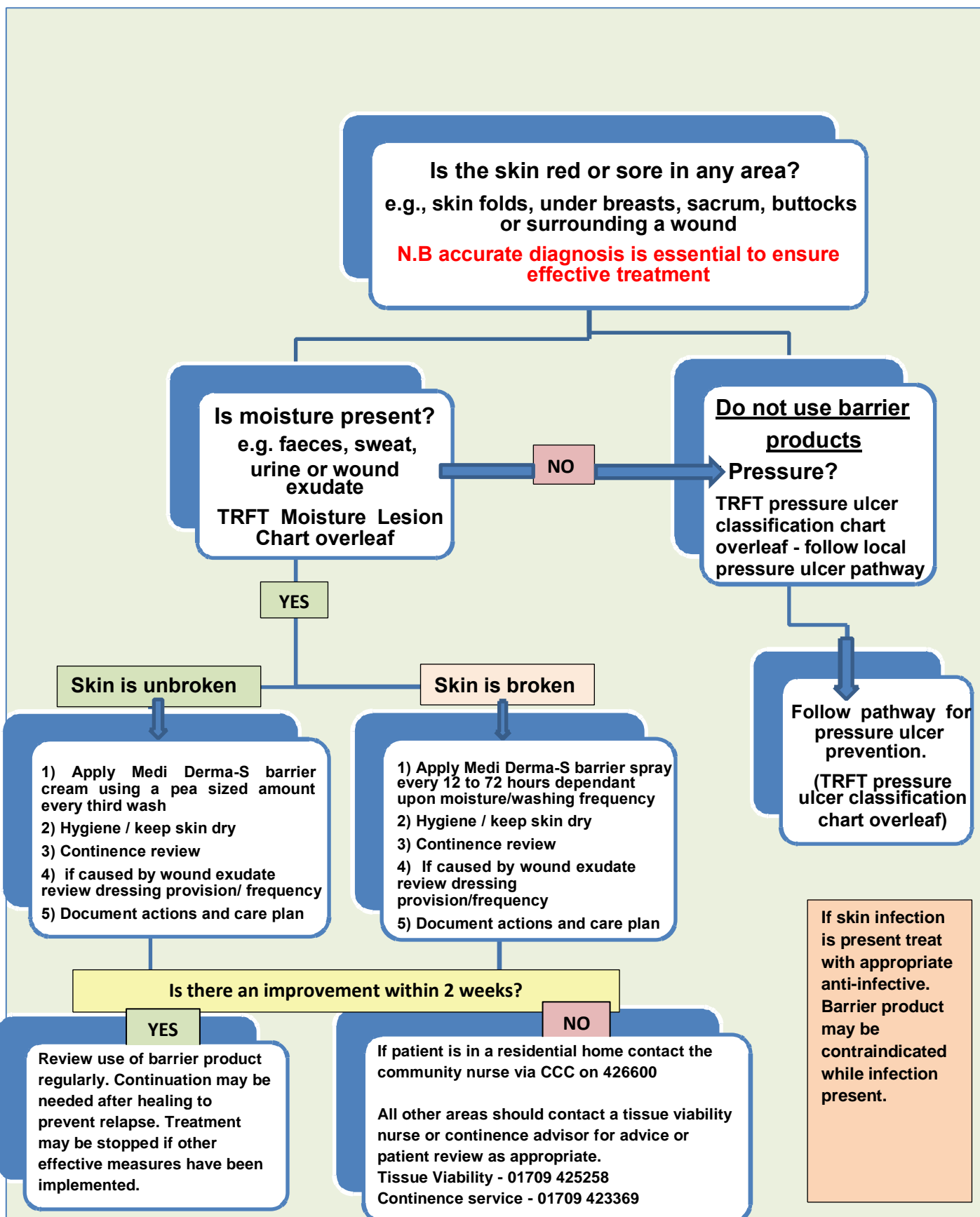


Moisture Damage Pathway



Moisture Lesion Chart



The Rotherham
NHS Foundation Trust

Cause Moisture must be present caused by urinary incontinence or diarrhoea, sweating or wound exudate

Location		<p>A moisture lesion is not usually over a bony prominence A combination of moisture and friction may cause moisture lesions in skin folds</p> <p>A lesion that is limited to the anal deft only and has a linear shape is not a pressure ulcer and is likely to be caused by moisture Perianal redness/skin irritation is most likely to be a moisture lesion due to faeces</p>
Shape		<p>Diffuse, different superficial spots are more likely to be moisture lesions</p> <p>In a kissing ulcer (copy lesion) at least one of the wounds is likely to be caused by moisture (urine, faeces, sweating or wound exudate)</p>
Depth		<p>Moisture lesions are superficial (partial thickness skin loss) In cases where the moisture lesion gets infected the depth and extent of the lesion can be enlarged/deepen extensively</p> <p>*There is no necrosis in a moisture lesion*</p>
Edges		<p>Moisture lesions have diffuse or irregular edges</p>
Colour		<p>Red skin not uniformly distributed</p> <p>Pink or white surrounding skin-maceration due to moisture</p> <p>If the skin is red and dry or red with a white sheen consider fungal infection or intertrigo - seek medical opinion</p>

If in doubt contact Tissue Viability Team for further advice on 8206 (hospital) or 01709 423258

Adapted from De Floor et al (2005)
Author : Lead Nurse Tissue Viability - Version 1 - September 2013
TRFT Graphic Design Service 01709 426352 / LGz z 10/18 Version 2

Pressure Ulcer Classification Chart

Superficial CATEGORY 1



- Intact skin with non-blanchable redness or a localized 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, warmer or cooler as compared to adjacent tissue
- Category 1 pressure ulcers may be difficult to detect in individuals with dark skin tones. May indicate "at risk" individuals (a heralding sign of risk-)

Superficial CATEGORY 2



- Partial thickness loss of dermis presenting as a shallow open ulcer with a pink wound bed without slough or "bruising"
- May also present as an open/ruptured serum filled blister
- This category should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation

*Bruising appearance and blood filled blister would indicate deep tissue injury

DEEP CATEGORY 3



- Full thickness skin loss. Subcutaneous fat may be visible but bone tendon and muscle are not exposed
- May include undermining and tunnelling
- The depth varies by anatomical location bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and can be shallow in contrast areas of significant adiposity can develop extremely deep category 3 pressure ulcers
- Bone / tendon is not visible or directly palpable

DEEP CATEGORY 4



- Full thickness tissue loss with exposed bone (or directly palpable, tendon)
- Often includes undermining or tunnelling
- The depth varies by anatomical location. The depth varies by anatomical location bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and category 4 ulcers can be shallow
- Category 4 pressure ulcers can extend into the muscle and/or supporting structures (e.g. fascia, tendon or joint capsule)

DEEP UNSTAGEABLE



- Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, grey, green, brown, black, eschar) in the wound bed.
- Until enough slough and/or eschar is removed to expose the base of the wound, the true depth can not be determined

Stable (dry, adherent, intact without erythema) eschar the heels serves as "the body's natural biological cover" and should not be removed

SUSPECTED 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 may further evolve and become covered by thin eschar
- Evolution may be rapid exposing different levels of tissue even with optimal treatment

**If in doubt contact Tissue Viability Team for further
advice on 8206 (hospital) or 01709 423258**

Adapted from EPUAP/NPUAP/PIA 2014 Author : Lead Nurse Tissue Viability
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