Guidelines for Data Collection and Submission

Pressure Injury Indicator

May 2023

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Purposes

The purposes of the pressure injury survey are to:

1. Determine the rate of hospital acquired pressure injury occurrence
2. Determine the rate of unit acquired pressure injury occurrence
3. Explore the relationship between nursing assessments performed, interventions used, and pressure injury development

Rationale

The development of hospital acquired pressure injuries (HAPI) places the patient at risk for other adverse events and increases resource consumption and healthcare costs. Recommendations from the International Pressure Injury Prevention and Treatment Clinical Practice Guideline on pressure injuries include the identification of individuals at risk and early implementation of prevention interventions to prevent pressure injury occurrence. In most at-risk patients, interventions to reduce pressure, friction and shear, and to mitigate other patient risk factors (immobility, incontinence, impaired nutrition, etc.) will decrease pressure injury development and the worsening of existing pressure injuries.

Pressure injury prevention requires multidisciplinary effort and administrative support. Nurses and patient care interventions play an important role in pressure injury prevention and management across healthcare settings. Measurement of pressure injury occurrence allows organizations to assess the quality of care delivered, direct and evaluate quality improvement initiatives, and examine other institutional processes such as nurse staffing ratios that may affect pressure injury outcomes.

Published Reliability Studies


Definitions

Measures of Pressure Injury Occurrence

**Prevalence**
Prevalence is a common measure of pressure injury occurrence.

Definition—A cross-sectional count of the number of cases in a population. It measures the total number of persons with a pressure injury in a hospital/hospital unit on the day of the NDNQI pressure injury survey. It includes those admitted to the healthcare facility with a pressure injury and those who developed one between admission and the time of the survey.

Calculation of this indicator requires documentation on all patients who are on the reporting unit(s) on the designated survey date.

**Prevalence Rate (also called a point prevalence):**

\[
\frac{\text{Total number of patients with a pressure injury at a particular point in time}}{\text{Total number of patients in the population studied at a particular point in time}} \times 100\%
\]

**Hospital Acquired Pressure Injury (HAPI) Rate**
Hospital acquired pressure injury (HAPI) rate measures the number of patients with pressure injuries at a specific point in time that were acquired within the facility. This term only describes pressure injuries that were acquired after admission to the facility.

Definition—A count of the number of patient who acquired (developed) a new pressure injury after admission to the hospital. It is intended to differentiate hospital acquired pressure injuries from those acquired in the community. For patients with pressure injuries, the origin of the pressure injury also must be determined (hospital, hospital/unit or community acquired).

Calculation of the HAPI rate requires the record of any patient with a pressure injury at the time of the survey be examined for evidence of a pressure injury on admission. If a review of the patient record finds no evidence of the pressure injury on admission (present on admission), then the pressure injury is hospital acquired.

**HAPI Rate:**

\[
\frac{\text{Number of patients who acquired a pressure injury after admission to the hospital}}{\text{Total number of patients in the population studied}} \times 100\%
\]

**Unit Acquired Pressure Injury (UAPI) Rate**
Unit acquired pressure injuries are a subset of hospital acquired pressure injuries. The Unit Acquired Pressure Injury (UAPI) rate is an NDNQI-specific measure.
Definition—A new pressure injury that developed after arrival to the unit. It is intended to differentiate HAPI that are acquired on the survey unit from HAPI acquired on other units.

Calculation of this rate requires the record of any patient with a pressure injury at the time of the survey be examined for evidence of a pressure injury on arrival to the unit. If there is no documentation that the pressure injury was present on arrival to the survey unit, then the pressure injury is counted as unit acquired.

**UAPI Rate:**
Number of patients who acquired a pressure injury after arrival to the unit Total number of patients in the population studied.

**Pressure Injury and Staging Definitions**

**Pressure Injury**
A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. 8, 9

- **Pressure** - Pressure is the force (per unit area) exerted perpendicular to the skin surface.10 Pressure damages the skin and underlying tissues by (1) directly deforming and damaging cells and tissue invoking inflammatory changes; (2) compressing small blood vessels hindering blood flow and nutrient supply and (3) through ischemia-reperfusion injury.

- **Shear** - Shear is a commonly used term that encompasses two concepts, shear strain and shear stress. Shear stress is the force (per unit area) exerted parallel to the tissue. Shear strain is the actual distortion or deformation of tissue as a result of shear stress.11 Some shear strain occurs at rest. Shear strain is intensified in certain clinical situations (e.g., raising the head of the bed > 30 degrees; dragging rather than lifting while repositioning). One layer of tissue slides over another, deforming adipose and muscle tissue and disrupting blood flow.

- **Microclimate** - Microclimate describes the temperature and humidity in a specified location. The skin’s microclimate affects the skin structure, function and response to mechanical loading forces, making it more susceptible to pressure injury development.11 Increases in humidity can weaken the skin making it more vulnerable to skin damage and dry skin results in more brittle skin. When the term is used in conjunction with support surfaces, microclimate refers to temperature and humidity at the support surface/body interface. 11

- **Locations** - Pressure injuries usually occur over a bony prominence, but pressure injuries can develop in any tissues subjected to pressure and shear.

**Pressure Injury Staging**
Pressure injuries are staged based on the level of tissue injury or damage that is visible or can be directly palpated.

When the deepest anatomic structures within the injury are visible and can be identified, the numeric stages are used. (Stages 1-4). When the deepest anatomic structures of the wound cannot be identified other categories may apply:
• Unstageable when the extent of tissue damage is obscured by slough or eschar.
• Deep Tissue Pressure Injury (DTPI) in the process of evolution.
• Unstageable and DTPI should be staged when the deepest anatomic structures of the injury can be identified.
• Pressure injuries on mucosal membranes should not be staged.
• Staging is used to define the maximum anatomic depth of tissue damage and should not take into account the extent of healing.
• Pressure injuries do not necessarily progress from Stage 1 through 4, nor do they necessarily heal from Stage 4 through 1.
• The tissue around the pressure injury should be assessed for signs of more extensive damage than can be readily visualized.
• Partial thickness pressure injuries involve only the epidermis and dermis (Stages 1 and 2).
• Full thickness pressure injuries (Stage 3, Stage 4) extend into deeper tissue layers (fat, fascia, muscle, bone, tendon). Unstageable pressure injuries are considered obscured full thickness pressure injuries as the true extent of damage cannot be confirmed until the wound base is visible.
• Undermining and tunneling may be present within full thickness pressure injuries.

