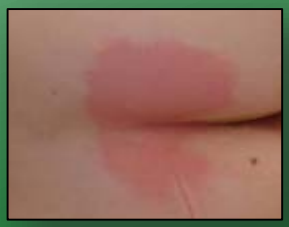
NATIONAL PRESSURE ULCER ADVISORY PANEL

# Pressure Ulcers: Just the facts!

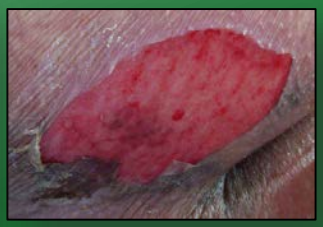
## Definition

A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear.

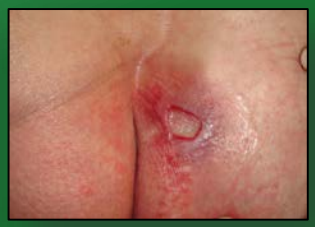
## Stages of pressure ulcers



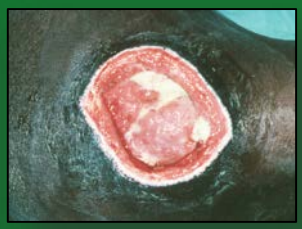
**Stage I: Non-blanchable erythema** Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching.



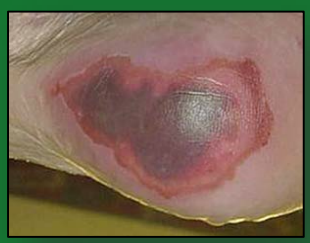
**Stage II: Partial thickness** Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled or sero-sanginous filled blister.



**Stage III: Full thickness skin loss** 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 tunneling.



**Stage IV: Full thickness tissue loss** Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunneling.



**Suspected Deep Tissue Injury** Purple or maroon localized area of discolored 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. 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.

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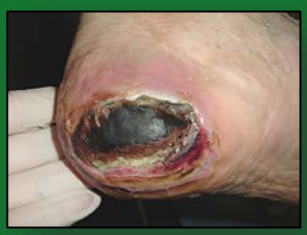

**Unstageable: Full thickness skin or tissue loss** Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined; but it will be either a Category/Stage III or IV. 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.

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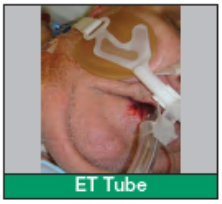
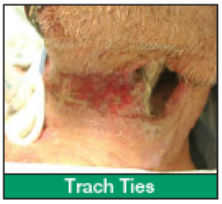
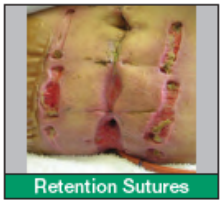
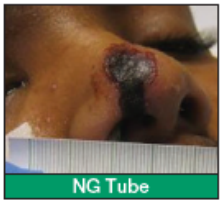
# Best Practices for *Prevention* of *Medical Device-Related* Pressure Ulcers

- ✔ **Choose** the correct size of medical device(s) to fit the individual
- ✔ **Cushion** and protect the skin with dressings in high risk areas (e.g., nasal bridge)
- ✔ **Remove** or move the device daily to assess skin
- ✔ **Avoid** placement of device(s) over sites of prior, or existing pressure ulceration
- ✔ **Educate** staff on correct use of devices and prevention of skin breakdown
- ✔ **Be aware** of edema under device(s) and potential for skin breakdown
- ✔ **Confirm** that devices are not placed directly under an individual who is bedridden or immobile


ET Tube


Trach Ties


Retention Sutures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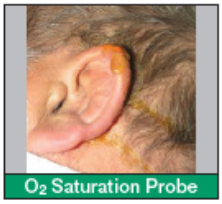
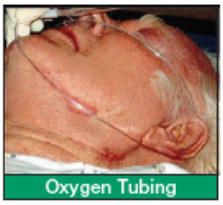
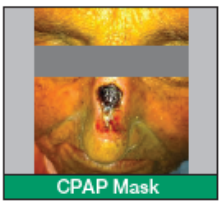
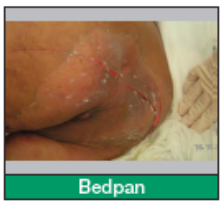
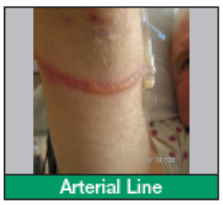
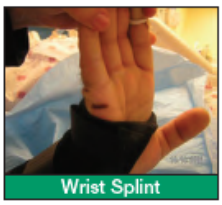

$O_2$ Saturation Probe


Oxygen Tubing


CPAP Mask


Bedpan


Arterial Line


Wrist Splint



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