Skin Integrity Survey Training Package
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Introduction

- This package has been developed to help you recognise and classify common wounds such as pressure injuries, leg and foot ulcers, and skin tears.

- Research on models of care indicates that the provision of evidence based wound care, preventative strategies, chronic disease management and improved communication and educational opportunities among health professionals can significantly improve wound healing and reduce the risk of recurrence

Guidelines

A number of systematic reviews and evidence based guidelines are available on assessment, management and prevention of wounds. You are encouraged to review these guidelines for more comprehensive information to support the learning process.

Venous Leg Ulcers
• Australian Wound Management Association (AWMA), *Australian and New Zealand Clinical Practice Guidelines for Prevention and Management of Venous Leg Ulcers*, 2011, AWMA: Barton. ACT.

Arterial Leg Ulcers
Guidelines

**Diabetic Foot Ulcers**

**Pressure Injuries**

**Skin Tears**
The aim of the package is to help you develop:

• An understanding of the causes of common wound types

• Skills in identifying common wound types from photographs and wound descriptions

• Skills to accurately stage / categorise common wound types from photographs and wound descriptions
There are three short tutorials in this package and a quiz. Each tutorial provides information for you to read and activities for you to complete. The quiz at the very end should only be attempted once you have completed the tutorials.

The package is self-directed – you can take as much time as you need to complete the tutorials. You can work through the tutorials as many times as you like. Each tutorial and the quiz should take approximately 30 minutes to complete.

Tutorial 1: Pressure Injuries
Tutorial 2: Leg Ulcers
Tutorial 3: Skin Tears
Quiz
What is a pressure ulcer or injury?

- A pressure injury is a localised damage to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear (NPUAP 2016).

There are many different terms used to describe pressure ulcers:

- Pressure areas
- Pressure sores
- Decubitus ulcers
- Bed sores
- Pressure necrosis
- Ischaemic ulcers
Where do pressure injuries occur?

- The sacrum or coccyx, ischium, and heels are the most common sites for pressure ulcers.

Other sites are:
- toes
- Ankle / malleoli
- foot
- elbows
- ears
- nose

(Heinhold et al. 2014)
How pressure injuries occur

- Pressure injuries occur when cells and capillaries sustain intense and/or prolonged compressed between bone & skin by an external surface.
- Damage to the skin can result from shearing forces or friction, often in conjunction with pressure.
- Shearing forces usually occur due to sliding or dragging the skin across a support surface.
- Friction is the abrasion of the epithelial surface by rubbing against an abrasive or resistant surface.
- Presence of moisture, malnutrition, poor perfusion and other co-morbidities can affect the ability of the skin to resist this type of damage.
When can pressure injuries occur? Choose one of the items in the list below:

a) When skin is compressed
b) When skin is dragged
c) When skin is rubbed
d) All of the above
The answer is:

d. Pressure injuries can occur when the skin is compressed, which may be in combination with being dragged or rubbed
Where do pressure injuries occur?

(Source: Bryant 2000:226)
Pressure Injury Staging

Pressure injuries are staged as:
- Stage I
- Stage II
- Stage III
- Stage IV

The higher the stage number the deeper the tissue involvement.

An additional three categories are:
- Unstageable
- Deep Tissue Pressure Injury
- Mucosal Membrane Pressure Injury

(NPUAP 2016)
Pressure Injury Staging

- The ulcer stage at the time of assessment sometimes appears less than the stage documented in records if the ulcer has started to heal.

- The pressure injury should be staged according to the maximum anatomic depth of tissue damage.

- Healing ulcers should not be reverse staged. That is, a Stage IV pressure injury can not become a Stage III, Stage II or Stage I pressure injury.
Stage I Pressure Injuries

- Stage I pressure injuries present as localised areas of non-blanchable erythema, compared to the surrounding skin.

- The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue.

- Stage I may be difficult to detect in individuals with dark skin tones. Darkly pigmented skin may not have visible blanching and its colour may differ from the surrounding area.

- May indicate "at risk" persons.

- Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.

(NPUAP 2016)
Stage I Pressure Injuries

How do I determine if it’s a stage I pressure injury?

