Kent Community Health NHS
NHS Trust

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**	*dd/mm/yyyy*				
Wound Dimensions Ensure Medical Photography / Wound tracing available ***in patient notes***	***Use disposable measuring device***	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 / Volume: High 5 (10, 8, 6); Medium 3 (8, 6, 4); Low 1 (6, 4, 2)		10 8 6 4 2	10 8 6 4 2	10 8 6 4 2	10 8 6 4 2	10 8 6 4 2
Exudate Colour	Clear, Cloudy, Pink ***e.g. Blood,*** Green ***e.g. Pus,*** Yellow or brown, etc		Pink				
Odour of Wound ***Professional's judgment***	None, Mild, Offensive, Foul, Extreme		Foul				
Level of Infection ***Only swab if spreading cellulitis, systemic symptoms, immunosupp'd***	Colonised: ***no reaction/symptoms***						
	Critically Colonised: ***delayed healing, pain***		√				
	Local Infection: ***erythema less than 2cm***						
	Spreading Infection: ***erythema more than 2cm and/or systemic infection***						
Pain at wound site ***Use pain Score 0 (no pain) to 10 (unbearable pain)***	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):			dd/mm/yyyy				

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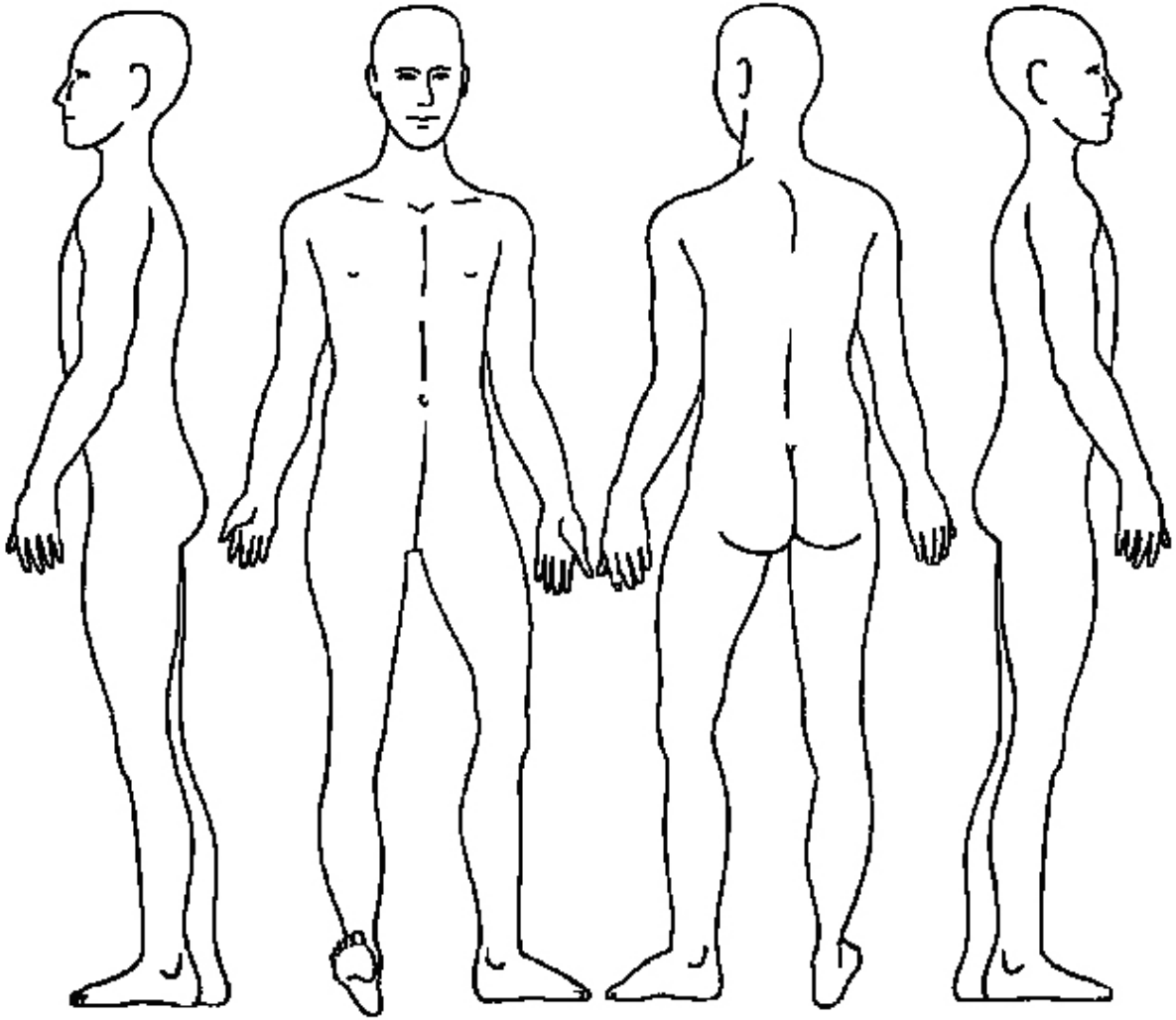
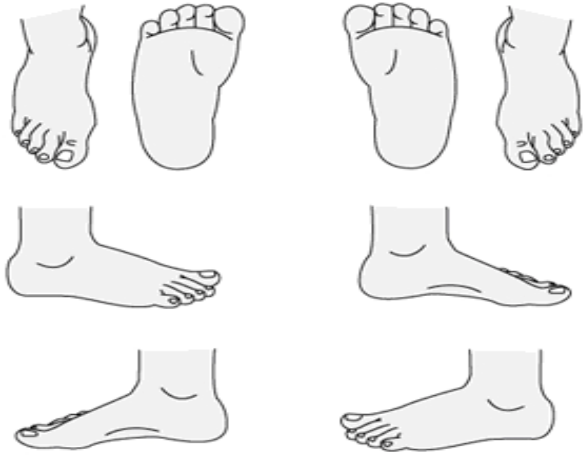
Skin Integrity / Pressure Ulcer Body Map

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.

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





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Assessment / reassessment date	Description / Aetiology	Signature