

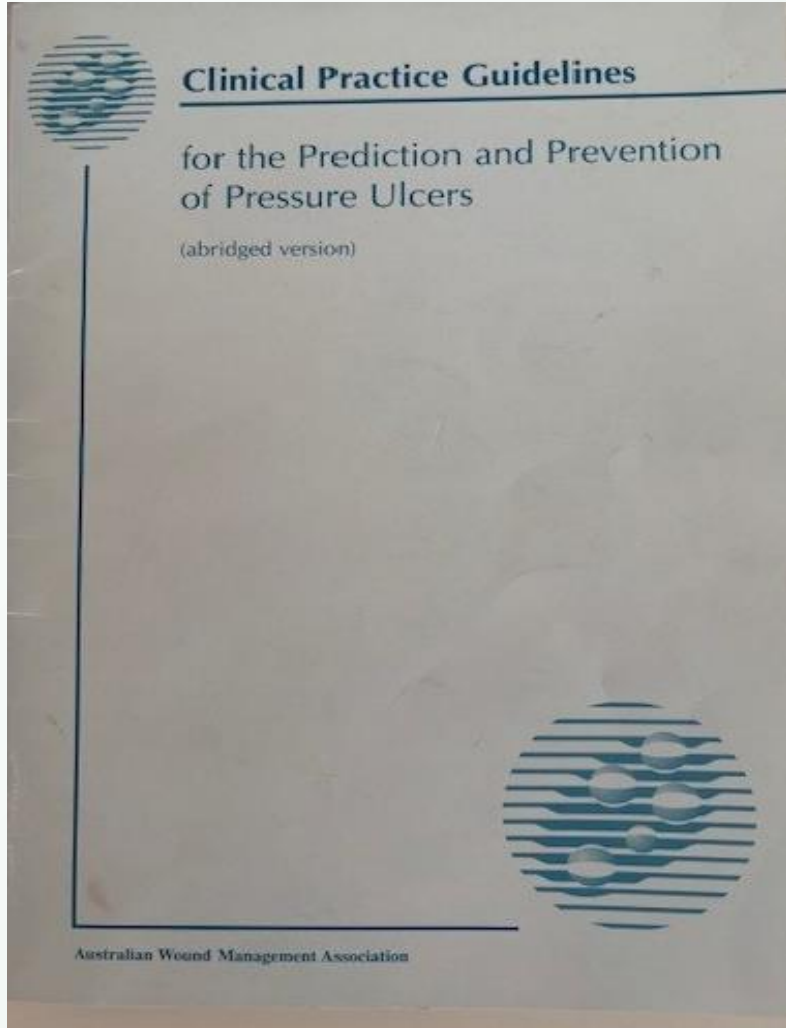


PAN PACIFIC Pressure Injury Alliance

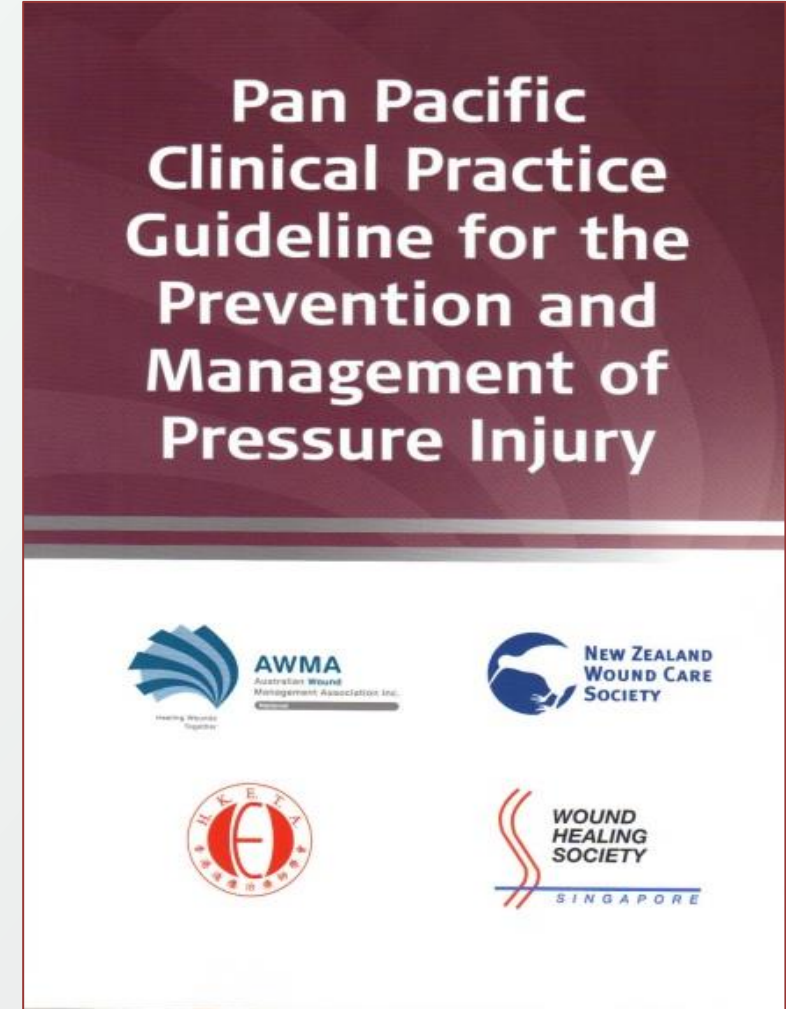
Keryln Carville RN, PhD, STN(Cred), FWA
Chair PPPIA



