Pressure Management Assessment Tool (PMAT)

Version 1.0 March 2012

Client name: _____ Date: _____

PART 1: INTERVIEW

The following section should be completed by a clinician. Please have your client and/or caregivers involved with pressure management care answer all of the questions below. All information collected in this section is meant to be client and/or caregiver report only. Part 2 will involve actual evaluation of client performance related to each of the areas discussed in Part 1.

Pressure Ulcer History

1. Where is (are) your current pressure ulcer(s) located? Check all that apply:

LOCATION	YES		NO	LIKELY CAUSE	LENGTH OF TIME WITH ULCER	HAS ULCER DETERIORATED OR IMPROVED SINCE DEVELOPING?
Ischial Tuberosity (buttock bone)	**Right** ☐	**Left** ☐				
Greater Trochanter (hip bone)	**Right** ☐	**Left** ☐				
Coccyx (tailbone)						
Sacrum (above tailbone)						
Heel	**Right** ☐	**Left** ☐				
Other areas of lower limb ***Describe:***	**Right** ☐	**Left** ☐				
Elbow	**Right** ☐	**Left** ☐				
Scapula (shoulder blade)	**Right** ☐	**Left** ☐				
Occiput (back of head)						
Other ***Describe:***						

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2.	**Have you ever had other pressure ulcers in the past? YES ____ NO ____** **If no, please proceed to the next section on *physical status*.** **If yes, please answer the following questions regarding your previous pressure ulcers:**

LOCATION	YES		NO	LIKELY CAUSE	LENGTH OF TIME WITH ULCER	METHOD USED TO HEAL PRESSURE ULCER
Ischial Tuberosity (buttock bone)	**Right** ☐	**Left** ☐				
Greater Trochanter (hip bone)	**Right** ☐	**Left** ☐				
Coccyx (tailbone)						
Sacrum (above tailbone)						
Heel	**Right** ☐	**Left** ☐				
Other areas of lower limb ***Describe:***	**Right** ☐	**Left** ☐				
Elbow	**Right** ☐	**Left** ☐				
Scapula (shoulder blade)	**Right** ☐	**Left** ☐				
Occiput (back of head)						
Other ***Describe:***						

Physical Status		
1.	**What is your medical diagnosis?**	
2.	**Do you experience any pain related to your pressure ulcer?**	**YES ____ NO ____** **If yes, what do you do to manage your pain?**
3.	**Do you have full sensation (feeling) throughout your body?**	**YES ____ NO ____** **If yes, please proceed to the next question** **If no, please indicate which parts of your body do not have full sensation:**

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4.	**Do you have any secondary medical conditions that affect your circulation (e.g. Diabetes, Peripheral Vascular Disease)?**	**YES ____ NO ____** **If no, please proceed to the next question** **If yes, please indicate what medical condition(s) you have:**
5.	**Do you have decreased strength in any parts of your body?**	**YES ____ NO ____** **If no, please proceed to the next question** **If yes, please indicate which parts of your body have decreased strength:**
6.	**Do you have spasticity?**	**YES ____ NO ____** **If no, please proceed to the next section on *positioning and repositioning strategies*** **If yes, please answer the remaining questions in this section**
6a)	**What part(s) of your body moves when you experience spasms?**	
6b)	**What types of things trigger your spasms to occur?**	
6c)	**Do your spasms make it difficult for you to stay positioned properly in any of the following situations (check all that apply):**	**☐ Lying in bed** **☐ Sitting in your wheelchair** **☐ Sitting on your toilet or commode** **☐ In your bathtub or on a bathseat** **☐ Travelling in a vehicle** **☐ Propelling or driving your wheelchair** **☐ Other (describe):**
6d)	**What do you do to help your spasms stop once they occur?**	
6e)	**Do you take medication to help reduce your spasms?**	**YES ____ NO ____** **If yes, please list medication and dose:** **If no, are there any medications you tried in the past to help reduce your spasms? YES ____ NO ____** **If yes, please list medication(s) and indicate reason for discontinuing use:**

