

PRESSURE INJURY PREVENTION AND MANAGEMENT

Purpose: To promote the prevention of pressure injury development and promote the healing of existing pressure injuries.

PREVENTION

Risk Assessment

1. Consider bedfast and chairfast individuals to be at risk for development of pressure injury.
2. Use a structured risk assessment, such as the Braden Scale, to identify individuals at risk for pressure injury as soon as possible (but within 8 hours of admission).
3. Refine the assessment by including these additional risk factors.
 - Fragile skin
 - Existing pressure injury of any stage, including those ulcers that have healed or are closed
 - Impairments in blood flow to the extremities from vascular disease, diabetes, or tobacco use
 - Pain in areas of the body exposed to pressure
4. Repeat the risk assessment at regular intervals and with any change in condition.
 - Admission/Readmission, weekly for 4 weeks post-admission, then quarterly or with a change of condition.
5. Develop a plan of care based on the areas of risk, rather than on the total risk assessment score. For example, if the risk stems from immobility, address turning, repositioning, and the support surface. If the risk is from malnutrition, address nutrition, etc.

Skin Care

1. Inspect all the skin upon admission as soon as possible (but within 8 hours).
2. Inspect the skin at least daily for signs of pressure injury, especially nonblanchable erythema.
3. Assess pressure points, such as the sacrum, coccyx, buttocks, heels, ischium, trochanters, elbows, and beneath medical devices.
4. When inspecting darkly pigmented skin, look for changes in skin tone, skin temperature and tissue consistency compared to adjacent skin. Moistening the skin assists in identifying changes in color.
5. Cleanse the skin promptly after episodes of incontinence.
6. Use skin cleansers that are pH balanced for the skin.
7. Use skin moisturizers daily on dry skin.
8. Avoid positioning an individual on an area of erythema or pressure injury.

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Nutrition

1. Consider the use a valid and reliable screening tool to determine risk of malnutrition, such as the Mini Nutritional Assessment.
2. Refer all individuals at risk for pressure injury from malnutrition to a registered dietitian.
3. Assist the individual at mealtimes to increase oral intake.
4. Encourage all individuals at risk for pressure injury to consume adequate fluids and a balanced diet.
5. Assess weight changes over time.
6. Assess the adequacy of oral, enteral, and parenteral intake.
7. Provide nutritional supplements between meals and with oral medications, unless contraindicated.

Repositioning and Mobilization

1. Turn and reposition all individuals at risk for pressure injury, unless contraindicated due to medical condition or medical treatments.
2. Choose a frequency for turning based on the support surface in use, the tolerance of skin for pressure and the individual's preferences.
3. Consider lengthening the turning schedule during the night to allow for uninterrupted sleep for low risk residents.
4. Turn the individual into a 30-degree side lying position and use your hand to determine if the sacrum is off the bed.
5. Use wedges, pillows, other devices to maintain positioning as needed.
6. Avoid positioning the individual on body areas with pressure injury.
7. Ensure that the heels are free from the bed, off-loaded.
8. Consider the level of immobility, exposure to shear, skin moisture, perfusion, body size and weight of the individual when choosing a support surface.
9. Continue to reposition an individual when placed on any support surface.
10. Use a breathable incontinence pad when using microclimate management surfaces.
11. Use a pressure redistributing chair cushion for individuals sitting in chairs or wheelchairs.
12. Consider repositioning weak or immobile individuals in chairs hourly.
13. Place thin foam or breathable dressings under medical devices.
14. OT screen for proper positioning and devices as appropriate.

Education

1. Teach the resident and family about risk for pressure injury.
2. Engage the resident and family in risk reduction interventions.
3. Education to staff members on measures for the prevention of pressure injuries.

Prevention Process:

1. The licensed nurse will complete a Skin/Body Observation upon admission/readmission, then weekly and as needed.

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2. The licensed nurse will complete Skin Risk Assessment for residents on admission/readmission, weekly for 4 weeks, quarterly, at time of new pressure injury identification, and as needed.
3. Certified Nursing Assistants will inspect resident skin during bathing activities and report any irregularities or concerns to licensed nurse for evaluation.
4. Interventions will be implemented, and care planned to prevent pressure injury development or to promote pressure injury resolution.

Examples of interventions based on individualized resident needs may include the following. This list is not all-inclusive, nor does it apply to every resident or situation:

- Pressure reduction/redistributing mattress to bed.
- Pressure reduction/redistributing cushion to wheelchair
- Keep skin clean and dry and moisturized
- Promote nutrition and hydration – refer to Registered Dietitian as needed
- Avoid friction or shearing when assisting resident with transfers
- Manage incontinence and use moisture barrier
- Repositioning of residents; provision of required assistance as allowed and tolerated.
- Use positioning devices (pillow, blanket, folded sheet, etc.) to prevent skin-on-skin contact when positioning a resident on their side in bed.
- Maintain the head of bed at the lowest position based on resident medical condition
- Encourage and promote the elevation/off-loading of resident heels when in bed and prevent residents' feet from encountering foot board
- Increase mobility and activities as tolerated
- Avoid positioning the resident directly on medical devices such as tubes, drains, and other foreign objects

MANAGEMENT

Pressure Injury Definition:

A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs because of intense and/or prolonged pressure or pressure in combination with shear.

Pressure Injury Staging- Pressure injuries are staged to indicate the extent of tissue damage.

Stage 1 Pressure Injury: Non-blanchable erythema of intact skin which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.

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Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).

Stage 3 Pressure Injury: Full-thickness skin loss in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Stage 4 Pressure Injury: Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.

Deep Tissue Pressure Injury: Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon or purple discoloration or epidermal separation revealing a dark wound bed or blood-filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle, or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.

Medical Device Related Pressure Injury:

This describes an etiology. Medical device related pressure injuries result from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure

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injury generally conforms to the pattern or shape of the device. The injury should be staged using the staging system.

Mucosal Membrane Pressure Injury: Found on mucous membranes with a history of a medical device in use at the location of the injury. Due to the anatomy of the tissue these ulcers cannot be staged.

Procedure when a pressure injury is identified:

- Notify the physician/provider and the resident's responsible party
- Complete and document an initial assessment of the pressure Injury when it is identified to include the location, stage, size in centimeters, tissue type(s), color, peri wound condition, wound edges, sinus tracts, undermining, tunneling, exudate, odor, pain.
- Initiate treatment in accordance with physician orders.
- Implement interventions as appropriate
- Develop an individualized care plan to promote healing of the pressure injury.
- Complete and document a thorough weekly assessments of the pressure injury.
- Conduct a root cause analysis of the development of all pressure injuries.

<https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/quick-safety/quick-safety-issue-25-preventing-pressure-injuries/preventing-pressure-injuries/#.Y5CtAy-B22s>

<https://npiap.com/page/PreventionPoints>

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