Pressure Injury Prevention & Management for Inpatients

Patient presents to hospital

Within 8 hours of presentation complete the admission screening/assessment process to guide clinical decision making. If pressure injury (PI) risk factors are identified attend a skin assessment

Does the patient have an existing PI or *area of concern?

No

Does the patient have PI risk factors?

No

Reassess:
- If there is a change to health status or mobility
- On transition of care
- If a PI or *area of concern develops
- Based on clinical judgement

Yes

Reassess as per BOX A
- For patients with PI or an *area of concern, skin and pain assessment should occur during each shift as a minimum and be documented

Yes

BOX A – Reassess:
Daily skin assessment and review care plan/prevention strategies and:
- If there is a change to health status or mobility
- Pre-operatively, and repeated as soon as possible after surgery
- Postnatally, prior to leaving the birthing setting
- On transition of care
- If a pressure injury or *area of concern develops
- Based on clinical judgement

- Develop the care plan in consultation with the patient and/or carer considering the goal of care and preferences
- Provide education for patient and/or carer on management/prevention strategies
- Implement prevention strategies appropriate to the risk factors within 2 hours of identification
- Make referrals as appropriate (e.g. Wound Care clinician, Occupational Therapist, Physiotherapist, Dietitian etc.)
- Document the PI in patient health care record, including wound chart
- Report the PI in IMS+ if it occurred during the current episode of care or significantly deteriorated
- Communicate PI risk factors, PI present and management at handover and transition of care

*Area of concern examples are blanching erythema or an area of incontinence associated dermatitis that requires increased monitoring

NSW GOVERNMENT
CLINICAL EXCELLENCE COMMISSION