



Health



CLINICAL
EXCELLENCE
COMMISSION



MONITORING & AUDITING FRAMEWORK



PRESSURE INJURY
PREVENTION
PROJECT

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INTRODUCTION

This document sets out the minimum essential elements of a pressure injury prevention and management monitoring and audit framework, linked to recommendations set out in NSW Health Pressure Injury Prevention and Management Policy (2014). Care planning and delivery should be consistent with this policy and best-practice guidelines and be appropriate for the patient population. A monitoring and auditing framework for pressure injury prevention and management aligned with this policy should include:

1. A point prevalence survey undertaken at least annually

This demonstrates the observed prevalence of pressure injury in an organisation (numbers of patients with pressure injuries at a specific point in time), and indicates the scale of the issue.

Concurrent collection of audit data demonstrates compliance with core aspects of preventive care, measured as care quality indicators¹⁻⁴. Concurrent collection of audit data for care processes, alongside a point prevalence survey, enables linkage of care processes with patient outcomes (development of pressure injury or not). Audit data may also be collected separately from the point prevalence survey, as noted below.

2. Regular monitoring of recorded pressure injury incidence in an organisation, extracted from routinely collected data sets

Incidence data demonstrates occurrence of new cases within an organisation and is a reflection of quality of care. This data demonstrates pressure injuries acquired within the current organisation. If the patient transfers between facilities, each pressure injury is only an incident case in the site where it develops.

The quality and completeness of routinely collected data are not equal to that of dedicated data collection (such as a point prevalence survey), but routine data enables trend monitoring closer to real time (e.g., monthly figures can be extracted), supporting quality improvement initiatives, with less resource requirement.

3. Best-practice clinical audit of care process documentation

It is recommended that data be collected regularly at a frequency determined locally, to support quality improvement initiatives and demonstrate compliance with National Safety and Quality Health Service Standards^{5,6}.

Each method and section can be used separately, but it is recommended that all three elements are used for comprehensive quality monitoring and to support quality improvement.

This document takes a generic (rather than setting-specific) approach and provides a 'minimum data set' and 'best-practice' methods to acquire the data. Organisations may identify additional data to support local initiatives.

It is recognised that some modification of methods may be required to suit local contexts, particularly community settings. Organisations should adhere to principles of good practice and employ rigorous methods to ensure collection of valid and reliable data.

GUIDANCE FOR POINT PREVALENCE SURVEY

AIMS

The point prevalence survey aims to:

- Identify pressure injury prevalence within the organisation
- Identify core pressure injury prevention practices, including documentation, adherence to best-practice and evidence-based guidelines, to evaluate and inform strategic planning on service quality improvement, and demonstrate trends in care processes and patient outcomes
- Determine the severity and anatomical location of identified pressure injuries, distinguishing between pre-existing lesions and those acquired during this admission/episode of care
- Provide data for benchmarking between organisations.
- **Documentation Audit** identifies pressure injury prevention care planned and documented for the patient, to evaluate care and support quality improvement.
- **Equipment Audit** visually identifies any pressure injury prevention equipment in use with the patient, to relate this to clinical and risk status.
- **Patient Assessment** visually identifies and describes any skin lesion due to pressure injury affecting the patient, and its origin (whether or not developed during current period of care with this organisation).

POINT PREVALENCE SURVEY PREPARATION

Information is also available in an accompanying educational module from the Health Education & Training Institute (HETI).

Role of the Executive Sponsor

Every organisation needs an identified **Executive Sponsor**, whose role is to facilitate planning, resourcing and delivery of the survey and to support subsequent quality improvement.

Role of the Organiser/Organising Team

Every organisation needs an identified **Organiser/Organising Team**, whose role is to take responsibility for the overall planning, preparation, conduct and evaluation/debrief of the delivery of the survey. More specifically, their role is to:

- Ensure that governance procedures for the survey are identified, aligned with the organisation, LHD and NSW Ministry of Health clinical governance frameworks

- Liaise with local Human Research Ethics Committees to ensure that locally agreed appropriate approvals are obtained, as required
- Ensure that roles and responsibilities within the survey are understood and accepted at all levels of the organisation
- Establish a group of stakeholders to support planning, delivery and review of survey procedures and findings
- Engage consumers in all aspects of the survey
- Initiate the survey and ensure that key players are identified (e.g., survey staff, clinical unit leads)
- Ensure that survey preparation, conduct, debriefing and reporting occur as planned
- Ensure completion of data management, analysis and report-writing, in collaboration with others, e.g., local quality manager, clinical governance unit
- Establish/enact a reporting framework for survey procedures and outcomes, enabling both management and clinician awareness of findings
- Act as point of contact during the survey, providing an advisory/trouble-shooting/arbitration function, as required
- Ensure a pressure injury clinical lead (local lead or contact) is identified for every clinical unit (ward/department or community team)
- Identify survey team members. A survey team is required for every clinical unit or community team surveyed. It should be comprised of two, or optimally three, surveyors, at least one of which must be independent of that clinical unit (i.e., it is not their 'home' ward or team). Examples of survey teams in different settings are set out in Appendix 1
- Agree Pressure Injury Point Prevalence Survey date
- Ensure survey staff and clinical unit leads attend pressure injury education and diagnosis refresher, survey information, planning and debrief meetings
- Prepare Pressure Injury Point Prevalence Survey Documentation Pack:
 - Point Prevalence Survey Documentation Audit Tool
 - Point Prevalence Survey Patient Equipment Audit Tool
 - Point Prevalence Survey Patient Assessment Tool
 - Point Prevalence Survey Clinical Unit Record Sheet
 - Pressure Injury Prevention – Pressure Injury Care Review
 - Pressure Injury Point Prevalence Survey – Information for Staff
- Additional general documents have been developed to support pressure injury prevention
 - Pressure Injury Prevention – Information for Patients and Families
 - Pressure Injury Classification System

