Bradford District Care
NHS Foundation Trust

Categorisation and Reporting Guidance

Light skin tones

Definition

"A pressure ulcer is localized damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or other device), resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open ulcer and may be painful".

(NHS Improvement 2018)

Category 1

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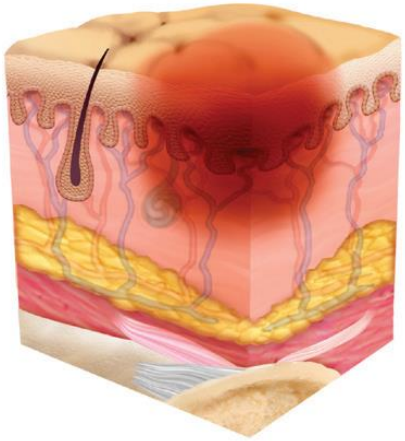
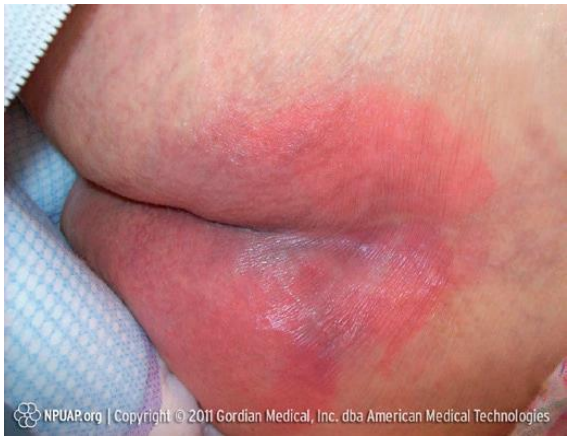
Category 1 pressure ulcer – Non blanchable erythema
Intact skin with non-blanchable redness of a localized area, usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler compared to adjacent skin

MAY INDICATE AT RISK PATIENTS – IR-e NOT required
TV referral if patient non-concordance identified, to refer to non-concordance pathway and flowchart and complete mental capacity assessment





Category 2

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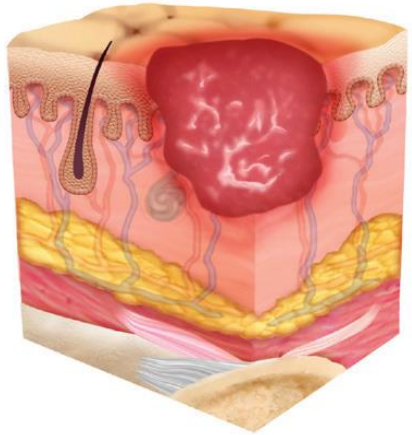
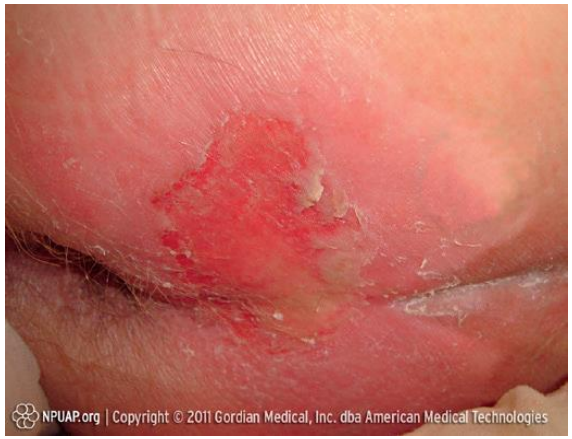
Category 2 pressure ulcer – Partial thickness skin loss
Partial thickness loss of dermis presenting as a shallow ulcer with a red/pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising (Bruising indicates SDTI)
IR-e required – to re report if deterioration to category 3
TV referral if patient non-concordance identified, and refer to non-concordance pathway and flowchart and complete mental capacity assessment





Category 3

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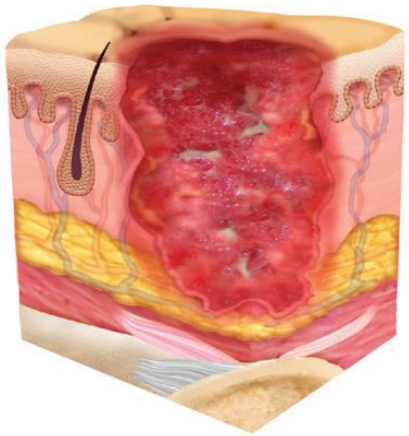
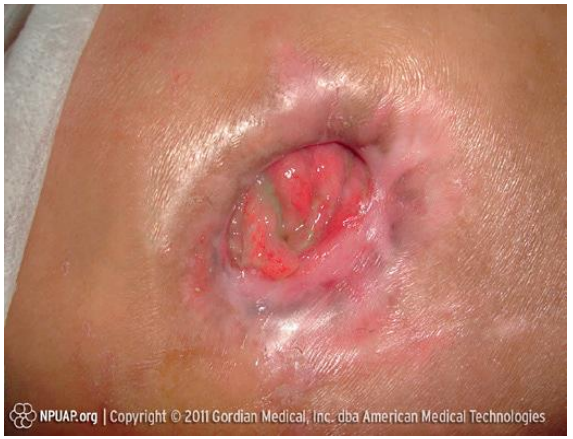
Category 3 pressure ulcer – Full thickness skin loss
Subcutaneous fat may be visible, but bone, tendon, or muscle will not be exposed. Slough may be present but does not obscure depth of tissue loss and may include undermining or tunnelling. The depth of a category 3 pressure ulcer will vary with location on the body

