

Pressure Injury Prevention and Management

Summary The purpose of this policy directive is to provide direction for a consistent best practice approach to pressure injury prevention and management in NSW Health facilities.

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Audience All Staff

PRESSURE INJURY PREVENTION AND MANAGEMENT POLICY

PURPOSE

The purpose of this policy is to:

1. Minimise the incidence of pressure related injuries to NSW Health patients through adequate risk assessment, risk management and appropriate treatment
2. Establish a consistent, systematic best-practice approach to pressure injury prevention and management across NSW Health
3. Support Health Services to comply with the relevant National Safety and Quality Health Service Standards (NSQHSS) in relation to pressure injury prevention and management
4. Increase the awareness of staff, patients and the public to the importance of pressure injury prevention and management strategies.

MANDATORY REQUIREMENTS

It is the responsibility of each health service to:

1. Adopt best practice guidelines to prevent and manage pressure injuries
2. Take reasonable steps to ensure appropriate patient care for patients at risk of and with pressure injuries
3. Ensure they comply with the National Safety and Quality Health Service Standards (NSQHSS).

IMPLEMENTATION

An implementation guide to support this policy will be available early 2014.

Clinical Excellence Commission is responsible for:

- Developing and supporting the implementation of the best practice guidelines and provide advice to health services
- Reviewing reported patient pressure injury incidents and investigation reports derived from incident management systems (e.g. Incident Information Management System - IIMS), conducting analysis, and disseminating information gained.

Chief Executive of Local Health District/Network (LHD/N) is responsible for:

- Implementing best practice guidelines for the prevention and management of pressure injuries
- Allocating resources to enable effective prevention and management of pressure injuries, including:
 - a. Delegating the day-to-day responsibility of establishing and monitoring the implementation of this policy to the relevant senior managers and/or governance group/committee
 - b. Making appropriate education and training available to all clinical and support staff (e.g. wardspersons and hotel services).

Senior Health Management is responsible for:

- Establishing local clinical practice which follows best practice guidelines, to support safe and effective prevention and management of pressure injuries
- Making appropriate education and training in pressure injury prevention and management available to staff
- Encouraging a culture of harm prevention and patient participation in their own care
- The availability and accessibility of necessary products and equipment to ensure safe and effective patient care for pressure injury prevention and management
- Developing, implementing and monitoring the product and equipment strategies for the prevention and management of pressure injuries.

LHD/N Clinical Governance Unit is responsible for:

- Supporting and monitoring this policy in line with best practice guidelines for the prevention and management of pressure injury
- Collecting, collating, analysing and evaluating relevant data to improve patient safety and supporting quality improvement activities
- Providing feedback to the relevant clinical unit/s validated information on outcomes in relation to this policy.

All NSW Health staff are responsible for:

- Complying with this policy and best practice guidelines to deliver safe clinical practice to prevent and manage pressure injuries
- Documenting and communicating the pressure injury risk assessment and prevention strategies to all relevant members of the multidisciplinary team
- Notifying pressure injury incidents in the incident reporting system (e.g. IIMS) in accordance with the NSW Health Incident Management Policy
- Providing best practice wound management to optimise healing of pressure injuries
- Developing the care plan in partnership with patients and/or carers
- Providing information and education to patients and/or carers on the risk, prevention and management of pressure injuries.

REVISION HISTORY

Version	Approved by	Amendment notes
PD2014_007	Director General	Replaces PD2005_257 and IB2013_008
IB2013_008	Deputy Director General	To advise that the Pan Pacific Clinical Practice Guidelines for the Prevention and Management of Pressure Injury 2012 are to be referred to as best practice until PD2005_257 Clinical Practices - Pressure Ulcer Prevention is revised
PD2005_257	Director General	Replaced PD2002/77

ATTACHMENTS

1. Pressure Injury Prevention and Management Policy - Procedures

Pressure Injury Prevention and Management Policy



Issue date: March-2014

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CONTENTS

1	INTRODUCTION	1
1.1	NSQHSS, Standard 8 – Preventing and Managing Pressure Injuries	2
1.2	Key definitions.....	2
2	GOVERNANCE	3
3	CLINICAL PRACTICE – PREVENTING AND MANAGING PRESSURE INJURY	4
3.1	Pressure Injury Risk.....	4
3.2	Risk Assessment.....	4
3.3	Prevention Strategies.....	6
3.4	Care Planning and Documentation	7
3.5	Managing Pressure Injuries	7
3.6	Transfer of Care	8
4	RESOURCES FOR PREVENTING AND MANAGING PRESSURE INJURY	8
5	COMMUNICATION WITH PATIENTS AND/OR CARERS	9
6	EDUCATION AND TRAINING	9
7	REPORTING	9
7.1	Pressure Injury Incidents.....	9
7.2	Auditing and reporting	10
8	REFERENCES	10
9	RELATED LITERATURES, DOCUMENTS AND RESOURCES	11
10	APPENDIX	12
10.1	Clinical practice flowchart for the prevention and management of pressure injuries for inpatients.....	12
10.2	Clinical practice flowchart for the prevention and management of pressure injuries for Multi-Purpose Service (MPS) long stay facilities and NSW Health Residential Aged Care (RAC) facilities	13
10.3	Clinical practice flowchart for the prevention and management of pressure injuries for non-inpatient (community) nursing services, ambulatory facilities or clinics	14
10.4	Pressure injury classification system	15

