Developed in collaboration with the Wound Care Champions, Wound Care Specialists, Enterostomal Nurses, and South West Regional Wound Care Program (SWRWCP) members from Long Term Care Homes, Hospitals, and South West Community Care Access Centre contracted Community Nursing Agencies in the South West Local Health Integration Network.	
Title	**Procedure: NPUAP Staging System for Pressure Injuries (Updated 2016)**
Background	• Pressure injuries are classified based on the depth of tissue injury, using staging systems like the National Pressure Ulcer Advisory Panel (NPUAP) Staging System for Pressure Injuries • The stage of a wound is determined at the initial assessment of the wound by noting the deepest layer of tissue involved, and is **NEVER** re-staged unless the wound progresses through deeper tissue layers • Pressure injuries are **NEVER** back-staged. This is because as a full-thickness pressure Injury 'heals' it fills with granulation tissue. This granulation tissue does not replace the muscle, fat, and dermal layers that were lost, and as such back-staging does not reflect physiologic wound healing[1] • Pressure Injury development does not necessarily progress from one stage to the next in a linear fashion, i.e. a stage I Injury may suddenly become a stage IV Injury • The universal four stage (stage I-IV) NPUAP Staging System for Pressure Injuries was developed in collaboration with the Agency for Health Care Research and Quality (formerly known as the Agency for Health Care Policy and Research), based on a method of classifying pressure injuries described by Shea in 1975[2]. The staging system was further defined in 2007 with the addition of two stages: suspected deep tissue injury, and unstageable pressure injuries
Indications	This procedure is intended to be used by front line registered health care providers, to assist with their assessment and management of individuals admitted with or presenting with a pressure Injury.
Procedure	**NOTE: The use of the "NPUAP Staging System for Pressure Injuries (Updated 2016)" is but one part of the holistic assessment of an individual admitted with or presenting with a pressure Injury.** **Assessment** 1. Review the person's medical chart for: a. Any previous pressure Injury staging documentation b. Current wound care orders **Planning** 1. Expected outcomes: a. Information from your assessment allows for the proper staging of the person's pressure Injury using the "NPUAP Staging System for Pressure Injuries (Updated 2016)" b. The person reports minimal discomfort associated with the

dressing change and wound assessment

c. Registered nursing staff, in collaboration with other involved health care disciplines and the person with the wound or their substitute decision maker (SDM)/power of attorney for personal care (POA C) (if applicable) are able to use the assessment information, in conjunction with your holistic person and wound assessment, to initiate/modify and implement an appropriate, person-centered, interdisciplinary plan of care which contains clear directions to staff and others who are providing the person with direct care

2. Explain the dressing change and wound assessment procedure and purpose to the person and/or their SDM/POA C (if applicable) and obtain verbal or implied consent
3. Assess the need for pre-procedure pain medication as removal of dressings and/or the dressing change procedure itself can be painful. The person may require pain medication before the dressing change/wound assessment, and if so, they **must** be allotted enough time to allow the drug's peak effect to take place BEFORE initiating the dressing change/assessment

Implementation

1. Provide for privacy and ensure the person is in a comfortable position to facilitate assessment of the wound
2. Wash your hands and attend to the person with your assessment documentation and dressing supplies
3. If the person in bed, raise the bed (if you are able to) to an appropriate ergonomic working position to facilitate ease of assessment. Otherwise position yourself in an appropriate ergonomic position to allow for the wound assessment while preventing self-injury
4. Ensure adequate lighting
5. Don clean disposable gloves, and expose the person's wound by removing the existing wound dressing as per the manufacturer's instructions. You may consider the application of gown, goggles, and/or a mask if the risk for spray or splash back exists
6. Dispose of soiled dressings in the appropriate receptacle
7. Remove your gloves and dispose of them in the appropriate receptacle
8. Wash your hands and put on a new pair of clean disposable gloves, and cleanse the wound as ordered or as per the "South West Regional Wound Care Program's Dressing Selection and Cleansing Enabler – HEALABLE" or "South West Regional Wound Care Program's Dressing Selection and Cleansing Enabler – MAINTENANCE/NON-HEALABLE", as indicated. Gently pat the wound dry with gauze (if needed)
9. Assess the wound using the "NPUAP PUSH Tool 3.0" (see "Procedure: NPUAP PUSH Tool 3.0")
10. Assess the depth of the tissue injury/pressure Injury stage using the

