On-Time Pressure Ulcer Prevention

Self-Assessment Worksheet for Pressure Ulcer

The Self-Assessment Worksheet is designed to help staff review how they currently identify residents who have experienced a change in pressure ulcer risk, how they determine if new clinical interventions are needed, and how they determine what those interventions are. The self-assessment tool is intended to help identify the current processes and structures the nursing home uses to prevent pressure ulcers and identify gaps and places for improvement. It is intended to help staff think about ways to transform these processes and how to begin to use the pressure ulcer prevention reports in clinical discussions. The self-assessment tool is an important first step in implementing the reports into current workflow.

The team is expected to use the Self-Assessment Worksheet to help understand current pressure ulcer prevention practices. This is the first step to help them determine how to transform their current practices and to identify ways to incorporate the On-Time Reports into current practice. It is expected that the facilitator will work with the change team to identify gaps in current pressure ulcer prevention practices and help them see ways to incorporate the reports to improve these practices and improve clinical interventions.

The Self-Assessment Worksheet shows how the nursing home:

- Identifies how they identify which residents are at risk of pressure ulcers,
- Identifies how they develop interventions to prevent pressure ulcer formation,
- Identifies how they discuss at-risk residents and formulate changes in care plans, and
- Identifies how they carry out root cause analysis when a pressure ulcer occurs.

The Self-Assessment Worksheet has four sectons:

- Section 1: Screening for Pressure Ulcer Risk
- Section 2: Pressure Ulcer Prevention Plan
- Section 3: Communication Practices
- Section 4: Investigations/Root Cause Analysis of Pressure Ulcer Development

Self-Assessment Worksheet for Pressure Ulcer Prevention

Section 1: Screening for Pressure Ulcer Risk

In this section, we would like to learn more about your facility's pressure ulcer risk activities.

1. Does your facility have a pressure ulcer risk policy?

   Yes ❑ No ❑ **If no, skip to Question 3.**

2. If yes, does the policy include the following:

		Yes	No
a.	Clinical areas to be covered	❑	❑
b.	Timing or frequency of assessments	❑	❑
c.	Documentation requirements	❑	❑
d.	Communication to care team	❑	❑

3. Does your facility provide training to nursing staff on how to accurately assess for pressure ulcer risk?

   Yes ❑ No ❑

4. Does the pressure ulcer risk assessment use a standardized assessment tool (for example, Braden score of Norton tool)?

   Yes ❑ No ❑ **If yes, skip to Question 6.**

5. If not using a standardized tool, does the assessment tool that the facility uses cover the following:

		Yes	No
a.	Impaired mobility	❑	❑
b.	Incontinence	❑	❑
c.	Nutritional deficits	❑	❑
d.	Diabetes diagnosis	❑	❑
e.	Peripheral vascular disease diagnosis	❑	❑
f.	Contractures	❑	❑
g.	History of pressure ulcers	❑	❑
h.	Paralysis	❑	❑

6. How frequently is the risk assessment tool completed?
   a. ❑ Monthly
   b. ❑ Quarterly
   c. ❑ Annually
   d. ❑ Change of condition
   e. ❑ Other (specify): _____

7. When are residents screened for pressure ulcer risk? Check all that apply.
   a. ❑ Upon admission/readmission
   b. ❑ With a change in condition
   c. ❑ With each MDS assessment
   d. ❑ When weight loss has occurred
   e. ❑ Change in meal intake
   f. ❑ Change in fluid intake
   g. ❑ Change in mobility
   h. ❑ Change in continence
   i. ❑ Change in communication

8. Do your facility's pressure ulcer risk assessment activities include a comprehensive skin assessment/inspection*?

   Yes ❑ No ❑

   **A comprehensive skin assessment is defined as a full head to toe and front and back assessment of the skin, the body's largest organ, for any breakdown or reddened areas. This includes attention to all bony prominences, ears, scalp, in between toes, etc.*

