This is a guide only and does not replace clinical judgment

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promoting healthy skin

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Pressure Injuries

Information for **health professionals**

promoting healthy skin

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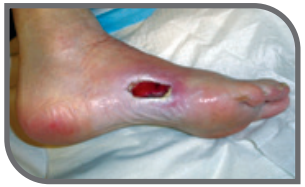
Pressure Injuries

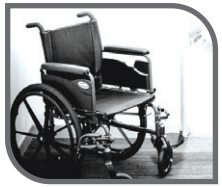
Assessment

- All clients should have a structured risk assessment performed and documented:
  - on admission
  - at regular intervals thereafter
  - following any change in health status
- Assessment should be done by staff with training and expertise in the area
- Assess the skin of at risk clients regularly as needed
- Regularly assess and document wound characteristics, including: location, size, stage, signs of infection, wound bed, undermining, and progress in healing. Re-evaluate treatment if no progress in two weeks.
- Undertake a comprehensive, holistic assessment

A pressure injury is localised damage to the skin and/or underlying tissue, as a result of pressure, or pressure in combination with shear

EPUAP, NPIAP, PPPIA 2019





Risk factors

- Immobility or reduced physical mobility
- Increased body temperature
- Loss of sensation
- Poor or altered perfusion
- Presence of constant moisture on skin
- Poor nutrition and hydration
- Dry skin or erythema
- Acute or severe illness

Management

- Document the pressure injury stage using an accepted classification system
- Position all clients with a pressure injury on a pressure redistribution support surface that meets their individual needs
- For heel pressure injuries, elevate heels off the bed
- Avoid positioning individuals directly on pressure injuries or bony prominences
- Reposition at regular intervals based on the person's needs and support surface
- Limit the time and degree (<30°) of head of bed elevation consistent with the person's condition and health needs
- Ensure optimal hydration and nutritional intake
- Gently cleanse the wound with a neutral, non-toxic solution
- Debride necrotic and devitalised tissue where appropriate

  **Debridement should only be undertaken by health professionals with expertise in the area*
- If there are signs of infection or delayed healing:
  - investigate via biopsy or swabs
  - consider topical antimicrobial dressings and/or debridement
- Implement a pain management plan

Prevention

- Develop and implement a plan to address individual risks to skin integrity
- Provide a high specification reactive support foam for clients found at risk
- Off-load pressure on heels for clients at risk
- Avoid vigorous rubbing of skin at risk of pressure injuries
- Avoid prolonged sitting in a bed or chair
- Avoid foam rings, donuts, non-medical grade sheepskin, or fluid filled bags
- Reposition the client as frequently as required, considering their risk
- Educate clients and carers on ways to minimise risk
- Employ correct lifting and manual handling techniques
- Protect skin exposed to friction: consider using a foam dressing on bony prominences
- Use a pH balanced skin cleanser and, if needed, barrier creams