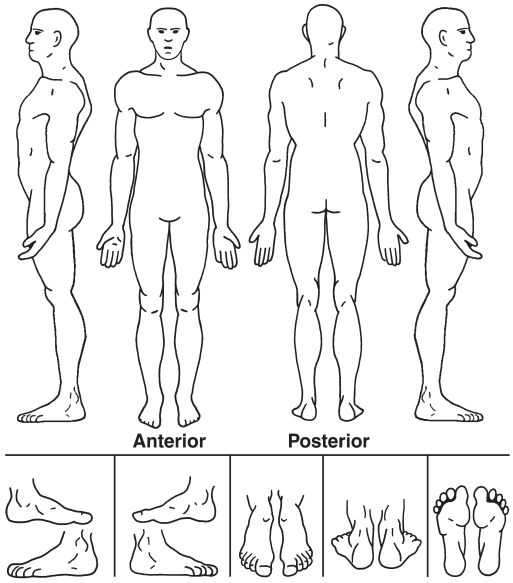
WEEKLY PRESSURE INJURY RECORD



NOTE: *When documenting the length and width of a pressure injury, use the resident's/patient's body as a road map. The head at north and the feet at south. The width should be measured from side to side.*

RISK FACTORS/CAUSE

❑ Diabetes Mellitus ❑ Incontinence ❑ Paralysis ❑ Sepsis ❑ Venous ❑ Arterial

❑ End-stage disease ❑ Other _____

DESCRIPTION OF STAGES

Stage 1: Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema, redness or changes in sensation, temperature or firmness may precede visual changes. Color changes of intact skin, such as purple or maroon discoloration, may indicate deep tissue pressure injury.

Stage 2: Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist and may also present as an intact or open/ruptured blister. Granulation tissue, slough and eschar are not present.

Stage 3: Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed.

Stage 4: Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location.

Unstageable Pressure Injury: Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed.

Deep Tissue Pressure Injury: Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue.

Medical Device Related Pressure Injury: Pressure injury resulting from the use of devices designed and applied for diagnostic or therapeutic purposes. The discoloration may appear differently in darkly pigmented skin. The resultant pressure injury generally conforms to the shape of the device. This injury should be staged using the staging system.

Mucosal Membrane Pressure Injury: Found on mucous membranes with a history of a medical device in use at the location of the injury. Due to the anatomy of the tissue, these injuries cannot be staged.

DATE OF ONSET: _____

SITE/LOCATION: _____

DATE	STAGE	SIZE IN CM (LENGTH x WIDTH)	DEPTH (cm)	EXUDATE TYPE/AMOUNT	12 9 3 6 Tunneling (cm)_____ Undermining (cm)_____	ODOR	WOUND BED	SURROUNDING SKIN COLOR	SURROUNDING TISSUE/ WOUND EDGES

CULTURE SENT	Response to Treatment/Comments:	DATE NOTIFIED		
❍ Yes/Date		Dietary	Physician	Family
❍ No		DATE HEALED		

NUTRITIONAL/HYDRATION STATUS:

Ideal body weight.....	❍ At	❍ Above	❍ Below
Actual weight.....	❍ Stable	❍ Gaining	❍ Losing
Food intake	❍ 75-100%	❍ 50-75%	❍ Below 50%
Skin turgor.....	❍ Good	❍ Fair	❍ Poor
Urine	❍ Adequate	❍ Inadequate	

PREVENTIVE MEASURES/PROGRESS:

Turned q _____ hours

Pressure relieving interventions:

❑ High protein supplements ❑ Multivitamins/Zinc

PAIN: Is resident experiencing pain related to wound?

❍ Yes – See Pain Flow Sheet ❍ No ❍ Unable to communicate

ADDITIONAL NOTES

Signature/Title:_____ Date:_____

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed