Suspected Deep Tissue Injury (DTI): Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

Stage I: Intact skin with non-blancheable 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 dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.

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

Stage IV: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present or some parts of the wound bed. Often includes 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.

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

Nursing Documentation EPIC Electronic Healthcare

**Record:**
- Nursing Assessment & Reassessment:
  - Integumentary/Skin condition; Assess for presence of skin breakdown
  - Skin Integumentary head to toe assessment: Assess skin color; condition, temperature, integrity, location; turgor
  - Pressure Ulcer Risk Assessment using (Braden Scale) on admission & daily;
  - Initiate Best Practice Advisory (Care Plan) for score of 18 & below & for patient with actual skin breakdown.
  - Presence of Pressure Ulcer (notify MD to document presence of pressure ulcer);
  - Photographic Documentation – scan to media manager
  - Document if present on admission (POA)
  - Document pressure ulcer properties on first initial assessment then at least once/week & when there is a change in pressure ulcer characteristics. Document location; stage; state of healing; shape; size in cm: length, width, depth, tunneling, undermining and margins, drainage characteristics amount & odor
  - Assess & document assessment, treatment and dressings, dressing status every shift
  - Document other interventions: pressure relief - air mattress/devices, turning and offloading, pain management & nutrition interventions

**Interventions:**
- Pressure Relief: Offloading and avoidance of shearing forces with appropriate support surfaces: Air mattress, PRAFO “Pressure Relieving ankle/foot orthosis”; Chair cushion; position with pillow
- Activity: Turning with ROM q 2 hrs; Ambulate: exercise as able & OOB on a chair
- Nutrition: Dietary consult; Check Albumin level & total protein level. Address nutrition deficiency
- Perineal Care: Incontinent & Foley care
- Pain Management: Use World Health Organization (WHO) guidelines for pain management.

**Superficial/shallow/Deep wound**

**Red or Yellow wound**

**Infected wound**

**Necrotic Wound**

**Skin/Pressure Ulcer Risk Assessment**

**Stop NO YES**

**Is there a potential risk Braden Scale score of 18 below?**

**Presence of Pressure Ulcer**

**Place on skin care protocol**

**Initiate interventions to prevent pressure ulcers: pressure relief activity, nutrition, perineal care, incontinence care**

**Suspected Deep Tissue Injury (DTI)**

**Stage I:** No exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

**Stage II:** Full thickness tissue loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.

**Stage III:** Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

**Stage IV:** Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present or some parts of the wound bed. Often includes 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.