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Research Article

Nursing Strategies to Prevent Pressure Injuries in Hospitalized Patients

Nawaf Rashed Oudah Alzahrani[1]*, Tahani Hamoud Bin Muzil Alanazi[2], Hanan Salem Butayhan Alenazi[3], Amani Hulayyil Jatli Alanzei[4], Maram Faleh Alnakhli[5], Bandar Naqa Trihib al Oraidy[6], Alshammari Abeer Awad S[7], Alanazi Sami Awadh E[8], Aryam Alshayish Falah Aldahmashi[9], Morifah Falah K Alhazmi[10]

[1]Nursing – Children's Hospital – Taif – Makkah Region – Saudi Arabia
* **Corresponding Author Email:** nralzahrani@moh.gov.sa - **ORCID:** 0000-0002-5247-7050

[2]Nursing Technician – Ministry of Health Branch in the Northern Borders – Arar – Northern Borders – Saudi Arabia
Email: Tahalanazi@moh.gov.sa- **ORCID:** 0000-0002-5247-7150

[3]Nursing Technician – North Medical Tower – Arar – Northern Borders – Saudi Arabia
Email: hsalenazi@moh.gov.sa - **ORCID:** 0000-0002-5247-7250

[4]Nursing Technician – Al-Aziziyah Health Center – Arar – Northern Borders – Saudi Arabia
Email: Amanix1411@gmail.com- **ORCID:** 0000-0002-5247-7350

[5]Nursing Technician – Mental Health Hospital – Madinah – Madinah Region – Saudi Arabia
Email: Maramfj11@gmail.com - **ORCID:** 0000-0002-5247-7450

[6]Nursing Technician – Al-Shifa Health Center – Hafar Al-Batin – Eastern Region – Saudi Arabia
Email: khaledalghazy00@gmail.com - **ORCID:** 0000-0002-5247-7550

[7]Nursing Technician – Al-Zahra Primary Health Care Center – Hail – Hail Region – Saudi Arabia
Email: abeerawa2023@gmail.com - **ORCID:** 0000-0002-5247-7650

[8]Nursing Technician – Medical Supply Department – Arar – Northern Borders – Saudi Arabia
Email: saalenzi@moh.gov.sa - **ORCID:** 0000-0002-5247-7750

[9]Nursing Technician – North Medical Tower – Arar – Northern Borders – Saudi Arabia
Email: aallenazi@moh.gov.sa- **ORCID:** 0000-0002-5247-0150

[10]Nursing Technician – King Fahd Alddahia Primary Health Center – Arar – Northern Borders – Saudi Arabia
Email: Reemiiy94@gmail.com - **ORCID:** 0000-0002-5247-7800

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Abstract:

Preventing pressure injuries, also known as pressure ulcers or bedsores, is a crucial responsibility of nurses in hospital settings. To effectively mitigate the risk of these injuries, nurses implement a variety of proactive strategies. Regular skin assessments are essential for identifying patients at high risk, particularly those with limited mobility or impaired sensation. Nurses are trained to categorically evaluate skin integrity, noting any early signs of pressure damage. Additionally, the use of pressure-relief devices, such as specialized mattresses and cushions, can significantly reduce the amount of pressure exerted on vulnerable areas of the body. Nurses are also educated on the importance of repositioning patients at frequent intervals, typically every two hours, to alleviate sustained pressure and improve blood circulation. In addition to physical interventions, nurses play a vital role in educating patients and their families about the importance of skin care and maintaining mobility. Encouraging patients who are able to shift their weight and move independently contributes to their overall well-being and decreases the chances of developing pressure injuries. Adequate nutrition and hydration are also essential components, as they enhance skin health and promote healing. Nurses can work closely with dietitians to ensure patients receive the necessary dietary support. Documenting care and patient changes is vital for continuity and communication within the healthcare team, facilitating a more comprehensive approach to prevention. Ultimately, through vigilant assessments, patient education, and collaboration with

other healthcare professionals, nurses significantly contribute to reducing the incidence of pressure injuries in hospitalized patients.