Stage 1 Nonblanchable Erythema of Intact Skin.
Intact skin with a localized area of nonblanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.8, 9

Stage 2 Partial-thickness Skin Loss with Exposed Dermis.
Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).8, 9

Stage 3 Full-thickness Skin Loss.
Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.8, 9

Stage 4 Full-thickness Skin and Tissue Loss.
Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.8, 9
Unstageable Obscured Full-Thickness Skin and Tissue Loss.
Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on ischemic limb or heels should not be softened or removed.8, 9

Deep Tissue Pressure Injury (DTPI) Persistent Nonblanchable Deep Red, Maroon or Purple Discoloration.
Intact or nonintact skin with localized area of persistent nonblanchable deep red, maroon, purple discoloration, or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.8, 9, 12, 13

Device Related Pressure Injury
Device related pressure injuries result from medical devices, equipment, furniture and everyday objects that have applied pressure to the skin. The resultant pressure injury generally conforms to the pattern or shape of the device. If it is the result of a device designed and applied for diagnostic or therapeutic purposes, it is termed a medical device related pressure injury (MDRPI).15 The term device related describes the etiology.
Use the staging system to stage device related pressure injuries

Mucosal Membrane Pressure Injury
Mucosal membrane pressure injuries are found on mucous membranes, usually with a history of a medical device in use at the location of the injury. Due to the anatomy of the tissue these injuries cannot be staged.8, 9, 14, 15

Additional Pressure Injury Descriptions

Non-Visible Pressure Injury
This is not a pressure injury stage within the NPIAP staging system. Rather it is a category created by NDNQI to count for a known pressure injury located under a non-removal dressing or device that cannot be visualized at the time of the skin inspection and the stage is not documented in the patient’s record.

Note: Non-removable devices include all devices that are not normally removed in the course of patient care (e.g., casts, endotracheal tubes, and pressure dressings) and any dressing or device with a physician order to not remove.

Healing Pressure Injury
Pressure injuries that are healing should not be reverse staged; rather they should be staged based on the maximum anatomic depth of tissue damage that was recorded in the patient record.16
Healed or Closed Pressure Injury
Pressure injuries that have healed are no longer considered pressure injuries.
Pressure injuries that have been closed by surgical flaps or grafts are considered surgical sites and are no longer considered pressure injuries.

Re-Opened or Recurring Pressure Injury
Scar tissue from a healed full thickness pressure injury has less tensile strength than normal tissue. It is therefore more susceptible to re-injury. These injuries have been described as "reopened", "recurrent" or "new" depending on the degree of healing and level of maturity of the old injury.17

For the purposes of NDNQI data collection, these injuries should be staged based on the depth of damage in the new injury, regardless of the original stage.

Pressure Injuries and Skin changes at the End of Life
Pressure injuries and skin changes at the end of life have been described by various authors. At the current time there remains no universally accepted nomenclature to describe this phenomenon. Terminology such as Kennedy Terminal Ulcers, Skin Changes at Life’s End (SCALE), Trombley-Brennan Terminal Tissue Injuries (TTI), and chronic skin failure are all currently used to describe this phenomenon.18

Avoidable or Unavoidable Pressure Injury
Some pressure injuries are unavoidable.18-21

Despite definitions published by CMS for use in long term care and NPIAP, there are no universally acceptable criteria for determining whether a pressure injury that occurs in the acute care setting is unavoidable.

For the purposes of NDNQI data collection, both avoidable and unavoidable pressure injuries will be considered pressure injuries until such criteria are developed.

Origin of Pressure Injuries

Community Acquired Pressure Injury
Community acquired refers to a pressure injury that developed prior to hospital admission. The existence of the pressure injury was documented on the admission skin assessment or the survey was done on day 1 of the patient’s hospital stay and the pressure injury was already present. Pressure injuries that are present on admission and worsen during the patient’s length of stay are still considered community acquired.

Standards of care for most hospitals require that an admission skin assessment be completed and documented within 24 hours of admission or sooner.
Per Medicare guidelines, patients who are transferred between acute care, rehab, sub-acute or long-term care units are considered admitted or discharged even if the units are located on the same campus.

Note: if a patient has been transferred between 2 campuses and the medical record number and admission status assigned on the first campus will remain the same on the second campus, substitute the unit admission performed on the second campus for the hospital admission assessment.

**Hospital Acquired Pressure Injury**

Hospital acquired refers to a new pressure injury that develops after admission to a facility. This may also be termed nosocomial or facility-acquired. The patient’s admission record should be reviewed for the documentation of a pressure injury. If there is no documentation within 24 hours that the pressure injury was present on admission, then the pressure injury should be counted as hospital acquired.

**Unit Acquired Pressure Injury**

Unit acquired refers to a new pressure injury that develops after arrival to the survey unit. The unit admission assessment should be reviewed for the presence of pressure injury. If there is no documentation that pressure injury was present on arrival to the unit, then the pressure injury should be counted as unit acquired.

Note—All unit acquired injuries are a subset of hospital acquired injuries.

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**Pressure Injury Risk Status**

A program of pressure injury prevention involves identifying patients at risk for developing pressure injuries. Evidence of risk assessment should be documented in the patient’s record.

**Skin Assessment**

Skin assessment for pressure injury detection encompasses a comprehensive evaluation of the patient’s skin from head to toe. Techniques used include both a visual as well as tactile assessment. Emphasis should be on bony prominences and other at-risk areas for pressure injury development (e.g. medical devices). The goal is to assess skin integrity in an effort to detect an emerging or existing pressure injury.\(^\text{22}\)

Patient skin should be assessed on admission. Specifically, an admission skin assessment should be performed and documented within 24 hours of admission. While specific time parameters are not universally defined, some organizations recommend a full skin assessment within the first 4-8 hours of the hospital
admission. The International Pressure Injury Prevention and Treatment Clinical Practice Guideline recommends a full skin assessment as soon as possible after admission to the facility. For patients who are at risk for pressure injuries, skin should be inspected at least daily.

Pressure Injury Risk Assessment

A pressure injury risk assessment is the evaluation of patient risk for pressure injury development. Use of a validated instrument (scale) for assessing pressure injury risk is recommended by the Agency for Healthcare Research and Quality (AHRQ) and the International Pressure Injury Prevention and Treatment Clinical Practice Guideline. The guideline also recommends an assessment of additional risk factors not measured on a validated pressure injury scale be included in the patient’s assessment of pressure injury risk. These include but are not limited to such factors as age, perfusion, oxygenation, comorbidities (diabetes, vascular disease), general health status, and current or prior pressure injuries. Clinical judgement also informs the pressure injury risk assessment.

Both the Braden and Norton Scales for assessing pressure injury risk have been validated for adults in research studies. The Braden Scale is used most commonly in the United States. Pediatric and neonatal units use different pressure injury risk assessment scales. For example, some units use the Braden Q for children less than 8 years old, the Braden QD scale for patients up to age 21, and the Neonatal Skin Risk Assessment Scale (NSRAS) for newborns.

NDNQI does not require facilities use a particular scale to submit pressure injury data.

Facilities should assess pressure injury risk as soon as possible after admission. In some facilities, the risk assessment may be part of the admission skin assessment documentation. However, NDNQI views these as two separate pieces of information.

Pressure injury risk should be reassessed daily or every shift to detect potential changes in patient condition which increase risk. All pressure injury risk assessments should be documented in the patient’s record.

Patient “At Risk” for Pressure Injuries

The determination of a patient’s risk status (at risk/not at risk) is based on the cut score last pressure injury risk assessment recorded in the patient’s record:

<table>
<thead>
<tr>
<th>Scale Name</th>
<th>Cut Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Braden Scale (&gt;8yrs)</td>
<td>18 or less</td>
</tr>
<tr>
<td>Braden Q Scale (children to 8yrs)</td>
<td>16 or less QD Scale</td>
</tr>
<tr>
<td>Braden QD Scale (premature infants to 21 years)</td>
<td>13 or higher</td>
</tr>
<tr>
<td>Neonatal Skin Risk Assessment Scale (NSRAS)</td>
<td>13 or higher</td>
</tr>
<tr>
<td>Norton Scale (adults)</td>
<td>15 – 16 or less</td>
</tr>
</tbody>
</table>
The cut scores provided are the generally accepted cut scores for each scale. Hospitals/units may sometimes use other scales or subscales of larger risk assessment scales to determine pressure risk status.

**Pressure Injury Prevention**

Research has identified that a program of pressure injury prevention reduces pressure injury occurrence. A program of prevention includes daily skin assessment, daily risk assessment, pressure redistribution surface use, routine repositioning, nutritional support and moisture management.

Pressure injury prevention interventions received by the patient should be documented in the patient’s medical record.

For NDNQI, documentation of interventions received within 24 hours of the survey for at-risk patients will be considered evidence of their use. The presence of a healthcare provider or nursing order is not adequate evidence of prevention in use.

**Skin Assessment**

The skin of at-risk patients should be assessed from head to toe at least daily and documented in the patient record. Ideally, the skin should be inspected more frequently, such as every shift or each time the patient is repositioned.

Pay particular attention to the skin over bony prominences and under medical devices (e.g., oxygen tubing, drainage tubing, casts, splints, cervical collars or other removable medical devices). Skin under the edges of non-removable devices may be assessed if it can be done so without displacing the device. For patients with a history of recent surgery, carefully examine the anatomical areas that were under pressure during the operative procedure. For infants, pediatric, and critical care patients, also pay particular attention to skin over the occiput.

**Support Surfaces: Pressure Redistribution**

Special support surfaces should be used to redistribute pressure on skin and subcutaneous tissue or other parts of the body exposed to pressure. Support surfaces are made up of various components including air, gel, water and various types of foam. These materials are used to make mattresses, overlays, specialty mattresses or chair cushions that redistribute pressure over tissues. Support surfaces may be powered or non-powered. Support surfaces may have additional features such as alternating pressure, air fluidization, low air loss, multi-zones, turn assist or lateral rotation. Support surface selection needs to take into account the individual patient’s needs and overall clinical condition of the patient.
For NDNQI, pressure redistribution also includes use of padding or positioning devices for most at risk patients and use of prophylactic multi-layer polyurethane foam dressing on sacrum and heels in high risk patients. For example, uses of positioning devices or pillows to suspend heels off the bed or padding of tubing and other medical devices. Evidence may be documented in the patient record or observed in the patient’s room at the time of the survey (for example, the patient is lying on a pressure redistribution mattress).

In some cases, the at-risk patient may have a documented contraindication to the application of some types of support surfaces (e.g., unstable spinal fracture), the patient may refuse to use the special support surface or the patient’s risk factors may indicate the patient doesn’t need a special support surface.

**Routine Repositioning**

Routine repositioning is the turning or repositioning of patients at regular intervals to reduce the duration and magnitude of tissue pressure. The current clinical International Pressure Injury Prevention and Treatment Clinical Practice Guideline recommends that repositioning frequency be based on the individual patient and support surface in use.¹

The protocols in many facilities specify repositioning every 2 hours for patients unable to reposition themselves while in bed. Patients who are at high risk may need more frequent repositioning. Slow gradual turns and small shifts may be trialed in patients with varying levels of hemodynamic instability. ³⁷ Chair-bound patients who can reposition themselves should be taught to weight-shift. Chair-bound patients who are unable to reposition themselves should be repositioned at least every hour while sitting and the time spent seated should be limited.

Attention should be given to correct postural alignment (e.g., no slouching). Early mobility programs should be implemented as soon as clinically feasible and activity should be increased based on patient tolerance.

Use transfer aids such as lift sheets to protect patient skin when transferring across bed and chair surfaces. Safe patient handling devices and designated patient lift devices are often safer and more effective for both patient and provider. Lift patients, rather than dragging them, when repositioning. Head position in bed should be 30 degrees or less unless clinically contraindicated. A 30-degree side-lying position is preferred over a 90-degree side-lying position.¹

Repositioning should be documented in the patient record. In some cases, the at-risk patient may have a documented contraindication to the application of this intervention (e.g., physician orders because the patient is too hemodynamically unstable), the patient may refuse to be repositioned or the patient may be able to reposition him/herself without assistance and this intervention is unnecessary.

For NDNQI, posted turning schedules and healthcare provider or nursing orders are inadequate evidence of routine repositioning.

**Nutritional Support**

Nutritional deficiencies diminish the ability of skin and soft tissue to tolerate pressure. Optimizing nutritional intake for patients at pressure injury risk is recommended in the current International Pressure Injury Prevention and Treatment Clinical Practice Guideline, including adjustments in protein intake. Recommended ranges for protein intake to prevent pressure injuries is 1 to
1.5g/kg/day based on patient age and comorbidities.38,39

Nutritional screening should be conducted for all patients at risk for pressure injuries. All patients screened as at risk for nutritional deficits, should be referred to a registered dietitian for further evaluation and treatment.38 Vitamins and minerals should be added as needed but by themselves are insufficient nutritional supports for a patient at nutritional risk. Strategies to enhance patient intake of the recommended diet include attention to patient food preferences, facilitation of access to food and assistance with meals and snacks, and modification of dietary restrictions that result in decreased intake.

