

Adapted from EPUAP/NPUAP 2009

Superficial



EPUAP - Category/Grade I

- Non-blanchable erythema of intact skin: persistent redness in light pigmented skin.
- Discolouration of the skin: observe for a change of colour as compared to surrounding skin. In darker skin, the ulcer may be blue or purple.
- Warmth, oedema, induration or hardness as compared to adjacent tissue may also be used as indicators, particularly on individuals with darker skin.
- May include sensation (pain, itching).



EPUAP System - Category/Grade 2

- Partial thickness skin loss involving epidermis, dermis or both.
- Presents clinically as an abrasion or clear blister.
- Ulcer is superficial without bruising*
- Check for moisture lesion.

*Bruising appearance and blood filled blister would indicate deep tissue injury.

Deep



EPUAP - Category/Grade 3

- Full thickness skin loss. Subcutaneous fat may be visible but bone, tendon and muscle are not exposed.
- May include undermining and tunneling.
- The depth varies by anatomical location (bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and grade 3 ulcers can be shallow.
- In contrast area of significant adiposity can develop extremely deep grade 3 pressure ulcers.
- Bone/tendon is not visible or directly palpable.

Plus: Unclassified PU - now Grade 3

- Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, grey, green, brown, black, eschar) in the wound bed. Until enough slough is removed to expose the base of the wound, the true depth cannot be determined; but it will be either grade 3 or 4.
- Stable eschar (dry, adherent, intact without erythema or fluctuance) on the heels serves as 'the body natural (biological) cover' and should not be removed.
- Should be documented as grade 3 until proven otherwise.



EPUAP - Category/Grade 4

- Full thickness tissue loss with exposed bone (or directly palpable), tendon.
- Often include undermining and tunneling.
- The depth varies by anatomical location (bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and grade 4 ulcers can be shallow.
- Grade 4 ulcers can extend into the muscle and/or supporting structures (eg fascia, tendon or joint capsule).



Moisture Lesions

- Redness or partial thickness skin loss involving the epidermis, dermis or both caused by excessive moisture to the skin from urine, faeces or sweat.
- These lesions are not usually associated with a bony prominence.
- They can however be seen alongside a pressure ulcer of any grade.