

RN's... Did You Know?!?!

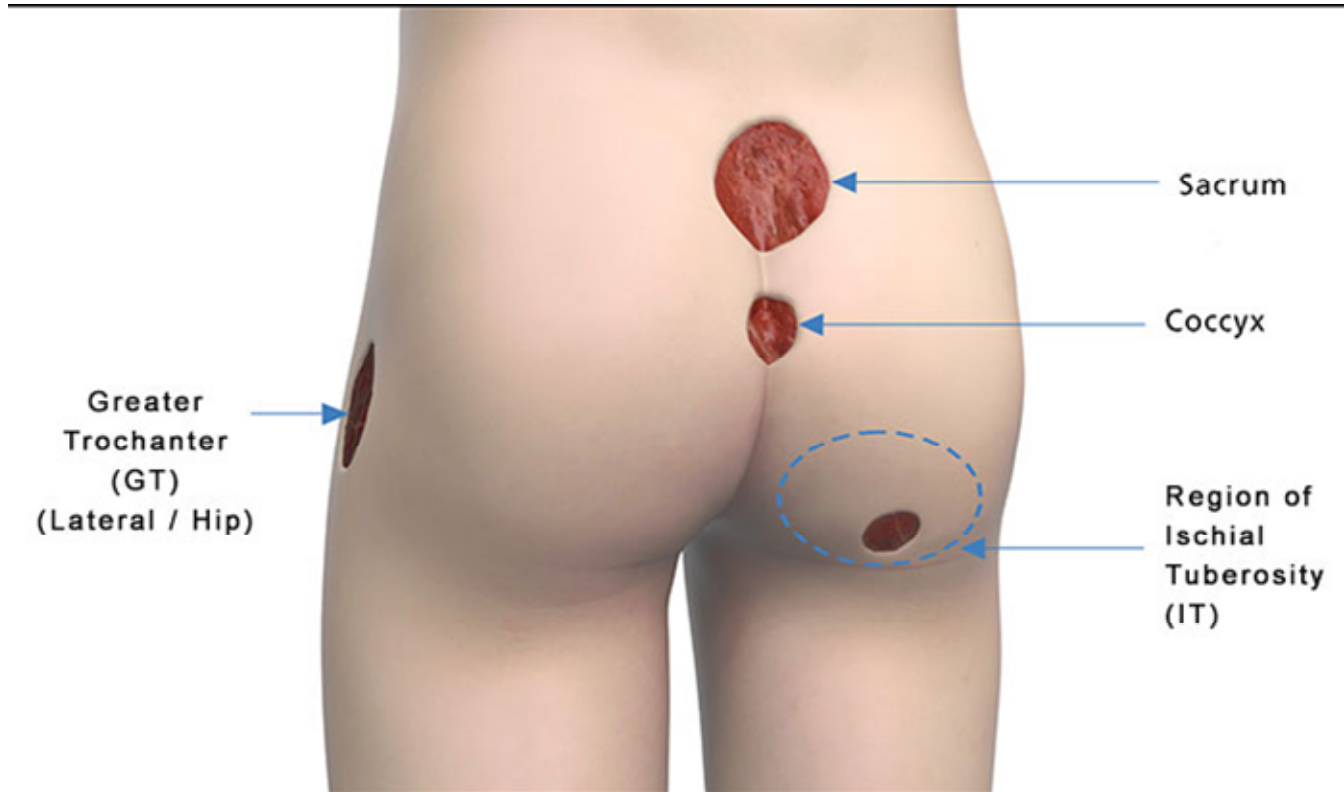


Nurses Can &
Should Stage
Wounds!

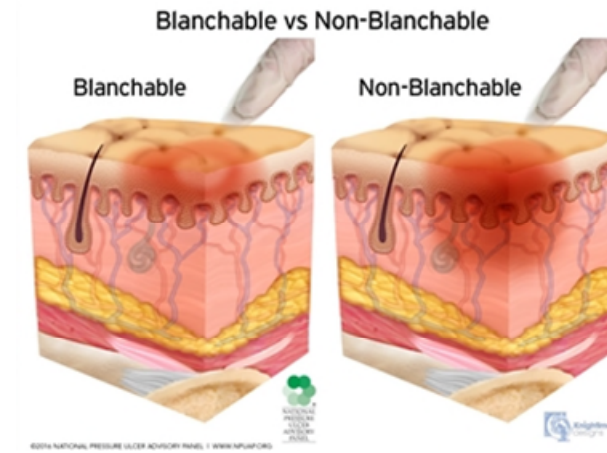
Just know your resources!

If in doubt contact a
supervisor, educator, wound
specialist or wound champion.

Always Identify Proper Location!



Perform Blanch Test



Apply light pressure with finger for a few seconds, then release & monitor for return of normal skin color

Normal skin color returns

Blanchable
(Area lightens when pressure is applied)

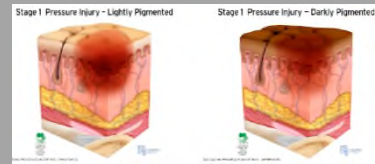
Normal skin color doesn't return

Nonblanchable
(area remains red, doesn't lighten when pressure is applied)

Stage 1 Pressure Injury

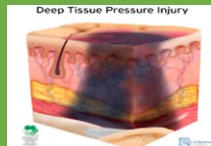
STAGE 1

Intact skin with area of nonblanchable redness
Discoloration may appear differently in darkly pigmented skin, in these cases, look for differences in color (darker or lighter), tissue that is warm or cool to touch, or tissue that is hard or soft.

