

LTC Pressure Ulcer (PrU) Management & Documentation

Document in the Resident's record evidence of the following within the **First 24 Hours** of Admission/Readmission:

- Comprehensive skin assessment performed
- Evaluation and staging for each existing pressure ulcer
- History of previous pressure ulcers
- Completion of a validated risk assessment tool (Braden, Norton, Norton Plus)
- Determination of risk status based on the results of the risk assessment
- If determined to be at risk; development of a plan of care that includes interventions for each identified risk factor
- Treatment plan consistent with current professional standards initiated for each existing pressure ulcer

**** A treatment plan for each pressure ulcer, consistent with current professional standards must be initiated within 24 hours of admission****

The treatment plan may include, but is not limited to the following:

- A repositioning plan
- Activities
- Dressings and wound treatments
- Nutritional support
- Moisture and incontinence management
- Pain management
- Support surfaces (bed and chair)

Pressure Ulcer Stages

Suspected Deep Tissue Injury (DTI): 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 skin.

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.

Stage II: Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer bed, without slough. May also present as an intact or open/ruptured serum-filled blister.

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 the tissue loss. May include undermining or tunneling.

Stage IV: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the ulcer bed. Often includes undermining or tunneling.

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 ulcer bed.

National Pressure Ulcer Advisory Panel, 2007.
Refer to www.npuap.org for further description and illustrations.

**** Any of the following indicates the resident is "At Risk" for a pressure ulcer:**

- Braden score of 18 or less
- Norton score of 14 or less
- Norton Plus score of 15 or less
- History of pressure ulcer
- Current ulcer
- Impaired bed/chair mobility
- Bladder/bowel incontinence and/or moisture
- Impaired nutritional status
- Impaired functional status

Plan of care incorporating interventions for each identified risk factor must be implemented within 24 hrs of admission.

Pressure Ulcer Evaluation and Documentation

Although no consensus exists on documentation content, most recommendations include the following components:

- Type of ulcer, how long present, and in what setting did it occur
- Size of ulcer (in centimeters, length x width x depth)
- Stage of ulcer
- Location of ulcer
- Epithelialization
- Presence or absence of exudate (describe if present)
- Presence or absence of odor in the wound (after cleaning)
- Presence or absence of granulation tissue
- Presence or absence of eschar or necrotic tissue
- Description of periwound tissues (macerated, inflamed, viable)
- Evidence of wound undermining, tunneling, or sinus tracts
- Evidence that wound has improved by or before end of 4th week
- If no improvement, treatment plan modified, or justification for continuing current plan
- Evidence that treatment plan for each ulcer was implemented as written

Skin Assessment Components

D	Describe Integrity
E	Edema
R	Review Sensory Status
M	Moisture
A	Atrophic Changes
T	Turgor/Texture
O	Observe Nail Composition/Hair Quality
L	Look & Feel Color and Temp Variations
O	Observe Skin Folds
G	Gerontodermatological Changes
I	Inquire about Allergies and PMH
C	Callus
A	Assess Vascular Status
L	Lesions (rashes, scars, bruising, hemosiderin, nevi, etc.)

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F314 Surveyor Guidance: Monitoring Considerations

Daily Monitoring:

- Evaluate ulcer if no dressing is present
- Evaluate status of dressing if present (draining, leaking, intact)
- Status of skin area surrounding ulcer
- Presence/indication of possible complications
- Evaluate whether pain; if present, is adequately controlled
- Document when a change or complication is identified

Weekly or Dressing Change Monitoring:

- Location and staging of ulcer
- Size, depth, location, & any undermining, tunneling, or sinus tract
- Presence of exudate, and type if present
- Presence of pain (use WILDA assessment)
- Status of wound bed, color, and type of tissue; evidence of healing or necrosis
- Description of wound edges and surrounding tissue