



Standard 8

Preventing and Managing Pressure Injuries

Safety and Quality Improvement Guide



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Table of Contents

The National Safety and Quality Health Service Standards	2
Terms and definitions	5
Standard 8: Preventing and Managing Pressure Injuries	6
Criterion: Governance and systems for the prevention and management of pressure injuries	8
Criterion: Preventing pressure injuries	16
Criterion: Managing pressure injuries	24
Criterion: Communicating with patients and carers	28
References	30
Appendix: Links to resources	31





Standard 8: Preventing and Managing Pressure Injuries

The National Safety and Quality Health Service Standards

The *National Safety and Quality Health Service (NSQHS) Standards*¹ were developed by the Australian Commission on Safety and Quality in Health Care (the Commission) in consultation and collaboration with jurisdictions, technical experts and a wide range of other organisations and individuals, including health professionals and patients.

The primary aims of the *NSQHS Standards* are to protect the public from harm and to improve the quality of care provided by health service organisations. These Standards provide:

- a **quality assurance** mechanism that tests whether relevant systems are in place to ensure minimum standards of safety and quality are met
- a **quality improvement** mechanism that allows health service organisations to realise developmental goals.

Safety and Quality Improvement Guides

The Commission has developed Safety and Quality Improvement Guides (the Guides) for each of the 10 *NSQHS Standards*. These Guides are designed to assist health service organisations to align their quality improvement programs using the framework of the *NSQHS Standards*.

The Guides are primarily intended for use by people who are responsible for a part or whole of a health service organisation. The structure of the Guides includes:

- introductory information about what is required to achieve each criterion of the Standard
- tables describing each action required and listing:
 - key tasks
 - implementation strategies
 - examples of the outputs of improvement processes
- additional supporting resources (with links to Australian and international resources and tools, where relevant).

Direct links to these and other useful resources are available on the Commission's web site:

www.safetyandquality.gov.au

The Guides present **suggestions** for meeting the criteria of the Standards, which should not be interpreted as being mandatory. The examples of suggested strategies and outputs of improvement processes are **examples only**. In other words, health service organisations can choose improvement actions that are specific to their local context in order to achieve the criteria. The extent to which improvement is required in your organisation will heavily influence the actions, processes and projects you undertake.

You may choose to demonstrate how you meet the criteria in the Standards using the example outputs of improvement processes, or alternative examples that are more relevant to your own quality improvement processes.

Additional resources

The Commission has developed a range of resources to assist health service organisations to implement the *NSQHS Standards*. These include:

- a list of available resources for each of the *NSQHS Standards*
- an *Accreditation Workbook for Hospitals* and an *Accreditation Workbook for Day Procedure Services*
- *A Guide for Dental Practices* (relevant only to Standards 1–6)
- a series of fact sheets on the *NSQHS Standards*
- frequently asked questions
- a list of approved accrediting agencies
- slide presentations on the *NSQHS Standards*.



Overarching NSQHS Standards

Standard 1: Governance for Safety and Quality in Health Service Organisations, and *Standard 2: Partnering with Consumers* set the overarching requirements for the effective application of the other eight *NSQHS Standards* which address specific clinical areas of patient care.

Standard 1 outlines the broad criteria to achieve the creation of an integrated governance system to maintain and improve the reliability and quality of patient care, and improve patient outcomes.

Standard 2 requires leaders of a health service organisation to implement systems to support partnering with patients, carers and other consumers to improve the safety and quality of care. Patients, carers, consumers, clinicians and other members of the workforce should use the systems for partnering with consumers.

Core and developmental actions

The *NSQHS Standards* apply to a wide variety of health service organisations. Due to the variable size, structure and complexity of health service delivery models, a degree of flexibility is required in the application of the standards.

To achieve this flexibility, each action within a Standard is designated as either:

CORE

- considered fundamental to safe practice

OR

DEVELOPMENTAL

- areas where health service organisations can focus activities or investments that improve patient safety and quality.

Information about which actions have been designated as core or developmental is available on the Commission's web site.

Quality improvement approaches in health care

Approaches to improving healthcare quality and safety are well documented and firmly established. Examples of common approaches include Clinical Practice Improvement or Continuous Quality Improvement. The Guides are designed for use in the context of an overall organisational approach to quality improvement, but are not aligned to any particular approach.

Further information on adopting an appropriate quality improvement methodology can be found in the

[NSW Health Easy Guide to Clinical Practice Improvement](#)²

[CEC Enhancing Project Spread and Sustainability](#)³

[Institute for Healthcare Improvement \(US\)](#)⁴



The National Safety and Quality Health Service Standards (continued)

Roles for safety and quality in health care

A range of participants are involved in ensuring the safe and effective delivery of healthcare services. These include the following:

- **Patients and carers**, in partnership with health service organisations and their healthcare providers, are involved in:
 - making decisions for service planning
 - developing models of care
 - measuring service and evaluating systems of care.

They should participate in making decisions about their own health care. They need to know and exercise their healthcare rights, be engaged in their healthcare, and participate in treatment decisions.

- Patients and carers need to have access to information about options and agreed treatment plans. Health care can be improved when patients and carers share (with their healthcare provider) issues that may have an impact on their ability to comply with treatment plans.
- The role of **clinicians** is essential. Improvements to the system can be achieved when clinicians actively participate in organisational processes, safety systems, and improvement initiatives. Clinicians should be trained in the roles and services for which they are accountable. Clinicians make health systems safer and more effective if they:
 - have a broad understanding of their responsibility for safety and quality in healthcare
 - follow safety and quality procedures
 - supervise and educate other members of the workforce
 - participate in the review of performance procedures individually, or as part of a team.

When clinicians form partnerships with patients and carers, not only can a patient's experience of care be improved, but the design and planning of organisational processes, safety systems, quality initiatives and training can also be more effective.

- The role of the **non-clinical workforce** is important to the delivery of quality health care. This group may include administrative, clerical, cleaning, catering and other critical clinical support staff or volunteers. By actively participating in organisational processes – including the development and implementation of safety systems, improvement initiatives and related training – this group can help to identify and address the limitations of safety systems. A key role for the non-clinical workforce is to notify clinicians when they have concerns about a patient's condition.
- The role of **managers in health service organisations** is to implement and maintain systems, resources, education and training to ensure that clinicians deliver safe, effective and reliable health care. They should support the establishment of partnerships with patients and carers when designing, implementing and maintaining systems. Managing performance and facilitating compliance across the organisation is a key role. This includes oversight of individual areas with responsibility for the governance of safety and quality systems. Managers should be leaders who can model behaviours that optimise safe and high quality care. Safer systems can be achieved when managers in health service organisations consider safety and quality implications in their decision making processes.
- The role of **health service senior executives and owners** is to plan and review integrated governance systems that promote patient safety and quality, and to clearly articulate organisational and individual safety and quality roles and responsibilities throughout the organisation. Explicit support for the principles of consumer centred care is key to ensuring the establishment of effective partnerships between consumer, managers, and clinicians. As organisational leaders, health service executives and owners should model the behaviours that are necessary to implement safe and high quality healthcare systems.



