POLICY TITLE: Skin Assessment, Wound Care & Pressure Ulcer Prevention (PSF)

DEPARTMENT: Clinical Patient Care ORIGINATION DATE: 08/01/1991
CATEGORY: Patient Care Services EFFECTIVE DATE: 06/25/2013

SCOPE:
This policy applies to Clinical nursing, Wound care Nurse, and Medical Staff

PURPOSE:
1. To provide guidelines for the various disciplines in proper skin assessment.
2. To apply evidence-based principles of wound care and delineate wound care responsibilities for the various disciplines involved diagnosing and managing wounds.
3. To identify pressure ulcer prevention responsibilities for the various disciplines and institute evidence based practice approaches to reduce pressure ulcer occurrence.

STATEMENT OF POLICY:
1. The guidelines in this policy are to be used to provide excellence in skin and wound care.
   • Control or eliminate causative factors
   • Provide systemic support to reduce existing and potential co-factors
   • Maintain a physiologic wound environment including: adequate moisture level, normal temperature, bacterial balance, and mildly acidic pH.
2. Acute surgical wounds are cared for according to the individual surgeons’ preference.

PROCEDURE:
I. Assessment
   A. General Assessment
      1. Head-to-toe assessment should be done on admission to care setting.
      2. Assessment should include:
         a. Skin temperature
         b. Skin color
         c. Skin integrity
         d. Skin texture/turgor
         e. Moisture status
      3. Skin assessment should be accomplished:
         a. Assess the patient on admission.
         b. Assess the patient at least every 12 hours if the score is in the low or moderate risk category
         c. Assess the patient at least every 8 hours if the score is in the high risk category.
      4. PT’s, CNA’s, RT’s, and OT’s are to report any skin abnormalities to the RN for a more thorough assessment.
      5. Identify individual risk factors for pressure ulcer development by performing the Braden Risk Assessment Scale per the standard of care defined in each practice area.
      6. Assess for additional risk factors for developing pressure ulcers including but not limited to:
         a. Factors affecting tissue perfusion and oxygenation-peripheral vascular disease/peripheral arterial disease, diabetes, cardiovascular instability, vasopressor

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use, low blood pressure, oxygen use, smoking history, steroid use or chemotherapy/radiation therapy.

b. Advanced age >65
c. Obesity
d. Emaciation
e. Alteration in skin integrity-dry skin, erythema, blanchable erythema, presence of existing wounds
f. Surgery duration>4 hours
g. Medications: NSAIDS, sedatives, hypnotics, analgesics
h. Mechanical ventilation
i. Hip fracture
j. LOS greater than 96 hours
k. Fluid overload or dehydration
l. History of previous pressure ulcer
m. Spinal cord injury
n. Increased temperature
o. Chronic illness
p. Diastolic blood pressure <60
q. Uncontrolled pain

7. Assess for pressure ulcers:
   a. Ask patient to identify any areas of discomfort or pain over boney prominences
   b. Visualize and palpate over boney prominences for: Non-blanchable erythema, purple or maroon discolored skin, with or without blistering, areas of tissue that are painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue (especially in individuals with darkly pigmented skin).
   c. Assess skin and mucous membranes areas and other areas subjected to device-related pressure:
      • Check over ears, nares, lips, urethra, or other areas where tubing interfaces with skin
      • Check legs/feet for areas where sequential compression devices (SCDs) interface with skin
      • Check skin under other devices (e.g. bipap mask, ET Tube holder, Foley tubing, and feeding tubes)
      • Check under CPM, Brace, Casts, C-Collars and Splints

8. Assess specific vulnerable pressure points for bed and chair bound patients:
   • Supine [position-occiput, sacrum, heels, scapulae, elbow
   • Sitting position-ischial tuberosities, coccyx, plantar surfaces of feet
   • Side-lying position-trochanters, ears, knees, ankles
   • Check all skin folds for skin related issues and skin on skin pressure ulcers

