



Pressure injuries

Standardised care process

Objective

To promote an evidence-based approach in the risk assessment, prevention, skin assessment and management of pressure injury (PI) wounds for older people who live in a residential aged care setting.

Why the prevention, assessment and management of pressure injuries is important

Pressure injuries are potentially life threatening, decrease the resident's quality of life and are expensive to manage. Prevention management is advocated for minimising a resident's risk of developing a pressure injury (Beeckman et al. 2020; Rae, Isbel & Upton 2018).

Definitions

Biofilm: a community of multispecies microbes that stick tenaciously to the wound bed (Murphy et al. 2020, p. S5).

Bottoming out: the state of support surface deformation beyond critical immersion whereby effective pressure redistribution is lost (EPUAP/NPIAP/PPPIA 2019, p. 379).

Debridement: The removal of devitalized (non-viable) tissue from, or adjacent to, a wound. The process effaces the wound bed of exudates, detaches bacterial colonies, and allows a stimulatory environment to be established (EPUAP/NPIAP/PPPIA 2019, p. 380).

Hard-to-heal wound (formerly known as 'chronic' wound): a wound that has failed to respond to evidence-based standard of care. The concept of wound hygiene is based on the premise that all hard-to-heal wounds contain biofilm. Because of the speed with which wound biofilm forms, a wound that exhibits exudate, slough and an increase in size by the third day of its occurrence may already be defined as hard-to-heal (Murphy et al. 2020, p. S7).

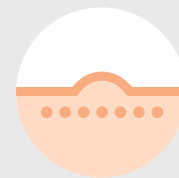
Immersion: penetration (sinking) into a support surface, measured by depth (EPUAP/NPIAP/PPPIA 2019, p. 383).

Offload: to remove pressure from any area (EPUAP/NPIAP/PPPIA 2019, p. 384).

Periwound: the area immediately adjacent to the wound edge and extending out as far as the tissue colour and consistency changes extend (EPUAP/NPIAP/PPPIA 2019, p. 385)

Pressure injury (PI): localised tissue damage usually over a bony prominence from pressure (causing tissue compression), often in combination with shear (causing tissue deformation). Pressure injury is caused by prolonged pressure on the skin or tissues from an underlying surface. Chair or bed surfaces cause the majority of pressure injuries. Devices such as casts and splints, tubing, straps and clothing can also cause pressure injury (Therapeutic Guidelines Limited 2019).

The injury may present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of softer tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, comorbidities and condition of the soft tissue (Persaud-Jaimangal, Ayello & Sibbald 2020, p. 502).



Support surfaces: specialized devices for pressure redistribution designed for management of tissue loads, microclimate, and/or other therapeutic functions (i.e., any mattress, integrated bed system, mattress replacement, overlay, or seat cushion, or seat cushion overlay) (EPUAP/NPIAP/PPPIA 2019, p. 155).

- **Active support surface:** a powered support surface that has the ability to change its load distribution properties with or without an applied load. Support surfaces with alternating pressure features; that is, a feature that provides pressure redistribution via cyclic changes in loading and unloading (i.e., inflation and deflation of air-filled cells) as characterized by frequency, duration, amplitude, and rate of change parameters are an example of an active support surface (EPUAP/NPIAP/PPPIA 2019, p. 155).
- **Reactive support surface:** a powered or non-powered support surface with the ability to change its load distribution properties only in response to an applied load (EPUAP/NPIAP/PPPIA 2019, p. 155).

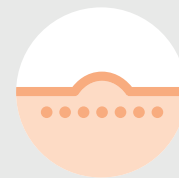
Wound hygiene: a structured method for overcoming the barriers to healing associated with biofilm, comprising strategies for cleansing, debridement, refashioning the wound edge and dressing the wound (Murphy et al. 2020, p. S5).

Team

Manager, registered nurses (RNs), enrolled nurses (ENs), personal care attendants (PCAs), leisure and lifestyle staff, general practitioner (GP), wound consultant, nurse practitioner (NP), continence advisor allied health professionals (such as a dietitian, physiotherapist, occupational therapist, podiatrist, exercise physiologist), residents and/or family/carers.

