

# Helpful Definitions Related to Heel Ulcer Prevention

**Albumin:** One of a group of simple proteins. In the blood, acts as a carrier molecule and helps maintain blood volume and blood pressure. The principal function of albumin is to provide colloid osmotic pressure, preventing plasma loss from the capillaries.<sup>1</sup>

**Braden Scale:** A commonly used assessment tool that quantifies the degree to which a person is at risk for developing a pressure ulcer. Each assessment parameter is measured on a scale from a low of 1 to a high of 4, including the individual's sensory perception, moisture, activity, mobility, nutrition, and friction and shear. The lower the number, the higher the risk for pressure ulcer development. Individuals are at risk for developing pressure ulcers if the total score is less than 17.<sup>1</sup>

**CVA:** *Cerebrovascular accident (stroke)*; a sudden loss of neurological function, caused by vascular injury to the brain.<sup>1</sup>

**Edema:** A local or generalized condition in which the body tissues contain an excessive amount of tissue fluid.<sup>1</sup>

**Hyperglycemia:** Abnormally high blood sugar levels, as are found in people with diabetes mellitus or people treated with some drugs.<sup>1</sup>

**Immunocompromised:** Having an immune system that is incapable of a normal full reaction to pathogens or tissue damage.<sup>1</sup>

**Obesity:** An unhealthy accumulation of body fat. In adults, damaging effects of excess weight are seen when the body mass exceeds 25kg/m<sup>2</sup>. Obesity is defined as having a body mass index of greater than 30 kg/m<sup>2</sup>.<sup>1</sup>

**Perfusion:** The circulating of blood through tissues.<sup>1</sup>

**Pressure Ulcer - Stage I:** Non-blanchable redness of intact skin in a localized area, usually over a bony prominence. Darkly pigmented skin may not blanch; its color may differ from surrounding tissue.<sup>2</sup>

**Pressure Ulcer - Stage II:** Partial thickness loss of dermis; presents as shallow open ulcer with a red pink wound bed, no slough present. May be an intact or open/ruptured serum-filled blister.<sup>2</sup>

**Pressure Ulcer - Stage III:** Full thickness tissue loss. May be able to see subcutaneous fat; can NOT see bone, tendon or muscle. Slough may be present but you can still see the depth of tissue loss. Undermining and tunneling may be present.<sup>2</sup>

**Pressure Ulcer - Stage IV:** Full thickness tissue loss with exposed bone, tendon or muscle. May have slough or eschar but still can see base of wound. Undermining and tunneling often present.<sup>2</sup>

**Pressure Ulcer – Suspected Deep Tissue Injury:** Local area of purple or maroon discolored intact skin or blood-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.<sup>2</sup>

**Pressure Ulcer – Unstageable:** Full thickness tissue loss but the wound bed is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black).<sup>2</sup>

**PVD:** *Peripheral vascular disease*; any condition that causes partial or complete obstruction of the flow of blood to or from the arteries or veins outside the chest.<sup>1</sup>

**TKR:** *Total knee replacement*; surgical removal of a diseased or injured knee and its replacement with an orthosis.<sup>1</sup>

1. *Taber's Cyclopedic Medical Dictionary*. 20th ed. Philadelphia: F.A. Davis Company, 2005. 2. NPUAP. Pressure Ulcer Stages Revised by NPUAP. Available at: [www.npuap.org/pr2.htm](http://www.npuap.org/pr2.htm). Accessed on: April 16, 2008.