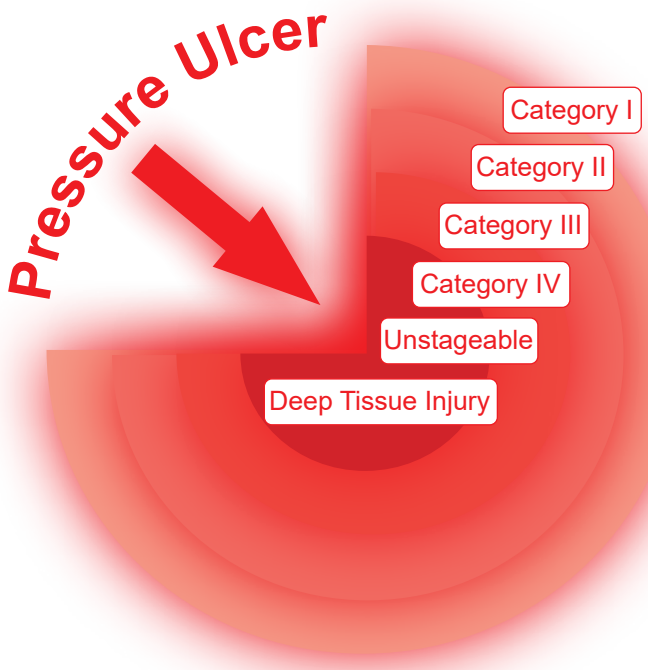
Quality Approved Resource

Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Pressure Ulcers

Patient information leaflet



With YOU in mind

Introduction

This leaflet is about pressure ulcers and includes information about

- what they are
- what can cause them
- and how they can be treated

If you are not sure about anything in this leaflet please ask a member a member of staff to contact the Tissue Viability team.

What is a pressure ulcer?

A pressure ulcer (sometimes called a bed sore or pressure sore) is when your skin and underlying tissue gets damaged causing a painful ulcer.

How does the skin get damaged?

The damage is usually caused by one of three main things:

- **Pressure** – the weight of the body pressing down on the skin
- **Shear** – when layers of skin are forced to slide over one another, for example when you slide down or are pulled up a bed or chair
- **Friction** – rubbing of the skin.

What are the symptoms of a pressure ulcer?

Category I

A pressure ulcer may initially appear as a red area of skin that does not disappear after a few hours and it may feel tender. The area may become painful and purple in colour. Continued pressure and poor circulation can cause the skin and tissue to break down.

Category II

A shallow wound or blister may appear.

Category III

The wound extends through the protective layer of the skin into the underlying layers of skin and tissue.

Category IV

This is when the damage is so great it extends through the skins layers and fatty tissue to the underlying tendons, ligaments and bone.

Who is affected?

Pressure ulcers can affect people of any age, particularly those with poor mobility who spend prolonged periods in bed or in a chair or are unable to change their position or have impaired nerve sensation.

Older people can be more likely to develop pressure ulcers, particularly if they have any of the following:

- poor nutrition
- poor circulation
- lack of sensation
- previous pressure ulcers.

Who can get pressure damage?

Anyone can get pressure damage regardless of age.

But those most at risk are people:

- who have trouble moving and cannot change position themselves
- with neurological conditions or spinal cord damage that prevent them registering pain over part of their body
- who are incontinent, seriously ill, or have had surgery
- who have poor nutrition and hydration
- who are very young or very old
- who are older and who are ill or have suffered an injury like a broken hip resulting in impaired mobility
- with memory problems
- with a history of previous pressure damage.

Pressure ulcers can be very serious if they are not cared for properly. They can mean a lot of pain and longer stays in hospital. Severe pressure ulcers can even damage the muscle and bone underneath the skin. At worst pressure ulcers can be life threatening if they become infected. This is why they **must** be avoided.

Can pressure ulcers be prevented?

In the majority of cases, yes. The most important factor in preventing ulcers is identifying your risk and then avoiding prolonged pressure on an area of the skin. This can be achieved by changing your position regularly throughout the day. If you are unable to do this yourself you should be moved regularly.

A clinical risk assessment will advise the team how frequently is required in response to your individual needs.

