

Stage 1 pressure ulcer  
Stage 2 pressure ulcer

Intact skin with nonblanchable redness

Partial loss of dermis. Shallow open ulcer, usually shiny, or dry. Red-pink wound bed without sloughing or bruising.

Stage 3 pressure ulcer

Full thickness tissue loss, subcutaneous fat may be visible. Possible undermining

Stage 4 pressure ulcer

and tunneling.  
Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present as well as undermining and tunneling.

Unstageable pressure ulcer

Full thickness tissue loss, wound base covered by slough and eschar therefore depth cannot be determined.

Slough yellow, tan, gray,  
Nursing interventions to prevent pressure ulcers

green, or brown.  
Reposition bed bound pt every two hours, instruct pt in wheelchair to shift their weight every hour. Use of cushions to optimize nutrition and hydration.

Cognition

All the processes involved in human thought

External nutrition

Nutrition support via tube feedings

Parenteral nutrition

Nutrition supplied intravenously

DRI

Refers to a set of nutritional based values that serve for both assessing and

# Study Guide For Stage 3 Dog

**Kim Heldman**



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