

Pressure Injuries



This BPR Brief is an abridged version of the **Best Practice Recommendations for the Prevention and Management of Pressure Injuries**. In alignment with a global health-care perspective, Wounds Canada is committed to provide support to patients to help them adapt to and self-manage their condition in the face of social, physical and emotional challenges. This document uses the **Wound Prevention and Management Cycle** (WPMC) (Figure 1) as the basis for clinical decision making. For clinicians, this document is meant as a cue for treatment; it provides non-inclusive examples listed below each recommendation. For policy makers, it highlights (in ***bold italics***) actions and policies that support best practice.

Wounds Canada follows a population health strategy for wound care that enables us to address the entire range of individual and collective factors that determine health, including:

- Better health: health of the general population improved; behavioral, social, economic and environmental determinants addressed; preventative care rewarded
- Better health care: patient-centred, reliable, safe, evidence-based treatment; care managers co-ordinate total health-care delivery; evidence-based treatment with outcome tracking
- Better value: costs and cost improvements monitored; readmissions to hospital reduced; early interventions to reduce per patient costs implemented; unnecessary or duplicate procedures eliminated; information management technologies utilized

For more information on content, levels of evidence or tools related to a particular recommendation, click on the links provided.

We strongly recommend that before using this BPR Brief the user read the full best practice recommendation (BPR) document. To obtain a copy of the full document, go to: www.woundscanada.ca/docman/public/health-care-professional/bpr-workshop/172-bpr-prevention-and-management-of-pressure-injuries-2/file.

Introduction

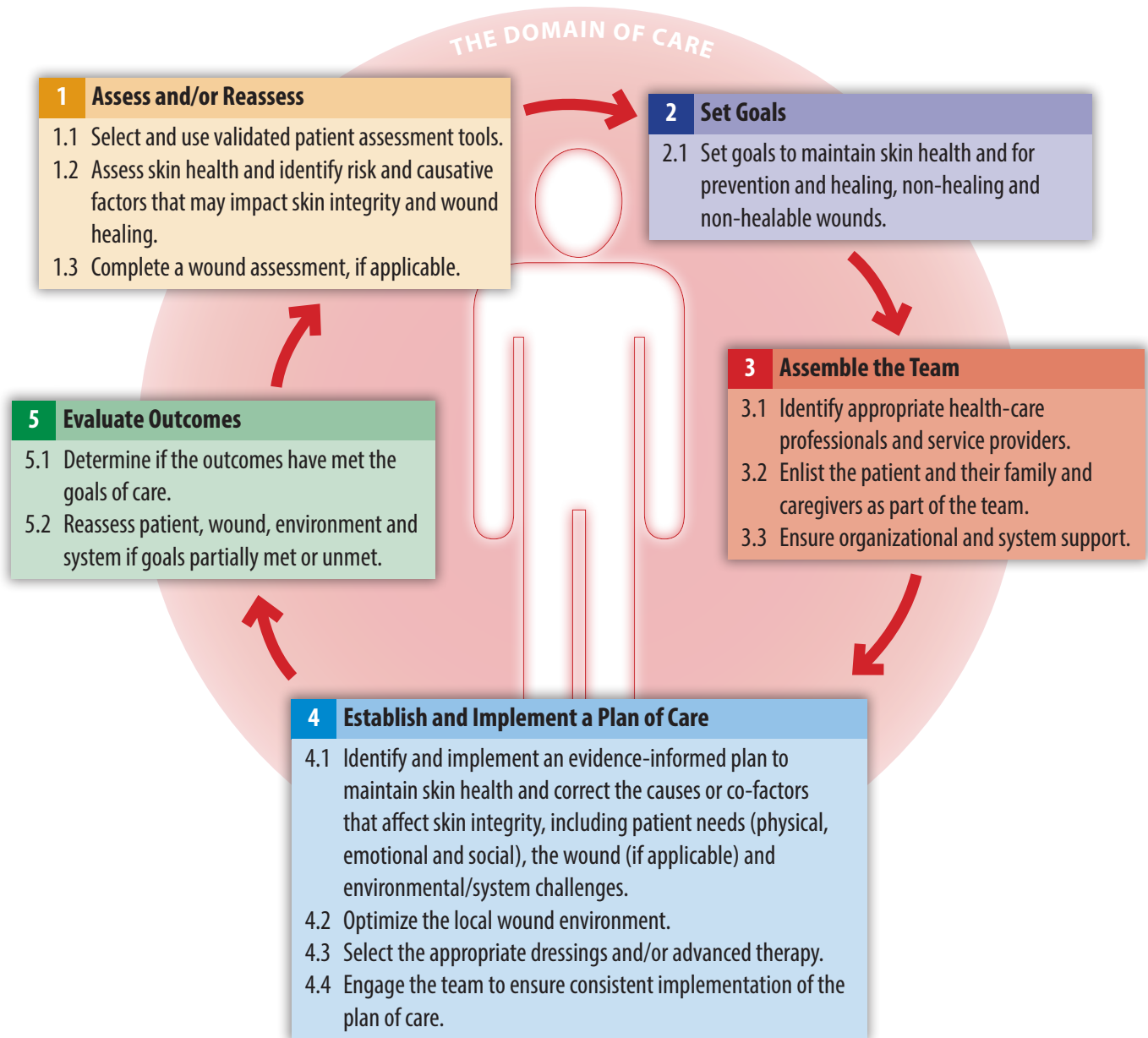
The prevention of pressure injuries (PI) continues to be a concern in Canadian health-care systems. In a 2004 study funded by the then Canadian Association of Wound Care (now Wounds Canada), the overall prevalence of pressure ulcers (PU) across all health-care settings was 26%, with approximately 70% of these wounds considered preventable. According to published literature, clinical practice and expert opinion, nearly all pressure injuries can be prevented.

