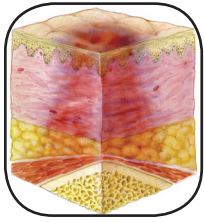


## Guidelines for Staging Pressure Ulcer(s)

The following criteria can be used as a quick educational reference tool to help identify the appropriate stage of a pressure ulcer. These are defined by the NPUAP Guidelines (2010).

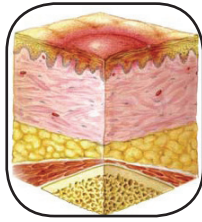


**Suspected Deep Tissue Injury – depth unknown**

Purple or maroon localized area of discolored 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 become covered by thin eschar.

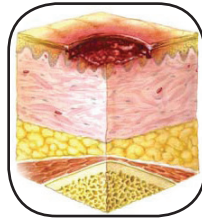
Evolution may be rapid exposing additional layers of tissue even with optimal treatment.



**Category/Stage I: Non-blanchable erythema**

Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue.

Category I may be difficult to detect in individuals with dark skin tones. May indicate "at risk" persons.

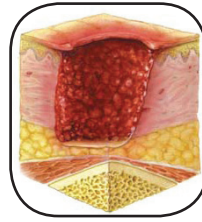


**Category/Stage II: Partial thickness**

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 or sero-sanguinous filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising\*.

This category should not be used to describe skin tears, tape burns, incontinence associated dermatitis, maceration or excoriation.

\*Bruising indicates deep tissue injury.

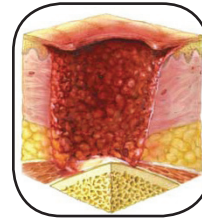


**Category/Stage III: Full thickness skin loss**

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 the depth of tissue loss. May include undermining and tunneling. The depth of a Category/Stage III pressure ulcer varies by anatomical location.

The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and Category/Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage III pressure ulcers.

Bone/tendon is not visible or directly palpable.



**Category/Stage IV: Full thickness tissue loss**

Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunneling. The depth of a Category/Stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and these ulcers can be shallow.

Category/Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis or osteitis likely to occur. Exposed bone/muscle is visible or directly palpable.



**Unstageable/Unclassified: Full thickness skin or tissue loss – depth unknown**

Full thickness tissue loss in which actual depth of the ulcer is completely obscured 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 are removed to expose the base of the wound, the true depth cannot be determined; but it will be either a Category/Stage III or IV. 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.

## Pressure Ulcer Assessment and Documentation Guidelines

Pressure ulcer documentation should be completed once per week, at minimum. Below is a recommended guide of areas to cover in detail. Additional documentation may be required or preferred in specific situations.

### **Risk Assessment**

Use validated assessment tool (such as the Braden Scale)

### **Location**

Describe using anatomically correct terminology. Refer to the body as a face of a clock (i.e. 12 o'clock toward client's head)

### **Size**

Describe size including length, width and depth in centimeters. Use measuring guide or bull's eye and cotton tipped applicator if necessary.

### **Category/Stage**

Describe the category/stage of the wound. (See reverse side)

### **Wound Characteristics**

Describe the wound bed and wound edges including the kind of tissue present in the wound and surrounding the wound bed (i.e. granulation tissue, slough, eschar, epithelial tissue, swelling, induration, etc.).

### **Undermining and Tunneling**

Describe if present. Measure in centimeters and document location.

### **Drainage**

Describe the type, amount, color and odor.

### **Pain**

Describe the pain associated with management - location, type, quality, severity, timing, etc.

### **Treatment**

Describe any irrigation, treatment and dressings applied.

### **Support Surface**

Describe the type of device(s) used for the bed and chair.

### **Client/Family Teaching**

Describe any client/family teaching done and their response.



U.S.: 1.800.851.3449, Fax 1.888.551.3449  
Outside the U.S.: 1.618.277.9173, Fax 1.618.277.9561  
www.therohogroup.com • cs@therohogroup.com



LITD00404 Rev. 05/10 SP 05/10