Pressure Injury: Prevention and Management in Adults & Children (Summary)

(NOTE: 'Patient' refers to patient, resident or client in this document)

Site Applicability

PHC sites

Practice Level

Basic skills for the following professions (within their respective scope of practice):

- NP, RN, RPN, LPN
- OT, PT, RD

Quick Links

Need to Know

- This decision support tool is a summary of the British Columbia Provincial Interprofessional Skin and Wound Committee's pressure injury prevention, management, and Braden Scale guidelines and procedures. For more detailed information, please refer to Related Documents.
- A pressure injury (PI) (also known as pressure ulcers, bed sores or decubitus ulcers) is "localized damage to the skin and/or underlying tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open injury 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 soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue" (NPUAP, 2016, p.1).

- PIs cause considerable harm to patients, hindering functional recovery, frequently causing pain, and the development of serious infections. PIs have also been associated with an extended length of stay, sepsis, and mortality.
- Any stage 3 or stage 4 PI that is acquired after admission to hospital is designated as a 'Never Event' by the Canadian Patient Safety Institute. Stage 3 and 4 injuries can lead to serious harm/ complications including sepsis or death.
- The Braden Scale for Predicting Pressure Sore Risk (ages 6 and up) and the Braden Q Scale (ages 5 and below) are the validated risk assessment tools used for determining PI risk. These tools assess for six key factors (subscales) that contribute to the development of PIs.

I.	Sensory Perception	IV.	Mobility
II.	Moisture/ Incontinence	V.	Nutrition
III.	Activity	VI.	Shear and friction

- PIs can be reduced through admission assessments, inspecting the skin daily, managing moisture on skin, minimizing pressure, friction and shear; optimizing nutrition and hydration, using pressure redistribution devices and avoiding skin massage.
- There are numerous unmodifiable risk factors for skin breakdown that may lead to pressure injury development (e.g. conditions that decrease oxygenation and/ or perfusion, medications that pre-dispose skin to fragility or breakdown, previous skin breakdown, etc.)
- All patients as being at risk of developing a PI must have a Braden Prevention Intervention Care Plan developed and implemented.
- Patients and family members and caregivers must be provided with education and prevention strategies on PI risk factors (e.g. Patient Health Education Materials).
- Every PI must be staged. See Pressure Injuries.
- Every PI must be reported to Patient Safety and Learning Systems (PSLS).
    - If pressure injury was present on admission
    - If pressure injury develops during admission
    - At transition of care (e.g. *transfer from acute to long term care OR between units)*
    - When a pressure injury worsens (progresses towards Stage 4)
- Assessment of Braden is recommended for patients in Emergency Departments who are admitted and awaiting an inpatient bed
- Prior to transfer, advance notice should be given to other receiving facility or unit for patients requiring specialized pressure redistribution equipment.

Guideline

Frequency of Assessments

Complete assessments to determine risk of PI development as per following schedule:

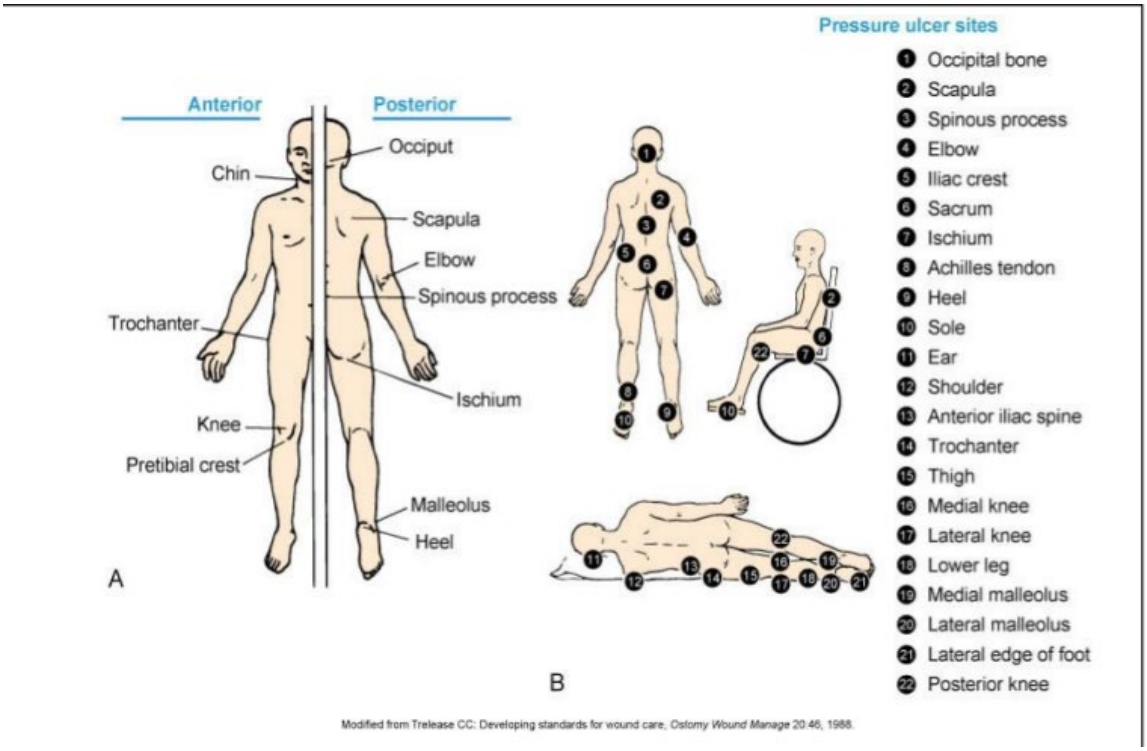
	On Admission complete Braden and Skin Assessments:	For Adults with **Braden 18 or less** complete routine Braden and Skin Assessments:	For adults with **Braden 19 or greater** complete routine Skin Assessments:
Critical Care	Within 8 hours of admission	Every Shift	Every Shift
Acute Inpatient Units	Within 8 hours of admission	Every Shift	At least daily
Rehabilitation Units	Within 24 hours of admission	Every Shift	With bathing
Long Term Care	On move-in day	See Site Specific for more details.	With bathing
Operating Room	All patients considered Very High Risk. Ensure appropriate linen is used on each surface (e.g. air mattresses, seating cushions, etc.) Pressure Injury Prevention Interventions as per operating room protocols.		
Surgical Day Care	Braden Assessment to be completed on all patients who will be admitted to acute care.		
All areas	Repeat Braden and Skin Assessments if: • Condition has deteriorated • Patient has been transferred		

Assessment

1. **Assess for patient concerns:**
   - quality of life issues that may impact treatment (e.g. palliative/end-of-life care);
   - effect of patient's current environment on care;
   - patient/ family goals of care and preferences for prevention, treatment and management of risk factors;
   - any culture or traditions impactful on care; and
   - patient/family ability and motivation to comprehend and participate in the prevention plan.

2. **Assess risk for pressure injury development using:**
   a. Braden Scale for Predicting Pressure Sore Risk. (See Appendix A)

3. **Complete a Head-to-Toe Skin Assessment:**



- visualize the skin from head to toe, remove clothing as needed (including socks);
- assess bony prominences (see picture below) for evidence of blanchable or non-blanchable erythema, a deep tissue injury, a pressure injury, or that the skin is intact and healthy;
- for patients with darkly pigmented skin: colour changes may not be visible, or are very subtly different between areas of potential pressure and the surrounding skin. It is important to not rely on colour changes but the complete skin assessment and consider any abnormalities assessed in an area of potential pressure to be considered indicative of a pressure injury. See Related Documents for resources to assist with assessing skin and PIs for different skin tones.
- assess large and deep skin folds for bariatric (obese) clients at risk for maceration, inflammation and/or, as a result of increased tissue weight, pressure damage;
- assess behind the neck, mid back, under arms/breasts, under panniculus, buttocks, sacral and perineal areas, upper and lower thighs, elbow and knee crease, calves, ankles, and heels and other areas of high adipose tissue concentration;
- assess mucosal membranes for mucosal membrane pressure injury if a tube/drain is in place;

