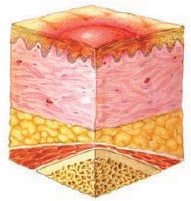
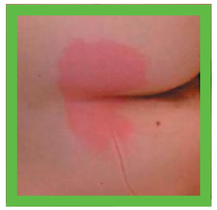
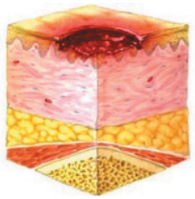
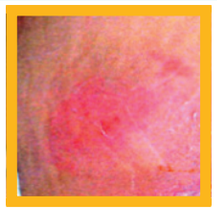
PRESSURE ULCER GRADING CHART

Superficial

Category I: Non-blanching Erythema

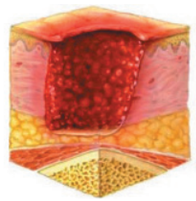
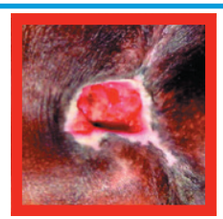
Intact skin with non-blanching redness of a localised area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area.
The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category/Stage I may be difficult to detect in individuals with dark skin tones.
May indicate "at risk" individuals (a heralding sign of risk)

Category 2: Partial Thickness Skin Loss

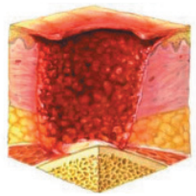
Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, or with thin slough. May also present as an intact or open/ruptured serum filled blister.
Presents as a shiny or dry shallow ulcer without slough or bruising.* This Category/Stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.
**Bruising indicates suspected deep tissue injury.*

Deep

Category 3: Full Thickness Skin Loss

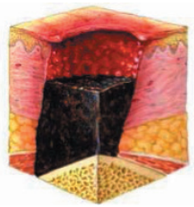
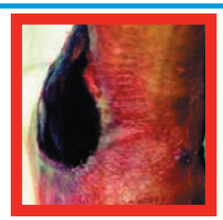
Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunnelling. The depth of a Category/Stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category/Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage III pressure ulcers. Bone/tendon is not visible or directly palpable.




Category 4: Full Thickness Tissue Loss

Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunnelling. The depth of a Category/Stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category/Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.directly palpable.

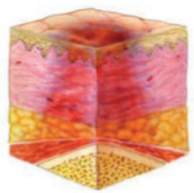
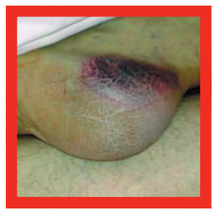
Unstageable

Unstageable: Depth Unknown

Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/Stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed.

SDTI

Suspected Deep Tissue Injury: Depth Unknown

Purple or maroon localised area of discoloured 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. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.

Adapted from the International NPUAP/EPUAP Pressure Ulcer Classification System 2014
https://improvement.nhs.uk/documents/2229/Top_tips_to_manage_pressure_ulcers_dec2018rev9jan.pdf

https://www.bda.uk.com/foodfacts/pressuresoresfoodfact.pdf

PRESSURE DAMAGE

SKIN CARE

- Continue frequent skin inspection during every episode of care
- Ensure pads are changed when soiled
- Cleanse skin following episodes of incontinence with product recommended by the Community Nurse or TVN
- Apply barrier cream if evidence of moisture
- Ensure appropriate repositioning regime in place and documented
- Notify Community Nurse

PRESSURE CARE / MOVING

- Monitor equipment functionality and use
- DO NOT SIT OUT patients with sacral damage- offload in bed using 30-degree tilt
- Minimise high risk patient sitting - max 2 hours
- Encourage bed rest between meals
- Avoid bony prominences when positioning
- Position with 30-degree tilt using a pillow
- Reposition 2 hourly or as directed by the Community Nurse
- Implement repositioning chart

NUTRITION

- Implement food and fluid chart
- Encourage and monitor food and fluid intake, report any concerns

DOCUMENT

- Skin changes/skin care/non compliance
- Equipment functionality – particularly airflow mattress/cushion use and settings
- Communication with District Nurse
- Communication with other health professionals
- Report regularly to Manager/District Nurse
- Notify Manager/District Nurse of any changes

This guide has been produced by
Community Matron Sarah Stringer

EARLY SIGNS OF PRESSURE DAMAGE

SKIN CARE

- Inspect pressure areas during each episode of care
- Check for discoloured skin, observe if different to nearby skin colour when
- Toileting/washing/bathing/dressing/ undressing
- Apply barrier cream to affected moisture damaged skin
- Increase toileting and ensure pads are changed when soiled
- Keep skin dry and clean
- Report changes, increase in bowel movements or increased urine odour to Community Nurse

PRESSURE CARE / MOVING

- Ensure correct use of equipment
- Utilise foot protectors, speak to Community Nurse if swelling present
- Use slide sheets to minimize shearing and friction
- Ensure air mattress/cushions are set to correct weight of patient
- Ensure continence sheets are not placed between patient and mattress/cushion
- Utilise pressure cushion at all times e.g. mealtimes/ outside appointments/outings/ wheelchair use
- Reposition/mobilise regularly as dictated by patient's overall condition
- If patient unable to mobilise but can weight bear, assist to stand from seat at regular intervals, encourage foot exercises

NUTRITION

- Encourage and monitor fluid and food intake
- Report any concerns/changes

DOCUMENT

- Skin changes /skin care/non compliance
- Equipment use /repositioning/non compliance
- Pad changes/increase in bowel movements/ urine odour
- Food and fluid intake
- Notify Manager/District Nurse of any changes

NHS
Bedfordshire
Community Health Services

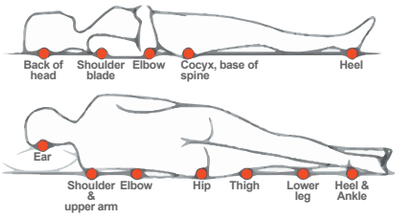
PREVENTION OF PRESSURE ULCERS

A CARER'S GUIDE

PREVENTION

IS BETTER

THAN CURE



NO SIGNS OF PRESSURE DAMAGE

SKIN CARE

- Inspect skin routinely every episode of care
- Observe for moisture
- Keep skin clean and dry
- Apply barrier cream if moisture evident
- Regular pad changes when toileting

PRESSURE CARE / MOVING

- Encourage repositioning/toileting
- Obtain pressure cushion and mattress - ensure all residents have standard cushion and mattress

NUTRITION

- Observe food and fluid intake

DOCUMENT

- Skin changes
- Repositioning/mobilising/non-compliance – check pressure relieving equipment in place and whether an upgrade is required
- Pad changes/skin care given/barrier cream applied
- Food and fluid intake
- Notify Manager/health professional of any changes