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| SUBJECT: STAGING AND PRESSURE ULCER PROTOCOL | | | | NO. | |
| **Stage I:** Intact skin with non-blanchable redness of localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.   1. Nurse to initiate newly acquired skin sheet. 2. Initiate positioning/turning schedule per licensed nurse if appropriate. 3. Apply proper in house skin care products. 4. Notify physician. 5. Nursing to monitor at a minimum of weekly. 6. Weights as ordered. 7. Notify Dietary Department. Add Vitamin C juice ½ c. BID.   **Stage II:** 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.   1. Nurse to initiate newly acquired skin sheet. 2. Initial and weekly measurements of involved area. Document on pressure sheet. 3. Notify dietary manager of Stage II. 4. Weights as ordered. 5. Initiate positioning/turning schedule per licensed nurse if appropriate. 6. Notify physician for treatment orders. 7. Initiate air mattress overlay for bed and/or cushion for chair. 8. Dietary manager to have Registered Dietician do nutritional assessment at next visit. 9. If not already on a dietary supplement initiated BID. 10. If not already on vitamin, notify physician and recommend a multivitamin. 11. Add vitamin C juice ½ cup BID.   **Stage III:** Full thickness skin loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed.  Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.   1. Nurse to initiate skin sheet. 2. Initial and weekly measurements of involved area. Document findings. 3. Initiate positioning/turning schedule per licensed nurse if appropriate. 4. Notify physician for treatment order or for change in condition. 5. Notify Dietary manager of Stage III. 6. Weights as ordered. 7. Nutritional assessment by Registered Dietician on next visit. 8. Dietary add vitamin C juice, TID and 2oz. Protein with breakfast. 9. If not already on dietary supplement initiate BID. 10. If not already on vitamin, notify physician and recommend multivitamin with zinc. 11. If diabetic recommend multivitamin, 220mg zinc, and vitamin C 500mg. Table daily. 12. Initiate air mattress overlay for bed and/or cushion for chair. | | | | | |
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| **Stage IV:** 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 or tunneling.   1. Nurse to initiate newly acquired skin sheet. 2. Initial and weekly measurements of involved area. Document findings. 3. Notify physician for treatment order or for change in condition. 4. Notify physician of any signs of infection. 5. Notify Dietary manager of Stage IV. 6. Initiate I & O. 7. Nutritional assessment by Registered Dietician on next visit. 8. Vitamin C juice ½ Cup TID, 2 oz. Protein at breakfast. 9. If not already on dietary supplement initiate BID and double meat portion at lunch, dependent on diet and if not contraindicated. 10. If not already on vitamin, notify physician and recommend multivitamin with zinc. 11. If diabetic and not already on dietary supplement notify physician and recommend sugar free dietary supplement BID. 12. If diabetic recommend multivitamin with zinc and vitamin C 500 mg. daily. 13. Initiate positioning/turning schedule. 14. Initiate air mattress and/or chair cushion. 15. If after 2-4 weeks, no improvement is noted or it is worsening notify MD for change in treatment orders.   **Unstageable:** Full thickness tissue loss in which the base of the ulcer in covered by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown, or black) in the wound bed.   1. Treat as Stage IV.   **Deep Tissue Injury:** 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.   1. On going assessment for complications (i.e.):  * Osteomyelitis * Bacteremia * Advancing Cellulitis * Endocrditis * Maggot infestation * Meningitis * Sinus tract or abscess | | | | | |
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| 1. Nutritional Assessment:   The goal of nutritional assessment and management is to ensure that the diet of the individual with a pressure sore contains nutrients adequate to support healing. Multiple studies indicate that malnutrition is a risk factor for pressure ulcer formation. Furthermore, the stage of wound is correlated with the severity of nutritional deficits, particularly low protein intake or below-normal serum albumin. Clinically significant malnutrition is diagnosed if (1) serum albumin is less than 3.5 mg/dl., (2) total lymphocyte count is less than 1,800/mm 3 or (3) body weight has decreased more than pressure ulcer healing in malnourished nursing home patients.   1. Pain Assessment:   Assess all residents for pain related to the pressure ulcer or its treatment. Pain management must be addressed on the resident’s plan of care. | | | | | |
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