Despite the focus on prevention to date, pressure injury incidence rates have not significantly decreased in Canada when compared with other countries around the world, including the U.S. An integrated approach focused on prevention is required to make a significant difference in incidence rates. For optimal effectiveness, teams need to be inter-professional and integrated to include the person at risk of, or with a, pressure injury (as the first team member), along with their families, care partners and relevant and relevant departments such as purchasing and housekeeping (in the institutional setting).

Approximately 70% of pressure injuries are considered preventable.

Disclaimer: This document provides a brief clinical enabler for the content provided in the relevant chapter(s) of *Best Practice Recommendations for Skin Health and Wound Management 2025*. It is not intended to provide comprehensive information on the given topic(s). For more complete information on specific best practice recommendations, refer to the full publication at: <https://www.woundscanada.ca/news/752-bpr-new>

Figure 1: Wound Prevention and Management Cycle (WPMC)



For the complete version of Best Practice Recommendations for the Prevention and Management of Pressure Injuries, visit [here](#).

1 Assess and/or Reassess

- 1.1 Select and use validated patient assessment tools.
- 1.2 Assess skin health and identify risk and causative factors that may impact skin integrity and wound healing.
- 1.3 Complete a wound assessment, if applicable.

Assessment must occur to determine the factors that may impact skin integrity and wound healing. Patient assessment includes history and current health status, skin status, baseline skin tone (and wound, if applicable), environmental factors and system factors. If, after the WPMC has been completed, goals of care have not been fully met, reassessment must take place, followed by the rest of the recommendations in the WPMC. **Assessment tools need to be available and in use in all care settings, supported by staff education and policy.**

Let assessment guide prevention, referrals and intervention.

1.1 Select and use validated patient assessment tools (Specific populations are discussed below)

Pressure-injury-specific risk assessment tools include: the Braden Scale for Predicting Pressure Ulcer Risk, Braden Q Scale, InterRAI Pressure Ulcer Risk Scale, Norton Pressure Sore Risk Assessment Scoring System, Waterlow Scale for Stratification of Pressure Sore Risk, Gosnell Scale, Spinal Cord Injury Pressure Ulcer Scale

To support Indigenous communities, Wounds Canada has developed Pressure Injuries: A guide for Alberta with a focus on Indigenous health. Available [here](#).

1.2 Identify risk and causative factors that may impact skin integrity and wound healing (patient, wound, environment and system)

1.2.1 Patient: Physical, emotional and lifestyle

Admission tools standardized to identify risk and causative factors for all patients need to be available and supported by staff education and policy. Physical risk and causative factors include: sensory perception deficits, skin exposure to moisture, decreased physical activity and mobility, inadequate nutrition and hydration, presence or risk of friction and/or shearing forces (e.g., muscle spasms), hypotension, vascular disease, obesity, pain, extremes of age, institutionalization on a critical care unit, and acute, severe chronic or terminal illness.

