### CLASSIFICATIONS of PRESSURE INJURY

**Stage I pressure injury: non-blanchable erythema**
- Intact skin with non-blanchable redness of a localized area usually over a bony prominence.
- Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area.
- The area may be painful, firm, soft, warmer or cooler compared to adjacent tissue.
- May be difficult to detect in individuals with dark skin tones.
- May indicate "at risk" persons (a heralding sign of risk).

**Stage II pressure injury: partial thickness skin loss**
- Partial thickness loss of dermis presenting as a shallow, open wound with a red-pink wound bed, without slough.
- May also present as an intact or open/ruptured serum-filled blister.
- Presents as a shiny or dry, shallow ulcer without slough or bruising (NB bruising indicates suspected deep tissue injury).
- Stage II PI should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.

**Stage III pressure injury: full thickness skin loss**
- Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunnelling.
- The depth of a stage III PI varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage III PIs can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage III PIs. Bone or tendon is not visible or directly palpable.

**Stage IV pressure injury: full thickness tissue loss**
- Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed.
- The depth of a stage IV pressure injury varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these PIs can be shallow. Stage IV PIs can extend into muscle and/or supporting structures (e.g. fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone or tendon is visible or directly palpable

**Unstageable pressure injury: depth unknown**
- Full thickness tissue loss in which the base of the PI is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the PI bed.
- Until enough slough/eschar is removed to expose the base of the PI, the true depth, and therefore the stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as the body’s natural biological cover and should not be removed.

**Suspected deep tissue injury: depth unknown**
- Purple or maroon localised area or discoloured, 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.
- Deep tissue injury may be difficult to detect in individuals with dark skin tone. Evolution may include a thin blister over a dark wound bed. The PI may further evolve and become covered by thin eschar.
- Evolution may be rapid, exposing additional layers of tissue even with optimal treatment

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### STAR CLASSIFICATION of SKIN TEARS

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1a</td>
<td>A skin tear where the edges <strong>can</strong> be realigned to the normal anatomical position (without undue stretching) and the skin or flap <strong>is not</strong> pale, dusky or darkened.</td>
</tr>
<tr>
<td>Category 1b</td>
<td>A skin tear where the edges <strong>can</strong> be realigned to the normal anatomical position (without undue stretching) and the skin or flap <strong>is</strong> pale, dusky or darkened.</td>
</tr>
<tr>
<td>Category 2a</td>
<td>A skin tear where the edges <strong>cannot</strong> be realigned to the normal anatomical position (without undue stretching) and the skin or flap <strong>is not</strong> pale, dusky or darkened.</td>
</tr>
<tr>
<td>Category 2b</td>
<td>A skin tear where the edges <strong>cannot</strong> be realigned to the normal anatomical position (without undue stretching) and the skin or flap <strong>is</strong> pale, dusky or darkened.</td>
</tr>
<tr>
<td>Category 3</td>
<td>A skin tear where the skin flap is completely absent.</td>
</tr>
</tbody>
</table>
HOW TO COMPLETE THE REGIONAL WOUND CHART

In order to standardise wound management in the Gippsland region, the wound assessment chart will now have a consistent format across the region. The charts have been designed to be utilised in acute, community and aged care settings. The following instructions are to facilitate the correct use of the chart. The wound assessment chart will also be used in the District Nursing Services to collect the quarterly wound data for the Department of Health.

Data collection for District Nursing Services
The following data needs to be collected on cessation of service (death or discharge) and when EACH wound heals.

- UR
- Wound aetiology
- Location
- Date of injury
- Date of healing (cessation) - The date the wound no longer requires a dressing or the person is discharged or has died. Excludes ongoing compression.
- If wound healed (yes or no)

This information will be requested on a quarterly basis from the DH. It will be collated and given back to organisations to benchmark against each other and to establish a regional profile.

A CHART IS COMPLETED FOR EACH INDIVIDUAL WOUND except where several wounds exist in close proximity and are treated with the same dressing or regime.

FRONT PAGE –
The first page is completed with each new chart.

Wound Aetiology / History – provide a brief history of current management strategies and any relevant previous treatments

Allergies / Sensitivities - List allergies/sensitivities and the reaction that it causes.

Wound type – Tick the wound type Eg Acute – surgical or wound < 3 weeks old. A chronic wound is only a wound which will not fit into any other wound aetiology. Eg Leg ulcer or pressure injury. For a non-acute lower leg wound, the lower limb assessment chart should be completed by a suitably qualified nurse / CNC.

Factors affecting healing – Tick any factors that will negatively affect the wound healing.

Wound Location – Tick the location and mark with an X the wound location on the body aspect.

Referrals – List any referrals made and/or investigations performed.

BACK PAGE – Product Selection
This page is ONLY to be completed when the dressing regime or products used for wound management are changed. If the regime is changed the person instigating the change must record the reason the regime was changed and sign the new treatment regime. After 6 changes there must be a new chart.

INSIDE PAGES – Clinical wound assessment
The second or third page is completed every time the wound dressing is attended. There is provision for 14 episodes of wound care to be recorded.

Wound Number – is recorded if the individual has more than one wound consecutively.

Week Number – is recorded if the service is required or prefers to monitor outcomes on a weekly basis.

Symptoms of impending infection – If one or more of these are present in the wound bed or surrounding tissue then specific management to reduce microbial load needs to be instigated. The level of intervention, topical antimicrobial, oral or IV antibiotic will depend on the level of host response.

DEFINITION of TISSUE TYPES

Epithelial tissue –
Epithelial tissue is also known as the top layer of your skin. Epithelialisation occurs as epithelial cells migrate over granulation tissue from the wound margins, hair follicles and sweat glands within the wound.

Granulation tissue –
New connective tissue and tiny blood vessels that form on the surfaces of a wound during the healing process. Granulating tissue is composed of collagen and "ground substance", and contains new capillary loops that give granulation tissue its characteristic red colour.

Slough –
Slough refers to moist necrotic tissue. This type of devitalised tissue is soft, moist and often stringy in consistency and is usually yellow, white or grey in colour.

Eschar –
Necrotic devitalised tissue. Appears as hardened dark scab or leathery base.