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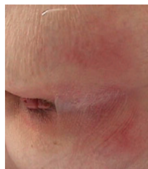
International NPUAP/EPUAP pressure ulcer classification system[1]

A pressure ulcer is localised injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear.

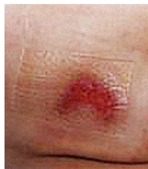
Category/stage I: nonblanchable erythema



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. Category/Stage I may be difficult to detect in individuals with dark skin tones. May indicate 'at risk' individuals (a heralding sign of risk).

Category/stage II: partial thickness skin loss

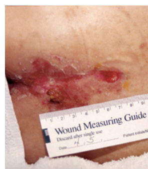


Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.

Presents as a shiny or dry shallow ulcer without slough or bruising.* This Category/Stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.

*Bruising indicates suspected deep tissue injury.

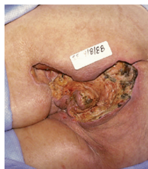
Category/stage III: full thickness skin loss



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 varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have 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 on some parts of the wound bed. Often include undermining and tunneling.

The depth varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have 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 possible. Exposed bone/tendon is visible or directly palpable.

You've got it covered with 3M™ Cavilon™ Skin Care Products

Pressure ulcers and incontinence associated dermatitis (IAD) are clinically and pathologically different conditions, but recent evidence suggests an association between IAD and pressure ulcers.[2]

For practical guidance on how to assess, prevent and manage IAD using the Cavilon range of skin care products download your free copy of the IAD Best Practice Principles document published by Wounds International at www.woundsinternational.com and search 'IAD moving prevention forward'

3M™ Cavilon™ Durable Barrier Cream

3M™ Cavilon™ No Sting Barrier Film

3M™ Cavilon™ Continence Care Wipes

References

1 National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and treatment of pressure ulcers: quick reference guide. Emily Haesler (Ed.). Cambridge Media: Perth, Australia; 2014.

2 Beeckman D. et al. A systematic review and meta-analysis of incontinence-associated dermatitis. Incontinence and moisture as risk factors for pressure ulcer development. Research in Nursing & Health. 2014.

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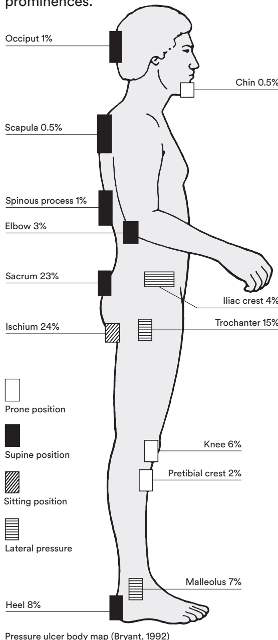
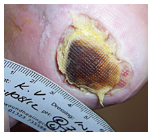
Pressure ulcer body map

Pressure ulcers can appear over any bony prominences.



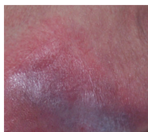
Pressure ulcer body map (Bryant, 1992)

Unstageable: depth unknown



Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, grey, 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 Category/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.

Suspected deep tissue injury: depth unknown



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 evolve and become covered by thin eschar. Evolution may be rapid, exposing layers of tissue even with optimal treatment.

Note: Use of skin care products does not avoid the need for pressure relief.