**Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Unit:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Resident** | **Room**  **No.** | **Present on Admit or In-House** | **Location of Wound** | **Type of Wound** | **Stage/ Pressure Previous Week** | **Stage/ Pressure Current Week** | **Treatments** | **Treatment**  **Changed** | **Improved (I)**  **Worsening (W)**  **Comments** |
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| 1. **Number Residents with Facility Acquired Pressure Injuries:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **% Residents with Facility Acquired Pressure Injury (A÷B)** \_\_\_\_\_\_\_\_ 2. **Total Number of All Residents in Census:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **Wound Type Key:** | **1**  Pressure Injury | **2**  Surgical | **3**  Venous Stasis | **4**  Arterial Ulcer | **5**  Skin Tear | **6**  Abrasion | **7**  Laceration | **8**  Diabetic Ulcer | **9**  Burn | **10**  Other |   **Pressure Injury Stages: Suspected Deep Tissue Injury:** Purple or maroon localized area of discolored **intact** skin or blood-filled blister.  **Stage 1:** Intact skin. Redness that **DOES NOT BLANCH**. Skin tones may appear red, maroon, blue, purple. Affected area may be warm, boggy or firm.  **Stage 2:** Skin is cracked, blistered, sheared or torn. Partial thickness wound. Does not heal with granulation.  **Stage 3:** Broken skin, deep tissue involvement. Full thickness wound.Muscle, tendon, or bone is **NOT** visible.  **Stage 4:** Broken through all layers of tissue. Full thickness wound. Muscle, tendon, or bone may be visible.  **Unstageable:** Base of ulcer is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown, or black) in the wound bed. | | | | | | | | | | |