A pressure injury is a ‘localised injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction’.

This hospital-acquired complication includes the diagnoses of:

- Stage III ulcer
- Stage IV ulcer
- Unspecified decubitus ulcer and pressure area.

Why focus on pressure injuries?

Each year, patients in Australia experience a large number of pressure injuries, with 4,313 pressure injuries occurring in Australian public hospitals in 2015–16. The rate of hospital-acquired pressure injuries in Australian hospitals was 9.7 injuries per 10,000 hospitalisations in 2015–16.

Pressure injuries take a long time to heal, which has consequences for patients’ quality of life, as such injuries can cause severe pain, and can involve sleep and mood disturbance as well as susceptibility to infection. They also adversely affect rehabilitation, mobility and long-term quality of life. Pressure injury prevention therefore presents an important challenge in acute care hospitals. A number of best practices have been shown to be effective in reducing the occurrence of pressure injuries, but these practices are not used systematically in all hospitals.

Hospital-acquired pressure injuries extend the length of hospitalisation, which impacts on patients and their families. These injuries also increase the cost of admission incurred by the health service. This additional cost may be the result of an increased length of stay or more complex care requirements. While there is an increased financial cost, the most significant cost is the pain and discomfort experienced by the patient.

* The specifications for the hospital-acquired complications list providing the codes, inclusions and exclusions required to calculate rates is available on the Commission’s website.

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**HOSPITAL-ACQUIRED COMPLICATION RATE**

<table>
<thead>
<tr>
<th>1. Pressure injury</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Falls resulting in fracture or intracranial injury</td>
<td>4</td>
</tr>
<tr>
<td>3. Healthcare-associated infections</td>
<td>135</td>
</tr>
<tr>
<td>4. Surgical complications requiring unplanned return to theatre</td>
<td>20</td>
</tr>
<tr>
<td>5. Unplanned intensive care unit admission</td>
<td>n/a</td>
</tr>
<tr>
<td>6. Respiratory complications</td>
<td>24</td>
</tr>
<tr>
<td>7. Venous thromboembolism</td>
<td>8</td>
</tr>
<tr>
<td>8. Renal Failure</td>
<td>2</td>
</tr>
<tr>
<td>9. Gastrointestinal bleeding</td>
<td>14</td>
</tr>
<tr>
<td>10. Medication complications</td>
<td>30</td>
</tr>
<tr>
<td>11. Delirium</td>
<td>51</td>
</tr>
<tr>
<td>12. Persistent incontinence</td>
<td>8</td>
</tr>
<tr>
<td>13. Malnutrition</td>
<td>12</td>
</tr>
<tr>
<td>14. Cardiac complications</td>
<td>69</td>
</tr>
<tr>
<td>15. Third and fourth degree perineal laceration during delivery</td>
<td>358</td>
</tr>
<tr>
<td>16. Neonatal birth trauma (per 10,000 births)</td>
<td>49</td>
</tr>
</tbody>
</table>

a per 10,000 hospitalisations except where indicated
b n/a = national data not available
Significant reductions in pressure injury rates are being achieved in some hospitals through preventive initiatives. The rate for pressure injuries at Principal Referral Hospitals’ was 9.8 injuries per 10,000 hospitalisations in 2015–16. If all Principal Referral Hospitals above this rate reduced their rate to 9.8 per 10,000 hospitalisations, then 727 pressure injuries would have been prevented, and more when other facilities are considered.

* Hospitals were classified in the Principal Referral Hospitals peer group for these purposes according to the Australian Institute of Health and Welfare’s former definition of major city hospitals with more than 20,000 acute weighted separations and regional hospitals with more than 16,000 acute weighted separations.

What is considered best practice for preventing pressure injury?

All hospital-acquired complications can be reduced (but not necessarily eliminated) by the provision of patient care that mitigates avoidable clinical risks to patients.

The health service organisation providing services to patients at risk of pressure injuries:
- Has systems for pressure injury prevention and wound management that are consistent with best-practice guidelines
- Ensures that equipment and devices are available to decrease the risk and effectively manage pressure injuries.

Clinicians caring for patients at risk of pressure injuries:
- Conduct comprehensive skin inspections in accordance with best-practice time frames and frequency
- Provide pressure injury prevention and care in accordance with best-practice guidelines.

