Pressure Injury Flow Chart

**Assessment**
- Undertake a pressure injury risk assessment (e.g., Waterlow, Braden)
  - on admission
  - at regular intervals
  - upon a change in health status
- If a client is found to be ‘at risk’, assess skin at least daily
- Suspected stage 1 pressure injuries should be reassessed 20 minutes after pressure is relieved
- Regularly assess for pain and develop a pain management plan if appropriate

**Wound Bed Management**
- Irrigate with warm clean water or normal saline
- Clean the wound gently
- Remove necrotic or devitalised tissue*
- Select a dressing which will:
  - maintain a moist wound bed
  - manage wound exudate
  - protect the surrounding skin
  - minimise shear, friction & pressure
  - topical negative pressure may benefit stage III & IV ulcers

**Management**
- Use a high specification reactive or active support surface for clients with pressure injuries
- Stage III, IV, unstageable or deep tissue injuries require an alternating pressure, low air-loss, continuous low pressure system, or air-fluidised bed; close observation; and a repositioning regime
- Avoid positioning directly on bony prominences or pressure injuries
- Avoid shear and friction
- Limit the amount of time the head of bed is elevated
- Use pillows and foam wedges to elevate or reposition bony prominences e.g., heels
- Manage wound exudate
- Protect the surrounding skin
- Avoid positioning directly on bony prominences or pressure injuries
- Avoid foam rings, donuts or fluid filled bags
- Avoid shear and friction
- Regularly assess for pain and develop a pain management plan if appropriate
- Limit the amount of time with head of bed elevated
- Avoid potentially irritating substances on the skin
- Avoid maceration of skin – use barrier
- Use pillows and foam wedges to elevate or reposition bony prominences e.g., heels
- Maintain a moist wound bed

**Prevention**
- Individuals found at risk should have a preventive plan in place
- Provide a high-specification foam or active support mattress for at risk clients
- Off-load heels for at risk clients
- Avoid positioning directly on bony prominences
- Avoid potentially irritating substances on the skin
- Avoid maceration of skin – use barrier preparations or creams
- Maintain optimal nutritional status

**Risk factors for a Pressure Injury**
- Reduced physical mobility
- Loss of sensation
- Impaired cognition or level of consciousness
- Incontinence
- Poor nutrition or recent weight loss
- Dry skin or skin in constant contact with moisture
- Acute or severe illness

**Symptoms of pressure damage**
- Localised heat, oedema, redness
- Skin feels firm or boggy to touch
- Darkly pigmented skin may be maroon or purple rather than red

**Progress and outcome of interventions, including use of a validated healing scale**

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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/necrotic 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 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 tunneling.
- Depth varies according to anatomical location.

**Stage IV**
- Full thickness loss with exposed bone, tendon or muscle.
- Slough or eschar may be present.
- Often includes undermining and tunneling.
- Depth varies by anatomical location.

**Suspected deep tissue injury**
- Purple or maroon localized area of discoloration intact 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.

**Unstageable/Unclassified**
- Full thickness 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.

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**References:**
- RNAO. Risk assessment and prevention of pressure ulcers. (Revised). Toronto, ON: RNAO 2011
- Royal College of Nursing. Management of pressure ulcers. London: RCPN and NICE 2005

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