Positioning and Repositioning Strategies

POSITIONING AND REPOSITIONING IN BED

1.	**How long do you spend in bed on an average day?**	**_____ Total hours/day**
2.	**Do you stay in bed this entire time without a break?**	**YES ____ NO ____** **If no, please describe how you break up your time in bed over a 24 hour period:**

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3.	**Do you reposition yourself or have others reposition you for the purpose of *pressure redistribution (i.e. shifting or relieving pressure away from specific parts of your body)* while in bed?**	**YES ____ NO ____** **If no, meaning you do not reposition yourself for the purpose of pressure redistribution, why not?** **If no, please proceed to the next section on *positioning and repositioning in wheelchair*** **If yes, please answer the remaining questions in this section**
4.	**Please indicate what types of repositioning movements you perform (or others perform for you) while in bed (check all that apply):**	**☐ turning** **☐ shifting up and down on the bed surface** **☐ shifting left and right on the bed surface** **☐ other (describe):**

5. Which of the following positions do you alternate between while in bed (check all that apply):

BED POSITION	YES	NO	DESCRIBE BODY POSITION	LENGTH OF TIME IN THIS POSITION	EQUIPMENT USED
On your back *without* the head of the bed raised					
On your back *with* the head of the bed raised _____ degrees					
On your right side					
On your left side					
On your stomach					
Sitting up in bed					

POSITIONING AND REPOSITIONING IN WHEELCHAIR

1.	**How long do you sit in your wheelchair on an average day?**	**____ Total hours/day**
2.	**Do you stay in your wheelchair this entire time without a break?**	**YES ____ NO ____** **If no, please describe how you break up your time in your wheelchair over a 24 hour period:**

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3.	**Do you reposition yourself or have others reposition you for the purpose of *pressure redistribution* while sitting in your wheelchair?**	**YES ____ NO ____** **If no, meaning you do not reposition yourself for the purpose of pressure redistribution, why not?** **If no, please proceed to the next section on *positioning and repositioning while toileting*** **If yes, please answer the remaining questions in this section**
4.	**Please indicate what types of repositioning movements you perform (or others perform for you) while in your wheelchair (check all that apply):**	**☐ leaning in different directions** **☐ shifting in different directions** **☐ pushing up** **☐ operating dynamic seat functions through your wheelchair** **☐ other (describe):**
5.	**How frequently do you move for the purpose of *pressure redistribution* while in your wheelchair?**	**____ times/hour**
6.	**How long do you hold each *pressure redistribution* movement that you perform in your wheelchair?**	**_____ seconds OR _____ minutes**

POSITIONING AND REPOSITIONING WHILE TOILETING

1.	**How long do you sit on your toileting equipment at one time?**	**_____ minutes OR _____ hours**
2.	**Do you reposition yourself or have others reposition you for the purpose of *pressure redistribution* while toileting?**	**YES ____ NO ____** **If no, meaning you do not reposition yourself for the purpose of pressure redistribution, why not?** **If no, please proceed to the next section on *positioning and repositioning while bathing*** **If yes, answer the next question**
3.	**Please indicate what type of repositioning movements you perform (or others perform for you) while toileting (check all that apply):**	**☐ leaning in different directions** **☐ shifting in different directions** **☐ pushing up** **☐ other (describe):**

