

REST HAVEN - YORK

PRESSURE ULCER PROTOCOL

Prevention & Early Intervention

Goal:

To identify residents at risk for pressure ulcers
To create an environment to promote the prevention
of pressure ulcers

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. (NPUAP 2007)

Since timely intervention for pressure ulcers is important, staff nurses may initiate treatment based on the Rest Haven Pressure Ulcer Protocol and then notify the Wound Care Manager or Treatment Nurse on day shift for follow-up.

1. Licensed nursing staff perform pressure ulcer risk assessment on all newly admitted residents using the **Braden Scale – For Predicting Pressure Sore Risk** form (Briggs Form 3166P); then weekly for the first four weeks; quarterly with the MDS; and whenever there is a significant change in a resident's status (RNAC Office to alert the Wound Care Manager of any significant changes). In addition, the **Pressure Ulcer Risk Factor** form is completed on admission quarterly with the MDS; and whenever there is a significant change in a resident's status.
2. Residents who are at risk for pressure ulcers (Braden scores of 18 or less) should be turned and repositioned for pressure redistribution at least every two hours. All staff (RNs, LPNs, CNAs, PTs, PTAs, OTs, etc.) participate in repositioning residents who are at risk for breakdown at least every two hours.

3. Licensed nursing staff assure that residents who are at risk for breakdown (Braden scores of 18 or less) are on pressure redistribution surfaces and have other preventive devices PRN.
4. Licensed nursing staff select pressure redistribution devices as appropriate for an individual resident, such as:

- Floating Heels on pillows
- Heel protectors
- Heel elevators
- Chair or wheelchair cushions
- Mattress overlays
- Elbow protectors
- Skin sleeves

5. For residents who are incontinent of urine, stool or both, licensed nursing staff initiate the Incontinence-Related Skin Care protocol as necessary.
6. Licensed nursing staff obtain preventive nutritional or therapy consults (physical or occupational) as needed.

Documentation:

1. Licensed nursing staff write pressure ulcer prevention – early intervention orders on order sheet “per protocol” and sign
2. Licensed nursing staff complete the **Skin/Wound Reporting Form** PRN
3. Licensed nursing staff initiate the **Skin/Wound Documentation Form** and place on the treatment kardex PRN

The Rest Haven Pressure Ulcer Protocol is based on the AHCPR CPGs for Pressure Ulcers (1992, 1994) and the 2008 AMDA CPG on Pressure Ulcers.

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STAGE 1

Stage 1:

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. (NPUAP 2007)

The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage 1 may be difficult to detect in individuals with dark skin tones. May indicate "at risk" persons (a heralding sign of risk). (NPUAP 2007)

Select the appropriate interventions from the six columns below. Protocols may be individualized for a resident by order of the attending or consulting physician. Since timely intervention for pressure ulcers is important, staff nurses may initiate treatment and then notify the Wound Care Manager or Treatment Nurse on day shift for follow-up.

Pressure Redistribution	Topical Treatment Options	Labs	Therapy Consult	Nutritional Intervention	Vitamin Intervention
Pressure reducing mattress Pressure reducing mattress overlay if appropriate Repositioning schedule If heels red, irritated or painful, float heels, use heel protectors or heel elevators If out of bed in chair or wheelchair, chair cushion if appropriate	Skin Sealant -or- Transparent Film -or- Cream -or- Ointment	None	Not routine for stage 1 - only by special request	<u>Orally Fed:</u> No Registered Dietician (RD) Assessment. Diet as ordered by physician. - weights twice monthly <u>Enteral Feeding:</u> RD Assessment with enteral feeding as ordered by Physician	<u>Orally Fed</u> MVI with minerals daily <u>Enteral Feeding:</u> None

Notes:

Assess ulcers and review protocols at least weekly.

Do not massage reddened areas.

Initiate the incontinence protocol if a resident is incontinent of urine, stool or both.

Documentation:

1. Licensed nursing staff write orders on order sheet "per protocol" and sign
2. Licensed nursing staff complete the **Skin/Wound Reporting Form**
3. Licensed nursing staff initiate the **Skin/Wound Documentation Form** and place on the treatment kardex
4. Physicians should be notified by FAX of resident's pressure ulcer condition using the **Pressure Ulcer Notification FAX** form.
5. The Wound Care Manager or her designee completes the **Avoidable versus Unavoidable Form** as deemed necessary.

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STAGE 2

Stage 2:

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. (NPUAP 2007)

Presents as a shiny or dry shallow ulcer without slough or bruising (Bruising indicates suspected deep tissue injury). This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. (NPUAP 2007)

Select the appropriate interventions from the six columns below. Protocols may be individualized for a resident by order of the attending or consulting physician. Since timely intervention for pressure ulcers is important, staff nurses may initiate treatment and then notify the Wound Care Manager or Treatment Nurse on day shift for follow-up.

Pressure Reduction/ Relief	Topical Treatment Options	Labs	Therapy Consult	Nutritional Intervention	Vitamin Intervention
Pressure reducing replacement mattress Pressure relieving mattress overlay if appropriate Repositioning schedule If heels broken down, float heels, use heel protectors or heel elevators If out of bed in chair or wheelchair, chair cushion if appropriate	Wound Bed Preparation* If signs or symptoms of infection noted, notify Treatment Nurse, Wound Care Manager and/or physician.** Skin Sealant -or- Transparent Film -or- Thin or Regular Hydrocolloid -or-	Pre ALB as determined by RD	Not routine for stage 2 - only by special request	<u>Orally Fed:</u> RD Assessment with diet as ordered by physician. - weights twice monthly <u>Enteral Feeding:</u> RD Assessment with enteral feeding as ordered by physician	<u>Orally Fed</u> MVI with minerals daily Vitamin C 500 mg daily <u>Enteral Feeding:</u> MVI with minerals daily Vitamin C 500 mg daily (if not in feeding)

	Hydrogel -or- Foam -or- Cream -or- Ointment -or-- Combination ***** Antibiotics -or- Antimicrobials -or- Silver -or- Cadexemer Iodine for infected ulcers				
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* Wound bed preparation includes cleansing with normal saline or a non-cytotoxic wound cleanser prior to applying a new dressing and removal of necrotic tissue (slough or eschar), foreign bodies, etc. unless contraindicated.

** Infected pressure ulcers may need special topical and/or systemic treatment.

Notes:

Assess ulcers and review protocols at least weekly.

Initiate the incontinence protocol if a resident is incontinent of urine, stool or both.

Pressure-induced blisters are -by definition - considered to be stage 2 pressure ulcers.

Documentation:

1. Licensed nursing staff write orders on order sheet "per protocol" and sign
2. Licensed nursing staff complete the **Skin/Wound Reporting Form**
3. Licensed nurse staff initiate the **Skin/Wound Documentation Form** and place on the treatment kardex
4. Physicians should be notified by FAX of resident's pressure ulcer condition using the **Pressure Ulcer Notification FAX** form.
5. The Wound Care Manager or her designee completes the **Avoidable versus Unavoidable Form** as deemed necessary.

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STAGE 3

Stage 3:

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. (NPUAP 2007)

The depth of a stage 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage 3 pressure ulcers. Bone/tendon is not visible or directly palpable.

Select the appropriate interventions from the six columns below. Protocols may be individualized for a resident by order of the attending or consulting physician. Since timely intervention for pressure ulcers is important, staff nurses may initiate treatment and then notify the Wound Care Manager or Treatment Nurse on day shift for follow-up.

Pressure Reduction/ Relief	Topical Treatment Options	Labs	Therapy Consult	Nutritional Intervention	Vitamin Intervention
Pressure reducing mattress replacement Pressure reducing mattress overlay if appropriate Repositioning Schedule If heels broken down, float heels, heel protectors or heel elevators If out of bed in chair or wheelchair, chair cushion if appropriate	Wound Bed Preparation* If signs or symptoms of infection noted, notify Treatment Nurse, Wound Care Manager and/or physician.** Transparent Film -or- Thin or Regular Hydrocolloid -or-	Pre ALB	Routine consult	<u>Orally Fed:</u> RD Assessment with diet as ordered by physician. - weights twice monthly <u>Enteral Feeding:</u> RD Assessment with enteral feeding as ordered by physician	<u>Orally Fed</u> MVI with minerals daily Vitamin C 500 mg daily <u>Enteral Feeding:</u> MVI with minerals Daily Vitamin C 500 mg daily (if not in tube feeding)