Acknowledgement

This standardised care process (SCP) has been developed for public sector residential aged care services (PSRACS) by the Australian Centre for Evidence Based Care (ACEBAC) at La Trobe University through the Department of Health and Human Services Strengthening Care Outcomes for Residents with Evidence (SCORE) initiatives. This SCP is one of a series of priority risk areas reviewed based on the best available evidence in 2023.



Brief standardised care process

Recognition and assessment

Complete a comprehensive pressure injury risk assessment with all residents:

- on admission
- whenever their condition changes
- daily where there is a known risk or an existing pressure injury wound.

On presentation of a pressure injury:

- assess the wound
- classify the level of tissue loss using a validated classification tool
- conduct nutritional screening and assessment
- document the wound assessment and classification outcomes.

Interventions

Pressure injury prevention

- Start an individualised management prevention plan including:
 - referral to a dietitian, occupational therapist or physiotherapist
 - selection of an appropriate support surface
 - schedule and technique for repositioning
 - protection of the resident's skin.

Pressure injury management

- Set treatment goals consistent with the values and goals of the resident.
- Re-evaluate and maintain pressure injury prevention interventions.
- Conduct a comprehensive pain assessment.
- Reposition resident to offload the pressure injury.
- Use an appropriate support surface.
- Use aseptic non-touch technique during dressing procedures. Protect the wound while showering.
- Implement principles of wound hygiene.
- Choose an appropriate dressing based on the wound's characteristics.
- Consider using adjunct treatments for stage 2–4 pressure injuries. Refer to wound consultant or NP.
- Consider surgical intervention for unresponsive stage 3 and 4 pressure injuries. Refer to GP.

Referral

- Wound care specialist (nurse or physician) or wound clinic
- Podiatrist
- Orthotist
- Continence advisor
- Dietitian
- Infection control specialist or microbiologist
- Physiotherapist or occupational therapist
- Surgeon

Evaluation and reassessment

- Regularly reassess the resident's risk of developing a pressure injury.
- Reassess the skin on an ongoing basis, particularly around high-risk areas.
- Regularly reassess prevention strategies and adapt these as required.
- Evaluate interventions and adjust the care plan as required.
- Monitor any signs and progress towards healing.
- Review for signs of infection and pain during wound care interventions.
- Regularly review repositioning schedules for at-risk residents.

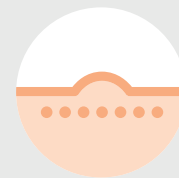
Resident involvement

- Fully inform and involve the resident and their family/carers in preventing and managing pressure injuries.
- Educate the resident and family/carers to recognise the early signs of a pressure injury.
- Encourage the resident and family/carers to relieve or redistribute pressure through frequent repositioning.
- Provide psychosocial support as needed.

Staff knowledge and education

Educate staff on the prevention, assessment and management of pressure injuries, including:

- how to conduct and recognise the difference between a risk assessment, skin and tissue assessment, and pressure injury classification
- selection and use of support surfaces, offloading devices and other equipment
- how to evaluate pressure injury prevention and management plans, including escalating and de-escalating care.



Full standardised care process

Recognition

Pressure injury risk assessment

Complete a comprehensive pressure injury risk assessment:

- on admission within 24 hours of entry to the facility
- whenever the resident's condition changes
- daily where there is a known risk or an existing pressure injury wound.

Pressure injury identification

Check for pressure injury:

- during routine care
- during comprehensive skin and tissue assessments, conducted periodically as indicated by the resident's degree of pressure injury risk.

Assessment

Pressure injury risk assessment

A comprehensive assessment of risk factors should be undertaken by a health professional with training and expertise in this area.

Important: Completing a risk assessment tool is only one step. There are four steps to completing a comprehensive pressure injury risk assessment.