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POSITIONING AND REPOSITIONING WHILE BATHING		
1.	**How long do you use your bathing equipment at one time?**	**_____ minutes OR _____ hours**
2.	**Do you reposition yourself or have others reposition you for the purpose of *pressure redistribution* while bathing?**	**YES ____ NO ____** **If no, meaning you do not reposition yourself for the purpose of pressure redistribution, why not?** **If no, please proceed to the next section on *positioning and repositioning on other sitting surfaces*** **If yes, answer the remaining questions in this section**
3.	**Please indicate what type of repositioning movements you perform (or others perform for you) while bathing (check all that apply):**	**☐ leaning in different directions** **☐ shifting in different directions** **☐ pushing up** **☐ other (describe):**
POSITIONING AND REPOSITIONING ON OTHER SITTING SURFACES		
1.	**Are there any other sitting surfaces that you sit on over a 24 hour period (e.g. sofa)?**	**YES ____ NO ____** **If no, please proceed to the next section on transportation** **If yes, please answer the remaining questions in this section**
2.	**How long do you sit on other sitting surfaces at one time?**	**_____ minutes OR _____ hours**
3.	**Do you reposition yourself or have others reposition you for the purpose of *pressure redistribution* while using other sitting surfaces?**	**YES ____ NO ____** **If no, meaning you do not reposition yourself for the purpose of pressure redistribution, why not?** **If no, please proceed to the next section on *positioning and repositioning during transportation*** **If yes, answer the remaining questions in this section**
4.	**Please indicate what type of repositioning movements you perform (or others perform for you) while using other sitting surfaces (check all that apply):**	**☐ leaning in different directions** **☐ shifting in different directions** **☐ pushing up** **☐ other (describe):**
POSITIONING AND REPOSITIONING DURING TRANSPORTATION		
1.	**Do you transfer out of your wheelchair when using transportation?**	**YES ____ NO ____** **If no, please proceed to the next section on *support surfaces*** **If yes, please answer the remaining questions in this section**
2.	**How long do you sit on the transportation surface at one time?**	**_____ minutes OR _____ hours**
3.	**Do you reposition yourself or have others reposition you for the purpose of *pressure redistribution* while sitting on the transportation surface?**	**YES ____ NO ____** **If no, meaning you do not reposition yourself for the purpose of pressure redistribution, why not?** **If no, please proceed to the next section on *support surfaces*** **If yes, answer the remaining question in this section**

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4.	**Please indicate what type of repositioning movements you perform (or others perform for you) during transportation (check all that apply):**	**☐ leaning in different directions** **☐ shifting in different directions** **☐ pushing up** **☐ other (describe):**

Support Surfaces		
BED AND MATTRESS		
1.	**What type of bed and mattress do you use?**	**BED:** **MATTRESS:**
2.	**Do you use any other equipment to assist with positioning or repositioning while in bed?**	**YES ____ NO ____** **If yes, list equipment used:**
WHEELCHAIR AND SEATING COMPONENTS		
1.	**What type of wheelchair, cushion and back support do you use?**	**WHEELCHAIR:** **CUSHION:** **BACK SUPPORT:**
2.	**Do you use any other equipment to assist with positioning or repositioning while in your wheelchair?**	**YES ____ NO ____** **If yes, list equipment used:**
TOILETING EQUIPMENT		
1.	**What type of equipment do you use for toileting?**	**☐ toilet** **☐ commode** **☐ other (describe):**
2.	**Do you use any other equipment to assist with positioning or repositioning while toileting?**	**YES ____ NO ____** **If yes, list equipment used:**
3.	**Is there padding on the surface of your toileting equipment?**	**YES ____ NO ____**
BATHING EQUIPMENT		
1.	**What type of equipment do you use for bathing?**	**☐ bathtub** **☐ bath seat or bench** **☐ other (describe):**
2.	**Do you use any other equipment to assist with positioning or repositioning while bathing?**	**YES ____ NO ____** **If yes, list equipment used:**
3.	**Is there padding on the surface of your bathing equipment?**	**YES ____ NO ____**

