Pressure Ulcer Definition and Staging

This pocket reference is designed as a guide for clinicians in staging pressure ulcer tissue damage. A pressure ulcer is a localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of pressure or pressure in combination with shear.

Stage I: Nonblanchable 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. Stage I may be difficult to detect in individuals with dark skin tones. May indicate "at risk" persons (a heralding sign of risk).

Stage II: Partial Thickness Skin Loss
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. This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. Bruising indicates suspected deep tissue injury.

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 stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage III pressure ulcers. Bone/tendon is not visible or directly palpable.

Stage IV: Full Thickness Tissue Loss
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 tunneling.

The depth of a stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage IV ulcers 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.

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.

Unstageable: Depth Unknown

Full thickness tissue loss in which the base of the ulcer 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 fluctuance) eschar on the heels serves as the body’s natural (biological) cover and should not be removed.

Pressure ulcer descriptions from Pressure Ulcer Prevention & Treatment Clinical Practice Guideline. NPUAP-EPUAP 2009. P. 19-20
For more information, visit www.3m.com/WoundConditions, contact your 3M Critical & Chronic Care Representative or call the 3M Helpline at 1-800-228-3957.

Frequent Anatomical Sites of Pressure Ulcers

Pressure Ulcer Assessment Parameters
Perform head to toe assessment upon admission and intervals consistent with patient condition and facility policy and procedures.

- Location/Distribution
- Dimensions
  - length
  - width
  - depth
- Exudate
  - color
  - consistency
  - odor
  - amount
- Condition
  - base
  - surrounding
  - skin
  - sinus tracts/undermining
- Infection signs or symptoms
  - local vs. systemic
  - Pain
  - Presence of medical device(s)

Other Types of Skin Damage Commonly Confused with Pressure Ulcers

Incontinence-Associated Dermatitis — inflammatory damage of the skin due to exposure to urine and/or stool. Skin is erythemic and skin loss may or may not be present. In addition to the perineum, areas of involvement may include: lower abdomen, anterior and medial thighs and groin folds; sacrococcygeal area, buttocks, and posterior thighs. Damage is not localized to a bony prominence and tends to be diffuse conforming to area of exposure to urine or stool.

Moisture lesions — superficial, clean lesions resulting from exposure to moisture, or the interaction of friction and moisture. Lesions are clean, without necrotic tissue. Lesions are often irregularly shaped and edges are not well defined. Localization over a bony prominence is not typical. Common locations include the gluteal fold, the sacrococcygeal area and opposing surfaces of the buttocks. Maceration of the surrounding skin is common.