Bethesda Hospital

Member of HealthEast Care System

# 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.

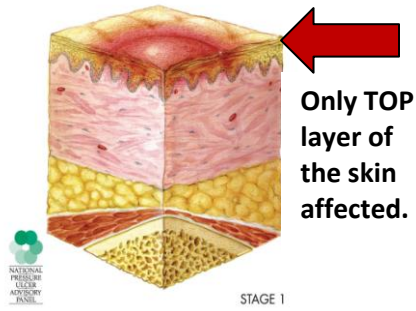
***Watch for:***

***-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***




**Only TOP layer of the skin affected.**

*What do I do when I see **RED**?*

***R*eposition** the patient or medical device to remove pressure from the area and **report** your findings to the patient's nurse.

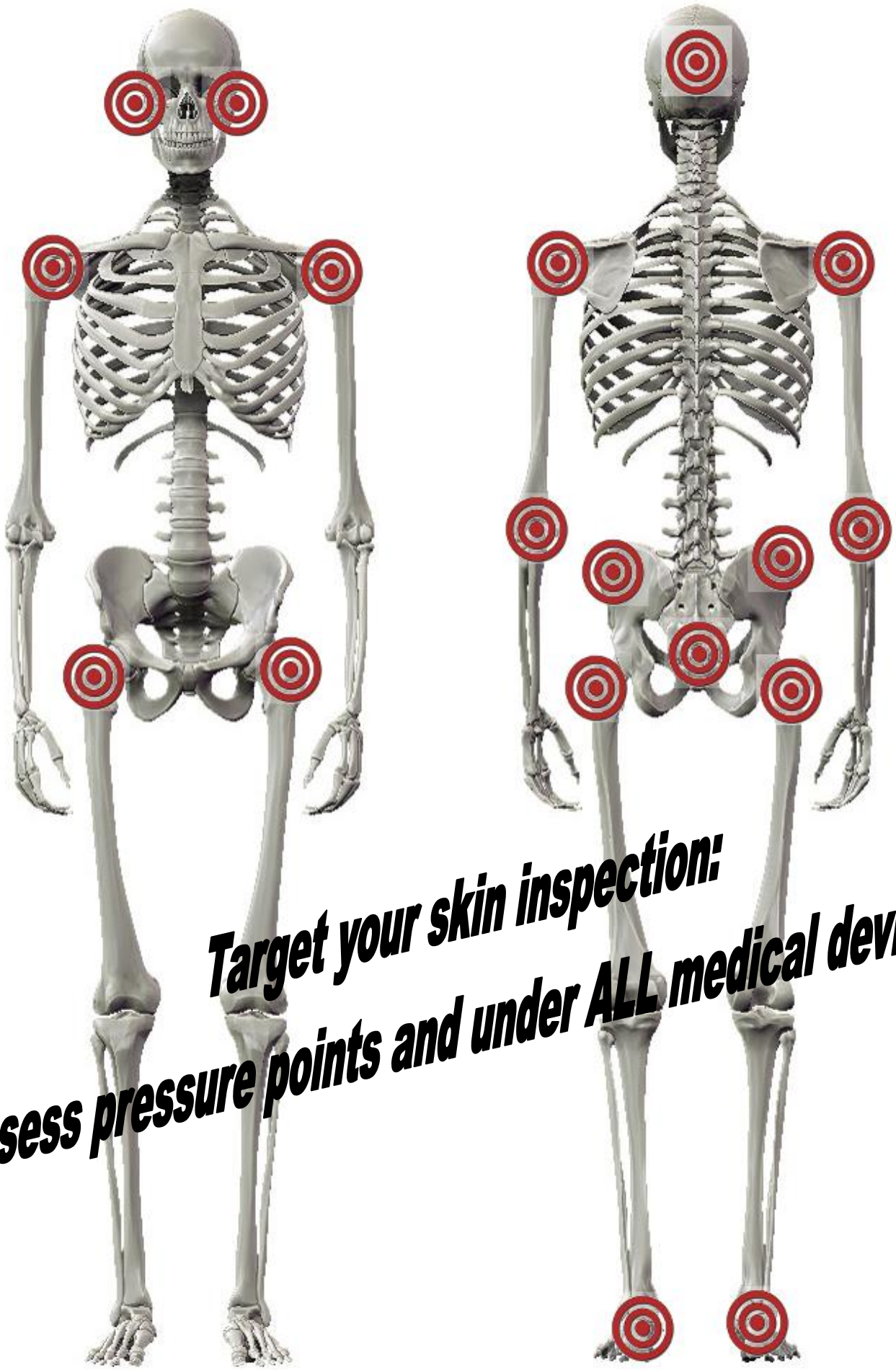
***E*ncourage** & **endorse** interventions to protect the patient's skin: repositioning of the patient and/or medical device, recommend alternative pressure redistribution device, loosen equipment.

***D*ocument** 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!**