# Pressure Ulcers

**By: Esther Hattler BS,RN,WCC**

Staging

# Objectives

- The attendee will be able to list  the 6 stages of pressure ulcers.

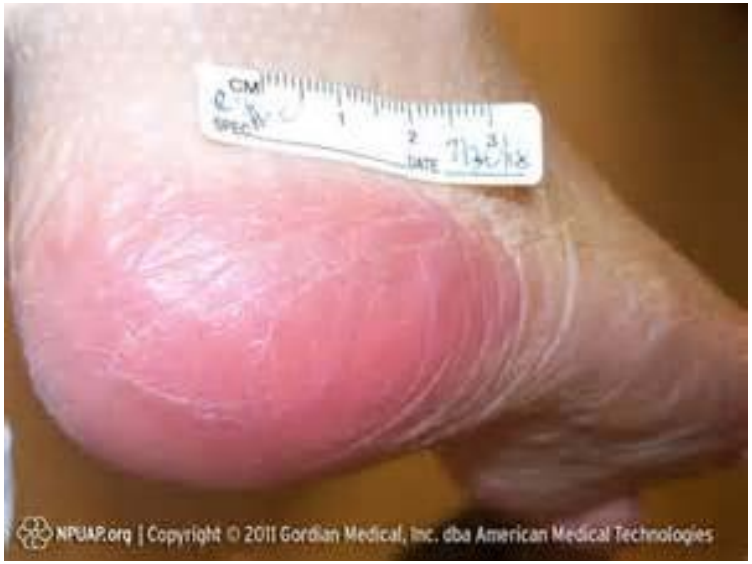
# Stage I

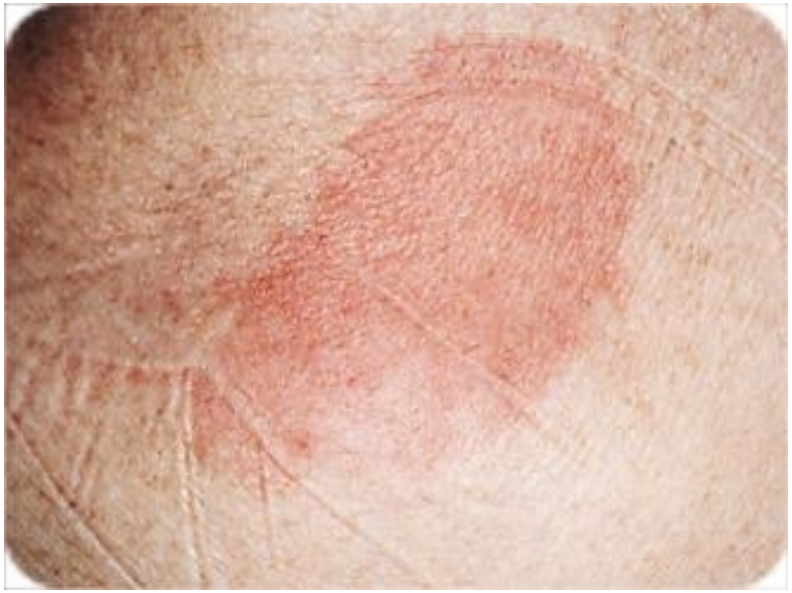
- Definition
- Intact skin with non-blanchable redness of a localized area usually over a bony prominence.
- Darkly pigmented skin may not have visible blanching. Its color may differ from surrounding area.

# Description Stage I

- The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue.
- Stage I may be difficult to detect in individuals with dark skin tones.
- May indicate “at risk” persons (a heralding sign of risk).

# Pictures stage I



# Stage II

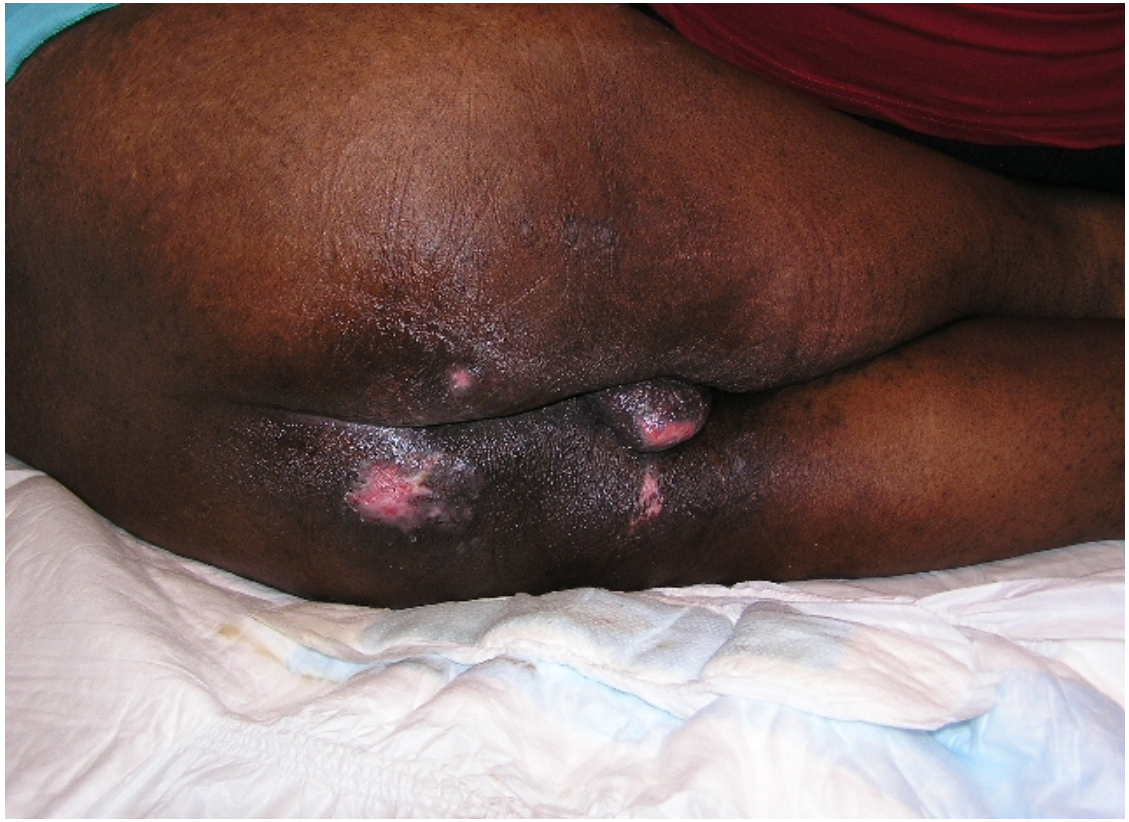
- Definition
- Partial thickness loss of dermis presenting as a shallow open ulcer with a red/pink wound bed, WITHOUT slough.
- May also present as an intact or open ruptured serum filled blister.

