Pressure ulcer categorisation

Blanching erythema
Healthy skin may develop transient redness when subjected to pressure – for example, if the legs are crossed. To test if damage has occurred, light finger pressure should be applied to see if the skin blanches (goes white). In darker skin tones, redness may present as a darker area that is grey or purplish. This is not a pressure ulcer.

Example of skin blanch
Blanch in dark skin

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 compared to adjacent tissue. Category 1 may be difficult to detect in individuals with dark skin tones. May indicate ‘at risk’ individuals (a heralding sign of risk).

This redness is persistent and does not blanch
This redness will not blanch when pressure is applied

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 should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.

*Brusing indicates suspected deep tissue injury.

An intact serum-filled blister
A shallow open ulcer with a red pink wound bed without slough
A superficial ulcer with a collapsed blister

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 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue, and Category 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category 3 pressure ulcers. Bone/tendon is not visible or directly palpable.

Full thickness tissue loss. Subcutaneous fat is visible but no bone, tendon or muscle

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 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 4 ulcers can extend into muscle and/or supporting structures (eg fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.

In this wound, the bone is clearly visible
This wound shows exposed muscle

Unstageable: depth unknown
Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore category, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as ‘the body’s natural (biological) cover’ and should not be removed.

This occipital ulcer is covered by softening necrosis
This heel ulcer is covered by hard dry eschar
The necrotic cap on this heel has softened and started to separate
Although still firmly attached, there is a ring of demarcation where this eschar has been rehydrated

Suspected deep tissue injury: depth unknown
Purple or maroon localised area of discoloured 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 compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.

This heel ulcer appears as a dry blood blister
This heel ulcer appears as a linear area of deep purple black discolouration

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Pressure ulcer categorisation

Device-related pressure ulcers (DRPU)

‘Pressure ulcers that result from the use of devices designed and applied for diagnostic or therapeutic purposes.’

While some DRPU may also be allocated a category of damage, others may not as they are on parts of the anatomy that do not have the same structures as the skin – for example, the mucosal membrane. Where possible, a device-related ulcer should be categorised and the presence of a device noted by the addition of a (d) after the category.

Moisture-associated skin damage

This can occur due to the presence of any type of moisture on the skin, including incontinence, leakage from stoma, saliva, wound exudate and sweat

Mucosal pressure ulcers

Mucosal pressure ulcers cannot be categorised as the tissue does not have the same layers as the skin and therefore does not conform to the definitions. These PU are therefore uncategorisable (NOT unstageable) . They are usually caused by devices and therefore should be recorded as PU (d), locally you may wish to denote them as “Mucosal” or “Uncategorisable”.

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