Stages of a Pressure Injury

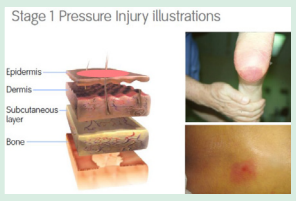
NPIAP (National Pressure Injury Advisory Panel)

Provincial Wound Program
HEALTH ASSOCIATION NOVA SCOTIA

STAGE 1

Think Tomato: A tomato does not turn white when you press on it, the tomato stays red - it is non-blanchable.

Mackintosh, Gwilliam, & Williams. Teaching the Fruits of Pressure Ulcer Staging. J Wound Ostomy Continence Nurs. 2014;41(4):381-387.



WHAT YOU COULD SEE:

- Intact skin with localized area of non-blanchable erythema.
- Change in firmness.
- The area is pinkish/reddish color and does not change over time when pressure is removed. Black et, al. (2016)
- Darkly pigmented skin may not show visible blanching; however, the color of the Stage 1 PI will appear different than the color of surrounding skin.

WHAT YOU SHOULD NOT SEE:

- Purple or maroon discoloration this may mean Deep Tissue Injury.
- Open areas.

STAGE 2

Think Potato: a potato peeler has been swiped across the surface of a potato, a partial thickness loss to the potato's skin.

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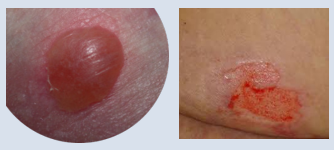

WHAT YOU COULD SEE:

- Partial thickness loss of skin with exposed dermis.
- Pink granulated tissue in wound bed.
- No slough in the wound bed.
- Can be a serum filled blister that is intact or broken

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STAGE 3

Think Apple: with a bite taken from it (full thickness tissue loss).

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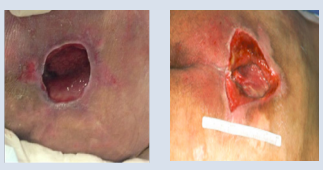

WHAT YOU COULD SEE:

- Full thickness loss of skin, adipose (fat) is visible, granulation tissue in wound bed.
- Bone, tendon, or muscle is **not** visible or directly palpable.
- Wound bed contains slough or fatty tissue.
- The slough, or dead tissue is not preventing you from viewing the wound bed.
- Caused by pressure/shear. Black et, al. (2016)

WHAT YOU SHOULD NOT SEE:

- Muscle, bone, tendons and ligaments, and cartilage.
- Slough or eschar obscures the base of the wound then it is unstageable.

STAGE 4

Think Peach: The peach pit is visible, representing underlying structures such as bone / ligaments / tendons.

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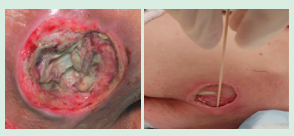

WHAT YOU COULD SEE:

- Full thickness loss of skin and tissue loss with exposed or directly palpable muscle, tendon, ligament, cartilage or bone in ulcer.
- Slough or eschar may be visible.
- Epibole (rolled edges) may be present, undermining and/or tunneling often occur.
- Caused by pressure/shear. Black et, al. (2016)

KEY POINT:

- Granulation tissue may be present
- Depth of tissue damage may vary by anatomical location
- If slough or eschar obscures the base of the wound, then it is an unstageable PI

NOTE: If you see bone assume osteomyelitis

UNSTAGEABLE

Think Rotten Fruit: You cannot stage it because you cannot see what's underneath the dead tissue.

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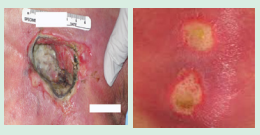

WHAT YOU COULD SEE:

- Full thickness skin and tissue loss, extent of damage cannot be determined because wound bed is not visible. Black et, al. (2016)
- Tissue covered with eschar or slough; the extent of tissue damage can not be determined because the base of the wound is covered with dead tissue.
- The wound should be stage once the slough or eschar is removed.
- Boggy slough or eschar often reveals stage 3 or Stage 4 PI when removed.

SUGGESTED TREATMENT:

- Stable eschar (i.e.dry adherent, intact without erythema or fluctuance) on the heel of ischemic limb softened or removed.
- Protect this area and keep it dry, do not apply dressing that keep the area moist (i.e. Foams).

AHRQ Agency for Healthcare Research and Quality

DEEP TISSUE INJURY

Think Eggplant: The skin covering the eggplant is intact. The purple coloring represents the presence of tissue injured by ischemia, pressure, and shear forces. Capillary bleeding from the injured and necrotic tissue is responsible for the discoloration.

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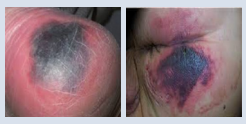


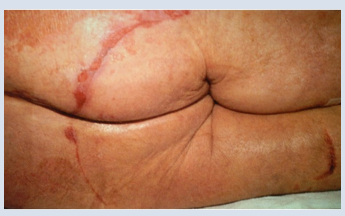
WHAT YOU COULD SEE:

- 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. Black et, al. (2016)
- Discoloration may appear differently in darkly pigmented skin.

KEY POINT:

- This is caused from intense and/or constant prolonged pressure/shear wound may evolve rapidly to reveal the actual extent of tissue injury.
- This may resolve without tissue loss.
- Do not describe DTPI for vascular, traumatic, neuropathic, or dermatologic conditions.

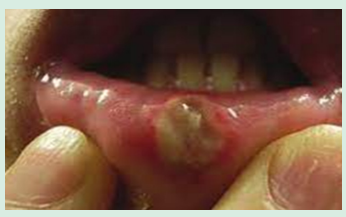
MEDICAL DEVICE PRESSURE INJURY



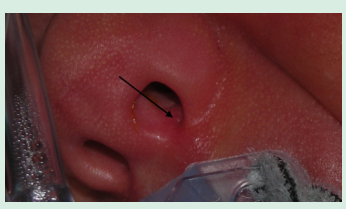
WHAT YOU COULD SEE:

- Results from the use of devices designed and applied for diagnostic or therapeutic purposes.
- The pressure injury usually conforms to the shape of the device.
- The injury is staged using the staging system. Edsberg et al. 2016

MUCOSAL MEMBRANE PRESSURE INJURY



This would be documented as "mucosal membrane pressure injury on the lower lip from a medical device"



WHAT YOU COULD SEE:

- Pressure injury found on mucous membrane with a history of a medical device at the site of injury.
- Mucosal tissue is very sensitive to pressure
  - Oxygen tubing
  - Endotracheal tubes
  - Nasogastric tubes
  - Urinary catheters
  - Fecal containment devices
- **NOT STAGED** using the staging system because mucosal tissue differs in anatomy from skin.