1 INTRODUCTION

The Australian Commission on Safety and Quality in Health Care (ACSQHC) has recognised pressure injuries as the fifth most costly commonly occurring preventable condition.¹ Many pressure injuries are preventable, and it is recognised that their lengthy healing time has consequences for quality of life including susceptibility to infection, pain, sleep and mood disturbance. They also impact on rehabilitation, mobility and long term quality of life. The prevention of pressure injuries is the responsibility of all staff who work in health regardless of location and position. Everyone from staff, patients and/or carers have a role to play in the prevention of pressure injuries.²

This Policy Directive describes best practice in accordance with the ACSQHC, National Safety and Quality Health Service Standards (NSQHSS), Standard 8 - *Preventing and Managing Pressure Injuries, 2012*.

Evidence indicates the most effective approaches to pressure injury prevention and management include:

- a) Timely risk assessment to identify risk factors
- b) Use of a validated risk assessment tool to guide clinical decision making to identify pressure injury risk
- c) The engagement of patients and/or their carers with clinicians
- d) Implementation of a plan of care that is:
 - Tailored to the individual and addresses their risk factors
 - Supported by systems of care that focus on prevention and optimise healing
 - Multifactorial and interdisciplinary
 - Delivered by staff with appropriate skills and knowledge who use appropriate prevention techniques and materials
 - Inclusive of access to appropriate products and equipment.
- e) Systems to monitor and analyse pressure injury data, and to implement relevant quality improvement activities.

Despite all prevention strategies being implemented to reduce the risk, pressure injuries may still occur in some patients, e.g. patients with skin failure in end stages of life as part of the dying process.

Appendix 10.1 provides a clinical practice flowchart for the prevention and management of pressure injuries for inpatients.

Appendix 10.2 provides a clinical practice flowchart for the prevention and management of pressure injuries for Multi-Purpose Service (MPS) long stay facilities and NSW Health Residential Aged Care (RAC) facilities.

Appendix 10.3 provides a clinical practice flowchart for the prevention and management of pressure injuries for non-inpatients (community nursing services, ambulatory facilities or clinics).

1.1 NSQHSS, Standard 8 – Preventing and Managing Pressure Injuries

The National Safety and Quality Health Service Standards (NSQHSS) were introduced nationally from 1 January 2013. Standard 8 describes the systems and strategies to prevent patients developing pressure injuries, and management when pressure injuries occur.

The Safety and Quality Improvement Guide is available at: [Standard 8: Preventing and Managing Pressure Injuries](#)

The NSQHSS are available at: <http://www.safetyandquality.gov.au/publications/national-safety-and-quality-health-service-standards/>

Standard 8 requires that:

- 1) Health service organisations have governance structures and systems in place for the prevention and management of pressure injuries
- 2) Patients are screened on presentation and pressure injury prevention strategies are implemented when clinically indicated
- 3) Patients who have pressure injuries are managed according to best practice guidelines
- 4) Patients and carers are informed of the risks, prevention strategies and management of pressure injuries.²

1.2 Key definitions

Active support surface	A powered support surface that produces alternating pressure through mechanical means, thereby providing the capacity to change its load distribution properties with or without an applied load. This generally occurs through alternation of air pressure in air cells on a programmed cycle time. Also called an alternating pressure support surface or a dynamic support surface. ³
Bony prominence	An anatomical bony projection. ³
Carers	Carers are people who provide unpaid care and support to family members and friends who have a disability, mental illness, chronic condition, terminal illness, an alcohol or other drug issue or who are frail aged. Carers provide emotional, social or financial support. ⁴ Carers include parents and guardians caring for children.
Classification of pressure injury	The classification of pressure injury is based on the National Pressure Ulcer Advisory Panel (NPUAP), European Pressure Ulcer Advisory Panel (EPUAP) cited in the Australian Wound Management Association <i>Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure Injury, 2012</i> . ³ See 10.2 for the description of the pressure injury classification system.
Must	Indicates a mandatory action. ⁵
NSW public health facility	For the purpose of this Policy, a NSW public health facility is any clinical unit or service that delivers healthcare services. Health facilities include hospitals, multi-purpose services, emergency services, ambulatory care services, Aboriginal Medical Services and community health services.

