Pressure injury prevention and treatment

Myths, tips and tools your team needs to know.
Welcome

Every day, we work with frontline clinicians and leading experts to identify what matters to you when it comes to fighting skin breakdown. That’s why we’ve gathered tools and resources to empower your team to overcome the challenges of pressure injury (PI) prevention and elevate the quality of care in your facility.

Our guide draws on the latest National Pressure Injury Advisory Panel (NPIAP) guidelines—the gold standard in PI prevention—to help your team do the right thing at the right time. From keeping staff current on the right interventions to prioritizing best practices and staff education, read on to find out how to improve outcomes and keep patients and residents safe.

This is how we make skin health second nature.
What’s inside?

How much do you know?

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How much do you know?

Boost your knowledge of the latest evidence-based best practices.
Test your knowledge of NPIAP guidelines: Myths vs. facts

Evidence-based best practices make up the foundation of the National Pressure Injury Advisory Panel (NPIAP) clinical practice guidelines. Supporting NPIAP recommendations helps you standardize prevention protocols across units, from frontline staff on up.

When it comes to the latest PI prevention guidelines, can you and your team separate fact from fiction? Take our quiz to find out. Then check your results at the bottom of the page.

<table>
<thead>
<tr>
<th></th>
<th>Myth</th>
<th>Fact</th>
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<tbody>
<tr>
<td>1</td>
<td>Keep skin of all patients or residents clean and well moisturized.</td>
<td>○ ○</td>
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<tr>
<td>2</td>
<td>After applying a sacral dressing, your job is done.</td>
<td>○ ○</td>
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<tr>
<td>3</td>
<td>Position individuals at risk for pressure injuries at a 30-degree side-lying angle.</td>
<td>○ ○</td>
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<tr>
<td>4</td>
<td>Turn patients every two hours.</td>
<td>○ ○</td>
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<tr>
<td>5</td>
<td>Avoid consistent use of zinc-based barriers on intact skin.</td>
<td>○ ○</td>
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<tr>
<td>6</td>
<td>Improper support surfaces may contribute to PI incident rates.</td>
<td>○ ○</td>
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<tr>
<td>7</td>
<td>Applying a little skin care product is good, a lot is better.</td>
<td>○ ○</td>
</tr>
<tr>
<td>8</td>
<td>Elevate heels using an offloading device for those at risk of developing PIs on this bony area.</td>
<td>○ ○</td>
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<tr>
<td>9</td>
<td>CNAs are typically task oriented.</td>
<td>○ ○</td>
</tr>
<tr>
<td>10</td>
<td>Prophylactic dressings on heels supplement offloading and other prevention strategies.</td>
<td>○ ○</td>
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Myth

Fact

Answers:

1. Fact
2. Myth
3. Fact
4. Myth
5. Fact
6. Fact
7. Myth
8. Fact
9. Myth
10. Fact

Turn the page to read more about the PI myths
Bust the common myths of pressure injury prevention

How’d you do on the quiz? Here, we dig a little deeper into the common myths and how you can help support NPIAP clinical guidelines across units, from frontline staff on up.

**Myth 1:** After applying a sacral dressing, your job is done.

**Fact:** Applying a sacral dressing should not be viewed as an end-all-be-all solution.

**Best practice:** NPIAP recommends at-risk individuals receive a soft silicone multi-layered foam dressing, but in conjunction with other prevention measures. Studies show that including this multifaceted practice can reduce pressure injury incidence.

**Myth 2:** Turn patients every two hours.

**Fact:** This previous turning and repositioning protocol no longer applies.

**Best practice:** According to the updated NPIAP 2019 guidelines, the frequency is determined on an individual basis, depending on activity levels and the person’s ability to reposition themselves. In addition, be sure you’re using the right support surfaces, and consider the following characteristics of each individual:

- Skin and tissue tolerance
- General medical condition
- Overall treatment objectives
- Comfort and pain

**Myth 3:** Applying a little skin care product is good, a lot is better.

**Fact:** While this sounds logical, when it comes to product usage, it’s not always the case.

**Best practice:** It’s important to follow the product application instructions, because sometimes over-applying can cause damage. For instance, excessive barrier products can crack, which breaks the seal and allows moisture in. It can also unnecessarily drive up your cost of skin care.