1.2.2 Environmental: Socio-economic, care setting, potential for self-management

Assessment of socio-economic determinants should include income, employment and working conditions, food security, environment and housing, early childhood development, education and literacy, social supports and connectedness, health behaviours, access to health care and services. It is critical to provide a culturally sensitive environment for care.

1.2.3 Systems: Health-care support and communication

Assessment of access to funding, availability of services and wound-related products, pressure redistribution surfaces, diagnostic services, service delivery personnel and co-ordination of care.

1.3 Complete a wound assessment, if applicable

The choice of wound assessment tool should be consistent across all care settings and supported by education and policy.

- The **National Pressure Injury Advisory Panel (NPIAP)** recommends that pressure injuries be categorized/staged according to the depth of original injury and not be categorized/staged in reverse as healing occurs.
- Wounds should be assessed for healing or deterioration using tools such as the **Bates-Jensen Wound Assessment Tool (BWAT)**, **Pressure Ulcer Scale for Healing (PUSH)**, **Sessing Scale**, **Spinal Cord Impairment Pressure Ulcer Monitoring Tool**.
- The presence or absence of infection and osteomyelitis should be assessed. Assess for infection using the **International Wound Infection Institute (IWII) continuum**. Other tests may include swabs, bone biopsy, x-rays, blood tests for inflammatory markers, MRI.
- Some conditions may co-exist so it is important that the assessment is able to differentiate the etiology of the injury (Table 1)

Table 1: Differential Diagnosis of Pressure Injury and Incontinence-associated Dermatitis (IAD)

	Pressure Injuries (Category /Stage1)	Pressure Injuries (Category /Stage 2)	Incontinence-Associated Dermatitis
Location	Over bony prominence or sites exposed to external pressure and shear, or associated with a medical device	Over bony prominence or sites exposed to external pressure and shear, or associated with a medical device	May be localized to the perineum, perigenital areas or generalized to include buttocks; gluteal fold; medial and posterior aspects of upper thighs; lower back; may extend over bony prominence
History	Exposure to pressure, shear, immobility	Exposure to pressure, shear, immobility	Urinary and/or fecal incontinence
Pain (for those with intact sensation)	Burning, itching, warmth	Burning, pain	Burning, itching, tingling, pain
Odour	None	Unlikely	Fecal and/or urine
Characteristics	Localized heat, edema and change in tissue consistency in relation to surrounding tissue (e.g., induration/hardness) have all been identified as warning signs for pressure injury development.	Shallow open area with distinct edges or margins	Area is diffuse with poorly defined edges with superficial, partial-thickness skin loss or may be intact skin with blanchable or non-blanchable, blotchy erythema Note: This may not be visible in people with darkly pigmented skin.
Periwound skin	Intact	Intact	Irritated, red
Infection	Rare	Rare, although secondary soft tissue infection may be present	Secondary superficial skin infection such as candidiasis may be present
Improvement	Pressure redistribution	Pressure redistribution	Control/containment of incontinence, effective skin protection

2 Set Goals

2.1 Set goals to maintain skin health and for prevention and healing, non-healing and non-healable wounds.

Goals of care need to revolve around the patient. Achieving goals will depend on the interplay of the patients' health status and lifestyle, the availability of resources and the knowledge and ability of care partners to provide optimal interventions. If these factors are not taken into consideration the goals of care may be unrealistic and unrealizable. The team should aim to set goals according to the **SMART principle**: **S**pecific, **M**easurable, **A**ttainable, **R**elevant and **T**imely.

2.1 Set goals for healthy skin, prevention of skin breakdown and management of healing, non-healing and non-healable wounds

SMART goals needs to be part of care planning and be supported by a care planning policy. Goals need to be established to enhance the patient's quality of life regardless of the healability of pressure injuries. Pressure injury prevention should be considered a patient safety goal.

2.1.1 Identify goals based on prevention or healability of wounds

- For prevention: Daily skin assessment starting now!
- For all wounds: Adequate positioning and pressure redistribution surfaces within two days
- For a healable pressure injury: Wound closure within three weeks
- For a non-healing pressure injury: Wound infection controlled within two weeks
- For a non-healable pressure injury: Alleviation of smell and pain within four days.

2.1.2 Identify quality-of-life and symptom-control goals

QoL and symptom control goals might include:

- Return to social activities (modified if necessary) within one month.
- Participate in 2–3 sessions of strength training and 50 minutes or more of low-intensity, low-impact aerobic exercises per week within one month.

