



Pressure Injury staging

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.

Stage 1

Non-blanchable erythema of intact skin with a localized area of nonblanchable erythema, which may appear differently in darkly pigmented skin.

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.

Stage 3

Full-thickness skin loss, 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.

Stage 4

Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer.

Unstageable

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

Medical Device Related Pressure Injury

Medical device related pressure injuries result from the use of devices; 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

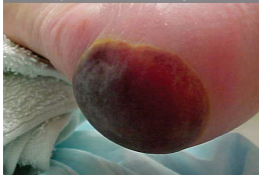
Mucosal membrane pressure injury is found on mucous membranes with a history of a medical device in use at the location of the injury.

Reference: Condensed from the NPIAP Press Release April 13, 2016: National Pressure Ulcer Advisory Panel (NPIAP) announces a change in terminology from pressure ulcer to pressure injury and updates the stages of pressure injury
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Stage 1



Stage 2



Stage 3



Stage 4



Unstageable



MDRPI



Mucosal

