# Pressure Injury Prevention for Critically Ill Adults

## Patient & Carers

1. Patients, carers are to be informed of the risks, prevention strategies and management of pressure injuries. Development of the pressure injury management plan is to occur in partnership with the patient, family and carers appropriate. NSQ Standard 8

2. Use a pressure injury risk assessment scale in conjunction with a comprehensive visual assessment to determine the patient's risk of pressure injury and to inform the development of a prevention plan. Consensus

3. The Braden scale is the recommended validated and reliable tool for assessing pressure injury risk in critically ill adults. Grade B

4. Inspect all of skin and mucosa attached to the patient within two hours of admission, at each repositioning and each shift change to identify indications of pressure injury including:
   - Skin
   - For fair skin races - erythema
   - For darker pigmented skin - persistent blue or purple hue
   - Blanching response
   - Localized heat
   - Oedema
   - Induration
   - Skin breakdown. Grade C

5. The skin and mucosa impacted by invasive medical devices (including but not limited naso-gastric tubes, tracheal tubes, IDUC, faecal management devices, nasopharyngeal airway and intravascular devices) should be inspected:
   - At the beginning of each shift
   - Each repositioning or adjustment
   - Where applicable at dressing change. Consensus IIMS

6. Documentation of pressure injury risk assessment scale and visual inspection to occur at a minimum of once each shift. Grade C

7. All patients are to be regularly assessed for pain, especially in relation to repositioning and in the presence of pressure injuries. If the patient has a pressure injury this should include wound pain assessment. Grade C

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## ASSESSMENT

### Level of risk

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Level of risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Age</td>
<td>Highly significant</td>
</tr>
<tr>
<td>* Length of stay</td>
<td>Highly significant</td>
</tr>
<tr>
<td>* Nutritional</td>
<td>High significant</td>
</tr>
<tr>
<td>* Incontinence</td>
<td>High significant</td>
</tr>
<tr>
<td>* Level of care</td>
<td>High significant</td>
</tr>
<tr>
<td>* BMI &lt;18</td>
<td>High significant</td>
</tr>
<tr>
<td>* Immobility/ less repositioning</td>
<td>High significant</td>
</tr>
<tr>
<td>* Infection*</td>
<td>High significant</td>
</tr>
<tr>
<td>* Spinal cord injury</td>
<td>High significant</td>
</tr>
</tbody>
</table>

### Risk Factors

- BMI >35
- Vasopressors
- Emergency admission

### Staging Pressure Injuries

1. **Stage 1 pressure injury**
2. **Stage 2 pressure injury**
3. **Stage 3 pressure injury**
4. **Stage 4 pressure injury**
5. **Suspicious deep tissue injury**
6. **Unstable pressure injury**

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## SUPPORT SURFACE

1. Implement preventive strategies to protect the patient's skin as soon as possible following admission or identification of high risk. Consensus

2. Conduct nutritional screening and assessment using a validated screening and assessment tools appropriate to the population and clinical setting. Grade A

3. Ensure individual caloric requirements are met for patients at risk of pressure injury. Grade A

4. As a minimum, use high specification reactive (constant low pressure) support foam mattress on beds and trolleys for patients at risk of pressure injuries. No one specific high specification reactive (constant low pressure) support foam mattress is better than any other. Grade A

5. Those classified as high risk or very high risk of pressure injury should have a active (alternating pressure) support mattress. Grade A

6. Any device used to prevent heel pressure injuries should be selected and fitted appropriately to ensure pressure is adequately offloaded and hyperextension of the Achilles tendon is avoided. Consensus.

7. When seated in a chair or wheelchair patients at risk of pressure injury should have the appropriate reactive or active cushion. Grade C

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## Repositioning

1. Unless contraindicated at risk patients should be repositioned at least every two hours even if on an active or reactive support surface. Grade B

2. When deciding on the frequency of repositioning and choice of patient position the clinician should consider:
   - Risk or presence of pressure injury
   - Skin response
   - Comfort/Pain
   - Cognition
   - Ability to move
   - Medical condition
   - Support service used Consensus

3. Reposition patients to reduce duration and magnitude of pressure over vulnerable areas, including under medical devices, bone prominences and heels. Grade A

4. As a minimum, position patients using 30° lateral inclination alternating from side to side or a 30° inclined recumbent position. Grade C

5. Ideally patients’ in seated positions should have pressure relief every 30-60 minutes. For specific patient groups (for example patients with spinal cord injuries) this may need to be more frequent. Grade C

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