3 Assemble the Team

- 3.1 Identify appropriate health-care professionals and service providers.
- 3.2 Enlist the patient and their family and caregivers as part of the team.
- 3.3 Ensure organizational and system support.

An integrated team is necessary to implement, adjust and sustain a plan to meet the patient-specific goals. The team should include the relevant health-care professionals and other service providers as required as well as the patient, family and their support system.

3.1 Identify appropriate health-care professionals and service providers

Team members may include: wound clinician, continence specialist, dietitian, family physician or primary care nurse practitioner, infectious disease specialist, mental health specialist, nurse, occupational therapist, orthopedic surgeon, orthotist, personal support worker, pharmacist, physiatrist, physical therapist, surgeon/plastic surgeon, social worker, speech-language pathologist, spiritual care practitioner.

3.2 Enlist the patient and their family and caregivers as part of the team

The team must include the patient and/or their family and care partners, with successful prevention and management of pressure injuries hinging on their collaboration and communication with other members of the team.

3.3 Ensure organizational and system support

Wounds Canada's resources and education align with a population health management model. This model encourages the proactive management of a total population at risk for adverse outcomes through a variety of individual, organizational and cultural interventions to improve patient, clinical and financial outcomes. The interventions are based on a risk-stratified needs assessment of the population, supported by a comprehensive governance infrastructure.

Health-care organizations need to be accountable for any pressure injury development under their purview. To ensure prevention is a focus and is adequately supported, they need to:

- ***Set appropriate policies and procedures and ensure they are being followed; this must include policies and procedures related to:***
 - ***screening/assessment***
 - ***communication***
 - ***education****
 - ***interventions***
 - ***documentation***
 - ***analysis of data***
 - ***continuous quality improvement*****
- ***Make available relevant and adequate financial, human and material resources***
- ***Create a culture of prevention that involves all staff (clinical and non-clinical), patients, family members and caregivers.***
- ***Ensure there is appropriate and equitable access to supplies and medical equipment such as moisturizers, skin barriers, therapeutic pressure redistribution surfaces and other devices.***

****It is essential that organizations support appropriate staffing and education so team members obtain adequate skills and knowledge to effectively manage the multiple complex issues related to pressure injuries. A needs assessment should be undertaken to identify knowledge gaps and ensure that educational sessions are tailored to meet those needs. Educational sessions need to utilize principles of adult learning, relate to clinical practice and reinforce strategies to sustain knowledge. Patients and their families can also benefit from education about pressure injury prevention.***

In order to achieve these steps and improve patient outcomes, establish or adopt a system-wide care pathway.

It's not what you put on a pressure injury, it's what you take off a pressure injury.

4 Establish and Implement a Plan of Care

- 4.1 Identify and implement an evidence-informed plan to maintain skin health and correct the causes or co-factors that affect skin integrity, including patient needs (physical, emotional and social), the wound (if applicable) and environmental/system challenges.
- 4.2 Optimize the local wound environment.
- 4.3 Select the appropriate dressings and/or advanced therapy.
- 4.4 Engage the team to ensure consistent implementation of the plan of care.

Ensure that care addresses the goals and considers patient needs, factors relating to the skin and wound (if applicable) as well as the environment and the system in which the team is situated.

4.1 Identify and implement an evidence-informed plan to support healthy skin, correct the causes or co-factors that affect skin integrity, including patient needs (physical, emotional and social), the wound (if applicable) and environmental/system challenges

The plan of care must be patient-driven, based on assessment and risk, and supported by available resources and policy.

- Daily skin care and inspection for early identification of at-risk areas
- **Pressure and shearing forces** should be addressed, through techniques such as proper positioning and frequent and safe repositioning and transfers, mobilization and minimization of bed rest, initiation and proper use of pressure redistribution **support surfaces** and transfer aides, and use of protective skin barriers.
- Proper positioning of tubing and devices must be ensured.
- Moisture can be addressed through techniques such as individualized bowel/bladder programs; use of bed-pans/urinals, absorbent pads/dressings, commercial moisture barriers; temporary use of condom/indwelling catheters or fecal management systems and use of moisture wicking materials.
- Nutrition and hydration support must be in place to support healing and address blood pressure and body mass index.
- Physical exercise is recommended to optimize body mass index and muscle strength, and to improve activity and mobility.
- Surgical intervention is an option to close recurrent, multiple or non-healing Category/Stage 3 and 4 pressure injuries provided it is consistent with the goals of care.

