Where Flaminal® Can Be Used

Flaminal® Hydro or Forte can be used where the tube images appear against the category.
Please refer to the instructions for use on guidance on how & when to apply Flaminal®

Pressure Ulcer Categorisation[1,2]

Flaminal® hydro

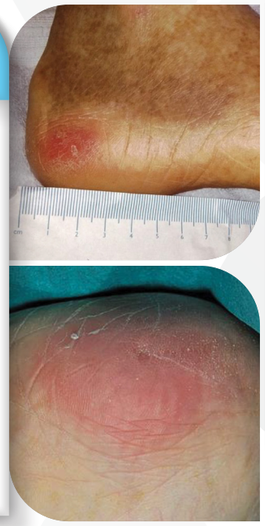
Pack Size	PIP	NHS
5 x 15g tubes	324-2971	ELG021
1 x 50g tube	344-9600	ELG025
500g tub	-	ELG029

Flaminal® forte

Pack Size	PIP	NHS
5 x 15g tubes	324-2963	ELG022
1 x 50g tube	344-9592	ELG023
500g tub	-	ELG028

Category 1: Non-Blanchable Erythema

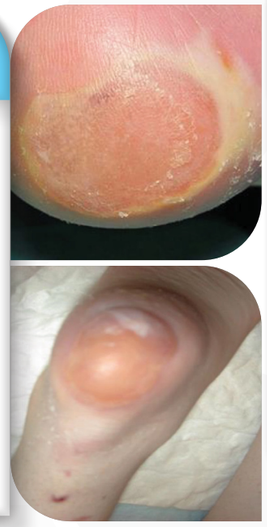
- Intact skin with non-blanchable redness, usually over a bony prominence.
- Darker skin tones may not have visible blanching; its colour may differ from the surrounding area.
- Area may be painful, firm or soft, warmer or cooler compared to adjacent tissue.



Category 2: Partial Thickness Skin Loss

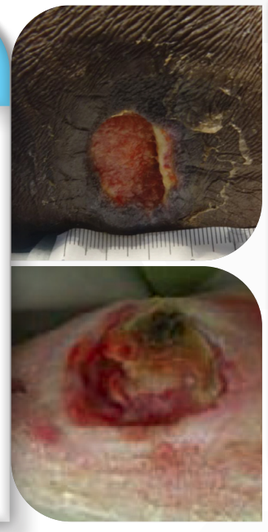
- Partial thickness loss of epidermis/dermis presenting as a shiny or dry shallow ulcer with a red/pink wound bed and without slough or bruising*
- May also present as an intact or open/ruptured serum-filled blister

** This category should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.*



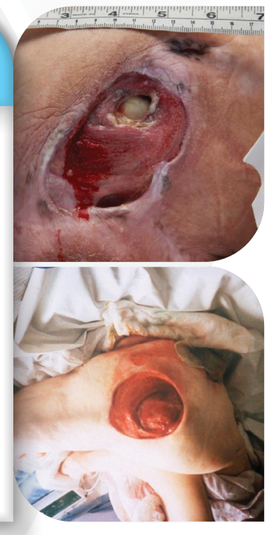
Category 3: Full Thickness Skin Loss

- Full thickness skin loss. Subcutaneous fat may be visible, but bone, tendon or muscle not exposed or palpable
- Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunnelling.
- Depth varies by anatomical location- if no subcutaneous tissue can be shallow, but areas of significant adiposity can be extremely deep



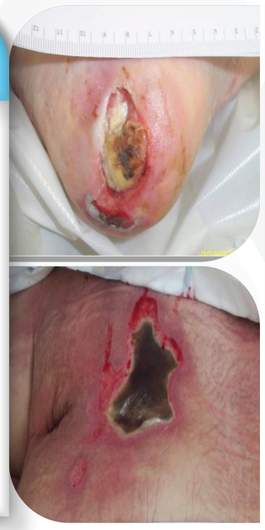
Category 4: Full thickness Tissue Loss

- Full thickness tissue loss with exposed or palpable bone, tendon or muscle.
- Slough or eschar may be present but does not obscure depth of tissue loss. Often undermining and tunnelling.
- Depth varies by anatomical location- if no subcutaneous tissue can be shallow.
- Can extend into muscle and/ or supporting structures (e.g. tendon)



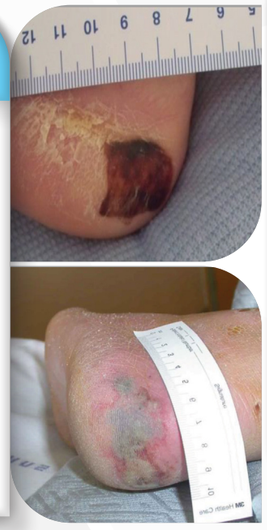
Unstageable: Depth Unknown

- Full thickness tissue loss - base of the ulcer covered by slough and/or necrotic tissue
- Until enough slough and/or necrotic tissue is removed to expose the base of wound, the true depth, and category, cannot be determined.
- Dry, intact eschar on the heels should not be removed, consider referral to podiatry for advice
- Once devitalised tissue removed & category established this should be documented



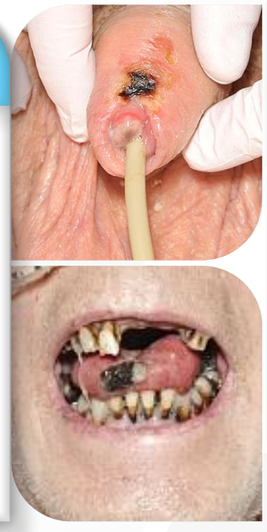
Suspected Deep Tissue Injury: Depth Unknown

- Epidermis is intact, purple or maroon area of discoloured intact skin or blood-filled blister
- Area may be painful, firm, mushy, boggy, warmer or cooler compared to adjacent tissue
- May be difficult to detect in individuals with dark skin tones- may include a thin blister over a dark wound bed.
- May evolve rapidly to become covered by thin eschar.



