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New Pressure Ulcer Status Tool

Through the Delphi Technique, a new tool was developed to assess the status of pressure ulcers. Further refinement of the tool's validity and reliability is on-going and will be reported along with a description of the Delphi Technique in a later issue of *Decubitus*.

PRESSURE SORE STATUS TOOL  
Instructions for Use

General Guidelines:

This tool consists of 13 items designed to determine pressure sore status. Fill out the attached rating sheet to assess a pressure sore's status after reading the definitions and methods of assessment described below. Evaluate the pressure sore once a week and whenever a change occurs in the wound. Rate the pressure sore according to each item by picking the response that best describes the wound and entering that score in the items score column for the appropriate data. When you have rated the pressure sore on all items, determine the total score by adding together the 12-item scores. The HIGHER the total score, the more severe the pressure sore status.

Specific Instructions:

1. **Size:** Determine by measuring the longest and the widest aspect of the exposed wound surface in centimeters; multiply length x width.
2. **Depth:** Partial thickness involves the epidermal and the dermal skin layers. Full thickness involves deeper tissue layers — subcutaneous fat, muscle, tendon and bone.
3. **Edges:** Edges that are not attached to wound base describes a wound with sides or walls, as well as edges and a base. Edges that are attached and flush with wound base describes wounds that do not have sides or walls. Rolled under, thickened edges are soft to firm to touch. Hyperkeratosis is the callous-like tissue formation around the wound. Fibrotic, scarred edges may feel hard to touch.
4. **Undermining:** Assess by inserting a cotton-tipped applicator under the wound edge, advance it as far as it will go without using undue force, raise the tip of the applicator so it may be seen or felt on the surface of the skin, mark the surface with a pen and measure the distance from the mark on the skin to the edge of the wound, and use a transparent, circular measuring guide divided into four pie-shaped quadrants to help determine percent of wound involved.
5. **Necrotic Tissue Types:** Yellow slough may vary from a thin, mucinous substance to thicker loose, stringy necrotic tissue. Fibrin slough may be normal in some phases of wound healing and may appear

as a paler yellow substance scattered through the wound bed. Eschar may be soft or hard and varies in color from light to dark black.

6. **Necrotic Tissue Amount:** Use a transparent, circular measuring guide divided into four pie-shaped quadrants to help determine percent of wound involved.

Not adherent = loosely attached to wound tissue.

Adherent = necrotic tissue is firmly attached to tissue in center or base of the wound.

Firmly adherent = necrotic tissue is attached to the edges of the wound.

7. **Exudate Type:** Some dressings interact with wound drainage to produce a gel or liquid, so before assessing exudate, gently cleanse the wound with normal saline or water.

8. **Exudate Amount:**

Scant, moist = defined as wound with no measurable exudate but is moist.

Small = defined as 1 to 4 cm sq. on gauze-type dressing once to BID or 1 to 4 cm sq. on semi-permeable membrane or hydrocolloid with dressing changed every four days.

Moderate = defined as 4 to 10 cm sq. on gauze-type dressing BID to TID or 4 to 10 cm sq. on semi-permeable membrane or hydrocolloid with dressing changed every four days.

Large = defined as 10 cm sq. on gauze-type dressing changed every 4 hours or more or 10 cm sq. on semi-permeable or hydrocolloid with dressing changed every 2 days or more frequently.

9. **Skin Color Surrounding Wound:** Dark-skinned persons show the colors bright red and dark red as a deepening of normal ethnic skin color. As healing occurs in dark-skinned persons, the new skin is pink in color and may never darken.

10. **Peripheral Tissue Edema:** Non-pitting edema may appear as skin that is shiny and taut. Pitting edema can be identified by firmly pressing a finger down into the tissues and waiting for five seconds; upon release of the pressure, the tissues fail to resume previous position and an indentation can be seen.

11. **Peripheral Tissue Induration:** Induration is defined as abnormal firmness of tissues with definite margins and may be assessed by attempting to gently pinch the tissues. Induration results in an inability to pinch the tissues. Use a transparent, circular measuring guide divided into four pie-shaped

