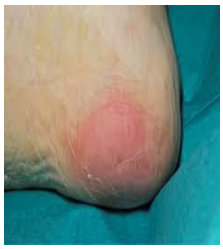
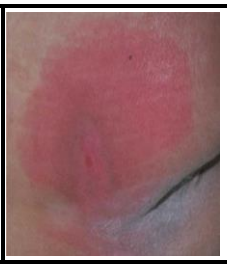
# Pressure Ulcer Category Chart

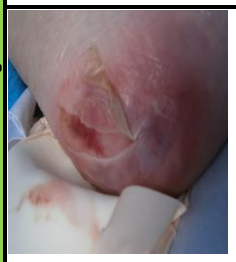
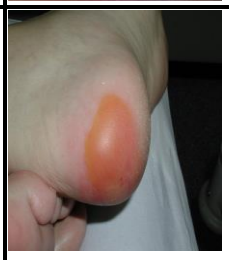
Northern Devon Healthcare NHS Trust

Adapted from EPUAP/NPUAP 2014

## Superficial

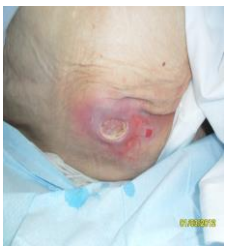
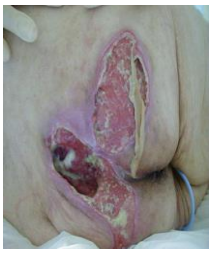



**EPUAP - Category/Grade I**
Non-blanchable erythema of intact skin: Darker skin tones may not have visible blanching but colour may differ to surrounding area.
Affected area may be painful, firmer, softer, warmer or cooler than the surrounding skin

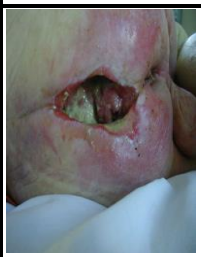
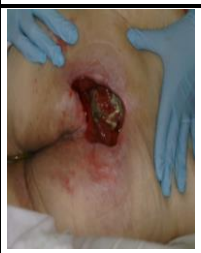



**EPUAP - Category/Grade 2**
Partial thickness skin loss involving epidermis, dermis or both.
Presents clinically as an abrasion or clear blister.
Shallow open ulcer with a red/pink wound bed without slough or bruising*.
May also present as an intact or open/ruptured blister
*'Bruising appearance and/or blood filled blister could indicate deep tissue injury'

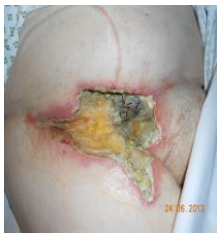
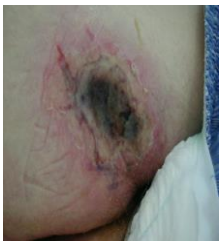
## Deep

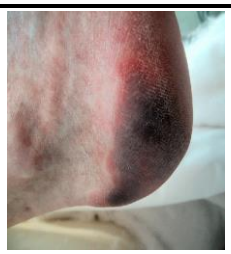
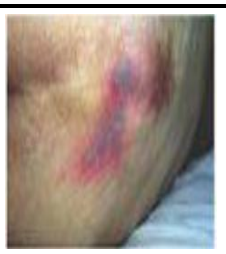
**EPUAP - Category/Grade 3**
Full thickness skin loss. Subcutaneous fat may be visible but bone, tendon and muscle are not exposed or palpable.
May include undermining and tunneling.
The depth varies by an anatomical location (bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and grade 3 ulcers can be shallow depending on anatomical location.
Slough may be present but does not obscure the depth of tissue loss.
In contrast areas of significant sub-cutaneous tissue can develop extremely deep grade 3 pressure ulcers.

**EPUAP - Category/Grade 4**
Full thickness tissue loss. extensive destruction with exposed or palpable bone, tendon or muscle. Often include undermining and tunneling. Slough may be present but does not obscure the depth of tissue loss. The depth varies by anatomical location (bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and grade 4 ulcers can be shallow depending on anatomical location. In contrast areas of significant sub-cutaneous tissue can develop extremely deep grade 3 pressure ulcers.

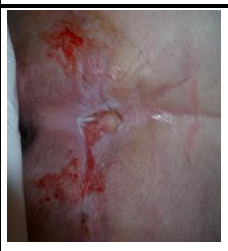



**EPUAP - Unstageable/Ungradeable**
Full thickness skin/tissue loss where the depth of the ulcer is compeltely obscured by the presence of necrotic tissue or slough. Until enough slough/necrotic tissue is removed to expose the base of the wound the true depth cannot be determined. It may be category 3 or category 4. Once established, the category must be documented/reported accordingly. **NB Not all ulcers should be debrided - contact Tissue Viability for advice.**

**EPUAP - Suspected Deep Tissue Injury**
Epidermis is intact, but the affected area can appear purple or maroon, or there may be a blood filled blister over a dark wound bed. This may develop over time to deeper tissue loss. Once established, the category must be documented/reported accordingly.

## Moisture

**Moisture Lesions and Pressure Ulcers**
Redness or partial thickness skin loss involving the epidermis, dermis or both caused by excessive moisture to the skin from urine, faeces or sweat or other moisture source.
If skin breakdown is due to a combination of pressure and moisture then they should be categorised and reported as pressure ulcers. If moisture is the only cause of skin breakdown please refer to the Skin excoriation and Moisture related skin damage guide (over).

# Excoriation and Moisture Related Skin Damage Tool

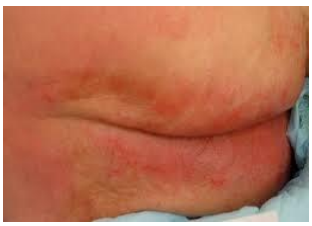
Northern Devon Healthcare NHS Trust

**Skin damage due to problems with moisture can present in a number of different ways. This tool aims to help you identify the cause to aid in decision making for treatments.**
**Moisture may be present on the skin due to incontinence (urinary and faecal), perspiration, wound exudate or other body fluids e.g. leaky legs, amniotic fluid.**
**Lesions caused by moisture alone should not be classified as pressure ulcers.**
**Observe for signs of skin infection e.g. candida (thrush) and treat accordingly. Do not use barrier films with candida infection as this will affect effectiveness of treatment.**

## Severity of skin excoriation

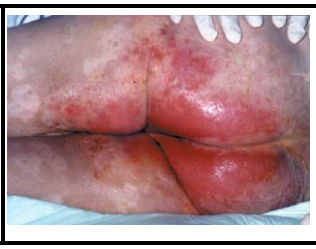
**Mild**
Erythema (redness) of skin only.

No broken areas present.



**Treatment:**
Clean skin with pH balanced skin or foam cleanser
Apply moisturiser +/- skin barrier cream/film. Any barrier product should not affect the absorbency of any continence products in use.

**Moderate**
Erythema (redness), with less than 50% broken skin.
Oozing and/or bleeding may be present.



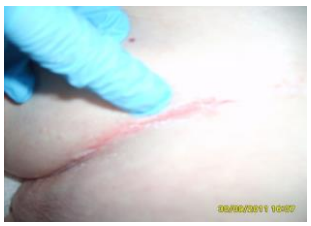
**Treatment:**
Clean skin with pH balanced skin or foam cleanser
Apply moisturiser +/- skin barrier cream/film. Any barrier product should not affect the absorbency of any continence products in use.
Seek advice from Tissue viability if no improvement within 3 days.

**Severe**
Erythema (redness), with more than 50% broken skin.
Oozing and/or bleeding may be present

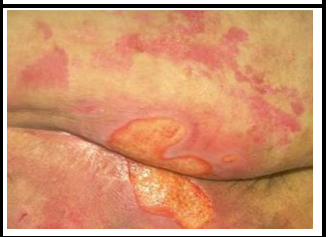
**Treatment:**
As mild/moderate, but if treatment ineffective use skin protectant foam and spray cleanser and skin protectant ointment (Medi Derma-Pro)

## Presentation of skin excoriation.

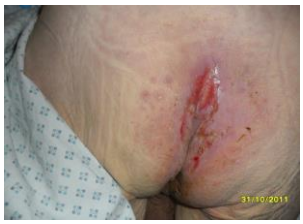
### Location
Located in peri-anal, natal cleft, groin or buttock area.
Not usually over a bony prominence



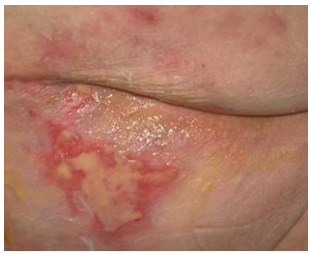
### Shape
Diffuse often multiple lesions
May be 'copy', 'mirror' or 'kissing' lesion on adjacent buttock or anal-cleft linear



### Edges
Diffuse irregular edges



### Necrosis
Generally no necrosis
May develop slough. May represent full thickness skin loss.



### Depth
Superficial partial thickness skin loss
May develop into full thickness skin loss especially in the presence of infection.

### Colour
Not uniform colour of redness may have pink or white surrounding skin (maceration)
Peri-anal redness