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#hello my name is…

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Lead Nurse, Tissue Viability

Acute and Partnerships

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- Anatomy of skin
- Discuss what is a pressure ulcer
- Pressure ulcer grading
- Moisture lesions
- Practical session
- Grading quizz

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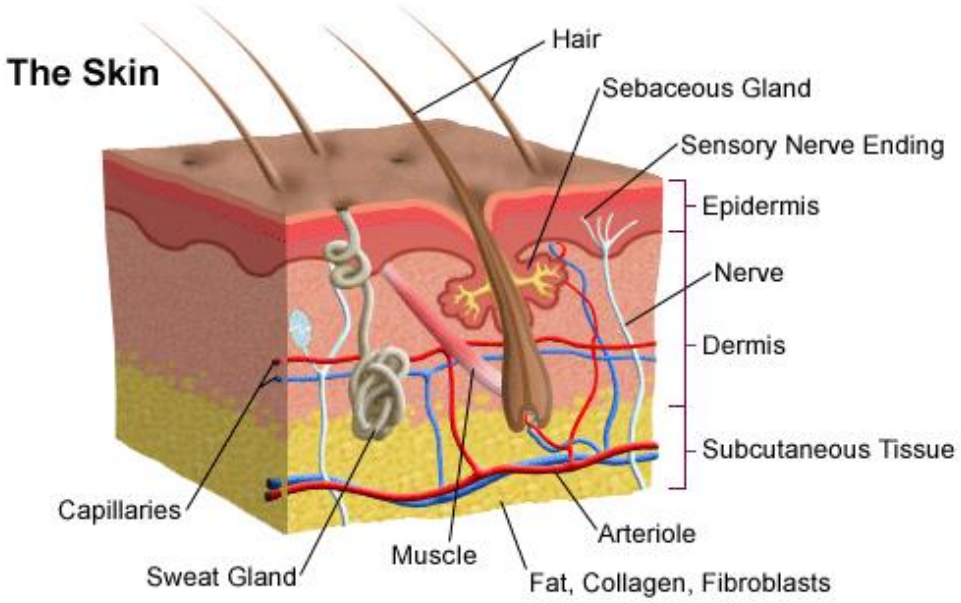
Skin structure

It has three main layers:

1. the epidermis
2. the dermis
3. subcutaneous layer



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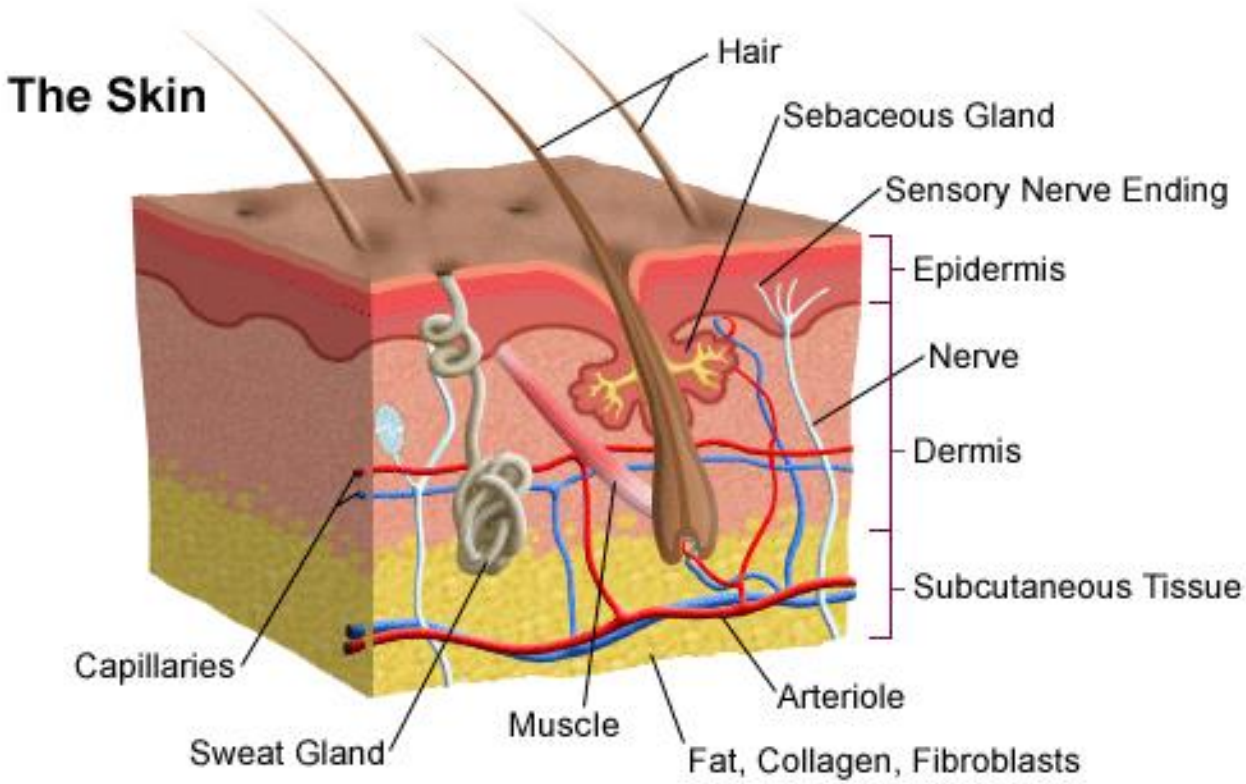
The thickness of skin varies from **0.5mm** thick on the eyelids to **4.0mm** thick on the heels of your feet



