# Pressure Ulcer Prevention Toolkit

## Module 2 ToolsPicture of puzzle with Tools piece highlighted

2A: Multidisciplinary Team

2B: Quality Improvement Process

2C: Current Process Analysis

2D: Assessing Pressure Ulcer Policies

2E: Assessing Screening for Pressure Ulcer Risk

2F: Assessing Pressure Ulcer Care Planning

2I: Action Plan

### 2A: Multidisciplinary Team

**Background:** Crucial to a pressure ulcer prevention initiative is the creation of a multidisciplinary implementation team that will oversee the improvement effort. This tool can be used to identify people from different interdisciplinary areas to take part on the implementation team.

**Reference:** Developed by Boston University Research Team.

**Instructions:** List the names of possible team members from each department or discipline and their area of expertise.

**Use:** Use this list to form your implementation team.

| **Discipline** | **Names of possible implementation team members from each area** | **Area of expertise** |
| --- | --- | --- |
| Senior manager |  |  |
| Quality improvement/Safety/risk manager |  |  |
| Wound staff |  |  |
| Wound nurse |  |  |
| Wound physician  |  |  |
| Staff nurse |  |  |
| Nursing assistants |  |  |
| Registered dietitian |  |  |
| Hospitalist physicians |  |  |
| Physical therapists |  |  |
| Occupational therapists |  |  |
| Medical/surgical staff |  |  |
| Other providers |  |  |
| Patient representative |  |  |
| Educator |  |  |
| Materials manager |  |  |
| Information systems staff |  |  |
| Clerical staff |  |  |

### 2B: Quality Improvement Process

**Background:** This tool will help you and your team identify the extent to which you have the resources for quality improvement (QI) in your organization. The form was developed by the Turning Point Initiative to assess if an organization has the needed systems in place to improve quality and performance.

**Reference:** Turning Point Performance Management National Excellence Collaborative. Performance Management Self-Assessment Tool. Available at: [www.turningpointprogram.org/toolkit/pdf/PM\_Self\_Assess\_Tool.pdf](http://www.turningpointprogram.org/toolkit/pdf/PM_Self_Assess_Tool.pdf).

**Instructions:** This tool should be filled out by the implementation team leader in consultation with the QI department. The “you” refers to your organization as a whole. Check the box that most accurately describes your organization’s current resources.

**Use:** If you find that your organization has fully operationalized QI processes, connect the pressure ulcer prevention initiative with these existing processes. If some processes are missing, advocate for them to be put into place in the context of the pressure ulcer initiative.

#### Quality Improvement Process

| **Assessment Question** | **No** | **Somewhat** | **Yes (fully operational)** |
| --- | --- | --- | --- |
| 1. **Do you have a process(es) to improve quality or performance?**
 |  |  |  |
| Is an entity or person responsible for decision-making based on performance reports (e.g. top management team, governing or advisory board |  |  |  |
| Is there a regular timetable for your QI process? |  |  |  |
| Are the steps in the process communicated? |  |  |  |
| 1. **Are managers and employees evaluated for their performance improvement efforts (i.e., is performance improvement in their job descriptions)?**
 |  |  |  |
| 1. **Are performance reports used regularly for decisionmaking?**
 |  |  |  |
| 1. **Is performance information used to do the following? (check all that apply)**
 |
| Determine areas for more analysis or evaluation |  |  |  |
| Set priorities and allocate/redirect resources |  |  |  |
| Inform policymakers of the observed or potential impact of decisions under their consideration |  |  |  |
| 1. **Do you have the capacity to take action to improve performance when needed?**
 |
| Do you have processes to manage changes in policies, programs, or infrastructure? |  |  |  |
| Do managers have the authority to make certain changes to improve performance? |  |  |  |
| Do staff have the authority to make certain changes to improve performance? |  |  |  |
| 1. **Does the organization regularly develop performance improvement or QI plans that specify timelines, actions, and responsible parties?**
 |  |  |  |
| 1. **Is there a process or mechanism to coordinate QI efforts among programs, divisions, or organizations that share the same performance targets?**
 |  |  |  |
| 1. **Is QI training available to managers and staff?**
 |  |  |  |
| 1. **Are personnel and financial resources allocated to your QI process?**
 |  |  |  |

### 2C: Current Process Analysis

**Background:** Before beginning a quality improvement initiative, you need to understand your current methods. This tool can be used to describe key processes in your organization where pressure ulcer prevention activities could or should happen.

