CPIAP
Canadian Pressure Injury Advisory Panel

Report On Repositioning Pressure Injuries

Shifting Mindsets And Transforming Culture To Support Practice Excellence

Second Annual Canadian Pressure Injury Advisory Panel Summit

November 21, 2025.
Carleton University,
Ottawa, Ontario

CPIAP is an official interest group of Nurses Specialized in Wound, Ostomy and Continence Canada (NSWOCC®)

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Acknowledgements

We wish to acknowledge that the land on which we gather is the traditional unceded territory of the Algonquin Anishnaabe People. CPIAP and NSWOCC work and operate on the traditional homeland of the many diverse First Nations, Métis, and Inuit people whose ancestors walked this land before us and those persons who we share this great land with today.

John Gregory, IIWCC, ISWA, Opencity Inc., produced these summit proceedings.

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INTRODUCTION

Opening this year's summit, CPIAP President Joshua Moralejo acknowledged the first annual monumental 2024 CPIAP Summit, which provided an opportunity to identify and validate gaps in pressure injury prevention and management across our Canadian nation. The calls to action from the 2024 CPIAP Summit are reproduced in Appendix 1. Dr. Sharon Gabison hoped that this 2025 summit would see the collective attendance, both in-person and online, speak to the commitment we all must make to shift our mindset and transform our culture to support practice excellence and stop pressure injuries. This 2025 CPIAP Summit also included four digital posters. These are in Appendix 2.

NSWOCC CEO Catherine Harley applauded the CPIAP Summit organizing committee for ensuring that the patient voice is prominent again. The language of the Health Standards Organization has shifted to an integrated, people-centred care approach. No longer patient-centred or person-centred, emphasizing that the relationship between the health care team and patient is inextricably bound. Measuring and monitoring pressure injuries by harnessing data and acting on it was a recurring theme throughout all sessions. Look at the results from the interactive session on technology use. An engaging panel debate about when a pressure injury might be unavoidable or avoidable. The panel epitomized the interprofessional collaboration critical to shifts in culture for pressure injury prevention and emphasized codecision making with our clients and patients as an essential involvement. The interprofessional team from Unity Health Toronto presented an illustration of the process methodology for a pressure injury prevention program.

In her role as President of the Canadian Nurses Association, Dr. Kimberly LeBlanc extended a welcome to the CPIAP Summit. "It's been an honour and a privilege the last couple of years to represent 500,000 nurses across this country. We are 500,000 strong. We have a voice. We can use that voice to bring influence to work with our patients. For example, I get to speak to politicians on the national stage about wound, ostomy, incontinence, and pressure injury issues. The whole interprofessional team needs to get involved to support the phenomenal work by advocates in the community."

About Canadian Pressure Injury Advisory Panel

To address the national issue of pressure injuries in Canada, CPIAP was formed in 2021, bringing together an interprofessional, nationwide panel of experts in pressure injury prevention and management, as an official interest group of Nurses Specialized in Wound, Ostomy and Continence Canada (NSWOCC). This pan-Canadian panel serves in a national advisory role and is represented by a cross section of health care professionals and researchers from different health care sectors from acute care to the community. Through organized workstreams, CPIAP supports making pressure injuries a national priority, drives standardization, advocates for policy solutions, and optimizes knowledge translation.

CPIAP is committed to seeing a Canada united in pressure injury prevention, management, and policy.

The Honourable Natalia Kusendova-Bashta, Ontario Minister of Long-term Care, provided a video message for the attendees in recognition of Stop Pressure Injury Day, in which she reminded everyone that "on any given day, one in four Canadians are affected by these injuries, which can greatly impact a person's quality of life." She described that recent investments in training more registered nurses, registered practical nurses, and patient support workers in skin and wound care will help bring more world-class care to those at risk.

Opening Remarks: Accreditation Canada

SANDRA YOUNG, PhD, RN, CAPM, CPHQ

Sandra Young, PhD, RN, CAPM, CPHQ

Standards and Education Health Standards Organization (HSO) Executive Director Dr. Young described the commitment by HSO and Accreditation Canada to optimizing skin integrity, highlighting the new era Health Quality 5.0.[1]

The required safety practices (RSPs) build upon the former required organizational practices (ROPs), recognizing that safety practices are the responsibility at every level of an organization and not limited to the organizational leader level. Dr. Young emphasized the active and visible leadership with commitment, looking at how everyone contributes, including clients and families, to ongoing improvement. The new RSPs also reflects the focus on being people powered and a strengthened measurement and monitoring component. This necessitates moving away from checking boxes toward understanding the difference. "It is not enough to report this is our pressure injury rate and check a box," says Dr. Young. "Why do you have a rate? What can we do differently? What do you compare to? And how are you showing a difference in not only quality outcomes, but safety and experience as well?"

An RSP is defined as an evidence-informed and measurable safety imperative in the delivery of safe, high-quality, and reliable care. RSPs focus on implementing proactive, safe, and reliable practices in partnership with clients to prevent, respond to, and manage physical, psychological, and cultural harm.

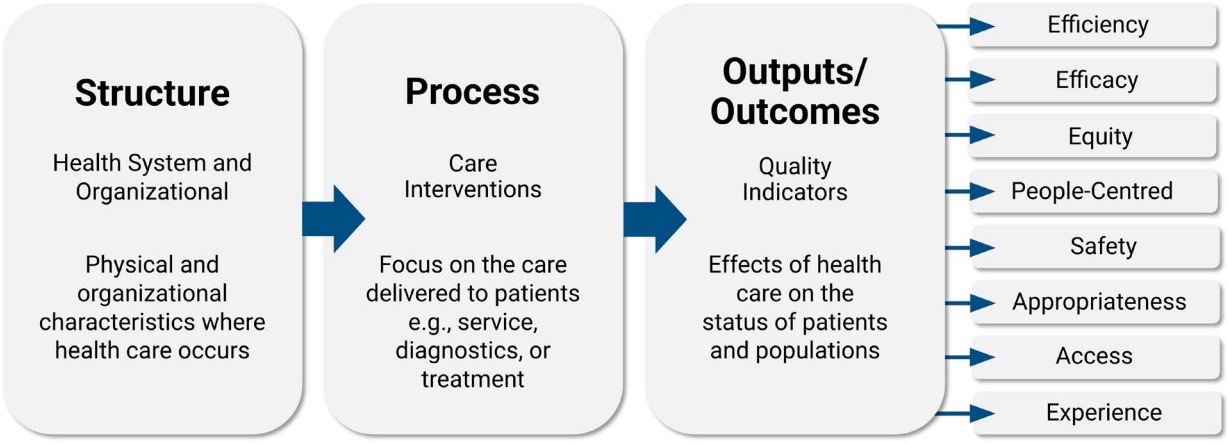
Health care decision making is a shared interprofessional team collaborative process with clients, their caregivers, and their care partners central to that process. Pressure injury prevention is a team game. It is critical to listen to frontline providers, clients, and families, as they often know best where to start. The Optimizing Skin Integrity RSP directs organizational leaders and teams to collaborate to implement the organizational evidence-informed program to optimize skin integrity.[2]

The RSP builds upon the work of Vincent and colleagues[3] in safety measuring and monitoring and follows their framework (see Figure 1). Harnessing pressure injury data for improvement is central to reporting harm and systems analysis. Shared learning is the behaviour that drives change (Figure 2).

Figure 1 *Framework for Safety Measurement and Monitoring*

Note. Vincent et al.[3] © HSO and Accreditation Canada, 2025.

Figure 2 *Harnessing Data for Pressure Injury*



Note. © HSO and Accreditation Canada, 2025.

In conclusion, Dr. Young summarized improvement strategies for continuous quality improvement. She encouraged attendees to focus on one thing at a time with small cycles of change that everyone can rally around.

"Start small. Do not be overwhelmed with big. It is great when you start to see that momentum, because, as I said, you make one change and many other outcomes result."
– Dr. Sandra Young.

HSO empowers and enables people around the world to continuously improve quality of care. Together with our partners, we do this by developing standards, assessment programs, and quality improvement solutions.

Accreditation Canada empowers and enables organizations to continuously improve quality of care through innovative assessment programs based on national and global standards.

Keynote Presentation by a Representative of NPIAP

JOYCE BLACK, PhD, RN, CWCN, FAAN, CWS

Joyce Black, PhD, RN, CWCN, FAAN

A preeminent authority on pressure injuries, Dr. Joyce Black examined the clinical perspective of pressure injuries and deep tissue pressure injury (DTPI) in at-risk populations: a) dark skin tones, b) critically ill patients.

PRESSURE INJURIES IN DARK SKIN TONES

Dr. Black presented an illustration of advanced DTPI of the buttocks, highlighting that one of the most critical pieces of data she seeks is not only the rate of pressure injuries in dark pigmented patients, but also the mortality. A study of the 5-year average rate of pressure injury in the US (2008–2012) reported 670,767 cases with Stage 3/4 disease.[4] The mortality is almost four times higher in people with a pressure ulcer† than without a pressure ulcer (9.1% versus 1.8%; odds ratio 5.08). The rates of pressure injury are higher in men, and the rates in African Americans are 2.4% higher than all other races. "That's significant to me, and that tells me that, at least in the study, it implied very strongly we're missing the pressure injuries in their Stage 1 and deep tissue injury phase," said Dr. Black.

