Policy Name: MANAGEMENT OF PRESSURE ULCERS AND WOUNDS	Policy Number: **0209**
	Effective Date: **MAY 9, 1996**
Approved By: Executive Team	Date Revised: June 18, 2020
Reason for Revision: Click on item below and select item from list. **CONTENT- Enter BELOW Reason for change Ex: Combined Policy ## and ##.** New format being used. Reviewed and updated.	Next Date for Review: June 18, 2023
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Policy

PRINCIPLES

- Residents who are receiving end-of-life care are at high risk for developing pressure ulcers and wounds. Agape Hospice health care providers will endeavor to prevent the development of pressure ulcer wounds. If a resident has an existing pressure ulcer wound, the focus will be to limit the deterioration, pain, infection, and odour of the wound.

OBJECTIVE:

- To provide comfort in palliative residents that are actively dying.
- To prevent the development of pressure ulcers at the end of life.
- To prevent infection, worsening of existing wounds, and control odour.

STAGING OF PRESSURE ULCERS

Stage 1 – is an observable pressure-related alteration of intact skin. In lightly pigmented skin it appears as a defined area of persistent redness. In darker skin tones it may appear as persistent red, blue or purple area.

Stage 2 – is partial thickness skin loss involving the epidermis and/or dermis. It presents as an abrasion, blister or shallow crater.

Stage 3 – is full thickness skin loss with damage or necrosis of the subcutaneous tissue extending down to the underlying fascia. It presents as a deep crater with or without undermining of adjacent tissue.

Stage 4 – is full thickness skin loss with extensive destruction, tissue necrosis or damage to the muscle, bone, tendon or joint capsule. It may have undermining or sinus tracts.

Eschar - is thick, dry, black necrotic tissue.

FORMS

Pressure Ulcer Prevention Tool (Waterlow)
Q 2 hour turns

CROSS REFERENCES

Policy # 0160 – Disposal, Storage and Cleaning of Wound Care Equipment

REFERENCES

Wound Management for Palliated Person presentation. Edie Attrell, RN, BN. Clinical Wound Consultant. Clinical Educator, Alberta Health Services.

Alberta Health Services, Calgary Zone, Skin and Wound Care Manual, Pages 44 – 70.

Pressure Ulcer Prevention Manual. Judy Waterlow, MBE SRN RCNT
Pressure Ulcer Staging – Wound Care Education Institute
Dressing Types Reference Sheet

Procedure

1. Residents will have a skin assessment completed by the Registered Nurse (RN) at the time of admission, as well as daily assessments.

   2.1 An initial in-depth assessment should include:
   a) Assessing the cause of the wound;
   b) Assessing the wound for:
      - location
      - stage
      - size and depth
      - presence of necrotic tissue
      - periwound tissue and wound edges
      - exudates and odor
      - signs of infection
      - pain

   The findings of the assessment should be **documented in detail in the progress notes in the residents' health record.**

2. The Pressure Ulcer Prevention tool (Waterlow) will be completed on admission and weekly on Wednesdays.
3. All residents will be placed on a therapeutic surface. Agape's *stryker comfort gel* mattresses are considered a therapeutic surface.
4. When deciding the best type of dressing for the wound, consider the following:
   - comfort
   - promotion of cleansing and debridement by product if appropriate
   - control of exudate/drainage
   - protection of surrounding skin/tissue from irritation
   - control of bleeding
   - helping contain odour
   - preventing contamination and infection
   - promotion of healing if appropriate
5. After the assessment and decision on dressing type is completed, the Medication and Wound Care Plan should be completed to reflect these assessments and instructions for ongoing wound care. It should include the type of dressing, any special treatments or topical applications ordered by the Attending Physician, the frequency of changes and the supplies required during the dressing change. This document will be kept at the front of each resident's MAR.
6. A two (2) day stock of dressing supplies will be kept in a zip locked bag in the resident's bedside closet.
7. If the wound does not respond to the present treatment, other solutions will be discussed with the physician.