Pressure Ulcer 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).

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Pressure Ulcer 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

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Pressure Ulcer Stage III: Full Thickness Skin 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.

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Pressure Ulcer 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.
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, NPAUP-EUAP. P 19-20. Images NPUAP copyright and used with permission. Image 2 Provided by 3M Skin & Wound Care Division
Suspected Deep Tissue Injury: 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.

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Pressure Ulcer Prevention Recommendations

- **Risk assessment**
  - Assess patient level of risk for pressure ulcer development using an appropriate risk assessment tool
  - Frequency of risk assessment determined by facility risk assessment policy and patient acuity
  - Determine individual care plan based on result of risk assessment

- **Skin assessment**
  - Complete skin assessment upon admission to facility
  - Regular skin inspection per facility protocol

- **Minimize pressure**
  - Determine appropriate pressure redistribution support surface
  - Provide turning and repositioning schedule according to overall patient condition and type of support surface in use
Pressure Ulcer Prevention Recommendations

- Minimize friction and shear
- Manage incontinence/moisture
- Management of nutrition and hydration needs
- Provide patient and family education
Pressure Ulcer Treatment Recommendations

Assessment

- Assess ulcer initially and at least weekly
- Assess and document:
  - Stage: based on a validated pressure ulcer classification system
  - Location
  - Size: length x width x depth
  - Presence of undermining and/or tunneling
  - Wound bed tissue: granular, nonviable tissue, eschar
  - Exudate amount, color, odor
Pressure Ulcer Treatment Recommendations

**Wound Management**

- Cleanse wound with each dressing change per facility protocol
- Provide debridement of nonviable tissue as appropriate
  - Do not debride stable, hard, dry eschar in ischemic limbs
- Determine appropriate topical wound care based on assessment findings to promote healing
- Consult physician or wound care specialist to evaluate wounds that show signs of infection or fail to progress
- Consider use of topical antimicrobial dressing if high bioburden suspected
- Modify plan of care based on assessment findings
Pressure Ulcer Treatment Recommendations

- Provide pressure redistribution
- Minimize friction and shear
- Manage incontinence/moisture
- Assessment and management of pain
- Management of nutrition and hydration needs
- Provide patient and family education
3M Wound Product Guide for Pressure Ulcer Treatment

<table>
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<tr>
<th>Stage I Pressure Ulcer</th>
<th>Stage II Pressure Ulcer</th>
<th>Stage III/IV Pressure Ulcer</th>
<th>Untreatable Pressure Ulcer</th>
<th>Suspected Deep Tissue Injury</th>
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<tr>
<td>Inflamed skin with non-blanchable redness of a localized area usually over a bony prominence. Docked granulated skin may not have visible blanching. Color may differ from the surrounding area.</td>
<td>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/porous serosanguinous blister.</td>
<td>Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed, though may be present out does not obscure the depth of the tissue loss. May include undermining and tunneling.</td>
<td>Full thickness tissue loss in which the base of the ulcer is covered by smooth yellow, tan, gray, green or brown or eschar (burnt, brown or black) in the wound bed.</td>
<td>Purple or maroon localized area of discolored intact skin or non-blistered tissue due to damage to 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.</td>
</tr>
</tbody>
</table>

**CLEAN:** 3M™ Cavilon™ Skin Cleanser  
**PROTECT:** 3M™ Cavilon™ No Sting Barrier Film  
**COVER:** 3M™ Tegaderm™ Transparent Film Dressing

**CLEAN:** 3M™ Wound Cleanser  
**PROTECT:** Cavilon No Sting Barrier Film  
**COVER:** Non-Draining to Minimal Drainage  
**FILL:** Non-Draining to Minimal Drainage  
**COVER:** See cover dressing choices noted under Stage III/IV for management of exudate level

**NOTE:** Debridement of ulcers with devitalized tissue is necessary. Notify M/D/Wound Consultant for debridement options.

Stable (dry, adherent, intact without exudema or fluctuance) eschar on the heels serves as the body’s natural biological cover and should not be removed.

National Pressure Ulcer Advisory Panel  
Updated Pressure Ulcer Stages  

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3M Resources

- For further information on 3M Advance Wound Care products and solutions contact:
  - Your 3M Skin Health Representative
  - 3M Health Care Customer Help Line
    - 1-800-228-3957
  - 3M Website
    - [www.3M.com/skinhealth](http://www.3M.com/skinhealth)
Pressure Ulcer Management – Reference List

- National Pressure Ulcer Advisory Panel: www.npuap.org
- Pressure Ulcer Prevention & Treatment, Quick Reference Guide: www.npuap.org/Final_Quick_Prevention_for_web_2010.pdf
- Pressure Ulcer Prevention & Treatment, Clinical Practice Guideline: www.npuap.org/resources.htm
- Wound, Ostomy, and Continence Nurses Society: www.wocn.org