# Description stage II

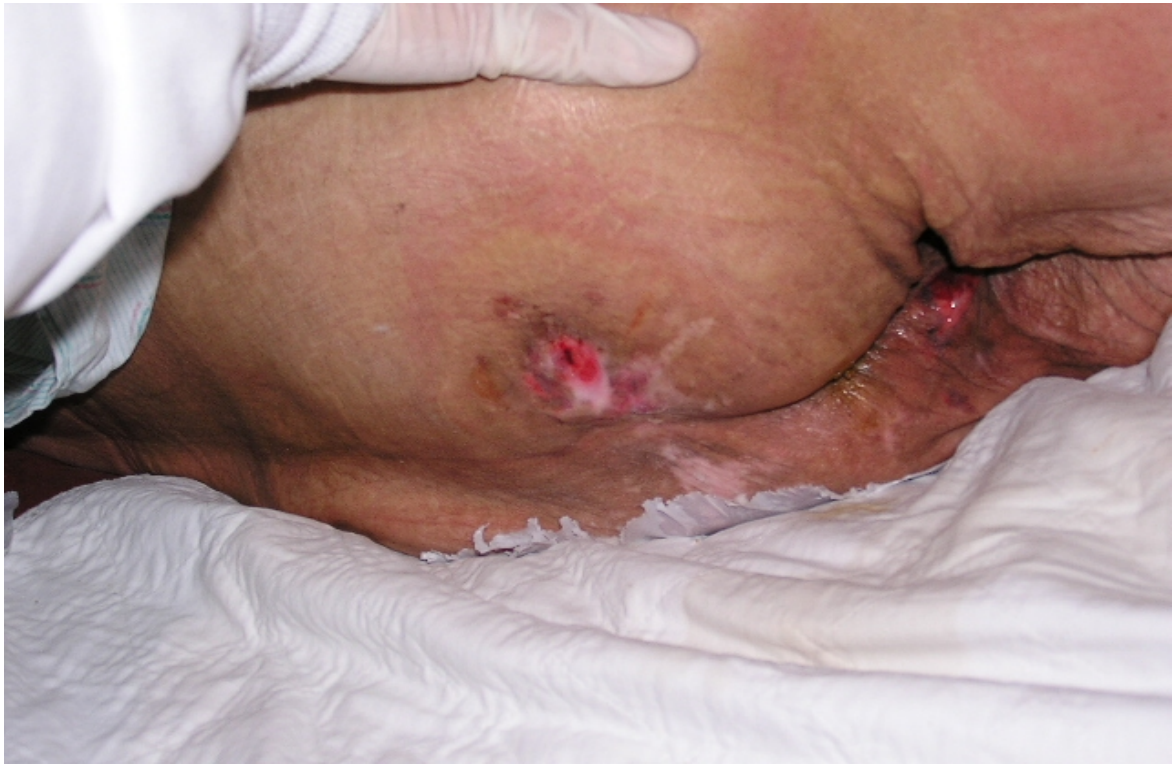
- Presents as a shiny or dry shallow ulcer WITHOUT slough or bruising.

- The stage II should NOT be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.

# Pictures stage II



# Stage II



# Stage III

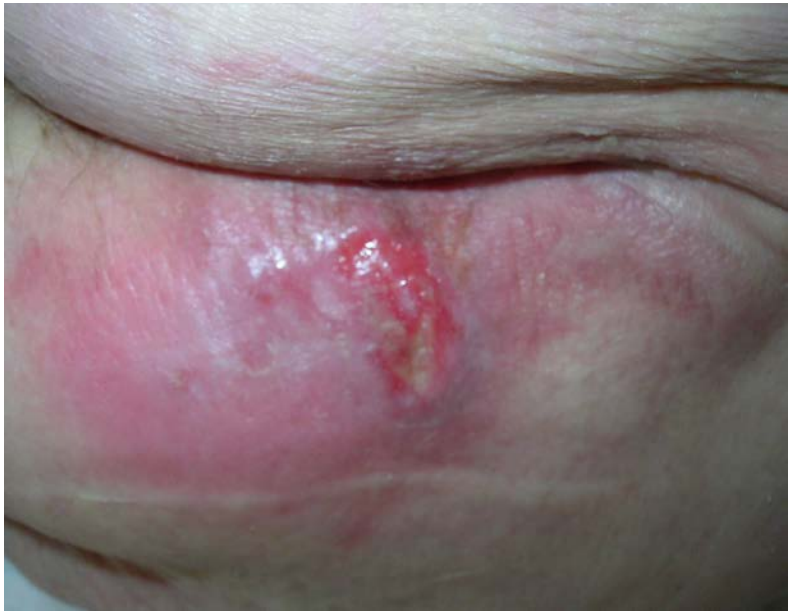
- Definition
- Full thickness tissue loss.  Subcutaneous fat may be visible but bone, tendon, or muscle are not exposed.
- Slough may be present but does not obscure the depth of tissue loss.  May include undermining and tunneling.

