Two page document.
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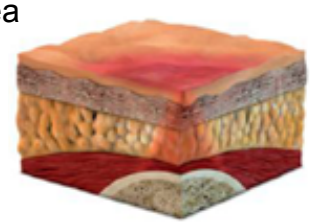
HSE Pressure Ulcer Staging Tool 2024

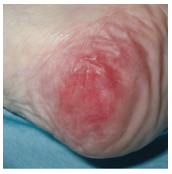
Adaptation of the European Pressure Ulcer Advisory Panel (EPUAP) Pressure Ulcer Classification Tool

Blanching Erythema as an Early Warning Sign

Areas of discoloured tissue that blanch (turn white) when fingertip pressure is applied indicate that damage is starting to occur but can be reversed. In darker skin tones, clinicians should assess for changes to colour, temperature, texture & sensation to skin.

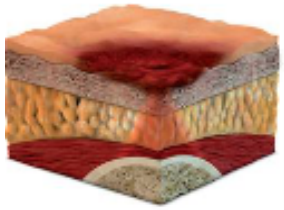
Stage 1 Pressure Ulcer:
Non-Blanchable Erythema





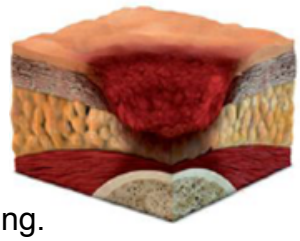
- Intact skin with non blanchable redness of a localised area usually over a bony prominence.
- Dark skin may not have visible blanching - its colour may differ from surrounding area.
- The area may be painful, firm, soft, warmer or cooler compared to adjacent skin.

Stage 2 Pressure Ulcer:
Partial Thickness Skin Loss

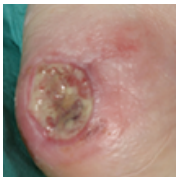


- Partial thickness loss of dermis presenting as a shallow, open wound with a red-pink wound bed, without slough or bruising
- May also present as an intact or open/serum-filled blister
- Presents as a shiny or dry, shallow ulcer without “adherent“ slough or bruising.
- Stage 2 pressure ulcers should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.

Stage 3 Pressure Ulcer:
Full Thickness Skin Loss

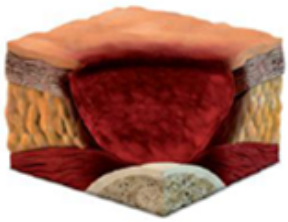


- Subcutaneous fat may be visible but bone, tendon or muscle are not exposed or directly palpable. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunnelling.



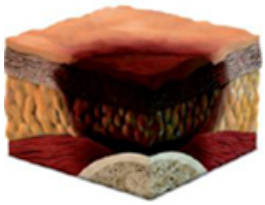
- The depth varies by anatomical location. Areas with significant subcutaneous tissue can develop deep Stage 3 pressure ulcers. However, in areas that do not have subcutaneous tissue, Stage 3 pressure ulcers can be shallow e.g. the bridge of the nose, ear, occiput and malleolus.

Stage 4 Pressure Ulcer:
Full Thickness Tissue Loss



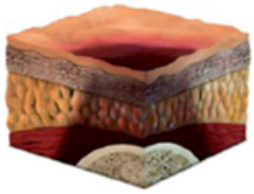
- Full thickness tissue loss with exposed bone, tendon or muscle visible or directly palpable. Slough or eschar may be present on some parts of the wound bed.
- The depth varies by anatomical location. Stage 4 pressure ulcers can be shallow in areas that do not have subcutaneous tissue e.g. the bridge of the nose, ear, occiput and malleolus.
- Stage 4 pressure ulcers can extend into muscle and/or supporting structures (e.g. Fascia, tendon or joint capsule), which can result in osteomyelitis, infection or sepsis.

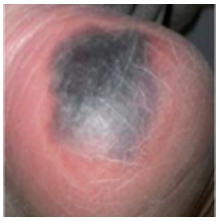
Unstageable Pressure Damage - Depth Unknown



- Full thickness tissue loss in which the base of the pressure ulcer is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the pressure ulcer bed.
- Until enough slough/eschar is removed to expose the base of the pressure ulcer, the true depth cannot be determined. These should be reported as at least Stage 3 pressure ulcers to ensure reporting occurs immediately. Once the extent of tissue damage is revealed, then the pressure ulcer can be restaged and reported as appropriate.
- Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serve as the body's natural biological cover and should not be removed.

Suspected Deep Tissue Damage



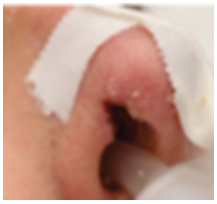


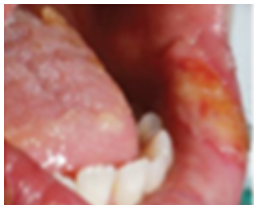
- A localised area of non-blanching erythema with purple/maroon discolouration of intact skin or blood-filed blister, due to damage from pressure and/or shear.
- The area may be preceded by tissue that is painful, firm, flaccid, boggy, and warmer or cooler compared to adjacent tissue.
- Deep tissue damage may be difficult to detect in individuals with dark skin tones. Clinicians should assess for changes to colour, temperature, texture and sensation to skin.
- Evolution may include a thin blister over a dark wound bed or may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment or it may take days or weeks to determine true extent of tissue damage. Record what you see in the healthcare record. Once the extent of tissue damage is revealed, the pressure ulcer can be staged and reported as appropriate.

Medical Device Related Pressure Ulcers (MDRPU)

- MDRPU are pressure ulcers that result from the use of devices used for diagnostic or therapeutic purposes. The damage caused often mimics the shape and distribution of the medical device.
- MDRPU can often occur in areas that are not easily visible or in areas with minimal soft tissue such as the bridge of the nose and ears.
- Unless the damage is to mucous membranes, they should be staged and reported in line with this Pressure Ulcer Staging Tool (2024).

Mucosal Pressure Ulcers





- These develop on mucosal membranes e.g. tongue, mouth, nasal passages, genitals and rectum, commonly as a result of a medical device.
- Mucosa does not have the same layers as the skin and therefore cannot be staged.
- These should be reported as mucosal pressure ulcers and their cause documented.
- If the pressure ulcer is unlikely to resolve without intervention or causes disfigurement, report it as a Serious Reportable Event (SRE).

Notes:

- This Pressure Ulcer Staging Tool (2024) was developed by the HSE National Improvement Programme for Wound Management, a collaboration between National Quality and Patient Safety and the Office of the Nursing and Midwifery Services Director. It is an adaptation of the European Pressure Ulcer Advisory Panel (EPUAP) Pressure Ulcer Classification Tool and reflects up-to-date clinical evidence as of Oct 2024.
- This Staging Tool should be used in conjunction with clinical judgment and local PPPGs.