## Pressure Ulcer Stages

<table>
<thead>
<tr>
<th>Stage I</th>
<th>Stage II</th>
<th>Stage III</th>
<th>Stage IV</th>
<th>Suspected Deep Tissue Injury (SDTI)</th>
<th>Unstageable</th>
</tr>
</thead>
</table>
| • Intact skin with localized, non-blanchable erythema over a bony prominence.  
  • The area may be painful, firm or soft and warmer or cooler when compared to surrounding tissue.  
  • Darkly pigmented skin may not show visible blanching, however the colour of the Stage I ulcer will appear different than the colour of surrounding skin.  
  • Indicates the patient is at risk for further tissue damage if pressure is not relieved. | • Partial thickness wound presenting as a shallow, open ulcer with a red/pink wound bed.  
  • May also present as an intact or open/ruptured serum-filled or serosanguinous-filled blister.  
  • Slough may be present but does not obscure the depth of tissue loss. | • Full thickness wound.  
  • Subcutaneous tissue may be visible but bone, tendon and muscle are not exposed.  
  • May include undermining or sinus tracks.  
  • Slough or eschar may be present but does not obscure the depth of tissue loss. | • Full thickness wound with exposed bone, tendon or muscle.  
  • Often includes undermining and/or sinus tracks.  
  • Slough or eschar may be present on some parts of the wound bed but does not obscure the depth of tissue loss. | • A localized purple or maroon area of intact skin or a blood-filled blister that occurs when underlying soft tissue is damaged from friction or shear.  
  • SDTI may start as an area that is painful, firm or mushy/boggy and warmer or cooler than the surrounding tissue but can deteriorate into a thin blister over a dark wound bed or a wound covered in thin eschar.  
  • Deterioration of SDTI may be rapid, exposing additional layers of tissue even with optimal treatment and may be difficult to detect in individuals with dark skin tones. | • A wound in which the wound bed is covered by sufficient slough and/or eschar to preclude staging. |

Developed by the BC Provincial Nursing Skin & Wound Care Committee. Images Stage 1, 2, & 3 retrieved June 14, 2012 from www.npua.org. Images Stage 4, SDTI, Unstageble and the definitions are from the BC Provincial Nursing Skin & Wound Committee Guideline: Pressure Ulcer Management Decision Support Tool found at www.clwkca.