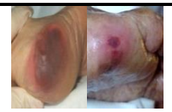
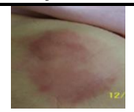
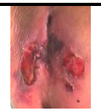
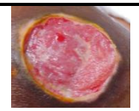
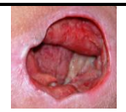
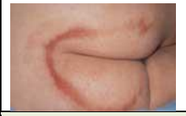
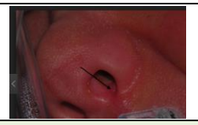
Community Care Pressure Injury Treatment Guideline

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.

Additional Pressure Injury definitions:

Photo									
Type	**Deep Tissue Injury (DTI)**	**Stage I**	**Stage 2**	**Stage 3**	**Stage 4**	**Unstageable**	**Medical Device Related**	**Mucosal Membrane**	
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 DTPI 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 viable, 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 eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).	Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (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 with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. 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 ischemic limb should not be softened or removed.	**This describes an etiology.** Medical device related pressure injuries result from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure injury generally conforms to the pattern or shape of the device. **The injury should be staged using the staging system. Treatments for the pressure injury are based off of stage. Device should be removed from location if able.**	Mucosal membrane pressure injury is found on mucous membranes with a history of a medical device in use at the location of the injury. **Due to the anatomy of the tissue these ulcers cannot be staged. Device should be removed from location if able**	
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 • Remedy Nutrashield • Remedy Antifungal Powder or Cream use for fungal/yeast rash to peri wound if yeast present • No Sting Skin Prep • Marathon		**Cleanse** Irrigate wound with NS or Wound cleanser **Primary Dressing** • Barrier wipe (Sureprep) • Skin Repair cream (Dry) or Nutrashield (dry/cracked) •Marathon •Collagen (endoform) **Secondary Dressing** •Gauze and tape •Silicone bordered foam (optifoam gentle)	**Cleanse** Irrigate wound with NS or Wound cleanser **Apply** •Barrier wipe (Sureprep) • Z-Guard or Calazime (weeping or denuded) **Primary Dressing** • calcium alginate (Maxorb Extra) •silver contact layer (Acticoat Flex 3) •silver calcium alginate (Maxorb Extra AG) • Collagen (endoform) **Secondary Dressing** •Gauze and tape •ABD •Sorbex • elastic net *Foam (Optifoam Non Adhesive) • Antimicrobial foam (hydrofera blue ready)	**Cleanse** Irrigate wound with NS or Wound cleanser **Primary Dressing** • Hydrogel (Skintegrity) •Silver hydrogel (Silvasorb) •Collagen (endoform) **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** • calcium alginate (Maxorb Extra) •silver contact layer (Acticoat Flex 3) •silver calcium alginate (Maxorb Extra AG) • Collagen (endoform) **Secondary dressing** •Gauze and tape •ABD •Sorbex •Foam (Optifoam non adhesive) *Hydrofera Blue (ready or classic)	**Cleanse** Irrigate wound with NS or Wound cleanser **Primary dressing** •Hydrogel (skintegrity) Impregnated gauze •Silver hydrogel (Silvasorb), •Silvadene •Santyl (cleanse with NS) • Hydrofera blue with hydrogel (skintegrity) beneath •Arglaes Powder Secondary dressing •Gauze and tape •ABD •Sorbex *Silicone bordered foam (optifoam gentle)	**Cleanse** Irrigate wound with NS or Wound cleanser **Primary Dressing** •Dakin's (bleach) •Acetic Acid (Vinegar) •calcium alginate (Maxsorb Extra) •silver calcium alginate (Maxorb Extra Ag) •Arglaes Powder **Secondary dressing** •ABD •Sorbex •Foam (Optifoam non adhesive) •Hydrofera blue (Ready)	**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** •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) •Hydrofera Blue (Ready or Classic)

*- can also be used as a primary dressing

Additional consults as needed

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

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)**

- **RNCM to Alert PC of skin condition; PC and RN collaborate for treatment orders**
- **RNCM to follow wound care policy & guideline for visit frequency/documentation**
- **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**

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