

(Words “Pressure Wound Video Series” and “Part II” appear on screen with the SCIRE logo at the top right corner.)

(Fades to next slide titled “Pressure Ulcer Staging.” “*Video contains Graphic Imagery” is noted below in smaller font.)

Female Narrator: Pressure ulcer staging.

(A physiotherapist examining the leg of a supine patient.)

Many individuals with SCI are at high to very high risk of developing a pressure ulcer due to their lack of sensation and decreased mobility.

(Narrator reads the words that appear on screen.)

A routine screen will help to identify areas of concern in the early stages of pressure ulcer development.

It is therefore recommended that a full body skin check is performed twice daily.

Perform a skin check in the morning to monitor the effects on the skin from positioning in bed, and in the evening to indicate if chair positioning can be a cause of skin compromise.

(Diagrams indicating areas at risk of developing pressure ulcers when sitting, lying on one side, and lying on the back for prolonged periods of time.)

Consider points of contact with support surfaces during these skin checks.

The most frequent areas affected when lying on one side are the side of the head, shoulder, hip, and ankle.

Lying on one’s back can direct pressure to the back of the head, tailbone, and heels.

The most frequent areas affected in sitting are the elbow, tailbone, sit bone, back of the knee, and the foot.

(A preview of the National Pressure Ulcer Advisory Panel home page and the words www.npuap.org appear on screen.)

The National Pressure Ulcer Advisory Panel has developed a system of staging pressure ulcers that is the currently accepted standard of practice.

(Video of a nurse preparing to examine a woman with SCI’s leg.)

Assigning a stage is based on inspection of the visible tissue condition.

It requires knowledge of the skin and underlying anatomical structures.

(A picture of all the equipment needed for a pressure ulcer inspection.)

Clean or aseptic technique is the routine standard of practice for inspection and dressing of most wounds unless otherwise indicated by a clinical specialist.

(British Columbia Patient Safety & Learning System's Pressure Ulcer Stages table chart appears on screen.)

Staging is essential for determining how serious a wound is, and for clinical decision making regarding wound care plans.

Pressure ulcer staging system has four levels, as well as a category of unstageable and suspected deep tissue injury.

(Slide titled "Stage 1 Pressure Ulcer" appears. Beneath title are descriptions that are read by the narrator. A photograph of a stage 1 ulcer shows mild redness of the skin. A drawing of the layers of tissue and fat of a stage 1 ulcer resembles healthy flesh except for a darker, bruise-like region on the surface tissue.)

A stage one pressure ulcer appears as intact skin with localized non-blanchable (does not go white when pressed) erythema, or redness, over a bony prominence.

The area might be painful, firm or soft, and warmer or cooler when compared surrounding tissue.

Stage 1 pressure ulcers have no measurable depth.

If redness is still evident 20-30 minutes after removing the pressure from the area, it should be classified as stage 1.

(An example of stage 1 pressure ulcer on a patient with darker skin tone. Pressure ulcer resembles a green/purple bruise.)

Stage 1 pressure ulcers may be more difficult to detect in people with darker skin pigments.

They may not show visible blanching, and may be more purple in colour.

The patient is at risk for further tissue damage if pressure causing a stage 1 pressure ulcer is not relieved.

(Slide titled “Stage 2 Pressure Ulcer.” Beneath title are descriptions that are read by the narrator. A photograph of a stage 2 ulcer shows a small, pink wound bed with red streaks and a yellow undertone. Drawing of the layers of tissue and fat of a stage 2 ulcer has an opening at the surface tissue and dark redness penetrating the surrounding surface tissue and fat layers.)

Stage 2 pressure ulcers present shallow open ulcers with red or pink wound bed. Slough (yellow or tan/brown dead tissue) may be present but does not obscure the depth of tissue loss.

(A photograph of a very red opening of the skin.)

Stage 2 pressure ulcers may also be present as intact blisters filled with fluid or blood, or ruptured blisters.

(Slide titled “Stage 3 Pressure Ulcer.” Beneath title are descriptions that are read by the narrator. A photograph of a stage 3 ulcer reveals a moist, red opening under a thick layer of tissue. A drawing of the layers of tissue and fat of a stage 3 ulcer has a huge opening wounding the surface tissue and fat layer beneath it, as well as the surface of the subcutaneous tissue.)

Stage 3 pressure ulcers involve full thickness tissue loss. Subcutaneous tissue may be visible, but bone, tendon or muscle are not exposed.

(A photograph of a pressure ulcer with deep red opening and yellow slough surrounding the wound.)

