

Pressure Injury Prevention and Management

Summary The Policy Directive outlines requirements for minimising the risk of pressure injuries through timely identification and management of modifiable risk factors and when pressure injuries are present appropriate treatment is provided.

Document type Policy Directive

Document number PD2021_023

Publication date 02 July 2021

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Review date 02 July 2027

Policy manual Not applicable

File number H21/98626

Status Review

Functional group Clinical/Patient Services - Aged Care, Critical Care, Medical Treatment, Nursing and Midwifery
Corporate Administration - Governance, Information and Data

Applies to Ministry of Health, Local Health Districts, Board Governed Statutory Health Corporations, Chief Executive Governed Statutory Health Corporations, Specialty Network Governed Statutory Health Corporations, Affiliated Health Organisations, Public Health System Support Division, Cancer Institute, Community Health Centres, NSW Ambulance Service, Dental Schools and Clinics, Public Hospitals

Distributed to Ministry of Health, Public Health System, Divisions of General Practice, NSW Ambulance Service, Private Hospitals and Day Procedure Centres, Health Associations Unions, Tertiary Education Institutes

Audience Allied Health Staff;Community Health staff;All Multipurpose Services (MPS) staff;All Clinical Staff and Executives;All Medical and Nursing Staff

PRESSURE INJURY PREVENTION AND MANAGEMENT

POLICY STATEMENT

All staff involved in patient care in NSW Health facilities/services are responsible for minimising the risk of pressure injuries through timely identification and management of modifiable risk factors and when pressure injuries are present appropriate treatment is provided.

SUMMARY OF POLICY REQUIREMENTS

On presentation/admission to a health service, all patients are to be screened to identify pressure injury risk factors, using an agreed risk screening process to guide clinical decision making.

If risk factors are identified, in partnership with the patient/family/carer, a plan of care with agreed strategies/interventions is to be developed considering the patients preferences and goal of care.

All care and treatment delivered to people who are at risk of pressure injury development or with an existing pressure injury is to be person centred and culturally sensitive.

A multidisciplinary approach to care provision to ensure appropriate intervention/strategies are implemented based on risk factor/s. The care plan is to be reviewed regularly for effectiveness, with referral to specialist providers as required.

Individuals with identified risk factors are to have regular skin assessments to monitor the effectiveness of prevention strategies.

Systems are in place to ensure adequate expertise, resources, products and equipment are readily available and accessible to provide best practice in pressure injury prevention and management.

All pressure injuries are to be documented in the medical record, specifying the classification and dimensions, anatomical location and if the pressure injury was acquired during the current episode of care or was pre-existing.

Clinical staff, who care for patients at risk of developing pressure injuries or with existing pressure injuries, are to undertake training in pressure injury prevention and management.

Systems and processes are to be in place to report/notify hospital/health service acquired pressure injury incidents, monitor and analyse pressure injury data, and implement relevant quality improvement activities to improve patient care as required.

A patient's pressure injury prevention and management health care needs are to be integrated into their transition of care planning process.

REVISION HISTORY

Version	Approved by	Amendment notes
July-2021 PD2021_023	Deputy Secretary, People, Culture and Governance Division	Rewritten to align with the International Prevention and Treatment of Pressure Injuries: Clinical Practice Guideline, 2019 and the Partnering with Consumers Standard.
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: Procedure.

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1 BACKGROUND

1.1 About this document

Pressure injuries are a frequently occurring health problem and reduce quality of life through pain and discomfort. They are a costly, and often preventable with many individuals at risk due to aging, frailty, and multimorbidity.^{1,2,3}

The Australian Commission on Safety and Quality in Health Care (ACSQHC) has designated pressure injuries as a Hospital Acquired Complication (HAC). HAC is a complication for which clinical risk mitigation strategies may reduce, but not necessarily eliminate, the risk of a complication occurring.⁴ Prevention of pressure injuries is the responsibility of all staff who work in health, regardless of location and position. Staff, patients and carers have a role to play in the prevention of pressure injuries.³

