

# CP-SKIN — Skin & Wound Score (Group W)

Pressure injury and wound risk. **Links to:** W1–W7, S5

Patient: \_\_\_\_\_ ID: \_\_\_\_\_ Date/Time: \_\_\_\_\_ Nurse: \_\_\_\_\_

| Item                        | 0                      | 1                         | 2                                | Score |
|-----------------------------|------------------------|---------------------------|----------------------------------|-------|
| <b>Moves in bed</b>         | Changes position alone | Needs help sometimes      | Cannot change position           |       |
| <b>Skin moisture</b>        | Dry                    | Sometimes damp            | Often wet (sweat, urine)         |       |
| <b>Nutrition</b>            | Eats well              | Eats half                 | Eats little                      |       |
| <b>Skin over bony areas</b> | Intact                 | Red but fades on pressing | Red that does not fade or broken |       |
| <b>Wound (if present)</b>   | Healing, clean         | Slow, some drainage       | Smell, pus, spreading red        |       |
| <b>TOTAL</b>                |                        |                           |                                  |       |

| Score | Level  | Action                                                |
|-------|--------|-------------------------------------------------------|
| 0–2   | Low    | Check skin daily                                      |
| 3–5   | Medium | Turn every 2–4 h, pressure-relief mattress            |
| ≥6    | High   | Turn every 2 h, wound plan, tissue-viability referral |

⚠ **Red flags — escalate at once regardless of score:** Spreading redness with fever

Score each item 0, 1 or 2 · add the total · follow the action band · any red flag = escalate (SBAR) · rescore after each intervention and at least once per shift.

**Nursing notes / action taken:**

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Original tool, not yet validated. Pilot and review with clinicians before clinical decisions. Supports, but does not replace, clinical judgment, validated scales and local policy.