1. Introduction

Pressure injuries, historically referred to as pressure ulcers, bedsores, or decubitus ulcers, represent a significant and persistent challenge within the global healthcare landscape. They are defined as localized damage to the skin and underlying soft tissue, usually over a bony prominence or related to a medical or other device, resulting from intense and/or prolonged pressure, or pressure in combination with shear [1]. The development of these injuries is not merely a dermatological concern; it is a profound indicator of patient health status and the quality of nursing care received. The consequences of hospital-acquired pressure injuries (HAPIs) are multifaceted, extending beyond the patient's physical suffering to encompass substantial psychological distress, financial burden on healthcare systems, and legal implications for healthcare providers.

The pathophysiology of pressure injury formation is a complex interplay of extrinsic and intrinsic factors. The primary extrinsic factor is prolonged, unrelieved pressure that exceeds capillary closing pressure (typically estimated at 32 mmHg), leading to ischemia, hypoxia, and subsequent necrosis of the affected tissues [2]. This pressure is often exacerbated by shear forces, which occur when layers of tissue slide against one another (e.g., when a patient slides down in bed), causing deformation and damage to capillaries, and friction, which damages the epidermis [3]. Intrinsic factors that significantly increase a patient's susceptibility include advanced age, immobility, sensory impairment, malnutrition, comorbidities such as diabetes and cardiovascular disease, and low perfusion states [4]. When these intrinsic risk factors converge with extrinsic mechanical loads, the likelihood of tissue breakdown increases exponentially.

The impact of pressure injuries on the individual patient is devastating. They cause severe pain, increase the risk of serious infections like cellulitis, osteomyelitis, and sepsis, and can lead to prolonged hospital stays, permanent disability, and a severely diminished quality of life [5]. The psychological toll, including social isolation, depression, and loss of dignity, is equally profound. From an economic perspective, the treatment of a single full-thickness pressure injury can cost tens to hundreds of thousands of dollars, placing an enormous strain on healthcare budgets [6]. Furthermore, in many countries, pressure injuries are considered a "never event"—a serious, preventable clinical complication that should not occur under proper care—leading to non-reimbursement from insurers and potential litigation [7]. Therefore, the prevention of these injuries is not just a clinical priority but an ethical, economic, and legal imperative for nursing professionals and healthcare institutions.

The cornerstone of preventive nursing care is a comprehensive and systematic risk assessment. The use of validated risk assessment tools, such as the Braden Scale for Predicting Pressure Sore Risk, is a fundamental nursing responsibility [8]. The Braden Scale evaluates six critical subscales: sensory perception, moisture, activity, mobility, nutrition, and friction/shear. A lower score indicates a higher risk, prompting the nurse to initiate a tailored prevention protocol. However, clinical judgment remains paramount, as these tools are aids to, not replacements for, astute nursing observation and critical thinking [9]. This initial assessment must be dynamic, repeated regularly and with any significant change in the patient's condition, to ensure that the prevention plan remains relevant and effective.

Following risk assessment, the development and execution of a evidence-based prevention plan constitute the core of nursing strategies. This plan is multifaceted, encompassing a bundle of interventions designed to address the various risk factors identified. These strategies can be broadly categorized into skin and tissue assessment, mechanical loading and support, microclimate management, nutritional support, and patient and family education. Each category requires specific nursing knowledge, skills, and a proactive, vigilant approach. The success of these interventions hinges on the nurse's ability to integrate them seamlessly into the overall plan of care, demonstrating leadership in coordinating efforts to protect the patient's skin integrity. This proactive, preventative model of care stands in stark contrast to a reactive one, underscoring the nurse's role not just as a healer, but as a guardian of patient safety.

The arsenal of nursing strategies for preventing pressure injuries is extensive and grounded in a growing body of evidence-based practice. The first line of defense involves meticulous skin care and regular, head-to-toe inspection. Nurses are tasked with keeping the skin clean and dry, managing incontinence promptly, and using moisturizers to maintain skin barrier function, thereby reducing the damaging effects of moisture and friction [10]. Any areas of persistent redness (non-blanchable erythema), which is a Stage 1 pressure injury, must

be documented meticulously and trigger an immediate escalation of preventive measures.

A critical and widely recognized nursing intervention is frequent repositioning. For patients confined to bed, this involves turning and repositioning at least every two hours, using techniques that minimize friction and shear, such as the proper use of draw sheets and trapeze bars [11]. For patients in chairs, repositioning should occur every hour. The positioning schedule must be individualized, as some high-risk patients may require more frequent turns. The use of positioning devices like pillows and foam wedges to keep bony prominences (e.g., heels, sacrum, trochanters) from direct contact with each other or the bed surface is an essential adjunct to this practice.