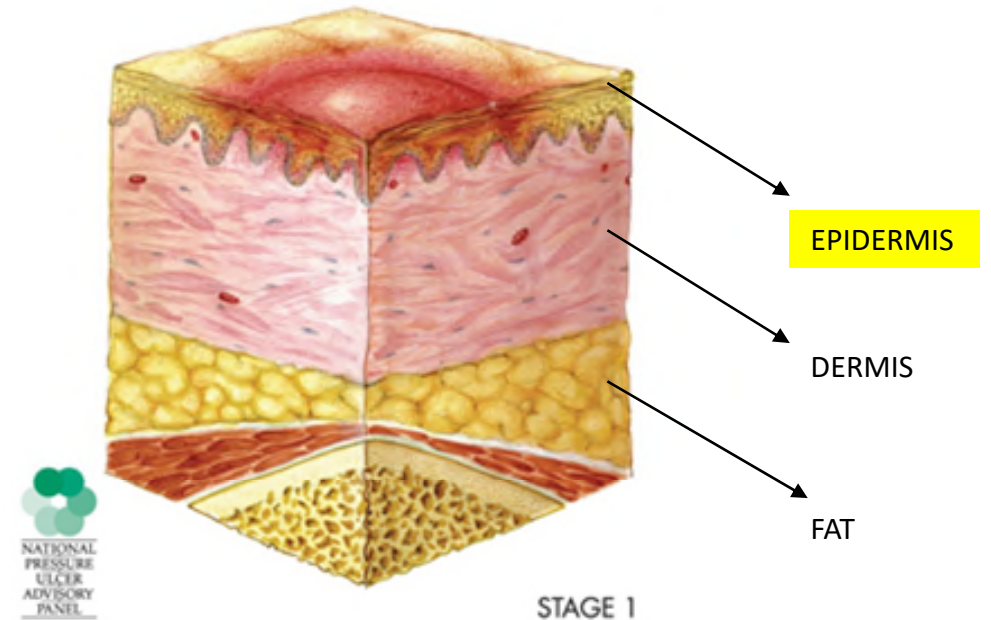


Changes in sensation, temperature and firmness may happen before visual changes are even noted.

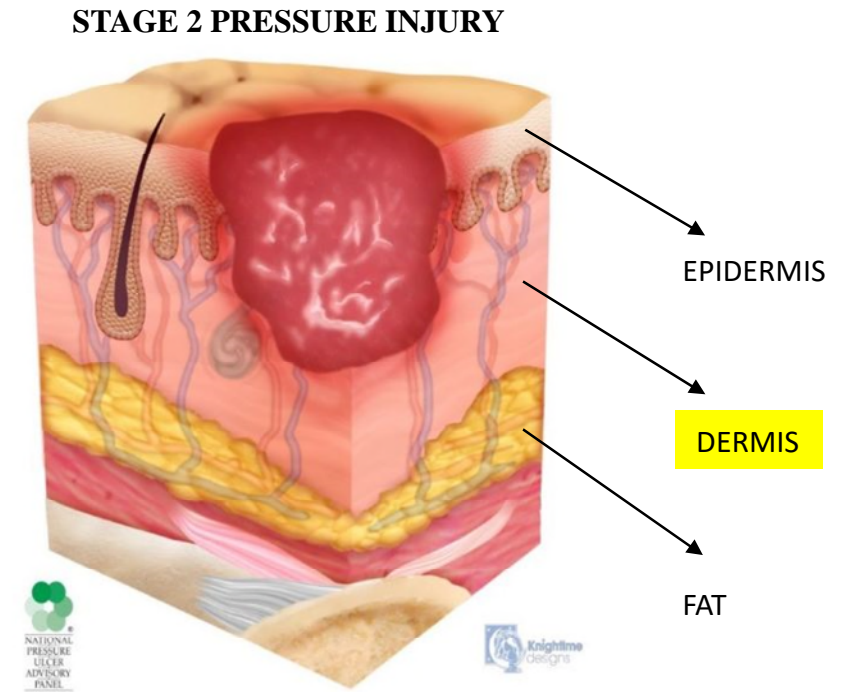
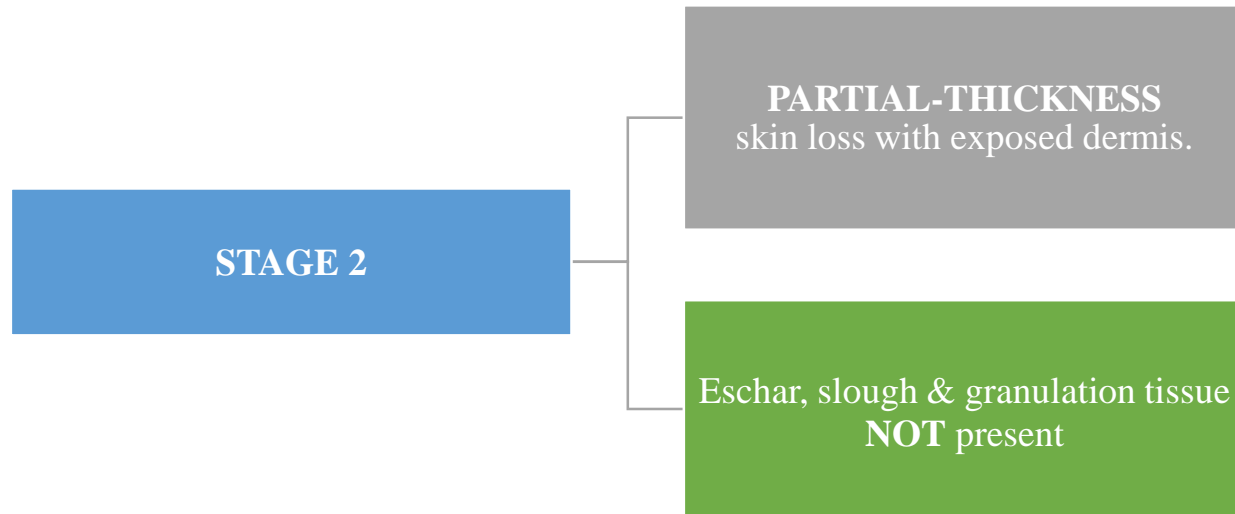
Color changes DO NOT include purple or maroon discoloration which may indicate deep tissue injury (DTI)