- 1. Nutritional risk screening** – use valid and reliable tools.
- 2. Validated pressure injury risk assessment** – use a validated pressure injury risk assessment tool (Braden scale, Norton risk-assessment scale, Waterlow score)
- 3. Any other comorbidities and general factors not included in the tool**

Consider all of the following:

- restrictions to the resident's mobility and activity
- existing pressure injuries, including stage 1
- diabetes mellitus
- general perfusion status

- perfusion status of the lower limbs, heels and feet
- body temperature
- sensory perception
- age
- skin moisture
- blood tests to assess the resident's overall health status
- general health.

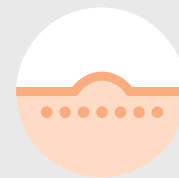
4. Skin and tissue assessment for pressure injury risk factors

Assess all skin head to toe, paying particular attention to bony prominences (sacrum, ischial tuberosities, greater trochanters and heels), under devices and any prophylactic dressings.

Identify any:

- pain at pressure points with or without palpation
- erythema and whether it blanches (consider potential cause)
- presence of existing pressure injuries
- evidence of previous pressure injury
- skin frailty
- other skin discolouration
- change in tissue consistency (for example, induration/hardness, oedema, boggy/mushiness) in relation to the surrounding tissue
- variations in moisture (for example, incontinence, sweating)
- variations in heat (for example, oedema or inflamed skin)
- non-intact skin
- scar tissue.

5. Document all risk assessment findings.



Pressure injury assessment

Stage classification

Classify and document the level of tissue loss by staging the pressure injury using the national Pressure Ulcer Advisory Panel (NPUP) / European Pressure Ulcer Advisory Panel (EPUAP) 2014 Pressure Injury Classification System.

General assessment

Conduct a comprehensive initial assessment of the resident with a pressure injury, including:

- Pain – verbal and non-verbal cues.
- Identify the causes and factors that delay healing.
- All factors identified in the pressure injury risk assessment **must** be considered, as these are likely to delay wound healing.
- Pay particular attention to potential sources of pressure and shear including:
 - inappropriate or faulty support surfaces
 - inappropriate positioning
 - inadequate repositioning regimes
 - prosthetics and other medical devices that come into contact with the skin
 - lifting and transfer aids
 - inadequate or absent bed mechanics.

Wound bed and periwound skin assessment

Consider using a validated tool to monitor pressure injury healing (for example, the Pressure Ulcer Scale for Healing (PUSH) Tool 3.0 or Bates- Jensen wound assessment tool). Check for:

- location, noting specific underlying bony prominence
- mechanism of pressure injury (use this information to determine whether the injury was caused by a device or by sitting, lying or slouching).
- duration.

For all stage 2, 3, 4 and unstageable pressure injuries, assess the:

- periwound skin
- wound bed, using the **TIME** framework acronym:
 - Tissue types
 - Infection and Inflammation, signs and symptoms.
 - Moisture balance
 - Epithelial edge
- wound size following thorough cleansing and, if necessary, debridement to expose the wound edge:
 - select a uniform, consistent method for measuring pressure injury size and surface area to facilitate meaningful
 - comparisons of wound measurements across time
 - maximum length, width (and/or surface area) and depth
 - length and direction of any undermining and tunnelling.

Wound measurements should always be taken with the resident in the same position.

Consider using digital photography as an adjunct to the documented wound assessment. A wound photograph does not replace a wound assessment.

Document all assessment findings.

Interventions

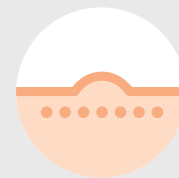
Pressure injury prevention plan

Start and maintain an individualised management prevention plan for residents who are at risk of developing, or have, a pressure injury.

This plan should consider the following:

Referrals

- Refer to dietitian – if nutritional risk and existing pressure injuries are identified through screening
- Refer to occupational therapist, physiotherapist and/or exercise physiologist or orthotist
 - if required for assistance with pressure redistribution, seating, manual handling, mobility.
- Refer to a seating expert – residents with, or at risk of, pressure injuries who spend prolonged periods in a chair or wheelchair.