**On the flip side:** Be sure you’re applying enough of a product such as moisturizer, which many caregivers use too sparingly, not covering the skin adequately.

**Myth 4:** CNAs are typically task oriented.

**Fact:** Certified nursing assistants are important healthcare professionals who can play a key role in PI prevention. Think about what they do every day. They directly interact with patients and residents—often more than any other caregivers. They get to know the people they care for, and a lot of that care is personal.

**Best practice:** It’s important to truly rely on your CNAs, build their confidence and educate them on best practices and how to use the right products in the right amounts.
Know the **4 risk factors of skin breakdown**

When caregivers know what might cause a pressure injury, they can more effectively assess, treat and prevent future skin breakdown.

It starts with these 4 contributing risk factors:

- **Prolonged pressure**
- **Friction**
- **Shear**
- **Excessive moisture**
Now that you know the secret, dig in a little more so you know the challenges, recommended interventions and tips to level-up your pressure injury prevention strategies.

**Prolonged pressure**

**Challenge:** Prolonged pressure increases the risk of injury because it can cut off blood flow to underlying tissues and cause cells to die. Higher risk areas include bony prominences like heels, hips and tailbone, and anywhere there’s a medical device or other object, such as a cell phone.

**Intervention:** Reduce pressure by positioning patients at the NPIAP-recommended 30-degree angle with wedges that are easy to use and comfortable for patients. For vulnerable heels, avoid using traditional pillows that can slip and skew leg alignment. Instead, use specially designed heel offloading devices and consider adding a prophylactic dressing at the heels.

**Tip:** Be sure to pay extra attention to patients who are immobile or can’t easily move by themselves, such as those in surgery and with spinal cord injuries.

**Friction**

**Challenge:** Friction occurs when skin is dragged across a surface, such as when a patient is moving in their bed.

**Intervention:** Protect patients’ sacral area with a five-layer foam dressing that helps reduce friction between the skin and the surface.

**Tip:** Bariatric patients are often at higher risk because they may be dragging their bodies when adjusting positions or getting in and out of bed.

**Shear**

**Challenge:** Shear happens when perpendicular and parallel forces work against each other, so one part of the body is pushed down, and another part is pushed side to side.

**Intervention:** Along with a five-layer foam dressing that can absorb shear force, use a repositioning sheet to safely and gently move patients to help redistribute pressure while in bed, as well as during transfer from one surface to another.

**Tip:** Friction and shear go hand in hand, so if you suspect one, it’s a good idea to intervene for both.

**Excessive moisture**

**Challenge:** Too much moisture or too little can weaken the skin’s natural barrier.

**Intervention:** The right system of skin care products can help keep fragile skin clean and properly hydrated. When incontinence is an issue, cleanse the skin promptly with a pH-balanced cleanser after each incontinence episode and consider using a moisture-proof dry pad. A five-layer silicone dressing can also help maintain skin’s optimal microclimate.

**Tip:** Look for moisture in skinfolds in areas such as armpits, beneath the breasts, genital areas and the abdomen. An antibacterial wicking sheet can be applied to help manage moisture and minimize skin damage.
Conduct a proper skin assessment.

The NPIAP recommends that caregivers perform a head-to-toe skin assessment when a patient or resident is admitted to a healthcare facility, as well as ongoing, documented assessments.

It’s key to pay attention to bony prominences that have less fatty tissue and are more vulnerable to these wounds. Inspect these bony areas:

- Sacrum
- Coccyx
- Buttocks
- Heels/feet
- Ischium (especially for chair-bound individuals)
- Trochanters
- Elbows
- Spine

Check the skin underneath medical equipment to help prevent medical device-related pressure injuries as well. When evaluating skin changes, it’s important to compare at-risk skin to the temperature of surrounding tissue and use adequate lighting. Watch out for signs of non-blanchable redness. Continued, close monitoring is key.

