

WOUND CARE FOR PHYSICIANS

Documentation and Treatment of Pressure Ulcers

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Why should we care?

- Professional Responsibility
- Liability/Litigation
 - \$\$ Awarded
- Future Regulations
 - You caused it, you heal it!
 - Treating one FT Pressure ulcer as high as \$70,000.

New Regulations

- Wound and skin care will be under the microscope starting October 2008.
- Under the Medicare Modernization Act Medicare has become an active payer and now will not pay for what they consider poor quality of care.
- IHI (Institute for Healthcare Improvement) has identified Pressure Ulcers as a key initiative.

P.O.A. Regulations

- Under the new regulations starting October 2008 we must document a pressure ulcer on admission if we want to get paid for the care of that wound.
- We will not be paid for pressure ulcers if they are not documented. At this time it is the responsibility of the physician to document the presence of a pressure ulcer.

Pressure Ulcer

- Definition: Localized areas of tissue necrosis that tends to develop when soft tissue is compressed between a bony prominence and external surface for a prolonged period of time.

Why over a bony prominence?

Blood supply is most easily cut off over a bony prominence because the pressure is compressing the tissue between the outside surface and the bone.

Staging of pressure ulcers

- Staging is an assessment system that classifies pressure ulcers based on tissue damage.

What is not a pressure ulcer?

- If the origin is not pressure than it is not a pressure ulcer.
- Wounds that are not pressure ulcers include:
 - Arterial ulcers
 - Venous ulcers
 - Diabetic ulcers
 - Surgical wounds
- Do not stage these wounds, use PT and FT.

Partial Thickness and Full Thickness

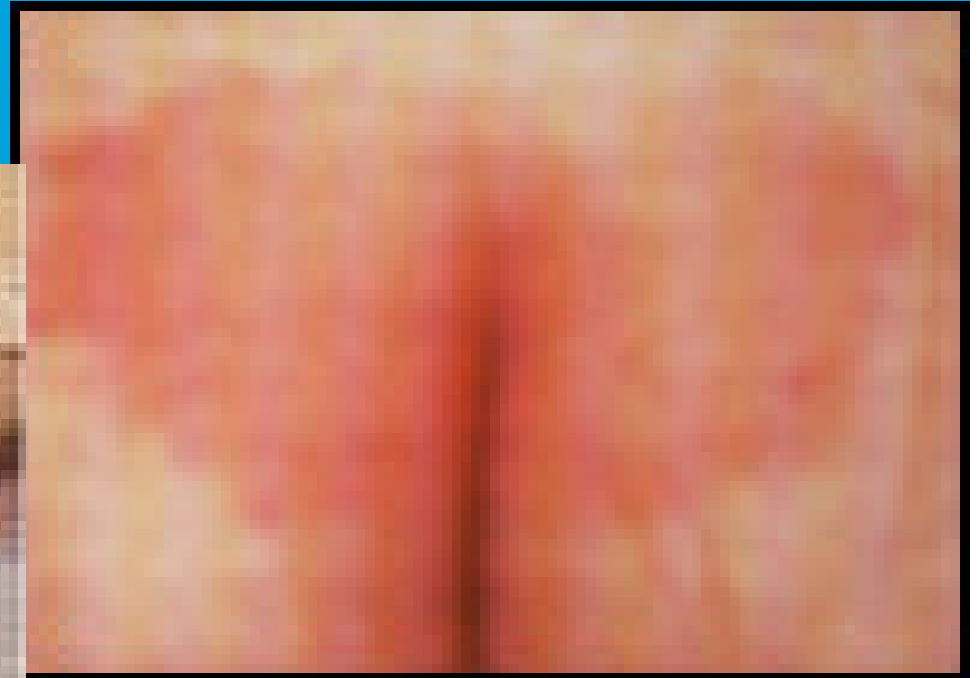
- Use Partial thickness for damage to epidermis and dermis.
- Use Full Thickness for wounds affecting subcutaneous level and below.