Technology and specialized equipment play a crucial role as adjuncts to manual repositioning. Support surfaces, including advanced static air mattresses, alternating pressure mattresses, and low-air-loss beds, are designed to redistribute pressure and manage the microclimate (temperature and humidity) at the skin-support surface interface [12]. The nurse's role involves selecting the appropriate support surface based on the patient's risk level and mobility status, and ensuring its correct operation. Heel pressure injuries are particularly common, and the use of heel suspension devices or pillows to completely offload the heels is a specific, highly effective strategy.

Furthermore, a holistic approach necessitates attention to the patient's nutritional status. Collaboration with dietitians is essential to ensure patients at risk receive adequate protein, calories, vitamins (particularly Vitamin C and Zinc), and fluids to support tissue repair and resilience [13]. Finally, patient and family education is a powerful yet sometimes underestimated nursing strategy. Educating patients and their families about the causes of pressure injuries, the importance of regular position changes, proper nutrition, and daily skin inspections empowers them to become active participants in their own care, both in the hospital and after discharge.

2. Current Evidence on Prevention Strategies

A foundational element of any effective prevention program is the systematic and accurate assessment of patient risk. The Braden Scale remains the most widely used and validated tool globally for predicting pressure injury risk. Its six subscales provide a structured framework for nurses to identify specific areas of vulnerability, such as excessive moisture from incontinence or limited mobility [14]. However, the literature consistently emphasizes that the tool itself is not infallible; its effectiveness is entirely dependent on the clinical judgment of the nurse and the consistent application of the associated prevention protocols for at-risk patients. Recent studies have explored the use of subscale scores to tailor interventions more precisely; for instance, a low score on the "moisture" subscale should trigger a rigorous incontinence management plan, while a low "mobility" score necessitates an immediate focus on repositioning and support surfaces [15]. Furthermore, emerging research is investigating the integration of biomarkers and technology, such as skin temperature monitoring with infrared thermography, to provide objective data that can complement traditional risk assessment tools and identify early-stage tissue damage before it is visible to the naked eye [16].

The evidence supporting regular repositioning for immobile patients is robust and forms a cornerstone of nursing care. The classic standard of turning patients every two hours is supported by decades of clinical observation and research aimed at relieving prolonged pressure over bony prominences. A seminal Cochrane review by Gillespie et al. reinforced that frequent repositioning is effective in preventing pressure injuries, though the optimal frequency and technique may need to be individualized [17]. The review noted that while the two-hour turning schedule is a good benchmark, patients with very high risk or those on advanced support surfaces might have different requirements. The evidence strongly cautions against the 90-degree lateral rotation, as it can generate damaging pressure over the trochanters. Instead, the 30-degree tilted side-lying position is recommended, as it significantly reduces interface pressure compared to the 90-degree position [18]. The role of shear and friction during repositioning is also critically important. Evidence supports the use of assistive devices like draw sheets or mechanical lifters to lift, rather than drag, patients across the bed surface, thereby preventing the internal tissue damage caused by shear forces [19].

The development and utilization of advanced support surfaces represent a major technological advancement in pressure injury prevention. The evidence base clearly differentiates between reactive (static) surfaces, such as foam, gel, and air mattresses, which redistribute pressure by conforming to the patient's body, and active (dynamic) surfaces, such as alternating pressure mattresses, which periodically change the points of contact and pressure. A comprehensive meta-analysis concluded that advanced static mattresses are significantly more effective than standard hospital mattresses, and that alternating pressure

mattresses are likely more effective than advanced static mattresses for high-risk patients [20]. The evidence for specialized heel offloading devices, such as heel suspension boots or pillows placed under the calves to elevate the heels, is particularly strong, making them a standard of care for patients unable to move their lower limbs independently [21]. Recent literature has also expanded the concept of support surfaces to include microclimate management. Surfaces that control temperature and moisture (low-air-loss and air-fluidized therapies) have shown efficacy in reducing the risk of injury, particularly in patients who are incontinent or who perspire heavily, as excessive moisture macerates the skin and makes it more susceptible to breakdown [22].

