

## **Examples of data collection and audit tools used within inpatient and community settings**

**Disclaimer: These tools have not been formally evaluated nor endorsed by the ACSQHC.**

The following tools have been provided as examples which can be adapted to suit at a local level

These example tools have been developed by Hunter New England Local Health District (HNELHD), originally based from the Victorian PUPP survey tool and later compared to the tools developed by WoundsWest:

<http://www.health.wa.gov.au/WoundsWest/education/index.cfm>.

Attached tools:

Community Wound Survey CHIME Audit Tool 2013

Adult Wound Audit Tool 2013

Community Wound Audit Tool 2013

## **Examples of paediatric pressure injuring risk assessment tools used within Australia**

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The following tools have been provided as examples which can be adapted to suit at a local level.

### **Braden Q Scale**

This is an adaptation of the Braden Scale for paediatrics which has been commonly used within Australia. Relevant literature includes:

- Curley, M.A.Q., Razmus, I.S., Roberts, K.E., & Wypij, D. (2003) Predicting pressure ulcer risk in pediatric patients. *Nursing Research*, 52(1), 22-33.
- Curley, M.A.Q., Quigley, S.M., & Lin, M. (2003) Pressure ulcers in pediatric intensive care: Incidence and associated factors. *Pediatric Critical Care Medicine*, 4 (3),284-290.
- Lund, C.H., Kuller, J., Lane, A.T., Lott, J.W., Raines, D.A., & Thomas, K.K. (2001). Neonatal skin care: Evaluation of the AWHONN/NANN research-based practice project on knowledge and skin care practices. *Journal of Obstetric, Gynecologic and Neonatal Nursing*, 30 (1), 30-51.

### **Glamorgan Pressure Ulcer Risk Assessment Scale**

Increasingly more commonly used in Australian paediatric units because of its relative simplicity and is available from the following location:

[http://www.healthcareimprovementscotland.org/our\\_work/patient\\_safety/tissue\\_viability\\_resources/paediatric\\_glamorgan\\_tool.aspx](http://www.healthcareimprovementscotland.org/our_work/patient_safety/tissue_viability_resources/paediatric_glamorgan_tool.aspx)



Attach Patient's  
Identity Label or  
MRN

**Community Wound Survey CHIME Audit Tool 2013**

Answer the following questions by auditing the CHIME nursing documentation

**1. Pressure Injury Risk Assessment**

- Any evidence of skin inspection on admission? Yes  No
- Was Waterlow risk assessment completed on admission? Yes  No
- Was risk reassessment completed as per policy? (*Check CHIME documentation up to 1 wk for very high risk; 1 month for others*) Yes  No  No Documentation

**2. Answer the following if the client has a wound**

- Has/ Have **all** the wound type issue(s) been entered into CHIME? Yes  No
- Has wound documentation been attended and is current? (*Check CHIME documentation up to 4 wks for chronic wounds*)
  - Wound assessment: Yes  No
  - Size measured: Yes  No
  - Wound image: Yes  No

**3. Answer the following if a pressure injury has been identified**

- Have pressure injury details been recorded on the Pressure Ulcer Notification Template in CHIME? Yes  No
- Has the pressure injury been reported to IIMS? Yes  No

**Verify the staging of pressure injury with the latest image on Chime.**

- **Do you agree with the staging of pressure Injury(ies) classified by the Community Nurse?**

Yes (If Yes, end of the survey)

No (*If no, please complete Table 1*)

No image (*If no image, please complete Table 1 after wound image taken or home visit*)

**Table 1. Verification of the staging of PU**

Site of pressure injury	Stage identified by CN	Stage identified by CNS	Other comments



Attach Patient's identity label

**1. GENERAL DATA**

DATE OF SURVEY \_\_/\_\_/\_\_ FACILITY: \_\_\_\_\_ WARD: \_\_\_\_\_ BED \_\_\_\_\_ CONSENT: YES  NO

**2. PATIENT DATA**

<b>GENDER:</b> M <input type="radio"/> F <input type="radio"/>	<b>AGE:</b> ____ YRS	<b>TYPE OF ADMISSION:</b> EMERGENCY <input type="radio"/> ELECTIVE <input type="radio"/>	<b>LENGTH OF STAY (ACUTE SETTING ONLY)</b> ____ DAYS
<b>Medical Speciality:</b> Medicine <input type="radio"/> Surgery <input type="radio"/> Emergency <input type="radio"/> Critical Care <input type="radio"/> Orthopaedics <input type="radio"/> Residential/Aged <input type="radio"/> Rehab <input type="radio"/> Other <input type="radio"/> _____		Risk category identified by surveyors with Waterlow tool? Not at risk <input type="radio"/> At risk <input type="radio"/> High risk <input type="radio"/> Very high risk <input type="radio"/>	

- 3. Have you identified any wound on the patient (including stage 1 Pressure Injury)?** Yes  No
- **What types of wound have you identified? Please tick the appropriate answer(s)**
- Pressure injury (if ticked, please go to Q4)  Skin tear (if ticked, please go to Q5)
- Surgical  Other Non-surgical wound  Antibiotics for infected wounds
- Was a **Wound image** taken (check documentation up to 1 week)? Yes  No  N/A
  - Was a wound assessment form completed (check documentation up to 1 week)? Yes  No  N/A

