Pressure Ulcers Memory Aid

POCKET GUIDE

This pocket guide is intended as a memory aid at the bedside. For more complete information on pressure ulcers, please refer to the Ferris-sponsored Pressure Ulcer Clinical Education and Protocol.

Contact your nurse administrator to obtain more complete information on this protocol.

Sponsored by:
Ferris Mfg. Corp.
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International: +1 630-887-9797
www.polymem.com

Guideline implementation is most likely to be successful when it includes reminder systems, education and a toolkit of multiple interventions. This pocket guide is intended to be used as a memory prompt following more extensive staff education using the Pressure Ulcer Clinical Education and Protocol. A formal, evidence-based pressure ulcer prevention program includes:

- A **risk assessment**, such as the Braden Scale (Norton, Waterlow, and Braden Q can also be used)
- A **systematic skin assessment** (performed daily on at-risk patients)
- Reducing **risk factors** (including improving skin health)
- Patient, family and staff **education**
- **Evaluation**, including prevalence and incidence studies

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BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK

SENSORY PERCEPTION ability to respond meaning - fully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch, or gasp) to painful stimuli, due to diminished level of consciousness or sedation. OR limited ability to feel pain over most of body	**2. Very limited** Responds only to painful stimuli. Cannot communicate discomfort (except by moaning or restlessness) OR has a sensory impairment which limits the ability to feel pain or discomfort over half of body.	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned. OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.				
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once per shift.	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals.				
ACTIVITY degree of physical activity	**1. Bedfast** Confined to bed.	**2. Chairfast** Ability to walk severely limited or nonexistent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours.				
MOBILITY ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. Slightly Limited** Makes frequent though slight changes in body or extremity position independently.	**4. No Limitation** Makes major and frequent changes in position without assistance.				

NUTRITION usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and/or maintained on clear liquids or IVs for more than 5 days.	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement OR receives less than optimum amount of liquid diet or tube feeding	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	**4. Excellent** Eats most of every meal. Never refused a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.				
FRICTION & SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction.	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair.					

Total Score

NOTE:

EACH DEFICIT IDENTIFIED BY THIS RISK TOOL, AS WELL AS OTHER RISK FACTORS (see Pressure Ulcer Clinical Education and Protocol), SHOULD BE ADDRESSED IN THE PATIENT'S INDIVIDUALIZED CARE PLAN.

PATIENT POSITIONING FOR PRESSURE REDISTRIBUTION

Prevent pressure ulcers by improving skin health and decreasing exposure to excessive pressure, friction, moisture, and shear. Specialty beds do not eliminate the need for repositioning.

Use a wedge to maintain 30° side lying position

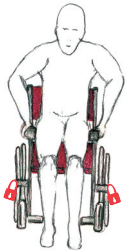
1. *Supine† right side*
2. *Supine† left side*
3. *Prone‡ right side*
4. *Prone‡ left side*

Use a thin prop to slightly relieve sacral pressure

5. *Supine† right side*
6. *Supine† left side*

Raise the head of bed slightly less than 30° for two more positions

7. *Supine† with the feet blocked*
8. *Supine† with the knees flexed*



Remember: lock wheels before lifting or shifting weight

» *Teach sitting patients to off-load every 15 minutes*

» *Ideally, immobile patients in chairs should be repositioned at least hourly*

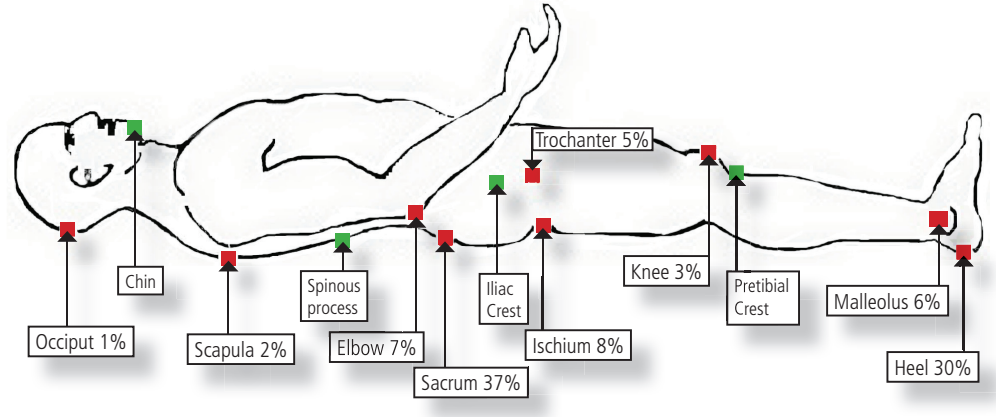
AHRQ positioning guidelines:

- Keep heels up and protected
- Head of bed no more than 30°
- Reposition at least every 2 hours
- Reposition even with support surfaces
- Use 30° lateral position for side-lying
- Avoid positioning over an ulcer
- Do not use ring-shaped devices ("donuts")
- Separate boney prominences

† face up
‡ face down

Heels must ALWAYS be floated!

COMMON LOCATIONS OF PRESSURE ULCERS



Indicates pressure ulcer locations with <1% occurrence frequency

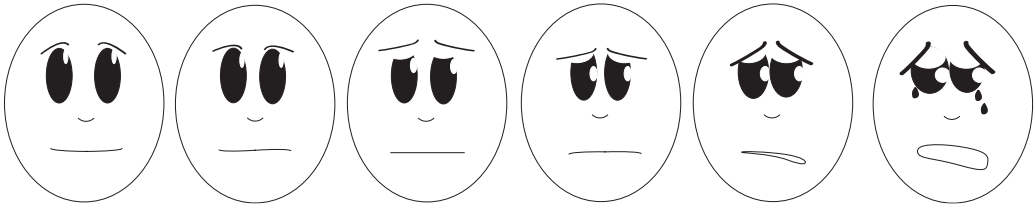
Not all open areas on or surrounding boney prominences are pressure ulcers. Herpetic lesions, candidiasis lesions and moisture lesions (from incontinence-associated dermatitis or excessive sweating) are not pressure ulcers.

Scales should not be used to compare patients with one another, but are very useful for assessing improvement or worsening of pain for a given patient. Appropriate systemic analgesics should be provided for adequate pain control. Wound management with PolyMem dressings often results in decreased procedural and persistent wound pain.

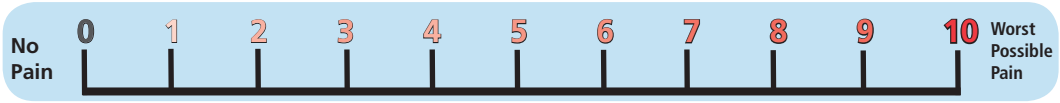
Visual Pain Scale

WHEN SHOWING THIS SCALE TO PATIENTS, FOLD AT THE BINDING. PATIENTS SHOULD NOT SEE THE NUMBERED SCALE.

Let patients know that each face represents the amount of pain they may be experiencing. The face on the far left indicates no pain, with the amount of experienced pain increasing with each face. The last face indicates the worst imaginable amount of pain. The patient does not have to be in tears to experience the worst imaginable amount of pain.



Analog Pain Scale



Pain Assessment in Advanced Dementia (PAINAD) Scale

Items*	0	1	2	Score
Breathing independent of vocalization	Normal	Occasional labored breathing. Short period of hyperventilation.	Noisy labored breathing. Long period of hyperventilation. Cheyne-Stokes respirations.	
Negative vocalization	None	Occasional moan or groan. Low-level speech with a negative or disapproving quality.	Repeated trouble calling out. Loud moaning or groaning. Crying.	
Facial expressions	Smiling or inexpressive	Sad. Frightened. Frown.	Facial grimacing.	
Body language	Relaxed	Tense. Distressed pacing. Fidgeting.	Rigid. Fists clenched. Knees pulled up. Pulling or pushing away. Striking out.	
Consolability	No need to console.	Distracted or reassured by voice or touch.	Unable to console, distract or reassure.	
			Total**	

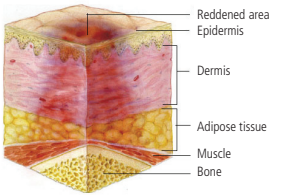
* Five-item observational tool

** Total scores range from 0 to 10 (based on a scale of 0 to 2 for five items), with a higher score indicating more severe pain (0="no pain" to 10="severe pain").

