

**Categorising Pressure damage. Adapted from EPUAP/ NPUAP 2014**

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| **Category** | **Image** | **Description** |
| **1** |  | **Non-blanchable erythema of intact skin:** persistent redness in light pigmented skin. Discolouration of the skin: observe for a change of colour as compared to surrounding skin.  In darker skin, the ulcer may be blue or purple.  Warmth, oedema, induration or hardness as compared to adjacent tissue may also be used as indicators, particularly on individuals with darker skin.  May include sensation (pain, itching). |
| **2** |  | **Partial thickness skin loss or blister.**  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 blister.  This category/stage should not be used to describe skin tears, tape burns, incontinence-associated dermatitis,  maceration or excoriation. |
| **3** |  | **Full thickness skin loss (fat visible).**  Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Some slough  may be present. May include undermining and tunnelling.  The depth of a Category 3 pressure ulcer varies by  anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and Category 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category 3 pressure ulcers. Bone/tendon is not visible or directly palpable. |
| **4** |  | **Full thickness tissue loss (muscle/bone visible)**  Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes  undermining and tunnelling.  The depth of a Category 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and these ulcers can be shallow. Category 4 ulcers can extend into muscle and/or supporting structures (for  example, fascia, tendon or joint capsule) making osteomyelitis or osteitis likely to occur. Exposed bone/muscle is visible or directly palpable. |

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|  | **Deep tissue injury or ‘unstageable’.**  These pressure injuries should be categorised and reported as a 4 until proven otherwise. If found to be less severe, the injury can be re-categorised. |

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| http://img.medscape.com/pi/features/slideshow-slide/pressure-ulcers/fig14.jpg | **Sero- sanguinous blister**  A purple/ red blood filled blister that usually is intact and commonly associated with shear and friction. When felt, it will be firm not ‘spongy’ as with a deeper injury.  This blister normally dries up over time and will eventually peel away.  This should be reported as a category 2 pressure ulcer. |

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| **Moisture lesions** | **Image** | **Description** |
| **These lesions should be incident reported as moisture NOT pressure** | C:\Documents and Settings\sarah.warner\my documents\My Pictures\wounds\Picture 025.jpg | Superficial loss of the epidermis and/ or dermis caused by urine and/ or faeces and perspiration which is in continuous contact with intact skin of the perineum, buttocks, groins, inner thighs and natal cleft.  Skin breakdown may be preceded by areas of erythema on intact skin.  The skin will either be excoriated, presenting as superficial broken skin which is red and dry or macerated, presenting as red and white, wet, soggy and shiny.  (All Wales BPS: Prevention & management of moisture lesions) |