Pressure Injury Management Guidelines

Unstageable 100% Eschar Full Thickness	Deep Tissue Injury	Kennedy Terminal Ulcer (KTU)	Mucosal Pressure Ulcer (MPru)	Medical Device Related Pressure Injuries
Unstageable –Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Further description: Until enough slough and/or eschar are removed to expose the base of the wound; the true depth cannot be determined; but it will be either a Category/Stage III or IV. 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.	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.	Partial to Full thickness tissue loss due to unavoidable skin breakdown or skin failure that occurs as part of the dying process. Ulcers typically present as pear shape, red/yellow/ black and occur suddenly in the sacral/coccygeal region.	Because of the anatomy of the mucous membranes, these ulcers should NEVER be staged. They often result from a device and present with what appears as "slough which is, and should be documented as, coagulum.	Pressure injuries that result from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant ulcer generally conforms to the pattern or shape of the device. Should be staged to the most severe tissue damaged depth.
• Off Load • Keep Dry • Cover/Protect	• Off Load • Protect	• Off Load • Debride if needed • Manage Exudate	Remove or rotate agitator cause (i.e. Oxygen tubing, endotracheal tubes, bite blocks, orogastric	• Off Load • Manage Exudate • Debride if needed

• Assess Support Surfaces • Decrease Friction/Shear	• Assess Support Surfaces • Decrease Friction/Shear	• Fill Cavity • Cover/Protect	and nasogastric tubes, urinary catheters, fecal containment devices	• Fill Cavity • Cover/Protect
Stable Eschar: • Keep area dry. • Keep area intact. • Assess wheel chair positioning • and seating. *Stable Eschar on heels:* (dry, no erythema, no exudate, fluctuance) - area does not need to be debrided. • Paint with Skin Prep or Betadine. • Offload heels. • No shoes. *Debridement Needed* if "Presence of exudate, erythema, fluctuance, odor or pain"	*Strategies to Protect:* *DTI on heels:* • Suspend heels with pillows, specialty cushions, boots. • Use skin protectants to keep skin intact. *DTI sacral/gluteal:* • Use moisture barrier to match type and amount of incontinence. • Assess repositioning interval. • Assess support surfaces. • Assess wheel chair positioning and seating.	KTU are treated symptomatically like any other pressure ulcer. After Stage of injury has been determined, see Management Guidelines for that stage for treatment.	Because of the location and cellular composition of *MPru*, there are no topical therapies that can be instituted to promote healing. Removal, padding or repositioning of device causing injury is of utmost importance to allow for healing.	Removal, padding or repositioning of device causing injury is of utmost importance to allow for healing and/or prevention. Residents with any type of medical device in place should be assessed at least twice a day for possible skin injury. After Stage of injury has been determined, see Management Guidelines for that stage for treatment.