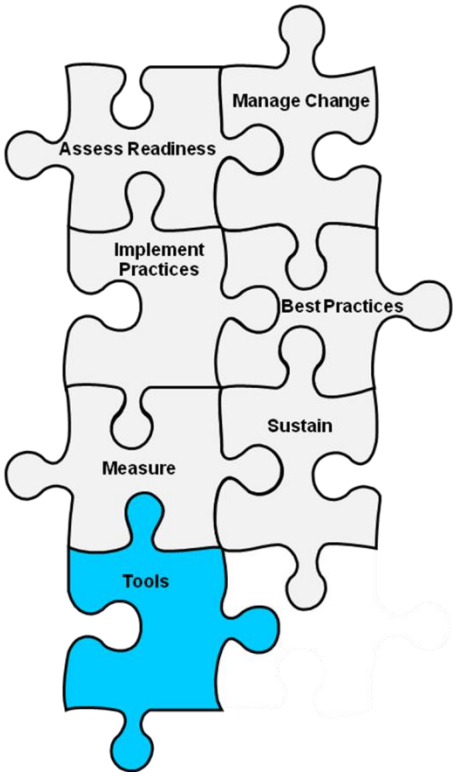
Section 7. Tools and Resources



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Tool 0A: Introductory Executive Summary for Stakeholders

Background: This template can serve as a letter to key players in the hospital to introduce them to the goals and purpose of a pressure ulcer project.

Reference: Developed by the Boston University Research Team.

Instructions: Adapt this letter as needed and present it to key players to enlist their support before mounting your pressure ulcer prevention project. You may want to use tool 1B, Key Stakeholder Analysis, to identify individuals and departments that may have an interest in the project.

Dear <Name>:

We would like to introduce you to a new pressure ulcer prevention project. We hope that you will support this exciting new endeavor.

What is this project? <Hospital name> is embarking on an important new initiative focused on the prevention of pressure ulcers among our acute care patients.

Why is this project important? Pressure ulcers acquired during acute care stays present significant treatment and recovery delays for patients, increase length and cost of inpatient stays, and have become a "never" event from the standpoint of Medicare reimbursement.

How might this project affect me/my area? In the past, pressure ulcer care has sometimes been seen as solely a nursing unit responsibility. However, recent research has made it clear that successfully reducing pressure ulcer incidence requires a coordinated multidisciplinary approach. Thus, the implementation of new prevention approaches may require, for example, the efforts of:

- Materials and supplies: Do we have the most evidence-based products and equipment necessary for preventing pressure and skin breakdown? Are new products evaluated with this outcome in mind?
- Housekeeping: Do standard bed-making techniques and materials result in too much moisture being retained next to patient skin?
- Information technology: Is information about skin assessment and pressure ulcer prevention interventions effectively integrated into the electronic medical record?
- Respiratory therapy: Is all respiratory equipment appropriately placed to reduce the chances of pressure sores developing where tubing or mouthpieces are in contact with patient skin?
- Medicine: Are appropriate orders on file or available for any needed special surfaces or other preventive measures?
- Quality improvement: Are QI training and techniques available to the team working on this effort?
- Transport: Is patient time on hard wheelchairs or stretchers minimized or mitigated when patients are taken off the unit for diagnostic or therapeutic activities?

What will happen? In this project, we will use the Agency for Healthcare Research and Quality's (AHRQ) new toolkit. This comprehensive toolkit outlines steps in the improvement process and provides relevant tools. Using these tools, we will assess staff awareness and knowledge of pressure ulcer prevention, analyze patient care processes to identify where there are risks to patient skin integrity, and target interventions in those areas. Pressure ulcer incidence while patients are under our care will be tracked and reported more widely so that progress can be assessed.

Everyone has a role: Most important in this effort is a shift of thinking and culture, from seeing pressure ulcers as the inevitable result of patient immobility to seeing them as never events that can be prevented through a comprehensive prevention program. Your support in helping <hospital name> staff make this shift is essential to the success of this effort. Thank you!

1A: Clinical Staff Attitudes Toward Pressure Ulcer Prevention

Background: The Staff Attitude Scale can be used to provide useful feedback on clinical staff beliefs regarding pressure ulcer prevention. It was adapted from a scale used by Moore and Price and uses a 5-point scoring system ranging from strongly agree to strongly disagree. Nurses who completed the scale in the study cited below had scores ranging from 28 to 50, with a median of 40.

Reference: Moore Z, Price P. Nurses' attitudes, behaviors, and perceived barriers towards pressure ulcer prevention. J Clin Nurs 2004;13:942-52.

Instructions:

Administer the survey. It can be used with all staff involved in direct patient care.
Typically, the survey is given anonymously. Depending on your organizational culture, you may want to ask for the name of the respondents to allow followup with individuals after the survey.
To score, assign a numeric value to each response. For most, "strongly disagree" =5, "disagree" = 4, and so on. However, questions 1, 6, 7, and 11 should be reverse scored. For those questions, "strongly disagree"= 1, and so on. Scores on this scale range from 11 (most negative attitudes) to 55 (most positive attitudes).

Use: The results from this survey can help to identify existing attitudes toward pressure ulcer prevention. You may want to administer it to different groups and compare the results to obtain insight on potential inconsistencies among staff. If you find scores that are lower than 40, one of the early goals of the interventions may be to address these misperceptions.

Views on Pressure Ulcer Prevention

Your role: _____ Date:_____

	Strongly agree	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly disagree**
1. All patients are at potential risk of developing pressure ulcers					
2. Pressure ulcer prevention is time consuming for me to carry out					
3. In my opinion, patients tend not to get as many pressure ulcers nowadays					
4. I do not need to concern myself with pressure ulcer prevention in my practice					
5. Pressure ulcer treatment is a greater priority than pressure ulcer prevention					
6. Continuous assessment of patients will give an accurate account of their pressure ulcer risk					
7. Most pressure ulcers can be avoided					
8. I am less interested in pressure ulcer prevention than other aspects of care					
9. My clinical judgment is better than any pressure ulcer risk assessment tool available to me					
10. In comparison with other areas of care, pressure ulcer prevention is a low priority for me					
11. Pressure ulcer risk assessment should be regularly carried out on all patients during their stay in hospital					

1B: Stakeholder Analysis

Background: The purpose of the stakeholder analysis is to help the project initiators identify what departments/individuals will have an interest in the project, where barriers might exist, and what actions need to be taken to obtain the buy-in and participation of those departments and individuals. This tool was adapted from a template developed by Project Agency, a British company focused on effective project management.

Reference: Available at: http://www.businessballs.com/project%20management%20templates.pdf.

Instructions: Complete the form with information regarding all the individuals you consider key stakeholders. You may need to set up a meeting with them to obtain their answers. Examples: information technology officer, director of supply/materials, housekeeping director, quality improvement (QI) department, therapy departments, diagnostic departments, emergency department.

Use: Use the completed template to identify actions needed to involve all stakeholders in the project. Ensure that all identified needs have been met before proceeding with the QI initiative. For example, the project may need process assistance from the QI department. Since this project may be competing with other QI priorities, it may be important to determine who shapes the QI agenda and how to get this project prioritized at a higher level. An example is shown in the form below. A blank form follows.

Stakeholder	Interest or requirement in the project	What the project needs from stakeholder	Perceived attitudes and risks	Actions to take
Example: health information systems officer	Gatekeeper for making any changes to the electronic medical record (EMR) system. Not necessarily interested in the project beyond his general mandate to keep the EMR tied to clinical documentation needs.	The project may need to add or make changes to any parts of the EMR that concern skin assessment, preventive measures, and skin care.	May not want to make changes until other changes are also in process, or other changes may already be in process.	Seek information about the process for requesting/making these kinds of changes and how this person relates in the overall organizational structure to project leaders/advocates.

Stakeholder	Interest or requirement in the project	What the project needs from stakeholder	Perceived attitudes and risks	Actions to take

1C: Leadership Support Assessment

Background: This tool can be used to assess senior leadership support for implementing a pressure ulcer prevention project.

Reference: Developed by Boston University Research Team.

Instructions: Complete the checklist.

Use: Review the responses to ascertain the level of leadership support. If the response to several of these items is no, it could threaten the success of your improvement process. Analyze the areas where support is not evident and take steps to inform leadership about the urgency to change.

Leadership Support Assessment	**Yes**	**No**
Patient safety is clearly articulated in the organization's strategic plan		
Someone in senior management is in charge of patient safety		
The facility has implemented a shared leadership model		
There is a dedicated budget allocated for patient safety activities		
The budget includes funding for education and training on patient safety issues such as pressure ulcer prevention		
Improved pressure ulcer prevention is a priority within the facility		
The facility has implemented a pressure ulcer prevention policy		
Current pressure ulcer prevention goals are being addressed		
There are visible role models/champions for pressure ulcer prevention		

1D: Business Case Form

Background: This tool can be used to make the case for the implementation of a quality improvement initiative by addressing the concerns of key leadership. The form was adapted from a template developed by Project Agency to help write a business case.

Reference: Available at: www.businessballs.com/project%20management%20templates.pdf.

Instructions: Complete the form with all the required information.

Use: Present the completed form to your project sponsor and discuss the potential benefits of the pressure ulcer prevention initiative.

Project Background (keep this brief)
General aims
Initial Risks
Expected Outcomes
Benefits of Implementing This Project
Initial Estimates of Cost and Time $: Time:
Outcome of the Business Case
Decision From (Project Sponsor)
Date

1E: Resource Needs Assessment

Background: The purpose of this tool is to identify resources that are available for a quality improvement initiative.

Reference: Developed by Boston University Research Team.

Instructions: Complete this checklist to assess the resources that are available and the resources that are still needed.

