

Pressure Ulceration

A pressure ulcer is localised damage to the skin and/ or underlying tissue, usually over a bony prominence (or related to a medical or other device), resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open ulcer and may be painful.^[1]

aSSKING

a tool to prevent and manage Pressure Ulcers



Classification

Category 1 pressure ulcer

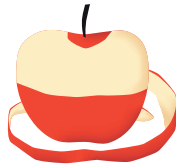
Identified as “non-blanchable erythema of intact skin.”



Think of the normal state of a delicious red apple. We can't “touch” an apple and make the colour be less vibrant or make the colour go away. Just like a **Category 1 pressure ulcer**, we can't take away the redness simply by touching it. It will not blanch because there are already signs of capillary compromise within the layers of the skin.

Category 2 pressure ulcer

Defined as partial thickness loss of the dermis presenting as a shallow open ulcer, or clear fluid blister.



Think of an apple being peeled; the layer of outside “skin” is being removed which may have affected the fleshy part of the apple. With **Category 2 pressure ulcers**, the superficial layer (epidermis) has been removed and the dermis possibly compromised. These wounds will not have slough, and they will be superficial in nature.

Category 3 pressure ulcer

Full thickness. They involve the underlying subcutaneous tissue. All layers of skin are missing, and the wound has greater depth.



Think of what your apple looks like when you take a nice healthy bite out of it, you are into the juicy “meat” of the apple. A **Category 3 pressure ulcer** is similar. It's migrated into the subcutaneous tissue and there is usually depth to these wounds.

Category 4 pressure ulcer

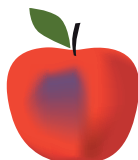
Also full thickness wounds, but the difference from category 3 is that underlying structures are involved.



If you were to bite too far into your apple, you would get to the core... the inner structure of the apple. This is what happens in a **Category 4 pressure ulcer**, you are down to the inner structure under the subcutaneous layer therefore exposing bone, tendon or muscle.

Deep Tissue Injury (DTI) pressure ulcer

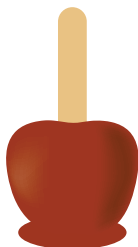
Purple or maroon coloured areas on intact skin or a blood-filled blister.



Imagine if your apple had a soft discoloured area. The skin looks intact, but you don't know how "bad" that apple is underneath that part. As with a suspected deep tissue injury this is letting you know that there is tissue damage underneath even though the skin is intact.

Unstageable pressure ulcer

Completely covered with eschar or slough, so that the depth of the base of the wound cannot be visualised.



Think of a caramel-covered apple; the caramel coats the apple and we therefore don't really know the state of the apple underneath. Just like an unstageable pressure ulcer, because of the slough or eschar obstructing the base of the wound, we don't know how deep it is, and therefore, we cannot categorise it, and therefore consider it unstageable.

Pressure damage vs Moisture lesion

Incontinence / moisture lesions are caused by incontinence or moisture and are not caused by pressure and / or shear. These are often misclassified as pressure ulcers.

	Likely to indicate a pressure ulcer	Likely to indicate a moisture lesion
Causes	Pressure and / or shear present	Moisture present e.g. urine, faeces, sweat and / or exudate
Location	Tends to be over a bony prominence	Lesion limited to skin folds, anal cleft, peri-anal area
Shape	Limited to one spot. Circular or regular shape with the exception of friction damage caused by dragging	Diffuse superficial spots, "kissing" shape, at least one wound caused by moisture
Depth	May be either partial or full thickness skin loss	Superficial, partial thickness skin loss
Necrosis	Necrosis may be evident	No necrosis
Edges	Distinct edges	Diffuse, irregular edges
Colour	Non-blanchable erythema, necrosis, slough	Erythema. Red but not uniformly distributed, pink or white surrounding skin.

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layer and border



Hydrotac® Transparent
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Unique Hydro-Responsive
Wound Dressing

[1] NHS Improvement (2018) Pressure ulcers: revised definition and measurement. Summary and recommendations

[2] Evans J, Stephen-Haynes J (2007) Identification of superficial pressure ulcers. J Wound Care 16(2): 54-6

[3] Ziegler. K et al. (2006) Reduced cellular toxicity of a new silver-containing antimicrobial dressing and clinical performance in non-healing wounds. Skin Pharmacol Physiol.19

For more information contact your local HARTMANN representative or contact our customer services team

HARTMANN UK & Ireland +44 (0)1706 363200 | Email: info@uk.hartmann.info | www.hartmann.co.uk

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