

Keryln Carville RN, PhD, STN(Cred), FWA Chair PPPIA

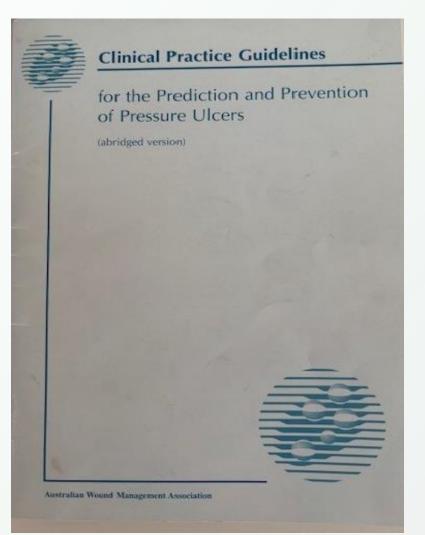












Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure Injury



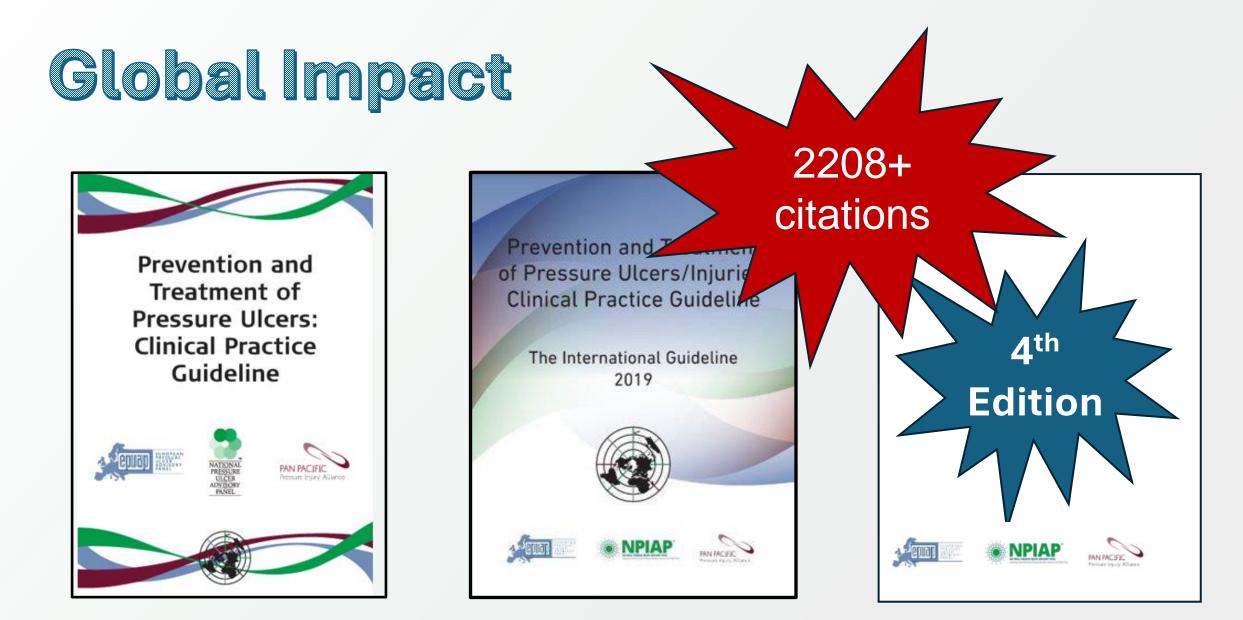
2001

2011

Expanding Partnerships

From small things, big things grow...





14 translations

20 translations

Guideline Governance Group (GGG)

Role:

- analyze the quality and clinical relevance of existing research;
- draft, review and revise Recommendations, Good Practice Statements,

Implementation Considerations;

- review Panel Group & Stakeholder comments;
- provide oversight and management of all guideline development processes;
- approve the final guideline.



