

On-Time Pressure Ulcer Self-Assessment

I. Nursing Home Profile

Name: _____

City / State: _____

Number of long term or chronic stay beds: _____

Number of short stay or sub-acute beds: _____

Total number of beds on Operating Certificate: _____

NOTE: The number of short stay and long term beds should equal the number of beds on the nursing home's Operating Certificate.

Point of contact (name/phone/email) _____

II. Able to commit to all of the following:

- Designation of project lead
- Participation in regular facility implementation team meetings (key members to include CNAs, charge and staff nurses, MDS and Wound RNs, and representatives from skin care team)
- Redesign CNA documentation and care processes related to pressure ulcer prevention
- Willingness to invest dollars in existing HIT or new HIT to support the implementation of the intervention: standardized CNA and skin/wound assessment documentation and clinical reports.

III. Assess Readiness Characteristics:

Review Criterion	Response
1. Administrator: Number of months in current position in this facility. (0 or 3 points)	
2. DON/DNS: Number of years in current position in this facility: (0 or 3 points)	
3. Percent of all full time CNAs whose tenure in the nursing home as CNA is three years or more. (0 – 3 points) Calculation: # full time CNAs three years or more = (a) _____ # CNA full time positions = (b) _____ % full-time CNAs with tenure three years or more = (a) / (b) = _____	
4. How many hours per week is a Registered Dietician at the facility? (0 – 3 points)	
5. Do you have a dedicated position for staff educator who has no other role? (0 or 3 points)	<input type="checkbox"/> Yes If Yes, name _____ <input type="checkbox"/> No
6. How many hours per week are budgeted for staff educator, excluding hours for employee health and infection control. (0 – 3 points)	
7. Do you have CNA team leads? Note: CNA team lead is a dedicated position that serves as mentor and leader to CNA peers. This position may or may not have a team assignment. (0 or 3 points)	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Experience with QI. Please append the following to the application: (0 – 5 points) i) Written policies and procedures for QI Committee; provide the names of the staff who are members of the QI committee and for each one specify the role, discipline, and term on the committee; describe how QI committee members are selected and how long they serve; describe how QI projects are identified and selected; describe how often the Committee meets and who determines the agenda.	Attach documents to application.

Review Criterion	Response
<p>ii) Describe a recent QI project and the changes in resident outcomes that occurred; describe how a successful QI project has resulted in changes to every day routine work;</p> <p>iii) Describe a recent QI project that was not successful and why it was not successful; What were the barriers and how did you address them? What did you learn to inform future QI efforts?</p>	
<p>10. Wound Management (0 – 6 points)</p> <p>i) Please select one of the following that best describes wound management at your facility:</p> <p><input type="checkbox"/> One person does all the wound assessments, wound measurements, and wound treatment plans facility-wide.</p> <p><input type="checkbox"/> For nursing units: there is one person who does all the unit's wound assessments, wound measurements, and wound treatment plans.</p> <p><input type="checkbox"/> Nurses covering the unit are responsible for wound assessments, wound measurements, and wound treatment plan reviews that are due during their shift. Multiple nurses are involved.</p> <p>ii) Do you have a dedicated wound team at your facility? If no, skip iii and iv. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>iii) Who participates on the Wound Team? Check all that apply.</p> <p><input type="checkbox"/> Dietary</p> <p><input type="checkbox"/> Rehab team member(s): PT, OT</p> <p><input type="checkbox"/> DON/DNS and/or Assistant DON/DNS</p> <p><input type="checkbox"/> Unit manager and/or Primary RN</p> <p>iv) How often does the Wound Team conduct wound rounds? Select one.</p> <p><input type="checkbox"/> Ad hoc</p> <p><input type="checkbox"/> Weekly</p> <p><input type="checkbox"/> Monthly</p>	
<p>11. Use of data. (0 – 3 points)</p> <p>Check all that apply:</p> <p><input type="checkbox"/> Reports other than MDS, e.g., reports produced by vendors such as Optimus or Medicus, are used for care planning. Please describe: _____</p> <p><input type="checkbox"/> My InnerView reports (quality benchmarking or satisfaction reports) used in monthly QI meeting and action plans developed to improve. Please include example action plan based on My InnerView report.</p>	

IV. Overview of Your Facility's Current Information Technology (IT) Systems and Your Plans for Future IT Purchases

The first column lists common documentation activities that lend themselves to IT. For any IT product that you have either purchased or are considering purchasing for the activity, please enter vendor or product name and contact information for the IT. Then please circle yes or no, as appropriate, to indicate whether you have already purchased the IT or are considering or planning to purchase it. If you do not use a computer to document any of the information and are not considering using a computer, please leave the spaces blank.

Software Purpose	Vendor/Product Name	Vendor Contact Name and Phone Number	Have You Purchased This IT? (circle one)	Currently Considering Purchase? (circle one)
Nursing note or assessment documentation			Yes / No	Yes / No
CNA daily documentation			Yes / No	Yes / No
Dietician note documentation			Yes / No	Yes / No
MDS data entry and submission			Yes / No	Yes / No
Billing			Yes / No	Yes / No
Physician order entry			Yes / No	Yes / No
Reporting and analysis using MDS data (e.g., EQUIP)			Yes / No	Yes / No
Other – i)			Yes / No	Yes / No
Other – ii)			Yes / No	Yes / No