The Policy Directive is revised in accordance with the [International Prevention and Treatment of Pressure Injuries: Clinical Practice Guideline, 2019](#).³ The Guideline is a collaboration between three partner organisations – the European Pressure Ulcer Advisory Panel (EPUAP), the National Pressure Injury Advisory Panel (NPIAP) and the Pan Pacific Pressure Injury Alliance (PPPIA). The goal of the guideline is to provide an update of evidence-based recommendations for the prevention and treatment of pressure injuries.³

The [National Safety and Quality Health Service Standards \(NSQHSS\), Comprehensive Care Standard](#)⁵, describes the systems and strategies to provide comprehensive care and identify risk of harm including the development of pressure injuries. This Policy also aligns with the Partnering with Consumers Standard, which ensures that systems are in place to design, deliver and evaluate care in partnership with consumers.⁵

The Comprehensive Care Standard requires that:

- Systems are in place to support clinicians to deliver comprehensive care
- Integrated screening and assessment processes are used in collaboration with patients, carers and families to develop a goal-directed, comprehensive care plan
- Safe care is delivered based on the comprehensive care plan, in partnership with patients, carers and family, including patients who are at the end of life
- Patients at risk of specific harm are identified, and clinicians deliver targeted strategies to prevent and manage harm.⁵

Evidence-based approaches to pressure injury prevention and management include:

- Timely identification of risk factors
- A standardised and documented risk screening process to identify if an individual is at risk of developing a pressure injury and guide clinical decision making
- Regular skin assessment for individuals with identified risk factor/s
- Communication of identified risk
- Engaging with patients and their carer/s in a culturally sensitive manner
- Developing, implementing and reviewing of a plan of care that is:

- Tailored to the individual's goal of care, preferences and addresses their risk factors
- Focused on prevention and wound healing if a pressure injury is present
- Comprehensive and interdisciplinary
- Delivered by staff with appropriate knowledge and skills who use evidence-based prevention and management strategies and resources
- Inclusive of access to appropriate products and equipment
- Systems to monitor and analyse pressure injury data, and to implement quality improvement activities.^{3,5}

It should be noted that even when all appropriate prevention strategies are consistently implemented to reduce the risk, in some cases pressure injuries are unavoidable, e.g. patients with skin failure at end of life.^{3,12}

Pressure Injury Prevention and Management resources are available on the [Clinical Excellence Commission website](#) for different care settings, including flowcharts Prevention and Management of Pressure Injuries for:

- Inpatients
- Residents of Multi-Purpose Service (MPS) Long Stay Facilities and NSW Health Residential Aged Care (RAC) Facilities
- Non-Inpatients (Community Services, Ambulatory Care or Clinics).

1.2 Key definitions

Active support surface

A powered support surface that produces alternating pressure through mechanical means, providing the capacity to change its load distribution properties with or without an applied load. This generally occurs through alternating 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 projection of bone.³

Carers

People who provide 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.⁶ Carers provide support for activities of daily living and include parents and guardians caring for children.

Classification of pressure injuries

Pressure injuries are classified using the [National Pressure Ulcer Advisory Panel \(NPUAP\) and European Pressure Ulcer Advisory Panel \(EPUAP\) 2009/2014](#)

[classification system](#) cited in the Australian Wound Management Association *Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure Injury, 2012*.⁷

Community Services

Services provided in the community setting and include but not limited to, Generalist Community Health Services, Palliative Care Services, Hospital in the Home, Child and Family Health Services, Chronic Care Services, Continence Services, Ostomy Services, Diabetes Services and Podiatry Services.

