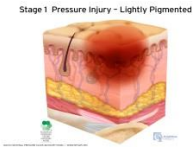
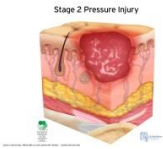
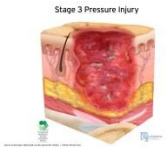
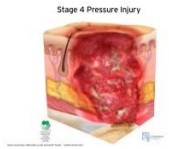
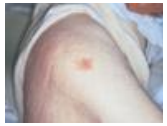
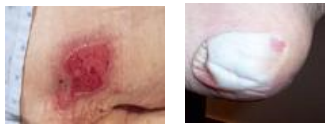
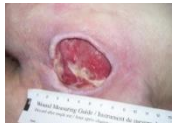
Assessment & Treatment of Pressure Injuries (PIs) Guideline Summary

	Pressure Injury Stage 1	Pressure Injury Stage 2	Pressure Injury Stage 3	Pressure Injury Stage 4
Clinical Parameters				
				
Client History	Exposure to pressure, moisture, friction and/or shear has occurred			
Location	Skin over bony prominences or skin exposed to other external pressure, medical or other device (tubes, splints, braces).			
Characteristics of the Pressure Injury	• Area of intact skin with local non-blanchable erythema (redness) with a change in temperature or firmness. • In darkly pigmented skin, the colour of area may differ from adjacent skin.	• Partial thickness tissue loss showing viable, pink or red, moist with a distinct wound margin. • May present as an intact or ruptured serum-filled blister. • Slough/eschar are not present	• Full thickness tissue loss with just the subcutaneous adipose layer exposed. • Slough/eschar is initially present. • The bridge of the nose, the ear, the occiput, and the malleolus has minimal depth of subcutaneous tissue and these Stage 3 PIs will be shallow in depth. • Healing wounds show granulation tissue. • Rolled edges (epibole) may be visible in chronic wounds.	• Full thickness tissue loss with the damage going through the subcutaneous adipose layer; fascia, muscle, tendon, ligament, cartilage &/or bone may be exposed. • Slough/eschar is initially present. • The bridge of the nose, the ear, the occiput, and the malleolus has minimal depth of subcutaneous tissue and these Stage 4 PIs will be shallow in depth. • Healing wounds show granulation tissue. • Rolled edges (epibole) may be visible in chronic wounds.
Treatment Goal	Resolution of the non-blanchable erythema through pressure redistribution.	Moist wound healing through epitheliali - zation and supported by pressure redistribution.	Moist wound healing through granulation and supported by pressure redistribution.	Moist wound healing through granulation and supported by pressure redistribution.
Care Plan Interventions	Initiate/maintain pressure injury prevention strategies (Link to Braden Intervention Guide). Hand hygiene, appropriate aseptic technique, cleanse/irrigate, protect the peri-wound skin, and dress the wound to manage exudate & maintain moisture balance.			
	• Monitor 2 times daily. • Do not cover with a dressing.	• For an intact blister use a protective dry gauze dressing. • Consult Physician/NP or Wound Clinician if intact blister iimpedes range of motion or at risk for friction/shear • If a ruptured blister is present, consult Physician/NP or Wound Clinician for debridement of devitalized blister tissue. • For open are, consider contact layer • For open area; If cover dressing does not adhere, consider use of a hydrophilic paste dressing. • Protec dressings from urinary or fecal contamination – use appropriate containment/collection devices.	• If soft, boggy slough or eschar is evident in the wound, **debride** using the most appropriate debridement method. • Pack/fill (gently) any dead spaces, tunneling wound bed cavity undermining with an appropriate wound filler. • Maintain an open wound edge by packing appropriately.	• If a soft, boggy eschar is evident in the wound, **debride** using the most appropriate debridement approach. • Remove bone fragments if noted contact the Physician/NP. • Consider use of a contact layer to protect any exposed fascia, muscle, tendon, ligament, cartilage or bone. • Pack/fill (gently) any undermining, tunneling wound bed cavity with a wound packing. • Maintain an open wound edge by packing appropriately.
Team	Refer to the Intraprofessional team, if needed.			
Reassess	If the pressure injury deteriorates, restage to the appropriate pressure injury stage.			

