



THE PRESSURE'S ON![™]

Getting It *Right* on Admission

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This educational poster was designed to offer guidance to clinicians for pressure ulcer staging and dressing selection for wound management.



Wound Dressing Selection Guide

B/Y/R	Black		Yellow			Red		Pink	
Wound Appearance									
Description	Eschar* (Colors may vary)	Predominantly Slough (Infection may be present)	Granulating/ Mixed Wound Tissue	Fibrin (Appears yellow)	Granulating and/or Epithelializing	Skin Tear	Epithelializing	Healed Wounds, Skin at Risk or Closed Surgical Incisions	Hypertrophic or Keloid Scarring
Exudate Level	= indication of exudate level Moderate to None		High ← to Moderate			Moderate ← to Scant		None	
Depth	Unknown	Deep	Deep/Shallow	Deep/Shallow	Deep/Shallow	Shallow	Shallow	Closed	Closed
Treatment Objective	Debride*	Cleanse, Debride, Absorb, Fill Dead Space			Protect, Hydrate, Fill Dead Space			Protect	Reduce Scarring
Suggested Products and Change Rates <small>To the right are management options for each wound condition</small>	Hypergel® (daily) Cover choices: Alldress® or Mepore® Pro or Mepilex® Border or Mepilex® Border Lite	Mesalt® (daily) Melgisorb® (Up to 3 days) Cover choices: Alldress® or Mepilex® or Mepilex® Border	<u>Deep</u> Mesalt® (daily) Melgisorb® (Up to 3 days) Cover choices: Alldress® or Mepilex® or Mepilex® Border <u>Shallow</u> Mepilex® Transfer or Mepilex® or Mepilex® Border (Up to 5 days)	<u>Moderate Exudate</u> Melgisorb® (Up to 3 days) Cover choices: Alldress® or Mepilex® Border <u>Minimal Exudate</u> Normlgel® and Alldress® or Mepilex® Border Lite (Up to 2 days) <u>Shallow</u> Mepilex® or Mepilex® Border (Up to 7 days)	<u>Moderate Exudate</u> Melgisorb® (Up to 3 days) Cover choices: Alldress® or Mepilex® or Mepilex® Border <u>Minimal Exudate</u> Normlgel®† and Alldress® or Mepilex® Border Lite (2 days) Mepilex® Border (Up to 7 days) <u>Contact layer</u> Mepitel® (Up to 10 days)	<u>Contact Layer</u> Mepitel®† (Up to 10 days) or Mepilex® Border (Up to 7 days) Mepilex® Border Lite (Up to 7 days) Mepilex® (Up to 7 days) Mepilex® Lite (Up to 7 days)	Mepitel®† (Up to 10 days) Mepilex® (Up to 7 days) Mepilex® Border (Up to 7 days) Mepilex® Border Lite (Up to 7 days) Mepilex® Lite (Up to 7 days) Normlgel®† and Alldress® (2 days) Mepore® Film (Up to 7 days) Mepore® (PRN) Mepore® Pro (PRN)	Mepilex® Border Lite Mepilex® Lite (Up to 7 days) Mepore® Film (Up to 7 days) <u>Post Surgical</u> Mepilex® Border Post-Op (Up to 7 days) Mepore® (PRN) Mepore® Pro (PRN) <u>Radiation Dermatitis</u> Mepilex® Lite (Up to 7 days) Mepilex® Transfer (Up to 7 days)	Mepiform® (Up to 10 days per dressing) Remove daily for inspection and cleansing of the skin
	Consider using ● Melgisorb® Ag or ● Mepilex® Ag when antimicrobial effect is desired								
Notations	<ul style="list-style-type: none"> ⊛ Mepitac®, Mefix®, Mepore® Film, or Tubifast® for additional fixation. ⊛ Normlgel® may be used to donate moisture. ⊛ Mepilex® Transfer: Secondary dressing needed for exudate management PRN. 					<ul style="list-style-type: none"> ⊛ Dressings with Safetac® soft silicone technology do NOT require use of skin barrier products. ⊛ Mepitel®: May irrigate or apply ointments over contact layer. Change secondary cover dressing PRN. 			

Individuals with wound infection or those at high risk for infection may require more frequent changes as well as adjunctive antibiotic therapy. Before any healing process can begin, two critical steps must be taken as part of a well-defined management protocol:

1) The wound assessment

2) Management of causative and contributing factors including unrelieved pressure, shear and friction, excessive moisture and altered nutritional status.

* Debridement of eschar may be contraindicated in some situations such as dry, fused, stable eschar. Debridement is indicated if signs/symptoms of infection are present.

† Normlgel-when packing wound space, impregnate gauze with Normlgel, loosely fill and cover.

‡ Normlgel, creams, or ointments may be applied over Mepitel as indicated. Mepitel may be left in place during wound cleansing and irrigation. Change secondary dressings as needed.

The information provided herein is not to be construed as the practice of medicine or substituted for the independent medical judgment of a patient's treating physician. This information, including but not limited to suggestions for product wear time, product selection and suggested use is based on generalizations and does not consider the unique characteristics of an individual's wound. Each patient's physician shall remain solely responsible for assessing the severity of patient wounds, determining the appropriate treatment, and managing treatment of the wound. For additional information, please refer to the applicable product insert or contact Mölnlycke Health Care at 800.882.4582.

