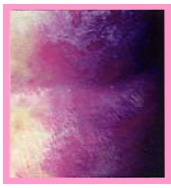
Classifications of Pressure Ulcers

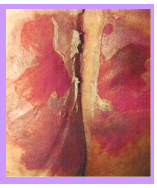


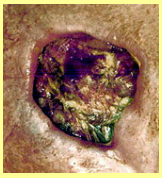
Stage I

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.

Stage II

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.



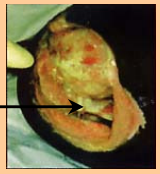


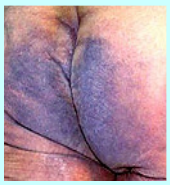
Stage III

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 tunneling.

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.



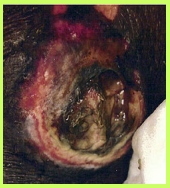


Deep Tissue Injury

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 that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

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.



This material was prepared by CFMC, the Medicare Quality Improvement Organization for Colorado, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. PM-2200-126 CO 2008

CFMC
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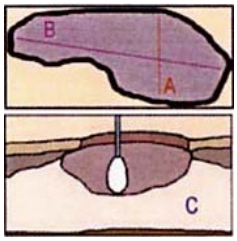
Documentation and Measuring

Pressure ulcer documentation should include:

- Wound location
- Stage
- Size
  length, width, depth
- Tunneling/sinus tract
- Undermining
- Nectocrotic tissue
  slough, eschar
- Exudate/drainage
  amount, color, odor
- Granulation
- Description of surrounding tissue
- Support surface
- Pain

Note the following skin characteristics:

- Color
- Temperature
- Moles
- Bruises
- Incisions
- Scars
- Intact
- Burns

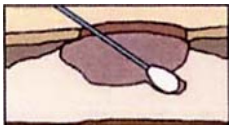


Measuring Wounds

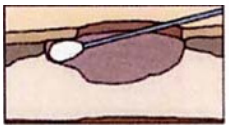
Measure the length "head to toe" at the longest point (A) and the width at the widest point (B). Measure depth (C) at the deepest point of the wound. *All measurements should be in centimeters.*

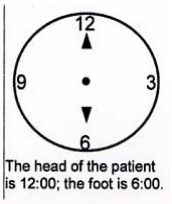
Using a clock format, describe the location and extent of tunneling (sinus tract) and/or undermining.

Tunneling/Sinus Tract
A narrow channel of passageway extending into healthy tissue.



Undermining
Tunneling wound that begins directly under the wound edge.





The head of the patient is 12:00; the foot is 6:00.

THIS RULER IS INTENDED FOR USE AS A REFERENCE ONLY.
TO PREVENT INFECTION, DO NOT USE THIS RULER TO MEASURE AN ACTUAL WOUND!