

Tier 3 – Pressure Ulcer Risk Determination and Differential Diagnosis

(i.e. wound care specialist, admitting physician or other individual with legal accountability for making diagnosis)

If Present Risk Factors associated with pressure ulcer risk for development and/or diagnosis

- Cognitive Impairment** Symptoms _____
- Ambulation/Mobilization Impairment (motor and/or sensory)** Symptoms _____
- Nutritional/Hydration Impairment** Symptoms _____
- Incontinence/Moisture (too wet/too dry) Impairment** Symptoms _____
- Contact with medical devices (i.e., braces, orthotics, cannulas, tubing), and/or any object in contact with the body.**

General Medical Conditions & Medications that have a co-morbidity effect on pressure ulcer development and/or healing.

- | | | |
|---|--------------------------------------|--|
| <input type="checkbox"/> Integumentary | <u>Analysis of Body Systems</u> | <input type="checkbox"/> Neurological |
| <input type="checkbox"/> Cardiovascular | | <input type="checkbox"/> Musculoskeletal |
| <input type="checkbox"/> Respiratory | | <input type="checkbox"/> Hematologic/Immunologic |
| <input type="checkbox"/> Gastrointestinal | | <input type="checkbox"/> Endocrine |
| <input type="checkbox"/> Genitourinary | <input type="checkbox"/> Medications | <input type="checkbox"/> Reproductive |

Comments _____

- 1. Existing open wound
- 2. Discoloration of intact skin
- 3. Description of area of interest (Reference 1 & 2)
Pain related to the wound (0 = none / 10 = most severe) _____

Depth Description

- Blanchable erythema of intact skin
- Non-blanchable erythema of intact skin
- Clear Fluid Blister
- Maroon and/or purple discoloration of intact skin
- Blood Filled Blister
- Partial thickness/skin loss involving epidermis and/or dermis
- Full thickness/skin loss involving damage or necrosis of the subcutaneous tissue; may extend down to but not through the underlying fascia
- Full thickness/skin loss involving damage or necrosis of the subcutaneous tissue extending through the underlying fascia, with muscle, tendon and/or bone exposure
- Base of wound obscured by slough and/or eschar

Depth Measurement: Length _____ Width _____ Depth _____

Amount of exudates

- None
- Minimum
- Copious

Type of exudates

- Present and thin, serous, watery, clear,
- Serousanguinous, thin, watery, pale red/pink
- Purulent, thin or thick, opaque, tan/yellow, with or without odor

Odor from wound

Type of necrotic tissue

- Slough
- Eschar

Granulation tissue

- None
- Present
- Severe

Epithelialization

Color around wound

- Normal for ethnicity
- Pale
- Blanchable erythema
- Non-blanchable erythema
- Purple

Palpation of peripheral tissue

- Normal
- Boggy
- Firm

Peripheral tissue edema

- None
- Non-pitting edema
- Pitting edema

Tier 3 – Pressure Ulcer Risk Determination and Differential Diagnosis

(i.e. wound care specialist, admitting physician or other individual with legal accountability for making diagnosis)

Edges

- None
- Indistinct
- Distinct
- Well defined, attached to wound base
- Well defined, not attached to wound base

Undermining of wound/ulcer

- None
- Present
- Tunneling
- Sinus tract

Color of intact skin over suspected DTI

- Normal for ethnicity
- Pale
- Blanchable erythema
- Non-blanchable erythema
- Purple

Sensation of intact skin over suspected deep tissue abnormality

- Normal
- Decreased
- Increased

Texture of intact skin over suspected deep tissue abnormality

- Normal
- Boggy
- Firm

Temperature of intact skin over deep tissue injury: F° _____ and/or C° _____

4. Closed wound (repaired full thickness defect closed by secondary intention causing scarring)

5. Location of area of interest (Reference 3)

	Right	Middle	Left		Right	Middle	Left		Right	Middle	Left
Head				Wrist				Thigh			
Occiput	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anterior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anterior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Temporal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lateral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Posterior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lateral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Posterior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								
Lip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								
				Hand				Knee			
Neck				Palm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anterior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anterior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Posterior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lateral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Finger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lateral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Posterior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					Posterior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Chest							
Shoulder				Lateral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Calf			
Anterior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anterior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anterior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lateral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sternum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Posterior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					Lateral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Abdomen				Posterior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Upper Arm				Lateral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Anterior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anterior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ankle			
Lateral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					Anterior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Posterior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Upper Back				Medial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lateral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Blade	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Malleolus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elbow				Spinal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Achilles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Column	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tendon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lateral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								
Posterior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lower Back				Foot			
				Lateral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anterior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fore Arm				Spinal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anterior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Column	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lateral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lateral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					Plantar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Posterior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sacrum				Posterior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coccyx	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Plantar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Buttock	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Metatarsal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Perineum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Posterior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Femoral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Trochanter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Tier 3 – Pressure Ulcer Risk Determination and Differential Diagnosis

(i.e. wound care specialist, admitting physician or other individual with legal accountability for making diagnosis)

6. Differential diagnosis. Based on the patient risk assessment and skin/soft tissue assessment of the area of interest, the following **type of wound** is consistent with the following findings:
- Closed pressure ulcer

 - Pressure Ulcer; DTI Stage I Stage II Stage III Stage IV and Unstageable

 - Arterial (Ischemic)
 - Partial Thickness
 - Full Thickness
 - Venous Stasis
 - Partial Thickness
 - Full Thickness
 - Lymphedema (Lymphatic)
 - Partial Thickness
 - Full Thickness
 - Neuropathic (motor, sensory and autonomic)
 - Partial Thickness
 - Full Thickness
 - Trauma (ex. chemical burn, i.e. perineal dermatitis)
 - Partial Thickness
 - Full Thickness
 - Surgical
 - Partial Thickness
 - Full Thickness
 - Other _____

7. **Type of wound** (Reference 6) and location (Reference 5) for all areas of interest. (Ex. *Stage III, Left Posterior Heel*)

1. _____ 2. _____ 3. _____ 4. _____ 5. _____

Did the patient refuse part or all of recommended clinical care based on the facility/agency protocol?

Comment on refused care:

Time/Date of Admission or Readmission

_____ (mm/dd/yyyy) _____ AM/PM

Time/Date of Evaluation

_____ (mm/d/yyyy) _____ AM/PM

Performed By:

Print

Signature

Date: _____