Pressure Ulcers

Pressure Ulcer Identified

Assessments Completed

Interventions Implemented

Desired Outcome?

Monitor

Reassess

Suspected Deep Tissue Injury

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.

Stage II

Partial-thickness loss of skin presenting as a shallow open ulcer with a well-defined base and undermined border, without slough. May also present as an intact or open/necrotic serosanguineous blister.

Stage III

Full-thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling.

Stage IV

Full-thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.

Unstageable

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.

Persistent purple or maroon areas? Changes in skin temperature, tissue consistency and/or sensation? Skin at risk?

Non-blanchable redness? Changes in skin temperature, tissue consistency and/or sensation? Skin at risk?

Exudate? Dry wound? Necrotic? Odor? Bone or muscle visible? Periwound skin at risk or impaired?

Exudate? Dry wound? Necrotic? Odor? Periwound skin at risk or impaired?

Exudate? Dry wound? Necrotic? Odor? Depth or undermining? Periwound skin at risk or impaired?

Exudate? Dry wound? Necrotic? Odor? Periwound skin at risk or impaired?

Exudate? Dry wound? Necrotic? Odor? Periwound skin at risk or impaired?

Exudate? Dry wound? Necrotic? Odor? Periwound skin at risk or impaired?

Pressure Ulcer Stages as revised and copyrighted by National Pressure Ulcer Advisory Panel, Feb., 2007

Pressure ulcer staging as per NPUAP 2007 ©

Cover/Protect skin: skin protectant, skin sealant, transparent film, thin hydrocolloid, skin foam, pressure relief devices

Cleanse intact skin: skin cleanser

Moisturize intact skin: skin moisturizer

Cover/Protect wound: wound cleanser or saline

Manage wound exudate:

Minimal - transparent film, thin hydrocolloid, thin foam

Moderate - hydrocolloid, foam, calcium alginate, collagen

Heavy - calcium alginate, foam, combinations of dressings

Debridie wound:

Dry - transparent film, hydrogel, hydrogelling impregnated gauze

Minimal - hydrocolloid, foam, calcium alginate

Hydrate wound: hydrogel, hydrating impregnated gauze

Manage wound odor: wound cleanser, odor absorbent dressing, more frequent dressing changes, antimicrobial dressing (i.e. Silver)

Protect intact skin: skin protectant, skin sealant, skin cleanser, transparent film

Cleanse wound: wound cleanser or saline

Manage wound exudate:

Minimal - thin hydrocolloid, thin foam

Moderate - foam, calcium alginate, combinations of dressings

Heavy - calcium alginate, foam, combinations of dressings

Debridie wound:

Dry - hydrogel, hydrating impregnated gauze

Minimal - foam, calcium alginate, combinations of dressings

Hydrate wound: hydrogel, hydrating impregnated gauze

Manage wound odor: wound cleanser, odor absorbent dressing, more frequent dressing changes, antimicrobial dressing (i.e. Silver)

Fill in dead space: calcium alginate, hydrating or impregnated gauze, foam cavity dressing

Developed in collaboration with

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*Pressure ulcer staging as per NPUAP 2007 ©
Suspected DTI/Stage I
A Stage I pressure ulcer involves a discrete area of skin involving the epidermis, dermis, or both. The ulcer appears as a defined area of intact skin that may present as a brownish discoloration of the wound and/or intact skin. Inflammation of the periwound tissue is present. Cooling or non-painful sensations may be present. Suspected DTI/Stage I
A Stage I pressure ulcer involves a discrete area of skin involving the epidermis, dermis, or both. The ulcer appears as a defined area of intact skin that may present as a brownish discoloration of the wound and/or intact skin. Inflammation of the periwound tissue is present. Cooling or non-painful sensations may be present.

A Stage II pressure ulcer involves transition of skin and underlying tissue. The ulcer may be painful. The ulcer may involve the epidermis, dermis, or both. The ulcer may present as an abrasion, blister or shallow crater due to damage of underlying soft tissue. The ulcer may present as an area of intact skin that is cooler as compared to adjacent tissue. The ulcer may present as an area with exposed dermis or epidermis. The ulcer may present as an area with exposed dermis or epidermis. The ulcer may present as an area with exposed dermis or epidermis. The ulcer may present as an area with exposed dermis or epidermis.

A Stage III pressure ulcer involves drainage of infected tissue. The ulcer may present as an area with exposed dermis or epidermis. The ulcer may present as an area with exposed dermis or epidermis. The ulcer may present as an area with exposed dermis or epidermis. The ulcer may present as an area with exposed dermis or epidermis.

A Stage IV pressure ulcer involves exposure of muscle, bone, or supporting structures. The ulcer may present as an area with exposed dermis or epidermis. The ulcer may present as an area with exposed dermis or epidermis. The ulcer may present as an area with exposed dermis or epidermis. The ulcer may present as an area with exposed dermis or epidermis.

Suspected DTI/Stage I
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