The National Safety and Quality Health Service (NSQHS) Standards (second edition), in particular the Comprehensive Care Standard, support the delivery of safe patient care. The advice contained in the hospital-acquired complication fact sheets aligns with the criteria in this standard, which are as follows:
- Clinical governance structures and quality-improvement processes supporting patient care
- Developing the comprehensive care plan
- Delivering the comprehensive care plan
- Minimising specific patient harms.
Top tips for prevention and management of pressure injury

The following provides key points for clinicians to consider to avoid this hospital-acquired complication

Assess all patients as soon as possible following admission to service and within a minimum of eight hours (or on initial visit for patients in the community)

Consult the patient and multidisciplinary team for care planning
Refer to guideline and/or product information for contraindications for therapies

**Nutritional screening**
Use a validated tool appropriate to the clinical setting (Grade B)

**Is the patient at nutritional risk?**

- YES
  - Conduct a comprehensive risk assessment including assessment of:
    - Clinical history
    - Psychosocial history
    - Mobility and activity
    - Continence
    - Intrinsic and extrinsic risk factors
    - Cognition
  - Use a validated pressure injury risk (PI) assessment scale (Grade B)
  - Conduct a complete skin assessment (Grade C).

- NO

**Conduct PI risk assessment**

**Does the patient have an existing pressure injury?**

- NO

**Does the patient have high risk of pressure injury?**

- NO

**NO**

**YES**

**Nutritional assessment**
Use a validated tool appropriate to the clinical setting (Grade B)

**Conduct PI risk assessment**

**Does the patient have an existing pressure injury?**

- NO

**Does the patient have high risk of pressure injury?**

- NO

**NO**

**YES**

**Strategies for patients at high risk**
- Use a high specification foam reactive (constant low pressure) support surface (Grade A) OR consider using an active alternate pressure) support surface (Grade A)
- Implement skin protection strategies
- Provide high protein nutritional supplements (Grade B)
- Consider arginine supplements (Grade C)
- Consider more frequent repositioning (Grade A)
- Patient education.

**Preventative strategies**
- Implement skin protection strategies
- Use constant low pressure redistribution support surfaces (Grade A)
- Regular repositioning (Grade A)
- Patient education.

**Assess existing PI**

**Pressure injury assessment**
Use a validated pressure healing assessment scale (Grade C)

**Pressure injury classification**
Use NPUAP/EPUAP pressure injury classification system

**Pain assessment**
Use a validated pain assessment tool (Grade C)

**Pain management**
- Develop an individualised pain management plan including regular analgesia
- Consider topical opioids when debriding (Grade C).

**Wound management**
- Debride the wound as indicated
- Treat infection – consider using iodine (Grade C)
- Select a wound dressing
- Consider negative pressure wound therapy (Grade C).

**Additional management options**
- Consider electrotherapy (Grade B).

**Ongoing risk assessment**

**Ongoing risk assessment**

**Document**
All assessments
All management plans
All interventions

Recommendation grades: Evidence based recommendations

- **Grade A** = Excellent evidence - body of evidence can be trusted to guide practice
- **Grade B** = Good evidence - body of evidence can be trusted to guide practice in most situations
- **Grade C** = Some evidence - body of evidence provides some support for recommendation(s) but care should be taken in its application
- **Grade D** = Weak evidence - body of evidence is weak and recommendation must be applied with caution

Source: Reproduced with the permission of the Australian Wound Management Association
## Clinical governance structures and quality-improvement processes

**to support best practice in pressure injury prevention and management**

Health service organisations need to ensure systems are in place to prevent pressure injuries through effective clinical governance and quality-improvement processes.

The NSQHS Standards (2nd ed.) describe actions that are relevant to the prevention and management strategies outlined below. These actions are identified in brackets.

