Assessment & Documentation of Pressure Injuries

Presented by

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The New Terminology and the MDS

• National Pressure Ulcer Advisory Panel (NPUAP) Updated Terminology and definitions April 2016
• NPUAP Definition August 2016 Press Release:
  • “CMS has been in discussions with the NPUAP to incorporate the new terminology. The rollout of the changes will be controlled by these agencies”
• Continue to follow MDS instructions – providers may continue previous definitions to fit MDS terminology or they may adapt the new terminology. Essentially the stages are the same just clarified definitions.
The Definition of Pressure Injuries

• National Pressure Ulcer Advisory Panel (NPUAP) Definition April 2016:

• A pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue.
The Definition of Medical Device Related Pressure Injury

• National Pressure Ulcer Advisory Panel (NPUAP) Definition April 2016:
  • This describes the etiology of the injury. Medical device related pressure injuries result from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure injury generally conforms to the pattern or shape of the device. The injury should be staged using the staging system.
The Definition of Mucosal Membrane Pressure Injury

• National Pressure Ulcer Advisory Panel (NPUAP) Definition April 2016:

  • Mucosal membrane pressure injury is found on mucous membranes with a history of a medical device in use at the location of the injury. Due to the anatomy of the tissue these injuries cannot be staged
The Etiology of Pressure Injuries

• Ischemia as a result of sustained deformation of soft tissues will lead to hypoxia, blocking of nutrient supply, and blocking of the removal of waste products. Deprivation of nutrients and change in pH due to waste products will eventually lead to tissue damage (NPUAP, 2014, p.21)
The Etiology of Pressure Injuries

• The duration of time for which tissue cells can endure the ischemia without damage differ for muscle, fat, and skin. Muscle tissues are more susceptible to damage than skin tissues.

• Skin is much stiffer than muscle and fat therefore deforms to a lesser degree in most clinical applications
  • NPUAP, 2014, p.21
Pressure Injuries
The Etiology of Pressure Injuries

- Lower thresholds of pressure and deformation can take a longer period of time before tissue damage occurs.
- Higher pressure and deformation strains at higher than 50% will almost immediately (within minutes) lead to tissue damage at the microscopic scale.
- Reperfusion that follows a period of prolonged ischemia may increase the degree of tissue damage because it involves release of harmful oxygen free radicals.

  - NPUAP, 2014, p.21
Contributing factors: Microclimate

- An increasing body of evidence suggests that the microclimate between skin and the supporting surface plays a role in the development of Stage 1 and 2 pressure injuries (NPUAP, 2014, p.21)
  - Microclimate is the humidly and temperature
  - Increased humidity and temperature can cause the skin to become weaker and less stiff
  - Excessively dry skin becomes more brittle and liable to break
Pressure Injuries
Contributing Factors: Shear (deformation of tissue)
Contributing Factors: Shear (deformation of tissue)
Moisture Associated Skin Damage (MASD), Secondary to incontinence or perspiration is NOT a pressure injury
Assessment

• **GOAL of Assessment:**
  – To determine the progress of the wound
  – To determine the appropriate topical management and overall interventions
Assessment

• **Wounds should be assessed/documentated at least every 7 days**
  - More frequently if:
    • Complications or
    • Per dressing change

• **A clean pressure injury with adequate blood supply & innervation should show evidence of stabilization or some healing within 2-4 weeks.**

• **Nurse Notes should reflect progress of wound only.**
Assessment

• The weekly wound assessment should be a team effort

• At a minimum the Floor Nurse and the Nurse Manager should be present!!!
Assessment

• **When a pressure injury is present, daily monitoring should include:**
  - An evaluation of the wound, if no dressing present
  - An evaluation of the status of the dressing, if present
  - The presence of complications
  - Whether pain, if present, is being adequately controlled
Comprehensive Assessment

• **ONE WOUND PER ASSESSMENT**
  • Date
  • Location
  • Stage
  • Size & Depth
  • Wound Base Description
  • Undermining & Tunneling
  • Drainage
  • Wound Edges
  • Odor
  • S/S of Infection
  • Pain
Wound Bed Assessment

• Describe the tissue in the wound bed using professional terms
  - Necrotic/eschar
  - Slough
  - Granulation
  - Epithelial
Wound Bed Assessment