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Skin structure

The skin is the largest organ of the body.

How much does it weigh?

What does it measure?

What size is it?

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What are the functions of the skin?

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10 functions of the skin:

1. Protection
2. Temperature control
3. Immunity
4. Movement and Growth
5. Excretion
6. Endocrine
7. Sensation
8. Absorption
9. Waterproofing
10. Storage centre

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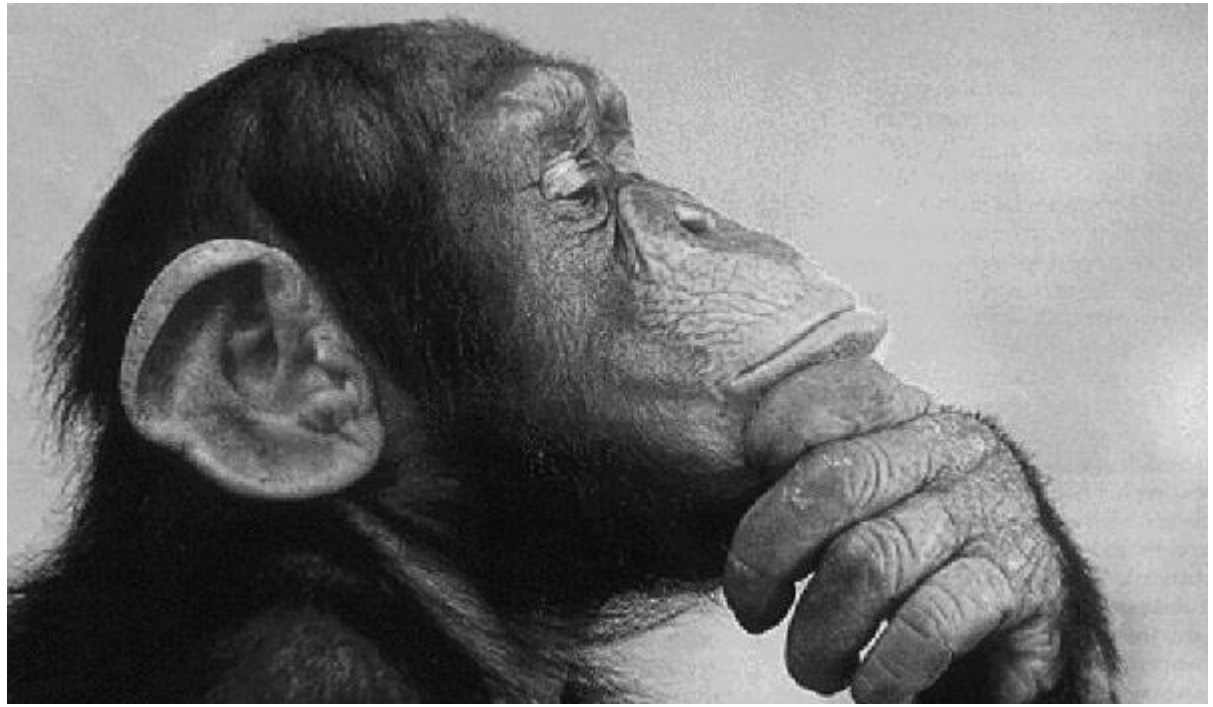
...so what is a pressure ulcer?



