ETIOLOGY OF PRESSURE ULCERS

Pressure Ulcer — 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.

PREDISPOSING FACTORS

Extrinsic Factors
1. Pressure
2. Shear
3. Friction
4. Moisture
5. Level of care
   - Inappropriate positioning
   - Poor lifting/handling techniques
   - Massage

Intrinsic Factors
1. Nutritional state
2. Mental status
3. Incontinence
4. Disease state
5. Mobility
6. Body type/weight
7. Age

PREVENTION AND TREATMENT STRATEGIES

Pressure Ulcer Prevention Points Related to Risk Assessment

1. Consider all bed or chair-bound persons, or those unable to reposition
2. Select a method of risk assessment interventions and outcomes
3. Assess on admission and at regular intervals
4. Identify all individual risk factors
5. Monitor and document

Prevention and Strategy Intervention

1. Pressure reduction
2. Maintenance of clean, intact skin
3. Nutritional evaluation and supplementation
4. Promotion of patient movement
5. Education of patient and family

Physical Lifting and Turning Regimens

1. Reposition bed-bound persons at least q2h, chair-bound q1h
2. Use positioning devices such as pillows or foam wedges
3. Written repositioning schedule
4. Donut-type devices should not be utilized
5. Use assistive devices when lifting patient
6. Total relief of pressure on heels

STAGING OF PRESSURE ULCERS

The staging of pressure ulcers defines their depth and level of tissue involvement.
Classification Strategy Consistent with NPUAP and WOCN

1. Deep Tissue Injury: Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear.

2. 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.
3. Stage II:	Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.
4. 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.
5. Stage IV:	Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.
6. 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.

Staging definitions recognize the following limitations:

1. Assessment of Stage I pressure ulcers may be difficult in patients with darkly pigmented skin.

2. When eschar is present, accurate staging of the pressure ulcer is not possible until the eschar has sloughed or the wound has been debrided.

<u>Assess Ulcer</u>

- Location
- Stage
- Size (length, width, depth)
- Sinus tracts/tunnels/undermining
- Exudate – type/amount
- Wound base – clean, granulated, eschar, slough
- Surrounding skin
- Phase of wound healing
- Signs/symptoms of infection
- Pain

<u>Note and Document</u>

- Surrounding tissue
- Color
- Exudate
- Undermining
- Wound edge
- Sinus tracts
- Odor

<u>Wound Color Classification</u>

1. Red wound – considered to be a new or clean wound that is healing
2. Yellow wound – some exudate and possible infection
3. Black wound – dead necrotic tissue