# Pressure Ulcer To Zero Phase 3

## Categorising/Staging of Pressure Ulcers (HSE, 2017)

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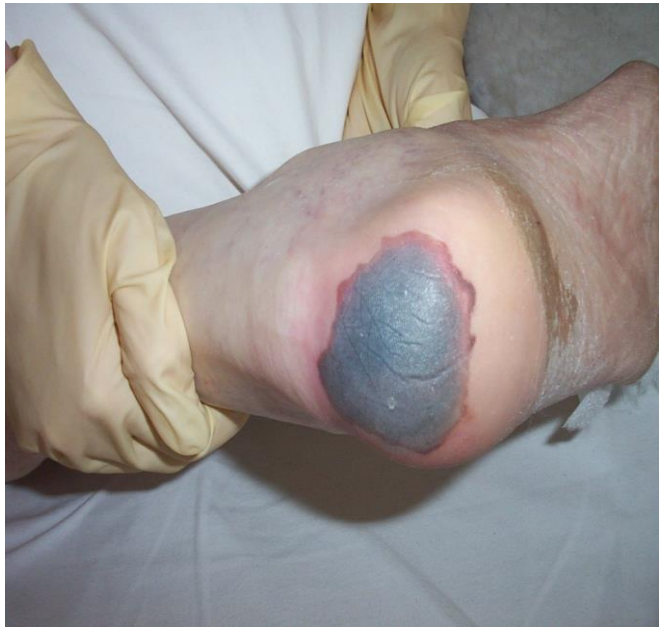
# Definition

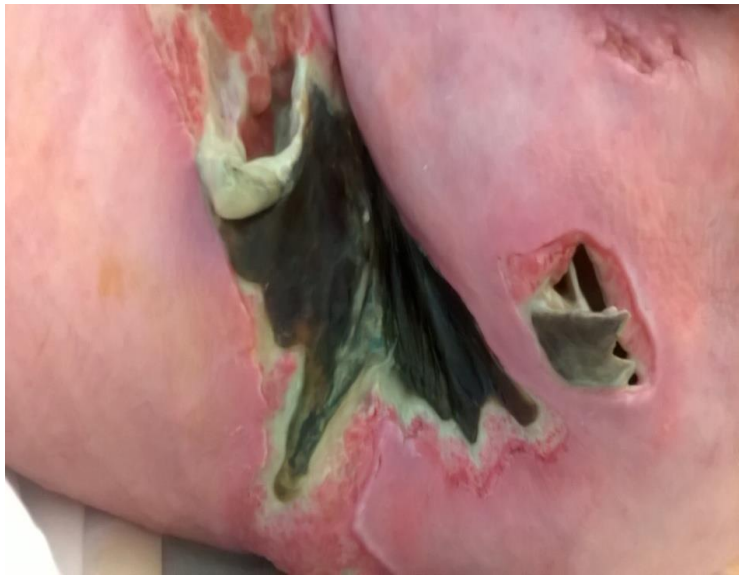


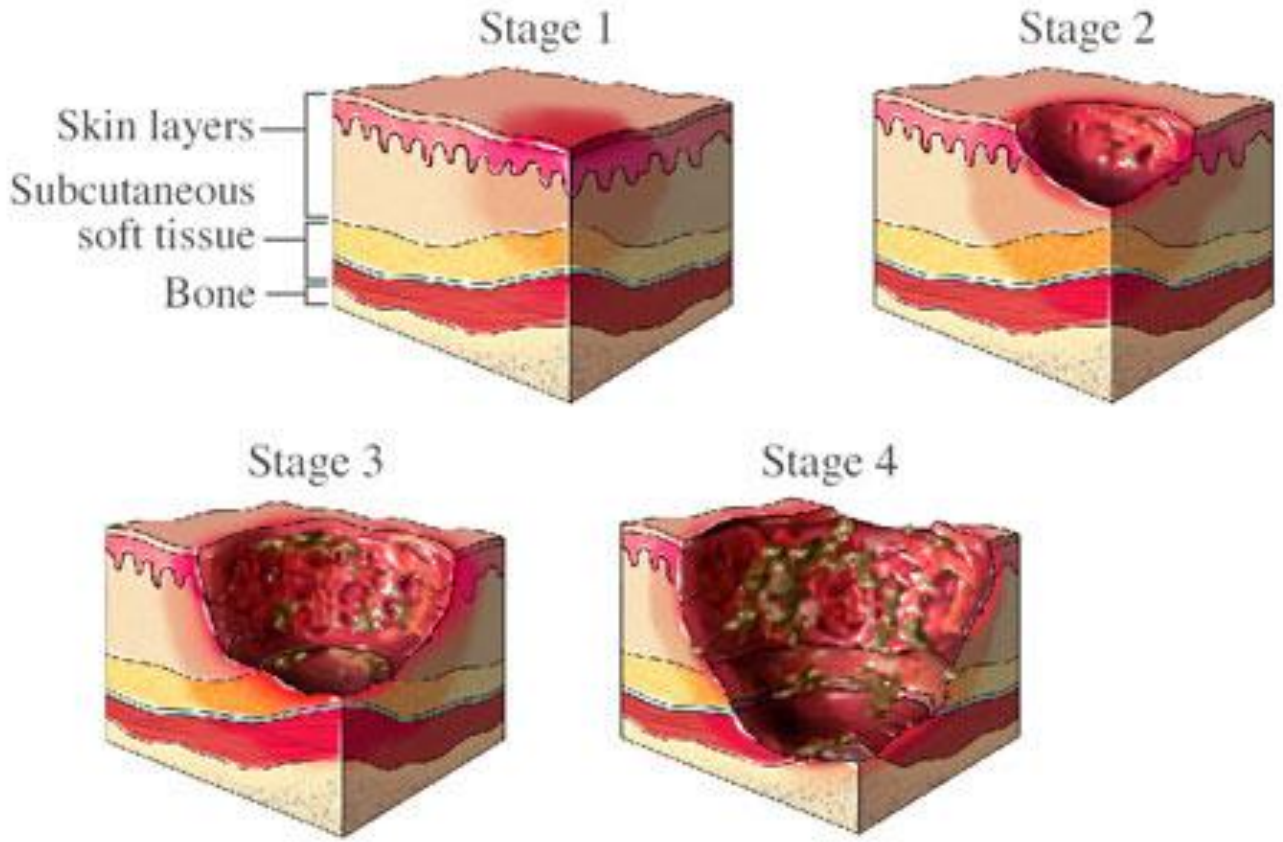
***"A pressure ulcer is defined as a localised injury to the skin and / or the underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear.***