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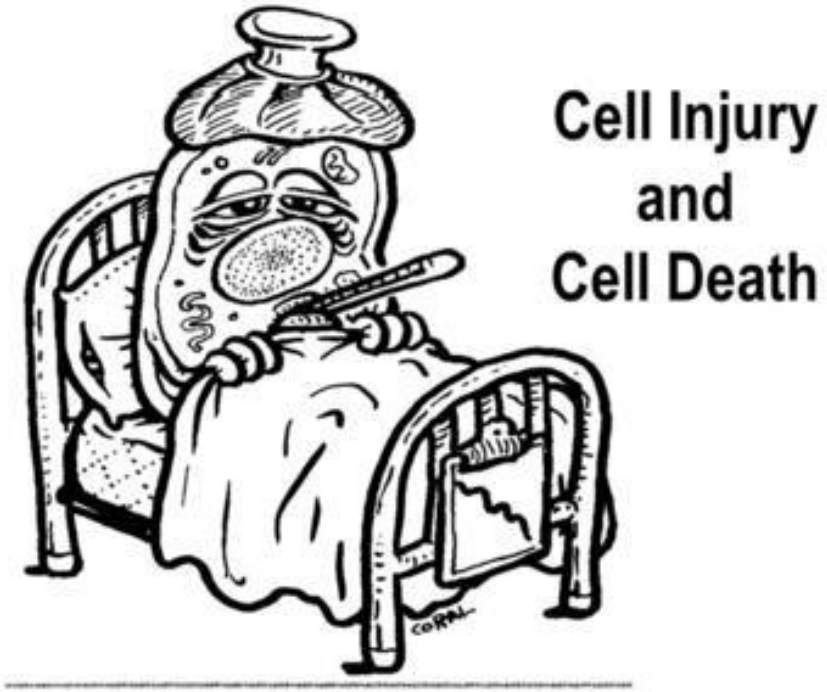
...so what is a pressure ulcer?



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Scottish Adaptation of the European Pressure Ulcer Advisory Panel (EPUAP) Pressure Ulcer Classification Tool

Early warning sign - Blanching erythema

Areas of discoloured tissue that blanch when fingertip pressure is applied and the colour recovers when pressure released, indicating damage is starting to occur but can be reversed. On darkly pigmented skin blanching does not occur and changes to colour, temperature and texture of skin are the main indicators.

Grade 1 - Non Blanchable Erythema

Intact skin with non-blanchable redness, usually over a bony prominence.
Darker skin tones may not have visible blanching but the colour may differ from the surrounding area.
The affected area may be painful, firmer, softer, warmer or cooler than the surrounding tissue.

Grade 2 - Partial thickness skin loss

Loss of the epidermis/dermis presenting as a shallow open ulcer with a red/pink wound bed without slough or bruising.*
May also present as an intact or open/ruptured blister.