If dietary intake is inadequate, provision of nutritional supplements, enteral or parenteral nutrition constitutes nutritional support for the purposes of the NDNQI survey. Because dehydration can also contribute to pressure injury development, hydration status should be monitored, and water offered as appropriate.38

For NDNQI survey:
- Nutritional support should be documented in the patient record, but also may be found in the patient’s room at the time of the survey (for example, the patient is receiving tube feeding or TPN).
- If a pressure injury survey is being conducted early in the patient’s hospital stay and a nutritional consult has been ordered, but not yet completed, this will count as nutritional support.
- In some cases, the at-risk patient may have a documented contraindication to the application of this intervention (e.g., patient is NPO for a procedure), the patient or parent/guardian may refuse nutrition or nutritional support, or this intervention may be unnecessary because the patient eats most of every meal and does not require supplementation.

Moisture Management

Excessively moist skin is more likely to break down when exposed to pressure and is susceptible to skin infections. Moisture management is particularly important for patients with conditions such as urinary and/or fecal incontinence or draining wounds. Interventions to manage moisture include keeping the patient clean and dry, using absorbent underpads and applying moisture barrier creams. Fecal containment devices may also be used to divert liquid stool from the skin.

Excessively dry skin is also susceptible to breakdown as the skin is more likely to crack when exposed to pressure. In these situations, interventions such as using a mild cleansing agent for cleansing the skin and products to moisturize dry skin should be instituted.

Moisture management should be documented in the patient record. For NDNQI survey:
Incontinence materials at the bedside are inadequate evidence of moisture management.

In some cases, the at-risk patient may have a documented contraindication to the application of these interventions, the patient may refuse these interventions, or these interventions may be unnecessary because the patient is continent and therefore not at risk from excess moisture or dryness.
Pressure Injury Survey Procedures

Team
Each facility must identify persons to perform the survey assessments. Hospitals may have multiple teams with one person designated as the head team leader of all teams. The head team leader should have a certification in wound care or have received additional education and training in pressure injury identification and staging. The head team leader must be familiar with NDNQI guidelines and is responsible for initial and review training for the team members, inter-rater reliability studies and for organizing data collection procedures.

Team members are needed for skin inspection, chart review and turning assistance. Individuals who will be conducting the skin inspection must be trained and skilled in pressure injury identification and staging and must have the ability to distinguish pressure wounds from other types of wounds. LPN/LVNs and UAPs should not conduct the skin inspection. Chart reviewers need skill in interpreting documentation in patient records.

When possible, assign team members to units other than their usual work unit to decrease the potential for bias in observation.

Training
The head team leader is responsible for training team members. Training consists of:

- Initial training
- Review training
- Inter-rater reliability studies

Studies to enhance inter-rater reliability should be established and repeated annually. Instructions and inter-rater forms are on the NDNQI website (Select Facility → Select Unit → Pressure Injuries → Documents)

Initial Training
New team leaders and team members should receive training on:

- NDNQI Pressure Injury Training
- NDNQI Pressure Injury indicator guidelines
- Skin assessment and common anatomical areas for pressure injuries
- NPIAP pressure injury staging definitions
- Definitions of Stage 1-4 pressure injuries
- Definitions of Unstageable Pressure Injury and Deep Tissue Pressure Injury (DTPI)
- Definition of Medical Device Related pressure injuries
- Mucosal membrane pressure injuries
- Pressure injury stage/appearance
- Review schematic drawings and example pictures of pressure injuries by stage
• Bedside observation of pressure injuries by stage
• Bedside observation of whether pressure injuries are medical device related
• Other wound types and skin injuries
• Differentiation among community-, hospital- and unit-acquired pressure injuries
• Data extraction from the patient record

It is recommended that new team leaders/members participate in a practice survey to familiarize themselves with data collection procedures.

**Review Training**

Prior to each subsequent survey, established team members should review:

• NDNQI Pressure Injury Indicator guidelines
• Skin assessment and common pressure injury locations
• Pressure injury staging definitions and sample pictures
• Definitions of other wound types and skin injuries

Prior to each survey, experienced team members should have at least one planning session to review data collection procedures.

**Organizing a Survey**

Frequent pressure injury surveys allow hospitals to closely monitor changes in pressure injury rates and rapidly implement corrective measures. Data from one survey per month can be reported to NDNQI. However, units may choose to conduct surveys more or less frequently. Whether reporting monthly or quarterly, pressure injury surveys should be as evenly spaced as possible. If multiple surveys are conducted each month, only submit data from the first survey of the month. Similarly, if multiple surveys are conducted each quarter but only one will be reported, only submit data from the first survey of the quarter.

The survey should be conducted on a designated day on all reporting units to avoid double counting patients who are transferred between units. Facilities are encouraged to survey all eligible units, but they are not required to do so.

The survey should be conducted on the number of patients on the unit at the time of survey, not as a running total over a 24-hour period. For better validity, the survey should be performed when the majority of patients are present on the unit. The time required to conduct a survey will depend on the number and size of the units participating. In NDNQI pilot testing, the average time to conduct a survey (skin inspection and record abstraction) was 12 minutes per patient.

Data collection for the Pressure Injury indicator may be combined with the NDNQI data collection for the Restraints indicator. If the data collection is not combined, the Pressure Injury survey should be separated from the Restraints survey by at least two weeks.
**Data Collection**

**Data collection steps:**

1. Generate a list of all patients assigned to the unit at the time the team is ready to begin data collection.
2. Patients who will be transferred or discharged should be examined first. On units where patients are expected to dress for the day (e.g., rehabilitation or behavioral health units), schedule the skin inspection before they get dressed. Also prioritize patients based on infection control principles.
3. The survey process should be explained to patients/parent/guardian as a quality improvement study on skin breakdown from pressure. The skin inspection should not proceed if the patient or parent/guardian of a patient refuses.
4. Inspect all bony prominences and body surfaces subject to pressure or pressure in combination with shear.
5. Whenever clinically possible, removes medical devices to assess the underlying skin.
6. If a pressure injury is identified, stage pressure injuries.
7. Identify whether pressure injuries were known to be related to a medical device.
8. Conduct record review to abstract data on pressure injury risk and prevention strategies in use.
9. Determine if pressure injury is community-, hospital- and/or unit-acquired.

