
PRESSURE ULCER PREVENTION AND WOUND CARE

PURPOSE:

To provide staff guidelines for documenting, assessing and preventing pressure ulcers and general procedures for skin care, pressure ulcer and wound care management.

POLICY:

Upon admission, daily, and per unit specific policy, every patient will be assessed for pressure ulcer risk by an assigned registered nurse.

General Skin Care Guidelines

1. Skin Assessment, Consult, and Documentation

The RN/LPN shall assess the patient for skin integrity risk factors on admission and will consult WOCN (Wound Ostomy Continence Nursing) if indicated. This initial skin assessment shall be documented on the Patient History, Assessment and Discharge Form (SN 1048), Pediatric Patient History, Assessment and Discharge Form (SN 6958), or Psychiatric Unit History, Physical and Psychosocial Assessment and Discharge Form (SN 6677).

2. Assessing High Risk Patients

The RN/LPN shall assess all high-risk patients for alteration in skin integrity and circulatory impairment each shift (8-12 hours).

- a. Assess HOT SPOTS (heels, occiput, toes, sacrum, posterior buttocks, over bony prominences, thoracic spine, scapula, ears, between the knees).
- b. Document assessment and report significant findings to the physician (redness, irritation, swelling, tenderness, actual skin breakdown, etc.).
- c. RN's and LPN's shall consult WOCN (Wound Ostomy Continence Nurse) for alterations in skin integrity.
- d. Nursing assistants and staff shall follow the turning schedule as assigned by the RN, observe skin integrity and report changes in skin integrity to the nurse immediately.

3. Ensuring Skin Integrity Status

All staff shall ensure the patient's skin is clean and dry.

4. Patient Immobilized or at Risk

If immobilized or at risk, the following shall be implemented and documented in the Medical Record:

- a. The patient shall be turned at least every 2 hours, unless contraindicated.
- b. Heel/elbow protectors shall be used as appropriate.
- c. Pressure reduction devices shall be used as ordered.
- d. Positioning devices such as foam or pillows may be placed between bony prominences to prevent direct contact.
- e. Staff shall maintain the head of the patient's bed at the lowest degree of elevation consistent with medical conditions and other restrictions. (Exception: An upright position may be used during meals and one hour after eating).
- f. Staff may use an extra sheet or incontinence airflow pads as needed, unless contraindicated by the specialty mattress/bed. Do not place plastic incontinence pads next to patient's skin.
- g. Use a sheet or slider board to move patient. LIFT, do not drag.
- h. Staff shall initiate the skin care kit (Aloe Vesta, perineal wash, and barrier) as appropriate.

5. Hydration and Nutrition Consult

The patient's hydration will be maintained and a nutrition consult initiated as indicated.

6. Bed Linens

Staff shall keep bed linens smooth, dry and clean.

7. Instructing Patient and Family/Caregiver

The RN/LPN shall educate the patient and family/caregiver regarding preventative measures as appropriate.

General Pressure Ulcer Management Guidelines**POLICY:****1. Nurse Initiation of Guidelines and WOCN Consult**

The RN/LPN shall initiate Pressure Ulcer Management Guidelines and consult WOCN (Wound Ostomy Continence Nurse) for at risk patients on admission and/or later if patient condition warrants.

2. Specialty Mattress/Bed Orders

The nurse shall consult the WOCN for specialty mattress/bed orders, and to evaluate patients for specialty mattress/bed needs.

3. Dressing Changes and Assessment

During dressing changes, the RN/LPN shall assess and document the following:

- a. **Location** of the pressure ulcer(s);
- b. **Size** (length and width at largest area);
- c. **Color, temperature, edema, odor, moisture and appearance of skin** around the ulcer
- d. **Stage of the wound** (using following table);
- e. **Exudate and drainage;**

Wound Stage	Description (See attached Appendix A for treatment guidelines)
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.
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.
II	Partial-thickness loss 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.
III	Full thickness 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.
IV	Full-thickness skin loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.
Unstageable	Full-thickness tissue loss in which the bed of the ulcer is covered by slough (yellow, tan, gray, brown or black) in the wound bed.

4. WOCN Policy Manual

The RN/LPN may refer to the **WOCN Policy Manual** located on each unit for additional wound care guidelines.