Support surfaces

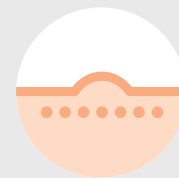
- Select a support surface, bed and chair that meet the resident's need for pressure redistribution based on the following factors:
 - level of immobility and inactivity
 - supports the resident's stability and full range of activities
 - need to influence microclimate control and shear reduction
 - body size, configuration and weight of the resident
 - number, severity and location of existing pressure injuries
 - risk of developing new pressure injuries
 - effects of posture and deformity on pressure distribution
 - mobility and lifestyle needs.

Repositioning

- General repositioning for all residents:
 - Reposition all residents with, or at risk of, pressure injuries on an individualised schedule, unless contraindicated.
 - Do not use ring or donut-shaped devices.
- Repositioning frequency:
 - No support surface provides complete pressure relief. Repositioning is always necessary.
 - To determine frequency, consider:
 - predicted skin and tissue tolerance based on skin assessment findings
 - level of activity, mobility and ability to independently reposition
 - general medical condition
 - overall treatment objectives
 - pain and comfort.
- Recognise that some residents may damage tissues with excessive movement. For example, residents with agitation or who regularly drag when self-repositioning.
- Implement repositioning reminder strategies to promote adherence to repositioning regimes.

- Repositioning techniques:
 - Reposition the resident to relieve or redistribute pressure using manual handling techniques and equipment that reduce friction and shear.
 - Avoid positioning a resident on existing pressure injuries, on areas of erythema, on their heels or other bony prominences, or directly on medical devices (for example, tubes, drainage systems).
- Repositioning in bed:
 - Keep the head of the bed as flat as possible.
 - When elevating the head of the bed, maintain elevations at 30° or lower, if possible.
 - Use the 30° lateral side lying position in preference to the 90° side lying position when positioning.
- Reposition and pressure redistribution for seated residents:
 - Avoid prolonged sitting sessions.
 - Perform regular skin assessments when a resident is seated on any chair and support surface combination to determine the most appropriate duration of seating sessions.
 - Ensure seated residents are positioned to maintain a proper posture, foot support, range of movement and pressure redistribution.
- Protect residents' skin from moisture, friction and shear by:
 - using correct transferring and manual handling equipment and techniques

Note: do not rub or massage areas at risk of pressure injury.



Manage skin health

- Implement a plan to manage skin health and protect from conditions that may cause moisture-associated skin damage, such as:
 - incontinence
 - wound exudate
 - excessive sweating, especially in skin folds
 - stomal leakage
 - saliva.

Note: do not rub or massage areas at risk of pressure injury

- Consider referral to a continence advisor.
- Reduce the risk of pressure injuries on heels by:
 - elevating resident with a specifically designed heel suspension device or a pillow/foam cushion. Offload heels completely to distribute the weight of the leg along the calf, without placing pressure on the Achilles tendon. The knees should be slightly flexed to prevent compression of the popliteal veins and subsequent deep vein thrombosis
 - using prophylactic dressings on heels in combination with heel offloading and other preventative interventions.
- Reduce the risk of medical device-related pressure injuries by:
 - not positioning on medical device
 - correctly sizing and shaping the device
 - correctly securing as per the manufacturer's instructions.
- Prophylactic dressings
 - If you are using prophylactic dressings, you must have processes in place to ensure the skin under the dressing is assessed daily for pressure injury.
 - Replace the dressing if it becomes dislodged, bunched up, loosened or excessively moist.

Pressure injury management plan

Set treatment goals consistent with the value and goals of the resident, with input from their family/carers, and develop a treatment plan that supports these values and goals.

Interventions to prevent pressure injuries should be re-evaluated and included in the management plan, together with the following additional strategies:

Nutrition

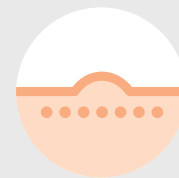
- Urgent referral to dietitian for nutritional assessment.

