Best Practice Guidance for Safeguarding Individuals with Pressure Ulceration

In partnership with the Safeguarding with Providers Group, a sub group of the Lancashire Safeguarding Adults Board

lancashire safeguarding adults board

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Executive Summary

This guidance has been designed to support practitioners, care providers and social care teams to provide assistance when there is concern about pressure ulceration and when this becomes a safeguarding matter.

Safeguarding relates to the need to protect individuals who may be in vulnerable circumstances. These are adults in need of care and support who may be at risk of abuse or neglect, due to the actions (or lack of action) of another person. In these cases, it is essential that local services work together to identify people at risk, and put in place interventions to help prevent abuse or neglect.

The Care Act 2014 requires agencies to work together to develop shared strategies for safeguarding adults. All health, social care professionals and care workers play a key role in safeguarding. It is everybody's responsibility to protect adults from abuse, harm and omissions of care.

This best practice tool will provide guidance for practitioners, when there is concern that pressure ulceration may have resulted from poor practice or neglect. Early reporting is essential to ensure appropriate corrective action is taken and to prevent the reoccurrence of pressure ulceration and further harm. The tool will standardise practice across services in relation to the safeguarding response in individuals where there is pressure ulceration. It will support a consistent approach to the evaluation of incidents involving pressure ulceration. It will also support health, social care professionals and care staff in decision making and in the identification of harm when an omission of care has taken place, or where there has been a failure to undertake the required holistic assessment and risk assessments of an individual's care and treatment needs.

Principles of Good Practice

All commissioners and providers of services working with adults have a responsibility to safeguard individuals from the risk of abuse or neglect and promote health and wellbeing. This includes the prevention and management of pressure ulcers.

- Care and support needs must be addressed by enabling patients to access appropriate services wherever possible in respect to promotion of tissue viability and associated risk factors.
- Additional support needs must be met by the timely provision of specialist assessments /risk assessments where required.
- Agency responses must be needs-led, with focus on the principles outlined in the Mental Capacity Act 2005 and the Human Rights Act 1998.
- Equality and diversity promotes equal opportunity for all, by giving individuals the chance to achieve their full potential free from prejudice and

discrimination. Equality and Diversity must be valued and fully considered in all agency responses.

Legislation and Guidance

The Care Act 2014 sets out a clear legal framework which requires agencies to have appropriate safeguarding arrangements in place. Safeguarding duties apply to an adult who:

- Has needs for care and support (whether or not the local authority is meeting any of those needs)
- Is experiencing, or at risk of, abuse or neglect
- As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect

Safety from harm and exploitation is one of our most basic needs. “Safeguarding” refers to a range of activity aimed at upholding an adult’s fundamental right to be safe. It is of particular importance for people who, because of their situation or circumstances, are unable to keep themselves safe.

Healthcare incidents which raise safeguarding concerns must be reported via internal incident reporting systems alongside making a local authority safeguarding alert where appropriate. Healthcare professional’s contribution to this process is invaluable in the identification of best practice and provision of on-going care and treatment.

All provider organisations have a responsibility to develop local robust arrangements to ensure that adult safeguarding becomes fully integrated into provider systems. This will result in greater openness and transparency about clinical incidents, learning from safeguarding concerns that occur within services and better clarity on reporting with more improved positive partnership working.

Safeguarding adults is shaped by 6 principles (DH 2011)

Principle 1: Empowerment	Presumption of person led decisions and consent
Principle 2: Protection	Support and representation for those in greatest need
Principle 3: Prevention	Prevention of harm and abuse is a primary objective
Principle 4: Proportionality	Proportionality and least intrusive response appropriate to the risk presented
Principle 5: Partnerships	Local solutions through services working with communities

Principle 6: Accountability	Accountability and transparency in delivering safeguarding

The Care Act 2014 defines wellbeing in relation to an individual to any of the following:

(a) Personal dignity (including treatment of the individual with respect);

(b) Physical and mental health and emotional well-being;

(c) Protection from abuse and neglect;

(d) Control by the individual over day-to-day life (including care and support, or support, provided to the individual and the way in which it is provided);

(e) Participation in work, education, training or recreation;

(f) Social and economic well-being;

(g) Domestic, family and personal relationships;

The Care Act also defines ten categories of abuse. For the purpose of this tool the following are applicable for individuals at risk of pressure ulcers.

