Healthcare Improvement Scotland's Improvement Hub

SPSP Networking day – Pressure ulcers

Tissue viability education

Afternoon sessions

Time	Topic	Room	Lead
13:00	Tissue viability education	Aspire	Heather Hodgson
	The basics of measurement for improvement	Hope	Alison Hunter and Claire Mavin
14:05	Tissue viability education	Aspire	Heather Hodgson
	The basics of measurement for improvement	Hope	Alison Hunter and Claire Mavin

NHS
Greater Glasgow and Clyde

Heather Hodgson

Lead Nurse, Tissue Viability
Acute and Partnerships
NHS Greater Glasgow and Clyde

Personal reflection on pressure ulcer diagnosis and grading

@SPSP_AcuteAdult #spsp_pu17

Up to 60% of the time diagnosis and grading are incorrect

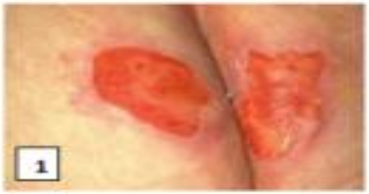
NHS
Greater Glasgow and Clyde

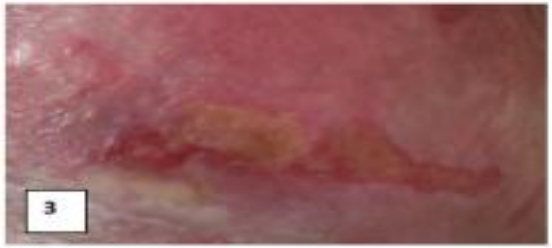
Without conferring can you please diagnose and grade the following skin damage

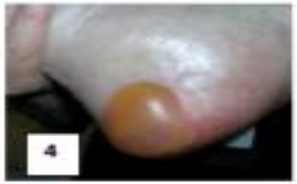
numbers 1 to 10 only

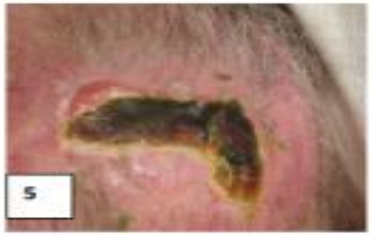
NHS
Greater Glasgow and Clyde

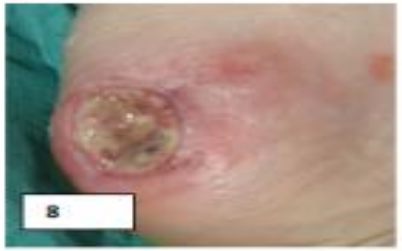
Tissue Viability Service – Education Grading Card

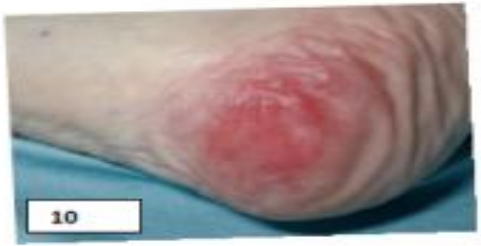












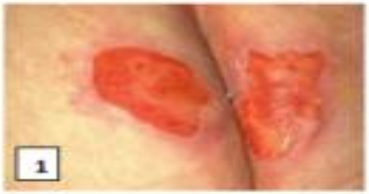
NHS
Greater Glasgow and Clyde

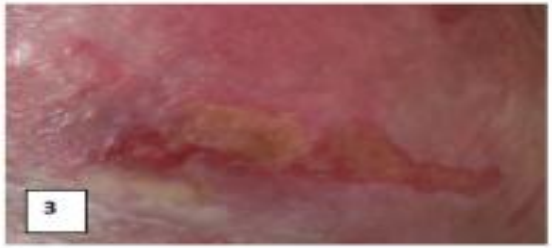
Now conferring can you please diagnose and grade the following skin damage

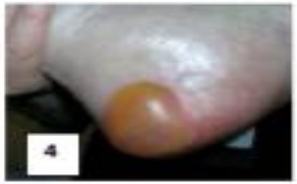
numbers 1 to 10 only

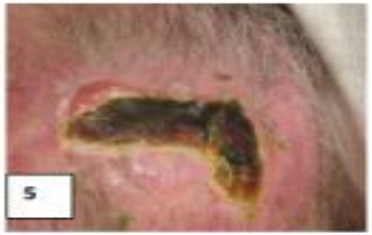
NHS
Greater Glasgow and Clyde

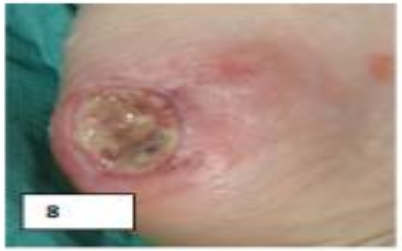
Tissue Viability Service – Education Grading Card

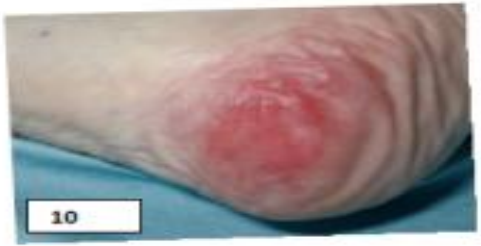












Scottish Adaptation of the European Pressure Ulcer Advisory Panel (EPUAP) Pressure Ulcer Classification Tool

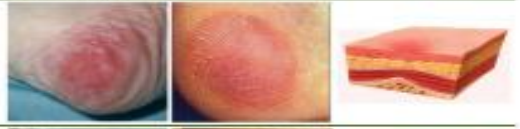
NHS Greater Glasgow and Clyde

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.