Background



2001



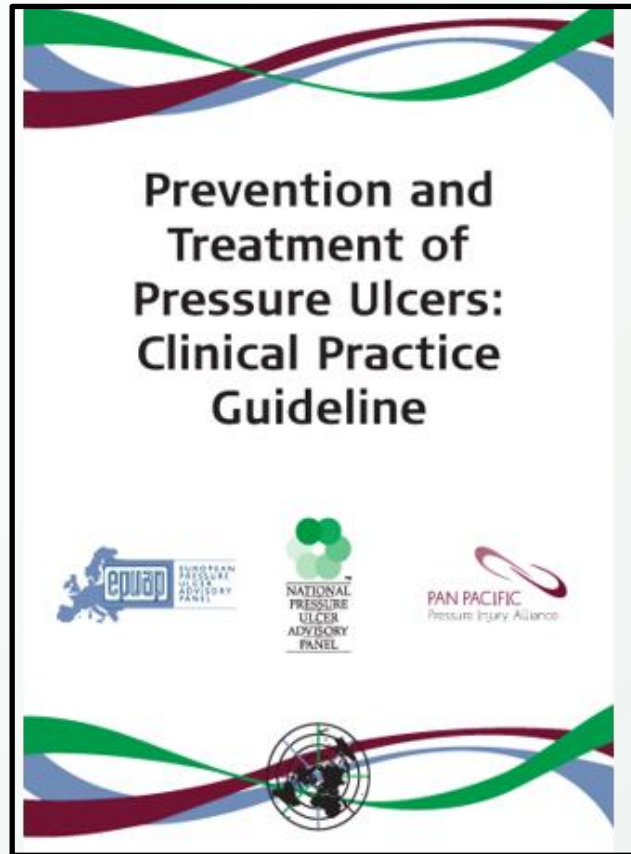
2011

Expanding Partnerships

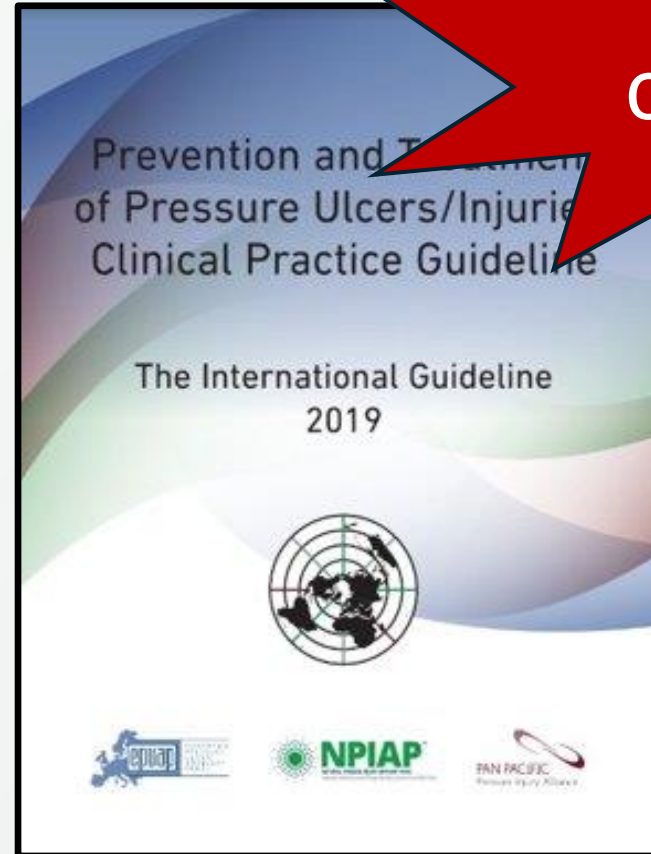
From small things, big things grow...



