# Pressure Ulcer Prevention and Management

This is an evaluative, quality management tool used by the Veteran Affairs (VA) OIG Office of Healthcare Inspections. I have modified it somewhat, and I believed it can be used by nursing services as they perform audits in their health care facilities (hospitals, nursing homes, hospices, district hospitals, or other care facilities) in the respective countries.

The purpose of the review /audit is to determine whether acute care clinicians provide comprehensive pressure ulcer prevention and management.

Suggestions for use are with documentsof patients with pressure ulcers, patients with hospital-acquired pressure ulcers, patients with community-acquired pressure ulcers, and patients with pressure ulcers at the time of the audit/review or onsite visit), and employee training records.

| REVIEW AREAS | YES | NO | COMMENTS |
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| The facility had a pressure ulcer prevention policy, and it addressed prevention for all inpatient areas and for outpatient care. | | | |
| The facility had an inter-professional pressure ulcer committee, and the membership included a certified wound care specialist (nurse or physician) | | | |
| Pressure ulcer data were analyzed and reported to facility executive leadership/nursing administration. | | | |
| Complete skin assessments were performed within 24 hours of acute care admissions. | | | |
| Skin inspections and risk scales were performed upon transfer, change in condition, and discharge. | | | |
| Staff were generally consistent in documenting location, stage, risk scale score, and date acquired. | | | |
| Required activities were performed for patients determined to be at risk for pressure ulcers and for patients with pressure ulcers. | | | |
| Required activities were performed for patients determined to not be at risk for pressure ulcers. | | | |

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| For patients at risk for and with pressure ulcers, inter-professional treatment plans were developed, interventions were recommended, and health record (EHR or manual) documentation reflected that interventions were provided. | | | |
| The facility offered restorative nursing services. | | | |
| Resident progress towards restorative nursing goals was documented, and interventions were modified as needed to promote the resident's accomplishment of goals. | | | |
| Facility staff completed and documented restorative nursing services, including active and passive range of motion, bed mobility, transfer, and walking activities, according to clinician orders and residents' care plans. | | | |
| When restorative nursing services were care planned but were not provided or were discontinued, reasons were documented in the health record (EHR/paper). | | | |
| The facility defined requirements for patient and caregiver pressure ulcer education, and education on pressure ulcer prevention and development was provided to those at risk for and with pressure ulcers and/or their caregivers. | | | |
| The facility defined requirements for staff pressure ulcer education, and acute care staff received training on how to administer the pressure ulcer risk scale, conduct the complete skin assessment, and accurately document findings | | | |
| If the patient's pressure ulcer was not healed at discharge, a wound care follow-up plan was documented, and the patient was provided appropriate dressing supplies. | | | |

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**OVERALL COMMENTS AND/OR RECOMMENDATIONS**