Pain	In the context of this policy, pain refers to an unpleasant sensory and emotional experience associated with a pressure injury. Patients may use different words to describe pain including discomfort, distress and agony. ³
Patient	Refers to inpatient, resident, client or any person that the health service provider owes a duty of care to in respect in the provision of health services. ⁶ Patient includes adults, paediatrics, infants and neonates.
Pressure Injury	A localised injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, shear and/or friction, or a combination of these factors. ³
Pressure Injury Risk Assessment scale/tool	Formal scale or score used to help determine the degree of pressure injury risk. The tool must be appropriate for the patient population in accordance with best practice guidelines e.g. Waterlow, Braden, Norton for adult population and Braden Q or Adapted Glamorgan for neonatal/infant and paediatric population. ³
Pressure Injury Risk Screening	For the purpose of this Policy, screening is a process to identify those individuals who may benefit by further assessment to reduce pressure injury risk. Those individuals include patients who are not necessarily perceived as at risk of, or already affected by pressure injury.
Should	Indicates a recommended action that should be followed unless there are sound reasons for taking a different course of action. ⁵
Skin assessment	General examination of the skin. ³ Skin assessment includes examination of the entire skin surface to check integrity and identify any characteristics indicative of pressure damage/injury. This entails assessment for erythema, blanching response, localised heat, oedema, induration and skin breakdown. Check the skin beneath devices, prosthesis and dressings when practical.
Staff	For the purpose of this Policy staff refers to any person working within the NSW Health system including contractors, students and volunteers.
Standard mattress	The definition of a “standard mattress” is variable, and may change between facilities and over time. High standard specification foam mattress that meets Australian Standards - classified as Type N according to Australian Standards (AS2281-1993). ³
Two part pressure injury assessment	The pressure injury risk assessment consists of two parts. a) Use a validated pressure injury risk assessment tool/ process appropriate for the patient population in accordance with best practice guidelines, and b) Skin assessment that is based on visual inspection. ³

2 GOVERNANCE

A senior manager and/or a governance group/committee is responsible for monitoring compliance with the health service pressure injury policies, procedures and protocols, and ensuring there are systems in place to monitor and analyse pressure injury data, and conducting relevant quality improvement activities.²

3 CLINICAL PRACTICE – PREVENTING AND MANAGING PRESSURE INJURY

3.1 Pressure Injury Risk

All LHD/Networks must take reasonable steps to have pressure injury risk screening and assessment processes in place appropriate for their patient populations.

As a minimum, risk screening of all patients must consider the three primary predictors of pressure injury development:

- 1) Mobility/activity which can be restricted by physical, excessive weight, sensory, cognitive, substance-related, affect and motivational problems
- 2) Factors influencing perfusion e.g. diabetes, peripheral vascular disease, poor venous return
- 3) Skin/pressure injury status:
 - a) General skin status relating to factors which may make the skin more vulnerable to pressure injury development
 - b) Pressure injury status including stage/grade 1 equivalent pressure injury, existing pressure injuries, and previous pressure injuries.

If a patient has a history of pressure injury or pressure injury is present they will be deemed at high risk.

A higher/lower level of risk may be determined for some patients based on the two-part risk assessment with consideration of co-morbidities and environmental factors informing clinical decision making.

3.2 Risk Assessment

As a minimum, all patients must undergo initial risk screening to inform the clinical risk assessment decision making process.

Risk assessment of patients using a validated tool is recommended and does not require a separate screening process.

The pressure injury risk assessment consists of two parts:

- a) Use a validated pressure injury risk assessment tool/ process appropriate for the patient population in accordance with best practice guidelines, and
- b) Skin assessment that is based on visual inspection.

The following table outlines risk assessment requirements based on patient care setting.

	Inpatients	Multi-Purpose Service (MPS) long stay facilities and NSW Health Residential Aged Care (RAC) facilities.	Non-inpatients (community nursing services, ambulatory facilities or clinics)*
First pressure injury screen or assessment to guide clinical decision making	Assessed within 8 hours of presentation to the health facility by health staff skilled in using the risk assessment tools or process appropriate for the patient population	Assessed within 8 hours of presentation to the health facility by health staff skilled in using the risk assessment tools or process appropriate for the patient population	Assessed at the first presentation by health staff skilled in using the risk assessment tools or process appropriate for the patient population
Patient at risk of developing a pressure injury the two part assessment to be repeated	Daily as a minimum and: <ul style="list-style-type: none"> • If there is a change to health status or mobility • Pre-operatively, and as soon as feasible after surgery • On transfer of care • If a pressure injury develops 	Weekly as a minimum and: <ul style="list-style-type: none"> • If there is a change to health status or mobility • On transfer of care • If a pressure injury develops 	Monthly as a minimum and: <ul style="list-style-type: none"> • If there is a change to health status or mobility • On transfer of care • If a pressure injury develops
Patient not at risk or low risk the two part screen or assessment to be repeated	Weekly as a minimum and: <ul style="list-style-type: none"> • If there is a change to health status or mobility • On transfer of care • If a pressure injury develops 	Monthly as a minimum and: <ul style="list-style-type: none"> • If there is a change to health status or mobility • On transfer of care • If a pressure injury develops 	<ul style="list-style-type: none"> • If there is a change to health status or mobility • On transfer of care • If a pressure injury develops
Pressure injuries present - skin inspection and pain assessment	Additionally should occur at each patient care intervention and/or positioning change.	Additionally should occur at each patient care intervention and/or positioning change	Additionally should occur at each patient care intervention and/or positioning change

***NB:** Community nursing services that are not the primary care provider for patients who are identified at risk must provide education to the patient and/or carer or other care provider so that they understand the level of risk and their responsibility for ongoing skin assessment monitoring.