Use: Ensure that all resources needed for launching a pressure ulcer prevention initiative are available.

Resource	Needed: Yes/No	Notes on what is needed
Funds		
Other Resources		
Staff education programs		
Quality improvement experts		
Physical/occupational therapy consultation on work practices		
Information technology support		
Specific products/tools (e.g., support bed and chair surfaces)		
Facilities and supplies (e.g., meeting rooms)		
Printing/copying		
Graphics/design		
Nonclinical time for team meetings and activities		
Other		

2A: Multidisciplinary Team

Background: Crucial to a pressure ulcer prevention initiative is the creation of a multidisciplinary implementation team that will oversee the improvement effort. This tool can be used to identify people from different interdisciplinary areas to take part on the implementation team.

Reference: Developed by Boston University Research Team.

Instructions: List the names of possible team members from each department or discipline and their area of expertise.

Use: Use this list to form your implementation team.

Discipline	Names of possible implementation team members from each area	Area of expertise
Senior manager		
Quality improvement/Safety/risk manager		
Wound staff		
Wound nurse		
Wound physician		
Staff nurse		
Nursing assistants		
Registered dietitian		
Hospitalist physicians		
Physical therapists		
Occupational therapists		
Medical/surgical staff		
Other providers		
Patient representative		
Educator		
Materials manager		
Information systems staff		
Clerical staff		

2B: Quality Improvement Process

Background: This tool will help you and your team identify the extent to which you have the resources for quality improvement (QI) in your organization. The form was developed by the Turning Point Initiative to assess if an organization has the needed systems in place to improve quality and performance.

Reference: Turning Point Performance Management National Excellence Collaborative. Performance Management Self-Assessment Tool. Available at: www.turningpointprogram.org/toolkit/pdf/PM_Self_Assess_Tool.pdf.

Instructions: This tool should be filled out by the implementation team leader in consultation with the QI department. The "you" refers to your organization as a whole. Check the box that most accurately describes your organization's current resources.

Use: If you find that your organization has fully operationalized QI processes, connect the pressure ulcer prevention initiative with these existing processes. If some processes are missing, advocate for them to be put into place in the context of the pressure ulcer initiative.

Quality Improvement Process

Assessment Question	No	Somewhat	Yes (fully operational)
1. Do you have a process(es) to improve quality or performance?			
Is an entity or person responsible for decision-making based on performance reports (e.g. top management team, governing or advisory board			
Is there a regular timetable for your QI process?			
Are the steps in the process communicated?			
2. Are managers and employees evaluated for their performance improvement efforts (i.e., is performance improvement in their job descriptions)?			
3. Are performance reports used regularly for decisionmaking?			
4. Is performance information used to do the following? (check all that apply)			
Determine areas for more analysis or evaluation			
Set priorities and allocate/redirect resources			
Inform policymakers of the observed or potential impact of decisions under their consideration			
5. Do you have the capacity to take action to improve performance when needed?			
Do you have processes to manage changes in policies, programs, or infrastructure?			
Do managers have the authority to make certain changes to improve performance?			
Do staff have the authority to make certain changes to improve performance?			
6. Does the organization regularly develop performance improvement or QI plans that specify timelines, actions, and responsible parties?			
7. Is there a process or mechanism to coordinate QI efforts among programs, divisions, or organizations that share the same performance targets?			
8. Is QI training available to managers and staff?			
9. Are personnel and financial resources allocated to your QI process?			

2C: Current Process Analysis

Background: Before beginning a quality improvement initiative, you need to understand your current methods. This tool can be used to describe key processes in your organization where pressure ulcer prevention activities could or should happen.

Reference: Adapted from: Quality Partners of Rhode Island. QI Worksheet E, Current Process Analysis. Available at: https://www.qualitynet.org/dcs/ContentServer?c=MQTools&pagename=Medqic%2FMQTools%2FToolTemplate&cid=1096585074914.

Instructions:

- Have the implementation team identify and define every step in the current process for pressure ulcer prevention.
- When defining a process, think about staff roles in the process, the tools or materials staff use, and the flow of activities.
- Everything is a process, whether it is admitting a resident, serving meals, assessing pain, or managing a nursing unit. The ultimate goal of defining a process is identifying problems in the current process.

Use: Determine if there are any gaps and problems in your current processes, and use the results of this analysis to systematically change these processes.

Tips:

- Take time to brainstorm and listen to every team member.
- Make sure the process is understood and documented.
- Make each step in the process very specific.
- Use one post-it note, index card, or scrap piece of paper for each step in the process.
- Lay out each step, move steps, and add and remove steps until team agrees on the final process.
- If a process does not exist (for example, there is no process to screen for pain upon admission and readmission), identify the related processes (for example, the process for admission and readmission).
- If the process is different for different shifts, identify each individual process.

Example: Process for Making Buttered Toast

Step	Define
1	Check to see if there is bread, butter, knife, and toaster.
2	If supplies are missing, go to the store and purchase them.
3	Check to see if the toaster is plugged in. If not, plug in the toaster.
4	Check setting on toaster. Adjust to darker or lighter as preferred.
5	Put a slice of bread in toaster.
6	Turn toaster on.
7	Wait for bread to toast.
8	When toast is ready, remove from toaster and put on plate.
9	Use knife to cut pat of butter.
10	Use knife to spread butter on toast.

Identify the steps of your defined process.

- Press for details.
- At the end of the gap analysis, compile the results in a document that displays each step so that team members have the map of the current process in front of them during the team discussion (Step 2).

Team discussion

Evaluate your current process as you define it:

- What policies and procedures do we have in place for this process?
- What forms do we use?
- How does our physical environment support or hinder this process?
- What staff are involved in this process?
- What part of this process does not work?
- Do we duplicate any work unnecessarily? Where?
- Are there any delays in the process? Why?

Continue asking questions that are important in learning more about this process.

2D: Assessing Pressure Ulcer Policies

Background: This worksheet can be used to determine if your facility has a policy for preventing and managing pressure ulcers. The tool is one of a series of Facility Assessment Checklists used to identify areas that need improvement in nursing homes and has been modified for hospitals.

Reference: Adapted from: Quality Partners of Rhode Island. Pressure Ulcers: Facility Assessment Checklists. Available at: https://www.qualitynet.org/dcs/ContentServer?cid=1098482996140&pagename=Medqic%2FMQTools%2FToolTemplate&c=MQTools.

Instructions: Complete the checklist. For certain questions, you may want to consult with appropriate staff in your organization.

Use: Use the results of this assessment to identify issues that you need to deal with, and formulate goals for your pressure ulcer prevention initiative.

Pressure Ulcer Policy Assessment

Does your facility's policy for the prevention and management of pressure ulcers include these components?

	Yes	No	Person Responsible	Comments
1. Does your hospital's policy include a statement regarding your facility's commitment to pressure ulcer prevention and management?				
Does your hospital's policy include a standard protocol for assessing a patient's risk for developing pressure ulcers?				
Does your hospital's policy state that all patients be reassessed for pressure ulcer risk at the following times: a. Upon admission b. Upon transfer c. When a change in condition occurs				
Does your hospital's policy state that a skin assessment should be performed on all patients at risk for pressure ulcers at the following times: a. Upon admission b. Daily c. Upon transfer				
Does your hospital's policy include who, how and when pressure ulcer program effectiveness should be monitored and evaluated?				
Does your hospital's policy include goals of pressure ulcer management such as: a. Prompt assessment and treatment b. Specification of appropriate pressure ulcer risk and monitoring tools c. Steps to be taken to monitor treatment effectiveness d. Pressure ulcer treatment techniques that are consistent with clinically-based guidelines				
Does your hospital's policy address steps to be taken if pressure ulcer is not healing?				

2E: Assessing Screening for Pressure Ulcer Risk

Background: The purpose of this tool is to determine if your facility has a process to screen patients for pressure ulcer risk. The tool is one of a series of Facility Assessment Checklists developed to identify areas that need improvement.

Reference: Quality Partners of Rhode Island. Pressure Ulcers: Facility Assessment Checklists. Available at: https://www.qualitynet.org/dcs/ContentServer?cid=1098482996140&pagename=Medqic%2FMQTools%2FToolTemplate&c=MQTools.

Instructions: Complete the checklist. For certain questions, you may want to consult with appropriate staff in your organization.

Use: Use the results of this assessment to identify issues that you need to deal with, and formulate goals for your pressure ulcer prevention initiative.

Assessment of Screening for Pressure Ulcer Risk

Does your facility have a process for screening that addresses all the areas listed below?

	Yes	No	Person Responsible	Comments
1. Do you screen all patients for pressure ulcer risk at the following times: • Upon admission • Upon readmission • When condition changes				
2. If the patient is not currently deemed at risk, is there a plan to rescreen at regular intervals?				
3. Do you use either the Norton or Braden pressure ulcer risk assessment tool? *If Yes, **STOP**. If No, please continue to #4.*				
4. If you are not currently using the Norton or Braden risk assessment, does your screening address the following areas: • Impaired mobility: ○ Bed ○ Chair • Incontinence: ○ Urine ○ Stool • Nutritional deficits: ○ Malnutrition ○ Feeding difficulties • Diagnosis of: ○ Diabetes Mellitus ○ Peripheral Vascular Disease • Contractures • Hx of pressure ulcers				

2F: Assessing Pressure Ulcer Care Planning

Background: This tool can be used to determine if your facility has a process for developing and implementing a pressure ulcer care plan for patients who have been found to be at risk or who have a pressure ulcer. The tool is one of a series of Facility Assessment Checklists developed to identify areas that need improvement.

Reference: Quality Partners of Rhode Island. Pressure Ulcers: Facility Assessment Checklists. Available at: https://www.qualitynet.org/dcs/ContentServer?cid=1098482996140&pagename=Medqic%2FMQTools%2FToolTemplate&c=MQTools.