<table>
<thead>
<tr>
<th>Policies, procedures and protocols</th>
<th>Health service organisations ensure policies, procedures and protocols are consistent with national evidence-based guidelines for the risk assessment, prophylaxis and management of pressure injuries. <em>(5.1a, 5.21)</em></th>
</tr>
</thead>
</table>
| Best-practice screening and management | Health service organisations:  
  • Agree on the process and criteria for pressure injury risk screening *(5.19, 5.7)*  
  • Inform the clinical workforce of screening requirements *(5.1c)*  
  • Identify a format for comprehensive skin inspections *(5.7)*  
  • Identify a format for prevention plans for high-risk patients *(5.7)*  
  • Identify a management plan format for patients with a pressure injury *(5.22)*  
  • Implement a wound management system. *(5.21)* |
| Identification of key individuals/governance groups | Health service organisations identify an individual or a governance group that is:  
  • Responsible for monitoring compliance with the organisation’s pressure injury policies, procedures and protocols *(5.5b)*  
  • Responsible for presenting data on the performance of pressure injury prevention and management systems to the governing body *(5.5b, 1.6, 1.25)*  
  • Responsible for overseeing the wound management system. *(5.5)* |
| Training requirements | Health service organisations:  
  • Identify workforce training requirements *(5.1c)*  
  • Train relevant staff on the use of risk screening, prevention plans and pressure injury management plans *(5.1)*  
  • Ensure workforce proficiency is maintained. *(1.28, 1.27, 1.22)* |
### Monitoring the delivery of prophylaxis and care

Health service organisations ensure mechanisms are in place to:

- Report pressure injuries *(1.1, 1.9)*
- Manage risks associated with pressure injury prophylaxis and management *(5.1)*
- Identify performance measures and the format and frequency of reporting *(1.9)*
- Set performance measurement goals *(1.8)*
- Collect data on compliance with policies *(1.7b)*
- Collect data about screening activities for pressure injury risk, including whether risk assessment is leading to appropriate action *(1.8)*
- Identify gaps in systems for screening patients for pressure injury *(1.8)*
- Collect data on incidence, prevalence and severity of pressure injuries (see Checklist) *(1.8a)*
- Ensure a root cause analysis is conducted for each occurrence of Stage III or IV pressure ulcer *(1.11c, 1.11d)*
- Provide timely feedback and outcomes data to staff *(1.9b, 5.2c)*

### Quality-improvement activities

Health service organisations:

- Implement and evaluate quality-improvement strategies to reduce the frequency and harm from pressure injuries *(1.8, 5.2a, 5.2b)*
- Use audits of patient clinical records and other data to:
  - identify opportunities for improving pressure injury prevention plans *(5.2)*
  - identify gaps and opportunities to improve the use of pressure injury prevention plans (such as increasing the number of at-risk patients who have pressure injury prevention plans implemented) *(5.2)*
  - monitor the overall effectiveness of systems for prevention and management of pressure injuries *(1.11g, 1.13c, 1.14g)*
- Use audits of patient clinical records, transfer and discharge documentation and other data to:
  - identify opportunities for improving pressure injury management plans *(5.2)*
  - assess compliance with pressure injury management plan requirements *(5.2)*
  - identify strategies to improve the use and effectiveness of pressure injury management plans *(5.2)*

### Equipment and devices

Health service organisations facilitate access to equipment and devices for the prevention and management of pressure injuries *(5.23b)*
Developing the patient’s comprehensive care plan
to support best practice in pressure injury prevention and management

Clinicians should partner with patients, carers and families in assessing risk, in providing appropriate information to support shared decision making, and planning care that meets the needs of patients and their carers.

| Identifying risk factors for pressure injuries | Clinicians identify risk factors for pressure injuries which include:
| | • Impaired mobility
| | • Impaired activity
| | • Impaired sensory perception
| | • Malnutrition or obesity
| | • Compromised skin integrity
| | • Increasing age
| | • Compromised or reduced blood supply to pressure points
| | • Severely compromised status of health.

| Implement risk assessment screening | Clinicians use relevant screening processes at presentation to assess the risk of pressure injury and requirements for prevention strategies.

| Clinical assessment | Clinicians comprehensively assess:
| | • Conditions
| | • Medications
| | • Risks identified through screening process.
| | Clinicians undertake routine comprehensive skin inspections for patients at risk of pressure injury and document skin inspections in the clinical record.

| Informing patients with a high risk | Clinicians provide information about pressure injury prevention and management to high-risk patients and their carers.

| Planning in partnership with patients and carers | Clinicians 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.

| Collaborating and working as a team | Medical, nursing, pharmacy and allied health staff work collaboratively to perform pressure injury risk assessment and clinical assessment. |
### Collaborating and working as a team
Medical, nursing, pharmacy and allied health staff collaborate to deliver pressure injury prophylaxis and management.

