Table 25-3: Stages of Pressure Ulcers Defined

Stage I	A nonblanchable area of erythema, which does not resolve after 30 minutes of pressure relief. In dark-skinned individuals this may present as discoloration of the skin, warmth, edema, induration or hardness. The skin is *always intact* with a stage I pressure ulcer.
Stage II	Partial-thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial with a pale pink wound bed and serous (never serosanguinous) drainage. May present as an abrasion or blister.
Stage III	Full-thickness skin loss involving damage to or necrosis of subcutaneous tissue. Wound bed is beefy pink but may have some necrotic tissue. There may be undermining of peri-wound skin or tunneling. Drainage may be serosanguinous. Underlying support structures are not visible.
Stage IV	Full-thickness tissue loss with extensive destruction, tissue necrosis or damage to muscle, bone or supporting structures. Support structures are visible (tendon, joint capsule, bone, fascia, muscle).

Pressure ulcers must be staged accurately for documentation, reimbursement, and standard of care issues. Pressure ulcers are never downstaged: a stage IV ulcer does not become a stage II, stage II does not become a stage I, etc. as it heals. It would be classified as a granulating stage IV or epithelializing stage IV or finally a healed stage IV.

Pressure ulcers cannot be accurately staged until the deepest viable tissue layer is visible. Ulcers covered with eschar or necrotic tissue cannot be staged until they are debrided. They can be documented as “full-thickness pressure ulcer unable to stage secondary to the presence of necrotic tissue.”