This wound may include undermining or sinus tracks, as well as slough or necrotic tissue. Undermining involves destruction of tissue beneath the intact skin of the wound perimeter. Tunnels or sinus tracks are channels that extend from any part of the wound into deeper tissue. The depth of a stage 3 pressure ulcer can vary greatly depending on the location and amount of surrounding subcutaneous tissue or fat in the area.

(Slide titled “Stage 4 Pressure Ulcer.” Beneath title are descriptions that are read by the narrator. A photograph of a stage 4 ulcer reveals a deep, moist, dark red and white/yellow opening. A drawing of the layers of tissue and fat of a stage 4 ulcer has a big hole tearing through the layers of tissue and fat, exposing the underlying bone.)

Stage 4 pressure ulcers involve full thickness tissue loss affecting skin and subcutaneous tissue, as well as underlying muscles, tendons, and bone.

Slough, eschar (scab), or necrosis (dead tissue), may be evident on the wound bed.

Undermining and tunneling are often present.

(Video of nurse checking a pressure ulcer's wound depth with a cotton-tipped probe.)

The depth of the wound can vary dramatically depending on the body location.

It is important to measure the depth of the wound, but it does not indicate stage.

Wound stage is always determined by the structures that are affected.

(A picture appears showing a part of a patient's head where hair is shaved to reveal a dark black, brown, and yellow wound under the skin surface.)

Anytime a wound bed cannot be visually assessed, it should be categorized as unstageable.

This can happen when slough or necrotic tissue is covering the wound.

(Another picture appears showing a dark wound under the skin resembling a dark purple bruise with a pink and red perimeter.)

A wound may also be unstageable because of a suspected deep tissue injury (SDTI).

SDTI may present as a localized purple area of intact skin or a blood-filled blister.

It also may be described as mushy, boggy, warmer or cooler than surrounding skin areas.

Suspected deep tissue injuries can deteriorate into a thin blister over a dark wound bed or a wound covered in thin eschar.

(Narrator reads slide titled "Other Signs of SDTI.")

Other signs of SDTI are tenderness or pain (if the patient has intact sensation), or increased spasticity.

(Video featuring a man with SCI transferring from a wheelchair to a bed.)

Suspected deep tissue injuries and unstageable pressure wounds may be caused by bumping a part of the body with low or absent sensation, during day-to-day activities.

Examples include feet contacting doors or walls, or hips hitting the tops of wheels during transfers.

Deterioration of a SDTI may be rapid (exposing additional layers of tissue even with optimal treatment), and may be difficult to detect in individuals with dark skin tones.

When using the staging system, do not report less severe stages as the pressure ulcer heals.

Once a certain amount of tissue damage occurs, the wound is always regarded at that severity.

For example, as a stage 4 pressure ulcer is resolving, report it as granulated, healed, or closed stage 4 pressure ulcer.

When the original stage of a pressure ulcer is unknown, it should be reported as evidence of a re-surfaced pressure ulcer of undetermined stage.

Accurate assessment, reassessment, and documentation of pressure ulcers is critical for monitoring healing, failure to heal, or deterioration of the wound.

(Camera scans over the Pressure Ulcer Stages chart which describes the different stages of pressure ulcers with definitions, graphics, and photographs.)

Effective communication regarding pressure ulcer staging and the use of accurate and universally recognized terminology and descriptors allows for common understanding among team members on the condition, progress and healing, and development of a complete and effective care plan.

(A copy of the Wound Assessment Parameters and Definitions sheet is shown on screen.)

Refer to the wound assessment parameters and definitions reference sheet available at www.scireproject.com for a glossary of current clinical wound terminology.

For more information, go to the National Pressure Ulcer Advisory Panel website at www.npuap.org

You can also see the BC patient safety and learning system: pressure ulcer stages sheet, available at www.scireproject.com.

The spinal cord injury specific guide to preventing and treating pressure sores is available online from the Ontario Neurotrauma Foundation.

(Words “Proudly Supported by” appear with the logos for Ontario Neurotrauma Foundation and Rick Hansen Institute below.)

(Previous screen fades and is replaced by the words “Thank You” followed by “Marvin Davidson, Colleen Riley, Shannon Handfield, Christine Kwong, Shannon Sproule, Jami Bennet, Matthew Querée” with the logo of the University of British Columbia on the bottom left corner and the logo of icord on the bottom right.)

(Words “Thank You to” appear, followed by the words “Saagar Walia, Dalton Wolfe, the wound care teams from the Spinal Cord Injury Knowledge Mobilization Network (SCI KMN).”)

(Words “Created by Merilin Paart at the Centre for Hip Health and Mobility’s Knowledge Mobilization Studio” appear with its logo and website at www.hiphealth.ca/KMS.)