Pain

- Conduct a comprehensive pain assessment.
- Implement an individualised pain management plan with appropriate pharmacological and non-pharmacological pain relief strategies. Include repositioning, offloading and consideration of support surface selection.

Repositioning

- Reposition the resident to optimally offload the pressure injury and maximise redistribution of pressure.
- For residents with a sacral or ischial pressure injury:
 - bed rest is indicated
 - refer to occupational therapist and wound consultant / nurse practitioner on extended bed rest as this negatively impacts emotional health and wellbeing.
- Refer to an occupational therapist for a progressive seating schedule to accommodate wellbeing and lifestyle factors if pressure injury fails to improve.



Support surfaces

- Consider changing to a specialty support surface when the resident:
 - cannot be positioned off the existing pressure injury
 - has pressure injuries on two or more turning surfaces (for example, the sacrum and trochanter) that limit repositioning options
 - has a pressure injury that fails to heal, or the pressure injury deteriorates despite appropriate comprehensive care
 - is at high risk for additional pressure injuries
 - has undergone flap or graft surgery
 - is in pain or uncomfortable
 - ‘bottoms out’ on the current support surface.

Foot – including heel and toes

- Urgent referral to podiatrist for offloading plan, advice regarding wound management and consideration of referral to orthotist.
- Urgent GP referral for arterial duplex doppler scan for peripheral arterial assessment or arrange peripheral arterial disease screening by podiatrist, wound management consultant or nurse competent in the procedure.

Medical devices

- If pressure injury is related to a medical device, refer to interdisciplinary team for review of type and fitting.

Wound bed and periwound skin treatment

- All stage 2, 3, 4 and unstageable pressure injuries require a wound management plan.
- If pain prevents adequate wound hygiene, consider topical anaesthetic. Refer for expert advice if required.

Infection prevention and management

Aseptic technique

- Use aseptic technique for all wound hygiene and dressing procedures. Use a waterproof cover over wound dressing while showering.

Wound hygiene

- Implement principles of wound hygiene to prevent pressure injuries from becoming hard-to-heal, and to treat those that are hard-to-heal.

Cleansing

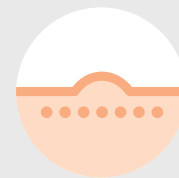
- Saline or water rinses/flushes will not remove biofilm. Ideally, use an antiseptic or antimicrobial wash or surfactant solution to aid surface and periwound cleansing.
- Use firm gentle pressure to clean, keeping in mind the comfort of the resident.
- Cleanse the wound bed to remove devitalised tissue, debris and biofilm.
- Cleanse the skin located 10–20 cm around the wound or the area that had been covered by a dressing or device (for example, bandages), whichever is larger, with the aim of decontaminating the area and removing dead skin scales and callus.

Debridement

- Avoid disturbing dry, hard, firmly attached, non-movable eschar in ischaemic limbs and feet, unless infection is suspected.
- For all other pressure injuries, use a debridement pad or gauze at each dressing change. Use as much physical force as is comfortable. Attempt to debride necrotic tissue, slough and debris in the wound bed and periwound skin.
- Debridement that does not achieve pinpoint bleeding of the wound bed, such as autolytic debridement, may not physically remove the biofilm. Refer to podiatrist or nurse competent in other forms of debridement.

Refashion wound edge

- Use gauze or debridement pad to remove necrotic, crusty and/or overhanging wound edges that may be harbouring biofilm.
- If skin edges are still not flat and level with the raw wound bed (like a ‘beach’), or if they are like a ‘cliff’, advancement of the wound edge may not occur. Refer to podiatrist or nurse competent in sharp debridement to refashion the wound edge.



Dress

- Following cleansing, debridement and the edges have been refashioned, all hard-to-heal wounds require an antimicrobial dressing.

Spreading or systemic infection

- If there are signs of spreading or systemic infection, seek urgent medical advice. Antibiotics may be needed.
- Refer to infection control nurse, infectious diseases consultant or microbiologist for recurrent or unresponsive infections.

