I. POLICY GUIDELINES

The organization is committed to providing a comprehensive wound management program to promote the resident’s highest level of functioning and well-being and to minimize the development of in-house acquired pressure ulcers, unless the individual’s clinical condition demonstrates they are unavoidable.

Any resident with a wound receives treatment and services consistent with the resident’s goals of treatment. Typically the goal is one of promoting healing and preventing infection unless a resident’s preferences and medical condition necessitate palliative care as the primary focus.

A commitment to the Wound Management Program is demonstrated by implementation of processes founded on accepted standards of practice, research-driven clinical guidelines, and interdisciplinary involvement.

II. DEFINITIONS

**Skin Tears, Lacerations, Cuts, and Abrasions** are wounds that usually result from impact (or related incidents) to extremely fragile skin.

**Arterial Ulcer** is an ulceration that occurs as the result of arterial occlusive disease when non-pressure-related disruption or blockage of the arterial blood flow to an area causes tissue necrosis. Arterial/ischemic ulcers may be present in individuals with moderate-to-severe peripheral vascular disease, generalized arteriosclerosis, inflammatory autoimmune disorders, or significant vascular disease elsewhere. The arterial ulcer is characteristically painful, usually occurs in the distal portion of the lower extremity, and may be over the ankle or bony areas of the foot. (Centers for Medicare and Medicaid Services [CMS], F309, Definitions §483.25).

**Diabetic Neuropathic Ulcer** requires that the resident be diagnosed with diabetes mellitus and have peripheral neuropathy. The diabetic ulcer characteristically occurs on the foot (CMS, F309, Definitions §483.25).

**Venous Insufficiency Ulcer** is an open lesion of the skin and subcutaneous tissue of the lower leg, usually occurring in the pre Tibial area of the lower leg or above the medial ankle. Venous insufficiency ulcers may be caused by one (or a combination of) factor(s) including: loss of (or compromised) value function in the vein, partial or complete obstruction of the vein, and/or failure of the calf muscle to pump the blood (CMS, F309, Definitions §483.25).

**Pressure Ulcer** is any lesion caused by unrelieved pressure that results in damage to the underlying tissue. Although friction and shear are not primary causes of pressure ulcers, friction and shear are important contributing factors to the development of pressure ulcers. (CMS, F314, Definitions §483.25).
**Avoidable Pressure Ulcer** means that the resident developed a pressure ulcer and that the facility did not do one or more of the following: evaluate the resident’s clinical condition and pressure ulcer risk factors; define and implement interventions that are consistent with the resident needs, resident goals, and recognized standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate (CMS, F314, Definitions §483.25).

**Unavoidable Pressure Ulcer** means that the resident developed a pressure ulcer even though the facility had evaluated the resident’s clinical condition and pressure ulcer risk factors; defined and implemented interventions that are consistent with the resident needs, resident goals, and recognized standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate (CMS, F314, Definitions §483.25).

**Stages of Pressure Ulcers (from National Pressure Ulcer Advisory Panel [NPAUP], 2007):**

**Suspected 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.

Further Description: 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-blancheable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.

Further Description: The 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.

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

**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.

Further Description: 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 include undermining and tunneling.

Further Description: 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.
Unable To Stage (UTS):

If a wound is covered with necrotic tissue or eschar and the wound bed cannot be visualized, the stage of the wound may be documented as Unable to Stage (UTS). After the wound is free of necrotic tissue the wound is staged in accordance with the Stage I to Stage IV definitions.

The minimum data set (MDS) requires classification of an “unstageable” wound with necrosis as a Stage IV. Coding on the MDS is done in accordance with the Resident Assessment Instrument (RAI) instructions, but in all other documentation, the wound is considered UTS.

Undermining or Tunneling is destruction underneath the wound edge.

III. STANDARDS OF PRACTICE AND GUIDELINES

The wound management program incorporates currently accepted standards of practice and guidelines. The following resources provide the framework and guiding principles for the pressure ulcer prevention and management program:

- NPAUP, NPAUP Report on Stages of Wound. 2007
- CMS: Guidance to Surveyors for Long Term Care: Regulation F272 (Comprehensive Assessment), F279 (Comprehensive Care Plans), F280 (Comprehensive Care Plan Revision), F281 (Services Provided Meet Professional Standards, F309 (Quality of Care), and F314 (Pressure Sores), and related requirements under F157 (Notification of Changes), F353 (Sufficient Staff), F385 (Physician Supervision), and F501 (Medical Director) (CMS, Guidance to Surveyors for Long Term Care Facilities. August 17, 2007)

IV. PROCEDURAL COMPONENTS

A. Accountability

1. The Wound Management Program identifies staff participation and accountability to include:
   a. Person responsible for program oversight and coordination
   b. Staff involved in prevention and treatment (and their roles)
   c. Expectation of all caregivers to observe resident skin integrity during the daily provision of the resident’s personal care

B. Admission Wound Assessment and Management

1. At the time of admission, the discharge records from the prior facility are reviewed for information relating to wounds or alteration in skin integrity. Staging from another facility is not adopted for use in the facility
2. Wounds are assessed at the time of admission (same shift) and if not possible, within 24 hours
3. The admission wound assessment should include at a minimum:
   a. Interview of resident or family about history of skin alterations
   b. Physical evaluation to include identification of:
      i. Skin alterations present on admission, skin discolorations and any evidence of scarring on pressure points
      ii. Signs/symptoms/diagnosis of peripheral vascular disease
      iii. Bed mobility
      iv. Continence
      v. Recent surgical procedure
      vi. Head-to-toe skin assessment
vii. Nutritional status and issues
c. Completion of a Skin Risk Assessment Tool
d. Comprehensive assessment of any wound to include:
   i. Location of wound
   ii. Length, width, and depth measurements recorded in centimeters
   iii. Direction and length of tunneling and undermining
   iv. Appearance of the wound base
   v. Type and percentage of tissue in wound
   vi. Drainage amount and characteristics including color, consistency, and odor
   vii. Appearance of wound edges
   viii. Description of the peri-wound condition or evaluation of the skin adjacent to the wound
   ix. Presence or absence of new epithelium at wound rim

4. Risk reduction measures such as use of heel protectors (designed for friction/shear reduction versus pressure reduction), elevation of lower extremities, participation in bowel and bladder program, etc are initiated if determined appropriate

5. Discussion with the attending physician and resident/responsible party includes notification of any skin impairment identified on admission

6. Orders are verified or obtained as needed

7. An admission/interim care plan is developed

8. Assessments and interventions implemented are documented in the resident record

C. Ongoing Wound Assessment

1. A system for weekly (or more frequent) wound assessment has been established

2. A tool is used for assessment and documentation (Braden Skin Risk Assessment or Norton Risk Assessment Tool) is identified

3. Comprehensive wound assessment should include at least the following parameters:
   a. Location of wound which may provide information related to the etiology of the wound as described in the Definitions section of this policy
   b. Length, width, and depth measurements recorded in centimeters
   c. Direction and length of tunneling and undermining
   d. Appearance of the wound base
   e. Type and percentage of tissue in wound (eschar, slough, granulation, epithelial)
   f. Drainage amount and characteristics including color, consistency, and odor
      i. Drainage may be described as
         (a) Serous: clear to straw colored
         (b) Serosanguinous: slightly bloody, pink colored
         (c) Sanguinous: bloody drainage; bloody drainage in a chronic wound may represent a sign of increased microbial load in the wound, which indicates an assessment for signs of infection is needed
         (d) Fibrinous: composed of cells and fibrin
         (e) Purulent: thicker, colorful, opaque
   g. Appearance of wound edges (irregular, “punched out,” calloused, macerated, desiccated, crater-like, intact)
   h. Description of the peri-wound condition or evaluation of the skin adjacent to the wound (discoloration, hematoma formation, presence of papules, pustules, denudement, erosion, edema, maceration, desiccation, induration)