Terms and definitions

At risk patients: Patients identified through a risk assessment scale and categorised as at 'high risk' for developing a pressure injury. Risk is measured by the consequences and likelihood of developing a pressure injury.

Audit: A systematic review of clinical care against a predetermined set of criteria.¹

Evidence based practice: Aims to apply the best available evidence gained from scientific methods to clinical decision making.¹

Flexible standardisation: Flexible standardisation recognises the importance of standardisation of processes to improve patient safety across a variety of contexts. The standardisation of any process and related data sets must be designed and integrated to fit the context of health service organisations, including varying patient and staffing profiles. These vary widely as health service organisations have differing functions, size, locations, structure and service delivery modes. Tools, processes and protocols should be based on best available evidence and the requirements of jurisdictions, external policy and legislation and adapted to the local context.

Governance: The set of relationships and responsibilities established by a health service organisation between its executive, workforce, and stakeholders (including consumers). Governance incorporates the set of processes, customs, policy directives, laws, and conventions affecting the way an organisation is directed, administered, or controlled. Governance arrangements provide the structure through which the objectives (clinical, social, fiscal, legal, human resources) of the organisation are set, and the means by which the objectives are to be achieved. They also specify the mechanisms for monitoring performance. Effective governance provides a clear statement of individual accountabilities within the organisation to help in aligning the roles, interests, and actions of different participants in the organisation in order to achieve the organisation's objectives. In these Standards, governance includes both corporate and clinical governance.

Outputs: The results of your safety and quality improvement actions and processes. Examples of outputs are provided in this guide. They are examples only and should not be read as being checklists of evidence required to demonstrate achievement of the criterion. Outputs will be specific to the actions, processes and projects undertaken in your context which will be influenced by your existing level of attainment against the criterion and extent to which improvement has been required.

Pressure injury: A localised injury to the skin and/or underlying tissue, usually located over a bony prominence. As a result of pressure, shear and/or friction or a combination of these factors damage occurs to the skin, muscle and/or bone.⁵

Pressure injury classification system: A validated classification system that identifies the level of injury. For example the international pressure ulcer classification system categorises the severity of pressure injuries from grade I to grade IV.⁶

Risk assessment scale: A formal scale or score using a structured approach to assessment which helps to determine the degree of pressure injury risk to a patient.⁵

Risk factor: Any factor which exposes the skin to excessive pressure or which diminishes the skin's tolerance to pressure.⁵

Screening: A process of identifying patients who are at risk or already have a pressure injury. Screening requires sufficient knowledge to make a clinical judgment.⁵

Skin assessment: General examination of the skin.⁵



Standard 8: Preventing and Managing Pressure Injuries

Clinical leaders and senior managers of the health service organisation implement evidence-based systems to prevent pressure injuries and manage them when they do occur. Clinicians and other members of the workforce use the pressure injury prevention and management systems.

The intention of this Standard is to:

Prevent patients from developing pressure injuries and effectively manage pressure injuries when they do occur.

Context:

It is expected that this Standard will be applied in conjunction with *Standard 1: Governance for Safety and Quality in Health Service Organisations* and *Standard 2: Partnering with Consumers*.

Introduction

Immobility, such as that associated with extended bed rest in hospital, can cause pressure injuries. Pressure injuries are a major contributor to the care needs of patients within the health industry.⁷⁻⁸ In the majority of cases, pressure injuries are preventable. Pressure injuries can occur in any patient with any or all of the associated risk factors. Risk factors are not restricted to decreased mobility, but also include factors such as nutritional status, skin integrity, age and the level of oxygenated blood supply to pressure points. A pressure injury can commence in any setting, including acute areas such as operating theatres and intensive care units, and in children or adults of any age.

Strategies to prevent pressure injuries have been identified and multiple evidence-based resources are available. Management of established pressure injuries has advanced with the increasing specialisation in wound management, research and technology.

This guide uses the *Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure Injury*⁵ as a primary resource. This resource includes comprehensive summaries of evidence, practice points and recommendations relevant to pressure injury prevention and management in both adults and children. It is available for download from:

<http://www.awma.com.au/publications/publications.php>

Further reading and resources are provided in the Appendix to this guide.

Implementing systems to prevent and manage pressure injuries

Standard 8 requires health service organisations to implement evidence-based systems to prevent pressure injuries and to manage them when they do occur. Systems need to be implemented to ensure clinicians and other members of the workforce use the appropriate pressure injury prevention and management strategies. This involves the development of an organisation-wide approach where the use of standardised risk assessment tools is embedded into usual practice. When pressure injuries are identified, the appropriate resources are required to ensure that they are managed according to best practice guidelines. Robust audit and data collection systems should be developed to evaluate the effectiveness of current strategies and identify areas where improvements can be made.



Criteria to achieve the Preventing and Managing Pressure Injuries Standard:

Governance and systems for the prevention and management of pressure injuries

Health service organisations have governance structures and systems in place for the prevention and management of pressure injuries.

Preventing pressure injuries

Patients are screened on presentation and pressure injury prevention strategies are implemented when clinically indicated.

Managing pressure injuries

Patients who have pressure injuries are managed according to best practice guidelines.

Communicating with patients and carers

Patients and carers are informed of the risks, prevention strategies and management of pressure injuries.

For the purposes of accreditation, please check the Commission's web site regarding actions within these criteria that have been designated as core or developmental.



Standard 8

Criterion: Governance and systems for the prevention and management of pressure injuries

Health service organisations have governance structures and systems in place for the prevention and management of pressure injuries

This criterion requires clinical leaders and senior executives of the health service organisation to implement evidence-based systems to prevent pressure injuries and to manage them when they do occur. These systems should also ensure that community acquired pressure injuries are identified when patients are admitted, and appropriate management plans are put in place. Including systems for the prevention and management of pressure injuries in clinical governance frameworks allows a coordinated and systematic approach to evaluation, education, resourcing, policy development and system improvements. Each healthcare facility in Australia is responsible for ensuring that their systems for preventing and managing pressure injuries are operational and effective.

Systems should be developed with consideration of local circumstances and the individual risks, roles and resources of each facility and each clinical area within a facility. Evaluation systems should ensure that high risk clinical areas are identified. While standardisation is desirable, systems must be flexible enough to meet the diverse needs of different patient populations within the healthcare organisation. Different tools and resources may be required to achieve appropriate risk assessment, screening and management of pressure injuries in different populations. For example, geriatric rehabilitation or intensive care units will be likely to have very different requirements from paediatric day surgery units. Governance frameworks should be designed to ensure that there are effective communication pathways in place that allow individual clinical areas to contribute to system design.

