

Systems Investigative Audit – Pressure Ulcer Prevention/Treatment

Purpose: To evaluate the decision-making process and adequacy of the facility's process in the prevention of pressure ulcers and appropriateness of treatment protocols.

- NOTE: the following audit criteria are broad. Select a current clinical practice guideline, or utilize the facility assessment tool for pressure ulcers, to guide your detailed audit.

Criteria:

1. Resident is screened within 24 hours of admission for risk of skin breakdown using a standardized risk-screening tool.
2. An appropriate pressure ulcer prevention or treatment care plan was put into place within the first 24 hours of admission for all residents whether high or low risk and according to current CPGs.
3. Skin/wound assessments/reassessment were done at appropriate intervals according to determined levels of risk and current CPGs,
 - Full skin assessment at least weekly with detailed documentation, according to CPGs, of wound condition, if present.
 - At least daily monitor pressure sites and areas of skin changes.
 - Progress of wound healing is reassessed q2-4 weeks and treatment plan re-evaluated if no evidence of progress noted.
4. The care plan incorporated the following care needs as well as all identified risk factors:
 - Needs for turning/positioning were identified.
 - Positioning/pressure relief product needs were identified and utilized consistently and properly.
 - Nutrition assessment was completed and identified needs included in the care plan.
 - Individualized skin care needs were identified and included in the care plan.
 - Interventions were included from all disciplines for either pressure ulcer prevention or treatment.
5. Care plan interventions were implemented as indicated.
6. Care plan was consistently evaluated and revised, based on current resident assessed needs.
7. Documentation of skin condition, intervention for risk factors, treatment of existing pressure ulcers and evaluation of effectiveness was timely, consistent, and follows recommended CPGs.
8. An appropriate system for communicating to all direct-care staff skin risk factors, interventions and changes in the plan of care was in place and functioned properly.
9. Responsibility and accountability was assigned for each phase of the pressure ulcer prevention/treatment process.
 - Those designated as responsible and accountable for monitoring the processes of pressure ulcer prevention/treatment carried out their responsibilities in a timely manner.
10. Policy and protocols are updated and communicated to all staff according to current clinical practice guidelines.
11. The QA/CQI committee had processes in place to track and identify patterns and to determine the root cause of skin breakdown events.
 - Identified solutions were system-oriented.
 - Content of staff education was determined by competency evaluations and identified areas of weakness.
12. If resident self-determination was a contributing factor in pressure ulcer development, reasonable counsel, education and alternatives were provided.

Reviewer: _____

Date of Review: _____

	Chart 1	Chart 2	Chart 3	Chart 4	Chart 5	Chart 6	Comments
1. Admission risk assessment completed with appropriate tool							
2. Skin needs care plan was in place within 24 hrs of admission							
3. Assessments and reassessments done at appropriate intervals							
4. Care plan incorporates all identified risk factors							
5. Interventions are implemented as indicated							
6. Care plan shows evidence of timely revisions based on assessed resident needs							
7. Skin condition, interventions and evaluation of interventions documented							
8. Staff demonstrates awareness/understanding of care plan content.							
9. Accountability is evidenced by those responsible for monitoring, assessment and follow-up							
10. Skin policy/protocols are current & followed consistently							
11. QA/CQI meetings focus on root-cause analyses							
12. Resident / family education provided							

Comparing your Practice Pressure Ulcers

Name of Facility: _____

Date Reviewed: ____/____/20____

- DIRECTIONS:**
1. Enter the resident's clinical record number or initials.
 2. Review the clinical record for evidence of each practice.
 3. Enter a "Y" if it is identified or an "N" if it is not identified. (Reviewers may have N/A for some records.)
 4. Tally the number of "Y"s identified for each best practice, divide by the total number of applicable records reviewed to determine the percent.

Enter Resident's Clinical Record ID # or Initials	Clinical Record										TALLY		%
	1	2	3	4	5	6	7	8	9	10	# Yes	Total #	
	1.												
2.													
3.													
4.													
5.													
6.													
7.													
8.													
9.													
10.													