

Friday, 16 October 2020

Nursing

Apples - Getting to the heart of pressure ulcer staging
The apple used as a tool for accurate staging

Stage 1
Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Shiny, persistent redness, pallor, cyanosis, or mottled discoloration and the loss of heat, pain, oedema, softness, or temperature changes can be noticeable compared to adjacent skin. Daily repainting skin may appear differently.
Think of an apple: The red colour will not go away when you touch it. This is like a Stage 1 pressure ulcer. It will not blanch because there are already signs of capillary compromise within the layer of skin.

Stage 2
Partial thickness skin loss involving epidermis, and often extending into a shallow open ulcer with a red wound bed. May present as a clear fluid-filled blister. A Stage 2 pressure ulcer does not contain any slough.
Think of an apple being peeled where you get used to remove the skin. A Stage 2 pressure ulcer would peel away from the dermis or more inner layers but not deeper.

Stage 3
Full thickness skin, subcutaneous fat, muscle, tendon, or bone is an exposed. Depth may be visible but it does not indicate the depth of tissue loss. May include undermining and tunnelling.
Think of when a red apple looks like when you take a nice healthy bite out of it, you are into the part of the apple. A Stage 3 pressure ulcer is similar usually with some depth to some signs of tunnels.

Stage 4
Full thickness skin loss with exposed bone, tendon or muscle. (Other tissues such as cartilage, and fat are missing).
Think of a red apple where the skin (epidermis) is like the core. A Stage 4 pressure ulcer is similar as you are through to the bone, muscle and tendons.

Deep Tissue Pressure Injury
Local or non-local skin with a dark area of persistent non-blanchable deep red, purple, or brown discoloration or localized necrosis resulting in a dark wound bed or blackened tissue.
Think of a bruised apple. The skin is intact but underneath there's bruise. The apple is still healthy but you can tell it is damaged. This is like a deep tissue pressure injury as you know there is some damage even though the skin is intact.

Unstageable
Full thickness skin loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed.
Think of a rotten apple where the rotten completely eats the apple. It is completely unrecognisable underneath by the apple's appearance. This is like an unstageable ulcer as you can't see how deep it is and hence is unstageable.

Medical device related pressure ulcer
Medical device related pressure ulcers result from the use of devices designed and used for diagnostic or therapeutic purposes.
Example: Ankle support, a cast, a baby, a wheelchair, a prosthetic, a brace, a splint, a collar.
Medical device pressure ulcers range in degree.

Ischaemic / avascular injuries
These injuries are caused by ischaemia or reduced or absent blood supply to the skin and the underlying tissues. They are usually caused by a blockage of the arteries or veins, due to the narrowing of the arteries (atherosclerosis) or the veins (phlebotomy). They are usually associated with peripheral vascular disease. The patient may have a combination of pressure damage and ischaemic / avascular damage. A patient may have a combination of pressure damage and ischaemic / avascular damage.

Think SSKIN!
The 5 main risk factors assist the prevention of pressure ulcers:
If a patient has at least 4 of the following risk factors, SSKIN is a good idea to use.

- Support
- Moisture
- Pressure
- Temperature
- Infection

Think of SCALE
Skin Changes At Life's End
At the end of life to reflect it is important to balance the skin care of the patient with the wishes and desires of the individual.
For more information look up: www.scale.org

HSC Health and Social Care

This poster has been created by Belfast HSC Trust and is supported by the Regional Pressure Ulcer Prevention Group led by the PHA. It is available for staff in any HSC organisation or the private/independent care home sector to download to assist staff in recognising, assessing and accurately staging pressure ulcer damage.

Details

Format

A4 poster

Target group

HSC staff and staff in independent/private care homes

Downloads

Attachment

Size

[SKIN apple poster HSC final 10.20.pdf](#) 2.75 MB

Tags

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