

GUIDING PRINCIPLES FOR PRESSURE INJURY PREVENTION AND MANAGEMENT IN NEW ZEALAND

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AND MANAGEMENT IN NEW ZEALAND - MAY 2017**

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FOREWORD

The guide is a foundational document for pressure injury prevention and management in New Zealand and has been developed to support local experience while enabling national consistency.

Pressure injuries (also known as 'pressure ulcers' or 'bedsores') cause pain, disability, hospitalisation and sometimes even death for those affected - as well as financial strain for all involved.

Most cases of pressure injuries are preventable - and preventing them before they develop or progress is a high priority for New Zealand's healthcare system. ACC, Ministry of Health and Health Quality & Safety Commission are working together with other health sector partners on national and local improvement initiatives to prevent pressure injuries.

ACC has seen treatment injury claims increase in numbers and cost. Between 2009 and 2016 the number of accepted treatment injury claims has increased by 63%. Each treatment injury represents a person accidentally harmed. Over the next five years, ACC will invest in patient safety and target evidence-based treatment injury prevention initiatives, including pressure injury prevention.

I would like to thank all involved in the development of the guide, with special mention to the Expert Reference Panel members which included our key partners Ministry of Health and Health Quality & Safety Commission.

Dr Peter Robinson
Chief Clinical Advisor
ACC

INTRODUCTION

The *Guiding Principles for Pressure Injury Prevention and Management in New Zealand* (the guide) provides New Zealand healthcare professionals and organisations with a high-level framework for best-practice care in preventing and managing pressure injuries.

A pressure injury (also known as a 'pressure ulcer' or 'bedsore') 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'.¹ Every year in New Zealand, an estimated 55,000 new pressure injuries occur, causing pain, disability, hospitalisation and sometimes even death for those affected – as well as financial strain for their families/whānau, and pressure on healthcare services and resources.²

However, in most cases pressure injuries are preventable – and preventing them before they develop or progress is a high priority for New Zealand's healthcare system.

THE FRAMEWORK: SIX BEST-PRACTICE PRINCIPLES

This guide recognises the important role of health professionals and organisations in providing New Zealanders with the best possible healthcare, every time they access healthcare services.

At its heart are six principles of best practice that are applicable to healthcare settings of all types, including hospitals, hospices, residential care facilities, primary healthcare settings and home-care situations. These principles are: people first; leadership; education and training; assessment; care planning and implementation; and collaboration and continuity of care.

The guide:

- explains the criteria for each of the principles in detail; high-quality care will be enabled when these criteria have been met;
- describes the services that those needing and receiving care, and their caregivers and representatives, can expect in relation to pressure injury prevention and management;
- outlines what the principles mean for healthcare organisations and their staff; and
- provides practical recommendations for preventing and managing pressure injuries in healthcare settings.

¹ National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. *Pressure Ulcers: Quick Reference Guide*, 2014

² KPMG. *The Case for Investment in a Quality Improvement Programme to Reduce Pressure Injuries in New Zealand*, 2016

SUPPORTED BY INTERNATIONAL AND LOCAL KNOWLEDGE AND EXPERTISE

The guide was developed by an Expert Reference Panel representing organisations across the New Zealand healthcare sector, including ACC, the Ministry of Health, the Health Quality & Safety Commission and the New Zealand Wound Care Society. It draws on evidence-based international guidelines and New Zealand reports on pressure injury prevention and management. It also supports the implementation of NZS 8134:2008 Health and Disability Services (Core) Standards, which aims to ensure safe and reasonable levels of service for consumers and to reduce the risk to consumers from those services.

It's important to note that the guide is evidence informed rather than evidence based. This reflects the panel's conclusion early in its development, that a significant body of international evidence is available and commissioning a systematic review would unnecessarily delay the implementation of pressure injury prevention strategies.

A FOUNDATION FOR HEALTHCARE EXCELLENCE

There is good evidence that pressure injuries can be significantly reduced³ and some New Zealand healthcare providers have already achieved substantial reductions. ACC resourced the development of the guide which is endorsed by the Ministry of Health and the Health Quality & Safety Commission. This guide is intended to help all healthcare organisations to reduce the incidence of pressure injuries among people in their care - and support the long-term health and wellbeing of all New Zealanders.

³ Demarre L, Van Lancker A, Van Hecke A, Verhaeghe S, Grypdonck M, Lemey J, Annemans L, Beeckman D. *The cost of prevention and treatment of pressure ulcers: A systematic review*. International Journal of Nursing Studies, 52(11):1754-74, November 2015

THE SIX PRINCIPLES FOR PREVENTING AND MANAGING PRESSURE INJURIES

- 1. PEOPLE FIRST:** People have access to care, and receive information and participate in shared decision-making about the care needed to prevent and manage pressure injuries.
- 2. LEADERSHIP:** Healthcare organisations demonstrate leadership by ensuring that they have systems and resources to prevent and manage pressure injuries.
- 3. EDUCATION AND TRAINING:** Healthcare workers at all levels have access to and support for acquiring current knowledge and skills that enable them to prevent and manage pressure injuries.
- 4. ASSESSMENT:** Pressure injury risk assessments are completed as part of admission, referral and transfer processes, with reassessments when people's health status changes. At-risk areas are checked regularly and whenever the opportunity arises.
- 5. CARE PLANNING AND IMPLEMENTATION:** Individualised, person-centred care plans employing evidence-based care bundles are developed, documented and implemented to reduce the risk of pressure injuries.
- 6. COLLABORATION AND CONTINUITY OF CARE:** Care support, information and resources move seamlessly with people transferring between healthcare settings.

