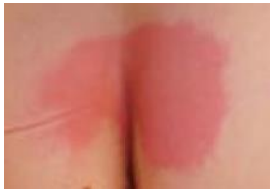
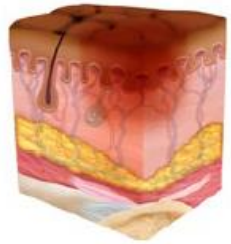
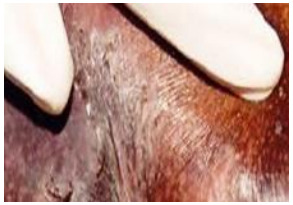
International NPUAP/EPUAP Pressure Ulcer Classification System

Category 1 – Non-blanchable Erythema

Intact skin with non-blanchable redness of a localised area, usually over a bony prominence. Darkly pigmented skin may not have visible blanching. Its colour may differ from the surrounding area.

The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category/Stage 1 may be difficult to detect in individuals with dark skin tones. May indicate “at risk” individuals (a heralding sign of risk).

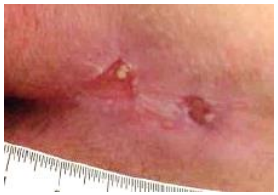





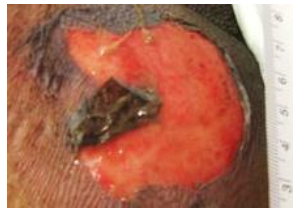
Category 2 – Partial Thickness Skin Loss

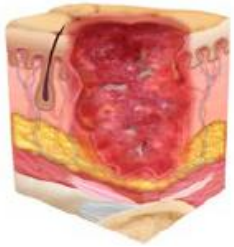
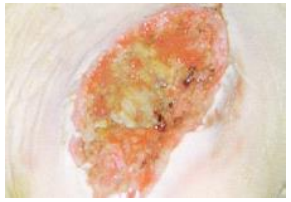
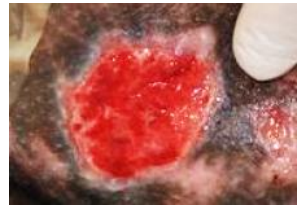
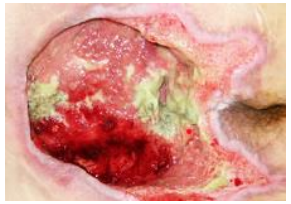
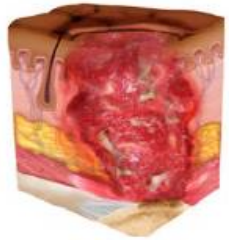
Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.

Presents as a shiny or dry shallow ulcer, without slough or bruising. * This Category/Stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.

* *Bruising indicates suspected deep tissue injury*



Category 3 – Full Thickness Skin Loss Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunnelling. The depth of a Category/Stage 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category/Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage 3 pressure ulcers. Bone/tendon is not visible or directly palpable.				
Category 4 – Full Thickness Tissue Loss Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunnelling. The depth of a Category/Stage 4 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. Category/Stage 4 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.
- Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels

(NHS Improvement 2018)

Deep Tissue Injury

Purple or maroon localized area.

Although the appearance of DTI is often described as a bruise, it should be noted that a DTI does not go through the colour changes typical of a bruise as it resolves

Deep tissue injury may be difficult to detect in individuals with dark skin tones

(NHS Improvement 2018)

Mucosal Skin Damage

Mucosal skin covers the tongue, gastrointestinal tract, nasal tract, urinary tract and vaginal tract. When pressure is applied to these areas, tissue damage can occur as a result of medical devices, that can include catheters, as well as other medical devices.

'Mucosal Pressure Ulcers (MPrU) are pressure ulcers found on mucous membranes with a history of medical device in use at the location of the ulcer (NPUAP, 2014)

It is recommended by NPUAP that the categorisations used for pressure ulcers, cannot be used for mucosal pressure damage due to tissue type and anatomical location of the ulcer.