

Blanching erythema

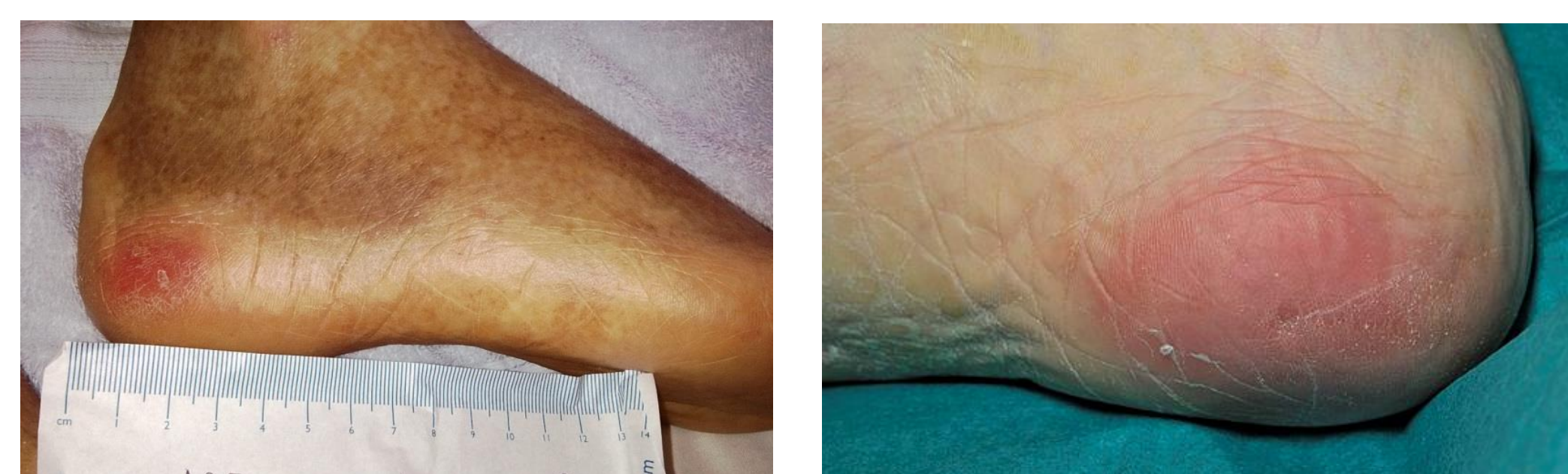
Healthy skin may develop transient redness when subjected to pressure – for example, if the legs are crossed. To test if damage has occurred, light finger pressure should be applied to see if the skin blanches (goes white). In darker skin tones, redness may present as a darker area that is grey or purplish. This is **not** a pressure ulcer.



Example of skin blanch



Blanch in darker skin



This redness is persistent and does not blanch This redness will not blanch when pressure is applied

Category 1: Non-blanchable erythema

Intact skin with non-blanchable 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 compared to adjacent tissue. Category 1 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, without 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 should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.

*Bruising indicates suspected deep tissue injury.



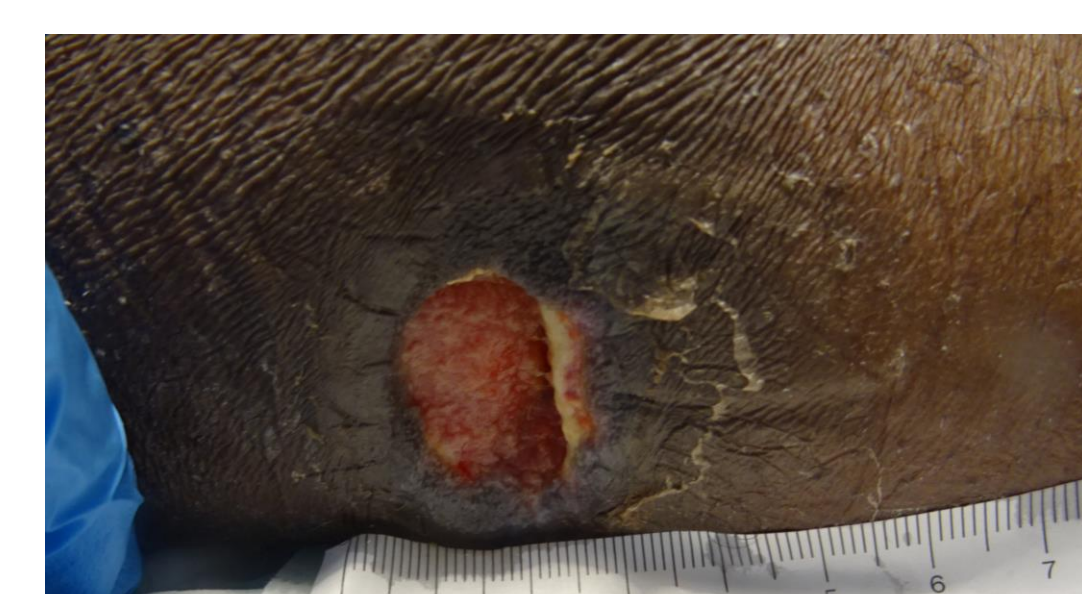
An intact serum-filled blister



A shallow open ulcer with a red pink wound bed without slough



A superficial ulcer with a collapsed blister



Full thickness tissue loss. Subcutaneous fat is visible but no bone, tendon or muscle

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 3: Full thickness skin loss

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. 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 (eg fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.



In this wound, the bone is clearly visible



This wound shows exposed muscle



This occipital ulcer is covered by softening necrosis



This heel ulcer is covered by hard dry eschar



The necrotic cap on this heel has softened and started to separate



Although still firmly attached, there is a ring of demarcation where this eschar has been rehydrated

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. 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.

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 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.



This heel ulcer appears as a dry blood blister



This heel ulcer appears as a linear area of deep purple black discoloration

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Pressure ulcer categorisation

Device-related pressure ulcers (DRPU)

'Pressure ulcers that result from the use of devices designed and applied for diagnostic or therapeutic purposes.'

While some DRPU may also be allocated a category of damage, others may not as they are on parts of the anatomy that do not have the same structures as the skin – for example, the mucosal membrane. Where possible, a device-related ulcer should be categorised and the presence of a device noted by the addition of a (d) after the category.



This infant has Category 1 damage to the cheeks and a small unstageable ulcer on the ear



This neonate has damage to the nares that cannot be categorised



The damage caused by this urinary catheter could be categorised as a DTI (d)



Although difficult to identify, this PU was caused by the leather ring at the top of an old-fashioned calliper



Damage has occurred where the spectacles and elastic from the oxygen mask press on the pinna of the ear



Although difficult to identify, this PU was caused by the patient having their feet caught in the bed sheets which were tightly twisted across the toes

Moisture-associated skin damage

This can occur due to the presence of any type of moisture on the skin, including incontinence, leakage from stoma, saliva, wound exudate and sweat



These multiple superficial lesions with diverse edges are typical of Incontinence Associated Dermatitis



The white cobblestone appearance of the tissue around this wound show evidence of significant maceration due to wound exudate remaining on the skin



Wounds related to IAD such as these are often extremely painful



This wound demonstrates how the epidermis can easily be stripped away by incontinence

Mucosal pressure ulcers



Mucosal pressure ulcers can not be categorised as the tissue does not have the same layers as the skin and therefore does not conform to the definitions. These PU are therefore uncategorisable (NOT unstageable). They are usually caused by devices and therefore should be recorded as PU (d), locally you may wish to denote them as "Mucosal" or "Uncategorisable".

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