



for improved outcomes



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). The ulcer appears as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue or purple hues.

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

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.

Goals of Care: restore skin integrity and avoid infection.

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



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.

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 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.

Goals of Care: restore skin integrity and avoid infection.

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 complete assessment of the wound.

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

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

NOTE: Heel ulcers may be left undebrided with pressure relief provided. Dressings may be used alone or in combination with mechanical and sharp debridement.

BACKGROUND INFORMATION:

A pressure ulcer is any lesion of the skin caused by unrelieved pressure resulting in damage to underlying tissue. Pressure ulcers usually occur over bony prominences such as the heel, coccyx or trochanter which are in contact with a surface, such as a bed, wheelchair, shoe or cast. When pressure is not relieved, tissue ischemia develops and a pressure ulcer results. Most pressure ulcers are preventable. Therefore, early risk assessment, skin care, attention to patient support surfaces and education are essential.

Standard practice is to assess and stage pressure ulcers using a scale from I-IV that is based upon depth of the wound, with IV representing the most serious degree of injury. Once 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 needs to be evaluated.

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, such as an 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 like 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:** proper turning; transferring and positioning techniques; support surfaces for bed or chair as indicated by level of risk. With heel/foot ulcers, provide appropriate pressure relief and orthotics as needed.
- **Support moist wound healing.**
- **Treat infection:** consult with physician to determine need for antibiotic therapy, debridement, cleansing and dressing approach.
- **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 agency protocol.

Stage I

Restore Clean `N Moist
Hollister Skin Cleanser
Restore Barrier Creme
Hollister Skin Conditioning Creme
Hollister Moisture Barrier Ointment
Hollister Skin Gel
Restore Extra Thin Hydrocolloid
EpiFlex Heel and Elbow Protectors

Stage IV

SKIN CARE

Restore Clean `N Moist
Hollister Skin Cleanser
Restore Barrier Creme
Hollister Skin Conditioning Creme
Hollister Moisture Barrier Ointment
Hollister Skin Gel
Premium Skin Barrier
Flexend Skin Barrier
EpiFlex Heel and Elbow Protectors

WOUND CARE

Restore Wound Cleanser
Restore Plus Hydrocolloid
Restore Hydrogel (gel, sponge, packing strip)
Restore CalciCare Calcium Alginate
Hollister Odor-Absorbent Dressing
Hollister Deodorizer Germicide

Stage II

SKIN CARE

Restore Clean `N Moist
Hollister Skin Cleanser
Restore Barrier Creme
Hollister Skin Conditioning Creme
Hollister Moisture Barrier Ointment
Hollister Skin Gel
EpiFlex Heel and Elbow Protectors

WOUND CARE

Restore Wound Cleanser
Restore Extra Thin Hydrocolloid
Restore Plus Hydrocolloid
Restore Hydrogel (gel, sponge, packing strip)
Restore CalciCare Calcium Alginate
Hollister Odor-Absorbent Dressing
Hollister Deodorizer Germicide

Unstageable

SKIN CARE

Restore Clean `N Moist
Hollister Skin Cleanser
Restore Barrier Creme
Hollister Skin Conditioning Creme
Hollister Moisture Barrier Ointment
Hollister Skin Gel

WOUND CARE

Restore Wound Cleanser
Restore Extra Thin Hydrocolloid
Restore Plus Hydrocolloid
Restore Hydrogel (gel, sponge, packing strip)
Hollister Odor-Absorbent Dressing
Hollister Deodorizer Germicide

Stage III

SKIN CARE

Restore Clean `N Moist
Hollister Skin Cleanser
Restore Barrier Creme
Hollister Skin Conditioning Creme
Hollister Moisture Barrier Ointment
Hollister Skin Gel
Premium Skin Barrier
Flexend Skin Barrier
EpiFlex Heel and Elbow Protectors

WOUND CARE

Restore Wound Cleanser
Restore Plus Hydrocolloid
Restore Hydrogel (gel, sponge, packing strip)
Restore CalciCare Calcium Alginate
Hollister Odor-Absorbent Dressing
Hollister Deodorizer Germicide

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