

Multiple Data Collection Points

CHART ABSTRACTION

CI-Pressure Injuries ~~Ulcers~~-MULT

RHSCIR ID #

Pressure Injury Assessment

☐ Acute care (or Emergency)

☐ Rehab care provided

☐ Information unavailable, unable to complete. Specify Reason: _____

☐ Information unavailable, unable to complete. Specify Reason: _____

1. **Was an initial pressure injury risk assessment completed using a validated, standardized risk assessment tool (Spinal Cord Injury Pressure Ulcer Scale (SCIPUS), Braden, etc.) within 72 hours of admission?**
 - ☐ Yes
 - ☐ No (*please go to question 3*)
2. **Based on the admission pressure injury risk assessment, were interventions provided and documented within 24 hours of the assessment?** (this includes but is not limited to: team ~~communication, change~~ communication, change of mattresses or wheelchair cushion, changes to frequency of turns, changes to frequency of skin checks, patient and family education, use of therapeutic small devices (e.g. heel lift wedges) or use of prophylactics (e.g. skin protection garments, dressings))
 - ☐ Yes
 - ☐ No
 - ☐ Considered not to be at risk (Braden more than 15; SCIPUS less than 2)
3. **After seven days of admission, was the patient reassessed using a validated, standardized risk assessment tool (SCIPUS, Braden, etc.)?** If more than one reassessment after seven days, use first available.
 - ☐ Yes
 - ☐ ~~No~~ No (*please go to question 5*)
4. **Based on the reassessed pressure injury risk assessment (from question 3), were interventions provided and documented within 24 hours of the assessment?** (this includes but is not limited to: team communication, change of diet, change of mattresses or wheelchair cushion, changes to frequency of turns, changes to frequency of skin checks, patient and family education, use of therapeutic small devices (e.g. heel lift wedges) or use of prophylactics (e.g. skin protection garments, dressings))
 - ☐ Yes
 - ☐ No
 - ☐ Considered not to be at risk

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☐ Clinician documented no additional intervention required

5. Any pressure injuries on admission or acquired during stay at facility?

☐ Yes [\(please go to question 6\)](#)☐☐ No [\(skip to Data Collection Details\)](#)

RHSCIR ID # _____
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6. Pressure Injury Tracking Table (See Definitions and Reference Tables on page 3)

		Admission Assessment (within 7 days after admission)		Discharge Assessment (within 7 days prior to discharge from facility)	
Identifier:	Onset:	Stage	Status	Stage	Status
Pressure injury # (to distinguish pressure injuries across stay):	<input type="checkbox"/> Prior to Admission <input type="checkbox"/> During stay (choose N/A for admission assessment)	<input type="checkbox"/> DTPI <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> U <input type="checkbox"/> N/A (No pressure injury at admission) <input type="checkbox"/> Unknown	Closed? (stage II, III, IV, U only) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Should be WORST stage during stay <input type="checkbox"/> DTPI <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> U <input type="checkbox"/> Unknown	Closed? (stage II, III, IV, U only) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Location (enter ONE location code from table below):					
Pressure injury # (to distinguish pressure injuries across stay):	<input type="checkbox"/> Prior to Admission <input type="checkbox"/> During stay (choose N/A for admission assessment)	<input type="checkbox"/> DTPI <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> U <input type="checkbox"/> N/A (No pressure injury at admission) <input type="checkbox"/> Unknown	Closed? (stage II, III, IV, U only) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Should be WORST stage during stay <input type="checkbox"/> DTPI <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> U <input type="checkbox"/> Unknown	Closed? (stage II, III, IV, U only) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Location (enter ONE location code from table below):					
Pressure injury # (to distinguish pressure injuries across stay):	<input type="checkbox"/> Prior to Admission <input type="checkbox"/> During stay (choose N/A for admission assessment)	<input type="checkbox"/> DTPI <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> U <input type="checkbox"/> N/A (No pressure injury at admission) <input type="checkbox"/> Unknown	Closed? (stage II, III, IV, U only) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Should be WORST stage during stay <input type="checkbox"/> DTPI <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> U <input type="checkbox"/> Unknown	Closed? (stage II, III, IV, U only) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Location (enter ONE location code from table below):					

RHSCIR ID # _____

RHSCIR ID # _____

☐ Unknown

☐ Unknown

If the participant has more than 3 pressure ~~injuries~~ulcers, please complete an additional CI – Pressure ~~Injuries~~Ulcers-MULT form. On the GRP, all pressure injury information can be entered into one table.

Reference Table / Legend (Please use reference tables below to complete the Pressure ~~Injuries~~Ulcer Tracking Table)

Location	Location Code		
	Right	Midline	Left
Occiput	A	B	C
Ear	D		E
	F		G
Elbow	H		I
Ribs	J		K
Spinous process	L	M	N
Iliac crest	O		P
Sacral	Q	R	S
Ischial tuberosity	T		U
Trochanter	V		W
Genitals	X	Y	Z
Knee	AA		BB
Malleolus	CC		DD
Heel	EE		FF
Foot	GG		HH
Other Location: _____	II	JJ	KK

NPUAP Pressure ~~Ulcer~~Injury Stages (2016 update): (Staging and illustrations can be found at: www.npuap.org/resources/educational-and-clinical-resources/)

Deep Tissue Pressure Injury (DTPI):	Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. Previous terminology was "suspected deep tissue injury", which this new definition encompasses; therefore SDTI can be included here.
I	Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.
II	Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present.
III	Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present.
IV	Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location.
<u>Unstageable Pressure Injury (U)</u>	Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar.

Note: Please do not use reverse staging to document a healing pressure injury. A Stage IV pressure injury cannot become a Stage III, Stage II, and/or subsequently Stage I. When a Stage IV injury has healed it should be classified as a healed Stage IV pressure injury not a Stage 0 pressure ~~injury~~ulcer. Reverse staging does not accurately characterize what is physiologically occurring in the ~~injury~~ulcer.

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Data Collection Details

Collected by: (please print name)		Initial Here:		Date Abstraction Completed:	YYYY-MM-DD
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