWB	Non-weight bearing
WW	Wheeled walker
Elev	Elevated
Dep	Depressed
WNL	Within normal limits
OW	Ontario Works
OSDP	Ontario Disability Support Program

Indications

This procedure is intended to be used by front line registered health care providers to assist with their assessment and management of individuals admitted with or presenting with a pressure Injury.

Procedure

NOTE: The use of the "Interdisciplinary Pressure Injury Contributing Factors Assessment Tool" is but one part of the holistic assessment of an individual admitted with or presenting with a pressure Injury.

Assessment

1. Thoroughly review the person's available medical records and add appropriate information to the "Interdisciplinary Pressure Injury Contributing Factors Assessment Tool" regarding the following:
    a. The person's name and Ontario Health Insurance Plan (OHIP) number or other identifier (ID Number), and the assessment date
    b. Neurological conditions:
        i. Any diagnosed neurological medical conditions, if present, i.e. ALS, epilepsy, brain tumors, Huntington's Disease, MS, muscular dystrophy, brain and/or spinal cord injuries, Parkinson's Disease, spina bifida, etc.
        ii. The date of onset, level of spinal cord involvement, and any details re the degree of any sensory/autonomic/motor losses, spasticity, and episodes of autonomic dysreflexia
    c. Bowel and bladder control and criteria for a nurse continence advisor assessment:
        i. Degree of current bladder and bowel continence, and details of any incontinence
        ii. Incidence/frequency of diarrhea/constipation and measures to treat (and their effectiveness)
        iii. Use of any indwelling catheters, condom catheters, or fecal collection devices
        iv. Use of any containment supplies, i.e. briefs, pads and their effectiveness
        v. History of urinary tract infections
        vi. History/details of any skin breakdown associated with bowel/bladder incontinence
        vii. Current involvement of a Nurse Continence Advisor
    d. Mobility and function:
        i. Level of assistance the person requires to roll, bridge, and move from lying to siting and vice versa in bed
        ii. Level of assistance the person requires to shift their weight, move from sitting-standing and from bed to chair and vice versa, and to transfer on/off toilet and into/out of tub/shower
        iii. Ambulation and weight-bearing status
        iv. Mobility aides currently in use (if applicable)
    e. Pressure redistribution aides in use:
        i. The type, supplier, and purchase/funding date of any bed, chair, wheelchair, wheelchair cushion, or other such pressure redistribution aides currently in use
        ii. The pressure redistributing wheelchair/chair seat width/depth
        iii. You may wish to add notes re subjective comfort of aides, usage, etc.

f. Braden Scale for Predicting Pressure Sore Risk:
    i. If this risk assessment was recently done, transcribe the results onto the "Interdisciplinary Pressure Injury Contributing Factors Assessment Tool". If not previously done, or if you feel the person's condition has changed since the previous assessment, see "Procedure: Predicting Pressure Sore Risk in Adults and Children" for guidance on how to complete this risk tool
g. Person's activity in the past 24 hours:
    i. Health care professional notes that refer to the person's activity in the past 24 hours. NOTE: identify the time of day and what activity was taking place
h. Mat evaluation:
    i. Details of any Mat evaluations, completed by an OT, PT, or other registered health care professional trained in Mat evaluations

Planning

1. Expected outcomes:
    a. Information from the person's chart, the person and/or their substitute decision maker (SDM)/power of attorney for personal care (POA C), and your assessment (and a Mat assessment – if applicable) will allow for the thorough completion of the "Interdisciplinary Pressure Injury Contributing Factors Assessment Tool"
    b. The information obtained in the "Interdisciplinary Pressure Injury Contributing Factors Assessment Tool" will allow for:
        i. The identification of any underlying cause(s) of the pressure wound(s)
        ii. The identification of any extrinsic, intrinsic, and iatrogenic factors affecting the person's ability to heal (if healing is a realistic goal), or factors putting them at risk for pressure Injury development
        iii. The identification of pertinent person-centered concerns
    c. Registered nursing staff, in collaboration with other involved health care disciplines and the person with the wound or their SDM/POA C (if applicable), will be able to use the assessment information to initiate/modify and implement an appropriate, person-centered, interdisciplinary plan of care which contains clear directions to staff and others who are providing the person with direct care
2. Explain the procedure and purpose of the assessment to the person and/or their SDM/POA C, and obtain verbal or implied consent

