PURPOSE:
To identify dressing and treatment modality options for Stage II pressure ulcers.

CONSIDERATIONS:
1. A Stage II pressure ulcer is defined as an area of partial thickness, loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising*. This stage should not be used to describe skin tears, tape, burns, perineal dermatitis, maceration or excoriation. Bruising indicates suspected deep tissue injury.
2. Obtain physician’s order for all treatment and cleansing agents.
3. Normal saline is an acceptable agent for cleansing pressure ulcers.
4. Use clean technique.
5. Topical treatment options for Stage II pressure ulcers include:
   a. Transparent films.
   b. Composite, hydrocolloid, hydrogel wafer, foam, antimicrobial dressing or alginate (for heavily exuding wounds only) dressings.
   c. Amorphous hydrogel and cover dressing.
6. Additional therapy modalities include:
   a. Nutritional support.
   b. Support surface.
   c. Electrical Stimulation-for recalcitrant Stage II Pressure Ulcers.
7. Continue to follow procedures for prevention and assessment of pressure ulcers. (See Pressure Ulcer and Wound Assessment.)

Option I
Options for clean granular wounds with minimal exudate:
1. Transparent Film. (See Integumentary- Transparent Film Application.)
2. Composite, Hydrocolloid, Hydrogel Wafer
3. Hydrocolloid (if no significant depth)
4. Hydrogel dressing (amorphous or impregnated gauze)
5. Apply secondary dressing, if needed.

Option II
Options for clean granular wounds with moderate to large amount of exudates:
1. Foam.
2. Calcium Alginate (for heavily exuding wounds).
3. Apply secondary dressing.

Option III
Options for granular wounds with local signs of infection:
1. Antimicrobial dressing, such as silver-based or cadexomer iodine based.
2. Apply secondary dressing, as dictated by amount of exudates.

EQUIPMENT:
Gloves
Gauze
Basin (optional)
Cleansing solution, normal saline or other
Protective bed pad
Amorphous Hydrogel as primary dressing
Secondary dressing
Skin protectant
Tape
Impervious trash bag

PROCEDURE:
1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. Clean wound with normal saline or wound cleanser per wound care orders. (See Integumentary- Wound Cleansing.)
4. Apply primary dressing according to manufacturer's guidelines and physician's orders.
5. Dress wound, as needed, with appropriate cover dressings following the manufacturer’s guidelines for use. (See Integumentary- Dressing Changes.)
6. Discard soiled supplies in appropriate containers.
7. Clean reusable supplies before leaving the home, according to agency policy.

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.
2. Instruct the patient/caregiver in:
   a. Care of the pressure ulcer.
   b. Pressure redistribution 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.