



## Pressure Ulcer Stages Revised by NPUAP

**February 2007** - The National Pressure Ulcer Advisory Panel has redefined the definition of a pressure ulcer and the stages of pressure ulcers, including the original 4 stages and adding 2 stages on **deep tissue injury** and **unstageable** pressure ulcers. This work is the culmination of over 5 years of work beginning with the identification of deep tissue injury in 2001.

Pressure Ulcer Definition	Pressure Ulcer Stages	
<p>A <b>pressure ulcer</b> is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction. A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated.</p> <p><b>This staging system should be used only to describe pressure ulcers.</b> Wounds from other causes, such as arterial, venous, diabetic foot, skin tears, tape burns, perineal dermatitis, maceration or excoriation should not be staged using this system. Other staging systems exist for some of these conditions and should be used instead.</p>	<p><b>Suspected Deep Tissue Injury (DTI):</b> 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. <b>Further description:</b> 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.</p>	<p><b>Stage III:</b> 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. <b>Further description:</b> 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.</p>
	<p><b>Stage I:</b> 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. <b>Further description:</b> 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)</p>	<p><b>Stage IV:</b> 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. <b>Further description:</b> 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.</p>
	<p><b>Stage II:</b> 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. <b>Further description:</b> 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</p>	<p><b>Unstageable:</b> 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. <b>Further description:</b> 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.</p>

Copyright: NPUAP 2007

Minnesota (Corporate Office)  
2025 4<sup>th</sup> St.  
White Bear Lake, MN 55110  
(651) 407-8699 • (651) 429-8721

Wisconsin  
350 Bishops Way, #201  
Brookfield, WI 53005  
(262) 787-8033 • (262) 787-8066

Illinois  
170 Quail Ridge Drive  
Westmont, IL 60559  
(630) 734-0233 • (630) 734-0266

Michigan  
250 Monroe NW, #400  
Grand Rapids, MI 49503  
(616) 717-5642 • (616) 717-5772

Ohio  
4449 Easton Way, 2<sup>nd</sup> Floor  
Columbus, OH 43219  
(614) 934-1797 • (614) 934-1001



## Pressure Ulcer Documentation Tips

When charting a description of a pressure ulcer, the following components should be a part of your **weekly** charting.

1. **LOCATION**
2. **STAGE per new NPUAP Definitions**
3. **DIMENSIONS:** Always measure **length, width, and depth** and document it in that order. Always recorded in **centimeters**.
  - ◆ **Length:** Longest head-to-toe measurement.
  - ◆ **Width:** Longest hip-to-hip measurement.
  - ◆ **Depth:** Is measured by gently inserting a pre-moistened cotton tipped applicator into the deepest part of the wound. The measurement from the tip of the applicator to the level of the skin surface is the depth.
4. **UNDERMINING/TUNNELING:** Recorded in centimeters. Measurement done as if the resident is on a clock with the resident's head at 12 noon.
  - ◆ **Undermining:** Measure the extent of the undermining clockwise, then the deepest part of the undermining (i.e., 1.5cm from 2-7 o'clock).
  - ◆ **Sinus tracts/Tunneling:** Measure the depth of the sinus tract/tunnel and give direction of the sinus tract/tunnel by the clock method (i.e., 3cm at 3 o'clock). If there is more than one sinus tract/tunnel, number each clockwise.
5. **WOUND BASE DESCRIPTION:** describe the wound bed appearance. If the wound base has a mixture of these, use the percentage of its extent (i.e., the wound base is 75% granulation tissue with 25% slough tissue).
  - ◆ **Granulation:** Pink or beefy red tissue with a shiny, moist, granular appearance.
  - ◆ **Necrotic Tissue:** Gray to black and moist
  - ◆ **Eschar:** Gray to black and dry or leathery in appearance.
  - ◆ **Slough:** Yellow to white and may be stringy or thick and may appear as a layer over the wound bed.
  - ◆ **Epithelial:** New or pink shiny tissue that grows in from the edges or as islands on the wound surface.
6. **DRAINAGE:**
  - ◆ **Amount:** Scant, moderate, or copious (small, medium, or heavy)
  - ◆ **Color/Consistency:** Serous, serosanguineous, purulent, or other.
  - ◆ **Odor:** If present or not
7. **WOUND EDGES:** Describe area up to 4cm from edge of the wound. Measure in centimeters. Describe its characteristics (light pink, deep red, purple, macerated, etc.).
8. **ODOR:** Present or not
9. **PAIN:** Associated with the wound. Interventions
10. **INFECTION:** yes or no. Describe signs and symptoms. Culture results and treatment.

**For more information on Pathway Health Services Wound Care Programs, please contact your nearest Pathway office or visit us at [www.pathwayhealth.com](http://www.pathwayhealth.com)**