- assess for medical device-related pressure injury by lifting medical device (if appropriate) (e.g., endotracheal tubes, tracheostomy, masks, splints, braces or restraints) to assess the underlying skin;
- assess for evidence of healed wounds;
- assess for evidence of fungal/bacterial infection;
- assess for evidence of contact dermatitis (e.g., itching or burning in areas corresponding to use of a product, device, lotion, cream);
- assess for changes in skin texture/turgor (e.g., dryness, thickness);
- assess for changes in skin temperature (warmth, heat) when compared to the surrounding skin (use back of fingers to test);
- assess for consistency of any reddened areas, such as bogginess (soft) or induration (hard);
- assess areas such as bruises or discolouration of the skin caused by blood leaking into the subcutaneous tissues, hematomas, blisters, excoriation or rashes; and
- assess patient perception of sensation. Pain or itching over bony prominences or medical devices as compared to surrounding skin.

Develop and Implement Pressure Injury Intervention Care Plan

1. **Address Patient Concerns:**
   - plan of care should take into account patient/family abilities, concerns, preferences and motivation for treatment;
   - develop strategies to address any lack of patient and family participation in an injury prevention plan of care. Educate patient/family about PIP strategies.
   - refer the patient to the appropriate professionals (e.g. RD, OT, PT) to support improved health and wound healing, e.g., improved diet, pressure reduction/redistribution, exercise plans, lower leg vascular assessment, diabetic foot assessment;
   - refer to Social Work, Counsellor or Aboriginal Health Representative if available for financial or psychosocial concerns and for emotional support and counselling as needed;
   - provide patient education booklet(s) on pressure injury prevention if needed (see Patient Health Education Materials); and
   - manage and provide pain relief. This may be through analgesics, positioning/ repositioning, use of therapeutic support surfaces, etc.

2. **Mitigate/plan care for risk factors when possible:**
   - support the patient to monitor any pre-existing illnesses such as stroke, neuromuscular conditions, diabetes mellitus, peripheral vascular disease, renal disease or cardiac disease and consult a physician /NP if changes occur;
   - support patient to take medication as prescribed;
   - support patient in strategies for chronic disease management;

- offer patients smoking cessation information and resources; and
- engage with patient around substance use goals, e.g. abstinence, harm reduction, and collaborate with care team on resources.

3. **The following table provides a summary of interventions that can be used to individualize a PI prevention care plan related to Braden Subscales for those areas that use Braden Scale Assessment.**

Table 2: Pressure Injury Prevention and Management Interventions for Acute & Rehab

See Related Documents: Braden Scale Intervention Guide for Summary

Legend • Interventions that should be considered and potentially used for ALL patients • Patient specific interventions that are individualized	
Braden Subscale	**Interventions**

Standard Interventions for All Clients	• Repeat Braden Risk Assessment as per schedule.
	• Repeat Head-to-Toe Skin assessment as per schedule.
	• Manage/ provide pain relief.
	• Provide skin care (cleansing, moisturizing, protecting and treating) as per Site Specific Skin Care Protocol. See Related Documents. Avoid hot water and scrubbing. Pat dry. Avoid powder/ talc. Avoid massaging over bony prominences.
	• Assess, prevent and treat moisture associated skin damage (e.g. incontinence associated dermatitis, intertrigo, etc.). See Related Documents for detailed information related to managing moisture and program specific information (e.g. operating room).
	• Promote activity/ mobility.
	• Support nutritional therapy.
	• Ensure good oral health. Mouth care at least once per shift.
	• Use appropriate continence containment products. Avoid briefs/ pads when possible.
	• Avoid multiple layers of bedding, and incontinence/ linen protector pads. Keep bed linens smooth.
	• Ensure appropriate linen is used on each surface (e.g. air mattresses, seating cushions, etc.)
	• Reduce/ eliminate shear & friction.
	  • Keep HOB less than 30^0 unless for meal time or tube feeds/ other clinical indications
	  • Lift, do not drag when repositioning in bed

