

Clinical	Skin Wound		
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Policy

Based on the comprehensive assessment of a resident, the facility must ensure that- A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers/injuries and does not develop pressure ulcers/injuries unless the individual's clinical condition demonstrates that they were unavoidable: and a resident with pressure ulcers/injuries receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers/injuries from developing.

Examples of impaired skin integrity include, but are not limited to, pressure injuries, venous (stasis) ulcers, arterial (ischemic) ulcers, diabetic (neuropathic) ulcers, surgical wounds, skin tears, and rashes.

The staging of pressure injury is consistent with the recommendations of National Pressure Injury Advisory Panel (NPIAP) and the RAI Manual, Section M.

DEFINITIONS:

Pressure Injury: refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. A pressure injury will present as intact skin and may be painful. A pressure ulcer will present as an open ulcer, the appearance of which will vary depending on the stage and may be painful. The injury occurs because 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 skin temperature and moisture, nutrition, perfusion, co-morbidities, and condition of the soft tissue.

Colonized/Infected

“Colonized” refers to the presence of micro-organisms on the surface or in the tissue of a wound without the signs and symptoms of an infection.

“Infected” refers to the presence of micro-organisms in sufficient quantity to overwhelm the defenses of viable tissues and produce the signs and symptoms of infection.

Debridement-Debridement is the removal of devitalized/necrotic tissue and foreign matter from a wound to improve or facilitate the healing process. Debridement methods may include a range of treatments such as the use of enzymatic dressings to surgical debridement to remove tissue or matter from a wound to promote healing.

Eschar/Slough

“**Eschar**” is dead or devitalized tissue that is hard or soft in texture, usually black, brown, or tan in color, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/edges of the wound.

“**Slough**” is non-viable yellow, tan, gray, green or brown tissue, usually moist, and can be soft, stringy, and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed.

Exudate - “Exudate” is any fluid that has been forced out of the tissues or its capillaries because of inflammation or injury. It may contain serum, cellular debris, bacteria, and leukocytes.

“**Purulent exudate/drainage/discharge**” is any product of inflammation that contains pus (e.g., leukocytes, bacteria, and liquefied necrotic debris).

“**Serous drainage or exudate**” is watery, clear, or slightly yellow/tan/pink fluid that has separated from the blood and presents as drainage.

Friction/Shearing

“**Friction**” is the mechanical force exerted on skin that is dragged across any surface.

“**Shearing**” occurs when layers of skin rub against each other or when the skin remains stationary, and the underlying tissue moves and stretches and angulates or tears the underlying capillaries and blood vessels causing tissue damage.

Granulation Tissue - “Granulation tissue” is the pink-red moist tissue that fills an open wound when it starts to heal. It contains new blood vessels, collagen, fibroblasts, and inflammatory cells.

Tunnel/Sinus Tract/Undermining -The terms tunnel and sinus tract are often used interchangeably.

- A “**tunnel**” is a passageway of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound.
- A “**sinus tract**” is a cavity or channel underlying a wound that involves an area larger than the visible surface of the wound.
- “**Undermining**” is the destruction of tissue or ulceration extending under the skin edges (margins) so that the pressure ulcer is larger at its base than at the skin surface. Undermining often develops from shearing forces and is differentiated from tunneling by the larger extent of the wound edge involved and the absence of a channel or tract extending from the pressure ulcer under the adjacent intact skin.

PRESSURE INJURY STAGING

Stage 1 Pressure Injury: 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 2 Pressure Injury: 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 3 Pressure Injury: 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 4 Pressure Injury: 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

Unstageable Pressure Injury: Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. Stable eschar (i.e., dry, adherent, intact without erythema or fluctuance) should only be removed after careful clinical consideration and consultation with the resident's physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws. If the slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed. If the anatomical depth of the tissue damage involved can be determined, then the reclassified stage should be assigned. The pressure ulcer does not have to be completely debrided or free of all slough or eschar for reclassification of stage to occur.

Deep Tissue Pressure Injury (DTPI): 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 is 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.

Additional pressure injury definitions:

Medical Device Related Pressure Injury: This describes an etiology. 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.

Mucosal Membrane Pressure Injury: 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.

Pressure Injuries at End of Life: Residents at the end of life, in terminal stages of an illness or having multiple system failures may have written directions for his or her treatment goals (or a decision has been made by the resident’s representative, in accordance with State law). The center’s care must reflect the resident’s goals for care and wishes as expressed in a valid Advance Directive, if one was formulated, in accordance with State law. However, the presence of an Advance Directive does not absolve the center from giving supportive and other pertinent care that is not prohibited by the resident’s Advance Directive.

The Kennedy Terminal Ulcer (KTU): KTUs have certain characteristics which differentiate them from pressure ulcers such as the following:

- KTUs appear suddenly and within hours;
- Usually appear on the sacrum and coccyx but can appear on the heels, posterior calf muscles, arms, and elbows;

RESOURCE DOCUMENTS	RESOURCE DOCUMENTS	ORIGINATION DATE	DATE REVISED	DATE REVIEWED
Administrator, Director of Nursing, licensed nurses	CMS: SOM F686 §483.25(b), §483.25(b)(1) RAI Manual, Section M National Pressure Injury Advisory Panel Prevention and Treatment https://npiap.com/		11/8/22	11/16/22