Physical abuse – including assault, hitting, slapping, pushing, misuse of medication restraint or inappropriate physical sanctions

Organisational abuse – including neglect and poor care practice within an organisation or specific care setting like a hospital or care home. This may range from isolated incidents to continuing ill-treatment.

Neglect and acts of omission – including ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating.

Self-neglect – this covers a wide range of behaviour such as neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding.

Psychological abuse –including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber bullying, isolation or unreasonable and unjustified withdrawal of services or supportive networks.

Discriminatory abuse – including forms of harassment, slurs or similar treatment; because of race, gender and gender identity, age, disability, sexual orientation or religion.

The Mental Capacity Act 2005 introduces two criminal offences of ill treatment and wilful neglect of a person who lacks capacity to make relevant decisions (section 44). The offences can apply to anyone caring for a person lacking capacity; this can include family members, carers, health/social care staff, an attorney appointed under lasting power of attorney, enduring power of attorney, or a court appointed deputy. It is important that all practitioners pay regard to the Act in supporting adults to make decisions or applying the best interest process where adults are not able to consent to their care or treatment.

Wilful neglect can be an intentional, deliberate, reckless act or omission or failure to carry out an act of care by someone who has care of an individual who lacks or where there is reasonable belief of a lack of capacity to care for themselves. The penalty for ill treatment or wilful neglect can range from a fine or a prison sentence for up to 5 years.

The Criminal Justice and Courts Act 2015 create two new criminal offences of ill-treatment or wilful neglect applying to individual care workers and care provider organisations.

Section 20 of the Act makes it an offence for an individual to ill-treat or wilfully neglect another individual of whom he has the care by virtue of being a care worker. A “care worker” is defined as anyone who, as paid work, provides social care for adults or health care for children or adults. The ‘wilful’ element of the neglect offence means that the perpetrator has acted deliberately or recklessly. Similarly, ‘ill-treatment’ is a deliberate act, where the individual recognised that he was inexcusably ill-treating a person, or else was being reckless as to whether he was doing so. Genuine errors or accidents by an individual would therefore not be caught within the scope of this offence. The offence carries a maximum penalty of imprisonment of up to 5 years and/or a fine.

Pressure Ulceration

Pressure ulcers affect around 700,000 people in the UK every year and many of these will develop whilst an individual is being cared for in a formal care setting (hospital, nursing home or care home). The reality is that many pressure ulcers are avoidable if simple knowledge is provided and preventative best practice is followed. Pressure ulcers remain a concerning and mainly avoidable harm associated with healthcare delivery. In the NHS in England, 24,674 patients were reported to have developed a new pressure ulcer between April 2015 and March 2016. Treating pressure damage costs the NHS more than £3.8 million every day. The national stop the pressure programme led by NHS Improvement has developed recommendations for trusts in England. These support a consistent approach to defining, measuring and reporting pressure ulcers.

Definition

A pressure ulcer should be defined as: “localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or other device), resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open ulcer and may be painful”.

A pressure ulcer that has developed due to the presence of a medical device should be referred to as a ‘medical device related pressure ulcer’. Pressure ulcers that have developed at end of life due to skin failure should be classified in the same way as all pressure ulcers, and not be given a separate category.

The definition of a new pressure ulcer within a setting is that it is first observed within the current episode of care. Where skin damage is caused by a combination of Moisture associated skin damage and pressure, it will be reported based on the category of pressure damage.