Missing Stage 1 pressure injury or a DTPI means that the injury is becoming more advanced. Are we caring for these people properly? Yet assessment is a challenge in dark skin tones. Assessment is straightforward in people with pale skin because the Stage 1 pressure injury or DTPI creates a sharp contrast in skin tone.

Dr. Black advised assessing all patients on admission with a skin tone tool using natural light and examining with moisturized or wet skin. Moistening the skin will often aid in visualizing colour change. Even wetting the skin with a syringe of saline can make a difference. Fluorescent light changes the colour of the skin. We should avoid any use of racial or ethnic terms in describing skin colour. Additionally, in many patients, pressure injuries cause pain, so asking the person about the location and intensity of pain using a validated pain score is valuable.

Which skin tone chart any facility uses is less important than having a consistent system for identifying how many people are developing pressure injuries by skin tone. The upper inner arm is used to determine skin colour and to compare it with the skin being assessed for pressure injury. Data will help guide what education is needed. "The idea is to get an accurate, objective assessment of skin tone," said Dr. Black. "Some of you are saying to yourself, where did this come from? How come I never heard a word about skin tone in my entire education? Well, you probably did not." In collaboration with Dr. Joyce Pittman, Dr. Black evaluated how well student nurses are being taught about skin tone. Their research examined both nursing textbooks and the use of mannequins. Specifically noting that there were no objectives of skin tone diversity and photographs. Many medical and nursing students receive education in nonpatient-related

†While Bauer et al.[4] used *pressure ulcer* in their paper, the current term is *pressure injury*.

situations in simulation labs with mannequins. This begs the question of how many of these mannequins have dark skin tones. Given that patients with dark skin tones have higher rates of pressure injuries that may be more fatal, this represents "a big gap," according to Dr. Black. One that could be "an easy gap to fill."

Pressure injury guidelines describe subepidermal moisture assessment for pressure injury detection in dark pigmented skin.[5] A device measures subepidermal moisture that makes a correlation between the accumulation of fluid and inflammation occurring as part of the early signs of pressure injuries. Higher subepidermal moisture suggests an elevated risk for that patient. The same guideline also recommends assessing skin and soft-tissue temperatures. Thermography measures blood flow into the skin; physiologically increased blood flow and inflamed tissue produce a differential in skin temperature around the suspected pressure injury.[6] If the skin is hot and inflamed, the image will be red or orange. If the skin is ischemic, it will appear purple or blue.

PRESSURE INJURIES CRITICALLY ILL PATIENTS

Patients in the intensive care unit and operating room are at significantly elevated risk of DTPI and pressure injury development.[7] Skin assessment on admission is critical, yet given the patient's immobility, it is difficult. Two nurses are required to effectively assess the skin; one moves the patient's skin, while the second nurse inspects it. Correctly staging of pressure injuries is essential to avoid arbitrarily staging any open wound as Stage 2. The incidence of pressure injuries in critical care is likely the highest in any unit, as sedation results in immobile patients whose skin is exposed to unrelenting pressure, which is aggravated by shear and complicated by other risk factors. Curtis and colleagues[8] recently published a systematic review of the impact of care bundles on the prevalence and incidence of pressure injuries in high-risk acute settings. A pressure injury can linger for months beyond the reason a patient arrives in critical care when the episode of care is otherwise forgotten. Interventions to heal the pressure injury send the patient back to the clinic for weeks or months. Dr. Black emphasized that, nevertheless, there are some practical interventions to mitigate the risk and highlighted the National Pressure Injury Advisory Panel (NPIAP) resource *Deep Tissue Pressure Injury or an Imposter?*.[9] These include summarizing initial DTPI, evolving DTPI, and in comparison to ischemia and trauma. Interventions include the right ICU-designed bed or bariatric bed, prophylactic foam dressings on the sacrum if the head of bed is at 30° or flip if the head of bed is at 45°. Additionally, start moving the patient soon to prevent positional disequilibrium, and use wedges. Dr. Black also emphasized the need to get the patient up as directed and to avoid depositing a patient in a chair for 12 hours without moving. "They can't just sit there," said Dr. Black. Instead, ensure there is a suitable seat cushion and move the patient hourly in the chair before placing them on their side when they return to the bed.

The incidence of pressure injury in the operating room is also elevated. Savci et al.[10] reported an incidence of 5.8% in the operating room setting. Many operating room-acquired pressure injuries are DTPI, arising from an entirely immobile and anesthetized patient. The highest risk patients are the prone cases, any case over 3 hours, open-heart bypass, and emergency abdominal surgery. An operating room-acquired pressure injury is defined as one appearing within 72 hours of surgery on the body(s) subjected to pressure in the operating room.[11] Interventions again are adequate padding on the operating room table, floating the heels, accounting for other risk factors, and attention to the patient positioning to reduce pressure. Where pressure injuries arise, investigate through root cause analysis to understand and make improvements.

Dr. Black guided the CPIAP Summit attendees with a quick tour of pressure injury treatment using an analogy of a three-legged stool. Any missing leg causes the stool to tip over. The three legs revolve around:

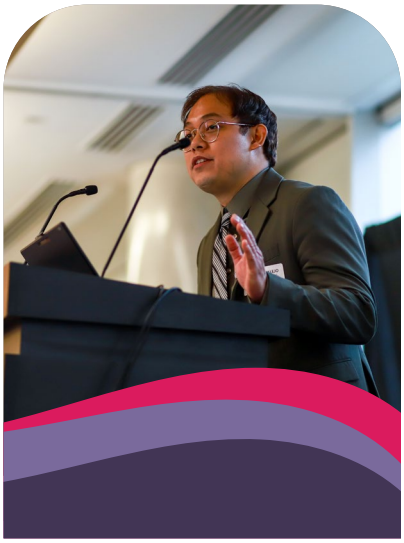
- controlling or curing the cause;
- nutrition; and
- local wound care.

To finish, Dr. Black noted that some patients have known compliance issues, particularly those with dementia. There are also patients whose wounds will never heal, so the goals of care shift from attempting to heal the wound to palliation, including odour management.

CPIAP Journey: Past, Present, and Future

JOSHUA MORALEJO, MScCH:WPC, BScN, RN, NSWOC, WOCC(C), IIWCC

CPIAP President Joshua Moralejo guided in-person and online attendees through the NSWOCC special interest group's work to represent Canada and address national pressure injury issues. As a result of the initial 3-year plan, much has already been achieved, specifically raising awareness of pressure injuries to make them a national health priority, promoting standardization, and transforming the culture of pressure injury management. The previous summit provided collective perspectives and responses from the crucial conversations to establish a further roadmap for CPIAP to work on in the years ahead.



Joshua Moralejo, MScCH:WPC, BScN, RN, NSWOC, WOCC(C), IIWCC

That evolving strategic plan focuses on four priorities, as shown in Figure 3.

Figure 3 *CPIAP Strategic Priorities*

Moralejo reinforced the clear mandate, capturing the voice of people with lived or living experience to guide and influence the board's decision making. He commended the CPIAP Board for their unanimous decision to appoint Luz Odrial, last year's summit speaker, as Patient Representative Director, noting her incredible passion and commitment to making a difference in the care and management of patients with pressure injuries.

Luz Odrial – CPIAP Patient Representative Director

Moralejo described many past, present, and future initiatives that each relate to one or more of the four priorities. As part of supporting standardization, a working group has developed **Pressure Point** as an environmental scan of pressure injury prevention and management resources, policies, and procedures across Canada. Moralejo

"We really encourage each and every attendee here today and the public to kindly visit our website to see the available resources, so that you can compare and contrast some of the similarities and potential differences and how we can align those practices together."
– Joshua Moralejo, CPIAP President.

paid tribute to the leadership of Nancy Schuttenbeld and Shannon Handfield. To learn more, visit https://www.cpiap.com/pressure-point, where you can also submit additional resources.

Other pressure injury standardization initiatives include Pressure Injury Excellence (PIE), which seeks to establish criteria and processes to recognize health care organizations that have exhibited exemplary commitment to pressure injury prevention and management. That recognition is also evident in the step to invite digital posters to the summit. The four digital posters can be found in Appendix 2.

The third strategic priority aims to lead pressure injury advocacy and policy change. The launch of the **Pressure Map** seeks to explore the impact of social determinants of health on pressure injury development and to gauge the gravity of this issue in Canada. Conducting an environmental scan will establish credible baseline data to help position CPIAP for advocacy. Moralejo also reiterated the importance of standardization and health policy for assessing and collecting data on pressure injuries across diverse skin tones. Accordingly, the CPIAP initiatives aim to drive inclusion of comprehensive approaches in identifying and assessing pressure injuries among persons with diverse skin tones. "Dr. Black highlighted the importance of really doing a comprehensive, multimodal approach in assessing people with dark skin tones. And I love how sometimes the talks blend in," said Moralejo. "It is important for us to really advocate for having a health policy or even a strong standard that mandates the importance of not just inspecting the skin, but the need for other comprehensive assessment approaches, from palpation and utilizing and leveraging even technology." Moralejo went on to share the "grandiose idea" that as a diverse nation, CPIAP builds a database to ensure appropriate staging of pressure injuries among diverse skin tones.