• If a patient / resident has an area of redness (potential stage I):
  • Reposition the patient / resident so all pressure is removed from the affected area for thirty minutes
  • Re-inspect the skin after thirty minutes
  • If redness remains and any one of the following skin changes are present (such as pain, itching, warmth/coolness or firm/boggy feeling on palpation) mark on the survey tool as a stage I pressure ulcer
  • Use the survey tool to document any patient / resident who has been repositioned and needed to be re-examined and note observations

(NPUAP 2016)
In the photo you can see the redness that has developed on the skin. The skin is intact with a non-blanching localised area of erythema. There may be changes in skin temperature (hotter or cooler than the surrounding skin) or firmness. The person may feel changes in sensation to the area and report itch or pain.

Stage I pressure injuries involve the outer layers of skin.
Stage II Pressure Injuries

• Partial-thickness loss of skin 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.

• This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.

*Bruising indicates suspected deep tissue injury

(NPUAP 2016)
Stage II Pressure Injuries

Staging of a blister

• If a blister is found with clear fluid present and the epidermis is clearly separated from the dermis, record as a stage II pressure injury.
Stage II Pressure Injuries

The area is superficial at this stage, and shows partial thickness skin loss.

(NPUAP 2016)
Stage III Pressure Injuries

• Full thickness tissue loss. Subcutaneous fat, granulation tissue and rolled wound edges are often present. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. May include undermining and tunnelling.

• The depth of a stage III pressure injury varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage III pressure injuries.

• Slough and/or eschar may be visible, however if it obscures the extent of tissue loss it is an Unstageable Pressure Injury.

(NPUAP 2016)
Stage III Pressure Injuries

The edges of the wound are usually irregular and may or may not be attached to the side or bottom of the area. If they are not attached as in the photo, it is known as undermining. Undermining is the separation of the tissues beyond the wound edges under the skin.

(NPUAP 2016)
Stage IV Pressure Injuries

- 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. Rolled edges, undermineing and/or tunneling often occur.

- The depth of a stage IV injury varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage IV injuries can extend into muscle and/or supporting structures (e.g. fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.

- If slough or eschar obscures the extent of tissue loss it is an Unstageable Pressure Injury.

(NPUAP 2016)
Stage IV Pressure Injuries

Full thickness tissue loss with exposed tendon visible at the wound edges and with undermining of the periwound skin.

(NPUAP 2016)
Deep Tissue Pressure Injury

• 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.

• This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. 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 III or Stage IV).

• Pain and temperature change often precede skin color changes.

• Discoloration may appear differently in darkly pigmented skin.

(NPUAP 2016)
Deep Tissue Pressure Injury

(NPUAP 2016)
Unstageable Pressure Injury

- **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 III or Stage IV pressure injury will be revealed.

- Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.
Unstageable Pressure Injury

Unstageable Pressure Injury - Dark Eschar

(NPUAP 2016)
Mucosal Membrane Pressure Injury

- Mucosal membrane pressure injury is found on mucous membranes with a history of a medical device in use at the location of the injury. Due to the anatomy of the tissue these ulcers cannot be staged.

(NPUAP 2016)
## Risk Factors

All patients are at risk of developing a pressure injury, especially those with one or more of the following risk factors.

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alteration in mobility &amp; activity</td>
<td>Contractures; fractures; injury; neurological disease/deficit; pain; bedbound; chairbound</td>
</tr>
<tr>
<td>Malnutrition</td>
<td>Dehydration; oedema; protein insufficiency; weight loss</td>
</tr>
<tr>
<td>Moisture</td>
<td>Drainage (wounds, fistulae); incontinence (urine, faeces); perspiration</td>
</tr>
<tr>
<td>Alteration in sensation &amp; consciousness</td>
<td>Central nervous system injury; cerebrovascular disease; degenerative neurological disease; drugs e.g. steroids, cytotoxics; major surgery; spinal cord injury; neuropathy</td>
</tr>
<tr>
<td>Co morbidities</td>
<td>Chronic heart failure, diabetes, anaemia, smoking, PVD, advanced age etc.</td>
</tr>
</tbody>
</table>

(NPUAP 2014)
Pressure injury prevention

Can pressure injuries be prevented?
- Yes - in most cases pressure injuries can be prevented

What prevention strategies can be done to maintain skin integrity?
- Conducting systematic and regular skin assessments to identify those at risk
- Avoiding extremes of hot and cold water
- Using mild, non-irritant skin cleansers and body products
- Ensuring limited or no exposure to excessive moisture (such as perspiration, urine or faeces) or dryness
- Avoiding excessive rubbing or massaging near or over bony parts of the body
- Avoiding positioning of the individual on an area of erythema whenever possible

(NPUAP 2014)
Pressure injury prevention

What prevention strategies can be done to maintain skin integrity?

