Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive
Quality Improvement Division

QI TALK TIME

Building an Irish Network of Quality Improvers

Categorising Pressure Ulcers/Staging of Pressure Ulcers

Speaker: Pat McCluskey & Gillian O'Brien

16th Nov 2017

Connect **Improve** **Innovate**

Speakers

Pat McCluskey

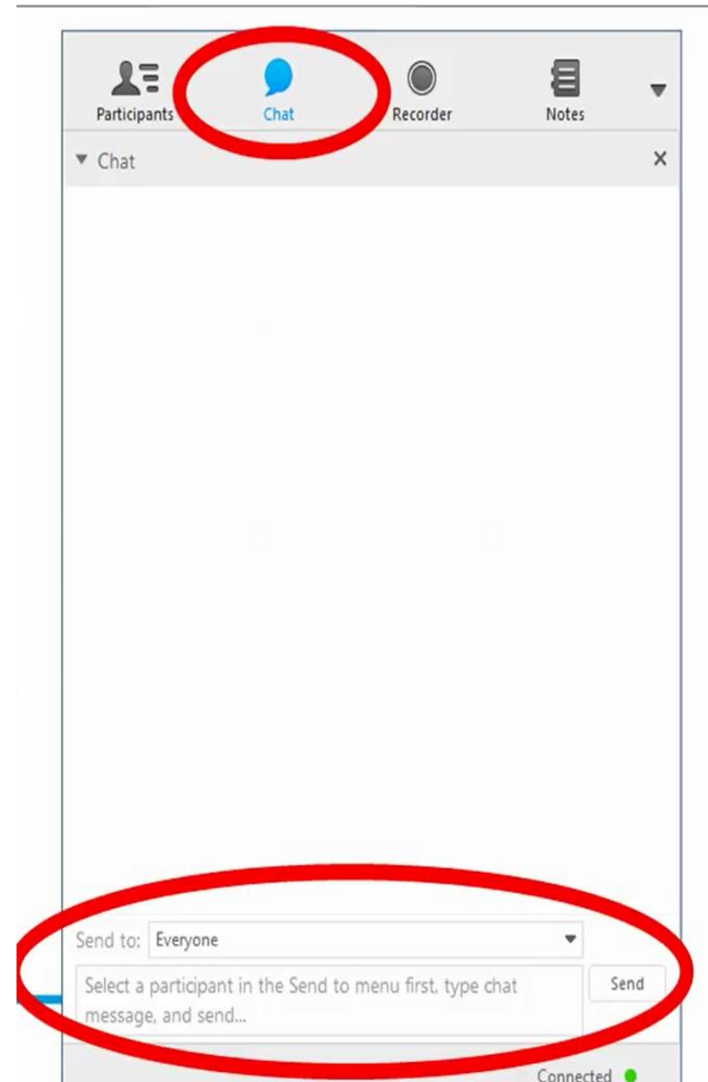
- Pat has worked in wound care since 1989. She is a Registered Advanced Nurse Practitioner in Wound Care & Tissue Viability in the Cork University Hospital Group. She is a member of the TVNAI & WMAI. Although the role of RANP encompasses education, guideline/policy development & research both at a regional and national level, her heart is in clinical practice.

Gillian O'Brien

- Gillian is a RANP in Tissue Viability in Naas General Hospital and specialises in wound and dermatology care. Gillian holds a MSc Nursing Advanced Practice and a HDip in Dermatology and Tissue Viability. Her special interests include wound infection, chronic wounds, dermatological conditions, minor surgery and pressure ulcers. Gillian is a member of national groups pertaining to wound care and guidelines, and is passionate about patient centred care and equity of access for all patients with wound and skin conditions.

Instructions

- Interactive
- Sound
- Chat box function
  - Comments/Ideas
  - Questions
- Q&A at the end
- **Twitter: @QITalktime**



Pressure Ulcer To Zero Phase 3
Categorising/Staging of Pressure Ulcers (HSE, 2017)

