

Pressure injury management, long-term care



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■ Introduction

One of the universally recognized quality indicators, a pressure injury is localized damage to the skin, underlying soft tissue, or both. Pressure injuries are usually located over a bony prominence or related to the use of a medical or other device and can develop as a result of intense or prolonged pressure or pressure combined with shearing force. Other factors that contribute to pressure injury development include moisture, friction, immobility, sensory loss, nutrition, perfusion, and certain underlying medical conditions.^[1] Areas over bony prominences are at particular risk for developing pressure injuries because the skin in these areas is less vascular. Such areas include the occiput, acromion process, scapulae, vertebrae, sacrum, coccyx, ischial tuberosities, condyles, malleoli, and calcanei.^[1]

A staging tool—such as the classification system developed by the National Pressure Injury Advisory Panel (NPIAP), found at <https://learn.npiap.com/products/npiap-staging-for-light-skin-poster> or <https://learn.npiap.com/products/npiap-staging-for-dark-skin-poster>—should be used to describe pressure injuries. In 2016, the NPIAP changed the terminology from "pressure ulcer" to "pressure injury" to more accurately describe pressure injuries to intact and ulcerated skin.

Using a staging tool to describe a pressure injury as it develops is helpful; however, as a pressure injury heals, the body doesn't replace the initially lost tissue and, therefore, the injury doesn't pass back through the same sequence of stages that it passed through when it formed. Consequently, the staging process shouldn't be used in reverse to describe a healing pressure injury.

When assessing a resident's skin, a nurse should be able to differentiate a pressure injury from other injuries, stage the pressure injury, and then develop and implement an individualized care plan based on the resident's needs.^[2] (See the "[Skin assessment, long-term care](#)" procedure.) Effectively managing pressure injuries in a long-term care setting requires a strong wound care team; a careful and accurate preadmission screening and preparation process that uses a validated risk tool for assessing pressure injuries, such as the Braden or Norton scale; protocols that have been reviewed, revised, and approved by the performance improvement committee; and the ability to address pressure injury risk factors.^[3] These risk factors include:

- impaired or decreased mobility or functional ability
- comorbid conditions
 - end-stage kidney disease
 - diabetes mellitus
- impaired blood flow to the area
- resident refusal to adhere to care
- cognitive impairment
- exposure of the skin to urine or feces (from incontinence)
- malnutrition

- inadequate hydration
- history of pressure injury.

Specific interventions to manage pressure injuries include continuous skin assessment, consistent monitoring, and interventions to prevent the formation of pressure injuries.^[3] (See the "[Pressure injury prevention, long-term care](#)" procedure.)

Federal regulations require long-term care facilities to actively prevent and effectively treat pressure injuries. They require each facility to ensure that a resident who enters the facility without pressure injuries doesn't develop pressure injuries, unless the resident's clinical condition demonstrates that they were unavoidable. They also require each facility to ensure that a resident who has pressure injuries receives the necessary treatment and services to promote healing, prevent infection, and prevent the development of new pressure injuries.^[4]

■ Equipment

- Disinfectant wipes or disinfectant spray and cloth
- Disposable plastic bag
- Disposable wound-measuring device
- Facility-approved pain assessment tool
- Facility-approved wound staging or classification system
- Gloves
- Light source
- pH-balanced skin cleaner
- Prescribed dressings
- Sterile cotton-tipped applicator
- Sterile composite dressing
- Sterile gauze pads
- Sterile normal saline solution, wound cleaner, or potable tap water
- Wound irrigation device (commercial wound irrigation device or 35-mL catheter-tip syringe with 19G needle or angiocatheter)^[5]
- Optional: medication applicator, other personal protective equipment, prescribed pain medication, prescribed topical medication, wound packing material

■ Preparation of Equipment

Inspect all equipment and supplies. If a product is expired, is defective, or has compromised integrity, remove it from resident use, label it as expired or defective, and report the expiration or defect as directed by your facility.

