

Wound Assessment & Treatment Guide

Stage	Definition	Best Practice Guidelines	Products
Document Wound Measurements Daily, Pictures Q Wednesday			
Deep Tissue Injury 	Persistent non-blanchable deep red, maroon or purple discoloration. Maybe intact or non-intact skin. Can be painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.	Braden scale <18 is at risk and prevention strategies initiated Assessment of high risk areas: back of head, scapula, ears, elbows, coccyx, sacrum, ischial tuberosity, knees, heels and ankles. Use of prevention booties Skin Assessment q shift **Consult skin and wound nurse via EPIC**	 
Stage 1 	Non-blanchable erythema of intact skin. Defined area of persistent redness in lightly pigmented skin. May appear red, blue, and purple tones in darker complexions.	Braden scale <18 is at risk and prevention strategies initiated **May not require a dressing, only if friction is an issue** 1. Transparent dressing change q 3-5 days 2. Tegaderm absorbent dressing change 4-7 days Skin Assessment q shift	 
Stage 2 	Partial thickness loss of epidermis and dermis presenting as a shallow open ulcer with a red/pink wound bed, without slough. May be serum-filled blister.	Braden scale <18 is at risk and prevention strategies initiated 1. Clean with NS 2. Apply barrier wipe to periwound 3. Apply Inadine to wound bed 4. Tegaderm absorbent dressing Change q Mon/Wed/Fri & pm	 
Stage 3 	Loss of epidermis and dermis into the subcutaneous tissue but bone, tendon or muscle are NOT exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling	Braden scale <18 is at risk and prevention strategies initiated Moisture balance Assess for infection every dressing change 1. Irrigate with NS 2. Apply barrier wipe to periwound 3. If packing required use AMD ribbon or silvercel 4. Foam dressing **Consult skin and wound nurse via EPIC**	   
Stage 4 	Full thickness skin loss with extensive destruction. Exposed bone, tendon or muscle. Probe to bone- susceptible to osteomyelitis	Braden scale <18 is at risk and prevention strategies initiated Moisture balance Assess for infection every dressing change 1. Irrigate with NS 2. Apply barrier wipe to periwound 3. If packing required use AMD ribbon or silvercel 4. Foam dressing **Consult skin and wound nurse via EPIC**	   

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