1

PRESSURE INJURY PREVENTION

CNA & NURSING HOME STAFF

NOTICE | MITIGATE | NOTIFY

Every Staff Member is a
Noticer & Notifier.

2

WHO IS AT RISK?

Watch for these risk factors.

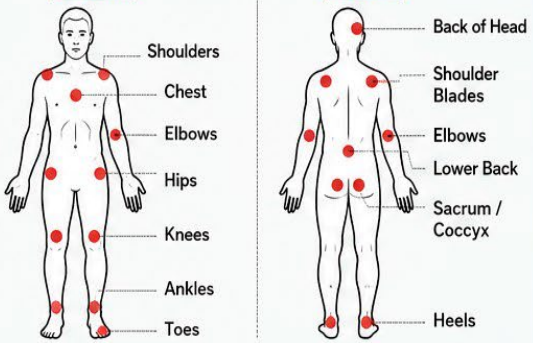
- Limited mobility
- Dependent for transfers
- Incontinence
- Dementia / cognitive impairment
- Weight loss
- Poor intake / dehydration
- Pain
- Poor circulation

High-Risk Areas:
Coccyx/Sacrum, Heels, Hips, Ankles, Elbows, Shoulder Blades, Back of Head

3

HIGH-RISK BODY AREAS

Check these areas every shift.



Check skin under devices and linens too!

4

EARLY WARNING SIGNS

Report any new or worsening changes.

Redness	Red, blue, purple, or darkened skin that does not blanch.
Blister	Fluid-filled blister or blood-filled area.
Temperature	Skin that feels warmer or cooler than normal.
Texture	Area that feels firm, mushy, or boggy.
Pain	Tenderness, itching, or pain in the area.
Other	Skin tears, moisture damage, or odor.

IF YOU SEE IT, REPORT IT!

5

MITIGATE

Prevent skin breakdown every shift.

- Reposition as ordered and per care plan.
- Offload heels – use pillows or boots.
- Keep skin clean and dry.
- Follow continence schedule.
- Encourage fluids and meals.
- Use lift devices and proper body mechanics.

REMEMBER:
Pressure + Moisture + Friction + Shear = Skin Breakdown

6

NOTIFY & DAILY CHECK

Communicate changes – Protect our residents.

DAILY CHECKLIST

- ☐ Skin inspected
- ☐ No new redness
- ☐ Repositioned per plan
- ☐ Heels offloaded
- ☐ Incontinence care completed
- ☐ Intake monitored
- ☐ Changes reported

REPORT IMMEDIATELY

- New skin changes or open areas
- Pain changes
- Weight loss concerns
- Poor intake / dehydration
- Equipment concerns
- Refusal of care

Use SBAR, Teach Back, Shift Report, and Document in EHR.

PRINT DOUBLE SIDED • CUT • FOLD ---------- FOLD ---------- FOLD ---------- LAMINATE FOR DURABILITY