**PURPOSE:**
To enhance local penetration of enzymatic debridment agents to the nonviable wound base of black, hard eschar on small pressure ulcers allowing autolytic debridement agents or chemical, enzymatic debriding agents to have direct contact with the ulcer bed. This is one example for scoring of eschar and the procedure itself varies greatly by institution and medical provider.

**CONSIDERATIONS:**
1. Scoring of an eschar may be done by a trained clinician under the agency's medical policy, State Practice Acts and physician order.
2. When eschar is black and hard, no enzyme or ointment will debride the pressure ulcer and healing will not take place. Debridement can only be done surgically or by scoring (cross hatching).
3. Not every homecare patient is a candidate for scoring to debride eschar. The candidate for the scoring procedure must be carefully chosen using the following guidelines:
   a. Supportive, involved family/caregiver.
   b. Bedbound, non-transportable patient.
   c. Small ulcer, for example, not larger than 2 inches (4.5 cm) on coccyx or 1 inch (2.5 cm) on the heel.
   d. Nutritional status at least fair.
   e. Medically fit patient i.e. no diagnosis of peripheral vascular disease, diabetes, anemia or hypoproteinemia.
4. Contraindications:
   a. Patient on anticoagulants.
   b. Patient is medically unfit.
   c. Lack of expertise in procedure.
   d. Nonhealable ulcer (i.e. lack of insufficient vascular supply to allow healing).
5. It is not possible to stage the pressure ulcer when it is covered with eschar.
6. Heel ulcers with dry, stable eschar need not be debrided if they do not have edema, induration, erythema or drainage.

**EQUIPMENT:**
- Antimicrobial solution
- Gauze sponges
- Gloves
- Sterile scalpel (#11 or #15)
- Normal saline
- Enzymatic or autolytic debriding agent
- 4x4 gauze pads
- Hypoallergenic tape

**PROCEDURE:**
1. Adhere to Standard Precautions.
2. Explain the procedure carefully to the patient/caregiver. The scoring procedure is painless and bloodless.
3. Position the patient to afford the nurse a good view of the ulcer and allow patient comfort.
4. Cleanse the eschar and surrounding tissue with antimicrobial soaked gauze sponge working in a circular motion from inside out. Use a new sponge for each stroke.
5. Rinse the area very well with normal saline until there is no trace of antimicrobial solution to prevent interaction with enzymatic agent.
6. Using a scalpel, carefully make parallel, vertical or horizontal incisions every 1/8-1/4 inch (.25-.5 cm) into the black eschar layer. Make a criss-cross pattern. Make the incision into the eschar layer only until a pale gray to pink color is observed in the incision. When making the incision into the eschar layer, it is possible to feel the difference between cutting into the hard eschar and the softer, underlying tissue. Scoring is just through the eschar layer, not into viable tissue. It may be necessary to go over the incisions more than once to achieve sufficient depth.
7. Apply a thin layer of enzymatic debriding agent or hydrogel on the eschar only. DO NOT apply to the viable skin around the ulcer.
8. Cover with a wet-to-dry dressing using normal saline, gauze pads and hypoallergenic tapes or transparent dressing.
9. Autolytic debridement involves the use of synthetic dressing to cover a wound and allow devitalized tissue to self-digest from enzymes normally present in wound fluids.
   a. Use transparent film or hydrocolloid wafer dressings to promote autolysis in superficial wounds.
   b. Use calcium alginites and exudates-absorptive dressings which absorb many times their weight, to debride extensive ulcers and to promote autolysis.
   c. DO NOT use occlusive dressing if the wound is infected.
10. Reposition patient.
11. Discard soiled supplies in appropriate containers.

**AFTER CARE:**
1. Document in patient's record:
   a. Procedure and observations.
   b. Patient's response to procedure.
   c. Instructions given to patient/caregiver.
2. Plan a revisit schedule to ensure that the dressing is changed at least every 24 to 48 hours.
3. Observe the wound closely for signs and symptoms of infection and patient's/caregiver's adherence to the care regime.
4. Instruct the patient/caregiver to:
   a. Change the dressing as ordered.
   b. Report signs and symptoms of infection including a change in the amount or character of the drainage and an elevated temperature.
   c. Give adequate hydration and diet to promote healing.
   d. Render prophylactic skin care to prevent or detect early or further skin breakdown.
   e. Evaluate the debridement process. After all the necrotic tissue is gone, use treatment for appropriate stage of pressure ulcer depending on the depth of the ulcer.

REFERENCES:
