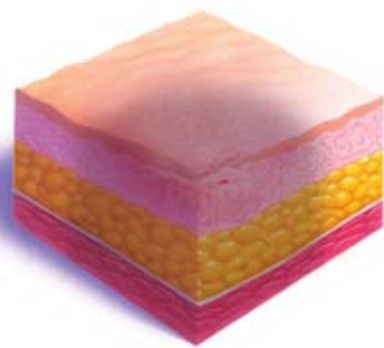


# Guidelines for Staging of Pressure Ulcers

The following criteria can be used as a visual aid to help identify and appropriately stage pressure ulcers. The definitions were derived from work done by the National Pressure Ulcer Advisory Panel and published in February 2007.

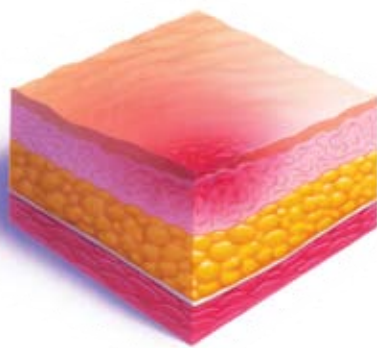


## Deep Tissue Injury

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.

### Further description:

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.

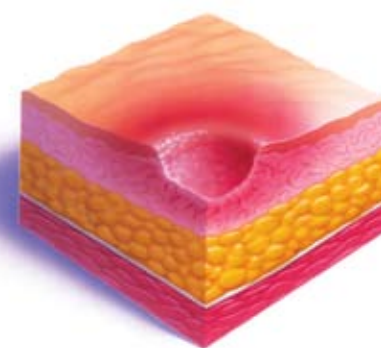


## Stage I

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.

### Further description:

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).



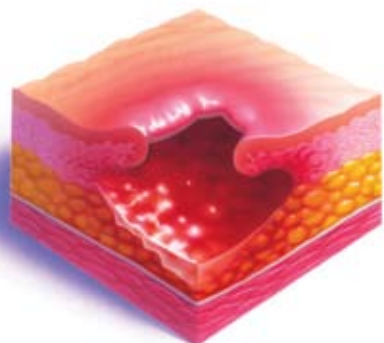
## Stage II

Partial thickness 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.

### Further description:

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 indicated suspected deep tissue injury*

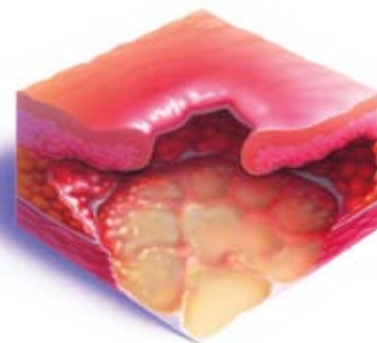


## Stage III

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.

### Further description:

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.

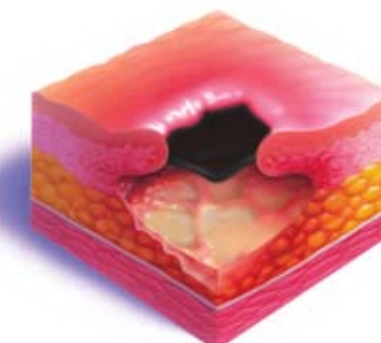


## Stage IV

Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.

### Further description:

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

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.

### Further description:

If slough and/or eschar obscures the true depth of the wound, the wound is considered unstageable. The presence of eschar on wound edges would not prohibit staging. 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.

## Wound Assessment Checklist

Pressure ulcer documentation should be completed at least WEEKLY and should cover each of the following areas in detail. The Risk Assessment Worksheet provided by Hill-Rom may be used.

- **Location**  
Be specific. Draw pictures to clarify, if necessary.
- **Size**  
Be sure to include length, width, and depth measurements, in centimeters. (Use measuring device).
- **Dressings**  
Describe the type of irrigation solution used and the dressing applied.
- **Drainage**  
Describe the amount, color, and odor of drainage as follows:  
A. AMOUNT-minimal, moderate, copious  
B. COLOR-serous, purulent, serosanguineous, bloody  
C. ODOR-present, absent
- **Undermining/Tunneling**  
Describe whether present, or absent. If present, measure involvement in centimeters and location within wound.
- **Visible Tissue in Wound**  
Describe the kind of tissue present in wound.  
Include reference to the presence of granulation tissue, slough, epithelial tissue, eschar, etc.
- **Stage**  
Stage according to NPUAP guidelines. Follow hospital or facility protocol. When eschar is present, accurate staging of the pressure ulcer is not possible until the eschar is removed.
- **Nutritional Assessment**  
- Lab test review  
- Adherence to dietary plan
- **Pressure Redistribution**  
- Note the surface or seat cushion in use  
- Describe the need to continue the same surface or whether a change in surface is indicated  
- Note whether or not heels have been elevated in response to intervention

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