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June 2022 Education

Clinical Practice Disease-Specific Guidelines
Pressure Ulcers/Injury

Agenda

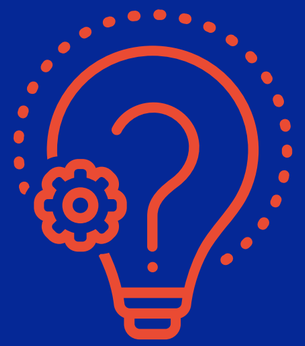
SerenaGroup Clinical Guidelines
Pressure Ulcers/Injury

- Definition
- Cause
- Assessment
- Prevention/Treatment
- Risk Factors
- Dressing Options
- Ordering Tests
- Appropriate Follow-Up
- Codes Related
- Reference
- Quiz

Definition

A localized injury to the skin or underlying tissue, usually over a bony prominence or related medical or other device, resulting from intense pressure in combination with shear and/or friction (NPIAP & NDNQI). PrUs can also result from low perfusion to the skin and soft tissues. In addition, PrUs may develop at life's end (Refer to SCALE).

Cause



Caused by prolonged pressure, friction, or shear either by themselves or in combination of each other over a bony prominence or where a medical or other device is left in place for a period of time.In addition, PrUs can develop due to a lack of blood supply, oxygen nutrients.

Assessment

Staged according to severity:

- **Stage I**- 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.
- **Stage II**- Partial thickness loss 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.

Assessment

- **Stage III**- 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.
- **Stage IV**- 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 tunneling typically occur.

Assessment

- **Unstageable**- 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.
- **Deep Tissue Injury (DTI)**-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.

Treatment

Based on the severity of the Stage of the Pressure Injury

- Prevention
  - Turn and reposition
  - Keep the skin clean and dry
  - When possible, avoid activities that lead to sheering
  - Keep the head of the bead less than 30 degrees unless contraindicated
  - Consider the use of specialty mattresses and cushions
  - Mobilize the patient as much as possible
  - Use a validated scoring system to assess risk of skin breakdown (e.g. Braden Scale)
  - Avoid dehydration
  - Consider nutritional supplementation or dietary consult
  - Manage fecal and urinary incontinence.
- Treatment
  - Continue guidelines for prevention
  - Follow The Practice of Wound Care
  - Evaluate the patient for osteomyelitis
  - Consider negative wound pressure therapy
  - Consider surgical referral for flap closure

Risk Factors

- Infection
- Osteomyelitis
- Fluid imbalance
- Protein-calorie malnutrition
- Disruption of quality of life

Dressing Options

- Maintain proper moisture balance
- Refer to SerenaGroup® Formulary

Order Tests

While there is no definitive lab test, there is agreement the following should be ordered, followed, and managed:

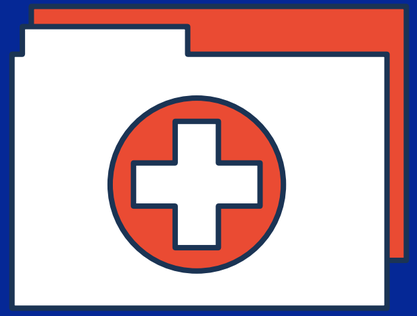
- HgbA1C- an indicator of long-term glucose control. The test reflects average glucose levels for the preceding 8-12 weeks.
- Glucose- elevated level can impede PMN leukocyte, chemotaxis, diapedesis & phagocyte production.
- CBC- measures: RBC, WBC, HGB, HCT, & platelets. Platelets release cytokines & PDGF which recruit cells to take part in healing.

Note: Pre-albumin and albumin levels are unreliable in most cases.