Pat Mc Cluskey ANP Wound care & Tissue Viability, Cork University Hospital Group

Gillian O' Brien ANP Wound care & Dermatology, Naas General Hospital

Definition

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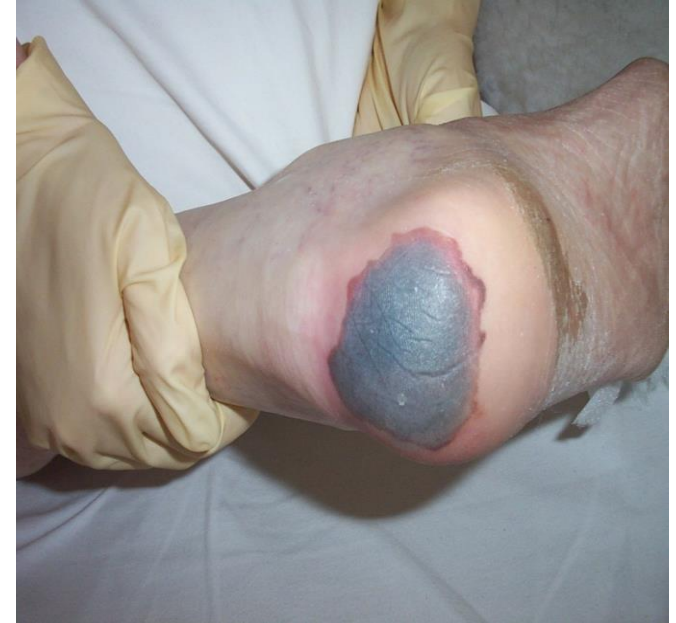
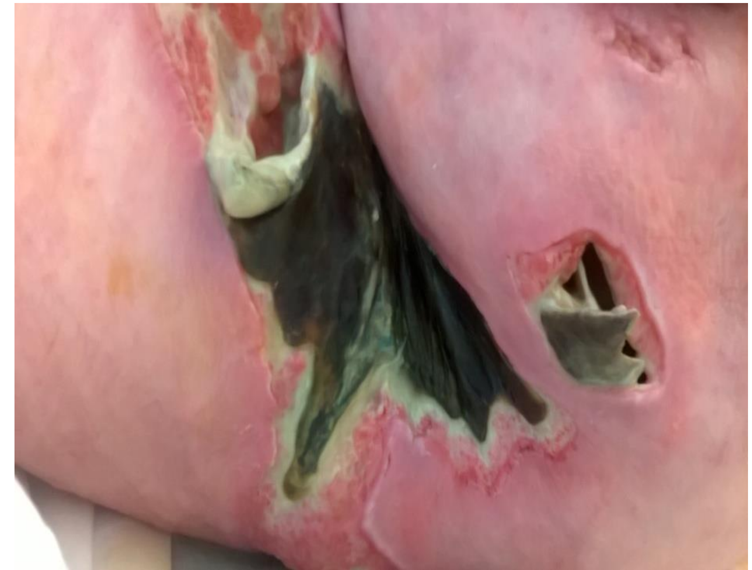


"A pressure ulcer is defined as a localised injury to the skin and / or the underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear.

(EPUAP/NPUAP/PPPIA 2014)

Both immobility and diminished activity are considered as primary risk factors

(Bergstrom et al 1992)



