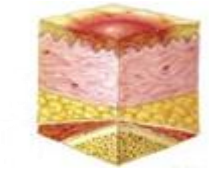
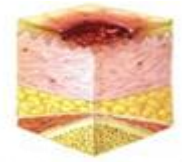
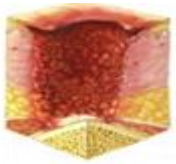
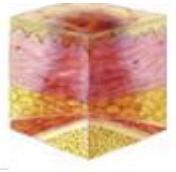
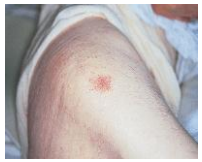
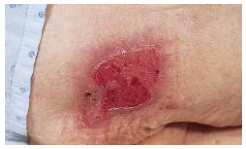
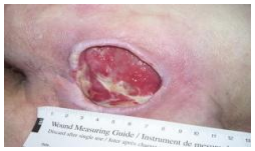
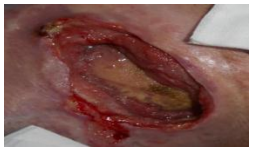
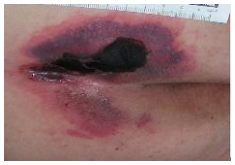
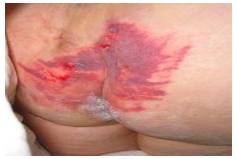
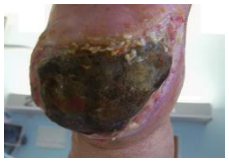
British Columbia Patient Safety & Learning System

Pressure Ulcer Stages

Stage I	Stage II	Stage III	Stage IV	Suspected Deep Tissue Injury (SDTI)	Unstageable
• Intact skin with localized, non-blanchable erythema over a bony prominence. • The area may be painful, firm or soft and warmer or cooler when compared to surrounding tissue. • Darkly pigmented skin may not show visible blanching, however the colour of the Stage I ulcer will appear different than the colour of surrounding skin. • Indicates the patient is at risk for further tissue damage if pressure is not relieved.	• Partial thickness wound presenting as a shallow, open ulcer with a red/pink wound bed. • May also present as an intact or open/ruptured serum-filled or serosanguinous-filled blister. • Slough may be present but does not obscure the depth of tissue loss.	• Full thickness wound. • Subcutaneous tissue may be visible but bone, tendon and muscle are not exposed. • May include undermining or sinus tracks. • Slough or eschar may be present but does not obscure the depth of tissue loss.	• Full thickness wound with exposed bone, tendon or muscle. • Often includes undermining and/or sinus tracks. • Slough or eschar may be present on some parts of the wound bed but does not obscure the depth of tissue loss.	• A localized purple or maroon area of intact skin or a blood-filled blister that occurs when underlying soft tissue is damaged from friction or shear. • SDTI may start as an area that is painful, firm or mushy/ boggy and warmer or cooler than the surrounding tissue but can deteriorate into a thin blister over a dark wound bed or a wound covered in thin eschar. • Deterioration of SDTI may be rapid, exposing additional layers of tissue even with optimal treatment and may be difficult to detect in individuals with dark skin tones.	• A wound in which the wound bed is covered by sufficient slough and/or eschar to preclude staging.
					
	 			 	

Developed by the BC Provincial Nursing Skin & Wound Care Committee. Images Stage 1, 2, & 3 retrieved June 14, 2012 from www.npuap.org. Images Stage 4, SDTI, Unstageble and the definitions are from the BC Provincial Nursing Skin & Wound Committee Guideline: Pressure Ulcer Management Decision Support Tool found at www.clwk.ca.