

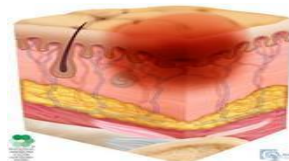
Blanching erythema: Healthy skin may develop transient redness when subjected to pressure – for example if the legs are crossed – to test if damage has occurred light figure pressure should be applied to see if the skin blanches (goes white). In darker skin tones redness may present as a darker area that is grey or purplish. This is NOT a pressure injury



Pressure Injury Categorisation Tool

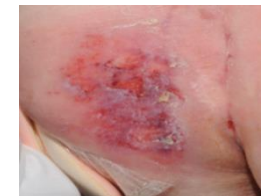
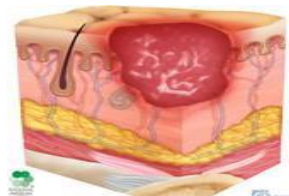
Grade 1: Non-blanchable Erythema

Intact skin with non-blanchable redness of a localised area usually over a bony prominence. Darkly pigmented skin may not have visible redness its colour may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category 1 may be difficult to detect in individuals with dark skin tones. Tissue is already damaged and needs immediate pressure relief.



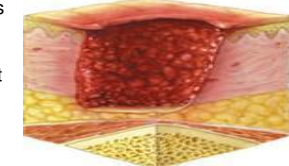
Grade 2: Partial Thickness Skin Loss

Partial thickness loss of dermis presenting as a shallow open injury 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 injury without slough or bruising.* This Grade should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.



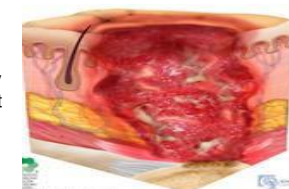
*Bruising can indicate suspected deep tissue injury.

Grade 3: Full Thickness Skin Loss Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. May include undermining and tunnelling. The depth of a Grade 3 pressure injury varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Grade 3 injuries can be shallow. In contrast, areas of significant adiposity can develop extremely deep Grade 3 pressure injuries. Bone & tendon is not visible or directly palpable.



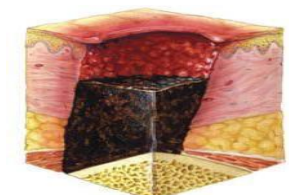
Grade 4 Full Thickness Tissue Loss

Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunnelling. The depth of a Grade 4 pressure injury varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these injuries can be shallow. Grade 4 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.



Unstageable: Depth Unknown

Full thickness tissue loss in which the base of the injury is covered by slough (yellow, tan, grey, 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 Grade, 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.

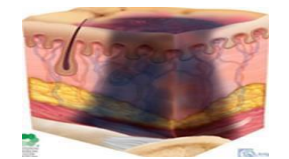


The necrotic cap on this heel has softened and started to separate

Although still firmly attached there is a ring of demarcation where this eschar has been rehydrated

Deep Tissue Injury: Depth Unknown

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 be rapid exposing additional layers of tissue even with optimal treatment.



Medical Device related Pressure Injuries

“Pressure Injuries that result from the use of devices designed and applied for diagnostic or therapeutic purposes.

Whilst some DRPI may also be allocated a Grade of damage others may not as they are on parts of the anatomy that does not have the same structures as the skin – for example the mucosal membrane. Where possible a device related injury should be categorised and the presence of a device noted by the addition of a (d) after the Grade.



This infant has Grade 1 damage to the cheeks and a small unstageable injury on the ear



This damage was caused by oxygen tubing



The damage caused by this urinary catheter could be categorised as a DTI (d)



This damage was caused by a bedpan



Although difficult to identify, this PI was caused by the leather ring at the top of a old fashioned calliper

Moisture Associated Skin Damage due to incontinence

This can occur due to the presence of urine and faecal moisture on the skin.