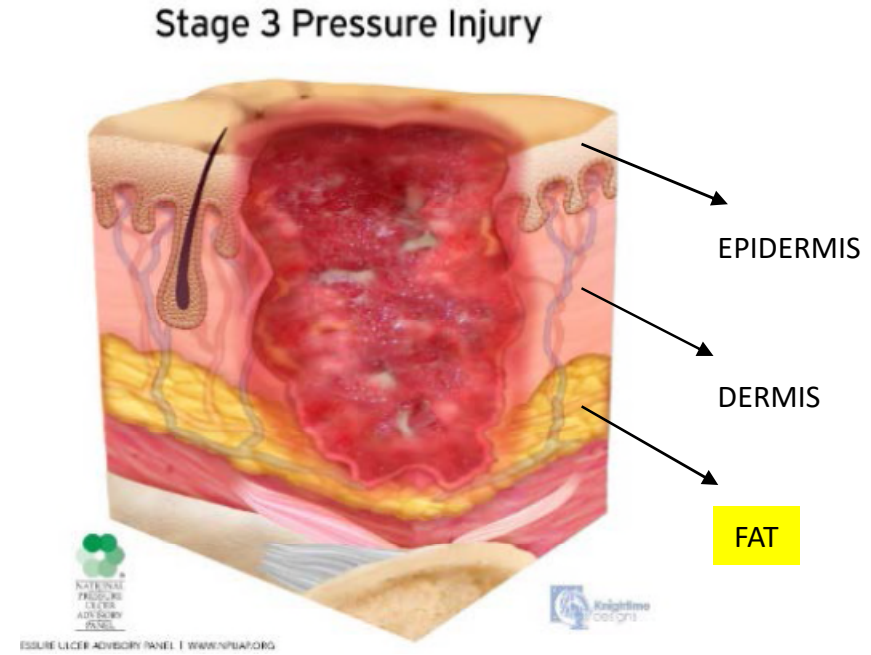
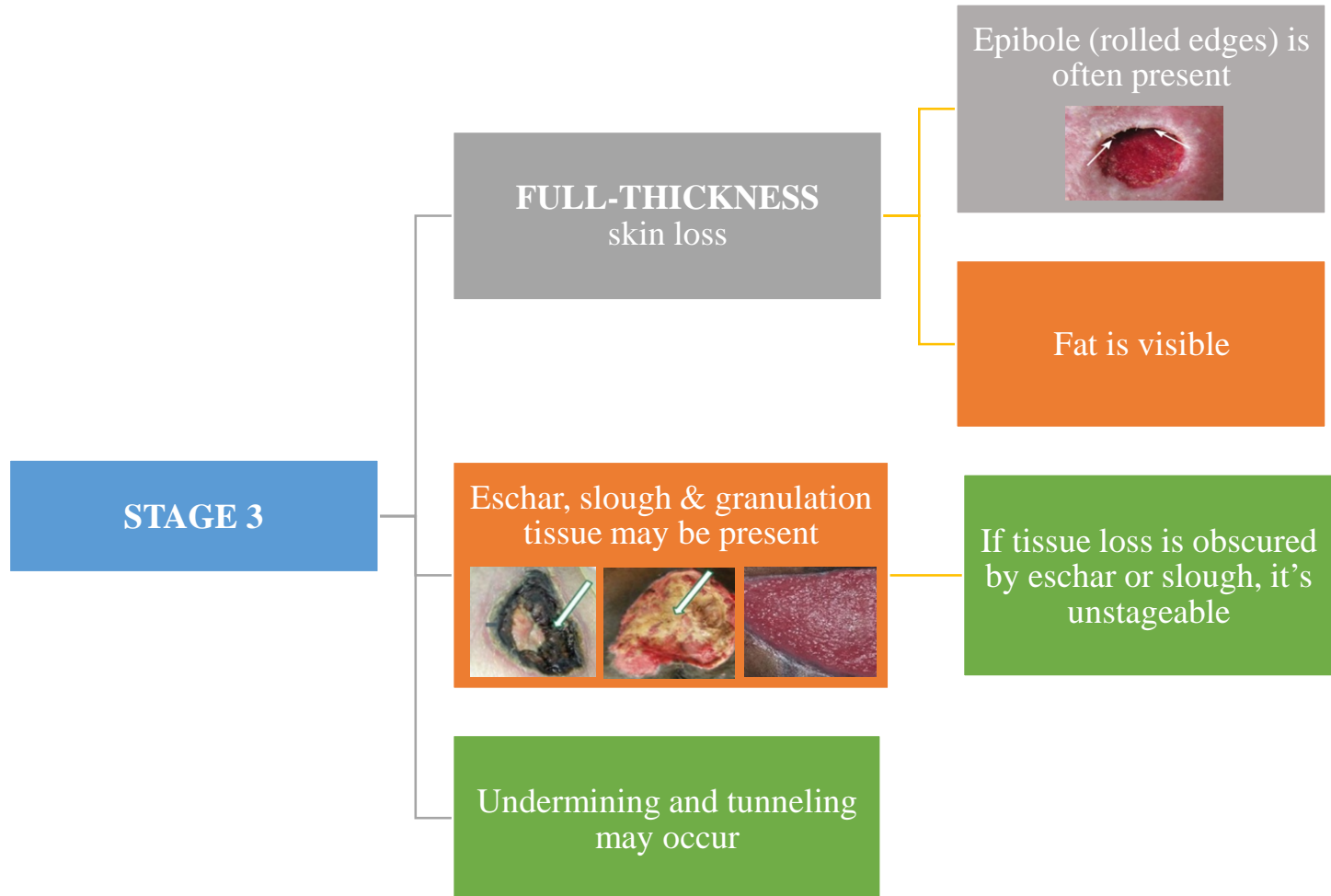
STAGE 1 PRESSURE INJURY



