

# Clinical Guideline

## Pressure Injury Prevention and Management Guideline

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**Policy developed by:** Public Health and Clinical Systems

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**Summary** The SA Health Pressure Injury Prevention and Management Policy Directive and Guideline describe clinical practice that is based on the *Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure Injury, 2012, Australian Wound Management Association*. The guideline describes systems for the delivery of care that is in accord with the *National Safety and Quality Health Service Standard 8, 2012, Australian Commission for Safety and Quality in Health Care*.

**Keywords** Pressure injury, pressure ulcer, prevention, management, wound, wound care, wound management, skin integrity, tissue integrity, injuries, standards, accreditation, safety, quality, national, ACSQHC, quality improvement, governance, clinical guideline

**Policy history** Is this a new policy? **N**  
Does this policy amend or update an existing policy? **Y**  
Does this policy replace an existing policy? **N**  
If so, which policies?

**Applies to** All SA Health Portfolio  
All Department for Health and Ageing Divisions  
All Health Networks  
CALHN, SALHN, NALHN, CHSALHN, WCHN, SAAS  
Other

**Staff impact** All Staff, Management, Admin, Students, Volunteers  
All Clinical, Medical, Nursing, Allied Health, Emergency, Dental, Mental Health, Pathology

**PDS reference** CG071

### Version control and change history

Version	Date from	Date to	Amendment
1.0	17/01/2013	18/06/2013	Original version
1.1	19/6/2013	16/7/2014	Removal of 3.1.2.5 Low Risk
1.2	17/07/2014	Current	Amendments to align standards, screening and assessment, and reporting requirements with National Safety and Quality Health Service Standard 8

# Pressure Injury Prevention and Management Guideline





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## 1 Principles

- 1.1 Pressure injuries are highly preventable, and it is recognised that their potentially long healing time has consequences for quality of life, susceptibility to infection, pain, sleep and mood, and the provision of services.
- 1.2 The management of the risk factors for pressure injuries such as poor skin condition, pain, impaired mobility and poor nutritional status will have wider benefits beyond reduction of pressure injury, and support patient-centred care, holistic care and healthy ageing.
- 1.3 The most effective approach to pressure injury prevention and management includes:
  - 1.3.1 timely screening and assessment to identify risk factors
  - 1.3.2 the engagement of patients and their carers with their health care providers and the treatment offered
  - 1.3.3 implementation of a plan of care that is:
    - 1.3.3.1 tailored to the individual and reduces their risk factors
    - 1.3.3.2 supported by systems of care that are focussed on prevention and optimising healing
    - 1.3.3.3 multifactorial and interdisciplinary
    - 1.3.3.4 delivered by a workforce with appropriate skills and knowledge who use appropriate techniques and materials to optimise healing and prevent or delay complications
    - 1.3.3.5 inclusive of access to appropriate equipment and products.
- 1.4 The SA Health Pressure Injury Prevention and Management Policy Directive and Guideline describes:
  - 1.4.1 clinical practice that is based on the *Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure Injury, 2012, Australian Wound Management Association*.
  - 1.4.2 systems for the delivery of care that is in accord with the *National Safety and Quality Health Service Standard 8, 2012, Australian Commission for Safety and Quality in Health Care*.
- 1.5 For this document the term patient is intended to include consumers, client, resident and others receiving health care.