Global Impact



14 translations



20 translations

2208+
citations

4th
Edition



Guideline Governance Group (GGG)

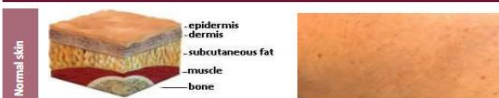
Role:

- 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.



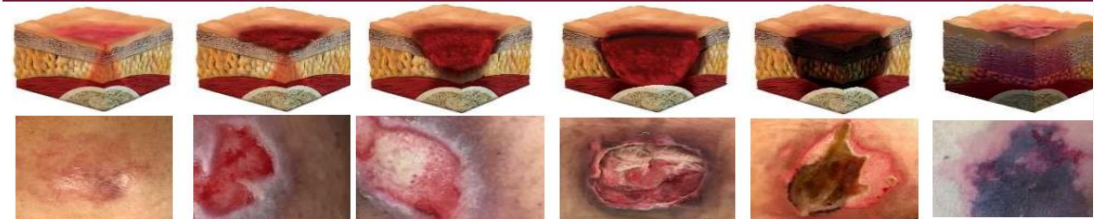
2025 GGG

PAN PACIFIC PRESSURE INJURY CLASSIFICATION SYSTEM FOR ASIAN SKIN TONES



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: Osborne Park, WA. 3D graphics: Owned by PPPIA. Photos: All photos courtesy of S. Law, used with permission. Also available in this series: PPPIA Classification System: Multicultural, PPPIA Classification System for Dark Skin Tones, PPPIA Classification System for Neonates and Children, PPPIA Classification System for Older Adults. More information and permission for use: www.pppia.org © PPPIA 2020

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 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 1 pressure injuries may be difficult to detect in individuals with darkly pigmented skin tone. May indicate 'at 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. May also present as an intact or open/ruptured serum-filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising (bruising indicates suspected deep tissue injury). Stage 2 pressure injuries should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.	Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure depth of tissue loss. May include undermining and tunnelling. The depth of Stage 3 pressure injuries varies by anatomical location. The bridge of nose, ear, occiput and malleolus do not have subcutaneous tissue and Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity 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 tunnelling. The depth of a Stage 4 pressure injury varies by anatomical location. The bridge of nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage 4 pressure injuries can extend into muscle and/or supporting structures (e.g. fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.	Full thickness tissue loss in which the ulcer base is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, (and therefore Stage) cannot be determined. Stable (dry, adherent, intact without erythema or fluctuant) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed.	Purple or maroon localised area of discoloured intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is pain, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Stage 1 pressure injuries may be difficult to detect in individuals with darkly pigmented skin tone. May indicate 'at risk' individuals (a heralding sign of risk).

