Preventing and Managing Pressure Injuries

Standard 8

FACTSHEET

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.

Pressure injuries are localised areas of damage to the skin or underlying tissue, caused by unrelieved pressure or friction. They occur most commonly over bony prominences such as the sacral area (the area at the base or bottom of the spine) and heel, but they can develop anywhere on the body.

While pressure injuries are generally considered to be preventable, research shows that pressure injuries are a major contributor to the care needs of patients within healthcare facilities.[1-2] Pressure injuries may impact significantly on the length of stay in health services, the cost of care, health outcomes and the comfort and quality of life of the individuals affected. In the majority of cases pressure injuries are preventable.

Facts and Figures

In 2009 pressure ulcers were identified to be the most common measurable medical error.[2]

It is estimated that between 15-25 percent of patients in the health system develop pressure ulcers.[3]

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

NSQHS STANDARDS

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Pressure injuries occur most commonly in the elderly but they can occur in any patient. Immobility, such as that associated with extended bed rest, can cause pressure injuries. In addition, factors such as poor nutrition, poor skin integrity and lack of available oxygen to tissues have been associated with pressure injuries. A pressure injury can commence in any setting, including acute areas such as operating theatres, during transportation to a health service and in intensive care units.

National and international bodies are currently discussing the correct terminology for pressure-induced wounds, often known as bed sores or ulcers. This Standard adopts the alternate term 'pressure injury' in line with national and international moves to recognise that ulcers are only one form of a pressure injury.

Solutions to prevent pressure injuries have been identified and are detailed in multiple evidence-based resources. The management of pressure injuries has also progressed with the use of screening and assessment tools, skin protection strategies, specialised equipment and increasing specialisation in wound management. Implementing solutions and monitoring for compliance with best practice requires ongoing education and an awareness of all risk factors associated with pressure injuries.

The aim of this Standard is to prevent patients developing pressure injuries and effectively manage pressure injuries when they do occur.

In brief, this Standard requires that:

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

Resources and Tools

The following tools and resources are available to assist with the implementation of this Standard:

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

Further Information

A full copy of the Preventing and Managing Pressure Injuries Standard is contained in the *National Safety and Quality Health Service Standards.* It describes the criteria, items and actions required for health services to meet this Standard and is available on the Commission's website at **www.safetyandquality.gov.au**.

References

1. 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.
2. 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.
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Australian Commission on Safety and Quality in Health Care
Level 7, 1 Oxford Street, Darlinghurst NSW 2010
GPO Box 5480, Sydney NSW 2001
Phone: (02) 9126 3600
Fax: (02) 9126 3613
Email: mail@safetyandquality.gov.au
www.safetyandquality.gov.au

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