##### **Definitions**

1. **Background**

**February 2007** - The National Pressure Ulcer Advisory Panel has redefined the definition of a pressure ulcer and the stages of pressure ulcers, including the original 4 stages and adding 2 stages on deep tissue injury and unstageable pressure ulcers. The definitions were refined by the NPUAP with input from an on-line evaluation of their face validity, accuracy clarity, succinctness, utility, and discrimination. "NPUAP is pleased to have completed this important task and look forward to the inclusion of these definitions into practice, education and research", said Joyce Black, NPUAP President and Chairperson of the Staging Task Force.

1. **Pressure Ulcer Definition**  
   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. A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated.
2. **Pressure Ulcer Stages**
   1. **Suspected 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. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.
      1. **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.
   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.
      1. **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)
   3. **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.
      1. **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

* 1. **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.
     1. **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.
  2. **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 include undermining and tunneling.
     1. **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.
  3. **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.
  4. **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.

##### **Procedure**

1. Assessment
   1. Skin condition will be observed and documented using the pressure ulcer risk assessment tool and the admission skin assessment
      1. The pressure ulcer risk assessment will be conducted on each resident:
         1. Upon admission
         2. Weekly for the first four weeks after admission for each resident

that scores low to moderately high

* + - 1. Quarterly
      2. When there is a change in cognition
      3. When there is an acute illness that changes the resident’s functional ability
      4. When transferred and/or discharged
  1. At least daily staff will observe and report potential and actual changes in skin condition
  2. Skin condition will be observed and reported by the nurse or nursing assistant with every bath
  3. Weekly skin condition evaluations are to be done and will assess skin color, moisture, temperature, integrity and turgor
  4. Dark Skinned Residents: When assessing skin condition, it is particularly important to assess for the presence of bogginess, mushiness, induration, coolness, increased warmth, discoloration

1. Nutrition and Hydration
   1. Monitor weight stability at least monthly
   2. Nutritional goals will be established upon admission
   3. Unless contraindicated, protein intake (for residents with nutritional compromise who have a pressure ulcer and for those at risk of developing pressure ulcers) should be approximately 1.2-1.5 gm/kg body weight daily. The higher end of the range should be used for those with larger, more extensive or multiple wounds.
   4. Albumin, pre-albumin and cholesterol may be useful to help establish overall prognosis; however, they may not correlate well with clinical observation of nutritional status.
      1. A practitioner may order test(s) that provide useful additional information or help with management of treatable conditions
   5. Except for residents that have fluid restrictions based on physician’s orders, the following guideline will be used to determine baseline daily fluid needs: Multiply the resident’s body weight in kilograms (kg: 2.2 lbs = 1 kg) X 30 ml
   6. Establish with interdisciplinary team ways to minimize clinically significant fluctuations of blood glucose
2. Bowel and Bladder Incontinence
   1. Based on clinical evidence and review of presenting risk factors, differentiate between incontinence dermatitis and pressure ulcers
      1. Perineal dermatitis may appear as a diffuse area of erythema or discoloration where urine and stool has come into contact with skin
         1. Dermatitis typically presents as intense erythema, scaling itching, papules, weeping and eruptions
      2. Dermatitis may occur in the area where the incontinence brief or under pad has been used
3. Interventions
   1. Based upon the assessment and the resident’s clinical condition, choices and identified needs, basic and routine care should include interventions to:
      1. Redistribute pressure (repositioning, heel protectors, etc.)
      2. Minimize exposure to moisture and keep skin clean
      3. Provide appropriate pressure redistributing support surfaces
      4. Provide non-irritating surfaces
      5. Maintain or improve nutrition and/or hydration status
   2. To the extent possible, avoid positioning the resident on an existing pressure ulcer
   3. For a dependent resident, reposition at least every two hours
      1. More frequent positioning may be warranted for individuals who are at higher risk for pressure ulcer development or who show evidence (e.g., Stage I pressure ulcers) that repositioning at 2 hour intervals is inadequate
   4. Teachable residents should be taught to shift his/her weight approximately every 15 minutes while sitting in a chair
   5. Mattresses will be pressure reducing.
   6. Static pressure redistribution devices (e.g., solid foam, convoluted foam, gel mattresses) may be indicated when a resident is at risk for pressure ulcer development or delayed healing. The use of these devices does not eliminate the necessity for periodic repositioning.
   7. Dynamic pressure reduction surfaces may be helpful when:
      1. The resident cannot assume a variety of positions without bearing weight on the pressure ulcer
      2. The resident completely compresses a static device that has retained its original integrity
      3. The pressure ulcer is not healing as expected and it is determined that further pressure relief is indicated
   8. Donuts are contraindicated for relieving pressure
   9. To provide comfort and to reduce sheering force, products such as sheepskin and heel and elbow protectors may be indicated
   10. The resident, family member and/or responsible party will be invited to participate in the care planning process
   11. If a resident refuses treatment and/or interventions the resident will be offered counseling on alternative options and/or consequences
4. Assessment of Pressure Ulcers
   1. Assessment of the ulcer itself will include
      1. The type of ulcer (pressure, versus non-pressure)
      2. The ulcer’s stage
      3. Ulcer’s characteristics
      4. Progress toward healing and potential complications
      5. Presence of infection
      6. Presence and treatment of pain
      7. Presence and type of dressing and treatment
   2. With each dressing change or at least weekly an evaluation of the pressure ulcer wound will be documented. The documentation will include:
      1. Location, staging and date observed
      2. Measurements
         1. No matter the shape of the ulcer size is measured according to the following: length is measured head to toe along the body axis, width is measure side to side
         2. Depth is measured once at the deepest point
         3. Location and extent (if applicable) of any undermining or tunneling/sinus tract
      3. Color, odor and amount of exudate if present
      4. Pain if present
      5. Wound bed: color, type of tissue including evidence of healing (granulation tissue, pink, beefy red, etc.) or necrosis
      6. Description of wound edges (peri-wound) and surrounding tissue
5. Dressings and Treatments
   1. When doing wound care, clean technique is appropriate unless otherwise ordered
   2. If a pressure ulcer fails to show some evidence of healing within 2-4 weeks, the treatment will be re-evaluated for appropriateness
6. Unavoidable Pressure Ulcers
   1. Unavoidable pressure ulcers occur when the facility has taken the following steps:
      1. Evaluated the clinical condition and risk factors
      2. Defined and implemented interventions
      3. Monitored and evaluated the impact of the interventions
      4. Revised the approaches as appropriate