Instructions: Complete the checklist. For certain questions, you may want to consult with appropriate staff in your organization.

Use: Use the results of this assessment to identify issues that you need to deal with, and formulate goals for your pressure ulcer prevention initiative.

Assessment of Pressure Ulcer Care Plan

Does the care plan for pressure ulcers address all the areas below (as they apply)?

	Yes	No	Person Responsible	Comments
Impaired Mobility • Assist with turning, rising, position • Encourage ambulation • Limit static sitting to 2 hours at any time				
Pressure Relief • Support surfaces: Bed • Support surfaces: Chair • Pressure-relieving devices • Repositioning • Bottoming out in bed and chair*				
Nutritional Improvement • Supplements • Feeding assistance • Adequate fluid intake • Dietitian consult as needed				
Urinary Incontinence • Toileting plan • Wet checks • Treat causes • Assist with hygiene • Use of skin barriers and protectants				
Fecal Incontinence • Toileting plan • Soiled checks				
Skin Condition Check • Intactness • Color • Sensation • Temperature				
Treatment • Physician-prescribed regimen • Appropriateness to wound staging • Treatment reassessment timeframe				
Pain • Screen for pain related to ulcer • Choose appropriate pain med • Provide regular pain med administration • Reassess effectiveness of med • Assess/treat side effects • Change or cease pain med as needed				

To determine if a patient has bottomed out, the caregiver should place his or her outstretched hand (palm up) under the mattress overlay below the existing pressure ulcer or that part of the body at risk for pressure formation. If the caregiver can feel that the support material is less than an inch thick at this site, the patient has bottomed out.

2G: Pieper Pressure Ulcer Knowledge Test

Background: This tool can be used to assess staff knowledge on pressure ulcer prevention. The 47-item test was developed by Pieper and Mott in 1995 to examine the knowledge of nurses on pressure ulcer prevention, staging, and wound description. Questions 1, 3, 15, 29, 33, and 40 have been modified from the original to make it more specific to hospital care.

Reference: Pieper B, Mott M. Nurses' knowledge of pressure ulcer prevention, staging, and description. Adv Wound Care 1995;8:34-48.

Instructions:

1. Administer the test to nursing and other clinical staff members.
2. It is generally recommended that responses be anonymous, but some staff might appreciate the opportunity to receive individual feedback. Find out what people on your unit want to do.
3. Use the answer key to evaluate the responses. Note that some questions may need to be modified for your hospital.

Use: Mean scores on this test are usually analyzed. Analyze the test results. If you find gaps of knowledge, work with your education department to develop and tailor educational programs that address these items.

Pieper Pressure Ulcer Knowledge Test

For each question, mark the box for True, False, or Don't Know.

	True	False	Don't Know
1. Stage I pressure ulcers are defined as intact skin with nonblanchable erythema in lightly pigmented persons.			
2. Risk factors for development of pressure ulcers are immobility, incontinence, impaired nutrition, and altered level of consciousness.			
3. All hospitalized individuals at risk for pressure ulcers should have a systematic skin inspection at least daily and those in long-term care at least once a week.			
4. Hot water and soap may dry the skin and increase the risk for pressure ulcers.			
5. It is important to massage bony prominences.			
6. A Stage III pressure ulcer is a partial thickness skin loss involving the epidermis and/or dermis.			
7. All individuals should be assessed on admission to a hospital for risk of pressure ulcer development.			
8. Cornstarch, creams, transparent dressings (e.g., Tegaderm, Opsite), and hydrocolloid dressings (e.g., DuoDerm, Restore) do not protect against the effects of friction.			
9. A Stage IV pressure ulcer is a full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structure.			
10. An adequate dietary intake of protein and calories should be maintained during illness.			
11. Persons confined to bed should be repositioned every 3 hours.			
12. A turning schedule should be written and placed at the bedside.			
13. Heel protectors relieve pressure on the heels.			
14. Donut devices/ring cushions help to prevent pressure ulcers.			
15. In a side lying position, a person should be at a 30 degree angle with the bed unless inconsistent with the patient's condition and other care needs that take priority.			
16. The head of the bed should be maintained at the lowest degree of elevation (hopefully, no higher than a 30 degree angle) consistent with medical conditions.			

	True	False	Don't Know
17. A person who cannot move him or herself should be repositioned every 2 hours while sitting in a chair.			
18. Persons who can be taught should shift their weight every 30 minutes while sitting in a chair.			
19. Chair-bound persons should be fitted for a chair cushion.			
20. Stage II pressure ulcers are a full thickness skin loss.			
21. The epidermis should remain clean and dry.			
22. The incidence of pressure ulcers is so high that the government has appointed a panel to study risk, prevention, and treatment.			
23. A low-humidity environment may predispose a person to pressure ulcers.			
24. To minimize the skin's exposure to moisture on incontinence, underpads should be used to absorb moisture.			
25. Rehabilitation should be instituted if consistent with the patient's overall goals of therapy.			
26. Slough is yellow or creamy necrotic tissue on a wound bed.			
27. Eschar is good for wound healing.			
28. Bony prominences should not have direct contact with one another.			
29. Every person assessed to be at risk for developing pressure ulcers should be placed on a pressure-redistribution bed surface.			
30. Undermining is the destruction that occurs under the skin.			
31. Eschar is healthy tissue.			
32. Blanching refers to whiteness when pressure is applied to a reddened area.			
33. A pressure redistribution surface reduces tissue interface pressure below capillary closing pressure.			
34. Skin macerated from moisture tears more easily.			
35. Pressure ulcers are sterile wounds.			
36. A pressure ulcer scar will break down faster than unwounded skin.			
37. A blister on the heel is nothing to worry about.			
38. A good way to decrease pressure on the heels is to elevate them off the bed.			
39. All care given to prevent or treat pressure ulcers must be documented.			

	True	False	Don't Know
40. Devices that suspend the heels protect the heels from pressure.			
41. Shear is the force that occurs when the skin sticks to a surface and the body slides.			
42. Friction may occur when moving a person up in bed.			
43. A low Braden score is associated with increased pressure ulcer risk.			
44. The skin is the largest organ of the body.			
45. Stage II pressure ulcers may be extremely painful due to exposure of nerve endings.			
46. For persons who have incontinence, skin cleaning should occur at the time of soiling and at routine intervals.			
47. Educational programs may reduce the incidence of pressure ulcers.			

Pieper Pressure Ulcer Knowledge Test: Answer Key

1. Stage I pressure ulcers are defined as intact skin with nonblanchable erythema in lightly pigmented persons.	**True**	
2. Risk factors for development of pressure ulcers are immobility, incontinence, impaired nutrition, and altered level of consciousness.	**True**	
3. All hospitalized individuals at risk for pressure ulcers should have a systematic skin inspection at least daily and those in long-term care at least once a week.	**True**	
4. Hot water and soap may dry the skin and increase the risk for pressure ulcers.	**True**	
5. It is important to massage bony prominences.		**False**
6. A Stage III pressure ulcer is a partial thickness skin loss involving the epidermis and/or dermis.		**False**
7. All individuals should be assessed on admission to a hospital for risk of pressure ulcer development.	**True**	
8. Cornstarch, creams, transparent dressings (e.g., Tegaderm, Opsite), and hydrocolloid dressings (e.g., DuoDerm, Restore) do not protect against the effects of friction.		**False**
9. A Stage IV pressure ulcer is a full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structure.	**True**	
10. An adequate dietary intake of protein and calories should be maintained during illness.	**True**	
11. Persons confined to bed should be repositioned every 3 hours.		**False**
12. A turning schedule should be written and placed at the bedside.	**True**	
13. Heel protectors relieve pressure on the heels.		**False**
14. Donut devices/ring cushions help to prevent pressure ulcers.		**False**
15. In a side lying position, a person should be at a 30 degree angle with the bed unless inconsistent with the patient's condition and other care needs that take priority.	**True**	
16. The head of the bed should be maintained at the lowest degree of elevation (hopefully, no higher than a 30 degree angle) consistent with medical conditions.	**True**	
17. A person who cannot move him or herself should be repositioned every 2 hours while sitting in a chair.		**False**
18. Persons who can be taught should shift their weight every 30 minutes while sitting in a chair.		**False**
19. Chair-bound persons should be fitted for a chair cushion.	**True**	
20. Stage II pressure ulcers are a full thickness skin loss.		**False**
21. The epidermis should remain clean and dry.	**True**	
22. The incidence of pressure ulcers is so high that the government has appointed a panel to study risk, prevention, and treatment.	**True**	

23. A low-humidity environment may predispose a person to pressure ulcers.	**True**	
24. To minimize the skin's exposure to moisture on incontinence, underpads should be used to absorb moisture.	**True**	
25. Rehabilitation should be instituted if consistent with the patient's overall goals of therapy.	**True**	
26. Slough is yellow or creamy necrotic tissue on a wound bed.	**True**	
27. Eschar is good for wound healing.		**False**
28. Bony prominences should not have direct contact with one another.	**True**	
29. Every person assessed to be at risk for developing pressure ulcers should be placed on a pressure-redistribution bed surface.	**True**	
30. Undermining is the destruction that occurs under the skin.	**True**	
31. Eschar is healthy tissue.		**False**
32. Blanching refers to whiteness when pressure is applied to a reddened area.	**True**	
33. A pressure redistribution surface reduces tissue interface pressure below capillary closing pressure.	**True**	
34. Skin macerated from moisture tears more easily.	**True**	
35. Pressure ulcers are sterile wounds.		**False**
36. A pressure ulcer scar will break down faster than unwounded skin.	**True**	
37. A blister on the heel is nothing to worry about.		**False**
38. A good way to decrease pressure on the heels is to elevate them off the bed.	**True**	
39. All care given to prevent or treat pressure ulcers must be documented.	**True**	
40. Devices that suspend the heels protect the heels from pressure.	**True**	
41. Shear is the force that occurs when the skin sticks to a surface and the body slides.	**True**	
42. Friction may occur when moving a person up in bed.	**True**	
43. A low Braden score is associated with increased pressure ulcer risk.	**True**	
44. The skin is the largest organ of the body.	**True**	
45. Stage II pressure ulcers may be extremely painful due to exposure of nerve endings.	**True**	
46. For persons who have incontinence, skin cleaning should occur at the time of soiling and at routine intervals.	**True**	
47. Educational programs may reduce the incidence of pressure ulcers.	**True**	

2H: Pressure Ulcer Baseline Assessment

Background: The purpose of this tool is to assess general staff knowledge on pressure ulcer prevention. It is shorter than the Pieper but has not been as widely used. The tool is available on the Web site of the Institute for Healthcare Improvement.