DEFINITIONS

This table provides definitions for key words used in this guide.

Care	The delivery of services to a person that include, but are not limited to, professional clinical assessments and the treatment and management of pressure injuries.
Care bundle	Developed as a structured way of improving care processes and patient outcomes, a care bundle is a small, straightforward set of evidence-based practices that, when delivered collectively and reliably, have been proven to improve a person's health outcomes.
Caregiver Kaiāwhina	A person employed within a healthcare, residential or community context who provides a component of direct care and is not covered by regulations. A caregiver may be delegated care activities such as skin inspections under local delegation and direction policy. Kaiāwhina is the over-arching term to describe non-regulated roles in the health and disability sector.
Families/Whānau or other carers	People caring for a person receiving care. They include next of kin and those with enduring power of attorney for the person receiving care.
Health professional	A person who is clinically trained and holds a New Zealand-recognised healthcare qualification. Also called 'clinicians', health professionals must be registered to practise with the appropriate bodies and are legally accountable for their practice.
Healthcare organisation	An entity responsible for providing or funding the delivery of health services in New Zealand. Examples include hospitals, aged-care facilities, respite-care facilities, hospices, domiciliary care providers, not-for-profit care providers and primary healthcare organisations (PHOs).
Healthcare organisation leader	A person employed in a position of influence in a healthcare organisation, who has a mandate to support education for staff and ensure that systems and resources are in place to prevent and manage pressure injuries.
Healthcare setting	A place where care is provided, such as a hospital ward, an operating theatre, a person's home, an emergency department, residential facility and a clinician's consulting room.
Healthcare worker	A person employed or subcontracted by a healthcare organisation who spends most of their time providing direct clinical care. Healthcare workers include health professionals, kaiāwhina and caregivers.
Multidisciplinary team	A group of healthcare workers from different disciplines, each providing specific services to the person receiving care in relation to pressure injury prevention and management. A multidisciplinary team could include, for example, a doctor, nurse, podiatrist and occupational therapist.
Shared decision-making	A collaborative process in which a person receiving care and their health professional(s) make healthcare decisions together. It takes into account the best clinical evidence available, as well as the person's values preferences and experience.
Staff	People who are employed by healthcare organisations or are subcontracted to deliver services, such as health professionals, kaiāwhina and caregivers.
Timely	Happening at a suitable time according to local, evidence-based policies and the person's condition, risk status and healthcare setting.

PEOPLE FIRST

People have access to care, and receive information and participate in shared decision-making about the care needed to prevent and manage pressure injuries.

CRITERIA

Under this principle people receive culturally appropriate care that reduces their risk of developing pressure injuries, whether they're living independently or receiving care at home, in a residential care facility or in hospital. They and their families/whānau or other carers have the information they need to make appropriate pressure injury prevention and management decisions. This information is provided in a way that they can understand and act on.

WHAT DOES THE PRINCIPLE MEAN FOR PEOPLE?

Every person who is at risk of developing a pressure injury, and those who care for them, have access to information on how to recognise the risks, undertake preventive and management measures and access support to reduce the occurrence of pressure injuries.

Care is planned in collaboration with people and their families/whānau or other carers, and they have the opportunity to ask questions about pressure injuries and their prevention and management. Information provided is comprehensive and available in languages that readers can understand.

WHAT DOES THE PRINCIPLE MEAN FOR HEALTHCARE ORGANISATIONS?

Healthcare organisations ensure that resources are in place to provide people and their families/whānau or other carers with adequate information on the risk of developing pressure injuries and how they can be prevented and managed.

WHAT DOES THE PRINCIPLE MEAN FOR STAFF?

All staff understand their roles and responsibilities for providing information on pressure injury prevention and management. Care plans are discussed and documented according to local and professional requirements, and people and their families/whānau or other carers are encouraged to ask how they can prevent pressure injuries developing.

PRINCIPLE 1
PEOPLE FIRST

PRACTICAL RECOMMENDATIONS (NOT EXHAUSTIVE)

When the 'people come first' principle is applied in practice:

1. People at risk of pressure injuries work in partnership with healthcare workers to make informed choices, set agreed goals and discuss how their pressure injury prevention goals will be achieved.
2. All information on a person's pressure injury prevention needs, including risk assessments, skin assessments and a care plan, is discussed, documented and made available to them and their family/whānau or other carers as appropriate.
3. Carers of people at risk of developing pressure injuries have access to educational materials that enable them to prevent and/or recognise pressure injuries. People and their families/whānau or other carers are given appropriate educational materials when their healthcare organisations begin delivering care.
4. People's next of kin, guardians and/or people with their enduring power of attorney can advocate for them when they are unable to do so themselves, and take part in care planning, goal setting and goal achievements.

LEADERSHIP

Healthcare organisations demonstrate leadership by ensuring that they have systems and resources to prevent and manage pressure injuries.

CRITERIA

Healthcare organisation leaders demonstrate their organisations' commitment to preventing and managing pressure injuries by ensuring that people can access and receive timely interventions and appropriate resources.

These leaders are responsible for developing and sustaining improvement plans to reduce pressure injuries.

WHAT DOES THE PRINCIPLE MEAN FOR PEOPLE?