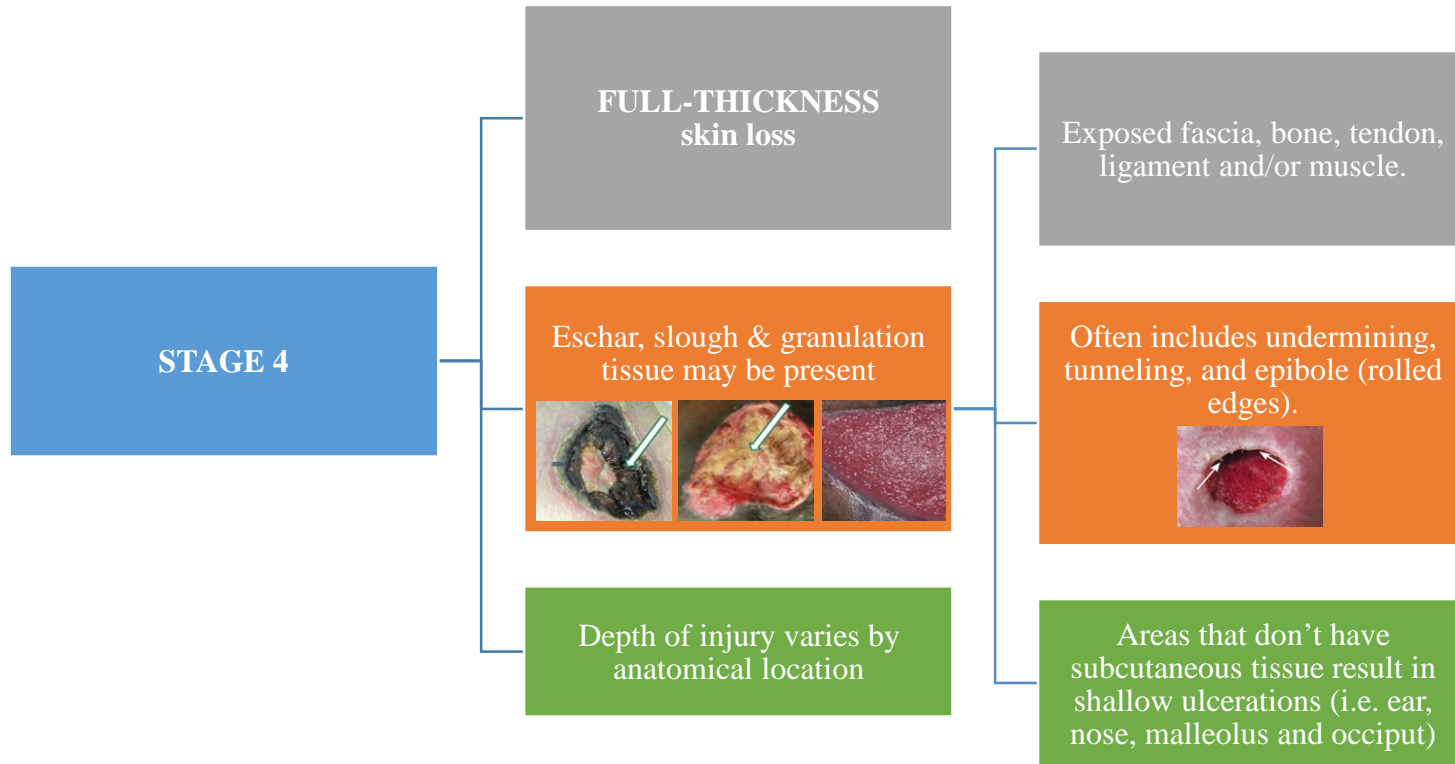
Stage 2 Pressure Injury



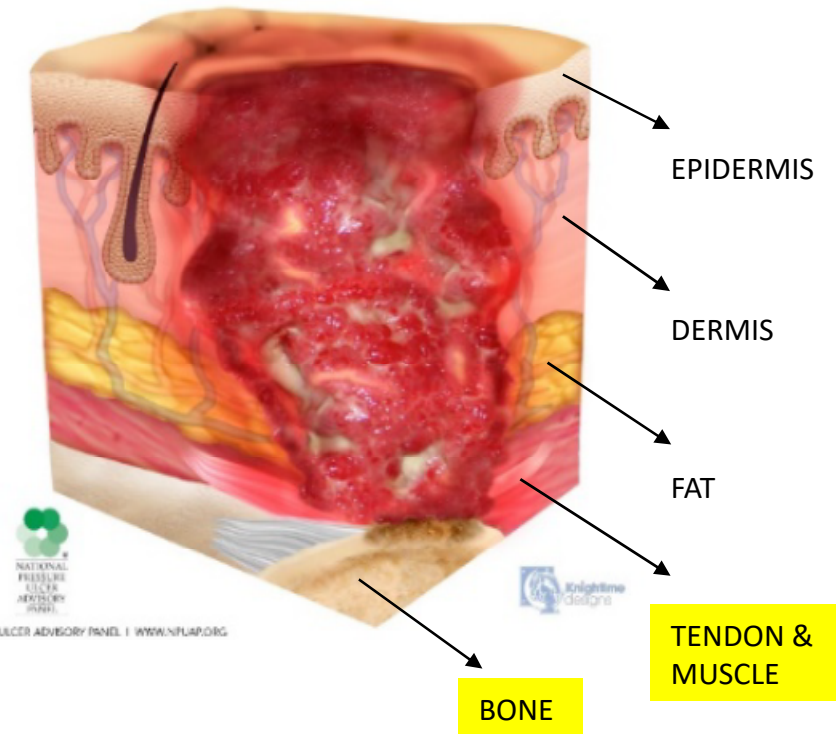
Stage 3 Pressure Injury



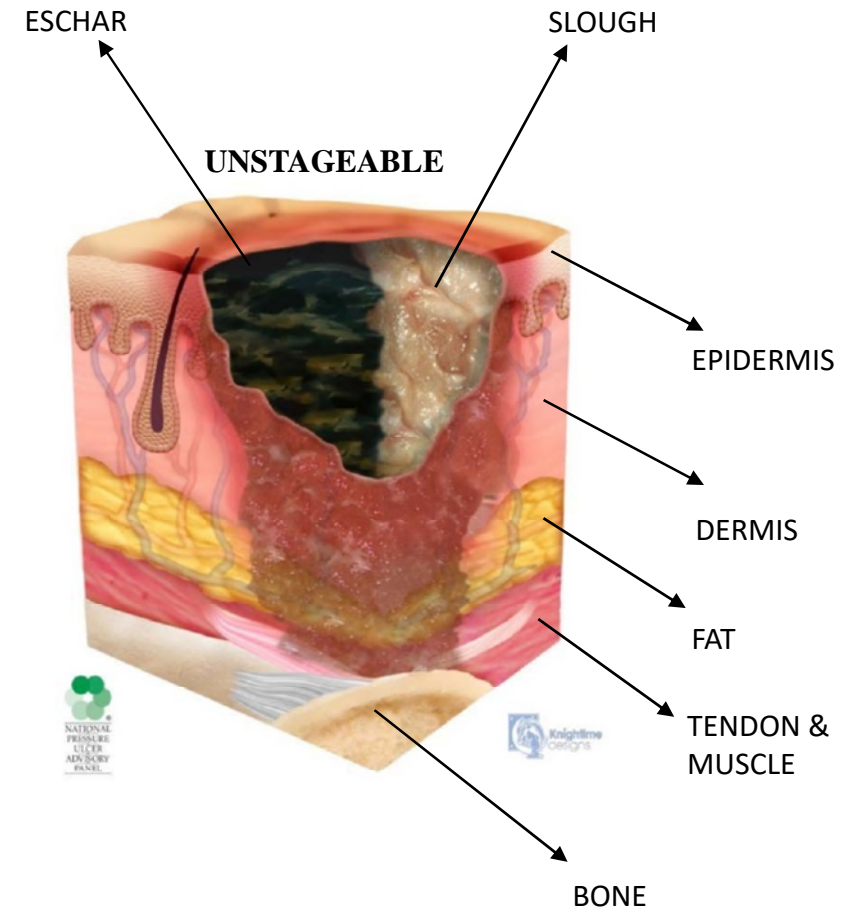
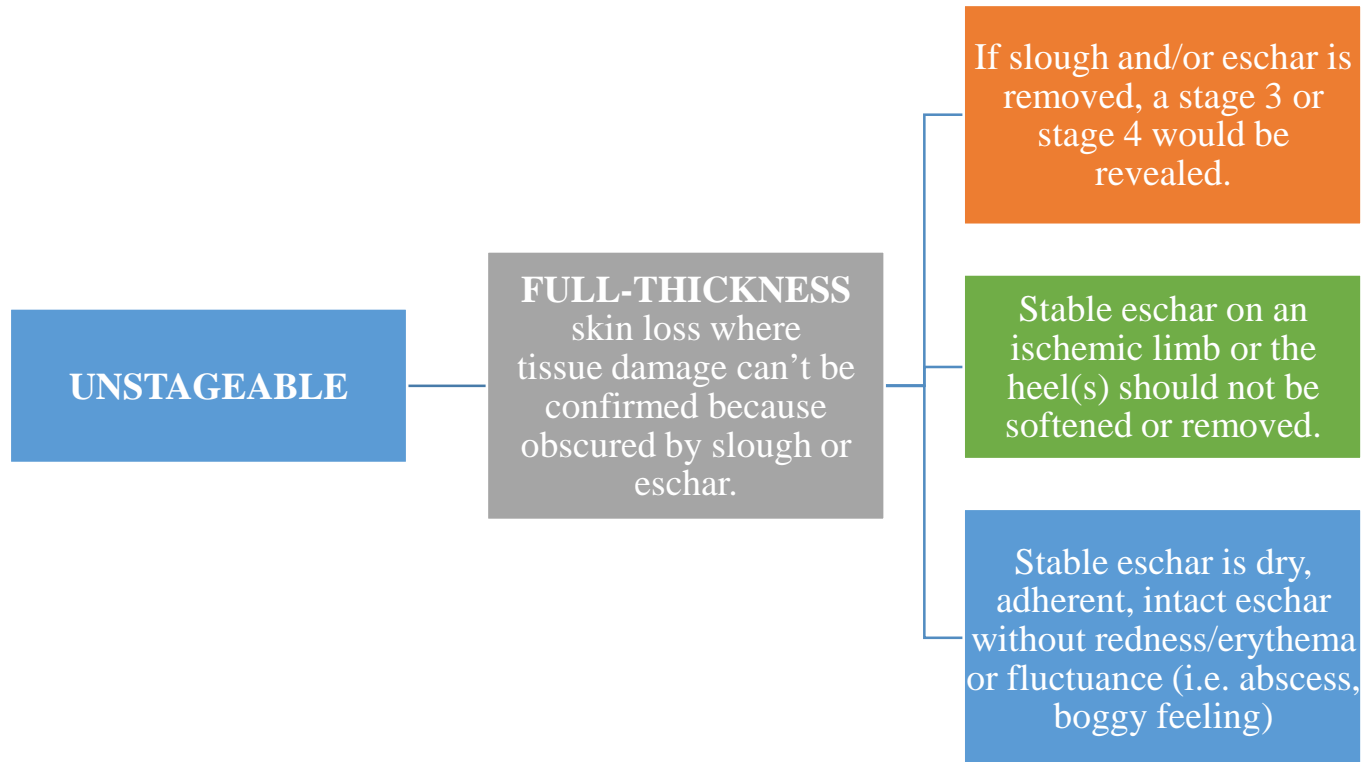
Stage 4 Pressure Injury



Stage 4 Pressure Injury



Unstageable Pressure Injury



Deep Tissue Injury (DTI)

Deep Tissue Injury

A pressure-related **injury** to subcutaneous **tissues** under intact skin. Initially, these lesions have the appearance of a **deep bruise**.

Intact or non-intact skin with localized area of persistent nonblanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister.