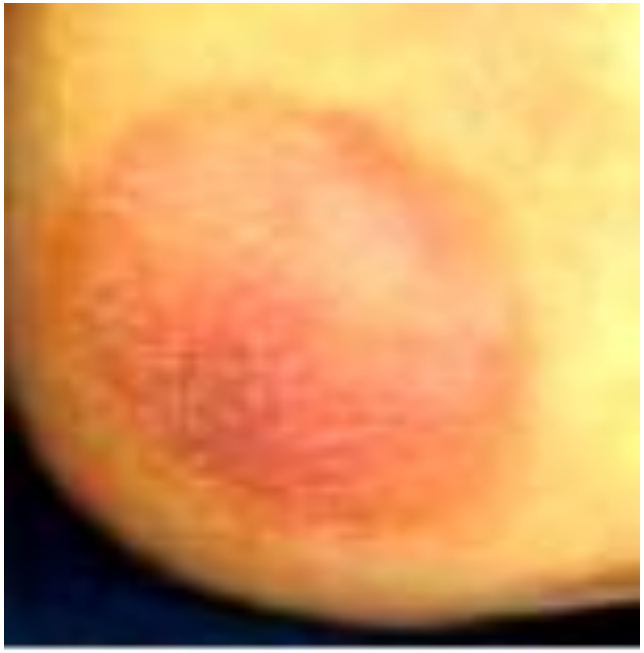
***(EPUAP/NPUAP/PPPIA 2014)***

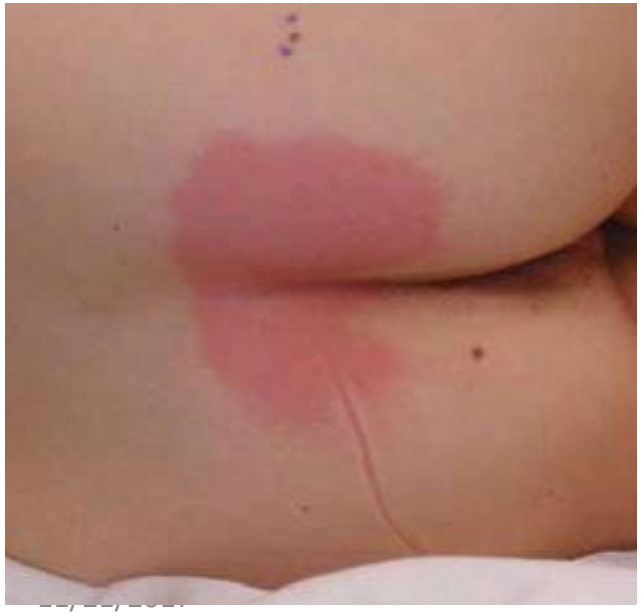
***Both immobility and diminished activity are considered as primary risk factors***

***( Bergstrom et al 1992)***




Stage 1
Stage 2
Skin layers
Subcutaneous soft tissue
Bone
Stage 3
Stage 4





# Category/Stage 1

- Appears as a defined area of persistent redness (Non-Blanching) in lightly pigmented skin. Intact & usually presents over a bony prominence

- In darker skin tones, it may appear with persistent red, blue or purple hues

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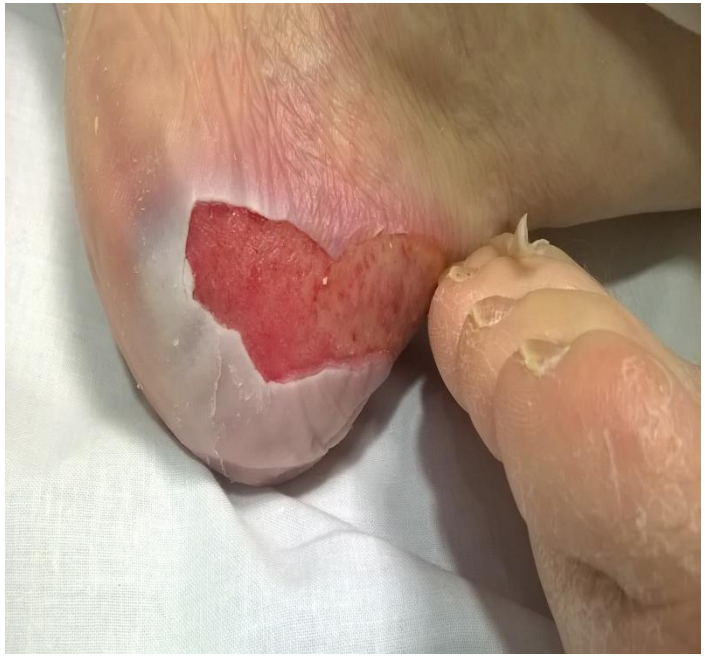
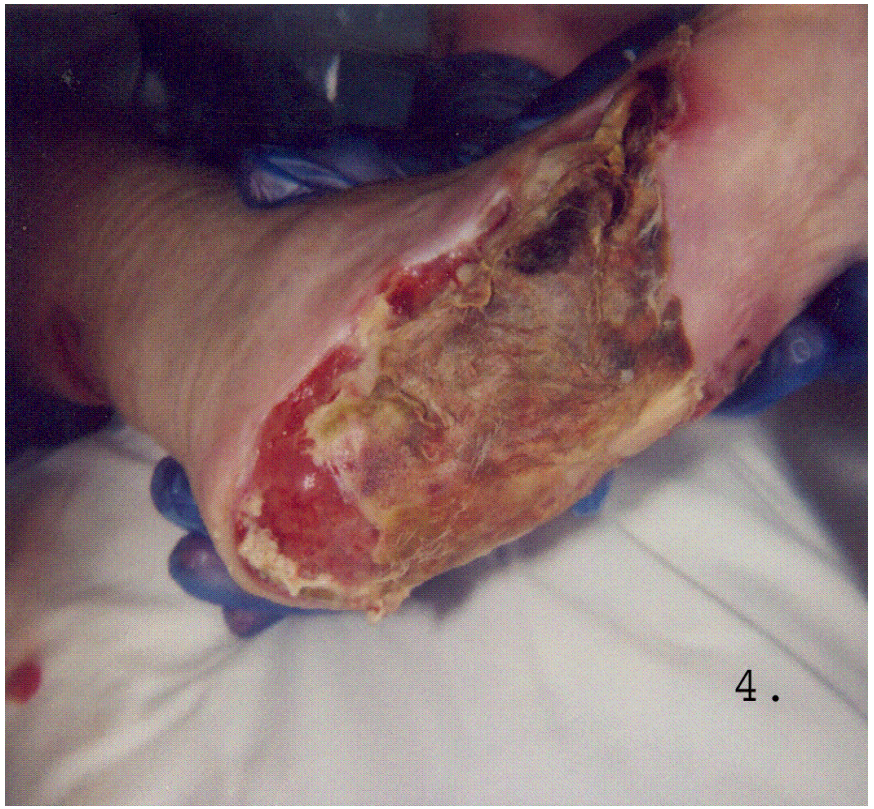
# Category/Stage ll Pressure Ulcer

Partial-thickness skin loss involving epidermis, dermis or both. The ulcer is superficial and presents clinically as an abrasion, blister or shallow crater



# Category/Stage III

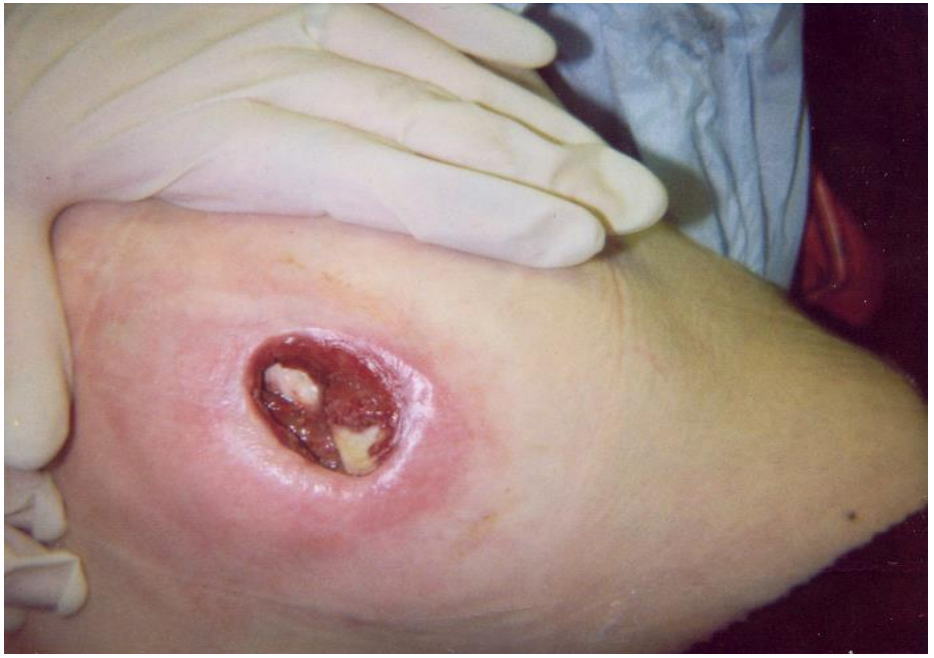
Full-thickness skin loss involving damage to, or necrosis of, subcutaneous tissue that may extend down to, **but not through**, underlying fascia. The ulcer may present clinically as a deep crater with or without undermining of adjacent tissue.