Follow-up

- Weekly in the acute phase
- Bi-weekly when stabilized
- Monthly if palliative in nature

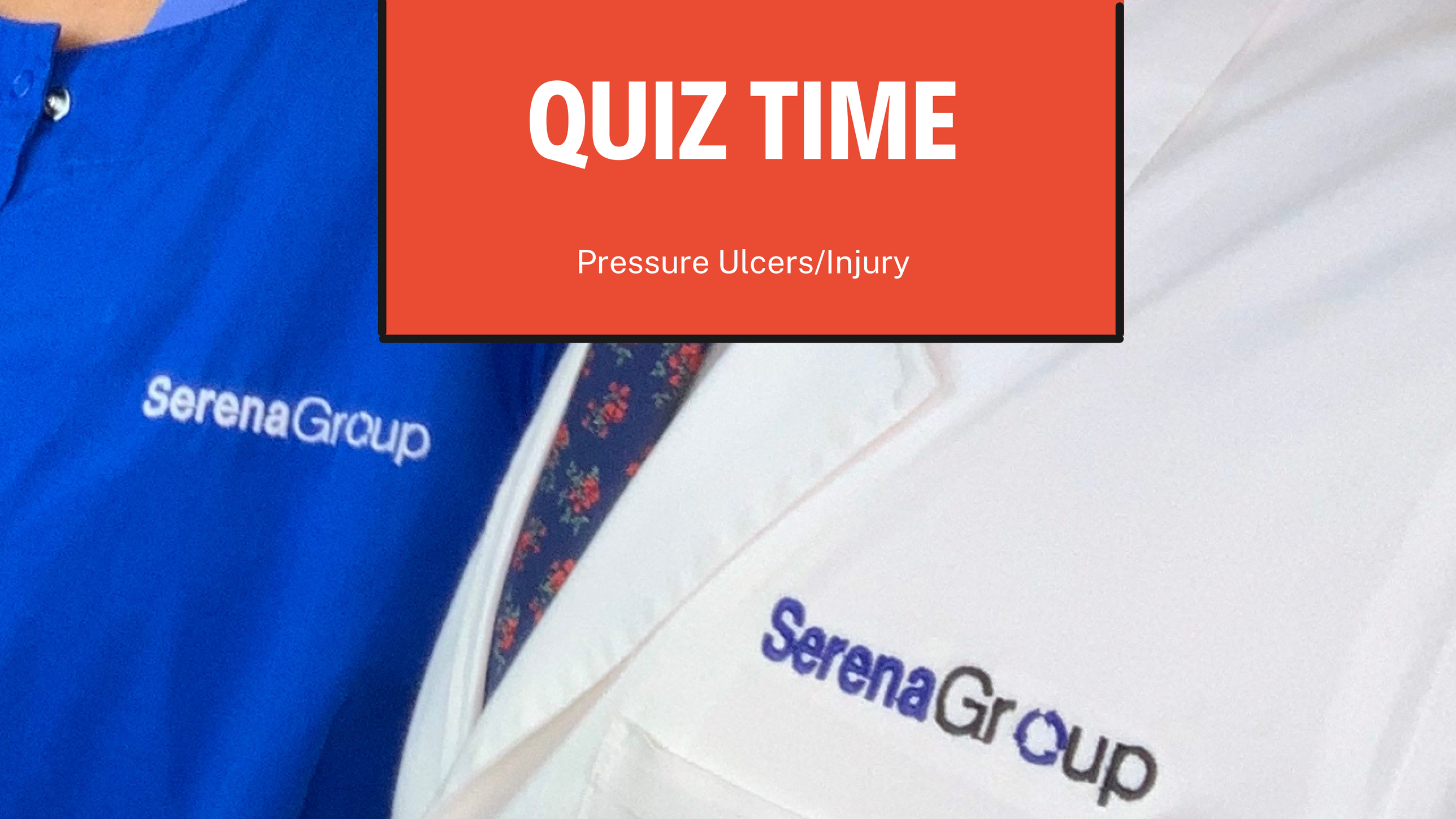
Codes Related



- I89.010 - I89.894

Reference

- The National Pressure Injury Advisory Panel. Pressure injury states. www.npiap.com.2016.
- Edsberg, L. E., Black, J. M., Goldberg, M., McNichol, L., Moore, L., & Sieggreen, M. (2016). Revised National Pressure Ulcer Advisory Panel Pressure Injury Staging System: Revised Pressure Injury Staging System. J Wound Ostomy Continence Nurs, 43(6), 585-597. doi:10.1097/won.0000000000000281.


