

Pressure Injury Prevention and Treatment Guidelines

Perform Skin Assessment and Braden Risk Scale every shift or with significant change in patient condition (ie: surgery, decline in condition).
 "AT RISK" IS 18 OR LESS

PREVENTION & STAGE 1 & INTACT DEEP TISSUE INJURY (DTI)

Consider Pressure Redistribution Device (bed, chair cushion, foam heel boots, heel foam, head cushion)

Reposition:
 Bed: Q 2h
 Chair: Q15 min

Shear/Friction Reduction
 -Pull/Slippy sheets
 -Overbed Trapeze
 -Hover mat
 -TAP System

HOB less than or equal to 30°*
Unless clinically contraindicated

Initiate Incontinence Mgmt. Guidelines

Apply Barrier (barrier spray/wipes, dimethicone cream) or Dressing (foam or Tegaderm Absorbent)

**if dressing has to be changed >2x/shift, then remove dressing & use barrier cream only.*

STAGE 2 & OPEN DEEP TISSUE INJURY (DTI)

Prevention Guidelines

Open

Clean with NS
 Protect Periwound Skin w/ Skin Sealant Wipe/Spray

Apply Barrier (barrier spray/wipes, dimethicone cream) or Dressing (foam or Tegaderm Absorbent)
**if dressing has to be changed >2x/shift, then remove dressing & use barrier cream only.*

Intact Blister

DO NOT OPEN OR DRAIN

STAGE 3 & STAGE 4

Prevention Guidelines

Shallow

Protect Periwound Skin w/ Skin Sealant Wipe/Spray

Foam dressing. Change Weekly

Deep

Protect Periwound Skin w/ Skin Sealant Wipe/Spray

NS moist kerlex roll gauze + ABD Chg.q12h

REQUIRED
 Page team/Notify NP/MD
 Consult Complex Wound Team

UNSTAGEABLE (ESCHAR COVERED)

Prevention Guidelines

Dry gauze dressing Chg Daily

CONSIDER CONSULTS

Simple Wound Team Consult (WOC nurse)
 Clinical Nutrition
 PT/OT, CM/SW

PT./CAREGIVER EDUCATION

Patient Education: Getwell Network & Krames Epic search "pressure injury"
 Nursing/Carepartner Education: -Skin Care Incontinence Guideline
 -Fecal Incontinence Guideline
 -Bed Decision Guideline

D/C PLANNING

Wound care supplies & instructions
 Home Health referral

DOCUMENTATION in EMR: Assessment, Treatment, Education, Consults, Discharge Planning