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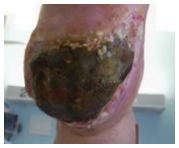
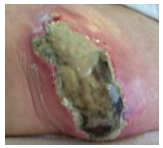
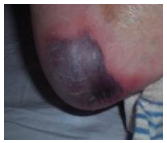
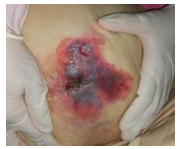
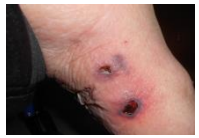
	Unstageable		Deep Tissue Injury		Medical Device Injury	Mucosal Injury
Clinical Parameters					Injury can have the appearance of any one of the Stages or be Unstageable or a DTI	Injury can have the appearance of any one of the Stages or be Unstageable or a DTI
						Coming Soon
Client History	Exposure to pressure, moisture, friction and/or shear has occurred.				Pressure from an external medical device.	Pressure from an internal medical related device.
Location	Usually over bony prominences.				Found under or around a medical device.	Found on the mucous membranes.
Characteristics of the Pressure Injury	Dry stable eschar firm cap.	Moist boggy eschar cap.	Dusky, boggy, or discoloured area of purple, maroon, ecchymosis, or a blood-filled blister		Usually conforms to the pattern or shape of the device.	
Treatment Goal	Maintain the dry, stable eschar protective cap.	Debride soft and/or boggy eschar slough.	Maintain the purple or maroon localized area of intact skin, and monitor for deterioration.		Moist wound healing and device management.	Mucosal membrane healing and correct fit of device.
Care Plan Interventions	Initiate/maintain pressure injury prevention strategies (Link to Braden Intervention Guide).					
	Hand hygiene, appropriate aseptic technique, cleanse/irrigation, protect the peri-wound skin, and dress the wound to manage exudate/ maintain moisture balance.					
	• Consult with Wound Clinician • **Keep the eschar area dry.** Do not cleanse. • Protect eschar area from water during showering. Do not tub bath or soak eschar area. • Paint the eschar and the 2.5cm beyond the wound edge daily or every other day with povidone iodine 10% • Leave open to the air or apply a dry dressing, do not use foam dressing	• Debride the soft, boggy eschar and/or slough with an appropriate method. • Gently fill/pack any dead spaces, tunneling wound bed cavity or undermining with an appropriate wound filler product to ensure • When the wound bed sufficiently exposed then re-stage to a Stage 3 or Stage 4 PI and follow that care plan.	• **Keep the injured area dry.** Do not cleanse. • Protect the injured area from water during showering. Do not tub bath or soak the area. • Protect the surrounding skin with a moisturizer, if needed. • Leave open to the air, or apply a dry breathable protective dressing in consultation with Wound Clinician. Do not use gels, transparent dressings, foams, or hydrocolloids or any other moisture retentive dressing. • Monitor for and treat S&S of infection.		• Initiate and maintain moisture prevention strategies. • Ensure correct fit of all medical device(s). • Examine skin under and around the device 2 times per shift. • Consider use of anchoring devices designed to secure tubing. • Reposition the anchoring of medical lines, catheters, tubes, as necessary.	• Examine mucosa under and around the device at least 2 times per shift, • Ensure correct sizing of medical related device(s). Reposition medical related device, if possible. • Refer to appropriate healthcare professional to assist with proper fitting of medical device, such as Respiratory Therapist, OT, PT, or Wound Clinician.
Team	Refer to the Intraprofessional team, if needed.					
Reassess	If the wound deteriorates, restage to the appropriate pressure injury stage.					Not applicable.