

Understanding NPUAP's updates to pressure ulcer terminology and staging

By Jeri Lundgren, BSN, RN, PHN, CWS, CWCN

On April 13, 2016, the National Pressure Ulcer Advisory Panel (NPUAP) announced changes in pressure ulcer terminology and staging definitions. Providers can adapt NPUAP's changes for their clinical practice and documentation, but it's important to note that, as of press time, the Centers for Medicare & Medicaid Services (CMS) has not adopted the changes. This means that providers can't use NPUAP's updates when completing CMS assessment forms, such as the Minimum Data Set (MDS) or Outcome and Assessment Information Set (OASIS). Instead, they must code the CMS assessment forms according to current CMS instructions and definitions. In addition, there is no ICD-10 code for pressure injury.

In a nutshell

Here are the key overall changes made by NPUAP:

- The term "pressure injury" replaces "pressure ulcers."
- Arabic numbers replace Roman numerals in the names of the stages.
- The term "suspected" has been removed from the Deep Tissue Injury diagnostic label.
- Additional pressure injury definitions were added for medical device related pressure injury and mucosal membrane pressure injury.



- The staging system definitions were updated.

The NPUAP updated terminology and staging system definitions are listed below.

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, comorbidities 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 in-

tact 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).

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, 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 deep tissue pressure injury to describe vascular, traumatic, neuropathic, or dermatologic conditions.

More definitions

Below are additional pressure injury definitions.

Medical-device related 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 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.

Next steps

Providers should carefully consider how these changes will affect their clinical and reimbursement systems. It's important to tell staff what definitions and terminology the organization will use for clinical practice, documentation, and completing CMS-mandated assessment forms. ■

Access **free resource: staging illustrations^A** from the NPUAP website.

Jeri Lundgren is the president of Senior Providers Resource in Cape Coral, Florida. She can be contacted at jeri@seniorprovidersresource.com.

Selected reference

National Pressure Ulcer Advisory Panel. National Pressure Ulcer Advisory Panel (NPUAP) announces a change in terminology from pressure ulcer to pressure injury and updates the stages of pressure injury. www.npuap.org/national-pressure-ulcer-advisory-panel-npuap-announces-a-change-in-terminology-from-pressure-ulcer-to-pressure-injury-and-updates-the-stages-of-pressure-injury/. April 13, 2016.

Online Resource

www.npuap.org/resources/educational-and-clinical-resources/pressure-injury-staging-illustrations/

Wear Your Certification With Pride.

Check out the **new**
NAWCO[®] Online Clothing Store!

Choose from the entire Lands End Business Outfitters collection. In addition, NAWCO also offers an online shop specifically for scrubs and lab coats.

Click **SHOP** on our website to visit our store.
Always open 24 hours a day, 7 days a week.
www.nawccb.org

