Pressure Injury Evidence-Based Practice Checklist

Assessing Risk	Present	Revision Needed	Revision Complete	Implemented
Risk assessment policy (NPIAP, WOCN, F686)				
Evidence-based risk assessment (Braden or Norton) completed on admission, readmission, weekly x 4, quarterly and with all condition changes? (NPIAP, F686)				
Systems established to ensure assessments are completed in timely manner and interventions are implemented, monitored, and revised (F686)				
Policy for scheduled head-to-toe skin assessments (including the skin under/around medical devices) on admission and at least weekly by licensed staff (NPIAP, WOCN, F686)				
Policy for scheduled head-to-toe skin observations and reporting twice weekly by CNA (NPIAP)				
Nutritional screening policy in place - admission and change of condition and ongoing assessments for newly admitted or facility acquired PI residents. (NPIAP, WOCN, F686)				
Prevention plan implemented according to each subset of the risk assessment and taking into consideration additional intrinsic/extrinsic risk factors, including: 1. BMI 2. Age 3. LOS 4. Smoking 5. Weight loss 6. ED Visits 7. Prolonged time on stretchers 8. Medications (sedatives, hypnotics, analgesics, and nonsteroidal anti-inflammatory drugs) 9. History of hip fracture (NPIAP, WOCN, F686)				
Assess the resident's skin and review medical record for history of PI (WOCN, F686)				

Prevention/Skin Care	Present	Revision Needed	Revision Complete	Implemented
Care plan for individualized turning and positioning programs (NPIAP, F686)				
Repositioning Guidelines (NPIAP, WOCN): • Implement repositioning reminder strategies to promote adherence to repositioning regiments.				
• Use 30-degree side lying position when turning and keep HOB as flat as possible unless medically contraindicated				
• Avoid positioning on existing PU, bony prominences, medical devices				
• Lift, do not drag for reduction of friction and shear				
• Transfer aides readily available				
• Use transfer aides to reduce friction and shear				
• Promote sitting OOB in an appropriate chair or wheelchair for limited period,				
• Encourage resident, if able to reposition weight in wheelchair or perform repositioning of wheelchair resident's hourly.				
• Feet on floor, footstool, or W/C pedals				
• Avoid slouching positions in bed and W/C				
• Offload the heel completely in such a way as to distribute the weight of the leg along the calf without placing pressure on the Achilles tendon and popliteal vein.				
• Use pressure redistribution support surfaces on bed and W/C according to risk (NPIAP, WOCN)				
• System for evaluating "bottoming out" with support surfaces in bed and chair (WOCN)				
• For high BMI residents: ensure bed and chair surface area are sufficiently wide to allow turning the resident				
Implement a skin care regime that includes (NPIAP): • Keeping the skin **clean** and appropriately **hydrated**				
• Cleansing the skin properly after episodes of incontinence				
• Avoiding the use of alkaline soaps and cleansers				

• **Protecting** the skin from moisture with a barrier product				
• Have skin care products conveniently available at the bedside				
• Use high absorbency incontinence products				
• Use of soft silicone multi-layered foam dressings to protect high risk areas (i.e., sacrum, heels)				
Practices to Avoid (NPIAP): • Rubbing/massaging red areas				
• Use of doughnuts				
• Prolonged positioning at semi fowler/high fowler when in bed; avoid side lying positions with direct pressure on the trochanter				
• No double padding/layers of linen				
Include resident in assessments (ask about pain, itching, hx, etc.) and include in prevention plan (NPIAP, WOCN, F686)				
Nutritional assessment; close monitoring for weight loss (F686)				
Treatment	**Present**	**Revision Needed**	**Revision Complete**	**Implemented**
Resident/family involved in plan of care decisions. treatment goals and interventions are consistent with the value and goals of the resident and family (NPIAP, WOCN, F686)				
Process established for accurate identification of wounds and PI staging (NPIAP, WOCN, F686)				
System for classifying non-pressure wounds (NPIAP)				
Wound investigation with documentation to support type of wound determined (PI, Arterial, Venous, Neuropathic, etc.) for all new wounds (NPIAP, WOCN, F686)				