NB: Non-inpatient spinal cord injury patients are at high risk however may have little change in health status and have prevention strategies in place. Patients may have reassessments completed every three months or if there is a change in health status or mobility.

3.3 Prevention Strategies

- 1) All patients identified as being at risk (with or without existing pressure injury) should have:
 - a) Best practice prevention strategies implemented as a priority within two hours of the assessment³
 - b) For inpatients pressure injury prevention strategies reviewed for their effectiveness:
 - At least four-hourly
 - At every patient care intervention
 - At handover
 - On transfer of care episode.
 - c) Best practice strategies reviewed as a minimum at each community nursing visit.

- 2) Prevention strategies that includes:
 - a) Repositioning and/or mobilising routine, including appropriate manual task techniques
 - b) Education of all patients/personal carers on regular repositioning and pressure relieving strategies
 - c) Management and monitoring of pain
 - d) Provision of appropriate products and equipment; support surfaces for beds, trolleys/wheelchairs, chairs, aids, equipment/devices, according to the patient's risk assessment
 - e) Reduction of pressure, friction, and/or shear through:
 - Use of active support surfaces/positioning aids during care, including theatre, intensive care and emergency departments
 - Use of dressing products (note dressing products do not reduce pressure)
 - Appropriate hazardous manual task techniques
 - Correct fitting, removal and checking of pressure from devices/orthoses/anti-embolic stockings, casts and other clinical equipment
 - f) Skin protection and moisture reduction
 - g) Continence management
 - h) Adequate nutrition and hydration, including high protein supplements where indicated (with dietitian supervision if available)⁸
 - i) Referral to health disciplines as clinically indicated for assessment and treatment.

- 3) Contra-indications for active support surface.

NB: In the case of the patient with an unstable spinal or unstable pelvic fracture, the active support surface is contra-indicated. This is regardless of the patient being identified as at risk for the development of pressure injury or if they have an existing pressure injury. The patient with an unstable spinal or unstable pelvic fracture should stay on the appropriate non-powered mattress and receive regular pressure relief for their condition. Adequate pain relief should be provided.

3.4 Care Planning and Documentation

- 1) The care plan must be documented and discussed with all patients and/or carers who are assessed as at risk, irrespective of degree of risk. This plan must be communicated during handover at the end of every shift in an acute, MPS long stay facility or NSW Health RAC facility, and as soon as possible (within 24 hours) of initial home visit for community services. Care plans are to include strategies aimed at:
 - a) Preventing the development of pressure injury/injuries
 - b) Optimising healing and preventing complications of existing pressure injury/injuries.
- 2) The care plan must include:
 - a) How the patient and/or carer are involved in the pressure injury prevention care planning process
 - b) Input from the multidisciplinary team about additional assessment, recommendations and treatment
 - c) Strategies for:
 - Pressure injury risk and skin assessment, monitoring and reassessment
 - Mobilising to maintain function
 - Position changes to relieve pressure, avoiding shear and friction
 - Skin hygiene
 - Pain assessment and management
 - Optimising hydration and nutrition, including supplementation and feeding assistance, if required
 - Promotion of continence and management of incontinence
 - Wound management
 - Oedema management
 - d) Strategies for protection of skin from moisture, high temperature, skin irritants and medical devices eg. gastrostomy and enteral feeding leakage, friction and skin trauma
 - e) Equipment, devices; manual task techniques to minimise wound pain, eliminate or reduce pressure, friction, shear and to protect existing pressure injury
 - f) Arrangements and planning for transfer of care.

3.5 Managing Pressure Injuries

- 1) **Prevention** - All patients with a pressure injury are at a high risk of the injury worsening, or developing other pressure injuries, and therefore:
 - a) Where possible, prevention strategies must be implemented immediately, and documented. Any exceptions and the rationale must be documented
 - b) The two part pressure injury assessment and pain assessment must be conducted and care planned.
- 2) **Assessment** of pressure injuries should occur when a pressure injury is identified, or on transfer of care at next dressing change.

Appendix 10.4 provides the description of the pressure injury classification system.³

- 3) **Wound Management** is provided by or supervised by staff with skills, knowledge and equipment to provide treatments in accordance with best practice.
- 4) **Document** the pressure injury in the patient health care record e.g. on a wound chart or care plan or in the Electronic Medical Record. Notify the pressure injury in the incident reporting and management system e.g. NSW Health Incident Information Management System (IIMS).
- 5) **Wound reassessment** should occur at least weekly. Wound management should be reviewed if not healing at an optimal rate, i.e. 25% reduction in four weeks.³
- 6) **Consultations** should occur in a timely fashion with medical or other health disciplines for their assessment and contribution, planning, and management.
- 7) **Pain** should be assessed in accordance with best practice guidelines at least every shift/home visit using a validated tool.
- 8) **Nutritional management** provided in accordance with NSW Health Nutrition Care Policy.