In the fourth strategic priority supporting knowledge translation, another working group has scoured Canada to build an index and repository of patient and family resources. Forty resources have been appraised against a content analysis framework examining components such as how the resources were formatted, the types of pressure injury prevention strategies highlighted, and how they were endorsed by their regional health authorities.[12] The Australian researchers noted the significant deficit in the availability of educational materials for acute care patients and their families, which we needed to address. "We want to make sure that we can make it easier for persons with lived experience to know what resources are available for them that they can utilize as part of their own toolkit," says Moralejo. Watch Violet's story on the Patient and Family Resources page as she navigates the health care system in Alberta. https://www.cpiap.com/patient-family-resources.

In summary, Moralejo stressed how crucial every member of the team is in the process. "If we are going to mitigate and prevent this issue, everybody's hands will have to be on deck," he says, noting that attending the CPIAP Summit shows commitment while asking everyone to be even more proactive.

"Every hand that we have on deck, every member of the team that we can bring in is another voice that collectively becomes a stronger voice that can push initiatives forward. It is good to have one person, but if we have an entire family that is devoted to one cause of making sure that we address the issues of pressure injury prevention management across Canada, then I think we can make strides. We can ensure that this vision becomes a reality."
– Joshua Moralejo, CPIAP President.

Life in the Fast Lane – A Patient's Story

MR. BOB BROWN

Bob Brown

"I live an active life!" declares Bob Brown by way of introduction. This epitomizes many with spinal cord injuries, who continue to live life to the full. "Not everyone with disabilities is elderly or bedridden—many live full, independent lives," he adds.

Brown described his life growing up as an active young person in western Ottawa, until a car accident as a teenager after work on his way to the family cottage made him the second quadriplegic to complete the rehabilitation program at the Royal Ottawa Hospital. It would be an understatement to say that he was anything less than a true trailblazer for the rights of those with disabilities. Over the years, he has become a prominent advocate for accessibility in the city. Jobs in various federal government agencies honed his skills in lobbying, advocacy, tribunals, and acting as a changemaker. His advocacy work has encompassed systemic disability issues; transportation accessibility, including low-floor bus; and housing models that have been successful in influencing government laws and policies. The direct funding housing model for hiring personal attendants is still in use today.

Pressure injuries are a recurring risk and can occur at any time to cause significant downtime for those with spinal cord injury. Consequently, skin care and prevention are critical. Yet the coordination of health care professionals and care aides too often further disrupts the lives of those seeking to live independently in the community.

In conclusion, Brown sought to reinforce specific messages for the CPIAP Summit audience:

- Coordination of health care professionals for all skin and health care-related activities is essential to enable community-based independent living. Time management is critical. Health care professionals need to be on time.
- Pressure injury prevention is critical and requires the ability to adapt and innovate to what is available.

"Don't be afraid to bend metal. That was a bit of advice that stayed with me for a long time."

– Bob Brown.

He highlighted the need for memory foam cushions and the benefits of air mattresses for maintain skin integrity.

The importance of community-based care and independent living for people with disabilities.

“The adrenaline junkie is still alive in me,” he says, after taking up scuba diving in 2007.

“It is more of a comment. I first want to say, I am in perfect awe of you. I applaud you for being out there and for sharing your story. But equally, to being the strong advocate you are for a patient population that is often not in the good position where you are at, you have created change. Lastly, I would say, I echo what you say [about] thermography, if we can get that to a place where technology is more readily available from a price point and accessibility, it is a game changer. I am looking to you, Bob, to create something innovative, so that technology can be available to everybody, just like a cup of tea.” – Lee Bateman, MClScWH, BN, RN, NSWOC, WOCC(C), IIWCC.

Lee Bateman, MCIScWH, BN, RN, NWOC, WOCC(C), IIWCC

From Evidence to Action: Unity Health Toronto's Journey in Pressure Injury Prevention

KAITLYN VINGOE, MN, RN; JANETH VELANDIA, MCIScWH, RN(EC), NSWOC, WOCC(C); PHUONG (LISA) PHAN, MN, RN; AND KALEIL MITCHELL, MBA, BSc, CAPM

The Unity Health Toronto (UHT) interprofessional team presented their pressure injury prevention program. UHT has employed a rigorous project management approach to this strategic imperative. The team described the application of the project management approach as the "secret sauce" leading to success. Four foundational building blocks provided the structure to the presentation: (a) governance, (b) best practice guidelines, (c) sustainability, and (d) project management. The multiyear initiative began in May 2022 with the establishment of the steering committee, which provides leadership, oversight, and direction on pressure injury prevention, with the goal of reducing hospital-acquired pressure injuries across UHT. The timeline shown in Figure 4 is informed by evidence-based practice, reflective practice, and cross-site learning and is shaped by Accreditation Canada Standards.

Figure 4 *UHT Pressure Injury Prevention Steering Committee Multiyear Timeline*

Note. © Unity Health Toronto.

Aligned with CPIAP and Accreditation Canada, this is a story about a journey coming together to achieve one single clinical goal. It starts with establishing the proper governance structure. UHT sought to ensure that voices throughout the different sites and care continuum were heard and represented. “It is not enough to be committed or interested,” says Vingoe. “You need teeth to push for change, meaning setting up for success is critical.” The interprofessional team has many competing priorities, and the strong governance ensured appropriate resource allocation, while leveraging data to make informed decisions.

The ability to use data to create actionable insights is central. The UHT team described how they leverage patient safety data through incident reporting. The needs assessment tool has proven a “treasure trove of qualitative insights on the experience and needs of our clinical teams,” adds Vingoe. This is supported by the electronic patient care record, which monitors real-time data from clinical documentation and provides progress updates.

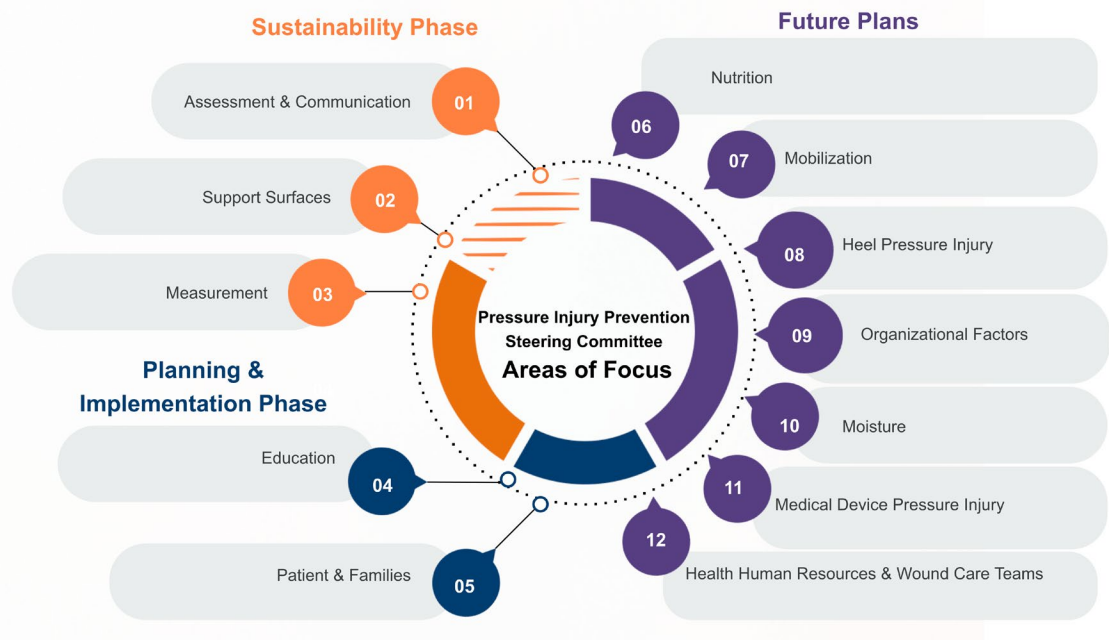
UHT worked to translate best practice guidelines into a practice framework. This is easier said than done across multiple sites and care settings. The 2019 International Clinical Practice Guideline chosen highlights the quality indicators essential for evaluating and improving care.[13] The UHT team reviewed indicators using the Model of Quality Evaluation proposed by Donabedian.[14] The quality indicators comprise three components:

- structure (e.g., technology, tools);
- process (e.g., documentation, assessment tools); and
- outcomes (e.g., pressure injury prevalence and incidence).

UHT adopted these indicators to anchor the system-wide pressure injury prevention framework and to develop the needs assessment tool. The best practice guidelines quality indicators were organized into 12 areas of focus, shown in Figure 5, and reordered according to priority and implementation. In turn, each indicator is linked to two guiding questions:

i) Is this practice or process present at the site?
ii) Is it being applied consistently and effectively in daily practice?