This shows examples of each stage ⁷ (severity) of pressure injury and should be easily accessible in every clinical unit.

Role of Clinical Unit Lead

The **clinical unit lead** is responsible to ensure that the patient's safety, privacy and dignity are maintained throughout the survey, in conjunction with each patient's nurse and survey teams. The **clinical unit lead** will:

- Liaise with the organiser(s) to ensure that the survey is conducted in line with requirements. The clinical unit lead is the local point of contact for queries. If unsure, the clinical unit lead consults the organiser(s)
- Ensure an adequate supply of patient ID stickers, and, if used, lodged in an accessible location for the clinical unit
- Distribute, or ensure distribution of, Pressure Injury Survey Patient Information Sheets either the day before or of the survey. This should go to every patient expected to be on the clinical unit during the survey. Ensure patients are made aware of the survey purpose and procedure. The clinical unit lead will answer questions from patients, liaising with survey organisers if necessary.
(Refer to **COMPLETING THE PATIENT ASSESSMENT TOOL** for discussion of consent.)

Role of Survey Staff

For every clinical unit AT LEAST one member of the survey team must be independent, i.e., not auditing their 'home' clinical units/teams.

Survey staff attend the clinical units solely to conduct the survey. They should refer requests for care to the patients' nursing teams.

Survey staff have responsibility to:

- Liaise with the survey organiser(s) to obtain date and clinical units to be audited
- Collect an adequate supply of survey documentation packs from the organiser(s) for each clinical unit
- Complete the:
 - Documentation audit
 - Equipment audit
 - Whole-body comprehensive skin assessment, based on visual inspection, preferably with the patient's clinical unit nurse or other member of the clinical unit nursing team present
 - Clinical Unit Record Sheet for all patients, using the survey tools provided.

POINT PREVALENCE SURVEY PROCEDURES

On Day of Survey

On entering the clinical unit, **survey staff** introduce themselves to the NUM/shift co-ordinator and **clinical unit lead**. All clinical units will be aware of the Point Prevalence Survey.

- **Survey staff** and the **clinical unit lead** identify patients who may require assistance with manual handling. In-patients who are leaving the clinical unit for diagnostic or surgical procedures, or who are to be discharged, should be surveyed as a priority, where possible.
- **Clinical unit lead** will obtain a list of patients/beds on the caseload to enable completion of the Clinical Unit Record Sheet as the survey is completed for each patient/bed. The **clinical unit lead** will ensure that adequate resources are available for completion of the survey (e.g., resources required for patients in isolation, etc).
- **Survey staff** complete all three survey components (documentation audit, equipment audit and skin inspection) for each patient before moving on.
- On completion of each patient survey, **staff** mark this off on the Clinical Unit Record Sheet.
- **Survey staff** and the **clinical unit lead** ensure that the Clinical Unit Record Sheet is completed for all patients on the day of the survey.
- Once the last patient has been surveyed, the **survey staff** collect the completed Clinical Unit Record Sheet, discuss any concerns with the nursing unit manager and return all survey documentation to the organiser(s).

COMPLETING THE DOCUMENTATION AUDIT TOOL

- **Survey staff** review each patient's health care record, i.e., medical notes, progress notes and other documents, such as nursing care plans/wound charts, etc., collating the specified information onto the Survey Documentation Audit Tool.
- This help sheet should be read together with the Documentation Audit Tool.
- On completion, the Documentation Audit Tool is checked to ensure that all data is complete before returning the health care record/case notes.
- The recording of an MRN is solely for the purpose of linking the three data collection components (documentation audit, equipment and patient assessment). When data is entered for analysis, code numbers must be allocated to the patients. **MRNs MUST NOT be retained with the data.** After data entry is completed, the MRN must be electronically deleted and/or paper data collection sheets must be disposed of, as confidential documents.

