**Hospital Acquired Pressure Injury (HAPI) Review Tool**

*For Quality Review Purposes; Privileged and Confidential – Fax to 615-343-3398*

**Patient:**

**MRN:**

**DOB:**

**Admit Date:**

**Admit Dx:**

**HAPI first documented date:**

**Unit/Room #:**

**Unit acquired Y / N**

**If no preceding unit(s) \_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| **PI Location** | **Stage** | **Device Related Y/N (if yes, what device)** |
|  |  |  |
|  |  |  |
|  |  |  |

Admit Braden: \_\_\_\_ Current Braden: \_\_\_\_

OR within past 72 hours Y/N

If yes, time in OR and type of surgical procedure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contributing Factors (Check all that apply)**

[ ]  Incontinence

 [ ]  Fecal

 [ ]  Urinary

[ ]  Signs of incontinence related dermatitis

[ ]  Reduced LOC/Patient sedated

[ ]  Sepsis diagnosis

[ ]  Multi-Organ Failure (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Multi-Trauma

[ ]  DM

[ ]  On Vasopressors at time PI discovered or within past 24 hours

[ ]  Peripheral Vascular Disease

[ ]  Hx of DM

[ ]  Restraints

[ ]  Malnutrition

[ ]  Hip fracture

[ ]  Anasarca

[ ]  Dying process

[ ]  Bedrest order

[ ]  Inability to turn (reason and documentation of Y/N) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  HOB >30 degrees and clinical indication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Interventions in use at time of PI discovery (Check all that apply)**

[ ]  Sacral Mepilex

[ ]  Heel Mepilex

[ ]  Heel lift boot

[ ]  Barrier ointment

[ ]  Wound team following? (Simple/Complex) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Foley

[ ]  External catheter

[ ]  BMS

[ ]  Turn & Position System (TAPS)

[ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mattress Type (printed on lower end of mattress):** [ ] Isolibrium (ICU) [ ] Isoflex LAL (Acute Care/Stepdown)

[ ]  Dolphin [ ] Bariatric [ ] Stretcher [ ] Posey

**Additional findings (use reverse if needed): What do you feel could have been done differently?**

Form completed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_