Pressure ulcers: revised definitions.

Summary and recommendations (V1)

"Studies examining pressure ulcer occurrence indicate that quantifying pressure ulcers is complex: the type of data collected and methods used during collection vary, which makes valid data comparisons difficult.

It is recognised that collecting and understanding data on the causes of harm is a key tenet of quality improvement approaches in healthcare. Accurate measurement must accompany a quality improvement method to make changes and improve outcomes for service users and patients.

The recommendations in this document are designed to support a more consistent approach to the definition and measurement of pressure ulcers at both local and national levels across all trusts".

(NHS Improvement 2019)

NB. This document is applicable to pressure ulcer development across all specialities, in all hospital and community settings.

Guidance/Descriptor	Rationale/supporting evidence	**Reference:**
We should use the term 'pressure ulcer'	This term is widely used in the UK and is consistent with the European Pressure Ulcer Advisory Panel's definitions.	European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers/Injuries: Quick Reference Guide. Emily Haesler (Ed.). EPUAP/NPIAP/PPPIA: 2019.
Definition A pressure ulcer is defined as: 'Localised damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, comorbidities and condition of the soft tissue'	This is a global definition and is used by the European Pressure Ulcer Advisory Panel (EPUAP), the National Pressure Injury Advisory Panel (NPIAP, formerly National Pressure Ulcer Advisory Panel) and the Pan Pacific Pressure Injury Alliance (PPPIA)	European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers/Injuries: Quick Reference Guide. Emily Haesler (Ed.). EPUAP/NPIAP/PPPIA: 2019.

International Pressure Ulcer Classification System Organisations should follow the current system recommended in the 2019 international guidelines (EPUAP/NPIAP/PPIA, 2019) (see Appendix 1). This system incorporates categories 1,2,3,4, deep tissue injury and unstageable ulcers.	The term 'category' can be used alongside the term 'stage' to enable practitioners to link category (referred to in PURPOSE-T) with the more commonly used term stage.	European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers/Injuries: Quick Reference Guide. Emily Haesler (Ed.). EPUAP/NPIAP/PPPIA: 2019.
Mucosal Pressure Ulcers We will record but not categorise mucosal pressure ulcers	Mucosal pressure ulcers **cannot** be categorised as the tissue does not have the same layers as the skin. Record as Mucosal Ulcer	
Device related Pressure Ulcers A device-related pressure ulcer (DRPU) may be caused by a medical device or a device, object, or product without a medical purpose. This includes a device or object that is in direct or indirect contact with skin ... or implanted under the skin, causing focal and localised forces that deform the superficial and deep underlying tissues.	A DRPU is distinct from a PU, which is caused primarily by body weight forces. The localised nature of device forces results in the appearance of skin and deeper tissue damage that mimics that of the device in shape and distribution.'	Gefen A, Alves P, Ciprandi G et al. Device related pressure ulcers: SECURE prevention. J Wound Care 2020; 29(Sup2a): S1–S52 https://www.magonlinelibrary.com/doi/full/10.12968/jowc.2020.29.Sup2a.S1 *(If link does not work by clicking on it, copy and paste link into internet browser)*
Medical Device Related Pressure Ulcers The term 'medical device-related pressure ulcer' focuses the health professional and others on pressure ulceration related only to medical devices. This may include products used to sustain life in sick patients— for example, continuous positive airway pressure (CPAP) masks, oxygen therapy tubing and endotracheal tubes, or less critical devices such as orthotic devices, indwelling lines and bed frames Medical Device-related pressure ulcers should be reported and identified by the notation of (md) after the report – e.g., Category 2 PU (md) – to allow their accurate measurement. Non-medical device related pressure ulcers, are reported under the general term pressure ulcers	The National Pressure Ulcer Advisory Panel's (NPUAP) 2016 definition of a medical device-related pressure ulcers should be used: "Pressure ulcers that result from the use of devices designed and applied for diagnostic or therapeutic purposes". We will report medical device related pressure ulcers separately from non-medical device pressure ulcers to identify themes and act to address these as appropriate. NB. Orthopaedic shoes, bandages and hosiery are classed as medical devices. Prescription glasses are **not** viewed as a medical device	National Pressure Ulcer Advisory Panel (NPUAP). Pressure Injury stages. 2016. https://cdn.ymaws.com/npuap.site-ym.com/resource/resmgr/npuap_pressure_injury_stages.pdf Gefen A, Alves P, Ciprandi G et al. Device related pressure ulcers: SECURE prevention. J Wound Care 2020; 29(Sup2a): S1–S52 https://www.magonlinelibrary.com/doi/full/10.12968/jowc.2020.29.Sup2a.S1 *(If link does not work by clicking on it, copy and paste link into internet browser)*