• Assisting with balanced nutrition
• Assisting with hydration
• Using positioning and turning schedules
• Using pressure reduction devices or equipment
• Individualised continence management plans and prompt skin cleansing
• Use of barrier products to protect skin from exposure to moisture
• Referrals to allied health

(NPUAP 2014)
Pressure injury prevention

What pressure injury prevention devices are available?

There are many different types of support surfaces and equipment available to reduce the pressure that parts of the body experience, these may include:

– Gel, foam, water and air mattresses
– Alternating pressure pads
– Alternating pressure mattresses
– Seat cushions
– Heel suspension devices/foam cushions

(NPUAP 2014)
Pressure injury prevention

* Products pictured are examples only and do not represent an endorsement of any company or particular device
Test Your Knowledge

For the following examples, identify the stage of pressure injury
What stage is this pressure injury?

- Reddened area on buttock does not blanch with lightly applied pressure.
  
  a. Stage I  
  b. Stage II  
  c. Stage III  
  d. Stage IV  
  e. Unstageable  
  f. Deep Tissue Pressure Injury
Answer: Stage I pressure injury

- A reddened area is seen
- The skin surface is unbroken
- No blistering of the skin is observed
- Skin colour remains unchanged after pressure is removed.
What stage is this pressure injury?

- a. Stage I
- b. Stage II
- c. Stage III
- d. Stage IV
- e. Unstageable
- f. Deep Tissue Pressure Injury
Answer:
Stage II pressure injury

- Blister with clear fluid and epidermis separated from dermis
What stage is this pressure injury?

- a. Stage I
- b. Stage II
- c. Stage III
- d. Stage IV
- e. Unstageable
- f. Deep Tissue Pressure Injury
Answer: Stage III pressure injury

- Full thickness tissue loss
- Granulation tissue, rolled wound edges and undermining present. No tendon, bone or muscle is visible.
- Slough is present but does not obscure the depth of tissue loss
What stage is this pressure injury?

Full thickness tissue loss with exposed tendon visible in the wound

a. Stage I  
b. Stage II  
c. Stage III  
d. Stage IV  
e. Unstageable  
f. Deep Tissue Pressure Injury
Answer: Stage IV pressure injury

- Full thickness skin loss
- Exposed tendon
What stage is this pressure injury?

Located on right heel and completely covered in eschar

a. Stage I
b. Stage II
c. Stage III
d. Stage IV
e. Unstageable
f. Deep Tissue Pressure Injury
Answer:

Unstageable pressure injury

- This ulcer is located on the right heel
- Eschar completely covers the wound base
What stage is this pressure injury?

Right heel with discoloured area

- a. Stage I
- b. Stage II
- c. Stage III
- d. Stage IV
- e. Unstageable
- f. Deep Tissue Pressure Injury
Deep Tissue Pressure Injury

Purple or maroon localized area of discoloured intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear

- The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue
Tutorial 2: Leg Ulcers

Chronic Leg Ulcer Definition

• A wound between the knee and ankle joint that is unhealed beyond four weeks.
# Types & characteristics of leg ulcers