Reference: Adapted from: Iowa Health Des Moines. Pressure Ulcer Baseline Assessment. Available at: www.ihi.org/NR/rdonlyres/F2EF9AB3-BB0F-4D3D-A99A-83AC7E0FB0D3/6224/IowaHealthDesMoinesPUBaselineAssesment.pdf.

Instructions: Administer the questionnaire to registered nurses and nursing assistants. The survey may need to be modified if certain questions are not consistent with your policies and procedures.

Use: Use the findings to assess gaps in knowledge. Work with your education department to tailor specific education programs to the needs of your staff.

Pressure Ulcer Baseline Assessment for Registered Nurse

For which factors in the Braden Scale are you evaluating the patient's ability to respond to verbal command?

A. Activity
B. Mobility
C. Sensory/Perception
D. Friction/Shear

Minimally, a patient in the acute care setting should be assessed for pressure ulcer risk at least every:

A. 48 hours
B. 24 hours
C. 8 hours
D. 4 hours

How often should you, the RN, assess and document skin condition?

A. Daily
B. Once a shift
C. Upon admission and discharge, every shift, and as patient condition warrants
D. Upon admission and discharge

What can you, the RN, do when one of your patients has discoloration of the skin (red, purple, blue) indicating pressure?

A. See what happens over the next 24 hours.
B. Let the next nurses know about it. Start a skin care plan.
C. Place the patient on a pressure-reducing surface and explain to the patient and family that the patient needs to limit pressure to the area.
D. B&C from above

Who is the *primary* person accountable for patient skin assessment, pressure ulcer prevention, and documentation?

A. WOC Nurse (ET nurse)
B. RN
C. Nursing assistant
D. All of the above

Pressure Ulcer Baseline Assessment for Nursing Assistant

What is the most common reason a patient gets a pressure ulcer?

A. Patient is a smoker.
B. Patient is very thin.
C. Patient is incontinent.
D. Patient does not move.

How often should you look at every patient's skin to look for signs of redness or discoloration?

A. Daily, when patient bathes.
B. Every time the patients asks me to look.
C. Every 8 hours.
D. The RN should do that.

The correct procedure for checking an air mattress every shift is

A. Push down and if it feels soft it is OK.
B. Ask the patients if it feels like there is enough air underneath them.
C. Do a hand check by placing palm up and feeling for a cushion of air under the heaviest areas of the body.
D. The air mattress should be OK once it is blown up and does not need to be checked.

What should you report to your patient's RN every shift?

A. Skin tears
B. Discoloration of skin, such as red, blue, or purple
C. Open sores
D. All of the above

Pressure Ulcer Baseline Assessment: Answer Key

Registered Nurse

For which factors in the Braden Scale are you evaluating the patient's ability to respond to verbal command?

A. Activity
B. Mobility
C. Sensory/Perception
D. Friction/Shear

Minimally, a patient in the acute care setting should be assessed for pressure ulcer risk at least every:

A. 48 hours
B. 24 hours
C. 8 hours
D. 4 hours

How often should you, the RN, assess and document skin condition?

A. Daily
B. Once a shift
C. Upon admission and discharge, every shift, and as patient condition warrants
D. Upon admission and discharge

What can you, the RN, do when one of your patients has discoloration of the skin (red, purple, blue) indicating pressure?

A. See what happens over the next 24 hours.
B. Let the next nurses know about it. Start a skin care plan.
C. Place the patient on a pressure-reducing surface and explain to the patient and family that the patient needs to limit pressure to the area.
D. B&C

Who is the *primary* person accountable for patient skin assessment, pressure ulcer prevention, and documentation?

A. WOC Nurse (ET nurse)
B. RN
C. Nursing assistant
D. All of the above

Nursing Assistant

What is the most common reason a patient gets a pressure ulcer?

A. Patient is a smoker.
B. Patient is very thin.
C. Patient is incontinent.
D. Patient does not move.

How often should you look at every patient's skin to look for signs of redness or discoloration?

A. Daily, when patient bathes.
B. Every time the patients asks me to look.
C. Every 8 hours.
D. The RN should do that.

The correct procedure for checking an air mattress every shift is

A. Push down and if it feels soft it is OK.
B. Ask the patients if it feels like they have enough air underneath them.
C. Do a hand check by placing palm up and feeling for a cushion of air under the heaviest areas of the body.
D. The air mattress should be OK once it is blown up and does not need to be checked.

What should you report to your patient's RN every shift?

A. Skin tears
B. Discoloration of skin, such as red, blue, or purple
C. Open sores
D. All of the above

2I: Action Plan

Background: The purpose of this tool is to provide a framework for outlining steps that will be needed to design and implement the pressure ulcer prevention initiative.

Reference: Adapted from material produced by MassPro, a participant in the Centers for Medicare & Medicaid Services Quality Improvement Organization Program.

Instructions:

1. Note the date and the objective. A sample objective is provided.
2. The form lists six key tasks. For each, list in the second column the steps that will be taken to address the task, including tools to be used.
3. In developing the plan, it is not expected that you will provide results, only that you will lay out what needs to be done.
4. In the last two columns, determine who will have lead responsibility for completing each task, and estimate an appropriate timeframe for completing the activities.
5. Use the plan as a working document that can be revised. As you begin to carry out the plan, you may need to make adjustments and add details to the later tasks.

Use: Use the completed sheet to plan, manage, and carry out the identified tasks. The plan should guide the implementation process and can be continually amended and updated.

A sample completed form is shown below, followed by a blank form.

Pressure Ulcer Prevention Action Plan **Date:** February 16, 2011

Improvement Objective: Implement standard pressure ulcer prevention practices within 6 months

Key Interventions/Tasks	Steps To Complete Task and Tools To Use	Team Members Responsible for Task Completion	Target Date for Task Completion
	Examples	**Examples**	**Examples**
1. Analyze current state of pressure ulcer prevention practices in this organization.	Identify strengths and weaknesses using process mapping and gap analysis. Tool 2C and Tools 2E-2G.	Team leader, RNs, and WOCNs	Within 6 weeks from initiative start
	Assess the current state of staff knowledge about pressure ulcer prevention. Tool 2H.	Education department	Within 6 weeks from initiative start
	Set target goals for improvement.	QI department	Within 8 weeks from initiative start
2. Identify the bundle of prevention practices to be used in redesigned system.	Determine how comprehensive skin assessment should be performed	Wound care team	Within 12 weeks from initiative start
	Decide which scale will be used for performing risk assessment.	Wound care team	Within 12 weeks from initiative start
	Decide what items of pressure ulcer prevention should be in your bundle	Clinical staff members	Within 12 weeks from initiative start
3. Assign roles and responsibilities for implementing the redesigned pressure ulcer prevention practices.	Examples	Examples	Examples
	Determine who will complete the daily skin and risk assessments. Tool 4A.	Implementation team	Within 16weeks from initiative start
	Identify unit champions.	Team leader	Within 16 weeks from initiative start
	Determine how prevention work will be organized at the unit level, such as paths of communication and lines of oversight.	QI team	Within 16 weeks from initiative start

Key Interventions/Tasks	Steps To Complete Task and Tools To Use	Team Members Responsible for Task Completion	Target Date for Task Completion
	Examples	**Examples**	**Examples**
4. Put the redesigned bundle into practice.	Engage staff and get them excited about the changes needed.	Team leader, unit staff	Within 12 weeks from initiative start
	Pilot test the new practices.	QI department	Within 20 weeks from initiative start
5. Monitor pressure ulcer rates and practices.	Determine how incidence and prevalence data will be collected. Tool 5A.	QI department	Within 6 weeks from initiative start
	Organize quarterly prevalence studies.	QI department	Within 6 weeks from initiative start, ongoing
6. Sustain the redesigned prevention practices.	Ensure continued leadership support.	Team leader	Within 4 weeks from initiative start and ongoing
	Ensure ongoing support from other units such as facilities management and IT.	IT, facilities management, PT, dietitians	Within 40 weeks from initiative start
	Designate responsibility and accountability for pressure ulcer prevention oversight and continuous quality improvement.	Team leader and implementation team	Within 40 weeks from initiative start

Pressure Ulcer Prevention Action Plan **Date: _____**

Improvement Objective:

Key Interventions/Tasks	Steps To Complete Task and Tools To Use	Team Members Responsible for Task Completion	Target Date for Task Completion
1. Analyze current state of pressure ulcer prevention practices in this organization.			
2. Identify the bundle of prevention practices to be used in redesigned system.			
3. Assign roles and responsibilities for implementing the redesigned pressure ulcer prevention practices.			
4. Put the redesigned bundle into practice.			
5. Monitor pressure ulcer rates and practices.			
6. Sustain the redesigned prevention practices.			