Staging of Pressure Ulcers

- National pressure ulcer advisory panel revised guidelines February 2007
- Includes original 4 stages and adding 2 stages for Deep Tissue Injury and Unstageable Ulcers

Stage I

- Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Pigmented skin may not have visible blanching; its color may differ from the surrounding area. Area may be painful, firm, soft, warmer or cooler than adjacent tissue.



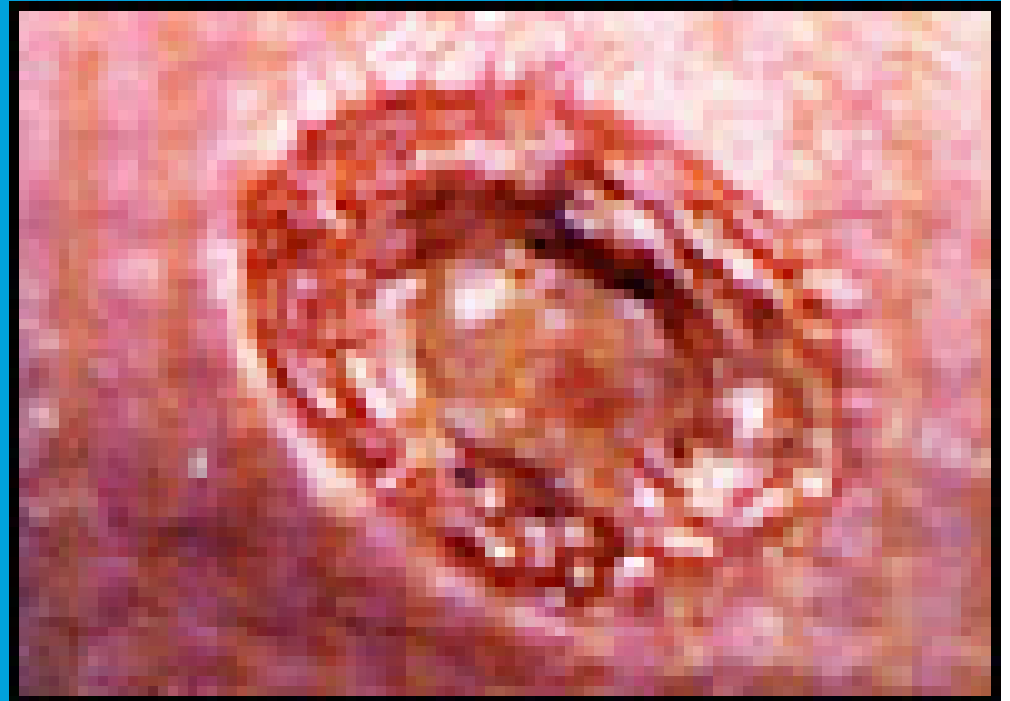
Stage II

- Partial thickness loss of dermis. Red/pink wound bed- No slough- No bruising
- What is not a stage II? Skin tears,tape burns,perineal dermatitis, maceration and excoriation.
- Stage II's do not have slough—EVER



Stage III

- Full thickness tissue loss. Subcutaneous fat may be visible. No bone, tendon or muscle are exposed
- Slough may be present, but does not obscure the depth of tissue loss. May include undermining and tunneling.



Stage IV

- Full thickness tissue loss with exposed or palpable bone, tendon or muscle. Slough or eschar may be present in some parts of the wound. High possibility of osteomyelitis with exposed bone.



Unstageable

- Base of ulcer is covered by slough (yellow, tan, gray, green or black).
- Dry adherent eschar such as what develops on heels is the body's defensive covering and we leave it alone.



Deep Tissue Injury

- Purple or maroon area of discolored intact skin or blood blister. Could be a thin blister over a dark wound bed.
- DTI is due to damage of underlying soft tissue from pressure and or shear.



Non- Pressure Etiologies

- LEAD (Lower extremity Arterial Disease)
- LEVD (Lower extremity Vascular Disease)
- Surgical
- Inflammatory Conditions
- Neuropathic
- Incontinence
- Friction and Shear
- Skin Tears





Interventions

Rationale #1:

Dressings should be chosen for their ability to manage the amount of drainage exuded by the wound.

i.e., absorb excess drainage in a heavily exuding wound,

or

contribute moisture in a scantily exuding wound

Wounds with Depth

Rationale #2

Wounds with depth exhibit better healing when

lightly filled (not packed)

with dressing material.

Wet Wounds

Alginate (i.e., Curasorb, Aquacel Ag)
Derived from Seaweed

- Direct wound contact
- Soft texture will not traumatize wound
- Moderate to heavily exudating wounds
- Depending upon the brand, this product may turn into a gel that is washed out of the wound or remain intact for removal as one piece
- Can desiccate (overly dry) tissues in wounds with less exudate
- Dressing frequency = BID to 1-3 days (depending on amount of exudate)
- **Not for dry wounds**

Dry Wounds

Hydrogel (i.e., Curafil Gel)
Donates moisture

- 2 forms:
 - Amorphous (Curafil gel - squeeze from a tube)
- Hydrates wounds that are too dry (promotes moist wound healing)
- Can promote autolytic debridement
- Not for heavily exuding wounds

Non-Adhering Dressing

- Good for Partial thickness wounds that are dry. This dressing adds moisture.
- Good for skin tears!!



Mepilex

- New Product at Presby! Handles fluid, protects and comes off easily. Can be used up to 7 days! Order from the storeroom.



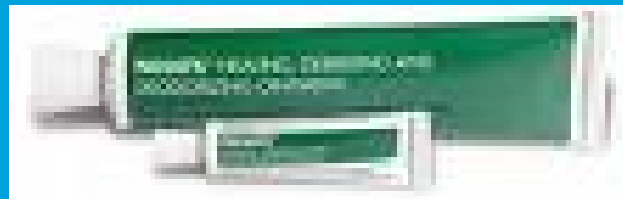
Xenaderm

- Ingredients: Balsam Peru, Castor oil, Trypsin USP
- Promotes healing, increases blood flow, Improves epithelialization, protective coating, reduction of pain
- Good for PT and stage II
- Literature indicates it is the best treatment for Deep tissue injury.

Enzymatic Debridement

- Chemical, Surgical, Autolytic
- Accuzyme, Panafil, Santyl

Reconsult when debrided

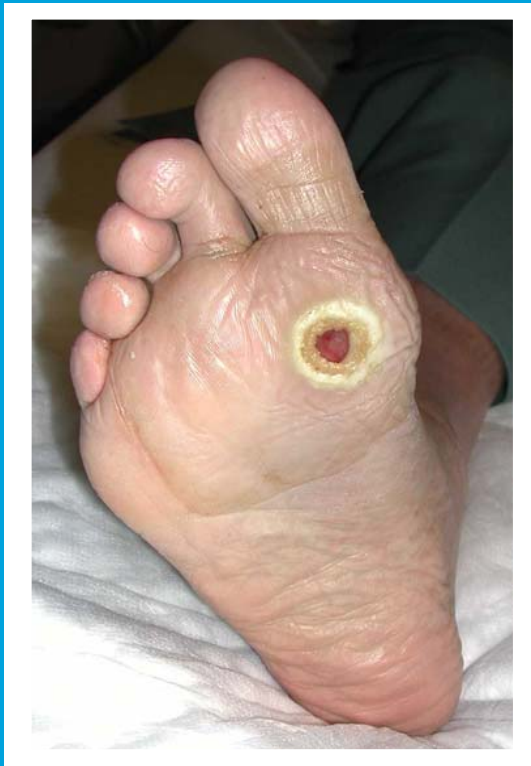


















Sources

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