G-150 Assessment and Staging of Pressure Ulcers

Pressure ulcers result from pressure applied with great force for short periods of time or less force over a longer period. Circulation is impaired depriving tissues of oxygen and other life sustaining nutrients. This process damages skin and underlying structures.

Common sites for pressure ulcers are over bony prominences where friction and force combine to break down skin.

Home care should use a risk assessment tool to determine risk and plan accordingly.

Applies To

Registered Nurses

Licensed Practical/Vocational Nurses

Other (*Identify*): _____

Pressure Ulcer Assessment Guide

In assessing the pressure ulcer, the following parameters should be addressed consistently.

1. Site, stage of ulcer, and size of ulcer (include length, width, and depth).
2. Presence of tunneling or undermining.
3. Presence of necrotic tissue (slough or eschar).
4. Drainage amount, color, and odor.
5. Granulation.
6. Pain.
7. Condition of surrounding tissue.

Staging a Pressure Ulcer

Stage 1

Non-blanchable redness of intact skin. In individuals with darker skin where redness is not visible, note discoloration, warmth, swelling and/or in duration. *(Use adhesive film dressing--healing can occur within 24 hours)*

Stage 2

Partial thickness skin loss - dermis, epidermis, or both superficial epithelial damage has occurred. Area is reddened and edematous; may have excoriation or blisters. Redness does not disappear when pressure is relieved. Surrounding area is red and scaly with irregular borders. *(Transparent dressings if non draining, hydrocolloid if draining).*

Stage 3

Full thickness skin loss--damage to subcutaneous tissue--may extend down to but not through underlying fascia. Deep crater with or without tunneling. Necrotic tissue; destruction of capillary bed, producing serosanguineous drainage. Surface of ulcer will likely be smaller than internal diameters *(Hydrocolloid dressings, if large amounts of drainage, absorptive product in wound and cover with hydrocolloid).*

Stage 4

Full thickness skin loss - extensive destruction and tissue necrosis. Destruction of deeper tissue, extending through subcutaneous layers into muscle mass and bone. Ulcer edge appears to "roll over" into the defect and is a tough, fibrinous ring. *(Often require surgical intervention.)*

Eschar

A tough, membranous layer covering ulcer. Layer may be rigidly adherent to the base of the wound. This stage is difficult to determine until eschar has sloughed off or has been removed surgically.

Related Procedures

None.

Policy History

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