Guidance

The Department of Health and Social Care’s definition of avoidable / unavoidable should no longer be used. Ceasing use of these terms will lead to all incidents being investigated to support organisational / system learning and appropriate actions; to move from focusing on ‘proving’ if an incident was unavoidable to using a range of definitions in practice. This is consistent with other categories of patient safety incidents. All incidents will need to be investigated, resulting in more pressure ulcers being recorded / reported by individual providers. There is likely to be an impact on local NHS contracts, as the existing approach is embedded in them.

Organisations should follow the current system recommended in the “international guidelines, NNPUAP/EPUAP/PPPIA (2014)” incorporating categories 1,2,3,4, to ensure there is minimal change to current practice with the view to standardising practice.

React to Red Skin is a campaign across health and social care that trains carers to recognise people at risk and to take steps to prevent pressure ulcers developing.

Safeguarding adults Protocol Pressure ulcers and the interface with a safeguarding enquiry makes reference to six key questions which should be considered to inform decision making in respect to escalation to safeguarding concerns due to pressure damage.

1. Has the patient or service user's skin deteriorated to either category 3 / 4 / unstageable or multiple sites of category 2 ulceration from healthy unbroken skin since the last opportunity to assess/visit?
2. Has there been a recent change in their clinical condition that could have contributed to skin damage? E.g. infection, pyrexia, anaemia, end of life care (Skin Changes at Life End), critical illness?
3. Was there a pressure ulcer risk assessment and reassessment with an appropriate pressure ulcer care plan in place and was this documented in line with the organisation's policy and guidance?
4. Is there a concern that the pressure ulcer developed as a result of the informal carer ignoring or preventing access to care or services?
5. Is the level of damage to skin inconsistent with the service user's risk status for pressure ulcer development? E.g. low risk –category 3 or 4 pressure ulcer?
6. If the individual has capacity to consent to every element of the care plan – Was the individual able to implement the care plan having received clear information regarding the risks of not doing so?
If the individual has been assessed as not having mental capacity to consent to any or some of the care plan - Was appropriate care undertaken in the individual's best interests, following the best interests checklist in the Mental Capacity Act Code of Practice (supported by documentation, e.g. capacity and best interest statements and record of care delivered)?

- Is there evidence that the person, or their representative, was involved with the care and support planning, and did they consent to the care plan?
- Is there evidence that this involvement was reviewed if care needs changed, and the current care plan would meet the needs of the person?
- Is there evidence that if the person was not consenting to the care plan that other remedial actions were considered to mitigate risk of harm?
- If at the point of the care plan being put in place it was identified that the person lacked capacity to consent to it, was the care plan lawfully put in place in their best interests?

Photographic evidence to support the report should be provided wherever possible. Consent for this should be sought as per local policy but sensitivity and care must be taken to protect the individual.

Body maps must be used to record skin damage and can be used as evidence if necessary at a later date. If two workers observed the skin damage they should both sign a body map.

Where there is a concern that pressure ulceration has occurred, the practitioner in discussion with the individual and or family should refer the individual on to appropriate healthcare services.

If there is evidence of poor care and or neglect the provider is to report this as a safeguarding adult alert into Lancashire County Council Customer Access Service on 0300 123 6721 and to the Care Quality Commission. Where there are identified risk factors for other individuals associated with pressure ulcer development, then individual holistic health needs assessment must be undertaken where appropriate or a referral made to the relevant healthcare professional.

Further information can be found in the Lancashire Safeguarding Adult Board 'Guidance for Safeguarding Concerns'. The document can be found here

Principles of Prevention:

aSSKINg together to **STOP the Pressure**

1. **Risk assessment**

Complete waterlow score within 6 hours, then weekly or if condition changes. Develop a Patient specific Pressure Ulcer Prevention Care Plan.

2. **Skin inspection**

Complete twice daily assessment under and around devices (more often if oedematous).