• Necrotic/eschar tissue – black, brown, or tan tissue
Wound Bed Assessment

• **Slough** – yellow or white tissue that adheres to the wound bed in strings or thick clumps, or is mucinous
Wound Bed Assessment

• **Granulation** – pink or beefy red tissue with a shiny, moist, granular appearance
Wound Bed Assessment

- Epithelial Tissue – New skin that is light pink and shiny even in darkly pigmented skin
Wound Bed Assessment

- Describe the tissue present in the wound bed using percentages:
  - 10% slough tissue, 90% granulation
  - Should equal 100%!!!!!!
Stage 1 Pressure Injury

- **Stage 1 Pressure Injury: Non-blanchable erythema of intact skin**
  - Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.
Stage 1 Appearance
Deep Tissue Injury

- Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration
  - Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3, or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.
Deep Tissue Injury

• Internal stresses and strains adjacent to bony prominences are substantially higher than those near the surface, and have the potential to cause damage in deep tissues before the superficial tissue is damaged (NPUAP, 2014, p.20)
Deep Tissue Injury
Evolution of a Deep Tissue Pressure Injury
Evolution of a Deep Tissue Pressure Injury
Stage 2 Pressure Injury

• Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis:
  Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSi), or traumatic wounds (skin tears, burns, abrasions).
Stage 2 Appearance
Wound Bed Assessment

- Stage 2 pressure ulcers heal by epithelialization (resurfacing), not granulation, therefore the wound base would be described as pink or red versus granulation tissue (impacts MDS 3.0 coding)
Stage 3 Pressure Injury

• Stage 3 Pressure Injury: Full-thickness skin loss:

Full-thickness loss of skin in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage, and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.
Stage 3 Pressure Injury
Stage 4 Pressure Injury

• Stage 4 Pressure Injury: Full-thickness skin and tissue loss

Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.
Stage 4 Appearance
NPUAP Position Statement (9-27-12)¹

• Although the presence of visible or palpable cartilage at the base of a pressure ulcer was not included in the stage 4 terminology; it is the opinion of the NPUAP that cartilage serves the same anatomical function as bone. Therefore, pressure ulcers that have exposed cartilage should be classified as a Stage 4.
Unstageable Pressure Injury

• **Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss**

Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on an ischemic limb or the heel(s) should not be removed.
Unstageable Appearance
Assessment
Pressure Injury Assessment

• Purpose of staging is for consistent communication of depth of tissue destruction

• Once staged, the injury should not be back staged, rather the wound should be described in terms of size, shape, color, drainage, and odor using one of the wound assessment measures (www.npuap.com)
Measuring the Pressure Injury

**Measure in centimeters**
Use a moistened sterile cotton tip applicator (NS or Sterile water)

**Length:** longest length from head to toe

**Width:** Widest width; side-to-side (90-degree angle) to length

**Depth:** From the visible surface to the deepest area
Assessment

- For tunneling or undermining, use the clock system with resident’s head at 12 o’clock
- When assessing, always use a moistened cotton swab and insert gently
Assessment

• Wound Drainage
  - Amount
  - Color
  - Consistency
Assessment

Pressure Ulcer Assessment

Surrounding Skin
- Erythema
- Edema
- Induration
- Crepitus
- Pain
- Warmth
Pressure Injury Assessment

• Odor if it is present (assess odor only after the dressing is removed and the wound is irrigated)

• Pain – nature, frequency and management

• Signs or symptoms of infection

• Overall Progress (stable, decline, improved or unchanged)
Pressure Injury

• **Documentation Tips**
  – Ensure care plan has appropriate goals
  – Only list the type of ulcer and location of it on the care plan (i.e., Pressure injury to right trochanter)
  – Once the pressure injury heals, ensure it gets listed on the care plan (i.e., history of pressure injury to right trochanter)
  – Physician diagnosis and prognosis are appropriate
Available Resources and Web Sites:

- [www.wocn.org](http://www.wocn.org) (Wound, Ostomy & Continence Nurse Society)
- [www.ahrq.gov](http://www.ahrq.gov) (Agency for Health Care Research and Quality, formally AHCPR)
- [www.aawm.org](http://www.aawm.org) (American Academy of Wound Management)
- [www.npuap.org](http://www.npuap.org) (National Pressure Ulcer Advisory Panel)
- [www.woundsource.com](http://www.woundsource.com) (Great source to find wound care products)
Resources

References:


Thank You for your Participation

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