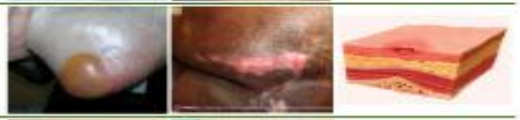
Grade 1 - Non Blanchable Erythema

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.



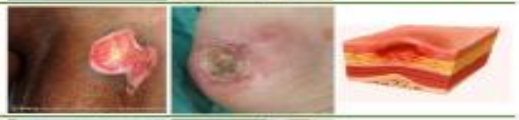
Grade 2 - Partial thickness skin loss

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

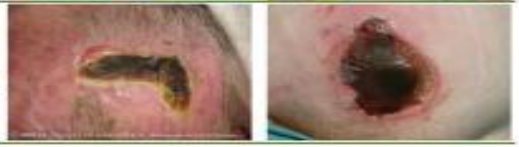
Extensive destruction with exposed or palpable bone, tendon or muscle. Slough may be present but does not obscure the depth of tissue loss. Often includes undermining or tunnelling.**

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 extra fatty tissue, ulcer development can be deep. Grade 3 pressure ulcers where bone, tendon, muscle is not 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

NHS QIS · care Inspectorate · NATVNS · NHS SCOTLAND

PPR - 268608

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. locia, 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.

Moisture Lesions:

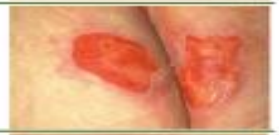
Skin damage due to exposure to urine, faeces or other body fluids

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.

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)

www.tissueviabilityscotland.org

Updated May 2014. Review date: May 2016

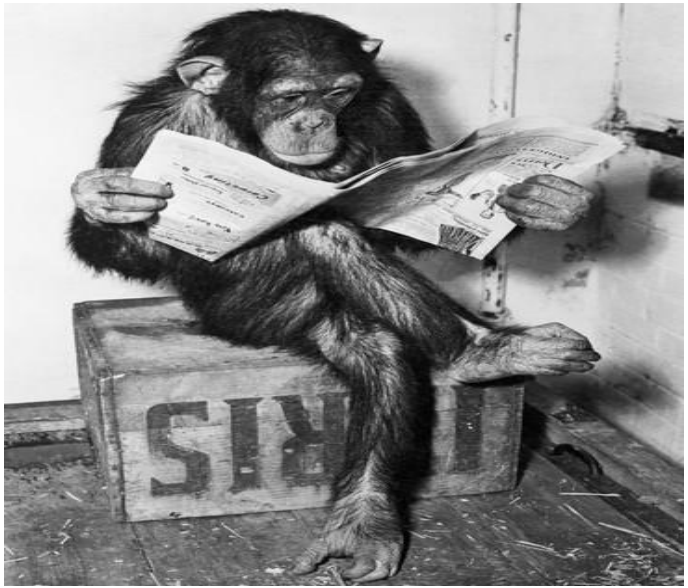
mi - 268608

NHS Greater Glasgow and Clyde

NHS
Greater Glasgow and Clyde

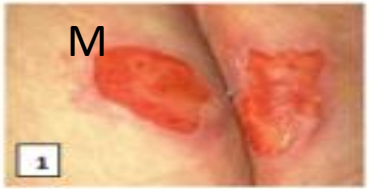
Using tools can you please diagnose and grade the following skin damage

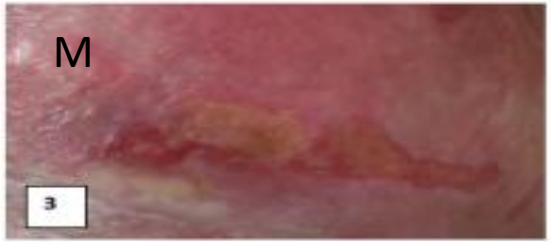
numbers 1 to 10 only

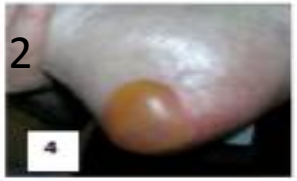


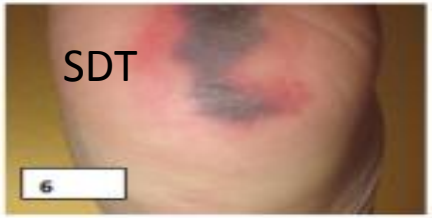
NHS Greater Glasgow and Clyde

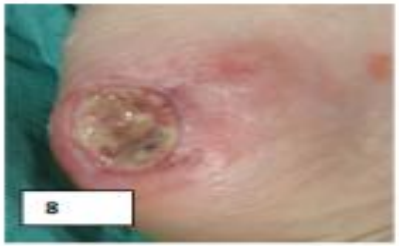
Tissue Viability Service – Education Grading Card

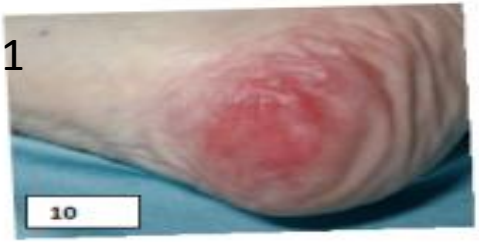












To summarise

Pressure ulcer diagnosis and grading is:

Challenging

Easy to get wrong

More accurate with collaboration

Simplified using tool