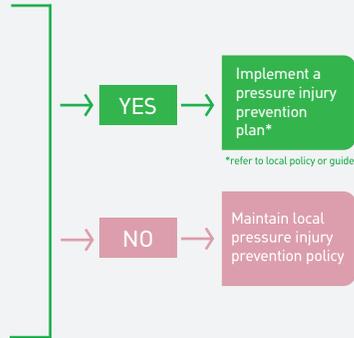
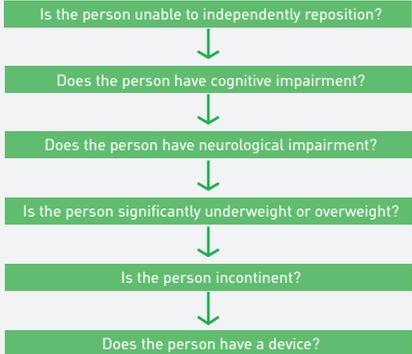


# Pressure Injury Assessment and Staging Clinical Decision Tree

## No pressure injury after assessment



## TIPS

### Wound assessment should include:

- Pain score
- Wound characteristics
- Exudate: Type, amount, colour, viscosity, malodour
- Edges: Flat, raised, rolled, undermined, colour
- Peri-wound skin: Erythema, pigmentation, induration
- Temperature, macerated, dry
- Infected or suspected biofilm
- Prevention and management of pressure injuries requires a multidisciplinary team approach

### Optimise pressure redistribution, consider:

- A five-layer silicone foam dressing on the sacrum and heels where appropriate and consider context
- High specification foam pressure redistributing support surface or speciality alternating pressure relieving support surface
- Promote skin health: Assess skin and tissue with every risk assessment
- Implement a skin hygiene care plan that includes cleaning and hydrating of the skin, cleansing after incontinence episodes

## Pressure injury after assessment

