

Pressure Ulcer Assessment

Data Collection Point

(check ONE only):

- Acute care (or Emergency and Acute care) provided
- Rehab care provided

Information unavailable, unable to complete. Specify Reason: _____

1. Any pressure ulcers during stay at facility? (please include any ulcers present on admission to the facility)

- Yes
- No (skip to Data Collection Details on page 3)

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

Definitions related to pressure ulcer form:

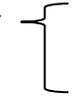
Closed: Ulcer is covered with epithelium (even a very thin layer) with no drainage

Healing: Decreasing in size, depth, amount of necrotic tissue or exudates, or increasing granulation tissue, etc. (see below)

Resolved: Skin is intact and no longer red, purple, indurated, painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

Pressure Ulcer Assessment

1. Was a skin integrity risk assessment completed at admission?

- Yes → 
 - SCIPUS (Score: ____)
 - Braden (Score: ____)
 - Other (specify): _____
- No

2. Was a pre-albumin level tested?

- This is a proxy for general nutritional status.*
- Yes → **Level: ____ (g/L)**
 - No

3. Any pressure ulcers at admission assessment? (please include any ulcers present on admission to the facility)

- Yes → Complete Sections **A** and **B** of table below at admission for each ulcer and Section **C** at discharge.
- No

Assessment Date: ____ / ____ / ____
 YYYY - MM - DD

Clinician Name/Signature: _____

4. Any pressure ulcers following admission to the facility (i.e. during stay)?

- Yes → Complete Sections **A** **B** **C** at discharge
- No

Assessment Date: ____ / ____ / ____
 YYYY - MM - DD

Clinician Name/Signature: _____

5. Pressure Ulcer Tracking Table (See Definitions and Reference Tables on page 3)

Pressure Ulcer Identifier A		Admission Assessment (within 7 days after admission) B		Discharge Assessment (within 7 days prior to discharge from facility) C			
Location (enter ONE location code from table above): <input type="text"/>	Onset: <input type="checkbox"/> Prior to Admission <input type="checkbox"/> During stay	Stage at Admission to Facility: <input type="checkbox"/> SDTI <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 ulcer at admission) <input type="checkbox"/> Unknown	Qualifier at Admission If Stage II, III, or IV: Closed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Healing? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Stage at D/C from Facility: <input type="checkbox"/> SDTI <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> Unknown	Qualifier at Discharge if Stage SDTI, I, II, III, or IV: Resolved? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Closed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Healing? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	What type of non-surgical treatment was used? <input type="checkbox"/> Biophysical (ultrasound, Estim, etc.) <input type="checkbox"/> Pressure redistribution (sleeping and seating surface changes) <input type="checkbox"/> Dressings (including VAC dressing, occlusive, etc.) <input type="checkbox"/> Minor/bedside debridement <input type="checkbox"/> Other (specify): _____	Has the ulcer been surgically treated? (Includes major surgical methods such as direct closure, skin grafting, rotation flaps or debridement of ulcer surface; do not include minor debridement [i.e. bedside debridement by RN/OT/PT].) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, date surgically treated: _____/_____/_____ YYYY / MM / DD
	Date of Appearance: ____/____/____ YYYY / MM / DD <input type="checkbox"/> Unknown						

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

Reference Table / Legend (Please use reference tables below to complete the Pressure 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 Stages: (Staging and illustrations can be found at: www.npuap.org/resources/educational-and-clinical-resources/)	
SDTI (Suspected Deep Tissue Injury):	Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure/and or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.
I	Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area.
II	Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.
III	Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.
IV	Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.
V	Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown, or black) in the wound bed.
Note: Please do not use reverse staging to document a healing pressure ulcer. A Stage IV pressure ulcer cannot become a Stage III, Stage II, and/or subsequently Stage I. When a Stage IV ulcer has healed it should be classified as a healed Stage IV pressure ulcer not a Stage 0 pressure ulcer. Reverse staging does not accurately characterize what is physiologically occurring in the ulcer.	

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