A holistic and evidence-based prevention strategy extends beyond mechanical load management to encompass meticulous skin care and nutritional support. The link between incontinence-associated dermatitis (IAD) and pressure injury development is well-established. Damaged, moist skin is far more vulnerable to the effects of pressure and shear. The evidence supports a structured skin care regimen that includes gentle cleansing with pH-balanced cleansers, the application of moisture barrier creams or ointments to protect the skin, and the use of absorbent pads or containment devices that wick moisture away from the skin [10]. In terms of nutrition, the evidence confirms that hypoalbuminemia and low body mass index (BMI) are independent risk factors for pressure injury development. Protein-calorie malnutrition compromises tissue integrity and the body's ability to repair early damage. A systematic review by Posthauer et al. provided strong recommendations for individualized nutritional support, emphasizing adequate protein intake (1.25-1.5 g/kg/day), sufficient calories (30-35 kcal/kg/day), and supplementation with Arginine and Vitamin C, which are crucial for collagen synthesis and immune function [23]. The literature underscores the necessity of interdisciplinary collaboration, where nurses must partner with dietitians to conduct thorough nutritional assessments and implement targeted interventions for at-risk patients.

Finally, the literature has increasingly focused on the importance of implementation science—the study of methods to promote the systematic uptake of evidence into routine practice. A bundle approach, where a set of three to five evidence-based interventions are consistently implemented together for every at-risk patient, has proven highly effective. A typical bundle might include: a comprehensive skin assessment on admission, standardized risk assessment using the Braden Scale, a structured repositioning schedule with appropriate support surfaces, and meticulous moisture management [24]. The success of such bundles is heavily dependent on organizational culture, ongoing staff education, and strong nursing leadership. Audit and feedback, where unit-level pressure injury data is reported back to frontline staff, has also been shown to improve adherence to prevention protocols.

3. Defining Nursing Roles in Pressure Injury Prevention

The primary objective is to explicate the nurse's non-negotiable role as the first-line assessor and clinical decision-maker. This begins with the imperative of conducting a timely and thorough risk assessment upon patient admission and at regular intervals thereafter. The objective is not merely to document a Braden Scale score, but to integrate this data with comprehensive clinical judgment. This involves a meticulous head-to-toe skin inspection, with particular attention to bony prominences and areas under medical devices, to establish a baseline and identify any early signs of tissue damage [25]. Furthermore, the nurse's role extends to assessing the patient's total clinical picture, including nutritional status, level of consciousness, continence, and perfusion, all of which contribute to tissue tolerance. The objective is to frame the nurse as a diagnostic agent whose assessment triggers a specific, individualized plan of care, ensuring that prevention is proactive rather than reactive [26]. This study will explore the barriers to consistent assessment, such as time constraints and documentation burdens, and propose strategies to uphold this critical role.

A second, core objective is to define the nurse's central role as the implementer and coordinator of evidence-based clinical interventions. This involves translating risk assessment into direct, hands-on action. The specific objectives under this role include: executing and documenting a systematic repositioning schedule tailored to the individual's needs and support surface; selecting, initiating, and monitoring the effectiveness of appropriate pressure-redistributing devices; and performing diligent skin care, including managing moisture and applying skin barrier products [27]. The nurse's role is not passive; it requires critical thinking to adjust interventions based on the patient's changing condition. For instance, a patient who develops a fever may have increased metabolic demands and perspiration, requiring more frequent skin checks and microclimate management. This objective also encompasses the nurse's responsibility in preventing medical device-related pressure injuries,

which account for a growing proportion of HAPIs. This requires regularly assessing the skin under devices such as oxygen tubing, cervical collars, and Foley catheters, and repositioning these devices when safely possible [28].

Beyond direct clinical care, a crucial objective of this research is to articulate the nurse's indispensable role as an educator and patient advocate. Patient and family education is a powerful, yet often underutilized, preventive strategy. The nurse's objective is to empower patients and their families by explaining the causes of pressure injuries, the rationale behind interventions like turning, and the importance of nutrition and mobility [29]. For patients with some mobility, education on small, independent weight shifts can be highly effective. The nurse also acts as a staunch advocate, ensuring that the patient's voice is heard. This may involve communicating identified risks and needed resources to the broader multidisciplinary team, including physicians, dietitians, and physical therapists [30]. In environments with staffing challenges, the nurse must advocate for the necessary resources, such as additional help for safe patient handling or appropriate support surfaces, to ensure that the standard of care is not compromised. This advocacy role is fundamental to creating a culture of safety.

