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| Guidance for Categorising Deep Tissue Injury and Unstageable pressure damage |

**Deep Tissue Injury: Depth Unknown**

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 may

further evolve and become covered by thin eschar.

Evolution may be rapid exposing additional layers of

tissue even with optimal treatment.

**Things to consider: -**

* Know the difference between a bruise and deep tissue injury (a bruise with morph through several colour changes)
* Offloading the area is key to a positive outcome.
* If deep tissue injury breaks down treat like any other wound
* Wound formulary downloads guidance from TV website.
* Difference between blood blister caused by surface friction when it dries and peels off there is no underlying damage. Deep tissue injury (DTI) Blood blister breaks down underlying skin discolouration or erosion is present

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* Contact(email) Tissue viability if support is required

(EPUAP2014)

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| Unstageable Guidance |



Unstageable: Depth Unknown

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/Stage, 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.

EPUAP (2014)

**Things to consider: -**

**If you incident pressure ulcer as unstageable it will be classed as an IR incident requiring investigation.**

* Is clinical action needed to debride or not?
* Is the wound a palliative wound (not actively trying to heal but managing the symptoms)
* Circulation – is there good blood flow to the wound (do a lower leg assessment if required)
* Risk of bacteria load -local wound infection – sepsis (assess for symptoms AMBEL tool)

* General health of patient poor nutrition weight loss systemic infection will delay or stop healing.
* High blood sugars will prevent or delay healing.
* What does the patient want?
* If you do an episode of debridement and you clear sufficient dead tissue can you recategorise?
* If you are unsure email TV for support, we are happy to help.