



NPUAP Position Statement on Staging – 2017 Clarifications

January 24, 2017

Introduction and Background

Recognizing that new research findings called for an updating of our 2007 staging definitions, NPUAP appointed a multi-disciplinary Staging Task Force to review the scientific literature and prepare refined definitions.

- We launched an inclusive, multi-year process designed to produce the best outcome.
- Definitions were initially revised based on new research and common clinician queries submitted to NPUAP after release of the 2007 NPUAP Staging System.
- An open invitation was issued for stakeholder comments. All stakeholder comments were reviewed and incorporated into a second draft as appropriate.
- A professionally mediated consensus conference was held in April 2016 and was attended by over 400 multidisciplinary professionals from around the world. Changes supported by research were not considered as part of the consensus process. Participants deliberated and then voted on the changes not addressed by research, yet critical to clinical practice.
- The new staging definitions were adopted and then promulgated.¹

The consensus process has an appropriate and useful role in clarifying issues not yet elucidated by research and also serves to identify future research questions. The NPUAP Staging Consensus conference was convened with these goals in mind.

Response from Professional and Government or Regulatory Organizations

The NPUAP has worked actively with a number of entities to ensure the smooth implementation of the new NPUAP Staging System.

- The Wound Ostomy and Continence Nurses Society (WOCN[®]) supports the new staging system.
- The Academy of Nutrition and Dietetics supports the new staging system.
- The National Database for Nursing Quality Indicators (NDNQI) revised its database, data collection guidelines, CE training modules and quality measures to conform to this change.
- The Journal of Wound Ostomy and Continence Nurses has committed to using the term “pressure injury” in future publications.

In Process:

- There have been ongoing discussions between NPUAP and CMS to facilitate implementation for documentation, quality monitoring and reimbursement.
- Coding systems such as LOINC and SNOMED CT are being analyzed for congruence with the new staging system.
- Pressure injury is listed as a synonym for pressure ulcer in the beta draft of the ICD-11.²
- The Veterans Affairs is revising teaching materials to align with these changes.
- The Partnership for Patients - Hospital Engagement Network (HEN) is dually listing pressure injury/ulcer in its materials.
- The Joint Commission has posted the new staging system on its website as a point of information.
- The International Guideline Group will examine the new NPUAP Staging System as well as new evidence as they revise the international pressure ulcer guideline for 2019.

The NPUAP recognizes that change is difficult and significant efforts are being made to implement these changes in databases, instructional materials, and electronic health records. The NPUAP is very appreciative of the nation-wide efforts being undertaken to improve pressure injury identification, documentation and monitoring. As implementation has spread, the NPUAP has had several requests for clarification. The statements noted below are designed to respond to those requests and further clarify the position of the NPUAP.

Position Statements

Position Statement 1: The diagnosis of a “pressure injury” does not mean that the health care provider(s) “caused” the injury.

Pressure injury simply means the tissue is injured by pressure (and/or shear). It does not assign blame or in any way imply that the injury was “caused” by anything that health care providers “did” or “failed to do”. The word “injury” occurs frequently in the medical literature (e.g., kidney injury, spinal cord injury, closed head injury) to identify the existence of tissue injury, without assigning blame. For example, “injury” appears 5,525 times in SNOMED CT, while “ulcer” appears 2,577 times.

“Pressure injury” is a more accurate label than “pressure ulcer” because some presentations of the phenomena are not open ulcers; yet all can be legitimately classified as tissue injuries. The NPUAP carefully considered the possibility that the word “injury” might be misinterpreted to imply causation by the health care provider. However, stakeholders reviewing early drafts of the new NPUAP staging definitions were overwhelmingly supportive of this change. Position Statement 1 has been written to officially correct any lingering misconceptions about the NPUAP’s intent.

Also note that a similar change was made in Australia in 2011 and was embraced and driven by health care providers and policy makers. The Australian Wound Management Association (AWMA) observed that a narrow legal interpretation of the word should not stop providers

from using “injury” to most accurately describe a clinical condition they diagnose and treat. Increased pressure injury litigation has not been reported. Use of the term “pressure injury” has encouraged providers to refocus on “prevention”. Injuries can often be prevented (e.g., falls). Ulcers are usually part of larger pathological process (e.g., venous ulcers, diabetic foot ulcers).

Position Statement 2: Some pressure injuries are unavoidable despite provision of evidence-based care by the health care team.

The NPUAP has long maintained that some pressure injuries are unavoidable and has held two consensus conferences in an effort to clarify this issue.^{3,4} **As a result, in any legal matter, “causation” should not be implied by use of the word “injury”. Rather, evidence must be presented to support a theory of causation based on a careful analysis of the preventive care provided (or not provided) to the individual in accordance with acceptable standards of evidence-based pressure injury prevention.** A plaintiff must prove that a provider had a “duty” to the patient, “breached that duty”, “causing” an “injury”. Evidence must be presented to support all four components (duty, breach of duty, injury, and causation). Injury is only one of four evidentiary components and has a specific (and limited) definition in law. The legal definition of the term should not be conflated and applied to the many physiologically based uses of the term in health care (e.g., spinal cord injury, traumatic brain injury, pressure injury). We refer the reader to the NPUAP definition of unavoidable pressure injury³ and the International Guideline on Pressure Ulcer Prevention and Treatment⁵ for further details.

