GENERAL PRESSURE ULCER MANAGEMENT GUIDELINES

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 admissions and/or later if patient conditions warrants.

2. Specialty Mattress/Bed Orders
   Additionally, the nurse shall consult the WOCN for specialty mattress/bed orders.

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); use centimeters.
   c. **Color, temperature, edema, odor, moisture and appearance of skin around the ulcer**
   d. **Stage of the wound** (using following table);

<table>
<thead>
<tr>
<th>Wound Stage</th>
<th>Description (See Appendix A for Treatment Guidelines)</th>
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</thead>
<tbody>
<tr>
<td>I</td>
<td>An 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:</td>
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<tr>
<td></td>
<td>a. Skin temperature (warmth or coolness)</td>
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<td></td>
<td>b. Tissue consistency (firm or boggy feel)</td>
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<td></td>
<td>c. Sensation (pain, itching)</td>
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<td>II</td>
<td>Partial-thickness skin loss involving epidermis d/or dermis. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.</td>
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<tr>
<td>III</td>
<td>Full-thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.</td>
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<td>IV</td>
<td>Full-thickness skin loss with extensive destruction; tissue necrosis; or damage to muscle, bone, or supporting structures (e.g. tendon, joint capsule, etc.).</td>
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<tr>
<td>Slough &amp; Eschar Covered Wound</td>
<td>Pressure ulcer cannot be staged.</td>
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</table>

4. WOCN Policy Manual
   The RN/LPN may refer to the WOCN Policy for additional wound care guidelines.
Guidelines for Staging Pressure Ulcers

Stage I

An 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
- Sensation

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

Stage II

Stage II ulcers may include Partial thickness as well as loss of skin involving epidermis and/or dermis. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.

Stage III

Stage III ulcers may include Full-thickness loss of skin involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.
Full-thickness tissue loss with extensive destruction, tissue necrosis or damage to muscle, bone or supporting structures. Undermining and sinus tracts also may be associated with Stage IV pressure ulcers.