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Stage 1

Skin layers

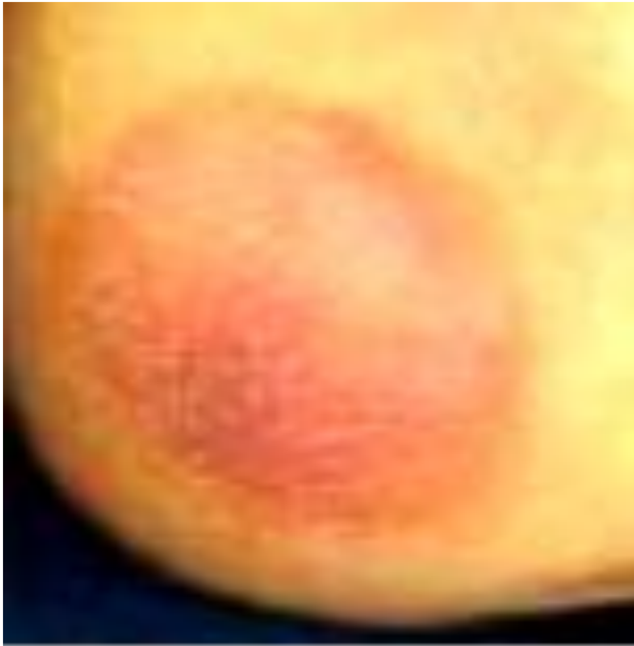
Subcutaneous soft tissue

Bone

Stage 2

Stage 3

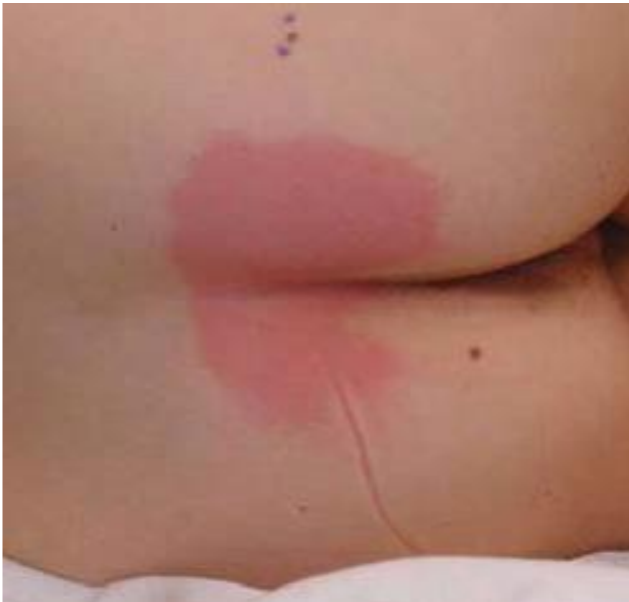
Stage 4



Category/Stage 1

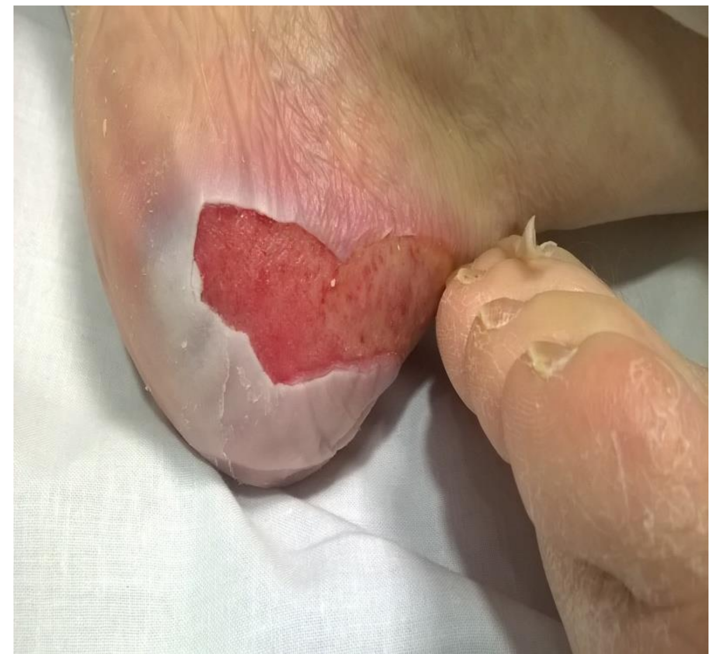
- Appears as a defined area of persistent redness (Non-Blanching) in lightly pigmented skin. Intact & usually presents over a bony prominence

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



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

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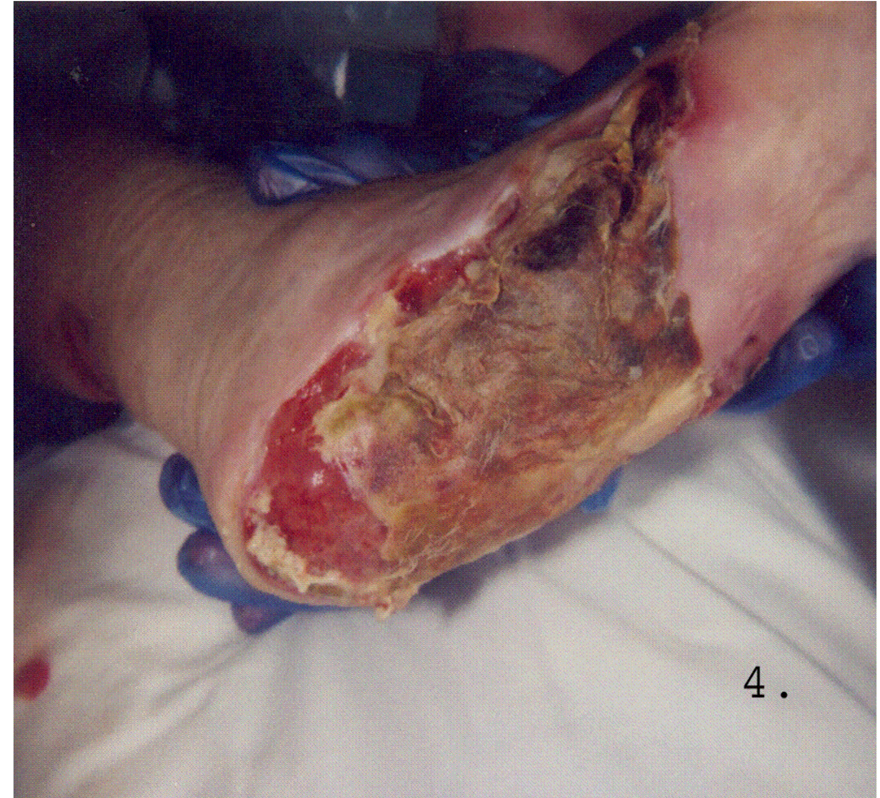
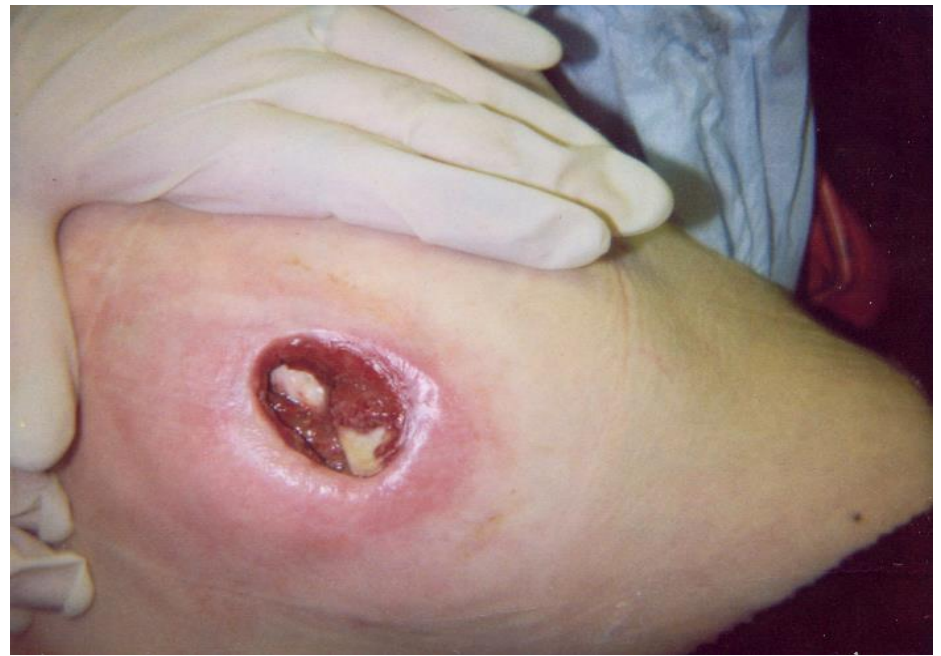
Full-thickness skin loss involving damage to, or necrosis of, subcutaneous tissue that may extend down to, **but not through**, underlying fascia. The ulcer may present clinically as a deep crater with or without undermining of adjacent tissue.