Skin Changes at Life's End (SCALE) SCALE will be used to define unavoidable skin changes which occur during the dying process. Potential SCALE should be reported on Datix and investigated using the regional benchmark for pressure ulcer care (i.e., Pressure Ulcer Post incident review) to determine that there are no omissions relating to pressure ulcer care (unless consistent with the persons expressed wish). If there are no omissions in pressure ulcer prevention care, damage will be deemed SCALE and should they be removed from the reporting system. If there are omissions in pressure ulcer prevention care **but these did not lead to harm,** the incident should be recorded as an unavoidable pressure ulcer with learning. If there are omissions in care and it could have affected outcome, these will be recorded as an avoidable pressure ulcer	These skin changes have a different aetiology to pressure damage. They may indicate that a patient is entering multi-organ failure with skin failure as an element of the dying process. "when the heart or brain is compromised …blood is shifted …first from the skin and soft tissues towards the heart and brain, and then from visceral organs" (Ayello et al, 2019) "… when the capillaries become leaky, local haemorrhage can cause a red colour on the surface of the skin… If local ischemia is complete and the blood supply shuts down, a black colour can result". "… cells can no longer survive in zones of physiologic impairment such as hypoxia, local mechanical stresses, impaired delivery of nutrients, and build-up of toxic metabolic by-products" (Levine 2016; 2017) Whilst this is accepted, we cannot become complacent. Skin care is an integral part of palliation. We know that pressure damage at life's end adversely affects the quality of the end life and death for the person receiving care and their loved ones (Samuriwo, 2021). It is therefore important to ensure that all care that could be given, was given.	Ayello EA., Levine JM., Langemo D., Kennedy-Evans KL., Brennan MR., and Sibbald GR. (2019) Re-examining the Literature on Terminal Ulcers, SCALE, Skin Failure, and Unavoidable Pressure Injuries. Adv Skin Wound Care. 2019 Mar;32(3):109-121. Levine, JM.. (2016) Skin failure an emerging concept. J Am Med Dir Assoc. 17(7):666-9 Levine, J. (2017) Unavoidable pressure injuries, terminal ulceration and skin failure: in search of a unifying classification system. Adv Skin Wound Care 30 (5):200-2 Samuriwo, R. (2021) End of life skin care – Research informing theory to traverse between Scylla and Charybdis? Palliative Medicine 35 (6) 986-987
Deep Tissue Injuries All potential deep tissue injuries should be reported on Datix. All DTIs that persist beyond 72 hours require a Post Incident review to determine if avoidable or unavoidable	It is important to recognise that DTI remains one of the most serious forms of pressure injury. The pressure is exerted at the muscle-bone interface, but due to the resiliency of the skin, the colour change is not immediate, in contrast to a bruise. The process leading to deep tissue pressure injury precedes the visible signs of purple or maroon skin by about 48 hours. Then about 24 hours later, the epidermis lifts and reveals a dark wound bed. This phase of deep tissue injury evolution is often confused with skin tears. Within another week, the wound bed	National Pressure Injury Advisory Panel Evolution of Deep Tissue Pressure Injury – available from: https://cdn.ymaws.com/npiap.com/resource/resmgr/press_releases/NPIAP_-_Evolution_of_DTPI.pdf (Accessed 09/01/2024)