9. When a skin condition, wound, pressure ulcer is noted, the wound should be assessed as follows by the floor nurse and documented under the wound intervention by the clinical nurse.
   a. Location
   b. Size in centimeters, length, width, depth, tunneling and undermining:
• Length is measured by placing the ruler of the point of greatest length (head to toe)
• Width is measured by placing the ruler at the point of greatest width (side to side)
• Depth is measured by inserting a cotton tip applicator into the wound and marking the skin level with the thumb and forefinger.
• Tunneling extends from any part of the wound and migrates through subcutaneous tissue or muscle. This can be measured with a cotton tip applicator to skin level. Describe the location of a tunnel to the face of a clock.
• Undermining describes tissue destruction under the intact skin at the perimeter of the wound. This can be measured with a cotton tip applicator and note the point on the face of the clock where the undermining starts and ends.

10. Appearance of wound bed: granulation tissue, healthy red tissue, yellow, tan, brown, gray or black tissue covering all or part of the wound and noting any exposed bone, tendon.
   1. Appearance of wound edges: Intact or rolled under.
   2. Appearance of surrounding tissue:
      • Color (erythema, pale, blue)
      • Texture (moist, dry, indurated, boggy, macerated)
      • Skin temperature (warm, cool)
      • Integrity of surrounding tissue (denuded, macerated, eroded, papules, pustules, and lesions)

B. Wound drainage:
   1. Type- sanguous, serosanguous, purulent, serous, brown, tan, green
   2. Amount- none, minimal, moderate, large, copious
   3. Odor- none, mild, foul

C. Wound pain- pain at the wound site must be evaluated in order to understand the origin of the pain. Once that has been determined, a pain control plan can be instituted. For example: if pain is from neuropathy, the plan might be to request an order for Lyrica™, from the LIP, and monitor its effect. If the pain is from the dressing drying out and sticking to the wound, the plan is a more moist dressing.

D. Nutritional Assessment:
   1. Should be performed and documented in Gen Adm Data Group completed on admission and within the Braden Scale at the frequency defined per the standard of care in each area.
   2. Nutrition consult will be automatically generated when an abnormality is documented in the Gen Admin Data group and when “very poor” or “probably inadequate” is selected in the Braden scale.
   3. Nutrition consult may be requested by the Primary Nurse based on the assessed needs of the patient.
   4. Adequate nutrition is necessary for wound healing. A nutrition consult should be made on all patients admitted with wounds.

II. Diagnosis and Wound Care Consult

A. The LIP should be made aware of the wound so they can assess, document, and make any needed modifications to the wound care. Determinations of full or partial thickness as well as
staging the wound are documented by the LIP. The Wound care nurse can be consulted through a LIP order to assist with this process.

B. Documentation of wound assessment is completed in the EMR. The LIP will diagnose the type of wound (pressure, venous, arterial, neuropathic, etc). The physician will document the stage of a pressure ulcer and state if it was present on admission. The primary nurse should describe the wound’s appearance as delineated in this policy.

C. The Wound care nurse is consulted via entering an order into the EMR. A physician order is required for all Wound nurse consults. No Nurse consults are accepted. Wound nurse is available Mon-Fri 0900-1730 and on weekends and holidays on call from 0900-1500. Interventions should be initiated per attached Wound Care Guidelines and Protocol until Wound care nurse is available.

D. The Wound care nurse can help with staging and should be consulted for wound with these characteristics:
   1. A wound that turns from pink/red to yellow, tan, brown or black
   2. Initial presentation of a wound that is yellow, tan, brown, black, maroon or bruised
   3. The area around the wound becomes red, swollen, warm, macerated, or develops a rash
   4. The drainage becomes brown, purulent, develops an odor, or increases in amount
   5. The wound dressing does not stay in place
   6. The dressing cannot handle the amount of drainage from the wound

E. The Wound care nurse will be consulted for:
   1. The area around the wound continues to deteriorate by becoming red, swollen, warm, macerated, or develops a rash.
   2. The wound drainage amount increases, becomes, brown, purulent, develops an odor.
   3. Prescribed dressing does not adequately absorb the wound drainage or will not stay in place.