Hydrogel -or- Foam -or- Cream -or- Ointment -or-- Calcium Alginate -or- Hydrofiber -or- Combination ***** Antibiotics -or- Antimicrobials -or- Silver -or- Cadexemer Iodine for infected ulcers**					

* Wound bed preparation includes cleansing with normal saline or a non-cytotoxic wound cleanser prior to applying a new dressing and removal of necrotic tissue (slough or eschar), foreign bodies, etc. unless contraindicated.

** Infected pressure ulcers may need special topical and/or systemic treatment.

Notes:

Assess ulcers and review protocols at least weekly.

Initiate the incontinence protocol if a resident is incontinent of urine, stool or both.

Documentation:

1. Write orders on order sheet "per protocol" and sign
2. Complete the **Skin/Wound Reporting Form**
3. Initiate the **Skin/Wound Documentation Form** and place on the treatment kardex
4. Physicians should be notified by FAX of resident's pressure ulcer condition using the **Pressure Ulcer Notification FAX** form.
5. The Wound Care Manager or her designee completes the **Avoidable versus Unavoidable Form** as deemed necessary.

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REST HAVEN - YORK PRESSURE ULCER MANAGEMENT

STAGE 4

Stage 4:

Full thickness tissue loss without exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. (NPUAP 2007)

The depth of a stage 4 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 4 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. (NPUAP 2007)

Select the appropriate interventions from the six columns below. Protocols may be individualized for a resident by order of the attending or consulting physician. Since timely intervention for pressure ulcers is important, staff nurses may initiate treatment and then notify the Wound Care Manager or Treatment Nurse on day shift for follow-up.

Pressure Reduction/ Relief	Topical Treatment Options	Labs	Therapy Consult	Nutritional Intervention	Vitamin Intervention
Pressure reducing replacement mattress Pressure reducing mattress overlay if appropriate Repositioning schedule If heels broken down, heel protectors or heel elevators If out of bed in chair or wheelchair, chair cushion if appropriate	Wound Bed Preparation* If signs or symptoms of infection noted, notify Treatment Nurse, Wound Care Manager and/or physician.** Transparent Film -or- Thin or Regular Hydrocolloid -or-	Pre ALB	Routine consult	<u>Orally Fed:</u> RD Assessment with diet as ordered by physician. - weights twice monthly <u>Enteral Feeding:</u> RD Assessment with enteral feeding as ordered by physician	<u>Orally Fed</u> MVI with minerals Daily Vitamin C 500 mg daily Zinc 50 mg daily <u>Enteral Feeding:</u> MVI with minerals Daily Vitamin C 500 mg daily Zinc 50 mg daily (if not in tube feeding)

	Hydrogel -or- Foam -or- Cream -or- Ointment -or-- Calcium Alginate -or- Hydrofiber -or- Combination ***** Antibiotics -or- Antimicrobials -or- Silver -or- Cadexemer Iodine for infected ulcers**				

* Wound bed preparation includes cleansing with normal saline or a non-cytotoxic wound cleanser prior to applying a new dressing and removal of necrotic tissue (slough or eschar), foreign bodies, etc. unless contraindicated.

** Infected pressure ulcers may need special topical and/or systemic treatment.

Notes:

Assess ulcers and review protocols at least weekly.

Initiate the incontinence protocol if a resident is incontinent of urine, stool or both.

Documentation:

1. Write orders on order sheet "per protocol" and sign
2. Complete the **Skin/Wound Reporting Form**
3. Initiate the **Skin/Wound Documentation Form** and place on the treatment kardex
4. Physicians should be notified by FAX of resident's pressure ulcer condition using the **Pressure Ulcer Notification FAX** form.
5. The Wound Care Manager or her designee completes the **Avoidable versus Unavoidable Form** as deemed necessary.

