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MDS Alert

Quality of Care: When a Pressure Ulcer Doesn't Seem to Be Healing, Look for These Key Reasons

Know what to consider if you see this when wound bed slough clears, advises expert.

First step: When a wound's healing trajectory stalls, consider whether your original wound assessment is on target, advises **Jenny Hurlow, RN, GNP, CWOCN,** a wound specialist and nurse practitioner in Memphis, Tenn. For example, "were there really healthy granular buds on the wound bed?" Or did you see a decrease in wound bed slough, "which is a sign of improvement but not truly evidence of wound healing?"

Another question: Is there a simple explanation for the inadequate wound healing? Once you "really tune in," you may find, for example, that the resident is sitting for hours on his pressure ulcer when the family takes him out for a few hours on the weekend, says **Ameet Vohra, MD, CWS,** founder of National Vohra Wound Physicians in Miramar, Fla.

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Other potential causes of a non-healing or worsening wound include the following:

1. Wound infection or critical colonization. "To assess a pressure ulcer or other wounds for infection, look for increased drainage, odor, and peri-ulcer erythema and induration," advises Hurlow. While chronic wounds with nerve and tissue damage will produce continual woundrelated discomfort, a patient who complains of increased wound pain should "trigger suspicion of evolving wound infection," she adds.

Look for this: "A biofilm becomes macroscopic where you can see it once critical colonization or an infection is pretty well established," says Hurlow. (For tips on managing a biofilm, see the next MDS Alert.)

When you see signs of wound infection, obtain a specimen for culture in order to select the appropriate antibiotic, Hurlow advises. "A tissue specimen is the gold standard," she says. But if that's not possible to obtain, "a swab specimen obtained by the Levine technique is a more practical and very effective option." (Review the Levine technique at www.nursingcenter.com/library/static.asp?pageid=811925.)

Clinical tip: "Sometimes as a wound bed slough clears," you'll see "newly exposed bone or fascia," Hurlow advises. And if you don't see granulation tissue begin to cover these structures "in a timely fashion," the provider may need to consider evaluating the patient for an underlying bone infection, she suggests.

2. A decline in nutrition or health status. A stalled wound-healing trajectory may be a sign of deteriorating nutrition or problems with other body systems, says Hurlow. For example, "heart or lung deterioration could result in poorer wound tissue oxygenation."

3. Improper management of wound exudate. "Inadequately managed wound exudate will impair healing and increase risk of wound infection," warns Hurlow. So look at whether caregivers are changing the absorptive dressing often enough, which in some cases they may need to do more often than every 24 hours, she says. "Negative pressure wound therapy may be the only way to adequately manage wound exudate in some larger sacral pressure ulcers."

4. An incorrect pressure ulcer diagnosis. Skin lesions or ulcers that aren't located over a bony prominence may not be pressure-related, unless you can trace them to an external device, such as catheter tubing, says Hurlow. As an example, one patient had an upper-back wound "that was perfectly round, which is typical of pressure ulcers. But it wasn't over a bony prominence," she says. "The wound did not respond to two weeks of a standard moist wound healing strategy. A tissue biopsy showed it was a skin cancer."

Tip: "Doing a careful medical history can help identify wound etiology," says Vohra. For example, he recounts how two HIV patients had what appeared to be "classic pressure ulcers" in the sacral area. But the ulcers were actually caused by a Herpes simplex infection "that manifests in the sacral area in a way that looks exactly like a decubitus ulcer. So we treated them with an antiviral for herpes and they did quite well."

5. Vascular insufficiency. "Vascular problems can affect pressure ulcer healing," says Hurlow. "A sacral pressure ulcer is generally well perfused as long as the patient is positioned off the wound," she says. But that may not be the case for heel or ankle pressure ulcers, as "there are no large arteries that go to the lateral aspect of the foot.

Thus, if a person has peripheral artery disease, the skin over the lateral foot/ankle is the first to suffer." If you suspect this is the case, obtain an ankle-brachial index and arterial ultrasound, she advises. "The next step may be to refer the individual to a vascular specialist for a more detailed evaluation" and to see if revascularization is an option. "Hyperbaric oxygen therapy is also a consideration, especially for diabetics."