Figure 5 *Steering Committee Areas of Focus*



Note. The areas of focus commenced with the creation of working groups for each with a stated goal and identified collaborators shown in orange, followed by two depicted in blue, with future work planned for the remaining seven. © Unity Health Toronto.

Everyone recognizes the challenges of variations in definitions, practices, and reporting across different sites and settings. For UHT "developing harmonized visual identifiers [in the electronic patient record] has enabled a clear, consistent, and reliable identification for those with Braden Scale Score of 18 or less," comments Phan.

The driving force behind the progress made at UHT has undoubtedly been the fastidious attention to detail in project management, reflected in Figures 4 and 5. The illustration provided by the UHT team exemplifies organizational change management. The whole strategy has necessitated high levels of communication. The organization has demonstrated some working group achievements along the way, as shown in Table 1.

Table 1 *UHT Working Group Achievements*

Assessment and Communication	Support Surfaces	Measurement
Standardized risk and skin assessment processes now available in the EPR with automated prompts and care plan triggers	Unified decision tree for therapeutic surface selection	Standardize hospital-acquired pressure injury definitions
Interprofessional communication of risk through standardized handover and visual identifiers	Processes for maintenance, replacement, and equipment readiness across sites	Optimized incident reporting tool as required reporting and measurement system across the network
Developed unified pressure injury prevention policy	New role for clinical equipment coordination at the rehab site	EPR dashboards set up to track pressure injury prevention data trends

Note. EPR = electronic patient record. © Unity Health Toronto.

UHT is one of Canada's largest Catholic health care networks serving patients, residents, and clients across the full spectrum of care, spanning primary care, secondary community care, tertiary, and quaternary care services to postacute through rehabilitation, palliative care, and long-term care, while investing in world-class research and education. Watch the Unity Health Toronto World Pressure Injury Prevention Day 2025 video https://m.youtube.com/shorts/jjEYa33saCg

Annemarie Laroque, RN, SWAN – SWAN Community of Practice Leader

National Pressure Injury Recommendations to Support Policy Change

CHESTER HO, MD, AND SHARON GABISON, PhD, MSc, BScPT, BSc, IIWCC

Chester Ho, MD

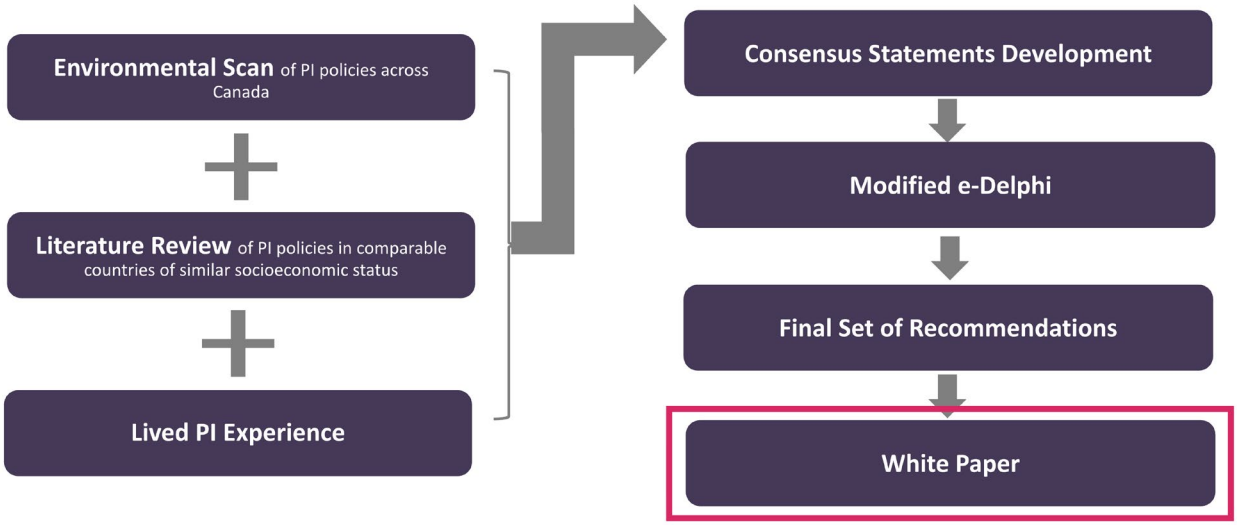
Sharon Gabison, PhD, MSc, BScPT, BSc, IIWCC

Drs. Ho and Gabison presented on one of the four CPIAP strategies described earlier to make pressure injuries a national priority. Drs. Ho and Gabison shared the work of Dr. Ho's master's student Dr. Ashfaq who has been working with them on developing a pressure injury white paper. The purpose of the study was to identify, understand, and achieve consensus regarding the experiences of Canadians affected by pressure injuries and to prioritize strategies that may enhance the outcomes of persons affected by pressure injuries.

"Across Canada, there is a lack of adequate uniform standards and practices for pressure injury prevention and management, and this has been recognized by CPIAP. What there is out there is quite variable in terms of the quality of care that individuals are receiving. There really is a pressing need to standardize and optimize pressure injury prevention and management to improve care for individuals who need it, ensure health equity, reduce the high costs, and, as Dr. Joyce Black says, reduce unnecessary pain and suffering. Effective change is required, and it really must incorporate policies, practice guidelines, [a] readiness to change, and appropriate resources."
– Sharon Gabison, President Elect CPIAP.

Drs. Ho and Gabison shared their progress toward the urgently needed Canadian pressure injury prevention and management white paper, which will serve as a foundational document that will help influence policy development at the system level and will ensure equitable care is delivered across all sectors. This essential work has already conducted an environmental scan and key informant interviews, ensuring that individuals with lived experience were represented, as well as the caregivers who support them. A rapid review of the literature examines pressure injury policies in countries with comparable socioeconomic status, including Australia, the Netherlands, and the UK. It concluded that each of these counties emphasized evidence-based guidelines, risk assessment tools, staff education, and the use of pressure redistribution surfaces as part of the core strategy. An interactive session at the 2025 NSWOCC Annual Conference involved voting to narrow down an original set of 30 recommendation statements. Dr. Ho outlined how these final 14 recommendations will be incorporated into a Canadian white paper, shown in Figure 6.

Figure 6 *Process for Developing a Pressure Injury White Paper*



Note. PI = pressure injury.

Dr. Gabison defined a white paper and contrasted it with other documents, such as guidelines or standards. A white paper informs or explains a particular approach, policy or solution to a problem and can help organizational leaders, policy makers, researchers, and analysts advocate for change.

In summary, Dr. Ho notes that Nova Scotia has a clear policy requiring that all facility-acquired and community-acquired pressure injuries that progress to an advanced stage be reported to the health ministry. "Nova Scotia is the poster child for that," states Dr. Ho. "After they have made their reporting of advanced pressure injuries mandatory, they have seen a significant decrease in the prevalence of pressure injuries. I think that's quite an important outcome to learn from."

The final part of Figure 6 concerns the white paper development built upon the consensus recommendations, which Dr. Ashfaq will complete as a master's thesis. A manuscript will then be submitted for publication in a peer-reviewed journal. CPIAP is well-positioned to help disseminate the final 14 consensus recommendations and consult with policy experts on how to use them to influence health policies.

Quintuple Aim–a framework developed by the U.S. Institute for Health Improvement across five aims: improving population health, improving [patient] care, improving workforce well-being, and advancing health equity. https://www.ihi.org/library/topics/quintuple-aim

Delphi–a methodology to achieve a pre-agreed level of consensus among a defined group of experts.

Blueprint for Pressure Injury Data Collection to Action

CHRISTINA E. HAGNER, MN, BScN, RN, NSWOC, WOCC(C)

Christina E. Hagner, MN, BScN, RN, NSWOC, WOCC(C)

Christina Hagner began by asking how easily summit attendees could access the number of pressure injuries in their care setting.

a. I wouldn't know where to start.
b. I can request it, but often don't get exactly what I'm looking for.
c. It's at my fingertips.
d. People can access data in their care settings.

Data is a fundamental element of change management; "show me the data," the mantra goes. Organizational cultures should and will base decisions on data. Data helps paint a picture of and sustains quality improvement initiatives. Acknowledge that different team members will want to see different meaningful data. A senior leader may want numbers, costs, or the impact on workforce capacity, whereas a health care aide may want to know how long the intervention will take them to complete and how it will affect their daily schedule. Hagner explains that data must be presented in a way that resonates with the values and motivations of the person you hope to engage. If you miss the mark, your message will likely be lost. In some instances where the picture is incomplete, you may need to collect your own data to fill the gaps.

