PROMOTE SAFETY ACROSS THE BOARD

>>>

DATE OF LAST HAPU/I:

Hospital-Acquired Pressure Ulcers/Injuries (HAPU/I) Top Ten Checklist

- Conduct prevalence studies to collect data on pressure ulcer/injury occurrences and to observe processes of care in real time to identify opportunities to improve the reliability of care delivery.
- Learn from HAPU/I by conducting a root cause analysis on Stage 3, 4 and unstageable ulcer/injuries and by analyzing HAPU/I data for trends by unit for patient characteristics, anatomical location and other contributing factors.
- Conduct a pressure ulcer/injury risk assessment within four hours of admission. Reassess at intervals defined by patient care need.
- Activate HAPU/I prevention bundles for high-risk patients, including appropriate surface selection, off-loading pressure (turning and repositioning), nutrition and a moisture management plan.
- Assess reliability of documentation of pressure ulcer/injury present on admission and of appropriate classification of moisture versus pressure related skin damage.
- Provide annual education and competency evaluation on early detection of Stage 1, assessing darkly pigmented skin, staging of pressure ulcer/injuries and differentiating pressure from moisture related skin damage.
- Investigate clinical practices regarding skin safety in the operating room and in the prevention and reporting of medical device-related pressure ulcer/injuries.
- Establish a partnership with nutritional services to ensure timely nutritional assessments and implementation of interventions for high-risk patients.
- Assess adequacy of moisture management and skin care products, support surfaces (ER carts, OR Tables, ICU units, medical/surgical units) and shear prevention devices (lifts, glide sheets). Engage executive leadership in planning for upgrading or replacement as needed.
- Engage patients and families in HAPU/I prevention. Design a process to engage patients and families in assessing for early warning signs and participating in preventive measures.