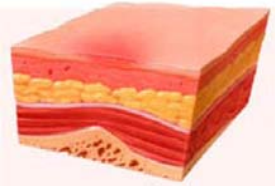


Definition of a Pressure Ulcer:

“A pressure ulcer is localised injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated.”

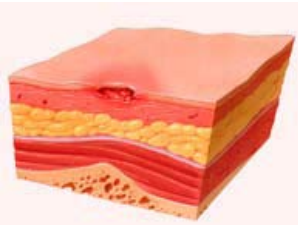
Important: Skin tears, tape burns, incontinence associated dermatitis, maceration or excoriation should not be classed as pressure ulcers

Stage I



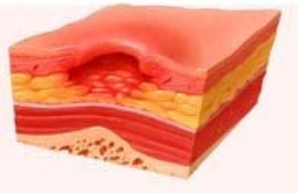
Stage I: Intact skin with non-blanchable redness of a localised area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue.

Stage II



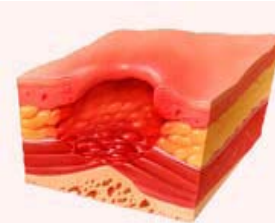
Stage II: Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled or sero-sanguineous filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising.

Stage III



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. This stage may include undermining and tunneling.

Stage IV



Stage IV: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. This stage often includes undermining and tunneling. Exposed bone/muscle is visible or directly palpable.

Reference: European Pressure Ulcer Advisory Panel and National Pressure Ulcer Advisory Panel. Prevention and treatment of pressure ulcers: quick reference guide. Washington DC: National Pressure Ulcer Advisory Panel; 2009.