Actions required	Implementation strategies
8.1 Developing and implementing policies, procedures and/or protocols that are based on current best practice guidelines	
<p>8.1.1 Policies, procedures and/or protocols are in use that are consistent with best practice guidelines and incorporate screening and assessment tools</p>	<p>Key task:</p> <ul style="list-style-type: none"> • Develop or review polices, procedures and/or protocols and ensure they are consistent with national evidence-based guidelines for the prevention and management of pressure injuries <p>Suggested strategies:</p> <p>You are required to adapt or develop policies, procedures and protocols that describe the:</p> <ul style="list-style-type: none"> • roles, responsibilities and accountabilities of individuals, groups and committees who manage, monitor and report on pressure injuries • processes for screening and assessment of patients at risk of pressure injury • identification and reduction of pressure injury risks • management of pressure injuries and factors related to their risk, including prevention or delay of complications • mechanisms available to optimise management and maximise quality of life for patients with pressure injuries • information provided to patients and carers • processes, format, frequency and forums for reviewing reported data • orientation, training and education requirements for the workforce • use and maintenance of pressure injury prevention and management equipment and devices. <p>Processes that focus on prevention of hospital acquired pressure injuries will require engagement from all levels of the organisation.⁵ Understanding how the organisation performs in the prevention of pressure injuries will require local data collection, review and analysis as well as the ability to identify trends and benchmark between services.²</p> <p>Screening and assessment processes may be separate or combined. A screening tool will involve a preliminary assessment of the factors that increase the risk of developing a pressure injury (see Action 8.5.1).</p> <p>There is evidence to support the use of a risk based assessment in combination with professional clinical judgement. A variety of risk assessment scales are available.^{5,9,10} Health services should select the most applicable scale(s) for their patient population and ensure they are applied consistently across the organisation.</p> <p>Outputs of improvement processes may include:</p> <ul style="list-style-type: none"> • policies, procedures and protocols that are evidence based, consistent with best practice guidelines and incorporate screening and risk assessment tools • reports from audits, prevalence surveys and incident reporting that inform the organisation’s prevention and management policies, protocols and procedures.



Actions required	Implementation strategies
8.1 Developing and implementing policies, procedures and/or protocols that are based on current best practice guidelines (continued)	
8.1.2 The use of policies, procedures and/or protocols is regularly monitored	<p>Key tasks:</p> <ul style="list-style-type: none">• Identify an individual or a governance group that is responsible for monitoring compliance with the organisation's pressure injury policies, procedures and protocols• Develop and apply mechanisms for collecting data on compliance with policies and rates of pressure injuries <p>Suggested strategies:</p> <p>You should monitor the use of policies, procedures and protocols. You should review compliance data so that areas for improvement can be identified. Where necessary, you should use this information to modify policies, procedures and protocols to ensure they are clinically relevant, easily understood and optimise opportunities for consistent best practice.</p> <p>It is important that clinicians retain the ability to use their clinical judgement to set a treatment plan. However, where a clinician specifies treatment that is contrary to policy, this should be clearly documented.</p> <p>Audit of patient clinical records should be designed to identify when policies, procedures and protocols are being used, as well as situations where the policy is not applicable.</p> <p>The frequency of regular audit should be determined by considering the risk profile of the patient population in your organisation. If incidents of healthcare-acquired pressure injuries are increasing or unacceptably high, additional, targeted, audits may be necessary to evaluate the effectiveness of quality improvement actions that are taken.</p> <p>Outputs of improvement processes may include:</p> <ul style="list-style-type: none">• agendas, minutes and/or reports of relevant committees and meetings related to pressure injury prevention and control processes• reviews of patient clinical records and case notes against policies, procedures and protocols• audit of clinical practice to identify variance from best practice and assess the effectiveness of the tools and procedures that are used to identify individuals at risk of developing pressure injuries.

Actions required	Implementation strategies
8.2 Using a risk assessment framework and reporting systems to identify, investigate and take action to reduce the frequency and severity of pressure injuries	
<p>8.2.1 An organisation-wide system for reporting pressure injuries is in use</p>	<p>Key task:</p> <ul style="list-style-type: none"> • Implement a reporting system that is accessible and efficient for the workforce to use <p>Suggested strategies:</p> <p>You are required to have a standardised, organisation-wide framework for the mandatory reporting of pressure injuries. The incident reporting system should include capacity to report pressure injuries and collect sufficient data to allow the assessment of the relevant contributing factors.^{5,11,12} Root cause analysis of a sample of reported cases may be a useful strategy to identify systems issues that have contributed to the development of pressure injuries.</p> <p>Surveys, education and training sessions and focus group interviews can provide information about the awareness and perceptions of the workforce on the prevention and management of pressure injuries. These may assist in identifying barriers to reporting pressure injuries.</p> <p>Outputs of improvement processes may include:</p> <ul style="list-style-type: none"> • incident reporting forms and processes included in policies, procedures and protocols • reports on audit and incident data about the prevalence and incidence of pressure injury within the organisation • educational resources and workforce attendance records and/or results of competency based training on pressure injury reporting systems • agendas, minutes and/or reports of relevant committees and meetings that include data reports on the incidence and prevalence of pressure injuries.
<p>8.2.2 Administrative and clinical data are used to regularly monitor and investigate the frequency and severity of pressure injuries</p>	<p>Key tasks:</p> <ul style="list-style-type: none"> • Develop or adapt a comprehensive system to collect data on the incidence and severity of pressure injuries • Use data about the incidence and severity of pressure injuries to monitor the overall effectiveness of your systems for prevention and management of pressure injuries <p>Suggested strategies:</p> <p>Routine data collection and analysis should be focussed on identifying the number, location and severity of pressure injuries. Effective data systems will also distinguish between patients who are admitted with a pressure injury already present, and those who develop a pressure injury during care. This will allow targeted risk mitigation strategies to be developed.</p> <p>Regular trend reporting on pressure injuries at senior levels of the organisation will enable the implementation of improvement strategies to reduce the incidence and severity of pressure injuries.</p> <p>Outputs of improvement processes may include:</p> <ul style="list-style-type: none"> • documented processes to extract data on pressure injuries from clinical and administrative data systems, including the incident reporting system • documentation of trends in pressure injury incidence, prevalence and severity.



Actions required	Implementation strategies
8.2 Using a risk assessment framework and reporting systems to identify, investigate and take action to reduce the frequency and severity of pressure injuries (continued)	
8.2.3 Information on pressure injuries is regularly reported to the highest level of governance in the health service organisation	<p>Key tasks:</p> <ul style="list-style-type: none">• Develop or confirm a structure for reporting pressure injury data, including the identification of performance measures and the format and frequency of reporting• Nominate a sponsor from the senior governance group to take responsibility for presenting data on the performance of pressure injury prevention and management systems to the governing body <p>Suggested strategies:</p> <p>For organisation-wide improvements to be successful, information needs to be provided to the workforce at all levels of the organisation. This allows both local and system-wide actions to be implemented to reduce the incidence and severity of harm from pressure injuries. For the senior governance group, decisions about workforce, training and resource allocation are all within their remit.</p> <p>Reporting information on trends in pressure injuries and the impact on the health service will allow the senior governance group to make informed decisions about required action.</p> <p>Outputs of improvement processes may include:</p> <ul style="list-style-type: none">• reports on routine performance measures for pressure injuries, including frequency, severity and rates of injuries acquired within the facility versus those acquired prior to admission• agendas and minutes from governance meetings that include routine reporting of information about pressure injuries in your organisation• reports detailing actions taken by governance groups to improve performance of the pressure injury prevention and management system.

