

FAQs for pressure ulcer staging

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Staging pressure ulcers can be challenging. Below are some common questions—and answers—about staging.

Q If a pressure ulcer heals (completely epithelialized over), but later reopens at the same site, how should it be staged?

A According to the National Pressure Ulcer Advisory Panel, if a pressure ulcer reopens in the same site, the ulcer should be listed at the previous staging diagnosis (for example, if it was a Stage IV before it closed, it would be a Stage IV when it reopened).¹

Remember that pressure ulcers heal to a progressively more shallow depth. They don't replace lost muscle, subcutaneous fat, or dermis before they reepithelialize. Instead, the full-thickness ulcer is filled with scar tissue composed primarily of endothelial cells, fibroblasts, collagen, and extracellular matrix. A Stage IV pressure ulcer, therefore, can't become a Stage III, Stage II, or subsequently Stage I pressure ulcer.¹

Q Can pressure ulcer staging be used for venous ulcers?

A No. The National Pressure Ulcer Advisory Panel and European Pressure Ulcer Advisory Panel state that a pressure ulcer classification system can't be used to describe tissue loss in wounds other than pressure ulcers.²

Q If a wound first presents as a suspected deep-tissue injury (SDTI) and then

becomes open, should I chart it as a healing SDTI or restage it as it presents?

A Staging is based on the deepest level of tissue destruction through the layers of skin; therefore, you stage according to what level of destruction you see and/or feel. So, as the ulcer changes characteristics, you should restage it based upon what you see.

Remember to refer back to the definitions for each stage, and if you can't tell what you are looking at, document the wound as unstageable.

Q Once a pressure ulcer is debrided, does it become a surgical wound and no longer need staging?

A According to the Centers for Medicare & Medicaid Services (CMS), a pressure ulcer that has been surgically debrided remains a pressure ulcer, and isn't considered a surgical wound.^{3,4}

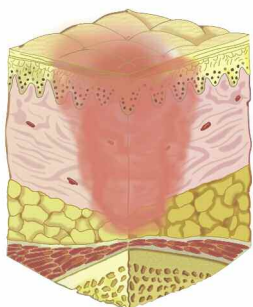
Q What would be the new stage for a Stage II pressure ulcer that develops slough?

A Because staging is based on the deepest level of tissue destruction through the layers of skin, you would stage the ulcer according to the level of destruction you see and/or feel.

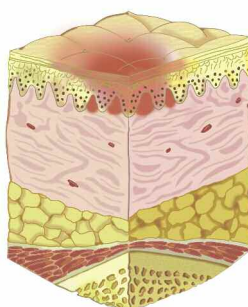
If the Stage II ulcer is covered in slough to the extent you can't see or palpate the deepest level of tissue destruction, it would be considered unstageable. However, if there is scattered, superficial slough and the deepest level of tissue destruction can be seen or palpated, then the ulcer would be either a Stage III or Stage IV.

Q If a Stage IV pressure ulcer is repaired with a surgical flap, would it still be a Stage IV or would it be unstageable?

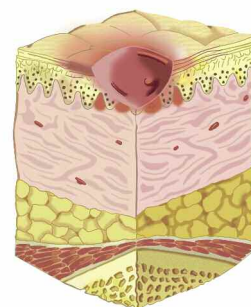
Stages of pressure ulcers



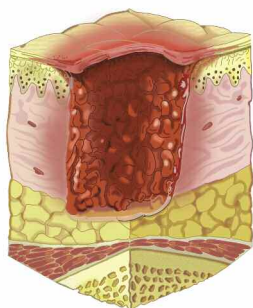
Suspected deep tissue injury



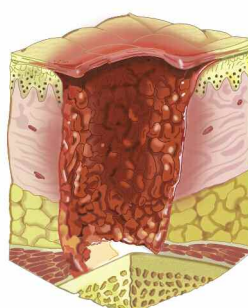
Stage 1



Stage 2



Stage 3



Stage 4



Unstageable

A According to the CMS, if a muscle flap, skin advancement flap, or rotational flap is performed to surgically replace a pressure ulcer, the area is considered a surgical wound and is no longer a pressure ulcer. If the flap fails, continue to code the area as a surgical wound until it's healed.^{3,4}

Q Can a wound have two stages? My patient has a Stage III pressure ulcer, but I also see dark purple around part of it. Should I document it as Stage III with suspected deep-tissue injury?

A A wound can't have two stages. The entire pressure ulcer should be staged based upon the deepest level of tissue destruction in the ulcer, so in this case the wound would be considered Stage III.

A Stage III depth is deeper than a suspected deep-tissue injury.

Q I know that friction and shearing contribute to pressure ulcer development but when do I stage it? For example, a patient's elbow has rubbed across the surface of the bed, resulting in missing epidermis. Is this now an abrasion or a Stage II pressure ulcer?

A The situation you describe would be an abrasion.

It's worthwhile to consider the role of friction and pressure ulcers. Friction force occurs when two objects rub against each other. Friction isn't a direct cause of pressure ulcers, but can contribute to shear stresses in skin and in deeper tissue layers, which, in combination with pressure, results in pressure ulcers.⁵

Q Can a patient have a friction wound without pressure?

A Friction force occurs when two objects rub against each other. According to Hanson and colleagues, “Friction abrades the skin of the epidermis and dermis, thereby decreasing the amount of pressure needed to create a pressure ulcer.”⁶

Q Can a patient have a shearing wound without pressure?

A Yes, but it’s rare. Pressure on soft tissues, especially when over a bony prominence, will cause some degree of shear through tissue distortion.^{2,5} Shear stresses arise from forces applied tangentially to a surface and cause deformation of the object involved. Shear stresses usually occur in combination with pressure.⁵

Q A patient’s waistband dug into his side and caused skin breakdown. Is this considered a pressure ulcer?

A Yes. Pressure along with friction from the constriction of the waistband is most likely the cause of the skin breakdown, and this would be considered a pressure ulcer.

Q A patient has a cast or device removed and there is skin breakdown underneath. Is this a pressure ulcer?

A Yes, this would be considered a pressure ulcer and would need to be staged according to depth of the tissue destruction.

Q My patient has a pressure ulcer that is 100% filled with slough, and I’ve determined it’s unstageable. In addition to documenting length and width, should I also try to determine a depth? Can you technically have a depth that is 0.1 cm?

A It can be difficult to measure depth in superficial partial-thickness ulcers or wounds covered with slough. If the depth is less than 1 mm, document as “< 0.1 cm.”⁷

Keep in mind that if a wound is open, it will have depth, because at least the epidermis has been penetrated. The epidermis has a thickness of 0.1 to 0.6 mm, and the dermis thickness can range from 2 to 4 mm. ■

Resources

- **National Pressure Ulcer Advisory Panel. NPUAP pressure ulcer stages/categories.**
- **Pressure ulcer staging test. Practice your skills.**

References

1. National Pressure Ulcer Advisory Panel. The facts about reverse staging in 2000. The NPUAP Position Statement. <http://www.npuap.org/wp-content/uploads/2012/01/Reverse-Staging-Position-Statement%E2%80%A8.pdf>. Accessed November 1, 2012.
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