

A pressure injury (also known as a pressure ulcer) is localised damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities, and condition of the soft tissue.<sup>1</sup>

This guide is designed to be a reference tool for clinicians to help stage pressure injury tissue damage.

## Stage 1 Pressure Injury

Non-blanchable erythema of intact skin



Intact skin with a localised area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes.

Colour changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.<sup>1</sup>

## Stage 2 Pressure Injury

Partial-thickness skin loss with exposed dermis



The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough, and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel.

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 (MARS), or traumatic wounds (skin tears, burns, abrasions).<sup>1</sup>

## Stage 3 Pressure Injury

Full-thickness skin loss

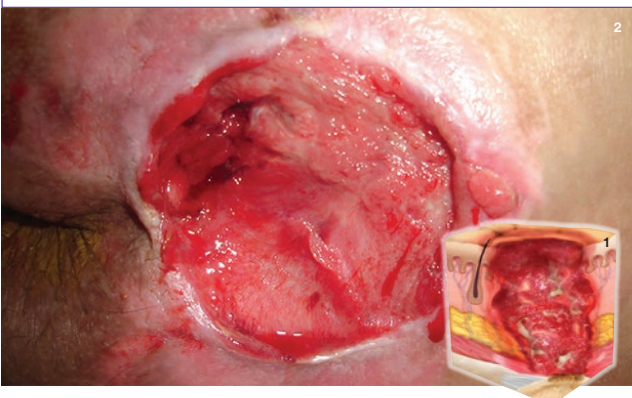


Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer, and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. 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.<sup>1</sup>

## Stage 4 Pressure Injury

Full-thickness skin and tissue loss

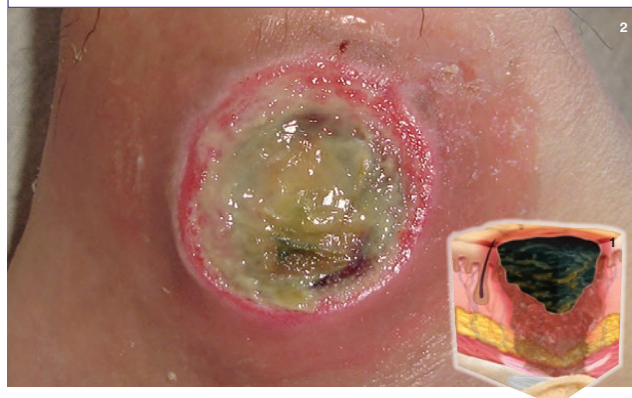


Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining, and/or tunneling often occur. Depth varies by anatomical location.

If slough or eschar obscures the extent of tissue loss, this is an Unstageable Pressure Injury.<sup>1</sup>

## 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.<sup>1</sup>

## Deep Tissue Pressure Injury

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



Intact or non-intact skin with localised area of persistent non-blanchable deep red, maroon, or 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. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury or may resolve without tissue loss.

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.<sup>1</sup>

## Additional Pressure Injury Definitions<sup>1</sup>



### Medical Device-Related Pressure Injury

This describes an aetiology. Medical device-related pressure injuries result 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 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. Due to the anatomy of the tissue, these ulcers cannot be staged.

For more information visit [3M.com.au/medical](http://3M.com.au/medical) or contact your 3M Medical Solutions representative.