Actions required	Implementation strategies
8.2 Using a risk assessment framework and reporting systems to identify, investigate and take action to reduce the frequency and severity of pressure injuries (continued)	
<p>8.2.4 Action is taken to reduce the frequency and severity of pressure injuries</p>	<p>Key task:</p> <ul style="list-style-type: none"> • Use administrative and clinical data to recommend and prioritise quality improvement activities <p>Suggested strategies:</p> <p>You should use data to identify risks, plan improvement strategies, and address gaps and inconsistencies in your systems for the prevention and management of pressure injuries. This may involve specific action at unit or service level as well as organisation-wide changes such as improving policy or modifying training resources.</p> <p>Actions may include:</p> <ul style="list-style-type: none"> • working with clinicians to analyse data and develop local solutions to identified issues • resolving systems issues that may be identified (for example, timely access to necessary equipment) • making amendments to policy, procedures and/or protocols • providing additional education and training for clinicians • improving or developing communication material and information resources for clinicians, patients and carers • using an accepted practice improvement method to act on data showing areas for improvement. This may include taking a multidisciplinary approach and the use of Plan, Do, Study, Act cycles. <p>Outputs of improvement processes may include:</p> <ul style="list-style-type: none"> • relevant reports on analysis of pressure injury information • risk register or log that includes actions to address identified risks • quality improvement plan that includes actions to address issues identified • examples of system-wide quality improvement activities that have been implemented • examples of improvement activities that have been adapted and adopted at the local level to reduce the frequency and severity of pressure injuries in high risk areas • educational resources and records of workforce attendance at training on pressure injury prevention and management • communication material, including brochures, factsheets and posters developed for the workforce and patients and carers.



Actions required

Implementation strategies

8.3 Undertaking quality improvement activities to address safety risks and monitor the systems that prevent and manage pressure injuries

8.3.1 Quality improvement activities are undertaken to prevent pressure injuries and/or improve the management of pressure injuries

Key task:

- **Implement and evaluate quality improvement strategies to reduce the frequency and harm from pressure injuries**

Suggested strategies:

You should use a standardised quality improvement methodology to bring about change. For example, as part of the process of quality improvement you should evaluate the impact of actions that are taken. This may require information gathering in addition to routine data collection. For example, to identify if there is timely access to necessary equipment, audit of the time from risk assessment to intervention might be conducted.

Outputs of improvement processes may include:

- reports on the evaluation of data collected pre and post the implementation of improvement activities
- risk register or log that includes actions to address identified risks
- quality improvement plan that includes actions to address issues identified
- examples of improvement activities that have been implemented and evaluated
- feedback provided to the workforce on the results of audit and actions to address issues identified
- agendas, minutes and/or reports of relevant committees and meetings that detail improvement actions taken
- orientation, training and education resources that incorporate data from evaluation reports
- workforce attendance records and/or results of competency based training
- orientation processes and resources for casual, agency and locum clinicians
- communication material developed for the workforce and patients and carers on improvement activities and outcomes.

Actions required	Implementation strategies
8.4 Providing or facilitating access to equipment and devices to implement effective prevention strategies and best practice management plans	
<p>8.4.1 Equipment and devices are available to effectively implement prevention strategies for patients at risk and plans for the management of patients with pressure injuries</p>	<p>Key task:</p> <ul style="list-style-type: none"> • Facilitate access to equipment and devices for the prevention and management of pressure injuries <p>Suggested strategies:</p> <p>You should ensure easy access to equipment and devices that can prevent pressure injuries or reduce harm when injuries have already been sustained.</p> <p>Examples of actions that can be considered to facilitate access to equipment and devices include:</p> <ul style="list-style-type: none"> • evaluate equipment and device requirements, usage and effectiveness • determine the type and number of support devices your organisation may require and options for accessing the equipment • schedule routine maintenance and coordinate ad hoc repair to maximise the availability of equipment. <p>Outputs of improvement processes may include:</p> <ul style="list-style-type: none"> • register of equipment and devices • procedures, protocols and guidelines for the use of and access to equipment • register of workforce training in the use of equipment and devices • equipment utilisation reports • clinical audit of equipment use • register of equipment maintenance and safety checks.



Standard 8

Criterion: Preventing pressure injuries

Patients are screened on presentation and pressure injury prevention strategies are implemented when clinically indicated

Using a standard screening tool or process to identify patients who are at risk of pressure injury enables you to implement appropriate prevention strategies.⁵ A number of screening tools are available for different patient populations, including adults and children, for example, the Braden Scale, Norton Scale and Waterlow Score.^{5,9-10}

When patients are identified as being at risk for pressure injuries, a comprehensive skin inspection should be undertaken within 8 hours, and repeated regularly throughout the patient's admission.⁵ This helps to identify risk factors specific to individual patients. Targeting individual risk factors reduces the rate of pressure injuries because patient specific care plans can be put in place. Comprehensive skin inspection also ensures that existing pressure injuries are identified so that management plans can be put in place.

Evidence-based screening and skin inspection tools, policies, procedures and protocols should be easily accessible for use by the workforce. Evaluation should include audit of compliance with screening tools processes, documentation of skin inspections and pressure injury prevention plans.

Actions required	Implementation strategies
<p>8.5 Identifying risk factors for pressure injuries using an agreed screening tool for all presenting patients within time frames set by best practice guidelines</p>	
<p>8.5.1 An agreed tool to screen for pressure injury risk is used by the clinical workforce to identify patients at risk of a pressure injury</p>	<p>Key task:</p> <ul style="list-style-type: none"> • Agree on the process and criteria for screening and inform the clinical workforce of these requirements <p>Suggested strategies:</p> <p>You are required to develop systematic processes for assessing pressure injury risks in collaboration with the clinical workforce.</p> <p>Agreed screening processes may or may not involve the use of a published risk assessment screening tool, but will include a preliminary assessment of the factors that lead to increased risk of pressure injury. These factors include:</p> <ul style="list-style-type: none"> • pressure on the tissue from impaired mobility, activity or sensation • tissue integrity that is adversely affected by environmental factors (such as shear or friction forces acting on the skin) or factors related to the individual (such as nutritional status, oxygen delivery, skin temperature, age and gender, the use of modifiable high-risk medicines such as non-steroidal anti-inflammatories, or the presence of chronic disease). <p>There is limited research addressing the validity of pressure injury screening tools, though there is evidence that they are more effective in identifying pressure injury risk than the use of clinical judgement alone.¹³ You should use tools such as the Braden Scale, the Waterlow Score or the Norton Scale as reliable methods of assessing pressure injury risk in adults.⁵ Specific risk assessment tools are available for use in particular patient populations such as maternity, paediatrics and those with spinal cord injuries.⁹</p> <p>The agreed screening process should include identification of risk factors and a decision about the need for comprehensive and ongoing skin inspection. You should document this in the patient clinical record.</p> <p>Outputs of improvement processes may include:</p> <ul style="list-style-type: none"> • policies, procedures and protocols on screening for pressure injury risk accessible to the clinical workforce • an agreed risk assessment screening tool is available for use by the workforce • audit of patient clinical records for documentation of screening • communication to the clinical workforce on the criteria and processes for pressure injury risk assessment screening.