Specialist high specification foam or special mattresses, such as air filled alternating pressure mattresses and cushions that redistribute pressure help reduce pressure on sensitive areas can be used.

Regular inspection of high risk pressure areas is important to detect early signs and prompt medical care should be provided.

It is also important to keep skin healthy, clean and dry. Use a mild non perfumed and PH neutral soap and warm (not hot) water. Apply moisturisers so the skin doesn't get too dry. If you must spend a lot of time in bed or in a wheelchair, check your whole body every day for spots, colour changes or other signs of damage. A member of the care team can help with this if required.

The best way to avoid pressure damage is to keep moving – turn over or change position as often as possible. To help you with this you should get advice from your Named Nurse or the healthcare team on the best ways to:

- sit and lie down
- adjust your sitting and lying positions
- support your feet
- keep a good posture.

They can also advise on:

- how often you need to move or get help to be moved
- what type of equipment you can use to help
- how best to manage your diet and hydration needs.

Can diet/hydration prevent pressure ulcers?

A healthy diet that includes plenty of vitamin C and zinc is important to maintain healthy skin and may help prevent pressure ulcers developing. Ensuring that you drink enough fluids to prevent dehydration is essential for maintaining healthy skin.

How do you treat pressure ulcers?

Treating a pressure ulcer is much more difficult than preventing one. Treatment of pressure ulcers includes relieving pressure and keeping the ulcer clean. Dressings are used to encourage healing and appropriate antibiotic therapy can treat infection where required.

The removal of dead tissue, skin grafting and plastic surgery may also be required. It's important to improve nutrition and to treat any underlying condition that's contributing to the problem.

What are the risk factors associated with pressure ulcers?

The risks associated with pressure ulcers vary depending on the severity. People who have Category I or Category II pressure ulcers may feel uncomfortable and complain of some pain to the damaged area. The greatest risks are associated with Category III and Category IV pressure ulcers, as these go deeper into the body. Some risks include:

- severe pain and bad odour (malodour)
- damage to surrounding skin if the pressure ulcer is very wet
- hard to heal wounds
- significant scarring
- increased risk or infections, such as Osteomyelitis and Cellulitis
- death.

There are also medications such as sedatives that may lessen your sensitivity to pain and some specialist medications can reduce the strength of the skin, making it more susceptible to damage. Specialist advice regarding your medications will be provided by your doctor and pharmacist.

Where do pressure ulcers develop

Pressure ulcers can occur over any bony prominence but common areas for pressure ulcers to develop are:

- elbows
- hips
- sacrum (base of your pelvis)
- heels.

How can infected pressure ulcers be treated?

The treatment of an infected pressure ulcer depends on the severity of the infection, its location, presentation and type of organism involved. Once these factors have been identified the healthcare team will agree with you the best and most appropriate treatment options. Sometimes this is medicated ointment applied direct to the skin or application of a specialist dressing or where appropriate antibiotic medication.

How can I tell if a pressure ulcer is getting better?

As a pressure ulcer heals, it slowly gets smaller. Less fluid drains from it. New healthy skin starts growing at the bottom of the ulcer. This new skin is light red or pink and looks lumpy and shiny. It may take two to four weeks of treatment before you see these signs of healing and significant pressure ulcers can take many months to heal.

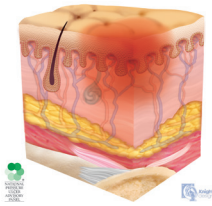
12 Top Tips for preventing pressure damage

There are some simple ways of preventing pressure ulcers. If you are at risk, then these can be used for you to guide the person who cares for you.

Remember that the healthcare team are there to help you. If you think you or someone you know is at risk of developing pressure damage please speak to a member of the healthcare team.