### Delivering pressure injury prevention strategies in partnership with patients and carers
Clinicians, patients and carers work in partnership to use the comprehensive care plan to deliver pressure injury prevention strategies where clinically indicated, for example by:
- Re-positioning and/or mobilising regularly
- Reducing pressure, friction, or shear
- Managing pain
- Protecting skin, reducing moisture and optimising skin hygiene and temperature
- Providing adequate nutrition and hydration
- Managing continence.

### Delivering pressure injury management in partnership
Clinicians, patients and carers work in partnership to manage patients who have pressure injuries according to best-practice guidelines.

### Monitoring and improving care
Clinicians should:
- Monitor the effectiveness of these strategies in preventing pressure injury and reassess the patient if pressure injury occurs
- Review and update the care plan if it is not effective or is causing side effects
- Engage in reviewing clinical outcomes, identifying gaps and opportunities for improvement.

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### Delivering comprehensive care to prevent and manage pressure injury
Safe care is delivered when the individualised care plan, that has been developed in partnership with patients, carers and family, is followed.

### Documenting and communicating the care plan
Clinicians document in the clinical record and communicate:
- The findings of the screening process
- The findings of the clinical assessment process including skin inspections
- The pressure injury prevention plan.
Minimising specific patient harm

Patients at risk of specific harms are identified, and clinicians deliver targeted strategies to prevent and manage these harms.

Nutrition and hydration

Clinicians should ensure the nutritional and fluid requirements of the patient are planned, delivered and adjusted as appropriate and the patient’s intake is monitored.

Checklist for measuring and monitoring pressure injury

- Incidence and prevalence measures are frequently monitored
- Pressure injury rates are examined on a monthly basis
- Information on rates is disseminated to key stakeholders and staff
- Root cause analysis is conducted for each occurrence of a Stage III or IV pressure ulcer.

Notes on Incidence and Prevalence

Two types of measures can be monitored: incidence and prevalence rates.

Incidence describes the number or percentage of people developing a new ulcer while in your facility or on your unit. Therefore, incidence only counts pressure injuries developing after admission. Incidence rates provide the most direct evidence of the quality of your care. Therefore, your quality improvement efforts should focus on incidence rates.

Prevalence describes the number or percentage of people having a pressure ulcer while on your unit. It may reflect a single point in time, such as on the first day of each month. This is known as point prevalence. However, it can also reflect a prolonged period of time, such as an entire hospital stay. This is known as period prevalence. Both types of prevalence rates (point and period) include pressure injuries present on admission as well as new ulcers that developed while in your facility or on your unit. Therefore, prevalence rates can provide a useful snapshot of the pressure injury burden but they say less about your quality of preventive care than do incidence rates.

Make sure everyone looking at the data understands the difference between incidence and prevalence. Incidence rates capture only new pressure injuries developing during an admission. Prevalence rates include all pressure injuries present in a group of patients – those that developed during a hospital stay as well as those that developed elsewhere.

There is no single ‘right’ approach to measuring pressure ulcer rates. Every approach has advantages and disadvantages. While we make specific recommendations above, the most important thing is to be consistent. Rates calculated by one approach or methodology cannot be compared to rates calculated another way.
Additional resources


Agency for Healthcare Research and Quality (US). Preventing Pressure Ulcers in Hospitals: A Toolkit for Improving Quality of Care: PSI 032016.


Note on data

The data used in this sheet are for hospital-acquired complications recorded during episodes of care in Australian public hospitals in 2015–16. Data are included where hospitals were able to identify that the complication had arisen during an admission using the condition onset flag. Figures reported by the Independent Hospitals Pricing Authority (IHPA) may differ due to the IHPA’s methodology, which applies different inclusion/exclusion criteria.
References


2. Independent Hospital Pricing Authority (AU). Activity Based Funding Admitted Patient Care 2015–16, acute admitted episodes, excluding same day.