<table>
<thead>
<tr>
<th>Factor</th>
<th>Arterial Leg Ulcers</th>
<th>Venous Leg Ulcers</th>
<th>Diabetic Foot Ulcers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Wound location</strong></td>
<td>Usually affect the toes or shin or occur over pressure points i.e. lateral malleolus or sites subjected to trauma or rubbing of footwear</td>
<td>Typically above the medial or lateral malleolus, on the lower third of the leg</td>
<td>Usually the sole of the foot or over pressure points i.e. metatarsal heads (especially first and fifth), great toe or heel</td>
</tr>
<tr>
<td><strong>Depth</strong></td>
<td>Usually shallow but may be deep</td>
<td>Usually shallow</td>
<td>Shallow to deep, may have tracking and/or undermining</td>
</tr>
<tr>
<td><strong>Appearance of wound bed</strong></td>
<td>Pale grey or yellow with no evidence of new tissue growth. Necrosis or cellulitis may be present, tendons may be exposed</td>
<td>Referred to as ruddy or beefy red, granular in appearance</td>
<td>Granulation tissue unless peripheral arterial disease is present. May have deep necrotic area, may be dry, cellulitis or osteomyelitis may be present, neuropathic ulcers almost always accompanied by eschar and often exposed tendons</td>
</tr>
</tbody>
</table>

(London & Donnelly 2008; AWMA 2011)
<table>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Wound shape &amp; margins</strong></td>
<td>Smooth, even, regular; shape will conform to injury if caused by trauma; 'punched out' appearance</td>
<td>Flat, irregular wound margins without undermining</td>
<td>Smooth, even; may be small at surface with large subcutaneous abscess; may have callus around the edges</td>
</tr>
<tr>
<td><strong>Exudate</strong></td>
<td>Minimal exudate</td>
<td>Moderate to heavy</td>
<td>Low to moderate. An infected ulcer may have purulent exudate</td>
</tr>
<tr>
<td><strong>Surrounding skin</strong></td>
<td>Pale, shiny, taut skin; cold legs/feet (in a warm environment), may be no hair on legs/toes, dependent rubor, pale or blue feet, gangrenous toes</td>
<td>Ankle flare, telangiectasia, varicose veins, oedema, atrophie blanche, maceration, hyperpigmentation, hyperkeratosis, eczema, lipodermatosclerosis, scarring from previous healed ulcers</td>
<td>Dry, thin, frequently calloused; periwound hyperkeratosis is common and indicates undermined edges</td>
</tr>
<tr>
<td><strong>Pain</strong></td>
<td>Often accompanied by severe pain at rest; pain often increases with leg elevation; pain may also increase with ambulation</td>
<td>Ranges from no pain to severe, constant pain. Pain is usually relieved by elevation of the limb</td>
<td>No sensation, or constant or intermittent paraesthesias; numbness or burning of surrounding tissue.</td>
</tr>
</tbody>
</table>

(London & Donnelly 2008; AWMA 2011)
Common sites of leg ulcers

(London and Donnelly 2008)
Venous Leg Ulcers

- Ulcer due to venous hypertension. Chronic venous insufficiency in the deep veins of the legs leads to shunting the venous return into the superficial veins, in which pressure and flow rate are increased. (AWCN 2007:52)
Venous Leg Ulcers

Features of venous leg ulcers

- Lipodermatosclerosis – also known as ‘woody fibrosis’ because of the texture of the skin
- Haemosiderin staining
- Atrophie blanche
- Oedema
- Eczema

Venous leg ulcer located on left lateral gaiter (Wound Healing Community Outreach Service)
Venous Leg Ulcers

Atrophie blanche

Inverted champagne bottle leg

(Wound Healing Community Outreach Service)
Venous Leg Ulcers

Above: Ankle flare

Above: Haemosiderin staining

Left: Oedema & eczema

(Wound Healing Community Outreach Service)
Arterial Leg Ulcers

- Ulcer resulting from inadequate blood supply due to arterial insufficiency.
- These ulcers are characterised as punched out in appearance and usually located on the distal lower limb.
- The foot or limb may appear cyanosed, have poor tissue perfusion, cool to the touch with absent or diminished pulses.
- The ulcer is usually associated with intermittent claudication and the person may have rest pain.

(AWCN 2007:52)
Arterial Leg Ulcers

Punched out appearance
Shiny, hairless limb
Ulcers located over areas of trauma (toes, dorsum of foot, medial malleolus)
Mottled, cyanosed skin

(Wound Healing Community Outreach Service)
Diabetic Foot Ulcers

- Ulcer usually on the foot associated with neuropathy and/or vascular disease and/or infection in a patient with diabetes. (AWCN 2007:52)
Diabetic Foot Ulcers

Note callous surrounding the wounds
Regular wound margins
Located over areas of pressure i.e. heel and toes

(Wound Healing Community Outreach Service)
Test your knowledge

For the following examples, identify the type of ulcer
Type of ulcer?