2025 GGG



edi ski	oidermis ermis docutaneous fat uscle ane	Text adapted from: International NPUAP/EPUAP Pressure Uleer Classification System (2009,2014) p. National Pressure IUer Advisory Panel (INPUAP), European Pressure Uleer Advisory Panel (EPUAP), Pressure Injury Aliance (PPPIA), Prevention and Treatment of Pressure Uleer: Clinical Pressice Glude Emily Heaster (Ed.) Cambridge Media: Obsome Pank, W.A. 30 graphics. Dwraed by PPIA. Nextes Phot with Light Skin Tones, PPIA Classification System for Nones, PPIA Classification System (or Ol Dan's Skin Tones, PPIA Classification System for Nones, PPIA Classification System for Ol Dan's Skin Tones, PPIA Classification System for Science, PPIA Classification System for Ol				
Stage 1	Stage 2	Stage 3	Stage 4	Unstageable	Suspected Deep Tissue Injury	
Intact skin with non-blanchable redness of a localised area usually over bony prominences. Darkly jegmented skin may not have visible blanching; its colour may differ from the surrounding area. The area may be painful, firm, soft, adjocent tissue. Stage 1 pressure in individuals with darkly pigmented skin tone. May indicate ist risk' individuals (a heralding sign of risk).	Partial thickness loss of dermis presenting as a shallow open ulcer with a red/pink wound bed, without slough. Nay also present as an intract or open/ruptured serum-filled bilster. Presents as a shiny of slough or builsing (bruising indicates suspected deep tissue injury). Stage 2 pressue injuries should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excorlation.	Full thickness tissue loss. Subcutareous far may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure depth of Issue loss. May include undermining and tunnelling. The depth of Stage 3 location. The bridge of nots, ear, occiput and malleolus do not have subcutaneous tissue and Stage 3 ulcers can be shallow. In contrast, areas of significant adjoosity can develop extremely deep Stage 3 pressure injuries. Bone/tendon is not visible or directly palpable.	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 unneilling. The depth of a Stage 4 pressure injury varies by anatomical occiout and malieolus do not have subcutaneous tissue and these ulcers can be shallow. Stage 4 pressure injuries can extend into vulcers can be shallow. Stage 4 pressure injuries can extend into structures (e.g. fascia, tendon or piont capsule) making ostemwelitis possible. Exposed bone/tendon is wisible or directly palpable.	Full thickness tissue loss in which the ulcer base is covered by slough (vellow, tan, grav, green or brown) and/or eschar (tan, brown or black) in the slough and/or eschar to slough and/or eschar to the wound the true debth, land therefore Stage) 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.	Purple or marcon localised discoloured intact skin or filled blister due to dan underlying soft tissue from and/or shear. The area preceded by tissue that is firm, mushy, boggy, wa tissue. Deep tissue induvit dissue. Deep tissue induvit difficult to detect in indivit include a thin blister over wound bed. The wound mae evolve and be covered eschar. Evolution may b exposing additional layers.	

FUR ADULTS WITH LIGHT SKIN TONES

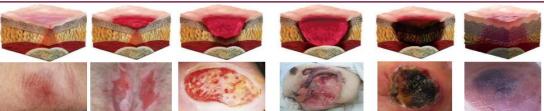
FAIN FAGILIC Pressure Injury Alliance

PAN PACIFIC

Pressure Injury Allia

Text adapted from: International NPUAP/EPUAP Pressure Ulcer Classification System (2009, 2014) published in: National Pressure Ulcer Advisory Panel (NPUAP), European Pressure Ulcer Advisory Panel (EPUAP), Pan Pacific Pressure Injury Alliance (PPPIA), Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline. 2014: Emily Haesler (Ed.) Cambridge Media: Obsorne Park, WA. 3D graphics: Owned by PPPIA. Photos: All photos courtesy Dr K. Carville, used with permission. Also available in this series: PPPIA Classification System: Multicultural, PPPIA Classification System for Asian Skin Tones, Dark Skin Tones, PPPIA Classification System for Neonates and Children, PPPIA Classification System for Asian Skin Tones, PPPIA Classification System for Older Adults. More information and permission for use: www.pppia.org © PPPIA 2020

