Self-Assessment

Pressure Injury (PI) Risk Assessment

Statement	Rating on 1 to 10 Scale *1=Strongly Disagree 10=Strongly Agree*	Comments
A system is in place for comprehensive visualization of skin on admission/readmission by licensed nurses.		
A system is in place for comprehensive visualization of skin weekly by licensed nurses.		
A system is in place for comprehensive visualization of skin daily by CNAs.		
A policy is in place for completing/validating risk assessments (e.g., Braden, Norton) on admission/readmission and weekly x 4, quarterly and with significant change.		
A system is in place for assigning accountability to monitor risk assessment completion and implementation of interventions		
A baseline plan of care is developed addressing resident preferences/goals, needs identified in the completed assessments and other identified risks (e.g., Braden/Norton, initial skin observation, nutrition, etc.).		
Interdisciplinary Team (IDT) members, within their scope, have a system that facilitates assessment of pressure injury risk.		
CAA analyses are designated to various members of the IDT for completion.		
IDT members collaborate based upon the integrated assessment to develop a comprehensive plan of care specific to each resident.		
Residents and families participate in the assessment process, interventions, and the development of plan of care.		
Challenge:		
For the next 3 months, what action plan will you develop to enhance pressure ulcer risk assessment processes?		

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