Wound Care 101-
Pressure Wounds

Everything you always needed to know but didn’t want to ask …..

Speakers

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Objectives for Pressure Wounds - Management and Treatments

- Will be able to
- Discuss Pressure Wound Etiology
- Describe the Classification System for Pressure wound
- Name explain the different Stages in the Classification System
- Name and discuss at least 3 Risk factors
- Name and discuss at least 1 Prevention Assessment Tool
- Name and discuss at least 5 patients pressure points
- Name and discuss at least 1 Tool used to identify if the Wound is healing
- Name and discuss Interventions you will do
- Name and discuss at least 1 medical and 1 Surgical Interventions
Pressure Wounds- Management and Treatments
Pressure Wound Etiology

Pressure
- Any wound caused by unrelieved pressure or a combination of pressure and shear forces.

History of Names
- Bed Sore thought cause was prolonged time in bed
- Decubitus - (Latin) lying down

We now know a pressure ulcer
- can happen in less than 2 hrs.
- The patient in bed.
- Patient NOT in bed from devices on patient that do not fit correctly… boots, casts, splints
- Inverse relationship of pressure and time
  - Higher pressure – decrease time – ulcer
  - Lower pressure - longer amt of time - ulcer
Pressure Wounds  Risk Factors

Main Risk Factors
- Pressure and time
- Shear
- Moisture
- Impaired Mobility
- Malnutrition

Other Risk Factors
- Decreased Sensation
- Age of patient
- History of Pressure Ulcers
- More risk factors a patient has the higher chance they may get a pressure ulcer
Prevention of Pressure Wounds –
Assessment Tools

- Tools that predict what patient may develop a pressure wound
  - Braden Scale
  - Norton Scale
  - Gosnell Scale
Pressure Wounds are Staged

1994 the Staging Classification System used was from Shea’s System from 1975.

2009 the EPUAP (European Pressure Ulcer Advisory Panel) and the NPUAP (National Pressure Ulcer Advisory Panel) are the Organization that work to develop and define the Classification System for pressure ulcers we use today

– Each Stage has a definition that describes the depth of skin or tissue destruction involved.
– Depending on the amount of necrotic tissue present it may be staged or non-stagable.
Pressure Ulcers:

NATIONAL PRESSURE ULCER ADVISORY PANEL
Stage I Pressure Ulcer Definition

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.
Stage I 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)
Deep Tissue Injury Definition

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.
Deep Tissue Injury Description

- The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.
- 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.
Stage II Definition

- 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.
Stage II 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.
Stage III Definition

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.
Stage III 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 IV Definition

- 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.
Stage IV 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 Definition

- 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.
Unstageable 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.
NAPUAP Position Statement

- Reverse staging should not be used to describe the healing of pressure ulcers
- The body is unable to regenerate certain tissues (fat, fascia, muscle), therefore, reverse staging is inaccurate when used as a parameter for wound healing
Pressure points
Pressure Ulcer Tools for Assessment for Wound Healing

These tools identify changes in the wound to see if wound is healing.

- Sessing Scale
- BWAT Bates-Jensen Wound Assessment
- PUSH Tool- Pressure Ulcer Scale for Healing
Interventions

- Team approach
  - Coordination,
  - Communication
- Documentation
- Education with the Patient and caregiver
- Wound Care

Devices for Pressure – reduction and Pressure – relieving.
  - Beds,
  - Seat cushions

Therapeutic Exercises
  - Strengthening, Gait training and Flexibility
Medical and Surgical Intervention

Medical Testing
- Infection
- Nutrition

Surgical
- Debridement
- Musculocutaneous Flaps
Case Study – Pressure Ulcer
What would you do?
Questions
References

- Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline. EPUAP, NPUAP, Pan Pacific. 2014