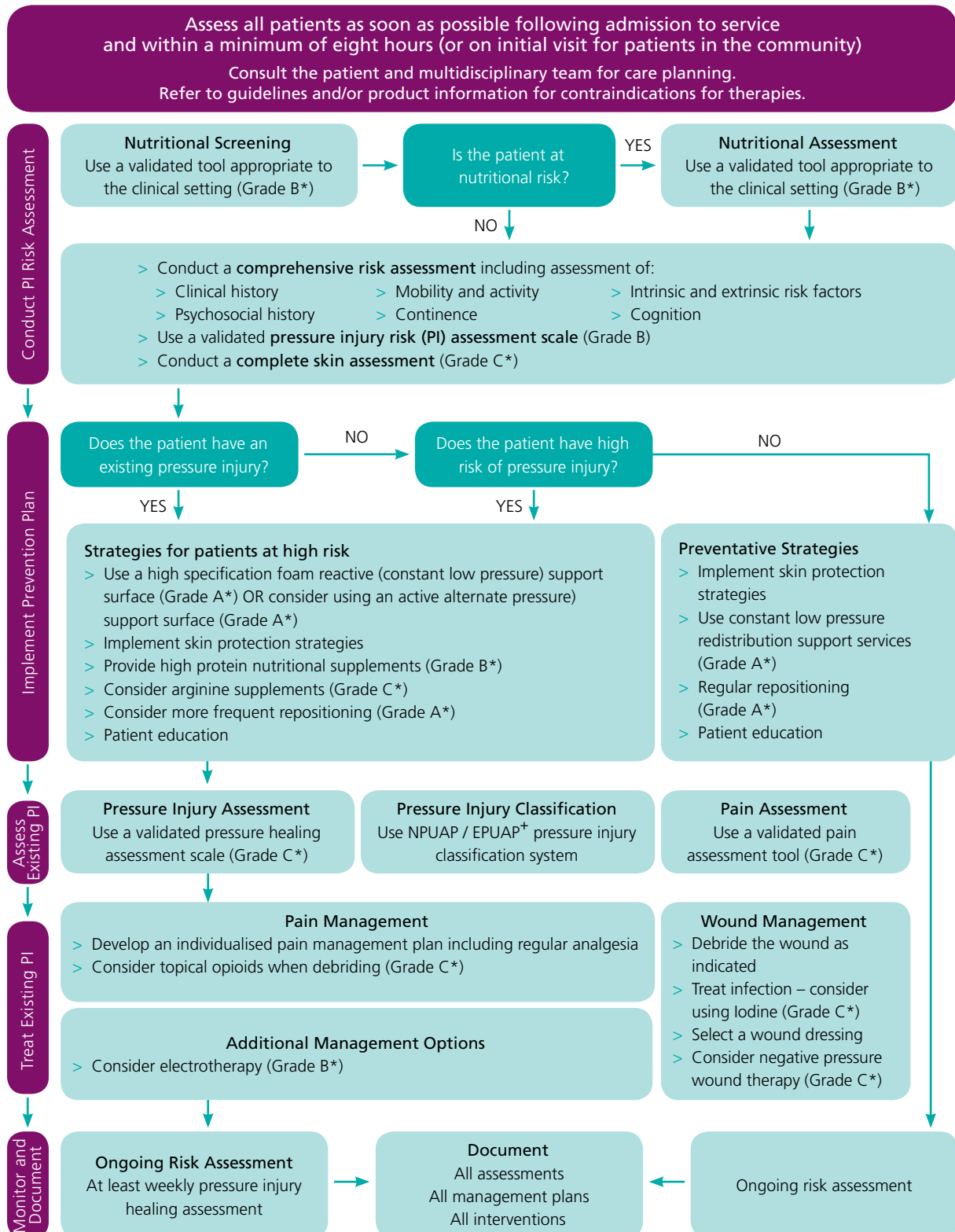
## 2 Governance and quality improvement

- 2.1 All policies, protocols or procedures are based on current agreed best practice guidelines and accreditation standards, and a system for their review is in place.
- 2.2 There are committees and work groups that have responsibility for monitoring and improving performance, and for conducting relevant quality improvement activities.
- 2.3 Pressure injuries that have developed or deteriorated during an episode of health care are reported via the incident reporting system (Safety Learning System).
- 2.4 Pressure injury data is monitored, analysed and acted upon by ward, unit and / or service-level work groups or committees.
- 2.5 Systems are in place to ensure that both adequate expertise and resources such as equipment and products are available to enable the provision of best practice prevention and wound management.

### 3 Clinical practice – preventing and managing pressure injuries

Clinical practice is summarised in the following flow chart. This is reproduced from *Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure Injury, 2012* with permission from Australian Wound Management Association.

Flow chart for prevention and management of pressure injury



\* Grade refers to level or strength of evidence  
+ NPUAP / EPUAP Pressure Ulcer Treatment Quick Reference Guide 2009.