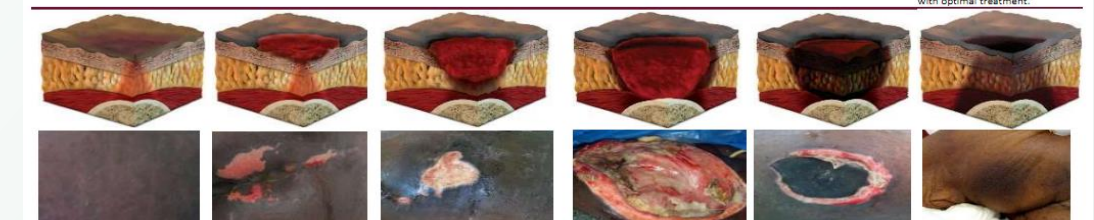


FOR DARK SKIN TONES



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: Osborne Park, WA. 3D graphics: Owned by PPPIA. Photos: All photos courtesy of Dr. Kevin Carville, used with permission. Also available in this series: PPPIA Classification System: Multicultural, PPPIA Classification System for Adults with Light 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 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 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 1 pressure injuries may be difficult to detect in individuals with darkly pigmented skin tone. May indicate 'at 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. May also present as an intact or open/ruptured serum-filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising (bruising indicates suspected deep tissue injury). Stage 2 pressure injuries should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.	Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure depth of tissue loss. May include undermining and tunnelling. The depth of Stage 3 pressure injuries varies by anatomical location. The bridge of nose, ear, occiput and malleolus do not have subcutaneous tissue and Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity 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 tunnelling. The depth of a Stage 4 pressure injury varies by anatomical location. The bridge of nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage 4 pressure injuries can extend into muscle and/or supporting structures (e.g. fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.	Full thickness tissue loss in which the ulcer base is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, (and therefore Stage) cannot be determined. Stable (dry, adherent, intact without erythema or fluctuant) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed.	Purple or maroon localised area of discoloured intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and be covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.

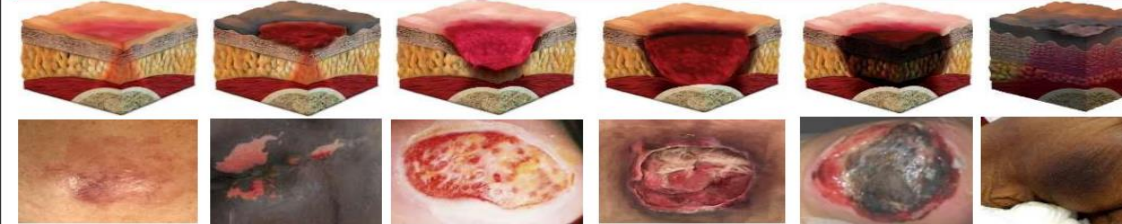


PAN PACIFIC PRESSURE INJURY CLASSIFICATION SYSTEM: MULTICULTURAL

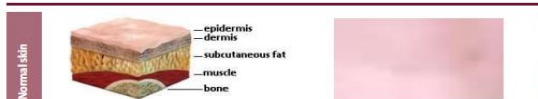


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Stage 1	Stage 2	Stage 3	Stage 4	Unstageable	Suspected Deep Tissue Injury
Intact skin with non-blanchable redness of a localised area usually over bony prominences. Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage 1 pressure injuries may be difficult to detect in individuals with darkly pigmented skin tone. May indicate 'at 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. May also present as an intact or open/ruptured serum-filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising (bruising indicates suspected deep tissue injury). Stage 2 pressure injuries should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.	Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure depth of tissue loss. May include undermining and tunnelling. The depth of Stage 3 pressure injuries varies by anatomical location. The bridge of nose, ear, occiput and malleolus do not have subcutaneous tissue and Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity 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 tunnelling. The depth of a Stage 4 pressure injury varies by anatomical location. The bridge of nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Stage 4 pressure injuries. Bone/tendon is not visible or directly palpable.	Full thickness tissue loss in which the ulcer base is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, (and therefore Stage) cannot be determined. Stable (dry, adherent, intact without erythema or fluctuant) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed.	Purple or maroon localised area of discoloured intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over wound bed. The wound may further evolve and be covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.

