

The Following definitions are from the National Pressure Ulcer Advisory Panel up-date 2/2007

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><u>DTI (Deep Tissue Injury):</u></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><u>Stage III:</u></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><u>Stage I:</u></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><u>Stage IV:</u></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><u>Stage II:</u></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><u>UN (Unstageable):</u></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>

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

1. **LOCATION**
2. **STAGE Pressure ulcers ONLY per NPUAP Definitions on previous page OR for lower extremity wounds (arterial, venous and neuropathic) use the following definitions:**
  - **Partial Thickness** – A partial thickness wound is confined to the skin layers; damage does not penetrate below the dermis and may be limited to the epidermal layers only.
  - **Full-Thickness** – A full-Thickness wound indicates that damage extends below the epidermis and dermis (all layers of the skin) into the subcutaneous tissue or beyond (into muscle, bone, tendons, etc.).
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. If too shallow to measure record as “superficial”.
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/Eschar Tissue:** Black or brown tissue that can be dry or moist in appearance
  - ◆ **Slough:** Yellow to white tissue and may be stringy, thick or moist in appearance
  - ◆ **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, calloused, etc.).
8. **ODOR:** Present or not
9. **PAIN:** Associated with the wound. Interventions
10. **PROGRESS:** Improved, No Change, Stable, or Declined.