Hagner encouraged everyone to remember three important things:

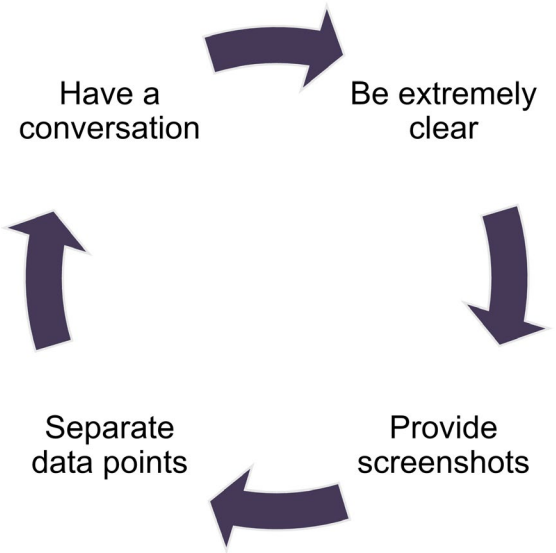
1. Data is critical to the success of your project.
2. Data will open doors or shut them, depending on how you present the situation.
3. Data is never missing; it can always be sourced.

The ability to use data requires the clinical staff to collaborate with nursing informatics so that each can correctly comprehend what is being sought. By way of illustration, Hagner shared a typical communication.

> "Hey, is there an easy way to tell how many pressure injuries were acquired in the community versus the hospital? I'd like to know the ratios, ideally separated by stage, stratified by care setting (if possible) and maybe community. Could we pull from the time the field was mandatory until now? Oh, and ideally in fiscal year format, so I can see the ratios change over time. Thank you so much."

If nursing informatics struggle to interpret the question, the results may be disappointing. Figure 7 proposes some tips to help facilitate improved communication.

Figure 7 *Data Tips and Tricks*



Note. © Christina E. Hagner.

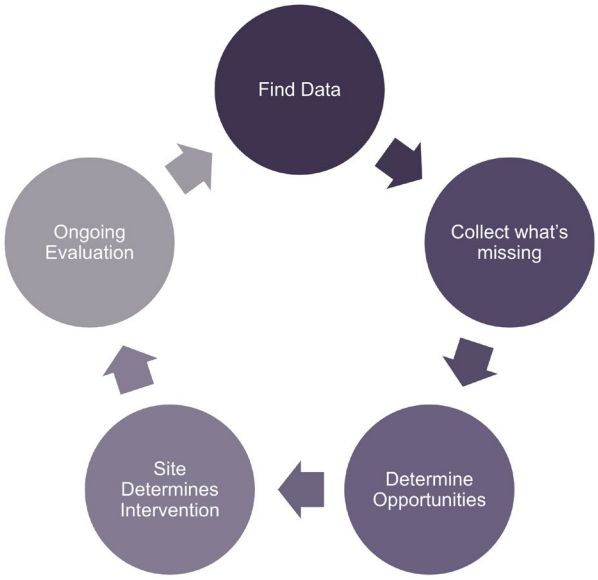
The UHT team demonstrated the role that organizational culture plays in a data-driven approach to documentation and quality improvement. Vancouver Coastal Health Authority (VCHA) collaborates with First Nations to embed the groundbreaking ownership, control, access, and possession (OCAP) principles into the actual data-sharing agreement, ensuring clarity on who owns what data and what data can be shared. See the textbox about OCAP. The VCHA legal team has collaborated with First Nation communities to apply the OCAP principles through a data-sharing agreement with the expansion of a shared electronic health record in these settings.

It is evident that developing a standardized framework to implement pressure injury prevention across diverse care settings is built on putting data to work. VCHA and UHT both follow a similar quality indicator framework around structure, process, and outcomes. Change management requires champions. A first step in pressure injury prevention is engaging with sites and identifying a champion. The champion is critical to the success of your project. Hagner argues that sustainability is "foundational frontline practice." Reality is that champions will move out of their roles elsewhere. Outcomes can take a downward turn, so building a succession plan for site champions is essential to ensure sustainability. "Site champions [are] very important to sustaining your work," states Hagner.

Earlier presentations had reinforced the importance of both standardized definitions and data collection forms. "Standard definitions make it a lot easier to be able to compare cohorts," says Hagner. With VCHA, "this allowed us to have a really structured approach to thinking about when we want to scope and scale this work to different sites to compare them to each other and see how things were going."

Among the lessons learned is that when implementing something, it must start with a baseline assessment of who's at risk. The literature points to a reporting gap in pressure injuries. With as many as half of all home health nursing visits related to wounds, what is happening to the number of wound assessments? Is there a change? How has this translated into the number of health care-acquired pressure injuries? Figure 8 shares some tips on sustaining the data cycle.

Figure 8 *Sustaining the Data Cycle*



Note. © Christina E. Hagner.

In conclusion, Hagner emphasizes that "we want to remember the human behind the data and the reason why we're here, to do better for them."

> OCAP [ownership, control, access, possession] is a First Nations principle that asserts that First Nations communities own their own data. They are responsible for the data. They are responsible for how the data is shared. They have control over data collection processes within their communities. They own and control how this information can be stored, interpreted, used and shared.
> https://fnigc.ca/ocap-training

Filsan Abdi, BScN, stomothérapeute

Interactive Session: Use of Technology in Pressure Injury Prevention and Assessment

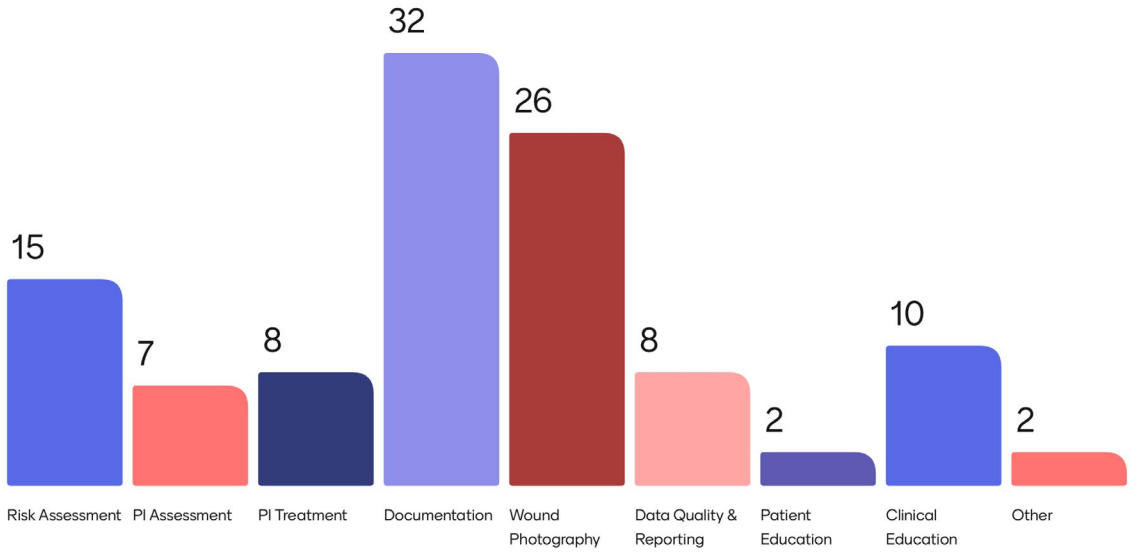
SHARON GABISON, PhD, MSc, BScPT, BSc, IIWCC, AND JOSHUA MORALEJO, MScCH:WPC, BScN, RN, NSWOC, WOCC(C), IIWCC

Sharon Gabison, PhD, MSc, BScPT, BSc, IIWCC

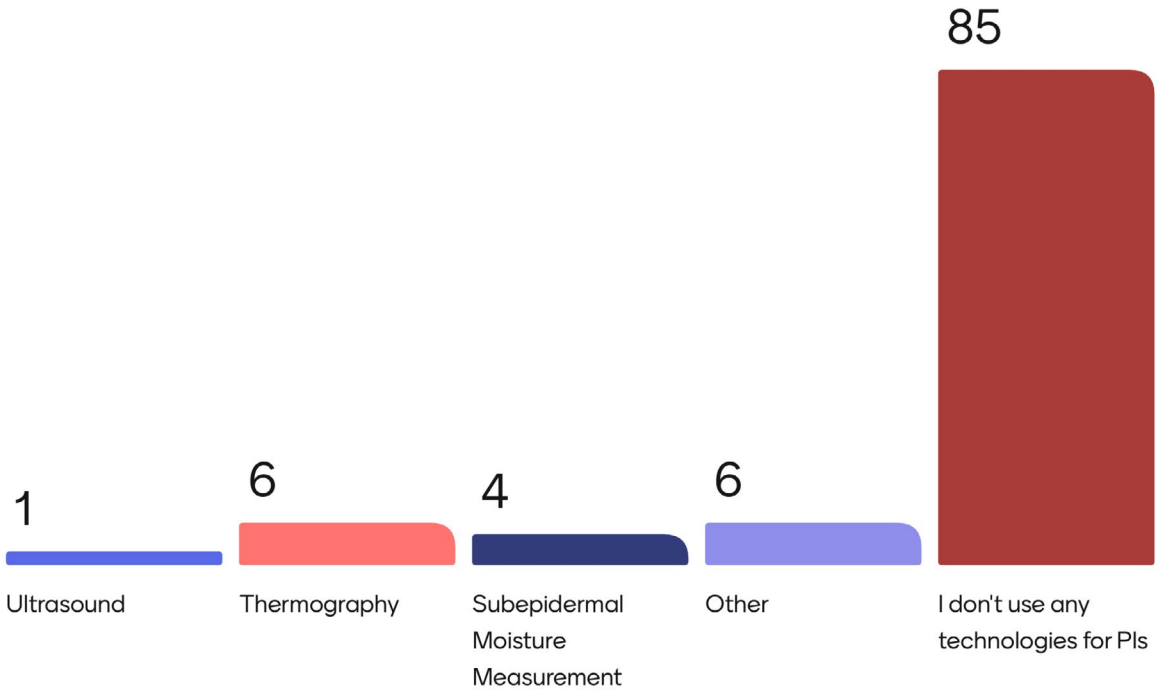
Dr. Gabison and Joshua Moralejo started by asking the summit participants both in Ottawa and online via Mentimeter "What does technology mean to you?" (*n* = 119). They then shared Google artificial intelligence (AI) definition.

