PURPOSE:
To identify dressing and treatment modality options for suspected deep tissue injury pressure ulcers.

CONSIDERATIONS:
1. Suspected Deep Tissue Injury (DTI) is defined 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 areas may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.
2. Further description: DTI may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over dark wound bed. The wound may further evolve and become covered with thin eschar. Evolution maybe rapid, exposing additional layers of tissue destruction, even with optimal treatment.
3. If protection from shearing is needed, application of transparent film is indicated (not recommended for blistered DTI).
4. Use clean technique.
5. Topical treatment options for DTI pressure ulcers include:
   a. Lubricating sprays.
   b. Moisturizing lotions and gels.
   c. Skin protectants.
   d. Transparent films.
   Frequent assessment of the wound is needed to identify and manage changes in wound status. Additional therapy modalities include:
      a. Support surface.
      b. Nutritional support.
      c. Offloading of affected area
6. Continue to follow procedures for prevention and assessment of pressure ulcers. (See Pressure Ulcer and Wound Assessment.)

Option I
Use of Lubricating Sprays/Moisturizing Lotions and Gels/Skin Protectants

EQUIPMENT:
Gloves
Soap, mild/non-oily or commercial skin cleanser
Lubricating spray or moisturizing lotion
Skin protectant
Moisture barrier

PROCEDURE:
1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. Wash affected area with wound cleanser agent, as ordered, or soap and water.
4. Gently apply moisturizer to skin, if needed.
5. Substitute a moisture barrier or skin protectant if patient is incontinent of urine or feces or has excessive sweating.
6. Lotions and moisture barriers need to be reapplied as directed by manufacturer. Usage is product type specific
7. Discard soiled supplies in appropriate containers.

AFTER CARE:
1. Document in patient’s record:
   a. Procedure.
   b. Patient’s response to procedure.
   c. The condition of the patient according to the assessment procedure for pressure ulcers (see wound and pressure ulcer assessment).
2. Instruct the patient/caregiver in:
   a. Care of the pressure ulcer.
   b. Pressure reduction techniques. (See Pressure Ulcer - Prevention.)
   c. Reporting signs and symptoms of infection and other areas of breakdown.
   d. Diet to promote healing.
   e. Medications/disease processes that may be impeding healing.
   f. Activities permitted.

Option II
Transparent Film. (See Integumentary- Application of Transparent Film.)