4. Wound complications including infection, fistula development, etc. are assessed for
   a. Localized signs of infection including:
      i. Erythema
      ii. Induration
      iii. Increased drainage
iv. Change in character of tissue  
v. Foul odor (determined after cleaning wound)  
vi. Increased pain at wound site  
vii. Delayed wound healing  
viii. Classic signs of infection are not always evident in a granulating chronic wound or in elderly residents  
b. Systemic signs of infection including:  
i. General malaise  
ii. Mental confusion  
iii. Loss of appetite  
iv. Leukocytosis  
v. Fever (often not present in elderly adults)  
vi. Occasionally hypothermia is seen indicating a poor central nervous system response  
vii. Blood sugar changes in diabetic residents  
5. Types of wound (pressure related versus non-pressure related) are differentiated  
6. Pressure ulcer stages are defined:  
a. Backstage only for MDS as required  
7. Wounds are identified as avoidable or unavoidable  
a. If unavoidable, documentation in the medical record includes assessments, interventions, re-assessments and additional interventions, as well as the identification of the resident’s medical diagnosis and complication factors that lead to the conclusion that the wound is unavoidable  
8. Progress toward healing is monitored  
a. Standard based on AHRQ (formerly AHCPR)  
b. If the wound shows no sign of healing within two to four weeks, the plan of care is re-evaluated, and it is determined whether to continue or modify the plan of care  
i. If the facility opts to continue the plan of care without modifications the rationale for doing so is documented in the medical record  
ii. The complexity of a resident’s condition may affect responsiveness or tolerance to treatments and this is considered in the review of the plan of care  
iii. NOTE: A chronic wound (one greater than 30 days old) may make very slow progress and in some cases may only show a decrease in measurements of 0.5cm a month. In these cases it is important to monitor wound progress through other parameters, including tissue type, appearance, and drainage. Use of the “PUSH” tool for monitoring wound progress is recommended, which may be downloaded from the NPUAP Web site: www.npuap.org  
9. Classify “Other” Skin Impairments  
a. Non-pressure related skin impairment (including skin tears) are classified as either partial thickness or full thickness  
i. Partial Thickness Skin Impairment involves loss of epidermis and possible partial loss of dermis. The tissue loss of a partial-thickness wound is similar to that of a Stage II pressure ulcer  
ii. Full Thickness Skin Impairment involves tissue destruction extending through the dermis to involve the subcutaneous layer and possibly muscle and bone. The tissue loss of a full thickness wound is similar to that of a Stage III/IV pressure ulcer  

D. Wound Management Principles  
1. Wound management principles provide the basis for effective wound care and should be considered in development of the plan of care  
2. Wound management principles include, and are not limited to:  
a. Control or elimination of causative factors such as:  
i. Pressure
ii. Shear  
iii. Friction  
iv. Moisture  
v. Circulatory impairment  
b. Provision of systemic support to reduce existing and potential co-factors such as:  
i. Nutritional and fluid support per assessed need  
ii. Control of systemic conditions affecting wound healing per medical plan of care  
c. Maintenance of a physiologic local wound environment including, and not limited to:  
i. Preventing and managing infection  
ii. Cleansing wound  
iii. Removing non-viable tissue (debridement)  
iv. Managing exudates  
v. Eliminating dead space  
vi. Controlling odors  
vii. Protecting the wound  
viii. Managing pain  

E. Wound Care/Dressings  
1. General infection control practices are maintained during wound care and dressing changes  
2. With assistance of Medical Director, wound management protocols are established and consistent with clinical practice guidelines for various stages of pressure ulcers  
3. “Clean” versus sterile technique for standard wound management is identified  
4. NOTE: Accepted standards are “clean” dressings/technique except immediately post-sharp/surgical debridement  
5. A protocol for cleansing and irrigation of wounds has been established  
   a. Use an irrigation pressure of approximately 8 psi (may be achieved by 35-ml syringe with angiocath)  
6. The wound of devitalized tissue is debrided  
   a. NOTE: Incorporate debridement “exceptions” into policy, including stable necrotic heel ulcers and stable ischemic wounds  
7. Dressing options are identified to maintain a moist wound environment  
   a. Use a dressing that controls exudate but does not dry out the wound base  
   b. Protect peri-wound skin and keep area dry  
8. A dressing algorithm/protocol to facilitate selection of appropriate dressings has been developed  
   a. Determine if dressing formulary is “closed” (only those dressings/products may be used)  
      or “open” (dressing algorithm is generally used but other treatment options are permitted)  
9. If the wound has depth, it is filled loosely with strip gauze or fluffed 2x2s or 4x4s. If tunneling or undermining is noted, the tunnel and/or undermined areas are loosely filled with gauze (typically strip gauze)  
10. A protocol is established for physician evaluation of suspected wound infection including:  
   a. Types of wound cultures performed in the facility  
   b. Consideration of systemic antibiotics in presence of bacteremia, cellulitis, sepsis, or osteomyelitis  
11. Adjunctive therapies available are defined (e-stim, vacuum assisted wound closure, growth factors)  
12. The treatment plan is re-evaluated if a clean pressure ulcer shows no evidence of healing within two to four weeks  