**Reference:** Adapted from: Quality Partners of Rhode Island. QI Worksheet E, Current Process Analysis. Available at: <https://www.qualitynet.org/dcs/ContentServer?c=MQTools&pagename=Medqic%2FMQTools%2FToolTemplate&cid=1096585074914>.

**Instructions:**

* Have the implementation team identify and define every step in the current process for pressure ulcer prevention.
* When defining a process, think about staff roles in the process, the tools or materials staff use, and the flow of activities.
* Everything is a process, whether it is admitting a resident, serving meals, assessing pain, or managing a nursing unit. The ultimate goal of defining a process is identifying problems in the current process.

**Use:** Determine if there are any gaps and problems in your current processes, and use the results of this analysis to systematically change these processes.

**Tips:**

* Take time to brainstorm and listen to every team member.
* Make sure the process is understood and documented.
* Make each step in the process very specific.
* Use one post-it note, index card, or scrap piece of paper for each step in the process.
* Lay out each step, move steps, and add and remove steps until team agrees on the final process.
* If a process does not exist (for example, there is no process to screen for pain upon admission and readmission), identify the related processes (for example, the process for admission and readmission).
* If the process is different for different shifts, identify each individual process.

**Example: Process for Making Buttered Toast**

**Step Define**

1. Check to see if there is bread, butter, knife, and toaster.
2. If supplies are missing, go to the store and purchase them.
3. Check to see if the toaster is plugged in. If not, plug in the toaster.
4. Check setting on toaster. Adjust to darker or lighter as preferred.
5. Put a slice of bread in toaster.
6. Turn toaster on.
7. Wait for bread to toast.
8. When toast is ready, remove from toaster and put on plate.
9. Use knife to cut pat of butter.
10. Use knife to spread butter on toast.

**Identify the steps of your defined process.**

* Press for details.
* At the end of the gap analysis, compile the results in a document that displays each step so that team members have the map of the current process in front of them during the team discussion (Step 2).

**Team discussion**

**Evaluate your current process as you define it:**

* What policies and procedures do we have in place for this process?
* What forms do we use?
* How does our physical environment support or hinder this process?
* What staff are involved in this process?
* What part of this process does not work?
* Do we duplicate any work unnecessarily? Where?
* Are there any delays in the process? Why?

**Continue asking questions that are important in learning more about this process.**

### 2D: Assessing Pressure Ulcer Policies

**Background:** This worksheet can be used to determine if your facility has a policy for preventing and managing pressure ulcers. The tool is one of a series of Facility Assessment Checklists used to identify areas that need improvement in nursing homes and has been modified for hospitals.

**Reference:** Adapted from: Quality Partners of Rhode Island. Pressure Ulcers: Facility Assessment Checklists. Available at: <https://www.qualitynet.org/dcs/ContentServer?cid=1098482996140&pagename=Medqic%2FMQTools%2FToolTemplate&c=MQTools>.

**Instructions:** Complete the checklist. For certain questions, you may want to consult with appropriate staff in your organization.

**Use:** Use the results of this assessment to identify issues that you need to deal with, and formulate goals for your pressure ulcer prevention initiative.

