**Instructions:** Focus on hospital acquired pressure injuries stage 2 or greater within the last 12 months. Audit chart documentation 72 hours prior to the HAPI discovery and 72 hours after it was discovered if applicable. Enter N/A for questions that do not apply.

1. If the answer to the question is “YES”, mark an X in the box. Leave the box empty if there is no documentation that this important process occurs.

2. The processes with the most blank boxes could be a priority focus.

**Do NOT** spend more than 20-30 minutes per chart!

### HAPI DETAIL — briefly document HAPI details

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<tbody>
<tr>
<td>Anatomical Location of HAPI</td>
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<td>Length of stay (LOS) when discovered</td>
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<td>Stage when discovered</td>
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<td>The patient was transferred prior to discovery</td>
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<td>Unit patient was on when HAPI discovered</td>
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### PROCESS

#### Risk Screening

A standard HAPI risk screening tool was used to assess this patient’s risk.

#### Support Surface

Support surface — the patient was on a specialty support surface.

Patient was placed on specialty surface in ER.

If patient was not on a specialty surface in the ED, what was their length of stay?

Patient was placed on specialty mattress in the OR.

If OR specialty surface was not used, what was the OR length of stay?

#### Skin Assessment

Head to toe skin assessment is documented per policy on admission

Skin Inspection is conducted per policy
Redness is recognized before skin breakdown occurs and is alleviated with pressure relief

**Keep Moving**

- Mobilization — patient is mobilized to their highest ability
- Pressure redistribution is documented Q2H for immobile patients
- Patient is mobilized in a way to prevent friction and shear. Immobilized patients are moved with equipment, glide sheets used
- Heels are floated for immobile patients
- Sacral foam dressing in place to protect from shear and moisture (N/A if injury is not on sacrum)
- Head of bed (HOB) not greater than 30 degrees

**Incontinence/Moisture**

- Moisture — incontinence managed optimally — external catheters, fecal collection devices
- Barrier cream used
- Moisture from drainage and interiginous skin related issues is managed
- If moisture score 1 or 2, or incontinence or moisture present, patient is placed on a low air-loss mattress

**Nutrition/Hydration**

- Nutritional consult completed or nutritional interventions in place for high risk patient
- Food intake documented and addressed. i.e. supplements provided if intake documented as inadequate or poor
- Patient’s fluid intake was addressed

**Medical Devices: trach, O2, cervical collar, orthotics — hand or foot braces**

- Protective measures were taken to prevent device-related injury: foam padding, protective dressings, repositioning of the device

**Patient and Family Engagement (PFE)**

- Documentation present that the patient’s HAPI risk was discussed with patient and/or family
- Documentation present that the patient’s or family’s understanding of the need for HAPI prevention is validated using teach-back
- Documentation present that the patient and/or family have been educated about repositioning, protective skin care measures, hygiene and nutrition/hydration.
- Documentation present that the patient and family are actively engaged in preventative skin care via use of teach-back or patient or family member’s active engagement in preventative care.