International Classification for Wound Care		
Stage	Description	Clinical Presentation
Stage I Non-blanchable erythema	Intact skin with non-blanchable redness of a localized area usually over a bony prominence.	The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. May be difficult to detect in individuals with dark skin tones.
Stage II Partial thickness skin loss	This category should not be used to describe skin tears, tape burns, incontinence associated dermatitis, maceration or excoriation.	Shallow open ulcer with a red pink wound bed, without slough or bruising or an open/ruptured serum-filled or sero-sanginous filled blister. Bruising indicates deep tissue injury.
Stage III Full thickness skin loss	The depth of Stage III pressure ulcers varies by anatomical location. They can be very shallow on the bridge of the nose, ear, occiput, and malleolus but areas of significant adiposity can develop extremely deep Stage III pressure ulcers.	Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Bone/tendon is not visible or directly palpable.
Stage IV Full thickness tissue loss	The depth of Stage IV pressure ulcers varies by anatomical location. They can be very shallow on the bridge of the nose, ear, occiput, and malleolus. Can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis or osteitis likely to occur.	Bone, tendon or muscle is exposed with tissue loss. Slough or eschar may be present. Often includes undermining and tunneling. Exposed bone/muscle is visible or directly palpable.

http://www.hopkinsmedicine.org/gec/series/wound_care.html#phase_healing