QUIZ TIME
Pressure Ulcers/Injury
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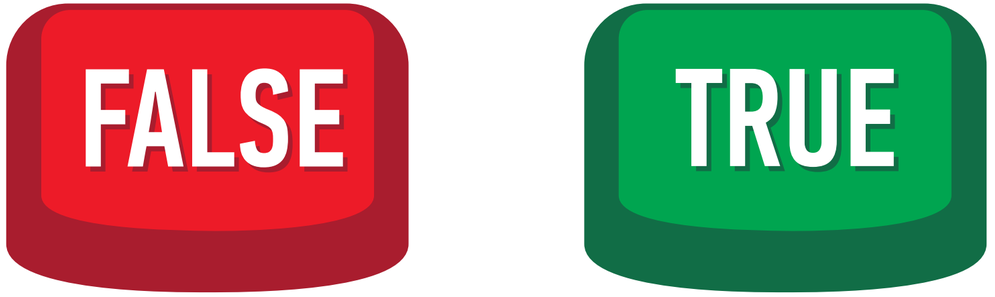
Question 1

Pressure Ulcers/Injury

The definition is a localized injury to the skin or underlying tissue, usually over a bony prominence or related medical or other device, resulting from intense pressure in combination with shear and/or friction (NPIAP & NDNQI).



Answer 1

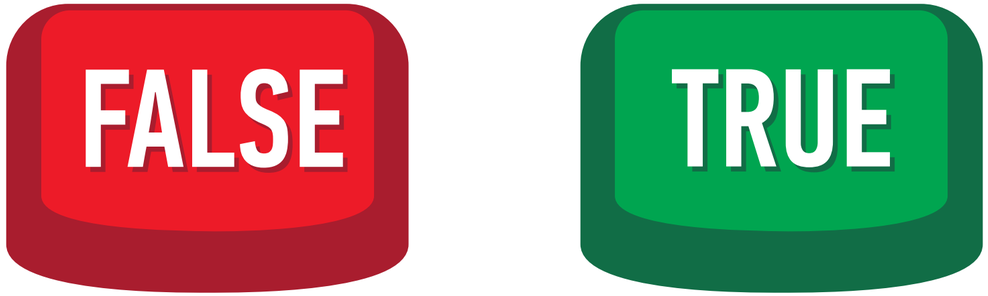
Pressure Ulcers/Injury

The definition is a localized injury to the skin or underlying tissue, usually over a bony prominence or related medical or other device, resulting from intense pressure in combination with shear and/or friction (NPIAP & NDNQI).

Question 2

Pressure Ulcers/Injury

Risks include infection, osteomyelitis, fluid imbalance, protein-calorie malnutrition, and disruption the of the patient's quality of life.



Answer 2

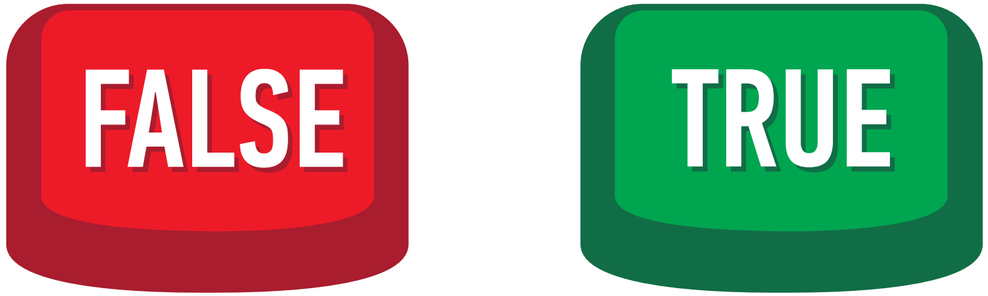
Pressure Ulcers/Injury

Risks include infection, osteomyelitis, fluid imbalance, protein-calorie malnutrition, and disruption the of the patient's quality of life.

Question 3

Pressure Ulcers/Injury

Dressing options must include dry dressings on the ulcer.



Answer 3

Pressure Ulcers/Injury

Proper dressing of the ulcer is a **multilayer compression therapy.**

to maintain proper moisture balance.

Question 4

Pressure Ulcers/Injury

Weekly follow-up through-out treatment.