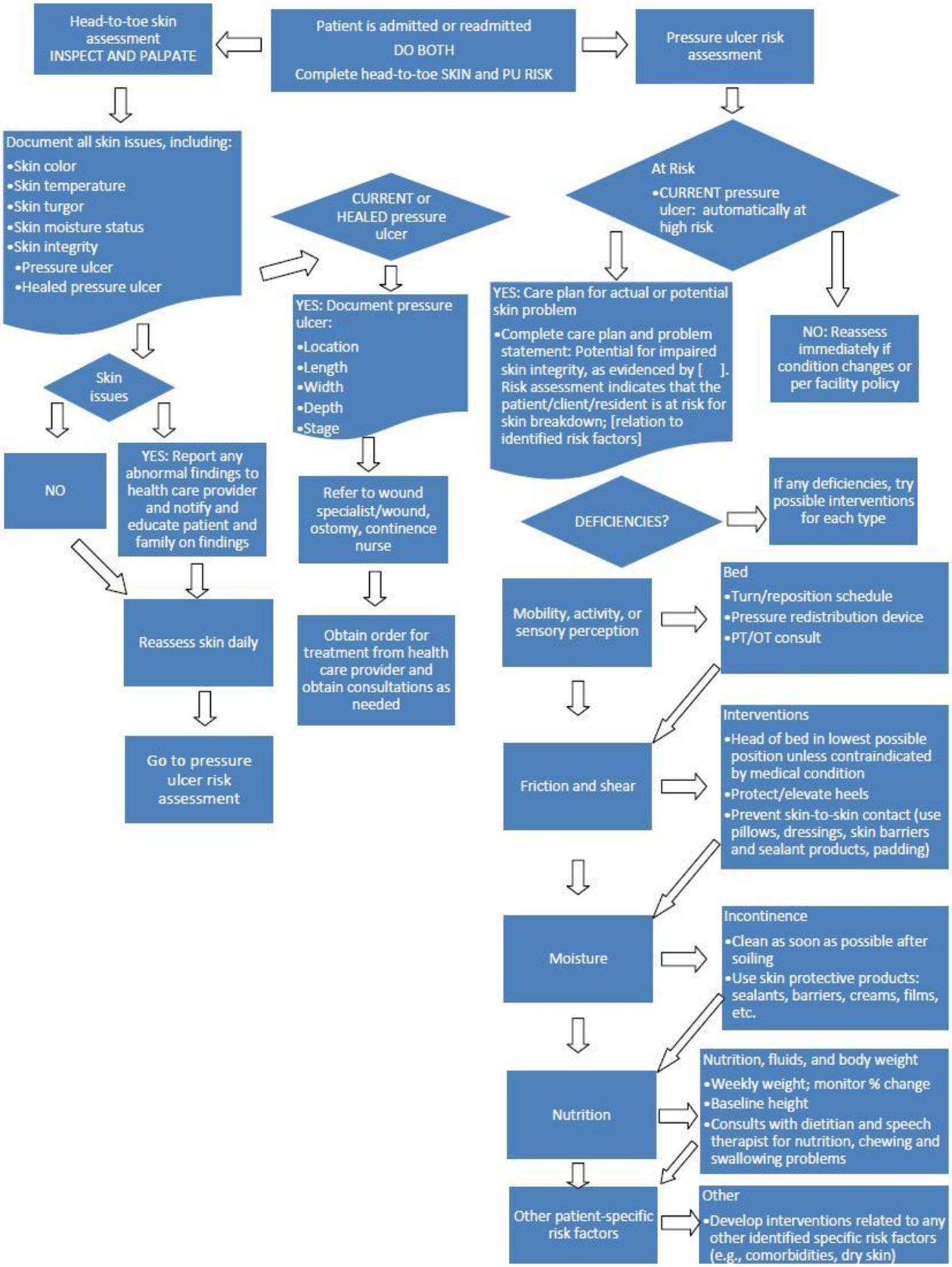
3A: Pressure Ulcer Prevention Pathway for Acute Care

Background: This tool is an example of a clinical pathway, detailing the relationship among the different components of pressure ulcer prevention.

Reference: Developed by Zulkowski and Ayello (2009) in conjunction with the New Jersey Hospital Association Pressure Ulcer Collaborative.

Use: This tool can be used by the hospital unit team in designing a new system, as a training tool for frontline staff, and as an ongoing clinical reference tool on the units. This tool can be modified or a new one created to meet the needs of your particular setting. If you prepared a process map describing your current practices, you can compare that to desired practices outlined on the clinical pathway.

Pressure Ulcer Prevention Pathway



3B: Elements of a Comprehensive Skin Assessment

Background: This sheet summarizes the elements of a correct comprehensive skin assessment. You could, for example, integrate them into your documentation system or use this sheet for staff training.

Reference: Developed by Boston University Research Team.

Skin Temperature

Most clinicians use the back rather than the palm of their hand to assess the temperature of a patient's skin.

Remember that increased skin temperature can be a sign of fever or impending skin problems such as a Stage I pressure ulcer or a diabetic foot about to ulcerate.

- Touch the skin to evaluate if it is warm or cool.
- Compare symmetrical body parts for differences in skin temperature.

Skin Color

- Ensure that there is adequate light.
- Use an additional light source such as a penlight to illuminate hard to see skin areas such as the heels or sacrum.
- Know the person's normal skin tone so that you can evaluate changes.
- Look for differences in color between comparable body parts, such as left and right leg.
- Depress any discolored areas to see if they are blanchable or nonblanchable.
- Look for redness or darker skin tone, which indicate infection or increased pressure.
- Look for paleness, flushing, or cyanosis.
- Remember that changes in coloration may be particularly difficult to see in darkly pigmented skin.

Skin Moisture

- Touch the skin to see if the skin is wet or dry, or has the right balance of moisture.
- Remember that dry skin, or xerosis, may also appear scaly or lighter in color.
- Check if the skin is oily.
- Note that macerated skin from too much moisture may also appear lighter or feel soft or boggy.
- Also look for water droplets on the skin. Is the skin clammy?
- Determine whether these changes localized or generalized.

Skin Turgor

- To assess skin turgor, take your fingers and "pinch" the skin near the clavicle or the forearm so that the skin lifts up from the underlying structure. Then let the skin go.
- If the skin quickly returns to place, this is a normal skin turgor finding.

- If the skin does not return to place, but stays up, this is called “tenting,” and is an abnormal skin turgor finding.
- Poor skin turgor is sometimes found in persons who are older, dehydrated, or edematous, or have connective tissue disease.

Skin Integrity

- Look to see if the skin is intact without any cracks or openings.
- Determine whether the skin is thick or thin.
- Identify signs of pruritis, such as excoriations from scratching.
- Determine whether any lesions are raised or flat.
- Identify whether the skin is bruised.
- Note any disruptions in the skin.
- If a skin disruption is found, the type of skin injury will need to be identified. Since there are many different etiologies of skin wounds and ulcers, differential diagnosis of the skin problem will need to be determined. For example is it a skin tear, a pressure ulcer, or moisture-associated skin damage or injury?

3C: Pressure Ulcer Identification Notepad

Background: Reporting of abnormal skin findings among nursing staff is critical for pressure ulcer prevention. This notepad can be used by nursing aides to report any areas of skin concern to nurses.

Reference: This material originated from Status Health and was adapted for use by Mountain-Pacific Quality Health, the Medicare quality improvement organization for Montana, Wyoming, Hawaii, and Alaska, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. Contents presented do not necessarily reflect CMS policy. The work was performed under the 9th Statement of Work, MPQHF-AS-PS-09-16.

Instructions: Place an X on any suspicious lesion and give the note to a nurse for followup on the issue.

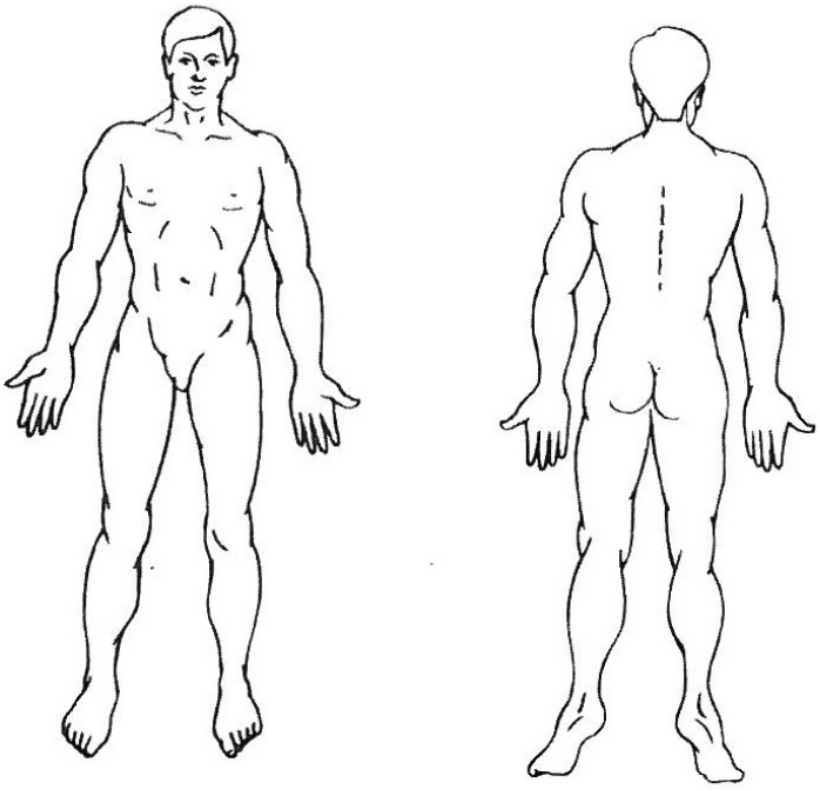
PRESSURE ULCER IDENTIFICATION POCKET PAD

Place the patient's/resident's name on the top of the pad, date it and place an "X" on the area on the body where you see the skin concern. Give this to the nurse and ask him or her to check the patient/resident. They will follow up as needed.

