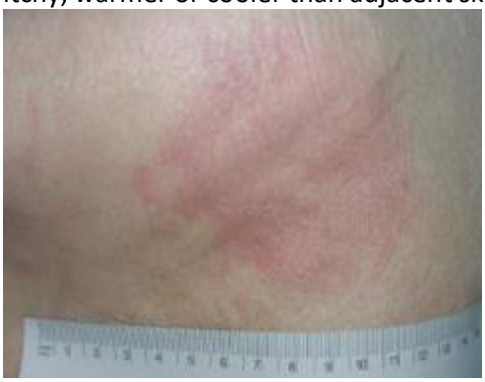
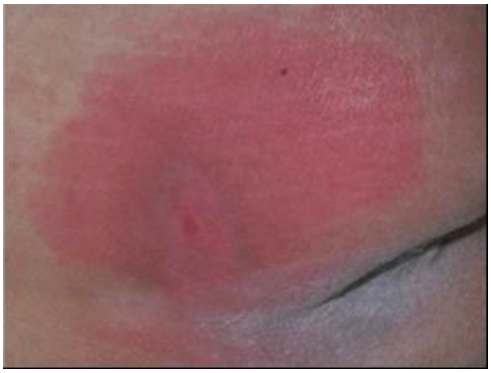
Warning following pages contain graphic images of Pressure Ulcers

Pan Berkshire Safeguarding Adults: Pressure Ulcer Safeguarding Pathway
Appendix 5.4 – Pressure Ulcer Classification Examples

Category 1

Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching, the colour may differ from the surrounding area. The area may be painful, firm, soft, itchy, warmer or cooler than adjacent skin.





Blanchable is when there is a **red ulcer** that when pushed the redness goes away then comes back. Non-blanchable is when the skin is pushed the area stays red that means that there is little or no blood flow going to that area.

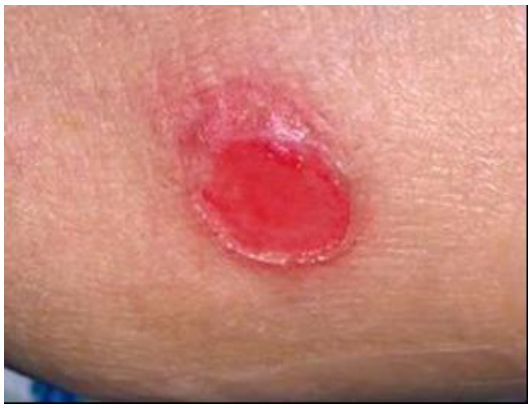
Bony province -a part of the body with limited subcutaneous tissue over a bone. Examples include the heels, the pelvis, and the sacrum

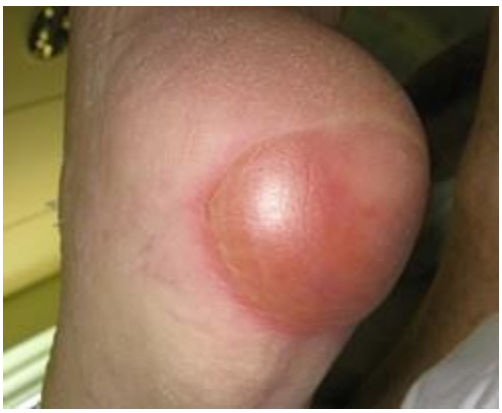
Category 2

Partial thickness skin loss presents as either:

- A shallow open ulcer with a red/pink wound bed, without slough.
- As an intact or ruptured clear fluid filled blister.

