Pressure Ulcer Pocket Guide

Supporting Stop the Pressure Ulcer Day

ConvaTec

ConvaTec is committed to supporting **Stop the Pressure Ulcer Day** this November (#StopThePressure).

As such, we have launched **#TimeisPressure**, as a means of providing resources to help raise awareness of pressure ulcers and aid their prevention.

Follow our pocket guide for pressure ulcer classification and SSKIN pressure ulcer triggers.

Think...

SSKIN[1]

Pressure ulcer triggers

Does the person you are looking after have any or a combination of the following:

S **Surface.** Make sure your patients have the right support

S Does their **Skin look red or sore?** This is one of the first indicators of a pressure ulcer developing, especially if it is over a pressure point such as heels, **buttocks and base of back**

K Is the person that you are caring for unable to **Keep moving?** Are they spending more time in **the chair or not going to bed?**

I **Has the person that you are caring for become Incontinent (skin is wet with urine or faeces)** and there is no care plan in place?

N Do they have adequate **Nutrition (are they eating and drinking properly)?** Reduced intake of food and drink can increase the risk of developing pressure ulcers.

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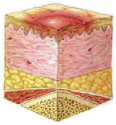
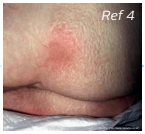
(Adapted from) International (NPUAP / EPUAP) Pressure Ulcer Classification System[2]

CATEGORY 1

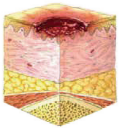


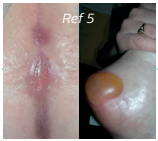


Non-Blanchabl-
E-

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.

CATEGORY 2

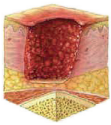


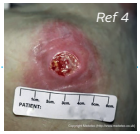


Partial Thickne-
Sk-

as a shallow open ulcer with a red/pink wound bed, without slough. May also present as a serum-filled intact or open/ruptured blister.

CATEGORY 3





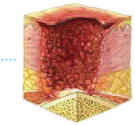
Full Thickness
Sk-

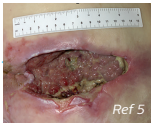
not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunnelling.

From October 2018, NHS Improvement recommended that the term CATEGORY is used nationally to measure and record all pressure ulcers[3]

#StopThe Pressure

CATEGORY 4

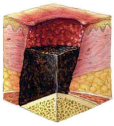


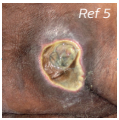


Full Thickness Tissue Loss

Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunnelling.

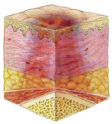
UNSTAGEABLE

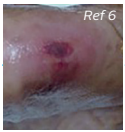




Depth unknown, full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category cannot be determined.

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.

