#### Title

**Procedure: NPUAP Staging System for Pressure Ulcers (Updated 2007)**

#### Background

- Pressure ulcers are classified based on the depth of tissue injury, using staging systems like the National Pressure Ulcer Advisory Panel (NPUAP) Staging System for Pressure Ulcers
- 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 ulcers are **NEVER** back-staged. This is because as a full-thickness pressure ulcer ‘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
- Pressure ulcer development does not necessarily progress from one stage to the next in a linear fashion, i.e. a stage I ulcer may suddenly become a stage IV ulcer
- The universal four stage (stage I-IV) NPUAP Staging System for Pressure Ulcers 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 ulcers described by Shea in 1975. The staging system was further defined in 2007 with the addition of two stages: suspected deep tissue injury, and unstageable pressure ulcers

#### 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 ulcer.

#### Procedure

**NOTE: The use of the “NPUAP Staging System for Pressure Ulcers (Updated 2007)” is but one part of the holistic assessment of an individual admitted with or presenting with a pressure ulcer.**

**Assessment**

1. Review the person’s medical chart for:  
   a. Any previous pressure ulcer 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 ulcer using the “NPUAP Staging System for Pressure Ulcers (Updated 2007)”  
   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 ulcer stage using the
“NPUAP Staging System for Pressure Ulcers (Updated 2007)”:
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 **suspected 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 ulcer
c. If there is partial loss of the dermis or an intact or open serum-filled blister, then you have a **stage II** pressure ulcer
d. If there is full thickness tissue loss +/- visible subcutaneous fat, then you have a **stage III** pressure ulcer
e. If there is full thickness tissue loss with exposed bone, tendon, and/or muscle then you have a **stage IV** pressure ulcer
f. If you have a wound in which the wound base is obscured by slough and/or eschar, then you have an **unstageable** pressure ulcer (you would further stage the pressure ulcer 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 ongoing “NPUAP PUSH Tool 3.0” scores on the designated form according to your organization’s policy, and document the persons NPUAP pressure ulcer 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
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<th>Evaluation</th>
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<tbody>
<tr>
<td>1. Unexpected Outcomes:</td>
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<tr>
<td>a. The wound is not staged as per “NPUAP PUSH Tool 3.0” guidelines</td>
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<td>b. The ulcer is back-staged</td>
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<td>c. The person complains of intolerable pain during your wound assessment/dressing change</td>
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<td>2. Re-assess the wound using the “NPUAP PUSH Tool 3.0” at a minimum weekly, and re-consider the stage of the ulcer 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)</td>
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<th>Related Tools (NOTE: these tools and their instructions can be found on the SWRWCP’s website: swrwoundcareprogram.ca)</th>
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<td>• NPUAP Staging System for Pressure Ulcers (Updated 2007)</td>
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<tr>
<td>• Procedure: NPUAP PUSH Tool 3.0</td>
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