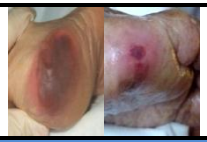
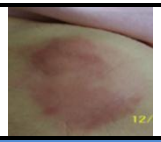
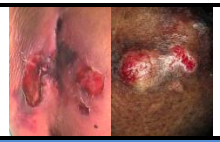
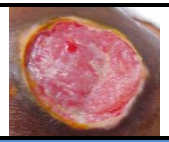
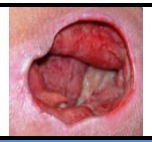
Community Care Pressure Ulcer Treatment Guideline

A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear.

Photo										
Type	**Suspected Deep Tissue Injury (SDTI)**	**Stage I**	**Stage II**		**Stage III**		**Stage IV**		**Unstageable**	
Definition	**SDTI –**Purple or maroon localized area of discolored skin or blood filled blister due to damage of underlying tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue **Further Description- SDTI** may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed.. Evolution may be rapid exposing of additional layers of tissue even with optimal treatment.	**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; it's color may differ from the surrounding area. **Further Description:** The area may be painful, soft, firm or warmer than adjacent tissue. It may be difficult to detect in individuals with dark skin tones.	**Stage II -** Partial thickness skin loss of epidermis and dermis presenting as a shallow crater or ulcer with a pink red 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, perineal dermatitis, maceration, or excoriation. **Bruising indicates deep tissue injury**.**		**Stage III – Full thickness tissue loss.** Subcuous 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 /or tunneling **Further Description** – The ulcer depth varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep ulcers.		**Stage IV – Full thickness tissue 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. **Further Description** – The depth varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Ulcers can extend into muscle and/or supporting structures making osteomyelitis possible.		**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 serves as "the body's natural (biological) cover" and should not be removed.**	
Exudate	**None**		**Dry to Scant**	**Moderate to Heavy**	**Dry to Scant**	**Moderate to Heavy**	**Dry to Scant**	**Moderate to Heavy**	**Dry to Scant**	**Moderate to Heavy**
Dressings / Treatment	**Cleanse** **Wash with soap and water, pat dry** **Apply** **Remedy Skin Repair Cream- general moisturizer** **Remedy Calazime Protectant Paste for damaged or denuded skin (incontinence)** **Remedy Nutrashield to at risk skin areas (can be used on partial thickness wounds) (use on stage I's to buttocks, incontinence, dry skin)** **Remedy Antifungal Powder or Cream use for fungal/yeast rash** **No Sting Skin Prep (skin barrier) to (intact) compromised area daily** **Marathon (can be applied to partial thickness) to compromised area Q 3-5 days**		**Cleanse** Irrigate wound with NS or Wound cleanser **Treatment Options** • Barrier wipe (Sureprep) • Calazime moisture and irritation •Silicone bordered foam (optifoam gentle) •Marathon	**Cleanse** Irrigate wound with NS or Wound cleanser **Apply** •Barrier wipe (Sureprep) • Calazime (weeping or denuded) • Skin repair cream (dry) or Nutrashield (dry/ cracked) • Calazime (weeping or denuded) **Primary Dressing** • Maxorb Extra •Acticoat Flex 3 •Maxorb Extra AG **Secondary Dressing** •Gauze and tape •ABD •Sorbex • elastic net *Foam (Optifoam Non Adhesive)	**Cleanse** Irrigate wound with NS or Wound cleanser **Primary Dressing Options** • Hydrogel (Skintegrity) •Silver hydrogel (Silvasorb) •Santyl (only use NS to cleanse) **Secondary dressings** •Gauze and tape *oil emulsion dressing and gauze changed daily (skin barrier to peri wound skin) with any of the hydrogels	**Cleanse** Irrigate wound with Wound cleanser **Primary Dressing Options** • Hydrogel (Skintegrity) •Silver hydrogel (Silvasorb) •Santyl (only use NS to cleanse) **Secondary dressing options** •Gauze and tape •ABD •Sorbex •Foam (Optifoam non adhesive)	**Cleanse** Irrigate wound with NS or Wound cleanser **Primary dressing options** •Hydrogel (skintegrity) Impregnated gauze •Silver hydrogel (Silvasorb), Impregnated gauze •Silvadene •Santyl (if using only use NS to cleanse) • Hydrofera blue with hydrogel (skintegrity) beneath **Cover** •Gauze and tape •ABD •Sorbex *Silicone bordered foam (optifoam gentle)	**Cleanse** Irrigate wound with NS or Wound cleanser **Primary Dressing options** •Maxorb Extra Ag •Arglaes Powder •Hydrofera Blue **Secondary dressing options** •ABD •Sorbex •Foam (Optifoam non adhesive)	**Cleanse** Irrigate wound with NS or Wound cleanser Treatment **• Betadine** **•Skin barrier (Sureprep)** **Keep Dry** **Float heels to relieve pressure** **Heel prevention boots (Heelmedix boots)**	**Cleanse** Irrigate wound with NS or Wound cleanser, **Primary Dressing options** •Maxorb Extra Ag (silver calcium alginate) •Arglaes Powder (silver powder) •Hydrofera Blue (bacteriostatic foam) •Dakin's (bleach) impregnated gauze •Acetic Acid (vinegar) impregnated gauze **Secondary dressing options** •ABD •Sorbex *Foam (Optifoam non adhesive)

Prevention Guidelines (for all pressure ulcer stages)

- **Pressure relief to area**
- **Turn and reposition q 2h in bed and q 1h in chair**
- **Pillows under legs to keep heels elevated off bed**
- **Heel prevention boots (heelmedix)**
- **Air mattress for stage III, IV pressure (consider for unstageable and SDTIs)**

Complete for SDTI, Stage I and II Pressures Ulcers

- **Complete Adverse Event Internal Reporting Form if acquired while enrolled**
- **RN can initiate above treatment options**
- **Alert PC of change of skin condition**
- **If no improvement with dressing selection in two weeks reevaluate and change dressing selection type**
- **Consult PT if offloading evaluation is desired**

Complete for Stage III, IV, and Unstageable Pressures Ulcers

- **Complete Critical Incident 2 Internal Reporting Form if acquired while enrolled**
- **RN to Alert PC of skin condition; PC and RN collaborate for treatment orders**
- **If no improvement with dressing selection in two weeks reevaluate and change dressing selection type**
- **Consult WOC nurse if PC desires**
- **Nutritional Consult**
- **PT consult for offloading evaluation**

*= can be used alone as a primary dressing