Appendix B: Skin Assessment

The word "*comprehensive*" is added in the first paragraph to emphasize that skin inspection should be based on a comprehensive head-to-toe assessment.

The following bullet point is added to the list of typical vulnerable areas to assess.

- Parts of the body in contact with devices, such as taping, restraint, tubes,etc.

Appendix C:

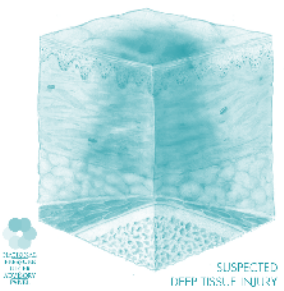
Additional tools for assessment of pressure ulcer risks are added.

Tools	Site
Modified Braden Q Scale (for Pediatrics)	http://nursing.advanceweb.com/SharedResources/Downloads/2007/090107/NW/nng090107_p55table1.pdf
Norton Pressure Sore Risk Assessment Scale Scoring System	www.rd411.com/wrc/pdf/w0513_norton_presure_sore_risk_assessment_scale_scoring_system.pdf
SCALE for End of Life	http://woundpedia.com/pdf/SCALEAbstractPanelMembersStatements.pdf
Spinal Cord Injury Pressure Ulcer Scale (SCIPUS)	www.scireproject.com/outcome-measures/spinal-cord-injury-pressure-ulcer-scale-scipus-measure
Waterlow Pressure Ulcer Risk Assessment Chart	www.judy-waterlow.co.uk/

Appendix E: International NPUAP-EPUAP Pressure Ulcer Classification System

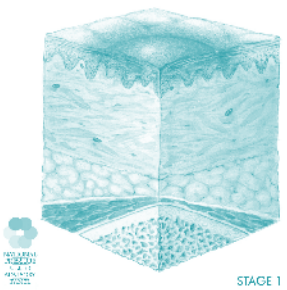
Appendix E: Staging of Pressure Ulcers on page 64 of the 2005 guideline is replaced by the following information. Note the change in the title of the appendix. Used with permission of the National Pressure Ulcer Advisory Panel & July 5, 2011.

Suspected Deep Tissue Injury: Purple or maroon localized area of discolored 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.

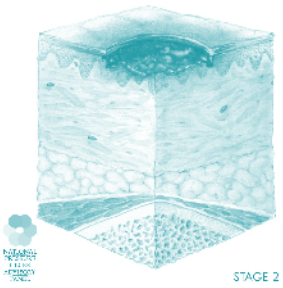
Category/ Stage I: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.



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" persons (a heralding sign of risk).

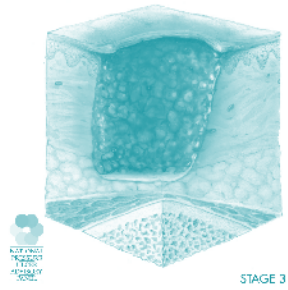
Category/Stage II: Partial thickness, loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.

Presents as a shiny or dry shallow ulcer without slough or bruising (bruising indicates suspected deep injury). This Category/Stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.



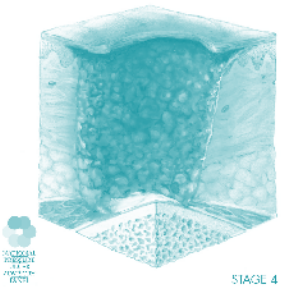
Category/Stage III: Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

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



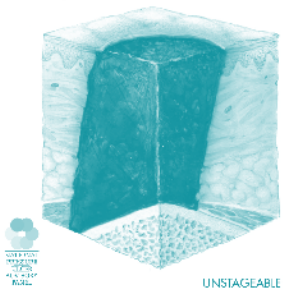
Category/Stage IV: Full thickness skin loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.

The depth of a Category/Stage 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, 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 determines. 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.



Appendix F: Force Management

Appendix F - Pressure Reduction and Pressure Relief on pg. 65 of the 2005 guideline is replaced by the following information. Note the change in the title of the appendix.

Decreasing peak points of pressure over the skin has been associated with a decreased risk of pressure ulcer development (Brienza et al., 2001). For this reason, it is important to consider the pressure between the client's skin and the surface upon which they are sitting or lying. Many devices are available to help manage pressure. Pressure is not the only force that contributes to pressure ulcer development; friction and shear also play a factor. To manage these forces caregivers require a solid understanding of these forces.

Pressure is defined as "the force per unit area exerted perpendicular to the plane of interest" (NPUAP, 2007, p. 127). To experience pressure, try this activity: