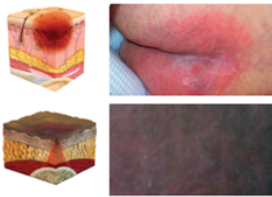


Pressure Ulcer Assessment & Classification in Different Skin Tones

NWCSP (2023) Categorisation System

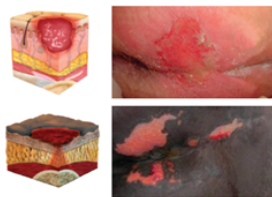
Category 1 - Non-Blanchable Erythema:

The ulcer appears as a defined area of persistent redness (erythema) in lightly pigmented skin tones, whereas in darker skin tones, the ulcer may appear with persistent red, blue or purple hues, without skin loss. The patient may report pain or discomfort over the area.



Category 2 - Partial Thickness Skin Loss:

Pressure ulcer with abrasion, blister, partial-thickness skin loss involving epidermis and or dermis.



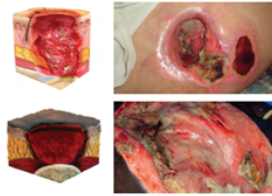
Category 3 - Full Thickness Skin Loss:

Pressure ulcer with full-thickness skin loss involving damage or necrosis of subcutaneous tissue. Undermining and tunnelling may occur, fascia, muscle, tendon, ligament, cartilage and or bone are not exposed.



Category 4 - Full Thickness Skin & Tissue Loss:

Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage and/or bone in the ulcer. There is an increased risk of osteomyelitis.



Mucosal Pressure Ulcer:

Mucosal membrane pressure ulcers occur in of the moist membranes that line the respiratory, gastrointestinal, and genitourinary tracts. They do not have the same anatomical structures as the skin therefore it is not possible to categorise them. They should be recorded only as Mucosal Pressure Ulcer without the allocation of a number.



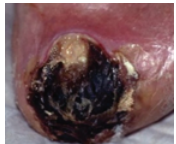
Device Related:

Medical device-related pressure ulcers/injuries (MDRPUs/MDRPis) are caused by external forces that are applied by skin-contacting medical devices.



Unstageable:

Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore category, cannot be determined. This will be at least a category 3 pressure ulcer and recorded accordingly with the revised process.



Deep Tissue Injury (DTI):

Purple or maroon localised area of discoloured intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. Deep tissue injuries may be difficult to detect in individuals with dark skin tones. This would be recorded as "vulnerable skin" assessed regularly and managed as appropriate.



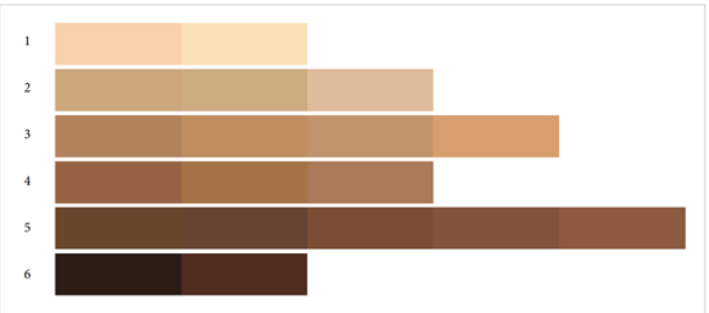
A pressure ulcer (PU) can be defined as:

*"Localised damage to the skin and/or underlying tissue, as a result of pressure, or pressure in combination with shear. Pressure injuries/ulcers usually occur over a bony prominence but may also be related to a medical device or other object"*¹

As discussed by Li et al², pressure ulcers are perceived as a global threat and present a significant health challenge world-wide.

It has been acknowledged that skin tone variance may affect early detection of pressure ulcers³ (Dhoonmoon et al, 2021). Early identification of changes to the skin is one of the most important tools to protect patients who are at risk of developing pressure ulcers.¹ Evidence has shown that it is difficult to accurately identify the early stages of pressure ulceration in patients with dark skin tones.⁴ As discussed by Andersson et al⁵, (2023); unrecognised damage can lead to worsening stages; prolonged periods of hospital stay; deterioration in patients' physical and psychological wellbeing; increased risk of sepsis and death; and elevated costs for healthcare services.

The Skin Tone Tool, adapted from Ho & Robinson⁶, is a validated classification tool that shows a range of skin tones so that the tone can be selected that most closely matches the patient's inside upper arm.



Indicators of pressure-related damage in dark skin tones (adapted from Dhoonmoon et al, 2021³)

- Changes in colour, which may present as redness, darkening, lightening or grey/blue/purple discolouration
- The skin may feel tight, spongy, or appear shiny
- Change in temperature (e.g. initial warmth - which may become cooler as tissue death occurs - or coldness)
- Change in tissue consistency (e.g. induration or hardness)
- Pain, discomfort or numbness over the affected area

Whilst these additional signs and symptoms are applicable to all skin tones, they can be particularly useful when caring for patients with dark skin tones when obvious pressure-related redness on the skin can be more difficult to identify.

CONSIDERATION FOR CLINICAL PRACTICE

Skin should be carefully inspected for any discolouration over pressure areas. Areas of discolouration in relation to surrounding skin should be assessed more closely for temperature changes, oedema, changes in tissue consistency and pain¹.

NOTE: This is a guide only, signs and symptoms of pressure ulcers may present differently on different skin tones. Education is a critical factor in ensuring that all members of the clinical team can strive to prevent and treat pressure ulcers according to the best evidence available.

REFERENCES

1. European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel, and Pan Pacific Pressure Ulcer Injury Alliance. Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline. The international Guideline 2019.
2. Li, Z. et al. (2020). Global Prevalence and Incidence of Pressure Injuries in Hospitalised Adult Patients: A Systematic Review and Meta-Analysis. Int J Nurs Stud. May;105:103546. doi:10.1016/j.ijnurstu.2020.103546.
3. Dhoonmoon, L., Fletcher, J., Atkin, L., et al. (2021). Best Practice Statement: Addressing Skin Tone Bias in Wound Care: Assessing Signs and Symptoms in People with Dark Skin Tones. London: Wounds UK.
4. Black, J. (2018). Using Thermography to Assess Pressure Injuries in Patients with Dark Skin. Nursing. 48(9):60-61. doi: 10.1097/01.NURSE.0000544232.97340.96.
5. Andersson, J., Imberg, S., & Rosengren, K. (2023). Documentation of Pressure Ulcers in Medical Records at an Internal Medicine Ward in University Hospital in Western Sweden. Nurs Open. 10(3):1794-1802.
6. Ho, B. K., and Robinson, J. K. (2015). Color Bar Tool for Skin Type Self-Identification: A Cross-Sectional Study. J Am Acad Dermatol. 73(2):312-313.



Remember... Prevention is better than cure!

#StopPressureUlcers #lovegreatskin #StopThePressure #aSKINg



#poweringPUprevention

WWW.DHG-HEALTHCARE.COM