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EQUIPMENT FOR OTHER SITTING SURFACES		
1.	**What equipment do you sit on when using other sitting surfaces not already mentioned?**	**List other sitting surface equipment:**
2.	**Do you use any other equipment to assist with positioning or repositioning while on other sitting surfaces?**	**YES ____ NO ____** **If yes, list equipment used:**
3.	**Is there padding on these other sitting surfaces?**	**YES ____ NO ____**
TRANSPORTATION EQUIPMENT		
1.	**What equipment do you sit on during transportation?**	**☐ standard seat in vehicle** **☐ additional padding/cushion on top of standard vehicle seat** **Type of padding/cushion:** **☐ other (describe):**
2.	**Do you use any other equipment to assist with positioning or repositioning during transportation?**	**YES ____ NO ____** **If yes, list equipment used:**

Mobility, Friction and Shear						
TRANSFERS						
1.	**How many transfers do you typically perform in a day? (one transfer = movement in ONE direction)**			**____ transfers/day**		
2.	**Do you always transfer in the same direction to get from surface to surface?**			**YES ____ NO ____** **If yes, which direction?**		
3.	**Do you perform any of the following transfers (check all that apply):**	TRANSFER	YES	NO	TRANSFER METHOD	EQUIPMENT USED
		BED				
		WHEELCHAIR				
		TOILET OR COMMODE				
		BATHTUB OR SHOWER				
		VEHICLE SEAT				
		OTHER ***Describe:***				

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POSITIONAL STABILITY		
1.	**Do you ever slide out of position on any of the support surfaces you use over a 24 hour period?**	**YES ____ NO ____** **If yes, which surfaces do you lose position on?** **If yes, how frequently do you need to reposition to get back into the correct spot on these surfaces? ____ times/hour**
WHEELCHAIR MOBILITY		
1.	**Do you ever slide out of position while propelling or driving your wheelchair?**	**YES ____ NO ____** **If yes, how frequently do you need to reposition to get back into the correct spot in your wheelchair?** **____ times/hour**
TRANSITIONAL MOVEMENTS		
1.	**Please describe how you manage (or how others manage) moving between different positions on all the support surfaces you use over 24 hours (check all that apply):**	**☐ sliding along support surface to reposition** **☐ lifting up away from support surface to reposition** **☐ other (describe):**

Heat and Moisture		
BLADDER AND BOWEL MANAGEMENT		
1.	**Are you currently on a bladder routine?**	**YES ____ NO ____** **If yes, please describe:**
2.	**How long does it take to complete your bladder routine?**	
3.	**Do you ever have bladder incontinence?**	**YES ____ NO ____** **If yes, how is the incontinence managed?** **If yes, how frequently does it occur?**
4.	**Are you currently on a bowel routine?**	**YES ____ NO ____** **If yes, please describe:**
5.	**How long does it take to complete your bowel routine?**	
6.	**Do you ever have bowel incontinence?**	**YES ____ NO ____** **If yes, how is the incontinence managed?** **If yes, how frequently does it occur?**
7.	**Do you ever feel excessively hot for extended periods of time over 24 hours?**	**YES ____ NO ____** **If yes, what do you do to reduce your body temperature?**

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8.	**Does your body tend to sweat over the course of 24 hours?**	**YES ____ NO ____** **If yes, what do you do to minimize the amount of moisture caused by this sweat?**

Self Management Behaviours			
SKIN CHECKS			
1.	**Do you perform skin checks?**	**YES ____ NO ____** **If no, why not?** **If no, please proceed to the next section on *clothing*** **If yes, answer the remaining questions in this section**	
2.	**Who performs skin checks?**	**☐ self ☐ health care professional** **☐ caregiver ☐ other (describe):**	
3.	**When are skin checks typically performed?**		
4.	**How frequently do skin checks occur?**		
5.	**What areas of your skin get checked? Please list all areas:**		
6.	**What do you look or feel for when performing a skin check?**		
7.	**What signs would indicate to you that there is/are an area of concern during a skin check?**		
8.	**What do you typically do when you come across something that concerns you during a skin check?**		
CLOTHING			
1.	**Please indicate the type of lower body clothing you typically wear over a 24 hour period:**	**Pants or shorts**	
		Footwear	
		Under garments	
		Other	

