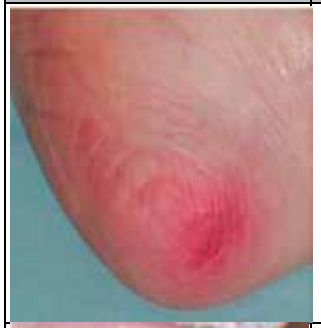
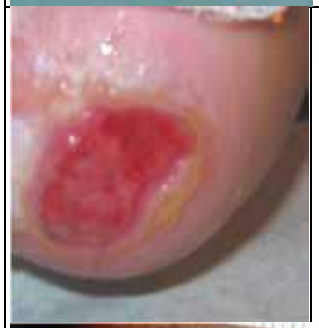
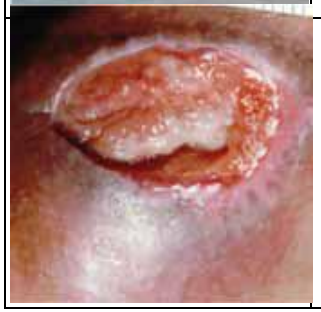
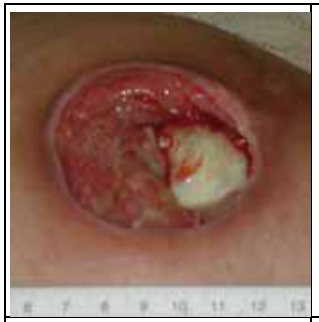
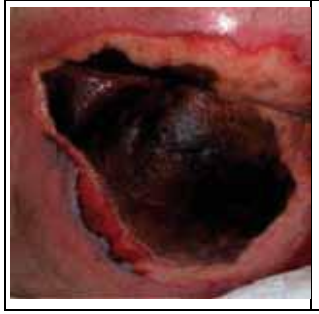
Pressure Injuries					
Picture of wound	**Wound**	**Indicator/descriptor**	**Management Aims**	**Product recommendations**	**Relevant Links**
	**Stage 1 Pressure injury** Non Blanchable Erythema	Intact skin with non-blancable redness of a localised area usually over a bony prominence. May be painful, firm, soft, warm or cool. May be difficult to detect in darker skin tones. May identify 'at risk' individuals.	Protect to prevent further injury	Transparent Hydrocolloid Adhesive Dressing (eg Comfeel TM) *Dependant on anatomical position, individual patient requirements and need to visualise wound with dressing intact*	Pressure Injury Prevention and Management Clinical Guideline
	**Stage 2 Pressure Injury** Partial Thickness Skin Loss	Partial thickness skin loss of dermis presenting as shallow, open wound with a red-pink wound bed, with no slough. May present as intact or ruptured serum filled blister. A shiny or dry, shallow ulcer without slough or bruising	Relieve pressure and protect wound from further trauma and contamination	Silcone Adhesive or non adherent foam may be considered	Pressure Injury Prevention and Management Clinical Guideline
	**Stage 3 Pressure injury** Full thickness Skin Loss	Full thickness tissue loss, subcutaneous fat may be visable but bone, tendon or muscle are not exposed. Slough may be present. Depth will depend on anatomical location	Relieve pressure and protect wound from further trauma and contamination	These wounds need thorough assessment to determine appropriate management. Hydrogel, Adhesive foam, Hydrofibre, Alginate or Silicone dressings may be considered	Pressure Injury Prevention and Management Clinical Guideline

	**Stage 4 Pressure Injury** Full Thickness tissue Loss	Full thickness tissue loss, with exposed bone, tendon or muscle. Slough or eschar may be present.	Relieve pressure and protect wound from further trauma and contamination	These wounds need thorough assessment to determine appropriate management. Hydrogel, Adhesive foam, Hydrofibre, Alginate or Silicone dressings may be considered A surgical review may be required at this stage	Pressure Injury Prevention and Management Clinical Guideline
	**Unstagable pressure Injury** Depth Unknown	Full thickness tissue loss in which the base is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black). True stage cannot be determined until enough Slough/Eschar is removed to measure actual depth	Unable to determine prior to debridement	Surgical debridement required	Pressure Injury Prevention and Management Clinical Guideline

Note: All dressing choices should be dependent on clinical assessment and individual patient needs