



**National Pressure Ulcer Advisory Panel
Position Paper on Staging Pressure Ulcers**

January 2012

Pressure ulcers have been defined by the National Pressure Ulcer Advisory Panel (NPUAP) in conjunction with the European Pressure Ulcer Advisory Panel (EPUAP) as localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear¹. A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated (NPUAP/EPUAP, 2008). One component of pressure ulcer descriptions is to classify them according to the amount of visible tissue loss, called the category, stage or grade of the ulcer. Describing the depth of tissue loss is an important aspect because payment turns on the level of tissue damage, plans of care are based on the stage or category of the ulcer depth and in the United States, pressure ulcers that reach full thickness, that is stage III or IV, deep tissue injury or those that are unstageable are considered “never events”; that is they should never happen. Therefore, accuracy is imperative in making this distinction.

Pressure ulcers are assigned a stage or category once the wound being assessed is diagnosed or determined to be a pressure ulcer. The classification system was not designed for use in any other wound type. Assigning a pressure ulcer stage is based on visual inspection to determine the extent of tissue destruction and wound depth. Pressure ulcer staging requires understanding of the anatomy of the skin and underlying tissues. The information to determine the stage of a pressure ulcer is not exclusively held by any profession.

Differentiating pressure ulcers from other wound etiologies is within the domain of registered nurses. As per the *Scope and Standards of Nursing Practice* detailed in the statement from ANA president, Rebecca M. Patton, MSN, RN, CNOR, RNs are expected to assess the patient’s skin, stage the wound and implement an individualized plan of care based on the patient needs. Due to licensed practical/vocational nurse state practice act restrictions, wounds that have the appearance of a pressure ulcer should be inspected and described by these nurses.

Nurses in particular examine the skin and are most likely to be the first professional to examine any skin lesion. In the absence of licensed independent practitioners/wound care specialist, the registered nurse needs to identify and stage the pressure ulcer so that early and appropriate care can be rendered. This care involves independently initiated nursing care, such as turning and repositioning.

In order to facilitate accurate diagnosis of any skin lesion, NPUAP supports the education of nurses to be able to accurately identify the anatomical location of a wound and its cause.

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- 1. European Pressure Ulcer Advisory Panel and National Pressure Ulcer Advisory Panel. Prevention and Treatment of Pressure Ulcers: Clinical Practice Guidelines. Washington, DC: National Pressure Ulcer Advisory Panel; 2009.**
- 2. Patton RM. Is Diagnosis of Pressure Ulcers within an RN's Scope of Practice? American Nurse Today 2010: Vol 5 (1); 20.**