Finally, this study aims to define the role of the nurse as a leader, quality improver, and lifelong learner in the context of pressure injury prevention. This objective shifts the focus from individual patient care to the systems level. Nurses, particularly those in senior or specialized roles like Wound Care Nurses, are instrumental in leading quality improvement (QI) initiatives. This involves collecting and analyzing unit-based pressure injury data, auditing adherence to prevention bundles, and providing feedback to the nursing team [31]. The objective is to position the nurse as an active participant in root cause analyses of any HAPIs that occur, fostering a non-punitive environment focused on systemic learning and improvement [32]. Furthermore, the nurse has a professional responsibility for lifelong learning—staying abreast of the latest evidence in wound prevention and incorporating new knowledge into practice. This also includes mentoring novice nurses and nursing students, thereby ensuring the sustainability of prevention efforts [33]. By fulfilling this leadership role, nurses directly influence the institutional policies and protocols that shape patient safety outcomes.

In summary, the aims and objectives of this research are constructed to provide a comprehensive and actionable definition of the nursing roles integral to pressure injury prevention. This framework positions the nurse not as a mere task-doer, but as a sophisticated, autonomous professional whose judgment and actions are central to patient safety. The successful prevention of HAPIs is dependent on the effective execution of these interconnected roles: assessor, clinician, educator, advocate, and leader. By clearly defining these roles, this study seeks to contribute to a reduction in preventable harm, an enhancement in the quality of nursing care, and an affirmation of the profession's vital contribution to healthcare outcomes [34].

4. Risk Evaluation Tools and Skin Inspections

The use of structured, validated risk assessment scales is a globally recognized best practice and a standard of care in pressure injury prevention. These tools provide an objective framework to standardize the assessment process, reducing reliance on variable clinical intuition alone. The most extensively researched and widely implemented tool is the Braden Scale for Predicting Pressure Sore Risk. The scale's strength lies in its assessment of six conceptually distinct but interrelated subscales: sensory perception, moisture, activity, mobility, nutrition, and friction/shear. Each subscale is scored from 1 (most impaired) to 3 or 4 (least impaired), with a total score ranging from 6 to 23. A lower total score indicates a higher risk, with a commonly used cut-off score of 18 signifying the onset of risk and triggering basic preventive protocols [35- 46]. Scores between 15-18 indicate "mild risk," 13-14 "moderate risk," and 10-12 "high risk," with scores of 9 or below denoting "very high risk," each level warranting progressively more intensive interventions [47].

However, the Braden Scale is not the only instrument available. The Norton Scale, developed earlier, assesses physical condition, mental state, activity, mobility, and incontinence. While it is still used in some clinical settings, particularly in Europe, it has been criticized for being less sensitive than the Braden Scale, especially in predicting risk in younger and critically ill populations [48]. The Waterlow Scale incorporates additional factors like sex, age, and specific medical conditions (e.g., tissue malnutrition, neurological deficit), but its complexity and tendency to over-predict risk, potentially leading to resource misallocation, have been points of contention in the literature [49]. The evidence strongly supports the Braden Scale as the most reliable and valid tool for acute care settings, but its effectiveness is entirely contingent upon proper

administration and, most importantly, the linkage of the score to specific, evidence-based interventions. A risk score is clinically meaningless if it does not trigger an actionable care plan.

5. Clinical Judgment and the Limitations of Risk Scales

While risk assessment tools are indispensable, the literature unequivocally emphasizes that they must be used as an *aid to*, not a *replacement for*, astute clinical judgment. Nurses must be trained to recognize situations where a tool's score may not fully capture a patient's risk profile. For instance, a patient with a stable Braden score of 19 (considered "not at risk") who develops septic shock, requiring high-dose vasopressors that compromise peripheral tissue perfusion, instantly becomes high-risk despite a static score [50]. Other "red flag" conditions that necessitate preventive interventions regardless of the total score include patients with fractures requiring traction, those with advanced vascular disease, and patients in the operating room for prolonged surgeries, where pressure is intense and sustained [51].

