

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*
 - *Mechanical or sharp debridement should only be done by trained clinicians*
- **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-fluidized 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, hips
- Provide high protein nutritional supplements, including arginine, for those with a stage 2 or greater pressure injury
- A multidisciplinary approach is needed, include physiotherapy, occupational therapy, nursing, dietitian and medical practitioner

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
- 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
- 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

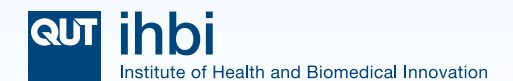
- Localised heat, oedema, redness
- Skin feels firm or boggy to touch
- Darkly pigmented skin may be maroon or purple rather than red

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 scale

References:

AWMA. *Pan Pacific Clinical Practice Guideline for Prevention and Management of Pressure Injury*. Osborne Park, WA: Cambridge Media 2012 • AAWC. *AAWC guideline of pressure ulcer guidelines*. Malvern, PA: AAWC 2010 • Stechmiller et al. *Guidelines for prevention of pressure ulcers*. *Wound Rep Regen* 2008. 16:151-168 • WOCN. *Guideline for prevention and management of pressure ulcers*. Mount Laurel NJ:WOCN 2010 • RNAO. *Risk assessment and prevention of pressure ulcers*. (Revised). Toronto, ON: RNAO 2011 • NICE. *The use of pressure-relieving devices for the prevention of pressure ulcers*. London: RCN 2004 • Royal College of Nursing. *Management of pressure ulcers*. London: RCN and NICE 2005 • Whitney et al. *Guidelines for treatment of pressure ulcers*. *Wound Rep Regen* 2006. 14:663-79



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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 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 tunnelling. 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 tunnelling.

Depth varies by anatomical location.



Suspected deep tissue injury

Purple or maroon localized area of discoloured intact 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.



Unstageable/Unclassified

Suspected deep tissue injury.

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.

Reference NPUAP 2007 <http://www.npvap.org/resources.htm>

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