Date: _____ Time: _____

Patient's/Resident's Name: _____

Reporter: _____



3D: The Braden Scale for Predicting Pressure Sore Risk

Background: This tool can be used to identify patients at-risk for pressure ulcers. The Braden Scale was developed by Barbara Braden and Nancy Bergstrom in 1988 and has since been used widely in the general adult patient population. The scale consists of six subscales and the total scores range from 6-23. A lower Braden score indicates higher levels of risk for pressure ulcer development. Generally, a score of 18 or less indicates at-risk status.

Reference: http://www.bradenscale.com/images/bradenscale.pdf. Reprinted with permission.

Instructions: Complete the form by scoring each item from 1-4 (1 for low level of functioning and 4 for highest level of functioning) for the first five risk factors and 1-3 for the last risk factor.

Use: Use this tool in conjunction with clinical assessment to determine if a patient is at risk for developing pressure ulcers and plan the care accordingly. In addition to the overall score, abnormal scores on any of the subscales should be addressed in the care plan.

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Braden Pressure Ulcer Risk Assessment

Patient's Name _____ Evaluator's Name _____ Date of Assessment

SENSORY PERCEPTION ability to respond meaningfully to pressure-related discomfort	**1. Completely Limited:** Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation. OR limited ability to feel pain over most of body surface.	**2. Very Limited:** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness. OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body.	**3. Slightly Limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned. OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	**4. No Impairment:** Responds to verbal commands, has no sensory deficit which would limit ability to feel or voice pain or discomfort.				
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist:** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	**2. Very Moist:** Skin is often, but not always, moist. Linen must be changed at least once a shift.	**3. Occasionally Moist:** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. Rarely Moist:** Skin is usually dry, linen only requires changing at routine intervals.				
ACTIVITY degree of physical activity	**1. Bedfast:** Confined to bed.	**2. Chairfast:** Ability to walk severely limited or non-existent. Cannot bear weight and/or must be assisted into chair or wheelchair.	**3. Walks Occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. Walks Frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.				
MOBILITY ability to change and control body position	**1. Completely Immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very Limited:** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. Slightly Limited:** Makes frequent though slight changes in body or extremity position independently.	**4. No Limitations:** Makes major and frequent changes in position without assistance.				
NUTRITION *usual* food intake pattern	**1. Very Poor:** Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement. OR is NPO and/or maintained on clear liquids or IV's for more than 5 days.	**2. Probably Inadequate:** Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. OR receives less than optimum amount of liquid diet or tube feeding.	**3. Adequate:** Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered. OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs.	**4. Excellent:** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.				
FRICTION AND SHEAR	**1. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation lead to almost constant friction.	**2. Potential Problem:** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3. No Apparent Problem:** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.					

3E: Norton Scale

Background: This tool can be used to identify patients at-risk for pressure ulcers. The Norton Scale was developed in the 1960s and is widely used to assess the risk for pressure ulcer in adult patients. The five subscale scores of the Norton Scale are added together for a total score that ranges from 5-20. A lower Norton score indicates higher levels of risk for pressure ulcer development. Generally, a score of 14 or less indicates at-risk status.

Reference: Norton D, McLaren R, Exton-Smith AN. An investigation of geriatric nursing problems in the hospital. London, UK: National Corporation for the Care of Old People (now the Centre for Policy on Ageing); 1962. Reprinted with permission.

Instructions: Complete the form by scoring each item from 1-4. Put 1 for low level of functioning and 4 for highest level functioning.

Use: Use this tool in conjunction with clinical assessment to determine if a patient is at risk for developing pressure ulcers.

Physical condition		**Mental condition**		**Activity**		**Mobility**		**Incontinent**		**Total Score**
Good	4	Alert	4	Ambulant	4	Full	4	Not	4	
Fair	3	Apathetic	3	Walk-help	3	Slightly limited	3	Occasional	3	
Poor	2	Confused	2	Chair-bound	2	Very limited	2	Usually-Urine	2	
Very bad	1	Stupor	1	Stupor	1	Immobile	1	Doubly	1	

3F: Care Plan

Background: Developing a care plan specific to the needs of each individual patient is critical. This tool is a sample care plan that gives specific examples of actions that should be performed to address a patient's needs. This example is based on the pressure ulcer risk assessment captured with the Braden Scale.

Reference: Developed by Zulkowski, Ayello, and Berlowitz (2010). Used with permission.

Instructions: This tool includes examples of interventions that may be considered for specific scores on each Braden subscale, along with the nurse and Certified Nursing Assistant (CNA) responsibilities for care provision. These should be tailored to meet the needs of your patient and used as examples of how all levels of unit staff have responsibilities for pressure ulcer prevention.

Use: Individualize the care plan to address the needs of at-risk patients.

Sample Care Plan

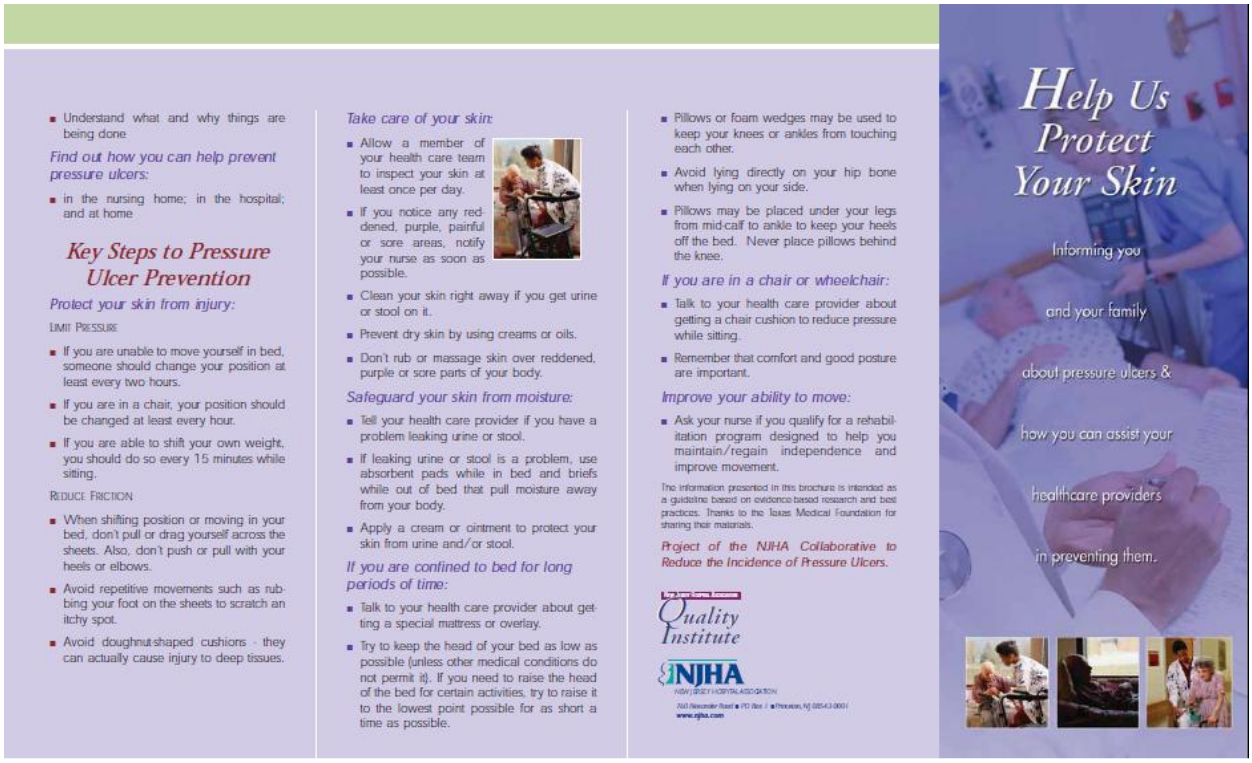
Braden Category	Braden Score: 1	Braden Score: 2	Braden Score: 3	Braden Score: 4
Sensory Perception	**Completely limited** • Skin assessment and inspection q shift. Pay attention to heels. • Elevate heels and use protectors. • Consider specialty mattress or bed. • Use pillows between knees and bony prominences to avoid direct contact.	**Very limited** • Skin assessment and inspection q shift. Pay attention to heels. • Elevate heels and use protectors. • Consider specialty mattress or bed.	**Slightly limited** • Skin assessment and inspection q shift. Pay attention to heels. • Elevate heels and use protectors .	**No limitation** • Encourage patient to report pain over bony prominences. • Check heels daily.
Moisture	**Constantly Moist** • Skin assessment and inspection q shift. • Use moisture barrier ointments (protective skin barriers). • Moisturize dry unbroken skin. • Avoid hot water. Use mild soap and soft cloths or packaged cleanser wipes. • Check incontinence pads frequently (q 2-3h) and change as needed. • Apply condom catheter if appropriate. • If stool incontinence, consider bowel training and toileting after meals or rectal tubes if appropriate. • Consider low air loss bed	**Moist** • Use moisture barrier ointments (protective barriers). • Moisturize dry unbroken skin. • Avoid hot water. Use mild soap and soft cloths or packaged cleanser wipes. • Check incontinence pads frequently (q 2-3h). • Avoid use of diapers but if necessary, check frequently (q 2-3h)and change as needed. • If stool incontinence, consider bowel training and toileting after meals. • Consider low air loss bed	**Occasionally Moist** • Use moisture barrier ointments (protective skin barriers). • Moisturize dry unbroken skin. • Avoid hot water. Use mild soap and soft cloths or packaged cleanser wipes. • Check incontinence pads frequently. • Avoid use of diapers but if necessary, check frequently (q 2-3h) and change as needed. • Encourage patient to report any other moisture problem (such as under breasts). • If stool incontinence, consider bowel training and toileting after meals.	**Rarely Moist** • Encourage patient to use lotion to prevent skin cracks. • Encourage patient to report any moisture problem (such as under breasts).
Activity	**Bedfast** • Skin assessment and inspection q shift. • Position prone if appropriate or elevate head of bed no more than 30 degrees. • Position with pillows to elevate pressure points off of the bed. • Consider specialty bed. • Elevate heels off bed and/or use heel protectors. • Consider physical therapy consult for conditioning and W/C assessment. • Turn/reposition q 1-2h. • Post turning schedule. • Teach or do frequent small shifts of body weight.	**Chairfast** • Consider specialty chair pad. • Consider postural alignment, weight distribution, balance, stability, and pressure relief when positioning individuals in chair or wheelchair. • Instruct patient to reposition q 15 minutes when in chair. • Stand every hour. • Pad bony prominences with foam wedges, rolled blankets, or towels. • Consider physical therapy consult for conditioning and W/C assessment.	**Walks Occasionally** • Provide structured mobility plan. • Consider chair cushion. • Consider physical therapy consult..	**Walks Frequently** • Encourage ambulating outside the room at least bid. • Check skin daily. • Monitor balance and endurance.

