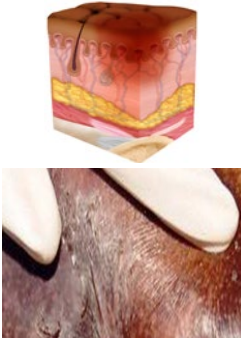







# NPIAP STAGING FOR LIGHTLY PIGMENTED SKIN

|  |   |  |   |   |   |
|--|---|--|---|---|---|
|  |   |  |   |   |   |
|  |   |  |   |   |   |
| <p><b>STAGE 1 PRESSURE INJURY: NON-BLANCHABLE ERYTHEMA OF INTACT SKIN</b></p> <p>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.</p> | <p><b>STAGE 2 PRESSURE INJURY: PARTIAL-THICKNESS SKIN LOSS WITH EXPOSED DERMIS</b></p> <p>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.</p> | <p><b>STAGE 3 PRESSURE INJURY: FULL-THICKNESS SKIN LOSS</b></p> <p>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 or bone is not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.</p> | <p><b>STAGE 4 PRESSURE INJURY: FULL-THICKNESS LOSS OF SKIN AND TISSUE</b></p> <p>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.</p> | <p><b>UNSTAGEABLE PRESSURE INJURY: OBSCURED FULL-THICKNESS SKIN AND TISSUE LOSS</b></p> <p>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 softened or removed.</p> | <p><b>DEEP TISSUE PRESSURE INJURY: PERSISTENT NON-BLANCHABLE DEEP RED, MAROON OR PURPLE DISCOLORATION</b></p> <p>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.</p> |

A pressure injury is localized 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.

# NPIAP STAGING FOR DARKLY PIGMENTED SKIN

|  |   |  |  |   |   |
|--|---|--|--|---|---|
|  <p><b>STAGE 1 PRESSURE INJURY: NON-BLANCHABLE ERYTHEMA OF INTACT SKIN</b></p> <p>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.</p> |  <p><b>STAGE 2 PRESSURE INJURY: PARTIAL-THICKNESS SKIN LOSS WITH EXPOSED DERMIS</b></p> <p>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.</p> |  <p><b>STAGE 3 PRESSURE INJURY: FULL-THICKNESS SKIN LOSS</b></p> <p>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 or bone is not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.</p> |  <p><b>STAGE 4 PRESSURE INJURY: FULL-THICKNESS LOSS OF SKIN AND TISSUE</b></p> <p>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.</p> |  <p><b>UNSTAGEABLE PRESSURE INJURY: OBSCURED FULL-THICKNESS SKIN AND TISSUE LOSS</b></p> <p>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 softened or removed.</p> |  <p><b>DEEP TISSUE PRESSURE INJURY: PERSISTENT NON-BLANCHABLE DEEP RED, MAROON OR PURPLE DISCOLORATION</b></p> <p>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.</p> |
|--|---|--|--|---|---|

## TIPS FOR STAGING DARKLY PIGMENTED SKIN:

- Moisten the skin
- Inspect for changes in pigmentation
- Palpate for edema
- Ask about pain in the area
- Avoid direct light