Position Statement 3: The numerical staging system does NOT imply linear progression of pressure injuries from Stage 1 through Stage 4, nor does it imply healing from Stage 4 through Stage 1.

The NPUAP has long maintained this position and issued a position statement recommending against “down staging” as early as the year 2000.⁶ One of the unintended consequences of identifying numerical stages of pressure injuries is that it invites the misinterpretation that “stage” implies a progression (forward or backward). NPUAP’s system implies no progression in any direction.

In collaboration with its international partner (the European Pressure Ulcer Advisory Panel), a recommendation was made to change the word, “stage” (or “grade”), to “category” to convey non directionality.⁷ Many European countries have replaced “stage” or “grade” with “category” to avoid this misinterpretation. The United States chose to stay with the term “stage”; however, this was done with the clear understanding that “stage” should not imply progression or reverse staging.

Position Statement 4: The NPUAP Staging System classifies pressure injuries based on the type of tissue loss that can be visualized or directly palpated.

Pressure injuries can be numerically staged (i.e. Stage 1, 2, 3 or 4), if the type of tissue injured can be visualized or directly palpated (e.g., in the case of Stage 4 when exposed bone is visible or directly palpated). The NPUAP also recognizes the very real clinical limitations of being able to visualize the types of tissues exposed by injury. Based on these limitations, the NPUAP staging system provides two additional options: (1) unstageable pressure injuries to address situations where the wound base is obscured by slough and/or eschar and (2) Deep Tissue Pressure Injury (DTPI) where the skin may still be intact, but is purple or maroon indicating deeper tissue damage has occurred. After DTPIs evolve, or unstageable pressure injuries are debrided, these injuries can be numerically staged. Due to the unique anatomy in mucosal membranes, pressure injuries in these tissues should be noted, but can never be staged.⁸

When classifying injuries caused by pressure and/or shear, the clinician has the following options:

- 1) If the type of tissue in the wound base can be evaluated, numerically classify as **Stage 1 or 2 or 3 or 4**, based on the deepest tissue type exposed.
- 2) If the wound base cannot be evaluated, classify as:
 - a) **Deep Tissue Pressure Injury (DTPI)** when the skin is intact with deep red, purple or maroon discoloration or blood blister(s).
 - b) **Unstageable** when the base is obscured by slough or eschar.
- 3) If on a **mucosal membrane**, document, but do not stage.

Position Statement 5: The pressure injury may be more extensive than initially apparent. The wound base and surrounding tissue should be assessed for variations in sensation, temperature, firmness, color and any expression of drainage from surrounding tissues when palpated.

In many situations, the level of tissue injury can be accurately assessed with visual inspection. However, the tissue surrounding the “visible injury” should be assessed for changes in sensation (e.g., pain), temperature (e.g., warmer from inflammation, colder as tissues die), firmness (firmer or boggy with tissue destruction and edema), color (signs of inflammation consistent with skin tone) and drainage expressed from surrounding tissues as they are palpated. This more thorough assessment of surrounding tissue may alert the clinician to more extensive damage than is readily visible. These additional findings should be described and documented.

Position Statement 6: Deep Tissue Pressure Injury (DTPI) may evolve into a full thickness wound despite optimal care.

A DTPI may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss.^{1,9} Since the NPUAP first made this statement in 2007, we have a better understanding of etiology¹⁰⁻¹² risk factors,¹³⁻¹⁵ differential diagnosis,¹⁶ and the natural evolution of DTPI.^{13,14,16-18} Off-loading the area still offers the best chance for tissue that is ischemic or injured, but not infarcted. Interventions for both the prevention and treatment of DTPI are

currently being investigated. However, given the current state of the science, it remains true that DTPI may evolve “exposing additional layers of tissue even with optimal treatment”.⁹

Position Statement 7: Any pressure injury should be treated in accordance with current evidence-based practices and monitored closely for changes that require re-evaluation of treatment strategies.

In 2011, the National Quality Forum (NQF) endorsed the following quality measure: “percent of patients or short-stay residents with Stage 2-4 pressure ulcer(s) that are new or worsened since admission”. Clinicians routinely use the NPUAP Staging System to identify “new” pressure injuries; however, worsening of pressure injuries is also evaluated based on the staging system. The NPUAP Staging System revisions are designed to improve the accuracy of staging when reporting “new” or “worsening” pressure injuries. Evolution of a DTPI on admission to a Stage 3 or 4 pressure injury should not be counted as “worsening” under this measure. As the nation’s leading scientific expert in pressure injury prevention and treatment, the NPUAP will continue to work with CMS on further refinements, including measures that more accurately monitor healing versus deterioration.

Three iterations of the NPUAP Staging System have been released (1989, 2007 and 2016). Each was based on the best available evidence of the time. As the nation’s leading scientific expert on pressure injury prevention and treatment, NPUAP has continuously monitored cutting-edge research, issuing staging updates and interim position statements as research evidence and clinical questions warranted. The NPUAP has provided the gold standard for diagnosis and classification of pressure injuries for nearly three decades, and counting. Pressure injuries are our primary focus. We look forward to continued collaboration with colleagues and stakeholders to “improve patient outcomes in pressure injury prevention and treatment through public policy, education and research”.

References

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NPUAP Position Statement on Staging – 2017 Clarifications

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