Ulcer located on the tip of the second toe on right foot.
Cool surrounding skin with mottled coloured skin

a. Arterial leg ulcer
b. Venous leg ulcer
c. Diabetic foot ulcer
Answer: Arterial leg ulcer
Type of ulcer?

a. Arterial leg ulcer
b. Venous leg ulcer
c. Diabetic foot ulcer
Answer: Venous leg ulcer

- Located on right medial gaiter
- Large ulcer with irregular margins
- Shallow wound bed
- Oedematous leg
Type of ulcer?

a. Arterial leg ulcer  
b. Venous leg ulcer  
c. Diabetic foot ulcer
Answer: Diabetic foot ulcer

- Periwound callous
- Located over area of high pressure
- Regular wound margins
Tutorial 3: Skin Tears

- A traumatic wound occurring principally on the extremities of older adults, as a result of friction alone or shearing and friction forces which separate the epidermis from the dermis (partial thickness wound), or which separate both the epidermis and the dermis from underlying structures (full thickness wound)

(STAR 2010)
Skin Tears

- **Pale, dusky or darkened skin or flap colour**: when compared to the individual’s ‘normal’ surrounding skin, may indicate ischaemia or the presence of haematoma, which may affect skin or flap viability.

- **Ischaemia**: inadequate tissue perfusion as evidenced by pale, dusky or darkened tissue.

- **Haematoma**: is a collection of blood or clot under the flap or realigned skin.

(STAR 2010)
Skin Tears

Category 1a

- A skin tear where the edges can be realigned to the normal anatomical position (without undue stretching) and the skin or flap colour is not pale, dusky or darkened.

(STAR 2010)
Skin Tears

Category 1b

- A skin tear where the edges can be realigned to the normal anatomical position (without undue stretching) and the skin or flap colour is pale, dusky or darkened.

(STAR 2010)
Skin Tears

**Category 2a**

- A skin tear where the edges *cannot* be realigned to the normal anatomical position and the skin or flap colour *is not* pale, dusky or darkened.

*(STAR 2010)*
Skin Tears

Category 2b

- A skin tear where the edges cannot be realigned to the normal anatomical position and the skin or flap colour is pale, dusky or darkened.

(STAR 2010)
Skin Tears

Category 3

• A skin tear where the skin flap is completely absent.
Test your knowledge

For the following examples, identify the type of skin tear
What is the category of this skin tear?

a) Category 1a
b) Category 1b
c) Category 2a
d) Category 2b
e) Category 3
Answer: Category 3

- A skin tear where the skin flap is completely absent.
What is the category of this skin tear?

a) Category 1a
b) Category 1b
c) Category 2a
d) Category 2b
e) Category 3
Answer: Category 1b

- A skin tear where the edges can be realigned to the normal anatomical position (without undue stretching) and the skin or flap colour is pale, dusky or darkened.
What is the category of this skin tear?

a) Category 1a  
b) Category 1b  
c) Category 2a  
d) Category 2b  
e) Category 3

(Wound Healing Community Outreach Service)
Answer: Category 1a

Category 1a

- A skin tear where the edges can be realigned to the normal anatomical position (without undue stretching) and the skin or flap colour is not pale, dusky or darkened.
What is the category of this skin tear?

a) Category 1a  
b) Category 1b  
c) Category 2a  
d) Category 2b  
e) Category 3
Answer: Category 2a

Category 2a

• A skin tear where the edges cannot be realigned to the normal anatomical position and the skin or flap colour is not pale, dusky or darkened.

(STAR 2010)
What is the category of this skin tear?

a) Category 1a  
b) Category 1b  
c) Category 2a  
d) Category 2b  
e) Category 3
Answer: Category 2b

Category 2b

- A skin tear where the edges cannot be realigned to the normal anatomical position and the skin or flap colour is pale, dusky or darkened.

