

Everything
You Need To
Know About...

Stage 4 Pressure Ulcers

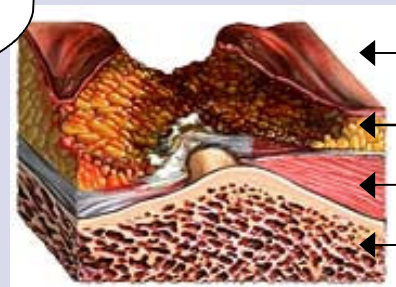
“An ounce of prevention may be worth tons rather than pounds of cure. Although on the surface, pressure relief/reduction devices, high protein diets, and appropriate dressing materials appear expensive, the actual cost in nursing hours, equipment, devices, and consumable supplies when caring for a client with even one pressure ulcer is far greater.”

(Motta, 2000, pp. 14-16)

What is a Stage 4 Pressure Ulcer?



- Full thickness tissue loss
- Exposed or directly palpable bone, tendon or muscle.
- Slough or eschar may be present in some parts of the wound bed
- Often involves undermining and tunneling (NPUAP, 2007).



How do I know if the Stage 4 is healing?



HEALING

- The wound will get smaller.
- Pinkish tissue usually starts forming along the edges of the sore and moves toward the center.
- You may notice either smooth or bumpy surfaces of new tissue.
- Some bleeding may be present. This shows that there is good blood circulation to the area.

SIGNS OF TROUBLE

- Increases size or amount of drainage.
- Increases redness or black (eschar) areas around the wound.
- Drainage has a foul odor and/or becomes a greenish color.
- The patient develops a fever.

*Call MD and/or
Wound Care RN



Department

This informational handout on Stage 4 Pressure Ulcers was created by the GSAA Inpatient Clinical Education Department.

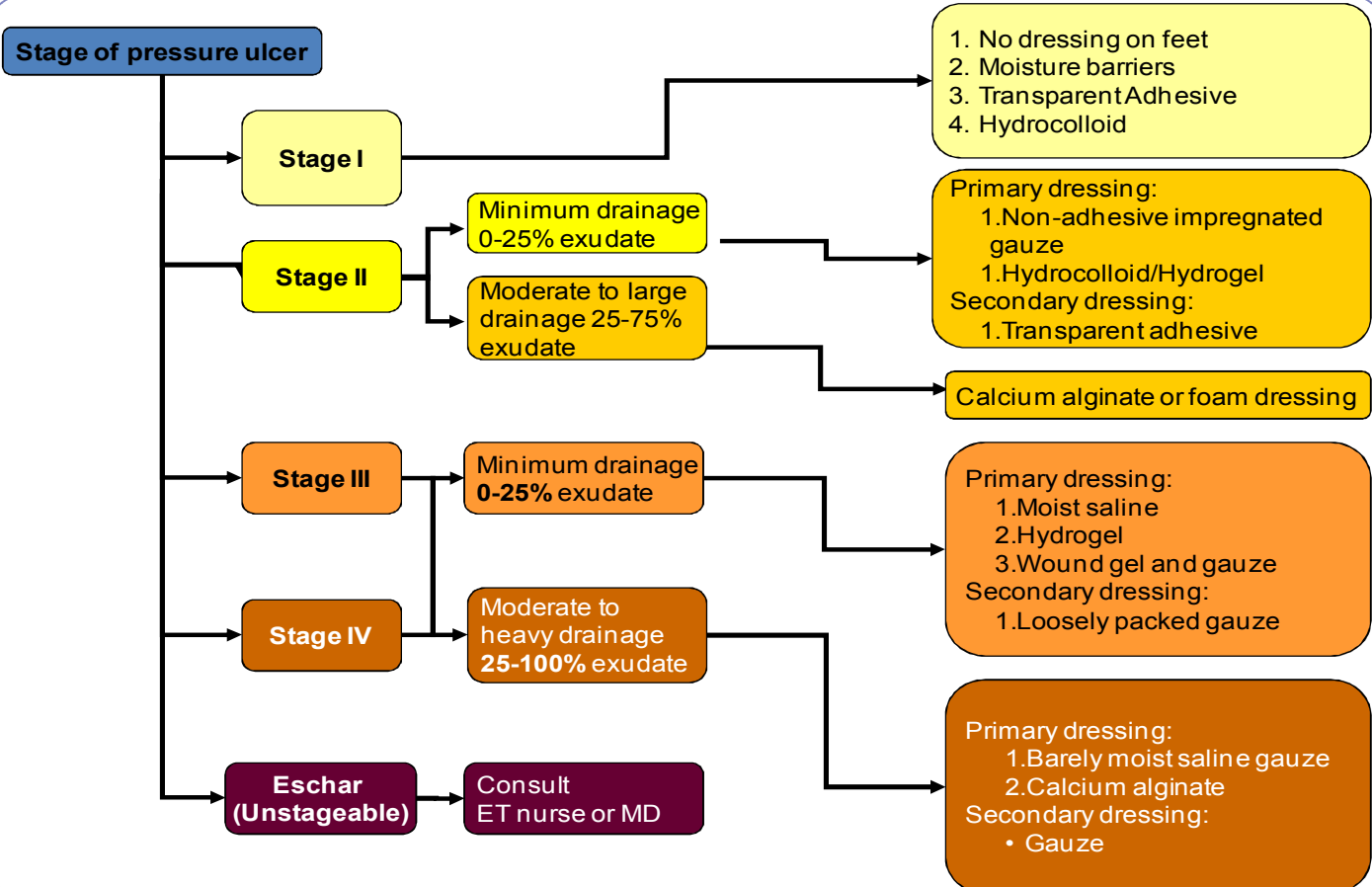
Content: Winchell Kuttner, RN, MSN and Bridget Sheehan, BSN, RN

Design: Bridget Sheehan, BSN, RN



How do I know what dressing or barrier to use?

Take a look at these two tables: the top table explains the process of selecting a dressing based on the staging; the bottom table explains the pathophysiology behind each type of treatment.



| Agent | Mechanism of Action | Dosage | Benefits |
|-----------------------------|-------------------------------------------------------------------------------|--------------------------------------------------------------------|------------------------------------------------------|
| Hydrocolloid | Maintains moist environment | Change every 3-7 days, depending on when seal is open around wound | Accelerates rate of healing compared to dry dressing |
| Hydrogel | Maintains moist environment | Once to four times daily | Accelerates rate of healing compared to dry dressing |
| Film | Protects wound | Once daily or less frequently | Use in superficial ulcers may protect undamaged skin |
| Alginate | Absorbent; maintains moist environment when sufficient wound fluid is present | Once daily or less frequently | Absorbs exudate |
| Moist saline gauze | Maintains moist environment | Three times daily or more frequently | Maintains moist environment |
| Petroleum gauze | Maintains moist environment | Once to four times daily | Maintains moist environment |
| Hypertonic saline wet gauze | Maintains moist environment | Twice daily or more frequently | Has antimicrobial activity |
| Iodine-solution wet gauze | Broad-spectrum antiseptic | Once to four times daily | Has antimicrobial activity |

References

National Pressure Ulcer Advisory Panel (2007). *Pressure ulcer stages revised by NPUAP*. Retrieved on December 18, 2007, from <http://www.npuap.org/pr2.htm>

Kawasaki, G., & Warms, C. (2007). Taking care of pressure sores. Retrieved from http://sci.washington.edu/info/pamphlets/pressure_soares.asp

Motta, G. (2000). Reimbursement relief. *Continuing Care*, 19, 14-16.