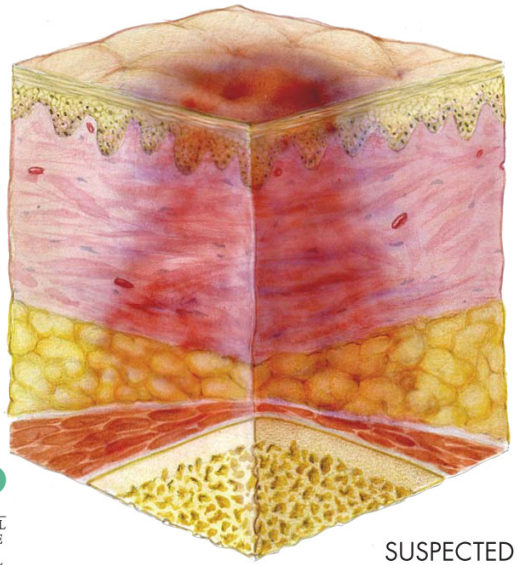
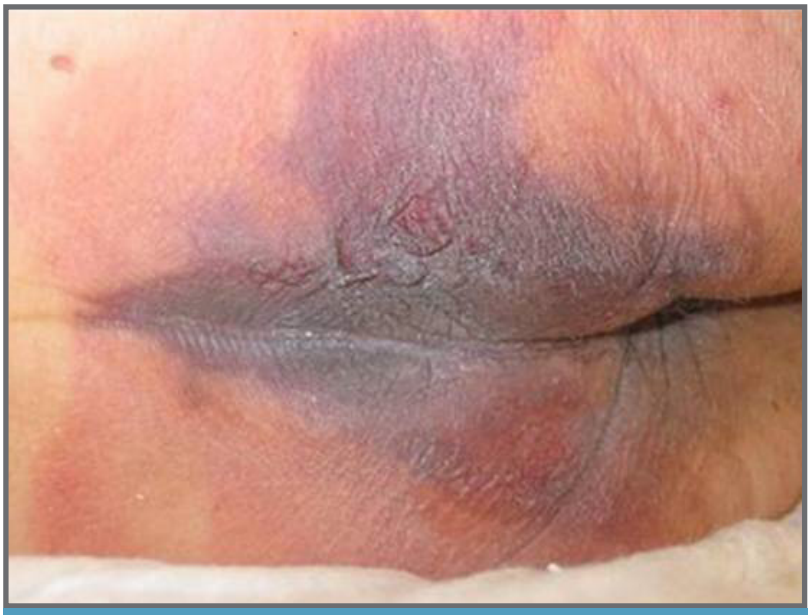
HOW TO IDENTIFY AN OR ACQUIRED PRESSURE ULCER?

A Perioperative pressure ulcer is any pressure-related tissue injury that presents i.e. non-blanchable erythema, purple discoloration or blistering within 48-72 hrs post-operatively and is associated with the surgical position. Scott (2015)





CABG 48 hrs Post-op

Suspected Deep Tissue Injury – depth unknown

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.

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