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### 3.1 Screening and assessment

3.1.1 On presentation, all patients and residents will be assessed within 8 hours for their risk of pressure injury and results documented. This assessment will consist of three parts;

3.1.1.1 Braden Scale (adult or paediatric – Braden Q). This includes a nutritional component

3.1.1.2 Skin assessment that is based on visual inspection and consideration of co-morbidities and skin history

3.1.1.3 Neonate screening tool such as the Neonatal Skin Risk Assessment Scale for predicting skin breakdown (NSRAS), selected from those recommended in *Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure Injury, 2012 Australian Wound Management Association*

3.1.1.4 Pain assessment selected from those recommended in *Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure Injury, 2012 Australian Wound Management Association*

3.1.2 The results of the three part assessment will determine level of risk. These assessments should be supplemented by clinical judgement that takes account of the likelihood of rapid deterioration such as in palliative or cachexic patients with failure of one or more systems, or lengthy complete immobility, such as surgery of many hours duration. A higher level of risk may be documented.

Where the Braden scale indicates that there may be malnutrition, completion of the Malnutrition Universal Screening Tool (MUST) or equivalent for paediatrics is recommended

Any adult or child with an existing pressure injury will be deemed to be at High risk.

For adults:

3.1.2.1 High risk- total Braden score of 12 or below or existing pressure injury, or Braden score of 13-14 plus clinical concern on skin inspection or related to relevant co-morbidities.

3.1.2.2

3.1.2.3 Medium risk – no pressure injury and either Braden score of 13-14, or 15-21 plus clinical concern related to relevant co-morbidities or visible skin issues.

3.1.2.4 Low risk – no pressure injury and Braden score 15-21 and no clinical concern on skin inspection or relevant co-morbidities

For paediatrics:

3.1.2.5 Very High risk – total Braden Q score of 9 or below or existing pressure injury

3.1.2.6 High risk – total Braden Q score of 10 to 12 or existing pressure injury or score of 13-15 plus concerns on skin inspection

3.1.2.7 Moderate risk – total Braden Q score 13 to 15 or score of 16 to 21 plus concerns on skin inspection

3.1.2.8 At risk / mild risk - Braden Q score of 16 to 23 and skin intact.

For neonates (babies less than 28 days older than full term);

3.1.2.9 If a pressure injury is present a baby is considered to be at risk. If the Neonatal Skin Risk Assessment Scale (NSRAS) is used a score of 13 or more is defined as at risk.

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- 3.1.3 For all patients at low or overall risk, all assessments (Braden (or Braden Q) screen, skin and pain assessment) should be repeated and documented;
- 3.1.3.1 if there is a change to health status or mobility; or
  - 3.1.3.2 more than 4 hours of complete immobility (such as during surgery); or
  - 3.1.3.3 change to their environment; or
  - 3.1.3.4 if a pressure injury develops;
  - 3.1.3.5 and at least weekly for inpatient settings and monthly elsewhere.
  - 3.1.3.6 for paediatrics, at least daily
  - 3.1.3.7 for neonates, at least every shift.
- 3.1.4 For all in patients at medium or high overall risk, all children at moderate, high or very high risk, and all neonates at risk all the assessments (Braden or Braden Q screen, skin and pain assessment) should be repeated and documented at least daily or more frequently *if required* every shift. In addition, skin will also be inspected and pain assessed;
- 3.1.4.1 during usual care, and on every nurse-initiated positioning change
  - 3.1.4.2 pre-operatively, and repeated as soon as feasible after surgery
  - 3.1.4.3 on transfer between units, and discharge to facilitate discharge planning and handover
  - 3.1.4.4 at every visit for non-inpatient or ambulatory facilities or clinics, where skin integrity is an ongoing concern
- 3.1.5 For all patients with a pressure injury, screening, skin and pain assessment should be a routine part of the management of the pressure injury, to ensure that the care plan is current and effective in optimising healing and minimising risk of other pressure injury.
- 3.1.6 For all consumers of non-inpatient facilities, at medium, high or very high risk, all assessments (Braden (or Braden Q) screen, skin and pain assessment) should be repeated at every visit when clinically indicated unless it is known and documented that another mechanism is in place for regular monitoring of skin and pressure injury risk.
- 3.2 Prevention strategies**
- 3.2.1 All patients identified as being at moderate, high or very high risk (with or without existing pressure injury) should have best practice prevention strategies implemented within 2 hours, and the strategies reviewed at least 4 hourly or at every patient intervention for their effectiveness. Prevention strategies include but are not limited to:
- 3.2.1.1 re-positioning and/or mobilising routine, including careful manual handling
  - 3.2.1.2 selection and provision of support surfaces, aids, equipment / devices to eliminate pressure if possible
  - 3.2.1.3 reduction of pressure, friction, and or shear through:
    - 3.2.1.3.1 use of active support surfaces during care, including theatre, intensive care and emergency departments
    - 3.2.1.3.2 safe manual handling techniques
    - 3.2.1.3.3 correct fitting, removal and checking of devices / orthoses / anti embolic stockings and casts etc.
  - 3.2.1.4 referral to other health disciplines team as clinically indicated for assessment and treatment.
  - 3.2.1.5 management of pain
  - 3.2.1.6 skin protection, moisture reduction and optimal skin hygiene and temperature
  - 3.2.1.7 adequate nutrition and hydration, including high protein supplements where indicated (with dietitian supervision if available)
  - 3.2.1.8 continence management

