# Pressure Ulcer Treatment

## Purpose

The purpose of this procedure is to provide guidelines for the care of existing pressure ulcers and the prevention of additional pressure ulcers.

## Preparation

1. Review the resident’s care plan to assess for any special needs of the resident.
2. Assemble the equipment and supplies as needed.

## General Guidelines

1. The pressure ulcer treatment program should focus on the following strategies:
   a. Assessing the resident and the pressure ulcer(s).
   b. Managing tissue loads.
   c. Pressure ulcer care.
   d. Managing bacterial colonization and infection.
   e. Operative repair of the pressure ulcers(s).
   f. Education and quality improvement.
2. When eschar is present, a pressure ulcer cannot be accurately staged until the eschar is removed.
3. It may be difficult to assess pressure ulcers in residents with casts, other orthopedic devices, or support stockings.

## Definitions and Descriptions

### 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.

**Further Description:**
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.

### Stage I Pressure Ulcer:

Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.

**Further Description:**
The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage I may be difficult to detect in individuals with dark skin tones. May indicate "at risk" persons (a heralding sign of risk).

### Stage II Pressure Ulcer:

Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.

**Further Description:**
Presents as a shiny or dry shallow ulcer without slough or bruising. This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. Bruising indicates suspected deep tissue injury.

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General Guidelines (continued)

Stage III Pressure Ulcer:
Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

Further Description:
The depth of a stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage III pressure ulcers. Bone/tendon is not visible or directly palpable.

Stage IV Pressure Ulcer:
Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.

Further Description:
The depth of a stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.

Unstageable:
Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

Further Description:
Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as “the body’s natural (biological) cover” and should not be removed.

Note: The MDS 2.0 does not allow for unstageable coding, so unstageable ulcers should be coded as Stage IV.

Interventions/Care Strategies
Pressure ulcer treatment requires a comprehensive approach, including:
1. Debridement.
3. Managing systemic issues (edema, venous insufficiency, etc.).
4. Maximizing the potential for healing.
5. Pain control.

Stage I Protocol
Stage I Pressure Ulcer Interventions/Care Strategies
1. Pressure:
   a. Determine cause of pressure and relieve;
   b. Redistribute pressure;
   c. Implement pressure-relieving device(s) in accordance with resident’s assessed needs;
   d. Evaluate until redness is no longer persistent;
   e. Persistent redness is determined only after pressure has been relieved for at least ¾ of the time it was applied and the redness remains;
   f. Notify physician, family and appropriate facility personnel; and
   g. Initiate a skin grid and care plan.

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Stage I Protocol (continued)

2. Incontinence:
   a. Cleanse with incontinence cleanser;
   b. Pat dry and evaluate need for protective barrier cream; and
   c. Consider scheduled toileting program.

3. Friction or Shearing:
   a. Reduce cause by using transfer techniques and devices as needed.

4. Immobility:
   a. Turn Schedule; and
   b. Restorative Nursing (range of motion, walking, bed mobility).

Stage II Protocol

Stage II Pressure Ulcer Interventions/Care Strategies

Clean, shallow, minimal drainage:

1. Protect;
2. Manage drainage;
3. Promote moist wound healing;
4. Treatment:
   a. Cleanse with normal saline or other skin cleanser in accordance with physician orders and facility protocol;
   b. Apply barrier cream, hydrogel or hydrogel sheet (cut to fit);
   c. Cover with non-adhesive light gauze or transparent dressing;
   d. Alternate dressing (use of thin hydrocolloid); and
   e. Change per physician order and manufacturer’s directions.
5. Manage pain.

Medium drainage:

1. Follow above procedure; consider the need for alginate or foam.

Follow-up

If wound does not improve in 2-3 weeks, notify physician. Consider a skin consult with a wound specialist.

Stage III Protocol

Stage III Pressure Ulcer Interventions/Care Strategies

1. Protect;
2. Fill dead space including tunnels and undermining;
3. Manage drainage;
4. Promote moist wound healing; and
5. Manage pain

No drainage:

1. Treatment
   a. Irrigate wound with normal saline or other designated wound cleanser;
   b. Irrigate wound with normal saline or other designated wound cleanser; use syringe to apply (4 to 15 psi);
   c. Apply hydrogel to wound cavity; and
   d. Change per order and manufacturer’s directions.