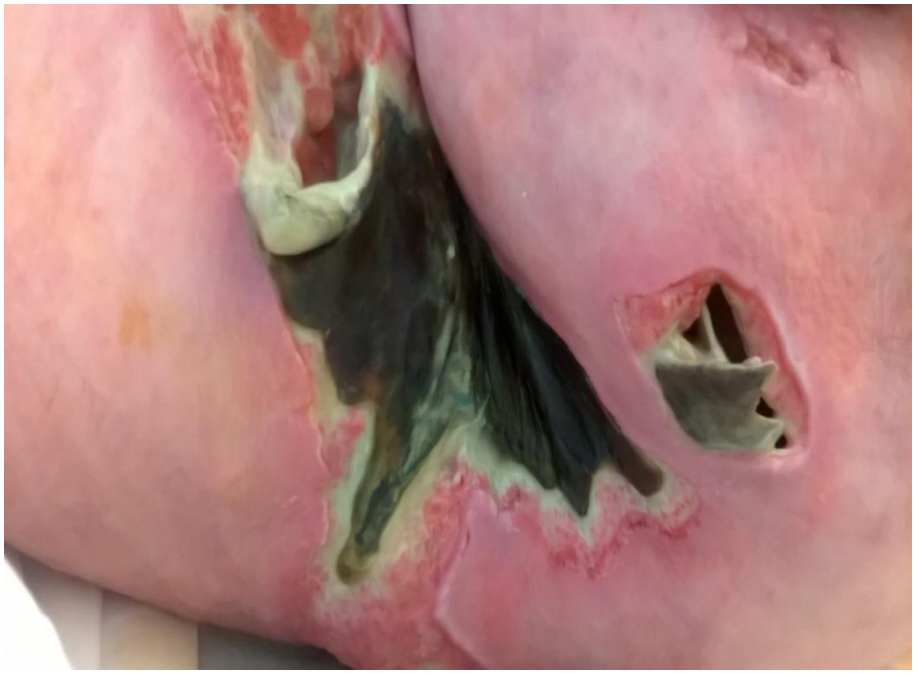


# Category/Stage 1V

Full-thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone or supporting structures (tendon, joint or capsule)

Undermining and sinus tracts also may be associated with stage 1V pressure ulcers





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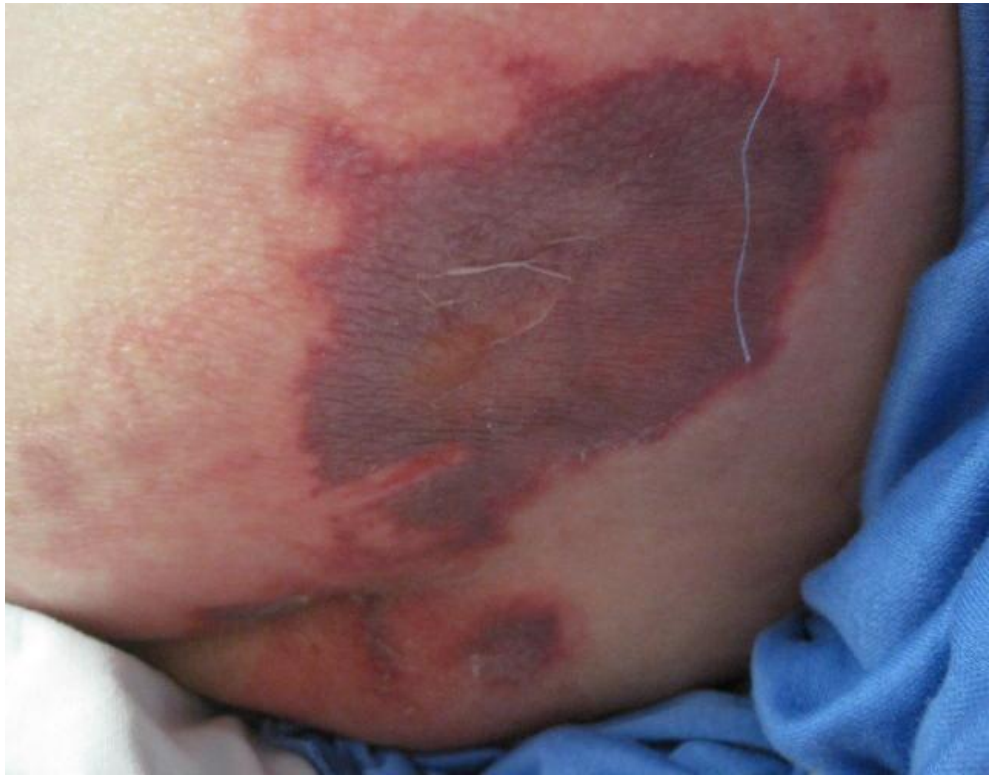
# Suspected deep pressure and shear induced tissue damage, depth unknown



