Pressure Ulcer Care Planning Assessment Form

Background: This tool can be used to determine if your facility has a process for developing and implementing a pressure ulcer care plan for patients who have been found to be at risk or who have a pressure ulcer.

Instructions: Complete the checklist. For certain questions, you may want to consult with appropriate staff in your organization.

Use: Use the results of this assessment to identify issues that you need to deal with, and formulate goals for your pressure ulcer prevention initiative.

Does the care plan for pressure ulcers address all the areas below (as they apply)?

	Yes	No	Person Responsible	Comments
Impaired Mobility • Assist with turning, rising, position • Encourage ambulation • Limit static sitting to 2 hours at any time				
Pressure Relief • Support surfaces: Bed • Support surfaces: Chair • Pressure-relieving devices • Repositioning • Bottoming out in bed and chair*				
Nutritional Improvement • Supplements • Feeding assistance • Adequate fluid intake • Dietitian consult as needed				
Urinary Incontinence • Toileting plan • Wet checks • Treat causes • Assist with hygiene • Use of skin barriers and protectants				
Fecal Incontinence • Toileting plan • Soiled checks				
Skin Condition Check • Intactness • Color • Sensation • Temperature				
Treatment • Physician-prescribed regimen • Appropriateness to wound staging • Treatment reassessment timeframe				
Pain • Screen for pain related to ulcer • Choose appropriate pain med • Provide regular pain med administration • Reassess effectiveness of med • Assess/treat side effects • Change or cease pain med as needed				

* To determine if a patient has bottomed out, the caregiver should place his or her outstretched hand (palm up) under the mattress overlay below the existing pressure ulcer or that part of the body at risk for pressure formation. If the caregiver can feel that the support material is less than an inch thick at this site, the patient has bottomed out.