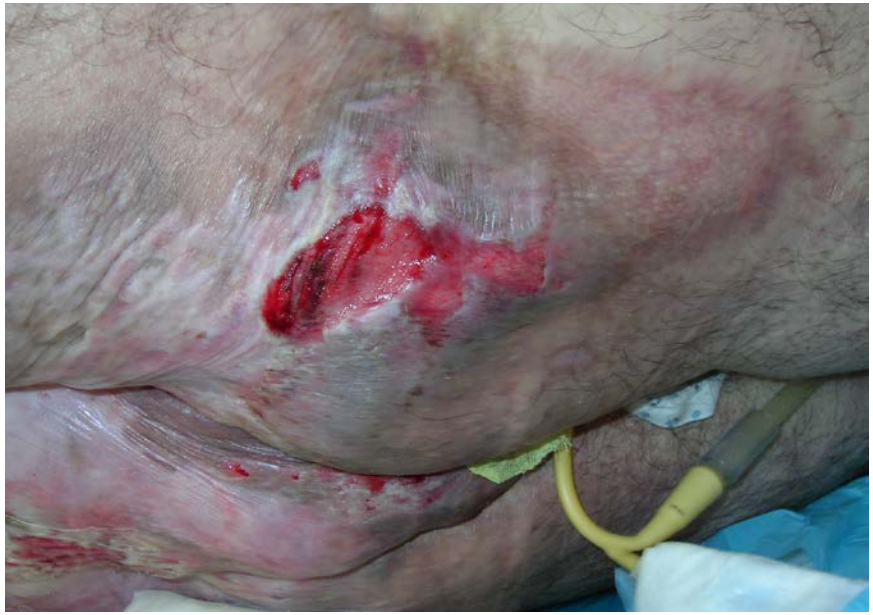
# Description stage III

- The depth of a a stage III pressure ulcer varies by anatomical location.  The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage III ulcers can be shallow.  In contrast, areas of significant adiposity can develop extremely deep stage III pressure ulcers.

- Bone/tendon is not visible or directly palpable.

# Pictures of stage III's





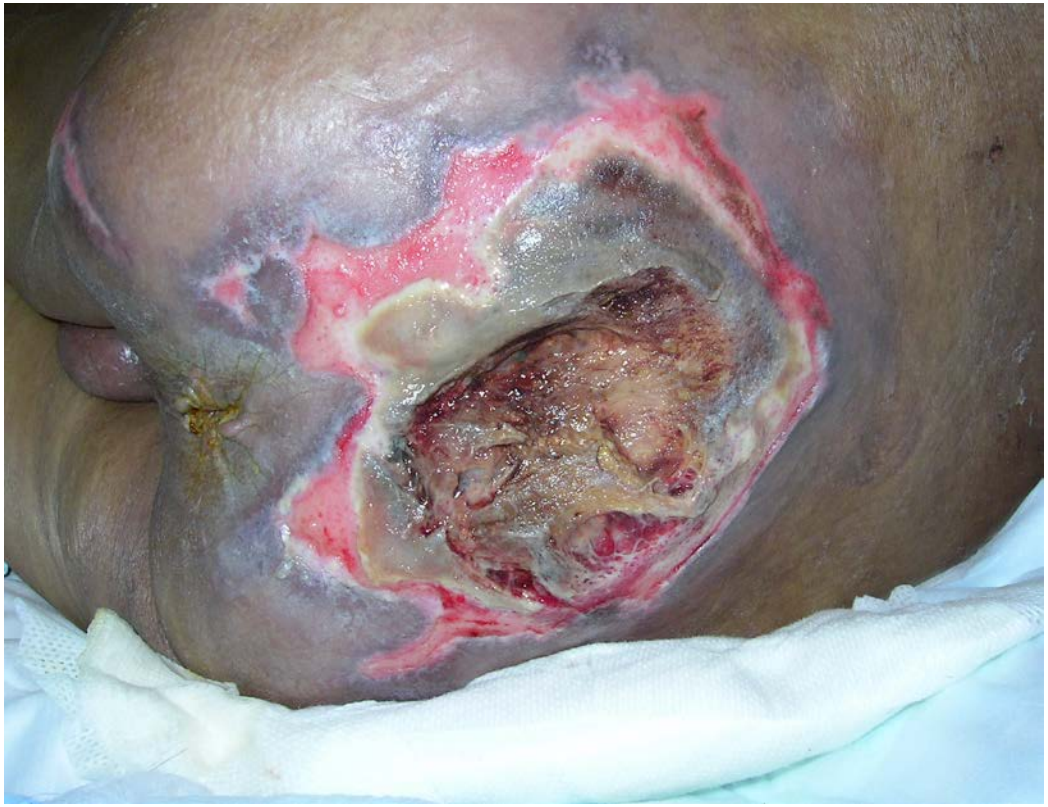
# Stage IV

- Definition
- 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.

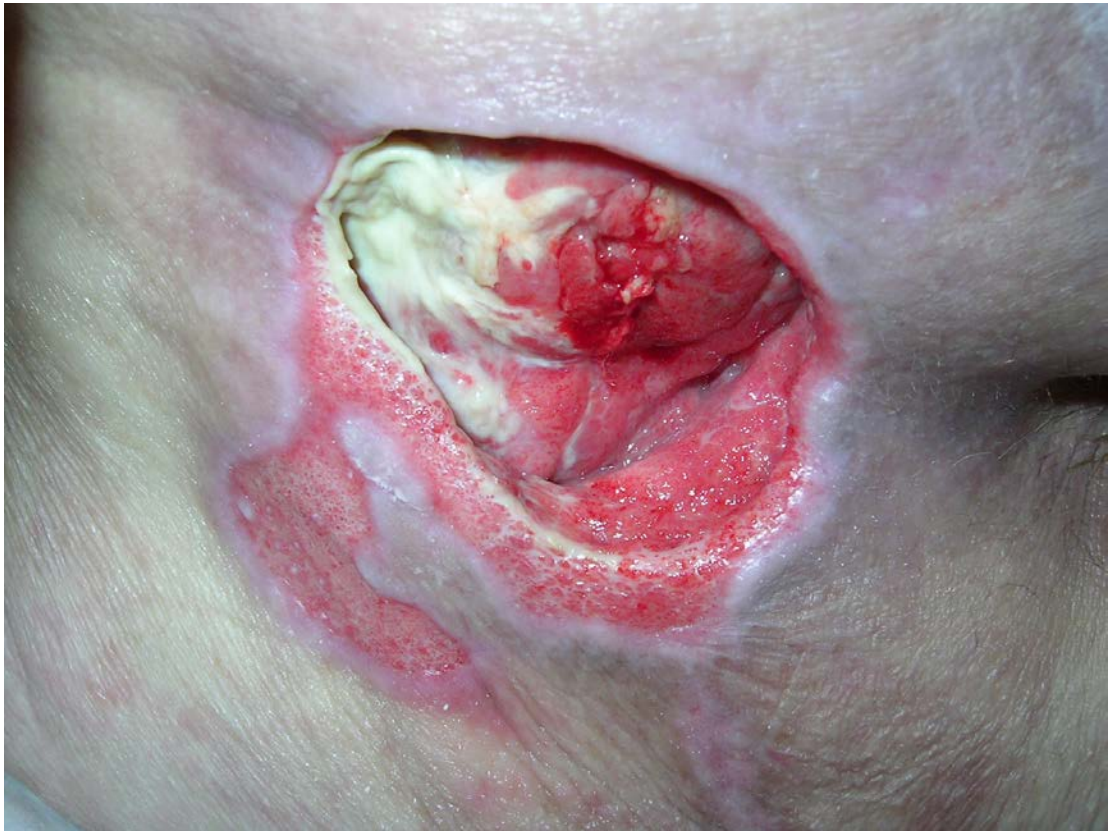
# Description of stage IV

- The depth of a 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.
- Stage IV ulcers can 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.