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2.	**Please indicate the type of upper body clothing you typically wear over a 24 hour period:**	**Shirts**	
		Outerwear	
		Under Garments	
		Other	
3.	**Please indicate any clothing accessories that you typically wear over a 24 hour period (e.g. belts):**		

SMOKING

1.	**Do you smoke?**	**YES ____ NO ____** **If yes, how much do you smoke in a typical day?**

Nutrition

1.	**Have you seen a dietitian since developing your current pressure ulcer(s)?**	**YES ____ NO ____** **If no, have you ever been seen by a dietitian in the past?**
2.	**Please describe the types of food that typically make up each meal and snack that you eat over a 24 hour period:**	
3.	**Please describe the types of fluid that you typically drink over a 24 hour period:**	
4.	**How much fluid do you typically drink over 24 hours?**	**____ cups/day**
5.	**When do you usually eat your meals and snacks throughout the day?**	
6.	**Do you have any concerns related to your ability to prepare meals for yourself or have others prepare meals for you?**	**YES ____ NO ____** **If yes, please describe concerns:**

END OF PART 1

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PART 2: ASSESSMENT

The following section should be completed by a clinician. Please have your client and/or caregivers involved with pressure management care perform the following assessments that are relevant to their situation. All information collected in this section is meant to be based on actual client and/or caregiver performance. Part 2 should be used to cross reference and correlate with responses provided in Part 1.

Pressure Ulcer Evaluation

Observe client performing (or providing direction to complete) a skin check and answer the following questions:

1.	**Is client capable of performing (or directing) a skin check?**	**YES ____ NO ____**
2.	**Can client describe what they should be looking for?**	**YES ____ NO ____**
3.	**Can client describe what they should be feeling for?**	**YES ____ NO ____**
4.	**Can client accurately identify any areas of concern?**	**YES ____ NO ____**
5.	SKIN CHECK: Complete a visual skin inspection and palpate bony areas to confirm location of wound and record relevant information below:	

LOCATION	STAGE	SIZE	DESCRIPTION
Right ischial tuberosity			
Left ischial tuberosity			
Right greater trochanter			
Left greater trochanter			
Coccyx			
Sacrum			
Right heel			
Left heel			
Other areas of lower limbs			
Right scapula			
Left scapula			
Occiput			
Other areas of upper body			

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6.	Please indicate if any of the following are found during skin check:	☐ **drainage from wound** ☐ **moisture from sweat** ☐ **moisture from incontinence** ☐ **other moisture (describe):** ☐ **heat at skin surface** ☐ **clothing accessories referencing to wound location (e.g. seams, buckles, buttons, zippers, pockets)** ☐ **bruises, scrapes, blisters, or tears**

Positioning Evaluation

Based on the information obtained in Part 1, evaluate client in each of the positions they report using as well as those positions that could be beneficial for them to use more effectively. Palpate and visually inspect ulcer in each position to confirm offloading.

SURFACE TO BE EVALUATED	POSITIONS TO BE EVALUATED	LOADING AT PRESSURE ULCER LOCATION		COMMENTS
		LOADED	OFFLOADED	
Bed	**Supine (flat)**			
	Supine with head of bed raised			
	Right side lying			
	Left side lying			
	Prone			
	Sitting up in bed			
Wheelchair	**Resting posture**			
Toilet and/or commode	**Resting posture**			
Bathtub or bathseat	**Resting posture**			
Vehicle	**Resting posture**			
Other sitting surfaces ***Describe:***	**Resting posture**			

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Postural Screen

Observe client when sitting in their wheelchair as well as other relevant sitting surfaces and describe postural tendencies and asymmetries below:

Pelvis and hips	
Lower extremities	
Trunk	
Upper extremities	
Head and neck	

Repositioning Evaluation

Based on the information obtained in Part 1, evaluate client doing each of the repositioning movements they report performing as well as those movements that could be beneficial for them to do more effectively. Palpate and visually inspect ulcer during each movement to confirm effectiveness of movement.