III. Plan

A. Clean technique in the standard of care for wound care, unless sterile technique is ordered by the LIP. It is acceptable for the nurse to implement sterile technique if situational judgment indicates that it would protect the patient. For example: A severely immunocompromised patient with a significant wound

B. Since most chronic wounds are colonized, routine wound cultures are not indicated if a culture is needed a tissue culture is recommended. Many chronic wound and/or immunosuppressed patients may lack the classic signs of infection. The classic sign of infection include increased purulent drainage, induration, warmth, pain or tenderness, and erythema.

C. The Wound care nurse evaluates the patient weekly, as needed, and as requested by primary nurse or MD.

IV. Intervention

A. Pressure ulcer prevention:
1. Implement interventions for skin care and pressure ulcer prevention as indicated in the risk assessment level and the individual risk factors identified.

2. For patients at risk and that have co-morbidities increasing the risk of pressure ulcer development, or presence of pressure ulcers, refer to the specialty bed policy for appropriate surface/bed needs to aide preventive patient care.

3. Patient education:
   a. Importance of repositioning, mobility, nutrition
   b. Signs and symptoms to report

4. Repositioning frequency will be determined by:
   a. Level of mobility
   b. General medical condition
   c. Individual tissue tolerance
   d. Skin assessment
   e. Support surface in use
   f. Complete more small shifts in weight more frequently in unstable patients
   g. Mobility restrictions will be indicated by provider (e.g. log roll, spine precautions, etc).

A. Wound Care Treatment
   1. Wound care treatment will be initiated according to the attached Wound care Guidelines.
   2. Wounds will be re-assessed at each dressing change
   3. Dressings are to be inspected each shift to be sure that they are dry and intact.
   4. The Wound care nurse is qualified to perform the following kinds of debridement:
      a. Conservative sharp- Selectively removing loosely non-adherent non-viable tissue using sterile instruments. There is little likelihood of blood loss; therefore, the risk to the patient is minimal. Surgical sharp wound debridement is a medical function and is to be performed by a physician.
   5. Dry stable eschar on the foot of a patient with adequate arterial circulation should not be debrided. These wounds should be kept clean and dry.

V. Evaluation

A. Monitoring of pressure ulcers:
   1. Pressure ulcer prevalence will be monitored quarterly by designated nursing staff.
   2. The studies will be overseen by the Wound care nurse to be used as comparative and benchmarking purposes.
   3. Data will be collected in accordance with statistical guidelines for prevalence studies
   4. Results of the studies will be reviewed by leadership and the staff for the needed improvements in systems/performance.

B. Reporting:
   1. Present on arrival (POA)
   2. Above skin issues will have thorough documentation on admission and with each shift including any contact with physician and/or Wound care nurse regarding the situation.
   3. Physician and Wound care nurse will be notified of pressure related wounds on admission. The physician will document presence of wound within 24 hours of admission.
   4. Hospital acquired ulcers.
VI. Documentation

A. Primary care nurse will document in EMR according to frequency per standard of care in designated practice areas:
   1. Patient skin status
   2. Risk for pressure ulcers
   3. Status of wound present
   4. Treatment plan and patient tolerance
   5. Pressure ulcer prevention Interventions
   6. Pressure ulcer Prevention Education
   7. Pressure Ulcer Prevention repositioning regime which includes position location in EMR

B. Instability to assess and/or intervene with pressure ulcer prevention interventions due to instability of patient condition, or by patient or family request if patient is receiving Comfort Care measures only.
   1. If patient refuses prevention interventions such as turning, education will be provided as to the importance of skin/pressure ulcer prevention interventions.

