The Christ Hospital

PATIENT CARE SERVICES POLICY/PROCEDURE

POLICY TITLE:	**Pressure Ulcer Prediction and Treatment**
APPROVED BY:	**Vice President Patient Care Services, Medical Director, Medical Executive Committee**
ORIGINATED BY:	**Skin/Wound Care Clinical Nurse Specialist**
REVISED/REVIEWED DATE:	**08/2011**

POLICY:

Patients who are at risk for developing pressure ulcers should be identified upon admission and when there is a change in their condition. Patients with existing pressure ulcers will be identified upon admission. Patients should not develop pressure ulcers while hospitalized unless their clinical condition demonstrates that skin breakdown is unavoidable. Patients admitted to the hospital with existing pressure ulcers and patients who develop pressure ulcers while hospitalized will receive assessment and treatment for their skin breakdown. A component of the assessment may include, but not limited to, photography. Photographs will be taken to provide documentation of each patient's progress and serve as a resource for quality assessment as well as evaluation. Photographs will be taken by the WOC nurse at their discretion and can include: initial assessment, significant change, and at discharge/healed. Photographs will become part of the patient's medical record.

RESPONSIBILITY:

- Registered Nurse
- Case Manager
- Patient Care Assistant
- Nurse Clinician, Enterostomal Therapy
- Clinical Nurse Specialist, Enterostomal Therapy

PROCEDURE:

I. Pressure Ulcer Risk Assessment

Assess all patients upon admission for risk of developing a pressure ulcer. Complete the Braden Risk Assessment Scale. After admission the Braden Scale should be completed daily on all patients.

Patients are considerd at risk if they score less than or equal to 18 (Ayello & Braden, 2002).

Initiate preventive interventions if the Braden score is ≤ 18. Care plan will be automatically fired in EPIC when the Braden score is less than or equal to 18.

Preventative Interventions:

1. Reposition patient at least every 2-4 hours in bed and when up in chair. (Pieper, B., 2006, Page 225). Record repositioning in *DOC Flow/Assess/Activity/Reposition.*
2. Utilize pressure reducing devices:
   A. Use an air-filled seat cushion for chair; do not use invalid ring or donut ring. (Pieper, B., 200, Page 245). Place a pillow under the calves to relieve heel pressure when in bed. A **HeeLift** boot can also be used. To document go to *DOC Flow/Assess/Activity/Misc. Interventions.*
   B. Place at risk patients on a pressure redistribution surface/bed. For post-operative orthopedic patients place on pressure redistribution surface if patient continues to be at risk 24 hours post-op. All ICU

3. Utilize no-rinse moisturizing body wash for bathing. Limit use of bar soap. Apply a moisturizing skin cream or lotion daily to dry skin and as needed. (Pieper, B., 2006, Page 227).
4. Monitor episodes of fecal or urinary incontinence. Provide incontinence management using foam cleanser and barrier ointment after each episode. Do not place plastic backed pads (chux) next to skin. Utilize launderable incontinence pads. Protect perirectal skin with a barrier ointment.
5. For liquid stool incontinence consider a fecal containment device. ~~See Policy 1.4.114 Fecal Incontinence Devices.~~ 1.4.147: Stool Containment/Incontinence devices
6. Consider a male external catheter for male urinary incontinence.
7. Encourage fluids unless fluid restriction is ordered.
8. Encourage adequate dietary intake. Complete Nutrition Assessment.
   An albumin less than 2.5 is considered to be severe risk for malnutrition and skin can break down. A pre-albumin less than 12 is considered to be at risk for malnutrition. (Makelbust, J., & Sieggreen, M. page 45).

II. Pressure Ulcer Assessment and Documentation

Make a referral to the Wound Ostomy Continence (WOC) Nurse for any Stage III or greater pressure ulcer. Patients being treated by a plastic surgeon for their pressure ulcer should not be referred to the Wound Care Specialist unless the surgeon enters an order for consult.

Assess all pressure ulcers initially and daily for location, stage, exudate, odor, color, undermining, tunneling, and condition of periwound skin. All POA (Present on Admission) pressure ulcers should be reported to a physician within 24 hours of admission. Record the pressure ulcer initially in *DOC Flow/Assess/Add LDA/Type in wound.* Record the pressure ulcer assessment in *DOC Flow/Assess/Row Wound.*

Measure the wound initially and then weekly. Wounds are measured as vertical by horizontal by depth in centimeters (Nix, D., Page 144).

Pressure ulcers should be classified using the staging system listed below.

Stage I: 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: 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, incontinence associated dermatitis, maceration or excoriation.

