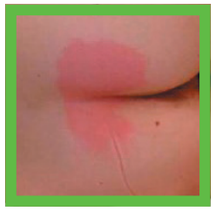
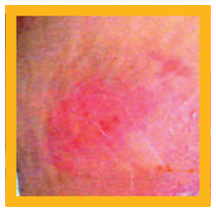
PRESSURE ULCER GRADING CHART

Superficial



Category I: Non-blanching Erythema

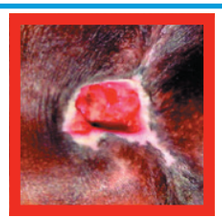
Intact skin with non-blanching redness of a localised area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area.
The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category 1 may be difficult to detect in individuals with dark skin tones.
May indicate "at risk" individuals



Category 2: Partial Thickness Skin Loss

Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed.
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 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 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category 3 pressure ulcers. Bone/tendon is not visible or directly palpable.

Category 4: Full Thickness Tissue Loss

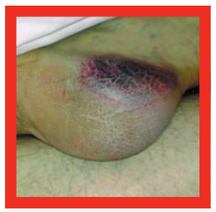
Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunnelling. The depth of a Category 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category 4 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.

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, 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

SURFACE

- Follow Amber recommendations
- Monitor equipment functionality and report any problems

SKIN

- Continue frequent skin inspection during every episode of care
- Check for discoloured skin, observe if different to nearby skin colour
- Keep skin dry and clean
- Notify Community nurses if skin is broken

KEEP MOVING

- Ensure appropriate repositioning regime in place and documented
- Implement repositioning chart
- Minimise sitting out to no more than 2 hours if sacral pressure ulcer present
- Reposition 2 hourly or as directed by the Community Nurse
- Encourage bed rest between meals
- Reposition with 30 degree tilt using a pillow
- Use slide sheets to minimize shearing and friction

INCONTINENCE

- Ensure pads are changed when soiled
- Cleanse skin following episodes of incontinence with product recommended by the Community Nurse or TVN
- Apply barrier cream/spray if evidence of moisture

NUTRITION

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

EARLY SIGNS OF PRESSURE DAMAGE

SURFACE

- Ensure correct use of equipment
- Utilise foot protectors, speak to Community Nurse if swelling present
- 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

SKIN

- Inspect skin over pressure areas during each episode of care
- Check for discoloured skin, observe if different to nearby skin colour
- Keep skin dry and clean

KEEP MOVING

- Use slide sheets to minimize shearing and friction
- 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

INCONTINENCE

- Apply barrier cream/spray to affected moisture damaged skin
- Increase toileting and ensure pads are changed when soiled
- Report changes, increase in bowel movements or increased urine odour to Community Nurse and document

NUTRITION

- Encourage and monitor food and fluid intake
- Report any concerns or changes in diet

NHS
East London
NHS Foundation Trust

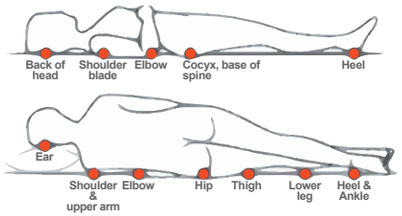
PREVENTION OF PRESSURE ULCERS

A CARER'S GUIDE

PREVENTION

IS BETTER

THAN CURE



NO SIGNS OF PRESSURE DAMAGE

SURFACE

- Ensure all at risk patients have a cushion and mattress if required
- Check equipment is being used
- Upgrade as required

SKIN

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

KEEP MOVING

- Follow repositioning regime
- Document any non-compliance with this

INCONTINENCE

- Regular pad changes when toileting
- Use barrier cream/spray if incontinent

NUTRITION

- Observe food and fluid intake

Document any skin changes, failure to follow recommended advice, communications with district nurses/other HCP's, increase in bowel movements, urine odour, decrease in mobility.
Notify manager/ health professional of any concerns

Original concept developed by Sarah Stringer 2019