Mucosal pressure injury

Mucosal membrane pressure injuries are pressure injuries of the moist membranes that line the respiratory, gastrointestinal and genitourinary tracts. Mucosal pressure injuries are primarily caused by medical devices exerting sustained compression and shear forces on the mucosa. Classification systems for pressure injuries of the skin and underlying tissue cannot be used to categorize mucosal pressure injuries.³

NSW public health facility

Any clinical unit or service that delivers public healthcare services. Health facilities include hospitals, multi-purpose services, emergency services, ambulatory care services, Aboriginal Medical Services and community health services and clinics.

Plan of care

Outlines the types and frequency of services required and the service provider details to meet care needs and mitigate identified risk factors.

Pressure Injury

Localised damage to the skin and/or underlying tissue, as a result of pressure or pressure in combination with shear and friction. Pressure injuries usually occur over a bony prominence but may also be related to a medical device or other object.^{3,10}

Pressure injury risk identification

A process to support identification of an individual's risk of developing a pressure injury.

Primary Care Provider

Primary healthcare providers include but are not limited to – General Practitioners, nurses (including general practice nurses, community nurses and nurse practitioners), allied health professionals, midwives, pharmacists, dentists, and Aboriginal Health Workers.

Risk screening

A process to support identification of an individual's risk of developing a pressure injury.³

Reactive Support Surface

Powered or non-powered support surface with the capability to change its load distribution properties in response to an applied load.¹¹

Skin assessment

Examination of the entire skin surface from head to toe to check integrity and identify any characteristics indicative of pressure damage/injury. This entails assessment for erythema, blanching response, localised temperature changes compared to surrounding skin, oedema, induration and skin breakdown. Consider different skin tones. The skin beneath devices, prosthesis and dressings are to be checked when practical and safe to do so.³

Staff

Any person working within the NSW Health system including clinicians, contractors, students and volunteers.

Unavoidable Pressure Injuries

Pressure injuries which occur despite consistent application of pressure injury prevention interventions. The implemented interventions were consistent with the patient's needs, goals, and recognised standards of practice, and there is evidence of monitoring and evaluation/revision of the interventions.¹²

Wound-related pain

An unpleasant sensory and emotional experience associated with a pressure injury. Patients may use different words to describe pain including discomfort, distress and agony.⁸ Patients with cognitive impairment or expressive dysfunction may be unable to communicate their pain.

2 GOVERNANCE

Health services are to have a senior manager and/or a governance group responsible for the health service pressure injury policies, procedures and protocols, ensuring there are systems and processes in place to monitor and analyse pressure injury data and conduct/support relevant quality improvement activities.⁵

3 PARTNERSHIP WITH PATIENTS AND/OR CARERS

Health services are to have systems to engage and partner with consumers and carers in care, to the extent that they choose. Education is to be provided to patients and their carers to address their pressure injury risk factors, and appropriate prevention and management strategies. This is to be supplemented with written information in plain language and resources for culturally and linguistically diverse populations. Information is easy to understand which will support partnerships.

Interpreters may be required for patients who are hearing impaired, those not fluent in English or whose preferred language is a language other than English.

Document partnering with patients and carers in the medical record when developing care/management plans and have open disclosure when a pressure injury develops during an episode of care.

Information to support the ongoing management of risk factors is to be provided on transition of care/discharge.⁵

4 CLINICAL PRACTICE REQUIREMENTS

4.1 Conduct screening

Health services are to have systems and processes appropriate for their patient populations, which identify risk factors and support care planning and shared decision-making.

Patients are to be screened for pressure injury risk as early as possible on presentation/admission:

- Within 8 hours of presentation to a health facility for inpatient and Multi-Purpose Service (MPS) long stay facilities and NSW Health Residential Aged Care (RAC) facilities
- At the first home visit or presentation for non-inpatient (community services, ambulatory facilities or clinics with clients at high risk) services.

