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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 Risk Watch report. 2. Initiate positioning/turning schedule, if appropriate. 3. Apply proper in house skin care products. 4. Notify physician. 5. Notify family/responsible party. 6. Update the plan of care to reflect new problem and interventions. 7. Nursing to monitor at a minimum of weekly. 8. Weights as ordered.   **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 Risk Watch report, if a newly acquired area. 2. Initiate positioning/turning schedule, if appropriate. 3. Initial and weekly measurements of involved area. Document on pressure sheet. 4. Notify dietary manager of Stage II. 5. Notify physician for treatment orders or for change in condition. 6. Notify physician of any signs of infection. 7. Notify family/responsible party if a new or reoccurring area. 8. Update the plan of care to reflect new problem, staging and interventions. 9. Dietary manager to have Registered Dietician do nutritional assessment at next visit and then monthly. 10. If not already on a dietary supplement, initiate daily. 11. Weights as ordered.   **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 Risk Watch report, if a newly acquired area. 2. Initiate positioning/turning schedule, if appropriate. 3. Initial and weekly measurements of involved area. Document on pressure sheet. 4. Notify Dietary Manager of Stage III. 5. Notify physician for treatment order or for change in condition. 6. Notify physician of any signs of infection. 7. Notify family/responsible party if a new or reoccurring area. 8. Update the plan of care to reflect new problem, staging and interventions 9. Dietary Manager to have Registered Dietician do nutritional assessment at next visit and then monthly. 10. If not already on dietary supplement, initiate BID 11. Dietary to add 2 oz protein daily. 12. Weights as ordered. | | | | | |
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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 Risk Watch report, if a newly acquired area. 2. Initiate positioning/turning schedule. 3. Initial and weekly measurements of involved area. Document on pressure sheet. 4. Notify Dietary Manager of Stage IV. 5. Notify physician for treatment order or for change in condition. 6. Notify physician of any signs of infection. 7. Notify family/responsible party if a new or reoccurring area. 8. Update the plan of care to reflect new problem, staging and interventions 9. Dietary Manager to have Registered Dietician do nutritional assessment at next visit and then monthly 10. If not already on dietary supplement initiate BID and double meat portion at breakfast. 11. Dietary to add 2 oz. protein daily. 12. If after 2-4 weeks, no improvement is noted or it is worsening notify MD for change in treatment orders. 13. Weights as ordered.   **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.    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.  Ongoing assessment for complications (i.e.):   1. Osteomyelitis 2. Bacteremia 3. Advancing Cellulitis 4. Endocarditis 5. Maggot infestation 6. Meningitis 7. Sinus tract or abscess   **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.  **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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