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### 3.3 Care planning and documentation

3.3.1 All patients who are identified on screening and skin assessment as being at moderate, high or very high risk will have a care plan documented and communicated during handover at the end of that shift in an acute or residential care setting, and within one week for community services. Care plans include strategies aimed at:

3.3.1.1 preventing the development of pressure injury(s) (section 3.2)

3.3.1.2 optimising healing and preventing complications of existing pressure injury(s).

3.3.2 The care plan will include, but not be limited to:

3.3.2.1 how the patient and carer are involved

3.3.2.2 input from multidisciplinary team about additional assessment, recommendations and treatment (refer to section 3.4.7)

3.3.2.3 routines and strategies for;

3.3.2.3.1 wound management

3.3.2.3.2 skin assessment and screening for pressure injury risk

3.3.2.3.3 mobilising to maintain function

3.3.2.3.4 position changes to relieve pressure, shear and friction

3.3.2.3.5 skin hygiene

3.3.2.3.6 pain assessment and management

3.3.2.3.7 optimising hydration and nutrition, including supplementation and feeding assistance if required

3.3.2.3.8 continence management.

3.3.2.4 strategies for protection of skin from moisture, high temperature and skin irritants, gastrostomy and enteral feeding, friction and skin trauma

3.3.2.5 strategies for management of other risk factors such as incontinence and oedema

3.3.2.6 To minimise pain, eliminate or reduce pressure, friction, shear and skin tears and protect existing pressure injury

3.3.2.6.1 use and monitoring of equipment, devices

3.3.2.6.2 careful manual handling techniques

3.3.2.7 arrangements and considerations for discharge planning.

### 3.4 Managing pressure injuries

3.4.1 Care is aimed at optimising healing and prevention of complications of existing pressure injury wounds. Care can include prevention strategies (see 3.2), assessment; documentation and monitoring of wound(s); wound management (dressings, therapies); pain management; nutritional interventions; pressure reduction; maintenance of mobility and promotion of circulation; and consult with or referral to relevant health disciplines.

3.4.2 Healing can take weeks or months and engaging the patient and carer in care will enhance outcomes.

3.4.3 **Prevention** – All patients with a pressure injury are at high risk of worsening or development of other pressure injury

3.4.3.1 Prevention strategies (section 3.2) should be implemented immediately, and documented

3.4.3.2 Wound management should be implemented immediately, and documented prior to comprehensive assessment and care plan development. Prevention and management strategies should include consideration of the handover of the management that was in place prior to presentation.



