

TIPS FOR PRESSURE ULCER CATEGORISATION¹

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



1. National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline. Emily Haesler (Ed.). Cambridge Media: Osborne Park, Western Australia; 2014

DEBRIDEMENT IN PRESSURE ULCERS

Rationale for debridement in PUs¹

- 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 PUs¹

- 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 healing²
- According to recent NICE guidance, using Debrisoft could result in savings of £15 million per annum nationally/up to £484 per patient²

2. National Institute for Health and Care Excellence (NICE) (2014) The Debrisoft monofilament debridement pad for use in acute or chronic wounds. London: NICE. Available at: guidance.nice.org.uk/mtg17

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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/

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PATHWAY TO ENHANCE RAPID PRESSURE ULCER CATEGORISATION

FURTHER READING

*See: All Wales Tissue Viability Nurse Forum and All Wales Continence Forum (2014) All Wales best practice statement on the prevention and management of moisture lesions. London: Wounds UK. Available at: www.wounds-uk.com/supplements/awtvnf-prevention-and-management-of-moisture-lesions

†See: Tips for categorising pressure ulcers on p5 (overleaf)

‡ National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline. Emily Haesler (Ed.). Cambridge Media: Osborne Park, Western Australia; 2014

§See: Quick Guide: Debrisoft® in practice (2014) London: Wounds UK. Available at: www.wounds-uk.com/quick-guides/quick-guide-on-debrisoft-in-practice

||See: Guidelines for Practice (2013) *Effective debridement in a changing NHS: A UK consensus*. London: Wounds UK. Available at: <http://www.wounds-uk.com/supplements/effective-debridement-in-a-changing-nhs-a-uk-consensus>

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?

YES

Refer to vascular specialist for assessment

NO

Is the skin intact?

YES

Assess the skin discolouration and categorise† as:

- Purple = Suspected deep tissue injury
- Red/non-blanching = Category 1

NO

Can you assess the full depth and extent of the PU?

NO = unstageable

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

Categorise† the pressure ulcer:

- Category II
- Category III
- Category IV

YES

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:

