PRESSURE ULCER LOCATIONS (bony prominences)

- R - Right
- L - Left
- 1 - Occiput
- 2 - Ear
- 3 - Scapula
- 4 - Spine Process
- 5 - Shoulder
- 6 - Elbow
- 7 - Ilac Crest
- 8 - Sacrum/Coccyx
- 9 - Ischial Tuberosity
- 10 - Trochanter
- 11 - Knee
- 12 - Malleolus
- 13 - Heel
- 14 - Toe
- 15 - 17 -

PRESSURE ULCER STAGES

- DEEP TISSUE INJURY (DTI) SUSPECTED: Purple or maroon localized area of discolored intact skin or blood filled blister due to damage of underlying soft tissue from pressure and/or shear. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler than compared to adjacent tissue.
- STAGE I: Intact skin with non-blanchable redness of a localized area usually over a boney prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.
- STAGE II: Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum filled blister.
- STAGE III: Full thickness tissue loss. Subcutaneous fat may be visible but bone tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.
- STAGE IV: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.
- UNABLE TO STAGE (UTS): Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown, or black) in the wound bed.

WOUND TYPE
- FT - Full Thickness
- Os - Ostomy
- P - Pressure Ulcer
- PT - Partial Thickness
- ST - Skin Tear
- SU - Surgical Wound
- O - Other:

WOUND/SKIN APPEARANCE
- BB - Blister-Blood Filled
- BE - Blister-Erythema
- BS - Blister-Serum Filled
- D - Discoloration
- E - Erythematous
- EP - Epithelialized
- G - Granulation
- N - Necrotic/Eschar
- NBE - Non-Blanched Erythema
- R - Rash
- S - Slough

SURGICAL WOUNDS
- B - Bleeding
- Bo - Bone
- CI - Closed/Resurfaced
- De - Dehisced
- Dr - Drain
- EA - Edges Approximated
- ES - Edges Separated
- EV - Eviscerated
- FB - Foreign Body
- H - Healed
- O - Open
- Sg - Surgical Glue
- St - Stapled
- Ste - Steristripped
- Su - Sutured

EXUDATE CONSISTENCY
- B - Biliary
- Br - Brown
- C - Clear
- F - Fecal
- G - Green
- P - Purulent
- S - Sanguinous
- Ser - Serous
- SS - Serosanguinous
- U - Urine

EXUDATE AMOUNT
- Co - Copious
- L - Large
- Mod - Moderate
- N - None
- Sc - Scant
- S - Small

SURROUNDING SKIN
- Ca - Callous
- C - Cool
- D - Deruded
- E - Ecchymotic
- ED - Edematous
- ER - Erythema
- I - Intact
- Ind - Induration
- M - Macerated
- R - Rash
- T - Tenderness
- TB - Tape Burns
- W - Warm

ODOR
- Y - Yes
- N - No

TUNNELING
- Y - Yes
- N - No

UNDERMINING
- Y - Yes
- N - No
### Pressure Ulcer Prevention & Wound Care Management Diagram, Referral & Care Plan

#### Outcome

- **1.** Patient/Family/Significant Other will verbalize understanding of protocol interventions.
- **2.** Patient skin will remain intact.
- **3.** Pressure ulcer will heal as evidenced by presence of granulation tissue and decrease in size.

#### Interventions

<table>
<thead>
<tr>
<th>Surface Selection</th>
<th>Incontinence Management</th>
<th>Nutritional Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard Bed (Foam Mattress)</td>
<td>Urinary Incontinence</td>
<td>Nutritional Consult</td>
</tr>
<tr>
<td>Specialty Bed/Surface: __________________________</td>
<td>Fecal Incontinence</td>
<td>Nutrition Order Carried Out</td>
</tr>
<tr>
<td>Pressure Relieving Chair Cushion</td>
<td>Moisture Barrier Type: __________________________</td>
<td>Encourage Oral Intake</td>
</tr>
<tr>
<td>Float Heels</td>
<td>Toileting Schedule</td>
<td></td>
</tr>
<tr>
<td>Heel Protectors</td>
<td>Urine/Stool Containment Device</td>
<td></td>
</tr>
<tr>
<td>reposition every 2 hours in bed</td>
<td>Nutritional Consult</td>
<td></td>
</tr>
<tr>
<td>reposition every 1 hour in chair</td>
<td>Nutrition Order Carried Out</td>
<td></td>
</tr>
</tbody>
</table>

Also refer to Pressure Ulcer Prevention Protocol Policy (TX.INT.1)

#### Date & Initials

<table>
<thead>
<tr>
<th>Start</th>
<th>Discontinue</th>
<th>Start</th>
<th>Discontinue</th>
</tr>
</thead>
</table>

### NURSING DIAGNOSIS–IMPAIRED SKIN INTEGRITY:

- **Actual**
- **Potential**

<table>
<thead>
<tr>
<th>Initials: __________________________</th>
<th>Related to: __________________________</th>
</tr>
</thead>
</table>

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**KH01327  Rev. 03/24/10**

**PATIENT CARE RECORD**