Long-Term Care Survey Alert

PRESSURE ULCER CARE: Pack Your Skin-Care Know-How With These FAQs About Deep Tissue Injury

Forewarned is forearmed in addressing this beguiling phenomenon.

What you don't know about suspected deep tissue injury or DTI can hurt your residents and survey record.

Know the definition: The updated **National Pressure Ulcer Advisory Panel** (NPUAP) guidelines for staging pressure ulcers define suspected DTI as a "purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue."

Janet Cuddigan, PhD, RN, CWCN, CCCN, a nursing professor and **University of Nebraska** and national wound care expert, sheds some light on the phenomenon of pressure-related injury that often takes time to show its true extent on the surface:

Q: How prevalent is DTI?

A: We do quarterly skin assessment studies at the **University of Nebraska Medical Center** and usually find that about 10 percent of pressure ulcers are DTI. People in other areas of practice have said they felt that percentage is higher. A physician from France said in his spinal cord rehab facility that it's more like 30 to 40 percent.

Q: What are the risk factors for developing DTI?

A: In some respects, the risk factors will mirror what we know from traditional pressure ulcer risk factors identified by the Braden scale, etc. We don't have the data at this point, but we are assuming that DTI is probably due to greater intensity and duration of pressure. Where I see them in acute care is in someone who has fallen and broken a hip, etc., and [was immobilized where she fell] as she couldn't get help for some time.

I always check bony prominences carefully in patients who have had long surgeries. Pressure ulcers tend to develop two to three days after immobility due to surgery. Some of these initially present as DTI with intact skin--and they tend to be more DTI. You also worry about patients with poor perfusion in addition to their other risk factors for pressure ulcers--for example, someone with low blood pressure. In a long-term care facility, you should carefully check the heels of people with peripheral vascular disease.

Q: Does the overlying skin always break open in someone with DTI?

A: If there is truly deep damage that won't recover with offloading of pressure, yes, the skin will break open. That's why we call it suspected DTI with intact skin. Sometimes [by offloading pressure], the area appears to recover and the skin does not break open. My suspicion is that the patient didn't have much deep tissue damage because if the tissue were truly dead, the skin would break open.

Q: Is DTI always over a bony prominence?

A: Usually, but it's possible to have it in other places. The key issue is that the patient had sufficient pressure to damage the tissue. I have seen DTI in a patient with a splint that was applied too tightly, but the pressure wasn't over a bone. The key is to look for a source of intense and prolonged pressure.

MDS coding tip: While the NPUAP guidelines for staging pressure ulcers designate suspected DTI as a separate category, you still code suspected DTI as a stage 1 pressure ulcer on the MDS if the overlying skin is intact. For a free copy of "New Staging Guidelines Increase Pressure To Juggle The Standard Of Care And MDS Coding," in MDS Alert, please e-mail your request to EditorMON@aol.com.