PRESSURE ULCERS

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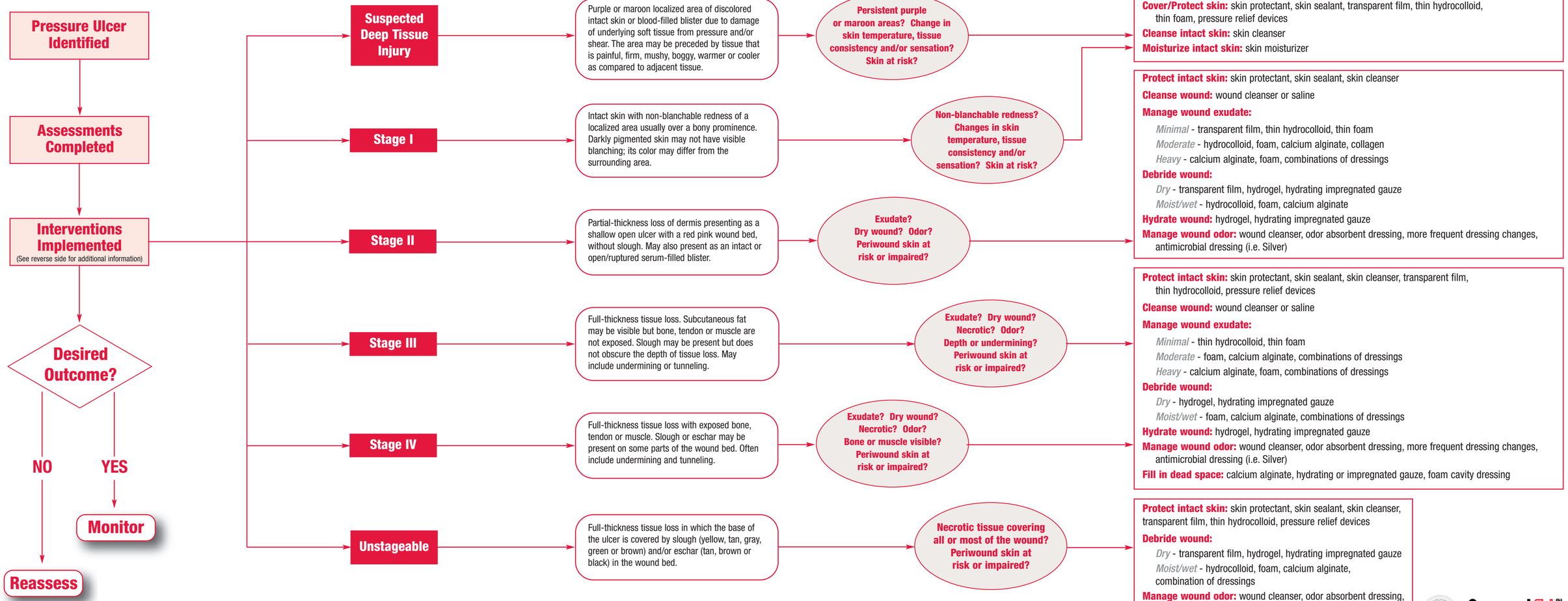

Pressure Ulcer Stages as revised and copyrighted by National Pressure Ulcer Advisory Panel, Feb., 2007

*Pressure ulcer staging as per NPUAP 2007 ©

Developed in collaboration with
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Bryant Rolstad Consultants, LLC, St. Paul, MN

Suspected Deep Tissue Injury: Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.

Goals of Care: limit or avoid tissue injury by pressure offloading.

Wound and Skin Care Objectives: Protect periwound skin and assess frequently.

A **Stage I** pressure ulcer is an observable pressure related alteration of intact skin whose indicators, as compared to an adjacent or opposite area on the body, may include changes in one or more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel), and/or sensation (pain, itching). In lightly pigmented skin the ulcer appears as a defined area of persistent non-blanchable redness. In darker skin tones, the ulcer may vary in color from the surrounding area.

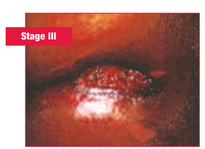
Goals of Care: maintain intact skin and improve tissue tolerance. Relieve pressure.

Wound and Skin Care Objectives: protect, cleanse and moisturize intact skin.

A **Stage II** pressure ulcer involves the epidermis, dermis or both. It is a superficial wound and may present as an abrasion, blister or shallow crater. Yellow slough and necrotic tissue are never present.

Goals of Care: restore skin integrity and avoid infection. Relieve pressure.

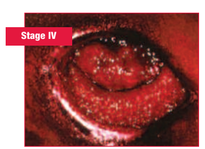
Wound and Skin Care Objectives: protect intact periwound skin, cleanse wound, manage wound exudate, debride wound, hydrate wound, and manage wound odor.



A **Stage III** pressure ulcer involves subcutaneous tissue that may extend down to, but not through, underlying fascia. It may present as a deep crater with or without undermining of tissue. Yellow slough or necrotic tissue may be present.

Goals of Care: restore skin integrity and avoid infection. Relieve Pressure.

Wound and Skin Care Objectives: protect intact periwound skin, cleanse wound, manage wound exudate, debride wound, hydrate wound, manage wound odor, and fill in dead space.



A **Stage IV** pressure ulcer involves muscle, bone or supporting structures. Undermining or sinus tracts may also be present.

Goals of Care: restore skin integrity and avoid infection. Relieve pressure.