"Technology in pressure injuries refers to the application of various tools, devices, and digital systems for the prevention, monitoring, assessment, and treatment of pressure injuries." – Google AI, 2025

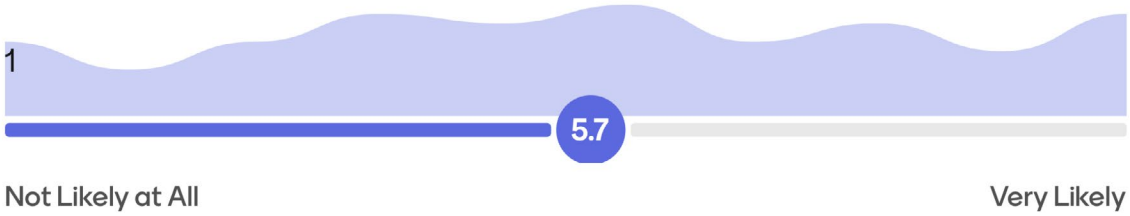
Responses for the next question "For what primary purpose do you use technology for pressure injury prevention and management in your practice?" revealed a spread of uses with documentation the greatest. (*n* = 110)



Asking “Which of the following technologies do you use most for early detection of pressure injuries?” highlighted that >80% are not using technology for the early detection of pressure injury. (*n* = 102)



Specifically, then exploring AI, 93% responded to say they are not using AI for pressure injury prevention and management. After further discussion 57% indicated that they are likely to adopt AI in their practice? (*n* = 92).



Dr. Gabison and Joshua Moralejo then asked, “What do you think are the potential benefits of the use of technology for pressure injury prevention and management?” and “What do you think are the challenges related to the use of technology in pressure injury prevention and management?” The highest responses in the free field word cluster analysis were early detection as a benefit (*n* = 91) and cost being the most significant challenge (*n* = 74).

BENEFITS OF TECHNOLOGY

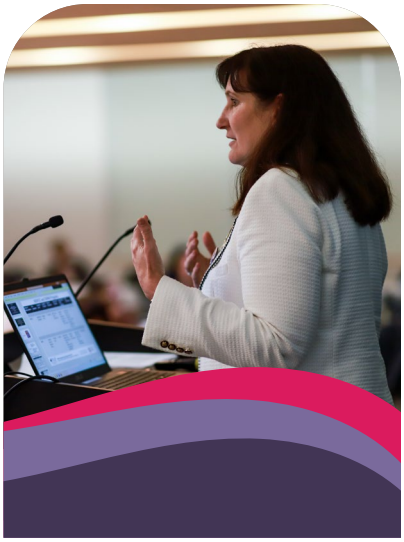
- Provide real-time data[15]
- Support clinical decision making[16]
- Promote workflow efficiency[17]
- Improves patient adherence[15]
- Support reduction of hospital-acquired-pressure injuries[18]
- Promotes quality of life of patients/clients[19]
- Reduce cost associated to pressure injuries[15]

POTENTIAL CHALLENGES IN ADOPTING TECHNOLOGY

- Capital cost / financial constraints
- Current system infrastructure limitations
- Impact on clinical workflows and staffing
- Competing needs[15,20]

Shifting the Culture Around Pressure Injury Prevention and Management in Long-Term Care

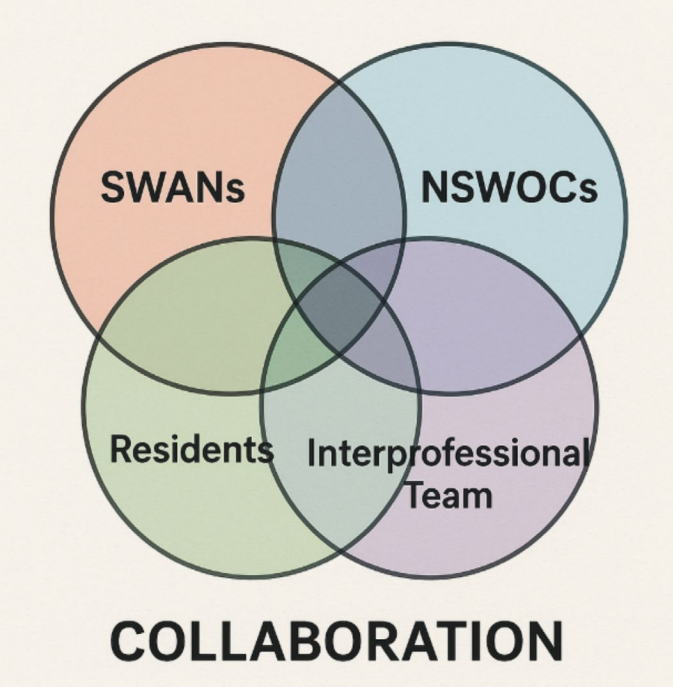
KIMBERLY LEBLANC, PhD, MN, BScN, RN, NSWOC, WOCC(C), FCAN, FNSWOC, FAAN



Kimberly LeBlanc, PhD, MN, BScN, RN, NSWOC, WOCC(C), FCAN, FNSWOC, FAAN

Dr. LeBlanc described the Nurse Specialized in Wound, Ostomy, and Continence (NSWOC) and Swin and Wellness Associate Nurse (SWAN) roles designed as two complementary programs working together in collaboration. The NSWOC provides the expertise, leadership, and mentoring for those aspects beyond the scope of practice of a SWAN. Pressure injuries are likely to affect 8% of long-term care (LTC) residents at some point. Over 25% of pressure injuries in LTC develop one week after discharge from an acute care hospitalization. A collaboration between an NSWOC and SWAN changes the culture from a reactive wound, ostomy, and incontinence management to proactive skin wellness, shown in Figure 9. "And that's our real goal. We want to look at overall skin wellness, and we want to be proactive rather than reactive," she states.

Figure 9 *Model of Wound Care Excellence*



Dr. LeBlanc explained the difference between the NSWOCs and the SWANs with assistance from Vida Johnston and Pierre Saintable. SWAN Lead Academic Advisor Vida Johnston, BScN, RN, NSWOC, WOCC(C), explained how, in those LTC facilities where she works with SWANs who have prevention and action in place, the referrals she receives are reduced and tend to be more appropriate referrals. In contrast, LTC facilities with no SWANs may need consultations from an NSWOC, many of which could have been managed by a SWAN. She has confidence that the SWANs are applying their knowledge, skills, and judgment to assessments; implementing prevention measures earlier; and avoiding

complications across the tri-specialty of wounds, ostomy, and continence. Waiting for an expert to arrive at an LTC facility can delay care, potentially worsening a resident's health and well-being. It is better to have on-site nurses with advanced knowledge, able to stabilize and put in place preventive measures, prior to the arrival of the NSWOC. "This is going to be the best thing for your clients, your budget, and your staff," says Johnston. She believes that "we need to do a better job of explaining to the administrators what the skin wellness associate nurse is and how they can be beneficial collaborative partners with the NSWOCs."

Vida Johnston, BScN, RN, NSWOC, WOCC(C) – SWAN Lead Academic Advisor

Dr. LeBlanc passed the microphone to Pierre Saintable, RPN, SWAN, GPNC(C), FCN, who is a clinical support nurse at Bruyère Health. He explained his work and studies at the Saint-Louis LTC facility, including an educational program using the pressure injury risk scale (InterRAI PURS) assessment tool as part of a prevention program. This includes looking at the support surface. "We created heel offloading posters and developed a turning clock so it's a visual for the staff, so they know to reposition the resident. We created the interdisciplinary team, which we call the 'wound squad', together with a skin and wound toolkit," he said. Dr. LeBlanc described him as a "poster child" for the SWAN program.