Question number	Question	How to respond
1-9	Date and patient details	Copy from patient record; use sticker if available
10	Was a fully completed comprehensive risk assessment documented/scored within eight hours of admission to the organisation, or community patient only: at first presentation to community nursing services for this episode of care?	Evidenced by comprehensive assessment, including clinical history, pressure injury risk, encompassing inspection of skin, mobility and activity, pain, nutritional state, continence, cognition and extrinsic risk factors ^{4,7} If incomplete/not comprehensive, score NO This question cannot be scored YES if question 13 is scored NO

Question number	Question	How to respond
11	If first risk assessment completed, identify the assessment tool used	Identify the risk scoring scale used (if any). Multiple choice or other offered
12	At the first risk assessment of this episode of care/admission, the documented risk category is...	Identify and record the category of risk documented for the patient at the first risk assessment of this episode of care/admission. Mark one category only
13	Was a comprehensive skin assessment documented within eight hours of admission, or community patient only: at first presentation to community nursing services for this episode of care?	Evidenced by assessment for erythema, blanching response, localised heat, oedema, induration and skin breakdown ⁷ Documentation should reflect that all elements of assessment are addressed. Skin intact' does not indicate comprehensive assessment occurred and should be scored NO A comprehensive skin assessment should be documented within eight hours of hospital/nursing care facility admission for all in-patients For community patients, a comprehensive skin assessment should be documented at first presentation or this episode of care
14	Patients at risk of pressure injury only: Hospital in-patients. Was a comprehensive skin assessment documented for each of the most recent three days or, community patients: was a comprehensive skin assessment recorded within the last month?	If patient assessed not at risk of pressure injury, mark as not applicable For patients identified as at risk of pressure injury, consider the following Hospital in-patients. Was a comprehensive skin assessment documented for each of the most recent three days? Audit records for the most recent three days only. If in hospital for less than three days, audit all in-patient days Community patients. Was a comprehensive skin assessment documented within the last month? Audit records for a maximum of one calendar month for community patients If there is not a skin assessment documented for every day (24hr period) for in-patients, or at least one assessment for community patients, answer NO Score NA if patient not currently identified as at risk of pressure injury
15	Is there any documented pressure injury within the most recent three days (in-patient) OR one month (community patient)?	Audit records for up to a maximum of the most recent three days (for hospital in-patients) or one month (for community patients), as above Record YES if any documentation of pressure

Question number	Question	How to respond
		injury within the appropriate time period
16	If a pressure injury has been documented, record all related incident pressure injury notification (e.g., IIMS) numbers in boxes	<p>If the patient has a pressure injury documented, there should be a notification of this in the organisation's incident recording system (e.g., IIMS)</p> <p>Record all serial numbers that relate to pressure injury. If there is no information about the topic of the reported incident, record the serial number and date. If in doubt, record it</p> <p>If more than three entries, continue at foot of page</p>
17	If pressure injury identified at Question 15 (above), list documented stage, location and origin - developed during current episode of care in this organisation (here)/or present on admission i.e., developed elsewhere) and whether the injury is current (yes) or healed/no longer present (no) for each pressure injury separately (e.g., for PI1, PI2, PI3 etc)	<p>As for question 15: review up to three most recent days (hospital in-patient) or one month of records (community patient), as appropriate. If in-patient stay less than three days, review total days as in-patient</p> <p>If pressure injury documented, list documented stage ^{4,7}, location and origin (i.e., whether developed here in this organisation or present on admission, so developed elsewhere) of every pressure injury. For example: stage 2 x 2, buttocks, developed here; unstageable x 1, sacrum, developed elsewhere</p> <p>Use the six categories of pressure injury (i.e., stages 1-4, suspected deep tissue injury, and unstageable)</p> <p>Record whether or not this is reported as a current pressure injury, i.e., unhealed today</p> <p>If no pressure injury documented, skip to question 20</p>
18	If the patient has an identified pressure injury, is there a wound management record/chart documenting every pressure injury?	<p>If the patient has a pressure injury, is there a wound management record/chart?</p> <p>Score NA if the patient DOES NOT have a pressure injury, or has a wound chart for another type of wound, e.g., surgical incision</p> <p>All patients with a pressure injury of any stage should have a wound chart. If no wound chart, answer no</p> <p>If wound chart does not list all current pressure injuries, answer no</p>

COMPLETING THE EQUIPMENT SURVEY TOOL

Organisations may choose to make lists and pictures of the different equipment used in their site available to survey staff, for ease of recognition.

- **Survey staff** complete the equipment survey, assisted as necessary by the nurse responsible for the care of the patient.
- Fill-in patient MRN and date and then visually inspect bed and chair. Identify bed type and, if appropriate, specific make and model of mattress and any cushion/additional seating on the chair. If unsure of make of mattress, consult **clinical unit lead**.
- Complete the Equipment Survey section of the tool.
- The recording of an MRN is solely for the purpose of linking the three data collection components (documentation audit, equipment and patient assessment). When data is entered for analysis, code numbers must be allocated to the patients. **MRNs MUST NOT be retained with the data.** After data entry is completed, the MRN must be electronically deleted and/or paper data collection sheets must be disposed of, as confidential documents.

COMPLETING THE PATIENT ASSESSMENT TOOL

Patient Consent

This framework sets out procedures to follow when the Point Prevalence Survey is conducted for the purpose of local practice improvement. In this situation, extraction of data from patients' records comprises a documentation audit. As skin inspection is prescribed as part of routine care^{5,7,8}, visual inspection of the patient's skin by local care staff is a form of observational audit.

Review and approval of the local human research ethics committee (HREC) may not be required⁹. If in doubt, consult a local HREC officer. If the Point Prevalence Survey is conducted for purposes other than review of local practice, the local HREC officer should be consulted, to discuss whether other actions, such as obtaining written informed consent, should be sought.