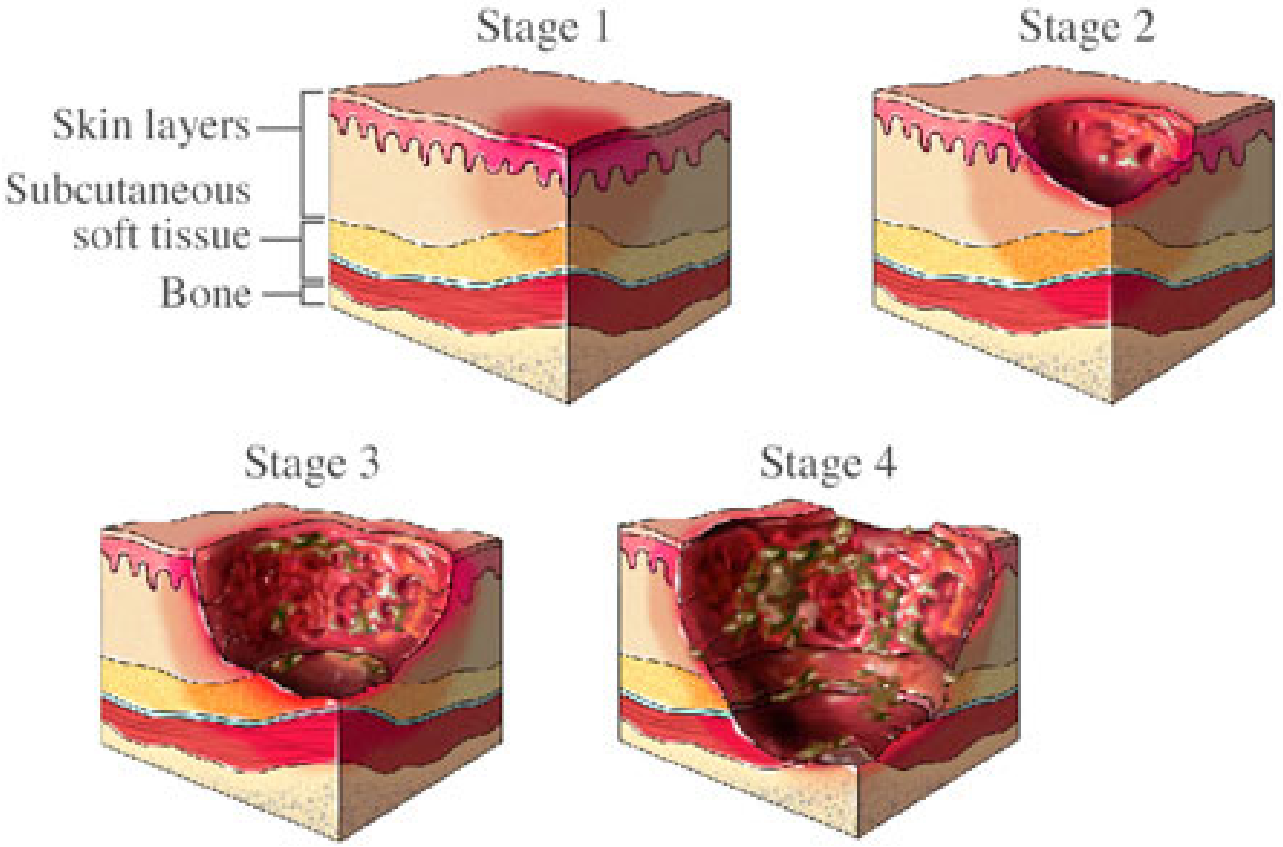
# Stage IV



# Stage IV



# Review of the Four Stages



# Unstageable

- Definition
- Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green, or brown) and/or eschar in the wound bed.
- The wound bed is not visible.

