# Pressure ulcers (pressure sores)

Royal Devon University Healthcare NHS Foundation Trust

**How to reduce the risk of acquiring pressure sores in hospital**

## Other formats

If you need this information in another format such as audio CD, Braille, large print, high contrast, British Sign Language or translated into another language, please contact the PALS desk on 01271 314090 or at ndht.pals@nhs.net.

**Please be aware this leaflet contains images of pressure sores, which some people may find upsetting.**

## What is a pressure sore?

This leaflet has been designed to help you understand the risks associated with developing a hospital-acquired pressure sore, and the measures you can take to reduce the likelihood of developing one.

*"A pressure sore is localised injury to the skin which may include the underlying tissue, usually over a bony prominence, as a result of direct pressure or shearing of the skin." (European Pressure Ulcer Advisory Panel)*

- Shearing – this may occur if you slide down, or are dragged up the bed or chair and the layers of skin are forced to slide over one another or over deeper tissues.

You may think that you are not at risk of developing a pressure sore because of your age, general fitness and activity levels, but when you are in hospital these factors change, increasing your risk.

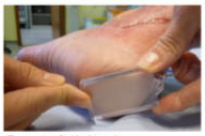
**Categorisation of pressure sores:**

We typically categorise pressure sores depending on their severity and presentation, and we will discuss this *with you if we discover a sore whilst you are a patient on the ward.*

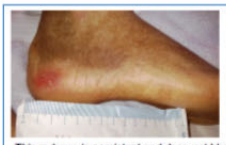
# Pressure ulcer categorisation

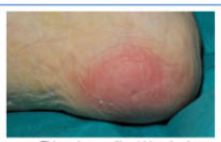
**Blanching erythema**

Healthy skin may develop transient redness when subjected to pressure – for example, if the legs are crossed. To test if damage has occurred, light finger pressure should be applied to see if the skin blanches (goes white). In darker skin tones, redness may present as a darker area that is grey or purplish. This is **not** a pressure ulcer.


Example of skin blanch


Blanch in darker skin


This redness is persistent and does not blanch


This redness will not blanch when pressure is applied

**Category 1: Non-blanchable erythema**

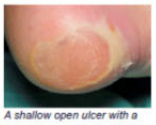
Intact skin with non-blanchable redness of a localised area, usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler compared to adjacent tissue. Category 1 may be difficult to detect in individuals with dark skin tones. May indicate 'at risk' individuals (a heralding sign of risk).

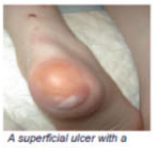
**Category 2: Partial thickness skin loss**

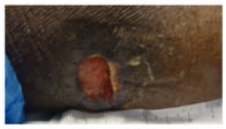
Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising.* This category should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.

**Bruising indicates suspected deep tissue injury.*


An intact serum-filled blister


A shallow open ulcer with a red pink wound bed without slough


A superficial ulcer with a collapsed blister


Full thickness tissue loss. Subcutaneous fat is visible but no bone, tendon or muscle

**Category 3: Full thickness skin loss**

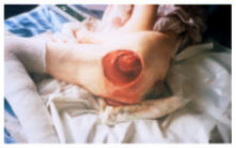
Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss.

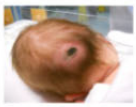
May include undermining and tunnelling. The depth of a Category 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue, and Category 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category 3 pressure ulcers. Bone/tendon is not visible or directly palpable.

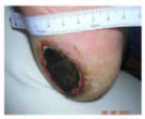
**Category 4: Full thickness tissue loss**

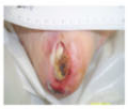
Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunnelling. The depth of a Category 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue, and these ulcers can be shallow. Category 4 ulcers can extend into muscle and/or supporting structures (eg fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.

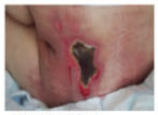

In this wound, the bone is clearly visible


This wound shows exposed muscle


This occipital ulcer is covered by softening necrosis


This heel ulcer is covered by hard dry eschar


The necrotic cap on this heel has softened and started to separate


Although still firmly attached, there is a ring of demarcation where this eschar has been rehydrated

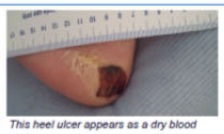
**Unstageable: depth unknown**

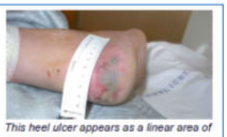
Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the wound bed.

Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore category, 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.

**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 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.


This heel ulcer appears as a dry blood blister


This heel ulcer appears as a linear area of deep purple black discolouration

*These images have kindly been supplied by members of the NHS Improvement pressure ulcer categorisation group. Permission has been given by the patients for them to be freely reproduced.*