Implementation

1. Provide for privacy
2. Ensure the person's SDM/POA C is present or available if the person does not have a reliable memory or is unable to accurately answer any questions on the "Interdisciplinary Pressure Injury Contributing Factors Assessment Tool"
3. Following the order of the "Interdisciplinary Pressure Injury Contributing Factors Assessment Tool", ask the person and/or their SDM/POA C questions to elicit responses to the identified items. Specific instructions:
    a. Before beginning the interview/assessment, ensure that the person's name, OHIP or other identifying number and the current date are added to the top of every page (in the header space where indicated)
    b. Neurological conditions present:
        ii. Confirm/determine the person's neurological medical condition diagnoses, if present, the date of onset, level of spinal cord involvement, and the details re the degree of any sensory/autonomic/motor losses, spasticity, and episodes of autonomic dysreflexia
    i. Bowel and bladder control and criteria for a nurse continence advisor assessment:
        i. Confirm/determine their current bladder and bowel continence status, details of any incontinence, and any incidence/frequency of diarrhea/constipation and measures in place to treat it (and their effectiveness)
        ii. Confirm/determine the use of any indwelling catheters, condom catheters, and/or fecal collection devices, and/or the use of any containment devices, i.e. briefs, pads, and the effectiveness of such measures
        iii. Confirm/determine any history of urinary tract infections, and any history/details of any skin breakdown associated with their bowel/bladder incontinence
        iv. Confirm/determine if the person is currently involved with a Nurse Continence Advisor, and if not, and if they qualify, discuss the criteria they have for a referral to such a health care provider and obtain their verbal consent to proceed with a referral (you do not need a physician order to refer)
    j. Mobility and function:
        i. Confirm/determine the level of assistance required to roll, bridge, and move from lying to sitting and vice versa in bed. When in doubt, ask/assist them to demonstrate
        ii. Confirm/determine the level of assistance required to

shift their weight, move from sitting-standing and from bed to chair and vice versa, and to transfer on/off toilet and into/out of tub/shower. When in doubt ask/assist them to demonstrate

iii. Confirm/determine their ambulation and weight-bearing status. When in doubt, ask/assist them to demonstrate

iv. Confirm/determine their use of mobility aides, i.e. wheelchairs, walkers, crutches, canes, raised toilet seats, commode chairs, hospital beds, bed rails, grab bars, etc. You may need to survey their environment

k. Pressure redistribution aides in use:

i. Confirm/determine the use of any pressure redistribution devices. Look at the devices and record the type, supplier, condition, and purchase/funding date of any bed, chair, wheelchair, wheelchair cushion, or other such pressure redistribution aides

ii. Ask the person about their satisfaction with such aides

iii. Using a measuring tape, measure the pressure redistributing wheelchair/chair seat width/depth (in cm), and record

l. Braden Scale for Predicting Pressure Sore Risk:

i. If this risk assessment was recently done, transcribe the results of the risk tool onto the "Interdisciplinary Pressure Injury Contributing Factors Assessment Tool". If not previously done, or if you feel the person's condition has changed since the previous assessment, see "Procedure: Predicting Pressure Sore Risk in Adults and Children" for guidance on how to complete this risk assessment

m. Person's activity in the past 24 hours:

i. Have the person recall their activity in the past 24 hours. NOTE: have the person identify the time of day and what activity was taking place, and record

n. Mat evaluation:

i. If a recent Mat evaluation has not been done, and the person requires a wheeled mobility or seating intervention, refer the person to an OT, PT, or other health care provider that has been TRAINED in Mat evaluations, for a Mat evaluation, if you are not trained to do so yourself. NOTE: you do not require a physician order to refer for a MAT assessment, but you do need consent from the person. Request that whomever completes the Mat evaluation, completes the 'Seating Goals', 'Recommendations', 'Funding Options', and 'Preferred Vendors' sections of the

	"Interdisciplinary Pressure Injury Contributing Factors Assessment Tool" 4. Upon completion of the form, sign the bottom of every page. Include your professional designation 5. Discuss your findings and the implications of those findings with the person and/or their SDM/POA C 6. Share the results of the pressure Injury contributing factors assessment and Mat assessment (if applicable) with the interdisciplinary members of the person's wound care team 7. Complete/update an interdisciplinary, person-centered plan of care as per your organization's policies, based on your holistic assessment 8. Store the completed "Interdisciplinary Pressure Injury Contributing Factors Assessment Tool" in the person's medical record for future reference. Should the person be transferred to another facility/service, a copy of this document should accompany them to prevent duplication of assessment and to promote the continuity of care **Evaluation** 1. Unexpected outcomes: a. Information from the person's available medical records, the person and/or their SCM/POA C, and your assessment (and the Mat assessment – if applicable) do not allow for the thorough completion of the "Interdisciplinary Pressure Injury Contributing Factors Assessment Tool" b. The information obtained does not allow you to: i. Accurately identify underlying cause(s) of the wound ii. Accurately identify extrinsic, intrinsic, and iatrogenic factors affecting the person's ability to heal (if healing is the goal) or putting them at increased risk for pressure Injury development iii. Identify pertinent person-centered concerns c. Registered nursing staff, in collaboration with other involved health care disciplines and the person with the wound and/or their SDM/POA C, are unable to use the assessment information to initiate/update and implement an appropriate, person-centered, interdisciplinary plan of care d. The "Interdisciplinary Pressure Injury Contributing Factors Assessment Tool" is not completed according to this procedure
References	1. Sussman C, Bates-Jensen B. The diagnostic process. In: Sussman C, Bates-Jensen B., eds. Wound Care: A collaborative practice manual for health professionals. Third Ed. Baltimore: Lippincott Williams & Wilkins, 1997:2-3.
Related Tools (NOTE: these tools and their instructions can be	• Procedure: Predicting Pressure Sore Risk in Adults and Children

found on the SWRWCP's website: swrwoundcareprogram.ca)	