We’re Targeting RED!
For Nursing staff

Stage I Pressure Ulcer Definition- “Intact skin with non-blanchable 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. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage I may be difficult to detect in individuals with dark skin tones”.-National Pressure Ulcer Panel (NPUAP), 2007.

Watch for:
- Reddened/discolored intact skin
- Area does not blanch (skin briefly lightens when touched)
- Altered temperature or sensation, pain
- Skin may feel softer or firmer than surrounding skin

What do I do when I see RED?

Reposition the patient or medical device to remove pressure from the area and report your findings to the patient’s nurse.

Encourage & endorse interventions to protect the patient’s skin: repositioning of the patient and/or medical device, recommend alternative pressure redistribution device, loosen equipment.

Document that you notified the patient’s nurse of the redness/abnormal inspection and any interventions you implemented.

Your role is paramount in assisting in the prevention and detection of Stage I pressure ulcers. You may be the first person to see redness developing on a patient’s skin.

When you do see RED, notify the patient’s nurse and partner with them to stop a Stage I pressure ulcer in its tracks!

TARGET prevention and early intervention to keep our patients’ skin healthy!
Target your skin inspection: Assess pressure points and under ALL medical devices!