Pressure Ulcer Prevalence Quality Study:  
Patient Observation & Inspection Worksheet

(Do not send this form to CALNOC)

This form is optional. It is designed for facilities that want to use separate teams for patient observation and chart review. The CALNOC Summary Data (see bottom of form) will be transferred to the form entitled “CALNOC Pressure Ulcer/Restraint Prevalence Study.” If you are not using two teams, record all data directly on the “CALNOC Pressure Ulcer/Restraint Prevalence Study” form.

Unit: ___________________ Patient: ____________________________________ Room #: __________________

Complete one form for each patient on the unit (whether they have observed ulcers or not).

Observed Pressure Ulcers: (add additional spaces if necessary) ___________NONE

Hospital Acquired?

Ulcer 1 Location_____________________________ Stage_____ Yes__ No__

Ulcer 2 Location_____________________________ Stage_____ Yes__ No__

Ulcer 3 Location_____________________________ Stage_____ Yes__ No__

Ulcer 4 Location_____________________________ Stage_____ Yes__ No__

Summary for CALNOC Report (transfer to chart review form for patients with pressure ulcers)

No. of Stage I pressure ulcers: ________  No. of Stage III pressure ulcers: ________

No. of Stage II pressure ulcers: ________  No. of Stage IV pressure ulcers: ________

No. of pressure ulcers unable to stage: ________

No. of suspected deep tissue injury: ________

No. of Stage I HAPU*: ________  No. of Stage III HAPU*: __________

No. of Stage II HAPU*: ________  No. of Stage IV HAPU*: __________

No. of HAPU* unable to stage: ________

No. of suspected deep tissue injury: ________

No. of device related hospital acquired ulcers: ________

* HAPU=Hospital Acquired Pressure Ulcers
NOTES
Pressure ulcers may be located over bony prominences or under a medical device/equipment. They are staged according to the extent of observable tissue damage. Only pressure related skin injury is included (NPUAP-AHCPR Ulcer Stages I-IV). Skin breakdown due to arterial occlusion, venous insufficiency, diabetes related neuropathy or incontinence dermatitis are not pressure ulcers and should not be reported in the prevalence quality study.

Mucous membrane ulcers are tissue disruption on mucous membranes due to ischemic pressure from medical devices. Mucous membranes do not have skin on them so the staging system for pressure ulcers cannot be used to stage mucosal pressure ulcers. Device related Mucous membrane ulcers are reported to CALNOC as device related ulcers.

Healing pressure ulcers should not be reverse staged; but staged based on the maximum anatomic depth of tissue damage that was recorded in the patient’s record. Closed/healed pressure ulcers are not counted as pressure ulcers.

International NPUAP-EPUAP Pressure Ulcer Definition (2009): A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated.

NOTE: In April, 2016, the National Pressure Ulcer Advisory Panel (NPUAP) announced a change in terminology from pressure ulcer to pressure injury and updated descriptions of the stages of pressure injury. The NPUAP is responsible for using science to make changes combined with consensus to clarify or amplify wording. The NPUAP has shared their changes with CMS and will be working with them on an implementation plan. CALNOC will defer implementation of any changes in CALNOC’s measures until regulatory agencies have officially reviewed and adopted the NPUAP recommendations.

NPUAP / EPUAP Pressure Ulcer Classification System

- **Category/Stage I:** Non-blanchable erythema
  Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category I may be difficult to detect in individuals with dark skin tones. May indicate “at risk” persons.

- **Category/Stage II:** Partial thickness
  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 or sero-sanguinous filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising (bruising indicates deep tissue injury). This category should not be used to describe skin tears, tape burns, incontinence associated dermatitis, maceration or excoriation.

- **Category/Stage III:** Full thickness skin loss
  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 injury. May include undermining and tunneling. The depth of a Category/Stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and Category/Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage III pressure ulcers. Bone/tendon is not visible or directly palpable.

- **Category/Stage IV:** Full thickness tissue loss
  Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunneling. The depth of a Category/Stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and these ulcers can be shallow. Category/Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis or ostetits likely to occur. Exposed bone/muscle is visible or directly palpable.

Additional Categories for the U.S.

- **Unstageable/Unclassified: Full thickness skin or tissue loss – depth unknown**
  Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined; but it will be either a Category/Stage III or IV. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as the body’s natural (biological) cover and should not be removed.

- **Suspected Deep Tissue Injury – depth unknown**
  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. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.