All people who are at risk of, or identified with, pressure injuries, regardless of the healthcare setting, are provided with care that minimises the risk of pressure injuries.

People have confidence in the systems and processes for preventing and managing pressure injuries.

WHAT DOES THE PRINCIPLE MEAN FOR HEALTHCARE ORGANISATIONS?

Healthcare organisations encourage a multidisciplinary team vision and shared responsibility for pressure injury prevention and management with cooperative approaches within and across the health and disability sector.

The organisations ensure that people have appropriate and timely access to resources in accordance with their assessed needs, and that they have enough staff and the right skill mix to provide best-practice pressure injury prevention and management.

Healthcare organisation leaders work with government agencies and other key stakeholders to ensure that pressure injury prevention and management strategies are effective, comprehensive and up to date at local and national levels.

Healthcare organisations regularly monitor the incidence of pressure injuries, and apply that knowledge to local quality improvement programmes and national surveillance initiatives, such as that undertaken by ACC, the Health Quality & Safety Commission and the Ministry of Health (www.hqsc.govt.nz/our-programmes/other-topics/new-projects/pressure-injury-prevention/measurement).

All severe pressure injuries (stages three and above) are investigated and managed in accordance with local policy, and reported to the relevant agency with the aim of improving healthcare systems and by doing so achieve better health outcomes for people. For example, public hospitals report to the Health Quality & Safety Commission via the serious adverse event (SAE) reporting system.⁴

⁴ <http://www.hqsc.govt.nz/our-programmes/adverse-events/>

Investigations are transparent and focus on systemic issues, with the goal of preventing the development of pressure injuries.

WHAT DOES THE PRINCIPLE MEAN FOR STAFF?

Healthcare organisation leaders, health professionals and caregivers have a shared responsibility to remain vigilant and involved in providing treatment and care in a way that minimises the risk of pressure injuries developing.

All staff are responsible for: identifying and raising any issues that could affect the delivery of care relating to pressure injury prevention and management; and continual improvements in the quality of that care.

All staff can identify designated management representatives for pressure injuries. They also know who to contact about escalating an issue (if needed) and have confidence in that escalation process.

PRACTICAL RECOMMENDATIONS (NOT EXHAUSTIVE)

When the 'leadership' principle is applied in practice, healthcare organisations have:

1. An organisation-wide vision for preventing harm from pressure injuries and improving safety for people receiving care.
2. Senior managers specifically responsible for ensuring that the criteria are met.
3. Pressure injury prevention and management policies and procedures.
4. A multidisciplinary approach to pressure injury prevention and management.
5. Processes for collecting data on pressure injury frequency and severity.⁵
6. Targets for reducing the onset and development of pressure injuries, which are regularly reviewed, revised and acted on to achieve continual quality improvements.
7. Assessment tools, care plans, audit tools and staff education programmes.
8. Information and resources (e.g. education material and equipment) that are available to families/whānau or other carers.
9. Pressure injury prevention 'champions', who facilitate prevention and management strategies in healthcare settings, and the infrastructure to support this role. The champions can be healthcare workers or healthcare organisation leaders, and need to have a positive influence on the overall delivery of care.
10. Mechanisms that facilitate timely access to specialist advice, equipment and resources to support care delivery.
11. Referral pathways (including, where possible, technology-enabled options) that support the safe transfer of people and information between services and healthcare settings and ensure continuity in their care.
12. Reporting systems for adverse events that investigate and identify the causes of pressure injury development and support learning to ensure that such injuries do not recur.

⁵ Health Quality & Safety Commission. Developing a National Approach to the Measurement and Reporting of Pressure Injuries, 12 September 2016. See: <http://www.hqsc.govt.nz/our-programmes/other-topics/new-projects/pressure-injury-prevention/measurement>

EDUCATION AND TRAINING

Healthcare workers at all levels have access to and support for acquiring current knowledge and skills that enable them to prevent and manage pressure injuries.

CRITERIA

Health professionals, kaiāwhina and caregivers have access to education and educational resources based on current evidence that enables them to provide culturally appropriate care that prevents and manages pressure injuries.

WHAT DOES THE PRINCIPLE MEAN FOR PEOPLE?

People have confidence in their healthcare workers' knowledge of, and ability to prevent and manage pressure injuries, and so comply with their care plans.

People and their families/whānau or other carers have information on how to recognise and avoid the development of pressure injuries.

WHAT DOES THE PRINCIPLE MEAN FOR HEALTHCARE ORGANISATIONS?

Healthcare organisations provide time, opportunities and supportive learning environments for education and training - enabling healthcare professionals, kaiāwhina and caregivers to gain and apply the necessary knowledge and skills in the prevention and management of pressure injuries.⁶

The organisations also offer and maintain systems for recording education and training, and identify and meet educational and training needs.

WHAT DOES THE PRINCIPLE MEAN FOR STAFF?

All staff demonstrate a current knowledge of, and skills in delivering, culturally appropriate care to people who are at risk of developing pressure injuries. This care includes assessing, identifying, preventing and managing pressure injuries.

Staff are supported in identifying their education and training needs and keep records of their professional development.

Staff can use the available equipment safely, and know how to assess that it is fit for purpose.