Pierre Saintable, RPN, SWAN, GPNC(C), FCN

Dr. Black's colleagues in the United States have shown that when wound, ostomy, and continence nurses are involved, there are improvements in patient quality of life, teaching and mentoring, cost reduction, efficiency, wound outcomes, incontinence outcomes, advanced treatments, research, and leadership. Dr. LeBlanc's research is beginning to focus on the impact these wound care excellence teams are having within the Canadian health care system, building on the work of Heerschap and Duff.[21] "We know anecdotally that we are making a difference. [LTC] facilities have reported fewer wounds, faster healing, and reduced hospital transfers. But perhaps most noticeably, they're describing feeling more empowered and more valued. This is a workforce

Think of a dream state. If a LTC facility sent Mrs. Jones into the hospital, they had also written on the transfer form that she had a pressure injury 4 months ago that they were able to close and where it was located. This is what we have been doing. Please make sure that Mrs. Jones is offloaded from that area. Busy emergency room nurses can then prioritize prevention. What if we give them a heads-up? Equally, what if acute care could discharge back to LTC, highlighting that Mrs. Jones has a DTPI? "Rather than blame, let us try and collaborate," says Dr. LeBlanc. "Let us send better communication back and forth to one another. We know that chronic wounds increase pain and infection." Especially applicable for LTC, we now know that dementia increases your risk of wounds. What does having a wound do to your dementia? Dr. Leblanc is studying this intersection.

development strategy that improves both quality and job satisfaction." Dr. LeBlanc states that SWANs can help bring about cultural change within LTC facilities. Fewer wounds translate to fewer hospital transfers with improved staff satisfaction. These concepts are encapsulated in the Nursing Retention Toolkit, as described by Dr. Leigh Chapman at last year's summit.[22]

The Canadian Nurses Association (CNA) accredits the NSWOC and SWAN education programs at the highest level. The World Council of Enterostomal Therapists (WCET) also accredits the NSWOC program. NSWOCs (advanced practice nurses) provide expert consultation and leadership together with SWANs (point-of-care champions trained in skin health, ostomy, continence and wound prevention) form a model of wound care excellence. Refer to Table 2. "This NSWOC/SWAN collaboration. It's a winning combination," concludes Dr. LeBlanc. "Moving forward, we want to expand the NSWOC/SWAN lead model across all long-term care networks. This requires getting involved to keep growing the SWAN as a role, because together, I think we can make huge strides and huge differences."

Table 2 *Comparison of NSWOC and SWAN*

Points of Differentiation	Prerequisites	Academic Level	Length of Program	Clinical Placement	Goal of the Program	Expectations of the Graduate	CNA Certification
NSWOC	BN/BScN or Equivalent	Masters level	15 months	225 hours of clinical placements	Graduate clinical specialists / experts and leaders in WOC nursing	Graduates will lead wound, ostomy, and continence teams as clinical specialists. Consultants in WOC care	Yes
SWAN	Practical nurse or diploma nurse	Practical nurse	6 months	Self-directed, student works through specific clinical scenarios under the guidance of an NSWOC	Graduate practical nurse leaders	Graduates will be WOC team members and work in collaboration with NSWOCs	No (Pending)

Interactive Discussion and Panel Debate: Are Pressure Injuries Avoidable?

The summit concluded with a lively expert panel discussion with Bob Brown, Dr. Black, Dr. Gabison, and Kaylem Boileau, MHSc, BASc, HBSc, RD, IIWCC, representing the perspectives of the person with lived experience, nurse, physiotherapist, and dietitian, respectively. Dr. Ho moderated the expert panel tackling four big questions.

- Are pressure injuries avoidable?
- When are they not avoidable?
- When are they not unavoidable?
- When are they avoidable?

Each panel member acknowledged that whether pressure injuries are avoidable is a difficult question to answer. There are myriad risk factors. Kaylem Boileau noted that, had I met you 20 years ago and addressed lifestyle factors and comorbidities, the conditions that put a patient at risk today could have been avoided. Age, weight, nutritional status, and climate all contribute. Dr. Black stressed that while many pressure injuries are avoidable, an organizational goal of zero pressure injuries is unachievable. The assessment of patients on first arrival into a facility is necessary. Are they at risk? Do they require a specialty support surface in the emergency room? Only through a thorough assessment using validated tools and documentation can we determine whether the patient's skin was intact upon arrival. If the assessment and documentation show the patient is at risk, it is imperative to act upon it. It should not be up to the person with a spinal cord injury to put up a fight to be taken off an unpadded gurney. Equipment must not be used inappropriately in health care organizational settings or in the community.

There are circumstances in which risk factors have been addressed and care plans developed, yet the patient/client does not want to be repositioned or no longer has the cognitive capacity to comprehend why it is important. The panel noted that what is avoidable/unavoidable depends on the plan of care. For patients nearing the end of life with end-stage organ failure, the priority is no longer physiological prevention but rather psychosocial support. Dr. Ho challenged the panel again, asking in which conditions they are avoidable. Many interventions were described, including ensuring a nutritional care plan is implemented (including referral to a dietitian) and offloading pressure on the heels in a patient with a hip fracture.

There are patients for whom pressure injuries can be unavoidable when they cannot be moved, and it would cause harm to move them, such as cases of unrepaired cervical fracture, a fractured pelvis, an open chest, or a patient with very severe intracranial pressure. Dr. Black predicts that what we consider unavoidable today may be avoidable in the future as medical care advances.

The panel debate centres on Dr. Ho's reference to an "essential concept of codecision making with our clients and patients." The interprofessional team should come together with the patient and their family to make informed choices with transparency over the risk of pressure injury. Clearly explaining "why" to the patient and family is critical with attention to their health literacy.

The passion Dr. Gabison shares is evident in her story. "I think that family members need to know right from the beginning. As soon as a patient is deemed at risk of developing a pressure injury, their family should be notified immediately. And one of the cases was a very unfortunate case here in Ontario that happened several years ago, where the family members were by their dad's bedside. It wasn't until he was transferred to another hospital that pressure injuries were seen beneath dressings. Had they known, they say they would have done something. Those family members and the individuals need to be told as soon as they're deemed at risk, then take that information and make an informed choice about how they're going to proceed," she said.

Call to Action in Repositioning Pressure Injury Prevention and Management

JOSHUA MORALEJO, MScCH:WPC, BScN, RN, NSWOC, WOCC(C), IIWCC, AND SHARON GABISON, PhD, MSc, BScPT, BSc, IIWCC

The CPIAP Summit sought to take a step towards shifting our mindset and transforming our culture to support practice excellence and stop pressure injuries. Dr. Black predicted that what we consider unavoidable today may be avoidable in the future as medical care advances. The CPIAP Summit proves that only by collaborating with a people-centred approach can we harness measurable data to support the implementation of pressure injury prevention strategies. CPIAP is driving that momentum for change. The CPIAP Board encourages readers of this summit report to share it with their local health care organizational teams.

The calls to actions from the 2024 Summit remain valid. Refer to them in Appendix 1. The twelve pressure injury prevention eDelphi consensus statements developed through the University of Alberta team are poised for publication in 2026. These cover five domains: population health, patient experience, provider experience, cost reduction, and health equity echoing the Quintuple Aims.

In addition to continuing to support the 2024 call to action, we recommend:

1. Strengthening the patient voice to drive pressure injury prevention and management strategy based on lived experience.
2. Implementing the International Guidelines for Pressure Injury Prevention and Management help standardize the approach to patient care.[23]
3. Enhancing understanding of the Canadian pressure injury landscape by publishing the national recommendations established by the expert consensus panel and disseminate widely with members of government, administrators, health care professionals and researchers.
4. Exploring emerging innovations and health technologies to improve pressure injury prevention.
5. Reinforcing proactive strategies for continuous quality improvement in pressure injury prevention and management across care sectors.

Scan the QR code to become a member of CPIAP and contact admin@cpiap.com to get involved.

LOOK OUT FOR THE CPIAP SYMPOSIUM ON NOVEMBER 20-21, 2026.

GLOSSARY

Deep tissue pressure injury is a persistent nonblanchable deep red, maroon or purple discolouration.

Pressure injury is localized 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.

Required safety practice is an evidence-informed and measurable safety imperative in the delivery of safe, high-quality, and reliable care.

Stage 1 pressure injury is a nonblanchable erythema of intact skin. Edema may also be present.

Stage 2 pressure injury is a partial-thickness skin loss with exposed dermis, intact or ruptured serum-filled blister/bulla.

Stage 3 pressure injury is a full-thickness skin loss, extends to adipose tissue but does not involve muscle and bone.

Stage 4 pressure injury is a full-thickness loss of skin and tissue, extends to muscle, bone, fascia, tendon and other deeper structures.

Unstageable pressure injury is an obscured full-thickness skin and tissue loss, extent of tissue damage is obscured by devitalized tissue.