C. Physician or Wound RN
   1. Stage of pressure ulcer
   2. If wound was present on admission
   3. Wound type and progress
<table>
<thead>
<tr>
<th>Problem</th>
<th>Assessment Findings</th>
<th>Treatment/Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incontinence</td>
<td>Without redness of perineal area</td>
<td>Clean with perineal cleanser. Apply Skin Protectant Paste with Zinc Oxide (Calazyme)</td>
</tr>
<tr>
<td>Incontinence</td>
<td>With redness of perineal area</td>
<td>Clean with perineal cleanser. Apply spray on topical dressing (Proderm)</td>
</tr>
<tr>
<td>Incontinence</td>
<td>With superficial skin breakdown or chafing</td>
<td>Clean with perineal cleanser. Apply Skin Protectant Paste with Zinc Oxide (Calazyme) (Do not attempt to remove)</td>
</tr>
<tr>
<td>Skin tears, superficial</td>
<td>Smaller than 2 cm. (approx. 1 inch)</td>
<td>Clean with wound cleanser, plain H2O or saline. Apply skin prep around the wound. Cover with clear absorbent acrylic dressing.</td>
</tr>
<tr>
<td>Skin tears, superficial</td>
<td>Larger than 2 cm.</td>
<td>Clean with wound cleanser. Apply wound gel liberally. Cover with adaptic &amp; dry dressing. Secure with stretch gauze tubing (Surgifix). Do not tape to skin. Change daily</td>
</tr>
<tr>
<td>Stage I pressure ulcer</td>
<td>Non blanchable redness lasting more than 30 minutes</td>
<td>Relieve pressure—multiboots to heels and every 2 hour turning schedule. Apply spray on topical dressing (Proderm) with gloved hand to area gently q.i.d. (Do NOT Rub).</td>
</tr>
<tr>
<td>Stage II pressure ulcer</td>
<td>Superficial loss of skin (like a broken blister area)</td>
<td>Relieve pressure. Clean with wound cleanser. Apply clear absorbent acrylic dressing (Tegaderm) or.</td>
</tr>
<tr>
<td>Stage III or IV pressure ulcer</td>
<td>Deep pressure ulcers with undermining or with visible bone, tendon or muscle</td>
<td>Relieve pressure. Stay off ulcer site, turn frequently. Clean with wound cleanser. Pack with gauze (fluffs or Kerlix) moistened with normal saline and cover with dry dressing (ABDs, fluffs, 4x4s).</td>
</tr>
<tr>
<td>Black heels</td>
<td>Without drainage</td>
<td>Relieve pressure with multiboots or pillows. Do not place heels ON pillow, rather hang them over pillow. No intervention. Check daily and document appearance. Notify SWAB Team if questions/concerns.</td>
</tr>
<tr>
<td>Difficult to remove tape, or other adhesive products</td>
<td>Skin tears with removal</td>
<td>Adhesive remover prepettes are available from CS. Follow package directions.</td>
</tr>
<tr>
<td>Tape, clear acrylic dressings etc. won’t adhere</td>
<td>Adhesive products lift up</td>
<td>Apply Skin Prep around wound. (Available as prepette from CS--follow package directions)</td>
</tr>
<tr>
<td>Thin patient with limited mobility, poor nutrition</td>
<td>Scores in moderate or High Risk category on Braden scale</td>
<td>Nutrition consult. Check bed to see if it has pressure relief. If not, obtain physician’s order for a pressure redistribution surface maintain pressure relief mode on the current bed. Reposition q 2 hours</td>
</tr>
</tbody>
</table>

**DEFINITIONS-NA**

**REFERENCES AND SOURCES OF EVIDENCE**

2. Armstrong, D, et al: (2008). Opportunities to Improve Pressure Ulcer Prevention and Treatment; A consensus paper from the International Wound Care Advisory (Level IV)

**POLICY VIOLATION**

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**REVIEW/APPROVAL SUMMARY**

**REVIEW/REVISION DATES:**
8/91, 12/93, 3/97, 10/99, 4/01, 7/01, 5/03, 4/06, 3/10

**APPROVAL BODY(IES):** Rose Ann Scibona  
**APPROVAL DATE:** 06/25/2013
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