3.6 Transfer of Care

Transfer of care for patients with an existing pressure injury, or at risk of developing a pressure injury, requires timely communication with doctors, next health care providers, patients and/or carers, other community or residential services, equipment suppliers, and appropriate allied health clinicians. Communication should include:

- 1) The goal of treatment
- 2) Classification and progress of pressure injury
- 3) Wound management
- 4) Prevention strategies
- 5) Follow-up care required.

4 RESOURCES FOR PREVENTING AND MANAGING PRESSURE INJURY

All LHDs/Networks must take reasonable steps to have:

- 1) Systems in place so that both adequate expertise and resources, products and equipment, are readily available and accessible to provide best practice in pressure injury prevention and wound management.
- 2) All pressure injury prevention equipment must be:
 - a) Used and maintained in accordance with manufacturers' instructions
 - b) Used and maintained in accordance with NSW Health Infection Control Policies
 - c) Used and maintained in accordance with NSW Health Workplace Health & Safety
 - d) Purchased in accordance with NSW Health Procurement Guidelines.

5 COMMUNICATION WITH PATIENTS AND/OR CARERS

All LHDs/Networks must take reasonable steps to have:

- 1) Systems in place to educate patients and/or carers of the risks, prevention strategies and management of pressure injuries.
- 2) Information, including written information and other resources, appropriate to the patient population.
- 3) Education to patients and/or carers by staff following the components of and/or using the CEC Pressure Injury Prevention Patient Information flyer which will be available on the [CEC Pressure Injury Prevention Project webpage](#)

6 EDUCATION AND TRAINING

All LHDs/Networks must take reasonable steps to have:

- 1) Orientation and ongoing training programs related to pressure injury prevention and management available to support staff in the delivery of quality patient care.
- 2) All clinical staff involved in direct patient care undertake training in pressure injury prevention and management.

As a minimum, this training should use the comprehensive pressure injury prevention and management education and training program provided by NSW Health.

- 3) Training for:
 - a) Clinical coders on pressure injury classification
 - b) Auditors and surveyors who conduct pressure injury audits and point prevalence surveys.
- 4) Systems in place to monitor education resources and records of attendance at training by staff on preventing and managing pressure injuries.

7 REPORTING

7.1 Pressure Injury Incidents

All LHDs/Networks must take reasonable steps to ensure:

- 1) All pressure injuries are notified in the local incident reporting and management system e.g. NSW Health Incident Information Management System (IIMS) and reported to the appropriate medical team.

This includes those pressure injuries present on admission, new pressure injuries, and those that have significantly deteriorated (progressed to the next stage of pressure injury) since admission.

- 2) A Severity Assessment Code (SAC) 2 rating is applied to health service acquired (i.e. local site) pressure injury of Stage 3, Stage 4, suspected deep tissue or unstageable as the length of stay may increase, there is a likelihood of disfigurement and additional treatment is required.
- 3) All incidents are investigated, recommendations reported and monitored in accordance with the NSW Health Policy on incident management.
- 4) The care plan is reviewed by the multidisciplinary care team, within twenty four hours if possible, if a pressure injury develops, or an existing pressure injury significantly deteriorates (progresses to the next stage of pressure injury).
- 5) When a pressure injury occurs during care, the patient and/or carer are informed in accordance with NSW Health Open Disclosure Policy.

7.2 Auditing and reporting

All LHDs/Networks must take reasonable steps to have systems in place to:

- 1) Identify pressure injuries that develop during episodes of care for which they are responsible. Reports should be reviewed regularly, preferably quarterly and have engagement from district clinical governance unit.
- 2) Ensure pressure injury data are communicated to executive sponsors and those responsible for governance of this aspect of clinical care.
- 3) Analyse pressure injury data to inform care, quality improvement and monitor progress. These requirements are ideally met by:
 - a) An annual point prevalence survey (combining audit of documentation with patient assessment using validated tools and supported by a training program for surveyors)
 - b) Biannual incidence reports derived from routinely collected data (patient activity data and incidence data), supported by a training program for coders.
- 4) Measure process data (risk assessment/risk assessment outcomes/preventive care prescribed/delivered) and outcomes data (pressure injury incidence per bed days and annual point prevalence).

8 REFERENCES

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- 2) Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service (NSQHS) Standard: Standard 8 Prevention and Management of Pressure Injuries 2012.

The Safety and Quality Improvement Guide: [Standard 8: Preventing and Managing Pressure Injuries](#)

The NSQHSS are available at:

<http://www.safetyandquality.gov.au/publications/national-safety-and-quality-health-service-standards/>

