



Position Statement: Pressure Ulcer Staging

Statement of Position

The Wound, Ostomy and Continence Nurses (WOCN) Society supports the use of the National Pressure Ulcer Advisory Panel Staging System (NPUAP).¹

Purpose of Statement

The WOCN Society supports universally recognized terminology and descriptors in the staging of pressure ulcers. The WOCN Society recognizes the importance of staging in the management of acute and chronic pressure ulcers. Accurate assessment, reassessment and documentation are critical for providing evidence of healing, failure to heal or deterioration. Effective communication regarding pressure ulcer staging requires the use of accurate and universally recognized terminology and descriptors.

History

A number of systems have been developed over the years for the classification or staging of pressure ulcers. The staging system currently recommended by the WOCN Society is the NPUAP February 2007 revised definitions of Pressure Ulcers and Stages of Pressure Ulcers.¹ These revisions are a culmination of five years of work by the NPUAP, which began with the identification of deep tissue injury in 2001.

Supportive Statements:

1. Staging of pressure ulcers is only one dimension of pressure ulcer assessment and documentation.
2. Education should be provided by wound care experts to other medical, nursing and lay personnel (including Medicare surveyors, regulatory agencies and third party payers) about the appropriate implementation of the NPUAP Staging System.
3. Assessment and documentation of pressure ulcer status includes comprehensive clinical data demonstrating evidence of progress in healing or failure to heal.

4. Assessment and documentation of pressure ulcer status includes:
 - staging
 - dimensions and depth
 - presence, location and depth of sinus tracts or undermined areas
 - status of the pressure ulcer bed (granulating or epithelializing vs. clean but not granulating or avascular)
 - volume, color and odor of exudate
 - evidence of infection in surrounding tissue (erythema, induration, crepitation)
 - status of pressure ulcer edges (closed and nonproliferative vs. open and proliferative)
5. Assessment data, sequentially recorded over time, can be used to objectively track the progress of the pressure ulcer.
6. The use of descriptors is needed to accurately convey the true state of the pressure ulcer in addition to documenting the stage.
7. Comprehensiveness of a pressure ulcer assessment may vary depending on the care setting and proficiency of the evaluator.

Additional Comments Regarding Staging

1. Staging of Healing Pressure Ulcers

The staging system, as recommended by the NPUAP and the WOCN Society, does not include a stage for granulating pressure ulcers. "Down-staging" of granulating pressure ulcers is not appropriate, since the full-thickness repair process involves replacement of the lost normal tissue with granulation tissue. For example, a granulating stage IV pressure ulcer should not be "down-staged" to a Stage III, because a Stage III pressure ulcer, by definition, is one with exposed subcutaneous tissue. Therefore, a granulating Stage IV pressure ulcer is most appropriately classified as a "granulating Stage IV" or "healing Stage IV." If the Stage IV pressure ulcer is completely healed, it can be classified as a "healed Stage IV," which conveys the pressure ulcer is now filled with granulation tissue and resurfaced with epithelium. When the original depth of the pressure ulcer is unknown and it is resurfaced, the stage cannot be determined by observation. However, when the pressure ulcer is resurfaced, with contracted scar tissue present, the healed pressure ulcer should be described as "evidence of a resurfaced full-thickness pressure ulcer" or "evidence of a resurfaced pressure ulcer of undetermined full-thickness depth."

2. **Staging of Pressure Ulcers Totally or Partially Covered with Slough or Eschar**

Pressure ulcers totally or partially covered with slough or eschar cannot be staged until the deepest viable tissue layer or identifiable structure is exposed, because the deepest viable tissue layer is unknown. It is appropriate to document the size, location and appearance of the ulcer as well as the status of the surrounding tissue, and to document "staging cannot be completed until the pressure ulcer base is visible."

Pressure ulcers partially covered with necrotic tissue but with identifiable muscle, bone or supporting structures (e.g. tendon, joint capsule) visible in the pressure ulcer base can be staged as a stage IV with necrotic tissue because the exposed tissue clearly indicates the ulcer meets the criteria for the most severe pressure ulcer stage. In contrast, a pressure ulcer partially covered with necrotic tissue with viable subcutaneous tissue visible in the pressure ulcer base cannot be staged, because pressure ulcers penetrating only to the subcutaneous tissue are appropriately classified as a Stage III, and debridement of the remaining necrotic tissue may reveal an area of greater depth such as exposed muscle or bone, indicating the pressure ulcer's true depth is Stage IV.

National Pressure Ulcer Advisory Panel Staging System¹

Pressure Ulcer Definition

A pressure ulcer 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.

Suspected Deep Tissue Injury

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 found to be painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

Further Description:

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.

Stage I

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.

Further Description:

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).

Stage II

Partial thickness loss of dermis presented 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.

Further Description:

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

Stage III

Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

Further Description:

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.

Stage IV

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.

Further Description:

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.

Unstageable

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.

Further Description:

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 heel serves as "the body's natural (biological) cover" and should not be removed.

Previous Statements:

Reviewed/Revised: July, 2006

Revised: August, 2007

Adopted: October, 2007

Citations:

1. National Pressure Ulcer Advisory Panel. Updated Pressure Ulcer Stages <http://www.npuap.org/pr2.htm>. Accessed July, 2007.

References:

Wound, Ostomy and Continence Nurses Society (2003). *Clinical Practice Guideline for Prevention and Management of Pressure Ulcers*.

Bryant, RA, Nix DP (2007). *Acute and Chronic Wounds: Current Management Concepts*. St. Louis: Mosby Year Book, 3rd edition