	• Lift heels to clear the surface while boosting and turning, etc. • When moving up in bed, ensure bed is flat; that hips are 10 cm above where the bed frame flexes; then raise the knee gatch 10 to 20° before HOB is raised. • Alleviate pressure (e.g., protect heels (suspend off the bed) and elbows using pillows or therapeutic devices. Do not use IV bags, towels, donut rings or sheepskin, etc.). • Frequently reposition medical devices that are against skin/ mucous membranes (e.g. feeding tubes, nasal prongs, pulse oximetry, etc.) • Use appropriate handling and transfer devices (e.g., sliding board, ceiling lifts, lift for bed to chair/stretcher transfers, air transfer or turning systems, etc.).
Nutrition - consider for subscale scores 2 or less:	○ If NPO, ensure adequate parenteral hydration/nutrition. ○ Ensure the patient is able to swallow safely as per site protocol. ○ Record and monitor weight. ○ Consult Registered Dietitian. ○ Consult Speech Language Pathologist if available.
Moisture (and Skin Care) - consider for subscale scores 2 or less:	○ Cleanse skin folds and perineal area after incontinence episodes as per Skin Care Protocol. See Related Documents. ○ For skin folds, use a skin fold textile (e.g. InterDry Ag) as per Skin Care Protocol. See Related Documents. ○ Consider support surface/coverlet with microclimate management. Consult OT/PT/ NSWOC as appropriate as per site workflow. ○ Consult NSWOC for skin care or wound management related issues as appropriate as per site workflow.
Friction/ Shear - consider for subscale scores 2 or less:	○ When sitting, ensure feet are on floor, or supported so hips/ knees are at 90^0 angle. ○ Use chair/wheelchair tilt features if available to allow for increased options for offloading. ○ Unless contraindicated, keep HOB 30^0 or less. Elevate to 30^0 or more for meals/ short periods only. ○ When HOB 30^0 or greater. Ensure knees are raised 10 to 20^0 before raising the HOB use handling equipment (e.g., sliding sheet). ○ Consider Trunk Release Method to ensure proper positioning. ○ Consult OT/PT/NSWOC as per site workflow.
Activity/ Mobility/ Sensory Perception –	○ Follow Friction/ Shear Interventions. ○ Use appropriate pressure redistribution surfaces (e.g. wheelchair cushion, bed mattress, adding pump to standard surface, etc.) as per site protocol.

consider for subscale scores 2 or less:	○ Position/reposition as per individualized care plan (e.g., q2h) including small shifts of position. ○ Use prophylactic silicone foam dressing on sacral/coccyx area. Check skin beneath dressing daily. Note: these dressings do not replace the need for offloading. Write "P" on dressing to indicate this is a preventative dressing. ○ Consult OT/PT/NSWOC as per site workflow.

Pressure Injuries:

- See Assessing skin and PIs with differing skin tones.
- If present, determine the stage of the PI. See How to Stage Pressure Injuries (PI).

Key Points for Staging PI's:

- PIs are staged based upon the assessment of tissue loss or damage and exposed underlying structures.
- PIs are staged as Stage 1, Stage 2, Stage 3, or Stage 4, Unstageable PI, or a Deep Tissue Injury. See How to Stage a Pressure Injury.
- PIs are often misdiagnosed as moisture associated dermatitis wounds (MASD) and vice versa. See MASD versus PI.
- Mucosal membrane pressure injuries are not staged.
- PIs are not reverse-staged. For example, as a Stage 4 PI heals or closes it is not reverse-staged to a Stage 3, Stage 2, and then Stage 1; it is documented as a healing Stage 4 PI.
- In Long Term Care, follow RAI-MDS guidelines for documentation.