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- 3.4.4 **Assessment and monitoring** of pressure injury or wound(s) – this should be completed and documented within the shift the presentation or discovery occurred, on a wound chart, care plan or medical record. There should be sufficient detail to enable monitoring of healing rate and should take into account previous wound management plan from handover or transfer information. Use of a pressure injury healing scale is also recommended. A wound chart should include, but not be limited to:
- 3.4.4.1 classification of the stage of pressure injury
  - 3.4.4.2 a photographic record if consent has been obtained
  - 3.4.4.3 location, and measurement of wound size and depth
  - 3.4.4.4 amount and type of exudate
  - 3.4.4.5 appearance of wound bed, peri-wound skin and condition of wound edges
  - 3.4.4.6 signs of infection, including results of swabs
  - 3.4.4.7 undermining, sinus tracts and tunnelling
  - 3.4.4.8 wound odour
  - 3.4.4.9 pain – during and between wound care
  - 3.4.4.10 other factors contributing to poor healing such as vascular disease.
- 3.4.5 **Wound management** is provided by or supervised by health professionals with skills, knowledge and equipment to provide treatments in accord with *Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure Injury, 2012 (Australian Wound Management Association)*. These include but are not limited to:
- 3.4.5.1 advanced assessment
  - 3.4.5.2 aseptic technique
  - 3.4.5.3 wound bed preparation (including debridement)
  - 3.4.5.4 skin and wound hygiene
  - 3.4.5.5 selection of wound dressings
  - 3.4.5.6 treatment of infection
  - 3.4.5.7 topical applications and irrigation
  - 3.4.5.8 other interventions such as electrotherapy, negative pressure wound therapy and hyperbaric oxygen treatments.
- 3.4.6 **Reassessment** should occur at each dressing change. Wound management should be reviewed if healing not at optimal rate within 1-2 weeks, depending on initial condition.
- 3.4.7 **Consults** to medical or other health disciplines for their assessment and contribution to care planning and management should occur in a timely fashion. Consider referral to:
- 3.4.7.1 dietitian for nutrition assessment and management
  - 3.4.8.2 podiatrist for lower limb pressure injury in patients with diabetes or known peripheral vascular disease for assessment of feet, footwear and nails
  - 3.4.7.3 vascular surgeon for assessment if compromised arterial circulation is suspected
  - 3.4.7.4 occupational therapist for assessment of ADL and aids / equipment including seating, home assessment
  - 3.4.7.5 plastic surgeon for assessment of stage 3, 4 or unstageable pressure injury
  - 3.4.7.6 a nurse with specialist skills in wound management for complex wounds and patient needs when there is uncontrollable exudate (i.e. highly absorbent dressings are saturated within 24 hours); necrotic (black) tissue; uncontrolled pain; extensive undermining or tunnelling; or no response to management in one to two weeks

- 3.4.7.7 infection control specialist for concerns with infection and antimicrobial therapy
- 3.4.7.8 social worker or discharge coordinator for complex discharge planning
- 3.4.7.9 a physiotherapist for review of transfer or manual handling techniques and mobility.
- 3.4.8 **Pain** is assessed at least every shift using a validated tool, and a pain management plan is developed with patient including timing of analgesics, care with dressing changes, manual handling, repositioning and support surfaces.
- 3.4.9 **Nutritional supplementation** – optimal healing requires additional intake especially of protein. The evidence based practice guidelines for the dietetic management of adults with pressure injuries, 2011, TransTasman Dietetic Wound Group, Dietetics Association of Australia recommend that practice includes:
  - 3.4.9.1 completion of the Malnutrition Universal Screening Tool (MUST tool) if Braden Scale indicates that there is nutritional risk
  - 3.4.9.2 assessment of the patient's ability to feed self, and provision of assistance as required
  - 3.4.9.3 monitoring and recording intake
  - 3.4.9.4 referral for dietitian consult if indicated by high risk on MUST and nutrition section of Braden
  - 3.4.9.5 monitoring fluid intake and optimising hydration.
- 3.5 **Discharge planning**
  - 3.5.1 Discharge planning for those with an existing pressure injury requires communication with doctor, next health care provider, patient and carer/s, other community or residential services, equipment suppliers and appropriate allied health clinicians. Communication should include goal of treatment, stage and progress of pressure injury and follow-up care required.

## 4 Clinical practice – providing products, equipment, devices, pharmaceuticals to support prevention and wound management

- 4.1 All health services should ensure that a safe environment is provided through service design, planning and regular audit of the environment and equipment, particularly support surfaces such as beds, barouches, theatre tables and chairs.
- 4.2 Storage and procurement processes should ensure that appropriate products, equipment, devices, dressings, topical applications and pharmaceuticals are readily available for consumer and staff use.
- 4.3 Staff training in their safe and effective use and monitoring is available.