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# Suspected deep pressure and shear induced tissue damage, depth unknown

In individuals with non-blanchable redness and purple/maroon discoloration of intact skin combined with a history of prolonged, unrelieved pressure/shear, this skin change may be an indication of emerging, more severe pressure ulceration i.e. an emerging **Category/Stage 111 or 1V Pressure Ulcer.**

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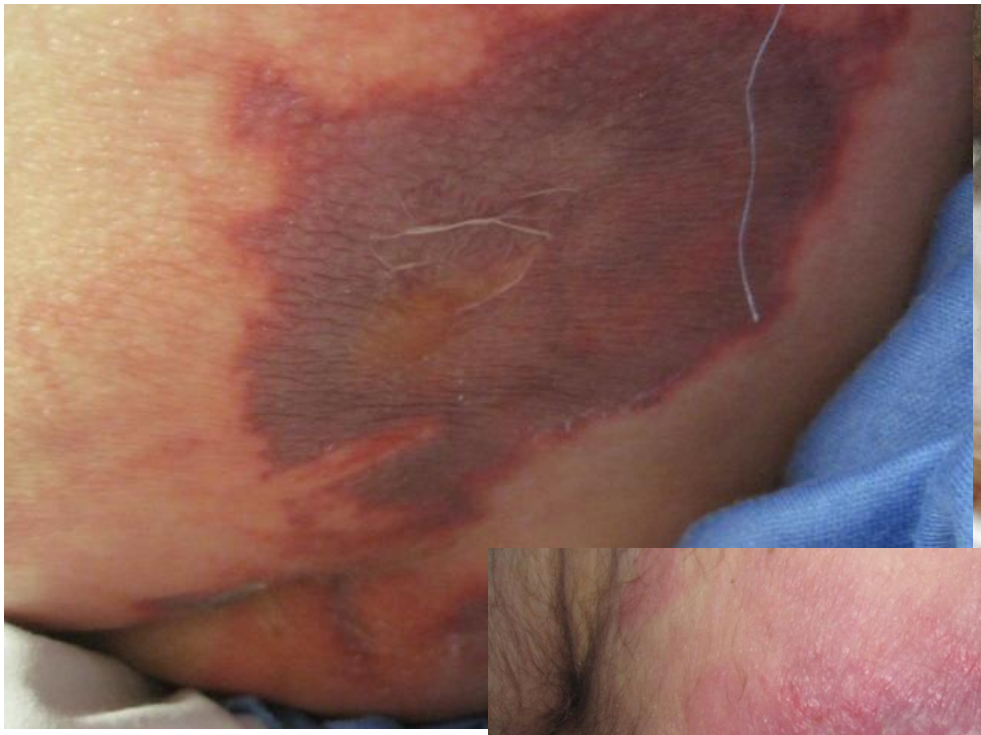
# Suspected deep pressure and shear induced tissue damage, depth unknown

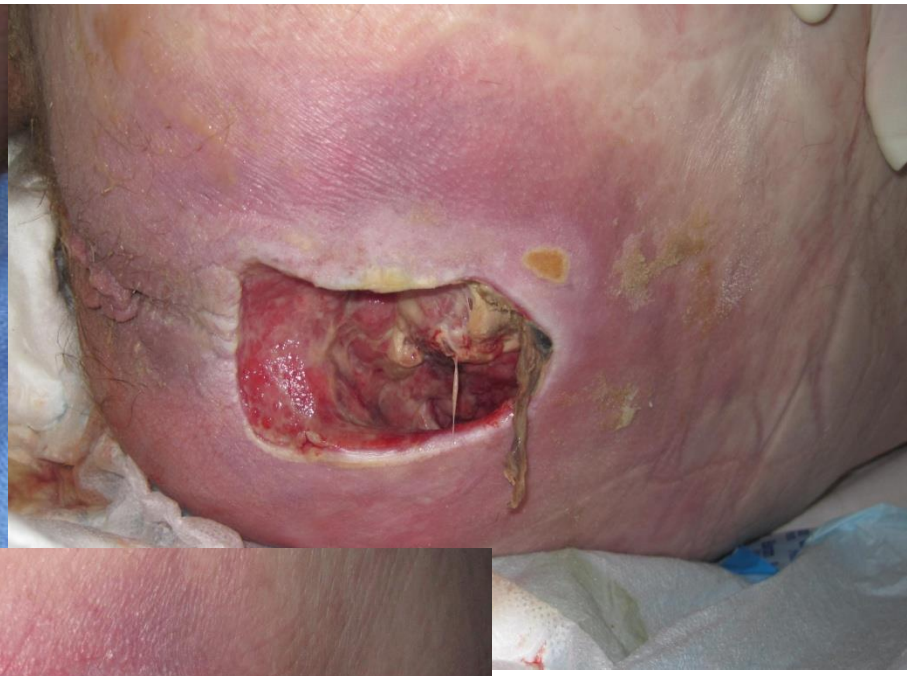
Clear recording of the exact nature of the visible skin changes, including recording of the risk that these changes may be an indication of emerging more severe pressure ulceration, should be documented in the patients health record