1. If PI present, determine wound care treatment plan, see Related Documents for DST's for wound management:
   - initiate all pressure injury prevention interventions;
   - initiate/continue wound care treatment plan as per routine wound management care.

2. Report PI in British Columbia Patient Safety Learning System (PSLS) when it is first identified, or if it has not already been reported previously.

Site Specific

Long Term Care:

Pressure Injury Risk and Head to Skin Assessments Schedule

- Complete Braden Scale Assessment and Skin Assessments on move- in day. Ensure Braden Care Plan is completed to direct care until RAI-MDS has been signed off.
- RAI-MDS to be signed off by Day 14: if delayed, repeat Braden weekly until RAI-MDS is completed. Update Braden Care Plan as needed.
- RAI-MDS is completed quarterly.
- A Full Assessment is completed at least annually and when there is significant change in the resident's condition. The Care Plan and Care Guide are reviewed and updated

Interventions

- From move-in day until RAI-MDS is signed off:
    - Develop and update pressure injury prevention care plan using the Residential Care Braden Protocol (Form ID-123).
- After RAI- MDS is signed off:
    - When a Pressure Injury Clinical Assessment Protocol (CAP) is triggered, the Care Plan and Care Guide are reviewed and updated for a PURS scale greater than 0.
        - For a PURS of 1-2 (low risk) there must be interventions documented on the Care Guide
        - For a PURS of 3 or above (moderate risk) both the Care Guide and Care Plan must be updated
- If a pressure injury is present, ensure the wound is assessed and the management is outlined on the Long Term Care Wound Treatment Plan (Form ID 6955). Consult Nurse Specialized in Wound, Ostomy and Continence (NSWOC) if needed.

Documentation

Using site-specific system (interdisciplinary notes, nurses' notes, electronic medical record), document:

- Braden Scale Score each time it is assessed (e.g. Cerner iView)
- Acute and Rehab: Document interventions and wound care treatment in iView in Cerner
- Patient/family education provided, response, concerns, and questions.
- If assessment identifies a PI, complete PSLS report.

PHC Long Term Care:

- Document Braden Assessment Score as per schedule outlined in Site Specific.
- Document as per RAI- MDS
- Document in paper chart as needed

- If wound is present, the assessment and care is documented on the Long Term Care Wound Assessment & Treatment Flow Sheet (Form 5745) and the Long Term Care Wound Treatment Plan (Form 6955).

PHC Perioperative Services

- Surgical Daycare: Braden Scale Assessment will be completed and documented in Cerner for all patients who will be admitted to PHC.
- Operating Room: The operating room staff document pre-procedure and post-procedure skin assessment in the OR Intraoperative Record in Cerner.

Patient and Family Education

1. Provide written and verbal patient and/or family education using language the patient/family understands. Include:
    - interdisciplinary wound care members' roles (e.g., OT,PT, SW, RD, Physician, NP, and/or NSWOC);
    - their care plan related to pressure injury prevention strategies and interventions;
    - signs of pressure injury and/or skin breakdown;
    - the importance of proper positioning and strategies for pressure redistribution; and
    - how to conduct a regular examination of their skin, especially over bony prominences.

Patient Health Education Resources (available in PHEM):

FO.650.P928: Preventing Pressure Injuries (Booklet)

- More extensive document providing detailed information. Intended for higher risk patients or those who already have a pressure injury. (*under revision)*

F0.650.P928B: Preventing Pressure Injuries (Brochure)

- Brief summary of prevention strategies in tri-fold pamphlet

F0.650.P928F: Preventing Pressure injuries (FactSheet)

- Brief summary of prevention strategies in single, double sided page

Related Documents

Braden Scale:

Braden Scale Interventions Guide – Adult – July 2017

Braden Q Intervention Guide

Procedure/ Documentation: Braden Risk & Skin Assessment – Adults – Nov 2017

Pressure Injury Prevention and Treatment – Provincial Guidelines:

Guideline: Prevention of Pressure Injury in Adults & Children – Feb 2018

Assessment & Treatment of Pressure Injuries in Adults & Children Guideline -2018

Assessment & Treatment of Pressure Ulcer Injury in Adults & Children Summary – 2018

Long Term Care

MDS Resources:

Pressure Injury Staging- Provincial Quick Reference Guide:

How to Stage a Pressure Injury- Feb 2018.