■ Implementation

- Verify the practitioner's order.
- Gather and prepare the necessary equipment and supplies.
- Perform hand hygiene.^[6]^[7]^[8]
- Confirm the resident's identity using at least two resident identifiers.^[9]
- Provide privacy.^[10]
- Explain the procedure to the resident and family (if appropriate) according to their individual communication and learning needs *to increase understanding, allay fears, and enhance cooperation.*
- Raise the bed to waist level before providing care *to prevent caregiver back strain.*^[11]

- Perform hand hygiene.^{[6][7][8]}
- Screen for and assess the resident's pain using facility-defined criteria that are consistent with the resident's age, condition, and ability to understand.^[12]
- Treat the resident's pain, as needed and ordered, using nonpharmacologic, pharmacologic, or a combination of approaches. Base the treatment plan on evidence-based practices and the resident's clinical condition, past medical history, and pain management goals.^[12]
- *Because pressure injury care can be painful, make sure the resident has been premedicated with prescribed pain medication, if indicated. Premedicate the resident for pain 30 minutes to 1 hour before the procedure, as needed and ordered, following safe medication administration practices to promote comfort during the procedure.*^[13]
- Ensure adequate lighting.
- Have a disposable plastic bag readily available *to discard used dressings and equipment.*^[14]
- Perform hand hygiene.^{[6][7][8]}
- Disinfect the resident's table or treatment tray using a disinfectant wipe or disinfectant spray and a cloth.^[15]
- Perform hand hygiene.^{[6][7][8]}
- Place the supplies, including the prescribed dressings, medications, sterile gauze pads, and cleaning solution, on the table or treatment tray. Arrange them according to the order of use *to avoid cross-contamination while performing wound care.*^{[16][17]} (See [Techniques for managing chronic wounds.](#))

TECHNIQUES FOR MANAGING CHRONIC WOUNDS

The Association for Professionals in Infection Control and Epidemiology and the Wound, Ostomy, and Continence Nurses Society have developed the following recommendations for managing chronic wounds.

Wound care intervention	Hand hygiene	Gloves	Wound care supplies	Instruments
Wound cleaning	Yes	Clean	Sterile normal saline solution or commercially prepared wound cleaner; maintain solution as clean*	Sterile irrigation device; maintain the device as clean*
Routine dressing change	Yes	Clean	Sterile; maintain supplies as clean*	Sterile; maintain instruments as clean*
Dressing change with debridement (mechanical, chemical, or enzymatic)	Yes	Clean	Sterile; maintain supplies as clean*	Sterile; maintain instruments as clean*
Dressing change with sharp conservative bedside debridement	Yes	Sterile	Sterile	Sterile

*Each facility should establish their own criteria for maintaining supplies and solutions, taking into consideration the manufacturers' recommendations, expiration dates, and costs.^{[16][17]}

- Perform hand hygiene.^{[6][7][8]}

- Put on gloves and, as needed, other personal protective equipment *to comply with standard precautions*.^{[14][18]}
- Position the resident to allow access to the pressure injury site.
- Remove the old dressing carefully by pushing the skin away from the dressing *to avoid tearing the resident's skin*.
- Discard the used dressing in the plastic bag.^[14]
- Remove and discard your gloves.^[14]
- Perform hand hygiene.^{[6][7][8]}
- Put on new gloves.^{[14][18]}

♦ **Clinical alert:** For managing chronic wounds, such as a pressure injury, no consensus exists among experts on the use of clean versus sterile technique. The Wound, Ostomy, and Continence Nurses Society recommends that you consider the following factors when selecting the technique for chronic wound care: resident's immune status; type, location, and depth of the wound; invasiveness of the wound care procedure; environment in which you'll deliver the care; and available wound care supplies.^{[16][17]} ♦