Pressure Ulcer Staging Guide

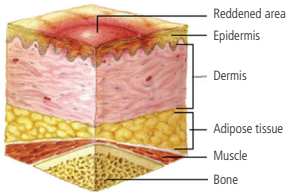
DEEP TISSUE INJURY

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. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.



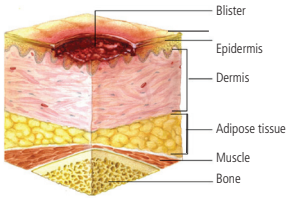
STAGE I

Intact skin with non-blanchable redness of a localized area, usually over a boney 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 may be difficult to detect in individuals with dark skin tones. May indicate "at risk" persons (a heralding sign of risk).



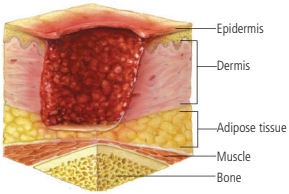
STAGE II

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. Presents as a shiny or dry shallow ulcer without slough or bruising (bruising indicates suspected deep tissue injury). This stage should not be used to describe skin tears, tape burns, perennial dermatitis, maceration or excoriation.



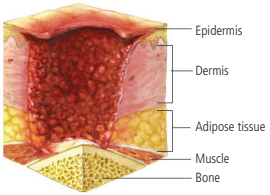
STAGE III

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.



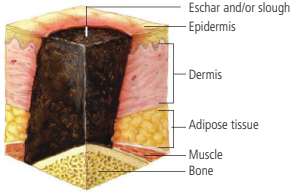
STAGE IV

Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes 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.

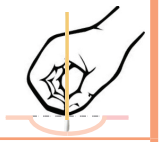


UNSTAGEABLE

Full thickness tissue loss in which the base of the ulcer is covered 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.



Wound Assessment Guide

Parameter	Definitions and Descriptors Pick-List
Location*	**R** or **L –** patient's right or left **+ medial, lateral, proximal or distal** + boney prominence over which the ulcer formed **(ischial, trochanter, sacral, heel, malleolus, scapular, elbow, knee, occipital, iliac)**
Stage*	This describes the original extent of tissue loss. Slough indicates the injury is a Stage III or IV. Deep Tissue Injury (**DTI**), **I, II, III, IV** or **Unstageable**: See Pressure Ulcer Staging pp.10 -11
Size (measure wounds in cm) 	**Length** is the longest initial dimension and **width** is its longest perpendicular. **Depth** is the deepest point – measure with a cotton-tipped applicator, pinched at the depth of the skin. Using towards the head as 12 o'clock, record the **position and depth of any undermining and tunneling**. Measure depth using two side-by-side applicators: one inside and one outside. 
Tissue Type (as a percentage of the whole)	Necrotic (nonviable, devitalized tissue): is it **loosely** or **firmly adherent?** Eschar or slough?
	Eschar: Black, brown, tan; Hard, soft, boggy / **Slough: White, yellow, tan, green; Soft, moist, stringy (fibrin), pulpy, mucoid**
	Clean avascular or **nongranulating:** pink or red, smooth without new growth. / **Blister** (bullae)
	Granulation: pink, red or dusky. **May be friable** (bleeds easily) or have **pocketing** (weak areas)

	Epithelialized: closed new skin where the wound once was: pink or white
Structures	Note any structures such as **bone, muscle fascia, tendon or joint** as **visible** or **palpable**
Exudate (Drainage)	**Amount: none, scant, minimal, moderate, large, copious** - How long was the dressing in place? **Consistency: thick** (common in infection), **thin** (typical of autolytic debridement), **sticky, watery** **Type: serous (clear), serosanguineous (pink), bloody, purulent (yellow, tan, green)**
Odor	**Absent, faint, moderate, strong, sweet, foul** – dressings, diet, and hygiene also influence odor
Edges	**Margins attached and sloped** (healthy), **unattached (undermined), fibrotic (hard, hyperkeratotic), epibole (rolled** – scar has closed off edge, which will prevent cell migration**), scarred, callous**
Periwound (Surrounding skin)	**Texture: moist, dry, scaled, boggy, crepitus, indurated (hard), macerated** (swollen and wet), **denuded (weepy), edematous** (swollen: is it **pitting**?), **intact (normal), good turgor, tenting** **Color: erythema (reddened), pale Temperature: (warm, cool, hot).** If there is a **rash**, describe it.
Pain	**0 – 10** : Use the pain scales provided. Try to record pain at rest, pain with activity and pain during dressing changes.