The wound may evolve rapidly to reveal actual extent of tissue injury or may resolve without tissue loss

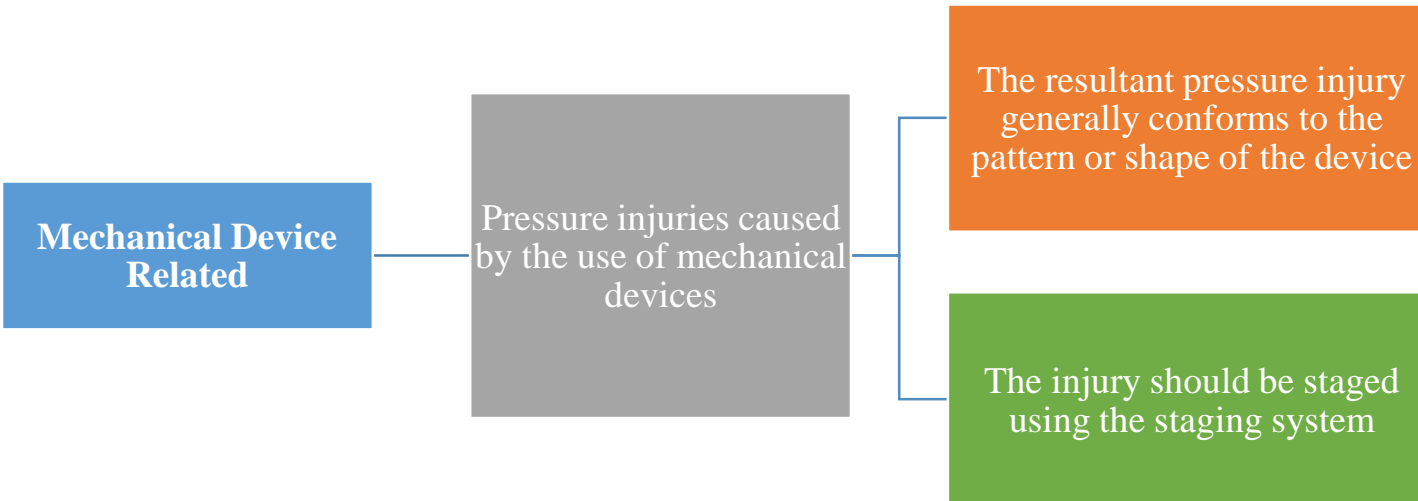
If deep tissue injury becomes necrotic, classify it as unstageable



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Mechanical Device Related Pressure Injury



Staging Scenario 1

CASE SCENARIO

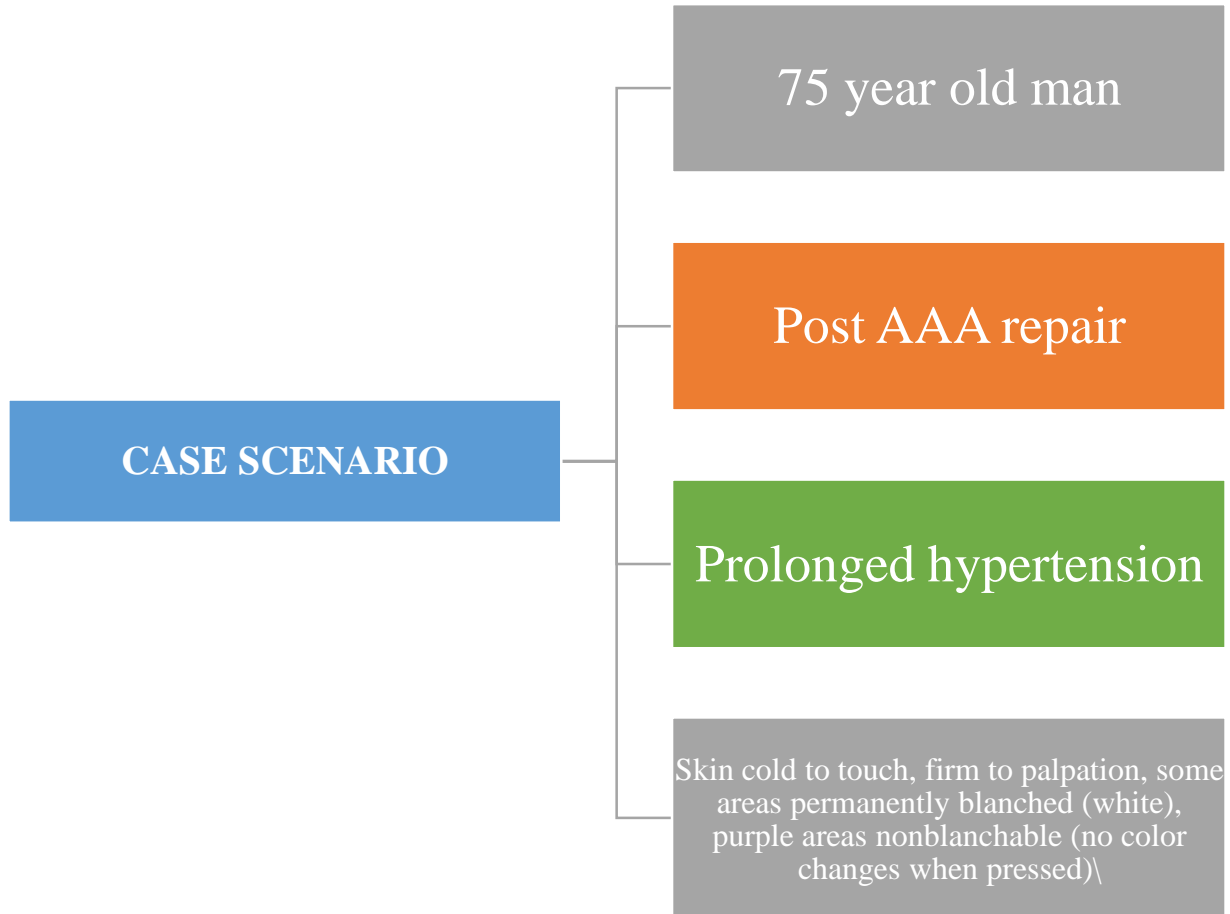
This 86 year old female has an area of reddened skin on the right heel.

The alteration in skin color persists under applied light pressure.