Risk screening must consider the three primary predictors of pressure injury development:

- 1) Mobility/activity and neurological status - which can be restricted by the following but is not limited to physical limitations, over/under weight, sensory deficits, impaired cognition, low affect, demotivation, medication/anaesthetic or pain.
- 2) Perfusion – related to diabetes, peripheral artery disease, venous insufficiency, respiratory disease, organ failure, medication.
- 3) Skin status (as reported by the patient or the carer):
 - a) General skin status relating to factors which may make the skin more vulnerable to pressure injury, e.g., redness, moisture, dryness, oedema
 - b) Skin integrity including current and previous pressure injuries.⁹

Patients with a history of or if a current pressure injury exists may be at risk of developing further pressure injuries.

4.2 Conduct skin assessment

When pressure injury risk factor/s are identified through the initial screening process, the patient is to have a documented skin assessment. Where skin assessment is outside the clinician's scope of practice, referral for skin assessment may be required. Ongoing, regular skin assessment appropriate to the care setting is required. See table 1 below.

In some situations, the patient may not give consent or is unsuitable to undergo a full skin assessment. The clinician must record in the medical record the reason why the skin assessment was not undertaken. In clinical situations when the risk of doing a skin assessment is outweighed by other risks to the patient or staff, the assessment is to take place as soon as practical after the risk is mitigated. Risks include:

- Clinical instability e.g. acute spinal cord injury, unstable fractures, active bleeding
- Medical device patency e.g. extracorporeal membrane oxygenation (ECMO), intra-arterial lines/sheaths
- Dressing wear time e.g. severe burn injury, negative pressure wound therapy

- Potential for physical harm to the patient or staff e.g. delirium, behavioural disturbance, psychological trauma e.g. sexual assault, cultural sensitivity, trauma history, mental illness
- Imminent death.

The skin assessment is to include a comprehensive head to toe assessment, focusing on skin overlying bony prominences including the occiput, sacrum, buttocks, heels, hips, pubis, thighs and torso. When the patient has a medical device the skin assessment is to include the skin under and around the device. For neonates, young children and critically unwell patients, the occiput requires careful attention.^{3,10}

Patients are to be reviewed if there is a change to a patient's health status or mobility, pre-operatively, as soon as feasible after surgery, postnatally prior to leaving the birthing setting, at transition of care, prior to discharge and if a pressure injury develops. If risks are identified, the plan of care is to be reviewed and ongoing skin assessment is required. If pressure injury risk factors are no longer present regular skin assessment is not required.

Table 1: Identification of risk factors, skin assessment and care plan review requirements based on the care setting¹.

	Inpatients	Multi-Purpose Service (MPS) long stay facility residents and NSW Health Residential Aged Care (RAC) facility residents.	Non-inpatients (community services, ambulatory care or clinics with clients at high risk)
First pressure injury screening and skin assessment to guide clinical decision making	<ol style="list-style-type: none"> 1. Screened as soon as possible - no later than 8 hours of presentation 2. Skin assessment on identification of risk factors 	<ol style="list-style-type: none"> 1. Screened within 8 hours of presentation 2. Skin assessment on identification of risk factors 	<ol style="list-style-type: none"> 1. Screened at the first home visit or presentation 2. Skin assessment (if practicable) on identification of risk factors
Identified risk factor/s	Skin assessment and plan of care reviewed daily, and: <ul style="list-style-type: none"> • Change in health status or mobility • Pre-operatively, and as soon as feasible after surgery • Postnatally, prior to leaving the birthing setting • Transition of care • Prior to discharge • If a pressure injury develops • Based on clinical judgement 	Skin assessment daily and plan of care reviewed regularly (on agreed review date), and: <ul style="list-style-type: none"> • Change in health status or mobility • Clinical change impacts on the needs, goals or preferences of the consumer • Transition of care • If a pressure injury develops • Based on clinical judgement 	Skin assessment and review of plan of care monthly (as a minimum) and: <ul style="list-style-type: none"> • Change in health status or mobility • Transition of care • If a pressure injury develops • Based on clinical judgement
No identified risk factor/s	Reassess: <ul style="list-style-type: none"> • Change in health status or mobility • Post operatively • Postnatally, prior to leaving the birthing setting • Transition of care • Prior to discharge • If a pressure injury develops • Based on clinical judgement 	Reassess: <ul style="list-style-type: none"> • Change in health status or mobility • Transition of care • If a pressure injury develops • Based on clinical judgement 	Reassess: <ul style="list-style-type: none"> • Change in health status or mobility • Transition of care • If a pressure injury develops • Based on clinical judgement
Pressure injury/ies - skin assessment and pain assessment completed and documented	During each shift as a minimum	During each shift as a minimum	At each home visit/appointment