Wound and Skin Care Objectives: protect intact periwound skin, cleanse wound, manage wound exudate, debride wound, hydrate wound, manage wound odor, and fill in dead space.

An **Unstageable** pressure ulcer is covered with eschar or slough which prohibits assessment of wound depth.

Goals of Care: protect viable tissue, remove necrotic tissue so that wound assessment and staging may be accomplished. Relieve pressure

Wound and Skin Care Objectives: protect intact periwound skin, debride wound and manage wound odor.

NOTE: Stable (dry, adherent, intact without erythema or fluctuance) eschar on heels serves as the "body's natural cover". These heel ulcers may be left intact with pressure relief provided.

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PRESSURE ULCERS

BACKGROUND INFORMATION:

A pressure ulcer a localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction. When pressure is not relieved, tissue ischemia develops and a pressure ulcer results. Most pressure ulcers are preventable. Therefore, early risk assessment, skin care, pressure offloading, attention to patient support surfaces and education are essential.

Standard practice is to assess and stage pressure ulcers according to the National Pressure Ulcer Advisory Panel's staging system. Once a pressure ulcer is staged, the healing wound is not restaged. Therefore, a healing stage III pressure ulcer does not become a stage II. It remains, according to the original diagnosis, a stage III pressure ulcer which is healing. The depth of the wound is only one of many factors which requires evaluation.

The algorithm on the reverse side provides a general path of decision-making for the assessment, management and treatment of pressure ulcers. Below is more detailed information which is intended to ***assist*** health care providers. This should be used along with the consultative services of a wound care specialist, WOC/ET nurse, physical therapist, clinical nurse specialist with expertise in wound management or a physician when indicated.

NURSING ASSESSMENTS:

The following provides a guideline for clinical assessment. Assessments are done at regular intervals and are used to drive treatment decisions.

- ***Assessment of risk or contributing factors:*** decreased sensory perception; moisture; immobility; poor nutrition; friction/shear. Tools such as the Braden Scale are helpful in determining patient risk.
- ***Assessment of nutrition, pain, previous ulcer care (if applicable), level of understanding, compliance in care, and learning style.***
- ***Assessment of wound:*** location; stage; infection; exudate; odor; size (length, width and depth); necrotic tissue; granulation; epithelialization; undermining and/or tunneling.
- ***Assessment of periwound skin:*** fragile; dry; macerated; indurated; erythematous.

GENERAL NURSING INTERVENTIONS:

The following information is designed as a guideline for care. Consult with a wound care specialist and/or physician with questions and when managing full-thickness and infected wounds.

- ***Minimize or eliminate the cause of the problem:*** Pressure offloading involves proper turning; transferring and positioning techniques; support surfaces for bed or chair as indicated by level of risk and/or severity of the wound. With heel/foot ulcers, provide appropriate pressure relief and orthotics as needed.
- ***Support moist wound healing.***
- ***Treat infection:*** Provide debridement, cleansing and antimicrobial dressing.
- ***Debride:*** this is based upon condition of the wound and the patient. Methods of debridement include autolytic, mechanical, sharp and enzymatic.
- ***Protect the wound from external contamination*** (e.g., fecal matter, urine, microorganisms) ***and trauma.***
- ***Perform daily skin inspection and care:*** this may include cleansing, moisturizing and the use of protective barriers.
- ***Provide adequate nutritional intake.***
- ***Manage pain.***
- ***Provide education:*** patient, family and caregiver.
- ***Document*** assessments and interventions.
- ***Reassess*** at regular intervals per facility protocol.

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Suspected DTI/Stage I

PERIWOUND SKIN CARE

Restore Cleanser & Moisturizer
Restore Skin Cleanser
Restore DimethiCreme
Restore Moisture Barrier
Restore Skin Conditioning Cream

WOUND CARE

Restore Extra Thin Hydrocolloid Dressing (to prevent friction injury)

Stage II/Stage III

PERIWOUND SKIN CARE

Restore Cleanser & Moisturizer
Restore Skin Cleanser
Restore DimethiCreme
Restore Moisture Barrier
Restore Skin Conditioning Cream

WOUND CARE

Restore Wound Cleanser
Restore Extra Thin Hydrocolloid Dressing
Restore Hydrocolloid Dressing
Restore Hydrogel Dressing
Restore Calcium Alginate Dressing with/without Silver
Restore Contact Layer Dressing with/without Silver
Restore Foam Dressing with/without Silver
Restore Odor-Absorbent Dressing

Stage IV

PERIWOUND SKIN CARE

Restore Cleanser & Moisturizer
Restore Skin Cleanser
Restore DimethiCreme
Restore Moisture Barrier
Restore Skin Conditioning Cream

WOUND CARE

Restore Wound Cleanser
Restore Hydrogel Dressing
Restore Calcium Alginate Dressing with/without Silver
Restore Contact Layer Dressing with/without Silver
Restore Foam Dressing with/without Silver
Restore Odor-Absorbent Dressing

Unstageable

PERIWOUND SKIN CARE

Restore Cleanser & Moisturizer
Restore Skin Cleanser
Restore DimethiCreme
Restore Moisture Barrier
Restore Skin Conditioning Cream

WOUND CARE

Restore Wound Cleanser
Restore Extra Thin Hydrocolloid Dressing
Restore Hydrocolloid Dressing
Restore Hydrogel Dressing
Restore Calcium Alginate Dressing with/without silver
Restore Contact Layer with/without Silver
Restore Foam Dressing with/without Silver
Restore Odor-Absorbent Dressing

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