

Pressure Injury Flow Chart

Assessment

- Undertake a comprehensive structured pressure injury risk assessment
 - on admission
 - at regular intervals
 - upon a change in health status
- If a client is found to be 'at risk', assess skin regularly according to individual needs
- Assess pressure injuries on admission and at least weekly and record wound characteristics and stage of injury
- Regularly assess pain

Wound Bed Management

- Cleanse gently non-irritating, non-toxic solutions
- Remove necrotic or devitalised tissue

However, if dry eschar is present, do not debride until arterial flow is established. Mechanical or sharp debridement should only be done by trained health professionals
- Select a dressing which will:
 - maintain a moist wound bed
 - manage wound exudate and bioburden
 - protect the surrounding skin
 - minimise shear, friction and pressure

Management

- Position all persons with a pressure injury on a pressure redistribution support surface that meets their individual needs
- Reposition at regular intervals based on individual need
- Avoid positioning directly on bony prominences or pressure injuries
- Avoid shear and friction
- Limit the amount of time the head of bed is elevated
- Investigate signs of infection or delayed healing
- Re-evaluate treatment if there is no progress in healing after two weeks
- Implement a pain management plan
- Ensure optimal hydration and nutrition, supplementing protein, calories and micronutrients if deficiencies exist

Prevention

- Individuals found at risk should have a preventive plan in place
- Provide a high-specification foam or active support mattress for those at risk
- Off-load heels for individuals at risk
- Protect skin from friction (e.g. consider foam dressings on bony prominences)
- Reposition as frequently as required, considering response, condition and support surface
- Avoid foam rings, donuts or fluid filled bags
- Limit the amount of time with head of bed elevated or time spent sitting, as possible
- Employ correct lifting and manual handling techniques
- Avoid maceration of skin—use barrier preparations
- Maintain optimal nutritional status
- Educate client/caregiver(s) on risks and ways to minimise risk

Risk factors for a pressure injury

- Immobility or reduced mobility
- Increased body temperature
- Compromised skin status (dry, erythema)
- Poor or altered perfusion
- Altered sensory perception
- Increased skin moisture
- Poor nutritional status
- Acute or severe illness

Signs of pressure damage

- Localised heat, oedema, redness, pain
- Skin feels firm or boggy to touch
- Darkly pigmented skin may be maroon or purple rather than red

Document

- Level of risk and risk factors present
- Prevention strategies
- Wound assessment and management (size, stage, location, tissue, exudate, surrounding skin, interventions)
- Progress and outcome of interventions, including use of a validated healing measure

References:

NPIAP, EPUAP and PPPIA, Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline. Haesler E (Ed) 2019, EPUAP/NPIAP/PPPIA. • Wounds Canada. Best Practice Recommendations for the Prevention and Management of Pressure Injuries, in Foundations of Best Practice for Skin and Wound Management, 2018, Wounds Canada. • Registered Nurses' Association of Ontario, Assessment and Management of Pressure Injuries for the Interprofessional Team, 3rd ed. 2016, RNAO: Toronto. • Bolton LL et al. Association for the Advancement of Wound Care Venous and Pressure Ulcer Guidelines. Ostomy Wound Management 2014; 60: 24-66. • Coleman S, et al. Patient risk factors for pressure ulcer development: Systematic review. International Journal of Nursing Studies 2013; 50: 974-1003. • Gould L, et al. Wound Healing Society 2015 update on guidelines for pressure ulcers. Wound Repair Regen 2016; 24: 145-62.



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Pressure ulcer classification system*



Stage I

Intact skin with non-blanchable redness of a localized area, usually over a bony prominence. The area

may be painful, firm, soft, warmer or cooler as compared to adjacent tissue.



Stage II

Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed. May also present as an intact or open/ruptured

serum-filled blister. The blister is shiny or a dry shallow ulcer without slough or bruising (if bruising is present in the blister it indicates deep tissue injury).



Stage III

Full thickness loss of skin. 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. Depth varies according to anatomical location.



Stage IV

Full thickness skin and tissue loss with exposed palpable bone, tendon or muscle. Slough or eschar may be present.

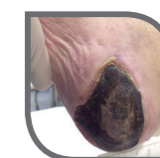
Often includes undermining and tunneling. Depth varies by anatomical location.



Suspected deep tissue injury

Persistent non-blanchable deep red, purple or maroon localised area of skin, or blood-filled blister, due to damage of underlying 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 tones.



Unstageable/Unclassified

Full thickness skin and tissue loss in which actual depth of the ulcer is completely obscured by slough and/or eschar. Staging cannot be determined until slough and/or eschar are removed.

*Reference EPUAP, NPIAP, PPPIA 2019

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