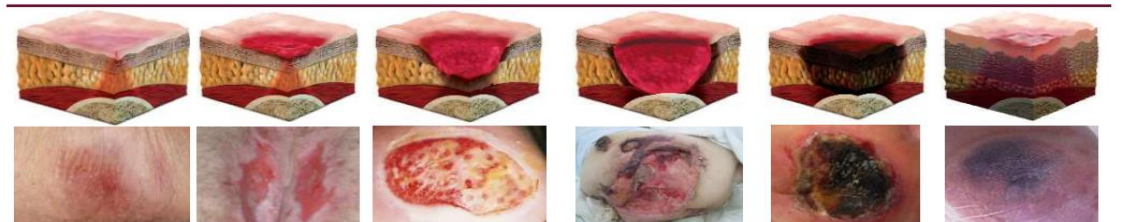


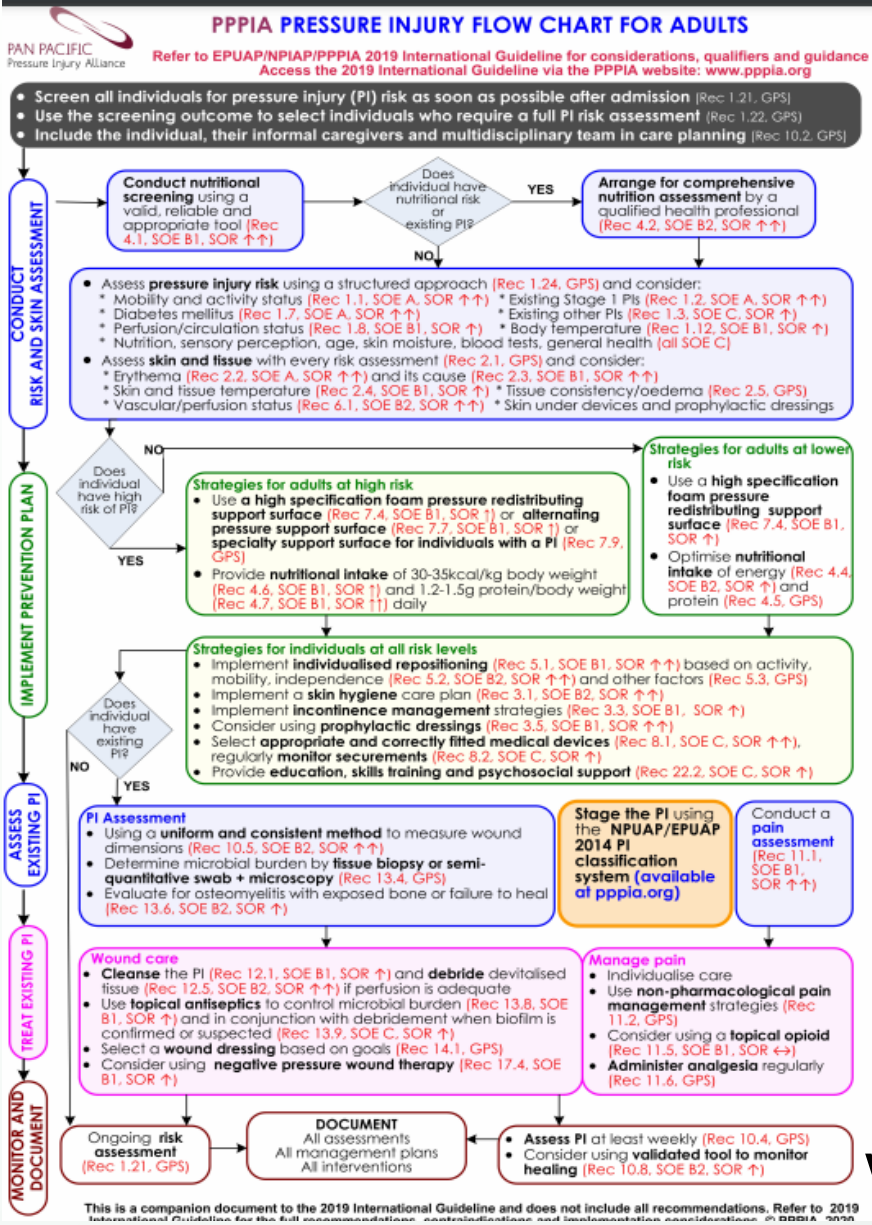
FOR ADULTS WITH LIGHT SKIN TONES



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: Osborne Park, WA. 3D graphics: Owned by PPPIA. Photos: All photos courtesy of Dr. K. Carville, used with permission. Also available in this series: PPPIA Classification System: Multicultural, PPPIA Classification System for 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 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 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 1 pressure injuries may be difficult to detect in individuals with darkly pigmented skin tone. May indicate 'at 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. May also present as an intact or open/ruptured serum-filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising (bruising indicates suspected deep tissue injury). Stage 2 pressure injuries should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.	Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure depth of tissue loss. May include undermining and tunnelling. The depth of Stage 3 pressure injuries varies by anatomical location. The bridge of nose, ear, occiput and malleolus do not have subcutaneous tissue and Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity 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 tunnelling. The depth of a Stage 4 pressure injury varies by anatomical location. The bridge of nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Stage 4 pressure injuries. Bone/tendon is not visible or directly palpable.	Full thickness tissue loss in which the ulcer base is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, (and therefore Stage) cannot be determined. Stable (dry, adherent, intact without erythema or fluctuant) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed.	Purple or maroon localised area of discoloured intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and be covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.

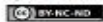
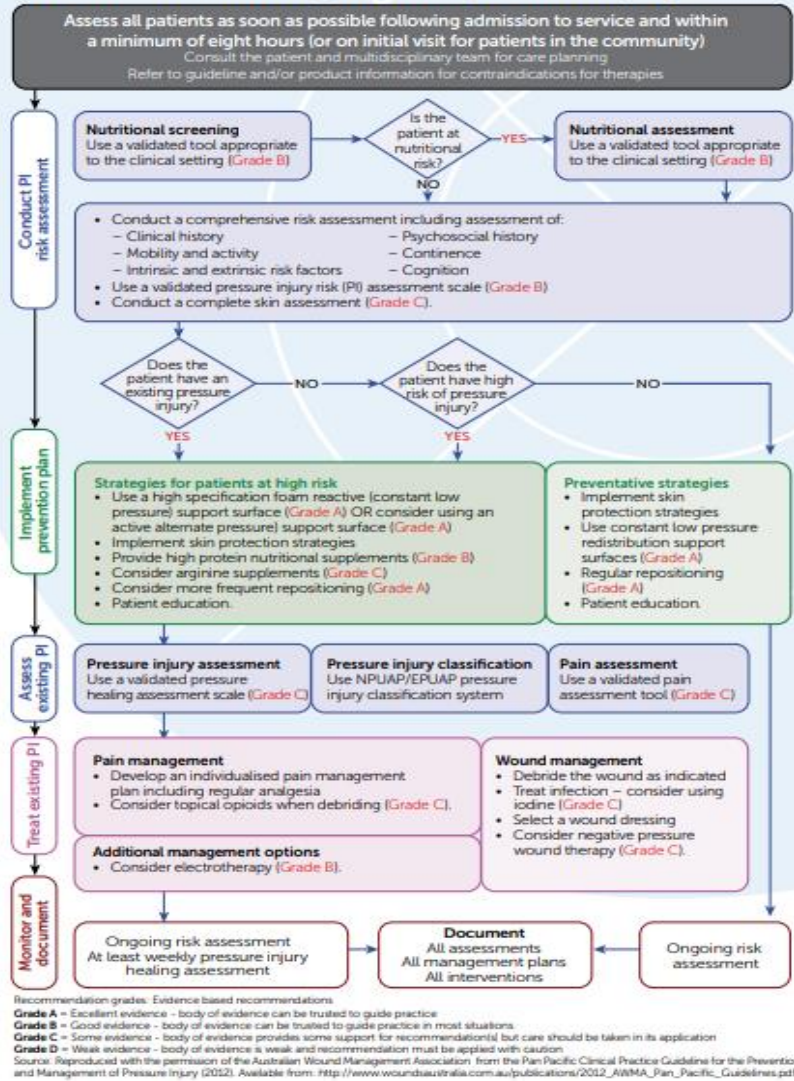