Stage 4 Suspected Deep Stage 2 Stage 3 Unstageable Stage 1 **Tissue Injury** Intact skin with non-blanchable Partial thickness loss of dermis Full thickness tissue loss. Full thickness tissue loss with exposed Full thickness tissue loss in Purple or margon localised area redness of a localised area usually presenting as a shallow open Subcutaneous fat may be visible, but bone, tendon or muscle. Slough or which the ulcer base is covered of discoloured intact skin or over bony prominences. Darkly ulcer with a red/pink wound bone, tendon or muscle are not eschar may be present on some parts by slough (yellow, tan, gray, blood-filled blister due to damage pigmented skin may not have bed, without slough. May also exposed. Slough may be present but of the wound bed. Often include green or brown) and/or eschar of under/ying soft tissue from visible blanching; its colour may present as an instat or does not obscure depth of tissue loss. undermining and tunnelling. The (tan, brown or black) in the pressure and/or shear. The area differ from the surrounding area. open/ruptured serum-filled May include undermining and depth of a Stage 4 pressure injury wound bed. Until enough slough maybe preceded by tissue that is The area maybe painful, firm, spice, bister, Presents as a shinor or tunnelling. The depth of sage 1 varies by anatomical location. The and/or eschart is abinful, firm, mush, boggy, warmer or cooler as compared to dry shallow ulcar without pressure injuries varies by anatomical bridge of nose, ear, occiput and expose the base of the wound, warmer or cooler as compared to adjacent tissue. Nay indicate st slough or bruining (bruining) location. The bridge of nose, ear, maleolus do not have subcutaneous the true depth, (and therefore adjacent tissue. Evolution may risk' individuals (a heralding sign of indicates suspected deep tissue occiput and malleolus do not have tissue and these ulcers can be Stage) cannot be determined. Include a thin blister over a dark injury). Stage 2 pressure injuries subcutaneous tissue and Stage 3 shallow. Stage 4 pressure injuries can Stable (dry, adherent, intact wound bed. The wound may should not be used to describe ulcers can be shallow. In contrast, extend into muscle and/or supporting without erythema or further evolve and be covered by skin tears, tape burns, perineal areas of significant adiposity can structures (e.g. fascia, tendon or joint fluctuance) eschar on the heels thin eschar. Evolution may be dermatitis, maceration or develop extremely deep Stage 3 capsule) making osteomyelitis serves as 'the body's natural rapid, exposing additional layers pressure injuries. Bone/tendon is not possible. Exposed bone/tendon is (biological) cover' and should of tissue even with optimal excoriation visible or directly palpable. visible or directly palpable. not be removed. treatment.





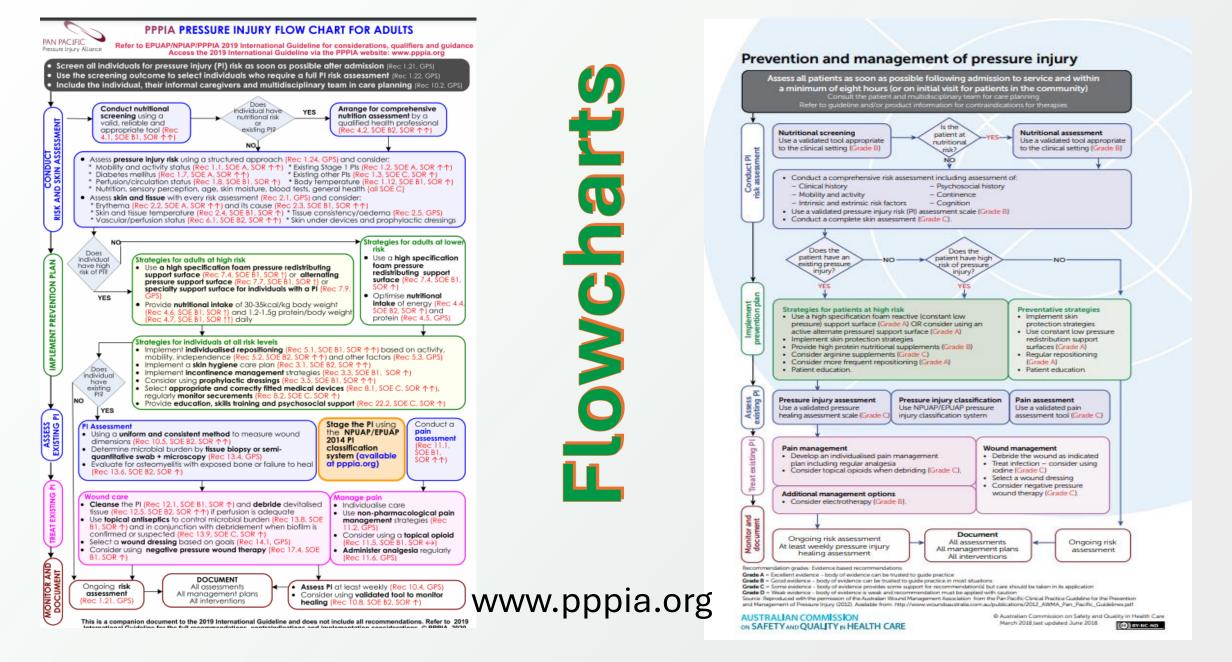
PAN PACIFIC PRESSURE INJURY CLASSIFICATION SYSTEM

