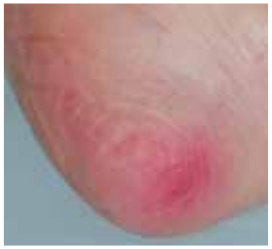
HOW TO CLASSIFY AND DOCUMENT PRESSURE INJURIES

The NPUAP/EPUAP Pressure injury classification system provides a consistent and accurate means by which the severity of a pressure injury can be communicated and documented.

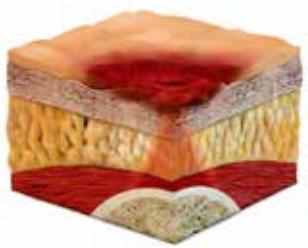
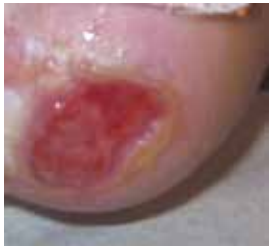
Stage 1

- Intact skin with non-blanchable redness of a localised area usually over a bony prominence.
- Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area.
- The area may be painful, firm, soft, warmer or cooler compared with adjacent tissue.
- May be difficult to detect in individuals with dark skin tones.
- May indicate "at risk" persons (a heralding sign of risk).

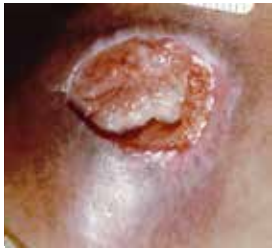
Stage 2

- Partial thickness loss of dermis presenting as a shallow, open wound with a red-pink wound bed, without slough.
- May also present as an intact or open/ruptured serumfilled blister.
- Presents as a shiny or dry, shallow ulcer without slough or bruising (NB bruising indicates suspected deep tissue injury).
- Stage 2 PI should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.

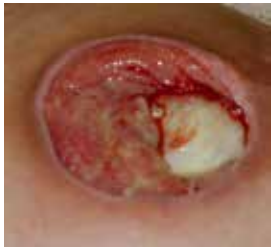
Stage 3

- Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunnelling.
- The depth of a stage 3 PI varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage 3 PIs can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage 3 PIs. Bone or tendon is not visible or directly palpable.

Stage 4

- Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed.
- The depth of a stage 4 pressure injury varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these PIs can be shallow. Stage 4 PIs can extend into muscle and/or supporting structures (e.g. fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone or tendon is visible or directly palpable.

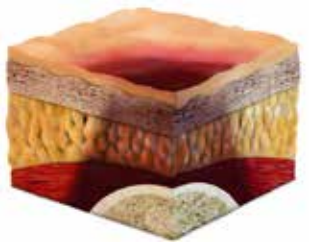
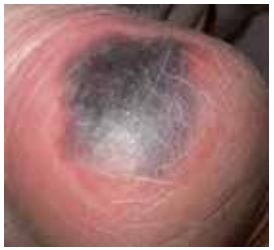



Unstageable

- Full thickness tissue loss in which the base of the PI is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the PI bed.
- Until enough slough/eschar is removed to expose the base of the PI, the true depth, and therefore the stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as the body's natural biological cover and should not be removed.


Stage – suspected deep tissue injury

- Purple or maroon localised area or discoloured, intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared with adjacent tissue.
- Deep tissue injury may be difficult to detect in individuals with dark skin tone.
- Evolution may include a thin blister over a dark wound bed. The PI may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.

All 3D graphics designed by Jarrad Gittos, Gear Interactive, http://www.gearinteractive.com.au
Photos stage, I,IV, unstageable and suspected deep tissue injury courtesy C. Young, Launceston General Hospital.
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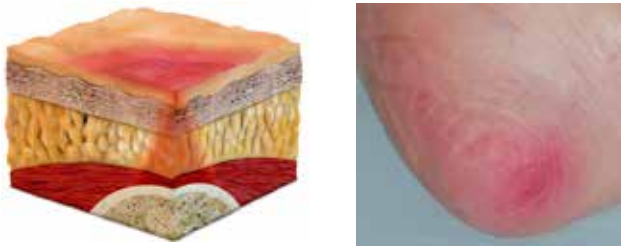
PRESSURE INJURES – WHAT TO LOOK FOR

Stage 1

A red area of skin that does not turn white when pressed with a finger (this is called non-blanchable redness). There may also be some swelling.

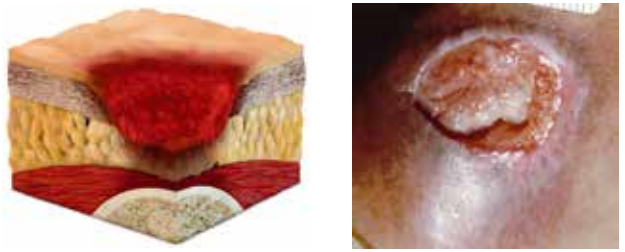


Stage 2

The top layer of skin is broken and the bottom of the wound looks red or pink or sometimes there is a blister, that may weep clear fluid.

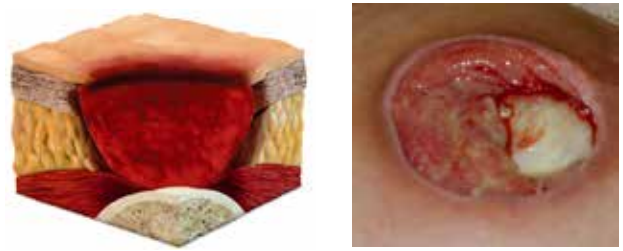
Stage 3

The wound is deeper, down to the bottom layers of skin. You may see fat, but not muscle, tendon or bone. There may be gaps (loss of tissue) under the edges of the skin.



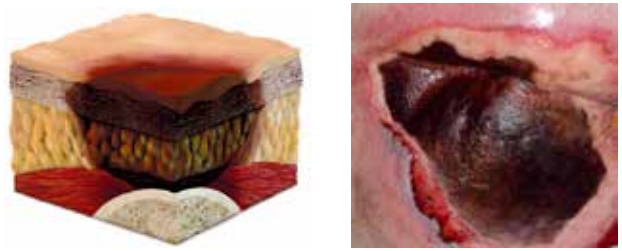
Stage 4

The wound is through the skin and into the muscle, tendon, bone, or cartilage.



Stage - Unstageable

This is a deep wound where there is a layer of dead tissue covering the bottom. This is called slough or eschar which may be yellow, tan, grey, green, brown or black.



Stage - Suspected Deep Tissue Injury

The skin on top may look purple, maroon or navy, or may look like a blood filled blister. It can be hard to see on dark skin. It may have felt painful, hard, mushy or boggy, and warmer or cooler than the adjacent tissue. It may break down quickly, even when off the area.

Guidance:
If your patient, client or family member has any areas of the skin you are concerned about: Turn and move them off this area. Check their skin on the pressure points they are now lying on. Elevate heels off bed. Notify your nurse, medical support or manager.

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