

# Staging Pressure Ulcers (2006)

## Summary

The WOCN recognizes the importance of wound assessment and staging in the management of acute and chronic pressure ulcers, and the pivotal role that nurses play in wound assessment and wound management. Accurate assessment, reassessment and documentation is critical in order to provide evidence of wound healing, failure to heal, or wound deterioration. Effective communication regarding wound staging requires the use of accurate and universally recognized terminology and descriptors.

## Background

A number of systems have been developed over the years for classification or "staging" of Pressure Ulcers. The staging system currently recommended by the NPUAP (National Pressure Ulcer Advisory Panel) and the WOCN Society is a four-stage system based on the tissue layers involved. This system was derived from previous staging systems proposed by Shea (1975), the International Association for Enterostomal Therapy (IAET, 1988) and the National Pressure Ulcer Advisory Panel (NPUAP, 1989 Consensus Conference).

## Stage I

An observable pressure-related alteration of intact skin whose indicators as compared to the adjacent or opposite area on the body may include changes in one or more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel), and/or sensation (pain, itching). The ulcer as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue or purple hues.

## Stage II

Partial-thickness skin loss involving epidermis or dermis, or both. The ulcer is superficial and presents as an abrasion, blister, or shallow crater.

## Stage III

Full-thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.

## Stage IV

Full-thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage IV pressure ulcers.

Accurate staging with this system is therefore dependent on assessment of the wound base and identification of the deepest tissue layer exposed in the wound. Examples may include nonblanchable erythema of intact epidermis, epidermis and/or dermis, subcutaneous tissue and fascia and/or muscle layer with possible involvement of the bone and/or supporting structures.

## Problem

Issues of the current staging system continue to include the correct staging of a full-thickness wound filled with granulation tissue and the appropriateness of "downstaging" a full-thickness wound. These issues affect payors, patients, medical supply companies, and all healthcare providers. These issues underscore the importance of using comprehensive wound assessment rather than "staging" alone in order to accurately reflect and document wound status.

Currently, an NPUAP subcommittee is addressing these issues. The pressure ulcer staging definitions are planned to be clarified and include deep tissue injury and unstageable. The WOCN will support the efforts of this committee.

## Recommendation and Rationale

### Staging of Healing Wounds

The staging system as recommended by the WOCN Society and the NPUAP does not include a stage for granulating wounds. "Downstaging" of granulating wounds is NOT appropriate since the full-thickness repair process involves replacement of the lost normal tissue with granulation tissue. For example, a granulating Stage IV wound should NOT be "downstaged" to a Stage III, since a Stage III wound by definition is one with exposed subcutaneous tissue. Therefore, a granulating Stage IV wound is most appropriately classified as a "granulating Stage IV" or "healing Stage IV." If the Stage IV wound is completely healed, it can be classified as a "healed Stage IV," which conveys that the wound is now filled with granulation tissue and resurfaced with epithelium. When the original depth of the wound is unknown and the wound is resurfaced, it cannot be classified. However, when the wound is resurfaced with contracted scar tissue present, the healed wound should be described as "evidence of resurfaced full-thickness wound" or "evidence of a resurfaced wound of undetermined full-thickness depth."

## **Staging of Wounds Totally or Partially Covered With Slough or Eschar**

These wounds cannot be staged until the deepest viable tissue layer or identifiable structure is exposed because the deepest viable tissue layer is unknown. It is appropriate to document the size, location, and appearance of the ulcer as well as the status of the surrounding tissue, and to document that "Staging cannot be completed until the wound base is visible."

Wounds that are partially covered with necrotic tissue but have identifiable muscle, bone or supporting structures (e.g., tendon, joint capsule) visible in the wound base can be staged as a Stage IV with necrotic tissue, since the exposed tissue clearly indicates that the ulcer meets the criteria for the most severe wound stage.

In contrast, a wound that is partially covered with necrotic tissue that has a viable subcutaneous tissue visible in the wound base CANNOT be staged, because wounds penetrating only to the subcutaneous tissue are appropriately classified as a Stage III, and debridement of the remaining necrotic tissue may reveal an area of greater depth such as exposed muscle or bone that indicate the wound's true depth is Stage IV.

## **The WOCN Supports**

1. Education provided by wound care experts to other medical, nursing, and lay personnel including Medicare surveyors, regulatory agencies, and third-party payors on the appropriate implementation of the National Pressure Ulcer Advisory Panel Staging System.
2. Assessment and documentation of wound status which includes comprehensive clinical data demonstrating evidence of progress in healing or failure to heal. Parameters for comprehensive wound assessment include: dimensions and depth; presence, location and depth of any sinus tracts or undermining areas; status of the wound bed (granulating or epithelializing vs. clean but not granulating vs. avascular); volume, color, and odor of exudate; evidence of infection in surrounding tissues (erythema, induration, crepitation); and status of wound edges (closed and nonproliferative vs. open and proliferative). Such data, when sequentially recorded over time, can be used to objectively track the progress of wound healing.
3. The use of wound descriptors to accurately convey the true state of the wound in addition to documenting the stage of the wound.

*Note: the WOCN recognizes that comprehensiveness of wound assessment may vary depending on care setting and proficiency of evaluator.*

## References

Wound Ostomy and Continence Nurses Society. (2003). Clinical Practice Guideline for Prevention and Management of Pressure Ulcers.

Bryant, R.A. (2000). Acute and chronic wounds: Nursing management. St. Louis: Mosby Year Book, 2nd edition.

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