Effective Pressure Ulcer Strategies
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Pressure Ulcer Management Cont’d
• Ulcer Assessment
• Staging
• Controlling bioburden
• Pain management
• Debridement
• Dressings
  – Change depending on wound healing
  – Clean technique during dressing changes
• Pressure redistribution
• Monitoring (PUSH Tool)
• Adjunctive therapy

Assessment & Treatment of PU’s
All pressure ulcers identified, assessed, recognized and addressed on admission, or after admission
• Any new pressure ulcer – reevaluate the adequacy of the plan for preventing pressure ulcers
Assessment

• Differentiate the type of ulcer
• Determine the ulcer’s stage
• Describe & monitor the ulcer’s characteristics
• Monitor the progress toward healing & potential complications
• Determine if infection is present
• Assess, treat and monitor pain, if present
• Monitor dressings and treatments

Type of Ulcers

Common ulcer types
• Pressure
• Vascular insufficiency/ischemic
• Neuropathic

Clinicians document the clinical basis for ANY determination that an ulcer is not pressure related, especially if the injury/ulcer has characteristics consistent with a PU but is determined not to be one.

Terminology

Undermining
Granulation
Eschar/Necrosis
Slough
Exudate
Wound edge attach
## Ulcer Characteristics

Facility has a system in place to assure protocols for daily monitoring & for periodic documentation of measurements, terminology, frequency of assessment, & documentation are implemented consistently throughout the facility.

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### Ulcer Characteristics

Pressure ulcer present—daily monitoring
- Evaluation of the ulcer if no dressing present
- Evaluation of the status of the dressing, if present
- Status of the area surrounding the ulcer
- Possible complications
- Whether pain is present

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### Ulcer Characteristics

- Observation of PU depends upon the type of dressing that is used
- Evaluation & documentation of PU with each dressing change, or AT LEAST WEEKLY (and more often if indicated by complications, or changes)
**Documentation**

Minimum documentation should include date, and
- Location & staging
- Size
- Exudate—purulent, serous, amount & odor
- Pain—episodic or continuous
- Wound bed—color & tissue type
- Description of wound edges & surrounding tissue
- Photographs—protocol

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**Size**

Perpendicular measurement Of the greatest extent of Length & Width

Depth

Undermining or tunneling

Rolled edge

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Stage I

Observable pressure related alteration of intact skin whose indicators as compared to the adjacent or opposite area on the body may include changes in one or more of the following: Skin temperature, tissue consistency, &/or sensation. The ulcer appears as a defined area of redness in lightly pigmented skin and red, blue or purple in darkly pigmented skin.

NPUAP 1998

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Stage II

Partial thickness skin loss involves the epidermis, dermis, or both. The ulcer is superficial and presents as an abrasion, blister, or shallow crater.
Stage III
Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. Presents as a deep crater with or without undermining of adjacent tissue.

Stage IV
Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures. May have undermining and tunneling.

MDS Version 2.0 Stage IV
Unstageable
Healing Pressure Ulcers

- Evidence of stabilization or some healing within 2-4 weeks (AHCPR 1994).
- If PU fails to show progress, reassessment of overall resident’s condition is needed.
- Document rationale if not changing treatment.
- Complications can occur (infection, cellulitis, etc.). Keep physicians informed.

Healing Pressure Ulcer

- Nursing home regulation—use the RAI to describe a healing PU.
- RAI manual instructs to identify depth in reverse order from deepest to lesser stage.

PUSH Tool

NPUAP-----Pressure Ulcer Scale for Healing
- A healing pressure ulcer, stage III & IV
- Always maintains the same stage, documents healing consistent with the healing process.
- L x W, Exudate amount, Type of Tissue
Colonized/Infected

- Colonized -- presence of bacteria on the surface or in the tissue of a wound without the S & S of infection
- Infected – presence of micro-organisms in sufficient quantity to overwhelm the defenses of viable tissues and produce S & S of infection

Bacterial Burden

Continuum

Infection

**Classic Signs** of Infection

- Purulent exudate
- Peri-wound warmth, swelling
- Induration erythema
- Increasing pain or tenderness
- Delayed healing
- Elevated WBC—bacteremia, sepsis or fever
Pain

Goal: Eliminate the cause of pain, to provide analgesia, or both
- Pain can interfere with ambulation & movement and contribute to immobility & PU development
- PU are painful
- Pain is an individual perception & response
- Pain scales 0-10

Dressings & Treatments

Stage I & II, clinical judgment & facility protocols based upon current standards of practice

Stage III & IV, clinical practice indicates PU needs to be covered

Treatment

- Moist wound dressings—a balance between moist and too moist to interfere with healing
- Product selection based on relevance of the product to the identified characteristics of the PU
- Wound characteristics assessed to assure TX are appropriate
Treatments

• PU dressing protocol—clean versus sterile technique—unless recently surgically debrided or repaired

Treatment--Debridement

Removal of non-viable tissue & foreign matter from a wound
Methods:
• Autolytic
• Enzymatic
• Mechanical
• Sharp/surgical
• Biosurgery

Autolytic

• Uses the body’s own endogenous enzymes to slowly rid a wound of necrotic tissue
Mechanical Debridement

The removal of foreign material and dead or damaged tissue by the use of physical forces.

• NON-Selective method
• Methods
  – Hydrotherapy (whirlpool)
  – Irrigation (pulsed lavage)
  – Wet-to-dry dressings

Facility may use:
• wet to dry dressings or solution to clean surface of wound bed & remove slough
  – limited circumstances—not healthy on granulation tissue

Enzymatic Debriders

• Proteolytic, chemical agent that breaks down devitalized tissue
• Indications: to debride full thickness necrotic wounds, pressure ulcers and dermal ulcers.
Surgical Debridement

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Larval/Maggot

- Rapid method for removing devitalized tissue
- Relatively inexpensive
- Wounds where sharp debridement may expose anatomic structure (bone, tendon, joint)
- Autolytic, mechanical or enzymatic has failed, and poor surgical candidate

Treatment protocols

Facility should be able to show that its treatment protocols are based upon current standards of practice & in accord with a facility’s policies and procedures as developed with the medical director’s review and approval.
F 314 Summary Concepts

- Evaluation & reevaluation
- Comprehensive Assessment
- Monitor ongoing
- Prevention
- Risk Factors
- Pressure Relief
- Treatment Interventions
- Physician informed
- RAI & Care Plan
  accurate & timely

Resources

- www.cms.internetstreaming.com
- www.amda.com
- www.wocn.com
- www.ahrq.gov
- www.npuap.gov