		PAN PACIFIC Pressure Injury Alliance				
•epidermis -dermis -dermis -subcutaneous fat -music -bone		Pri All Ca pe Wi To	Text adapted from: International NPUAP/EPUAP Pressure Ulier Classification Pressure Ulier Advisory Panel (NPUAP), European Pressure Ulier Advisory Alliance (PPIA), Prevention and Treatment of Pressure Uliers: Clinical P Cambridge Media: Obtome Park, WA. 3D graphics: Owned by PPPIA. Phot permission: Also available in his series: PPIA Classification System: Multice with Light Skin Torker, PPIA Classification System for Neonates and Childre More information and permission for user www.oppian.org		Panel (EPUAP), Pan Pacific Pressure In ractice Guideline. 2014: Emily Haesler (ros: All photos courtesy of S. Law, used v Jutural, PPPIA Classification System for Ad	
Stage 1	Stage 2	Stage 3	Stage 4	Unstageable	Suspected Deep	
Intact skin with non-blanchable redness of a localised area usually over bony prominences. Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage I pressure injuries may be difficult to detect in individuals with darkly pigmented skin tone. May indicate artisk Individuals (a heralding sign of risk).	dermis presenting as a shallow open ulcer with a red/pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled bilster. Presents as a shiny or dry shallow ulcer without slough or bruising (bruising indicates suspected	Full thickness tissue loss. Subcutaneous far may be visible, but bone, tendion or muscle are not exposed. Slough may be present but does not obscure depth of tissue loss. May include undermining and tunneiling. The depth of Stage 3 pressure injuries varies by anatomical location. The bridge of nose, ear, occiput and maileolus do not have subcutaneous tissue and Stage 3 uicers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Stage 3 pressure injuries. Bone/rendon is not visible or directly palpable.	Full thickness tissue loss with exposed bone, t endon or muscle. Sough or escher may be present on some parts of the wound bed. Often include undermining and tunnelling. The depth of a Stage 4 pressure injury varies by anatomical location. The bridge of nose, ear, occjout and malleolus do not have subcutaneous tissue and these uicers can be shallow. Stage 4 pressure injurises can extend into muscle ana/or supporting structures (e.g. fascia, tendon or joint capsule) making osteorwelltis possible. Exposed bone/tendon is visible or directly aplabele.	Full thickness tissue loss in which the ulcer base is covered by slough (vellow, tan, gray, green o brown) and/or eschar (tan, brown or black) in the wound bed. Unti enough slough and/or eschar i removed to expose the base o the wound, the true depth, (and therefore Stage) cannot be determined. Stable (dry adherent, intact withou erythema or fluctuance) escha on the heels serves as 'the body' natural (biological) cover' and should not be removed.	discoloured intect skin or blo filed blitser due to damage underlying soft tissue from press and/or shear. The area may spreceded by tissue that is pair firm, mushy, boggy, warmer d cooler as compared to adjac tissue. Deep tissue hipry may difficult to detect in individuals dark skin tones. Evolution r include a thin blitser over a c wound bed. The wound may fort	
	FUKI	DAKK SKIN TUNES			Pressure Injury Alliance	
Normal skin	-epidermis -dermis -subcutaneous fat -muscle -bone		Text adapted from: International NPUAF National Pressure Ulcer Advisory Panel (NI Injury Alliance (PPPIA), Prevention and Trea Cambridge Media: Osborne Park, WA, 30 g with parmission, Also available in this seri Adults with Light Skin Tones, PPIA Classifi Skin Tones, PPIA Classification System for More information and permission for use	PUAP), European Pressure Ulcer Adviso timent of Pressure Ulcers: Clinical Practi traphics: Owned by PPPIA. Photos: All p es: PPIA Classification System: Multici ation System for Neonates and Childrer Older Adults.	ry Panel (EPUAP), Pan Pacific Pressure ice Guideline. 2014: Emily Heesler (Ed.) hotos courtesy Dr Keryln Carville, used ultural, PPPIA Classification System for	
Stage 1	Stage 2	Stage 3	Stage 4	Unstageable	Suspected Deep	
Intact skin with non-blancha redness of a localised area usu user bony prominences. Dar pigmented skin may not hu visible blanching; its colour m d'hearea may baselindu, ifrmu si warmer or coler as compared adjacent tissue. Stage I press injuries may be difficult to det in individuals with dar pigmented skin tone. May indic 'at risk' individuals (a heraid sign of risk).	ally presenting as a shallow ope kly ulcer with a red/pink woun ave bed, without slough. May ale present as an intact of a open/ruptured serum-fille off, bilser. Presents as a shiny of to dry shallow ulcer withou red slough or bruising (bruisi indicates suspected deep tissu kly an uny). Stage 2 pressure injurt a should not be used to describ	n fat may be visible, but bone, tendon c muscle are not exposed. Slough may by present but does not obscure depth not r tissue loss. May include underminin d and tunnelling. The depth of Stage occiput and malleolus do not hav subcutaneous tissue and Stage 3 ulces can be shallow. In contrast, areas c significant adjosity can develo externely deep. Stage 3 pressur	 exposed bone, tendino or muscle. Slough or extent may be present on f some parts of the wound bed. Orten include undermining and a tunnelling. The depth of a Stage 4 pressure injury varies by anatomical no cociput and malleolus do nothave s subotaneous tissue and these f ulcars can be shallow. Stage 4 pressure injuries can extend into muscle a muscle 	by slough (vellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound back. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, (and therefore Stage) cannot be therefore Stage) cannot be therefore Stage) cannot be enderent, intact without erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological)	Tissue Injury Tissue Injury Purple or marcon localised area of discoloured intact skin or blood- filled blister due to damage of under/hying soft tissue fran may be greaceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to year and the state of the state may be difficult to detect in individuals with dark skin tones. Evolution may further evolve and be covered by thin eschar, Evolution may further evolve additional layers of tissue even with optimal treatment.	
Notar put						