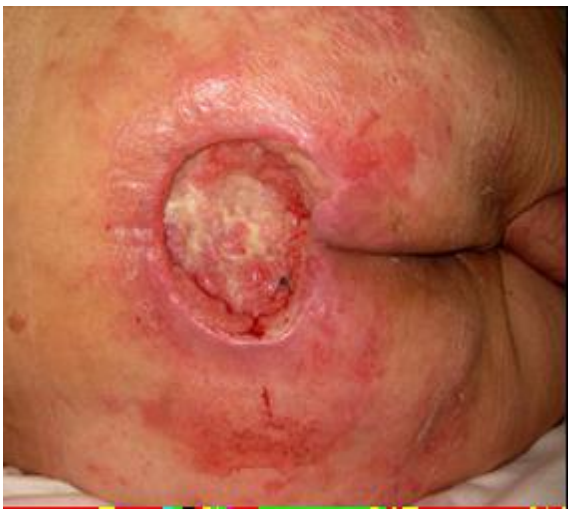
Ulcer is superficial without bruising.





Slough, a layer or mass of dead tissue separated from surrounding living tissue, as in a wound, sore, or inflammation.

Category 3
Full thickness skin loss. Subcutaneous fat may be visible, but bone, tendon and muscle are not exposed.
Slough may be present but does not obscure the depth of the ulcer.
May include undermining and tunnelling.
Category 3 ulcers can be shallow e.g. nose, ears, ankles.



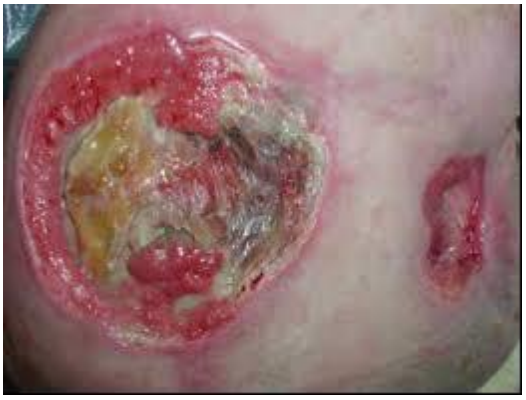
Subcutaneous fat, a layer of fat that lies just beneath the skin.

Slough/eschar, a layer or mass of dead tissue separated from surrounding living tissue, as in a wound, sore, or inflammation.

Undermining is caused by erosion under the wound edges, resulting in **a** large wound with a small opening**.**

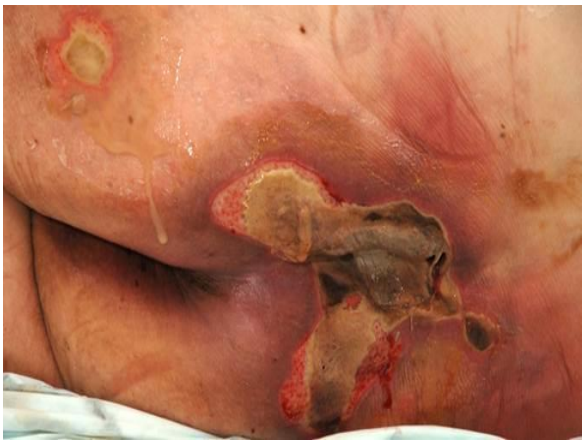
A tunneling wound is a wound that has progressed from an initial superficial disruption in the skin surface to a deeper level that can include skin layers and muscle tissue

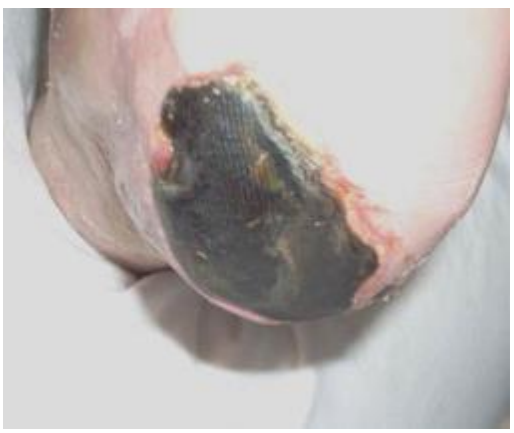
Category 4
Full thickness tissue loss with exposed bone, tendon (directly palpable or visible).
Slough or eschar may be present on some parts of the wound bed.
Often include undermining and tunnelling.
Can extend into the muscle and/or supporting structures (e.g. fascia, tendon or joint capsule).