As with all forms of care, it is important to ensure that the patient is fully informed, understands the rationale for care, and consents to this occurring⁶. Consent for the survey is not required in writing and can be obtained in the same way as consent for other routine risk assessment and care procedures. This includes those non-English-speaking patients via interpreters, from parents/responsible persons where children are involved, and from patients with cognitive and communication impairments, e.g., by verbal explanation using language appropriate to the patient's age, developmental stage and understanding, and the family/person responsible, where appropriate. For all patients, it is important to check for understanding and that the patient is happy for this to proceed⁶.

No special or different form of patient consent is required than for any other form of routine care, i.e., agreement/consent can be signalled, and accepted, in a number of forms, including verbal and behavioural (initiating actions in line with requested actions).

For ease of communication, a patient flyer has been developed and is included in this pack (Pressure Injury Prevention – Pressure Injury Care Review).

Patient Assessment

Skin assessment by visual inspection should be conducted by two **survey staff** in the presence of the patient's nurse. With paediatric patients, a family member/responsible person should be in attendance. Agreement of both **survey staff** on lesion type and stage will ensure that all lesions are correctly identified and staged.

It is recognised that in some locations it may not be practical to allocate two surveyors. In this case, the 'second opinion' can be sought from the patient's nurse. However, if **survey staff** have any uncertainty as to lesion type or stage, a third opinion must be sought from the **clinical unit lead** or other designated source of 'expert opinion', who will have undertaken update/training, as agreed, during planning stages.

The judgment and agreement of at least two staff is required both for consistency of diagnosis and because accurate identification and staging of pressure injuries is well-known to be difficult and susceptible to individual interpretation. Accurate diagnosis and staging of pressure injuries is important for patient care, as well as audit quality. If, however, any patient or parent/responsible person declines visual skin assessment, this must be respected and recorded in the Survey Patient Assessment Record, the Clinical Unit Record Sheet and in the patient's medical/nursing notes.

To minimise inconvenience, where possible complete skin inspection during the patient's bathing and shower period. If it is a wound known to be pressure-related, assessment should co-ordinate with planned dressing changes, where possible. If no dressing change is planned during the survey period, either a wound image can be viewed (this must be current, i.e., taken within a week of survey date), or the dressing should be taken down for wound assessment.

Participation will not interfere in any way with the patient's current treatment.

- Throughout the assessment, the **survey staff** and patient's nurse observe whether/how the patient is able to move or reposition in the bed/chair, to make a judgement whether the patient is able to independently reposition.
- **Survey staff** fill in patient MRN and date on the Survey Patient Assessment Record.
- **Survey staff** check that patients have received a copy of the Pressure Injury Survey Patient Information Sheet, that they understand what is entailed and consent to a skin inspection.
- **Survey staff** and the patient's nurse undertake a skin inspection, paying particular attention to common pressure injury anatomical sites: bony prominences, any areas noted to be painful by the patient, areas in relation to medical devices (e.g., splints, masks etc). Where possible, these devices should be removed for inspection. Ensure that full visibility of the patient's skin is obtained during the examination. Remove (and replace) anti-embolic stockings and other clothing that may obstruct visibility of the patient's skin. Look for signs such as erythema, blanching response, localised heat, oedema, induration and skin breakdown. Ask the patient about pain or discomfort. Pay particular attention to localised heat, oedema and induration in patients with darker skin tones and any areas where patients report discomfort/pain.
- If any lesion that may be a result of pressure injury is noted, both the **survey staff** and the patient's nurse visually assess it to form a definitive identification of pressure injury numbers, stage and location.
- If there is any uncertainty in identification of Stage 1 pressure injury, repeat assessment after a period of at least 30min without pressure on this area (i.e., patient positioned to relieve pressure). If there is uncertainty whether any lesion is a pressure injury, or in the staging of it, a third expert

opinion must be obtained (e.g., from the **clinical unit lead**). If uncertainty continues, the **organiser(s)** should be contacted.

- **Survey staff** complete the Survey Patient Assessment Record, check that all sections of the forms are completed and complete relevant fields of Clinical Unit Record Sheet.
- **If survey staff detect pressure injury not recorded in the patient's health care record, they** must alert the nurse looking after the patient and/or the nursing unit manager immediately. Documentation of this pressure injury added to the healthcare record subsequent to the patient assessment **MUST NOT** be included in the documentation audit.
- The recording of an MRN is solely for the purpose of linking the three data collection components (documentation audit, equipment and patient assessment). When data is entered for analysis, code numbers must be allocated to the patients. **MRNs MUST NOT be retained with the data.** After data entry is completed, the MRN must be electronically deleted and/or paper data collection sheets must be disposed of, as confidential documents.

Following completion of the Point Prevalence Survey, a debriefing should be arranged with all **survey staff, clinical unit leads** and survey **organiser(s)** to identify lessons learnt.

