### Distinguishing Between IAD and Pressure Injuries

<table>
<thead>
<tr>
<th>History</th>
<th>Location</th>
<th>Shape/edges</th>
<th>Presentation/Other</th>
<th>Symptom</th>
</tr>
</thead>
<tbody>
<tr>
<td>IAD</td>
<td>Affects perineum, genital area, buttocks, thighs, lower back; may extend to posterior aspects of gluteal fold, medial and lateral aspects of thigh, and/or associated with bony prominence</td>
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### Pressure Injury Assessment Parameters
- **Pressure Injury**: Assess the assessment area at admission and intervene consistent with patient condition and facility policy and procedures. Perform head-to-toe assessment upon admission and intervals consistent with patient condition and facility policy and procedures. 
- **Patient History**: Include information about exposure to medical devices. 
- **Symptoms**: Include pain, burning, irritation, redness, itching, swelling, and skin loss. 
- **Location**: Include the location of the injury. Due to the anatomy of the tissue, these ulcers cannot be staged. 
- **Shape/edges**: Include Distinct edges or poorly defined edges. 
- **Presentation/Other**: Include pink red, maroon, or purple discoloration. 
- **Pain**: Include persistent non-blanchable deep red, purple, or maroon discoloration. 

### Pressure Injury Staging Guide

- **Stage 1 Pressure Injury**: Non-blanchable erythema of intact skin. 
- **Stage 2 Pressure Injury**: Partial-thickness skin loss with exposed dermis. 
- **Stage 3 Pressure Injury**: Full-thickness skin loss. 
- **Stage 4 Pressure Injury**: Full-thickness skin loss with tissue loss. 
- **Unstageable Pressure Injury**: Deep tissue injury. 
- **Dermal Tissue Pressure Injury**: Partial-thickness skin loss with exposed dermis. 

### Pressor Injury Types

- **Medical Device-Related Pressure Injury**: Result from the use of devices designed and applied for diagnostic or therapeutic purposes. The device is selected to achieve specific end results and is typically applied for diagnostic or therapeutic purposes. The injury should be staged using the staging system. 
- **Mucosal Membrane Pressure Injury**: Result from the use of devices designed and applied for diagnostic or therapeutic purposes. The device is selected to achieve specific end results and is typically applied for diagnostic or therapeutic purposes. The injury should be staged using the staging system. 

### Medical Device-Related Pressure Injury: Medical Device-Related Pressure Injury

- **Medical Device-Related Pressure Injury**: Medical device-related pressure injuries result from the use of devices designed and applied for diagnostic or therapeutic purposes. The device is selected to achieve specific end results and is typically applied for diagnostic or therapeutic purposes. The injury should be staged using the staging system. 

### Mucosal Membrane Pressure Injury: Mucosal Membrane Pressure Injury

- **Mucosal Membrane Pressure Injury**: This describes an etiology. Medical device-related pressure injuries result from the use of devices designed and applied for diagnostic or therapeutic purposes. The device is selected to achieve specific end results and is typically applied for diagnostic or therapeutic purposes. The injury should be staged using the staging system. 

### Pressure Injury Staging Guide (PU/I) Staging Guide

1. **Staging Guide**
   - **Stage 1 Pressure Injury**: Non-blanchable erythema of intact skin.
   - **Stage 2 Pressure Injury**: Partial-thickness skin loss with exposed dermis.
   - **Stage 3 Pressure Injury**: Full-thickness skin loss.
   - **Stage 4 Pressure Injury**: Full-thickness skin loss with tissue loss.
   - **Unstageable Pressure Injury**: Deep tissue injury.

### Pressure Injury Definitions

- **Incontinence-Associated Dermatitis (IAD)**: Severe inflammation caused by liquid stool. Mixed incontinence, including fecal incontinence, may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. It may also be affected by microclimate, nutrition, perfusion, non-sterile ointment, and occlusion of soft tissue. This pocket guide is designed to be a reference tool for clinicians to help stage pressure injury tissue damage.

### Additional Pressure Injury Definitions

- **Incontinence-Associated Dermatitis (IAD)**: Severe inflammation caused by liquid stool. Mixed incontinence, including fecal incontinence, may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. It may also be affected by microclimate, nutrition, perfusion, non-sterile ointment, and occlusion of soft tissue. This pocket guide is designed to be a reference tool for clinicians to help stage pressure injury tissue damage.

### Footnotes

1. NPUAP.org ©2011 Gordian Medical, Inc. dba American Medical Technological Institute.
2. NPUAP.EU Pressure Ulcer Advisory Panel, 2018.
4. NPUAP copyright and used with permission. 
5. For more information, visit 3M.com/PressureInjury or call the 3M Helpline at 1-800-228-3957.

### Contact Information

3M Medical Solutions Division
3M Building 78-210
70-2008-3143-9
3M.com/PressureInjury
3M Medical Solutions Division
3M.com/Medical
1-800-228-3957
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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 as a red, purple, or brown macule. Presence of non-blanchable erythema or changes in sensation, temperature, or firmness 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 an ulcer or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissue injuries are not present. Granulation tissue, slough, and eschar are not present. 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), or traumatic wounds (skin tears, burns, abrasions).

Stage 3 Pressure Injury:
Full-thickness skin loss
Full-thickness skin loss in which adipose (fat) is visible in the ulcer, and granulation tissue and epibole (rolled wound edges) are often present. Muscle, tendon, ligament, cartilage, or bone are not exposed. Undermining and tunneling may occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss, this is a 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. Muscle and tendon may be visible. Edematous tissue (necrotic-tissue) can be mixed with adipose (fat) and deeper tissue injuries. If slough or eschar obscures the extent of tissue loss, this is a 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. Stable eschar (i.e., dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb 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 deep red, maroon, or purple discoloration, which may appear as a red, purple, or brown macule. Presence of persistent non-blanchable deep red, maroon, or purple discoloration, or changes in sensation, temperature, or firmness may indicate deep tissue pressure injury.