

Pressure Ulcer Assessment and Intervention Worksheet

Resident Name _____ Rm # _____ Physician _____

Date Identified _____ Previous Pressure Ulcer (Prior 90 days) _____

Nurse completing the worksheet _____

Probable Causal Factors:

(check all that apply)

1. _____ Diabetes
2. _____ End Stage Disease/Hospice
3. _____ Comatose
4. _____ Impaired transfer ability
(extensive/total dependence)
5. _____ Impaired bed mobility
(extensive/total dependence)
6. _____ Severe PVD
7. _____ Incontinence, bowel or bladder
8. _____ Skin desensitized to pain or pressure
9. _____ Restraint in use
10. _____ Significant weight loss
11. _____ COPD
12. _____ Paraplegia
13. _____ Quadriplegia
14. _____ Sepsis
15. _____ History of malnutrition or dehydration

Has the Resident had 2 or more of the following:

1. _____ Steroid Therapy
2. _____ Radiation
3. _____ Chemotherapy
4. _____ Renal Dialysis
5. _____ HOB up most of time

Does the Resident trigger any of the following CAAs?

1. _____ Urinary Incontinence
2. _____ Nutritional Status
3. _____ Cognitive Loss/Dementia
4. _____ Psychotropic Drug Use
5. _____ Physical Restraint

Initial Interventions/Additional Assessment Information:

1. Weekly measurement by Licensed Nurse _____
Date _____ Results _____

2. Physician Notification _____ Family Notification _____
Date _____ Date _____

3. Treatment Plan Ordered (date & description) _____

4. Last RD visit _____
Date _____ Recommendations _____

5. Care Plan Updated _____ 6. Weight loss of 5% in last month _____
Date _____ Y/N & Wt. _____

7. Appetite most meals _____
%

8. Pressure Reduction Equipment in use _____
Mattress _____ Wheelchair _____

9. Abnormal Lab Values _____
List any abnormal lab results _____ Date _____

Follow-up:

Pressure Ulcer healed _____ Responding to treatment _____
Date _____ Y/N and Date _____

Complications during course of treatment _____

Signature of DON _____