	is often necrotic. The lag between the "pressure event" and the change in colour of the skin makes the root cause analysis complex. It is important to be aware that 48 hours prior to the patient's skin being deep red, maroon, or purple, he/she may not have been in your facility	
Classifying Deep Tissue Injuries Stage 1- DTI that resolves within 72 hrs – record in the patients record and remove from the Datix reporting system. Stage 2 – DTI that exceeds 72 hrs but heals without scarring Stage 3 or 4 - DTI that persists beyond 72hrs and stage can be established within 30 days*, categorise as per EPUAP If the pressure ulcer cannot be categorised within 30 days, or if the patient is deceased, or the incident cause was unavoidable and there is no clinical reason to review, classify as a DTI *Due to resource issues it is not possible for the Tissue Viability Nurse Services across Northern Ireland to follow patients indefinitely, especially if there is no overarching clinical need. If the Tissue Viability Nurses are still involved in the patients care beyond 30 days, they should, of course, reclassify the injury as soon as the depth is known.	Unstageable and Deep Tissue Injury (DTI) ulcers should be reviewed by a clinician (any registrant involved in the patient's care) with appropriate skills on a weekly basis to help identify a definitive PU category and change the category as required Unstageable and DTIs are effectively 'holding' stages. The wounds can only be staged/categorised once the dead tissue is debrided. In some cases, the DTI will resolve without any open wound. If this occurs within 72 hours, the injury will be restaged as a stage 1 and removed from the reporting system After 72 hours, the damage cannot be deemed a stage 1; it will be a stage 2, 3, or 4 – however this may take a number of weeks to evolve. If the wound heals **without scarring**, it will be closed as a Stage 2. After 72 hrs, the damage will be investigated to determine if avoidable or unavoidable.	
Pre-admission pressure damage The definition of a pre-admission pressure is that it is observed during the skin assessment undertaken on admission to that service.	**Community Nurses*** should check the patient's skin on admission to the caseload. If pressure damage is noted, it will be deemed 'pre-admission to caseload'. It is important to note that the decision to admit to caseload is when skin check &	

	holistic assessment is done and not necessarily on a visit for venepuncture/removal of sutures for instance *The term community nurse is used to describe community nurses in general – e.g. paediatric, community psychiatric nurse, district nurse, community staff nurse, community learning disability nurse. If the patient was a new referral from a hospital setting or a nursing home, the community nurse must alert their TVN team/Clinical Nursing Home Support Team (as applicable) so the injury can be investigated. **Hospital Discharge: pressure relieving equipment not identified and requested –** if there is an omission in care, e.g., patient discharged from hospital and the need for pressure relieving equipment was not identified and highlighted, then the incident will be deemed hospital acquired and avoidable' It is recognised that there may be a time lag between discharge from hospital and the community nurse visit. If there is no evidence that the damage occurred in hospital (either from the nursing records, or the patient), and the investigation shows that all expected care/discharge arrangements were appropriate, then the incident will be deemed 'pre-admission to caseload'. If the hospital staff had highlighted the need for pressure ulcer relieving equipment to community nursing on discharge, and a community nurse did not see and assess the patient in keeping with the Regional Referral Criteria for District Nursing (DN) Service (Appendix 2), the incident will be deemed community acquired. If pressure damage (≥Stage 2) occurs whilst on a community nurses' caseload, a community pressure ulcer incident review	

	must be completed as per local arrangements to determine if there are lessons which can be shared. If the post incident review indicates that the DN did not communicate at risk status to formal carers – this should this be classed as avoidable. If the post incident review indicates that formal carers have not provided the expected care (detailed in the Support Time Table/Care Package), the incident will be deemed unavoidable from a community nurse perspective. However, the incident should then be investigated through the formal carer line management structure. **ED** staff should observe the skin of **at-risk** patients within 4 hours of triage. Any damage that occurs after a 4-hour stay will be deemed ED acquired unless there is a record of the damage in community (or patient/carer relays present pre-admission). **Theatre** Staff should observe the skin of **at-risk** patients pre and post-op. Any damage noted post op will be deemed theatre acquired unless there is already a record of the damage prior to surgery (hospital or community). **Recovery** wards staff should observe the skin of **at-risk** patients within 2 hours of admission. Any damage that occurs after a 2-hour stay will be deemed Recovery acquired unless there is already a record of the damage in the hospital or community. **Inpatient** staff should observe the skin of **at-risk** patients as soon as possible, but no longer than within 6 hours of admission. Any damage that occurs 6 hours after admission will be deemed hospital acquired unless there is a record of the damage in another ward/department or community.	

