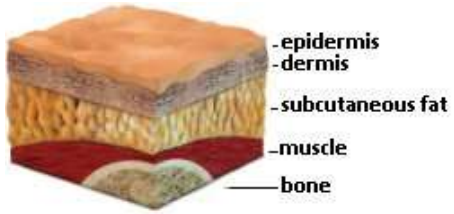
PAN PACIFIC PRESSURE INJURY CLASSIFICATION SYSTEM FOR ASIAN SKIN TONES

PAN PACIFIC
Pressure Injury Alliance

Normal skin



Text adapted from: *International NPUAP/EPUAP Pressure Ulcer Classification System (2009,2014)* published in: National Pressure Ulcer Advisory Panel (NPUAP), European Pressure Ulcer Advisory Panel (EPUAP), Pan Pacific Pressure Injury Alliance (PPPIA), Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline. 2014: Emily Haesler (Ed.) Cambridge Media: Osborne Park, WA. **3D graphics:** Owned by PPPIA. **Photos**: All photos courtesy of S. Law, used with permission. **Also available in this series:** PPPIA Classification System: Multicultural, PPPIA Classification System for Adults with Light Skin Tones, PPPIA Classification System for Neonates and Children, PPPIA Classification System for Dark Skin Tones, PPPIA Classification System for Older Adults.
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Stage 1	Stage 2	Stage 3	Stage 4	Unstageable	Suspected Deep Tissue Injury
Intact skin with non-blanchable redness of a localised area usually over bony prominences. 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 as compared to adjacent tissue. Stage I pressure injuries may be difficult to detect in individuals with darkly pigmented skin tone. May indicate 'at risk' individuals (a heralding sign of risk).	Partial thickness loss of dermis presenting as a shallow open ulcer 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 (bruising indicates suspected deep tissue injury). Stage 2 pressure injuries should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.	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 depth of tissue loss. May include undermining and tunnelling. The depth of Stage 3 pressure injuries varies by anatomical location. The bridge of nose, ear, occiput and malleolus do not have subcutaneous tissue and Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Stage 3 pressure injuries. Bone/tendon is not visible or directly palpable.	Full thickness tissue loss with exposed bone, t endon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunnelling. The depth of a Stage 4 pressure injury varies by anatomical location. The bridge of nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage 4 pressure injuries can extend into muscle and/or supporting structures (e.g. fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.	Full thickness tissue loss in which the ulcer base is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, (and therefore 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.	Purple or maroon localised area of 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 tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and be covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.