General Surgical Wound Care

1. Physician's Orders

Surgical wound care shall follow the physician's orders.

2. Dressing Changes Using Strict Aseptic Technique

If the physician orders dressing changes, the nurse shall use strict aseptic technique. Until the wound edges are well approximated, anything that touches the incisions shall be sterile including but not limited to sterile gloves, dressings, Q-tips and solutions. The nurse shall:

- a. Observe the surgical wound dressing every shift and document status;
- b. Report any signs of infection or dehiscence to the physician immediately (redness, swelling, in duration, tenderness, separation of the incision, odor, exudate, etc.);
- c. Monitor each shift for changes in skin integrity;
- d. Ensure patient is turned every two (2) hours while in bed. Document turning, repositioning schedule per flow sheet or in nurses narrative notes;
- e. Ensure patient changes position while in chair or wheelchair every hour so that the points under pressure will shift;
- f. Use pressure relief device/mattress as ordered;
- g. Provide pressure reducing/relieving device to wheelchair, as ordered.
Do not use donut type devices.

APPENDIX A – Treatment Guidelines	
Skin Tears/Abrasions	<ol style="list-style-type: none"> 1. Monitor each shift for changes in skin integrity and document findings. 2. Consult WOCN to evaluate and make written recommendations. 3. Notify MD, and follow prescribed treatment, which may include: <ol style="list-style-type: none"> a. transparent dressing or b. antibiotic ointment; leave wound open to air c. foam dressings d. gel dressings <p style="text-align: center;">(do not apply tape, wrap extremity with gauze)</p> 4. Document actions.
Venous Stasis Ulcers	<ol style="list-style-type: none"> 1. Monitor patient every shift for changes in skin integrity and document findings. 2. Ensure patient is turned every two (2) hours while in bed and document. 3. Elevate lower extremities while in bed and chair and document. 4. Low air loss bed as ordered and document. 5. Recommend consulting diabetic foot and limb clinic, document consult. 6. Recommend consulting Vascular Surgery for evaluation and vascular studies, document consult.

<p>For ALL Pressure Ulcers</p>	<p>For all wounds, the RN/LPN shall:</p> <ol style="list-style-type: none"> 1. Monitor each shift for changes in skin integrity and document findings. 2. Ensure patient is turned every two (2) hours while in bed. Position patient to remain off the pressure ulcer. Document position changes. 3. Provide pressure relief while in chair/wheelchair every two (2) hours by returning to bed. Do not place in supine position for the first two hours. 4. Use pressure relief mattress/device as ordered (i.e. low air loss mattress or cushions to wheelchair). Do not use donut type devices. 5. Place normal saline wet to moist dressing on wound as per MD order. 6. <u>If routine dressing changes are ordered,</u> The dressing changes and description of the wound/ulcer shall be documented in the Nurses 24 Hour Plan of Care.
<p>Stage 1 Additional Considerations</p>	<ol style="list-style-type: none"> 1. Use skin care kit. 2. Leave wound open to air. 3. Use heel/elbow pads as indicated. 4. Relieve pressure. 5. Reposition every two hours.
<p>Stage 2 Additional Considerations</p>	<p>The following require physician orders prior to implementation by the nurse:</p>
	<ol style="list-style-type: none"> a. Lower extremity pressure relief, such as elevating the lower legs. b. Transparent dressing: Change every three days or more often if dressing becomes dislodged. c. Hydrogel dressing: Change daily or twice/daily. d. Hydrocolloid dressing: Change every other day as ordered. e. All routine dressing changes shall be scheduled according to the WOCN policies/recommendations or physician's orders. The dressing change schedule shall be documented in the Nurses 24 Hour Plan of Care.