9. Who completes the skin assessment/inspection **on admission?**
   a. ❑ Admitting nurse
   b. ❑ Nursing assistant
   c. ❑ Wound/skin care nurse
   d. ❑ Nurse manager
   e. ❑ Nursing supervisor
   f. ❑ Director of nursing
   g. ❑ Other (specify)_____

10. Who completes routine skin assessments/inspections?
    a. ❑ Unit nurse
    b. ❑ Nursing assistant
    c. ❑ Wound care nurse
    d. ❑ Other (specify): _____

11. How often are skin assessments/inspections completed?
    a. ❑ Daily
    b. ❑ Weekly
    c. ❑ Monthly
    d. ❑ Other (specify): _____

12. Where are skin assessments/inspections documented?
    a. ❑ Medical record
    b. ❑ Nursing assistant documentation
    c. ❑ Skin assessment form
    d. ❑ Other (specify): _____

13. Do you screen all residents for pressure ulcer risk at the following times:
    a. Upon admission Yes ❑ No ❑
    b. Upon readmission/reentry Yes ❑ No ❑
    c. When there is a change in condition Yes ❑ No ❑
    d. With each MDS assessment Yes ❑ No ❑

14. If the resident is not currently deemed at risk, is there a plan to rescreen at regular intervals?
    Yes ❑ No ❑

15. Do you screen residents for pressure ulcer risk with the following diagnoses?
    a. Diabetes mellitus Yes ❑ No ❑
    b. Peripheral vascular disease Yes ❑ No ❑
    c. History of pressure ulcer Yes ❑ No ❑
    d. Paralysis Yes ❑ No ❑

Section 2: Pressure Ulcer Prevention Plan

For residents at risk, we would like to learn what is included in your pressure ulcer prevention care plan.

1. Do you develop a care plan for residents at risk of developing a pressure ulcer?

   Yes ❑ No ❑ **If not, skip to Section 3.**

2. Does your plan include interventions for **skin care**?

   Yes ❑ No ❑

3. Does your plan include daily skin assessments of **pressure points**?

   Yes ❑ No ❑

   3A. Does your daily assessment assess the following areas?

   a. Sacrum Yes ❑ No ❑
   b. Ischium Yes ❑ No ❑
   c. Trochanters Yes ❑ No ❑
   d. Heels Yes ❑ No ❑
   e. Elbows Yes ❑ No ❑
   f. Back of the head Yes ❑ No ❑
   g. Ears/nose Yes ❑ No ❑

4. Does your plan include interventions addressing **nutrition and hydration**?

   Yes ❑ No ❑

   4A. Does your plan include interventions to address:

   a. Feeding or swallowing difficulties Yes ❑ No ❑
   b. Undernourishment (e.g., weight loss, decreased meal intake) Yes ❑ No ❑

5. Does your plan include a nutritional screen for residents at risk of developing a pressure ulcer?

   Yes ❑ No ❑

5A Does the screen include any of the following:

a. Estimation of nutritional requirements Yes ❑ No ❑

b. Comparison of nutrient intake with estimated requirements Yes ❑ No ❑

c. Recommendation for frequency of reassessment of nutritional status Yes ❑ No ❑

d. Weight pattern change summary Yes ❑ No ❑

6. Does your plan include an assessment for **pain**?

Yes ❑ No ❑

7. Does your plan include an assessment for **decreased mental status**?

Yes ❑ No ❑

8. Does your plan include an assessment for **incontinence**?

Yes ❑ No ❑

9. Does your plan include an assessment for **medical device-related pressure**?

Yes ❑ No ❑

9A. Do recommendations for positioning include the following?

❑ a. Dealing with medical devices (oxygen tubing, catheters)

❑ b. Guidance for avoiding friction and shear

❑ c. Support surfaces

❑ d. Frequency of repositioning

10. Does your plan include an assessment for **friction and shear**?

Yes ❑ No ❑

10a. Does your plan include an assessment for **muscle spasms**?