¹ NB. Community services who are not the primary care provider for clients/consumers identified at risk for pressure injury are to provide education to the client/consumer and/or carer and primary provider. This will increase awareness and understanding of risk factors and their role in ongoing monitoring of skin integrity and the plan of care. People with spinal cord injury and other neurological disorders are at life-long high risk for pressure injuries. The plan of care is to be reviewed regularly, particularly if there is a change in health status or mobility.

4.3 Develop a prevention plan

For patients/clients who are at risk of, or have an existing pressure injury, the plan of care needs to:

- Be developed with the person, and/or their carer (when able) and documented in their medical record
- Include strategies aimed at preventing pressure injury/injuries and optimising healing and preventing complications of current pressure injury/injuries
- Document how the patient and/or carer are involved in the pressure injury prevention and management care planning process
- Have input from the interdisciplinary team about additional assessment, recommendations and treatment
- Be communicated via documentation in the medical record
- Be communicated during handover at the end of every shift in an acute, MPS long stay facility or NSW Health RAC facility, and within twenty-four hours of initial home visit for community services
- Have risk communicated, e.g. through the use of patient journey boards and care boards
- Be verbally communicated during bedside handover, intentional-rounding, safety huddles, journey board meetings and at transition of care.

4.4 Prevention Strategies

Patients with risk factors for pressure injury, either with or without pressure injury, are to have:

- Evidence based prevention strategies implemented as a priority within two hours of risk identification
- Targeted interventions/strategies based on the risk factor(s) identified and reviewed regularly for their effectiveness.

Repositioning and/or early mobilisation schedule to prompt or assist repositioning as clinically indicated and using appropriate manual handling techniques and equipment. Patients are to be educated and encouraged to perform independent, pressure relieving manoeuvres when able.

- A 30-degree side lying position is to be used when repositioning individuals in bed. Keep the head of the bed as flat as possible at no greater than 30-degrees elevation unless clinically necessary to facilitate breathing and/or prevent aspiration and ventilator-associated pneumonia.³

The knee break function is to be used to prevent the patient from sliding down the bed to reduce shear forces. The torso to thigh angle is to be no greater than 30-degrees.³

Pressure redistribution

- Mattress support surfaces which meet individualised requirements (i.e. weight, moisture, temperature, width, static or active surface types) are to be considered and regularly reviewed.
- Support surfaces (such as active and reactive) are to be used during care, including emergency departments, operating room, intensive care, dialysis units, and during transportation when clinically indicated and appropriate.

NB: In unstable spinal or pelvic fracture, active support surfaces are contra-indicated. This is regardless of the patient having identified risk factors for pressure injury or an existing pressure injury. Patients with unstable spinal or pelvic fracture are to stay on the appropriate non-powered support surface and receive regular pressure relief through lifting, as per spinal and pelvic fracture protocols.

- Seating support surfaces which meet the individualised requirements are to be considered and regularly reviewed.
- Other pressure redistribution and offloading equipment (e.g. repositioning devices or aids) are to be used according to individualised requirements and goals of care.
- Heels, Achilles tendon and popliteal vein are to be offloaded completely to distribute the weight of the leg along the calf.³

Medical devices

- Devices/orthoses, compression therapy/stockings, casts/splint and other devices are to be correctly fitted, repositioned or removed regularly to have underlying skin inspected. Devices and orthosis need to be checked within 1-2 hours of first application to ensure there is no pressure.¹⁰ The paediatric population is at increased risk of device related pressure injury.

