PRESSURE INJURY PREVENTION PATHWAY

Updated 2026 | Based on the International Guideline, Fourth Edition (NPIAP, EPUAP, PPPIA)

Admission or transfer in

Step 1: Screen as soon as possible after admission (RISK1)
Minimum: mobility or activity limits, medical devices, existing pressure injury
Head-to-toe skin and tissue assessment: look, touch, ask (STA1, STA5)

Existing pressure injury?

YES → **Classify (NPIAP) and document**
Individualised treatment plan
Consult wound care
Inform the physician
Start the prevention plan: existing injury means high risk

NO

Screen positive or high-risk group?

NO → **Not at risk now**
Rescreen at set intervals and whenever condition changes

YES

High-risk groups go straight to Step 2: critical care, spinal cord injury, critically ill neonates

Step 2: Full risk assessment (RISK2, RISK4)
Validated tool (e.g. Braden) with subscales, plus factors the tool misses: perfusion, devices, previous injury, surgery
Any mobility or activity deficit = at risk, whatever the total score. Use clinical judgement and document.

Medium and dark skin: erythema may not show. Compare temperature, firmness, oedema and pain with nearby skin; use good light.

Step 3: Individualised, risk-based prevention plan (RISK3): target each risk finding, agree with the person and family

Repositioning and mobility

- Every 2 or 3 hours, individualised; not routinely 4–6 hours (R7, R8)
- 30° lateral tilt; avoid 90° side-lying (R10)
- Head of bed at 30° or lower unless contraindicated (R11)
- Small frequent shifts if too unstable to turn (R9)
- Lift, do not drag: slide sheets and transfer aids (R3)
- Encourage mobilisation and self-repositioning
- Seated: limit time, regular weight shifts, pressure-redistributing cushion; no ring cushions

Support surfaces and heels

- Reactive pressure redistribution foam as a minimum; step up as risk rises (SS3)
- Float heels, knees flexed 5–10°; heel device off at least twice daily (H1, H2)
- No fluid-filled gloves or IV bags under heels

Skin and moisture

- Structured skin care; pH-balanced cleanser (4.5–5.5) (SK1)
- No massage or vigorous rubbing of bony prominences
- Breathable absorbent products, changed promptly; barrier product if incontinent
- Soft silicone foam dressing on sacrum and heels if high risk; check skin daily (SK2, H4)
- Low-friction fabrics if unable to reposition (SK3)

Medical devices

- Right size; least tension; check under and around regularly (DRPI1–3)
- Reposition or rotate devices; preventive dressing under devices (DRPI6)

Nutrition and hydration

- Screen nutrition; refer to dietitian if at risk (N1, N2)
- Supplements and protein if malnourished (N4, N5)

Person and family

- Teach the plan, warning signs and self-repositioning

Reassess and review: skin at every repositioning (STA6); risk and plan at set intervals, with any change in condition, transfer or surgery, and before discharge (STA5). Document what was done; audit compliance (RISK5).

Intervals for rescreening and reassessment are set by local policy; the guideline defines the triggers. Codes refer to International Guideline, Fourth Edition statements (2025–2026), **internationalguideline.com.**

IIWCG | Gulnaz Tariq | First edition 2010, Second edition 2015, Third edition 2020, updated November 2026