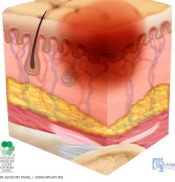

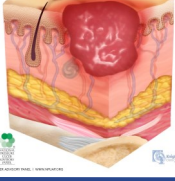

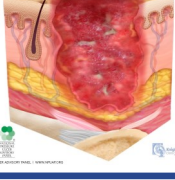

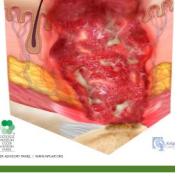



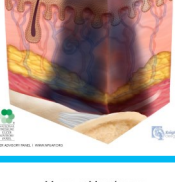
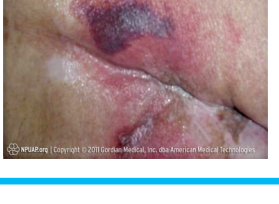
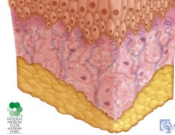



Pressure Injury Definitions

A pressure injury is defined as "Localised damage to the skin and/or underlying tissue, as a result of pressure or pressure in combination with shear. Pressure injuries usually occur over a bony prominence but may also be related to a medical device or other object".

<p>Stage I</p>	<p>Non-blanchable Erythema</p> <ul style="list-style-type: none"> Intact skin with non-blanchable redness of a localised area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage I may be difficult to detect in individuals with dark skin tones. 	<p>Stage 1 Pressure Injury – Edema</p> 	
<p>Stage II</p>	<p>Partial Thickness Tissue Loss</p> <ul style="list-style-type: none"> Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising.* This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. 	<p>Stage 2 Pressure Injury</p> 	
<p>Stage III</p>	<p>Full Thickness Tissue Loss</p> <ul style="list-style-type: none"> Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Stage III pressure ulcers. 	<p>Stage 3 Pressure Injury</p> 	
<p>Stage IV</p>	<p>Full Thickness Tissue Loss</p> <ul style="list-style-type: none"> Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunnelling. The depth of a Stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. 	<p>Stage 4 Pressure Injury</p> 	
<p>Unstageable</p>	<p>Depth Unknown</p> <ul style="list-style-type: none"> Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed. 	<p>Unstageable Pressure Injury – Slough and Eschar</p> 	
<p>sDTI Suspected Deep Tissue Injury</p>	<p>Depth Unknown</p> <ul style="list-style-type: none"> Purple or maroon localised area of discoloured intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. 	<p>Deep Tissue Pressure Injury</p> 	
<p>Mucosal</p>	<p>Not Part of the Staging System</p> <ul style="list-style-type: none"> Occurs on the moist membranes that line the respiratory, gastrointestinal and genitourinary tracts. Primarily caused by medical devices (generally tubing and stabilisation equipment) exerting compressive and shear forces on the mucosa. Where pressure is a significant factor in the aetiology of the mucosal wound, it should still be considered a pressure injury; however, it is inappropriate to use a pressure injury classification system to stage. 	<p>Mucous Membrane</p> 	 <p>Photo courtesy Tracy Nowicki</p>

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Classification system: International NPUAP/EPUAP Pressure Ulcer Classification System (2009,2014).

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