Patients and Family as Partners in Care

There has been an important shift toward developing self-care skills in persons with pressure injuries.

- Engaging individuals in prevention of complications and in treatment and interventions is recommended.
- Incorporate evidence-based resources relevant to the individual and care partners focused education and self-care on relevant learning. Utilizing multi-faceted approaches including verbal, web based tools, communication journals, phone and written materials is important with the patient and care partners.

4.2 Optimize the local wound environment: cleansing, debriding, managing bacterial balance and managing moisture balance

4.2.1 Cleansing: Non-irritating **wound cleansers** such as potable water, normal saline or commercially prepared wound cleansers should be used, depending on patient needs (see Wounds Canada's Product Pickers, below).

4.2.2 Debriding: Non-viable tissue should be **debrided** to promote wound closure (**if appropriate**) (see Wounds Canada's Product Pickers, below).

4.2.3 Managing bacterial balance: Any **local, spreading or systemic infection** must be treated, including osteomyelitis if present (see Wounds Canada's Product Pickers, below).

4.2.4 Managing moisture balance: **Moisture** can be contained or provided through dressing selection (see Wounds Canada's Product Pickers, below).

4.3 Select the appropriate dressings and/or advanced therapy

Select **products or advanced therapies** that will address the local wound environment needs as well as prevent trauma to fragile/friable tissue—including periwound skin (see Wounds Canada's Product Pickers, below).

4.4 Engage the team to ensure consistent implementation of the plan of care

Education/instruction should be available to all levels of care providers, including the patient and care partners, on topics such as:

- Potential risks of pressure injuries
- Daily skin assessment and care
- Nutrition (food, fluids) and exercise
- Use of pressure redistribution devices
- Wound care
- Signs of infection
- Self-management

Wounds Canada's Product Pickers

- **Wound Dressing Formulary:** describes common wound dressings in generic categories and lists usage considerations
- **Wound Dressing Selection Guide:** helps users choose appropriate primary and secondary dressings based on common clinical situations and wound care goals
- **Skin and Wound Clean-up:** helps users choose appropriate skin and wound cleansers as well as irrigating solutions
- Wounds Canada Nutrition and Wound Healing

5 Evaluate Outcomes

- 5.1 Determine if the outcomes have met the goals of care.
- 5.2 Reassess patient, wound, environment and system if goals partially met or unmet.

Evaluation of the plan of care should be routine and ongoing to identify whether the plan is effective in meeting the goal(s). If, after the cycle has been completed, goals of care have not been fully met, reassessment (Step 1) must take place, followed by the rest of the Wound Prevention and Management Cycle steps. ***The plan of care needs to be revisited at discharge to ensure that self-management strategies are in place to support the patient in sustaining the achieved outcomes after discharge.***

5.1 Determine if the outcomes have met the goals of care

Outcomes need to reflect goals of care and sustainability needs to reflect continuity of care; both need to be included in the plan of care and supported by policy. Outcomes may include:

- Achievement of blood pressure, body mass index, nutrition and exercise targets
- Prevention of pressure injury
- Achievement of a daily skin assessment and care routine
- Success level of pressure, shear and moisture management
- Resolution and/or prevention of infection +/- osteomyelitis
- Wound closure and prevention of recurrence

Team members should refer back to original goals and, through the use of validated tools, determine if the goals of the prevention or treatment plan have been met.

If the plan of care is appropriate and the wound is not improving, consider a biopsy to rule out skin disorders or a malignancy.

5.2 Reassess patient, wound, environment and system if goals are partially met or unmet

When goals of care are partially met or unmet, go back to Step 1 of the Wound Prevention and Management Cycle. Reassessment needs to consider gaps in care or the person's ability to adapt to their condition and engage in self-management.

5.3 Ensure sustainability to support prevention and reduce risk of recurrence

Sustainability may depend on access to appropriate equipment and services and collaboration among the person with or at risk for a pressure injury, their care partners, service providers and the interprofessional team of health-care professionals.

Additional Wounds Canada resources, including a variety of Product Pickers and brochures, are available online at: www.woundscanada.ca/health-care-professional/resources-health-care-pros/boutique.

Care at Home Series:

- Caring for Pressure Injuries at Home: Preventing and Managing Pressure Injuries
- Caring for Your Wound at Home: Changing a Dressing



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