Assessment

Despite your best efforts, patients do develop pressure ulcers from time to time. If a pressure ulcer develops, the Centers for Medicare & Medicaid Services requires a nurse to

- determine the pressure ulcer's stage
- describe and monitor the ulcer's characteristics
- monitor the healing progress
- determine whether infection is present
- assess, treat, and monitor pain
- monitor dressings and treatments

When a nurse evaluates a pressure ulcer, he or she does the following:

1.Notes the location. The nurse describes in detail the joints or prominences on which the ulcer appears.

2.Measures the pressure ulcer for length, width, and depth. Measurements are important because they help determine the status of the wound and, therefore, how the nurse should treat the ulcer.

3.Asks every day about pain. Ask how intense and frequent the pain is.

4.Looks for exudate. Exudate is the fluid that builds up in a pressure ulcer, and it can sometimes be helpful to heal the wound.

5.Looks at and evaluates the wound bed. Note the color of the wound. Ulcers should heal from the bottom up, and to do so, the wound bed must be clean and free from infection. Look at the granulation tissue—the pinkish, living tissue that fills a pressure ulcer when it starts to heal.

6.Looks for slough and eschar. These are both types of dead necrotic tissue. Eschar is thick-looking black tissue, and slough is typically yellowish.

Dressing and treatments

Pressure ulcer treatment can be a complex process, and a nurse will need to individualize treatment plans to both the needs of the patient and the stage of the wound. For all stages of pressure ulcers, the most important thing for CNAs to assist with is to **keep pressure off of the sore.**

It is also important to help the patient maintain good hygiene. Help him or her wash with mild soap and water, taking care not to rub the wound. While a wound heals, the sore will get smaller and pink tissue will start to form around its edges. Report any unusual changes in the wound, such as an increase in drainage, increased redness around the sore, or the formation of black areas around the wound.