Pressure injury prevention strategies – information for clinicians

Prevention strategies are to be targeted care actions/interventions based on the risk factor identified.

Patients with risk factors for pressure injury, either with or without pressure injury, are to have:

- Evidence based prevention strategies implemented as a priority within two hours of risk identification
- Targeted interventions/strategies based on the risk factor(s) identified and reviewed regularly for their effectiveness.

Repositioning and/or early mobilisation schedule

Prompt or assist repositioning as clinically indicated and using appropriate manual handling techniques and equipment. Patients are to be educated and encouraged to perform independent, pressure relieving manoeuvres when able.

- A 30-degree side lying position is to be used when repositioning individuals in bed. Keep the head of the bed as flat as possible at no greater than 30-degrees elevation unless clinically necessary to facilitate breathing and/or prevent aspiration and ventilator-associated pneumonia.
- The knee break function is to be used to prevent the patient from sliding down the bed to reduce shear forces. The torso to thigh angle is to be no greater than 30-degrees.

Pressure redistribution

- Mattress support surfaces which meet individualised requirements (i.e. weight, moisture, temperature, width, static or active surface types) are to be considered and regularly reviewed
- Support surfaces (such as active and reactive) are to be used during care, including emergency departments, operating room, intensive care, dialysis units, and during transportation when clinically indicated and appropriate.

NB: In unstable spinal or pelvic fracture, active support surfaces are contra-indicated. This is regardless of the patient having identified risk factors for pressure injury or an existing pressure injury.

Patients with unstable spinal or pelvic fracture are to stay on the appropriate non-powered support surface and receive regular pressure relief through lifting, as per spinal and pelvic fracture protocols.

- Seating support surfaces which meet the individualised requirements are to be considered and regularly reviewed
- Other pressure redistribution and offloading equipment (e.g. repositioning devices or aids) are to be used according to individualised requirements and goals of care
- Heels, Achilles tendon and popliteal vein are to be offloaded completely to distribute the weight of the leg along the calf.

Medical devices

- Devices/orthoses, compression therapy/stockings, casts/splint and other devices are to be correctly fitted, repositioned or removed regularly to have underlying skin inspected
- Devices and orthosis need to be checked within 1-2 hours of first application to ensure there is no pressure. The paediatric population is at increased risk of device related pressure injury.

Reduction of shear and friction

- Prophylactic dressings - note dressing products do not reduce pressure
- Appropriate manual handling techniques and equipment.

Pain Management

Ensure patients have adequate pain management to support early mobilisation and repositioning.

Education of patients/carers

Provide information on the importance of regular repositioning and other prevention strategies which address risk factors.

Skin protection and moisture balance

- Skin is cleaned and hydrated
- Skin is protected from excessive moisture with a barrier product
- Vigorous massage or rubbing of the skin is to be avoided as this can cause damage from shear and friction.

Continence management

For persons with incontinence

- A continence management plan is to be developed that facilitates individualised toileting, change of continence aids, and regular skin care
- Highly absorbent continence products to protect the skin in individuals with or at risk of pressure injuries who have urinary and/or faecal incontinence. These need to be checked and changed regularly
- Skin is to be cleansed after each episode of incontinence.

Adequate nutrition and hydration

Consideration of adequacy of total energy (calorie), protein, fluid, vitamin and mineral intake.

- Screening for nutritional deficiencies
- Nutrition assessment by a Dietitian (where available) if with or at risk of malnutrition or for those with severe pressure injuries (stage 3, stage 4, Unstageable and Suspected Deep Tissue). Risk factors for malnutrition may include unintentional weight loss, poor appetite, reduced oral intake, and increased gastrointestinal losses (e.g. diarrhoea, vomiting)
- Consideration of high energy high protein supplements, and/or arginine if recommended by a Dietitian or Medical Officer
- Feeding assistance, if required.

Referral to health disciplines

Referrals are to be made as clinically indicated for additional assessment and treatment.

Reference

Pressure Ulcer Advisory Panel, National Pressure Ulcer Advisory Panel, and Pan Pacific Pressure Injury Alliance. *Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline*. EPUAP/NPIAP/PPPIA, 2019.

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