3. **Support Surface** [skin-device interface]

Ensure correct sizing & appropriate fitting, following the device's instructions. Secure devices to prevent dislodgement without creating additional pressure. Protect skin-device interface and provide support [e.g., ventilator tubing, etc.]. Consider using prophylactic dressings in high risk areas [e.g., DuoDERM® on the bridge of the nose for non-invasive ventilation masks].

4. **Keep your patient moving**

Loosen/check/reposition devices at least 2 hourly [early removal] Caution: ensure depth of NGTs & EETs does not change. Avoid placement of devices under the patient or over previously injured sites. Reposition patients 2 hourly [Get dressed - Get moving! #**endPJparalysis**].

More frequent small shifts in position, special care moving patients in the prone position. Sit out for no longer than 2 hours at a time: less, if a faecal management system is in situ.

5. Incontinence & moisture [and oedema]

Keep skin clean, dry and protected from moisture, adhesive trauma and friction by applying a protective barrier [e.g. Cavilon no sting barrier film]. Elevate dependant body parts [to prevent oedema].

6. Identify category

Classify MDRPUs using the NPUAP, EPUAP, PPPIA System [seek advice when classifying mucosal membrane pressure ulcers; consider suspected deep tissue injury, incontinence associated dermatitis [moisture lesion] & skin changes at life's end]. Remember duty of candour - be open and honest.

7. Initiate treatment

Follow your individual organisation's Tissue Viability wound management guidelines and initiate a Patient specific Pressure Ulcer Care Plan.

8. Nutrition & hydration

Meet patient's nutritional requirements [calories, protein, management of blood glucose, vitamins, fluid intake and consider Dietitian review as appropriate].

9. Give information & share learning

Follow your individual organisation's policy on pressure ulcer prevention and use a collaborative multidisciplinary approach, get help and advice early and keep clear records.

Best Practice Indicators for Care and Treatment of Individuals at Risk of Pressure Ulcer Development or Skin Damage

- Interventions must be in place to support in educating patients, staff and carers regarding pressure ulcer prevention and skin damage. Seek advice where appropriate
- Individuals must be supported to be involved in their care and treatment.
- Within healthcare settings a holistic health needs assessment must be carried out
- A pressure ulcer risk assessment must be completed and reassessed accordingly as the individual's condition changes
- All documentation must reflect the individual's holistic health and social care needs; it must demonstrate implementation of care plans, risk assessments, equipment provision and referral to appropriate specialist teams / agencies

- The care plans must be regularly reviewed according to changing needs and risk assessments re-evaluated and must incorporate the principles of prevention (aSSKINg) listed above
- Pressure ulcer assessment must be documented using the NNPUAP/EPUAP/PPPIA (2014)" classification system. (appendix 1)
- Advice has been sought from the appropriate practitioner e.g. Nurse/Tissue Viability Nurse/GP for care of patients with complex wounds and complex pressure ulcers at category 3 and 4 or where an individual has multiple category 2 pressure ulcers
- The cause of the pressure ulcer must be identified e.g. seating, footstools, mattress, positioning etc. and appropriate actions implemented to reduce damage and encourage healing
- For patients non-concordant with the plan of care, e.g. where the individual refuses to adhere to prevention strategies in spite of education of the consequences of non-adherence", or due to lack of capacity to understand risks and consequences of not complying with agreed nursing/medical interventions, then a plan to reduce risk must be in place and reviewed regularly

Mental Capacity Act Implementation

- Have the principles of the Mental Capacity Act 2005 been followed and capacity assumed unless proven otherwise?
- Does the individual have mental capacity to consent to their care and treatment plan?
- Is there a reason to doubt the individual's capacity for decision specific care and treatment, if so then mental capacity assessment must be completed and documented?
- If the individual is found to lack capacity on the decision specific care and treatment need, then best interest process must be initiated with appropriate consultation with professionals/ family and IMCA where appropriate
- Have best interest processes been followed, in line with the Mental Capacity Act requirements?

