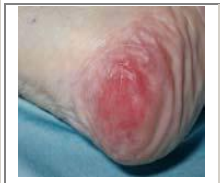
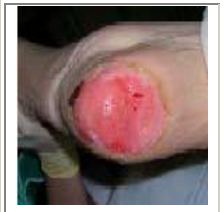
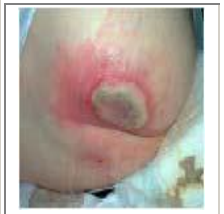
Section 6: Pressure Ulcers

Pressure ulcers are damage caused by extrinsic factors (pressure, shearing forces, friction) and intrinsic forces (illness, age, nutritional status, drug therapy). The toes, heels, sacrum and ischial tuberosites are at most risk of developing pressure ulcers. Moisture lesions should not be classified as pressure ulcers. For further guidance please refer to Scottish Excoriation & Moisture Related Skin Damage Tool and for product information see Continence Skin Care Leaflet & Product Guidelines.

Type	Indicator/Descriptor	Management Aims	Treatment Options	
			1st Line	2nd Line
 Click here for more examples	**Grade 1** Intact skin with non-blanchable redness of a localised area over a bony prominence. Apply light finger pressure to the site, remove finger to test for blanching.	To prevent further skin damage from pressure, shear, friction or moisture particularly over bony prominences.	NHST guidance for the use of small devices in the treatment and prevention of Grade 1 pressure ulcers (*Taken from the NHS Tayside Pressure ulcer prevention and the care of adults in hospital policy, January 2013)*	
 Click here for more examples	**Grade 2** Partial thickness loss of the dermis presenting as a shallow open ulcer with red/pink wound bed, **without** slough or bruising. May also present as an intact or open/ruptured serum-filled blister. The ulcer is superficial and presents clinically as an abrasion or blister.	To protect. To promote new tissue growth. **Not to be confused with skin tears, burns, incontinence dermatitis, moisture and excoriation as these have different treatment aims.**	**Hydrocolloid** If low exudate	**Soft silicone foam** If skin is friable
 Click here for more examples	**Grade 3** Full thickness tissue loss. Subcutaneous fat may be visible but not bone, muscle or tendon. Slough may be present but does not obscure the depth of tissue loss. May include tunnelling and undermining.	To remove any dead tissue. To promote new tissue growth.	**Hydrogel** If low exudate **Alginate** If high exudate	**Honey** Activon if low exudate. Medihoney if high **Fibrous hydrocolloid with foam** If moderate to high exudate and debridement is required Do not occlude
			Secondary dressing Not required with Fibrous hydrocolloid with foam dressing	
			Adhesive foam	**Soft silicone foam** If skin is friable

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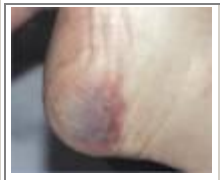
 Click here for more examples	**Grade 4** Extensive destruction, tissue necrosis* or damage to muscle, bone or supporting structures with or without full thickness skin loss.	To remove any dead tissue. To promote new tissue growth. Should ideally have sharp debridement (this should only be performed by those who are trained to debride wounds). May require plastic, vascular, orthopaedic or general surgery teams.	**Hydrogel** if low exudate **Fibrous Hydrocolloid** if high exudate	**Honey** Activon if low exudate. Medihoney if high exudate.
			Secondary dressing	
			Adhesive foam	**Soft silicone foam** If skin is friable
 Click here for more examples	**Unstageable Grade 3/4** Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. **Report on DATIX.**	To rehydrate eschar and remove any dead tissue. **Caution: If circulation is compromised on the heel/foot consider specialist referral before attempting debridement e.g. vascular or plastics.**	**Hydrogel** if low exudate	**Soft silicone foam** If skin is friable
			Secondary dressing	
			Adhesive foam	
 Click here for more examples	**Suspected Deep Tissue Injury** Localised area of purple/maroon intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. Evolution may include a thin blister over a dark wound bed	Relieve pressure to area – follow all aspects of policy. Observe at each position change - may spontaneously recover or evolution may be rapid exposing additional layers of tissue or unstageable 3 or 4. Report on Datix if develops to unstageable or Grade 3 or 4.	***For all Pressure Ulcers:** In the event of tissue necrosis extending to underlying bone, tendon or joint capsule, advancing cellulitis or ulcer related sepsis, surgical intervention may be necessary. See pressure ulcer referral pathway.	

Other considerations

- Larvae therapy can be used in patients requiring rapid debridement of slough/necrotic tissue
- It may be necessary to exclude potential osteomyelitis when dealing with deep wounds
- For wound infection see Section 10 .
- For deep cavities see Section 11.

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*****In the event of tissue necrosis extending to underlying bone tendon or joint capsule, advancing cellulitis, or ulcer related sepsis, surgical intervention may be necessary, refer to vascular or plastic surgery. See **Section 15: Referral Pathways.**

End of life: Management aims should be focussed on patient comfort and quality of life.

Provide patient with the Pressure Ulcer patient information leaflet available on Staffnet.

References

1. NHS Tayside. Pressure ulcer prevention and the care of adults in hospital policy. Click here
2. NHS Tayside. Pressure ulcer prevention and the care of adults in community policy. Click here
3. NHST guidance for the use of small devices in the treatment and prevention of Grade 1 pressure ulcers
4. NHS Tayside. Patient Information Leaflet: Pressure ulcers. Click here
5. European Pressure Ulcer Advisory Panel and National Pressure Ulcer Advisory Panel. Treatment of pressure ulcers: Quick Reference Guide. Washington DC: National Pressure Ulcer Advisory Panel; 2009. Available at: www.epuap.org
6. National Institute for Health and Clinical Excellence (NICE). Pressure Ulcers: The management of pressure ulcers in primary and secondary care. Clinical Guideline 29; September 2005. Click here

Further Reading

1. National Association of Tissue Viability Nurses Scotland (NATVNS). Scottish Adaptation of the European Pressure Ulcer Advisory Panel (EPUAP) Pressure Ulcer Classification Tool. May 2014

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