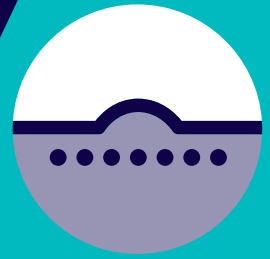


Pressure injuries

Standardised care process



Objective

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

Why the prevention 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 (Therapeutic Guidelines Limited 2016).

Definitions

Active support surface: 'a powered support surface that produces alternating pressure through mechanical means, thereby providing the capacity to change its load distribution properties with or without an applied load. This generally occurs through alternation of air pressure in air cells on a programmed cycle time. Also called an alternating pressure support surface or a dynamic support surface' (AWMA 2012).

Pressure injury: a localised injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of pressure, sheer or a combination of these factors (NPUAP et al. 2014, p. 12).

Pressure injuries usually result from pressure over a bony prominence. Shearing forces (produced by incorrect patient transfer technique) and friction (from repetitive movements by the patient) often contribute. (Therapeutic Guidelines Limited 2016)

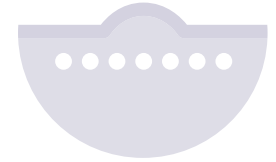
Reactive support surface: 'a support surface which, in response to applied pressure, distributes interface pressure over a wider body area through immersing and enveloping the patient. May be referred to as constant low pressure support surface or a static support surface' (AWMA 2012).

Team

Manager, registered nurses (RNs), enrolled nurses (ENs), personal care attendants (PCAs), leisure and lifestyle staff, general practitioner (GP), allied health professionals (such as a physiotherapist, occupational therapist and 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 2017.



Brief standardised care process

Recognition and assessment

Complete a comprehensive pressure injury risk assessment with all residents on admission, whenever their condition changes or 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

- Clean the wound and surrounding area using universal precautions.
- Immunocompromised residents and invasive wound procedures require aseptic technique.
- Debridement should be considered for removing necrotic or devitalised tissue.
- Before using topical treatment products (silver, medical-grade honey, antiseptics or antimicrobials) consider the clinical evidence that supports their use.
- Systemic antibiotics should only be considered where there is clinical evidence of spreading or systemic infection.
- Consider using adjunct treatments for stage 2–4 pressure injuries.
- Consider surgical intervention for unresponsive stage 3 and 4 pressure injuries.
- Implement an individualised pain management plan.
- Choose an appropriate dressing based on the wound's characteristics.
- Promote a healing environment.
- Prevent future pressure injury wounds.

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

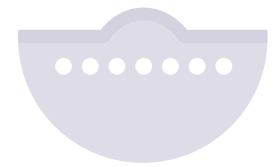
- Regularly reassess the resident's risk of developing a pressure injury.
- Reassess the skin on an ongoing basis, particularly around high-risk areas.
- Regularly reassess prevention strategies and adapt these strategies as required.
- Evaluate interventions and adjust the care plan as required.
- Monitor 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

- Support the resident's involvement in preventing and managing pressure injuries.
- Educate the resident to recognise the early signs of a pressure injury.
- Encourage the resident to relieve or redistribute pressure through frequent repositioning.

Staff knowledge and education

- Prevention, assessment and management of pressure injuries
- How to undertake a comprehensive skin assessment
- Use risk assessment tools for predicting and staging a pressure injury
- Development and implementation of an individualised skin care program
- Selection and/or use of pressure management devices
- Positioning/transferring techniques to decrease risk of tissue breakdown



Full standardised care process

Recognition

Complete a comprehensive pressure injury risk assessment:

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

Assessment

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

- use of a validated pressure injury risk assessment tool (Braden scale, Norton risk-assessment scale, Waterlow score)
- a thorough assessment of the skin for:
 - fragility
 - blanchable or non-blanchable skin discolouration and erythema
 - change in tissue consistency (induration/hardness, oedema) in relation to the surrounding tissue
 - variations in heat and moisture (for example, incontinence, oedema or inflamed skin)
 - changes in skin integrity
 - high-risk areas on bony prominences (sacrum, ischial tuberosities, greater trochanters and heels)
- identification of potential sources of pressure and shear including:
 - prosthetics and other medical devices that come into contact with the skin
 - support surfaces
 - lifting and transfer aids
- nutritional screening and assessment using appropriate validated screening and assessment tools
- blood tests to assess the resident's overall health status
- assessing any restrictions to the resident's mobility and activity
- assessing the resident's continence needs
- assessing the resident's cognition
- the resident's clinical history
- extrinsic risk factors (heating, air-conditioning, support surface microclimate).

Document all risk assessment findings.

Interventions

Pressure injury wound management

- Clean the wound and surrounding area at dressing changes using universal precautions. Irrigate with warm sterile isotonic saline (sodium chloride 0.9 per cent) or water.
- Use aseptic wound management techniques where the resident's immune status is compromised or when invasive wound procedures (such as conservative sharp wound debridement or biopsy) are required.
- Debridement (mechanical, sharp, autolytic or biological) should be considered to remove necrotic or devitalised tissue. This should be carried out by nurses who are knowledgeable and skilled in wound care.
- Topical silver or topical medical-grade honey can be used in heavily contaminated or infected pressure injuries.
- Topical antiseptics or antimicrobials should only be used where there is clinical evidence of infection or critical colonisation.
- Systemic antibiotics should only be considered where there is clinical evidence of spreading or systemic infection (such as systemic sepsis, cellulitis, underlying osteomyelitis).
- Surgical intervention may need to be considered when stage 3 and 4 pressure injuries are non-responsive to contemporary management strategies.
- Implement an individualised pain management plan with appropriate pharmacological and non-pharmacological pain relief strategies.
- Adjunct treatments that can be considered in combination with regular care in stage 2–4 pressure injuries include:
 - electrotherapy/electrical stimulation
 - ultraviolet light C therapy
 - low-frequency ultrasonic debridement.
- The choice of wound dressing will be guided by the goal of treatment and the size, depth and location of the wound and should take into account its ability to:
 - manage infection, odour and exudate
 - maintain a moist wound healing environment
 - protect the wound and surrounding skin from shear, friction, pressure and skin irritation
 - be cost effective.