The right support surfaces can have a positive impact.

Mattresses and cushions with specially designed pressure-redistribution features, including air, gel, water and foam, can reduce tissue deformation and improve tissue perfusion.

Support surfaces should fit the patient’s condition and need for microclimate control and comfort. It’s also helpful to consider the patient’s condition and where they spend the majority of their time.
3 Practice evidence-based turning and repositioning protocols.

Regular turning and repositioning for all individuals at risk for a pressure injury is key. In the past, the rule of thumb was every two hours. But now, the NPIAP advises that these protocols should be tailored to the patient’s medical condition, needs and preferences, as well as their existing areas of breakdown and support surfaces.

Follow these tips when it comes to turning and repositioning:

- **Use a 30-degree lateral turning position** to keep patients off the sacrum and trochanter.
- **Place a wedge or pillow** between the knees in a side-lying position to further protect the area. Note that clinicians often find that pillows are prone to sinking and changing shape, so they may not be the most reliable tool.
- **Offload the heels** either using pillows or with appropriate heel offloading devices (for prevention or stage 1 or 2 pressure injuries).
- **Consider silicone foam dressings** on patients at high risk for pressure injuries to protect bony prominences.
- **Use products** that make it safe and easy to turn and reposition patients.
- **Assist in repositioning** individuals in bedside chairs or wheelchairs hourly.
- **Add padding and protection** for surgical patients, especially for surgeries expected to last more than four hours.
- **Individuals who cannot turn themselves** should be repositioned at appropriate intervals established for that patient, regardless of the surface.
- **Consider non-skin-related factors**, such as respiratory, gastrointestinal and genitourinary functions when establishing a turning schedule.

4 Best-in-class skin care helps protect and soothe skin.

Studies show that a structured skin hygiene practice can help prevent pressure injuries. **Gentle skin care products** with evidence-based ingredients can protect fragile, aging skin and prevent breakdown and **moisture-associated skin damage (MASD)**. Residents who are incontinent and in post-acute care facilities are more vulnerable to MASD, which can be a contributing factor that increases an individual’s risk for pressure injury.

Shield this at-risk skin from breakdown by promptly cleansing the area after every incontinent episode. Follow up by applying a moisturizer and a barrier product. Provide better protection with pH-balanced skin care.
5 **Proper nutrition is important for wound healing.**

Individuals who are at risk for pressure injuries tend to also be at risk for both undernutrition and malnutrition. Research shows that malnutrition and weight loss can increase the risk of pressure injuries and **delayed wound healing**. That’s why nutrition is a key area of assessment for elderly patients and those whose illnesses cause reduced food intake over time. Encourage those at risk for pressure injuries to consume adequate fluids and a balanced diet, and assess weight changes over time. The right **clinical nutrition supplements** between meals and oral medications can help. Consult with a registered dietician to support patients who need help with adequate nutrition.

6 **Educate patients, residents and families about PI prevention.**

Discuss prevention goals with patients or residents, their family members and caregivers to drive adherence and ensure care and treatment plans are followed. When everyone is working toward the same goal, it’s easier to achieve. Patients who are included in their own care and treatment plans are more likely to follow them. Whether at home or in a healthcare setting, it’s helpful to educate family and caregivers on the best prevention strategies for the patient.

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*It’s great to have guidance so everybody is doing what’s best. That’s the philosophy of evidence-based best practices.*

**Joanne Labiak**, MSN, CRNP, CWOCN, CWS, DAPWCA and Medline consultant
Elevate your protocols

Improve outcomes with these must-have resources and interventions.
Build a Skin Champion team that promotes skin health best practices

Research shows that one of the most effective ways to improve outcomes is through subject matter champions. Like Skin Champions.

