SECTION L1: MOST SEVERE PRESSURE ULCER

Purpose

The Pressure Injury Advisory Group (PIAG) of the New Zealand Wound Care Society has formally agreed to now refer to all Pressure Ulcers as 'Pressure Injuries'.

This table is designed assist Assessors align the New Zealand Pressure injury classifications with the current interRAI 'Pressure Ulcer' definitions. It is for reference at the time of coding in L1: Most Severe Pressure Ulcer.

interRAI coding	interRAI coding definition	PIAG classification	PIAG definition
Stage 1: Any area of persistent skin redness	An area of skin that appears continually reddened and does not disappear when pressure is relieved. There is no break in the skin.	Stage 1: Non-blanchable erythema	Intact skin with non-blanchable redness of a localised area Darkly pigmented skin may not have visible blanching: its colour may differ from surrounding area. The area may be painful; firm; soft; warmer or cooler compared to adjacent tissue
Stage 2: Partial loss of skin layers	A partial-thickness loss of skin that presents clinically as an abrasion, blister or shallow crater	Stage 2: Partial thickness skin loss	Partial thickness loss of dermis presenting as a shallow open wound with a red-pink wound bed, without slough. May also present as an intact or open/ruptured serum filled blister. Presents as shallow ulcer without slough or bruising.
Stage 3: Deep craters in the skin	A full thickness of skin is lost, exposing the subcutaneous tissues. Presents as a deep crater with or without undermining of adjacent tissue.	Stage 3: Full thickness skin loss	Full thickness tissue loss. Subcutaneous tissue may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunnelling.
Stage 4:Breaks in skin exposing muscle or bone	A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.	Stage 4: Full thickness tissue loss	Full thickness tissue loss with exposed bone, Tendon or muscle. Slough or Eschar may be present on some parts of the wound bed.
Uncodable	Necrotic Eschar is predominant	Unstageable pressure injury: deep unknown.	Full thickness tissue loss in which the base of the pressure injury is covered by slough or eschar.
N/A	N/A	Suspected deep tissue injury: depth unknown	Purple or maroon localised area or discoloured, intact skin or blood filled blister due to damage of underlying soft tissue from pressure or shear force.

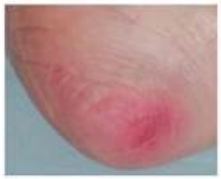
The Pressure Injury Advisory Group (PIAG) of the New Zealand Wound Care Society full descriptors and definitions of Pressure Injury Classifications within New Zealand:

HOW TO CLASSIFY AND DOCUMENT PRESSURE INJURIES

The NPUAP/EPUAP Pressure injury classification system provides a consistent and accurate means by which the severity of a pressure injury can be communicated and documented.

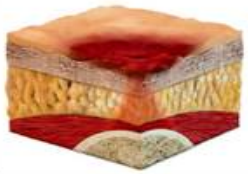
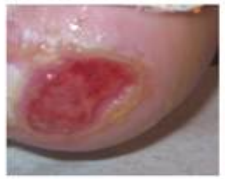
Stage I pressure injury: non-blanchable erythema

- Intact skin with non-blanchable redness of a localised area usually over a bony prominence.
- Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area.
- The area may be painful, firm, soft, warmer or cooler compared to adjacent tissue.
- May be difficult to detect in individuals with dark skin tones.
- May indicate "at risk" persons (a heralding sign of risk).

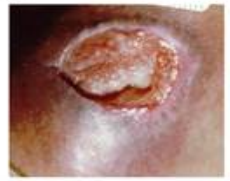
Stage II pressure injury: partial thickness skin loss

- Partial thickness loss of dermis presenting as a shallow, open wound with a red-pink wound bed, without slough.
- May also present as an intact or open/ruptured serum-filled blister.
- Presents as a shiny or dry, shallow ulcer without slough or bruising (NB bruising indicates suspected deep tissue injury).
- Stage II PI should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.

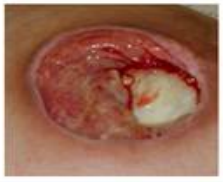
Stage III pressure injury: full thickness skin loss

- Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunnelling.
- The depth of a stage III PI varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage III PIs can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage III PIs. Bone or tendon is not visible or directly palpable.

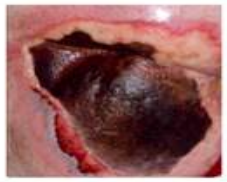
Stage IV pressure injury: full thickness tissue loss

- Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed.
- The depth of a stage IV pressure injury varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these PIs can be shallow. Stage IV PIs can extend into muscle and/or supporting structures (e.g. fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone or tendon is visible or directly palpable.

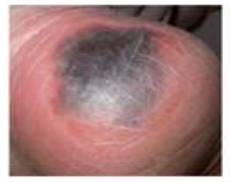
Unstageable pressure injury: depth unknown

- Full thickness tissue loss in which the base of the PI is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the PI bed.
- Until enough slough/eschar is removed to expose the base of the PI, the true depth, and therefore the stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as the body's natural biological cover and should not be removed.

Suspected deep tissue injury: depth unknown

- Purple or maroon localised area or discoloured, intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.
- Deep tissue injury may be difficult to detect in individuals with dark skin tone.
- Evolution may include a thin blister over a dark wound bed. The PI may further involve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.

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