⁶ Cox J, Roche S, Van Wynen E. *The effects of various instructional techniques on retention of knowledge about pressure ulcers among critical care and medical-surgical nurses*. Jnl Con Ed in Nursing;42(2):71-8, 2011

PRACTICAL RECOMMENDATIONS (NOT EXHAUSTIVE)

When the 'education and training' principle is applied in practice, health professionals, kaiāwhina and caregivers have access to education and training on pressure injury prevention, identification and management that are appropriate to their roles, skills and healthcare settings. Through this education and training they learn about, for example:

1. The physiology of skin and the pathophysiology of pressure injuries.
2. The risk factors associated with the development of pressure injuries.
3. The differences between conditions such as incontinence-associated dermatitis and pressure injuries.
4. Performing skin assessments as part of overall clinical assessments, and recognising the early signs and symptoms of pressure injuries.
5. Classifying and documenting pressure injury stages accurately and consistently based on an international staging classification system (see Appendix 3).
6. The treatment options for pressure injuries, including self-management, and the relevant equipment, devices and dressings.
7. Developing, implementing and evaluating individualised care plans based on identified risk.
8. When it is appropriate to seek specialist advice and how to do this.
9. Information leaflets⁷ on pressure injury risk factors, prevention and early identification, to whom and when to report any concerns, and the treatment options and support available for people at risk.
10. Culturally appropriate practices and communication approaches.

⁷ For examples see <http://www.nzwcs.org.nz/about-us/pressure-injuries-ulcers/worldwide-stop-pressure-injury-day>

ASSESSMENT

Pressure injury risk assessments are completed as part of admission, referral and transfer processes, with reassessments when people's health status changes. At-risk areas are checked regularly and whenever the opportunity arises.

CRITERIA

A structured assessment of a person's risk of developing pressure injuries, supported by clinical judgement appropriate to the healthcare setting,⁸ is completed as soon as possible after their admission to a healthcare organisation or their transfer to another healthcare setting.

Timely and regular reassessments of risk and skin integrity take place to identify any developing pressure injuries, any deterioration in existing pressure injuries, or changes in skin integrity (see Appendix 3). The reassessment frequency is based on any change in the person's health condition, needs or risk level or the healthcare organisation's policy, guided by an evidence base for the specific population group.

The formal skin integrity assessment (undertaken as part of the structured risk assessment) is supplemented by observation and reporting as part of daily care when it is possible to view pressure areas, such as when the person is moving, showering or receiving treatment.

All pressure injury risk and formal skin integrity assessments are clearly documented, including any barriers to assessments. Where a person declines a risk assessment or skin inspection, their reason is understood and documented in their clinical record and the plan is revised with the person to ensure the most appropriate approach to risk assessment.

WHAT DOES THE PRINCIPLE MEAN FOR PEOPLE?

A person's risk of developing pressure injuries is assessed by a healthcare professional on their admission to a health organisation and on their transfer to another healthcare setting,⁹ including a home-based care setting, to help with the development of a care plan. The assessment includes:

- Questions on health, nutrition, mobility and bowel and bladder function;
- A full skin inspection to identify any skin changes, especially around bony areas;
- An assessment of any equipment (such as a wheelchair, mattress or cushion) already in use or required;
- Advice on self-management in preventing pressure injuries;

⁸ National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. *Pressure Ulcers: Quick Reference Guide*, 2014

⁹ This includes emergency departments and while a person is being transported to a different care setting either within a facility or between facilities

- A discussion on the care required, treatment options and frequency of reassessments; and
- A discussion on any concerns identified or skin changes noted.

Kaiāwhina and caregivers are trained to observe skin integrity and report on skin changes, especially in risk areas, as part of delivering daily care.

WHAT DOES THE PRINCIPLE MEAN FOR HEALTHCARE ORGANISATIONS?

Healthcare organisations have clear policies and procedures to ensure that assessments of pressure injury risk and skin integrity are conducted in a comprehensive, consistent way by healthcare professionals with the appropriate training and skills, and are clearly documented. They also have processes for facilitating access to specialist advice when required.

Risk assessment and reassessment completion rates are monitored and procedures evaluated for effectiveness.

WHAT DOES THE PRINCIPLE MEAN FOR STAFF?

Healthcare professionals are responsible for undertaking and documenting risk assessments as soon as possible after people's admission to healthcare organisations or their transfer to new wards, services or healthcare settings, and for timely and regular reassessment including where there is a change in condition.

Using their clinical judgement and the results of the risk assessments, healthcare professionals work with people, caregivers and families/whānau or other carers to develop care plans to prevent pressure injuries.

Caregivers know who is responsible for undertaking and documenting risk assessments and report appropriately any changes in people's conditions or needs.

Staff are responsible for maintaining their knowledge and skills in undertaking pressure injury risk assessments and for helping to identify areas for improvement in assessments and the incidence of pressure injuries.