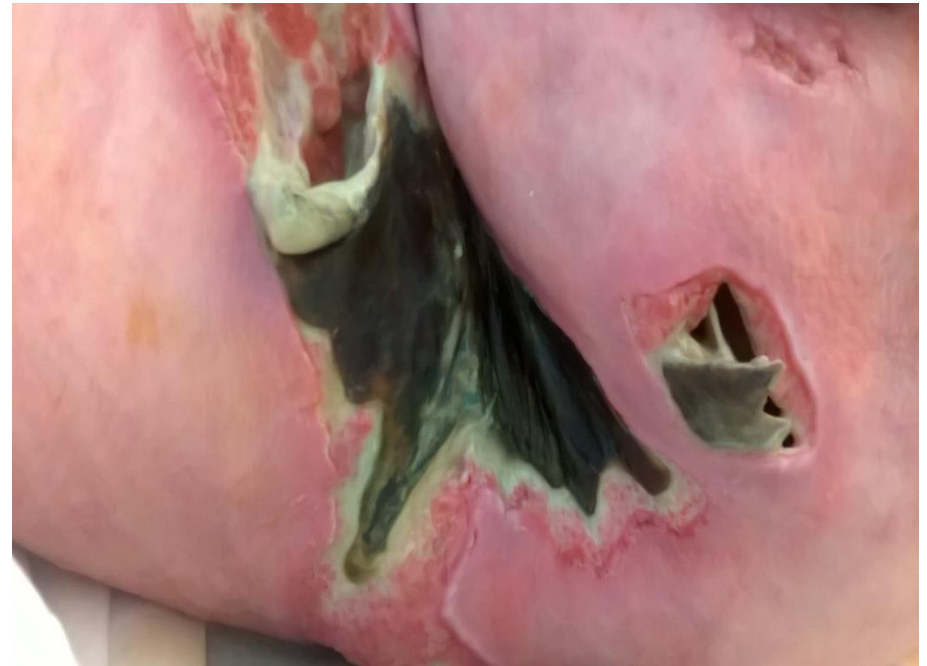


Category/Stage 1V

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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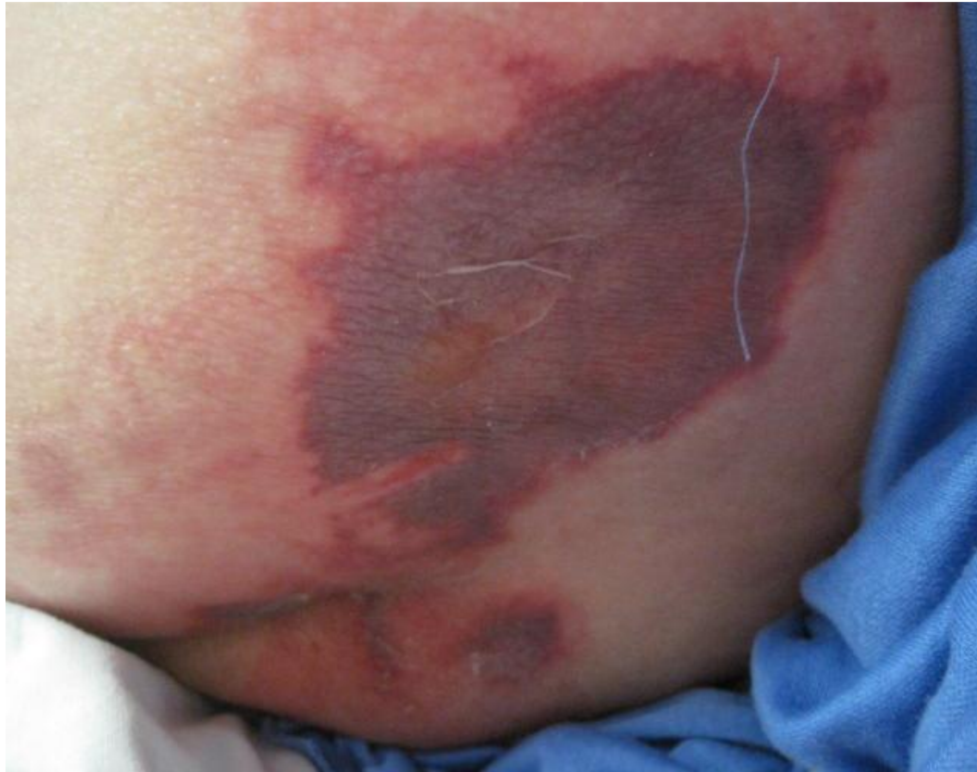
Suspected deep pressure and shear induced tissue damage, depth unknown



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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