Surgical management

- Contact a GP to consider a surgical consultation for a resident with a pressure injury that:
 - has advancing cellulitis or is a suspected source of sepsis
 - has undermining, tunnelling, sinus tracts and/or extensive necrotic tissue not easily removed by conservative debridement
 - is a stage 3 or 4 and not closing with conservative treatment.

Dressings

- Dressings alone are not sufficient to heal pressure injuries. Dressings are used as an adjunct to treat the causes of the pressure injury.
- Select the most appropriate wound dressing based on the goals and self-care abilities of the resident, and based on clinical assessment, including:
 - if hard-to-heal, use wound hygiene principles above
 - diameter, shape and depth of pressure injury
 - ability to achieve desired level of wound moisture
 - type and volume of wound exudate
 - type of tissue in the wound bed
 - condition of the periwound skin
 - presence of tunnelling and/or undermining
 - wound pain.
- Consider referral to wound CNC / NP for negative pressure wound therapy, as an adjunct therapy for increasing the rate of healing of stage 3 and 4 pressure injuries.

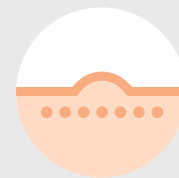
Referral

- Wound care specialist or wound clinic
- Podiatrist for specialised care of pressure injuries in the foot and ankle
- Orthotist for custom-made pressure-relieving boots/shoes
- Continence advisor
- Dietitian to assess and manage residents' nutritional status
- Infection control specialist or microbiologist for recurrent or unresponsive infections
- Physiotherapist or occupational therapist for pressure redistribution, seating, manual handling, and mobility
- Surgeon for surgical intervention, surgical debridement, flap closures and vascular assessment

Evaluation and reassessment

Evaluation of prevention plan

- Regularly reassess the resident's risk of developing a pressure injury, particularly when there is a change in clinical status.
- Conduct ongoing periodic comprehensive skin and tissue assessments:
 - as indicated by the resident's degree of pressure injury risk
 - to detect the early signs of pressure damage, particularly on at-risk areas.
- Regularly reassess prevention strategies and adapt these as required.
- Evaluate interventions, consider if healing is the aim and adjust the care plan as required.



Evaluation of management plan

For Stage 1 and suspected deep tissue injury PIs:

- Document daily skin assessments to ensure early identification of possible evolution into stage 2, 3, 4 or unstageable pressure injuries.

For all Stage 2, 3, 4 and unstageable pressure injuries:

- Document the status of the wound bed and periwound at each dressing change.
- Measure the wound at least weekly.
- Evaluate for any signs of healing such as:
 - smaller wound measurements
 - less non-viable tissue
 - fewer signs of infection.
- If the pressure injury does not show signs of healing within two weeks, re-evaluate the care plan.

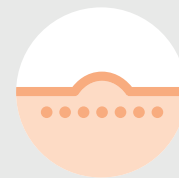
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- Educate the resident and family/carers to recognise the early signs of a pressure injury.
- Encourage the resident and family/carers to relieve or redistribute pressure through frequent repositioning.
- Provide psychosocial support as needed.

Staff knowledge and education

Educate staff about:

- the prevention, assessment and management of pressure injuries, including:
 - how to conduct and recognise the difference between a risk assessment, skin and tissue assessment, and pressure injury classification
 - selection and/or use of support surfaces, offloading devices and other equipment.
- how to evaluate pressure injury prevention and management plans, including escalating and de-escalating care.



Evidence base

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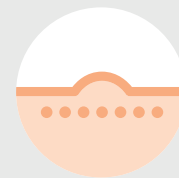
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Important note: This standardised care process (SCP) is a general resource only and should not be relied upon as an exhaustive or determinative clinical decision-making tool. It is just one element of good clinical care decision making, which also takes into account resident/patient preferences and values. All decisions in relation to resident/patient care should be made by appropriately qualified personnel in each case. To the extent allowed by law, the Department of Health and the State of Victoria disclaim all liability for any loss or damage that arises from any use of this SCP.

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