PRACTICAL RECOMMENDATIONS (NOT EXHAUSTIVE)

When the 'assessment' principle is applied in practice:

1. A risk assessment includes:
 - 1.1 A skin inspection, paying careful attention to areas over bony prominences and those in contact with equipment and devices.
 - 1.2 An assessment of risk factors such as mobility, relevant co-morbidities, cognition, nutrition, and bladder and bowel function.
 - 1.3 Consistent staging, in accordance with standard protocols on pressure injury development and progression and documented in the clinical notes.
 - 1.4 An assessment of the person's positioning and equipment needs.
 - 1.5 Referral pathways to appropriate health professionals or specialists, such as podiatrists, dieticians and wound care specialists.
 - 1.6 An assessment of the supports required for self-management or home-carer management as appropriate.
 - 1.7 Recording in the clinical notes information such as the stage and appearance of existing pressure injuries (including chronological digital photographs and/or personal diary entries where appropriate and/or possible) and any specialist referrals made. The pressure injury status (and associated information) is clear, especially at transfer, handover and discharge points.
 - 1.8 An evaluation of whether the risk has increased or decreased.
 - 1.9 An evaluation and revision of any existing care plan if required.
2. As part of perioperative assessments, healthcare professionals identify at-risk people in advance of the interventional procedures, noting their status, the procedures, the length of surgery and the required positioning. Appropriate body supports and positioning equipment, including protective padding, are ready at the time of the procedures.
3. Healthcare organisation leaders monitor compliance with risk assessment completion and how it relates to pressure injury incidence. Opportunities for improvement are identified as part of this monitoring.
4. Staff are encouraged to develop ways to give bedside prompts to families/whānau or other carers that increase their awareness of the risk of pressure injuries.

CARE PLANNING AND IMPLEMENTATION

Individualised, person-centred care plans employing evidence-based care bundles are developed, documented and implemented to reduce the risk of pressure injuries.

CRITERIA

An individualised care plan – based on clinical judgement, the risk assessment and the identified risk factors – is developed in collaboration with the person receiving care and/or their family/whānau or other carers.

The care plan is documented and implemented using evidence-based care bundles,¹⁰ with the aim of reducing the risk of pressure injuries developing or progressing (for an example, see Appendix 4).

The multidisciplinary team contributes to the care plan and its regular re-evaluation, responding to changes in care requirements based on individual need. The person participates in making decisions about their own healthcare, where they or their family/whānau or other carers can understand these decisions.

Where a care plan is not followed, for example due to personal choice or restricted access to services, the reason/circumstances are explored and documented in the person's clinical record, and the plan is revised with the person to ensure the most appropriate approach to prevent and manage pressure injuries.

WHAT DOES THE PRINCIPLE MEAN FOR PEOPLE?

People are consulted on their care requirements and participate in decision-making about their care. They receive care that is consistent with their agreed care plans, including:

- Skin care and changes in position and frequency;
- Access to the information, care or equipment they need to prevent and manage pressure injuries; and
- Dietary and hydration advice and support.

WHAT DOES THE PRINCIPLE MEAN FOR HEALTHCARE ORGANISATIONS?

Healthcare organisations have pressure injury prevention strategies and escalation processes that include access to and the implementation of all elements of an evidence-based care bundle.

Healthcare organisations ensure that appropriate, fit-for-purpose pressure-relieving equipment is available and accessible to meet people's identified needs.

¹⁰ Whitlock J. SSKIN Bundle: *Preventing pressure damage across the health-care community*. Brit Jnl Comm Nursing, Supplement, S32, 2013

The effectiveness of care plans is regularly monitored, with the results contributing to improved safety.

WHAT DOES THE PRINCIPLE MEAN FOR STAFF?

Staff are responsible for implementing and evaluating care plans based on people's risk of pressure injury. Care plans are developed with these people and in accordance with evidence-based care bundles (for an example, see Appendix 4).

Staff are responsible for: maintaining their knowledge and skills in developing and reviewing care plans; and helping to identify areas for improvement in implementing care plans and reducing the incidence of pressure injuries.

PRACTICAL RECOMMENDATIONS (NOT EXHAUSTIVE)

When the 'care planning and implementation' principle is applied in practice:

1. Care plans are agreed with the people receiving care and implemented to reduce the risk of pressure injuries and/or manage existing pressure injuries.
2. All care plans are documented and evaluated and people receive the information and support they need to improve their self-management.
3. Care plans include components such as those in an evidence-based care bundle (see Appendix 4 for an example). While they can be adapted to different healthcare settings, they always cover:
 - 3.1 Clinical assessments and skin inspections.
 - 3.2 Support surfaces and equipment, including body-supporting devices.
 - 3.3 Maintaining movement, including position-change frequency.
 - 3.4 Skin care regimes that include incontinence and moisture management.
 - 3.5 Nutrition and hydration support.
 - 3.6 Reassessments and care plan evaluations and revisions.
 - 3.7 Documentation of all the above, and recorded descriptions of the stages of any pressure injuries.
4. Compliance with their care plans is monitored in relation to the incidence of pressure injuries, and opportunities for improvements are identified.
5. Care delivery is monitored to ensure that it is appropriate for the people receiving it.
6. Care plans and their implementation are reviewed regularly in collaboration with the people receiving care and their healthcare professionals.
7. Necessary pressure injury prevention equipment is fit for purpose, appropriately used and regularly audited and repaired. An equipment replacement programme is in place.

COLLABORATION AND CONTINUITY OF CARE

Care support, information and resources move seamlessly with people transferring between healthcare settings.

CRITERIA

Continuity of care is maintained across different healthcare settings and multidisciplinary teams, with safe and effective transfers of information based on individuals' needs.

Information is recorded in care plans on structured risk assessments, skin integrity assessments, the stages of existing pressure injuries, prevention and management strategies, and the use of any equipment. This information moves with the person irrespective of who is providing their care¹¹ and where their care is being provided. There is seamless access to resources/equipment in all healthcare settings.

Collaboration on pressure injury prevention and management across healthcare settings enables the best use of resources and promotes seamless care.

WHAT DOES THE PRINCIPLE MEAN FOR PEOPLE?

People receive continuity of care when being transferred between healthcare settings or back to their homes. Their care plans are documented, implemented and transferred with them, and processes are in place to enable their continued access to the pressure injury prevention equipment they need.

WHAT DOES THE PRINCIPLE MEAN FOR HEALTHCARE ORGANISATIONS?

Healthcare organisations have systems to ensure: that care plans and information are shared; and that people and their family/whānau or carers have timely access to interventions and equipment to prevent pressure injuries during transfers.

When people are transferred from one healthcare setting to another, their pressure injury status is recorded by both the referring and the receiving healthcare settings.

Healthcare organisations have systems for monitoring the incidence and severity of pressure injuries among the people they care for. Opportunities for improvement are identified and changes are implemented.

Organisations support the consistent and reliable measurement of pressure injuries for the purpose of informing local quality improvement initiatives, contributing to the national surveillance picture and improving health outcomes for people.

¹¹ Institute for Clinical Systems Improvement. *Pressure Ulcer Prevention and Treatment*. 3rd Ed, 2014

WHAT DOES THE PRINCIPLE MEAN FOR STAFF?

All staff communicate proactively to ensure that people being transferred between healthcare settings have seamless care during the transfers and continuity of care at the receiving settings. This includes transfers within hospitals and while people are waiting for treatments/tests to be completed.

Staff provide receiving facilities with all records relevant to the transferring people's pressure injuries. These include risk assessments, skin integrity assessments and the stages of any existing pressure injuries, as well as supporting information such as people's equipment, mobility and nutritional needs.

When an at-risk person is being transferred, staff inform the receiving facility of their requirements, such as specialist equipment, **before** the transfer, ensuring seamless access to resources and equipment. Specialist equipment should be the same at both the discharging and the receiving facilities, until a review indicates that it is no longer appropriate.

PRACTICAL RECOMMENDATIONS (NOT EXHAUSTIVE)

When the 'collaboration and continuity of care' principle is applied in practice:

1. Person-centred care plans are used to inform handovers, transitions of care and discharge plans.
2. High-risk people are identified and pressure injury management plans are developed in collaboration with the staff responsible for the person's care during transfer, including ambulance transfers.
3. Where specialist equipment is leased, arrangements are in place to ensure on-going access to facilitate a person's transfers (such as changing cost codes with the equipment company)
4. Information such as discharge summaries, care home admission letters and any referrals for specialist input are communicated across healthcare settings.
5. Healthcare providers showing consistently good results in pressure injury prevention and management communicate openly, collaborate across sectors and share their learnings with other providers to support the achievement of national best practice.

GUIDE DEVELOPMENT METHODOLOGY

The *Guiding Principles for Pressure Injury Prevention and Management in New Zealand* (the guide) was developed with advice and support from a panel of pressure injury prevention experts nominated by a range of organisations (see Appendix 2 for a list of panel members).

This Expert Reference Panel met three times during the guide's development. After the first meeting ACC drafted the initial document based on the panel's advice and support, and in the next two meetings the draft was reviewed and amended. The draft was further peer reviewed by members of the panel, who provided comprehensive feedback to ensure that it was clear, accurate and fit for the New Zealand context. The guide was then shared with the sector for feedback, and the collated feedback was shared with the panel who agreed on the final document.

In developing the initial draft, comprehensive national and international evidence reviews for the development of clinical best-practice guidelines were identified. The Expert Reference Panel acknowledges the enormous amount of work undertaken by the Pan Pacific Pressure Injury Alliance and the National Institute for Health and Care Excellence in the United Kingdom.

The Expert Reference Panel drew significantly on two international clinical practice guidelines (available online; refer to the bibliography) and their evidence reviews, as well as guidelines developed by clinicians for clinicians. These guidelines were supported by extensive systematic reviews of the scientific literature on the development and prevention of pressure injuries. The Expert Reference Panel concluded that there was a sufficient body of evidence to support the proposed approach, and that a further systematic review of evidence would unnecessarily delay the implementation of pressure injury prevention strategies. This is therefore an evidence-informed, rather than evidence-based, guide to best practice.'

MEMBERSHIP OF THE EXPERT REFERENCE PANEL

This guide was developed with the advice and support of a panel of expert members, nominated by a range of organisations, whose expertise in pressure injury prevention made them outstanding contributors.

They were selected by their own organisations to provide perspectives from a range of clinical disciplines and care settings, as well as a consumer perspective for frail elderly people at risk of pressure injuries. The panel also drew on the experience of regional initiatives around New Zealand and the recommendations of a regional pressure injury prevention hui held in June and July 2016. The panel members and their respective organisations were:

Name	Role	Organisation
Julie Betts	Nurse Practitioner	Waikato District Health Board
Sean Bridge	Senior Injury Prevention Specialist	ACC
Helen Delmonte	Operations Manager	Mercy Parklands
Robin Griffiths	Chair, Senior Medical Advisor	ACC University of Otago
Andrew Jull	Associate Professor School of Nursing Senior Research Fellow, National Institute for Health Innovation Nurse Advisor Quality & Safety	University of Auckland Auckland District Health Board
Heather Lewis	Clinical Nurse Specialist	Middlemore Hospital
Jo Millar	Chair of Health Nation Advisory Group, Consumer Representative	Grey Power
Pamela Mitchell	Nurse Consultant, Wound Management	Christchurch Hospital
Lea-Anne Morgan	National Clinical Manager	Access Home Health
Debbie Palmer	Senior Enrolled Nurse	Atawhai Assisi Home & Hospital
Cormac Peirse	Clinical Manager	Ryman Healthcare
Carmela Petagna	Senior Portfolio Manager, Quality Improvement Programmes	Health Quality & Safety Commission
Marie Press	Nurse Director, Medical and Community Health	Hutt Valley District Health Board
Robin Sekerak	Brain Injury Specialist	ABI Rehabilitation
Bridget Smith	Planning & Improvement Manager	interRAI
Ginette Spence	Project Manager	ACC
Kathy Glasgow	Office of the Chief Nursing Officer	Ministry of Health

