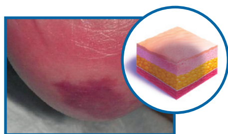
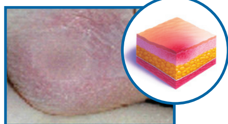
Guidelines for Staging of Pressure Ulcers*



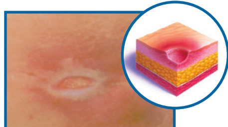
Deep Tissue Injury

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.



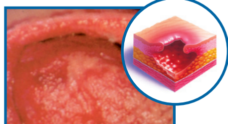
Stage I

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.



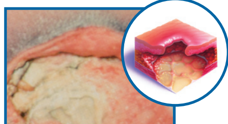
Stage II

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.



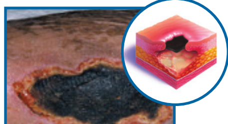
Stage III

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.



Stage IV

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(s) undermining and tunneling.



Unstageable

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.

**National Pressure Ulcer Advisory Panel (NPUAP) – February, 2007*

Wound Assessment Checklist

- Location
- Size
- Dressing Used
- Stage
- Pressure Redistribution
- Nutritional Assessment
- Drainage (Amount/Color/Odor)
- Viable Tissue in Wound
- Undermining/Tunneling

Braden Scale for predicting pressure ulcer risk (Copyright Braden and Bergstrom, 1988)

When eschar is present, a pressure ulcer cannot be accurately staged until the eschar is removed.

Sensory Perception ability to respond meaningfully to pressure related discomfort.	**1. Completely limited:** Unresponsive (does not moan, flinch or gasp) to painful stimuli, due to diminished level of consciousness or sedation, **OR** limited ability to feel pain over most of the body surface.	**2. Very limited:** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness **OR** has sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body.	**3. Slightly limited:** Responds to verbal commands but cannot always communicate discomfort or need to be turned, **OR** has some sensory impairment which limits the ability to feel pain or discomfort in 1 or 2 extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.
Moisture degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often but not always moist. Linen must be changed at least once a shift.	**3. Occasionally moist:** Skin is occasionally moist, requiring and extra linen approximately once a day.	**4. Rarely moist:** Skin is usually dry; linen only requires changing at routine intervals.
Activity degree of physical activity	**1. Bedfast:** Confined to bed.	**2. Chairfast:** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**3. Walks occasionally:** Walks occasionally during the day but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. Walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.
Mobility ability to change and control body position	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. Slightly limited:** Makes frequent though slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.
Nutrition usual food intake pattern	**1. Very poor:** Never eats complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take liquid dietary supplement **OR** is NPO and/or maintained on clear fluids or IV's for more than 5 days.	**2. Probably inadequate:** Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement, **OR** receives less than optimum amount of liquid diet or tube feeding.	**3. Adequate:** Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered, **OR** is on a tube feeding or TPN regimen, which probably meets most nutritional needs.	**4. Excellent:** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.
Friction and Shear	**1. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity contractures or agitation leads to almost constant friction.	**2. Potential problem:** Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3. No apparent problem:** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.	

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Note: Patients with a total score of 18 or less are considered to be at risk of developing pressure ulcers.
(19 - 23 = no risk, 15 - 18 = low risk, 13 - 14 = moderate risk, 10 - 12 = high risk, < to 9 = very high risk)