F. Documentation and Care Planning  
1. The wound management program documentation requirements include:  
   a. Identification of the location and frequency of wound documentation  
   b. Identification of forms used and format for reporting
c. Required comprehensive description of pressure ulcer weekly, at a minimum
d. Delineation of “in-house” documentation required (for example, weekly reports to the
   Director of Nurses) and by whom
e. Goals of the wound care plan collaboratively determined with the resident, family, and
   interdisciplinary team
f. Assigned responsibility/accountability for the initial care plan and for subsequent
   updating
g. Determined facility time frames for care plan updating
2. Resident risk factors and interventions are documented including:
   a. Impaired mobility
   b. Need for pressure relief such as support surfaces, repositioning, pressure relieving
      devices
c. Nutritional status
d. Incontinence
e. Skin condition
f. Complications such as infection and pain
g. General treatment regimen (delineating specific treatment is not necessary)
3. The resident medical record may contain different descriptions of the same skin ulcer at the
   same or similar points in time. This may lend to the appearance of conflicting medical record
   documentation as the facility attempts to balance regulatory required practices and current
   standards of practice
   a. The RAI/MDS documents, in accordance with Federal Regulation 42CFR 483.20(b)(1),
      may describe a healing or improving ulcer by reverse or backstaging (a Stage IV becomes
      a Stage III, etc.). The RAI/MDS documents may describe an ulcer with eschar or necrotic
      tissue that prevents otherwise accurate staging as a Stage IV. In accordance with the
      regulations, the facility is required to adopt these practices in the MDS assessment
      process despite the knowledge it is inconsistent with accepted standards of practice. In
      contrast, other national authorities and current standards of practice negate the above
      regulatory required process (www.ahrq.gov and www.npuap.org)
   b. In an effort to adhere to current standards of wound assessment in all documentation
      other than the MDS, medical records may describe an improving or healing ulcer versus
      “backstaging.” The wound should be described as a “healing Stage ___”
   c. In the event of eschar or necrotic tissue the facility typically regards this wound as
      “unable to stage” or “UTS.” A fundamental requirement of staging is the ability to
      visualize the base of the wound, which is not possible when eschar or necrotic tissue is
      present
4. Wound photography is not recommended as a component of the facility wound assessment
   protocol
   a. If wound photography is determined to be necessary, methods for assuring consistency in
      wound imaging need to be established as well as protocols to preserve image quality and
      storage
G. Notification
1. A written protocol is established for:
   a. Physician notification of pressure ulcer presence and responses to treatment
   b. Family notification of pressure ulcer presence, treatment plan, response to treatment, and
      changes in treatment due to wound deterioration
   c. “In-house” notification of interdisciplinary team members of the presence of a pressure
      ulcer and/or deterioration in wound status
   d. MDS Coordinator notification of the number of pressure ulcers and stages
H. Education/competency
1. Education resources available in-house and through external sources are identified
2. Education to interdisciplinary team members is provided upon orientation and annually on:
   a. Skin ulcer definitions per CMS §483.25
   b. Prevention and treatment of pressure ulcers
   c. Staging of pressure ulcers
   d. Monitoring wound progress/outcomes
   e. Facility protocols for documentation and notification
3. Education to certified nursing assistant staff members is provided on inspection, prevention, and management strategies upon orientation and annually
4. Education to residents and family members is provided during care planning meetings and annually to family council/group on:
   a. Etiology of pressure ulcers and risk factors
   b. Prevention and treatment strategies
5. Competency of staff upon orientation and annually is identified through use of competency skills checklists

I. Quality Improvement (QI)
   1. Oversight of the wound management program is provided by the Quality Improvement Committee and includes:
      a. Review of observation and documentation audits
      b. Analyzing pressure ulcer collected data and monthly reports
      c. Review of incidences and/or prevalence
   2. Action plans and goals to improve reported statistics and processes are developed
   3. Statistics, analysis of data, and performance improvement strategies are documented in the QI minutes
   4. Confidentiality language is noted on all quality documents
   5. Separate QI teams are established, as needed, to work on “focus” areas within the system established for pressure ulcer prevention and management
   6. A wound team is established as a sub-committee of the Quality Improvement Committee with:
      a. Defined frequency of wound team meetings
      b. Delineated activities to be accomplished