Pressure Injury Prevention & Early Recognition

PRACTICAL GUIDANCE FOR SKILLED NURSING TEAMS

GOAL **Recognize risk early, reduce avoidable pressure and respond quickly to new skin changes.**

1 WHO IS AT RISK?

- Immobility or limited mobility
- Decreased sensation
- Moisture or incontinence
- Poor nutrition or hydration
- Friction and shear
- Medical devices

2 PREVENTION THAT MATTERS

- Routine skin and risk assessment
- Individualized repositioning
- Heel offloading and support surfaces
- Moisture management
- Nutrition and hydration support
- Device checks, care-plan updates and reassessment

3 KNOW THE EARLY SIGNS

- Non-blanchable redness or persistent color change
- Deep red, maroon or purple discoloration
- Warmth or coolness compared with nearby skin
- Firmness, bogginess or altered tissue consistency
- New pain or tenderness
- Blistering, skin separation or open skin

4 QUICK STAGING REFERENCE

STAGE 1
Intact skin; non-blanchable redness or persistent color change.

STAGE 2
Partial-thickness skin loss with exposed dermis.

STAGE 3
Full-thickness loss; adipose tissue may be visible.

STAGE 4
Exposed or directly palpable fascia, muscle, tendon, cartilage or bone.

UNSTAGEABLE
True depth cannot be determined because slough or eschar obscures the wound bed.

DEEP TISSUE PRESSURE INJURY
Persistent deep red, maroon or purple discoloration; skin may be intact or non-intact.

CLINICAL PEARL

Pressure injuries are not downstaged as they heal.

NEW OR CHANGING SKIN BREAKDOWN?
ASSESS / DOCUMENT / OFFLOAD / UPDATE THE CARE PLAN / ESCALATE APPROPRIATELY