They might not wear capes, but Skin Champions are like superheroes who help prevent pressure injuries by promoting evidence-based best practices. Building—or maybe rebuilding—a Skin Champion team is a great way to keep skin care top of mind. Here’s how:

Gain leadership support

The key to launching and sustaining a Skin Champion team is getting leadership on board from the start. Be prepared with SMART goals, a sensible budget and solid plans to quantify results. SMART goals are:

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<tr>
<td>Specific</td>
<td>Measurable</td>
<td>Attainable</td>
<td>Relevant</td>
<td>Timed</td>
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<tr>
<td>What would you like the outcome to be? This is what gives your team credibility.</td>
<td>How will you know when you have reached the goals?</td>
<td>On a scale of 1 to 10, how confident do you feel you’ll achieve the goals?</td>
<td>Be sure your team’s goals align with the facility’s overall goals.</td>
<td>When do you want to reach the goals?</td>
</tr>
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Your proposed budget should include:

- Number of staff hours required
- Average salary of staff
- Number of meetings per year
- Preparation hours
- Annual supplies

Maintain C-suite support with regular updates that show pressure injury data.
Set up a successful team

Follow these 5 steps to create a strong and resilient Skin Champion team.

1. **Spread the word**
   Announce your call for Skin Champion team volunteers by hanging flyers in places where everyone can find them, including with physical therapists, certified nursing assistants, educators and doctors. Then hype it up—whether that means in person, virtually or through social media.

2. **Represent the whole system**
   When you’re putting your team together, be sure your team reflects all units. Remember, your patients may pass through several units during their stay, and all of them should have a pressure injury prevention strategy.

3. **Outline operations**
   With your team in place, it’s time to compose a charter. The charter is your North Star, your set of rules to follow. It might include:
   - Mission statement
   - Objectives
   - Team member expectations
   - Roles and responsibilities
   - Budget and resources
   - Success criteria

4. **Toot the team horn**
   Broadcast and boast about your team in the break room, at conferences and to leadership. And build camaraderie with a team name, T-shirts or buttons—something to give team members ownership and bragging rights.

5. **Keep the fire stoked**
   Here are some ways to help keep momentum going:
   - Encourage friendly competition between units
   - Communicate regularly with team members
   - Reward and recognize achievements
   - Send out monthly newsletters to introduce team members and publicize successes
   - Maintain an effective database to track outcomes that demonstrate the team’s value

If you’re not able to fully implement a Skin Champion team, that’s OK. Start to lay the groundwork and light the spark so you’ll be ready to jump right in.
Stage PIIs more easily with our Apple P.I.E. method

When it comes to pressure injuries, accurate staging is key to identifying the right treatment and intervention. Our patented Apple P.I.E. method was created by a Medline clinician to help caregivers visualize pressure injury stages. Annual Apple P.I.E. Day events make the concept memorable and interactive.

Pressure Injury Staging is as easy as Apple P.I.E.

Follow this Pressure Injury Explanation guide to see how the state of an apple compares to the stage of a pressure injury.

<table>
<thead>
<tr>
<th>Stage 1</th>
<th>Stage 2</th>
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<tbody>
<tr>
<td>Intact skin with a localized area non-blanchable erythema, which may appear differently in darkly pigmented skin.</td>
<td>Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister.</td>
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<tr>
<th>Stage 3</th>
<th>Stage 4</th>
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<tr>
<td>Full-thickness loss of skin, in which adipose (fat) is visible in the injury and granulation tissue and epibole (rolled wound edges) are present.</td>
<td>Full-thickness skin and tissue loss with directly palpable fascia, muscle, tendon, ligament, cartilage, or bone in the injury.</td>
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<tr>
<th>Unstageable</th>
<th>Deep Tissue Pressure Injury (DTPI)</th>
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<tbody>
<tr>
<td>Full-thickness skin and tissue loss in which the extent of tissue damage within the injury cannot be confirmed because it is obscured by slough or eschar.</td>
<td>Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood-filled blister.</td>
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Print and share the poster with your team so they can stage with confidence.

