Pressure Injury Prevention & Management
Evidence-Based Best Practices

Risk Assessment: Key Elements

- Complete a risk assessment as soon as possible after admission or with first contact by a health professional after admission.
- Repeat the risk assessment weekly for the first four weeks after admission, with a significant change in condition, and at least quarterly.
- Use a structured assessment process and a validated tool for conducting risk assessments (such as the Braden, Waterlow, or Norton scales).
- Include all the following in the risk assessment:
  - Head to toe skin assessment
  - Evaluation of mobility and activity
  - Presence of an existing pressure injury or previous history of a pressure injury
  - Pain assessment
  - Health history and medical diagnoses that indicate impaired circulation, oxygenation, or perfusion (such as diabetes, vascular disease)
  - History of smoking
  - Nutrition and hydration status, including a comprehensive nutritional assessment for those at risk for malnutrition or with an active pressure injury
  - Skin moisture
  - Body temperature
  - Sensory impairment or ability to respond to pressure-related discomfort
  - Medical and non-medical devices contact the skin, tissues, and/or mucous membranes

Wound Assessment: Key Elements

- Complete a comprehensive initial assessment for each pressure injury that includes all the following:
  - Complete health/medical, psychological, and social history
  - Head-to-toe skin assessment
  - Wound assessment that includes:
Use of a validated tool for healing (such as the PUSH, BWAT, or Design-R tool)
Location and size of the wound (length, width, and depth)
Stage of the wound, using the NPIAP 2016 staging system
Evaluation of the wound bed including the presence of granulation tissue, odor, necrotic tissue, drainage/exudate, or slough
Presence of undermining, tunneling or sinus tracts
Condition of the peri-wound tissue (color, temperature, bogginess, fluctuation, or edema)
Positioning and support surfaces
Pressure injury-related pain assessment
Nutritional status
Health-related quality of life assessment
Values and goals of the person, family, and/or responsible party
Risk for developing pressure injuries
Functional capacity
Healing environment, available resources and supports

- Complete a reassessment of the wound at least every seven days
- Weekly pressure injury reassessments should include all the following:
  - Use of a validated tool for healing (such as the PUSH, BWAT, or Design-R tool)
  - Location and size, including length, width, and depth
  - Stage, using the NPIAP 2016 staging system
  - Wound bed, including granulation, odor, necrotic tissue, drainage/exudate, or slough
  - Presence of undermining, tunneling, or sinus tracts
  - Condition of the peri-wound tissue, including color, temperature, bogginess, fluctuation, or edema
  - Positioning and support surfaces
  - Pain status
- Re-evaluation of interventions in no healing noted for two consecutive weeks

**Care Planning: Key Elements**

- Include measurable goals for pressure injury prevention and/or healing
- Interventions that address all the following (as applicable):
  - Baseline information
  - Preventative measures with specific instructions and timeframes for each
  - Person-centered repositioning instructions with considerations to mobility levels
  - Individualized nutrition plan
  - Location specific interventions
Specific support surfaces identified
Frequency of pressure injury risk assessment and/or reassessment of existing pressure injuries
Specific treatment instructions and timeframes for pressure injury care
Parameters for notifying the attending physician of changes in the pressure injury risk assessment and/or the status of or changes in existing pressure injuries
Education provided to the person, family members, and/or responsible party
  • Addresses and supports the person’s values and goals
  • Person-centered interventions are reviewed and updated based on findings of reassessment
  • The interdisciplinary team is involved in developing the care plan, including the person, family members, and/or responsible party

Outcomes: Key Elements
• Person-centered interventions identified in the care plan are implemented on a consistent basis
• Effectiveness of those interventions is monitored and evaluated

Other Considerations
• Does the person performing wound care have certification or advanced training in wound care?

Additional Resources
• National Pressure Injury Advisory Panel (NPIAP) Resources
• NPIAP Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline-The International Guideline