Data must be collected according to NDNQI standards:

<table>
<thead>
<tr>
<th>Acceptable</th>
<th>Unacceptable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin assessment and review of medical record of every patient surveyed</td>
<td>Review of medical record/chart audit only</td>
</tr>
<tr>
<td>Survey all patients on unit</td>
<td>Survey only: Patients deemed at risk Patients with injury A random sample of patients</td>
</tr>
<tr>
<td>Survey patients with no minimum or maximum length of stay</td>
<td>Survey only patients with a specific length of stay</td>
</tr>
</tbody>
</table>

**Patient Inclusion/Exclusion**

Include all patients on the unit
- regardless of age
- regardless of admission status (i.e., in-patient, out-patient, observation)
- regardless of length of stay
- NOTE: a patient with a very long length of stay, who was surveyed previously, should be counted and surveyed again as long as they remain a patient in the facility
- Count the number of patients that are excluded from the survey for the following reasons:
  - The patient or parent/guardian of a patient refused the exam.
  - The patient was off the unit during survey rounds for x-ray, surgery, or other testing or procedure.
  - The patient was medically unstable at the time of the survey and an assessment would have been contraindicated. "Medically unstable" applies to patients who cannot safely be turned for physiological reasons. The nature of the instability may vary. Examples include but are not limited to hemodynamic instability, uncontrolled pain or fracture waiting repair.
NOTE: Also use this category to capture patients who were excluded because surveying them was contraindicated for the health care workers on the survey team or for a specific patient population. For example, if the survey team or the facility as a whole decides not to include patients under isolation precautions in the survey in order to limit non-essential contact for the purpose of preventing the spread of disease or for the purpose of conserving limited resources (i.e., personal protective equipment), count those excluded patients in this category.

- The patient was actively dying and pressure injury prevention was no longer a treatment goal. These patients should be identified before the survey begins. Actively dying is considered the last few days of life when blood flow to organs (e.g., brain, heart, kidneys) is decreasing, respiratory distress is increasing and physiological instability is apparent, making turning unrealistic.

Injury Inclusion/ Exclusion

Include:
- Skin and Pressure Injuries at the End of Life
- Pressure injuries under medical devices
- Healing pressure injuries
- Pressure injuries located under non-removal dressings or devices
- Record the stage last documented in the patient’s record
- If the pressure injury stage is not documented, then the injury should be counted in the Non-Visible Pressure Injury category
- Pressure injuries on mucous membranes
- These pressure injuries should not be staged, but they should be counted in the Mucosal Membrane Pressure Injury category
- Pressure injuries that are present on admission, but worsen in stage
  - These pressure injuries should be counted in Total Number of Pressure Injuries only, not as hospital acquired or unit acquired
- Pressure injuries that may be considered unavoidable
- Pressure injuries from patients with a long length of stay, who have been included in previous Pressure Injury Prevalence study.

Exclude:
- Wounds that have a different etiology than pressure injuries. Examples: arterial, venous and diabetic foot ulcers, skin tears, moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ID), medical adhesive related skin injury (MARI), burns, traumatic wounds and dermatologic conditions
- Closed or healed pressure injuries

Eligible Unit Types

See the Eligible Unit Type Table in Appendix B of the Unit Management guidelines for a complete listing.
Reporting Interval

Data from one survey per month can be reported to NDNQI. However, units may choose to report only one or two surveys per quarter.

Notes –
- The reporting interval can vary by unit within a hospital. For example, the ICUs may report monthly and the medical-surgical units may report quarterly.
- The reporting interval can vary by quarters for a given unit. For example, a unit may report quarterly for Q1 and monthly for Q2.

Source

Data will come from two sources:
1. Patient assessments during survey rounds
2. Abstracted items from patient records

Data elements from the survey may be recorded on data collection sheets, scannable forms or entered directly into a computer on the unit or mobile device. It is the decision of the facility regarding what method will be used to record data. Outline the internal data sources and staff resources that will be used to report on this indicator.

It is very important to assure that data conform to NDNQI reporting requirements.

Data Collection Forms

Facilities may use forms provided by NDNQI or another vendor or create their own forms. NDNQI provides two types of forms for data collection on the NDNQI website: Excel spreadsheets with multiple patients per page and Word documents with one patient per page (Select Facility → Resources → Documents → Data Collection Forms → Pressure Injury & Pressure Injury-Restraint - Spreadsheet for Data Collection (Excel)). (Select Facility → Select Unit → Pressure Injuries →Documents). These forms may be modified to collect additional facility-specific data. Facilities must verify that any non-NDNQI form captures all of the NDNQI required data elements.

Data Entry

Selecting the Webpage
To enter data
• Select the facility from the navigation menu on the left side of the screen
• Select the unit from the navigation menu on the left side of the screen
• Select “Pressure Injury” from the navigation menu on the left side of the screen
• Select the year and quarter from the dropdown menus on the page
• Under the correct month, select whether the Pressure Injury and Restraint surveys were conducted together or separately:
  o Pressure Injuries
    ▪ Pressure Injuries - Separate Survey
  o Together
    ▪ Restraints & Pressure Injuries – Same Day

Note – When entering Pressure Injury and Restraint data, be sure to correctly select the data entry link based on the way the prevalence surveys were performed. Do not enter injuries and restraints separately if the data were collected the same day. Entering the same patient twice introduces error in data analysis.

Data entry for pressure injury is a two-step process. The first step is to complete the Pressure Injury Survey Summary page for each reporting unit. The second step is to enter data on the Individual Patient Data Entry page.

Data Elements for Survey Unit Summary Page

Unit Census at Start of Survey - Required
A count of all patients assigned to the unit at the time the team is ready to begin data collection. This is the population to be surveyed. Leave all fields blank if the unit had no patients on the designated survey day.

Number of Patients Included in the Survey - Required
The number of patients included in the survey is the Unit Census minus the number of excluded patients.

Date of Survey - Required
The date that the survey was conducted. Enter two digits for the month, two digits for the day, and four digits for the year: mm/dd/yyyy.

Reasons for Exclusion - Required
Record the number of patients that are excluded for each of the following reasons:
• Patient off unit
• Patient refused
• Unsafe for patient condition/Contraindicated*
• *See description on pages 15 above for details
• Patient actively dying
Note—The number of patients excluded plus the value for Number of Patients Included in the Survey must equal the value for Unit Census at Start of Survey.