Assessing Skin and PIs for with differing skin tones:

Pan-Pacific Pressure Injury Alliance (PPPIA):

- PPPIA Pressure Injury Classification System: Multicultural
- PPPIA Pressure Injury Classification System for Adults with Light Skin Tones
- PPPIA Pressure Injury Classification System for Dark Skin Tones
- PPPIA Pressure Injury Classification System for Asian Skin Tones
- PPPIA Pressure Injury Classification System for Older Adults
- PPPIA Pressure Injury Classification System for Neonates and Children

Moisture Management & Skin Care:

Guideline: Assessment, Prevention and Treatment of Moisture Associated Skin Damage (MASD) in Adults & Children

PHC Adult Skin Care Protocol

Wound Management:

Wound Management for Adults & Children

Wound Dressing Selection Guideline for Adults & Children

PHC: Wound Dressing Selection Quick Reference Guide

References

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Definitions

Never Event: Never events are patient safety incidents that result in serious patient harm or death and that are preventable using organizational checks and balances. Never events are not intended to reflect judgment, blame or provide a guarantee; rather, they represent a call-to-action to prevent their occurrence.

PURS (Pressure Ulcer Risk Scale): The PURS scale is a section of the interRAI Minimum Data Set (MDS) assessment typically completed at predetermined intervals after admission and then on predetermined intervals. The PURS identifies seven areas of pressure injury risk with a high score indicating a high risk for pressure injury development

RAI-MDS: Resident Assessment Instrument- Minimum Data Set

Appendix A: Braden Scale for Predicting Pressure Sore Risk

Braden Scale for Predicting Pressure Sore Risk

Sensory Perception Ability to respond meaningfully to pressure related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR Limited ability to feel pain over most of body	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness, OR Has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	**3. Slightly Limited** Responds to verbal commands but cannot always communicate discomfort or need to be turned, OR Has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	**4. No Impairment** Responds to verbal commands, has no sensory deficit which would limit ability to feel or voice pain or discomfort.
Moisture Degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	**2. Very Moist** Skin is often but not always moist. Linen/ continent briefs* must be changed once a shift	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen/continent briefs* change approximately once a day	**4. Rarely Moist** Skin is usually dry; linen only requires changing at routine intervals
Activity Degree of physical activity	**1. Bedfast** Confined to bed	**2. Chairfast** Ability to walk severely limited or nonexistent. Cannot bear own weight and/or must be assisted into chair or wheelchair	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours
Mobility Ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	**3. Slightly Limited** Makes frequent though slight changes in body or extremity position independently	**4. No Limitations** Makes major and frequent changes in position without assistance
Nutrition Usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein-rich foods** (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement, OR Is NPO and/or maintained on clear liquids or IV's for more than 5 days	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake includes only 3 servings of protein-rich foods** (meat or dairy products) per day. Occasionally will take dietary supplement, OR Receives less than optimum amount of liquid diet or tube feeding	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein-rich foods** (meat or dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement when offered, OR Is on a tube feeding or TPN regimen, which probably meets most of nutritional needs.	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of protein-rich foods** (meat or dairy products). Occasionally eats between meals. Does not require supplementation.
Friction and Shear	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures, or agitation leads to almost constant friction.	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair.	

Groups/Persons Consulted

PHC Advanced Practice Nurses (CNS/NP)

PHC Nurse Educator group

PHC Long Term Care Nurse Educators

PHC Long Term Care Council members

Developed By

Clinical Nurse Specialist, Wound, Skin, Ostomy & Continence

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