Yes ❑ No ❑

11. Does your plan include an assessment for **immobility**?

Yes ❑ No ❑

12. Does your plan include an assessment for **contractures**?

Yes ❑ No ❑

Section 3: Communication Practices

1. We are interested in how you communicate the pressure ulcer risk and prevention care plans to the interdisciplinary team. Please review the following list of meetings. For every meeting that occurs at your facility, indicate how often it occurs, who leads the meeting, and who attends.

Meeting	Pressure Ulcer Prevention Discussed Yes/No	Meeting Chair/Leader Name and Discipline	Staff Invited and in Attendance (indicate A – Always, V- Varies as needed)	Frequency of Meeting (Weekly, Biweekly, Monthly, Quarterly, Change in Condition, As Needed)
a. Care plan review b. Report or brief with CNAs c. Report or brief with department heads d. Medical staff e. QAPI* or performance improvement plan meeting f. Skin or wound meeting g. MD/APRN* rounds h. Report or brief with Dietary Department i. Report or brief with Social Services Department j. Report or brief with Therapy Department k. Report or brief with “Other”				

* QAPI = Quality Assessment and Performance Improvement; APRN = advanced practice registered nurse.

2. Training

Indicate the date of the most recent training provided for the following:

	Topic	Participants	Date
a.	Conducting an accurate skin assessment	Nurses	
b.	Conducting an accurate skin assessment	CNAs	
c.	Effective positioning	Nurses	
d.	Effective positioning	CNAs	
e.	Skin care	CNAs	
f.	Documentation—meal and fluid intake	CNAs	
g.	Documentation—positioning	CNAs	

Section 4: Investigations/Root Cause Analysis of Pressure Ulcer Development

1. Do you investigate each new in-house pressure ulcer according to your facility's policies and guidelines?

   Yes ❑ No ❑ Not Sure ❑

2. Do you investigate each new in-house pressure ulcer in a root cause framework?

   Yes ❑ No ❑ Not Sure ❑ **If no or not sure**, **stop here.**

3. In the course of your root cause analysis, do you look at the most recent pressure ulcer risk screen?

   Yes ❑ No ❑

   If yes, how do you check the accuracy of that screen?

   _____

4. In the course of your root cause analysis, do you check to see if the risk status of the resident has changed?

   Yes ❑ No ❑

   If yes, would your investigation include any of the following factors as affecting risk for a pressure ulcer? Check all that apply.

   a. ❑ Change in condition
   b. ❑ Weight loss
   c. ❑ Change in meal intake
   d. ❑ Change in fluid intake
   e. ❑ Change in mobility
   f. ❑ Change in continence
   g. ❑ Change in ability to communicate pain
   h. ❑ Other (specify): _____
   i. ❑ Other (specify): _____

5. Please review the following list of assessments to identify appropriate interventions to address pressure ulcer risk. Check the one(s) that you would investigate as part of your root cause analysis:

   a. ❑ Nutrition assessment for a resident with decreased meal or fluid intake
   b. ❑ Nutrition screen for a resident at risk of developing a pressure ulcer
   c. ❑ Pain assessment
   d. ❑ Cognitive assessment
   e. ❑ Incontinence assessment
   f. ❑ Medical device-related pressure assessment (e.g., oxygen tubing, catheters)
   g. ❑ Assessment for friction and shear
   h. ❑ Mobility assessment
   i. ❑ Contracture assessment
   j. ❑ Assessment for appropriate bed and chair support surfaces
   k. ❑ Positioning assessment
   l. ❑ Skin assessments per frequency designated by MD/NP
   m. ❑ Other (specify): _____
   n. ❑ Other (specify): _____

6. Assessments may reveal that a particular action should be taken (e.g., a toileting routine to prevent incontinence, diet change to encourage increased intake, new cushion for wheelchair). How would you find out if an intervention had been identified as necessary, but not carried out?

   _____

   _____

7. Are there any particular obstacles or challenges to investigating the root cause of pressure ulcers?

   _____

   _____

   _____