THE STUDY VAULT

Clinical Chaos

Pressure Injury Care

SKILL SNAPSHOT

Purpose

- Prevents additional pressure damage and supports healing through offloading, moisture control, nutrition, and ordered wound care.

When to use

- Any identified pressure injury or high-risk area, with care based on stage, tissue condition, perfusion, goals, and orders.

Supplies needed

- Risk/staging tools; pressure-redistribution surface; repositioning aids; dressings/cleanser; moisture barrier; measuring tools; PPE.

PREP + PATIENT SETUP

- Assess full skin, pressure risk, mobility, moisture, nutrition, perfusion, pain, devices, and goals of care.
- Stage accurately; do not reverse-stage healing wounds.

VAULT TIP

- No dressing can heal a wound that remains under pressure. Offloading is the first treatment.

STEP-BY-STEP

1. Hand hygiene; identify patient; explain plan and medicate for pain as needed.
2. Offload the affected area immediately. Float heels correctly and remove pressure from devices/tubing.
3. Create an individualized repositioning schedule based on condition, support surface, tolerance, and skin response—not a rigid clock alone.
4. Use lift sheets/equipment to reduce friction and shear; keep head of bed as low as clinically safe.
5. Remove old dressing with gloves; note drainage and discard. Hand hygiene and set up clean/sterile field per order.
6. Cleanse wound with ordered noncytotoxic solution. Do not aggressively scrub viable tissue.
7. Measure length, width, depth; assess tissue, edges, undermining/tunneling, exudate, odor, periwound, pain, and infection signs.
8. Apply ordered dressing to maintain appropriate moisture balance and fill dead space without overpacking.
9. Manage incontinence promptly with gentle cleansing and moisture barrier. Keep linens dry and wrinkle-free.
10. Use pressure-redistribution mattress/cushion; avoid donut devices unless specifically directed.
11. Coordinate protein/calorie/fluid assessment and nutrition support; optimize perfusion, glucose, mobility, and pain control.
12. Reassess at each dressing change and daily for deterioration, infection, device injury, or new pressure. Notify wound team/provider of changes.

SAFETY REMINDERS

- Do not massage reddened bony prominences.
- Stable dry heel eschar may be left intact unless infection/ischemia plan indicates otherwise.
- Do not stage mucosal injuries or reverse-stage healing wounds.
- New necrosis, crepitus, systemic infection, or exposed structure needs urgent evaluation.

COMMON MISTAKES

- Using donut cushions.
- Turning by dragging.
- Overpacking.
- Focusing on dressing while pressure continues.

DOCUMENTATION

- Stage/location and measurements.
- Wound/periwound findings and drainage.
- Dressing and response.
- Offloading/repositioning/support surface.
- Nutrition, teaching, consultations, changes.