The timing and frequency of risk assessment are also critical components of the protocol. Best practice guidelines mandate that a formal risk assessment be conducted upon admission to the hospital, within 24 hours, and then repeated regularly—at least every 24-48 hours or with any significant change in the patient's condition, such as a decline in mental status, a new diagnosis, or following major surgery [52]. This dynamic and recurring process ensures that the prevention plan remains responsive to the patient's evolving clinical status. Furthermore, the subscale scores provide invaluable diagnostic information. A low score on the "moisture" subscale directs attention to rigorous incontinence management, while a low "nutrition" score flags the need for an immediate dietary consultation. This granular analysis transforms the risk assessment from a simple number into a powerful clinical decision-making tool.

6. Systematic Skin Inspection as a Critical Adjunct

Parallel to the use of risk assessment tools, a thorough and systematic skin inspection is a non-negotiable nursing responsibility. This inspection serves two primary purposes: to establish a baseline of skin integrity upon admission and to monitor for early signs of tissue damage throughout the hospitalization. The admission skin assessment is crucial for distinguishing between a pre-existing injury and a hospital-acquired one, which has significant implications for quality metrics and reimbursement [53]. This initial inspection must be documented in meticulous detail, including any areas of non-blanchable erythema, scars from previous injuries, or other skin abnormalities.

A comprehensive skin inspection is a structured, head-to-toe examination. It requires adequate lighting and, with patient consent, the exposure of all skin surfaces. Particular attention must be paid to bony prominences, including the sacrum, coccyx, heels, ischial tuberosities, trochanters, elbows, and the occiput. However, the inspection must extend beyond these classic sites. In the era of advanced medical technology, nurses must be vigilant in assessing skin under and around medical devices, such as oxygen tubing, endotracheal tubes, cervical collars, Foley catheters, and compression stockings, as device-related pressure injuries now account for a substantial proportion of all HAPIs [54]. The skin under and at the edges of tapes and dressings also requires careful evaluation.

The most critical finding in a skin inspection is the identification of non-blanchable erythema (Stage 1 pressure injury), which presents as intact skin with a localized area of non-blanchable redness. This is the earliest visual indicator of impending tissue damage and represents a "stop sign" that demands immediate and escalated preventive action [55]. Techniques for assessment include gently pressing a finger over the reddened area; if the redness does not briefly turn white (blanch), it indicates that the underlying microvasculature is compromised. Any such finding must be documented with precision regarding location, size, color, and any associated symptoms, and must be communicated during handoff reports to ensure continuity of care. Emerging technologies, such as sub-epidermal moisture (SEM) scanners and high-frequency ultrasound, are being studied to detect pathological levels of edema in the tissue before it becomes visible on the surface, potentially allowing for even earlier intervention [56].

7. Staff Education and Competency:

The foundation of competency begins with structured foundational training that covers the core principles of pressure injury prevention. Traditional didactic sessions, while necessary for disseminating information, are often insufficient on their own. Effective foundational education must be comprehensive, covering the pathophysiology of pressure injury development, the accurate use and interpretation of risk assessment tools like the Braden Scale, and the rationale behind each component of the prevention bundle [57]. This includes detailed instruction on performing a

thorough skin assessment, proper repositioning techniques to minimize shear and friction, the indications for different types of support surfaces, and the principles of moisture management and nutrition. It is imperative that this education also addresses the insidious problem of medical device-related pressure injuries, teaching nurses to assess skin under and around devices routinely [58].

To enhance engagement and retention, modern foundational training should be interactive. This can be achieved through case-based learning, where nurses work through realistic patient scenarios, calculating Braden scores and developing appropriate care plans [59]. Furthermore, education must be ongoing and not a one-time event during hospital orientation. Annual competency reviews, coupled with "just-in-time" education—brief, targeted training provided at the point of care when a knowledge gap is identified—are essential for reinforcing principles and updating staff on new evidence or protocols [60]. The use of pre- and post-education knowledge assessments, using validated tools like the Pressure Ulcer Knowledge Assessment Tool (PUKAT), can help educators identify specific areas of weakness and tailor future sessions accordingly [61]. This robust foundational training ensures that all nurses share a common, evidence-based knowledge platform from which to practice.

