## TIPS FOR PRESSURE ULCER CATEGORISATION

### Suspected deep tissue injury
- Purple or maroon localised area of discoloured, intact skin or blood-filled blister
- May be difficult to detect in patients with dark skin tones
- May present with thin blister or eschar

### Category I
- Intact, localised area of non-blanchable erythema, typically over a bony prominence
- Blanching may present as different colour in patients with dark skin tones
- May be painful, firm, soft, or feel to be of a different temperature than surrounding tissue

### Category II
- Shallow, partial-thickness open ulcer with a red/pink wound bed, without slough
- Can also be an intact or open/ruptured serum-filled blister
- May be shiny or dry, without bruising

### Category III
- Full-thickness ulcer that may present with slough that does not obscure depth of tissue loss
- Subcutaneous tissue may be visible, but bone, tendon and muscle will not
- Undermining and tunnelling may be present

### Category IV
- Full-thickness ulcer with exposed bone, tendon or muscle
- May present with slough or eschar
- Undermining and tunnelling are often present

## DEBRIDEMENT IN PRESSURE ULCERS

### Rationale for debridement in PUs
- Generally, debridement is a key to wound bed preparation that can address barriers to healing and provide stimulatory healing effects
- Debridement of slough can help achieve full visualisation required for accurate PU categorisation

### Recommendations for debridement in PUs
- Perform debridement as needed to leave the wound bed free of devitalised tissue and covered with granulation tissue
- Manage pain associated with debridement
- Debride the wound bed or PU edge using a method determined as most appropriate by assessment of the patient and wound, in line with overall treatment goals
- Use of a monofilament pad removes slough and devitalized tissue, and potentially disrupts biofilm within the wound bed

### Key advantages of Debrisoft®
- Mechanical debridement with Debrisoft takes 2 to 4 minutes, on average
- Ideal for safely, gently removing debris and slough, to allow full visualisation for PU categorisation
- Debrisoft can be used by clinicians across all competency levels, from general/qualified practitioner to advanced practitioner
- By actively and rapidly removing debris, Debrisoft leaves the wound and skin clear and ready for healing
- According to recent NICE guidance, using Debrisoft could result in savings of £15 million per annum nationally up to £484 per patient

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For complete list of evidence, references, case studies and multimedia resources supporting the information in this guide, and to see Debrisoft in action, visit: www.activahealthcare.co.uk/debrisoft/
**PATHWAY TO ENHANCE RAPID PRESSURE ULCER CATEGORISATION**

1. **ASSESS**
   Perform a full holistic assessment of the patient, to confirm the wound is a pressure ulcer (not moisture-associated damage*) and identify causes of the PU. For lower-limb PUs, perform a thorough vascular assessment

- Is arterial insufficiency present?
  - NO
  - YES


**FURTHER READING**

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<td>*See: Tips for categorising pressure ulcers on p5 (overleaf)</td>
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**Categorise** the pressure ulcer:

- Category II
- Category III
- Category IV

Is the skin intact?
- NO
- YES

Can you assess the full depth and extent of the PU?
- NO = unstageable
- YES

Therefore rapid debridement‡ is required to enable fast-track categorisation as 3 or 4

Does the wound contain devitalised tissue that is soft and hydrated, and thus suitable for monofilament debridement?
- YES
- NO

Carry out rapid debridement to facilitate categorisation using Debrisoft® (single-use monofilament pad for mechanical debridement)§

Consider another method of debridement by referring to local debridement guidelines and/or UK consensus||

On completion of current/each debridement episode, reassess:

- Assess the skin discolouration and categorise† as:
  - Purple = Suspected deep tissue injury
  - Red/non-blanching = Category I

- Refer to vascular specialist for assessment