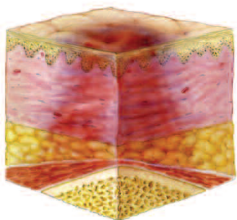


# PRESSURE ULCERS

## Pressure ulcer staging guide



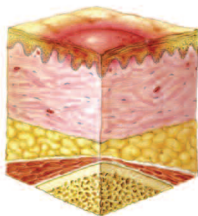
SUSPECTED  
DEEP TISSUE INJURY

### **Suspected Deep Tissue Injury:**

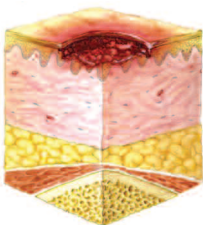
Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

### **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 I



STAGE 2

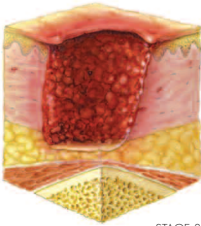
### **Stage II:**

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.



# PRESSURE ULCERS

## Pressure ulcer staging guide continued



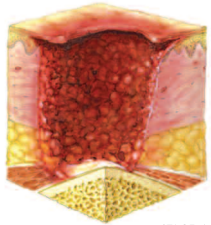
STAGE 3

### Stage III:

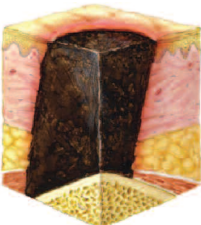
Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

### 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 undermining and tunneling.



STAGE 4



UNSTAGEABLE

### 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.



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