Assessment and Documentation of Pressure Ulcers

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Training Objectives

• Describe etiologies of pressure ulcers
• Discuss how to properly assess and describe a pressure ulcer
• Demonstrate how to properly document pressure ulcers

Pressure Ulcers

• 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 and/or friction

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Pressure Ulcers

Wounds NOT Caused by Pressure

Other Dermal Injuries
Lower Extremity Wounds

- Arterial insufficiency
- Venous insufficiency
- Peripheral neuropathy/diabetic
- Referred to the F309 tag

Pressure Ulcers

THE EFFECTS OF PRESSURE
Contributing Factors

Contributing factors

SHEAR

Contributing Factors: Shear

Force of Shear

Rolling Effect
Contributing Factors: Shear

Contributing Factors: Friction

Contributing Factors: Friction
ASSESSMENT

• When a pressure ulcer is present, daily monitoring should include:
  – An evaluation of the ulcer, if no dressing present
  – An evaluation of the status of the dressing, if present
  – The presence of complications
  – Whether pain, if present, is being adequately controlled

ASSESSMENT

• Wounds should be assessed/document on a weekly basis, however when there is a complication or change identified daily monitoring/documentation maybe necessary, until resolved. However, the amount of observation of wound bed possible will depend on the dressing that is used (many dressings are meant to stay in place for several days).

  • A clean pressure ulcer with adequate blood supply & innervation should show evidence of stabilization or some healing within 2-4 weeks.

  • Nurse Notes should reflect progress of wound only.

ASSESSMENT

• Date
• Location
• Stage
• Size & Depth
• Wound Base Description
• Undermining & Tunneling
• Drainage
• Wound Edges
• Odor
• S/S of Infection
• Pain
ASSESSMENT
A COMPLETE DATE
(month/day/year)

ASSESSMENT

♦ LOCATION
♦ LOCATION
♦ LOCATION

Wound Bed Assessment

• Describe the tissue in the wound bed using professional terms
  – Necrotic/eschar
  – Slough
  – Granulation
  – Epithelial
Wound Bed Assessment

• Necrotic/eschar tissue – black, brown, or tan tissue

Wound Bed Assessment

• Slough – yellow or white tissue that adheres to the wound bed in strings or thick clumps, or is mucinous

Wound Bed Assessment

• Granulation – pink or beefy red tissue with a shiny, moist, granular appearance
Wound Bed Assessment

- Epithelial Tissue – New skin that is light pink and shiny (even in darkly pigmented skin)

Wound Bed Assessment

- **Describe the tissue present in the wound bed using percentages:**
  - 30% epithelial tissue, 70% granulation tissue
  - Should equal 100%!!!!!

Stage I Pressure Ulcer

- **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; its color may differ from the surrounding area.

  **Further description:**
  The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage I may be difficult to detect in individuals with dark skin tones. May indicate "at risk" persons (a heralding sign of risk)
Stage I Appearance

Suspected Deep Tissue Injury
- Purple or maroon localized discolored, intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue.

Further description:
Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.

Deep Tissue Injury
Stage II

- Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink 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 suspected deep tissue injury

Stage III

- 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.

**Further description:**
- The depth of a stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage III pressure ulcers. Bone/tendon is not visible or directly palpable.
Stage III

• 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.

Further description:
The depth of a stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.

Stage IV

Further description:
The depth of a stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.
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 on the heels serves as "the body's natural (biological) cover" and should not be removed.

**Assessment**

*Unstageable Pressure Ulcer*

*Ulcer NOT stageable until eschar removed*
Name That Stage

Pressure Ulcer Assessment
- Purpose of staging is for consistent communication of depth of tissue destruction
- Once staged, the ulcer should not be back staged, rather the wound should be described in terms of size, shape, color, drainage, and odor using one of the wound assessment measures (www.npuap.com)

Measuring the Open Area
Measure in centimeters
- Use a moistened sterile cotton tip applicator (NS or Sterile water)
- **Length:** longest length from head to toe
- **Width:** Widest width; side-to-side (90-degree angle) to length
- **Depth:** From the visible surface to the deepest area
• For tunneling or undermining, use the clock system with resident’s head at 12 o’clock
• When assessing, always use a moistened cotton swab and insert gently

Assessment
• Wound Drainage
  – Amount
  – Color
  – Consistency

Assessment

Pressure Ulcer Assessment

- Surrounding Skin
  - Erythema
  - Edema
  - Induration
  - Crepitation
  - Pain
  - Warmth
Pressure Ulcer Assessment

- **Odor** if it is present (assess odor only after wound is irrigated)
- **Pain** – nature, frequency and management
- **Signs or symptoms of infection**
- One tool that can be used to monitor changing status of a pressure ulcer is the PUSH tool (www.npuap.org). However, it is not a comprehensive assessment of the wound.

Pressure Ulcers

- **Documentation Tips**
  - Ensure care plan has appropriate goals
  - Only list the type of ulcer and location of it on the care plan (i.e., Pressure ulcer to right trochanter)
  - Once the pressure ulcer heals, ensure it gets listed on the care plan (i.e., history of pressure ulcer to right trochanter)
  - Physician diagnosis and prognosis are appropriate

Resources

- **Available Resources and Web Sites:**
  - [www.wocn.org](http://www.wocn.org) (Wound, Ostomy & Continence Nurse Society)
  - [www.ahrq.gov](http://www.ahrq.gov) (Agency for Health Care Research and Quality, formerly AHCPR)
  - [www.aawm.org](http://www.aawm.org) (American Academy of Wound Management)
  - [www.npuap.org](http://www.npuap.org) (National Pressure Ulcer Advisory Panel)
  - [www.woundsource.com](http://www.woundsource.com) (Great source to find wound care products)
Thanks for your participation!!!

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