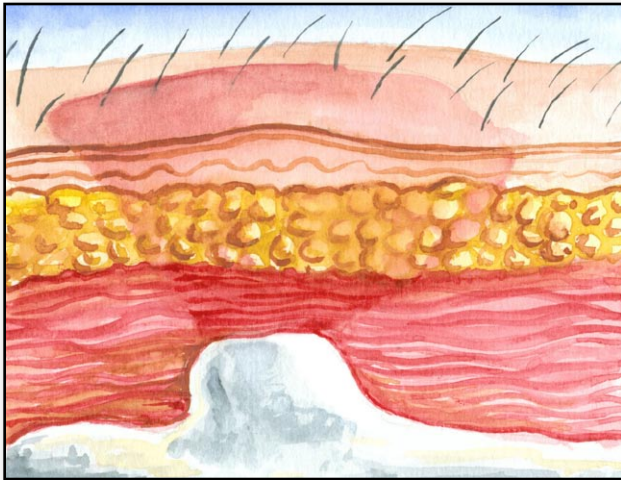
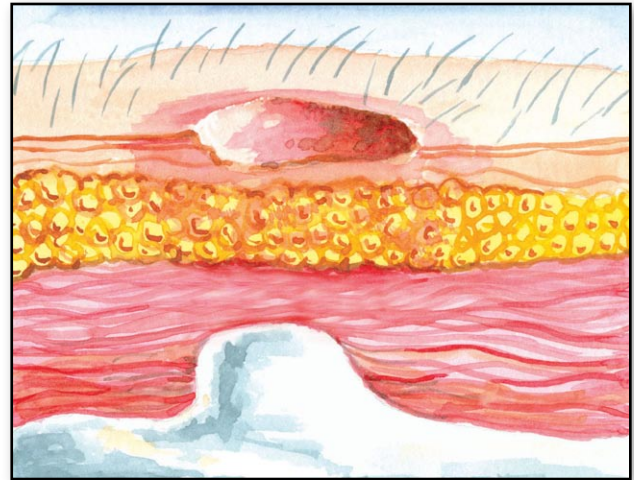


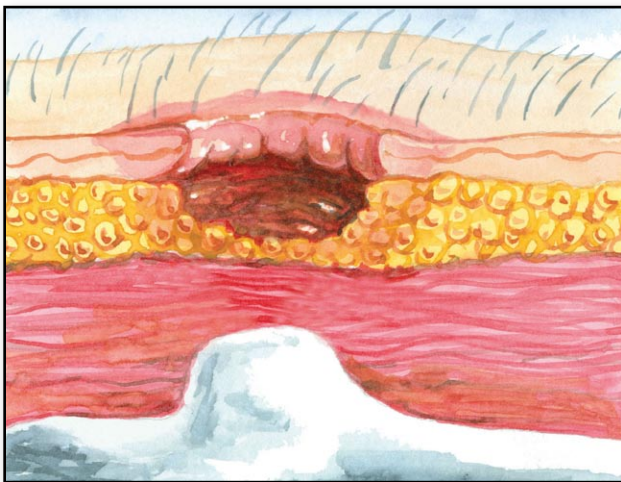
Pressure Ulcer Stages



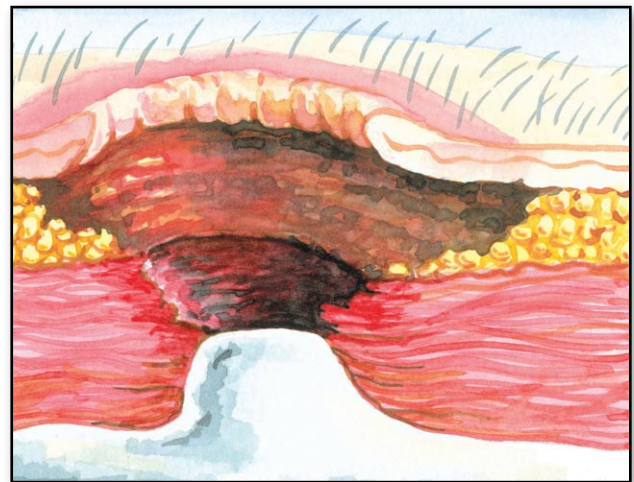
Stage I: Intact skin with non-blanchable redness of a localized area usually over a bony prominence.*



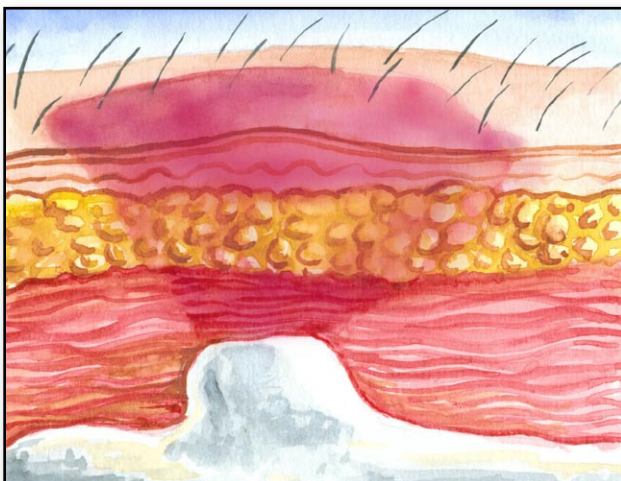
Stage II: Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough.*



Stage III: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed.*



Stage IV: Full thickness tissue loss with exposed or palpable bone or tendon or exposed muscle. Slough or eschar may be present on some parts of the wound bed.*



Suspected Deep Tissue Injury: Bruising, purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear.*

*For complete definitions of each pressure ulcer stage, visit www.wounds411.com and review the patient handout entitled *Pressure Ulcer Staging System*.

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