A New Way of Looking at Pressure Injuries

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In early April 2016, the National Pressure Ulcer Advisory Panel (NPUAP) announced several changes and updates related to pressure ulcers.[1]

Terminology

One of the most significant updates is a change in terminology from *pressure ulcer* to *pressure injury* to more accurately reflect the nature of pressure-related trauma. In the past, the term *pressure ulcer* was used to describe both stage 1 pressure ulcers and deep tissue injury, even though the skin is intact in both instances and no "ulcer" is present. Under the updated system, *pressure injury* is used to describe the results of all types of pressure-related trauma, regardless of whether the skin is intact or ulcerated.

The term *suspected* is no longer used to describe deep tissue pressure injuries.

Staging

The panel made updates to the stages of pressure injury. Stages are now identified using Arabic numbers 1, 2, 3, and 4 instead of Roman numerals.

Two types of pressure-related injury were given their own labels: medical device-related pressure injury and mucosal membrane pressure injury.

Medical Device-related Pressure Injury:
These injuries result from the

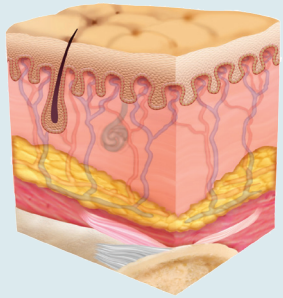
Pressure Injury Defined

Pressure injury is defined as "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 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."[1]

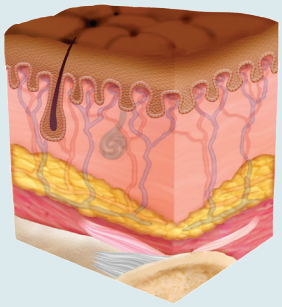
NPUAP Stages of Pressure Injury[1] – April 2016

Healthy Skin

Caucasian



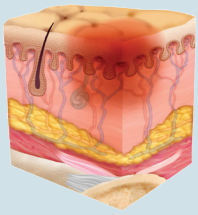
Non-Caucasian



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. Colour changes do not include purple or maroon discolouration; these may indicate deep tissue pressure injury.

Caucasian



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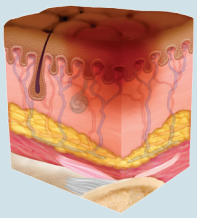
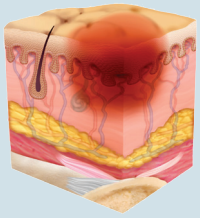
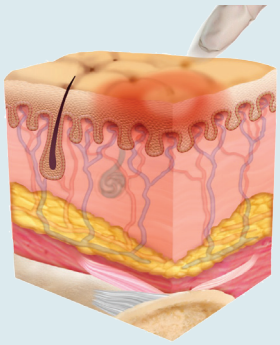


Edema

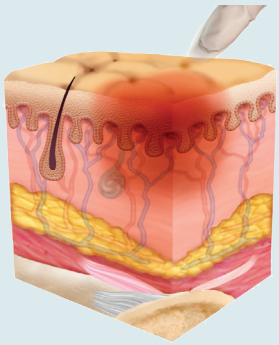


Blanchable and non-blanchable skin

Blanchable

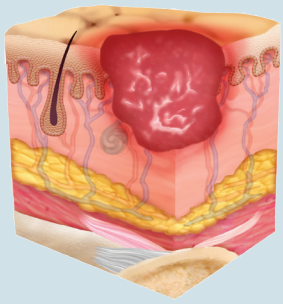


Non-blanchable



Stage 2 Pressure Injury:
Partial-thickness skin loss with exposed dermis

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. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel.



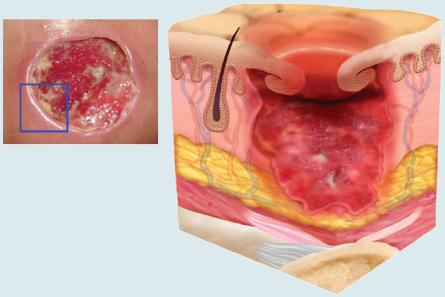
This stage should not be used to describe:

- moisture-associated skin damage (MASD) including incontinence associated dermatitis (IAD)
- intertriginous dermatitis (ITD)
- medical adhesive related skin injury (MARSI)
- traumatic wounds (skin tears, burns, abrasions)

NPUAP Stages of Pressure Injury[1] – April 2016

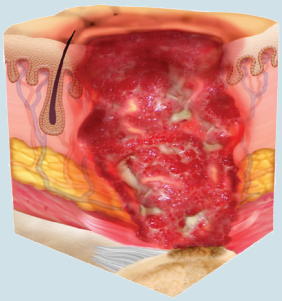
Stage 3 Pressure Injury:
Full-thickness skin loss

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.



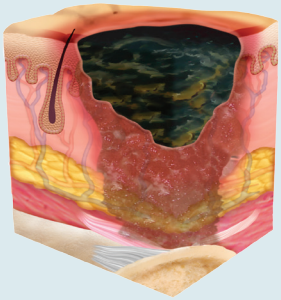
Stage 4 Pressure Injury:
Full-thickness skin and tissue loss

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 – dark eschar

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 (i.e., dry, adherent, intact without erythema or fluctuance) on an ischemic limb or the heel(s) should not be removed.



Pressure Injury Staging Photos

Photos are available for educational purposes online. Visit the following website to download the images: www.npuap.org/resources/educational-and-clinical-resources/pressure-injury-staging-illustrations/.

For additional information go to www.npuap.org.

Mucosal Membrane Pressure Injury:
These are pressure injuries found on the mucous membranes with a history of use of a medical device and are not staged. These injuries may conform to the shape or pattern of the device used by the clinician to provide care. They should be staged using the NUPAP staging system.

Why is this important?

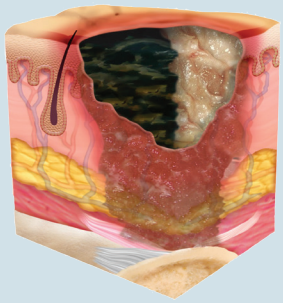
- **Accuracy** – clinicians can more accurately describe the skin injury related to pressure.
- **Patient safety** – clinicians can more accurately report pressure related incidents.

NPUAP Stages of Pressure Injury[1] – April 2016

Deep Tissue Pressure Injury:
Persistent non-blanchable deep red, maroon or purple discolouration

Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discolouration or epidermal separation revealing a dark wound bed or blood-filled blister. Pain and temperature change often precede skin colour changes. Discolouration 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.



- **Medical device pressure injuries** – clinicians can report pressure injuries due to medical devices as they are now recognized in the updated staging system.

What are the clinical implications?

- **Policy change** – clinicians should use the new definitions when reporting and documenting skin injury related to pressure.
- **Education revisions** – educators should access the NPUAP definitions and photos online to ensure a consistent approach to assessment, reporting and documentation of pressure injuries.

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Reference

1. National Pressure Ulcer Advisory Panel. National Pressure Ulcer Advisory Panel (NPUAP) announces a change in terminology from pressure ulcer to pressure injury and updates the stages of pressure injury. 2016. Retrieved from www.npuap.org/national-pressure-ulcer-advisory-panel-npuap-announces-a-change-in-terminology-from-pressure-ulcer-to-pressure-injury-and-updates-the-stages-of-pressure-injury/.