- Inspect the wound. Note the anatomic location and the color, amount, and odor of drainage as well as the presence of necrotic debris.^[3]
- Clean the wound with sterile normal saline solution, wound cleaner, or potable tap water. *No evidence supports the use of any particular wound cleaning solution or technique for pressure injuries.*^[5] Cleaning can be done under running water at a sink or in a shower if the resident is able. Avoid tap water if the resident is immunocompromised.^[19]
- To mechanically clean the wound, start at its center and, working in a circular pattern, gently clean the wound with a gauze pad moistened with sterile normal saline solution, wound cleaner, or potable tap water. Work toward the edge of the wound and surrounding skin. Don't press hard or scrub a clean wound *because doing so will damage tissue and slow healing*. Don't return to the center of the wound with the gauze pad after cleaning it *to avoid recontaminating the wound*. Remove loose tissue with the gauze pad.
- If adherent material is present in the wound, irrigate the wound using a wound irrigation device *to deliver a pressure that's adequate to clean the surface of the pressure injury without causing trauma to the wound bed; 4 to 15 psi (0.28 to 1.05 kg/cm²) is typically considered sufficient and safe for wound cleaning.*^{[3][5]} A 35-mL syringe with a 19G needle or angiocatheter generates an 8-psi irrigation pressure stream.^[5]
- Pat the wound dry with a sterile gauze pad, and then discard the used pad.^[14]
- Clean the periwound skin with a pH-balanced skin cleaner *to promote pressure injury healing*.
- Remove and discard your gloves.^[14]
- Perform hand hygiene.^{[6][7][8]}
- Put on new gloves.^{[14][18]}
- Reassess the condition of the skin surrounding the wound as well as the wound bed. Note the characteristics of the clean wound bed and surrounding skin. Assess for a foul odor and other signs of infection, such as erythema, edema, and friable or irregular granulation tissue.^[3]
- Measure the wound with a disposable wound-measuring device (for example, a square, transparent card with concentric circles arranged in bull's-eye fashion and bordered with a straight-edge ruler). Use a uniform, consistent method for measuring the wound *to allow for meaningful comparisons for evaluating wound healing.*^[20]

- Gently insert a sterile cotton-tipped applicator into the wound to measure wound depth and assess for wound tunneling and undermining.^[20] *Tunneling usually signals wound extension along fascial planes.* Gauge tunnel depth by determining how far you can insert the applicator.
- Classify the wound using a staging or classification system *to assess the severity of the wound.*^{[3] [20]}
- Use a medication applicator to apply topical medication, if prescribed, following safe medication administration practices.^[13]
- If wound packing is necessary, pack the wound as prescribed. Dressing selection should be based on the tissue in the wound bed, periwound skin condition, and treatment goals. The type of dressing may vary over time as the wound heals or deteriorates.
- Cover the wound with the sterile composite dressing.
- Reposition the resident *to promote comfort.*^[3]
- Reassess and respond to the resident's pain by evaluating the response to treatment and progress toward pain management goals. Assess for adverse reactions and risk factors for adverse events that may result from treatment.^[12]
- Return the bed to the lowest position *to prevent falls and maintain the resident's safety.*
- Discard used supplies in appropriate receptacles.^[14]
- Remove and discard your gloves and, if worn, other personal protective equipment.^[14]
- Perform hand hygiene.^{[6] [7] [8]}
- Notify the practitioner if you find signs of infection or wound deterioration. If necrotic tissue is present in the wound, the wound requires debridement *because necrotic tissue impedes wound healing by providing a medium for bacterial growth and creating a barrier to granulation, contraction, and epithelialization in the wound bed.*^[3]
- Document the procedure.^[21]

■ Special Considerations

- Each resident admitted to a long-term care facility should undergo a skin assessment, including a pressure injury risk assessment using a facility-approved tool, such as the Braden scale or the Norton scale.^{[3] [4]} Assess a newly admitted resident's pressure injury risk weekly for a month and then at least quarterly after that. If a resident is at high risk for pressure injuries, perform monthly reassessment. Also assess pressure injury risk when a resident's condition changes, when a resident is readmitted to the facility or returns from a leave of absence, and when a new pressure injury site is noted.^[4]
- Pressure injury management calls for a multidisciplinary team approach.^[3] A registered nurse specially trained in wound care typically leads the team. A certified nursing assistant implements measures to prevent pressure injury formation and reports signs of skin breakdown to the registered nurse. A dietitian provides a dietary plan that promotes wound healing. A wound care practitioner may be needed to debride wounds. The director of nursing oversees the pressure injury program and provides staff members with performance improvement measures, *so they can gauge the quality of their care and improve as needed.*

■ Complications

Complications associated with pressure injury management may include:

- infection
- necrosis
- cellulitis

- septicemia
- sinus tracts
- heterotrophic calcification
 - amyloidosis
- pain
- osteomyelitis
- squamous cell carcinoma^[22]
- social isolation.