Points for consideration for the identification of safeguarding concerns where individuals have developed pressure ulcers or skin damage

- Is the care plan appropriate to meet the individual's needs? **If not this could be an omission of care**
- Have risk assessments been reviewed to reflect changing needs? **If not this could be an omission of care / lapse in treatment**

- Has the individual been offered referral on to appropriate health agencies as their health needs indicate? **If not this could be an omission of care / lapse in treatment**
- Has the individual been referred to their GP/Practice Nurse/Community Nurse/Tissue Viability Specialist? **If not this could be an omission of care / lapse in treatment**
- Is practice in line with the Mental Capacity Act requirements? **If not this could be an omission of care / lapse in treatment**
- If there are concerns regarding self-neglect please refer to the LSAB self-neglect framework

Examples of when a safeguarding alert should be made

- Where the individual lacks capacity for care and treatment for pressure ulcer management and have developed preventable pressure ulcers due to a lapse in care at category 3 and or 4, then refer to the LSAB safeguarding policy
- 'When raising a Safeguarding alert, where there is a lapse in care the alerter must provide as much detail as possible using the checklist within the 'Guidance for Safeguarding Concerns' The alerter must ensure that the individual has had access to appropriate nursing/medical intervention. A decision will be made on a case by case basis as to whether this meets the threshold for a safeguarding enquiry
- Where there is indication that there have been omissions of care , due to care plans not reflecting individual needs, which result in pressure ulcer development of category 3 and above, then a safeguarding alert must be made to Lancashire County Council Customer access service on 0300 123 6721
- Organisations with a NHS contract must report all category 3 and 4 pressure ulcers as Serious Incidents (SI). Some pressure ulcers will meet the definition of a SI, some pressure ulcers categorised at 3 and 4 may not meet the threshold of a safeguarding enquiry. Classifying all category 3 and 4 pressure ulcers as safeguarding incidents may lead to a 'burden' of investigation, that makes it difficult to move forward quickly and implement learning

Consideration of possible safeguarding alerts

- Consideration must be given to individual circumstances on a case by case approach to consider lapse in care or treatment, as the category of a pressure ulcer does not always indicate the severity of the wound. For example, an infected category 2 pressure ulcer may lead to septicaemia and death whereas a small category 3 pressure ulcer on the ear (designated as category

3 because cartilage will be exposed with loss of overlying skin) may not have serious consequences for the individual

- Consider as to whether there is a pattern, theme or trend identified which requires further enquiry into clinical practice issues
- Consideration must be given to the development of skin damage which is part of a pattern and or where there have been similar incidents involving the individual or others

Responsibilities of Commissioners

Commissioners have responsibility to:

- Ensure that all services which they commission meet nationally identified quality standards which are managed through the contracting and quality process
- To monitor and seek assurance that providers are learning from incidents and actively minimising the risk of them happening again
- Ensure that high quality services are commissioned with a focus on safeguarding adults
- Safeguard adults as required by professional regulators, service regulators and supported in law
- Identify and manage safeguarding concerns appropriately
- Support provider organisations to contribute to the safeguarding process
- Seek assurance that services understand their safeguarding activity to enable accountability and ownership of learning and improvement

Responsibilities of Providers

All provider services must ensure that:

- Safeguarding adults is an integral part of patient care
- Safeguarding concerns are identified, reported and managed appropriately
- Practitioners are supported by their organisations to contribute to the safeguarding process
- They understand safeguarding activity and lessons learnt, to enable accountability and ownership of learning and improvement
- Individuals are consulted regarding the safeguarding process in line with the principles of Making Safeguarding Personal (2018)
- Individual's wishes feelings and beliefs are recorded
- Information is shared with consent where appropriate, where possible, respecting the wishes of those who do not consent to share confidential information. Information must be shared without consent if, it is judged that

lack of consent can be overridden in the public interest, due to a lapse in care or treatment