***Location and Stage are the same throughout the treatment and are repeated to identify the ulcer.**

Pressure Ulcer Dressing Selection Guide

After completing the patient and wound assessments, cleanse the wound bed according to your facility's protocol and choose a wound dressing using the following algorithm.

Refer back to this algorithm at each dressing change. Sometimes it is beneficial to rinse the periwound area, but when PolyMem® dressings are used, they continuously cleanse the wound bed, so unless there is visible loose material or contamination in the wound bed, manually cleansing or rinsing the actual wound bed at dressing changes is unnecessary.

PolyMem promotes autolysis, which should produce increased thin yellow exudate and decreased slough within 3-4 days. Wounds with dry stable eschar suggest underlying circulatory problems. They should be left open to air and assessed daily. If the underlying cause is addressed, autolytic debridement with PolyMem becomes appropriate.

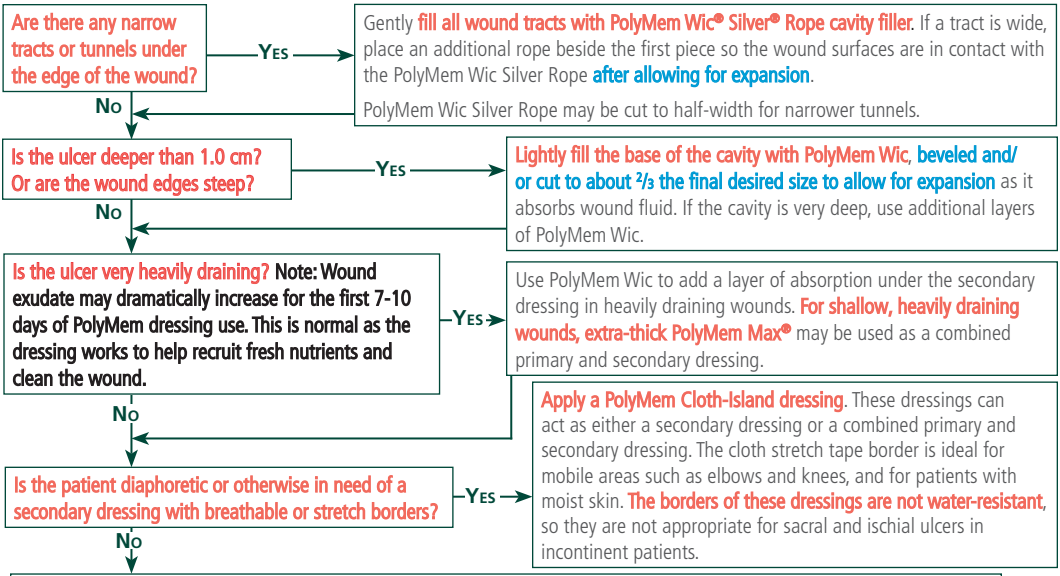
PolyMem dressings should maintain direct contact with the exposed surfaces of the wound, slough or eschar in order to provide best results. PolyMem should also be in direct contact with as much of the periwound as possible.

PolyMem dressings are available in a variety of configurations that include adhesive cloth-backed dressings, adhesive film-backed dressings and pads without adhesive borders.

PolyMem dressing formulations are also available as primary dressings which are designated "WIC" dressings. **The PolyMem Wic® dressings will expand as wound fluid is absorbed. In order to allow for expansion, cut the dressings 30% smaller than the wound when placing them in cavities or tunnels.**

PolyMem dressings are available with silver incorporated into the formulation for when antimicrobial benefits are desired. Silver dressings might be appropriate if the patient is 1) at high risk for infection due to medications, poor nutritional status or other illnesses or 2) if there are signs of possible deep infection, such as thick foul drainage, reddened periwound, excessive drainage and swelling. Deep infections should also be addressed systemically.