Actions required	Implementation strategies
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8.5 Identifying risk factors for pressure injuries using an agreed screening tool for all presenting patients within time frames set by best practice guidelines (continued)

8.5.2 The use of the screening tool is monitored to identify the proportion of at-risk patients that are screened for pressure injuries on presentation

Key task:

- **Develop and apply mechanisms for collecting data about pressure injury screening activities**

Suggested strategies:

Monitoring systems should be designed to capture information regarding the number of patients assessed and identified as being at risk of pressure injuries, and the proportion of patients who are assessed for any pressure injuries that may already be present.

Monitoring and data collection systems should identify:

- the proportion of patients who are screened at admission for their risk of pressure injury
- the proportion of patients who are identified as at risk of pressure injury through the initial screening process
- the proportion of patients identified as being at risk through the initial screening process that are assessed for any pressure injuries that may already be present.

Outputs of improvement processes may include:

- evaluation, audit and feedback processes to determine use of the screening tool, compliance with screening requirements and completion of a skin assessment for patients who are identified as being at risk
- information from incident monitoring where it captures data on screening of pressure injury risks.

8.5.3 Action is taken to maximise the proportion of patients who are screened for pressure injury on presentation

Key task:

- **Use audit and other data to identify gaps in systems for screening patients for pressure injury**

Suggested strategies:

You should use audit data and other information to develop improvement strategies in collaboration with the clinical workforce.

Actions should include:

- resolving systems issues that may be identified (for example, making changes to workflow to encourage completion of comprehensive risk assessments when they are required)
- making amendments to policy, procedures and/or protocols
- providing additional education and training for clinicians
- improving or developing communication material and information resources for clinicians, patients and carers (for example developing flow charts to illustrate the actions required when a patient is identified as being at risk of pressure injury).

Outputs of improvement processes may include:

- feedback provided to the workforce on the results of audit and actions to address issues identified
- agendas, minutes and/or reports of relevant committees and meetings that detail improvement actions taken
- orientation, training and education resources that incorporate data from evaluation reports
- examples of improvement activities that have been implemented and evaluated
- workforce attendance records and/or results of competency-based training.

Actions required	Implementation strategies
<p>8.6 Conducting a comprehensive skin inspection in timeframes set by best practice guidelines on patients with a high risk of developing pressure injuries at presentation, regularly as clinically indicated during a patient’s admission, and before discharge</p>	
<p>8.6.1 Comprehensive skin inspections are undertaken and documented in the patient clinical record for patients at risk of pressure injuries</p>	<p>Key task:</p> <ul style="list-style-type: none"> • Develop or adapt a process and documentation template to prompt the clinical workforce to undertake and document comprehensive skin inspections as part of routine patient care <p>Suggested strategies:</p> <p>You should use a risk assessment tool which is acknowledged as best practice to identify patients at risk.¹⁴ Documentation of comprehensive skin assessments must be systematic so that aspects relating to the condition of the patient, any pressure injury that is found, and the plan of care are accurately recorded.^{15,16}</p> <p>Comprehensive skin assessment for patients screened as high risk for pressure injury should generally be incorporated into routine admission processes. In addition, risk screening re-assessment should be integrated into patients’ daily care plans, especially for those who are identified as at risk of developing a pressure injury or have an existing pressure injury.</p> <p>Outputs of improvement processes may include:</p> <ul style="list-style-type: none"> • policies, procedures and protocols include tools to guide comprehensive skin assessment and documentation of findings • evaluation, audit and feedback processes showing that patients at risk of pressure injuries are being assessed in line with specified protocols.
<p>8.6.2 Patient clinical records, transfer and discharge documentation are periodically audited to identify at-risk patients with documented skin assessments</p>	<p>Key task:</p> <ul style="list-style-type: none"> • Collect data on the use of assessment tools through audit of clinical records, transfer and discharge documentation <p>Suggested strategies:</p> <p>You are required to carry out a systematic review of patient clinical records to provide information on the frequency of documented skin assessments. Audit should also identify the proportion of documented skin assessments that comply with the assessment policies, procedures and protocols.</p> <p>Outputs of improvement processes may include:</p> <ul style="list-style-type: none"> • data from patient clinical records and case notes, transfer and discharge documents • reports or analysis of trends relating to pressure injuries • agendas, minutes and/or reports of relevant committees and meetings that include information relating to the evaluation and audit of patient clinical records • reports to the clinical workforce on the results of the audit, and actions to address issues identified.



Actions required	Implementation strategies
8.6 Conducting a comprehensive skin inspection in timeframes set by best practice guidelines on patients with a high risk of developing pressure injuries at presentation, regularly as clinically indicated during a patient’s admission, and before discharge (continued)	
8.6.3 Action is taken to increase the proportion of skin assessments documented on patients at risk of pressure injuries	Key task: <ul style="list-style-type: none">• Use audit and other data to identify gaps or deviations in compliance with assessment requirements Suggested strategies: <p>You are required to use audit data and other information to develop improvement strategies in collaboration with the clinical workforce.</p> <p>Actions may include:</p> <ul style="list-style-type: none">• resolving systems issues that have been identified (for example, making changes to workflow to encourage completion of skin assessments when they are required)• making amendments to policy, procedures and/or protocols• providing additional orientation, training and education for clinicians• improving or developing communication material and information resources for clinicians, patients, families and carers (for example developing or improving templates to guide the process and documentation of skin assessments). Outputs of improvement processes may include: <ul style="list-style-type: none">• examples of improvement activities that have been implemented and evaluated• feedback provided to the workforce on the results of audit and actions to address issues identified• agendas, minutes and/or reports of relevant committees and meetings that detail improvement actions taken• quality improvement plan that includes actions to address issues identified.

