The following is a tool to assist perioperative personnel collect data related to the occurrence of perioperative pressure ulcer development in surgical patients. The audit tool should be adapted to your facility.

OR Chart Summary for Pressure Ulcer Data Collection

(How-to Guide/Information)

Patient **Medical Record Number**

Age **ASA**

Pressure Ulcer:
Location, description, and severity of pressure ulcer.
Pictures are helpful.
Date the pressure ulcer was reported. May include the date that a formal report is due.

Preoperative diagnosis

OR procedure(s)

Surgery date(s)

Total procedure time (Cut time to close time)

Total anesthesia, positioning, and prep time before procedure begins

Total time after procedure, before transfer out of the OR

Preoperative Skin Assessment

Preoperative Assessment
Factors relating to ability to move (ie, mental status/orientation or sedation) and physical limitations (contractures, fractures, severe pain, decreased mobility, obesity)
Other risk factors (ie, moisture, presence of tubes/drains/catheters, nutritional status, and NPO status)

OR Position/Reposition

OR Positioning Equipment Used
Include use of preventative dressings and off-loading boots. RNs should be very specific when charting what was used. Remember if you didn't chart it, you didn't use it, and you cannot collect data about prevention and outcomes.

Patient Transfer

What equipment was used to transfer the patient?
What kind of bed/stretcher was used?

Postoperative Skin Assessment

Summary of OR Contributing Factors/Risks

Additional Considerations

Use your institution's own pressure ulcer data.

Who is at risk for a pressure ulcer at your institution? Which of these factors did the patient have?

Did your RNs use every prevention measure to prevent the pressure ulcer?

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