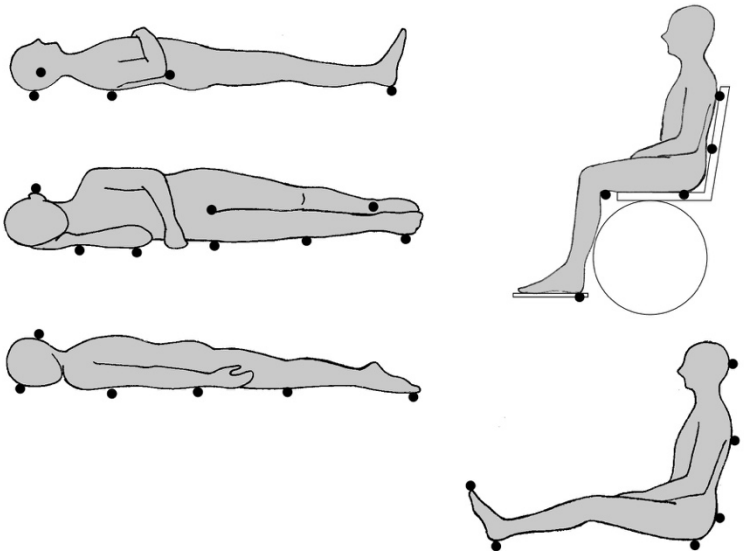
*To cite this poster please use: NHS Improvement Pressure ulcer categorisation group (2019) Pressure Ulcer Categorisation. Available from http://nhs.stopthepressure.co.uk/*

NHS England and NHS Improvement

## Where can pressure sores develop?

Common sites for developing pressure sores are:

- Heels
- Sacrum
- Elbows
- Hips
- Scalp
- Ankles



## How can I reduce the risk of developing a sore?

1. Keep moving/change positioning. Nursing or therapy staff will assist you with this if required or they will enable you to reposition yourself independently.
2. If you are in a semi reclined position in bed, make sure the knee break on your bed is raised to relieve the pressure on your lower back, bottom and heels. If you are uncomfortable, please ask to speak to one of the nursing or therapy staff who can advise on positioning.
3. If you are sitting in a chair, make sure you are well supported with your feet flat on the floor and your back fully supported by the backrest. Your hips and knees should be at a 90 degree bend. There should a small gap between the back of your knee and the front edge of the seat to prevent pressure building up behind your knees. Your arms should be able to rest comfortably on the armrests. This position will help to avoid pressure building up around your lower back and bottom and will help you to reposition yourself. If you are uncomfortable, please ask to speak to one of the nursing or therapy staff, who can advise on positioning.
4. Ensure you are eating and drinking well.
5. Ensure your skin is kept free from moisture.
6. You may be given special equipment if required.

## What can you expect from us?

When you are admitted to the ward the nursing staff will carry out a full assessment of your skin integrity and will ask you if you have any sore areas of skin or any existing sores. These will then be examined and acted on accordingly.

If you do have a pressure sore, with your consent you may be asked if we can photograph it. If you should develop a pressure sore, the nurse caring for you will record this, and again with your consent you may be asked if we can take a photograph of the sore. The reason for the photograph is so that we can see if the sore is improving or deteriorating and act accordingly. We may also share the photos with our tissue viability specialist nurses for further advice about your care.

In the event of a sore occurring, the nurse caring for you will discuss this fully with you.

You will be asked every day if we can check your skin to enable us to identify promptly any possible problems. Assessing your skin on admission to the ward and at regular intervals thereafter is an important task for nursing staff to do, so please don't be offended if we ask you personal questions about your skin; we ask everyone!

## How are pressure sores treated?

If you have an existing pressure sore, or develop a new one, a care plan will be developed with you. We will identify an appropriate dressing for the sore if one is needed. We will also develop a plan with you to ensure that you regularly re-position yourself, or are assisted to do so in order to minimise the risk of further pressure sores developing, and to help to heal any existing ones. This plan will be discussed with you fully.

If you have a pressure sore, the nurse caring for you will discuss this fully with you.

## Possible consequences of developing a pressure sore

If you already have or develop a pressure sore, the consequences may be as follows:

- Increased pain
- Reduced physical activity
- Lengthened hospital stay
- The need for additional nursing input when you go home
- The possibility of infection

## Follow up

If you need any ongoing care in relation to prevention of pressure sores, equipment or care of a pressure sore, the ward staff will advise you before you leave. You may need support at home from a community nurse or therapist (physiotherapist or occupational therapist) and this will be arranged for you. If you need any pressure relieving equipment (e.g. bed, mattress, cushion etc.) then you will be advised of this and we will explain how this will be provided for you at home.

## Further information

www.nationalwoundcarestrategy.net/pressure-ulcer

www.nhs.uk/conditions/pressure-sores

www.epuap.org

## References

Dealey C, Posnett J, walker A. (2012) The cost of pressure ulcers in the United Kingdom. Journal of Wound Care. 21 (6) 261-266

Moore Z, Cowman S, Conroy RM. (2011) A randomized controlled clinical trial of repositioning using the 360 tilt for the prevention of pressure ulcers. Journal of Clinical Nursing Sep 20 (17-18) 2633-2644

NHS Improvement (2018). Pressure ulcers: revised definition and measurement. Summary and recommendations. NHS Improvement: London.

National Institute for Health and Care Excellence (2014) *Pressure ulcers: prevention and management of pressure ulcers.* NICE Clinical guideline 179. Available at: https://www.nice.org.uk/guidance/cg179

## PALS

The Patient Advice and Liaison Service (PALS) ensures that the NHS listens to patients, relatives, carers and friends, answers questions and resolves concerns as quickly as possible. If you have a query or concern, call 01271 314090 or email ndht.pals@nhs.net. You can also visit the PALS and Information Centre in person at North Devon District Hospital, Barnstaple.

## Have your say

Royal Devon University Healthcare NHS Foundation Trust aims to provide high quality services. However, please tell us when something could be improved. If you have a comment or compliment about a service or treatment, please raise your comments with a member of staff or the PALS team in the first instance.

'Care Opinion' comments forms are on all wards or online at www.careopinion.org.uk.

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