The National Pressure Ulcer Advisory Panel (NPUAP) published updated definitions of pressure ulcers in February 2007. These definitions were followed in October 1, 2008 by the “Present on Admission” (POA) focus of Centers for Medicare and Medicaid Services (CMS). This new focus identified pressure ulcers as a hospital-acquired condition whose management would be the financial responsibility of the institution.

Stage I pressure ulcer development often can be curtailed by offloading. Clinicians managing pressure ulcers should be diligent about patient re-positioning via turning schedules, with special attention to bony prominences and the bed, only elevating the head of the bed beyond 30˚ for less than 1 hour at a time. Additionally, other factors that undermine healthy intact skin should be considered, such as friction and shear, incontinence and moisture, and nutrition and hydration.

Prevention is always the best course of action. No cookie-cutter recipe exists for the treatment of a Stage I pressure ulcer. The periwound skin should be examined and contributing factors treated. If the skin is moist, protective barrier creams should be used and the source of the moisture determined and contained or managed. Incontinence can be addressed by implementing toileting schedules or by diverting the urine and stool from the skin surface. The effects of friction and shear can be reduced by using lift sheets and overhead trapeze bars when possible. Dressing selection should be patient-appropriate: absorptive hydrocolloids with a thin edge that resists rolling, foam dressings with a gentle adhesive border. Heels should be bridged, floated, or suspended — socks will not do the trick and if the patient has active legs, pillows will not work. The patient’s nutritional and hydration status should be monitored and diet modified as necessary.

Prevention and treatment are a team effort. Clinicians should educate and solicit the cooperation of the patient, caregivers, family, nursing personnel, nutritionists, therapists, and physicians. The presence of a Stage I pressure ulcer indicates damage already has occurred; to navigate this slippery slope, we must render quality care that contributes not only to the quality of life for our patients, but also to the financial well-being of our institutions.

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