Point Prevalence Survey Documentation Pack

The following pages include the pressure injury tools and resources:

1. Pressure Injury Point Prevalence Survey – Documentation Audit Tool
2. Pressure Injury Point Prevalence Survey – Patient Equipment Audit Tool
3. Pressure Injury Point Prevalence Survey – Patient Assessment Tool
4. Pressure Injury Point Prevalence Survey – Clinical Unit Record Sheet
5. Pressure Injury Prevention – Pressure Injury Care Review
6. Pressure Injury Point Prevalence Survey – Information for Staff

Additional Resources

1. Pressure Injury Prevention – Information for Patients and Families
2. Pressure Injury Classification System

All resources can be found as stand-alone documents on the CEC Pressure Injury Website:

<http://www.cec.health.nsw.gov.au/programs/pressure-injury-prevention-project>

PRESSURE INJURY POINT PREVALENCE SURVEY

DOCUMENTATION AUDIT TOOL

Survey staff to complete: see guidelines. Place X in box or as instructions.

1. Today's date ____/____/____

2. MRN _____

3. Sex of Patient M F

4. Age of Patient _____

5. Date of Birth ____/____/____

6. Clinical Unit/Dept

7. Date Admitted to Facility ____/____/____

8. Date admitted to Clinical Unit ____/____/____

9. Type of admission: Planned admission [] Emergency/non-elective []

Pressure Injury Risk Screening

10. Was a fully completed comprehensive risk assessment documented/scored within eight hours of admission to the organisation? Or, **community patients only**, at first presentation to community nursing services for this episode of care? Yes No

11. If first risk assessment completed, the assessment tool used was:

Waterlow [] Braden [] Norton [] Braden Q []

Glamorgan [] Other (name) _____

12. At first risk assessment of this episode of care, the documented risk category is (mark one):

Not at risk [] At risk [] Low risk []

Medium/moderate risk [] At high risk [] At very high risk []

13. Was a comprehensive skin assessment documented within eight hours of admission? or, **community patients only** at first presentation to community nursing services? Yes No

14. **PATIENTS AT RISK OF PRESSURE INJURY ONLY:**

If patient assessed as not at risk of pressure injury, mark as NA

Hospital in-patients. Was a comprehensive skin assessment documented on each of the most recent three days? Yes No

If patient in hospital for less than three days, score for total days of in-patient stay

Community patients. Was a comprehensive skin assessment documented within the last month? Yes No



MRN _____

Today's date ____/____/____

15. Is there any documented pressure injury EITHER within the most recent three days (in-patient) or one month (community patient)? Yes No

16. If pressure injury has been documented, record all related incident notification numbers (e.g., IIMS) in the boxes below.

Date ____/____/____ []

Date ____/____/____ []

Date ____/____/____ []

17. If pressure injury identified at question 15 (above), list documented stage, location and origin for each pressure injury (e.g., PI1, PI2, PI3 etc). Record if each:

Developed during current episode of care in this organisation (here) or

Was present on admission i.e., developed elsewhere and

Whether the injury is current (yes) or healed/no longer present (no):

		Developed		Current
		Here	Elsewhere	Y or N
PI1. Stage	Location	[]	[]	[]
PI2. Stage	Location	[]	[]	[]
PI3. Stage	Location	[]	[]	[]
PI4. Stage	Location	[]	[]	[]

18. If the patient has an identified pressure injury, is there a wound management record/chart documenting every current pressure injury? Yes No

Once this is complete put a X in the box for this patient on the Clinical Unit Record Sheet

PRESSURE INJURY POINT PREVALENCE SURVEY

PATIENT EQUIPMENT AUDIT TOOL

Survey staff to complete

MRN _____

Today's date ____/____/____

Bed, mattress & seating in use for the patient

Please put **X** in the box that describes the type of mattress/seating in use today and supply mattress/cushion brand name

Support Surfaces (mattress)		In use	Requested, not arrived	Comments
Basic hospital foam mattress				
Reactive (constant low pressure)	Non-powered	Foam		
		Gel		
		Air		
		Combination		
	Powered	Low air loss		
		Other powered reactive		
Active	Powered alternating air overlay			
	Powered alternating air mattress replacement			

Support Surfaces (chair cushion)		In use	Requested, not arrived	Comments
Basic hospital chair				
Reactive	Non-Powered	Foam		
		Gel		
		Air		
		Combination		
Active	Powered alternating air cushion			

Comments _____



PRESSURE INJURY POINT PREVALENCE SURVEY

PATIENT ASSESSMENT TOOL

Survey staff to complete

MRN _____ Clinical Unit _____ Today's date ____/____/____

Skin Inspection – Please put X in relevant box

1) Has the patient consented to skin inspection? Yes No

2) Can the patient independently reposition? Yes No

3) Does the patient have a pressure injury? Yes No

4) If yes, where do you understand each pressure injury (e.g., first pressure injury (PI1), second (PI2) etc) to have developed?

	PI1	PI2	PI3	PI4
In this hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the community	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In an aged care facility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unsure/don't know	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5) Location and stage of each pressure injury. If present:

Indicate number of pressure injuries, each stage & location, left or right as appropriate.