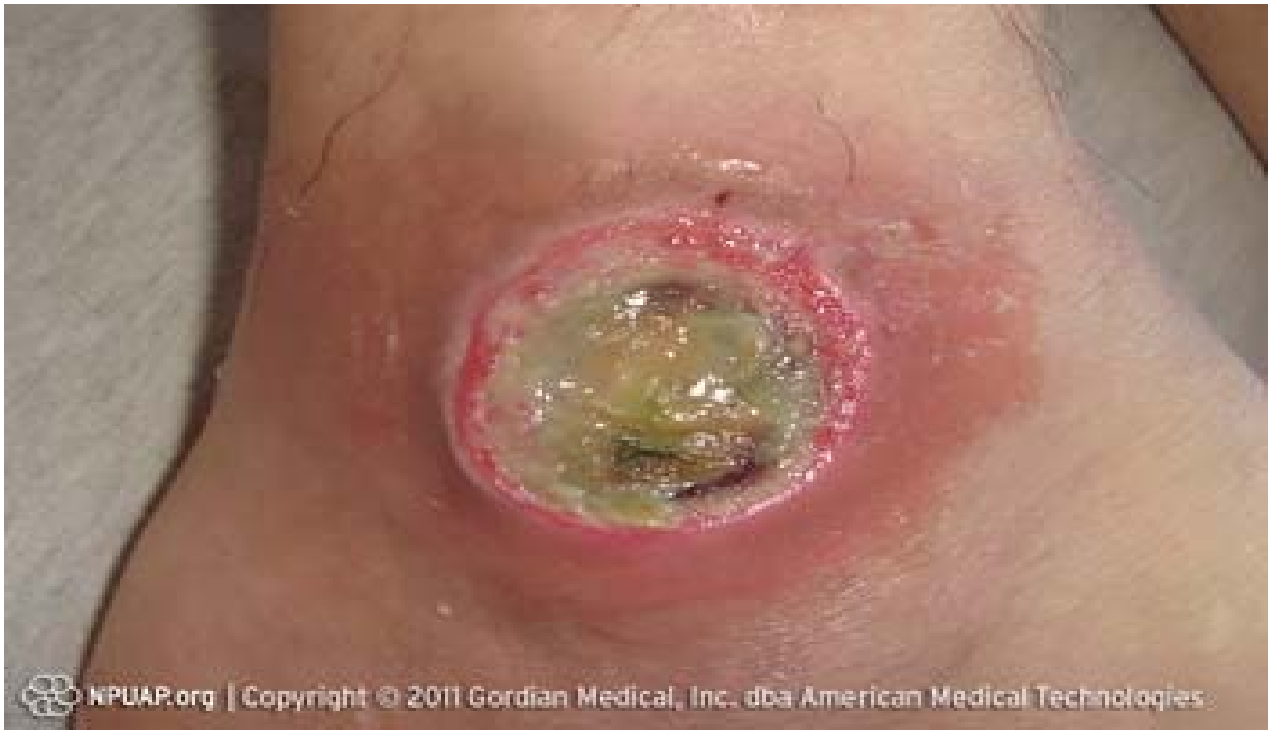
# Description of Unstageable

- Until enough slough and/or eschar is removed to expose the base of the wound, the true depth and therefore stage cannot be determined.

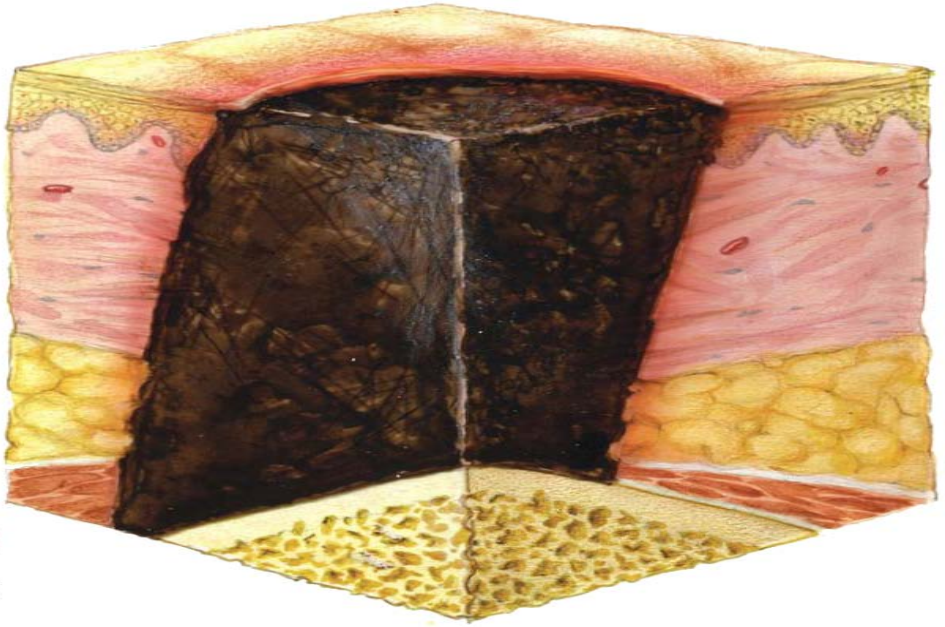
- Stable eschar (dry, adherent, intact without erythema or fluctuance) on the heels serves as “the body’s natural (biological) cover” and should NOT be removed.

# Pictures of Unstageable's

# Unstageable



# Unstageable



# Deep Tissue Injury

- Definition

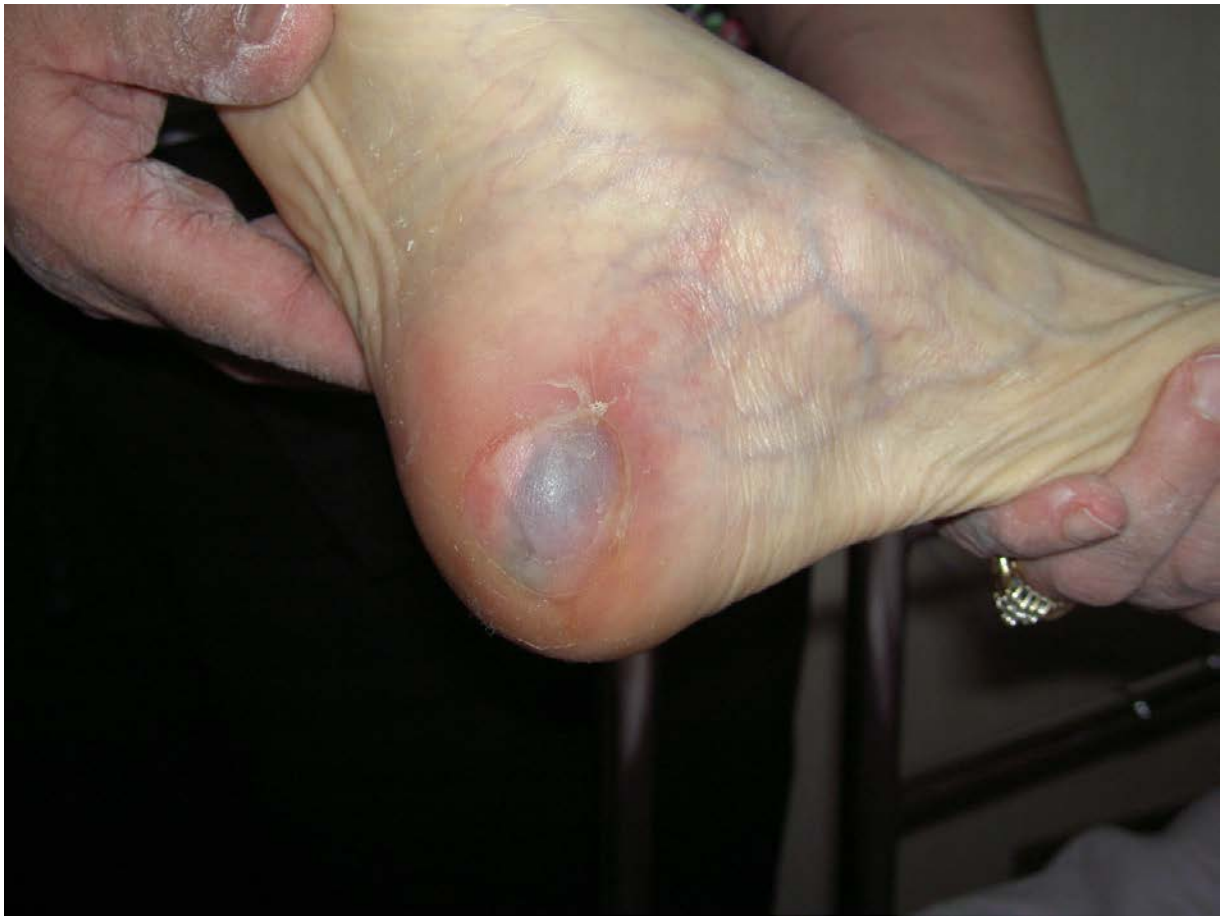
- Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear.