THE PRESSURE'S ON!TM

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BACKGROUND

The impact of pressure ulcers on hospitals:

- 63% increase in hospitalized patients with pressure ulcers between 1993 and 2003¹
- 9 out of 10 patients were covered by a government program (Medicare or Medicaid)¹
- In FY 2007, CMS reported 257,412 cases of preventable pressure ulcers as secondary diagnoses^{2,3}

The Budget Deficit Reduction Act of 2005 required CMS to identify high cost, high volume conditions that resulted in higher payments to hospitals AND were preventable with best practices.⁴ **Pressure ulcers (decubitus ulcers) have been identified as one of these conditions.**

As of October 1, 2008, hospitals will not be reimbursed for the care of Stage III or IV pressure ulcers that the patient acquires during their hospital stay. The requirement for hospitals to track these ulcers by ICD 9 codes has already begun.

WHAT THIS MEANS

- Higher quality of care within US hospitals
- New requirements

Required: Diligent assessment and documentation of the condition of the skin of all patients upon admission.

For a hospital to be paid the higher DRG for a patient who has a Stage III or Stage IV pressure ulcer, the physician/provider must document at some point during the hospitalization either that the Stage III or IV pressure ulcer was present on admission or that its status on admission was clinically undetermined by the end of the hospitalization.⁵

Because "pressure ulcer" is a diagnosis, it must be documented by a physician or a physician extender and co-signed by the physician. Because assessment, documentation and staging has often been a nursing function, collaboration is appropriate and encouraged. However, the final, timely documentation in the medical record of Medicare patients must be done by the physician/provider.

Due to the critical importance of the timely documentation regarding the stage of the ulcer, diligence by every member of the patient's care team will be essential. This may require communication with the attending physician requesting H&P documentation related to the ulcer's presence on admission (POA).

ESSENTIALS OF STAGING

- ONLY pressure ulcers should be staged; wounds of other etiologies (venous insufficiency, arterial, diabetic/neuropathic foot ulcers, trauma, etc) should be described as partial or full thickness or other appropriate system of documentation (e.g., Wagner grades for diabetic foot ulcers).
- The pressure ulcer staging system is based on degree and type of tissue destruction, NOT pure depth. Anatomical location must be considered as areas with minimal tissue over bone may be deeper than they appear.
- Because in deeper stages (Stage III and IV) tissue destroyed is replaced by granulation tissue and ultimately scar, pressure ulcers are not staged in a reverse manner, i.e., a Stage IV does not progress to a Stage III, II or I. The stage remains the same throughout the healing process.⁶
- It may be necessary to gently palpate the base of deeper ulcers to assess for location of structures (bone, tendon) in order to determine stage.
- Staging is only one part of a comprehensive wound assessment.

NPUAP PRESSURE ULCER STAGES WITH DESCRIPTIVE IMAGES

PRESSURE ULCERS WHEN SKIN IS GENERALLY INTACT

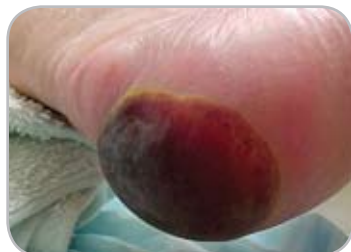
SUSPECTED DEEP TISSUE INJURY⁷



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. This damage is also difficult to detect in dark skin tones.



The evolution may include a thin blister over a dark wound bed, then the wound may further evolve and become covered by thin eschar. Further evolution may be rapid deterioration exposing additional layers of tissue even with optimal treatment.



STAGE I⁷



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. This area may be painful, firm, soft, warmer, or cooler as compared to adjacent tissue. Stage I areas may be difficult to detect in individuals with dark skin tones, and the presence of this skin discoloration may indicate "at risk" persons (a heralding sign of risk).

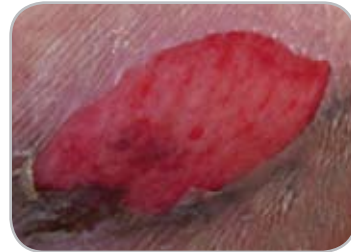


PRESSURE ULCERS WITH SKIN DESTRUCTION

STAGE II⁷



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.



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.



*Bruising indicates suspected deep tissue injury

STAGE III⁷



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.



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 IV⁷



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.



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.



UNSTAGEABLE⁷



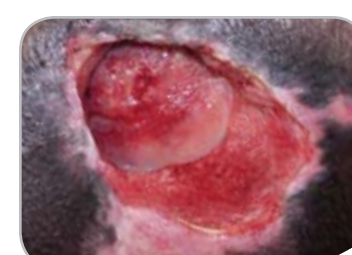
Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, 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.



STAGING CHRONIC PRESSURE ULCERS



Assessing the patient with a chronic pressure ulcer presents challenges since the original level of tissue destruction cannot be determined visually. Every effort should be made to obtain prior clinical records and the most thorough history possible from the patient and/or family.



A determination of the most accurate stage may be possible through assessment of identifiable wound characteristics:

- Scar tissue in the periwound area
- Rolled, contracted edges with or without undermining
- Red (granulating or hyper-granulating) or pink (non-granulating) wound tissue



- Location in relationship to underlying structures
- If the ulcer is overlying a bony structure that can be palpated, this could be documented as a Stage IV ulcer.
- If no depth or underlying structures can be appreciated, this could be documented as a Stage III or IV.

Facility, local and regional regulations should always be considered when documenting these types of wounds. Any judgment on the stage **would be subjective, at best.**

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