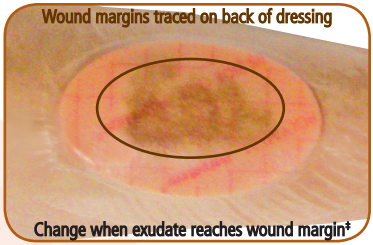
Answer the following questions to choose the best dressing for the pressure ulcer:


Are there any narrow tracts or tunnels under the edge of the wound?
Yes
Gently fill all wound tracts with PolyMem Wic® Silver® Rope cavity filler. If a tract is wide, place an additional rope beside the first piece so the wound surfaces are in contact with the PolyMem Wic Silver Rope after allowing for expansion.
PolyMem Wic Silver Rope may be cut to half-width for narrower tunnels.
No
Is the ulcer deeper than 1.0 cm? Or are the wound edges steep?
Yes
Lightly fill the base of the cavity with PolyMem Wic, beveled and/or cut to about ⅔ the final desired size to allow for expansion as it absorbs wound fluid. If the cavity is very deep, use additional layers of PolyMem Wic.
No
Is the ulcer very heavily draining? Note: Wound exudate may dramatically increase for the first 7-10 days of PolyMem dressing use. This is normal as the dressing works to help recruit fresh nutrients and clean the wound.
Yes
Use PolyMem Wic to add a layer of absorption under the secondary dressing in heavily draining wounds. For shallow, heavily draining wounds, extra-thick PolyMem Max® may be used as a combined primary and secondary dressing.
No
Is the patient diaphoretic or otherwise in need of a secondary dressing with breathable or stretch borders?
Yes
Apply a PolyMem Cloth-Island dressing. These dressings can act as either a secondary dressing or a combined primary and secondary dressing. The cloth stretch tape border is ideal for mobile areas such as elbows and knees, and for patients with moist skin. The borders of these dressings are not water-resistant, so they are not appropriate for sacral and ischial ulcers in incontinent patients.
No
Apply the PolyMem Film-Island dressing or Shapes® by PolyMem dressing that best fits the size and shape of the wound and surrounding intact skin, as either a secondary dressing over PolyMem Wic or as a combined primary and secondary dressing. If the patient's skin is cool, initial adhesion will be improved if an open palm is placed over the dressing borders momentarily to warm them in place. These dressings are water-resistant, so they are especially well suited for sacral ulcers on incontinent patients. They are also very low friction, so they tend to stay in place well during repositioning and transfers.

Easy as 1.2.3.

First Time Only:

1. Clean wound per facility protocol†
2. Place PolyMem dressing on wound*
3. Change when exudate reaches wound margin‡



Dressing Changes:

1. Remove old dressing
   NOTE: Do not disturb the wound bed
2. Place new PolyMem dressing on wound site*
3. If infection is present, treat appropriately

†Initial wound cleansing should be as thorough as the patient's condition permits. Debridement of devitalized tissue from the wound bed is critical to achieve healing. PolyMem dressings promote autolysis. If a patient has cellulitis or sepsis, initial sharp or surgical debridement may be needed.

‡More frequent changes may be indicated if the patient has a wound infection, compromised immune system or diabetes, or when quicker removal of non-viable tissue from the wound bed is desired.

*For wounds with depth and/or tunnels, PolyMem Wic wound fillers are available.

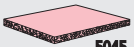
This is an overview. Please see package insert for complete instructions.