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DEEP TISSUE INJURY (DTI)

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. (NPUAP 2007)

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 [When eschar is present it becomes a Stage 4]. Evolution may be rapid exposing additional layers of tissue even with optimal treatment. (NPUAP 2007)

Select the appropriate interventions from the six columns below. Protocols may be individualized for a resident by order of the attending or consulting physician. Since timely intervention for pressure ulcers is important, staff nurses may initiate treatment and then notify the Wound Care Manager or Treatment Nurse on day shift for follow-up.

Pressure Reduction/ Relief	Topical Treatment Options	Labs	Therapy Consult	Nutritional Intervention	Vitamin Intervention
Pressure reducing mattress replacement Pressure reducing mattress overlay if appropriate Repositioning schedule If heels affected, float heels, heel protectors or heel elevators If out of bed in chair or	Skin Sealant -or- Transparent Film -or- Povidone-Iodine	Pre ALB as determined by RD	Not routine for DTI. Only by special request	<u>Orally Fed:</u> RD Assessment with diet as ordered by MD <u>Enteral Feeding:</u> RD Assessment with diet as ordered by MD	<u>Orally Fed</u> MVI with minerals daily Vitamin C 500 mg daily <u>Enteral Feeding:</u> MVI with minerals Daily Vitamin C 500 mg daily (if not in tube feeding)

wheelchair, chair cushion if appropriate					
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Notes:

Assess ulcers and review protocols at least weekly.

Initiate the incontinence protocol if a resident is incontinent of urine, stool or both.

Documentation:

1. Licensed nursing staff write orders on order sheet "per protocol" and sign
2. Licensed nursing staff complete the **Skin/Wound Reporting Form**
3. Licensed nursing staff initiate the **Skin/Wound Documentation Form** and place on the treatment kardex.
4. Physicians should be notified by FAX of resident's pressure ulcer condition using the **Pressure Ulcer Notification FAX** form.
5. The Wound Care Manager or her designee completes the **Avoidable versus Unavoidable Form** as deemed necessary.

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PALLIATIVE CARE

GOAL:

To provide comfort

To prevent wound deterioration when possible

To prevent infection when possible

Since timely intervention for pressure ulcers is important, staff nurses may initiate treatment and then notify the Wound Care Manager or Treatment Nurse on day shift for follow-up.

1. When a resident is placed on comfort care or hospice, clarify with the hospice nurse & resident's physician that pressure ulcer care is to follow the palliative pressure ulcer care protocol.
2. Provide positioning for comfort and pressure reduction with the use of pillows, bed cradles and other appropriate devices. Consider the use of a group 1 mattress overlay for comfort. Minimize turning if it causes discomfort or pain. Individualize & modify the resident's repositioning schedule as appropriate.
3. Topical antimicrobials (such as povidone iodine, acetic acid, Dakin's Solution) may be used to reduce bioburden and prevent wound infection.
4. Antimicrobial cleansers and odor reducing gravel (kitty litter) placed in a container under the resident's bed (and changed at least weekly) can be used to reduce wound-related odors.
5. For residents who are incontinent of urine, stool or both, initiate the Incontinence Related Skin Care protocol as necessary.
6. Obtain nutritional, physical therapy or occupational therapy consults as appropriate.

Documentation:

1. Licensed nursing staff write orders on order sheet "per protocol" and sign
2. Licensed nursing staff complete the **Skin/Wound Reporting Form** PRN
3. Licensed nursing staff initiate the **Skin/Wound Documentation Form** and place on the treatment kardex PRN.
4. Physicians should be notified by FAX of resident's pressure ulcer condition using the **Pressure Ulcer Notification FAX** form.
5. The Wound Care Manager or her designee completes the **Avoidable versus Unavoidable Form** as deemed necessary.

The Rest Haven Pressure Ulcer Protocol is based on the AHCPR CPGs for Pressure Ulcers (1992, 1994) and the 2008 AMDA CPG on Pressure Ulcers and Palliative Wound Care: Managing Chronic Wounds across Life's Continuum: A Consensus Statement from the International Palliative Wound Care Initiative (2004).