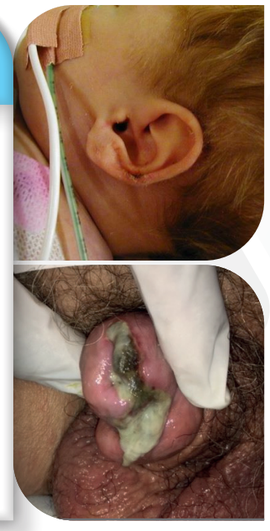
Mucosal Pressure Ulcer:

- Develop on mucosal membranes eg. tongue, mouth, nasal passages, genital, rectum
- Cannot be categorised as the tissue does not have the same layers as the skin
- These PU are therefore uncategorisable (NOT unstageable)
- They are usually caused by devices and therefore should be recorded as PU (d) or mucosal pressure ulcer



Device-Related Pressure Ulcer:

- Result from the use of devices designed and applied for diagnostic/therapeutic purposes
- Some may be allocated a category of damage eg. cheeks, ears. Others may not as they appear in places that do not have the same structures as the skin eg. the mucosal membrane (see mucosal pressure ulcer)
- Where possible, a device-related ulcer should be categorised and presence of device noted by adding (d) after the category.



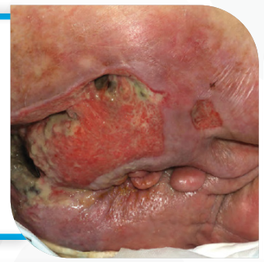
NOTE: The FIRST time a patient is treated for wounds which might reach the level of bones and joints or with exposed bones and joints, the patient should be under observation for at least 30 minutes after the administration of Flaminal® (Hydro or Forte)

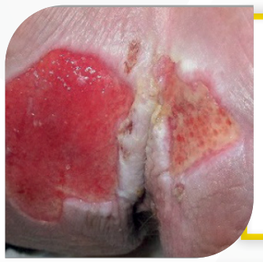
References:
1. NHS Improvement Pressure ulcer categorisation group (2019) Pressure Ulcer Categorisation. Available from http://nhs.stopthepressure.co.uk/IMAGES TAKEN FROM THIS SOURCE
2. NHS Scotland(2021) Scottish Adaptation of the European Pressure Ulcer Advisory panel (EPUAP) Pressure Ulcer Classification Tool. Available online at: https://www.healthcareimprovementscotland.org/idoc.ashx?docid=1f2f3549-1d38-431d-be6e-e79627e50754&version=-1

CE 0344

Pressure Ulcer or Moisture Associated Skin Damage (MASD)?[1]

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





MASD is defined as inflammation and erosion of the skin caused by prolonged exposure to various sources of moisture, including urine or stool, perspiration, wound exudate, mucus or saliva

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Wound Attributes	Pressure Ulcer	MASD	Additional Comments
Cause	Pressure or shear present	Moisture must be present	If both pressure/shear and moisture present it could be a combined lesion
Location	Over a bony prominence	May occur over a bony prominence but pressure and shear should be excluded as causes, and moisture should be present.	A combination of moisture, pressure and friction may cause moisture lesions in skin folds.
Shape	Circular wounds or wounds with a regular shape are most likely, but the possibility of friction injury has to be excluded.	Indistinct superficial spots are more likely. In a kissing ulcer at least one of the wounds is most likely caused by moisture.	Irregular or diverse wound shapes are often present in a combined lesion.
Depth	Partial-thickness skin loss is present when only the top layer of the skin is damaged (cat 2). In full thickness skin loss, all skin layers are damaged (cat 3 or 4)	Superficial depth (partial thickness skin loss). In cases where the moisture lesions get infected, the depth and extent of the lesion can be enlarged/deepened extensively	If friction is exerted on a moisture lesion, this will result in superficial skin loss in which skin fragments are torn and jagged
Necrosis	A black necrotic scab on a bony prominence is a pressure ulcer.	There is no necrosis in MASD	Necrosis softens up and changes colour but is never superficial. Distinction should be made between necrotic scab and a dried-up blood blister
Edges	If edges are distinct, most likely.	Often have indistinct, diverse or irregular edges	Jagged edges are seen in moisture lesions that have been exposed to friction.
Colour	**Red:** if non-blanchable, most likely cat 1 For people with darkly pigmented skin persistent redness may manifest as blue or purple **Red in the wound bed:** granulation tissue and likely cat 2, 3 or 4 **Yellow in wound bed:** slough or softened necrosis, likely cat 3 or 4 **Black in the wound bed:** Black necrotic tissue indicates cat 3 or 4	**Red:** If not uniformly distributed, likely to be a moisture lesion **Pink or white surrounding skin:** Maceration due to moisture	**Red skin:** If the skin (or lesion) is red and dry or red with a white sheen, it could be a fungal infection. **Green in wound bed:** Infection likely.

References:
1. Susan Yates (2012) Differentiating between pressure ulcers and moisture lesions. Wound Essentials 2012, Vol 2 p16-22

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