Slough/eschar, a layer or mass of dead tissue separated from surrounding living tissue, as in a wound, sore, or inflammation.

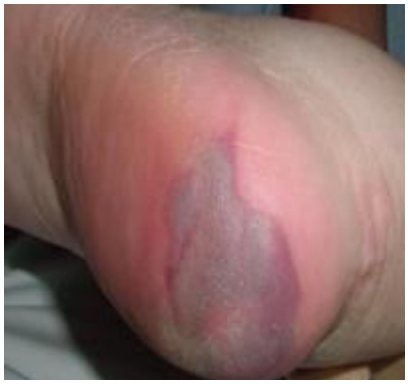
Unstageable
Full thickness tissue loss the wound bed (base) is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black).
Until the wound bed (base) is exposed the true depth and category cannot be determined.
Stable eschar on the heels serves as “the body’s natural (biological) 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 as compared to adjacent tissue.

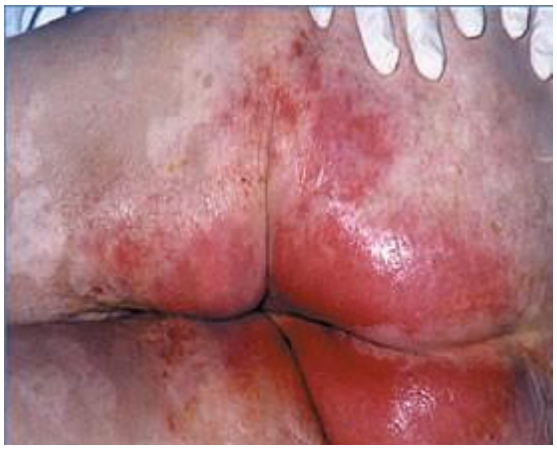


Shear, an applied force that tends to cause an opposite but parallel sliding motion of the planes of an object. Such motions cause tissues and blood vessels to move in such a way that blood flow may be interrupted, placing the patient at risk for pressure ulcers

Moisture Lesions / IAD (Incontinence Associated Dermatitis)

Redness or partial thickness skin loss involving the epidermis, dermis or both caused by excessive moisture to the skin from urine, faeces or sweat.

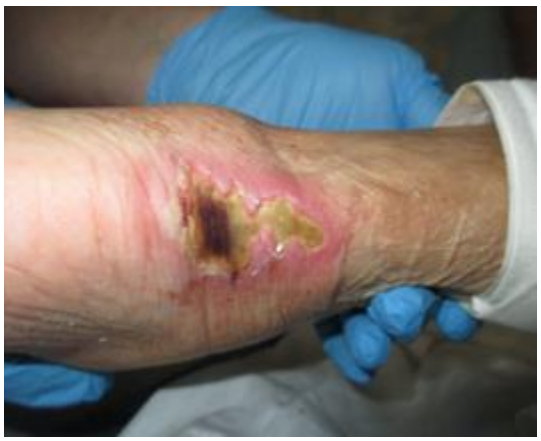
These lesions are not usually associated with a bony prominence.



Medical Device-related

Medical Device-related pressure ulcers result from the use of devices designed and applied for diagnostic or therapeutic purposes. The pressure ulcer generally conforms to the pattern or shape of the device.

NB: Pressure ulcers related to medical device use are not a new category of pressure ulcer and should be classified according to level of tissue loss using this Pressure Ulcer Classification System.



Adapted from: Royal Berkshire NHS Foundation Trust: Pressure Ulcer Classification: Pressure Ulcer Grading VERSION 4 WORD Jan 2019.pdf (royalberkshire.nhs.uk)