Identify which is PI1, PI2 etc as in question 4:

Location of Pressure Injury	Stage of injuries					
	1	2	3	4	Unstageable	Suspected deep tissue injury
Sacrum						
Buttocks						
Ischial						
Trochanter/hip						
Heels						
Elbows						
Ankles						
Shoulders						
Face						
Ears						
Head (e.g., occiput)						
Other/s, specify:						



PRESSURE INJURY PREVENTION

PRESSURE INJURY CARE REVIEW

Pressure injury

Sometimes when people don't move for a long time the pressure from lying or sitting in the same position can cause damage. We call this a 'pressure injury'. You may also hear this called a 'bed sore' or 'pressure ulcer'.

Pressure injuries can happen quickly, be painful and very difficult to heal, and may lead to other complications.

Participating in a pressure injury care review

To help improve the prevention of pressure injuries in our hospital, we are conducting a review on the care we provide. These types of reviews are conducted regularly throughout health care systems globally.

As a patient, you will be invited to be included in this review and checked for pressure injury. This will occur in the ward.



PHOTO: Clinical nurse consultant checking the heel of a patient for signs of a pressure injury

What is included in the review

As part of the review, we will:

- check whether you would like to participate
- provide you with the opportunity to ask any questions regarding the review
- talk with you about what we are looking for and what we see
- check your skin to see if you have a pressure injury
- check the equipment in use
- check documentation of your care
- tell the team looking after you if we find any pressure injuries
- seek specialist advice, if needed
- provide you with the opportunity to ask any additional questions

How the information will be used

The information will be used by health professionals to provide better care for patients in our health system. All information gathered will be de-identified when used in reports.

Thank you for reading this information sheet. If you have any questions, please speak to the Nurse Unit Manager.

About the Pressure Injury Prevention Project

The Pressure Injury Prevention Project is run by the Clinical Excellence Commission. It promotes best practice for the prevention and management of pressure injuries in New South Wales health care facilities.

For further information on the Pressure Injury Prevention Project, please visit <http://www.cec.health.nsw.gov.au/programs/pressure-injury-prevention-project>

Pressure Injury Prevention: Pressure Injury Care Review
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PRESSURE INJURY
PREVENTION
PROJECT



CLINICAL
EXCELLENCE
COMMISSION

PRESSURE INJURY PREVENTION

INFORMATION FOR PATIENTS AND FAMILIES

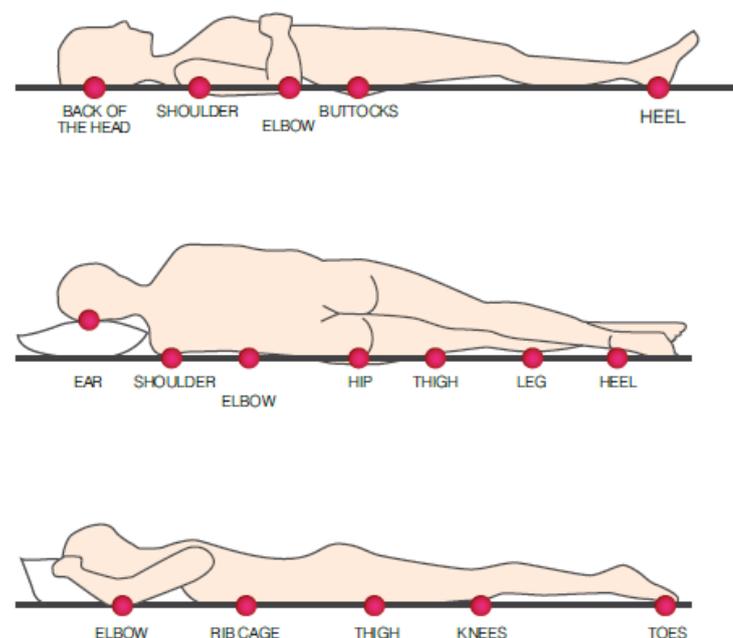
Pressure injury

A pressure injury, also referred to as a pressure ulcer or bed sore, is an injury to the skin caused by unrelieved pressure and may occur when you are unable to move due to illness, injury, or surgery.

Pressure injuries can happen quickly, from lying or sitting in the same position for too long. They can be painful, take a long time to heal, and may lead to other complications.

Pressure injuries may develop under plasters, splints or braces, and around medical equipment such as tubes, masks or drains.

The diagrams below show the areas of the body at risk of pressure injury when lying and sitting.



People at increased risk

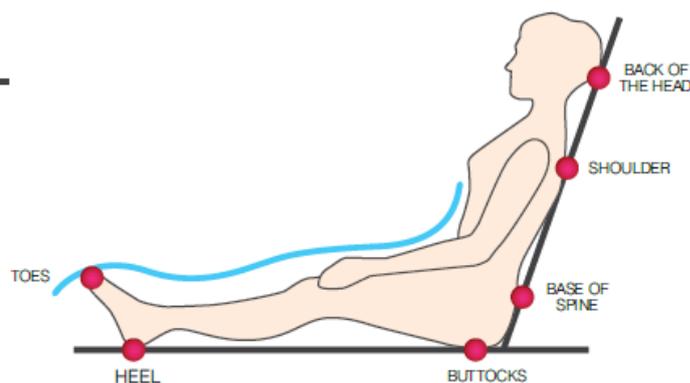
You have an increased risk of developing a pressure injury if you are:

- Elderly or very young
- Immobile or having an operation
- Underweight, eating poorly or have experienced recent weight loss
- Overweight
- Incontinent

Signs of a pressure injury

Check your skin and look for the warning signs:

- Redness/skin discoloration
- Tenderness, pain, or itching in affected areas
- Blistering
- Broken Skin



Reducing the risk of pressure injury

Patients, family, care givers and staff can all help to reduce the risk of a pressure injury.