Reduction of shear and friction:

- Prophylactic dressings - note dressing products do not reduce pressure
- Appropriate manual handling techniques and equipment

Pain Management ensures patients have adequate pain management to support early mobilisation and repositioning.

Education of patients/carers on the importance of regular repositioning and other prevention strategies which address risk factors.

Skin protection and moisture balance:

- Skin is cleaned and hydrated
- Skin is protected from excessive moisture with a barrier product
- Vigorous massage or rubbing of the skin is to be avoided as this can cause damage from shear and friction.

Continence management for persons with incontinence

- A continence management plan is to be developed that facilitates individualised toileting, change of continence aids, and regular skin care.

- Highly absorbent continence products to protect the skin in individuals with or at risk of pressure injuries who have urinary and/or faecal incontinence. These need to be checked and changed regularly.
- Skin is to be cleansed after each episode of incontinence.

Adequate nutrition and hydration, is to be provided, including:

- Consideration of adequacy of total energy (calorie), protein, fluid, vitamin and mineral intake
- Screening for nutritional deficiencies
- Nutrition assessment by a Dietitian (where available) if with or at risk of malnutrition or for those with severe pressure injuries (stage 3, stage 4, Unstageable and Suspected Deep Tissue). Risk factors for malnutrition may include unintentional weight loss, poor appetite, reduced oral intake, and increased gastrointestinal losses (e.g. diarrhoea, vomiting)
- Consideration of high energy high protein supplements, and/or arginine if recommended by a Dietitian or Medical Officer
- Feeding assistance, if required.

Referral to health disciplines are to be made as clinically indicated for additional assessment and treatment.

4.5 Assess existing pressure injuries

Classification and assessment of pressure injuries is to occur when a pressure injury is identified, during serial wound management and on transfer of care (at the next dressing change). Pressure injuries are classified using the EPUAP/NPUAP 2009/2014 classification system.

Pain assessments are to be conducted to include pain management in the plan of care.

4.6 Managing existing pressure injuries

Plan of care that addresses risk factors and includes wound and pain assessment and management. The plan of care is to be reviewed by the multidisciplinary team within twenty-four hours of pressure injury identification wherever possible. If a pressure injury develops or an existing pressure injury significantly deteriorates (progresses to a more severe stage) the patient is to be reviewed.

Wound Management is to be provided or supervised by clinicians with knowledge, skills, and resources to provide treatment in accordance with best practice.

4.7 Monitor and document

Document in the medical record and complete wound chart(s) for pressure injuries, including if they were present on presentation or developed during the episode of care. Pressure injuries are to be notified through the incident management system if the injury was acquired during the current episode of care. Documentation is to include a pressure injury classification, anatomical location and dimensions. Capture and upload an image of the pressure injury as part of the documentation to monitor outcomes.

Wound reassessment is to occur as frequently as required, but at least weekly. Severe or a pressure injury that is not healing as anticipated, i.e. 25% reduction in four weeks³ are to be reviewed by a clinician with expertise in wounds.

Consultations are to occur in a timely fashion with clinicians with expertise in wounds, medical or other health disciplines for their assessment, management and interventions. The use of virtual health to facilitate the consultation and reduce the need for patient or clinicians to travel is to be considered.

Pain is to be assessed and managed using best practice guidelines (using a validated pain tool) and documented.

Nutritional support is to be provided in accordance with NSW Health Nutrition Care Policy.

Prevention of additional pressure injuries as patients with a pressure injury are at a high risk of the injury worsening or developing other pressure injuries. See section 4.4 on prevention strategies.

4.8 Transition of Care

Transition of care for a patient at risk or with a pressure injury requires timely communication with health care providers taking over/resuming care, the patient and/or their carers, other community or residential services, equipment suppliers, and allied health clinicians. Communication is to include:

- Goals of care (healing, maintenance, or palliation)
- Classification, anatomical location and dimensions of the pressure injury
- Wound management
- Ongoing prevention/management strategies
- Follow-up care.