*Bruising indicates suspected deep tissue injury.

Stage III: 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: Full-thickness skin loss with 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, or 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 join 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.

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. (NPUAP, 2007).

Do not backstage a healing ulcer. Example: A Stage III ulcer cannot become a Stage II ulcer. It should be described as a healing Stage III ulcer until closed (Maklebust, J., 2001, Page 54).

Do not stage ulcers with yellow fibrin slough or eschar in the wound bed. Wounds can be staged only when the wound bed is clear of debris and can be seen. (Cooper, D., 2000, Page 60).

Daily assessment should be waived if the wound dressing is not changed daily. Assessment is completed when the dressing is changed. Record the projected date of the next dressing change in *Dear Staff Hand Off Note*.

III. Pressure Ulcer Management

A. Partial thickness ulcers or Stage I and Stage II pressure ulcers can be managed by nursing staff. The primary nurse may consult the WOC Nurse if the wound is not responding to standard care or the primary nurse identifies that the patient has factors inhibiting wound healing.

Standard Care of Partial Thickness Pressure Ulcers (Stage I & II)

1. Initiative all preventative interventions listed above.
2. Reposition patient every two – four hours whether in bed or chair.
3. Dressings are not necessary for Stage I pressure ulcers however the RN may choose to apply one.
4. Stage II pressure ulcers may have any of the following dressings applied.

Dressing	Indications	Frequency of Change
Clear Acrylic (Tegaderm Absorbent)	Wounds with no depth and dry to low exudate	Weekly and PRN if loose
Foam (3M Tegaderm Foam)	Wounds with moderate to high exudate	1-7 days. Change when saturated.
Barrier Paste (Calazime)	Wounds without defined borders, may have fragile periwound skin. IAD	Apply twice daily. When cleaning only remove soiled paste.
Vasolex Ointment *Note: Vasolex is a medication and requires a physician'e order.*	Wounds without defined borders, may have fragile periwound skin. IAD	Apply twice daily.

5. The WOC nurse or staff nurse may choose a different plan of care based on the patient's unique wound care needs. If WOC nursing is consulted the Wound Care Order Set will be initiated.

B. **Stage III and Stage IV pressure ulcers** are full thickness wounds. They require a wound consult by a WOC Nurse.

1. Enter a consult *for Wound Care Nurse*.
2. A wound care specialist will see the patient within 24 hours after receiving the consult. They are available Monday through Friday.
3. A wet to moist normal saline dressing can be applied until the consult is made. Change the dressing twice daily.
   Record the pressure ulcer assessment in *DOC Flow/Assess/Row Wound.*
4. A WOC Nurse will assess the wound and make a plan of care with the nurse. Care plan will be entered into EPIC. The Wound Care Order Set will be initiated.

IV. Photography Procedure

A. The WOC Nurse will explain and document the use of wound photography to the patient, Significant Other, Durable Power of Attorney for Healthcare, or next of kin..

B. A patient's refusal to permit any wound photography will be respected and documented in Epic (Notes activity).

C. At the discretion of the WOC Nurse, using hospital approved equipment, photographs will be considered part of the wound assessment. The WOCN taking the photograph should perform the following:

1. Conceal identifying characteristics such as tattoos, birthmarks, jewelry and areas of the body not related to the wound assessment as much as possible. Drapes should be used to eliminate distracting items from the background.
2. Identify each wound with a pre-printed label identifying the patient. The contents of the label will include:
   a. Patient's name
   b. Medical record number
   c. Date of birth
   d. Date of photo
   e. Wound location

3. Lighting
   a. Use natural light (no flash) when possible.
4. Composition
   a. Avoid clutter in the background i.e.: clothing, towels.
   b. When possible, include a ruler in each photo.
   c. Place a blue pad or similar solid colored background beneath the area to be photographed, if possible, and position the patient to facilitate maximum exposure of the wound.
5. Technique:
   a. Position the patient in the same manner for each set of photos to best show consistency as the wound progresses.
   b. Take the photo from the same angle each time.

D. Photographs will be transferred from the camera to the secure location: V:\WOCN_Photos. The photographs will then be entered into the patient's electronic medical record.
   a. Access the patient's chart via Hyperspace > Epic
   b. Click Notes activity > New Note > insert Smart Text > Click the Image icon on the toolbar > Click Browse > locate Wound_Photo folder on the shared drive > double click on the patient's photograph > click Insert > the photography will be imbedded in the patient's note > complete the note > click Sign.

E. Photographs will be considered a part of the patient's medical record. Patient's personal request for any photographs must be fulfilled through the Medical Records Department.

References:

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