Braden Category	Braden Score: 1	Braden Score: 2	Braden Score: 3	Braden Score: 4
Mobility	**Completely Immobile** • Skin assessment and inspection q shift. • Turn/reposition q 1-2 hours. • Post turning schedule. • Teach or do frequent small shifts of body weight. • Elevate heels. • Consider specialty bed.	**Very Limited** • Skin assessment and inspection q shift. • Turn/reposition 1-2 hours. • Post turning schedule. • Teach or do frequent small shifts of body weight. • Elevate heels. • Consider specialty bed.	**Slightly Limited** • Check skin daily. • Turn/reposition frequently. • Teach frequent small shifts of body weigh. • PT consult for strengthening/conditioning. • Gait belt for assistance.	**No Limitations** • Check skin daily. • Encourage ambulating outside the room at least bid. • No interventions required.
Nutrition	**Very Poor** • Nutrition consult. • Skin assessment and inspection q shift. • Offer nutrition supplements and water. • Encourage family to bring favorite foods. • Monitor nutritional intake. • If NPO for > 24 hours, discuss plan with MD. • Record dietary intake and I & O if appropriate.	**Probably Inadequate** • Nutrition consult. • Offer nutrition supplements and water. • Encourage family to bring favorite foods. • Monitor nutritional intake. • Small frequent meals. • If NPO for > 24 hours, discuss plan with MD. • Record dietary intake and I & O if appropriate.	**Adequate** • Monitor nutritional intake. • If NPO for > 24 hours, discuss plan with MD. • Record dietary intake and I&O if appropriate.	**Excellent** • Out of bed for all meals. • Provide food choices. • Offer nutrition supplements. If NPO for > 24 hours, discuss plan with MD. • Record dietary intake.
Friction and Shear	**Problem** • Skin assessment and inspection q shift. • Minimum of 2 people + draw sheet to pull patient up in bed. • Keep bed linens clean, dry, and wrinkle free. • Apply elbow/heel protectors to intact skin over elbows and heels. • Elevate head of bed 30 degrees or less.	**Potential Problem** • Keep bed linens clean, dry, and wrinkle free. • Avoid massaging pressure points. • Apply transparent dressing or elbow/heel protectors to intact skin over elbows and heels.	**No apparent problem** • Keep bed linens clean, dry, and wrinkle free.	

3G: Patient and Family Education Booklet

Background: This is an example of an education booklet that can be handed out to patients at-risk for pressure ulcers and their families. The booklet was developed by the New Jersey Collaborative to Reduce the Incidence of Pressure Ulcers.

Reference: Available at: http://www.njha.com/qualityinstitute/pdf/pubrochure.pdf.



- Understand what and why things are being done

Find out how you can help prevent pressure ulcers:

- in the nursing home; in the hospital; and at home

Key Steps to Pressure Ulcer Prevention

Protect your skin from injury:

LIMIT PRESSURE

- If you are unable to move yourself in bed, someone should change your position at least every two hours.
- If you are in a chair, your position should be changed at least every hour.
- If you are able to shift your own weight, you should do so every 15 minutes while sitting.

REDUCE FRICTION

- When shifting position or moving in your bed, don't pull or drag yourself across the sheets. Also, don't push or pull with your heels or elbows.
- Avoid repetitive movements such as rubbing your foot on the sheets to scratch an itchy spot.
- Avoid doughnut-shaped cushions - they can actually cause injury to deep tissues.

Take care of your skin:

- Allow a member of your health care team to inspect your skin at least once per day.
- If you notice any reddened, purple, painful or sore areas, notify your nurse as soon as possible.
- Clean your skin right away if you get urine or stool on it.
- Prevent dry skin by using creams or oils.
- Don't rub or massage skin over reddened, purple or sore parts of your body.

Safeguard your skin from moisture:

- Tell your health care provider if you have a problem leaking urine or stool.
- If leaking urine or stool is a problem, use absorbent pads while in bed and briefs while out of bed that pull moisture away from your body.
- Apply a cream or ointment to protect your skin from urine and/or stool.

If you are confined to bed for long periods of time:

- Talk to your health care provider about getting a special mattress or overlay.
- Try to keep the head of your bed as low as possible (unless other medical conditions do not permit it). If you need to raise the head of the bed for certain activities, try to raise it to the lowest point possible for as short a time as possible.

- Pillows or foam wedges may be used to keep your knees or ankles from touching each other.
- Avoid lying directly on your hip bone when lying on your side.
- Pillows may be placed under your legs from mid-calf to ankle to keep your heels off the bed. Never place pillows behind the knee.

If you are in a chair or wheelchair:

- Talk to your health care provider about getting a chair cushion to reduce pressure while sitting.
- Remember that comfort and good posture are important.

Improve your ability to move:

- Ask your nurse if you qualify for a rehabilitation program designed to help you maintain/regain independence and improve movement.

The information presented in this brochure is intended as a guideline based on evidence-based research and best practices. Thanks to the Texas Medical Foundation for sharing their materials.

Project of the NJHA Collaborative to Reduce the Incidence of Pressure Ulcers.

Quality Institute

NJHA

NEW JERSEY HOSPITAL ASSOCIATION

760 Alexander Road ■ PO Box 1 ■ Princeton, NJ 08543-0001
www.njha.com

Help Us Protect Your Skin

Informing you

and your family

about pressure ulcers &

how you can assist your

healthcare providers

in preventing them.

4A: Assigning Responsibilities for Using Best Practice Bundle

Background: This tool can be used to determine who will be responsible for each of the tasks identified in your bundle of best practices for preventing pressure ulcers. One way to generate interest and buy-in from the staff is to ask them to self-assign their responsibilities from a prioritized list of tasks that need to be accomplished.

Reference: Developed by Boston University Research Team.

Instructions: Complete the table by entering the different best practices and the specific individuals who will be responsible for completing each task.

Use: Use this tool to assign and clarify the roles and responsibilities of each staff member.

What practices will we use?	**Who will be responsible?**
Example: *Perform comprehensive skin assessment on admission, daily or if condition deteriorates.*	*Example:* *RN*

4B: Staff Roles

Background: This table gives an example of how responsibilities may be assigned among different staff members.

Reference: Developed by Boston University Research Team.

Wound care team*	
Wound Care Physician	• Directs patient care, orders tests and treatments, and reviews results • Collaborates on treatment with wound nurse • Helps facilitate communication between medical staff, wound team, and unit staff for pressure ulcer practice
Certified Wound Care Nurse	• Assesses wounds, does complex treatments, collaborates with physician for care orders • Works with staff on pressure ulcer education and daily treatments • Works with all members to educate patient/family about care • Coordinates prevalence and incidence audits
Unit based team	

RN	• Conducts or supervises accurate assessment and documentation of head-to-toe skin assessment and pressure ulcer risk (Braden Scale or Braden Risk Assessment) on admission, daily, and if condition deteriorates (or according to facility policy)
	• Documents care plan tied to identified risk
	  ○ Sensory perception
	  ○ Moisture
	  ○ Activity
	  ○ Mobility
	  ○ Nutrition
	  ○ Friction/Shear
	• Performs or supervises performance of care plan procedures or treatments
	• Collaborates with other staff to ensure timely and accurate reporting of any skin issues
	• Notifies wound nurse of any skin conditions or high-risk patients
	• Notifies physician of any skin problems
	• Educates patient/family about risk factors

LPN	• Conducts accurate assessment and documentation of head-to-toe skin assessment and pressure ulcer risk (Braden Scale) on admission, daily, and if condition deteriorates (or according to facility policy)
	• Documents care plan tied to identified risk
	  ○ Sensory perception
	  ○ Moisture
	  ○ Activity
	  ○ Mobility
	  ○ Nutrition
	  ○ Friction/Shear
	• Performs care for risk as needed
	• Informs RN of any skin issues

* May be large or small group that includes nurses and/or physicians in an outpatient or inpatient setting.