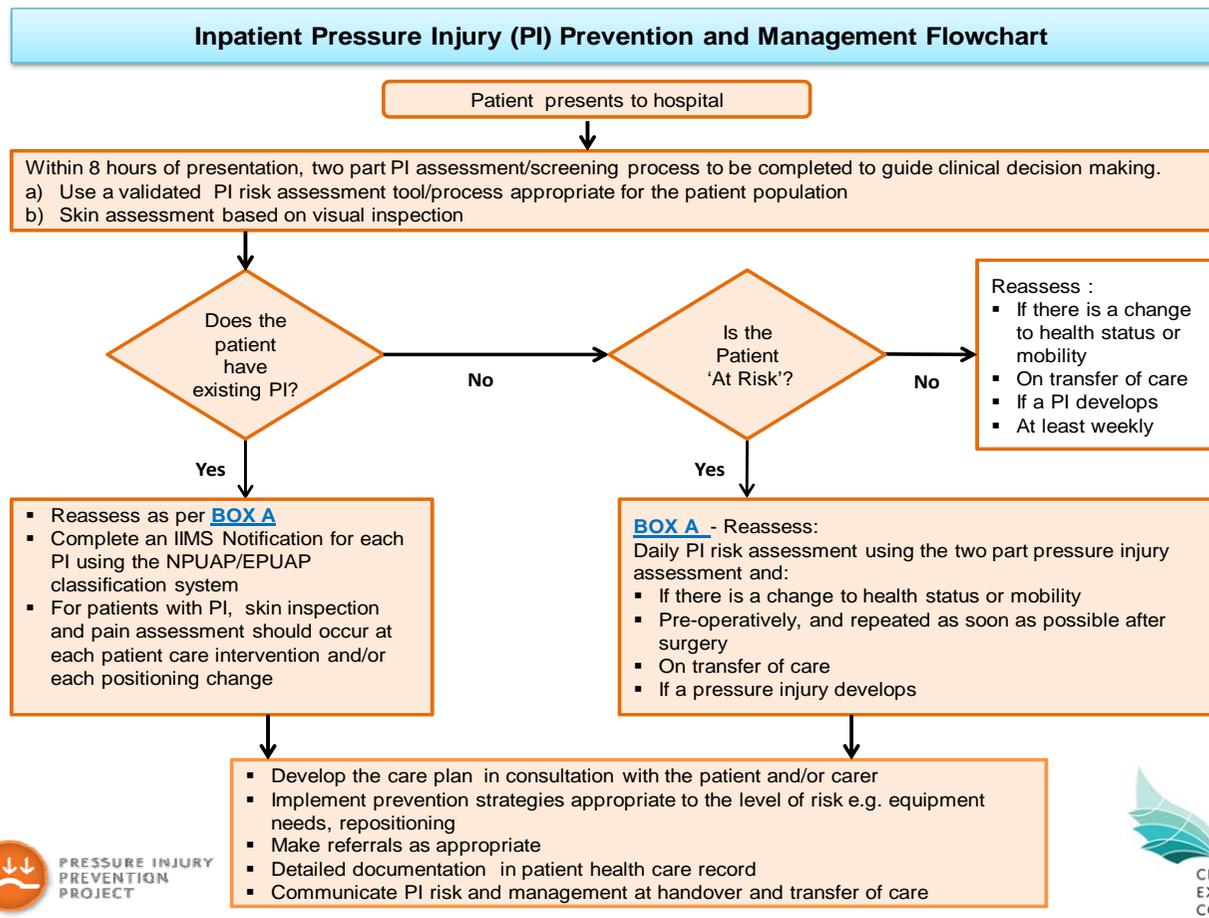
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9 RELATED LITERATURES, DOCUMENTS AND RESOURCES

