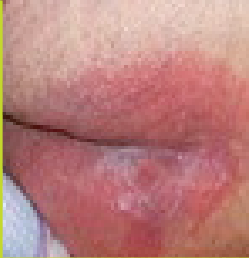
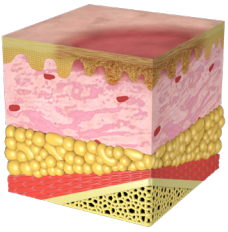

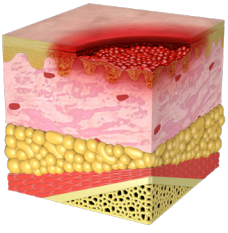
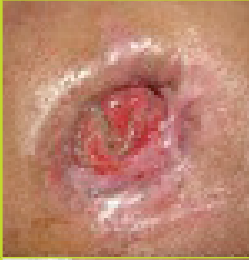
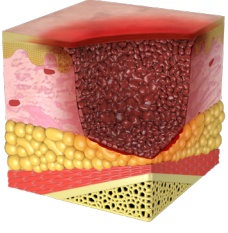

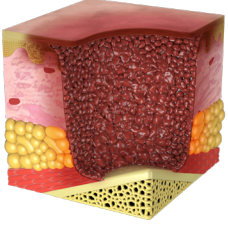

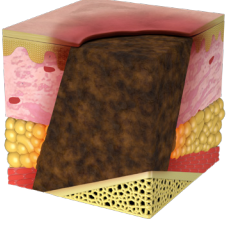

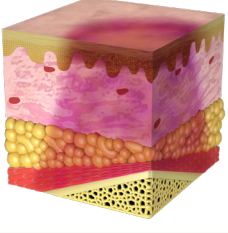


Pressure Ulcer Categorisation Guide

How to Categorise¹

Category I		Intact skin with localised non-blanchable erythema, usually over a bony prominence. Skin discolouration, warmth, oedema, hardness or pain may be present and may differ compared to adjacent tissue. May indicate "at risk" persons.	
Category II		Partial thickness loss of dermis presenting as a shiny or dry, shallow open ulcer with a red/pink wound bed with minimal slough or bruising. Can also include intact or ruptured blisters. Does not include skin tears, tape burns, incontinence associated dermatitis, maceration or excoriation.	
Category III		Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed or directly palpable. Some slough may be present. May include undermining and tunnelling. Depth varies by location and can be shallow in areas without subcutaneous tissue eg. on the ear, or extremely deep in areas of significant adiposity.	
Category IV		Full thickness tissue loss with visibly exposed or directly palpable bone, tendon or muscle. Often includes undermining and tunnelling. Depth varies by location and can be shallow in areas without subcutaneous tissue eg. on the ear. Can extend into muscle and/or supporting structures (eg. fascia, tendon or joint capsule) making osteomyelitis likely to occur.	
Unstageable/ Unclassified		Full thickness tissue loss where actual ulcer depth is obscured by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black). True depth cannot be determined until enough slough and/or eschar is removed, but will be either a Category III or IV. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heel should not be removed until a Doppler assessment has been completed.	
Suspected Deep Tissue Injury (SDTI)		Purple or maroon localized area of discoloured intact skin or blood-filled blister due to pressure/shear damage of underlying soft tissue. May be preceded by painful, firm, boggy, warmer or cooler skin as compared to adjacent tissue. Evolution may be rapid, exposing additional tissue layers even with treatment.	

Based on International NPUAP-EPUAP-PPPIA Pressure Ulcer Classification System.¹

NB: Injuries may be more difficult to detect in more darkly pigmented skin, and may not have visible blanching; its colour may differ from the surrounding area.

Reference: 1. NPUAP, EPUAP and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers: Quick Reference Guide. Emily Haesler (Ed.). Cambridge Media: Osborne Park, Western Australia; 2014.



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