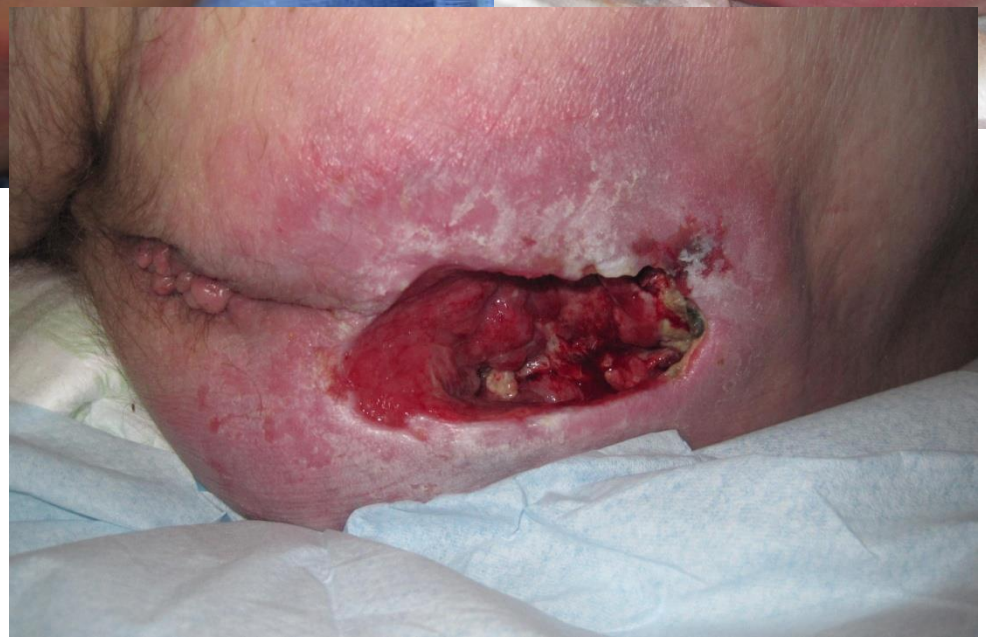
These observations  should be recorded in tandem with information pertaining to the patient history of prolonged, unrelieved pressure/shear

It is estimated that it could take **3-10 days** from the initial insult causing the damage,  to become a **Category/Stage 111 or 1V Pressure Ulcer** (Black et al, 2013)

# Emerged Category/Stage 1V PU









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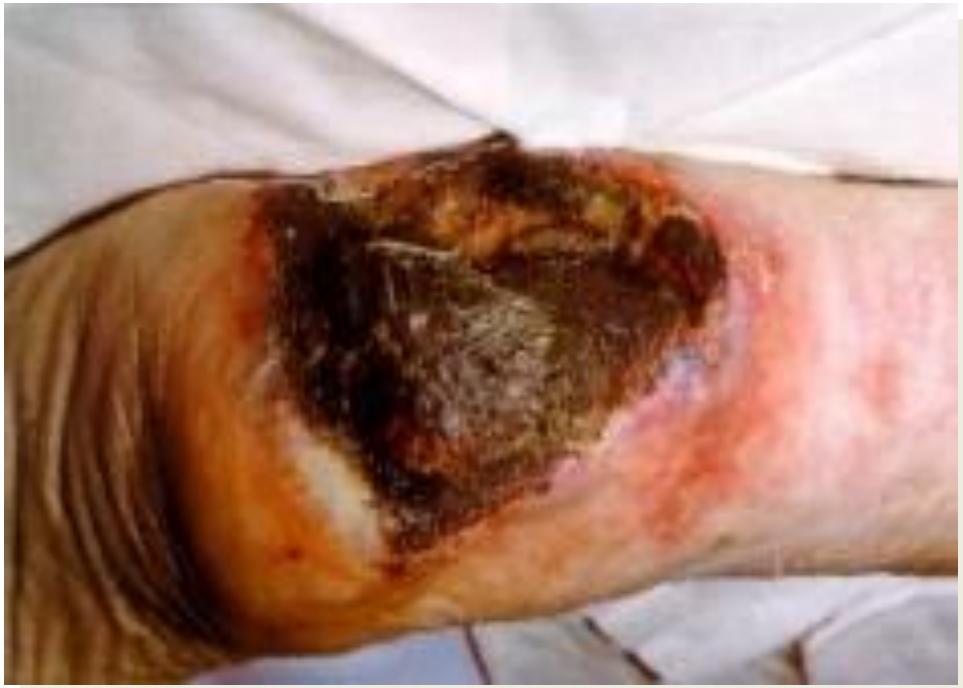
# At least a Category/Stage 111



