Pressure Ulcer Staging Guide

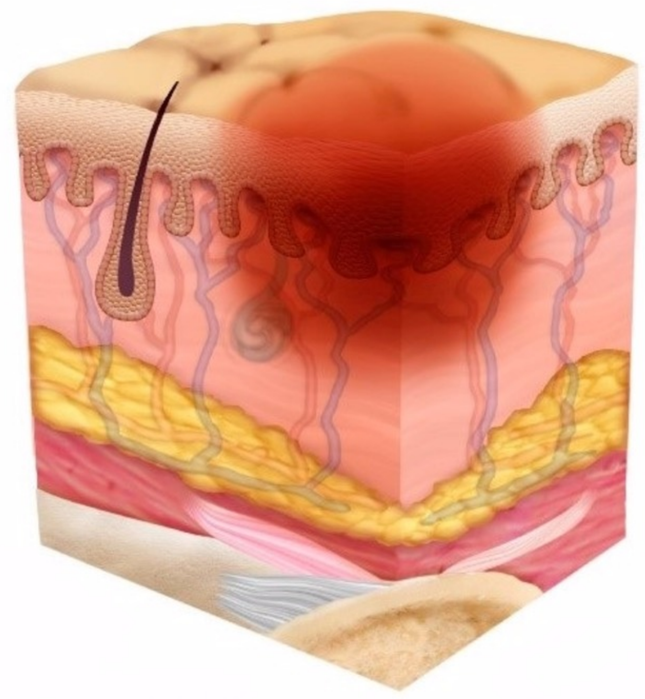
01

Localized redness in areas of intact skin

Non-blanchable redness

Sensation/Firmness Changes

Temperature Differences

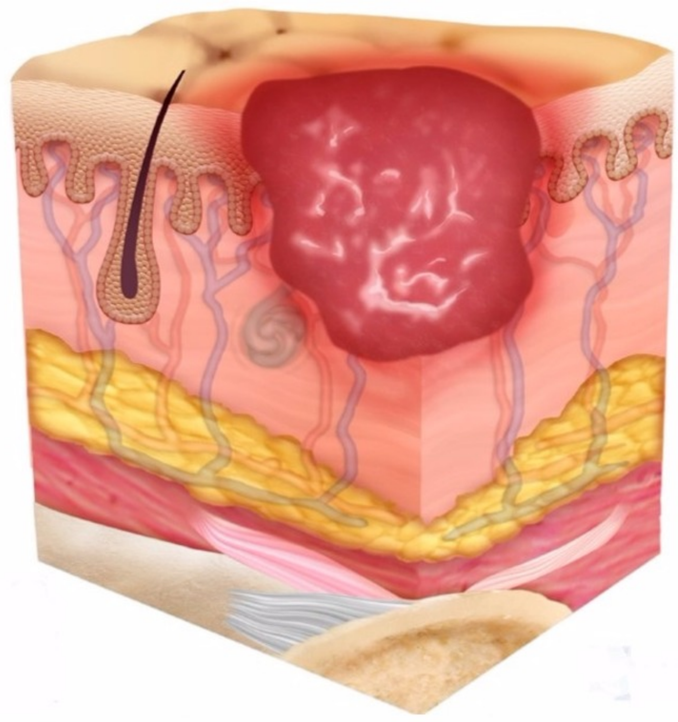


02

Partial-thickness loss of skin with dermis exposed

Wound bed pink/red and moist

Fat and deeper tissues NOT exposed



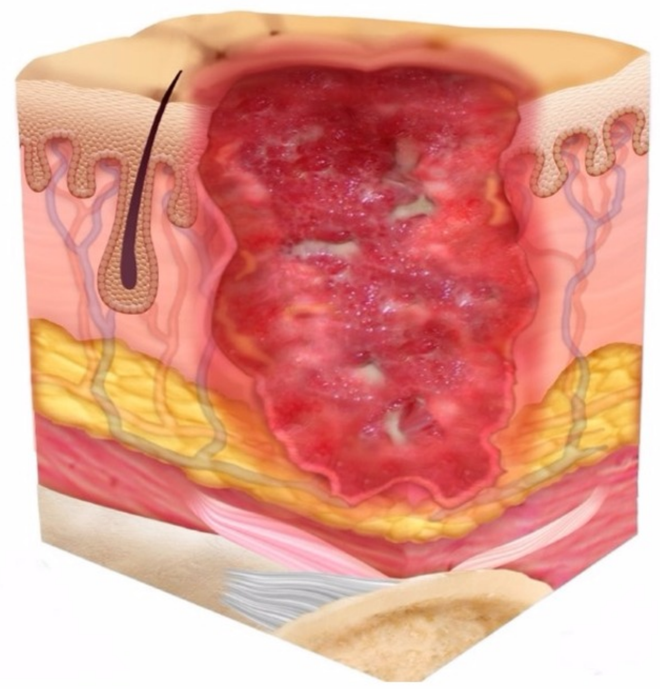
03

Full-thickness loss of skin

Fat and granulation tissue visible in ulcer

Tunneling may begin to occur

Epibole (rolled edges) can occur

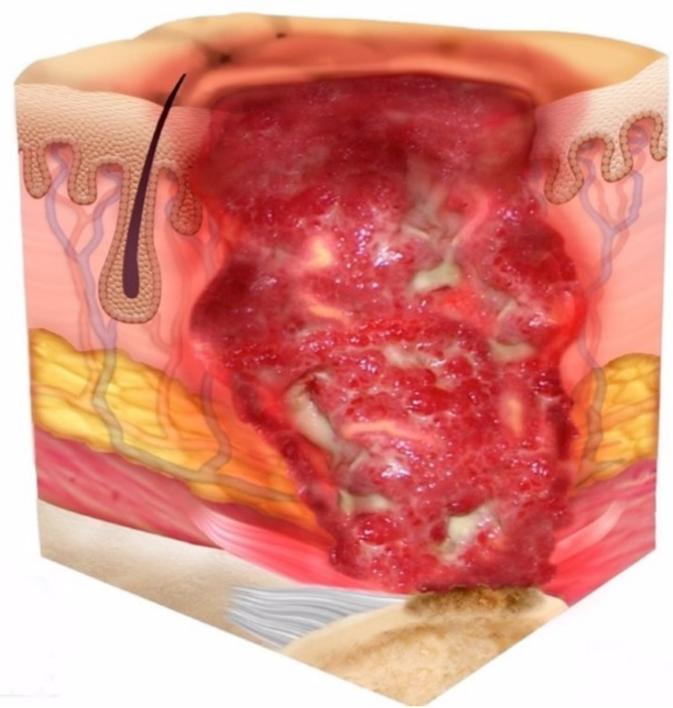


04

Full-thickness loss of skin and tissue

Exposure of bone, muscle, and tendons

Undermining and tunneling likely



Unstageable

Obscured full-thickness skin and tissue loss

Slough or eschar present

Tissue damage cannot be confirmed due to obstruction of visibility