With each dressing change wound is assessed and documented. Documentation includes (NPIAP, F686): • Location and staging • Size • Exudate, if present • Pain, if present • Wound bed • Description of wound edges and surrounding tissue				
Changes in wounds are reported to the physician, wound/treatment nurse, and others as appropriate				
Process for monitoring healing (NPIAP, WOCN, F686): • Compare assessment findings to previous assessments of the PI to monitor progress towards healing or				
• Consider using a validated tool to monitor PI healing				
Select a uniform, consistent method for measuring PIs to facilitate meaningful comparisons of wound measurements across time.				
Weekly PI Logs include initial date assessed, specific location, stage of PI, L x W x D; tunneling, undermining, tissue type, wound bed, wound edges, exudate, odor, peri wound, pain, progress (NPIAP, WOCN, F686)				
Wounds without evidence of healing in 2 weeks reassessed by interdisciplinary team for appropriate treatment change (NPIAP, WOCN, F686)				
Wound related Pain is assessed and treated - verbal and non-verbal tool available (NPIAP, WOCN, F686)				
Access to appropriate selection of dressings needed to match wound type and description: Hydrocolloid, Transparent, Hydrogel, Alginate, Foam, Silver Impregnated, Honey, Cadexomer Iodine, Silicone Contact Layer, Collagen, Negative Pressure Wound Therapy (NPIAP)				
Palliative care model available when goal is not to heal (NPIAP)				
Nutrition assessment: estimation of nutritional requirements/intake vs. requirements/interventions added/monitoring at frequent intervals (NPIAP, WOCN, F686)				
Adequate hydration provided/monitoring for S/S of dehydration (NPIAP, WOCN, F686)				

Documented Evidence of Education – Orientation/Annually per policy	Present	Revision Needed	Revision Complete	Implemented
Resident/family of prevention and treatment (NPIAP, WOCN)				
Etiology and risk factors for PIs – All Nursing Staff (NPIAP, WOCN)				
Risk assessment tool – Licensed Staff (NPIAP, WOCN)				
Comprehensive skin assessment/observation and skin care – All Nursing Staff (NPIAP, WOCN)				
Assessment/observation of non-Caucasian skin – All Staff (NPIAP)				
Assessment/observation for S/S of infection – All Nursing Staff (NPIAP, WOCN)				
Principles of prevention and wound healing including evaluating healing status – Licensed Nurses (WOCN)				
Strategies to minimize PI recurrence – Licensed Nurses (WOCN)				
Positioning techniques – All Nursing Staff				
Differentiating types of ulcers/staging vs. partial/full thickness/pressure, arterial, venous, neuropathic, skin tears, moisture-associated skin damage, medical adhesive related skin damage - Licensed Staff (NPIAP)				
Risk of medical devices causing pressure points – All Nursing Staff (NPIAP)				
Incontinence care and barrier product – All Nursing Staff (NPIAP)				
Pain control: routine med administration and/or prior to tx; time out when causing pain; moist wound bed reduced pain; non-adherent dressings reduce pain – Licensed Staff (NPIAP)				
Nutrition – All Nursing Staff (NPIAP)				
Selection and use of support surfaces – Licensed Nurses (bed and chair; NPIAP)				
Wound care, including wound dressing selection – Licensed Nurses (NPIAP)				
Documentation – Licensed Nurses (NPIAP)				
Importance of professional approach – Licensed Nurses (NPIAP)				

Implementing Best Practices				
At an organizational level (NPIAP): • Develop and implement a structured, tailored, and multi-faceted quality improvement program to reduce the incidence of PIs				
• Assess the knowledge that health professionals have about pressure injuries to facilitate implementation of a quality improvement program				
• Assess and maximize the availability and quality of equipment and standards for its use as a part of a quality improvement plan to reduce the incidence of PIs				
• Engage all key stakeholders in oversight and implementation of the quality improvement program to reduce the incidence of PIs				
• Include evidence-based policies, procedures and protocols and standardized documentation systems to reduce the incidence of PIs				
• Provide clinical decisions support tools as part of a quality improvement plan to reduce the incidence of PIs.				
• Provide clinical leadership in PIP and treatment as part of a quality improvement plan to reduce PIs.				
• Provide education in PI prevention and treatment as part of a quality improvement plan.				
• Regularly monitor, analyze, and evaluate performance against quality indicators for PI prevention and treatment,				
• Use feedback and reminder systems to promote the quality improvement program and its outcomes to stakeholders.				