Prevention Guidelines

- Pressure relief to area
- Turn and reposition q 2h in bed and q1h in chair
- Consider Heel prevention boots (heelmedix)
- Air mattress for stage III, IV pressure injuries (Consider for unstageable, severe DTI and high risk members)

**Community Care Pressure Injury Treatment Guideline**

A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue.

**Type**

- **Deep Tissue Injury (DTI)**
- **Stage 1**
- **Stage 2**
- **Stage 3**
- **Stage 4**
- **Unstageable**

**Definition**

- **Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister.** Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTP to describe vascular, traumatic, neuropathic, or dermatologic conditions.

- **Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.**

Partial-thickness loss of skin with exposed dermis. The wound bed is visible, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose fat is not visible and deeper tissues are not visible. Granulation tissue, slough and exudate are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and sheath in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (ITD), intermittent dermatitis, pressure-related skin injury (MARS), or traumatic wounds (skin tears, burns, abrasions).

- **Full-thickness loss of skin, in which adipose fat (if visible) is in the ulcer and granulation tissue and epidermis (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.**

- **Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance on the heel or scaphoid limb should not be softened or removed.**

Due to the anatomy of the tissue these ulcers cannot be staged. Device should be removed from location if able.

**Medical Device Related**

- **Mucosal Membrane**

Mucosal membrane pressure injury is found on mucous membranes with a history of a medical device in use at the location of the injury.

**Exudate**

<table>
<thead>
<tr>
<th>Exudate</th>
<th>None</th>
<th>Dry to Scant</th>
<th>Moderate to Heavy</th>
<th>Dry to Scant</th>
<th>Moderate to Heavy</th>
<th>Dry to Scant</th>
<th>Moderate to Heavy</th>
<th>Dry to Scant</th>
<th>Moderate to Heavy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dressings</strong></td>
<td><strong>Treatment</strong></td>
<td><strong>Change</strong></td>
<td><strong>Cleanse</strong></td>
<td><strong>Primary Dressing</strong></td>
<td><strong>Secondary Dressing</strong></td>
<td><strong>Secondary Dressing</strong></td>
<td><strong>Care</strong></td>
<td><strong>Change</strong></td>
<td><strong>Primary Dressing</strong></td>
</tr>
<tr>
<td>Change</td>
<td>Wash with soap and water, pat dry *</td>
<td></td>
<td><strong>Irritate wound with NS or Wound cleanser</strong></td>
<td><strong>Barrier wipe (Silver Prep)</strong></td>
<td><strong>Impregnated gauze</strong></td>
<td><strong>Saline wipe (Optifoam)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Remedy Skin Repair Cream</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Remedy Nutritional Powder or Cream use for fungal/yeast rash to pen wound if yeast present</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*No Sting Skin Prep Marboths</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Additional Consults as needed**

- **Consult Internal WOC nurse**
- **Dietician Consult**
- **PT consult for offloading evaluation**
- **External consults to be ordered as appropriate by**

RNCP to Alert PC of skin condition; PC and RN collaborate for treatment orders
RNCP to follow wound care policy & guideline for visit frequency/document
If no improvement with dressing selection in two weeks reevaluate and change dressing selection type
Complete Reportable Incidents for all stage III, IV, and unstageable pressure injuries-PACE ONLY

**Can also be used as a primary dressing**

- *Sorbs (Opalform Non-adhesive)
- *Hydrofibra Blue (Ready or Classic)

**Medical Device Related**

- *Sorbs (Opalform Non-adhesive)
- *Hydrofibra Blue (Ready or Classic)

Created: May 2012 JA
Last Revised: 10.09.2017