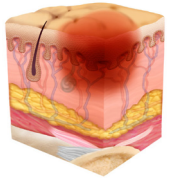
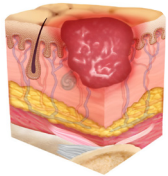
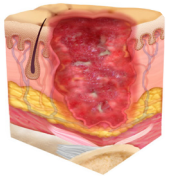
Pressure injury **staging scale**



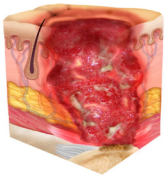
Stage 1:
Pressure injury: Non-blanchable erythema of intact skin
Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes.



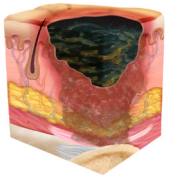
Stage 2:
Partial-thickness skin loss with exposed dermis
The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).



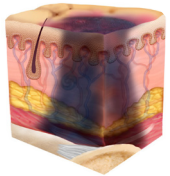
Stage 3:
Full-thickness skin loss
Full-thickness loss of skin, in which adipose (fat) is visible in the injury and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed.



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 injury. Slough and/or eschar may be visible. 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 injury 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.



Deep tissue:
Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon or purple discoloration or epidermal separating revealing a dark wound bed or blood filled blister. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss.

Medical device related pressure injury:
This describes an etiology. Medical device related pressure injuries result from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure injury generally conforms to the pattern or shape of the device. The injury should be staged using the staging system.

Mucosal membrane pressure injury:
Mucosal membrane pressure injury is found on mucous membranes with a history of a medical device in use at the location of the injury. Due to the anatomy of the tissue these ulcers cannot be staged.

Braden scale for predicting pressure injury risk

Sensory perception	**1** Completely limited	**2** Very limited	**3** Slightly limited	**4** No impairment
Moisture	**1** Constantly moist	**2** Very moist	**3** Occasionally moist	**4** Rarely moist
Activity	**1** Bedfast	**2** Chairfast	**3** Walks occasionally	**4** Walks frequently
Mobility	**1** Completely immobile	**2** Very limited	**3** Slightly limited	**4** No limitation
Nutrition	**1** Very poor	**2** Probably inadequate	**3** Adequate	**4** Excellent
Friction and shear	**1** Problem	**2** Potential problem	**3** No apparent problem	

Score
At risk (15-18)
Moderate risk (13-14)
High risk (10-12)
Very high risk (9 or below)

Contact your Stryker representative for more information.

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