The definition of avoidable or unavoidable pressure damage should be assigned AFTER a full investigation using the Regional Pressure Ulcer Incident Review form.	**'Avoidable'** means that the person receiving care developed a pressure ulcer and the provider of care did not do one of the following: • evaluate the person's clinical condition and pressure ulcer risk factors • plan and implement interventions that are consistent with the persons needs and goals, and recognised standards of practice • monitor and evaluate the compliance and impact of the interventions • or revise the interventions as appropriate **'Unavoidable'** means that the person receiving care developed a pressure ulcer even though the provider of the care had: • evaluated the person's clinical condition and pressure ulcer risk factors • planned and implemented interventions that are consistent with the persons needs and goals and recognised standards of practice • monitored and evaluated the impact of the interventions and revised the approaches as appropriate • or the individual refused to adhere to prevention strategies in spite of education of the consequences of non-adherence	National Patient Safety Agency (2010) Defining Avoidable and Unavoidable Pressure Ulcers. Pittman J, Beeson T, Dillon J, Yang Z, Mravec M, Malloy C, Cuddigan J. Hospital-Acquired Pressure Injuries and Acute Skin Failure in Critical Care: A Case-Control Study. J Wound Ostomy Continence Nurs. 2021 Jan-Feb 01;48(1):20-30. Schmitt, Shawneen; Andries, Marti K.; Ashmore, Patti M.; Brunette, Glenda; Judge, Kathleen; Bonham, Phyllis A.. WOCN Society Position Paper: Avoidable Versus Unavoidable Pressure Ulcers/Injuries. Journal of Wound, Ostomy and Continence Nursing 44(5):p 458-468, September/October 2017. | DOI: 10.1097/WON.0000000000000361
All reports should identify the patient using the Health and Care number.	To reduce duplication of reporting.	NHS Improvement (2018) Pressure ulcers: revised definition and measurement Summary and recommendations June 2018 https://www.england.nhs.uk/wp-content/uploads/2021/09/NSTPP-summary-recommendations.pdf
All acquired pressure ulcers, including those that are considered avoidable and unavoidable, should be incorporated in local PU monitoring.	This will ensure that the extent of pressure ulcer occurrence in Northern Ireland is quantified.	NHS Improvement (2018) Pressure ulcers: revised definition and measurement Summary and recommendations June 2018

		https://www.england.nhs.uk/wp-content/uploads/2021/09/NSTPP-summary-recommendations.pdf
Moisture-associated skin damage (MASD) is not classified as pressure damage and therefore should **NOT** be counted or reported in addition to pressure ulcers.	MASD is classified as an irritant-contact dermatitis; see Table 1 (WHO, 2020). Common irritants can include urine, stool, perspiration, saliva, intestinal liquids from stomas and exudate from wounds. **Table 1. Types of irritant contact dermatitis according to WHO ICD-11 coding** **EK02.2** Irritant contact dermatitis due to friction, sweating or contact with body fluids **EK02.20** Intertriginous dermatitis due to friction, sweating or contact with body fluids **EK02.21** Irritant contact dermatitis due to saliva **EK02.22** Irritant contact dermatitis due to incontinence **EK02.23** Irritant contact dermatitis related to stoma or fistula **EK02.24** Irritant contact dermatitis related to skin contact with protheses or sugical appliances	Fletcher J, Beeckman D, Boyles A et al (2020) International Best Practice Recommendations: Prevention and management of moisture-associated skin damage (MASD). Wounds International. https://woundsinternational.com/wp-content/uploads/sites/8/2023/02/77ece7a46c5c084762956b97f9096e53.pdf
Where skin damage is caused by a combination of MASD and pressure, it **should be reported** based on the category of pressure damage.		NHS Improvement (2018) Pressure ulcers: revised definition and measurement Summary and recommendations June 2018 https://www.england.nhs.uk/wp-content/uploads/2021/09/NSTPP-summary-recommendations.pdf
Skin damage caused by friction alone should not be classed as pressure damage on Datix and should be excluded from pressure ulcer reporting. Friction wounds should be reported on Datix as trauma.	This will ensure that only pressure ulcer data will be collected.	https://npiap.com/ *(If link does not work by clicking on it, copy and paste link into internet browser)*
If two or more pressure ulcers are noted at the same time, this will be recorded as on Datix and the most serious ulcer, if applicable, will be reported to the PHA	The detail will be given in the clinical incident narrative, but it will not be possible for the person who noted the damage to determine exactly when each pressure ulcer occurred.	
If pressure ulcers are noted on separate occasions (even within the same 24-hour period), they will be deemed separate incidents.	A plan of care should have been put in place the moment the first incident was noted. Whilst further damage could represent a deep ulcer coming to the surface, it is essential it is	

