



UPDATED PRESSURE INJURY DEFINITIONS AND STAGING

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Pressure injury stages are defined and updated by the National Pressure Injury Advisory Panel (NPIAP, formerly National Pressure Ulcer Advisory Panel or NPUAP). The most recent updates occurred during the NPIAP 2016 Staging Consensus Conference in Chicago. These changes updated the previous 2007 NPUAP Staging System. The first staging system was released in 1989.

Pressure injury has replaced terms including pressure wound, pressure ulcer or bed sore. The current NPIAP pressure injury definition is:

“A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury 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 condition of the soft tissue.”

Pressure injury staging is used to determine the degree of injury and direct treatment. It is critical that anyone on the health care team who is ‘staging’ a pressure injury is using the most up to date definitions and has adequate training to do so. Here are the updated NPIAP staging definitions:

STAGE 1 PRESSURE INJURY: NON-BLANCHABLE ERYTHEMA OF INTACT SKIN

Intact skin with a localized area of non-blanchable erythema, which 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 2 PRESSURE INJURY: PARTIAL-THICKNESS SKIN LOSS WITH EXPOSED DERMIS

The wound bed is viable, pink or red, moist and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result 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 including incontinence associated dermatitis, intertriginous dermatitis, medical adhesive related skin injury, or traumatic wounds (skin tears, burns, abrasions).

“A PRESSURE INJURY IS LOCALIZED DAMAGE TO THE SKIN AND UNDERLYING SOFT TISSUE USUALLY OVER A BONY PROMINENCE OR RELATED TO A MEDICAL OR OTHER DEVICE.”

STAGE 3 PRESSURE INJURY: FULL-THICKNESS SKIN LOSS

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. The 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 4 PRESSURE INJURY: FULL-THICKNESS SKIN AND TISSUE LOSS

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.

UNSTAGEABLE PRESSURE INJURY: OBSCURED FULL-THICKNESS SKIN AND TISSUE LOSS

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

“THIS INFORMATION IS ALSO VERY PERTINENT FOR FUNDING SOURCES. NPIAP WORKS CLOSELY WITH THE CENTERS FOR MEDICARE AND MEDICAID SERVICES TO EDUCATE THIS PRIMARY FUNDING SOURCE ON THE LATEST EVIDENCE AND IMPROVE APPROPRIATE PRODUCT PROVISION.”

injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.

DEEP TISSUE PRESSURE INJURY: PERSISTENT NON-BLANCHABLE DEEP RED, MAROON OR PURPLE DISCOLORATION

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. 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.

NPIAP also has definitions for Medical Device Related Pressure Injury and Mucosal Membrane Pressure Injury.

Finally, NPIAP released a position statement on staging that includes seven individual positions. These positions address pressure injury causes, prevention, progression, limitations and more. This information is also very pertinent for funding sources. NPIAP works closely with the Centers for Medicare and Medicaid Services to educate this primary funding source on the latest evidence and improve appropriate product provision.

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REFERENCES

The National Pressure Injury Advisory Panel, npiap.com

Pressure Injury Stages
https://cdn.ymaws.com/npupap.site-ym.com/resource/resmgr/npupap_pressure_injury_stages.pdf

NPUPAP Position Statement on Staging – 2017 Clarifications
<https://cdn.ymaws.com/npupap.site-ym.com/resource/resmgr/npupap-position-statement-on-.pdf>

Michelle Lange is an occupational therapist with over 30 years of experience and has been in private practice, Access to Independence, for over 10 years. She is a well-respected lecturer, both nationally and internationally, and has authored numerous texts, chapters and articles. She is the co-editor of Seating and Wheeled Mobility: a clinical resource guide, editor of Fundamentals in Assistive Technology, Fourth Edition, NRRTS Continuing Education Curriculum Coordinator and Clinical Editor of NRRTS DIRECTIONS magazine. Lange is a RESNA Fellow and member of the Clinician Task Force. She is a certified ATP, certified SMS and is a Senior Disability Analyst of the ABDA.