■ Documentation

Documentation associated with pressure injury management includes:

- pressure injury characteristics
 - size
 - location
 - depth
 - stage
- presence or absence of necrosis, slough, tunneling, and exudate^[3]
- condition of the wound bed
 - evidence of healing (such as granulation)
 - presence of eschar
 - status of the periwound area
- wound classification or stage and tool used
- signs of infection
- pain assessment
 - medication administered
 - response to the medication
- wound care provided
 - response to wound care
- complications
 - date and time of practitioner notification
 - name of practitioner notified
 - prescribed interventions
 - response to those interventions
- teaching provided to the resident and family (if applicable)
 - understanding of that teaching
 - follow-up teaching needed.^[23]

■ Related Procedures

- [Skin assessment, long-term care](#)
- [Transparent dressing application](#)

■ Related UpToDate Patient Teaching Handouts

- [Pressure sores](#)

■ References

[\(Rating System for the Hierarchy of Evidence for Intervention/Treatment Questions\)](#)

1. National Pressure Ulcer Advisory Panel (NPUAP). (n.d.). *NPUAP pressure injury stages*. Retrieved February 2026 from https://cdn.ymaws.com/npuap.site-ym.com/resource/resmgr/npuap_pressure_injury_stages.pdf (Level VII)
2. Patton, R. M. (2010). Is diagnosis of pressure ulcers within an RN's scope of practice? *American Nurse Today*, 5(1), 20. Retrieved February 2026 from <https://www.myamericannurse.com/is-diagnosis-of-pressure-ulcers-within-an-rns-scope-of-practice/>

3. European Pressure Ulcer Advisory Panel, et al. (2019). *Prevention and treatment of pressure ulcers/injuries: Quick reference guide*. Retrieved February 2026 from https://internationalguideline.com/s/Quick_Reference_Guide-10Mar2019.pdf (Level VII)
4. Centers for Medicare and Medicaid Services. (2024). *State operations manual, appendix PP - Guidance to surveyors for long term care facilities. Federal regulation 483.12*. Retrieved February 2026 from <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf>
5. Wound, Ostomy, and Continence Nurses Society™ (WOCN®). (2016). *Guideline for prevention and management of pressure ulcers (injuries): WOCN clinical practice guideline series 2*.
6. Centers for Disease Control and Prevention. (2002). Guideline for hand hygiene in health-care settings: Recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force. *MMWR Recommendations and Reports*, 51(RR-16), 1–45. Retrieved February 2026 from <http://www.cdc.gov/mmwr/pdf/rr/rr5116.pdf> (Level VII)
7. World Health Organization (WHO). (2009). *WHO guidelines on hand hygiene in health care: First global patient safety challenge, clean care is safer care*. Retrieved February 2026 from https://iris.who.int/bitstream/handle/10665/44102/9789241597906_eng.pdf (Level VII)
8. Joint Commission. (2026). Standard NPSG.07.01.01. *Comprehensive accreditation manual for nursing care centers*. (Level VII)
9. Joint Commission. (2026). Standard NPSG.01.01.01. *Comprehensive accreditation manual for nursing care centers*. (Level VII)
10. Joint Commission. (2026). Standard RI.01.01.01. *Comprehensive accreditation manual for nursing care centers*. (Level VII)
11. Waters, T. R., et al. (2009). *Safe patient handling training for schools of nursing*. Retrieved February 2026 from <https://www.cdc.gov/niosh/docs/2009-127/pdfs/2009-127.pdf> (Level VII)
12. Joint Commission. (2026). Standard PC.01.02.07. *Comprehensive accreditation manual for nursing care centers*. (Level VII)
13. Joint Commission. (2026). Standard MM.06.01.01. *Comprehensive accreditation manual for nursing care centers*. (Level VII)
14. Occupational Safety and Health Administration. (2019). *Bloodborne pathogens, standard number 1910.1030*. Retrieved February 2026 from <https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1030> (Level VII)
15. Rutala, W. A., et al. (2008, revised 2024). *Guideline for disinfection and sterilization in healthcare facilities, 2008*. Retrieved February 2026 from <https://www.cdc.gov/infection-control/media/pdfs/Guideline-Disinfection-H.pdf> (Level I)
16. Wound, Ostomy, and Continence Nurses Society. (2012). Clean vs. sterile dressing techniques for management of chronic wounds: A fact sheet. *Journal of Wound, Ostomy, and Continence Nursing*, 39(Suppl. 2), S30–S34. Retrieved February 2026 from <https://doi.org/10.1097/WON.0b013e3182478e06> (Level VII)
17. Flores, A. (2008). Sterile versus non-sterile glove use and aseptic technique. *Nursing Standard*, 23(6), 35–39. Retrieved February 2026 from <https://doi.org/10.7748/ns2008.10.23.6.35.c6707> (Level VII)
[Abstract](#) | [Complete Reference](#)
18. Siegel, J. D., et al. (2007, revised 2024). *2007 guideline for isolation precautions: Preventing transmission of infectious agents in healthcare settings*. Retrieved February 2026 from <https://www.cdc.gov/infection-control/media/pdfs/Guideline-Isolation-H.pdf> (Level VII)
19. Moore, Z. E. H., & Cowman, S. (2013). Wound cleansing for pressure ulcers. *Cochrane Database of Systematic Reviews*. Retrieved February 2026

from <https://doi.org/10.1002/14651858.CD004983.pub3> (Level I)

20. Baranoski, S., & Ayello, E. A. (2020). *Wound care essentials: Practice principles* (5th ed.). Wolters Kluwer.
21. Joint Commission. (2026). Standard RC.01.03.01. *Comprehensive accreditation manual for nursing care centers*. (Level VII)
22. Berlowitz, D. (2025). Clinical staging and management of pressure-induced skin and soft tissue injury. In: *UpToDate*, Berman, R. S., & Schmader, K. E. (Eds.).
[UpToDate Full Text](#)
23. Krasowski, G., et al. (2015). A comparison of an antibacterial sandwich dressing vs dressing containing silver. *Wound Repair and Regeneration*, 23(4), 525–530. Retrieved February 2026 from <https://doi.org/10.1111/wrr.12301> (Level II)
[Abstract](#) | [Complete Reference](#)

■ Additional References

- Gabriel, A. (2021). Wound irrigation. *Medscape*. Retrieved February 2026 from <https://emedicine.medscape.com/article/1895071-overview>
- Stone, A. (2020). Preventing pressure injuries in nursing home residents using a low-profile alternating pressure overlay: A point-of-care trial. *Advances in Skin & Wound Care*, 33(10), 533–539. Retrieved February 2026 from <https://doi.org/10.1097/01.ASW.0000695756.80461.64> (Level IV)

Rating System for the Hierarchy of Evidence for Intervention/Treatment Questions

The following leveling system is adapted from *Evidence-Based practice in nursing & healthcare: A guide to best practice*, Fifth edition, by Bernadette Mazurek Melnyk and Ellen Fineout-Overholt (2023).

Level I	Evidence from a systematic review or meta-analysis of all relevant randomized controlled trials (RCTs)
Level II	Evidence from well-designed single RCTs (experimental)
Level III	Evidence from well-designed nonrandomized controlled trials (quasi-experimental), systematic reviews of a complete body of evidence, and intervention studies using mixed methods
Level IV	Evidence from well-designed case-control and cohort studies (observational)
Level V	Evidence from systematic reviews of qualitative and descriptive studies
Level VI	Evidence from single descriptive and qualitative studies, evidence-based practice implementation, and quality improvement projects
Level VII	Evidence from expert opinion, expert committee reports, and literature reviews

Data from Gyatt, G., & Rennie D. (2002). *Users' guides to the medical literature*. American Medical Association; Harris, R. P., et al. (2001). *Current methods of the U.S. Preventative Services Task Force: A review of the process*. *American Journal of Preventative Medicine*, 20, 21-35.