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