Rapid-cycle Improvement Program

Pressure Injuries Assessment

WHAT IS THIS TOOL?

This assessment allows hospitals to identify opportunities for improvement to reduce the risk of a patient developing pressure injuries. Use this tool to interview unit-based staff and compare current practices with recommended evidence-based best practices.

WHO SHOULD USE THIS TOOL?

Hospital-based quality improvement teams focused on reducing hospital-acquired PIs.

ASSESSMENT PROCESS:

- Review the hospital's internal policies and protocols.
- Review electronic medical records for select patients to evaluate the presence of documented assessments and interventions.
- Complete the assessment with unit-based staff from multiple hospital areas to ensure that unit-to-unit variation is accounted for in any hospital-wide action plans developed as a result of the assessment.
- Review responses with your EQIC project manager for additional guidance and next steps.

HQIC | Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES
iQUALITY IMPROVEMENT & INNOVATION GROUP

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EVIDENCE-BASED PRACTICE	PRACTICE IN PLACE?	NOTES
ORGANIZATIONAL STRUCTURE AND CULTURE		
An interdisciplinary team or committee focused on PI prevention meets regularly.	Yes No	
This team reports to the hospital quality improvement committee or board of directors.	Yes No	
The hospital has identified an executive sponsor.	Yes No	
There are designated unit-based champions across the hospital.	Yes No	
The hospital has a performance improvement program in place.	Yes No	
Policies/protocols have been developed and updated with current guidelines/evidence-based recommendations.	Yes No	
New treatments, equipment designed to assist with treatment and prevention are frequently evaluated.	Yes No	
Patient stories are shared with frontline staff and board members.	Yes No	
DATA COLLECTION AND REPORTING		
PI prevalence is monitored.	Yes No	
Prevalence studies aimed at identifying hospital-acquired PIs are performed:	Annually Quarterly Monthly Bi-weekly Weekly Varies by unit Never	
PI prevalence rates are delineated by unit location.	Yes No	
PI prevalence rates are shared with frontline unit staff.	Yes No	
PI prevalence rates are reported to the quality improvement committee or board of directors.	Yes No	

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EVIDENCE-BASED PRACTICE	PRACTICE IN PLACE?	NOTES
STAFF EDUCATION		
The hospital uses a standardized reporting mechanism (i.e., dashboard) to track prevalence and outcomes.	Yes No	
Staff that receive education and training on PI prevention strategies include *(check all that apply)*:	Providers Frontline staff Clinical support staff Transport staff Environmental staff	
Staff education about PI prevention and treatment is provided:	At orientation Annually Other; describe: ____________	
Education on how to assess for changes in lightly and darkly pigmented skin is provided.	Yes No	
RISK ASSESSMENT		
The hospital uses a validated risk assessment tool to identify patients at risk of PI as early as possible in the hospital visit (i.e., Braden Scale).	Yes No	
The validated risk assessment tool is programmed into the EMR. If yes, the tool includes information for each element that makes up the overall risk score.	Yes No Yes No	
The risk assessment is: • completed every shift • completed with changes in the patient's condition • completed upon transfer to a different level of care • documented in the EMR	 Yes No Yes No Yes No Yes No	
There is a reminder/prompt to complete the risk assessment in the EMR.	Yes No	
Nutritional status risk is considered for patients who are nil per os or at high risk of undernutrition or malnutrition from their illness.	Yes No	

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EVIDENCE-BASED PRACTICE	PRACTICE IN PLACE?	NOTES
RISK ASSESSMENT (CONTINUED)		
The patient's plan of care is based on the areas related to being at risk for developing PI, rather than on the total risk assessment score (i.e., a patient who is confined to bed should have the head of the bed elevated 30° at all times and use a trapeze to lift themself).	Yes No	
Patient and care partner participate in: • risk assessment • risk reduction interventions • education about PI risk	 Yes No Yes No Yes No	
Identified risks are explained to the patient and care partner.	Yes No	
SKIN CARE		
Skin is inspected within eight hours of admission.	Yes No	
Skin is inspected for signs of PI, especially non-blanchable erythema, at least daily.	Yes No	
Inspection includes: • skin temperature • skin color • skin moisture • skin turgor • skin integrity • skin tone specific to lightly and darkly pigmented skin	 Yes No Yes No Yes No Yes No Yes No Yes No	
Pressure points, i.e., sacrum, coccyx, buttocks, heels, ischium, trochanters, elbows and beneath medical devices are included in the skin inspection.	Yes No	
Skin is promptly cleansed after episodes of incontinence.	Yes No	
Skin cleansers used are pH balanced.	Yes No	
Skin is moisturized at least daily.	Yes No	