Actions required	Implementation strategies
8.7 Implementing and monitoring pressure injury prevention plans and reviewing when clinically indicated	
<p>8.7.1 Prevention plans for all patients at risk of a pressure injury are consistent with best practice guidelines and are documented in the patient clinical record</p>	<p>Key tasks:</p> <ul style="list-style-type: none"> • Develop a format for prevention plans to be used for high risk patients • Train relevant workforce on the use of prevention plans <p>Suggested strategies:</p> <p>You should use pressure injury prevention plans that are based on best practice guidelines as these can improve a patient’s outcome. When the details of a prevention plan are included in clinical handover information, they can facilitate continuity of care between health services providing care.</p> <p>Effective pressure injury prevention plans rely on comprehensive assessment using an agreed risk assessment scale, the identification of all potential risks, and the development of tailored prevention plans for at risk patients.^{5,12,15} Prevention plans are not static and you are required to review and repeat these whenever there is a change in the patient’s condition and on discharge.⁵</p> <p>You should implement a pressure injury prevention plan that includes, but is not limited to:</p> <ul style="list-style-type: none"> • implementing skin protection strategies • considering the nutritional needs of a patient • consideration of the need for constant low pressure redistribution support surfaces • regular re-positioning • appropriate input from allied health team members (for example, dieticians for nutritional advice and pharmacists for medicines review) • patient education. <p>Outputs of improvement processes may include:</p> <ul style="list-style-type: none"> • policies, procedures and protocols specifying the requirements for pressure injury prevention plans that are evidence based and consistent with national guidelines • templates for prevention plans • examples of patient clinical records with completed pressure injury prevention plans.



Actions required

Implementation strategies

8.7 Implementing and monitoring pressure injury prevention plans and reviewing when clinically indicated

(continued)

8.7.2 The effectiveness and appropriateness of pressure injury prevention plans are regularly reviewed

Key task:

- Use patient clinical record audit and other data to identify opportunities for improving pressure injury prevention plans

Suggested strategies:

Factors that can improve the effectiveness of pressure injury prevention plans include:

- a workforce that understands the need for, and the use of, pressure injury prevention plans
- documentation that is clear and concise
- an approach to prevention that is multidisciplinary
- a closed feedback loop between use of the plans and pressure injury incident rates.

An assessment of the efficacy of prevention plans is part of the ongoing monitoring of outcomes for patients identified as being at risk, and those that develop pressure injuries.⁵ When pressure injuries are reported, information should be gathered about what, if any, prevention plan was in place.

Outputs of improvement processes may include:

- data and reports from audit of patient clinical records for re-assessment and review of an individual's pressure injury prevention plan
- pressure injury management plans that describe consultation with relevant stakeholders and reflect a multidisciplinary approach to pressure injury care
- documented review of policies and procedures.

8.7.3 Patient clinical records are monitored to determine the proportion of at risk patients that have an implemented pressure injury prevention plan

Key task:

- Use patient clinical record audit and other data to identify gaps and opportunities for increasing the number of at risk patients who have pressure injury prevention plans implemented

Suggested strategies:

You should audit patient clinical records and case notes to determine the proportion of at risk patients who have a documented pressure injury prevention plan. It may be necessary to conduct bedside audits of practice to determine if at risk patients are being cared for in accordance with their individualised pressure injury prevention plans. You could link this with other bedside audit activities such as audit of pressure ulcer prevalence.

Outputs of improvement processes may include:

- audits of patient clinical records that identify patients with a current injury prevention plan
- reports on bedside audits undertaken to determine if documented pressure injury prevention plans have been effectively implemented
- feedback to the workforce on the results of audit, and actions to address issues identified.

Actions required	Implementation strategies
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8.7 Implementing and monitoring pressure injury prevention plans and reviewing when clinically indicated (continued)

8.7.4 Action is taken to increase the proportion of patients at risk of pressure injuries who have an implemented prevention plan

Key task:

- **Review data and information available on risk assessment, incidence and management of pressure injuries in your health service and implement strategies to improve the use of pressure injury prevention plans**

Suggested strategies:

To improve the proportion of patients at risk of pressure injuries who have prevention plans implemented, you are required to identify where in the system issues might be occurring. Clinical practice improvement activities can then be targeted at areas where the biggest improvements can be made, and re-evaluated to determine their effectiveness.

You should use evaluation, audit and feedback data and other information to develop improvement strategies in collaboration with the clinical workforce.

Actions may include:

- resolving systems issues that may be identified (for example, improving access to equipment and resources required to implement prevention plans)
- making amendments to policy, procedures and/or protocols
- providing additional education and training for clinicians
- improving or developing communication materials and information resources for clinicians, patients and carers (for example developing or improving templates to guide the process of developing and implementing a prevention plan).

Outputs of improvement processes may include:

- feedback provided to the workforce on the results of audit and actions to address issues identified
- agendas, minutes and/or reports of relevant committees and meetings that detail improvement actions taken
- orientation, training and education resources that incorporate data from evaluation reports
- examples of improvement activities that have been implemented and evaluated.



Standard 8

Criterion: Managing pressure injuries

Patients who have pressure injuries are managed according to best practice guidelines

Care of pressure injuries requires a multifaceted approach. Necessary interventions will vary depending on the individual patient, and the location and severity of the pressure injury. In some cases, input from a multidisciplinary team including wound care experts, nutritionists and pharmacists may be necessary. In others, minimal intervention may be required.

You should implement a comprehensive wound management system that can address assessment, treatment, monitoring and documentation of pressure injuries.⁵ Include pressure injury classification systems, wound healing and pain scales in your assessment policies, procedures and protocols. Ongoing pressure injury risk assessment and monitoring is required to ensure that management plans are effective.

Pressure injury management should be based on the best available evidence. Evaluation and audit should be focused on ensuring that clinical practice is consistent with the evidence-based policies, procedures and processes that are in place.

Actions required	Implementation strategies
8.8 Implementing best practice management and ongoing monitoring as clinically indicated	
<p>8.8.1 An evidence-based wound management system is in place within the health service organisation</p>	<p>Key task:</p> <ul style="list-style-type: none"> • Develop or adapt a wound management system and identify individual(s) or groups with responsibility for overseeing this system <p>Suggested strategies:</p> <p>You are required to implement a comprehensive wound management system which describes the protocols and processes for patient care once a patient’s pressure injury has been identified. It should address assessment, treatment, monitoring and documentation of pressure injuries. Relevant guidelines can be found at:⁵</p> <p>http://www.awma.com.au/publications/2012_AWMA_Pan_Pacific_Guidelines</p> <p>Assessment of pressure injuries should incorporate:</p> <ul style="list-style-type: none"> • the use of a validated pressure healing assessment scale • the use of a pressure injury classification system • assessment of pain using validated self-reporting tools such as verbal descriptor, visual analogue or numerical scales.¹⁷ <p>Treatment should address:⁵</p> <ul style="list-style-type: none"> • pain management • wound management • adjunctive treatment options such as electrotherapy or medical grade sheepskin. <p>Management should involve ongoing assessment of pressure injury risks, pressure injury healing assessments and documentation of all management plans, treatments and interventions provided.</p> <p>Outputs of improvement processes may include:</p> <ul style="list-style-type: none"> • policies, procedures and protocols that describe the wound management systems that are evidence-based and consistent with best practice guidelines • designated roles, responsibilities and accountabilities of the individual or group with oversight of the wound management system • orientation, education and training resources about managing pressure injuries.