	investigated independently of the first pressure ulcers identified.	
If a pressure ulcer deteriorates, e.g. a stage 2 evolves into a stage 3, care must be investigated to ensure there were no omissions. If there are no omissions in care, restage/re-categorise the original injury. If there are any omissions which could have contributed to the deterioration, the original injury will be restaged/re-categorised and the incident will be deemed avoidable. The more serious incident will be reported to the PHA*.	A certain proportion of pressure ulcers that appear superficial will evolve – they are a manifestation of a deeper injury (this includes blanching erythema and stage 1). Reporting the more serious incident will prevent double counting of incidents. Whilst Trust validation processes are different, it is imperative that final data (end of year data) is validated prior to being submitted to the PHA. NB It is recognised that there is a risk of double counting an incident which has deteriorated, e.g. stage 2 reported in one quarter and the deterioration in another quarter. However, the risk is low and validation process should correct any anomalies.	
Pressure ulcers that meet the HSCB criteria for a Serious Incident (SI) should be recorded on Datix and reported through serious incident reporting process. using the normal pathways of reporting Trusts should use the Regional HSC Risk Matrix - see attached document	It is important to note, that full thickness pressure ulcers do not always meet the criteria for a serious adverse incident – the wound may be quite small, e.g. 0.2 x 0.2cm, and heal quickly. However, pressure ulcers which lead to significant harm should be reported and investigated – these are likely to be incidents classified as moderate, major or catastrophic harm. Within the context of an avoidable pressure ulceration, significant harm is defined as: • Loss of life • Loss of limb • Requiring surgery intervention under general or regional anaesthesia. • Sepsis or Osteomyelitis • At the provider organisation discretion	 HSC Regional Risk Matrix - April 2013 (ι

The following data should be reported to the PHA 1. Total number of Stage 2 & above hospital acquired adult inpatient pressure ulcers (excluding out-patients & Day Cases) 2. Total number of Stage 3 & above hospital acquired adult inpatient pressure ulcers (excluding out-patients & Day Cases) 3. Total number of Stage 3 & above avoidable hospital acquired adult inpatient pressure ulcers (excluding out-patients & Day Cases) 4. Total number of adult community patients (16+) on the district Nursing Caseload who acquire a pressure ulcer 5. Total number of adult community patients (16+) on the district Nursing Caseload who acquire a stage 3 or above pressure ulcer 6. Total number of adult community patients (16+) on the district Nursing Caseload who acquire an avoidable stage 3 or above pressure ulcer 7. SSKIN Bundle Compliance in a Hospital setting 8. SSKIN Bundle compliance in Community setting	**Total Number** is all acquired pressure damage; avoidable and unavoidable **An adult inpatient** is defined as a person aged 16+, in a hospital setting. *People who develop a pressure ulcer when attending as a day case, or an outpatient will be excluded from the data reported to the PHA. This includes patients attending for renal dialysis. Do not include pressure ulcers which occur under a plaster cast applied as an outpatient (ED, Fracture clinic, Minor Injuries). *These incidents should however, be recorded locally, investigated, and learning should be shared. **A community patient** is defined as a person aged 16+ living in their own house, a supported living environment, or a residential home. **Stage 2 and above** means, stage 2, 3, 4, mucosal, DTI and unstageable damage. **Stage 3 and above** means stage 3, 4, DTI and unstageable damage	

Appendix 1: Pressure Ulcer Classification

Please note that pressure ulcers in Northern Ireland are classified using the International NPUAP/EPUAP Pressure Ulcer Classification System (2009, 2014) – see highlighted column.