- Promote a healing environment if this is the documented aim by:
 - keeping the skin clean, dry and moisturised
 - assisting the resident to remain hydrated and nourished.
- Inspect the skin daily.

Pressure injury prevention

An individualised prevention plan should be instigated for residents who have, or are at risk of developing, a pressure injury. This should consider the following:

- Provide pressure-relieving or redistribution support surfaces (high-specification, reactive (constant low pressure) or active (alternating pressure) support surfaces on beds and seating).
- Repositioning:
 - Instigate regular repositioning for residents in bed – six-hourly for those at risk and four-hourly for those at high risk (at a minimum) or as defined by individual circumstances.
 - Maintain the head of the bed at its lowest degree of elevation or below 30 degrees.
 - 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).
 - Encourage seated residents to shift their weight every 15 minutes and limit their time in a sitting position, particularly if there is no pressure-relieving support system in place.
 - Ensure seated residents are positioned to maintain a proper posture, foot support, range of movement and pressure redistribution.
- Protect residents' skin from damage caused by friction or shear by:
 - using correct transferring and manual handling equipment and techniques
 - avoiding rubbing or massaging areas of the skin at risk of a pressure injury.
- Protect residents' skin from exposure to excessive moisture with a barrier product.

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

- Regularly reassess the resident's risk of developing a pressure injury, particularly when there is a change in their clinical status.
- Reassess the resident's skin on an ongoing basis 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.
- Monitor the signs and progress towards healing. Use pressure injury assessment scales and serial weekly digital wound imaging.
- Monitor the resident for any signs of infection and pain during wound care interventions.
- Regularly review repositioning schedules for at-risk residents.

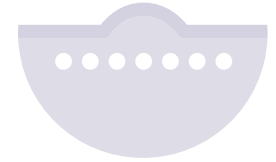
Resident involvement

- Support the resident's and family's involvement in preventing and managing pressure injuries.
- Educate the resident to recognise the early signs of a pressure injury.
- Encourage the resident to relieve or redistribute pressure through frequent repositioning.

Staff knowledge and education

Provide staff education on:

- the prevention, assessment and management of pressure injuries
- how to undertake a comprehensive skin assessment
- how to use risk assessment tools for predicting and staging pressure injuries
- development and implementation of an individualised skin care program
- selection and/or use of pressure management devices
- positioning and transferring techniques to decrease the risk of tissue breakdown.



Evidence base for this standardised care process

Australian Wound Management Association (AWMA) 2012, *Pan Pacific clinical practice guideline for the prevention and management of pressure injury – abridged version*, Cambridge Publishing, Osborne Park.

Butcher G, Pinnuck L 2013, 'Wound bed preparation: ultrasonic-assisted debridement', *British Journal of Nursing*, vol. 22, Sup 4, S36–S43.

Department of Health 2012, *Strengthening care outcomes for residents with evidence (SCORE)*, Ageing and Aged Care Branch, Victorian Government, Melbourne.

Edwards H, Gibb M, Finlayson K, Jensen R 2013, *Champions for skin integrity: CSI guide and resource pack*, Queensland University of Technology, Brisbane.

National Pressure Ulcer Advisory Panel (NPUAP), European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance 2014, *Prevention and treatment of pressure ulcers: quick reference guide*, Emily Haesler (ed.), Cambridge Media, Osborne Park.

Price B, Young T 2013, 'Debridement consensus: recommendations for practice', *Wound Essentials*, vol. 8, no. 1, pp. 71–76.

Registered Nurses' Association of Ontario (RNAO) 2011, *Risk assessment and prevention of pressure ulcers, 2011 supplement*, RNAO, Toronto.

Registered Nurses' Association of Ontario (RNAO) 2016, *Assessment and management of pressure injuries for the interprofessional team (3rd edn)*, RNAO, Toronto.

Therapeutic Guidelines Limited 2016, *Therapeutic guidelines: Ulcer and wound management*, version 1, Ulcer and Wound Management Expert Group, TGL, Melbourne.

Wounds UK 2013, *Best practice statement: eliminating pressure ulcers*, Wounds UK, London.

Important note: This 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 Human Services and the State of Victoria disclaim all liability for any loss or damage that arises from any use of this SCP.

To receive this publication in an accessible format phone 9096 6963, using the National Relay Service 13 36 77 if required, or email <acqiu@dhhs.vic.gov.au>.

Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

© State of Victoria, Department of Health and Human Services, March 2018. (1802012)

ISBN 978-1-76069-294-0 (pdf/online)

Available from the department's website at <www2.health.vic.gov.au/ageing-and-aged-care/residential-aged-care/safety-and-quality/improving-resident-care/standardised-care-processes>.