**Unit Acquired Injury Reporting - Required**
- **Yes** = If all of the surveyed patients were assessed for the presence or absence of unit acquired injuries
- **No** = If unit acquired injury data were not collected

**Risk Assessment Scale Required**
Select the pressure injury risk assessment scale(s) used on this unit:
- **Braden** = if this is the only risk assessment scale used on this unit
- **Braden Q** = if this is the only risk assessment scale used on this unit
- **Braden QD** = if this is the only risk assessment scale used on this unit
- **NSRAS (Neonatal Skin Risk Assessment Scale)** = if this is the only risk assessment scale used on this unit
- **Norton** = if this is the only risk assessment scale used on this unit
- **Multiple Scales** = if more than one scale is used on this unit
- **Other** = if another scale or method is used or if the source of the assessment instrument used is unknown

**Data Elements for Individual Patients**

**Patient Age**
Select the age of each patient on his/her last birthday from the dropdown list. Leave this field blank if the patient’s age was omitted from the data collection form. Options will vary by unit type, e.g., adult units are limited to years only.

- **Years** = for patients 1 year and older, select the patient’s age in years between 1 and 90. For HIPAA compliance, all patients older than 90 years on any unit will be aggregated into a 90+ age category and all patients older than 20 years on pediatric units will be aggregated into a 20+ category. Enter 90 in this field for all patients older than 90 years. A number greater than 90 will not be saved.
- **Months** = for infants under 1 year, select the patient’s age in months between 1 and 11
- **Days** = for newborns less than 1 month old, select the patient’s age in days between 1 and 30. If the newborn is less than 24 hours old, select 1.
- **Weeks** = for Neonatal ICU patients only, select the newborn’s gestational age at birth. Select number of weeks between <20 and >41. Round fractions to the nearest whole number.

**Patient Gender**
Select the gender for each patient:
- **Female**
- **Male**
Leave this field blank if data are being entered from a secondary source (data collection form) and there is no documentation of gender.

**Restraint Information**

If the unit is conducting the Restraint and Pressure Injury surveys together, Restraint data should be collected according to the indicator guidelines, available on the NDNQI website: (Select Facility → Resources → Documents → Indicator Guidelines → Guidelines for Data Collection and Submission for Restraints (PDF))

**Skin Assessment on Admission (within 24 hours)**

Review the patient’s record for documentation that the admission skin assessment was completed within 24 hours of hospital admission.

- **Yes** = an admission skin assessment was documented within 24 hours of hospital admission
- **No** = an admission skin assessment was not documented within 24 hours of hospital admission
- **Pending (admitted w/in last 24 hours)** = the survey is being conducted on day 1 of the patient’s hospital stay and the admission skin assessment has not yet been documented

**Pressure Injury Risk Assessment on Admission (within 24 hours)**

Review the patient’s record to determine whether or not a pressure injury risk assessment was documented within 24 hours of hospital admission.

- **Yes** = a pressure injury risk assessment was documented within 24 hours of hospital admission
- **No** = a pressure injury risk assessment was not documented within 24 hours of hospital admission
- **Note**—If “No” is selected, the next available field will be **Time Since Last Pressure Injury Risk Assessment**.

- **Pending (admitted w/in last 24 hours)** = the survey is being conducted on day 1 of the patient’s hospital stay and the pressure injury risk assessment has not yet been documented
  - **Note**—If “Pending” is selected, the next available field will be **Total Number of Pressure Injuries**.

**Risk Assessment Scale on Admission (within 24 hours)**

This option will be available if Multiple Scales was selected on the Unit Summary page. Select the risk assessment scale used for each patient:

- Braden Scale
- Braden Q Scale
- Braden QD Scale
- NSRAS
- Norton Scale
- Other

**Risk Assessment Score on Admission (within 24 hours)**

If Braden, Braden Q, Braden QD, NSRAS or Norton were selected previously (on Unit Summary page or previous field), select the documented admission scale value from the drop down list or enter the number into the data collection form.
NOTE: If “Other” was selected for **Risk Assessment Scale on Admission**, data cannot be entered in this field.

**Time Since Last Risk Assessment** - Required

Review the patient’s record to determine how long before the survey the last risk assessment was recorded. Select the time frame that indicates the number of hours, days or weeks since the last pressure injury risk assessment was recorded. Exclude any risk assessment/reassessment conducted at the time of the survey.

- >0 to 12 hours
- >12 to 24 hours
- >24 to 48 hours
- >48 to 72 hours
- >72 hours to 1 week
- >1 week

If the survey was conducted after day 1 of the patient’s hospital stay and the patient has never been assessed for pressure injury risk, then select:

- Never assessed for risk

**NOTE:** If “Never assessed for risk” is selected, the next available field will be **Total Number of Pressure Injuries**.

**Last Risk Assessment Scale**

This option will be available if **Multiple Scales** was selected on the **Unit Summary** page. Select the risk assessment scale used for each patient:

- Braden Scale
- Braden Q Scale
- Braden QD Scale
- NSRAS
- Norton Scale
- Other

**Last Recorded Risk Assessment Score**

If “Braden”, “Braden Q”, “Braden QD”, “NSRAS” or “Norton” was selected previously (on **Unit Summary** page or previous field), select the last documented scale value from the drop down list or enter the score value onto the data collection form. Do not include risk assessment scores obtained at the time of the survey. Leave this field blank if a score is missing from the data collection form.

**NOTE:** If “Other” was selected, data cannot be entered in this field.

**Patient At Risk Based on Last Assessment** Required

Select one of the following to indicate the patient’s pressure injury risk status at the last recorded pressure injury risk assessment. Do not use pressure injury risk assessments completed at the time of the survey to answer this question.

- **Yes** = patient was determined to be at risk based on the last recorded risk assessment scale score
• **Yes** = patient was determined to be at risk based on other patient risk or clinical factors
• **No** = patient was not at risk based on the last recorded pressure injury risk assessment

**NOTE:** If “No” is selected, the next available field will be Total Number of Pressure Injuries.

**NOTE:** Use the cut-off scores determined in this guide on page 9.

**Pressure Injury Prevention Within Past 24 Hours Required if patient at risk** If the patient is at risk, review the patient’s record for documentation of pressure injury prevention provided within the past 24 hours. Evidence will include documentation of one or more of the following interventions: skin assessment, pressure redistribution surface, routine repositioning, nutritional support, or moisture management. Only the following findings may be counted as interventions in the absence of documentation in the patient record: (1) if the patient is lying/sitting on a pressure redistribution surface at the time of the survey, this may be counted as pressure injury redistribution surface, and (2) if the patient is receiving parenteral or enteral nutrition at the time of the survey, this may be counted as nutritional support.