**4. PRESSURE INJURY**

Abbreviations: PI=Pressure Injury; HAPI= Hospital Acquired Pressure Injury  
Table 2. Anatomical site of pressure injury

Anatomical Site	No. of Stage 1 PI	No. of Stage 2 PI	No. of Stage 3 PI	No. of Stage 4 PI	Deep Tissue Injury (DTI)	Un-stageable
Sacrum						
Trochanter						
Heel						
Toe						
Other						
<b>Total no. of PI</b>						
<b>Total no. of HAPI</b>						

- Number of PI present *on admission to the facility* \_\_\_\_\_
- Has this been reported to IIMS? Yes  No
- Number of *new PI acquired after the arrival to the unit:* \_\_\_\_\_
- Has the HAPI been reported to IIMS? Yes  No
- Has Pressure Ulcer Notification Sticker been completed? Yes  No

**5. SKIN TEAR**

- Total number of skin tear identified: \_\_\_\_\_
- Have you identified any hospital acquired skin tear? Yes  No
- Total number of skin tear acquired in the facility: \_\_\_\_\_
- Has the hospital-acquired skin tear been reported to IIMS? Yes  No

**6. SKIN AND RISK ASSESSMENT**

- Any evidence of skin inspection on admission? Yes  No
- Has pressure injury risk assessment been complete in Emergency Department? Yes  No  N/A
- Was a risk assessment completed within 8 hrs of admission (exclude ED assessment)? Yes  No
- Was risk reassessment completed as per policy? (Check documentation up to 1 wk for acute & subacute; 1 month for residential care.) Yes  No  No Documentation
- Was Waterlow risk assessment used in the latest assessment? Yes  No  (If no, please specific \_\_\_\_\_)

**7. PREVENTION INTERVENTION**

- Does this patient **require** pressure relieving device? Yes  No  If yes, is it appropriate? Yes  No
- Is there any documentation of **repositioning**? (Check medical record in the last 5 days) Yes  No  N/A
- Has the patient received any education on pressure injury prevention? Yes  No  N/A



Attach Patient's identity label

Date of Survey \_\_/\_\_/\_\_ Community Centre: \_\_\_\_\_ CONSENT: YES  NO

1. DEMOGRAPHICS

Gender: M <input type="radio"/> F <input type="radio"/>	Age: _____ Yrs	Does client live with a carer? Yes <input type="radio"/> no <input type="radio"/>
Has the client been discharged from hospital within the last 2 weeks? Yes <input type="radio"/> No <input type="radio"/>	Risk level identified by Surveyor with Waterlow risk assessment tool? Not at risk <input type="radio"/> At risk <input type="radio"/> High risk <input type="radio"/> Very high risk <input type="radio"/>	

2. MOBILITY

- Does client require help to roll over in bed or getting up? Yes  No  (if no, go to next session)
- If yes, is carer able to assist repositioning? Yes  No  No carer
- If the client is unable to reposition her/himself, how often can the carer reposition the client:  
1-2 hourly  3-4 hourly  > 4 hourly  No regular regime  No carer

3. EDUCATION

Have you received any forms information on pressure ulcer prevention? Yes  no  not sure

4. PRESSURE REDISTRIBUTING DEVICE

- Are pressure redistributing device(s) currently insitu?  
Yes  NA (no device required/ patient declined)  No  (if na/no, please go to next session)
- if yes**, is this device appropriate? Yes  No
- How long was the waiting period for the client to obtain the device? ( If client has more than 1 device, indicate the longest waiting period )  
Not applicable  Within one week  2-3 weeks  One Month  > one month  Not sure
- Where did the client obtain the device? (Choose the longest one, if client has more than 1 device)  
Enablement NSW  Hunter Equipment Service  Loan from CHC  Self purchase  Hired Privately  Not sure

5. WOUND

- Have you identified any wound(s) on the patient (including stage 1 pressure injury)? Yes  no
- What types of wound have you identified? **Please circle the appropriate answer(s)**

Pressure injury	Skin tear	Grafts	Primary closure surgical wound	Dehiscence/ Cavity	Venous leg Ulcer	Mixed leg ulcer	NPWT
Pilonidal Sinus	Cancerous wound	Donor site	Surgical open wound	Diabetic Foot	Arterial leg ulcer	Undiagnosed leg ulcer	Burns

- Other wound (please state): \_\_\_\_\_
- Has **antibiotics** been prescribed for **wound infection** in the **past 2 weeks**? Yes  no
- If the client has more than 1 wound, record the wound type and duration for the **wound that has been present for the longest period of time**. Wound type: \_\_\_\_\_
- Duration of the wound: please **circle** the appropriate answer

<7days	>1wk- 2wks	>2wks- 6 wks	>6wks-3mths	>3mths-6mths	6mths- 1yr	>1 yr
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6. PRESSURE INJURY

ANATOMICAL SITE OF PRESSURE INJURY (PI )							Sources of the pressure injury/ies: • Please tick the appropriate answer(s) Hospital acquired <input type="radio"/> Community acquired ( prior to community nursing care ) <input type="radio"/> Developed during community nursing care <input type="radio"/>
Anatomical Site	No. of Stage 1 PI	No. of Stage 2 PI	No. of Stage 3 PI	No of Stage 4PI	No. of Deep Tissue Injury	No. of Un-stageable	
Sacrum							
Trochanter							
Heel							
Toe							
Other							
<b>Total</b>							