Prevention strategies are to be used during transportation or transition of care for patients at risk or with an existing pressure injury.³

5 RESOURCES

All health services are to have systems in place so that adequate expertise and resources, including equipment, devices and products, are available and accessible to provide best practice in pressure injury prevention and management.

Pressure injury prevention products, devices and equipment are to be purchased in accordance with NSW Health Procurement Guidelines and used in accordance with:

- The manufacturers' instructions
- NSW Health Infection Control Policies
- NSW Health Workplace Health & Safety Policy.

6 EDUCATION AND TRAINING

Clinical staff providing care to patients at risk of or with pressure injuries are to undertake training in pressure injury prevention and management, modules are available on My Health Learning.

Health services are to have:

- Orientation and ongoing training programs related to pressure injury prevention and management available to ensure staff have the knowledge, skills and resources to deliver quality care
- Health professionals with expertise are available to provide clinical education for pressure injury prevention and management for staff caring for patients with complex needs
- Targeted education available for:
 - Clinical coders on pressure injury classification and condition onset
 - Auditors who conduct audits related to pressure injuries
- Systems in place to monitor education and records of training for staff on preventing and managing pressure injuries.

7 REPORTING

7.1 Pressure injury incidents

Hospital/health service-acquired pressure injuries, which have developed after eight hours of presentation, are to be notified in the incident management system and communicated to the admitting medical team or primary care provider. Notification is also a requirement for pressure injuries that have deteriorated (progressed to a more severe pressure injury) since admission. Unstageable pressure injuries and suspected deep tissue injuries require review for definitive staging.¹³ Where definitive staging is likely to occur after the transition of care, the health service is to communicate with the ongoing care provider to confirm staging. Definitive staging is to be entered into the medical record and the incident management system particularly for unstageable pressure injuries or suspected deep tissue injuries that are staged as a stage 3 or stage 4.

Hospital/Health Service-acquired pressure injuries are reviewed and recommendations reported and monitored in accordance with the NSW Health Policy Directive *Incident Management* ([PD2020_047](#)). When a pressure injury occurs or deteriorates to a more severe injury during an episode of care, the patient and/or carer are informed in accordance with the NSW Health Policy Directive *Open Disclosure Policy* ([PD2014_028](#)).

Stage 3, stage 4, unstageable and suspected deep tissue pressure injuries which are hospital/health service-acquired are to have a clinician with expertise in wound management on the Incident Review Team, where possible.

Pre-existing pressure injuries do not require notification in the incident management system. These are to be documented in the medical record and wound chart.

7.2 Monitoring

Health services are to have systems in place to:

- Identify pressure injuries that develop during the episode of care
- Review pressure injury data regularly, at a minimum quarterly
- Ensure pressure injury data is communicated to the health service executive and those responsible for governance of clinical care
- Analyse pressure injury data to inform care, quality improvement activities and monitor progress.

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Collaborators, Prevalence, associated factors and outcomes of pressure injuries in adult intensive care unit patients: the DecubICUs study, *Intensive Care Med*, 2021, 47:160–169 <https://doi.org/10.1007/s00134-020-06234-9>

9 RELATED LITERATURE, DOCUMENTS AND RESOURCES

- NSW Procurement Guidelines
- NSW Health policies and guideline (i.e. incident management, nutrition care, open disclosure, infection control and workplace health and safety) can be found at: <https://www1.health.nsw.gov.au/pds/Pages/pdslanding.aspx>
- Leading Better Value Care Standards for Wound Management September 2019 http://eih.health.nsw.gov.au/_data/assets/pdf_file/0010/558352/NSW-Health_Wound-Standards_September-2019.PDF
- Australian Commission on Safety and Quality in Health Care March 2018 <https://www.safetyandquality.gov.au/sites/default/files/migrated/Pressure-injury-short-clinician-fact-sheet.pdf>