**NOTE:** Healthcare Provider orders or nursing orders in a patient’s record are inadequate evidence of an intervention if the intervention itself was not documented.

• **Yes** = pressure injury prevention was in use within the past 24 hours for this at-risk patient OR the interventions were considered but all were contraindicated, unnecessary for patient or patient refused
• **No** = pressure injury preventions were not used within the past 24 hours for this at risk patient
• **Pending** (admitted w/in last 24 hours) = the survey is being conducted on day 1 of the patient’s hospital stay, the patient was determined to be at pressure injury risk but pressure injury prevention has not yet been implemented

**NOTE:** If “No” or “Pending” is selected, the next available field will be Total Number of Pressure Injuries.

**For “At Risk” Patients – Prevention Interventions In Use Within Past 24 Hours**

If “Yes” was entered in the previous data field, the following five fields should be completed. If data for a given pressure injury prevention intervention were not collected, leave the corresponding field blank.

**Skin Assessment Documented**

Review the patient’s record for documentation of a skin assessment within the past 24 hours.

• **Yes** = a skin assessment was documented within the past 24 hours
• **No** = a skin assessment was not documented within the past 24 hours
• **Documented contraindication** = the intervention was not implemented within the past 24 hours due to a documented contraindication

**Pressure Redistribution Surface**

Review the patient’s record for documentation of a pressure redistribution surface in use within the past 24 hours. Also consider documentation of heel elevation and padding of medical devices. Select “Yes” if the patient is lying or sitting on a pressure redistribution surface at the time of the survey.

• **Yes** = there is documentation of pressure redistribution surface use within the past 24 hours or evidence was seen in the room at the time of the survey
• **No** = no pressure redistribution surface was in use within the past 24 hours
• **Documented contraindication** = the intervention was not implemented within the past 24 hours due to a documented contraindication
• Unnecessary for patient = the patient does not require this intervention
• Patient refused = the patient has refused the use of a pressure redistribution surface

Routine Repositioning
Routine repositioning has been implemented as prescribed for patients unable to reposition themselves. In this context, “implemented as prescribed” means that the patient was repositioned at the frequency set in the patient’s plan of care or according to the facility policy/protocol.

Review the patient’s record for documentation of repositioning as prescribed within past 24 hours. Exclude as evidence a posted turning clock at the bedside.

• Yes = there is documentation of patient repositioning as prescribed within the past 24 hours
• No = the patient has not received routine repositioning as prescribed within the past 24 hours
• Documented contraindication = the intervention was not implemented within the past 24 hours due to a documented contraindication
• Unnecessary for patient = the patient does not require this intervention (e.g., the patient is able to turn him/herself)
• Patient refused = the patient refused to be repositioned

Nutritional Support
Review the patient’s record for documentation of nutritional support within the past 24 hours. Select “Yes” if the patient is receiving parenteral or enteral nutrition at the time of the survey.

• Yes = there is documentation the patient received nutritional support within the past 24 hours or evidence for nutritional support was seen in the room at the time of the survey
• No = the patient has not received nutritional support as prescribed within the past 24 hours
• Documented contraindication = the intervention was not implemented during the past 24 hours due to a documented contraindication
• Unnecessary for patient = the patient does not require this intervention
• Patient refused = the patient refused nutritional support

Moisture Management
Review the patient’s record for documentation of moisture management within the last 24 hours. Incontinence materials or products at the bedside are inadequate evidence of their use or application.

• Yes = there is documentation that the patient received interventions to manage moisture within the past 24 hours
• No = the patient has not received moisture management as prescribed within the past 24 hours
• Documented contraindication = the intervention was not implemented within the past 24 hours due to a documented contraindication
• Unnecessary for patient = the patient does not require this intervention
• Patient refused = the patient refused this intervention
Number of Pressure Injuries

Count each pressure injury found on skin inspection and determine the stage for each. For known pressure injuries that cannot be visualized during the survey because they are located under non-removable dressings or devices, use the last documented stage in the patient’s record. Pressure injuries on mucous membranes should be counted in the Mucosal Membrane category.

*If maximum depth visible:*
- Stage 1
- Stage 2
- Stage 3
- Stage 4

*If unable to determine maximum depth*
- Unstageable Pressure Injury
- Deep Tissue Pressure Injury
- Non-Visible Pressure Injury

Mucosal Membrane Pressure Injuries are counted, but not staged.

Pressure injuries that are healing should **not** be reverse staged; rather they should be staged based on the maximum anatomic depth of tissue damage that was recorded in the patient’s record.

Pressure injuries at the end of life (e.g. Kennedy Terminal Ulcers) should be staged and counted in the appropriate category.

Sum the injuries in each category (total, hospital and unit acquired). For hospital acquired and unit acquired injuries, sum the number of injuries at each stage.

**Total Number of Pressure Injuries - Required**

Record the total number of pressure injuries found on the patient at the time of the survey. If the patient had zero pressure injuries, enter 0. Do not leave this field blank.

If the patient had one or more pressure injuries at the time of the survey, determine whether each injury was present on admission to the hospital, and if not, whether it was acquired before or after arrival to the survey unit.

**Total Number of Hospital Acquired Pressure Injuries - Required**

Enter the number of pressure injuries acquired since admission to this facility. If the patient had no hospital acquired injuries, enter 0. The number of Hospital Acquired Injuries cannot be larger than the Total Number of Pressure Injuries.

NOTES: This number must equal Total Number of Pressure Injuries if admission skin assessment is coded with “no.” This field will not be available if the admission skin assessment is coded with “pending.”

**Total Number of Hospital Acquired Pressure Injuries Related to Medical Device**

Enter the number of pressure injuries for this patient known to be related to use of a medical device. If the patient had no hospital acquired pressure injuries, enter
0. The value for **Total Number of Hospital Acquired Injuries Related to Medical Device** cannot be larger than the value for **Total Number of Hospital Acquired Pressure Injuries**.

**NOTE**: Only count pressure injuries known to be related to a medical device. If unknown or unsure, do not count.

**# Each Stage of Hospital Acquired Pressure Injuries - Required**

If the patient had one or more hospital acquired pressure injuries, sum and record the number for each stage.