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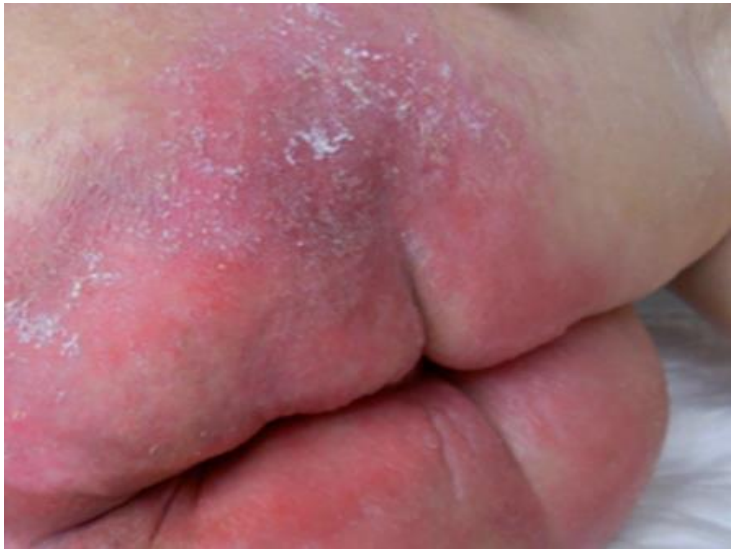
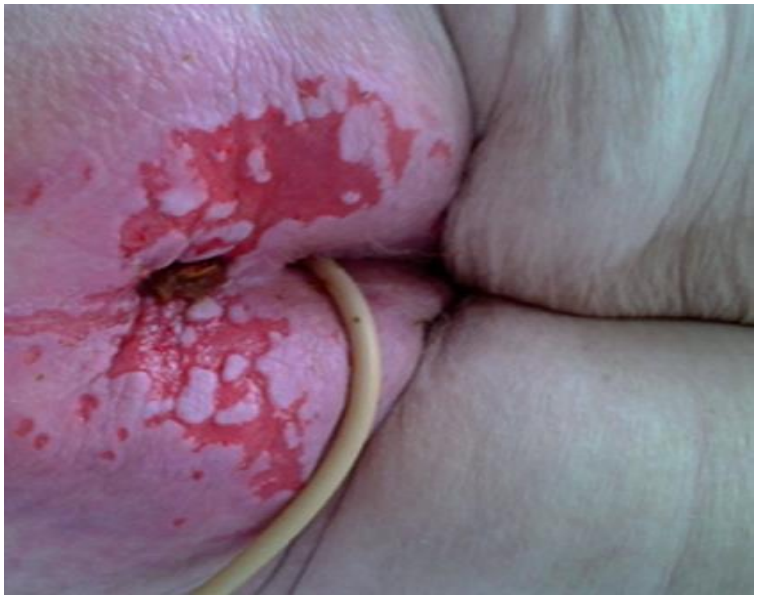
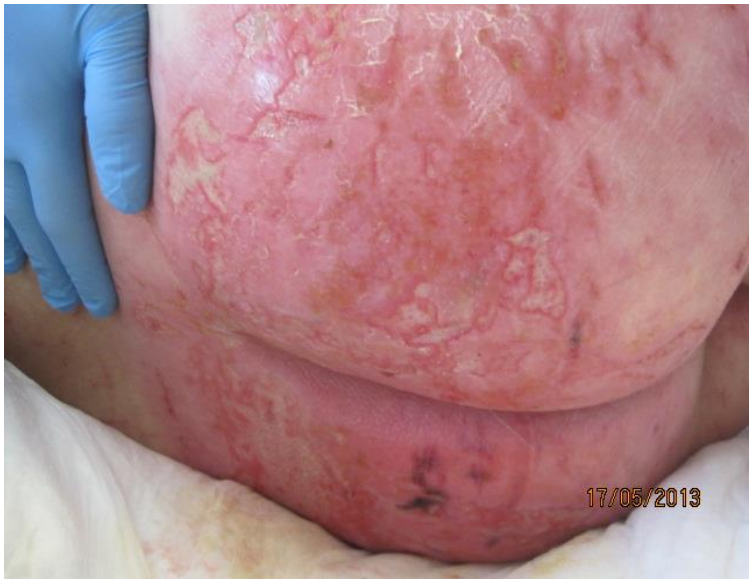
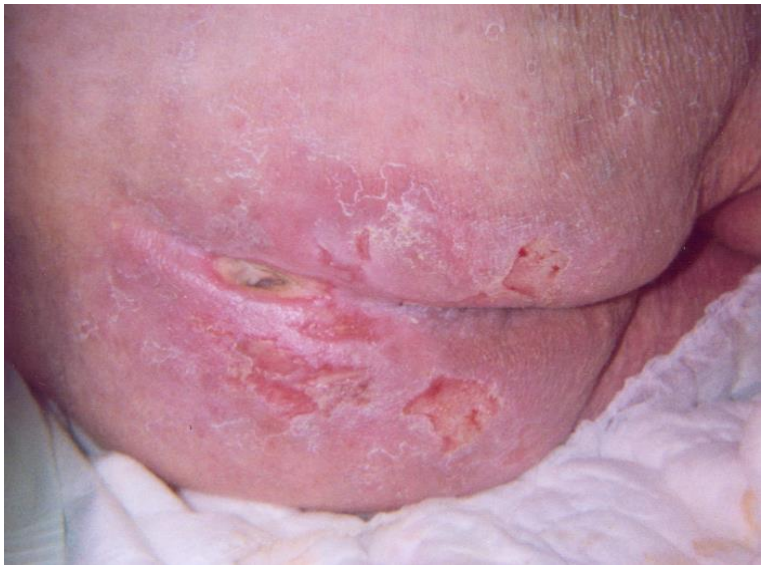
# Moisture Associated Lesions

