Meridian - Wichita

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 dependent)
5. _____Impaired bed mobility (extensive/total dependent)
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 Raps?

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 __________ (Date) Family Notification__________ (Date)
3. Treatment Plan Ordered______________________________________
4. Last RD visit ______ (Date) ______________________________ (Recommendations)
5. Care Plan Updated ____________ (Date)
6. Weight Loss of 5% in last month ________
7. Appetite Most Meals______________ (%)
8. Pressure Reduction Equipment in use ______________ (Mattress) ______________ (Wheel Chair)
9. Abnormal Lab Values ______________________________ (List any abnormal lab results and date)

Follow-up

Pressure Ulcer Healed_________Responding to Treatment_______________
Complications During Course of Treatment____________________________
Signature of DON____