International NPUAP/ EPUAP Pressure Ulcer Classification System (2009, 2014)	WHO ICD-11 (2018)	NPUAP Classification System (April 2016)
Category/Stage I pressure ulcer: Non-blanchable erythema	**EH90.0 Pressure ulceration grade 1**	**Stage 1 Pressure Injury: Non-blanchable erythema of intact skin**
Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category/Stage I may be difficult to detect in individuals with dark skin tones. May indicate "at risk" individuals (a heralding sign of risk).	Pressure ulceration grade 1 is a precursor to skin ulceration. The skin remains intact but there is non-blanchable redness of a localized area, usually over a bony prominence. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. It can be difficult to detect in individuals with dark skin but affected areas may differ in color from the surrounding skin. The presence of pressure ulceration grade 1 may indicate persons at risk of progressing to frank ulceration.	Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.

International NPUAP/ EPUAP Pressure Ulcer Classification System (2009, 2014)	WHO ICD-11 (2018)	NPUAP Classification System (April 2016)
Category/Stage II pressure ulcer: partial thickness skin loss	**EH90.1 Pressure ulceration grade 2**	**Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis**
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 blister. Presents as a shiny or dry shallow ulcer without slough or bruising.* This Category/Stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. **Bruising indicates suspected deep tissue injury.*	Pressure injury with partial thickness loss of dermis. It presents as a shallow open ulcer with a red or pink wound bed without slough or as a serum-filled or serosanguinous blister which may rupture. This category should not be used to describe skin tears, tape burns, incontinence associated dermatitis, maceration or excoriation.	Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).

International NPUAP/ EPUAP Pressure Ulcer Classification System (2009, 2014)	WHO ICD-11 (2018)	NPUAP Classification System (April 2016)
Category/Stage III: Full thickness skin loss	**EH90.2 Pressure ulceration grade 3**	**Stage 3 Pressure Injury: 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. The depth of a Category/ Stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category/ Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage III pressure ulcers. Bone/ tendon is not visible or directly palpable.	Pressure ulcer with full thickness skin 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. There may be undermining and tunneling into adjacent structures. The depth varies by anatomical location: grade 3 pressure ulcers can be shallow in areas with little or no subcutaneous fat (e.g. bridge of the nose, ear, occiput and malleolus). In contrast, grade 3 pressure ulcers can be extremely deep in areas of significant adiposity.	Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

International NPUAP/ EPUAP Pressure Ulcer Classification System (2009, 2014)	WHO ICD-11 (2018)	NPUAP Classification System (April 2016)
Category/Stage IV pressure ulcer: Full thickness tissue loss	**EH90.3 Pressure ulceration grade 4**	**Stage 4 Pressure Injury: Full-thickness skin and tissue loss**
Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. The depth of a Category/Stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category/ Stage IV ulcers an extend into muscle and/ or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.	Pressure ulcer with visible or directly palpable muscle, tendon or bone as a result of full thickness loss of skin and subcutaneous tissue. Slough or eschar may be present. The depth varies by anatomical location: grade IV pressure ulcers can be shallow in areas with little or no subcutaneous fat (e.g. bridge of the nose, ear, occiput and malleolus) but are typically deep and often undermine or tunnel into adjacent structures.	Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/ or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

International NPUAP/ EPUAP Pressure Ulcer Classification System (2009, 2014)	WHO ICD-11 (2018)	NPUAP Classification System (April 2016)
Unstageable: Depth unknown	**EH90.5 Pressure ulceration, ungradable**	**Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss**
Full thickness tissue loss in which the base of the ulcer is covered 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 is removed to expose the base of the wound, the true depth, and therefore Category/ Stage, cannot be determined. 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.	Pressure ulcer with full thickness skin 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, it is not possible to determine whether the ulcer is grade 3 or grade 4.	Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.