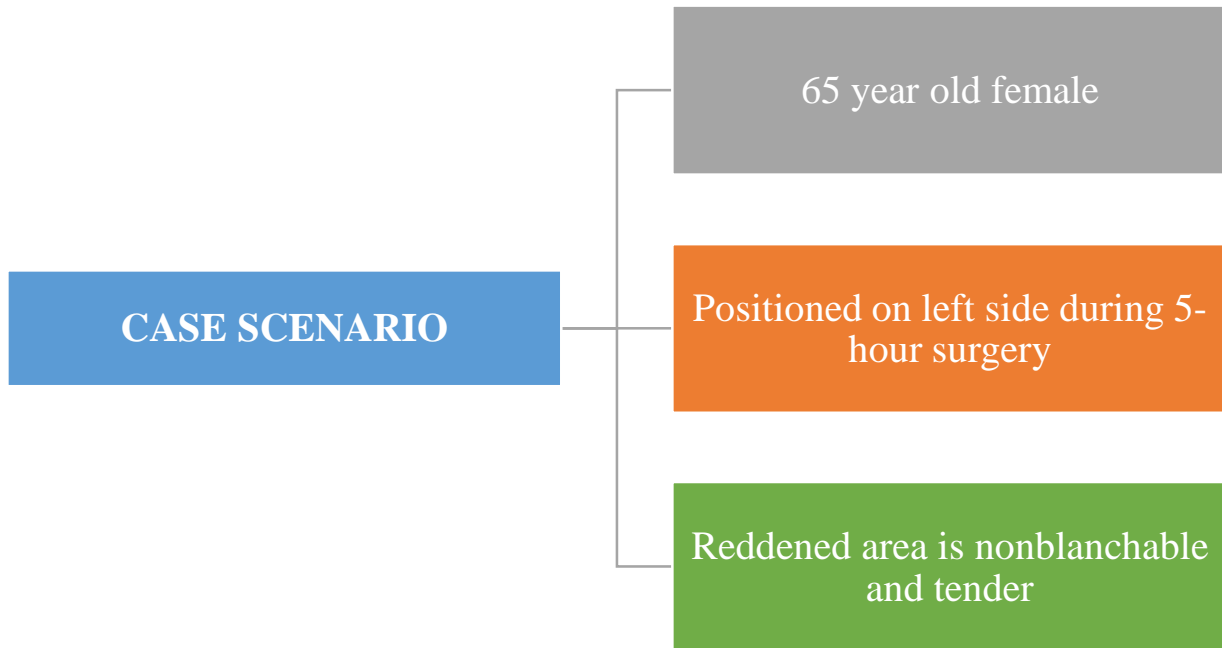
There is no break in the skin surface.