Free Downloads of Resources

risk).

www.pppia.org



Partners in 4th Edition Guideline Development and Dissemination



Chinese Nursing Association Canadian Pressure Injury Advisory Panel Enterostomal Therapy Nurse Association (Thailand) International Inter-professional Wound Care Group (IIIWCG) Indonesia Wound Care Clinician Association Indonesian Wound Enterostomal Continence Nurses Association (InWECNA) Japanese Society of Pressure Ulcers Korea Association of Wound Ostomy Continence Nurses Malaysian Society of Wound Care Professionals Nurses Specialized in Wound, Ostomy and Continence Canada Pan African Pressure Injury Alliance Saudi Chapter of Enterostomal Therapy Brazilian Association of Enterostomal Therapy (SOBEST) World Council of Enterostomal Therapists® Partners Wound Healing Association of Southern Africa Wound Ostomy and Continence Nurses[™] Society Wounds Canada







NPIAP, EPUAP, PPPIA 2014 & 2019

- Clinical Practice Guideline (CPG) Downloadable and hard copies. The CPG contained Recommendations, Good Practice Statements, Implementation Considerations and a summary of the supporting evidence for prevention and treatment as well as supplemental materials.
- **Quick Reference Guide (QRG)** free English language download, free translation downloads and a hard copy for sale. The QRG contained Recommendations and Good Practice Statements for prevention and treatment. It was used as a basis for translations managed by EPUAP.
- **Data Extraction Tables and Evidence to Decision Frameworks** were made available for free on the international guideline website (<u>https://www.internationalguideline.com</u>).







2025 Outputs...

Clinical Practice Guideline (CPG):

- Digital free downloads it will be a dynamic document
- Printed copy for sale
 - Contains Recommendations, Good Practice Statements, Implementation Considerations for prevention
 and treatment

Quick Reference Guide (QRG) – Digital free downloads & printed copy for sale.

Data Extraction Tables and Evidence to Decision Frameworks made available for free on the interactive guideline website (<u>https://www.internationalguideline.com</u>).







Ath Edition Prevention

28 February, 2025

1 March, 2025

Rydges Central Sydney



From small things, big things grow...



To the many clinicians, researchers, consumers and stakeholders who contributed to the International Pressure Injury/Ulcer Guideline 4th Edition.