Grade 3 - Full thickness skin loss

Subcutaneous fat may be visible but bone, tendon or muscle is not visible or palpable.
Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunnelling. **

Grade 4 - Full Thickness Tissue Loss

Extensive destruction with exposed or palpable bone, tendon or muscle. Slough may be present but does not obscure the depth of tissue loss. Often includes undermining or tunnelling.**

Suspected Deep Tissue Injury:

Epidermis will be intact but the affected area can appear purple or maroon or be a blood filled blister over a dark wound bed. Over time this skin will degrade and develop into deeper tissue loss.
Once grade can be established this must be documented.

Ungradable:

Full thickness skin / tissue loss where the depth of the ulcer is completely obscured by slough and / or necrotic tissue. Until enough slough and necrotic tissue is removed to expose the base of the wound the true depth cannot be determined. It may be a Grade 3 or 4 once debrided. Once grade can be established this must be documented.

Combination Lesions:

These are lesions where a combination of pressure and moisture contribute to the tissue breakdown.
They still need to be graded as pressure damage as above but awareness of other causes and treatments is needed.
See Excoriation & Moisture Related Skin Damage Tool

*Bruising can indicate deep tissue injury

**The depth of a Grade 3 or 4 pressure ulcer varies by anatomical location. Areas such as the bridge of the nose, ears, occiput and malleolus do not have fatty tissue so the depth of these ulcers may be shallow. In contact areas which have excess fatty tissue can develop deep Grade 3 pressure ulcers where bone, tendon, muscle is not directly visible or palpable.

Ref: European Pressure Ulcer Advisory Panel and National Pressure Ulcer Advisory Panel. (2009) Prevention and treatment of pressure ulcers: quick reference guide. National Pressure Ulcer Advisory Panel, Washington DC
NHS Quality Improvement Scotland (2009) Best Practice Statement: Prevention and management of pressure ulcers. NHS Quality Improvement Scotland, Edinburgh

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Scottish Excoriation & Moisture Related Skin Damage Tool

Skin damage due to problems with moisture can present in a number of different ways. This tool aims to help you identify the cause to aid in decision making for treatments.
Moisture may be present on the skin due to incontinence (urinary and faecal), perspiration, wound exudate or other body fluids e.g. lochia, amniotic fluid.
Lesions caused by moisture alone should not be classified as pressure ulcers.

Combination Lesions:

These are lesions where a combination of pressure and moisture contribute to the tissue breakdown. They still need to be graded as pressure damage but awareness of other causes and treatments is needed.
See Pressure Ulcer Grading Tool

Incontinence Related Dermatitis (IRD)

Mild

Erythema (redness) of skin only. No broken areas present.

Moderate

Erythema (redness), with less than 50% broken skin.
Oozing and/or bleeding may be present.

Severe

Erythema (redness), with more than 50% broken skin.
Oozing and/or bleeding may be present.

Treatment:

Prevention/Mild IRD:
Cleanse skin e.g. foam cleanser or pH balanced product. Apply Moisturiser +/or skin protectant e.g. barrier cream/film which does not affect absorbency of continence products.

Moderate-Severe IRD:
Cleanse skin e.g. foam cleanser or pH balanced product. Apply liquid/spray skin protectant, OR barrier preparation, if no improvement refer to local guidelines or seek specialist advice.

NB:
Observe for signs of skin infection, e.g. candidiasis, and treat accordingly (do not use barrier films as this will reduce effectiveness of treatment)

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Updated May 2014. Review date: May 2016

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Moisture Lesions:

Skin damage due to exposure to urine, faeces or other body fluids

Location

Located in peri-anal, gluteal, cleft, groin or buttock area. Not usually over a bony prominence.

Shape

Diffuse often multiple lesions. May be 'copy', 'mirror' or 'kissing' lesion on adjacent buttock or anal-cleft.
Linear

Edges

Diffuse irregular edges.

Necrosis

No necrosis or slough.
May develop slough if infection present.

Depth

Superficial partial thickness skin loss.
Can enlarge or deepen if infection present.

Colour

Colour of redness may not be uniform. May have pink or white surrounding skin (maceration).
Peri-anal redness may be present.

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Tissue Viability Service – Education Grading Card

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