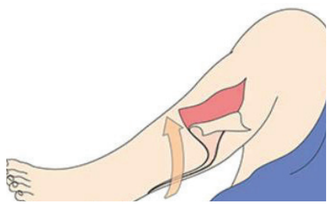
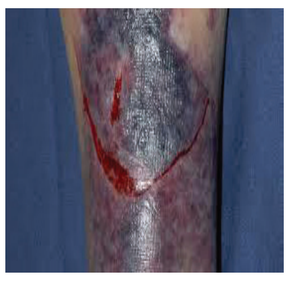
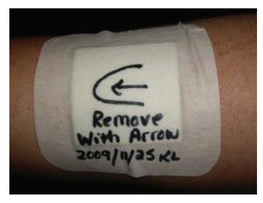
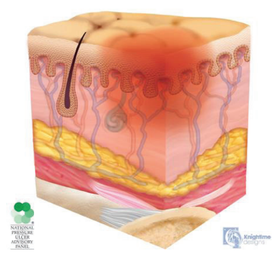
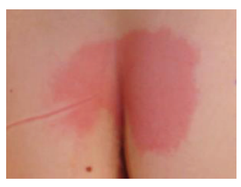
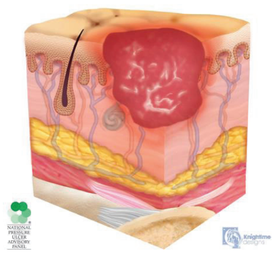
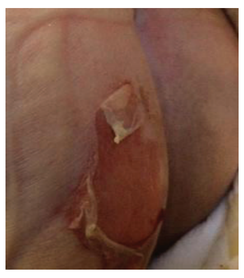
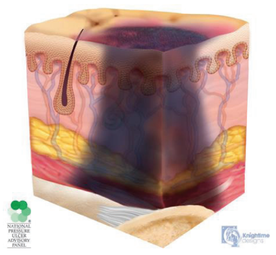
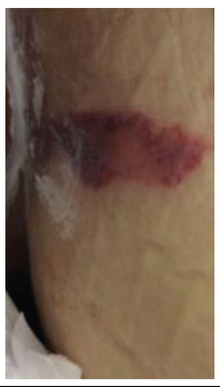
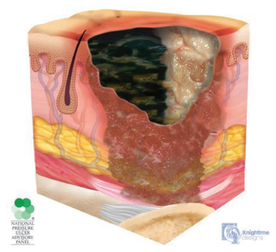
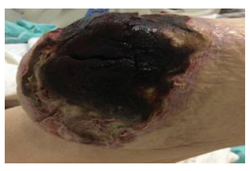
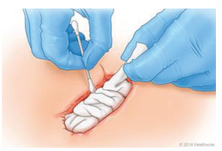
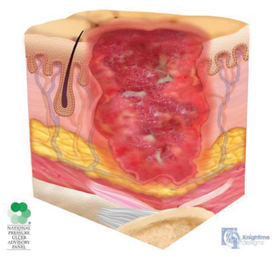
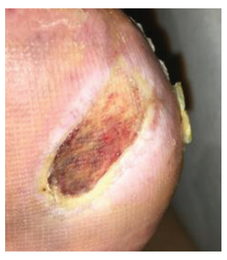
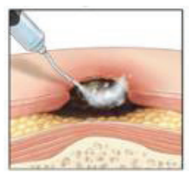
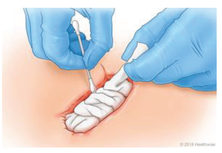
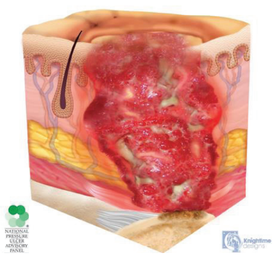
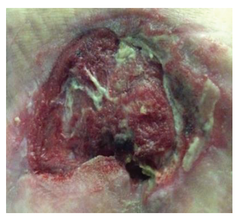
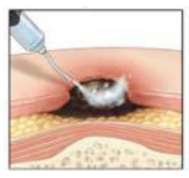
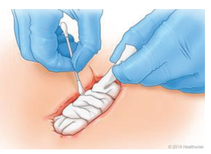
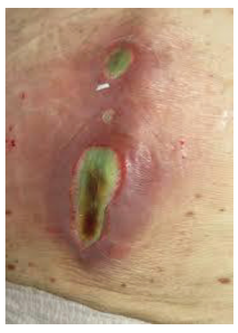
Pressure injury staging and nursing management

