

Guidelines for Staging of Pressure Injuries*

*National Pressure Ulcer Advisory Panel (NPUAP) – Accessed April 2016.



Stage 1



Stage 1
with Edema



Stage 2



Stage 3



Stage 3
with Epibole



Stage 4



DTI



Unstageable with
Dark Eschar



Unstageable with
Slough & Eschar

PRESSURE INJURY

A pressure injury is localized damage to the skin and/or 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 injury 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.

STAGE 1

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

Partial-thickness loss of skin 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.

STAGE 3

Full-thickness loss of skin, in which adipose (fat) is visible in the injury 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.

STAGE 4

Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the injury. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location.

DEEP TISSUE 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.

UNSTAGEABLE

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

MEDICAL DEVICE RELATED PRESSURE INJURY

This describes an etiology. Medical device related pressure injuries result 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

Mucosal membrane pressure injury is 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.

WOUND ASSESSMENT CHECKLIST

- Location
- Size
- Dressing Used
- Drainage (Amount/Color/Odor)
- Undermining/Tunneling
- Stage
- Pressure Redistribution
- Nutritional Assessment
- Viable Tissue in Wound

Braden Scale for predicting pressure injury risk (Copyright Braden and Bergstrom, 1988)

When eschar is present, a pressure injury cannot be accurately staged until the eschar is removed.

Sensory Perception ability to respond meaningfully to pressure related discomfort	1. Completely limited: Unresponsive (does not moan, flinch or gasp) to painful stimuli, due to diminished level of consciousness or sedation, OR limited ability to feel pain over most of the body surface.	2. Very limited: Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body.	3. Slightly limited: Responds to verbal commands but cannot always communicate discomfort or need to be turned, OR has some sensory impairment which limits the ability to feel pain or discomfort in 1 or 2 extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.
Moisture degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often but not always moist. Linen must be changed at least once a shift.	3. Occasionally moist: Skin is occasionally moist, requiring an extra linen approximately once a day.	4. Rarely moist: Skin is usually dry; linen only requires changing at routine intervals.
Activity degree of physical activity	1. Bedfast: Confined to bed.	2. Chairfast: Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	3. Walks occasionally: Walks occasionally during the day but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. Walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.
Mobility ability to change and control body position	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	3. Slightly limited: Makes frequent though slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.
Nutrition usual food intake pattern	1. Very poor: Never eats complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take liquid dietary supplement OR is NPO and/or maintained on clear fluids or IVs for more than 5 days.	2. Probably inadequate: Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement, OR receives less than optimum amount of liquid diet or tube feeding.	3. Adequate: Eats over 1/2 of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered, OR is on a tube feeding or TPN regimen, which probably meets most nutritional needs.	4. Excellent: Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.
Friction and Shear	1. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity contractures or agitation leads to almost constant friction.	2. Potential problem: Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	3. No apparent problem: Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.	

Note: Patients with a total score of 18 or less are considered to be at risk of developing pressure injuries. (19 - 23 = no risk, 15 - 18 = low risk, 13 - 14 = moderate risk, 10 - 12 = high risk, < 9 = very high risk)

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