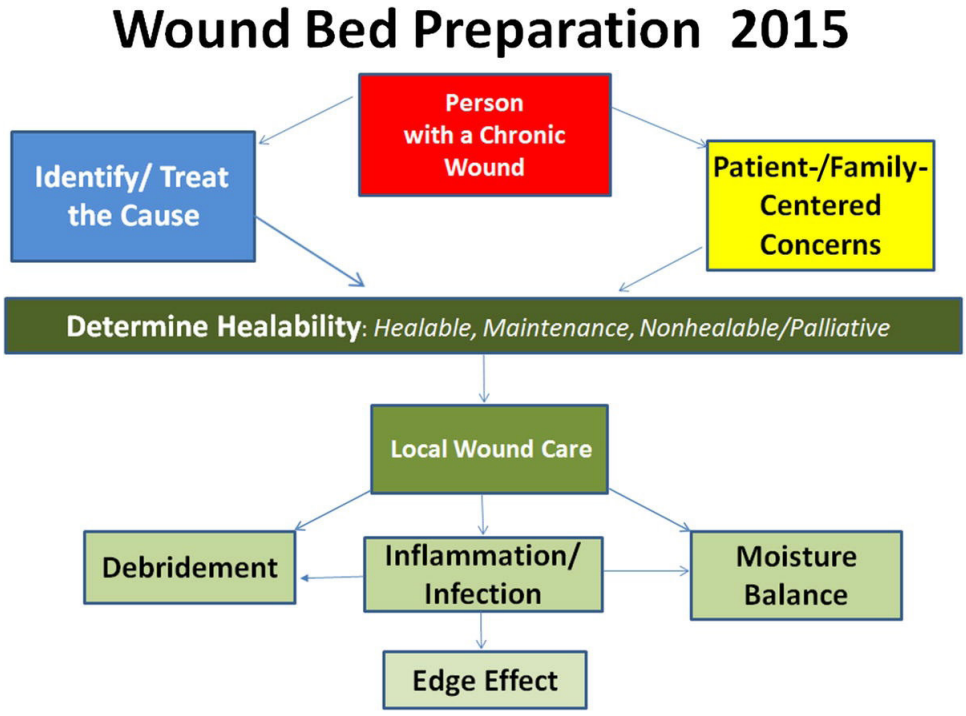
Guiding Framework

The National Pressure Ulcer Advisory Panel (NPUAP) defines a pressure injury as "localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue" (NPUAP, 2016, para 3). The NPUAP classifies pressure injuries using stages that denote different degrees of tissue loss. For additional information on the NPUAP's Pressure Injury Staging System, please refer to **Appendix E**.

The wound-bed preparation paradigm uses an interprofessional approach to systematically outline the key principles of chronic wound (i.e., pressure injury) management for the interprofessional team. Within the context of current evidence in pressure injury assessment and management, the expert panel has developed and organized this Guideline according to the wound-bed preparation paradigm and with an interprofessional and person-centred lens on pressure injury care. (For definitions of the various components of the paradigm—including patient (person)-/family-centred concerns[G], healability,[G] local wound care[G], debridement[G], inflammation[G], infection[G], moisture balance[G], and edge effect[G]—please refer to **Appendix A**.)

Figure 1: Wound-Bed Preparation Paradigm, 2015



Source: Reprinted from "Optimizing the Moisture Management Tightrope with Wound Bed Preparation 2015," by R. Sibbald, J. A. Elliott, E. A. Ayello, and R. Somayaji, 2015, *Advances in Skin and Wound Care, 28*(10), p. 468. Copyright 2015 by Wolters Kluwer Health, Inc. Reprinted with permission.