

PRESSURE ULCER TERMINOLOGY: GLOSSARY OF USEFUL WOUND CARE TERMS

Alternating Pressure Mattress	An alternating pressure mattress uses pumps to push air through the mattress in alternating cycles. These mattresses relieve high pressure throughout the body, especially in areas most prone to developing pressure ulcers.
Antibiotics	Antibiotics are drugs used to treat bacterial infections. Antibiotics work by destroying or preventing the spread of bacteria.
Bed Sore	The term 'bed sore' is often used interchangeably with 'pressure ulcer' (see Pressure Ulcer).
Blanchable Erythema	Blanchable erythema is when redness in the skin, often caused by inflammation, turns white when pressure is applied with a finger. The affected area will turn red again when the pressure is removed.
Braden Scale	The Braden Scale is a tool used to assess a patient's risk of developing a pressure ulcer.
Cellulitis	A bacterial infection underneath the skin. Symptoms include swelling, pain, warmth, and severe redness. Cellulitis normally affects the lower legs, but it can also occur on the face and arms where there is a break in the skin.
Debridement	Debridement is the removal of necrotic (dead) or infected skin from the wound bed. Debridement promotes better wound healing by reducing the bacterial burden within the wound, thereby decreasing the risk of infection, malodour, and discomfort.
Dermis	The dermis is the middle layer of the skin, located between the epidermis and the hypodermis. The dermis is the skin's thickest layer, composed of fibrous and elastic tissue.

Diascopy	<p>A diascopy is a non-invasive test for blanchability carried out by applying pressure with a finger to observe any changes in the colour of the skin.</p> <p>A diascopy is used to identify whether erythema is caused by inflammation within the body's superficial vessels or due to haemorrhage.</p>
Epidermis	<p>The epidermis is the outermost of the three main layers that comprise the skin.</p>
Erythema	<p>Redness in the skin caused by inflammation.</p>
Exudate	<p>A fluid that oozes out of cuts, areas of infection, and inflammation. Exudate is made up of water, electrolytes, proteins, enzymes, and nutrients. It is sometimes called pus.</p>
Grade 1 Pressure Ulcer	<p>A Grade 1 pressure ulcer is when the skin is not broken, but requires monitoring and care. The skin appears reddened, even when no pressure has been applied. The skin will usually feel warmer and harder than the surrounding skin, as well as more sensitive to pain.</p>
Grade 2 Pressure Ulcer	<p>A Grade 2 pressure ulcer involves partial-thickness skin loss. This means the top layers of the skin are damaged. The skin may resemble a superficial blister or abrasion.</p>
Grade 3 Pressure Ulcer	<p>A Grade 3 pressure ulcer is defined as full-thickness skin loss. This is because all the skin's layers are damaged, and the wound extends into the subcutaneous tissue. The wound may be covered in slough (dead skin and pus) and there may be the presence of necrotic tissue (dead skin).</p>
Grade 4 Pressure Ulcer	<p>A Grade 4 pressure ulcer occurs when the wound and surrounding skin have sustained extensive damage, with much of it becoming necrotic. The muscles, tendons, and bones may also have significant damage. The wound is usually either covered in slough or has begun to scab.</p>

Hydrocolloids	Hydrocolloid dressings contain a gel that helps to create an optimal wound healing environment by protecting the periwound and promoting the growth of new cells. Hydrocolloids are primarily used to treat Grade 2 and 4 pressure ulcers.
Infection	A reaction caused by microorganisms such as bacteria or viruses invading the body.
Maceration	Maceration is the softening and breaking down of the skin because of prolonged exposure to moisture.
Necrotic Tissue	Necrotic tissue is dead tissue, usually located in or around the wound bed. Necrotic tissue cannot resume normal cellular function again even if blood flow is increased to the area.
Non-blanchable Erythema	Non-blanchable erythema is when any redness in the skin, often caused by inflammation, does not turn white when pressure is applied with a finger.
Oedema	Oedema is an accumulation of fluid in the tissues of the body. The swelling usually occurs in one part of the body at a time (i.e., the legs or ankles). However, it can be distributed more evenly around the body, depending on the cause.
Partial-thickness Skin Loss	Partial-thickness skin loss occurs when the damage in the wound bed does not extend below the dermal layer.
Full-thickness Skin Loss	Full-thickness skin loss occurs when the damage in the wound bed involves the total loss of the epidermal and dermal layers. It sometimes extends to the subcutaneous layer and sometimes even into the muscle and bone.
Pressure	Pressure is when force is applied to the surface of the skin. The pressure compresses the tissues and can even cause damage at a subcutaneous level. Damage to the soft tissues is usually greater when pressure is applied over a bony part of the body.

Pressure Sore	The term 'pressure sore' is often used interchangeably with 'bed sore' and 'pressure ulcer' (see Pressure Ulcer).
Pressure Ulcer	The term 'pressure sore' is often used interchangeably with 'bed sore' and 'pressure ulcer' (see Pressure Ulcer).
Periwound	The area immediately surrounding the wound bed is known as the periwound.
Slough	<p>This is regarded as a by-product of wound inflammation. Slough is usually a pale yellow or off-white colour and is made up of dead skin, protein, fibrin, leucocytes, and microorganisms.</p> <p>Slough prolongs the wound's inflammatory response, increases the risk of infection by attracting bacteria and can lead to malodour.</p>
SSKIN Framework	<p>The SSKIN Framework is a five step model for the prevention of pressure ulcers. SSKIN is an acronym for:</p> <p>Surface: make sure patients have adequate support. Skin inspection: early inspection equals early detection. Keeep patients moving. Incontinence/moisture: patients should be clean and dry. Nutrition/hydration: maintain a healthy diet and adequate hydration.</p>

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