PRESSURE INJURY PREVENTION:

Translating Evidence into Practice

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Aim To describe how ACT Health has translated evidence for pressure injury prevention (PIP) and management into practice, 2002-2015.

Background Pressure injuries remain an important nurse sensitive patient safety issue. They predispose patients to pain, depression, infection, delayed healing, loss of independence, issues with body image and even death. Pressure injuries increase health sector financial costs secondary to increased length of stay and complex and expensive medical and surgical interventions.

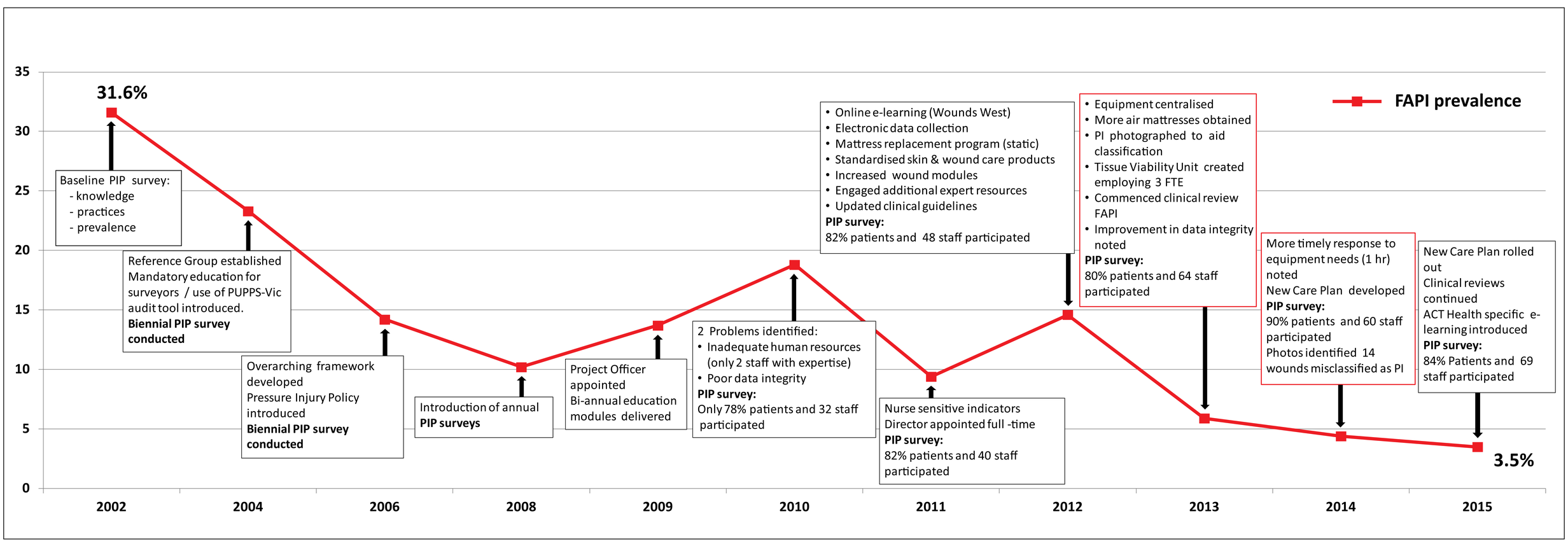
Methods Between 2002 and 2015 ACT Health introduced a number of evidence based actions which included annual PIP surveys and Clinical Reviews of significant facility acquired Pressure Injuries to determine the effect of these actions.

The methodology used for PIP surveys has been consistent and includes a similar tool for data collection, skin integrity of all consenting patients, review of clinical documentation, education of data collectors and photographs of pressure injuries found. The Clinical Review tool is based on the definition of unavoidable pressure injury and includes risk assessments completed, interventions consistent with the individual patient's needs, and the impact of the interventions monitored, documented and revised as appropriate.

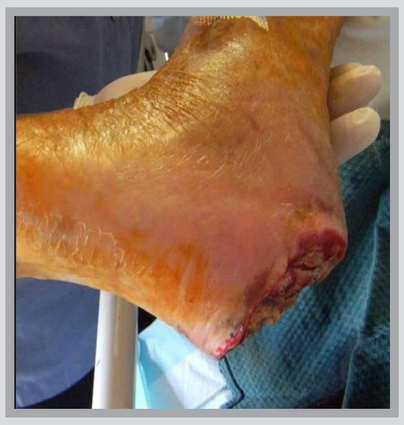
Results for 2015

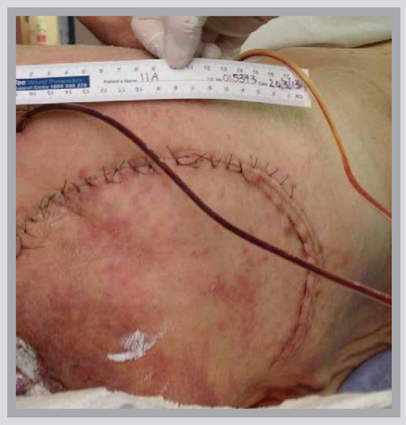
- 453 patients were surveyed
- Facility acquired prevalence reduced from 31.6% in 2002 to 3.5% in 2015
- Regression analysis adjusted for patient risk, age and mobility showed a significant difference between 2012 & 2013 results (p=0.0001)
- In 2015 the classification of facility acquired pressure injuries was largely stage 1 and stage 2 with 3 significant pressure injuries identified. (n= 2 unstageable, n=1 suspected DTI)
- When photographs examined: 17 suspected pressure injuries found to be skin tears, incontinence associated dermatitis, bruising or diabetes foot ulcers
- Clinical reviews of significant facility acquired pressure injuries (stage 3 & above) showed most were unavoidable

Timeline: Actions and Facility Acquired Pressure Injury (FAPI) Prevalence 2002 to 2015



Clinical review to determine if FAPI are avoidable or unavoidable 2014- September 2015





Key Messages

- The point prevalence of FAPI reduced significantly over the past 13 years.
- Introduction of photography enhances correct classification of wounds.
- Translating evidence into practice can improve the safety and quality culture and patient outcomes.
- ACT Health recognises that further surveys and clinical reviews need to be conducted to determine if the downward trend in pressure injury prevalence can be sustained.

References
1. Pressure Ulcers: *Avoidable or Unavoidable? Results of the National Pressure Ulcer advisory Panel Consensus Conference.* Ostomy Wound Management February 2011. pp 24-36.
2. 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: Perth, Australia; 2014.

PREVENTION *IS* BETTER THAN CURE