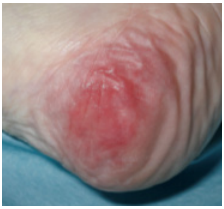
1. Identify if you are at risk.
2. Check skin for signs of early damage. Do you have any key areas that are showing a change of colour, blisters, swelling or patches of hot or cool skin or are you experiencing pain at a particular point on your body?
3. Make sure you turn and change position regularly so you don't put ongoing pressure on the same bit of skin.
4. If you are being lifted, make sure proper lifting techniques are being used and that your skin is not being dragged against something such as the bed or hoist sling.
5. Make sure your bedding is clean, dry, wrinkle free and that there are no crumbs in the bed.
6. Eat a well-balanced diet and drink plenty of fluids. The Trust Dietetics Team can support you with this.
7. If you have to sit or lie for long periods of time, make sure you have cushions or mattresses or other equipment to help reduce the risk of damage. The Trust Tissue Viability Specialist can advise.
8. Do not rub or massage the skin.
9. Keep your skin clean and dry and don't use excessive amounts of skin cream or talcum powder.
10. Do not use creams or ointments without consulting your doctor.
11. Only use special garments like pads and dressings to protect at risk areas like elbows and knees after consultation with the Tissue Viability Nurse.
12. Protect your skin from friction.

Category of Pressure Ulcers

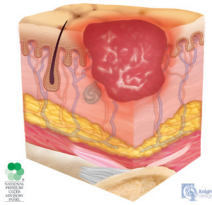


Category I: Non-blanchable Erythema

Intact skin with non-blanchable redness of a localised area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area.

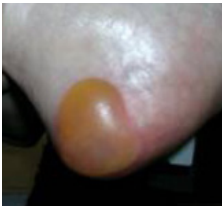


The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category I may be difficult to detect in individuals with dark skin tones. May indicate “at risk” individuals (a heralding sign of risk).



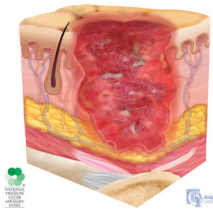
Category II: Partial Thickness Skin Loss

Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ ruptured serum filled blister.



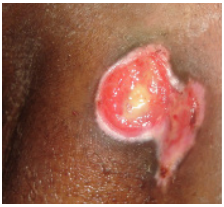
Presents as a shiny or dry shallow ulcer without slough or bruising.* This Category should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.

*Bruising indicates suspected deep tissue injury.

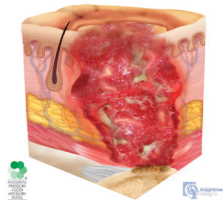


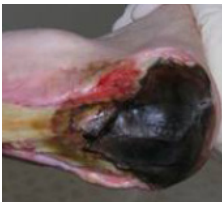
Category III: Full Thickness Skin Loss

Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunnelling.



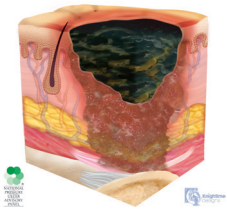
The depth of a Category III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category III pressure ulcers. Bone/ tendon is not visible or directly palpable.





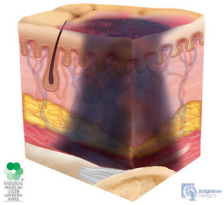
Category IV: Full Thickness Tissue Loss

Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunnelling. The depth of a Category IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category IV ulcers 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.



Unstageable

Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, 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. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed.



Deep Tissue 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.

Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound mayfurther evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.

References

- National Institute for Health and Care Excellence [NICE] (2014) Pressure Ulcers: Prevention and Management of pressure ulcers. Clinical guideline 179.
- Tissue Viability Society (2013) Seating and Pressure Ulcers: Clinical Practice Guideline.
- European Pressure Ulcer Advisory Panel [EPUAP] (2019) Prevention and Treatment of Pressure Ulcers/Injuries: Clinical practice Guideline.
- Royal College of Nursing [RCN] (2005) The Management of Pressure Ulcers in Primary and Secondary Care: A Clinical practice guideline.
- Royal College of Nursing [RCN] (2001) Pressure Ulcer risk assessment and prevention.
- National Pressure Ulcer Advisory Panel [NPUAP] (2015) Prevention and Treatment of Pressure Ulcers: Quick Reference Guide.

Further information about the content, reference sources or production of this leaflet can be obtained from the Patient Information Centre. If you would like to tell us what you think about this leaflet please get in touch.

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Published by the Patient Information Centre

Ref, PIC/746/1124 November 2024 V4

www.cntw.nhs.uk Tel: 0191 246 7288

Review date 2027

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