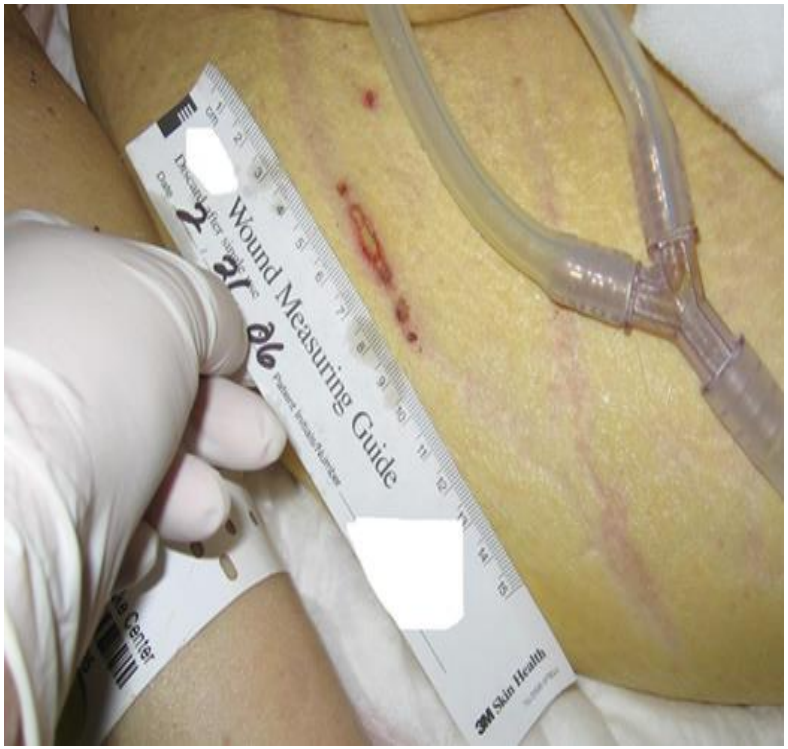






# Medical Device Related Pressure Ulcer




**34.5% of Hospital Acquired Pressure Ulcers** occur in patient's with medical devices
(Black Cuddigan et al, 2010)

Patients with medical devices are 2.4 times more likely to develop PU's of any kind
(White, 2005)

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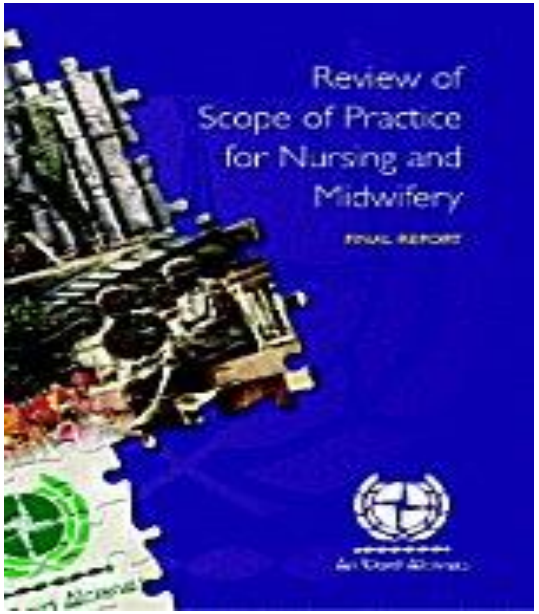
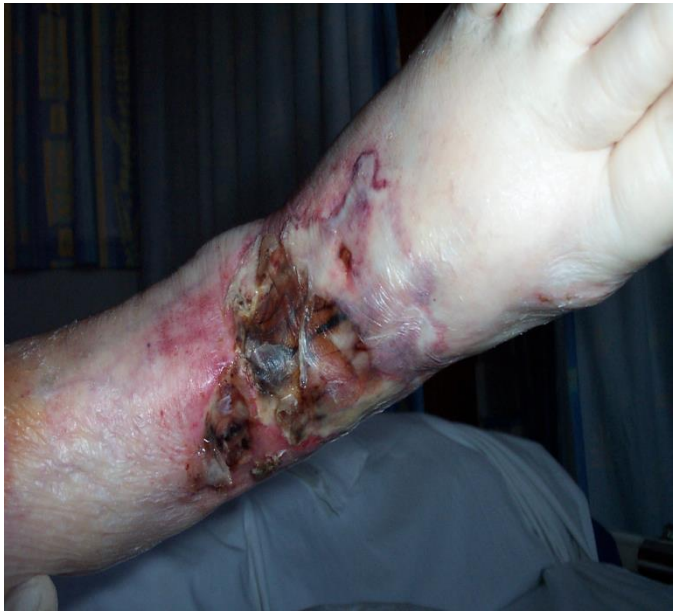
# Scope of Practice Document...Document...



**Do no harm!!**