IR-e required – to re report only if deterioration to category 4

TV referral

If patient non concordant, refer to non-concordance pathway and flowchart and complete mental capacity assessment





Category 4

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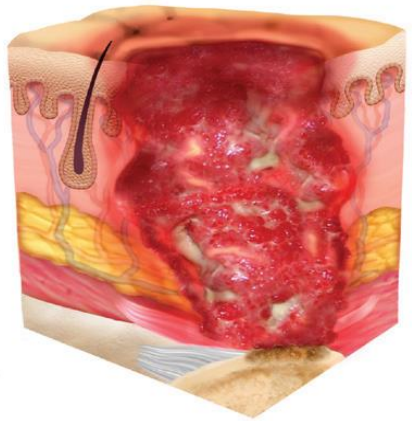
Category 4 pressure ulcer – Full thickness tissue loss

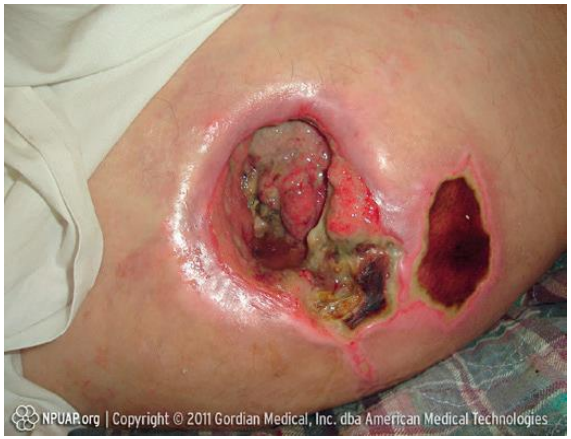
Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining or tunnelling. The depth of a category 4 pressure ulcer can vary dependent on location and can extend into muscle and/or underlying structures (eg fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable

IR-e required

TVN Referral

Refer to non-concordance pathway and flowchart and complete mental capacity assessment if identified patient non-concordance





Unstageable

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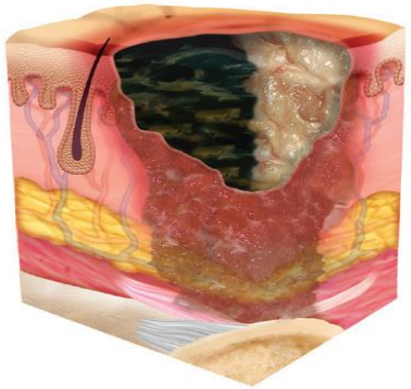
Unstageable pressure ulcer - depth unknown –
Full thickness tissue loss in which the base of the ulcer is covered by slough (Yellow, tan, grey, green or brown) and/or eschar (tan, brown or black). Until enough slough and/or eschar is removed to expose the base of the wound, the true depth and category cannot be determined

IR-e required – to re report only if deterioration to category 4

TV referral

Refer to non-concordance pathway and flowchart and complete mental capacity assessment if identified patient non-concordance



SDTI

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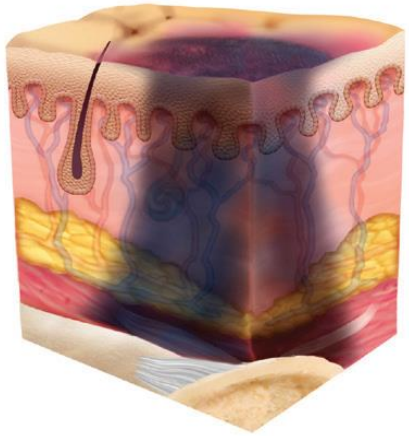
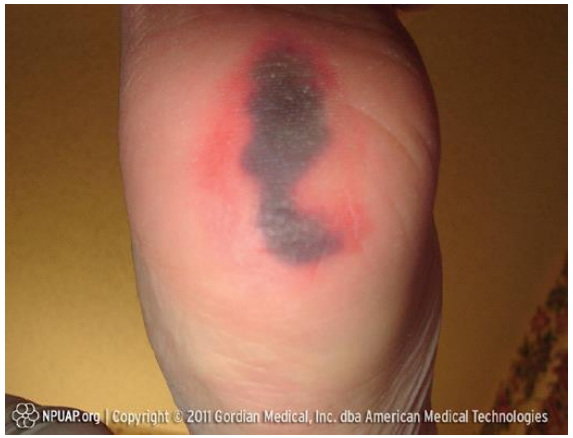
Suspected deep tissue injury - depth unknown
Purple or maroon localised area of discoloured intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment
IR-e required – to re report only if deterioration to category 4
TV referral
Refer to non-concordance pathway and flowchart and complete mental capacity assessment if identified patient non-concordance





MASD

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Moisture associated skin damage – This can occur due to the presence of any type of moisture on the skin, including incontinence, leakage from a stoma, saliva, wound
exudate and sweat. Multiple lesions with diverse edges are typical of incontinence associated dermatitis

THIS CAN INCREASE THE RISK OF PRESSURE DAMAGE

IR-e required when acquired in BDCFT only

To re report only if deterioration to category 2 and above pressure damage

TVN Referral for all non-concordance and refer to
non-concordance pathway and flowchart and complete
mental capacity assessment