# Deep tissue Injury description

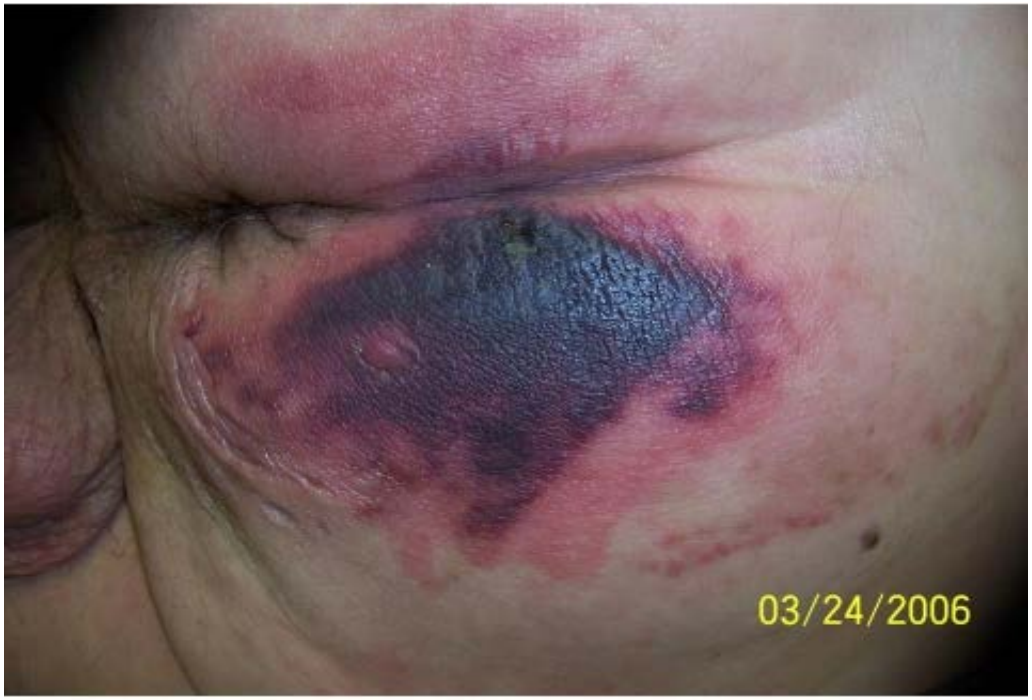
- The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

- Deep tissue injury may be difficult to detect in dark skin. 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.

