

Pressure Ulcer Assessment / reassessment

Use one sheet per wound. Complete Body Map and label Wound number as per body map

Patient name:	Ward/team:	NHS No:																	
DOB:	Hosp/base:	Hosp No:	GP:																

Example

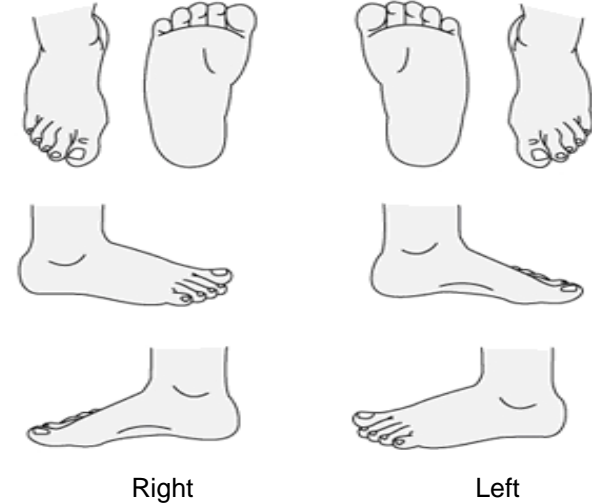
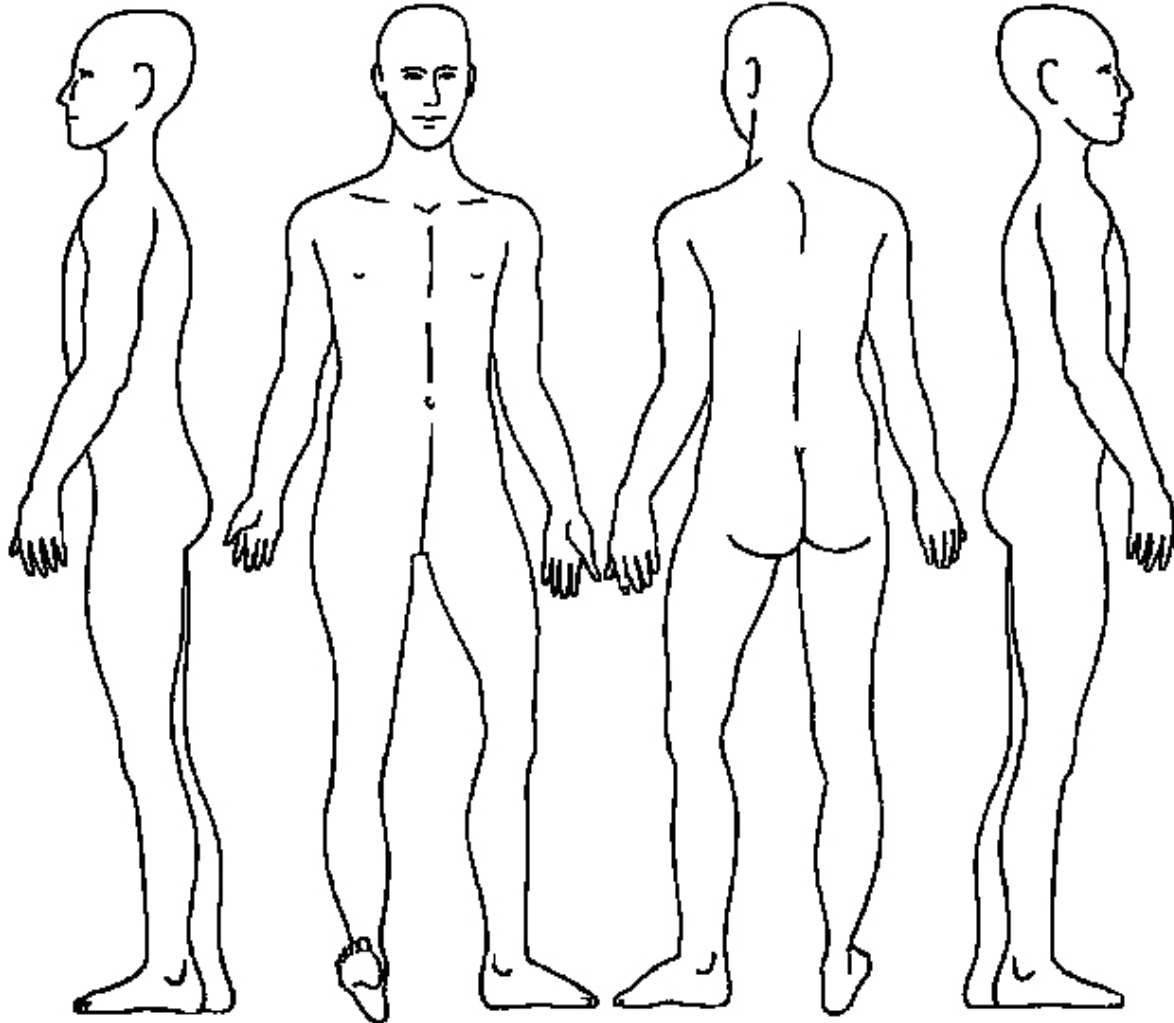
Wound number from body map:		Assessment Date	<i>dd/mm/yyyy</i>																			
Wound Dimensions Ensure Medical Photography / Wound tracing available in patient notes	<i>Use disposable measuring device</i>	Length (cm)	35																			
		Width (cm)	20																			
		Depth (cm)	5																			
		Tracking	none																			
		Undermining	none																			
Category of pressure ulcer (1, 2, 3, or 4)			1																			
Tissue type (Nature of Wound bed) Indicate all applicable and estimate % of tissue type present	Epithelialisation	Pink margins and/or	10%																			
	Granulation: Healthy	Pink/red, moist,	40%																			
	Granulation: Less	Pale pink,																				
	Overgranulation	Bright Red																				
	Necrotic	brown/grey/off white																				
	Eschar	Black/brown																				
	Slough	white or yellow	50%																			
	Mixed Tissue: ligament, tendon, muscle etc																					
Other: State																						
Surrounding Skin Condition	Healthy, Macerated, Excoriated, Oedematous, etc		Macerated																			
Wound Margins	Cliff, Sloping, Rolled, Advancing, etc		sloping																			
Exudate	Viscosity <table border="1" style="font-size: small;"> <tr> <td></td> <td>High 5</td> <td>Medium 3</td> <td>Low 1</td> </tr> <tr> <td>High 5</td> <td>10</td> <td>8</td> <td>6</td> </tr> <tr> <td>Medium 3</td> <td>8</td> <td>6</td> <td>4</td> </tr> <tr> <td>Low 1</td> <td>6</td> <td>4</td> <td>2</td> </tr> </table>		High 5	Medium 3	Low 1	High 5	10	8	6	Medium 3	8	6	4	Low 1	6	4	2	10	10	10	10	10
			High 5	Medium 3	Low 1																	
		High 5	10	8	6																	
		Medium 3	8	6	4																	
		Low 1	6	4	2																	
		8	8	8	8	8	8															
6	6	6	6	6	6																	
4	4	4	4	4	4																	
2	2	2	2	2	2																	
Exudate Colour	Clear, Cloudy, Pink e.g. Blood, Green e.g. Pus, Yellow or brown, etc		Pink																			
Odour of Wound <i>Professional's judgment</i>	None, Mild, Offensive, Foul, Extreme		Foul																			
Level of Infection <i>Only swab if spreading cellulitis, systemic symptoms, immunosupp'd</i>	Colonised: <i>no reaction/symptoms</i>																					
	Critically Colonised: <i>delayed healing, pain</i>		√																			
	Local Infection: <i>erythema less than 2cm</i>																					
	Spreading Infection: <i>erythema more than 2cm and/or systemic infection</i>																					
Pain at wound site <i>Use pain Score 0 (no pain) to 10 (unbearable pain)</i>	After dressing change		0																			
	Nocturnal		2																			
	Intermittent		4																			
	Continuous		0																			
Patient's description of Pain	Throbbing, Burning, Stabbing, Stinging etc		Throbbing																			
Type of Pain	Generalised, Infection, Neuropathic, Vascular, etc		Infection																			
Pain Management Strategy (state type)			N/A																			
Treatment goals must be transcribed onto careplan																						
Wound assessed by: PRINT NAME			ANother																			
Review date (4 weeks or sooner if clinically indicated):			<i>dd/mm/yyyy</i>																			

Skin Integrity / Pressure Ulcer Body Map

If foot or ankle ulcer - refer to Podiatry and / or lower limb assessment. Mark location with 'X' and number each wound. Wound tracing may be appropriate.

Pressure Ulcers - Grade 4 refer to Tissue Viability Team. Medical photography recommended Grade 2, 3 and 4.

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Assessment / reassessment date	Description / Aetiology	Signature