CNA	• Checks skin each time person is turned or cleaned or bed is changed • Reports any skin issues to nurse • Turns/repositions patient as ordered • Offers liquids each time in room • Keeps skin clean and reapplies protective skin barrier • Applies products (lotion, cream, skin sealant, etc.) as needed
Hospitalist	• Reviews needs for specific types of rehabilitation therapy • Writes orders for specific interventions
Other staff, such as dietitian, physical therapist, pharmacist, assigned to specific unit	• Act as resource for unit staff • Educate family if problem is identified • Modify treatment as needed • Provide specialized care for patients

4C: Assessing Staff Education and Training

Background: The purpose of this tool is to assess current staff education practices and to facilitate the integration of new knowledge on pressure ulcer prevention into existing or new practices.

Reference: Adapted from Facility Assessment Checklist developed by Quality Partners of Rhode Island. Available in the Nursing Home section of the MedQIC Web site: https://www.qualitynet.org/dcs/ContentServer?cid=1098482996140&pagename=Medqic%2FMQTools%2FToolTemplate&c=MQTools.

Instructions: Complete the form by checking the response that best describes your facility.

Use: Identify areas for improvement and develop educational programs where they are missing.

Facility Assessment

Date:

A. Does your facility have initial and ongoing education on pressure ulcer prevention and management for both nursing and nonnursing staff?

__ **No**. If no, this is an area for improvement.

__ **This is an area we are working on.**

__ **Yes**.

B. Does your facility's education program for pressure ulcer prevention and management include the following components?

	Yes	No	Person Responsible:	Comments:
1. Are new staff assessed for their need for education on pressure ulcer prevention and management?				
2. Are current staff provided with ongoing education on the principles of pressure ulcer prevention and management?				
3. Does education of staff provide discipline-specific education for pressure ulcer prevention and management?				
4. Is there a designated clinical expert available at the facility to answer questions from all staff about pressure ulcer prevention and management?				
5. Is the education provided at the appropriate level for the learner (e.g., CNA vs. RN?)				
6. Does the education provided address risk assessment tools and procedures?				
7. Does the education include staff training on documentation methods related to pressure ulcers (e.g., location, stage, size, depth, appearance, exudates, current treatment, effect on activities of daily living, pressure redistributing devices used, nutritional support)?				

C. What areas of knowledge does the assessment of staff suggest need more attention in education?

5A: Unit Log

Background: The main purpose of this tool is to summarize the results of the daily comprehensive skin assessments for pressure ulcers on all patients. The form can be completed by registered nurses and nursing assistants.

Reference: Developed by Boston University Research Team.

Instruction: Complete the form for all patients with information on the number of pressure ulcers present and the stage of the deepest ulcer. Use the standardized skin inspection form, using one form for each month.

1. On the first of each month list the current unit census.
2. When a patient is discharged:

    - From the facility, write DC and draw a line from the last day to the end of the month.
    - Within the facility, write the room number transferred to and draw a line through the remainder of the month.

3. When a patient is admitted:

    - Add the name to the sheet.
    - Draw a line from day 1 to the date patient was admitted to the unit.

4. A patient may be on any unit multiple times during a month.

    - Treat each time the patient leaves as a discharge or transfer.
    - Treat each time a patient is readmitted to a unit as a new admission.

5. Record each day the results of the comprehensive skin assessment. Include whether the patient has an ulcer, the number of different ulcers, and the stage of the deepest ulcer.

Use: At the end of the month, use this log to calculate your pressure ulcer prevalence and incidence rates. Examine the rates and identify trends over time. Share the results with your unit staff and administrative leadership. For all Stage III and IV pressure ulcers, consider doing a root cause analysis to find out what led to their occurrence.

Unit Log

MONTH				**Days**												
Patient Name	Admission Date	Admission Number	Room Number	1	2	3	4	5	6	7	8	9	10	11	12	13

5B: Preventing Pressure Ulcers Data Tool

Background: This tool can be used to measure key processes of care by abstracting medical records data.

Reference: Adapted from materials available at the Montana Rural Healthcare Performance Improvement Network Web site. Available at: www.mtpin.org/index.php?p=documents&category_id=118&lp=archivedstudies&lcat_id=20.

Instructions: Complete the form by following the case inclusion and exclusion criteria outlined below:

- Cases to Include:All inpatients admitted to the unit
- Cases to Exclude: All newborns and hospice patients; all patients with a length of stay (LOS) less than 24 hours (observation less than 24 hours, same day surgery, emergency department and other ambulatory care patients).

Use: Use the reviewed data to evaluate key processes of care, such as performance of the daily comprehensive skin assessment or individualized care planning. Define a performance target for each key process and analyze if that target is met. Share the findings with the unit staff and leadership.

Date: _____
Unit: _____ MR# Number: _____

1. Date of admission (mm/dd/yy): _____ - _____ - _____

2. Admitted to: _____ acute care ____ obs > 24 hr _____ intensive care _____ swing bed

_____other (STOP ABSTRACTION; not a qualifying case)

3. Admitted from: _____ home _____ LTC or SNF facility _____ assisted living facility

_____ other acute care hospital _____ other

4. Length of stay (LOS): _____ equal to or greater than 24 hours; LOS in days = _____ days

_____less than 24 hours (STOP ABSTRACTION)

5. Did the patient receive a facility-approved pressure ulcer risk assessment within 24 hr of admit?

____ No (skip to question 9)

____ Yes

6. Does the risk assessment tool include a Braden Scale or modified Braden Scale score?

_____ No

_____ Yes

7. Was the patient identified <u>on admission</u> as being **<u>at risk</u>** for pressure ulcer development?

_____ No

_____Yes; complete the following table:

***For at-risk patients**, are the following interventions documented:*	Yes	No
a. Consult to wound team		
b. Skin inspected daily		
c. Patient repositioned every 2 hours or 'up ad lib'		
d. Pressure redistributing device in place within 24 hours of risk identification		
e. Nutrition assessment completed within 24 hours of risk identification		
• Nutrition assessment includes dietary consult		
• Nutrition assessment includes admit and weekly weight recorded		
f. Provider orders special diet within 24 hours of risk identification		
g. Barrier cream applied if moisture issues identified		
h. Information given to patient and family		

8. Was the patient identified <u>on admission</u> as being **<u>at low risk</u>** for pressure ulcer development?

_____ No

_____Yes; complete the following table:

For patients with low risk on admission, *was the following completed?*	Yes	No
a. Documentation of daily skin inspection		
b. Documentation of risk assessment daily		

9. If the patient did not have a pressure ulcer identified on admission, did the patient develop one or more pressure ulcers during the hospital stay?

____ Ulcer present on admission

____ No

____ Yes; stage(s)_____; complete the following table:

For patients developing pressure ulcer during this admission*, are the following interventions documented as completed?*	Yes	No
a. Provider notified of pressure ulcer prior to end of shift		
b. Consult to wound team		
c. Skin inspected daily		
d. Patient repositioned every 2 hours or "up ad lib"		
e. Pressure redistributing device in place within 24 hours of risk identification		
f. Nutrition assessment completed within 24 hours of risk identification		
• Nutrition assessment includes dietary consult		
• Nutrition assessment includes admit & weekly weight recorded		
g. Provider orders special diet within 24 hours of risk identification		
h. Barrier cream applied if moisture issues identified		
i. Provider order for wound care on the chart within 24 hours of notification		
j. Wound care implemented as ordered		
k. Pressure ulcer assessed for healing, worsening as ordered		
l. Patient and family notified of skin problem		

12. Was the patient discharged with one or more pressure ulcers?

____ No

____ Yes; stage(s)_____

5C: Assessing Comprehensive Skin Assessment

Background: This sample protocol illustrates how to evaluate the performance of a comprehensive skin assessment.

Reference: Developed by Boston University Research Team.

Sample protocol for assessing performance of comprehensive skin assessment

1. Take a sample of records of patients newly admitted to your unit within the past month. As few as 10 records may be sufficient for initial assessments of performance.
2. Identify medical and nursing notes from the first 24 hours of hospitalization. These should include the admission nursing assessment, physician's admission note, and subsequent nursing progress notes.
3. Determine whether there is any documentation of a skin examination. This might include mention of any lesions or specific mention that none are present.
4. Determine how comprehensive the initial skin assessment was. Is there specific mention of all five dimensions of the assessment: temperature, color, moisture, turgor, and whether skin intact.
5. Calculate the percentage having any documentation of skin assessment as well as having a comprehensive exam.

5D: Assessing Standardized Risk Assessment

Background: This sample protocol illustrates how to evaluate the performance of standardized risk assessment.

Reference: Developed by Boston University Research Team

Sample protocol for assessing performance of standardized risk assessment

1. Take a sample of records of patients newly admitted to your unit within the past month. As few as 10 records may be sufficient for initial assessments of performance.
2. Identify nursing notes from the first 24 hours of hospitalization. This should include the admission nursing assessment, subsequent nursing progress notes, or any notes specifically documenting pressure ulcer risk assessment.
3. Determine whether there is any documentation of the completion of the standardized risk assessment. This may include a Braden Scale, Norton Scale, or other system. Completion should be indicated by the assignment of an actual score.
4. Calculate the percentage having the actual score completed.

5E: Assessing Care Planning

Background: This sample protocol illustrates how to evaluate the performance of care planning.

Reference: Developed by Boston University Research Team

Sample assessment of care planning performance

1. Take a sample of records of patients newly admitted to your unit within the past month who have an abnormal standardized risk assessment. As few as 10 records may be sufficient for initial assessments of performance.
2. For each patient, determine on which dimensions of the standardized risk assessment there was a score that was not normal.
3. Identify the care plans prepared shortly after admission.
4. Determine whether each abnormally scored dimension of the standardized risk assessment is addressed in the care plans.
5. Calculate the percentage of abnormally scored dimensions of the standardized risk assessment that are addressed in the care plan.