Actions required	Implementation strategies
8.8 Implementing best practice management and ongoing monitoring as clinically indicated (continued)	
8.8.2 Management plans for patients with pressure injuries are consistent with best practice and documented in the patient clinical record	<p>Key task:</p> <ul style="list-style-type: none">• Develop a management plan format for patients with a pressure injury and train the clinical workforce in its use <p>Suggested strategies:</p> <p>Management plans for patients with pressure injuries should be consistent with clinical guidelines and address areas such as:</p> <ul style="list-style-type: none">• skin assessment and reassessment• positioning program• pressure redistribution devices• referrals to allied health and technical services, such as occupational therapy, podiatry, physiotherapy, dietetics• evaluation of patient outcomes to interventions• reduction of risk (for example, through improved nutrition, increased mobility and management of continence). <p>Outputs of improvement processes may include:</p> <ul style="list-style-type: none">• templates for pressure injury management plans• clinical guidelines for pressure injury management• audits of completed management plans in clinical records and case notes.
8.8.3 Patient clinical records are monitored to determine compliance with evidence-based pressure injury management plans	<p>Key task:</p> <ul style="list-style-type: none">• Review patient clinical records to assess compliance with pressure injury management plan requirements <p>Suggested strategies:</p> <p>Audit the records of patients who develop pressure injuries to identify if management plans are in place and clinical guidelines are being followed.</p> <p>Outputs of improvement processes may include:</p> <ul style="list-style-type: none">• audit of patient clinical records for pressure injury wound assessment and management plans that comply with policies, protocols and procedures.

Actions required	Implementation strategies
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8.8 Implementing best practice management and ongoing monitoring as clinically indicated
(continued)

8.8.4 Action is taken to increase compliance with evidence based pressure injury management plans

Key task:

- **Use information from patient clinical record reviews to identify strategies to improve the use and effectiveness of pressure injury management plans**

Suggested strategies:

To improve the proportion of patients who have pressure injury management plans implemented, you are required to evaluate where in the system issues might be occurring. You can then target clinical practice improvement activities at areas where the biggest improvements can be made, and re-evaluate to determine their effectiveness.

You should use evaluation, audit and feedback data and other information to develop improvement strategies in collaboration with the clinical workforce.

Actions may include:

- resolving systems issues that may be identified (for example, improving access to equipment and resources required to manage pressure injuries)
- making amendments to policy, procedures and/or protocols
- providing additional orientation, training and education for clinicians
- improving or developing communication materials and information resources for clinicians, patients and carers (for example developing or improving guidance materials for patients, families and carers on the importance of good nutrition). This may include online materials, brochures, factsheets and posters.

Outputs of improvement processes may include:

- feedback provided to the workforce on the results of audit and actions to address issues identified
- orientation, training and education resources that incorporate data from evaluation reports
- examples of improvement activities that have been implemented and evaluated
- workforce attendance records and/or results of competency based training.



Standard 8

Criterion: Communicating with patients and carers

Patients and carers are informed of the risks, prevention strategies and management of pressure injuries

Providing patients and carers with relevant and usable information about the risks, prevention and management of pressure injuries allows them to participate in care. Patients and carers should be involved in discussions and decisions about the prevention and management of pressure injuries. This is likely to increase the effectiveness of care plans as patients and carers can provide information about factors that are specific to the individual. It also allows patients and carers to participate in implementing pressure injury prevention plans, which may assist in reducing the incidence and severity of pressure injuries.

Actions required	Implementation strategies
8.9 Informing patients with a high risk of pressure injury, and their carers, about the risks, prevention strategies and management of pressure injuries	
<p>8.9.1 Patient information on prevention and management of pressure injuries is provided to patients and carers in a format that is understood and is meaningful</p>	<p>Key task:</p> <ul style="list-style-type: none"> • Provide information for patients and carers about the prevention and management of pressure injuries <p>Suggested strategies:</p> <p>Patients and carers can assist healthcare providers to prevent and manage pressure injuries. You should involve them in the prevention and management of pressure injuries as this may reduce the frequency and severity of pressure injuries. You should provide patients and carers with information that will assist them to understand and participate in the development of effective and appropriate strategies.</p> <p>Strategies to distribute information may include:</p> <ul style="list-style-type: none"> • brochures, fact sheets, posters and other printed and online material • providing opportunities for patients to discuss pressure injuries with clinicians on presentation for care and during care • broadcasting prevention and management messages about pressure injuries on patient television and audio services. <p>Outputs of improvement processes may include:</p> <ul style="list-style-type: none"> • materials used in patient and carer education such as brochures, fact sheets, posters, videos and trusted web sites • patient information that is available in a range of formats and languages • patient feedback on the usefulness of information.
8.10 Developing a plan of management in partnership with patients and carers	
<p>8.10.1 Pressure injury management plans are developed in partnership with patients and carers</p>	<p>Key task:</p> <ul style="list-style-type: none"> • Inform patients, family and carers about the purpose and process of developing a pressure injury management plan and invite them to be involved in its development <p>Suggested strategies:</p> <p>You should engage patients and carers in the development of management plans. This provides an opportunity to share information with the patients and carers. It also provides patients and carers with an opportunity to inform the workforce about factors that are specific to that patient and which may have an impact on the effectiveness of the management plan.</p> <p>Management plans should document the involvement of patients and carers.</p> <p>Outputs of improvement processes may include:</p> <ul style="list-style-type: none"> • pressure injury management plans that provide space for patient comment and signature, and evaluation of the rate of completion • evaluation and results of patient and carer experience surveys regarding pressure injury management.

