Pressure injury classification system[1]

Smith+Nephew

Category/stage 1 pressure injury

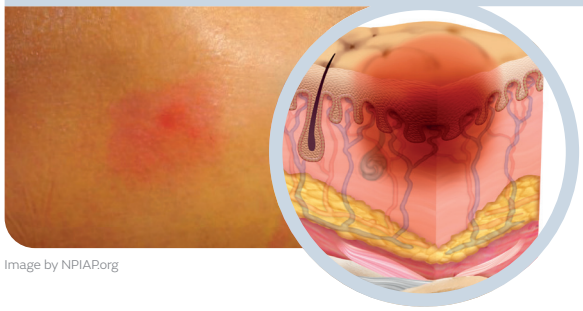


Image by NPIAP.org

Intact skin with localized area of non-blanchable redness; may appear differently in darkly pigmented skin. Presence of blanchable redness 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.

Unstageable pressure injury

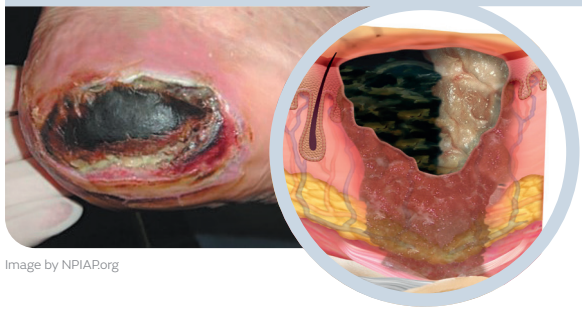


Image by NPIAP.org

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 softened or removed.

Category/stage 2 pressure injury

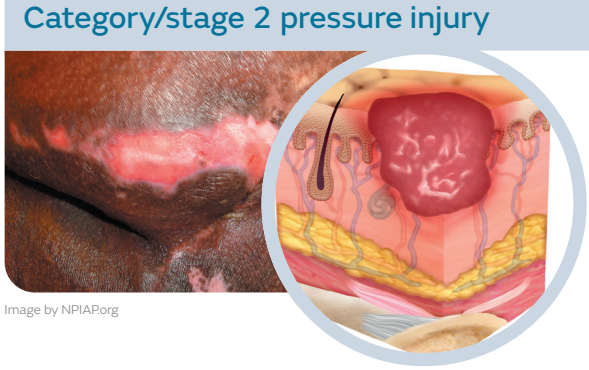


Image by NPIAP.org

Partial-thickness loss of skin with exposed dermis; wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister; Adipose (fat) and/or deeper tissues are not visible; Granulation tissue, slough and eschar are not present; This stage should not be used to describe moisture-associated skin damage, medical adhesive related skin injury, or traumatic wounds.

Deep tissue pressure injury

Image by NPIAP.org

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. The wound may evolve rapidly to reveal the actual extent of tissue injury or may resolve without tissue loss.

Category/stage 3 pressure injury

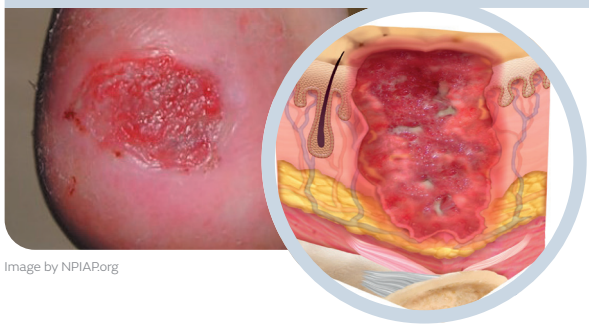
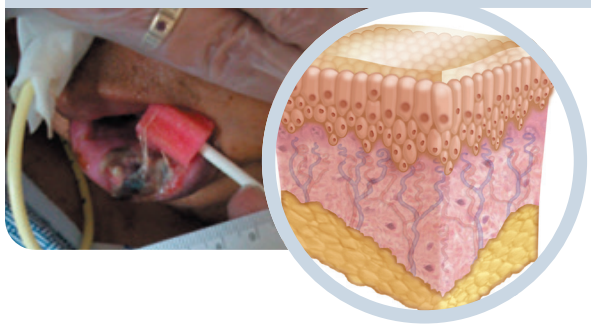


Image by NPIAP.org

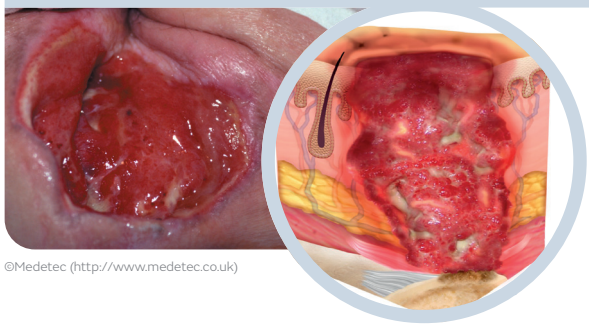
Full-thickness loss of skin; adipose (fat) is visible in the ulcer; granulation tissue and epibole (rolled wound edges) are often present; slough and/or eschar may be visible. Depth of tissue damage varies by anatomical location; undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss; this is an unstageable pressure injury.

Mucous membrane pressure injury



Tissue damage 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**.

Category/stage 4 pressure injury



©Medetec (http://www.medetec.co.uk)

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.

Medical device related pressure injury

Image by NPIAP.org

Classify according to above classifications

Results 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/graded according to the pressure ulcer/injury classification system.

Advanced Wound Management
Smith & Nephew Medical Ltd
101 Hessle Road
Hull HU3 2BN, UK

T +44 (0) 1482 225181
F +44 (0) 1482 328326

www.smith-nephew.com

1. European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline. Emily Haesler (Ed.) EPUAP/NPIAP/PPPIA: 2019.