### Suspected deep tissue injury

Epidermis will be intact but the affected area can appear purple or maroon or be a blood-filled blister over a dark wound bed. Over time this skin will degrade and develop into deeper tissue loss. Once grade can be established this must be documented.

### Ungradable

Full thickness skin/tissue loss where the depth of the ulcer is completely obscured by slough and/or necrotic tissue. Until enough slough and necrotic tissue is removed to expose the base of the wound, the true depth cannot be determined. It may be a Grade 3 or 4 once debrided. Once grade can be established this must be documented.

### Combination lesions

These are lesions where a combination of pressure and moisture contribute to the tissue breakdown. They still need to be graded as pressure damage as described in this tool but awareness of other causes and treatments is needed. See Excoriation & Moisture-related Skin Damage Tool.

### Resources

For all resources on reducing pressure ulcers in care homes, visit www.pressureulcer.scot

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Early warning sign - blanching erythema

Areas of discoloured tissue that blanch when fingertip pressure is applied and the colour recovers when pressure is released, indicating damage is starting to occur but can be reversed.

On darkly pigmented skin, blanching does not occur and changes to colour, temperature and texture of skin are the main indicators.

Grade 1

Non-blanchable erythema

Intact skin with non-blanchable redness, usually over a bony prominence.

Darker skin tones may not have visible blanching but the colour may differ from the surrounding area.

The affected area may be painful, firmer, softer, warmer or cooler than the surrounding tissue.

Grade 2

Partial thickness skin loss

Loss of the epidermis/dermis presenting as a shallow open ulcer with a red/pink wound bed without slough or bruising.

May also present as an intact or open/ruptured blister.

Grade 3

Full thickness skin loss

Subcutaneous fat may be visible but bone, tendon or muscle is not visible or palpable.

Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunnelling.

Grade 4

Full thickness tissue loss

Extensive destruction with exposed or palpable bone, tendon or muscle.

Slough may be present but does not obscure the depth of tissue loss. Often includes undermining or tunnelling.

1. Bruising can indicate deep tissue injury.

2. The depth of a Grade 1 or 2 pressure ulcer varies by anatomical location. Areas such as the bridge of the nose, ear, scalp and midline do not have fatty tissue so the depth of these ulcers may be shallower in contrast areas which have excess fatty tissue. Pressure ulcers where bone, tendon or muscle is not directly visible or palpable may be deeper.