**Total Number of Unit Acquired Pressure Injuries**

This field will be available only if “Yes” was entered in the **Unit Acquired Injury Reporting** field on the **Unit Summary** page.

Enter the number of injuries acquired since arrival to the unit. If the patient had no unit acquired injuries, enter 0. The value for **Total Number of Unit Acquired Pressure Injuries** cannot be larger than the value for **Total Number of Hospital Acquired Pressure Injuries**.

**NOTE**: This field should not be completed if “Pending” was entered in the **Skin Assessment on Admission** field.

**Total Number of Unit Acquired Pressure Injuries Related to Medical Device**

Enter the number of injuries acquired since arrival to the unit known to be related to the use of a medical device. If the patient had no unit acquired injuries, enter 0. The value for **Unit Acquired Pressure Injuries Related to Medical Device** cannot be larger than the value for **Total Number of Unit Acquired Pressure Injuries**.

**NOTE**: Only count pressure injuries known to be related to a medical device. If unknown or unsure, do not count.

**# Each Stage of Unit Acquired Pressure Injuries**

If the patient had one or more unit acquired injuries, sum and record the number for each stage.

surveyed patients for Pressure Injury and the number of surveyed patients for Restraints do not match.

Verify the number of patients on the Unit Summary page for each indicator.

**Data Validation**

**Saving a Record**

Once all the data elements have been entered, click the SAVE button. A message will be displayed on the webpage that the record has been successfully saved.

When an individual assault record is saved, a record identification number will be automatically generated. Record this number for future reference. It will be required if data corrections are necessary.
Data Summary Report
Run a Data Summary Report and review it for accuracy in order to confirm that all data was entered successfully and correctly. Users should check these reports after each data entry session and again before the quarterly deadline (Select Facility → Reports → Data Summary Reports).

Data Entry Status Report
Selecting this report generates a spreadsheet that displays how many months of data have been submitted for the quarter for every eligible indicator on each unit in a facility. It also displays how many months of data have been submitted for the quarter for eligible facility-level indicators.

Error Report Management
Error Reports alert users to data mismatches (true errors) or missing data (potential errors). Users should check these reports after each data entry session and again before the quarterly deadline (Select Facility → Reports → Error Reports).

The following error reports may be generated for the Pressure Injury indicator.

Pressure Injury and Restraint Patients Count Mismatch
This report is generated when the number of surveyed patients for Pressure Injury and the number of surveyed patients for Restraints do not match. Verify the number of patients on the Unit Summary page for each indicator.

Data with uncorrected mismatches will be removed by NDNQI during clinical report processing.

Pressure Injury Patients Count Mismatch
This report is generated when the number of individual patient records does not match the number of surveyed patients reported on the Unit Summary page.

Correct the number of patients on the Unit Summary page or add the missing individual patient records.

Data with uncorrected mismatches will be removed by NDNQI during clinical report processing.

Pressure Injury Missing Months
These reports are generated when data have been entered for one or two months in the quarter, but not for all three months. Complete data entry if needed.

However, if the unit was closed for a month, the missing month report is not an error and should be ignored. No data will be removed by NDNQI.
# Indicator Notes

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q2 2023; May</td>
<td>Clarification on capturing pressure injuries for patients with long length of stay</td>
</tr>
<tr>
<td>Q1 2023</td>
<td>Formatting updated</td>
</tr>
<tr>
<td>Q1 2021</td>
<td>Revised definition guidelines to align with NPIAP Guidelines</td>
</tr>
<tr>
<td>Q1 2020</td>
<td>Broadened description of “Medically Unstable/Unsafe for Patient Condition/Contraindicated” reason for exclusion from the survey to include patients excluded because of contraindications for the health care workers on the survey team or for the general patient population</td>
</tr>
<tr>
<td>Q1 2020</td>
<td>Changed copyright; updated website navigation instructions</td>
</tr>
<tr>
<td>Q4 2018</td>
<td>Added Braden QD Scale to list of Risk Assessment Scales</td>
</tr>
<tr>
<td>Q1 2018</td>
<td>Added Pressure Injury Missing Months and Pressure Injury and Restraint Missing Months to Error Report Management Section</td>
</tr>
<tr>
<td>Q1 2017</td>
<td>Revised guidelines to align with the NPUAP changes in terminology from pressure ulcer to pressure injury and updates to the pressure injury stage definitions; added data elements for nonvisible, mucosal membrane and medical-device related pressure injuries; retired indeterminable category; added monthly option to reporting interval</td>
</tr>
<tr>
<td>Q4 2014</td>
<td>Updated labels for sDTI and mucosal pressure ulcers to align with NPUAP</td>
</tr>
<tr>
<td>Q2 2014</td>
<td>Changed copyright</td>
</tr>
<tr>
<td>Q1 2014</td>
<td>Updated cover page with new logo and replaced Appendix B</td>
</tr>
<tr>
<td>Q1 2012</td>
<td>Included adult/pediatric BMT, burn, high, moderate, blended acuity, adult LTAC &amp; universal bed units</td>
</tr>
<tr>
<td>Q3 2009</td>
<td>Added reasons for exclusion from survey, Braden Q and NSRAS risk assessment scales, admission skin and risk assessment, moisture management for prevention intervention, indeterminable category; removed other prevention intervention; included pediatric, neonatal Level III, geripsych and peds rehab units</td>
</tr>
<tr>
<td>Q3 2007</td>
<td>Aligned definitions of pressure ulcer stages with 2007 NPUAP Guidelines and added DTI</td>
</tr>
<tr>
<td>Q4 2006</td>
<td>Added unit acquired reporting and types of pressure ulcer prevention interventions</td>
</tr>
<tr>
<td>Q4 2003</td>
<td>Added stage of each HAPU, time since last risk assessment and prevention protocol, included adult rehab units</td>
</tr>
<tr>
<td>1998</td>
<td>Indicator developed 1998 for adult critical care, step-down, medical, surgical, med-surg units</td>
</tr>
</tbody>
</table>
References


37. Brindle, C. Tod; Malhotra, Rajiv; O'Rourke, Shelby; Currie, Linda; Chadwik, Debbie; Falls, Pam; Adams, Christi; Swenson, Jacob; Tuason, Dhol; Watson, Stephanie; Creehan, Sue, Turning and Repositioning the Critically Ill Patient With Hemodynamic Instability: A Literature Review and Consensus Recommendations Journal of Wound, Ostomy and Continence Nursing, 2013; 40(3); 254-267.


Appendix

Figure 1: Injury Categorization and Staging Algorithm