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

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.

Braden Q Scale

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


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:

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

<table>
<thead>
<tr>
<th>Site of pressure injury</th>
<th>Stage identified by CN</th>
<th>Stage identified by CNS</th>
<th>Other comments</th>
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</tbody>
</table>

This survey tool was designed by Margo Asimus (NP- Wound Management) and Iris Li (Co-ordinator-Wound Management & PUPP).  

Version 3 April 2013
### 1. General Data

- **Date of Survey:**
- **Facility:**
- **Ward:**
- **Bed:**
- **Consent:** Yes ☐ No ☑

### 2. Patient Data

- **Gender:** Male ☑ Female ☐
- **Age:** ___ yrs
- **Type of Admission:**
  - Emergency ☐
  - Elective ☐
- **Length of Stay (Acute Setting Only):** ___ days

**Medical Speciality:**
- Medicine ☐
- Surgery ☐
- Emergency ☐
- Critical Care ☐
- Orthopaedics ☐
- Residential/Aged ☐
- Rehab ☐
- Other ☐

**Risk Category Identified by Surveyors with Waterlow tool:**
- Not at risk ☐
- At risk ☐
- High risk ☐
- Very high risk ☐

### 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**

<table>
<thead>
<tr>
<th>Anatomical Site</th>
<th>No. of Stage 1 PI</th>
<th>No. of Stage 2 PI</th>
<th>No. of Stage 3 PI</th>
<th>No. of Stage 4 PI</th>
<th>Deep Tissue Injury (DTI)</th>
<th>Unstageable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sacrum</td>
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<td>Other</td>
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<td><strong>Total no. of PI</strong></td>
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<td><strong>Total no. of HAPI</strong></td>
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</tbody>
</table>

- **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 ☐
- **Was Waterlow risk assessment used in the latest assessment?**
  - Yes ☑ No ☐ (If no, please specify)

### 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 ☐

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This survey tool was designed by Margo Asimus (NP- Wound Management) and Iris Li (Co-ordinator-Wound Management & PUPP).

March 2013
1. DEMOGRAPHICS

<table>
<thead>
<tr>
<th>Gender: M ☑  F ☑</th>
<th>Age: _____Yrs</th>
<th>Does client live with a carer? Yes ☑  No ☑</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has the client been discharged from hospital within the last 2 weeks? Yes ☑  No ☑</td>
<td>Risk level identified by Surveyor with Waterlow risk assessment tool? Not at risk ☑  At risk ☑  High risk ☑  Very high risk ☑</td>
<td></td>
</tr>
</tbody>
</table>

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 form of information on pressure ulcer prevention? Yes ☑  No ☑  Not sure ☑

4. PRESSURE REDISTRIBUTING DEVICE

- Are pressure redistributing device(s) currently in situ? 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)

<table>
<thead>
<tr>
<th>Pressure injury</th>
<th>Skin tear</th>
<th>Grafts</th>
<th>Primary closure surgical wound</th>
<th>Dehiscence/ Cavity</th>
<th>Venous leg Ulcer</th>
<th>Mixed leg ulcer</th>
<th>NPWT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilonidal Sinus</td>
<td>Cancerous wound</td>
<td>Donor site</td>
<td>Surgical open wound</td>
<td>Diabetic Foot Ulcer</td>
<td>Arterial leg ulcer</td>
<td>Undiagnosed leg ulcer</td>
<td>Burns</td>
</tr>
</tbody>
</table>
- 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 | >1yr |

6. PRESSURE INJURY

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Sources of the pressure injury/ies:
- Please tick the appropriate answer(s)
  - Hospital acquired ☑
  - Community acquired (prior to community nursing care) ☑
  - Developed during community nursing care ☑

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