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EVIDENCE-BASED PRACTICE	PRACTICE IN PLACE?	NOTES
SKIN CARE (CONTINUED)		
Progress toward healing is assessed using a valid and reliable PI assessment scale (e.g., the Bates-Jensen Wound Assessment Tool or the Pressure Ulcer Scale for Healing©).	Yes No	
Patients, care partners and families are educated about products, benefits and how to maintain good skin care prior to discharge.	Yes No	
NUTRITION		
A validated screening tool, such as the Mini Nutritional Assessment, is used to determine risk of malnutrition. The screening score and interpretation are populated in the EMR.	Yes No Yes No	
Nutrition care plans are individualized and documented for patients with or at risk of a PI, malnourished or at risk of malnutrition developing. Nutrition care plan goals and interventions are communicated to the healthcare team.	Yes No Yes No	
All individuals at risk for PI from malnutrition are referred to a registered dietitian/nutritionist.	Yes No	
Adults with a PI who are malnourished or at risk of malnutrition receive: • 30-35k cal/kg body weight per day • 1.25-1.5g protein/kg body weight per day	 Yes No Yes No	
Assistance is provided during mealtimes to ensure the patient is able to maintain adequate oral nutrition.	Yes No	
Patients at risk for PI are encouraged to maintain adequate nutritional and fluid intake. • Information on the importance of adequate nutritional and fluid intake is provided to patients and care partners. • Care partners are encouraged to help patients meet nutritional requirements.	Yes No Yes No Yes No	

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EVIDENCE-BASED PRACTICE	PRACTICE IN PLACE?	NOTES
NUTRITION (CONTINUED)		
Routine assessments of the adequacy of oral, enteral and parenteral intake occur.	Yes No	
High-calorie, high-protein nutrition supplements are provided to patients between meals and with oral medications (unless contraindicated).	Yes No	
TOILETING/INCONTINENCE MANAGEMENT		
Urinary/fecal management includes: • proactive toileting plan • wet checks • treatment of causes • assistance with hygiene • immediate cleaning • use of skin barriers and protectants	 Yes No Yes No Yes No Yes No Yes No Yes No	
Patient and care partner participate in PI prevention and care by assisting with (for example): • repositioning patient (unless contraindicated) • alerting staff if dressings shift or move • alerting staff to any other areas of concern	 Yes No Yes No Yes No	
POSITIONING AND MOBILIZATION		
All individuals at risk for PI are routinely turned and positioned, unless contraindicated.	Yes No	
A minimum of two people and a draw sheet are used to passively pull individuals up in bed.	Yes No	
Turning frequency is patient-specific and based on: • the support surface in use • tolerance of skin for pressure	 Yes No Yes No	

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EVIDENCE-BASED PRACTICE	PRACTICE IN PLACE?	NOTES
POSITIONING AND MOBILIZATION (CONTINUED)		
Hospital uses a turning schedule for PI prevention. If yes, the turning schedule allows for uninterrupted sleep during the night.	Yes No Yes No	
30° side-lying position and the "hand test" are used to determine if the sacrum is off the bed.	Yes No	
Heels are free from the bed. Heel offloading devices or polyurethane foam dressings are used on individuals as appropriate.	Yes No Yes No	
A polyurethane foam dressing is placed on pressure points, e.g. sacrum, elbows, etc., for individuals who cannot be moved or are positioned with the head of the bed elevated over 30°.	Yes No	
A policy or procedure is available or in place for requesting specialized support surfaces (e.g., active alternating pressure support or reactive, constant low-pressure support surface).	Yes No	
Selection criteria for choosing support surface includes: • level of immobility • exposure to shear • skin moisture • perfusion • body size and weight	 Yes No Yes No Yes No Yes No Yes No	
A breathable incontinence pad is used when using microclimate management surfaces (i.e., materials that allow local tissue and moisture control at the body/surface interface).	Yes No	
A pressure redistributing chair cushion is provided for individuals sitting in chairs or wheelchairs.	Yes No	
Static sitting is limited to two hours at any time.	Yes No	
Removable devices are removed to assess skin at least once per shift.	Yes No	

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EVIDENCE-BASED PRACTICE	PRACTICE IN PLACE?	NOTES
MANAGEMENT OF MEDICAL DEVICES		
Thin foam or breathable dressings are applied under medical devices.	Yes No	
Level of edema and condition of skin under device(s) is assessed at least once per shift.	Yes No	
Devices are not placed directly under individuals who are bedridden or immobile.	Yes No	
Skin injury prevention methods and treatments are explained to the patient and care partner.	Yes No	

THIS TOOL IS BASED ON:

Agency for Healthcare Research and Quality. *Preventing Pressure Ulcers in Hospitals*. Content last reviewed April 2023. https://www.ahrq.gov/patient-safety/settings/hospital/resource/pressureulcer/tool/index.html

European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline. *The International Guideline*. Emily Haesler (Ed.). EPUAP/NPIAP/PPPIA: 2019 https://guidelinesales.com/page/NPIAP

Munoz, N; Litchford, M; Cox, J; Nelson, JL; Nie, AM; Delmore, B. Malnutrition and Pressure Injury Risk in Vulnerable Populations: Application of the 2019 International Clinical Practice Guideline. *Adv Skin Wound Care*. 2022 Mar 1;35(3):156-165. doi: 10.1097/01.ASW.0000816332.60024.05. PMID: 35188483. https://cdn.ymaws.com/npiap.com/resource/resmgr/white_papers/Munoz_et_al_2022_Malnutritio.pdf

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