International NPUAP/ EPUAP Pressure Ulcer Classification System (2009, 2014)	WHO ICD-11 (2018)	NPUAP Classification System (April 2016)
Suspected deep tissue injury: Depth unknown	**EH90.4 Suspected deep pressure-induced tissue damage, depth unknown**	**Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration**
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.	An area of soft tissue damage due to pressure or shear which is anticipated to evolve into a deep pressure ulcer but has not yet done so. The affected skin is typically discolored purple or maroon and may display hemorrhagic blistering. It may be painful and edematous. It can be either warmer or cooler than adjacent tissue. Evolution into a deep ulcer may be rapid even with optimal treatment.	Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood-filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.

Health and Social Care

Regional Referral Criteria for District Nursing (DN) Service

Any Out of Hours URGENT referrals, after 5pm, weekends and public holidays, must be made directly to relevant Trust DN contacts.

(See Appendix 1 - Regional District Nursing Referral Contact Details)

Introduction

The District Nursing Service accepts referrals from a wide range of sources in line with the criteria through the Trust referral management processes outlined below. The District Nurse assesses care needs and delivers a range of nursing interventions for people in their own home or close to their home. The District Nursing Service plays a key role in supporting independence, managing long-term conditions, providing palliative and end of life care and preventing and treating acute illnesses (A District Nursing Framework 2018-2026 | Department of Health (health-ni.gov.uk)

The District Nurse uses a population health-based approach and proactively works with GPs, other Health and Social Care professionals, as well as individuals, families, carers, communities and voluntary agencies to deliver expert, effective and efficient care.

Criteria for Referral

A referral can be made to the District Nursing Service if an adult requires a holistic person-centred nursing assessment or a nursing intervention and meets one or more of the following criteria:-

- Is unable to leave their home due to mental or physical illness.
- Has a nursing need which makes a home visit more appropriate.
- Has been identified as having specific nursing equipment prescribed for home use.
- Has been identified as palliative or requires assessment of end of life care needs.

The District Nursing team may have to contact the referrer to:-

- Confirm any detail or priority of referral.
- Consider any alternative venue or service available to provide care.

Making a Referral

Referrals to the service can be made by GP practices, other professionals and the general public:-

- Via electronic Clinical Communication Gateway (CCG).
- To an individual Trust according to the accompanying table of contact details. (Appendix 1)

Health and Social Care

As part of the referral process:-

- The person and/or carer must be aware of and consent to a referral to the District Nursing Service (if able).
- The persons address and contact details must be accurate.
- All relevant information must be forwarded to the District Nursing Service, including any issues pertaining to staff safety, safeguarding or Mental Capacity Deprivation of Liberty (DoL). Any delay in receiving adequate information may result in a delay in prioritising the referral.
- A supply of medication (including nurse 'authorisation to administer medication' documentation) and dressings must be provided, where required, for treatment following hospital discharge or treatment room care.

Referral Response

The District Nursing Service does not operate a waiting list. Visits will be prioritised based on reason for referral and accompanying information. Visiting times and frequency of ongoing care will be agreed with the patient following assessment.

The District Nursing Team will respond to a referral request within the following time-frames:-

- **SAME DAY– requires a visit on day of referral.**
  A nursing intervention is required to prevent a ***potential serious risk.*** The District Nursing Team will triage the referral within 4 hours and action on the same day. The referrer will be contacted if this timeframe cannot be achieved or is deemed inappropriate by the triage nurse.

- **48 HOURS – requires a visit within 48hrs (Please Stipulate date).**
  The District Nursing Team will triage the referral within 24 hours, to determine the urgency of the referral and action within 48 hours. The referrer will be contacted if this timeframe cannot be achieved or is deemed inappropriate by the triage nurse.

- **ROUTINE / Non Urgent – requires a visit in more than 48 hours, on date specified or determined by the District Nursing Team.**
  The nursing intervention is not urgent in nature. The District Nursing Team will triage the referral within 24-48 hours and schedule a visit accordingly

Discharge

A person will be discharged from the District Nursing Service when:-

- Care has been completed, they can be clinically maintained in another care setting or the person/carer/family can self-manage.
- The person requests to be discharged from the service.
- The person transfers out of the GP Practice area, resulting in alignment to another caseload holder/Trust
- The person is deceased.