



# Pressure Injury Prevention & Management

## Care Plan Highlights

A person-centered care plan should be developed for anyone with conditions that increase the risk for developing a pressure injury (PI) or for anyone with an existing PI. Care plans should be reviewed at least quarterly, with any significant change of condition, when a risk or skin assessment has changed, or when the goals are not being met. Care plan revision may require a modification in the expected goals and/or multi-disciplinary approaches.

### Problems/Needs Statement

- At risk for developing a PI, related to baseline information, such as identified risk factors, validated risk assessment tool score, etc.
- Actual PI, as evidenced by location, PUSH score, description (length/width/depth), NPIAP stage, tunneling/undermining, exudate, tissue type and any other appropriate descriptions of the wound

### Goals/Outcomes

- Measurable and realistic goals, specifying dates for short-and long-term goals
- For those at risk – PU will not develop
- For those with an existing PI – response to treatment

### Interventions/Approaches

- Education of the person, family, or responsible party, including the person's values and wishes, identified risk factors, treatment plan, and routine head-to-toe assessment
- Timing and frequency of risk assessment and re-evaluation of existing PI
- Specific interventions based on the identified risk factors and wound assessments
- Treatments orders, including any medications, dressing changes, nutritional support, positioning or support surfaces
- Communication between nursing staff, physician, and other members of the interdisciplinary team

- Pain assessment and current treatments, including need for premedication before wound care
- Current physical status
- Treatment re-evaluation if no improvement in wound status in two consecutive weeks

**Interdisciplinary Team Members**

- The person and his/her chosen representatives are included in the care planning process
- Identify which department and/or staff members are responsible for implementing each approach/intervention

**Resources**

[HHSC Quality Monitoring Program – Pressure Injury Prevention and Management](#)

[National Pressure Injury Advisory Panel \(NPIAP\) Resources](#)

## Care Plan Example – At Risk for Pressure Injury

Problem/Need	Goal/Outcomes	Interventions/Approaches	Team Members
<p>Mrs. Smith is at risk for developing a PI related to:</p> <ul style="list-style-type: none"> <li>• 72 years old</li> <li>• Mild cognitive impairment</li> <li>• Bladder incontinence</li> <li>• Mobility impairment – uses wheelchair for mobility</li> <li>• Braden score of 10 (high risk)</li> </ul>	<p>Short-Term: Mrs. Smith will permit staff to help her reposition at least every 2 hours for 75% of attempts over the next 90 days.</p> <p>Long-Term: Mrs. Smith will not develop skin breakdown of any type during her stay.</p>	<p>Review importance of hydration, repositioning, blood sugar control, reducing friction and incontinent care with Mrs. Smith and her daughter.</p> <p>Discuss the impact of Alzheimer’s on the ability to follow directions and complete tasks with Mrs. Smith and her daughter.</p>	<p>Nurse, reinforced by CNA and other team members: dietitian, physical therapist</p>
		<p>Observe skin condition daily</p> <p>Head-to-toe skin assessment at least weekly</p> <p>Braden Scale quarterly and with change of condition (per facility policy)</p> <p>If redness/breakdown is noted, notify nurse immediately</p> <p>Provide fluids and nutrition per dietitian recommendations</p> <p>Albumin levels will be monitored every 6 months per current order</p> <p>Physical therapy 2x per week as ordered</p>	<p>CNA, nurse dietitian physical therapist</p>
		<p>Remind Mrs. Smith to shift her weight at least hourly while up in wheelchair or in a seated position in bed</p> <p>Assist Mrs. Smith to turn/reposition in bed at least every 2 hours during the day/evening, avoiding friction or shearing. If she refuses, try again in 15 minutes</p> <p>Mrs. Smith prefers not to be awakened every 2 hours at night, and asks that staff help her with incontinent care and repositioning at 11 pm and 3 am each night</p> <p>Pressure relieving overlay on top of mattress</p> <p>Gel pad to be used when up in her wheelchair</p> <p>Check for incontinence every 2 hours while awake, and provide incontinent care as needed</p> <p>Complete three-day voiding/incontinence log and evaluate for a scheduled or prompted continence promotion plan.</p>	<p>CNA, nurse, physical therapist, dietitian</p>

## Care Plan Example: Actual Pressure Injury

Problem/Need	Goal/Outcomes	Interventions/Approaches	Team Members
<p>Mr. Jones has an existing PI as evidenced by:            Stage 2 to right heel on admission from hospital on 3/13/22</p> <ul style="list-style-type: none"> <li>• 1 cm x 2 cm x 1 cm, pink granulation tissue in wound bed.</li> <li>• No exudate, undermining or tunnelling</li> <li>• 3/14/22 PUSH score 6</li> </ul> <p>Significant history:</p> <ul style="list-style-type: none"> <li>• 84 years old</li> <li>• O2 via NC (COPD)</li> <li>• BMI-15, visible bony prominences</li> </ul>	<p>Short term goals:</p> <ul style="list-style-type: none"> <li>• PI will show signs of healing with a PUSH score of 4 or less in the next 90 days.</li> <li>• Maintain an acceptable level of pain during dressing changes (3/10 per Mr. Jones).</li> <li>• No additional PIs will develop</li> </ul> <p>Long term goal:            Once current PI has healed, Mr. Jones will maintain intact skin for the remainder of his stay.</p>	<p>Review importance of hydration, repositioning, and ways to reduce friction with Mr. Jones</p> <p>Discuss current treatment plan including dressing change procedures and pain management options</p>	<p>Nurse, reinforced by CNA</p>
		<p>Observe Mr. Jones' skin condition during daily care, with a head-to-toe skin assessment at least weekly            Braden Scale: weekly x 4, then monthly and with change of condition (per facility policy)            Weekly wound assessment with measurements, PUSH score and skin assessment update            Daily dressing change with Mepilex foam, assess for S/S of infection            Pre-medicate with Tylenol #3 – 1 tablet, 1 hour prior to dressing change            Notify MD and DON if wound shows no improvement within 2 weeks            Pressure points (ears, nares, cheeks) r/t use of nasal cannula must be inspected every shift or with any complaint of discomfort – use foam padding in these areas            If redness or new breakdown is noted, notify the nurse immediately for follow-up</p>	<p>CNA            wound care nurse            respiratory therapist</p>

Problem/Need	Goal/Outcomes	Interventions/Approaches	Team Members
		<p>Mr. Jones ambulates independently but needs reminders to offload pressure from heels when in bed.</p> <p>Low air-loss mattress on bed</p> <p>He does not want to use foam blocks but will use pillows to offload pressure from his heels</p> <p>Mr. Jones can reposition himself in bed but needs assistance with placement of the pillows for his heels</p> <p>He prefers to wear open heeled shoes for comfort when out of bed</p>	Nurse, CNA
		<p>Weigh Mr. Jones weekly on Thursday morning, using the same scale each time</p> <p>Immediately notify the charge nurse of any weight loss from one week to the next</p> <p>Labs as ordered to evaluate Mr. Jones' nutritional status: serum albumin, prealbumin, iron, folate, B12 - notify MD/dietitian of results</p> <p>Mr. Jones eats a regular diet, plus a protein shake twice daily (he prefers the chocolate shake)</p> <p>If Mr. Jones eats less than 50% of his meal, offer substitutes, or an additional snack if he prefers</p>	CNA, nurse dietitian dietary manager

**NOTE:** This is not an actual care plan and should not be copied for use in the facility. It is intended to provide examples of key elements of best practice regarding person-centered care planning for pressure injury prevention and management.