	"NPUAP Staging System for Pressure Injuries (Updated 2016)": a. If the tissue is intact but has a thin blister over a dark wound bed that becomes covered by thin eschar, you have a **deep tissue injury** b. If the tissue is intact but there is an area of non-blanchable redness that is/isn't painful, firm/soft, warmer/cooler than the surrounding skin, then you have a **stage I** pressure Injury c. If there is partial loss of the dermis or an intact or open serum-filled blister, then you have a **stage II** pressure Injury d. If there is full thickness tissue loss +/- visible subcutaneous fat, then you have a **stage III** pressure Injury e. If there is full thickness tissue loss with exposed bone, tendon, and/or muscle then you have a **stage IV** pressure Injury f. If you have a wound in which the wound base is obscured by slough and/or eschar, then you have an **unstageable** pressure Injury (you would further stage the pressure Injury once the wound base becomes visible) 11. Apply a new dressing as per the person's medical order or as per the "South West Regional Wound Care Program's Dressing Selection and Cleansing Enabler – HEALABLE" or "South West Regional Wound Care Program's Dressing Selection and Cleansing Enabler – MAINTENANCE/NON-HEALABLE", using clean technique unless otherwise indicated, i.e. unless the wound is considered acute 12. Assist the person to a comfortable position as required 13. Lower the person's bed to an appropriate height (if applicable), and ensure the person's safety, i.e. apply side rails, personal alarm, restraints as per the person's care plan/medical orders 14. Clean reusable equipment/surfaces touched during the procedure with warm soapy water or detergent wipes and dry thoroughly to prevent cross infection, returning reusable equipment to the appropriate places. Dispose of any personal protective equipment and soiled dressing supply materials in the appropriate receptacle 15. Remove and dispose of your gloves in the appropriate receptacle and wash your hands 16. Discuss your findings and the implications of those findings with the person and/or their SDM/POA C 17. Share the results of your assessment with the interdisciplinary members of the person's wound care team 18. Complete documentation as required, i.e. document initial and on-going "NPUAP PUSH Tool 3.0" scores on the designated form according to your organization's policy, and document the persons NPUAP pressure Injury stage in their medical records 19. Utilize the findings of your assessment in conjunction with your holistic person and wound assessment, to complete/update and implement an interdisciplinary, person-centered plan of care

	Evaluation 1. Unexpected Outcomes: a. The wound is not staged as per "NPUAP PUSH Tool 3.0" guidelines b. The Injury is back-staged c. The person complains of intolerable pain during your wound assessment/dressing change 2. Re-assess the wound using the "NPUAP PUSH Tool 3.0" at a minimum weekly, and re-consider the stage of the Injury at a minimum of weekly (remember, you can further stage the wound if the depth of injury increases, but you **CANNOT** back-stage the wound as the wound deficit fills in with granulation tissue)
References	1. Maklebust J. Pressure Ulcer staging systems: NPUAP Conference Proceedings. Adv Wound Care. 1995;8(4):28-11-28-14. 2. Shea JD. Pressure sores: Classification and management. Clin Orthop. 1975;112:89-100.
Related Tools (NOTE: these tools and their instructions can be found on the SWRWCP's website: swrwoundcareprogram.ca)	• NPUAP Staging System for Pressure Injuries (Updated 2016) • South West Regional Wound Care Program's Dressing Selection and Cleansing Enabler – HEALABLE • South West Regional Wound Care Program's Dressing Selection and Cleansing Enabler – MAINTENANCE/NON-HEALABLE • NPUAP PUSH Tool 3.0 • Procedure: NPUAP PUSH Tool 3.0