<p>Stages 3 & 4 Additional Considerations</p>	<ol style="list-style-type: none"> 1. Consult Nutritional Services 2. Daily treatments shall be documented in the Nurses 24 Hour Plan of Care. The following require physician’s orders prior to implementation by the nurse: <ol style="list-style-type: none"> a. Lower extremity pressure relief device, such as elevating the lower legs. b. Clean wound bed with ordered solution prior to dressing application. c. For moderate-heavy drainage, topical treatment options ordered by the MD may include: <ol style="list-style-type: none"> 1. Wound gel to gauze, change every day as ordered. 2. Enzymatic debrider to wound bed for promotion of granulation. Cover with gauze. Change daily as ordered. 3. Normal Saline (0.9% sterile Sodium Chloride irrigation) gauze to pack wound. Change twice a day as ordered. 4. Lightly pack wounds with sinus tract with normal saline moistened gauze to fill dead space as ordered. 5. For heavy drainage, MD may order calcium alginate rope/sheet, aquacel or foam dressing. 6. For moderate to heavy exudates and nonviable tissue necrosis, the MD may order enzymatic debriding agent to necrotic area.
<p>Slough and Eschar Covered Wounds</p>	<ol style="list-style-type: none"> 1. Notify MD & follow orders. 2. Include a notation that wound cannot be staged at this time.
<p>References:</p> <p>Nursing Policy: E-15 E.T./ Wound Ostomy Continence Nurse Nursing Standards of Care: For the Ostomy Patient (#17) Nursing Standards of Care: For the Immobilized Patients (#7) WOCN Policy Manual: Located on the your Unit [More information regarding Dressing Types] Website: www.sh.lsu.edu</p>	

BIBLIOGRAPHY

- Bergstrom N, Bennett MA, Carlson CE, et al. Treatment of Pressure Ulcers. (December 1994). Clinical Practice Guideline, No. 15. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service, Agency for Health Care Policy and Research. AHCPR Publication No. 95-0652.
<http://hstat.nlm.nih.gov/hq/Hquest/screen/TextBrowse>
- Brubacher, Lynda. (1994). Care of the Patient with Potential/Actual Skin Breakdown. *Manual of Patient Care Standards*. Gaithersburg, Md.; Aspen Publishers, Inc.
- Fletcher, Kathleen. (April 2005). Skin: Geriatric Self-Learning Module. MEDSURG Nursing, 14, 138-142.
- Green, Eleanor & Katz Jacqueline. (1995). Alterations in Skin Integrity Related to Pressure Ulcers. *Clinical Practice Guideline for the Adult Patient*. St Louis: Mosby.
- Heard, Laura. (1995). Care of the Patient with Potential for Skin Breakdown Related to Pressure Ischemia. *Clinical Practice Guidelines for the Adult Patient* (Eleanor Green & Jacqueline Katz). St. Louis: Mosby
- Hewitt, B., Davis, M., & Bell, R. (2000). HOT SPOTS. Unpublished.
- Holmes, H. Nancy (ed.) (2002). Skin Care. *Illustrated Manual of Nursing Practice* (3rd ed.) (pp 1075-1087). Philadelphia: Lippincott, Williams and Wilkins.
- Nettina, Sandra M. (2001). Pressure Sores. *The Lippincott Manual of Nursing Practice* (7th ed.) (pp 183-185). Philadelphia: Lippincott.
- Perry, Anne G. & Potter, Patricia A. (1998). Pressure Ulcer Care Techniques. *Clinical Nursing Skills and Techniques* (4th ed.) (pp189-215). St. Louis: Mosby.
- Panel for the Prediction and Prevention of Pressure Ulcers in Adults. Pressure Ulcers in Adults: Prediction and Prevention. (May 1992). Clinical Practice Guideline, Number 3. AHCPR Publication No. 92-0047. Rockville, MD: Agency for Health Care Policy and Research, Public Health Service, U.S. 5Department of Health and Human Services.
<http://hstat.nlm.nih.gov/hq/Hquest/screen/TextBrowse>
- Potter, Patricia A. & Perry, Anne G. (5th ed.) (2003). Skin Integrity and Wound Care. *Basic Nursing: Essentials for Practice* (pp 843-884). St. Louis: Mosby.
- Wound, Ostomy and Continence Nurses Society. (1996). Staging Pressure Ulcers. *Position Statement*. <http://www.wocn.org/publications/posstate/staging.htm>.
- National Pressure Ulcer Advisory Panel (2007) Updated Staging System. www.npuap.org

Jamie Jett, MBA, RN
Director, Patient Care Support/Medicine Services

Signature

Date

Jean DiGrazia, MBA, RN
Acting Assistant Hospital Administrator and CNO
Patient Care Services

Signature

Date