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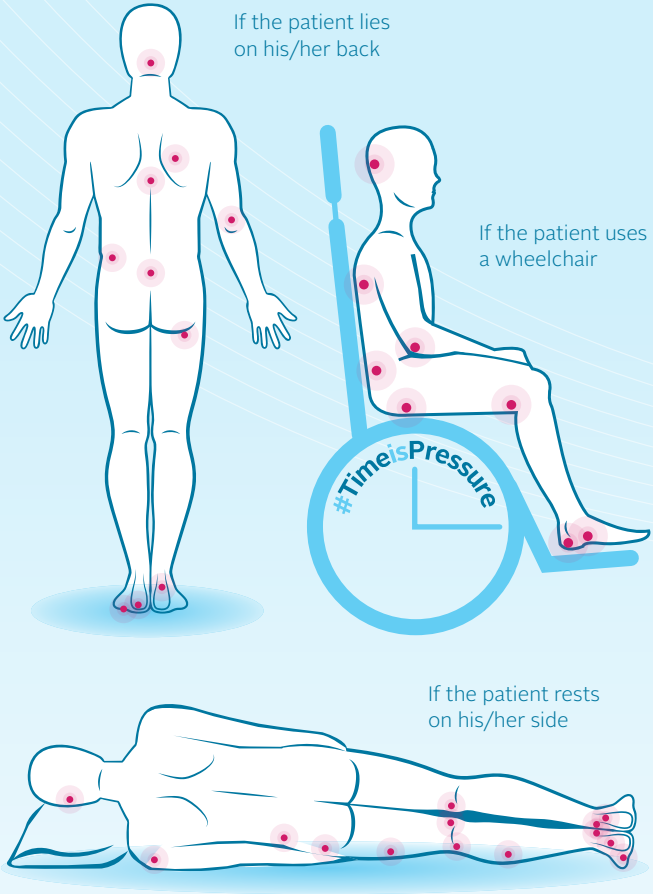
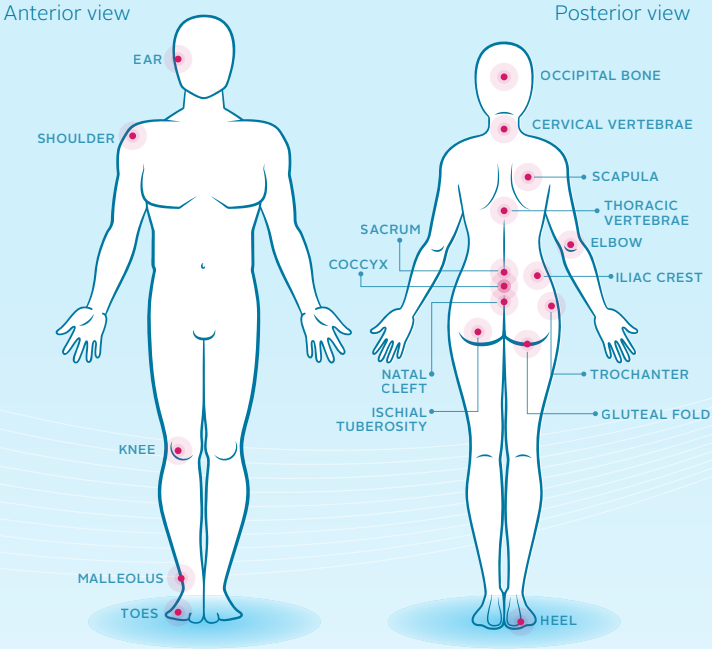
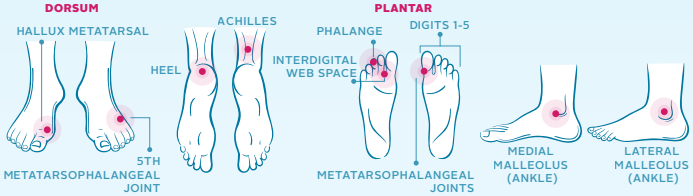
Common pressure ulcer locations *adapted from 6*



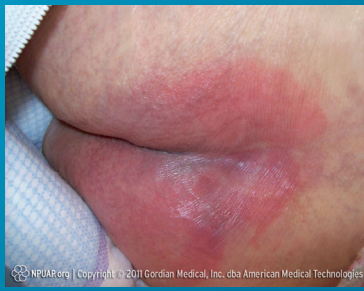


Although bony prominences are particularly susceptible to pressure ulcer development, an ulcer can develop on any soft tissue under prolonged pressure, e.g. from lying on a urinary catheter.



Moisture–Associated Skin Damage (MASD)

The term **Moisture-Associated Skin Damage (MASD)** commonly referred to as moisture lesions [7] has been introduced to describe damage that occurs in response to the prolonged exposure of a patient's skin to perspiration, urine, faeces or wound exudate. [8,9]



MASD can be caused by several conditions, including incontinence-associated dermatitis; intertriginous dermatitis; periwound moisture-associated dermatitis and peristomal moisture-associated dermatitis. Identifying the cause can help to ensure appropriate prevention and management interventions are implemented. [9]

It is important to recognise the difference between MASD and pressure ulcers. However, it is also vital to consider that once MASD occurs, there is a high risk of pressure ulcer development as well as increased risk of infection and morbidity. [7]

References

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2. National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers: Quick Reference Guide. Emily Haesler (Ed.). Cambridge Media: Osborne Park, Australia; 2014. http://www.epuap.org/wp-content/uploads/2016/10/quick-reference-guide-digital-npuap-epuap-pppia-jan2016.pdf
3. NHS Improvement Pressure ulcers: revised definition and measurement Summary and recommendations June 2018 Publication code: CG 73/18 https://improvement.nhs.uk/documents/2932/NSTPP_summary__recommendations_2.pdf
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7. Young T (2012) The causes and clinical presentation of moisture lesions. Wounds UK 8(2) S9-S10
8. https://www.woundsource.com/patientcondition/moisture-associated-skin-damage-masd
9. Dowsett D, Allen L (2013) Moisture-associated skin damage made easy. Wounds UK 9(4). Available from: www.wounds-uk.com/made-easy

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