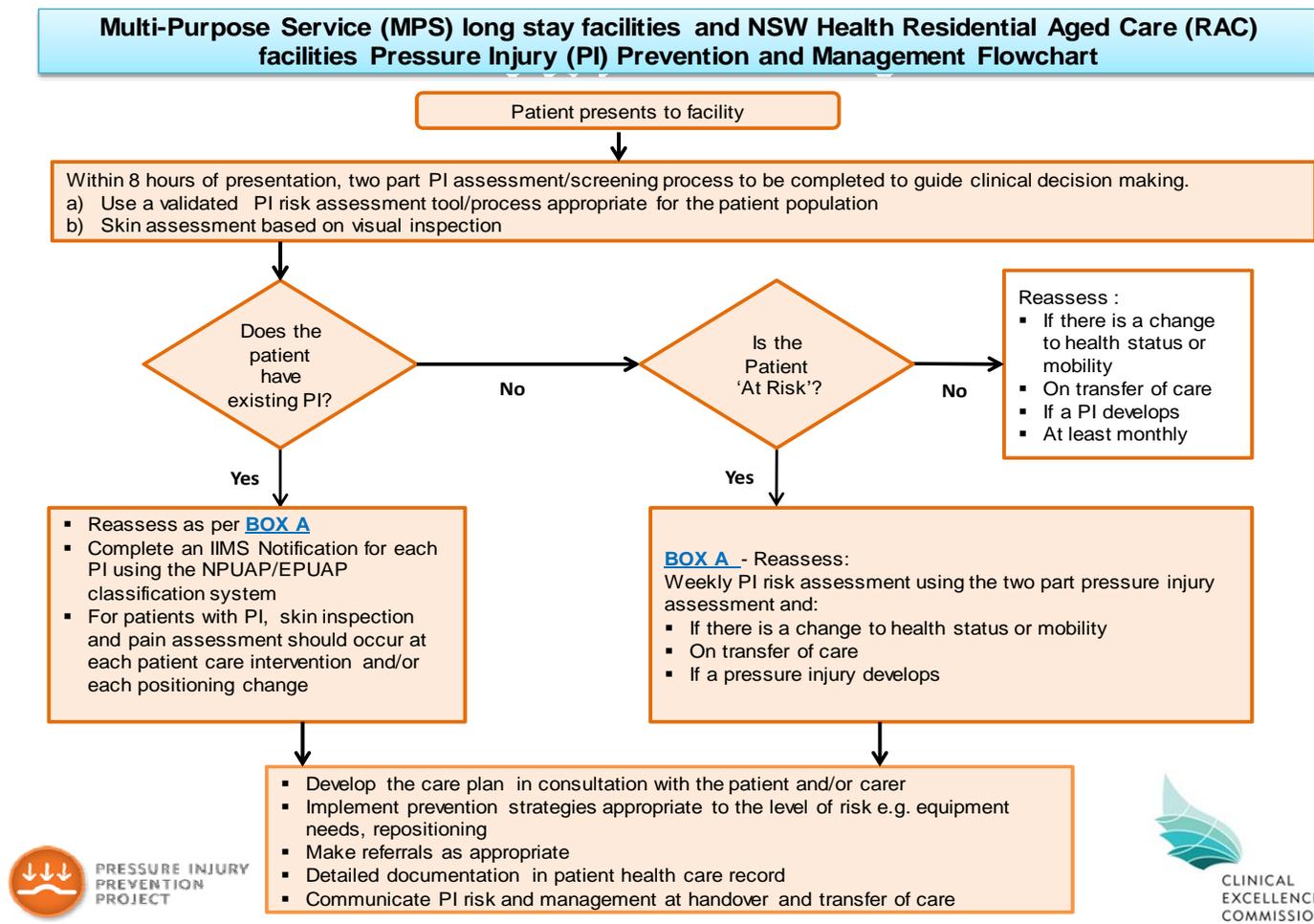
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- 2) Getting Started Kit: Prevent Pressure Ulcers, How-to Guide 2008. 5 Million Lives Campaign. Institute for Healthcare Improvement; Cambridge, MA
- 3) [NSW Procurement Guidelines](#)
- 4) The related NSW Health policies and guideline (i.e. incident management, nutrient care, open disclosure, infection control and workplace health and safety) can be found at: <http://www.health.nsw.gov.au/policies/pages/default.aspx>
- 5) Other (NSQHS) Standards underpinned this policy are Standard 1 (Governance for Safety and Quality in Health Service Organisations) and Standard 2 (Partnering with Consumers) which can be found at: :
<http://www.safetyandquality.gov.au/publications/national-safety-and-quality-health-service-standards/>
- 6) Pressure Area Care: Management 2012. The Joanna Briggs Institute
- 7) Pressure Ulcer Treatment Quick Reference Guide 2009. EPUAP and NPUAP. Document available at: <http://www.epuap.org/guidelines/>
- 8) Pressure Ulcers: Prevention and Management 2011. The Joanna Briggs Institute
- 9) Standards For Wound Management, 2010. Australian Wound Management Association, Cambridge Publishing, West Leederville WA.
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10 APPENDIX

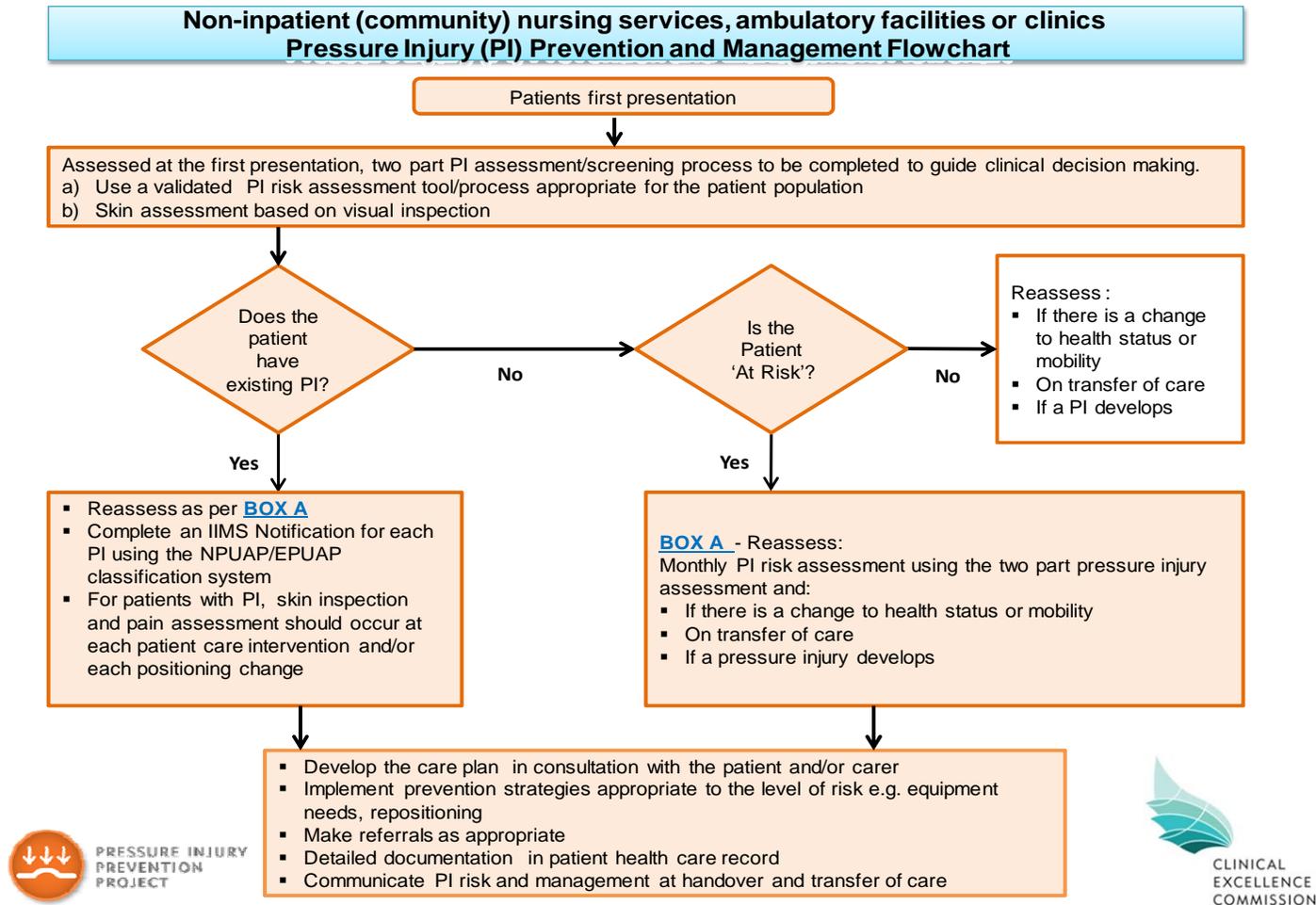
10.1 Clinical practice flowchart for the prevention and management of pressure injuries for inpatients



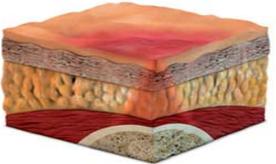
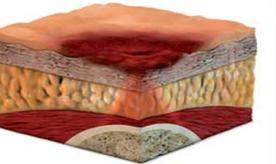
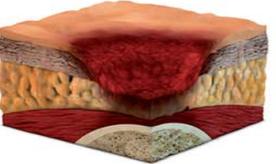
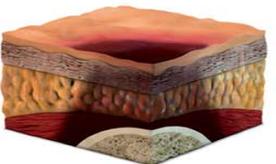
10.2 Clinical practice flowchart for the prevention and management of pressure injuries for Multi-Purpose Service (MPS) long stay facilities and NSW Health Residential Aged Care (RAC) facilities



10.3 Clinical practice flowchart for the prevention and management of pressure injuries for non-inpatient (community) nursing services, ambulatory facilities or clinics



10.4 Pressure injury classification system

Stage I pressure injury: non-blanchable erythema	Stage II pressure injury: partial thickness skin loss	Stage III pressure injury: full thickness skin loss			
<ul style="list-style-type: none"> Intact skin with non-blanchable redness of a localised area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler compared to adjacent tissue. May be difficult to detect in individuals with dark skin tones. May indicate "at risk" persons (a heralding sign of risk). 	<ul style="list-style-type: none"> Partial thickness loss of dermis presenting as a shallow, open wound with a red-pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Presents as a shiny or dry, shallow ulcer without slough or bruising (NB bruising indicates suspected deep tissue injury). Stage II PI should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. 	<ul style="list-style-type: none"> Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunnelling. The depth of a stage III PI varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage III PIs can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage III PIs. Bone or tendon is not visible or directly palpable. 			
					
Stage IV pressure injury: full thickness tissue loss	Unstageable pressure injury: depth unknown	Suspected deep tissue injury: depth unknown			
<ul style="list-style-type: none"> Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. The depth of a stage IV pressure injury varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these PIs can be shallow. Stage IV PIs can extend into muscle and/or supporting structures (e.g. fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone or tendon is visible or directly palpable. 	<ul style="list-style-type: none"> Full thickness tissue loss in which the base of the PI is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the PI bed. Until enough slough/eschar is removed to expose the base of the PI, the true depth, and therefore the stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as the body's natural biological cover and should not be removed. 	<ul style="list-style-type: none"> Purple or maroon localised area or discoloured, intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tone. Evolution may include a thin blister over a dark wound bed. The PI may further involve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment. 			
					
<p>All 3D graphics designed by Jarrad Giffos, Gear Interactive, http://www.gearinteractive.com.au Photos stage I, I,IV, unstageable and suspected deep tissue injury courtesy C. Young, Launceston General Hospital. Photos stage II and III courtesy K. Carville, Silver Chain. Used with permission.</p>					

Based on National Pressure Ulcer Advisory Panel (NPUAP), European Pressure Ulcer Advisory Panel (EPUAP). Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline. 2009, Washington DC: NPUAP cited in Australian Wound Management Association. Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure Injury. Abridged Version, AWMA; March 2012. Published by Cambridge Publishing, Osborne Park, WA.