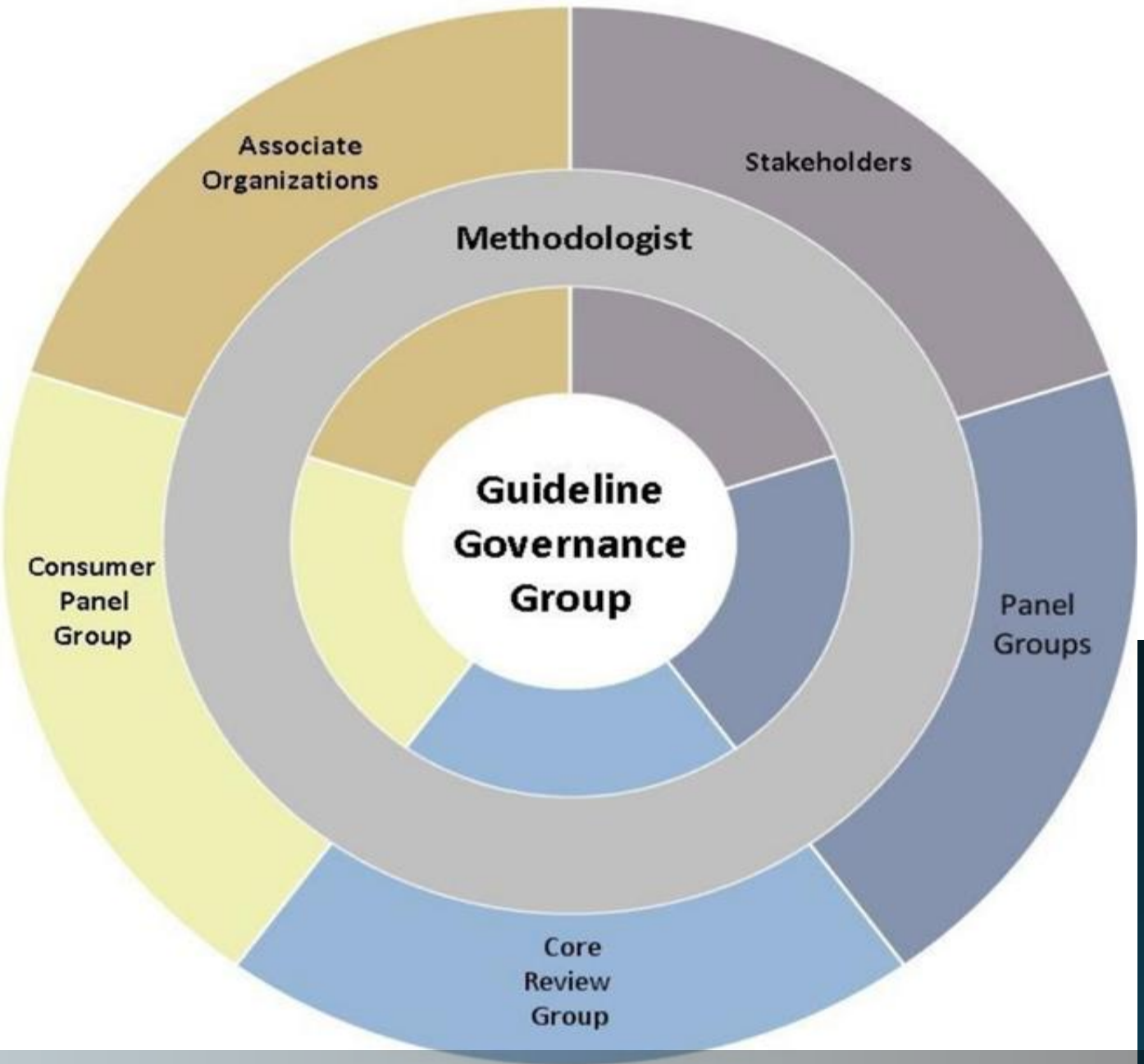
Flowcharts

www.pppia.org

Prevention and management of pressure injury



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 (IIWCG)

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®

Wound Healing Association of Southern Africa

Wound Ostomy and Continence Nurses™ Society

Wounds Canada



Pan African Pressure Injury Alliance



Partners



Outputs...

NPIAP, EPUAP, PPIA 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 (<https://www.internationalguideline.com>).



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 (<https://www.internationalguideline.com>).





4th Edition Prevention Launch

28 February, 2025

1 March, 2025

Rydges Central Sydney

From small things, big things grow...

DZIĘKUJĘ

ありがとう

OBRIGADO

谢谢

GRACIAS

THANK YOU

TAKK

SAĞOL

ευχαριστώ

спасибо

GRAZIE

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MERCI

BEDANKT



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