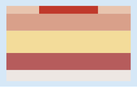
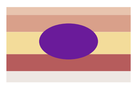
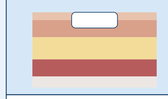
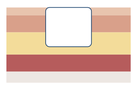
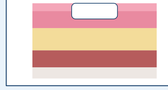
Pressure Injury Dressing Selection Guide

IIWCG Wound Care | 2026 | Based on the International Guideline (NPIAP, EPUAP, PPPIA)

Gulnaz Tariq, RN, RM, IIWCC, MSc Skin Integrity and Dermatology | November 2026

Dressing Selection by Stage

Stage	Goals	Wound care	Dressing options	Escalate when
Stage 1 	• Protect skin • Prevent progression	• Offload the area completely • Protect from moisture and friction • Check at least daily	• No dressing required • Film or soft silicone foam to protect from friction and shear • Barrier product if incontinent	• Does not resolve, or progresses • Heel: check perfusion
Suspected deep tissue injury 	• Offload • Monitor evolution	• Do not debride; mark, measure and photograph • Reassess at least daily; may evolve over days • Keep blood blisters intact	• Leave intact skin uncovered, or protect with soft silicone foam • Blood blister: non-adherent contact layer with absorbent cover	• Opens or darkens: reclassify • Boggy, fluctuant or new pain
Stage 2 	• Moist healing • Protect new epithelium • Manage exudate	• Cleanse with saline or potable water • Keep serum blisters intact unless tense or large (local policy) • Protect periwound skin	**Low exudate:** hydrocolloid, hydrogel, polymeric membrane **Moderate to heavy:** foam, calcium alginate, gelling fibre	• No signs of healing in 2 weeks • Diffuse, in skin folds: consider moisture damage
Stage 3 	• Fill dead space • Remove non-viable tissue • Moisture balance • Prevent infection	• Cleanse wound and periwound at every change • Debride slough when consistent with goals • Measure depth, undermining and tunnelling • Fill cavities loosely	**Minimal exudate:** hydrogel **Moderate:** alginate, gelling fibre rope, foam **Heavy:** superabsorbent • Antimicrobial if infection or biofilm • NPWT (WC3) once clean	• Infection signs • Undermining or tunnelling hard to manage • Not closing in a defined period: surgical review (WC6)
Stage 4 	• As Stage 3 • Protect exposed structures	• As Stage 3; keep bone and tendon moist • Probe to bone: assess for osteomyelitis (imaging, bone biopsy) • Rule out osteomyelitis before NPWT	• As Stage 3, with an antimicrobial contact layer if infection or biofilm • NPWT suggested (WC3, conditional)	• Suspected osteomyelitis or sepsis: urgent surgical review • Not closing with standard care
Unstageable 	• Agree goals first • Debride if healable • Protect if not	• Heel or poor perfusion with stable, dry eschar: do not debride; vascular assessment • Elsewhere: debride (autolytic, enzymatic, sharp) when consistent with goals, then reclassify	**Stable dry eschar:** keep dry, pad and offload; povidone-iodine paint per local policy **Autolytic:** hydrogel, hydrocolloid **Exuding:** alginate, gelling fibre, foam	• Eschar turns boggy, fluctuant, red or draining: urgent review and debridement
Device-related 	• Remove the cause • Protect	• Reposition, resize or remove the device; relieve tension • Stage with the same system • Check under the device every shift	• Dress by stage • Thin silicone foam or hydrocolloid under the device, without adding pressure (DRPI6)	• Recurs at the same site • Device cannot be moved: involve the team
Mucosal membrane 	• Remove the cause • Comfort	• Do not stage • Reposition or remove the device • Gentle cleansing with water; regular oral care	• Usually no dressing • Lubricant or barrier on lips per local policy • Treat oral thrush if present	• Deep or not healing: medical, ENT or dental review

Before Any Dressing

1. **Treat the cause**
   Offload, support surface, repositioning, nutrition
2. **Assess (WC1)**
   Size, bed, edges, periwound, infection, pain, goals
3. **Manage pain**
   Before and during dressing changes
4. **Cleanse**
   Wound and periwound skin at every change
5. **Debride**
   When consistent with goals and blood supply allows
6. **Manage infection**
   Therapeutic cleansing, antimicrobials, systemic if spreading
7. **Re-establish the edge**
   Refashion rolled or undermined edges
8. **Select the dressing**
   By exudate, tissue, infection, comfort, resources
9. **Consider advanced care**
   NPWT (WC3), electrical stimulation (WC4)

Wound care steps from WC2, International Guideline 2026. Frame with TIMERS: tissue, infection, moisture, edge, repair, social.

Match the dressing to the exudate

Dry or minimal	Low	Moderate	Heavy
Hydrogel Hydrocolloid Film (cover)	Hydrocolloid Polymeric membrane Thin foam	Foam Calcium alginate Gelling fibre	Superabsorbent Gelling fibre + foam NPWT

Infection or biofilm: add an antimicrobial (silver, iodine, PHMB, medical-grade honey, DACC). **Odour:** charcoal, after treating the cause.

Monitor and reassess (WC5)

- Inspect at every dressing change; full assessment if it deteriorates
- Full assessment at least weekly, same method and position
- Use a healing tool, e.g. PUSH or BWAT
- Re-evaluate the plan at 2 weeks: some healing expected
- No progress: reassess the whole person, consider biopsy and photography
- Medium and dark skin: use temperature, tenderness, tissue consistency and pain
- Assess pain every time with a validated tool
- End of life: comfort and symptom control may be the goal

Key Considerations

Infection and biofilm

- Covert signs: friable or excess granulation, breakdown, delayed healing, new pain or odour
- Overt signs: redness, warmth, swelling, pus
- Therapeutic cleansing and debridement first, then a topical antimicrobial
- Review antimicrobials after 2 weeks
- Spreading or systemic infection: systemic antibiotics and urgent review
- Fever with no other source: suspect pressure injury bacteraemia

Refer for surgical review (WC6)

- Advancing cellulitis or suspected source of sepsis
- Undermining, tunnelling, sinus tracts or extensive necrosis not easily debrided
- Stage 3 or 4 not closing with standard care in a defined period

Nutrition for healing

- Energy about 25–30 kcal/kg/day if calorimetry not available
- Protein for positive nitrogen balance: older adults 1.2–1.5 g/kg; critically ill 1.2–2.0 g/kg
- Offer supplements with energy, protein and micronutrients (N9); arginine and zinc formulas (N10, N11)
- Check renal function before high protein

NPWT safety

- Rule out osteomyelitis; confirm blood supply for heel and foot
- Caution with anticoagulants, bleeding or wounds near major vessels
- Stop and seek advice if bright red bleeding

References

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3. Swanson T, Ousey K, Haesler E, et al. IWII Wound Infection in Clinical Practice consensus document: 2022 update. J Wound Care. 2022;31(Sup12):S10-21.
4. Murphy C, Atkin L, Vega de Ceniga M, et al. Embedding wound hygiene into a proactive wound healing strategy. J Wound Care. 2022;31(Sup4a).
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Generic dressing categories only: follow your local formulary and manufacturers' instructions. Dressing types draw on the 2019 guideline; the 2026 chapter asks for selection by wound characteristics. This guide supports, and does not replace, clinical judgement.