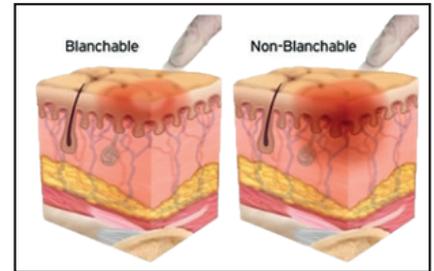


Early Warning Signs

Blanching /Erythema

Apply firm fingertip pressure for 5 seconds to the skin then remove the pressure. When pressure is removed the area may become lighter and then return to previous colour within 3 seconds.

Be mindful that not all skin tones will change (blanch) when finger-tip pressure is applied and there may be signs of new pain or discomfort over bony prominences.

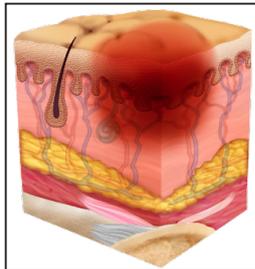


Grade 1

Non blanching erythema.

Skin intact. Be mindful that not all skin tones will change (blanch) when finger-tip pressure is applied.

Colour changes in persons skin tone. May present as red, purple/blueish or in the surrounding skin, appear lighter.



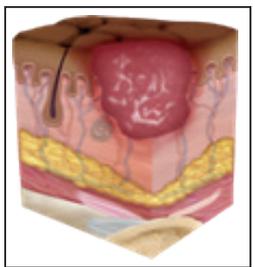
Area may be painful, changes in temperatures and texture may be present.

Grade 2

Loss of the epidermis/ dermis

Presenting as a shallow open ulcer with a red/pink wound bed. No bruising and typically no slough present.

May also present as an intact clear fluid filled blister or open / ruptured blister.

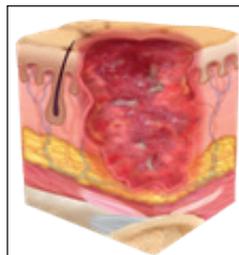


Grade 3

Full thickness skin loss.

Subcutaneous fat may be visible, but bone, tendon or muscle is not visible or palpable.

Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunnelling.

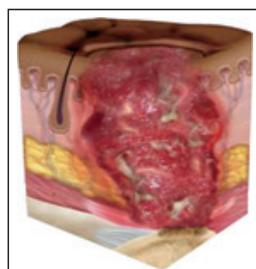


Grade 4

Full thickness tissue loss.

Extensive destruction with exposed or palpable bone, tendon or muscle.

Slough may be present but does not obscure the depth of tissue loss. Often includes undermining or tunnelling.



Grade 3 and 4 pressure ulcers depth can vary depending on the anatomical location. Ulcers on the ears, bridge of the nose, occiput and malleolus do not have subcutaneous tissue and can be shallow.

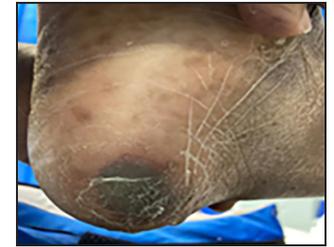
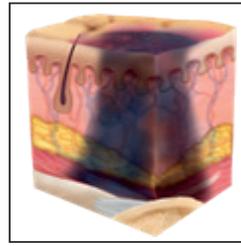
Suspected Deep Tissue Injury (SDTI)

An SDTI may **appear as a bruise** or present as a **blood-filled blister** over a wound bed. This may be less obvious in a dark skin tone.

Area may be painful, changes in temperatures and texture may be present.

Some SDTI pressure ulcers resolve or stay static. Sometimes skin will degrade and develop into deeper tissue loss.

Once grade can be established, this must be documented.

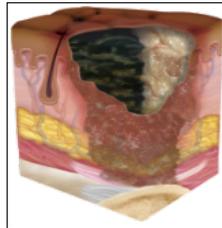


Ungradable

Full thickness skin/ tissue loss.

The full depth of the ulcer is obscured by slough and/ or necrotic tissue. Until enough slough and necrotic tissue is removed to expose the base of the wound the true depth cannot be determined.

It may be grade 3 or 4 once debrided. Once grade can be established this must be documented.



Mucosal Pressure Ulcer

These **develop on mucosal membrane** such as tongue, mouth, nasal passages, genitals and rectum.

Area may be painful, changes in temperatures and texture may be present.

Mucosal tissue does not have the same layers of the skin as the rest of the body so it cannot be graded and should be documented only as a mucosal pressure ulcer.



Pressure damage is often caused by devices such as catheters, tubing, orthotic appliances or any objects which are in prolonged contact with the skin.

Combination Lesions

These are lesions where a combination of pressure and moisture contribute to the tissue breakdown. They still need to be graded as pressure damage, but awareness of other causes and treatment options are required..



*Bruising can indicate deep tissue injury

*The depth of a Grade 3 or 4 pressure ulcer varies by anatomical location. Areas such as the bridge of the nose, ears, occiput and malleolus do not have fatty tissue so the depth of these ulcers may be shallow.

Ref: Healthcare Improvement Scotland, Prevention and Management of Pressure Ulcers Standards 2020, NPIAP-EP-UAP-PPPIA PRESSURE ULCER TREATMENT & PREVENTION 2019 QUICK REFERENCE GUIDE

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<https://npiap.com/page/PressureInjuryStages>

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