Download poster

medline.com/skin-health/
Amid staff shortages, caregiver burnout and healthcare crises, how do you continue to make prevention education a top priority? Here are some dos and don’ts that will keep your caregivers engaged.

**Do engage the audience**

How about adding some “potty talk” to your education? That’s what one of the Medline Skin Health Advisory Board members calls the educational reminders her team hangs in bathroom stalls. “When the nurses go into the bathroom, there will be at least 20 seconds where they’ll be staring at the wall,” she says. “So, we took advantage of that real estate.” They also make it humorous and memorable. Like the analogy of applying a skin barrier cream “like painting a child’s face” instead of “frosting a cupcake.”

**Do encourage the “why”**

Take every opportunity to explain why the evidence-based best practice calls for a certain protocol or product. “Nurses have to understand the why, not just the what or the how,” says Patricia Turner BSN, RN, CWOCN, CWS, Medline Director of Clinical Resources, Skin Health-Acute Care. “Why is turning and repositioning so important, why would I put on a sacral dressing, why am I going to get a patient on a support surface. Knowledge is empowerment.”

**Do use a variety of learning resources**

From online learning opportunities to on-point printed materials, there are amazing resources available, so take full advantage of what’s out there or even create some of your own. One Medline Skin Health Advisory Board member chooses a monthly pressure injury prevention topic that’s discussed in huddles. Then, based on challenges nurses have at the bedside, she creates a one-page booklet with tips nurses can refer back to.

**Do use simple decision trees**

Algorithms help make complicated prevention strategies easier. For example, check out this guide to determining the right heel protection.

**Don’t reinvent the wheel**

Using a turnkey educational program to create a Skin Champion team helps develop effective, systemwide pressure injury prevention.

**Don’t do it alone**

Consider partnering with another clinical expert to help you and your team identify gaps and opportunities. An on-site or virtual Skin Health discovery meeting provides customized recommendations and ongoing support.
A clinician-recommended system of products for PI prevention

You now know how the 4 contributing factors—pressure, shear, friction and moisture—can lead to pressure injuries. A comprehensive system of products designed to work better together and address these forces are key to PI prevention.

Utilizing a system of products that addresses all of those forces and helps to mitigate risk factors collectively is the way to drive the best possible outcomes for pressure injury prevention.

Patricia Turner, BSN, RN, CWOCN, CWS, Medline Director of Clinical Resources

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**Pressure redistribution**

- **Optifoam® Gentle EX**
  - Why clinicians recommend it: This multilayer foam dressing manages sacral pressure injuries by helping to minimize pressure, shear, and moisture.

- **HeelMedix® Heel Protectors**
  - Why clinicians recommend it: Achieve superior heel offloading and reduces pressure with intuitive, clinician-designed features.

- **Medline Remedy® Skin Care**
  - Why clinicians recommend it: Using evidence-based ingredients, this color-coded, caregiver-centric skin care system makes it easier to manage moisture.

- **Remedy® DriGo-HP™ Wicking Sheets**
  - Why clinicians recommend it: Perfect for skinfolds, this silky-smooth cloth reduces skin-on-skin friction and wicks away moisture for up to five days.

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**Skin care and moisture management**

- **HeelMedix® Heel Protectors**
  - Why clinicians recommend it: Achieve superior heel offloading and reduces pressure with intuitive, clinician-designed features.

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**Repositioning and offloading**

- **ComfortGlide™ Repositioning Sheets**
  - Why clinicians recommend it: Our low-friction repositioning sheets take 35% less effort to move patients than standard draw sheets.

- **ComfortGlide™ Wedges**
  - Why clinicians recommend it: These wedges achieve the NPIAP-recommended 30-degree angle and offload the sacrum.

- **ComfortGlide™ Drypads**
  - Why clinicians recommend it: Thanks to ultra-absorbent polymers, our drypads keep patients up to 26 times drier than the leading competitor.

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Discover more products to help prevent skin breakdown.
Stay up to date on skin and wound care

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References:
5. Data on file