Pressure Injury Prevention – Comprehensive Care Standard

Brighton Subacute Services

Marianne Piekkala-Fletcher CNT

October 2018
Learning outcomes

- Define pressure injury
- Discuss staging of pressure injuries
- Describe the evolution of a deep tissue injury
- Identify other skin conditions that may be confused with pressure injuries
- Identify sources of further information
Pressure Injury Definition

- A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device.
- The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense pressure, prolonged pressure or pressure in combination with shear.
- The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue.

Healthy Skin – Lightly Pigmented
Stage 1 Pressure Injury: Non-blanchable erythema of intact skin

- Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.
Variations

Stage 1 Pressure Injury – Edema

Stage 1 Pressure Injury – Darkly Pigmented
Blanchable vs. Non-Blanchable

NOT APPLICABLE
Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis

- Partial-thickness skin loss with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel.
Stage 3 Pressure Injury: Full-thickness skin loss

- Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present.
- Slough and/or eschar may be visible.
- The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds.
- Undermining and tunneling may occur.
- Fascia, muscle, tendon, ligament, cartilage or bone is not exposed.
- If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.
Stage 3 Pressure Injury with Epibole

Area of Focus
Stage 4 Pressure Injury: Full-thickness loss of skin and tissue

- Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer.
- Slough and/or eschar may be visible.
- Epibole (rolled edges), undermining and/or tunneling often occur.
- Depth varies by anatomical location.
- If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

©2016 National Pressure Ulcer Advisory Panel | www.npuap.org
Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss

- Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar.
- If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed.
- Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on an ischemic limb or the heel(s) should not be softened or removed.
Unstageable Pressure Injury - Slough and Eschar
Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration

- Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister.
- Pain and temperature change often precede skin color changes.
- Discoloration may appear differently in darkly pigmented skin.
- This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface.

©2016 National Pressure Ulcer Advisory Panel | www.npuap.org
The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss.

If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4).

Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.
Evolution of Deep Tissue Pressure Injury

Day 1 - Classify intact, discolored skin this pressure as a Deep Tissue Pressure Injury.

Day 3 - Classify discolored skin with epidermal blistering as a Deep Tissue Pressure Injury.

Day 10 - If the Deep Tissue Pressure Injury becomes necrotic, classify it as an Unstageable Pressure Injury.
NPUAP Pressure Injury Stages

Additional Considerations:
• Describes anatomic depth that is visible or palpable.
• Deeper damage possible
• Does not progress 1-4
• Does not heal 4-1. Do NOT downstage.
• Note if caused by a medical device
• Pressure injuries on mucous membranes should not be staged.
• Injury does not imply fault.

Numerically stage if depth visible/palpable:
• Stage 1
• Stage 2
• Stage 3
• Stage 4

Depth not visible:
• Unstageable
• Deep Tissue Pressure Injury (DTPI)
Medical Device Related Pressure Injuries (MDR PI)

- Medical device related pressure injuries result from the use of devices designed and applied for diagnostic or therapeutic purposes.
- The resultant pressure injury generally conforms to the pattern or shape of the device.
- The injury should be staged using the staging system.

This describes an etiology. It is not a stage.

- Use the staging system to stage.
- Then note whether the injury is known to be related to a medical device.
- When assessing medical device related pressure injuries, remove only those devices that can be safely removed.
- Prevention requires unique strategies.
Mucous Membrane
Best Practices for Prevention of Medical Device-Related Pressure Injuries in Critical Care

- Choose the correct size of medical device(s) to fit the individual
- Cushion and protect the skin with dressings in high-risk areas (e.g., nasal bridge)
- Inspect the skin in contact with device at least daily (if not medically contraindicated)
- Avoid placement of device(s) over sites of prior or existing pressure injury
- Educate staff on correct use of devices and prevention of skin breakdown
- Be aware of edema under device(s) and potential for skin breakdown
- Confirm that devices are not placed directly under an individual who is bedridden or immobile
Summary

- It is important to understand the underlying factors when staging pressure injuries correctly.
- If in doubt, ask a colleague or team leader to check.
- Participating in QBA is a great opportunity to learn about pressure injury prevention.
Further information and references

- Australian Commission on Safety and Quality in Health Care (ACSQHC) National Safety and Quality Health Services Standards (NSQHSS), Comprehensive Care Standard.
- http://www.npuap.org/resources/educational-and-clinical-resources/