(STAR 2010)
Quiz

• The test is comprised of 10 pictures of common wound types
• A description of each wound is provided
• Stage or classify each wound type
• Choose your answer from the list provided
• Answers provided separately
Question 1

Pressure injury is located in the neck area. Areas of tissue loss extend to the dermis.

- a. Stage I
- b. Stage II
- c. Stage III
- d. Stage IV
- e. Unstageable
- f. Deep Tissue Pressure Injury
Question 2

- This 84 year old lady has an ulcer located on the left posterior gaiter that has been present for 12 months.
- She has gross oedema of the lower leg.
- The wound has irregular wound margins.

Options:
- a) Pressure Injury
- b) Arterial Ulcer
- c) Venous Ulcer
- d) Diabetic Ulcer
- e) Perineal Dermatitis
- f) Skin Tear
Question 3

Area of deeply discoloured skin is noted on the right heel of this patient. Skin surface is intact.

a. Stage I
b. Stage II
c. Stage III
d. Stage IV
e. Unstageable
f. Deep Tissue Pressure Injury
Question 4

This 80 year old male has multiple areas of epidermal skin loss on the left arm. There are two epidermal tissue flaps present.
Question 5

- Pressure injury on coccyx
- Skin is reddened and does not blanch when light pressure is applied
- Epidermis is intact and there is no blistering of the skin

a) Stage I  
b) Stage II  
c) Stage III  
d) Stage IV  
e) Unstageable  
f) Deep Tissue Pressure Injury
Question 6

- Ulcers on buttocks
- Partial thickness skin loss
  
a) Stage I  
b) Stage II  
c) Stage III  
d) Stage IV  
e) Unstageable  
f) Deep Tissue Pressure Injury
This 78 year old man has an ulcer located on the left anterior shin that has been present for 6 months.

He has diminished pulses and pain in legs at rest.
Question 8

This 48 year old man has an ulcer located under the ball of his foot.

- Regular wound edges
- Calloused wound edges

Options:

a) Pressure Injury
b) Arterial Ulcer
c) Venous Ulcer
d) Diabetic Ulcer
e) Skin Tear
Question 9

What is the category of skin tear?

a) Category 1a  
b) Category 1b  
c) Category 2a  
d) Category 2b  
e) Category 3
Question 10

a) Pressure Injury
b) Arterial Ulcer
c) Venous Ulcer
d) Diabetic Ulcer
e) Skin Tear

This 68 year old man has an ulcer located on the left medial malleolus that has been present for 12 months.

The wound has irregular wound margins.

His leg has signs of haemosiderin staining and varicose veins.
Congratulations!
You have completed the Skin Integrity Survey Training Package
SKIN INTEGRITY SURVEY FORM

The back of the skin integrity survey form is designed to assist in the classification of wounds and medical conditions.
Avascular: without blood or lymphatic vessels.

Blanching hyperaemia: blanching of the skin in response to light finger point pressure being applied to an area of reactive hyperaemia, indicating that the microcirculation is intact (AWMA).

Erythema: non-specific redness of the skin which may be localised or general in nature. It may be associated with cellulitis, infection, prolonged pressure or reactive hyperaemia (AWMA).

Eschar: dry, avascular, necrotic tissue, typically black or brown in colour and of tough/leathery consistency.

Excoriation: the abrading or chafing of the skin.

Exudate: liquid material comprised of serum, fibrin, cellular debris and white blood cells that escapes from the tissues into a wound.

Friction: a force created by two contact surfaces moving across one another (AWMA).
GLOSSARY

Gaiter: the area of the lower extremity over which a gaiter fits roughly from the ankle to the proximal calf. It is in this area that the classic venous leg ulcer occurs.

Gangrene: local death of soft tissues due to loss of blood supply, anoxia and putrefaction. Also called wet gangrene.

Haematoma: a mass of usually clotted blood that forms in a tissue, organ or body space as a result of rupture of a blood vessel and often the result of blunt trauma.

Haemosiderin staining: deposition of haemosiderin (dead red blood cells) in tissue and seen on the skin as brown staining.

Hyperaemia: excess of blood in a tissue, engorgement or congestion of blood in a tissue.