- Staff will assess your level of risk of developing a pressure injury.
- If you are able to move yourself, involve your carers by asking them to remind you to change your position regularly. If you are unable to move yourself, staff will help you change your position frequently.
- Let staff know if your clothes or bedding are damp. Ask for help if you have a weak bladder or bowel.
- Let staff know if you are experiencing any warning signs (check over page).
- Drink fluids regularly, unless you are on a fluid restriction. You may be offered nutritional supplements if you are underweight, have recently lost weight, or have been eating poorly.
- Keep your skin clean and dry, use a 'skin-friendly' cleanser and moisturiser if appropriate.
- Be aware of the risk of a pressure injury under plasters, splints or braces, and around tubes, masks or drains.
- Specialised pressure-relieving equipment such as cushions and mattresses are available in hospital.

Managing a pressure injury

If you get a pressure injury:

- Staff will discuss how best to manage your pressure injury with you and your care giver. This may be called a 'care plan'.
- Use the prescribed equipment recommended at all times.
- Move frequently (where possible) to relieve pressure.

Heading home

When you go home from hospital with a pressure injury:

- Continue the care plan at home.
- Staff will organise ongoing care, which may include your GP or community nurse.
- Staff will advise you on how to obtain specialised equipment.



About the Pressure Injury Prevention Project

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Acknowledgements

Australian Wound Management Association.

Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure Injury.

Cambridge Media, Osborne Park, WA.

Pressure Injury Prevention: Information for Patients and Families
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PRESSURE INJURY
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PRESSURE INJURY POINT PREVALENCE SURVEY

INFORMATION FOR STAFF

The survey will be conducted on ____/____/____

Your survey team members are:

The purpose of the survey is:

- To identify pressure injury prevention care that has been planned and documented for the patient, to evaluate care and support quality improvement
- To visually identify any pressure injury prevention equipment in use with the patient, to relate this to clinical and risk status
- To visually identify and describe any skin lesion due to pressure injury that the patient currently has and whether or not its origin has developed in this hospital during this admission, or prior.



Occupational therapist checking the heel of a patient for signs of a pressure injury

This data demonstrates how well current prevention procedures are working, to inform future service and practice development and benchmark with other institutions.

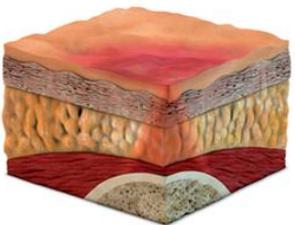
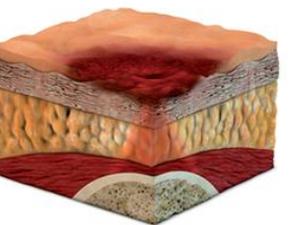
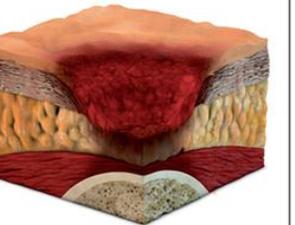
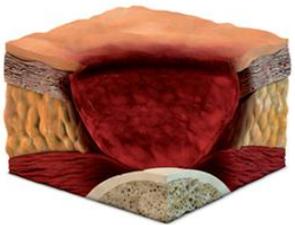
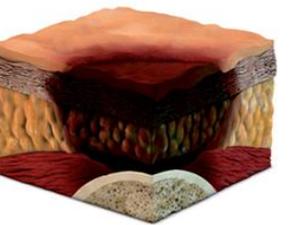


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Pressure injury classification system

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 Gittos, Gear Interactive, http://www.gearinteractive.com.au Photos stage, 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>					

MONITORING OF PRESSURE INJURY INCIDENCE

REGULAR MONITORING – GUIDANCE

Regular monitoring of recorded pressure incidence aims to:

- Identify the frequency of occurrence of pressure injury in the organisation to support organisational accreditation requirements ^{5, 13}
- Provide trends in pressure injury incidence to inform strategic planning on service quality improvement and benchmarking, differentiating pre-existing pressure injuries from those acquired within the organisation and detailing severity and anatomical location.

Pressure injury incidence is recommended for use as a local monitoring method, rather than prevalence, because incidence i.e., occurrence of new cases more closely reflects local care processes and data demonstrating incidence is more easily and routinely accessible.

It is recommended that organisations measure pressure injury incidence per month (numbers of patients that develop pressure injury, during their admission, during each calendar month) per 1,000 occupied bed days (OBD) as an outcome measure. Data should be reviewed at least annually at organisational level, monthly by clinical units.

There are different ways to collect the data required to calculate this measure.

INCIDENCE MONITORING PROCEDURE

Data on incidence of pressure injuries can be accessed from two different sources:

- Health Information Exchange (HIE) data ('case mix' or 'coder' data) and
- Incident management system data (such as NSW Health Incident Information Management System (IIMS) or Risk Man).