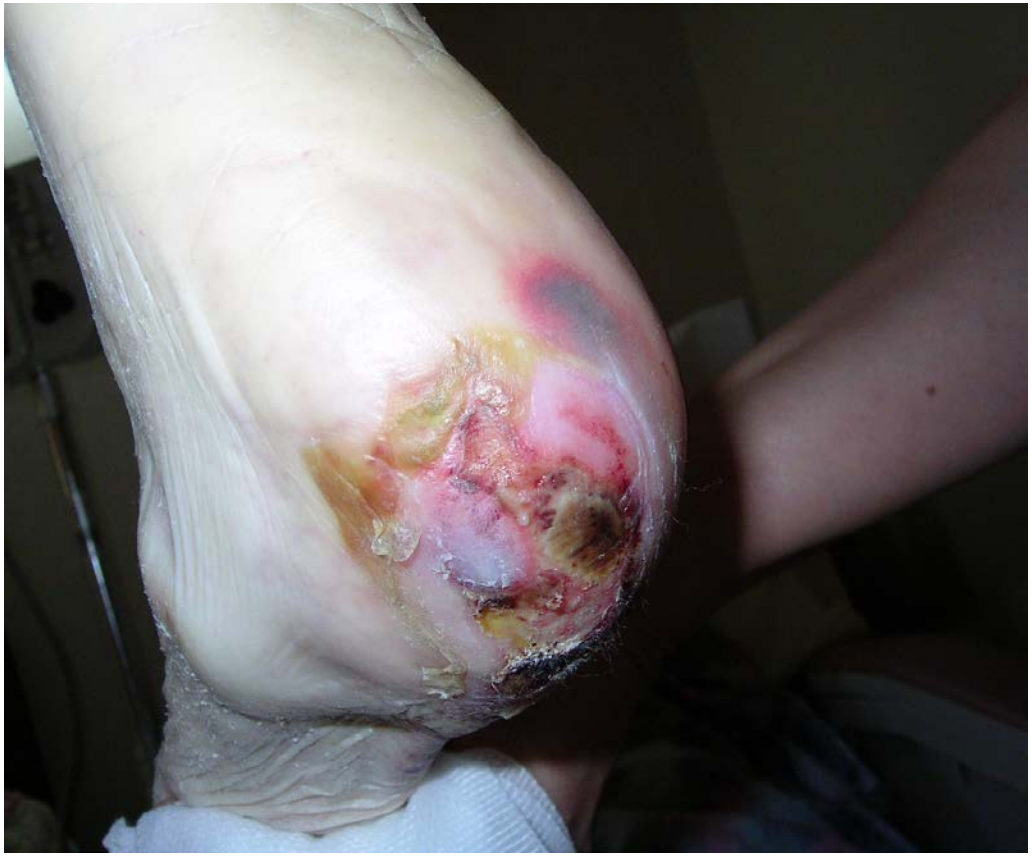
# Picture of Deep Tissue Injury



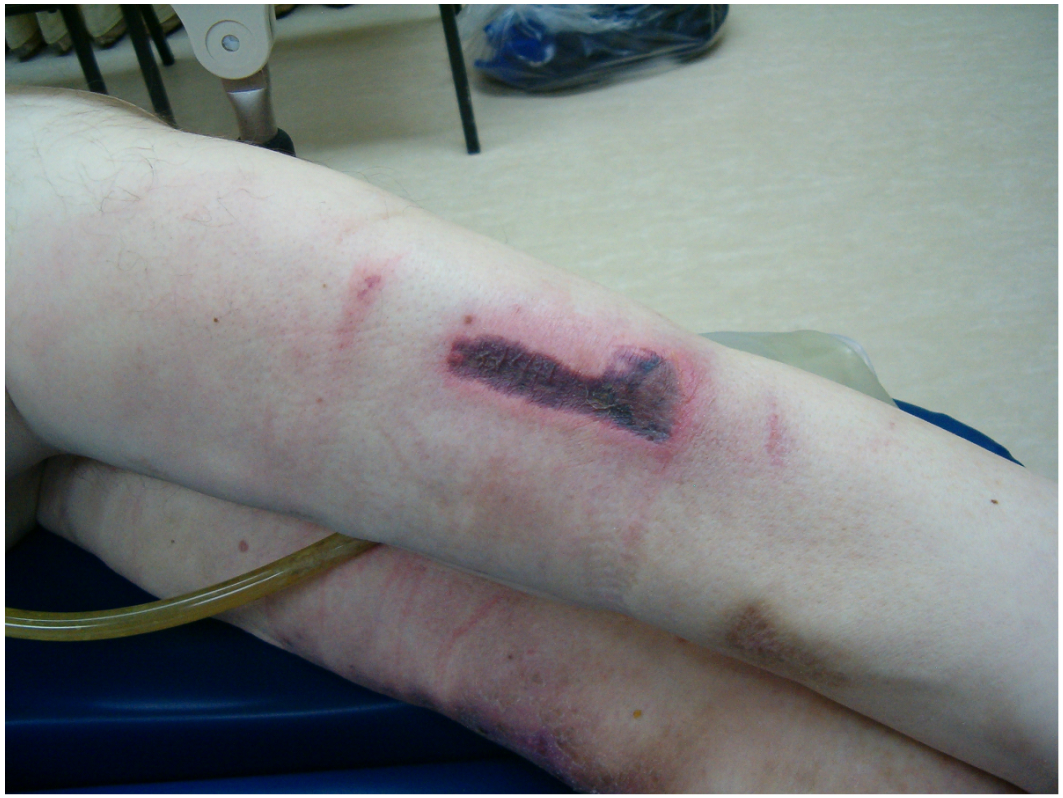
# Deep Tissue Injury



# Deep Tissue Injury



# Medical Device Related Pressure Ulcer



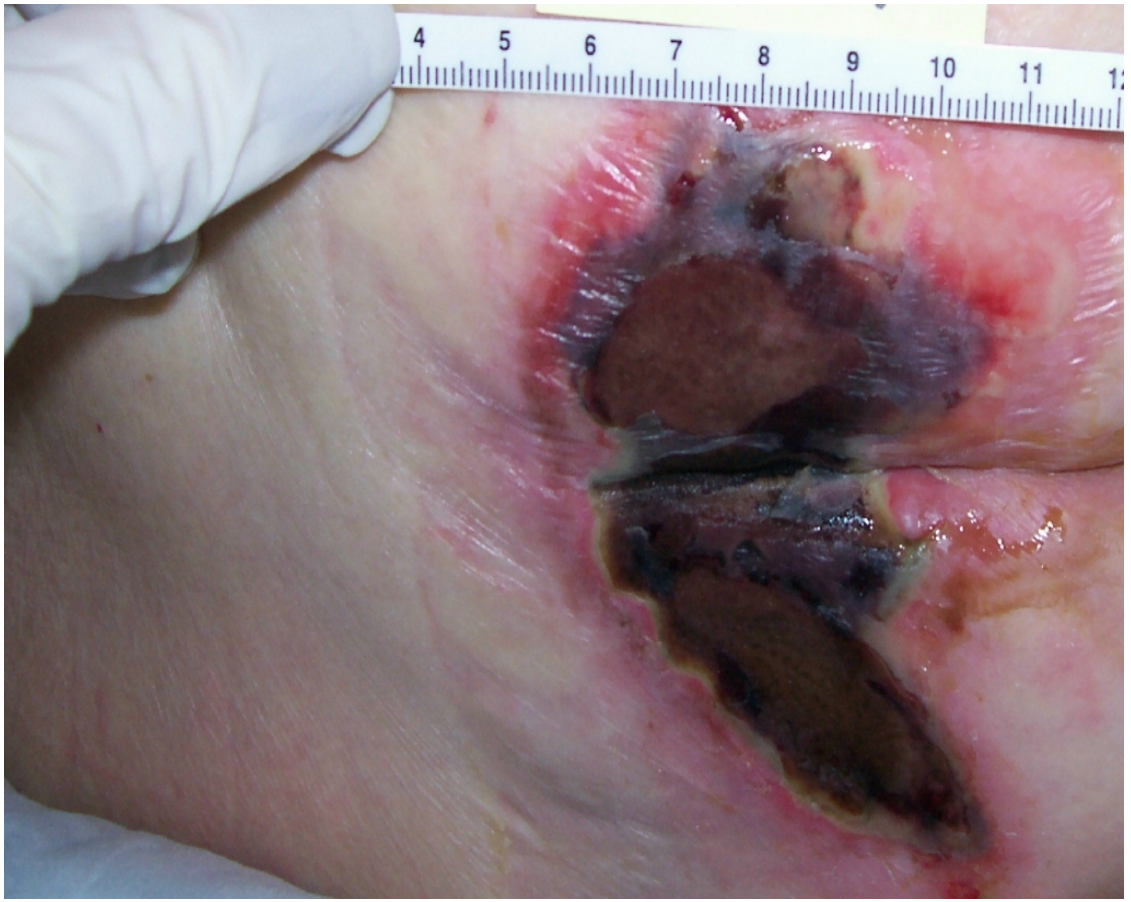
# Possible Medical Device Pressure Ulcers

