Pressure Injury Classification: Terminology and Staging
Objectives

After completing this lesson, the participants will be able to:

1. Define what a pressure injury is.
2. Identify the location of pressure points.
3. Describe the different stages of pressure injuries.
What is a pressure injury?

- Localized damage to the skin and/or underlying soft tissue.
- Usually over a bony prominence or related to a medical or other device.
- May present as intact skin or an open ulcer and may be painful.
What is a pressure injury? (continued)

- Occurs as a result of intense and/or prolonged pressure or pressure in combination with shear.
- The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and the condition of the soft tissue.
Know the pressure points...
Common pressure points at risk for injury

Common pressure points at risk for injury

Jackknife position
- Forehead or ear, depending upon position
- Anterior shoulders
- Illiac crests
- Knees, shins
- Toes

Wilson Frame position
- Forehead or ear, depending upon position
- Clavicles
- Elbows
- Illiac crests
- Knees
- Anterior ankles/feet

Prone position
- Forehead or ear, depending upon position
- Anterior shoulders and/or clavicles
- Chin
- Breasts (women)
- Genitalia (Men)
- Knees
- Toes
Pressure Injury Classification System: What has changed?
What has changed?

- The term “pressure injury” has replaced “pressure ulcer” in the NPUAP definitions.
- Arabic numbers, rather than Roman numerals will be used.
- The term “suspected” has been removed from Deep Tissue Injury.
- Additional definitions include Device-related Pressure Injury and Mucosal Membrane Pressure Injury.
Staging system

Classification for pressure injuries.
Describes the depth of tissue destruction visible.
If necrotic tissue present, accurate staging may not be possible.

NPUAP Position Statement

- Reverse staging should not be used to describe the healing of pressure ulcers.
- The body is unable to regenerate certain tissues (fat, fascia, muscle), therefore, reverse staging is inaccurate when used as a parameter for wound healing.
Stage 1 Pressure Injury

• Intact skin with a localized area of non-blanchable erythema; may appear differently in darkly pigmented skin.

• Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes.

• Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.
Stage 1 Pressure Injury illustrations

- Epidermis
- Dermis
- Subcutaneous layer
- Bone
Stage 2 Pressure Injury

- Partial-thickness loss of skin with exposed dermis.
- Wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister.
  - Adipose (fat) and/or deeper tissues are not visible.
  - Granulation tissue, slough and eschar are not present.
- Commonly results from adverse microclimate and shear in the skin over the pelvis and shear in the heel.
- This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).
Stage 2 Pressure Injury illustrations

Epidermis
Dermis
Subcutaneous layer
Bone
Differentiate Stage 2 Pressure Injury from Moisture-Related Dermatitis
Stage 3 Pressure Injury

- Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible.

- Depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds.

- Undermining and tunneling may occur.

- Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed.

- If slough or eschar obscures the extent of tissue loss; this is an Unstageable Pressure Injury.
Stage 3 Pressure Injury illustrations

Epidermis
Dermis
Subcutaneous layer
Bone
Stage 4 Pressure Injury

- Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer.
- Slough and/or eschar may be visible.
- Epibole (rolled edges), undermining and/or tunneling often occur.
- Depth varies by anatomical location.
- If slough or eschar obscures the extent of tissue loss; this is an Unstageable Pressure Injury.
Stage 4 Pressure Injury illustrations

- Epidermis
- Dermis
- Subcutaneous layer
- Bone
Stage 4 Pressure Injury illustrations

A

B

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Unstageable Pressure Injury

- Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar.

- If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed.

- Stable eschar (ie dry, adherent, intact without erythema or fluctuance) on an ischemic limb or the heel(s) should not be removed.
Unstageable Pressure Injury illustrations
Deep Tissue Pressure Injury

- Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister.
- Pain and temperature change often precede skin color changes.
- Discoloration may appear differently in darkly pigmented skin.
- This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. (Continued on next slide).
Deep Tissue Pressure Injury (continued)

• If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full-thickness pressure injury (Unstageable, Stage 3 or Stage 4).

• Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.
Deep Tissue Pressure Injury illustrations

Epidermis
Dermis
Subcutaneous layer
Bone
Medical Device-related Pressure Injury

- Results from the use of devices designed and applied for diagnostic or therapeutic purposes.
- The resultant pressure injury generally conforms to the pattern or shape of the device.
- The injury should be staged using the staging system.
Mucosal Membrane Pressure Injury

• Tissue damage found on mucous membranes with a history of a medical device in use at the location of the injury.

• Due to the anatomy of the tissue these injuries cannot be staged.
In summary: NPUAP Pressure Injury Classification System

<table>
<thead>
<tr>
<th>Previous staging system</th>
<th>Updated staging system</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure ulcer</td>
<td>Pressure Injury</td>
</tr>
<tr>
<td>Stage I</td>
<td>Stage 1</td>
</tr>
<tr>
<td>Stage II</td>
<td>Stage 2</td>
</tr>
<tr>
<td>Stage III</td>
<td>Stage 3</td>
</tr>
<tr>
<td>Stage IV</td>
<td>Stage 4</td>
</tr>
<tr>
<td>Unstageable Pressure Ulcer</td>
<td>Unstageable Pressure Injury</td>
</tr>
<tr>
<td>Suspected Deep Tissue Injury</td>
<td>Deep Tissue Pressure Injury</td>
</tr>
<tr>
<td></td>
<td>Device-related Pressure Injury</td>
</tr>
<tr>
<td></td>
<td>Mucosal Membrane Pressure Injury</td>
</tr>
</tbody>
</table>
Resources for pressure ulcers/injuries prevention

<table>
<thead>
<tr>
<th>Resources</th>
<th>Key information</th>
</tr>
</thead>
</table>
| Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline (NPUAP)  
www.npuap.org  
www.internationalguideline.com | Pictures of various pressure ulcer stages  
Quick reference guide to evidence-based prevention  
Quick reference guide for treatment |
| Guideline for Prevention and Management of Pressure Ulcers (WOCN Society)  
www.wcon.org | Pictures of pressure ulcers  
History and assessment factors  
Causes of pressure ulcers |