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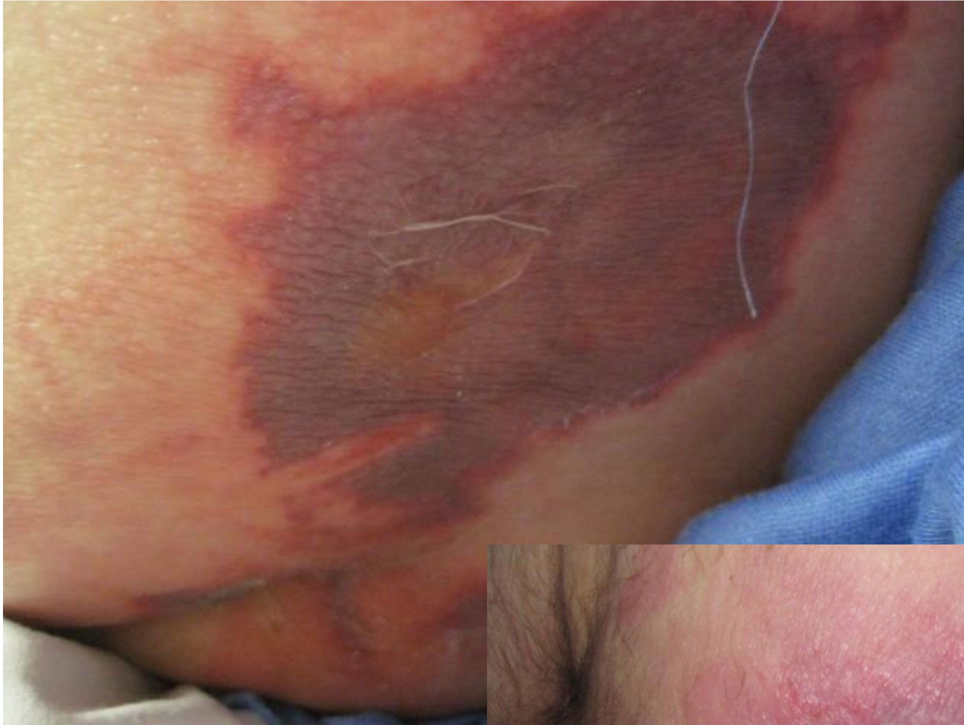
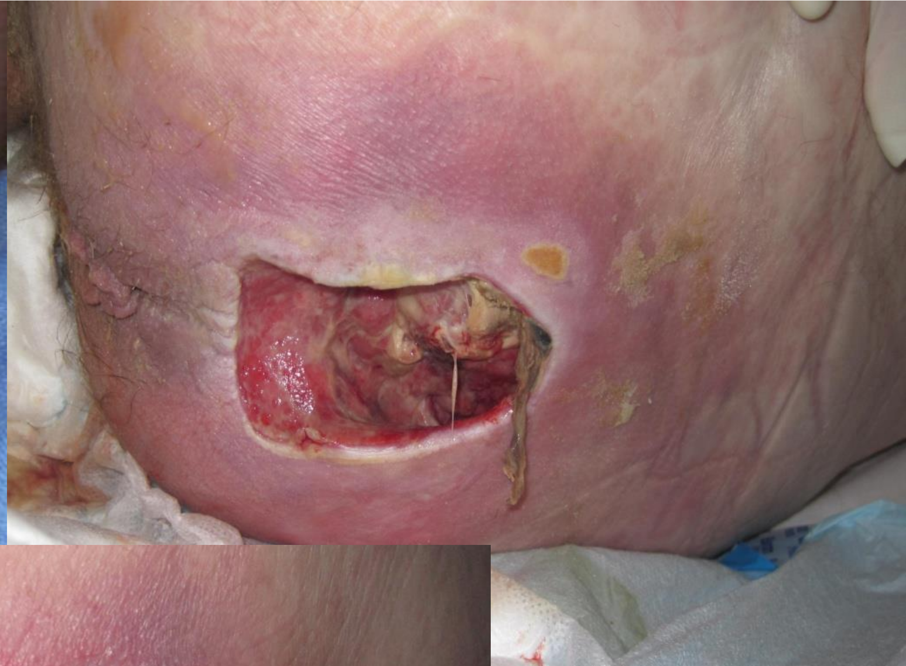
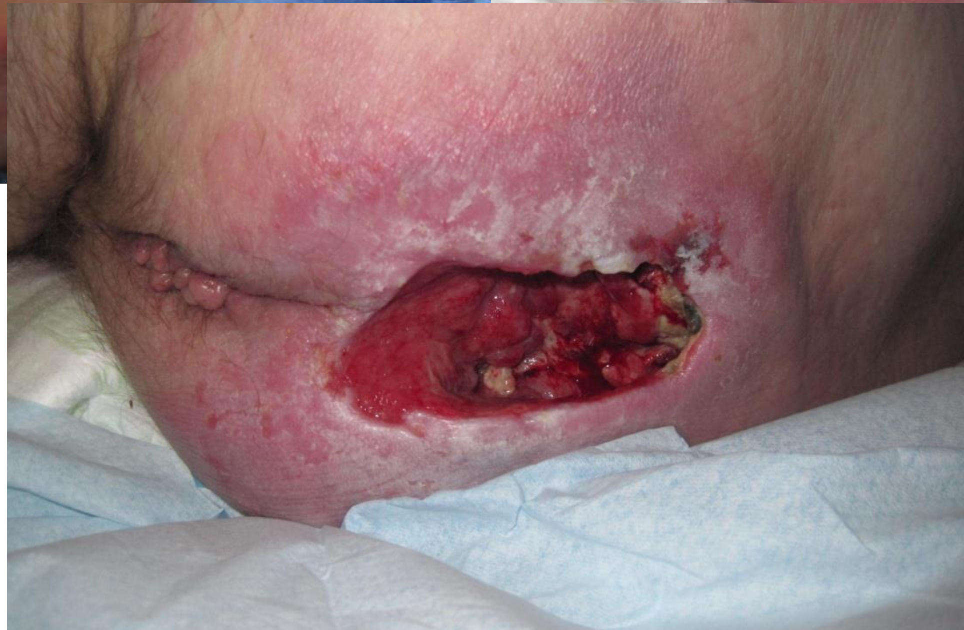
Clear recording of the exact nature of the visible skin changes, including recording of the risk that these changes may be an indication of emerging more severe pressure ulceration, should be documented in the patients health record