Induration: abnormal firmness of tissue with a definite margin. An increase in the fibrous elements in tissue commonly associated with inflammation and marked by loss of elasticity and pliability.
GLOSSARY

Ischaemia: deficiency of blood caused by functional constriction or obstruction of a blood vessels to a part.

Lateral: located at or on the side.

Lipodermatosclerosis: characteristic dermal changes that occur as the result of chronic venous insufficiency. It is manifest as a combination of induration, fibrosis, haemosiderin staining and inflammation.

Maceration: softening of the tissue by prolonged exposure to moisture. Macerated tissue often has a white appearance and feels boggy to the touch.

Medial: located at or towards the middle.

Necrosis: death of tissue.

Non-blanching hyperaemia: Persistent redness when light finger point pressure is applied to an area of reactive hyperaemia, indicating a disruption to the microcirculation. In lightly pigmented individuals this would be classified as a stage one pressure ulcer (AWMA).
GLOSSARY

Oedema: the presence of abnormal amounts of fluid in the intercellular tissue spaces of the body, usually applied to demonstrable accumulation of excessive fluid in the subcutaneous tissues.

Periwound: the area around a wound.

Pressure redistribution devices: devices that aim to reduce, relieve or redistribute tissue interface pressure in the prevention and treatment of pressure ulcers.

Pressure relieving devices: devices that aim to reduce pressure below 32mmHg, the capillary closing pressure. They function by using an alternating inflation/deflation support system.

Prevalence: The proportion of individuals in a population having a disease at a given time. This is the most frequently used measure of disease frequency e.g. in relation to pressure ulcers, a prevalence survey ascertains how many persons (or particular sub-set of persons) within a facility have a pressure ulcer at a particular point in time.
GLOSSARY

Reactive hyperaemia: abnormal compensatory mechanism following an episode of reduced perfusion from localised pressure. Relief of this pressure results in a sudden increase in blood flow to the affected tissue (AWMA).

Rest pain: Pain occurring usually in the extremities during rest in the sitting or lying position. The pain occurs in the absence of activity and is frequently related to advanced peripheral vascular disease.

Shear: A parallel load forcing the skeleton to slide forward against a resistance created between the skin and its contact surface. The epidermis and dermis remain relatively anchored to the contact surface while the deep fascia moves with the skeleton. These blood vessels between the dermis and the deep fascia may be distorted resulting in thrombosis and capillary occlusion (AWMA).

Stasis dermatitis or eczema: Dry, flaky, red, irritated skin caused by chronic venous hypertension. Usually occurs in the gaiter region of the lower leg.
Telangiectasia: Also known as spider veins, they are small enlarged blood vessels near the surface of the skin. Commonly located on the legs, below the knee and around the ankles.
Characteristics of a Venous Leg Ulcer

**Venous leg ulcers typically**
- Occur on the lower third of the leg
- Have pain usually relieved by elevation of the legs above heart level
- Are shallow and have irregular, sloping wound margins
- Produce moderate to heavy exudate

**The surrounding skin often has:**
- Haemosiderin (brown) staining
- Hyperkeratosis (dry, flaky skin)
- Venous stasis eczema
- Inverted champagne bottle leg appearance

Characteristics of a Diabetic Foot Ulcer

**Diabetic ulcers typically:**
- Occur on the sole of the foot or over pressure points e.g. toes
- The wound bed can be shallow or deep, producing low to moderate amounts of exudate
- The surrounding skin is usually dry, thin and frequently has callous formation
Characteristics of an Arterial Leg Ulcer

Arterial leg ulcers typically:
- Occur on the anterior shin, ankle bones, heels or toes
- Have pain which is relieved when legs are lowered below the level of the heart
- Have ‘punched out’ wound edges
- May have mummified or dry and black toes

The surrounding skin or tissue often has:
- Shiny or dry skin
- Devitalised soft tissue with dry or wet crust
- Thickened toe nails
- A purplish colour when the leg is lowered to the ground
- Loss of hair
- Cool skin
GLOSSARY

**Basal Cell Carcinoma**
- Pearly or waxy lump, may have telangiectasia; or well defined red patch
- Scaly, dry area
- May be shiny, pale or pink
- May ulcerate

**Squamous Cell Carcinoma**
- Thickened red, scaly area
- Unhealed sore
- Area is tender
References