8. Simulation-Based Learning: Bridging the Theory-Practice Gap

While foundational knowledge is crucial, the true test of competency occurs at the patient's bedside. Simulation-based education has emerged as a powerful pedagogical tool to bridge the notorious theory-practice gap. High-fidelity simulation allows nurses to practice and refine their skills in a realistic, yet risk-free, environment. Using a high-fidelity manikin in a simulated patient room, nurses can be presented with complex scenarios, such as a critically ill, hemodynamically unstable patient on a ventilator who is at high risk for pressure injuries [62]. The simulation can require the nursing team to conduct a collaborative skin assessment, select the appropriate support surface, and safely execute a repositioning maneuver while managing lines and tubes, all under time constraints.

The debriefing session that follows the simulation is where the deepest learning occurs. Facilitated by an expert, the debrief allows participants to reflect on their performance, discuss clinical decisions, and identify both strengths and areas for improvement in a non-punitive atmosphere [63]. Simulation can also be used to teach specific psychomotor skills, such as the correct application of a heel suspension device or the proper use of a trapeze bar to minimize shear during repositioning. Low-fidelity task trainers, for instance, can be used to practice staging pressure injuries on moulage wounds, improving diagnostic accuracy [64]. By providing hands-on, experiential learning, simulation builds not only competence but also confidence and clinical judgment, preparing nurses to respond effectively to the complex challenges of preventing HAPIs in real-world situations.

9. Knowledge Translation and Sustaining Competency

The ultimate goal of education is the sustained application of knowledge in daily practice, a process known as knowledge translation. This involves moving beyond simply "teaching" to actively "implementing and sustaining" best practices. A multi-faceted approach is most effective. One key strategy is the use of unit-based champions or skin integrity resource nurses. These are clinical nurses with a special interest and advanced training in wound prevention who serve as on-the-job mentors, resources, and role models for their peers, providing immediate feedback and reinforcing correct practices [65]. Their presence helps to create a culture of safety and continuous learning.

Audit and feedback is another powerful knowledge translation strategy. This involves regularly collecting data on process measures (e.g., adherence to risk assessment documentation, turning schedules) and outcome measures (e.g., HAPI rates) and then sharing this data back with the frontline staff in a timely and constructive manner [66]. Visual management tools, such as unit dashboards that display HAPI incidence rates over time, can motivate staff by showing them the positive impact of their consistent efforts. Additionally, integrating prompts and reminders into the electronic health record (EHR), such as automatic alerts for patients with a Braden score below a certain threshold, can nudge nurses to initiate the prevention bundle without relying solely on memory [67].

Finally, fostering a supportive and just culture is essential for sustaining competency. Nurses must feel psychologically safe to report near-misses or early-stage injuries without fear of blame or punishment. Leadership must actively support prevention efforts by ensuring adequate staffing levels and resources, recognizing that even the most competent nurse cannot turn a patient every two hours on a severely understaffed unit [68].

10. Conclusion

In conclusion, the prevention of pressure injuries is a fundamental aspect of nursing care and a definitive marker of healthcare quality. This research has systematically delineated the comprehensive role of the nurse, which extends far beyond a series of tasks to encompass the integrated functions of assessor, clinician, educator, advocate, and leader. The evidence unequivocally demonstrates that a successful prevention program is built upon a foundation of rigorous and dynamic risk assessment, coupled with meticulous skin inspections that can detect tissue compromise at its earliest stage. The core clinical interventions of frequent, safe repositioning and the judicious use of advanced support surfaces are critical for mitigating mechanical load, while holistic attention to nutrition and microclimate management addresses intrinsic patient factors.

However, the consistent application of these strategies is wholly dependent on a competent and confident nursing workforce. Therefore, investing in comprehensive staff education that moves beyond passive learning to embrace interactive, simulation-based, and competency-focused training is paramount. Sustaining this competency requires effective knowledge translation models, including the use of clinical champions, real-time audit and feedback, and a supportive organizational culture that provides the necessary resources and psychological safety for nurses to excel. Ultimately, eradicating preventable harm from pressure injuries is an achievable goal. It demands a unified commitment to evidence-based practice, where nurses are empowered as autonomous professionals and leaders in a relentless pursuit of patient safety, ensuring that every hospitalized patient receives the vigilant, proactive care required to preserve their skin integrity and their overall well-being.

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