- As part of the registration requirements arising from the Health and Social Care Act 2012, provider organisations are required to notify the Care Quality Commission (CQC) about events that indicate or may indicate risks to on-going compliance
- The registered person of the service provider is required to notify the CQC without delay of incidents which occur whilst services are being provided in the carrying out of a regulated activity. These include, **any abuse or allegation of abuse in relation to a service user; any incident which is reported to, or investigated by, the police; and any injuries to the service user**

Responsibilities of Care Quality Commission

- The CQC key lines of enquiry inspection (KLOE) methodology requires services to demonstrate that they are safe, effective, caring, responsive and well led
- Arrangements must be in place for continually reviewing safeguarding concerns, incidents and pressure ulcers to ensure themes are identified and any necessary action is taken
- Information regarding concerns received about the quality of care must be investigated thoroughly and services must be able to demonstrate the difference that this has made to how care support and treatment is delivered
- One of the KLOE is about how lessons are learned to prevent future incidents of a similar nature
- CQC registration requirements include the submission of relevant notifications and that any other legal obligations are met

Individuals who use health and social care services must be confident that important events that affect their welfare, health and safety are reported to the Care Quality Commission so that, where needed, action can be taken

Organisational Responsibilities of providers on an NHS Standard Contract

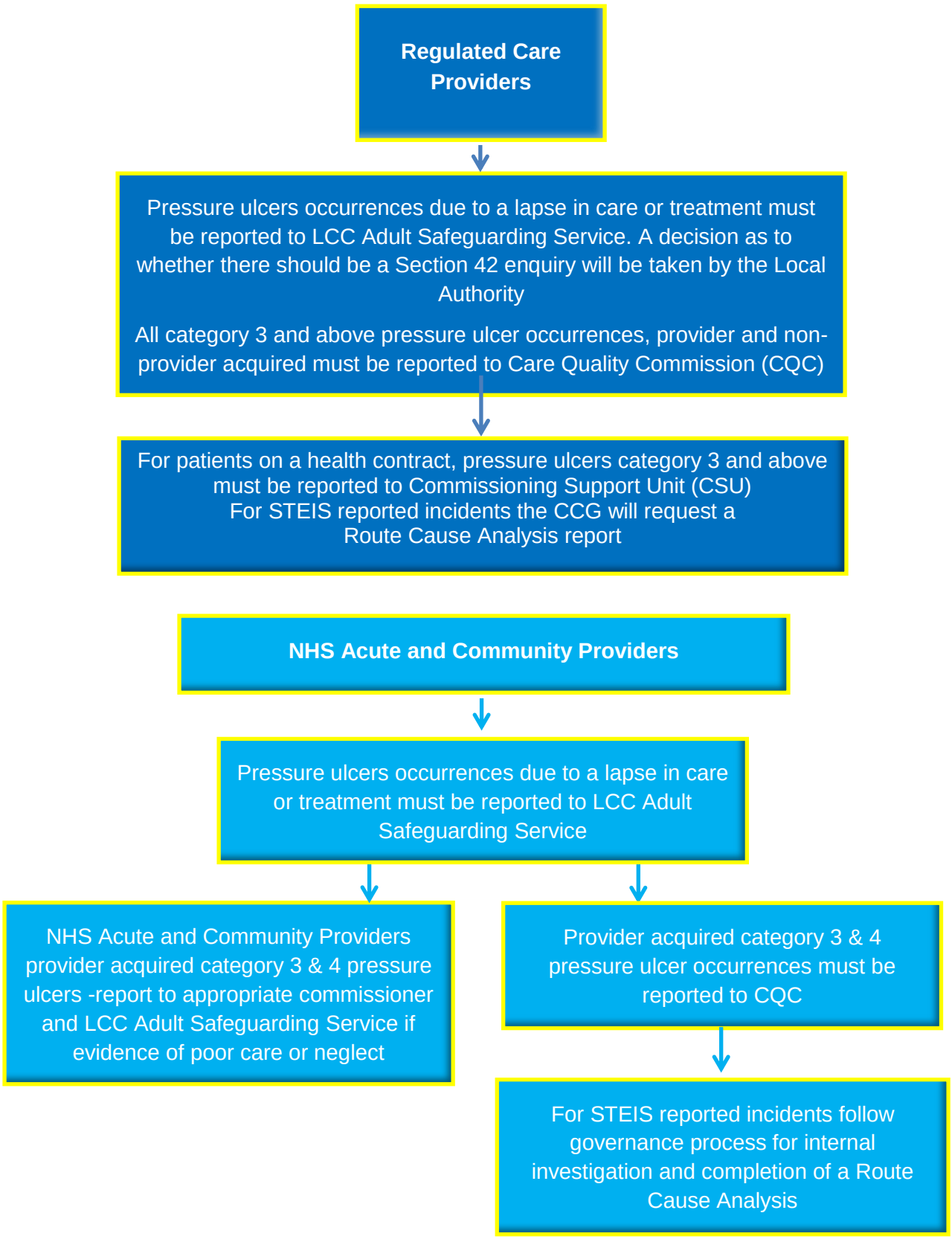
The National Framework for Reporting and learning from serious incidents requiring investigation provides guidelines to ensure that all incidents are reported to the relevant bodies to ensure full investigation (including independent investigations) and learning from significant events. Category 3 / 4 pressure ulceration is considered as a serious incident and must be reported to ensure a full investigation and lessons learnt. For further information please refer to the Commissioning Support Unit

Guidance for the reporting of patient safety incidents in Care Homes and Independent Sector Mental Health Providers.

Prevention and Treatment of pressure ulcers (NICE, 2014 updated 2018) provides guidance for the use of all health professionals, regardless of clinical discipline, who are involved in the care of individuals who are at risk of developing pressure ulcers, or those with an existing pressure ulcer. The guidance is intended to apply to all clinical settings, including hospitals, rehabilitation care, long term care, assisted living at home, and unless specifically stated, can be considered appropriate for all individuals, regardless of their diagnosis or other health care needs. Additional support for care and treatment and classification of pressure ulcers category 1-4 can be found here.

Organisations must also refer to their individual policies and procedures.

Reporting Process Map for Pressure Ulcers



Appendix 1

Pressure Ulcer Advisory Guidelines.

Information below has been taken from the Prevention and Treatment of Pressure Ulcers: Quick Reference Guide 2014

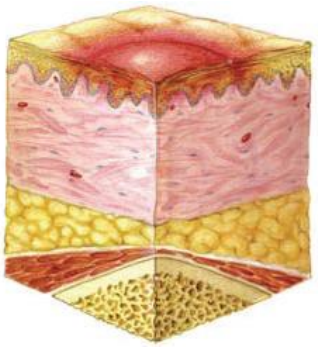
International NPUAP/EPUAP Pressure Ulcer Classification System

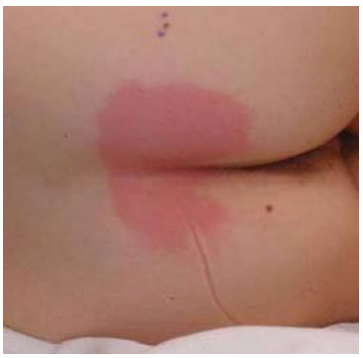
A pressure ulcer is localised injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated.

Category I: Non- Blanchable Erythema

Intact skin with non-blanchable redness of 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, soft, warmer or cooler as compared to adjacent tissue. Category/Stage I may be difficult to detect in individuals with dark skin tones. May indicate “at risk” individuals (a heralding sign of risk).