#### Pressure Ulcer Policy Assessment

**Does your facility’s policy for the prevention and management of pressure ulcers include these components?**

|  | **Yes** | **No** | **Person Responsible** | **Comments** |
| --- | --- | --- | --- | --- |
| 1. Does your hospital’s policy include a statement regarding your facility’s commitment to pressure ulcer prevention and management?
 |  |  |  |  |
| Does your hospital’s policy include a standard protocol for assessing a patient’s risk for developing pressure ulcers? |  |  |  |  |
| Does your hospital’s policy state that all patients be reassessed for pressure ulcer risk at the following times:1. Upon admission
2. Upon transfer
3. When a change in condition occurs
 |  |  |  |  |
| Does your hospital’s policy state that a skin assessment should be performed on all patients at risk for pressure ulcers at the following times:1. Upon admission
2. Daily
3. Upon transfer
 |  |  |  |  |
| Does your hospital’s policy include who, how and when pressure ulcer program effectiveness should be monitored and evaluated? |  |  |  |  |
| Does your hospital’s policy include goals of pressure ulcer management such as:1. Prompt assessment and treatment
2. Specification of appropriate pressure ulcer risk and monitoring tools
3. Steps to be taken to monitor treatment effectiveness
4. Pressure ulcer treatment techniques that are consistent with clinically-based guidelines
 |  |  |  |  |
| Does your hospital’s policy address steps to be taken if pressure ulcer is not healing? |  |  |  |  |

### 2E: Assessing Screening for Pressure Ulcer Risk

**Background:** The purpose of this tool is to determine if your facility has a process to screen patients for pressure ulcer risk. The tool is one of a series of Facility Assessment Checklists developed to identify areas that need improvement.

**Reference:** Quality Partners of Rhode Island. Pressure Ulcers: Facility Assessment Checklists. Available at: <https://www.qualitynet.org/dcs/ContentServer?cid=1098482996140&pagename=Medqic%2FMQTools%2FToolTemplate&c=MQTools>.

**Instructions:** Complete the checklist. For certain questions, you may want to consult with appropriate staff in your organization.

**Use:** Use the results of this assessment to identify issues that you need to deal with, and formulate goals for your pressure ulcer prevention initiative.

#### Assessment of Screening for Pressure Ulcer Risk

**Does your facility have a process for screening that addresses all the areas listed below?**

|  | **Yes** | **No** | **Person Responsible** | **Comments** |
| --- | --- | --- | --- | --- |
| 1. Do you screen all patients for pressure ulcer risk at the following times:
* Upon admission
* Upon readmission
* When condition changes
 |  |  |  |  |
| 1. If the patient is not currently deemed at risk, is there a plan to rescreen at regular intervals?
 |  |  |  |  |
| 1. Do you use either the Norton or Braden pressure ulcer risk assessment tool?

*If Yes,* ***STOP****. If No, please continue to #4.* |  |  |  |  |
| 1. If you are not currently using the Norton or Braden risk assessment, does your screening address the following areas:
	* Impaired mobility:
		+ Bed
		+ Chair
	* Incontinence:
* Urine
* Stool
* Nutritional deficits:
* Malnutrition
* Feeding difficulties
* Diagnosis of:
* Diabetes Mellitus
* Peripheral Vascular Disease
* Contractures
* Hx of pressure ulcers
 |  |  |  |  |

### 2F: Assessing Pressure Ulcer Care Planning

**Background:** This tool can be used to determine if your facility has a process for developing and implementing a pressure ulcer care plan for patients who have been found to be at risk or who have a pressure ulcer. The tool is one of a series of Facility Assessment Checklists developed to identify areas that need improvement.

**Reference:** Quality Partners of Rhode Island. Pressure Ulcers: Facility Assessment Checklists. Available at: <https://www.qualitynet.org/dcs/ContentServer?cid=1098482996140&pagename=Medqic%2FMQTools%2FToolTemplate&c=MQTools>.

**Instructions:** Complete the checklist. For certain questions, you may want to consult with appropriate staff in your organization.

**Use:** Use the results of this assessment to identify issues that you need to deal with, and formulate goals for your pressure ulcer prevention initiative.