## 5 Reporting pressure injury incidents

- 5.1 All pressure injuries, should be reported to the SA incident management system (Safety Learning System). The Reporting Guide will assist staff to report relevant details quickly and easily. With a pressure injury of Stage 2 or greater, the SAC rating will most commonly be 2 or 3 as the length of stay may increase, there is a likelihood of disfigurement and additional treatment is required.
- 5.2 All incidents involving 'new' or 'worsening of existing / observed after internal transfer' pressure injuries should be investigated to the level required by the SA Health Incident Management Policy and Guidelines. Progress on the implementation of all recommendations generated by the investigation must be reported and monitored in accordance with the SA Health Incident Management Policy and Guideline.

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- 5.3 Where a pressure injury arises during care (new), or an existing pressure injury significantly deteriorates and progresses to the next stage of pressure injury (worsening), a review of the care plan by the multidisciplinary care team is required within 24 hours using a team process that encourages shared learning and results in improvement to care. Where a pressure injury is noted after internal transfer between SA Health services, investigation of the handover and transfer process may be warranted. Notification of the pressure injury to the consumer and /or carer should be made in accordance with SA Health Open Disclosure Policy Directive.
  - 5.4 For community care provided by SA Health, all pressure injuries that occur during the episode of care are to be reported to SLS and noted in the case record and to the GP within 24 hours. A re-assessment of risk and interventions is conducted, then the care plan modified.

## 6 Communicating with patients and carers

- 6.1 Information should initially be provided to the patient and carer at the time of assessment and care planning, and thereafter as requested.
- 6.2 A care plan is then devised in collaboration with patient and carer where possible, and their involvement and preferences are documented.
- 6.3 Information should include, but should not be limited to, written information. Written information should be provided in a format that ensures its accessibility to the patient and takes account of health literacy principles.
- 6.4 Patient information should include, but not be limited to:
  - 6.4.1 Their risk factors for developing pressure injury, and what can be done to reduce those risks
  - 6.4.2 How to inspect skin and recognise skin changes. Body sites that are at greatest risk of pressure damage
  - 6.4.3 How to care for skin – hygiene, moisture
  - 6.4.4 Use of support surfaces and devices
  - 6.4.5 Methods for pressure redistribution including movement and positioning
  - 6.4.6 What their treatment schedule is and what they need to do
  - 6.4.7 Who and when to ask for further advice or assistance.

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## 7 Other recommended guidelines

- > National Safety and Quality Health Service Standard 8 Prevention and Management of Pressure Injuries 2011. Australian Commission on Safety and Quality in Health Care.
- > Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure Injury, 2012. Australian Wound Management Association, Cambridge Media Osborne Park, WA: ISBN Online 978-0-9807842-3-7 [www.awma.com.au/publications/publications.php#pipm](http://www.awma.com.au/publications/publications.php#pipm)
- > Wounds West. [www.health.wa.gov.au/woundswest/home/](http://www.health.wa.gov.au/woundswest/home/)
- > Standards For Wound Management, 2010. Australian Wound Management Association, Cambridge Publishing, West Leederville WA.
- > Evidence based practice guidelines for the dietetic management of adults with pressure injuries, 2011, Trans Tasman Dietetic Wound Group, Dietetics Association of Australia.
- > Victorian Government Health Information [www.health.vic.gov.au/pressureulcers/education.htm](http://www.health.vic.gov.au/pressureulcers/education.htm)
- > Wound and Lymphoedema Management, 2010. World Health Organization.
- > Pressure Ulcer Treatment Quick Reference Guide 2009. EPUAP and NPUAP [www.epuap.org/guidelines/Final\\_Quick\\_Treatment.pdf](http://www.epuap.org/guidelines/Final_Quick_Treatment.pdf)
- > Australian Charter of Healthcare Rights.
- > Getting Started Kit: Prevent Pressure Ulcers, How-to Guide 2008. 5 Million Lives Campaign. Institute for Healthcare Improvement; Cambridge, MA
- > Pressure Ulcers: Prevention and Management 2011. The Joanna Briggs Institute
- > Pressure Area Care: Management 2012. The Joanna Briggs Institute



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