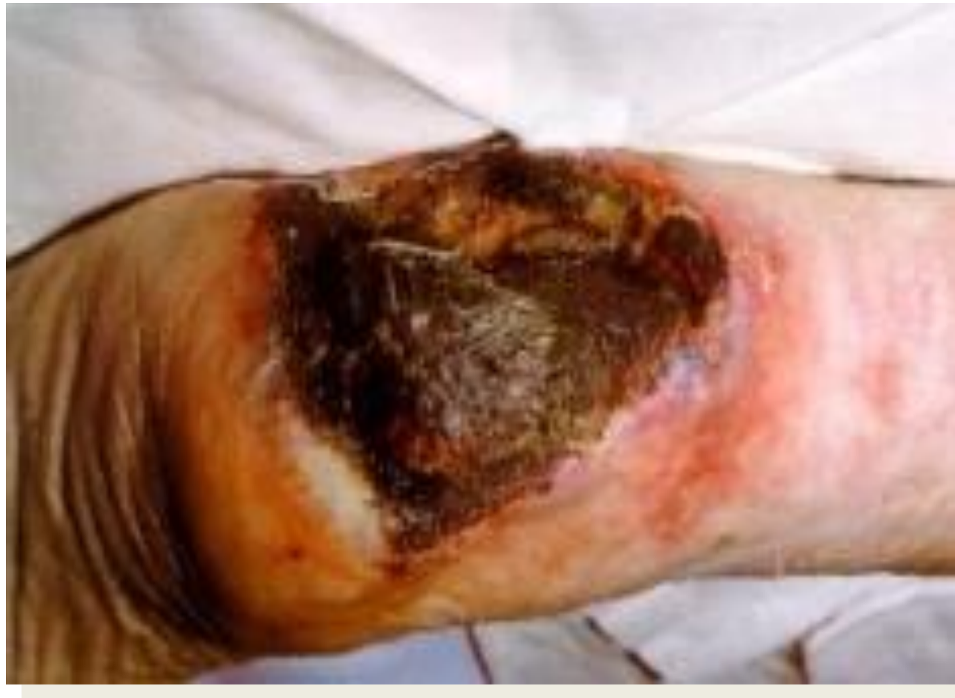
These observations should be recorded in tandem with information pertaining to the patient history of prolonged, unrelieved pressure/shear