Each has a different profile of advantages and disadvantages.

HIE data is available retrospectively as it is coded and entered after the patient has been discharged. Records are not usually complete until at least one month later, so there is a reporting delay. This data is coded using ICD-10, which only includes pressure injury stages 1-4, plus 'unspecified'.

Data quality is dependent upon:

1. Clear documentation of pressure injury within the patient health care record, with any pressure injury being correctly reported as 'pressure injury' within the documents scanned by coders
2. Correct coder recognition of recorded pressure injury.

Hence, training for staff in how and where to record pressure injury, and of coders for how and where to identify this documentation, is essential.

Data on occupied bed days can only be retrieved from HIE data.

Incident information system data can be accessed concurrently, is usually available within 24hrs of recording, so can be accessed at the end of each month for injuries occurring/recorded within that month. Data quality is dependent upon staff reporting each pressure injury. Despite such reportage being mandated, it is commonly incomplete, particularly for Stage 1 and 2 injuries. Data quality is also influenced by the reporting systems. Currently, IIMS is only able to record pressure injury Stages 1-4, and completion of the variable to identify origin of injury is not mandatory. Training, prompts and reminders for clinical staff are essential.

It is essential to agree which source of data to use and to be consistent.

Calculation procedure

Numerator Definition	Number of pressure injuries developed in the organisation within the specified timeframe
Denominator Definition	Total number of overnight occupied bed days within the specified timeframe
Measurement Period Length	Usually per calendar month, calculated monthly
Calculate rate as	$(\text{numerator}/\text{denominator}) \times 1,000$

For specific purposes, this calculation may be conducted using as the denominator patient separations within the specified timeframe.

NOTE: Automated reports may be available either locally or, in the future, through NSW Health resources, to access HIE data in report/graphical forms to facilitate identification of trends.

This data is currently available as six-monthly reports to members of the nursing group of the Health Round Table, a multi-national health care quality improvement organisation.

BEST-PRACTICE CLINICAL AUDIT

AIMS

The aims of best-practice clinical audit are to:

- Identify the degree to which core pressure injury prevention practices adhere to current best practice, evidence-based guidelines and accreditation criteria ^{5, 7, 8, 13}
- Provide data to inform strategic planning on service quality improvement. Demonstrate trends in care processes to track progress with quality initiatives.

AUDIT METHODS

Evidence-based pressure injury prevention practice is set out in internationally-agreed guidelines ^{4, 7} and reflected in national standards set for accreditation of hospitals ^{5, 13}. Each organisation should use these documents, in conjunction with a range of evidence-of-care quality, to set local priorities for quality improvement, supported by a program of regular auditing. A data set of core elements is contained within the Pressure Injury Point Prevalence Survey Documentation Audit Tool (see page 15), with guidance for data collection set out at pages 25 and 26. Organisations may wish to focus on specific elements or add to this to support specific quality improvement initiatives.

Each organisation should establish a regular auditing program and governance procedures for its implementation and reportage, in line with clinical governance procedures of the organisation, LHD and NSW Health accountability frameworks.

The Pressure Injury Point Prevalence Survey Documentation Audit Tool contains elements to demonstrate aspects of pressure injury prevention care. Items are relevant to support demonstration of compliance with Standard Eight for national accreditation ^{5, 13}.

Procedures for establishing and conducting quality audits are set out in the sections on Pressure Injury Point Prevalence Survey Preparation and Completing the Pressure Injury Documentation Audit Tool. These should be applied to meet the contexts of individual organisations in delivery of Best Practice Clinical Pressure Injury Prevention clinical audits.

ACKNOWLEDGEMENT

The audit tools and guidance set out in this document were developed in line with recommendations from:

- Australian Wound Management Association, New Zealand Wound Care Society, Hong Kong Enterostomal Therapist's Association and Wound Healing Society of Singapore (2012) ⁷
- National Pressure Ulcer Advisory Panel (NPUAP) and European Pressure Ulcer Advisory Panel: EPUAP (2009) ⁴
- NSW Health and Clinical Excellence Commission (2014) ⁸

and from tools published by:

- The National Pressure Ulcer Advisory Panel (2001) ¹⁴
- Prentice (2007) ¹⁰
- Strachan (2006) ¹¹
- Vanderwee et al (2006) ¹²

APPENDIX 1

EXAMPLES OF PRESSURE INJURY SURVEY STAFF TEAMS

Tertiary Facility

Team A

Clinical unit nurse

Clinical support officer

Clinical nurse consultant (any specialty)

Team B

Clinical unit nurse

Allied Health staff member

Nursing unit manager (another ward)

Team C

Clinical unit nurse

Quality manager

Wound resource nurse

Team D

Clinical unit nurse

Clinical nurse educator

Student nurse

Rural Area

Team E

Clinical unit nurse

WH&S co-ordinator

Community nurse

Team F

Nurse manager

Infection control nurse

Quality manager

Team G

Clinical unit nurse

Patient safety officer

Team H

Clinical unit nurse

Ward clerk

Continence advisor

Team I

Clinical unit nurse

Executive sponsor

Physiotherapist/dietician/
occupational therapist

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