The terms of reference for the panel were to:

- Provide operational and clinical input into the best practice guidance for initial assessment and prevention
- Provide advice on a consultation process that provides the best way to disseminate the developed material
- Engage peers throughout the development process, and strive to achieve consensus on best practice guidance.

The panel agreed that:

- Evidence for clinical effectiveness in terms of risk assessment and prevention was adequate and no further review of the scientific literature was necessary prior to drafting the guide
- While we do not have a complete picture of the severity and incidence of pressure injuries being sustained by people in New Zealand, there is sufficient evidence of an appropriate quality to justify action to prevent and manage pressure injuries
- There is significant variation in practice. This means that in some areas clinical best practice is being actively pursued and achieved, but there are areas where improvements can be made
- A flexible approach is needed in terms of preventing pressure injuries
- Local solutions may be determined by the care setting
- This guide is considered part of an overall approach to the prevention of injury, particularly in the frail elderly, and should be read in conjunction with the falls prevention guidance
- Timely access to resources for pressure injury prevention, such as mattresses, skin supports and equipment, is vitally important for effective prevention
- A lack of training is a barrier to the provision of best-practice care, whether this be at an undergraduate level or in postgraduate clinical training programmes
- A multidisciplinary approach to pressure injury prevention is essential, with commitment from all health professionals
- The causes of pressure injury are complex and multifactorial; prevention does not simply focus on skin care but also focuses on managing continence and nutrition and moving a person in a way that avoids further skin damage
- Timely, regular and structured assessments of vulnerable skin areas for the development of pressure injuries are necessary in order to prevent pressure injuries in those who are at high risk.

PRESSURE INJURY CLASSIFICATION SYSTEM

When reporting pressure injuries, it is important to record which of the stages has developed, as this can assist your healthcare organisation, and others, to identify priority areas for quality improvement work. Recording the correct information will also ensure that data reported in the national minimum dataset is correct. The figure on the next page will help with classifying a pressure injury¹².

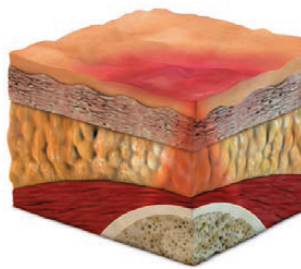
There is an internationally accepted classification system that enables pressure injuries to be described accurately. Refer to: National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. *Prevention and Treatment of Pressure Ulcers: Quick Reference Guide*. Emily Haesler (Ed.). Cambridge Media: Osborne Park, Western Australia; 2014.¹³

HOW TO CLASSIFY AND DOCUMENT PRESSURE INJURIES

The NPUAP/EPUAP Pressure injury classification system provides a consistent and accurate means by which the severity of a pressure injury can be communicated and documented.

Stage I pressure injury: non-blanchable erythema

- Intact skin with non-blanchable redness of a localised area usually over a bony prominence.
- Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area.
- The area may be painful, firm, soft, warmer or cooler compared to adjacent tissue.
- May be difficult to detect in individuals with dark skin tones.
- May indicate “at risk” persons (a heralding sign of risk).



Continued ...

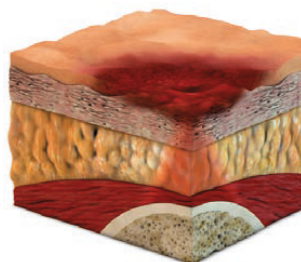
¹² While six stages are described for classification purposes, only four are stages. There are two categories of 'unstageable' - one where the injury is present but the depth is unknown and the other where it is not clear whether an injury is yet present. A copy of the above image is available from the New Zealand Wound Care Society

¹³ Available at: <http://www.npuap.org/wp-content/uploads/2014/08/Quick-Reference-Guide-DIGITAL-NPUAP-EPUAP-PPPIA-Jan2016.pdf>

HOW TO CLASSIFY AND DOCUMENT PRESSURE INJURIES *Continued ...*

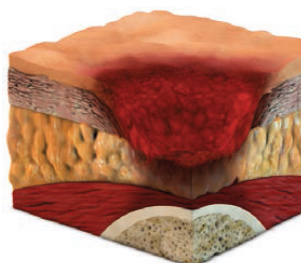
Stage II pressure injury: partial thickness skin loss

- Partial thickness loss of dermis presenting as a shallow, open wound with a red-pink wound bed, without slough.
- May also present as an intact or open/ruptured serum-filled blister.
- Presents as a shiny or dry, shallow ulcer without slough or bruising (NB bruising indicates suspected deep tissue injury).
- Stage II PI should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.



