NATIONAL PRESSURE ULCER ADVISORY PANEL

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The National Pressure Ulcer Advisory Panel provides multidisciplinary leadership for improved patient outcomes in pressure ulcer prevention and management through education, public policy and research.

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National Pressure Ulcer Advisory Panel (NPUAP) announces a change in terminology from pressure ulcer to pressure injury and updates the stages of pressure injury.

Washington, DC - The term "*pressure injury*" replaces "*pressure ulcer*" in the National Pressure Ulcer Advisory Panel Pressure Injury Staging System according to the NPUAP. The change in terminology more accurately describes pressure injuries to both intact and ulcerated skin. In the previous staging system Stage 1 and Deep Tissue Injury described injured intact skin, while the other stages described open ulcers. This led to confusion because the definitions for each of the stages referred to the injuries as *"pressure ulcers".*

In addition to the change in terminology, Arabic numbers are now used in the names of the stages instead of Roman numerals. The term *"suspected"* has been removed from the Deep Tissue Injury diagnostic label. Additional pressure injury definitions agreed upon at the meeting included Medical Device Related Pressure Injury and Mucosal Membrane Pressure Injury.

The updated staging definitions were presented at a meeting of over 400 professionals held in Chicago on April 8-9, 2016. Using a consensus format, Dr. Mikel Gray from the University of Virginia adeptly guided the Staging Task Force and meeting participants to consensus on the updated definitions through an interactive discussion and voting process. During the meeting, the participants also validated the new terminology using photographs.

Dr. Laura Edsberg from Daemen College in Buffalo, NY and Dr. Joyce Black from the University of Nebraska Medical Center in Omaha served as co-chairs of the Staging Task Force appointed by the NPUAP Board of Directors. Task force members included Margaret Goldberg, MSN, RN, CWOCN from Delray Wound Center, Florida, Laurie McNichol, MSN, RN, CWOCN, CWON-AP, from Cone Health in Greensboro, NC, Lynn Moore, RDN, from Nutrition Systems, Mississippi and Mary Sieggreen, MSN, CNS, NP, CVN, from Detroit Medical Center.

Pressure injuries are staged to indicate the extent of tissue damage. The stages were revised based on questions received by NPUAP from clinicians attempting to diagnose and identify the stage of pressure injuries. Schematic artwork for each of the stages of pressure injury was also revised and will be available for use at no cost through the NPUAP website in approximately 12-24 hours (http://www.npuap.org/resources/educational-and-clinical-resources/pressure-injury-staging-illustrations/**).**

The updated staging system includes the following definitions:

Pressure Injury:
A pressure injury is localized damage to the skin and/or 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.

Stage 1 Pressure Injury: Non-blanchable erythema of intact skin
Intact skin with a localized 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. 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
Partial-thickness loss of skin 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 (MARSI), or traumatic wounds (skin tears, burns, abrasions).

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.

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.

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 an ischemic limb or the heel(s) should not be 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, 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.

Additional pressure injury definitions.

Medical Device Related Pressure Injury:
This describes an etiology. Use the staging system to stage
This describes the etiology of the injury. 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 injuries cannot be staged.

More information will be forthcoming on teaching points for the new stages and the rationale for some of the changes in the staging system.

The National Pressure Ulcer Advisory Panel is a multidisciplinary group of experts in pressure injury. The NPUAP serves as the authoritative voice for improved patient outcomes in pressure injury prevention and treatment through public policy, education and research. Contact NPUAP at npuap@npuap.org.

National Pressure Ulcer Advisory Panel (NPUAP) FAQs

May 31, 2016

Why was there no consensus on some aspects of the new definitions?

Consensus is a process to develop a common understanding in areas where science cannot provide guidance, or such science is not yet available. In this process, NPUAP chose to develop new labels for pressure damaged soft tissue as "pressure injury" replacing pressure ulcer. The term "injury" was more inclusive of all 6 stages. Stage 1 is present as intact skin, as is Deep Tissue Pressure Injury, which has always used "injury" in the nomenclature.

The words "prolonged" and "intense" as the aspects of pressure that lead to ulceration have been described since Kosiak in 1961. The physics of pressure cannot be changed. Kosiak's work allowed understanding of Deep Tissue Pressure Injuries because they were initially seen in people who were subjected to intense pressure when they were found lying down on concrete, a kitchen floor etc., for a prolonged period of time. These are the same phenomena in cases of pressure injuries developing in the operating room. The work on pressure ulcer etiology and tissue mechanics has been extended by Oomen's laboratory in the Netherlands and Gefen's research group in Israel. Consensus was not required in this area. A specific time or specific pressure was not identified because the aspect of pressure injury development that must be factored into the equation is the individual tolerance for pressure.

Does the word injury increase the likelihood of being sued over a pressure injury?

This issue was discussed in detail by NPUAP prior to the conference. Plaintiff and defense attorneys who work in the pressure injury arenas were consulted. Their summarized responses were that *professionals need to develop the science; attorneys look at the facts in the case to determine if it was unavoidable*. For further information about unavoidable pressure injuries, please see the NPUAP's previously published work in this area (http://www.npuap.org/resources/white-papers/). While the word "injury" may be used in jury instructions, the definition would need to be explained within the clinical context. The word "injury" occurs in other clinical diagnostic labels that may or may not be litigated…acute kidney injury, spinal cord injury, traumatic brain injury…to name a few.

Did the consensus conference attendees make any significant changes in the proposed definitions?

Yes, numerous changes were made in the proposed definitions, e.g., the inclusion of nonmedical devices as a cause of exposure to pressure and the idea that some DTPI s can resolve. The manuscript from the conference will include all changes to each definition.

Why did we remove the term "Suspected" from Deep Tissue Pressure Injury?

The original definition was written over 10 years ago and little was known about the problem of DTI at that time. Today more is known and we are able to diagnose with more accuracy. Clinicians can add the word "suspected" to the documentation about any definition or condition. For example, a patient could have a suspected pressure injury or a suspected Stage 2 pressure injury.

This will be an expensive change in our system. When do we need to make these changes?

There were no changes to the stages of pressure injury; what you know today as a Stage II is still a Stage 2. Therefore, NPUAP recommends that your system be changed to include pressure injury when you are making other changes. Many organizations are incorporating the term "injury" into their documentation. It is likely that you made similar decisions a few years ago when acute renal failure became acute kidney injury or when changes to myocardial infarction over the past years led to Unstable Angina/STEMI/NonSTEMI as part of Acute Coronary Syndromes.

How soon will the Federal documents, MDS, OASIS, Acute Rehab IRF –PAI reporting regulations for skin conditions, change to the new staging terms?

The NPUAP is responsible for using science to make needed changes combined with consensus to clarify or amplify the wording. The NPUAP has shared the changes with CMS and looks forward to working with them on an implementation plan. All the changes are aimed at improving assessment and documentation precision.

Will NDNQI change their reporting systems to pressure injury?

Yes, the National Database of Nursing Quality Indicators is changing their reporting documents and training modules into the new system. The changes should go into effect in 2017.

How will we be paid for pressure injury since it is not in the ICD-10 codes?

The current ICD-10 coding system lists "pressure ulcer" and coders are supplied with synonyms for the condition including bed sore, decubitus ulcer, plaster ulcer, pressure area and pressure sore. The NPUAP is working with International Wound Organizations on the ICD- 11 to incorporate the term "pressure injury".

Does NPUAP have any training material on the new staging system?

Yes, a slide set is available on the NPUAP website. Artwork that accompanies the new staging system is available for free at http://www.npuap.org/resources/educational-and-clinical-resources/pressure-injury-staging-illustrations/