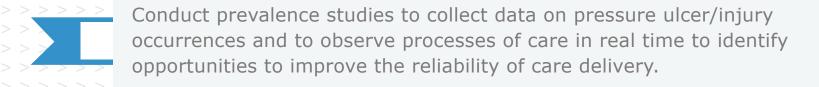
PROMOTE SAFETY ACROSS THE BOARD



DATE OF LAST HAPU/I:

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



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.