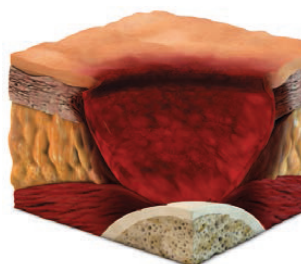
Stage III pressure injury: full thickness skin loss

- Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunnelling.
- The depth of a stage III PI varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage III PIs can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage III PIs. Bone or tendon is not visible or directly palpable.



Stage IV pressure injury: full thickness tissue loss

- Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed.
- The depth of a stage IV pressure injury varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these PIs can be shallow. Stage IV PIs can extend into muscle and/or supporting structures (e.g. fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone or tendon is visible or directly palpable.

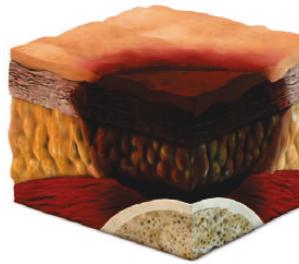


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HOW TO CLASSIFY AND DOCUMENT PRESSURE INJURIES Continued ...

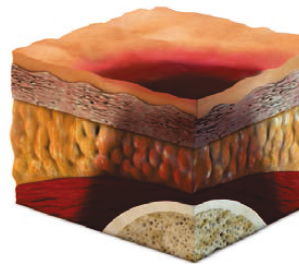
Unstageable pressure injury: depth unknown

- Full thickness tissue loss in which the base of the PI is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the PI bed.
- Until enough slough/eschar is removed to expose the base of the PI, the true depth, and therefore the stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as the body's natural biological cover and should not be removed.



Suspected deep tissue injury: depth unknown

- Purple or maroon localised area or discoloured, intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.
- Deep tissue injury may be difficult to detect in individuals with dark skin tone.
- Evolution may include a thin blister over a dark wound bed. The PI may further involve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.

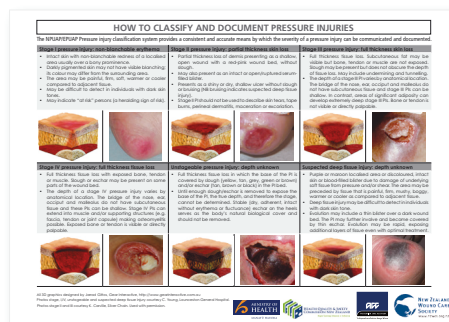


All 3D graphics designed by Jarrad Gittos, Gear Interactive, <http://www.gearinteractive.com.au>

Photos stage I, IV, unstageable and suspected deep tissue injury courtesy C. Young, Launceston General Hospital. Photos stage II and III courtesy K. Carville, Silver Chain.

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A printable version of 'How to classify and document pressure injuries' can be found at: www.acc.co.nz/treatmentsafety



SSKIN CARE BUNDLE: AN EXAMPLE

A care bundle organised around the SSKIN¹⁴ risk-factor-modification approach is included in the pressure injury prevention plan. It includes:

SKIN

Avoid positioning the person on an area of redness or where the skin does not appear to have recovered fully from previous loading.

Keep the skin clean and dry using a skin cleanser and moisturiser, and in areas of moisture a barrier cream.

Do not massage or rub skin that is at risk of pressure injury, as any high-friction massage can cause mild tissue disruption or provoke an inflammatory reaction, especially in frail elderly people.

SUPPORT SURFACES

Requirements for equipment such as support surfaces (including bed, chairs and cushions) are to be established appropriate to the care setting and the needs of the person, as well as the specific risk factors for the development of pressure injuries. Principles include:

- Support surfaces are individualised based on the risk factors identified and the person's needs
- Support surfaces are an adjunct to repositioning and overall skin care, rather than treatment in themselves, and repositioning should continue
- Seat-based stretchable or breathable cushions' conformance with body contours should minimise heating and the accumulation of moisture. The selection of seating support surfaces may depend on continence and other problems for seated person.

KEEP MOVING

All people receiving care are to be encouraged to mobilise where it is appropriate, and are to be provided with the appropriate supports and aids to enable them to do so safely.

Repositioning should aim to relieve or redistribute pressure on a vulnerable area. The frequency of repositioning will depend on the condition of the person and identified barriers to regular movement.

During repositioning it is essential to avoid subjecting the skin to pressure and shear force, so use manual handling aids to reduce friction and shear. Do not drag the person while repositioning. Slide sheets can also be used to spread the pressure on the individual's skin during repositioning.

Repositioning techniques are conducted in a safe manner for both the person and the carer. Use a mechanical lift with a split leg sling when transferring from bed to a wheelchair or bedside chair, and remove the sling immediately.

¹⁴ Gibbons W, Shanks HT, Kleinhelter P, Jones P. *Eliminating facility-acquired pressure ulcers at Ascension Health*. The Joint Commission Journal on Quality and Patient Safety, 32(9):488-96, 2006

INCONTINENCE

If incontinence is an issue, an individualised continence management plan is to be established. This includes:

- Cleanse the skin properly following episodes of incontinence
- Protect the skin from exposure to excess moisture with a barrier cream
- Use a skin moisturiser to hydrate the skin

If a Stage 1 injury still appears to be developing despite intervention, consider additional therapy such as microclimate control dressings or electrical stimulation.

NUTRITION

Where nutritional deficiency and malnutrition are identified, refer the person to a dietetic or nutrition team for a comprehensive nutrition assessment.

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The following documents were used to inform this document

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http://www.healthcareimprovementscotland.org/our_work/patient_safety/tissue_viability_resources/pressure_ulcer_standards.aspx

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