ABBREVIATIONS

AI	artificial intelligence
CPIAP	Canadian Pressure Injury Advisory Panel
DTPI	deep tissue pressure injury
HSO	Health Standards Organization
LTC	long-term care
NPIAP	National Pressure Injury Advisory Panel [US]
NSWOC	Nurse Specialized in Wound, Ostomy, and Continence
NSWOCC	Nurses Specialized in Wound, Ostomy and Continence Canada
OCAP	ownership, control, access, possession
RSP	required safety practices
SWAN	Skin and Wellness Associate Nurse
UHT	Unity Health Toronto
VCHA	Vancouver Coastal Health Authority

Appendix 1 – 2024 CPIAP Summit Calls to Action

Based on the recommendations from our esteemed speakers and the crucial conversations with clinical leaders, administrators, government officials, patients, and industry representatives present at the summit, several calls to action were identified.[22]

FEDERAL:

- make avoidable pressure injury (PI) management;
- a priority in our system to address this silent pandemic;
- a national strategy in support of standardized guidelines and interventions for PI prevention and management;
- a national PI framework that avoids duplication of effort;
- national data strategy that supports the collection, review, analysis, and utilization of PI data;

PROVINCIAL/TERRITORIAL:

- skin and wound committees to support standardized practices across the region, from urban to rural settings; and
- mandatory reporting of Stage 3 and 4 PI to provincial health ministries;

HEALTH CARE ORGANIZATIONS:

- have policies and procedures in place to support the interprofessional prevention and management of PI that reflect current best practice guidelines;
- have practices in place where PI prevention starts the moment a client enters your care;
- ensure incident reports are being completed for Stage 2–4 and unstageable PIs;
- ensure training of nurses, including NSWOCs, SWANs in LTC, physicians, physiotherapy, occupational therapy, personal support workers (PSWs) and allied health care professionals creating interprofessional teams on PI prevention and management, including knowledge of resources and referrals;
- support an organizational culture that is person-centred on skin risk assessment and prioritizes PI prevention; and
- ensure easy access to equipment, such as pressure redistribution mattresses, and services, such as access to a specialized nurse.

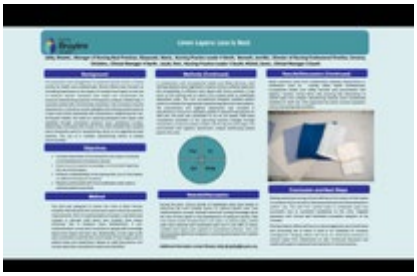
CLINICIANS:

- keep informed on current evidence on PI prevention and management;
- advocate for clients during your care, and during transitions of care;
- create PI prevention care plans for your patients;
- daily head-to-toe skin checks on all patients; and
- engage your interprofessional colleagues and refer to external clinicians when needed; and

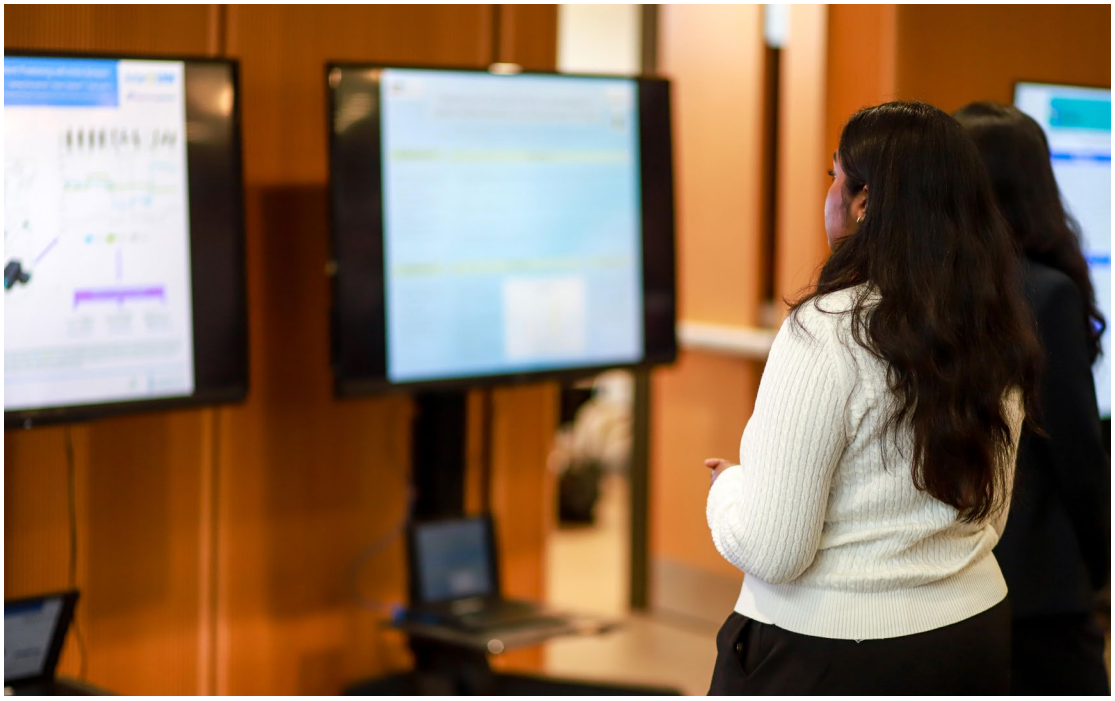
RESEARCHERS:

- areas of future research include Canada-wide PI prevalence study.

Appendix 2 – Digital Posters

Diversity and Inclusion in Action: Successful Gel Surface Implementation as a Pressure Injury Strategy By Groeneveld T, Bateman L, Feather J.	 Link to Poster	PressureSMART: A Canadian Multi-Partner Consortium: Addressing Pressure Injury Prevention to Healing on a Global Scale By Huisman E, Xu E, Jelaskoff K, Fraser R.	 Link to Poster
Pressure injury prevention at home: Detecting patient positioning with ankle sensors By Balakumar N, Islam A, Shahiri M, Dadkhah D, Ghomashchi H, Gabison S, Dutta T.	 Link to Poster	Linen Layers: Less is Best By Jaitly S, Klepaczek M, Bennett J, Cercena C, Jacob S, Michel S.	 Link to Poster

The digital poster award voted by the summit attendees went to the authors of the *Pressure injury prevention at home: detecting patient positioning with ankle sensors.*



Appendix 3 - Summit Agenda

Time	Presentation Topic	Presenter(s)
0830	Welcome and Territorial Land Acknowledgement	Joshua Moralejo, MScCH:WPC, BScN, RN, NSWOC, WOCC(C), IIWCC. CPIAP President Sharon Gabison, PHD, MSc, BScPT, BSc, IIWCC CPIAP President-Elect
0845	Opening Remarks: Accreditation Canada	Sandra Young, PhD, RN, CAPM, CPHQ Executive Director, Standards and Education Health Standards Organization (HSO)
0915	Keynote Presentation by a Representative of NPIAP	Joyce Black, PhD, RN, CWCN, FAAN, CWS
1000	CPIAP Journey – Past, Present, and Future	Joshua Moralejo, MScCH:WPC, BScN, RN, NSWOC, WOCC(C), IIWCC
1030	Networking and break with industry exhibitors	
1100	A Patient's Story	Mr. Bob Brown
1130	From Evidence to Action: Unity Health Toronto's Journey in Pressure Injury Prevention	Kaitlyn Vingoe, MN, RN Janeth Velandia, MCIScWH, RN(EC), NSWOC, WOCC(C) Phuong (Lisa) Phan, MN, RN Kaleil Mitchell, MBA, BSc, CAPM
1210	National Pressure Injury Recommendations to Support Policy Change	Sharon Gabison, PhD, MSc, BScPT, BSc, IIWCC Chester Ho, MD
1250	Networking and lunch with industry exhibitors	
1340	Blueprint for Pressure Injury Data Collection to Action	Christine E. Hagner, MN, BScN, RN, NSWOC, WOCC(C)
1410	Interactive Session: Use of Technology in Pressure Injury Prevention and Assessment	Sharon Gabison, PhD, MSc, BScPT, BSc, IIWCC Joshua Moralejo, MScCH:WPC, BScN, RN, NSWOC, WOCC(C), IIWCC
1450	Shifting the Culture Around Pressure Injury Prevention and Management in Long-Term Care	Kimberly LeBlanc, PhD, MN, BScN, RN, NSWOC, WOCC(C), FCAN, FNSWOC, FAAN
1520	Networking and break with industry exhibitors	
1540	Interactive Discussion and Panel Debate: Are Pressure Injuries Avoidable?	Panel: Person with Lived Experience: Mr. Bob Brown Nurse: Joyce Black, PhD, RN, CWCN, FAAN, CWS Physiotherapist: Sharon Gabison, PhD, MSc, BScPT, BSc, IIWCC Dietitian: Kaylem Boileau, MHSc, BASc, HBSc, RD, IIWCC Moderator: Chester Ho, MD
1620	Attendee Reflection and Next Steps	Joshua Moralejo, MScCH:WPC, BScN, RN, NSWOC, WOCC(C), IIWCC Sharon Gabison, PhD, MSc, BScPT, BSc, IIWCC

INDUSTRY AND PARTERS IN ACTION

Baxter

BioMiq

Coloplast Canada

MIMOSA Diagnostics

Mölnlycke Health Care

Nestlé Health Science

Perfuse Medtech Inc.

Pressure Care Relief Products by Casa CS

Project ECHO

Smith+Nephew

Urgo Medical Canada

XSENSOR Technology Corporation

Note. Convatec Canada was unable to attend in person.

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CPIAP
Canadian Pressure Injury Advisory Panel

CPIAP is an interprofessional collaboration dedicated to improving lives of persons affected by pressure injuries across the continuum of care through research, knowledge translation, policy, and advocacy

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Look out for the CPIAP Symposium on November 20-21, 2026.

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