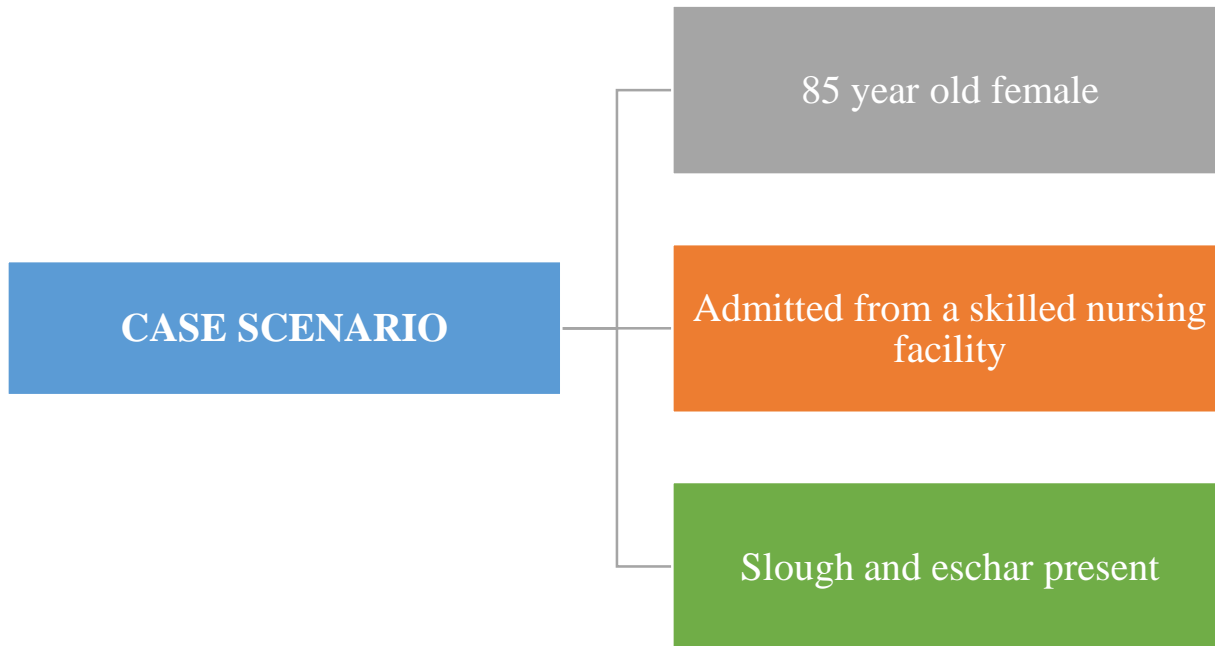
Staging Scenario 2



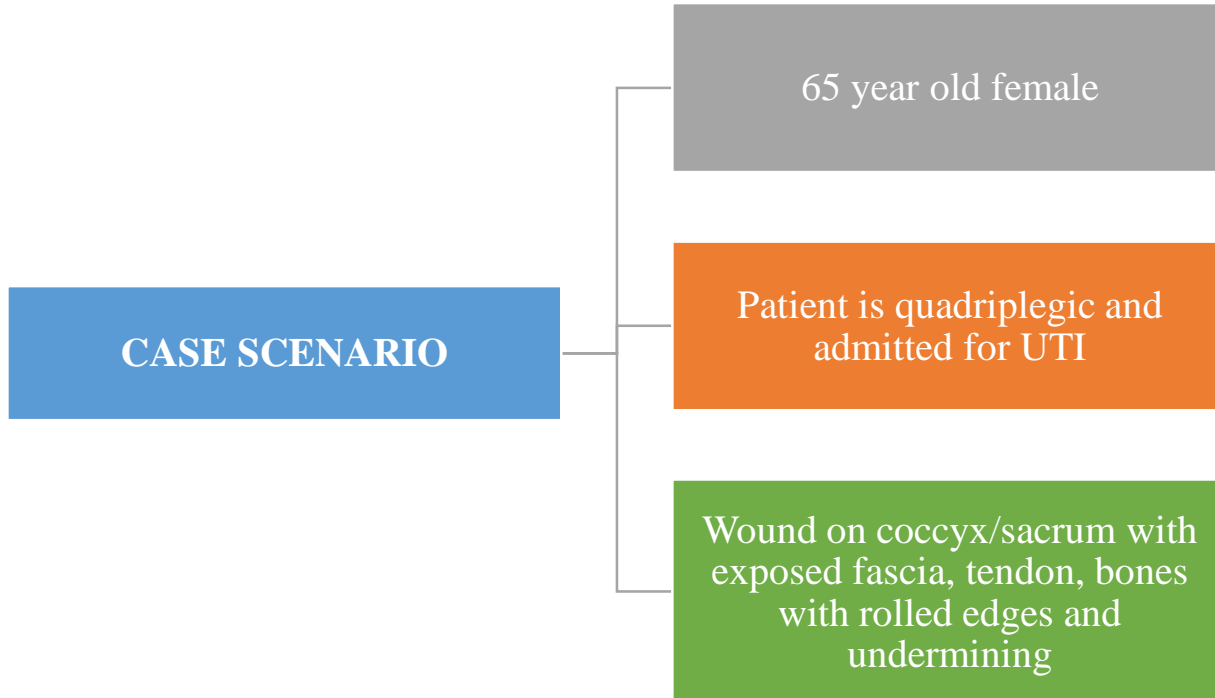
Staging Scenario 3



Staging Scenario 4



Staging Scenario 5



Staging Scenario 6

CASE SCENARIO

Female patient returning from PACU

She had an open laparotomy and was in the OR for 6 hours

She was hypovolemic and hypotensive in PACU and they never performed a skin check

You find an area of tissue that is darker than surrounding tissue & it's nonblanchable, the area is hot and patient complains of pain to that area



Staging Scenario 7

CASE SCENARIO

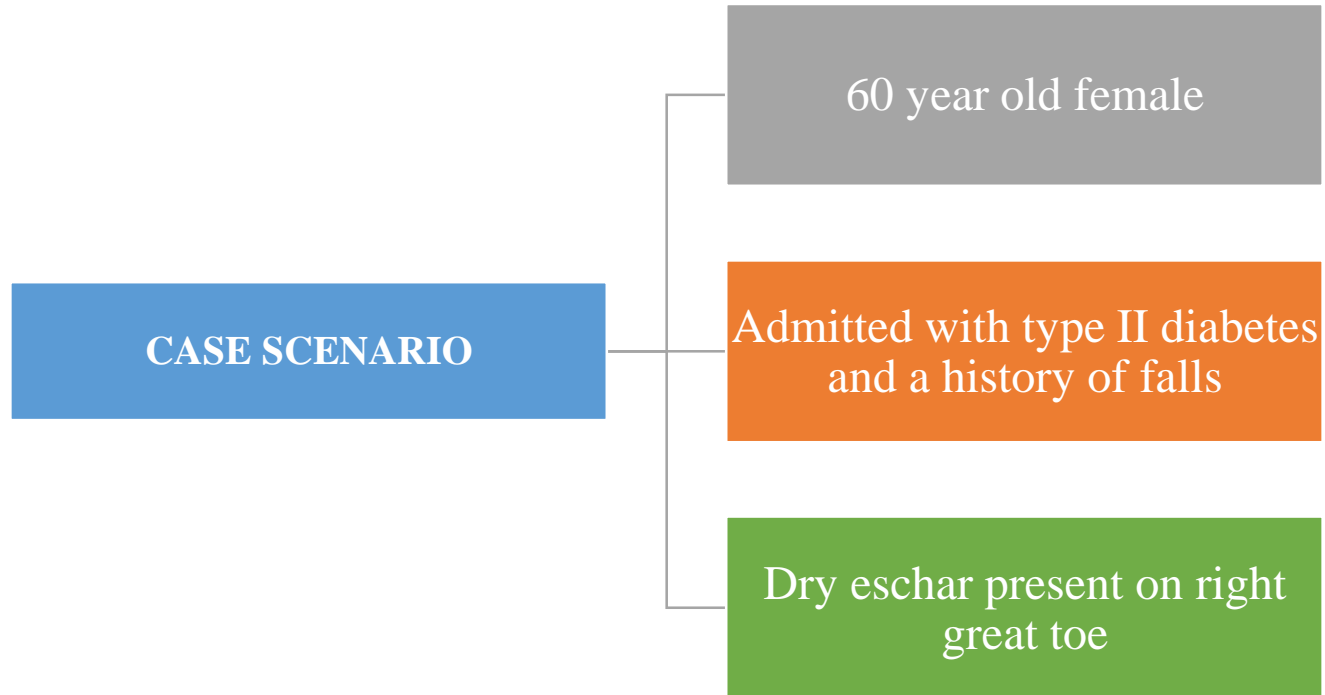
80 year old female

Admitted to medical surgical unit
for a fall and change in mental
status

Wound on ear with exposed fascia
and tendon with rolled edges



Staging Scenario 8



In this scenario, is it appropriate to remove the dry eschar?

Staging Scenario 9

CASE SCENARIO

40 year old male

Admitted in the ICU for acute pulmonary failure

Coccyx/sacrum wound with slough present with rolled edges, undermining and visible tendons



Staging Scenario 10

