Unstageable Pressure Injury:

Obscured full-thickness skin and tissue loss

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Conflict of interest

• none
Objective

- Define the new definition of unstageable pressure injury

- Discuss various management options of unstageable pressure injury

Old

Unstageable/Unclassified
Full thickness skin or tissue loss – depth unknown

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. 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.

Unstageable Full-Thickness Pressure Injury: Obscured Full-thickness skin and tissue loss

Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar.

If slough or eschar is removed a Stage 3 or Stage 4 pressure injury will be revealed.

Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the ischemic limb or heels should not be removed.
Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss

Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer/injury cannot be confirmed because it is obscured by slough or eschar.

If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed.

Unstageable Pressure Injury Examples

Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on an ischemic limb or the heel(s) should not be softened or removed.
One Study: Partial thickness, Zaratkiewicz, et. al., 2015
• Retrospective chart review
• Reported 48 unstageable PI covered with slough
• 31 followed the healing trajectory of full thickness wounds
• 17 followed the healing trajectory of partial thickness wounds.

Was slough present in these 17 wound? Or was the base of the dermis (reticular layer) easily misidentified as slough.

Reticular dermis

The reticular layer of the dermis (RD) consists of dense irregular connective tissue, which differs from the papillary layer (PD), which is made up of mainly loose connective tissue (note the difference in the number of cells). The reticular layer of the dermis is important in giving the skin its overall strength and elasticity, as well as housing other important epithelial derived structures such as glands and hair follicles.

Unstageable Pressure Injuries

Unstageable Injury on the Sacrum

Unstageable Injury on the Lateral Heel

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Treatment of Unstageable PI

Goal of treatment is to safely debride the PI to the point where they can be properly staged.

PI totally or partially covered with slough/eschar cannot be staged until the deepest viable tissue layer or identifiable structure is exposed.

Unstageable Pressure Injury Example

Unstageable Injury on the L. Ischium with tunneling and undermining
Unstageable: Care & Management

- Assessment
- Cleansing
- Debridement
- Dressings
- Support surface
- Pain Management

Assess Pressure Injury initially & weekly
Measurements: Weekly/ with significant changes
Document all debridement & method used
Document if staging PI after debridement is possible
Select a wound dressing that provides moist wound therapy, and promotes healing environment
Document type of wound dressing

Treatment & documentation

Lateral malleolar eschar
Slough
Granulation

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Cleansing

• Cleanse PI at time of each dressing change with saline or wound cleanser

• Use aseptic technique if immunocompromised or wound enters a sterile body cavity; otherwise clean wound management is appropriate

• Consider using cleansing solutions with surfactants with suspected infection or high levels of bacterial colonization

Debridement

• Debride devitalized tissue within the wound bed or edge of the PI when appropriate

• Necrotic tissue should be removed to decrease inflammation & reduce risk of infection
  • Exception is the heel in an ischemic limb
  • Debride the wound bed when the presence of biofilm is suspected or confirmed
Types of Debridement

- Surgical/Sharp--scalpel and scissors
- Conservative sharp--scalpel, curettes, scissors, or forceps
- Autolysis--moisture-retentive dressings
- Enzymatic--Collagenase
- Mechanical--wet to dry, wound irrigation, low frequency ultrasound, ultrasound mist, monofilament pads
- Biological--larval therapy

Do not debride stable, hard dry eschar in ischemic limbs

S/S of when to debride:
- Erythema
- Tenderness
- Edema
- Purulence
- Crepitis
- Malodor
Treatment

- Encourage repositioning as tolerated
- Use support surfaces

General Recommendations

- Support surfaces are part of a total management plan for pressure injury prevention and treatment
- Select a support surface that meets patient’s needs
  - Level of immobility and inactivity
  - Need for microclimate control & shear reduction
  - Size & weight of patient
  - Risk for new pressure injuries
  - Number, severity and location of existing pressure injuries
General Recommendations

• Do not base support surface selection solely on the perceived level of risk or current injury
• Continue to reposition patients placed on a support surface
• Choose positioning devices and incontinence pads, clothing and bed linen compatible with support surface
• Limit the amount of linen and pads placed on the beds

Pain Management

PAIN MEASUREMENT SCALE

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Treatment & dressing changes

• Coordinate pain medication with activities and dressing changes especially before debridement

• Consider topical anesthetics

Wound Dressings

• General Recommendation:
  – Ability to keep wound bed moist
  – Need to address bacterial bioburden
  – Nature & volume of wound exudate
  – Condition of the tissue in the injury/ulcer bed
  – Condition surrounding skin
  – Wound size, depth, and location
  – Presence of tunneling or undermining
  – Goals of the individual
Pre & Post debridement

Moist wound therapy

- Once granulation tissue is present in the wound bed
  - Use a dressing to retain moisture
  - Select dressings that match the wound bed characteristics
  - Consider adjuvant therapy for non-healing wounds
    - NPWT
    - Ultrasound
    - Electrical stimulation
Objective:
Inhibit growth of bacteria within the dressing - Bacteriostatic
Manage exudate

Treatment: Infected pressure injuries
Colonized & Critically Colonized Wounds

Treatment of Infected Ulcers

- Debridement
- Antimicrobial dressings
  - Silver
  - Hydrofera Blue
  - Honey
  - PHMB
  - Cadexomer iodine
- Antibiotics if patient is septic or bacteremic
Promoting Healing from Bottom of Wound

- Fill entire wound space
  - Called dead space
- Prevents pockets of unhealed tissue within wound bed
- Prevents anaerobic growth
- Options: Pack gently with
  - Paste or gel dressings
  - Alginate
  - Hydrofiber
  - Etc.
Be sure to examine the whole patient, not just the hole in the patient

“Thats all Folks!”
References


Available at npuap.org