Pressure Ulcers
Assessing and Staging

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Never Events: Pressure Ulcers

- **Pressure Ulcer Codes**: MD documentation of pressure ulcers determines the billable code for CMS hospital reimbursement of care.
- Stage III and IV are billable ONLY if they are accurately noted on admission (POA) by the MD.
- Time frame of documentation still debated.
- **CMS Changes**: October 2008: Stages III and IV acquired after admission will not be reimbursed.
- **TAKE HOME**: ACCURATE ADMISSION DOCUMENTATION Required.
Skin Assessment: Pressure Ulcers

http://3dscience.com/biomedical_animation_free_medical_image_clip_art.asp
What is a Pressure Ulcer?

• A pressure ulcer is a 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 and friction.
  
  – **Pressure**: Pressure compresses underlying tissue and small blood vessels against the surface below. Pressure is exerted vertically. Tissues become ischemic and die.
  
  – **Shear/Friction**: Friction is the resistance created when one surface moves horizontally against another (i.e., pulling a patient along bed linen). Shear occurs when one layer of tissue slides horizontally over another, deforming and destroying blood flow (i.e., when HOB is raised greater than 30 degrees). They both require the **addition of pressure** from a surface to cause the tissue injury.

• Adapted: NPUAP Guidelines for Staging 2007
Deep Tissue Injury (DTI)

- February 2007 the National Pressure Ulcer Advisory Panel (NPUAP) revised pressure ulcer stages
- Deep Tissue Injury (DTI) was added as a category because this pressure related tissue injury is:
  - A prolonged pressure or positioning within a short period of time that compromises tissue perfusion and creates a wound deep in the dermis that initially presents superficially. (e.g. patient found down, unexpected prolonged operative cases, patients on multiple IV vasopressors, etc)
  - DTI is a wound category of pressure ulcer staging
  - Is of high concern because depth of tissue injury is frequently significant (e.g. stage III or IV)

- Key assessment variable is that a change in skin is “sudden” …DTI happens and progresses quickly.
Skin Assessment: Suspected Deep Tissue Injury

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Skin Assessment:
Suspected Deep Tissue Injury

• **Suspected Deep Tissue Injury Description**
  – Purple or maroon discolored localized area of intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear
  – Area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent skin
  – Evolution may include thin blister that evolves to thin eschar
  – Evolution may be rapid and involve deep tissue even with optimal treatment

Adapted: NPUAP Guidelines for Staging 2007
Skin Assessment: Stage 1 Pressure Ulcer

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Skin Assessment: Stage 1 Pressure Ulcer

- **Stage 1 Pressure Ulcer Description**
  - Nonblanchable redness of intact skin
  - Usually over a bony prominence
  - When related to equipment, may be over soft tissue:
    - i.e. NG tube: nasal cartilage
    - Urinary tube: inner leg edema causing pressure
  - Darkly pigmented skin may not show visible blanching – color change from adjacent skin may be only indicator
  - Can be a temperature change, sensation change of increased pain, and or change with firmness or softness to adjacent area

Adapted: NPUAP Guidelines for Staging 2007
Stage 2 Pressure Ulcer

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Skin Assessment: Stage 2 Pressure Ulcer

- **Stage 2 Pressure Ulcer Description**
  - Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed without any slough
  - May present as an open/closed serum filled blister

- Adapted: NPUAP Guidelines for Staging 2007

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Stage 3 Pressure Ulcer

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Skin Assessment: Stage 3 Pressure Ulcer

- **Stage 3 Pressure Ulcer Description**
  - Full thickness tissue 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

- Adapted: NPUAP Guidelines for Staging 2007

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Skin Assessment: Stage 4 Pressure Ulcer

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Skin Assessment: Stage 4 Pressure Ulcer

- **Stage 4 Pressure Ulcer Description**
  - Full thickness tissue loss with exposed bone, tendon, or muscle
  - Slough or eschar may be present on some parts of the wound bed
  - Often include undermining and tunneling
  - Depth of Stage 4 ulcers vary by anatomical location: bridge of nose, ear, occiput, and malleolus do not have subcutaneous tissue, therefore a Stage 4 in this location can be very shallow

Adapted: NPUAP Guidelines for Staging 2007
Skin Assessment: Unstageable Pressure Ulcer

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Skin Assessment: Unstageable Pressure Ulcer

- **Unstageable Pressure Ulcer Description**
  - Full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in wound bed
  - Unable to determine full depth of tissue loss until enough slough or eschar has been removed to expose the base or true depth and stage of the ulcer.
  - Dry, intact eschar without erythema on the heels should remain intact and not removed

  
  Used with permission NDNQI

- Adapted: NPUAP Guidelines for Staging 2007
Treatment of Pressure Ulcers Guidelines at UCH
Approved Guidelines:
Nursing Evidenced Based Best Practice at UCH without a MD order
See UCH intranet: Clinical resources/ skin wound website

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Treatment of Pressure Ulcers Guidelines
See UCH intranet: clinical department/skin wound care/products

Complete patient assessment and risk tool

Continue to institute prevention measures with all treatment guidelines

Suspected Deep Tissue Injury Wound Team Consult

Utilize high risk interventions per Braden Scale and PUN Protocol

Draining: Cover with transparent acrylic dressing
Non-draining: Open to air

Clean with N/S

Stage I: Non Blanchable erythema of intact skin

Clean with N/S

Translucent clear dressing or hydrocolloid for protection against shear friction

Blister intact

Open wound

Protect with no sting barrier film and cover with hydrocolloid or hydrogel with gauze dressing

Protect with no sting barrier film and cover with acrylic dressing

Protect with no sting barrier film and cover with hydrocolloid and exudate absorbent dressing e.g. alginates, foams

Protect with no sting barrier film with moist N/S gauze and absorbent dressing

Patient/caregiver education

Utilize resources
- PT/IOT
- Nutrition
- Wound care consult
- Pressure Reducing devices

Discharge planning
- Home care referral
- Supplies
- Home Therapeutic surfaces

Document hospital and community acquired pressure ulcer as appropriate

Unstageable due to necrotic surface

Clean wound with N/S

Consider debridging options for necrotic portions, if appropriate to patient care plan

Draining necrotic

Consider debridging options for necrotic portions, if appropriate to patient care plan

Non-draining eschar

Protect with dry dressing

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