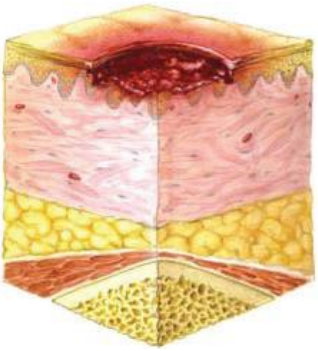


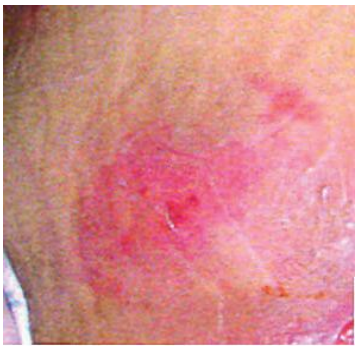


Category II: Partial Thickness Skin Loss

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 must not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.



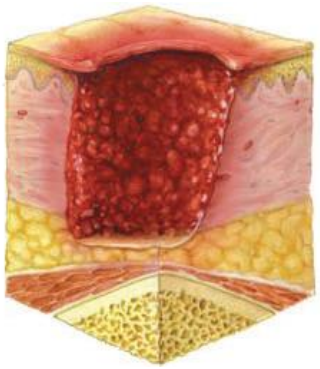


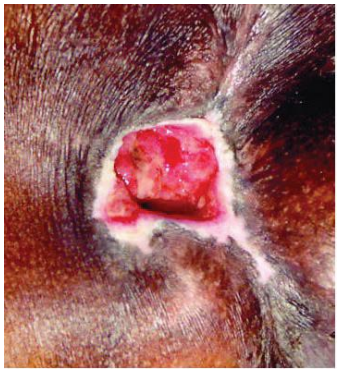
**Bruising indicates suspected deep tissue injury.*

Category III: Full Thickness Skin Loss

Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is 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 deeply in Category III pressure ulcers. Bone/tendon is not visible or directly palpable.

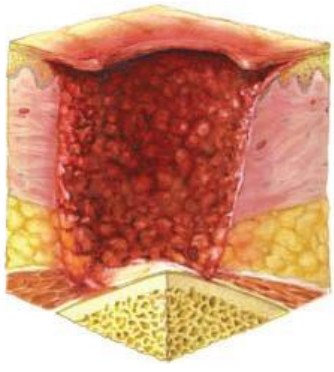




Category IV: Full Thickness Tissue Loss

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.

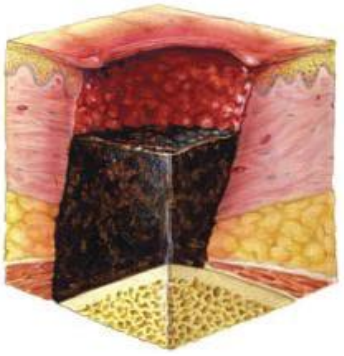
The depth of a Category IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category/Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible

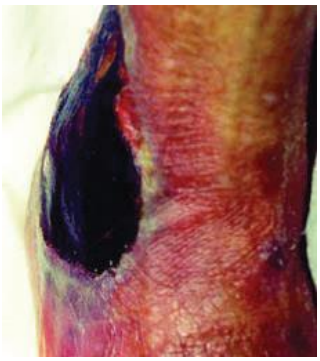


or directly palpable.

Unstageable: Depth Unknown

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.

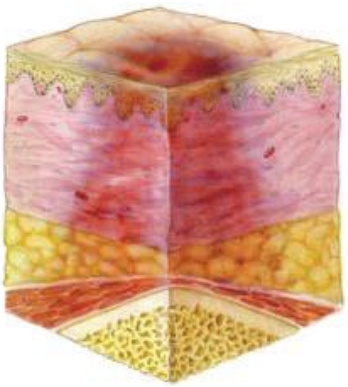


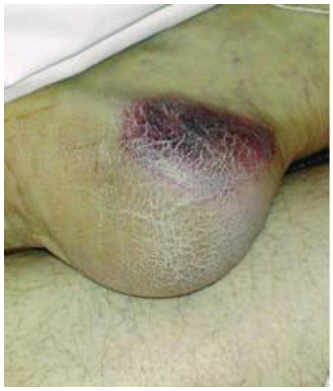


Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed.

Suspected 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.

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