Answer 4

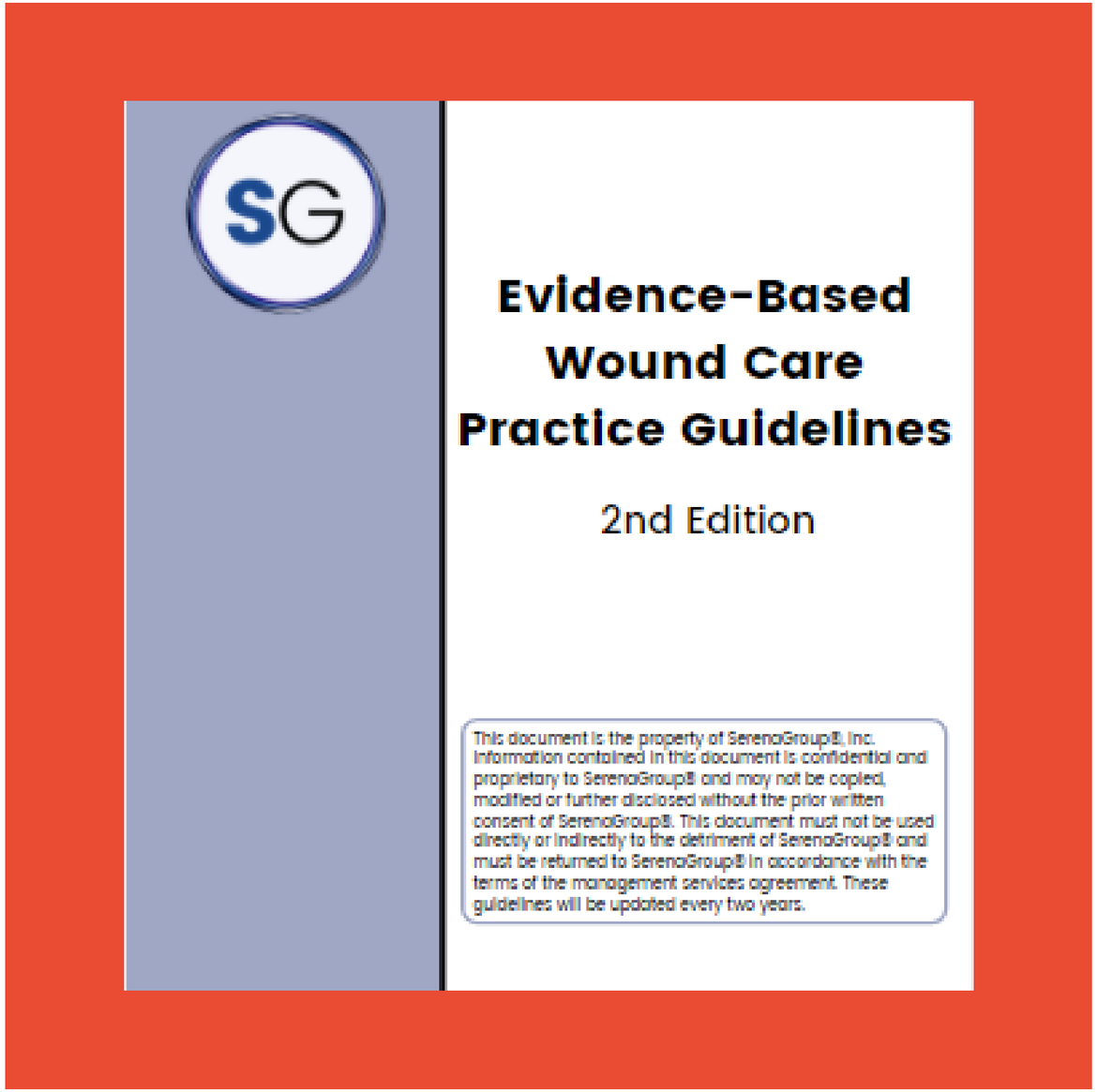
Pressure Ulcers/Injury

Weekly follow-up **through-out treatment**.

Weekly follow-up in the acute phase and then bi-weekly when stabilized. Monthly if palliative in nature.

Reference

To view the SerenaGroup Clinical Practice Disease-Specific Guildelines -- go to www.serenagroupinc.com in the Member's Portal



Thank you!

Nick, Nancy, Ally, Blair and Jill

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SerenaGroup

Building the Nation's Leading Wound Care Team