SUPPORT SURFACE	MOVEMENT DEMONSTRATED	CAPABLE OF MOVEMENT?		MOVEMENT IS EFFECTIVE?	
		YES	NO	YES	NO
Bed	**Turning**				
	Shifting up, down & to each side				
	Transitioning between sitting and lying				
Wheelchair	**Forward lean**				
	Upper body push-up				
	Right side lean				
	Left side lean				
	Dynamic tilt in space (____ °)				
	Other dynamic seat functions Describe:				
Toilet or commode	**Pressure redistribution movement**				
	Simulated pericare tasks				
Bathtub or bathseat	**Pressure redistribution movement**				
	Simulated bathing tasks				
Vehicle	**Pressure redistribution movement**				
	Simulated driving or passenger tasks				
Other sitting surfaces ***Describe:***	**Simulated tasks on these surfaces**				

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Support Surface Evaluation

Visually inspect each piece of equipment that is relevant to client's situation to determine appropriateness

SUPPORT SURFACE	TYPE OF EQUIPMENT	SET UP PROPERLY?		IN GOOD CONDITION?	
		YES	NO	YES	NO
Bed					
Mattress					
Wheelchair					
Cushion					
Back support					
Toilet and/or commode					
Bathtub or bathseat					
Vehicle seat					
Other sitting surfaces					

Mobility, Friction and Shear Evaluation

Based on the information obtained in Part 1, evaluate client doing each of the movements they report performing as well as those movements that could be beneficial for them to do more effectively

1.	**Please indicate the type(s) of transfers client performs (or that others assist with)**	**Check all that apply:** ☐ **Full body lift performed by caregivers** ☐ **Mechanical lift** ☐ **Sliding board** ☐ **Side transfer with partial lift using upper extremities only** ☐ **Side transfer with full lift using upper extremities only** ☐ **Scoot pivot** ☐ **Standing pivot** ☐ **Other (describe):**

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2.	Observe client performing the following movements that are relevant to their situation and record findings below:				
MOVEMENT DEMONSTRATED	**MOVEMENT EFFECTIVE?**		**SHEAR, FRICTION, OR TRAUMA WITH MOVEMENT?**		**DESCRIBE ANY ADDITIONAL CONCERNS**
	YES	**NO**	**YES**	**NO**	
Bed transfer					
Wheelchair transfer					
Toilet or commode transfer					
Bathtub or bathseat transfer					
Vehicle transfer					
Other transfers					
Manual wheelchair propulsion					
Power wheelchair driving					

Cognitive Screen

Based on information obtained in Part 1 as well as results from Part 2, list any concerns in the following areas that may affect client's ability to carry out pressure management recommendations

☐ **Insight** ☐ **Problem solving** ☐ **Awareness** ☐ **Comprehension** ☐ **Memory** ☐ **Behaviour** ☐ **Attitude** ☐ **Lifestyle choice** ☐ **Other (describe):**	**Describe concerns below:**

END OF PART 2

Client: _____ Date: _____

PART 3: FINDINGS

The following section should be completed by a clinician. After reviewing the results from Part 1 and Part 2 of the PMAT, please provide your general impression of the main factors that are currently contributing to client's pressure ulcer(s) as well as the strategies that will need to be implemented in order to eliminate these causative factors (assessment summary).
When providing recommendations please be specific and delegate the specific people that need to be involved to ensure each recommendation can be implemented.

ASSESSMENT SUMMARY:

RECOMMENDATIONS:

Report completed by:

PMAT disclaimer: **this is a clinical evaluation tool that continues to be developed and modified on a regular basis. If you want to ensure you are always using the most current version of this tool please contact the author at jlbirt@hsc.mb.ca.**