Pressure Injury Flow Chart

Assessment

- **Undertake a pressure injury risk assessment:**
  - on admission (as soon as possible)
  - at regular intervals
- If a person is found 'at risk', complete a comprehensive risk assessment, repeat regularly and on any change in health status
- Assess pressure injuries regularly and record wound characteristics, stage of pressure injury, and progress in healing
- Regularly assess pain with a validated tool plus clinical assessment

Wound Bed Management

- Cleanse gently with non-toxic solutions, e.g., water or normal saline
- Debride devitalized tissue, *however, do not debride dry eschar in ischaemic limbs or heels. *Debridement should be undertaken by trained clinicians*
- Investigate signs of infection or delated healing

Select a dressing which will:

- Maintain a moist wound bed
- Manage wound exudate
- Protect the surrounding skin
- Minimise shear, friction and presure

Management

- Position all persons with a pressure injury on a pressure redistribution support surface that meets their individual needs. An active support surface may be used for persons who cannot freely mobilise.
- Reposition at regular intervals based on the person's needs, use reminder strategies
- Avoid positioning directly on bony prominences or pressure injuries
- Avoid shear and friction
- Keep the head of bed as flat as possible considering the person's needs and comfort
- Re-evaluate treatment if there is no progress in healing after two weeks
- Implement an individualised pain management plan
- Ensure optimal hydration and nutrition, supplementing protein, calories and micronutrients if deficiencies exist

Prevention

- Persons found at risk should have a preventive plan in place
- Provide appropriate pressure redistributing surfaces on beds and seating, as appropriate for those at risk
- Off-load heels for people at risk
- Protect skin from friction (e.g. consider prophylactic dressings on bony prominences & under medical devices)
- Reposition as frequently as required, considering the person's response, condition and support surface
- Avoid foam rings, donut-shaped devices or fluid filled bags
- Limit time with head of bed elevated or time spent sitting
- Employ correct lifting and manual handling techniques
- Avoid maceration of skin (cleanse regularly, use barrier creams)
- Maintain optimal nutritional status
- Support and educate person/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
- Immature skin & length of stay in neonates
- Presence of medical devices
- Previous history of pressure injuries

Signs of pressure damage

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

Document:

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

References

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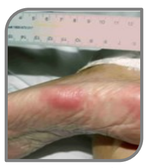
promoting healthy skin

Champions for Skin Integrity

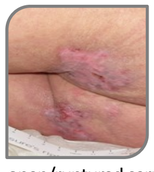
Pressure injury classification system

EPUAP, NPIAP, PPPIA 2019 Classification System



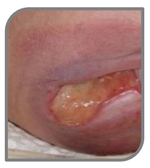
Stage I

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 skin 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 or 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 maybe 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 or eschar. Staging cannot be determined until slough and/or eschar are removed

This project was previously funded by the Australian Department of Health and Ageing under the Encouraging Better Practice in Aged Care (EBPAC) program