PRESSURE ULCER CLASSIFICATION





Category / Stage 1:

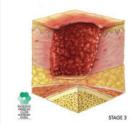
Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category I may be difficult to detect in individuals with dark skin tones¹.





Category/ 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 or sero-sanginous filled blister¹.





Category/ 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.





Category/ Stage IV:

Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunnelling. Category/Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule)¹





Unstageable/Unclassified: Full thickness skin or tissue loss - depth unknown

Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. ¹





Suspected Deep Tissue Injury - depth unknown

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. ¹

1. This extract has been taken from the Pressure Ulcer Prevention and Treatment EPUAP Review Guideline written by the European Pressure Ulcer Advisory Panel (2014). This poster is designed as a guide only and Invacare strongly recommend the full EPUAP guidelines are studied. Invacare accept no responsibility for medical intervention as a result of misinterpretation of the content of this poster.



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