Medium to heavy drainage:

1. Follow above procedure. Consider substituting alginate or foam.

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Stage IV Protocol

Stage IV Pressure Ulcer Interventions/Care Strategies

1. Protect:
   a. Fill dead space including tunnels and undermining;
   b. Manage drainage; and
   c. Promote moist wound healing.
2. Debride slough/eschar:
   a. Select the method of debridement most appropriate to the resident’s condition and goals (note: this is a physician task);
   b. Sharp, mechanical, enzymatic, and/or autolytic debridement techniques may be used when there is no urgent clinical need for drainage or removal of devitalized tissue; and
   c. If there is urgent need for debridement, as with advancing cellulitis or sepsis, sharp debridement should be used.
3. Treatment:
   a. Irrigate wound with normal saline or other designated wound cleanser. Use syringe to apply (4 to 15 psi);
   b. Apply an alginate dressing, foam dressing or hydrogel to wound cavity;
   c. Cover with DSD, change daily; and
   d. Change per physician order and manufacturer’s directions.
4. Manage pain.

Equipment and Supplies

The following equipment and supplies will be necessary when performing this procedure.

1. Dressing;
2. Tape;
3. Normal saline;
4. Disposable cloths, as indicated; and
5. Personal protective equipment (e.g., gowns, gloves, mask, etc., as needed).

Steps in the Procedure

1. Check the treatment administration record and obtain necessary supplies.
2. Explain procedure to resident and provide privacy. Position resident for dressing removal.
3. Assess the resident’s level of pain and provide analgesics, as ordered, before wound care.
5. Apply gloves.
6. Remove soiled dressing and place in opened plastic bag. Also remove soiled gloves and place in the plastic bag.
7. Wash hands.
8. Apply gloves.
9. Clean area with normal saline (unless otherwise specified by physician) and pat dry.
10. Open package and remove dressing, maintaining sterility.
11. Apply dressing/treatment according to manufacturer’s direction, care plan, and physician orders.
12. Remove and discard gloves.
13. Wash and dry your hands thoroughly.
14. If the resident desires, return the door and curtains to the open position and if visitors are waiting, tell them that they may now enter the room.
15. Place treatment bag in the biohazard waste container, if indicated.

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**Documentation**

The following information should be recorded in the resident’s medical record:

1. The type of treatment and resident response.
2. The date and time the wound care was given.
3. The position in which the resident was placed.
4. The name and title of the individual performing the care.
5. Any change in the resident’s condition.
6. All assessment data (i.e., color, size, pain, drainage, etc.) when inspecting the wound.
7. Resident tolerance of the procedure.
8. Any problems or complaints made by the resident related to the procedure.
9. Resident refusal of the treatment and the reason(s) why, and that risks of not complying, benefits of complying and alternatives explained.
10. The signature and title of the person recording the data.

**Reporting**

1. Notify the supervisor if the resident refuses the procedure or interventions.
2. If the resident is refusing care, an evaluation of the basis for refusal, and the identification and evaluation of potential alternatives is indicated.
3. Report other information in accordance with facility policy and professional standards of practice.

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<th>References</th>
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<tbody>
<tr>
<td><strong>MDS (RAPs)</strong></td>
<td>M4; M5; (RAP #16)</td>
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<tr>
<td><strong>Survey Tag Numbers</strong></td>
<td>F309; F314</td>
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<tr>
<td><strong>Related Documents</strong></td>
<td>Prevention of Pressure Ulcers&lt;br&gt;Pressure Ulcer Risk Assessment&lt;br&gt;Nutrition and Hydration to Maintain Skin Integrity (Nutrition and Hydration)</td>
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<td><strong>Risk of Exposure</strong></td>
<td>Blood–Body Fluids–Infectious Diseases–Air Contaminants–Hazardous Chemicals</td>
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<td><strong>Procedure Revised</strong></td>
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