Additional Pressure Injury Definitions

Medical Device-Related Pressure Injury: This describes the acute adverse effects of pressure injuries related to the use of devices designed and applied for diagnostic or therapeutic purposes. These devices may be applied over a short period of time or may be worn for a longer duration. The resultant pressure injury generally conforms to the pattern or shape of the device. The injury should be staged using the Pressure Injury Staging System. Medical Technologies.

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. Due to the anatomy of the tissue, these ulcers cannot have IAD. Below are additional differentiations between the two conditions:

- **IAD**
  - Loss of normal skin barrier.
  - Skin integrity compromised.
  - Antimicrobial treatment necessary.

- **Pressure Injury**
  - Lack of normal skin barrier.
  - Skin intact.
  - No antimicrobial treatment necessary.

Distinguishing Between IAD and Pressure Injuries

Pressure Injury

Medical Device-Related Pressure Injury

Mucosal Membrane Pressure Injury

Frequent Anatomical Sites of Pressure Injury

Pressure Injury Assessment Parameters

Stage 1 Pressure Injury

Stage 2 Pressure Injury

Stage 3 Pressure Injury

Stage 4 Pressure Injury

Unstageable Pressure Injury

Stage 5 Pressure Injury

Pressure Injury Staging Guide

Pressure Ulcer/Injury (PU/I)

Note: Do not stage mixed stage lesions. If a medical device is used, consider the device for pressure ulcer staging. Stage and document according to the best representation of the wound base.

Pressure injury definition and descriptions from Pressure Injury Staging Guide are from National Pressure Ulcer Advisory Panel. 2016 Staging Consensus Conference. Available online: https://www.npuap.org/resources/educational-and-clinical-resources/pressure-ulcer-staging-definition-and-descriptions/

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Stage 1 Pressure Injury: Non-blanchable erythema of intact skin

Intact skin with a localized area of non-blanchable erythema, which may appear different in darkly pigmented skin. Pressure of blanchable erythema 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.

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

The wound bed is viable, pink or red, moist, and may present as a superficial or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Undermining and/or tunneling may occur. If slough or eschar obscures the extent of tissue loss, this is a Suspected Deep Tissue Injury.

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/or epibole (rolled wound edges) are often present. Undermining and/or tunneling may occur. 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. Undermining and/or tunneling may occur. 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

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. If stable eschar is present, it should not be softened or removed.

Deep Tissue Pressure Injury:

Persistent non-blanchable deep red, maroon, or purple discoloration

Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, or purple discoloration, or an area of tissue pallor overlying a darkerened, shiny, or adherent tissue. Pain and temperature change often precede skin color changes. Discoloration may appear transient in early presentations or may differ in darkly pigmented skin. This injury may or may not be associated with a Stage 2 pressure injury. 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.