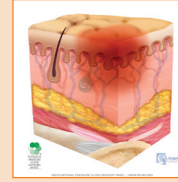


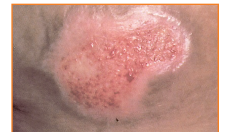
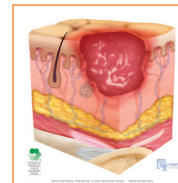
Stage 1: Non-blanchable erythema of intact skin

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.



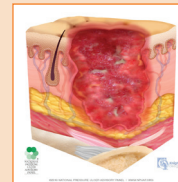
Stage 2: Partial-thickness skin loss with exposed dermis

Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist and may also present as an 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. 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).



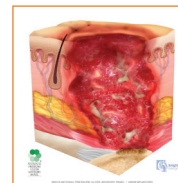
Stage 3: Full-thickness skin loss

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.



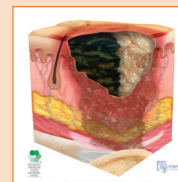
Stage 4: Full-thickness skin and tissue loss

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: 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, 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 DTPI to describe vascular, traumatic, neuropathic or dermatologic conditions.



1. **Location** of pressure injury.
2. **Stage** per NPUAP definitions (see other side).
3. **Size:** Always measure Length, Width and Depth in centimeters and document it in that order: L x W x D
 - Length = Longest head-to-toe measurement.
 - Width = Longest hip-to-hip measurement.
 - Depth = Measure the deepest part of the visible wound. If too shallow to measure, record depth as <0.1 cm.
4. **Undermining/Tunneling:** Measure the extent of the undermining/tunneling in centimeters. Document using the clock system, with the patient's head at 12 o'clock and feet at 6 o'clock.
 - Undermining = Tissue destruction underlying intact skin along wound margins (example: 2cm from 2-7 o'clock).
 - Sinus Tracts/Tunneling = A course or pathway of dead space extending in any direction from the wound surface that results in dead space (example: 3cm at 3 o'clock).
5. **Wound Base Description:** Describe the wound bed appearance. If the wound base has a mixture of tissues, document the percentage of each (example: wound base is 75% granulation tissue, 25% slough).
 - Granulation Tissue: Pink or beefy red tissue with a shiny, moist, granular appearance.
 - Necrotic Tissue: Gray to black and moist.
 - Eschar: Gray to black and dry or leathery in appearance.
 - Slough: Yellow to white and may be stringy or thick. May appear as a layer over the wound bed.
 - Epithelial Tissue: New or pink shiny tissue that grows in from the edges, or as islands on the wound surface.
6. **Drainage:** Measure the percentage of dressing involved with exudate to help gauge the amount.
 - Amount: None (dry bed), scant (moist bed), small (<25%), moderate/medium (25%-75%), copious/heavy (>75%).
 - Color/Consistency: Sanguineous (thin, bright red), serosanguineous (thin, watery, pale red/pink), serous (thin, watery, clear), purulent (thick or thin, opaque, tan/yellow), foul purulent (thick, opaque, yellow/green, odor).
7. **Wound Edges and Surrounding Tissue:**
 - Wound Edges: Defined/undefined, attached/unattached, epibole (rolled under), macerated, fibrotic, calloused.
 - Surrounding Tissue: Color, edema, firmness, texture, rash, maceration, induration, intact, etc.
8. **Odor:** Present or none. If odor is present, describe: strong, foul, pungent, fecal, musty, sweet, etc.
9. **Pain:** Describe pain associated with the wound (location, intensity, duration, etc.) and document interventions for pain and/or pressure reduction/relief.
10. **Progress:** Improved, no change, stable, declined.