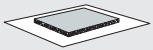
Pressure Ulcer Scale for Healing (PUSH) Tool 3.0

Length x Width (in cm²)	**0** 0	**1** < 0.3	**2** 0.3 - 0.6	**3** 0.7 - 1.0	**4** 1.1 - 2.0	**5** 2.1 - 3.0	**Sub-score**
		6 3.1 - 4.0	**7** 4.1 - 8.0	**8** 8.1 - 12.0	**9** 12.1 - 24.0	**10** > 24.0	
Exudate Amount	**0** None	**1** Light	**2** Moderate	**3** Heavy			**Sub-score**
Tissue Type	**0** Closed	**1** Epithelial Tissue	**2** Granulation Tissue	**3** Any Slough	**4** Any Necrotic Tissue		**Sub-score**
							TOTAL SCORE

The time to heal a pressure ulcer depends upon many patient variables as well as the size and stage of the wound. ♦ **Partial-thickness** pressure ulcers (Stage I and II) should show evidence of healing within 1-2 weeks of initiation of treatment. ♦ **Full-thickness** pressure ulcers (Stage III and IV) should show a reduction in size within 2-4 weeks. ♦ **If ulcer healing does not progress, the entire care plan should be re-evaluated.**

Products especially well suited for pressure ulcer care:





Cavity, Undermining, Tunneling Rope Dressing

1814*† 0.4″ x 14.0″

Wic and Wic Silver Cavity Filler

5733† 3.0″x 3.0″

Also available in:

1333*† 3.0″x 3.0″

5712 3.0″x 12.0″

Non-Adhesive Pad Dressing

5033 3.0″x 3.0″

5244 4.0″x 24.0″

Also available in:

5044 4.0″x 4.0″

5055 5.0″x 5.0″

5077 6.5″x 7.5″

5124 4.0″x 12.5″

Non-Adhesive Silver Pad Dressing

1124* 4.25″x 12.5″

Also available in:

1044* 4.25″x 4.25″

1077* 6.5″x 7.5″

Non-Adhesive Max and Max Silver Pad Dressing

1045* 4.0″x 4.0″

Also available in:

5045† 4.5″x 4.5″

5088 8.0″x 8.0″

1088* 8.0″x 8.0″

Adhesive Cloth-Backed and Cloth-Backed Silver Dressings


7203


7031

7203	2.0″x 2.0″	(1.0″x 1.0″ pad)
7031	1.0″x 3.0″	(1.0″x 1.0″ pad)

Also available in:

7405	4.0″x 5.0″	(2.0″x 3.0″ pad)
7606	6.0″x 6.0″	(3.5″x 3.5″ pad)
7042	2.0″x 4.0″	(2.0″x 1.5″ pad)
1766*†	6.0″x 6.0″	(3.5″x 3.5″ pad)

Adhesive Film-Backed Dressings


405


3042

405	4.0″x 5.0″	(2.0″x 3.0″ pad)
3042	2.0″x 4.0″	(2.0″x 1.5″ pad)

Also available in:

203	2.0″x 2.0″	(1.0″x 1.0″ pad)
606	6.0″x 6.0″	(3.5″x 3.5″ pad)
3031	1.0″x 3.0″	(1.0″x 1.0″ pad)
3412	4.0″x 12.5″	(2.0″x 10.0″ pad)

Adhesive Oval-Shaped and Oval-Shaped Silver Film-Backed Dressings


8015


1823

8015	2.0″x 3.0″	(1.0″x 1.5″ pad)
1823*	2.0″x 3.0″	(1.0″x 2.0″ pad)

Also available in:

8023	2.0″x 3.0″	(1.0″x 2.0″ pad)
8053	5.0″x 3.5″	(3.0″x 2.0″ pad)
8086	6.5″x 8.2″	(4.0″x 5.7″ pad)
1815*	2.0″x 3.0″	(1.0″x 1.5″ pad)
1853*	5.0″x 3.5″	(3.0″x 2.0″ pad)
1886*†	6.5″x 8.2″	(4.0″x 5.7″ pad)

Adhesive Sacral and Sacral Silver Film-Backed Dressings


1709

1709*	7.2″x 7.8″	(4.5″x 4.7″ pad)

Also available in:

3709†	7.2″x 7.8″	(4.5″x 4.7″ pad)

Non-Adhesive Tube Dressing

5335

5335	3.5″ x 3.5″	

3 & 4-digit numbers are reference numbers followed by the dimensions of available products

* *Reference numbers beginning with the "1" indicate silver dressings*

† *Included in "***Products especially well suited for pressure ulcer care***" box*

See Package Insert for complete instructions

MKL-374,REV-2,0113