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

At least a Category/Stage 111



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Moisture Associated Lesions

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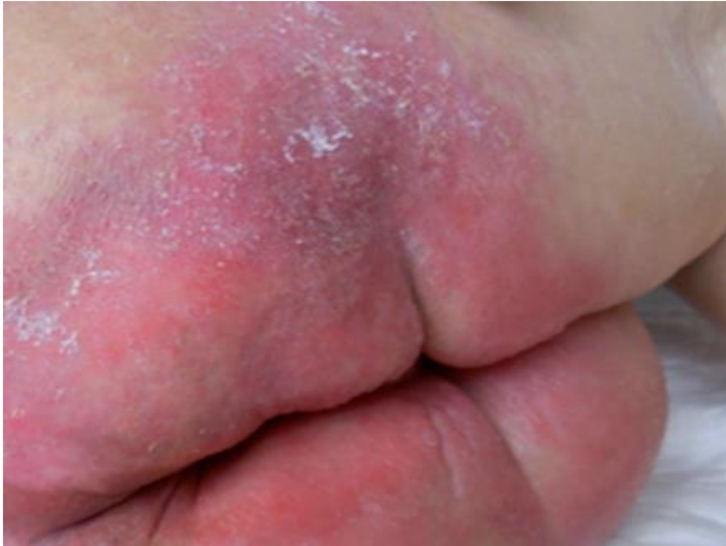
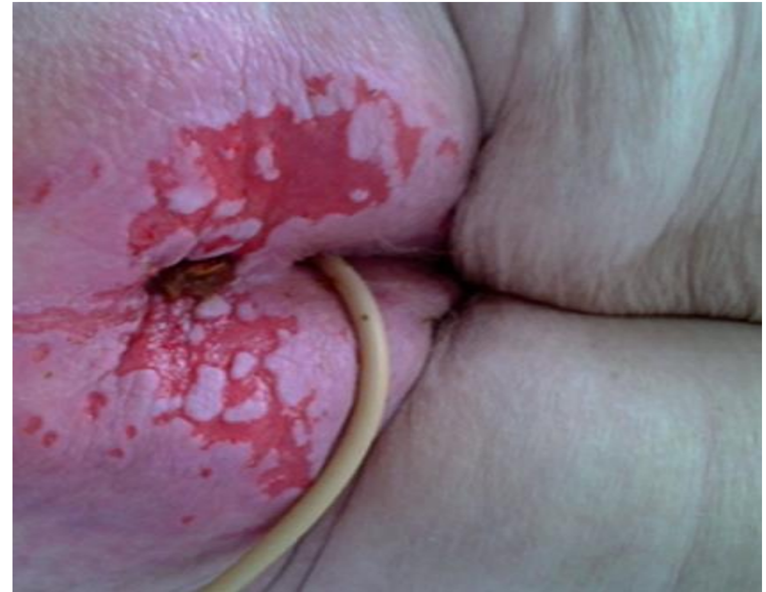
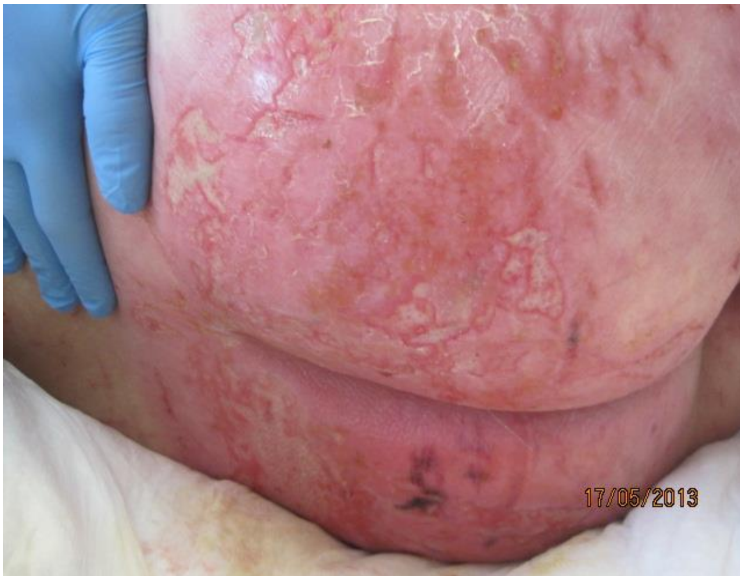
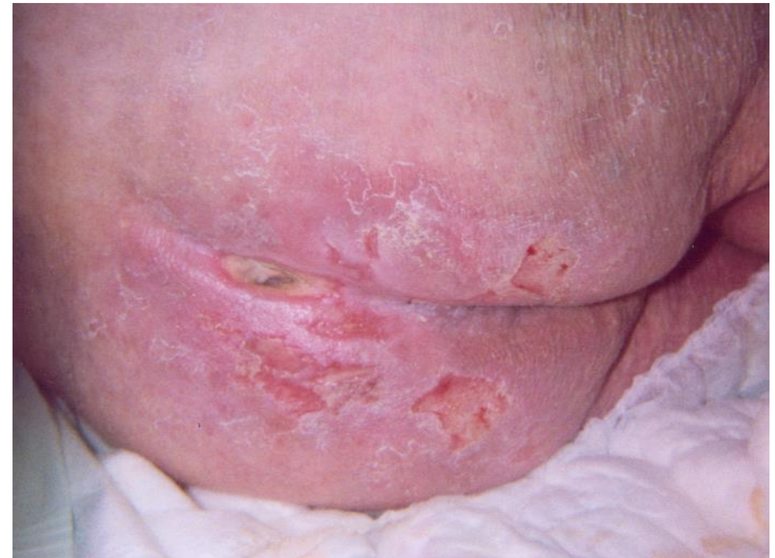
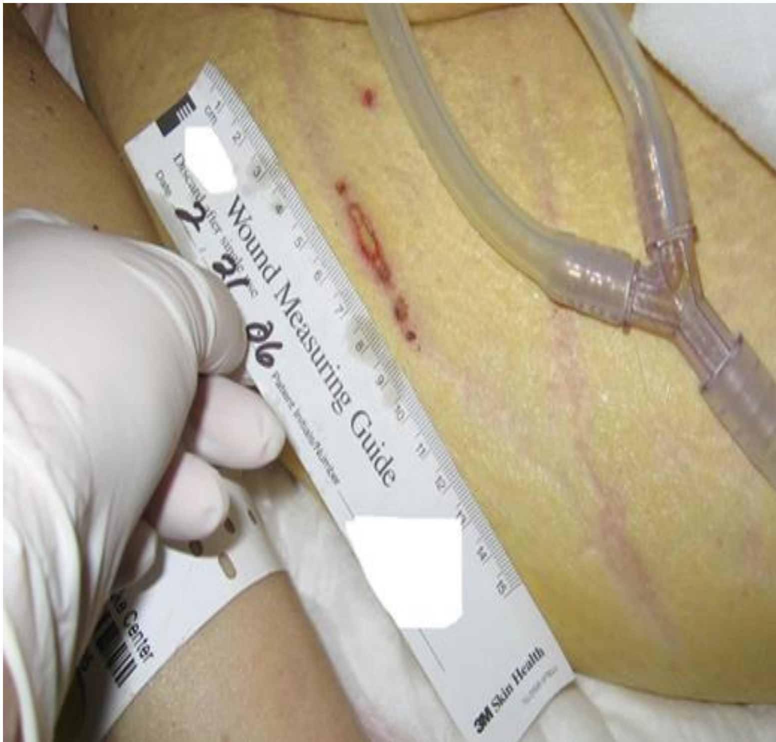








Medical Device Related Pressure Ulcer



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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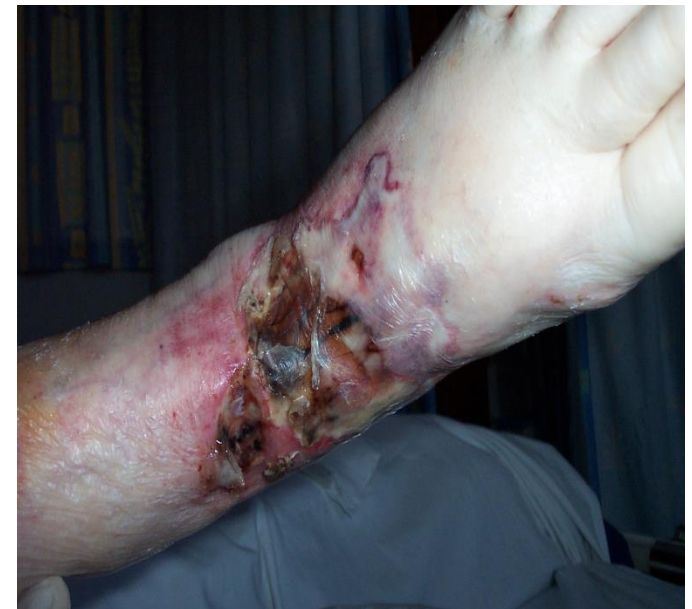
Scope of Practice Document...Document...



Do no harm!!

Helpful links

Framework for Improving quality

Improvement Knowledge and Skills Guide

http://www.hse.ie/eng/about/Who/QID/aboutQID/

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Next Webex – 21st November
Dr Peter Lachman:
Leading for Quality

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