References

1. Australian Commission on Safety and Quality in Health Care. *National Safety and Quality Health Service Standards*. Sydney. ACSQHC, 2011.
2. NSW Department of Health. *Easy Guide to Clinical Practice Improvement. A Guide for Health Professionals*. 2002. (Accessed at http://www.health.nsw.gov.au/resources/quality/pdf/cpi_easyguide.pdf)
3. Clinical Excellence Commission. *Enhancing Project Spread and Sustainability – A Companion to the ‘Easy Guide to Clinical Practice Improvement’*. Sydney. CEC, 2008.
4. How to Improve. Institute for Healthcare Improvement (US), 2012. (Accessed 3 September 2012, at www.ihl.org/knowledge/Pages/HowtoImprove/default.aspx)
5. Australian Wound Management Association. Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure Injury. Osborne Park, WA. Cambridge Media, 2012.
6. European Pressure Ulcer Advisory Panel and National Pressure Ulcer Advisory Panel. *Treatment of pressure ulcers: Quick reference guide*. Washington DC. National pressure Ulcer Advisory Panel, 2009.
7. Graves N, Birrell FA, Whitby M. Modeling the economic losses from pressure ulcers among hospitalized patients in Australia. *Wound Repair and Regeneration* 2005;13(5):462-467.
8. Van Den Bos J, Rustagi K, Gray T, Halford M, Ziemkiewicz E, Shreve J. The \$17.1 Billion Problem: The Annual Cost Of Measurable Medical Errors. *Health Affairs* 2011;30(4):596-603.
9. Guy H. Pressure ulcer risk assessment. *Nursing Times* 2012;108(4):17–20.
10. Long D. *Reliability and Validity of Two Paediatric Pressure Ulcer Risk Assessment Scales: Final Report 2008–2011*. Children’s Health Services, Royal Children’s Hospital, Queensland Government, 2011.
11. Department of Health. *Pressure Ulcer Point Prevalence Survey Statewide Report (PUPPS 3)*. Victorian Government, 2006.
12. Department of Health. *Pressure Ulcer Prevention and Management Practices Integration of Evidence*. Government of South Australia, 2005.
13. Joanna Briggs Institute. Pressure ulcers – prevention of pressure related damage. *Best Practice* 2008;12(2).
14. National Institute for Clinical Excellence. How to change practice: Understand, identify and overcome barriers to change. London, 2007.
15. Wound Ostomy and Continence Nurses Society (WOCNS). *Guideline for Prevention and Management of Pressure Ulcers*. Mount Laurel, New Jersey. WCONS, 2010.
16. Prentice J, Stacey M. Pressure ulcers: The case for improving prevention and management in Australian health care settings. *Primary Intention* 2001;9(3).
17. Macintyre P, Schug S, Scott D, Visser E, Walker S, editors. *Acute Pain Management: Scientific Evidence*. 3rd ed. Melbourne: ANZCA & FPM, 2010.



Appendix: Links to resources

International Organisations

Agency for Healthcare Research and Quality
www.ahrq.gov

Canadian Patient Safety Institute
www.patientsafetyinstitute.ca

Hong Kong Enterostomal Therapist Association
www.etnurse.com.hk/public/modules/web_page/index.asp

Institute for Healthcare Improvement
www.ihl.org

National Patient Safety Agency
www.npsa.nhs.uk

National Institute for Health and Clinical Excellence
www.nice.org.uk

Patient Safety First
www.patientsafetyfirst.nhs.uk

National Pressure Ulcer Advisory Panel
& European Pressure Ulcer Advisory Panel
www.npuap.org

New Zealand Wound Care Society
www.nzwcs.org.nz/

National Organisations

Australian Commission on Safety
and Quality in Healthcare
www.safetyandquality.gov.au

Australian Wound Management Association
www.awma.com.au/awma/index.php

Australasian Wound and Tissue Repair Society
www.awma.com.au/state/awtrs.php

Department of Health and Ageing
www.health.gov.au

State and Territory Organisations

ACT Health
www.health.act.gov.au

Department of Health and Human Services
www.dhhs.tas.gov.au

Department of Health
www.health.vic.gov.au

NSW Ministry of Health
www.health.nsw.gov.au

NSW Clinical Excellence Commission
www.cec.health.nsw.gov.au

Northern Territory Department of Health and Families
www.health.nt.gov.au

Office of Safety and Quality, Western Australia
www.safetyandquality.health.wa.gov.au

Patient Safety and Quality Improvement
Service, Queensland
www.health.qld.gov.au/psq/

Queensland Health
www.health.qld.gov.au

SA Health
www.sahealth.sa.gov.au

Victorian Quality Council
<http://www.health.vic.gov.au/qualitycouncil/index.htm>

Western Australian Department of Health
www.health.wa.gov.au

Audit and Data Collection

Healthcare Quality Improvement Partnership,
Resources for engaging clinicians in audit and
quality improvement
www.hqip.org.uk/engaging-clinicians-a-programme-to-improve-clinical-engagement-in-audit/

Queensland Health Audit tools for the National
Safety and Quality Health Service Standards
www.health.qld.gov.au/psq/safetyandquality/nsqhs-audit-tools.asp

Queensland Health Patient Audit Tool
for NSQHS Standard 8
www.health.qld.gov.au/psq/safetyandquality/docs/pip-audit-patient.pdf

Change Improvement

Australian Resource Centre for Healthcare Innovations

www.archi.net.au/resources/moc/making-change

Institute of Healthcare Improvement:

Register at www.ihl.org (free), then log in so that you can access resources on the IHI web site

- Change improvement white paper
- Engaging physicians in quality improvement

National Health and Medical Research Council, barriers to using evidence

www.nhmrc.gov.au/nics/materials-and-resources/materials-and-resources-subject/-subject-barriers-using-evidence

National Health and Medical Research Council, assessing the implementability of guidelines

www.nhmrc.gov.au/nics/materials-and-resources/materials-and-resources-subject/-subject-guideline-implementation

Clinical Governance

Department of Health, Victoria, Clinical governance policy framework

www.health.vic.gov.au/clinrisk/publications/clinical_gov_policy.htm

National Health Service (UK), Patient involvement and public accountability: a report from the NHS future forum

www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_127544.pdf

Queensland Health, Clinical governance framework and resources

www.health.qld.gov.au/psq/governance/webpages/gov_frame.asp

Victorian Healthcare Association, Clinical governance resources

www.vha.org.au/clinicalgovernanceresources.html

Education Programs

Australian Wound Management Association

www.awma.com.au/pages/education.php

Australian Practice Nurse Association

www.apna.asn.au/scripts/cgiip.exe/WService=APNA/ccms.r?PageId=11252

Department of Health, WA, Wounds West: online education

www.health.wa.gov.au/woundswest/education/index.cfm

Victorian Government Health Information, Pressure ulcers basics online education

www.health.vic.gov.au/pressureulcers/education.htm

Pressure Injuries Prevention and Management Information, Tools and Resources

Australian Wound Management Association Standards for Wound Management

www.awma.com.au/publications/2011_standards_for_wound_management_v2.pdf

Department of Health, WA, Wounds West: online education and resources, telephone support line

www.health.wa.gov.au/woundswest/home/

European Pressure Ulcer Advisory Panel and National Pressure Ulcer Advisory Panel, Treatment of pressure ulcers

www.epuap.org/guidelines/Final_Quick_Treatment.pdf

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

http://www.awma.com.au/publications/2012_AWMA_Pan_Pacific_Guidelines.pdf

Queensland Health, Pressure ulcer prevention and management – practical considerations for paediatric patients

www.health.qld.gov.au/psq/pip/docs/pup_paed.pdf

Queensland Health, Specialty fact sheet for pressure ulcer prevention and management in clients with spinal cord injury

www.health.qld.gov.au/psq/pip/docs/pup_spinal.pdf

Queensland Health, Reliability and validity of two paediatric pressure risk assessment scales

www.health.qld.gov.au/psq/pip/docs/rch-report2011.pdf

Trans Tasman Dietetic Wound Care Group, Guidelines for dietetic management of adults with pressure injuries

daa.asn.au/wp-content/uploads/2011/09/Trans-Tasman-Dietetic-Wound-Care-Group-Pressure-Injury-Guidelines-2011.pdf

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