- ET tube
- Trach ties
- NG tube
- Bedpan
- Oxygen tubing
- Foley catheter tubing
- SED’s (stockings)
- Plain “too tight” teds

# Kennedy Ulcer- end of life

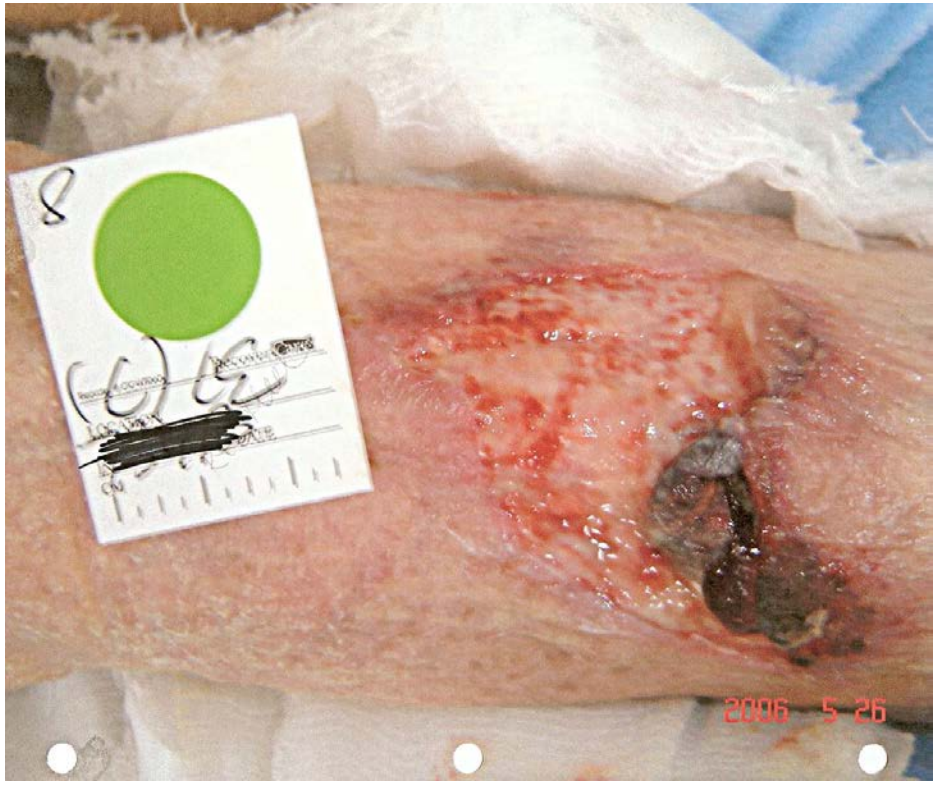
- Sudden onset in an end of life patient
- Most often on the sacrum, butterfly shape
- Deteriorates rapidly
  - The skin is an organ and it can be part of the multisystem failure.

# Kennedy Terminal Ulcer

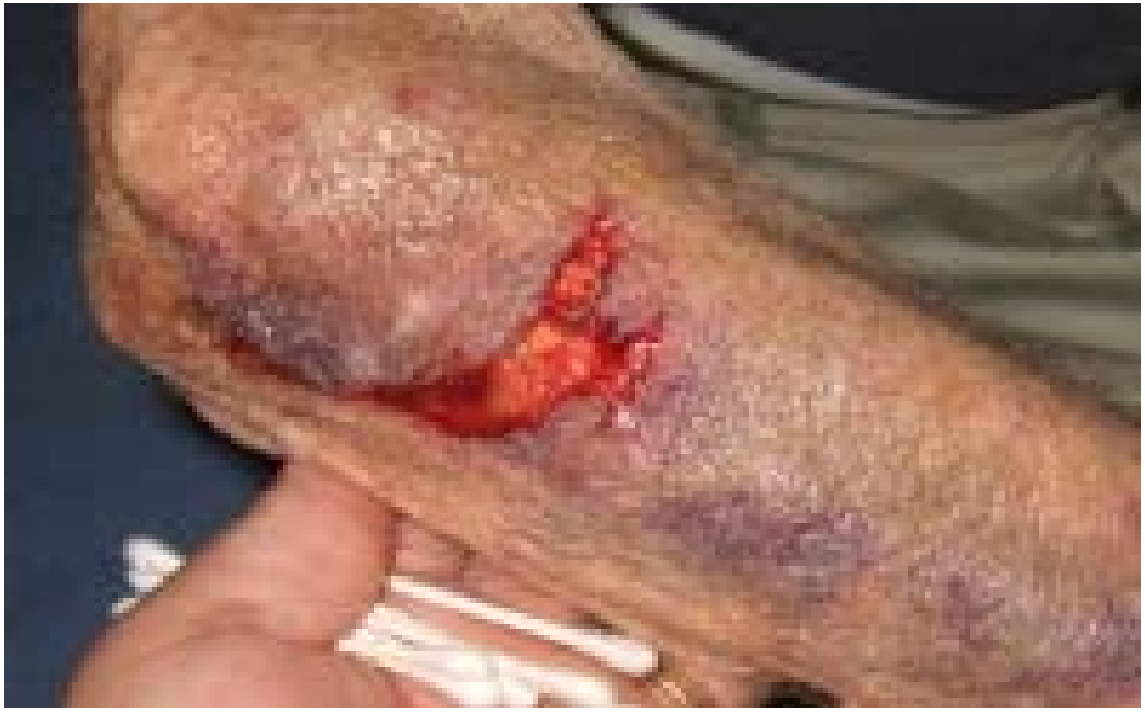


# Skin Tear

- Do NOT stage



# Skin tear



# Questions?

# Thank you!

# Resources

- National Ulcer Advisory Panel www.npuap.org
- Sardina, Donna, RN,MHA,CC,DWC, *Wound & Skin Care Pocket Guide*, Wound Care Institute, August 2012.
- Wound Photo CD, 2006, www.wcei.net