MARKHAM STOUFFVILLE HOSPITAL

Wound type	Description	Graphic	Picture	Dressing/Management	Dressing resources
Skin tear	**A traumatic wound caused by mechanical forces. Not extending into the subcutaneous layers.** *If not managed properly, can develop into a complex chronic wound.*			• Cleanse with normal saline • Re-approximate skin flap (aseptic technique) • Cover flap with Adaptic and Mepilex Foam Border • Direction of removal should be indicated on dressing • Change Q3 days and PRN Note: • If area is too large for a Mepilex Foam cover with abdominal pad and kling, or secure with paper tape • Tape to skin should be minimized as much as possible to prevent new skin tears • Dressing removal should be done away from the flap attachment site to preserve the flap and prevent further skin tearing **Goal:** Allow for wound healing and prevent further skin damage from occuring by applying a non-adherent dressing.	  
Stage 1: Non-blanchable erythema of intact skin	**Changes in sensation, temperature or firmness may precede visual changes.** *Colour changes do not include purple or maroon, which may indicate deep tissue injury.*			• Cleanse with normal saline • Apply Mepilex Foam Border • Assess dressing daily • Change Q3 days and PRN **Goal:** Prevent further skin damage/breakdown by applying a dressing that will offload some pressure from the area.	
Stage 2: Partial thickness skin loss & exposed derms	**Wound bed is viable, pink or red, moist and may also present as an intact or ruptured serum-filled blister.** *This stage is not used to describe moisture skin damage, dermatitis from incontinence or within skin folds.*			• Cleanse with normal saline • Apply Inadine and Mepilex Foam Border • Assess dressing daily • Change Q3 days and PRN Note: • For intact blisters, leave intact and open to air (applying a dressing to this area will promote autolytic debridement and promote the blister to open) **Goal:** Promote wound healing, prevent further damage and prevent infection by using adherent antimicrobial dressing.	
Suspected deep tissue injury	**Persistent, non-blanchable, deep red, maroon or purple discolouration.** *Intact or non-intact skin, a dark wound bed or blood-filled blister.*			• Offload pressure • Heel - boots and/or pillow • Sacrum - chair time or reposition of the area 1-2 hours at a time • Leave open to air even if blistered Note: • If boggy, notify NP Wound and Infectious Disease • Apply Mepilex Foam Border • Assess dressing daily • Change dressing Q3 days and PRN **Goal:** Prevent further tissue breakdown, this wound will most likely progress to a deeper wound.	
Unstageable pressure injury	**Obscured full-thickness skin and tissue loss.** *Base of wound is covered by dead tissue (eschar or slough), therefore unable to determine extent of tissue damage. Eschar that is dry and intact should **not** be softened or removed.*			**Notify NP Wound** and Prior to NP Wound Ostomy Continence consultation • Apply betadine wet-to-dry dressing • Change dressing **daily** **Goal:** Betadine will maintain the dry eschar or dry the slough until debridement is considered appropriate.	 
Stage 3: Full thickness skin loss	**Adipose (fat) is visible in the ulcer and granulation tissue and rolled wound edges are present.** *Slough and/or eschar may be visible, but should still allow visualization of tissue involvement. Undermining and tunneling may occur.*			**Notify NP Wound** and Prior to NP Wound Ostomy Continence consultation • Cleanse with normal saline irrigation solution • Pack wound wet to dry • Change dressing daily **Goal:** Daily wound assessment and care untiil addressed by NP.	 
Stage 4: Full thickness loss of skin and tissue	**Exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the wound.** *Slough and/or eschar may be visible, but should still allow visualization of tissue involvement. Undermining and tunneling may occur.*			**Notify NP Wound** and Prior to NP Wound Ostomy Continence consultation • Cleanse with normal saline irrigation solution • Pack wound wet to dry • Change dressing daily **Goal:** Daily wound assessment and care untiil addressed by NP.	 
Infected pressure injury	**Wounds that show clinical signs of local wound infection that may require the use of antimicrobial dressings.** *Signs of local wound infection include increased drainage, increased pain, purulent drainage, foul odour, erythema, edema and heat.*			**Notify NP Wound** • Cleanse with normal saline irrigation solution **Decreased** drainage: Acticoat flex **Increased** drainage: Silver based (Silvercel) • Cover with Mepilex Foam Border • Assess dressing daily • Change dressing Q3 days and PRN **Goal:** Provide antimicrobial coverage for a variety of organisms.	

Contact Information for Wound Ostomy Continence and ID Nurse Practitioner: (416) 561 - 2548 • woundconsult@msh.on.ca

Mepilex Border (Foam) Dressing

- easy to remove without damaging skin and minimizes pain
- absorption layer draws moisture and exudate protecting periwound skin from maceration
- spreading distributes exudate evenly
- retention layer stores exudate
- backing film prevents portal for bacteria/virus and moisture

Silvercel Non-Adhering Dressing

- releases silver ions that provide antimicrobial effects
- able to absorb moderate to heavy exudate
- minimizes skin maceration (softening & thinning)

Povidone iodine

- a complex chemical compound containing elemental iodine
- a broad spectrum antibacterial
- does not impede wound healing

Inadine (PVP-I) Non Adherent Dressing

- impregnated with polyethylene glycol and povidine iodine, a broad specturm antimicrobial
- easy to remove without damaging skin and minimizes pain

Adaptic Non-Adhering Dressing

- easy to remove without damaging skin and minimizes pain
- minimizes skin maceration (softening & thinning of skin)

Acticoat Flex Dressing

- antibacterial properties protects from bacterial colonization
- flexible and stretchy, improves patient movement and control
- helps progress the wound to closure

National Pressure Injury Advisory Panel. (2016, September). Pressure Injury and Stages.