QUICK GUIDE

ACCURATE PRESSURE ULCER ASSESSMENT

Wounds UK | Wound Essentials

PATHWAY TO ENHANCE RAPID PRESSURE ULCER CATEGORISATION

1. ASSESS
Perform a full holistic assessment of the patient, to confirm the wound is a pressure ulcer (not moisture-associated damage*) and identify causes of the PU. For lower-limb PUs, perform a thorough vascular assessment

Is arterial insufficiency present?

YES → Refer to vascular specialist for assessment

NO

Is the skin intact?

YES → Assess the skin discolouration and categorise† as:
- Purple = Suspected deep tissue injury
- Red/non-blanching = Category 1

NO

Can you assess the full depth and extent of the PU?

YES → Categorise† the pressure ulcer:
- Category II
- Category III
- Category IV

NO = unstageable
Therefore rapid debridement‡ is required to enable fast-track categorisation as 3 or 4

Does the wound contain devitalised tissue that is soft and hydrated, and thus suitable for monofilament debridement?

YES

Carry out rapid debridement to facilitate categorisation using Debrisoft® (single-use monofilament pad for mechanical debridement)§

NO

Consider another method of debridement by referring to local debridement guidelines and/or UK consensus||

On completion of current/each debridement episode, reassess:

FURTHER READING

*See: All Wales Tissue Viability Nurse Forum and All Wales Continence Forum (2014) All Wales best practice statement on the prevention and management of moisture lesions. London: Wounds UK. Available at: www.wounds-uk.com/supplements/awtvnf-prevention-and-management-of-moisture-lesions

†See: Tips for categorising pressure ulcers on p5 (overleaf)

‡ National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline. Emily Haesler (Ed.). Cambridge Media: Osborne Park, Western Australia; 2014

§See: Quick Guide: Debrisoft® in practice (2014) London: Wounds UK. Available at: www.wounds-uk.com/quick-guides/quick-guide-on-debrisoft-in-practice

||See: Guidelines for Practice (2013) *Effective debridement in a changing NHS: A UK consensus*. London: Wounds UK. Available at: http://www.wounds-uk.com/supplements/effective-debridement-in-a-changing-nhs-a-uk-consensus

TIPS FOR PRESSURE ULCER CATEGORISATION[1]

Suspected deep tissue injury

- Purple or maroon localised area of discoloured, intact skin or blood-filled blister
- May be difficult to detect in patients with dark skin tones
- May present with thin blister or eschar

Category I

- Intact, localised area of non-blanchable erythema, typically over a bony prominence
- Blanching may present as different colour in patients with dark skin tones
- May be painful, firm, soft, or feel to be of a different temperature than surrounding tissue

Category II

- Shallow, partial-thickness open ulcer with a red/pink wound bed, without slough
- Can also be an intact or open/ruptured serum-filled blister
- May be shiny or dry, without bruising

Category III

- Full-thickness ulcer that may present with slough that does not obscure depth of tissue loss
- Subcutaneous tissue may be visible, but bone, tendon and muscle will not
- Undermining and tunnelling may be present

Category IV

- Full-thickness ulcer with exposed bone, tendon or muscle
- May present with slough or eschar
- Undermining and tunnelling are often present

1. National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline. Emily Haesler (Ed.). Cambridge Media: Osborne Park, Western Australia; 2014

DEBRIDEMENT IN PRESSURE ULCERS

Rationale for debridement in PUs[1]

- Generally, debridement is a key to wound bed preparation that can address barriers to healing and provide stimulatory healing effects
- Debridement of slough can help achieve full visualisation required for accurate PU categorisation

Recommendations for debridement in PUs[1]

- Perform debridement as needed to leave the wound bed free of devitalised tissue and covered with granulation tissue
- Manage pain associated with debridement
- Debride the wound bed or PU edge using a method determined as most appropriate by assessment of the patient and wound, in line with overall treatment goals
- Use of a monofilament pad removes slough and devitalized tissue, and potentially disrupts biofilm within the wound bed

Key advantages of Debrisoft®

- Mechanical debridement with Debrisoft takes 2 to 4 minutes, on average
- Ideal for safely, gently removing debris and slough, to allow full visualisation for PU categorisation
- Debrisoft can be used by clinicians across all competency levels, from general/qualified practitioner to advanced practitioner
- By actively and rapidly removing debris, Debrisoft leaves the wound and skin clear and ready for healing[2]
- According to recent NICE guidance, using Debrisoft could result in savings of £15 million per annum nationally/up to £484 per patient[2]

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2. National Institute for Health and Care Excellence (NICE) (2014) The Debrisoft monofilament debridement pad for use in acute or chronic wounds. London: NICE. Available at: guidance.nice.org.uk/mtg17

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For complete list of evidence, references, case studies and multimedia resources supporting the information in this guide, and to see Debrisoft in action, visit: **www.activahealthcare.co.uk/debrisoft/**

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