#### Assessment of Pressure Ulcer Care Plan

**Does the care plan for pressure ulcers address all the areas below (as they apply)?**

|  | **Yes** | **No** | **Person Responsible** | **Comments** |
| --- | --- | --- | --- | --- |
| Impaired Mobility* Assist with turning, rising, position
* Encourage ambulation
* Limit static sitting to 2 hours at any time
 |  |  |  |  |
| Pressure Relief* Support surfaces: Bed
* Support surfaces: Chair
* Pressure-relieving devices
* Repositioning
* Bottoming out in bed and chair\*
 |  |  |  |  |
| Nutritional Improvement* Supplements
* Feeding assistance
* Adequate fluid intake
* Dietitian consult as needed
 |  |  |  |  |
| Urinary Incontinence* Toileting plan
* Wet checks
* Treat causes
* Assist with hygiene
* Use of skin barriers and protectants
 |  |  |  |  |
| Fecal Incontinence* Toileting plan
* Soiled checks
 |  |  |  |  |
| Skin Condition Check* Intactness
* Color
* Sensation
* Temperature
 |  |  |  |  |
| Treatment* Physician-prescribed regimen
* Appropriateness to wound staging
* Treatment reassessment timeframe
 |  |  |  |  |
| Pain* Screen for pain related to ulcer
* Choose appropriate pain med
* Provide regular pain med administration
* Reassess effectiveness of med
* Assess/treat side effects
* Change or cease pain med as needed
 |  |  |  |  |

To determine if a patient has bottomed out, the caregiver should place his or her outstretched hand (palm up) under the mattress overlay below the existing pressure ulcer or that part of the body at risk for pressure formation. If the caregiver can feel that the support material is less than an inch thick at this site, the patient has bottomed out.

### 2I: Action Plan

**Background:** The purpose of this tool is to provide a framework for outlining steps that will be needed to design and implement the pressure ulcer prevention initiative.

**Reference:** Adapted from material produced by MassPro, a participant in the Centers for Medicare & Medicaid Services Quality Improvement Organization Program.

**Instructions:**

1. Note the date and the objective. A sample objective is provided.
2. The form lists six key tasks. For each, list in the second column the steps that will be taken to address the task, including tools to be used.
3. In developing the plan, it is not expected that you will provide results, only that you will lay out what needs to be done.
4. In the last two columns, determine who will have lead responsibility for completing each task, and estimate an appropriate timeframe for completing the activities.
5. Use the plan as a working document that can be revised. As you begin to carry out the plan, you may need to make adjustments and add details to the later tasks.

**Use:** Use the completed sheet to plan, manage, and carry out the identified tasks. The plan should guide the implementation process and can be continually amended and updated.

A sample completed form is shown below, followed by a blank form.

**Pressure Ulcer Prevention Action Plan Date:** February 16, 2011

**Improvement Objective:** Implement standard pressure ulcer prevention practices within 6 months

| **Key Interventions/Tasks** | **Steps To Complete Task and Tools To Use** | **Team Members Responsible for Task Completion** | **Target Date for Task Completion** |
| --- | --- | --- | --- |
|  | **Examples** | **Examples** | **Examples** |
| 1. Analyze current state of pressure ulcer prevention practices in this organization.
 | Identify strengths and weaknesses using process mapping and gap analysis. Tool 2C and Tools 2E-2G. | Team leader, RNs, and WOCNs | Within 6 weeks from initiative start |
| Assess the current state of staff knowledge about pressure ulcer prevention. Tool 2H. | Education department | Within 6 weeks from initiative start |
| Set target goals for improvement. | QI department | Within 8 weeks from initiative start |
| 1. Identify the bundle of prevention practices to be used in redesigned system.
 | Determine how comprehensive skin assessment should be performed | Wound care team | Within 12 weeks from initiative start |
| Decide which scale will be used for performing risk assessment. | Wound care team | Within 12 weeks from initiative start |
| Decide what items of pressure ulcer prevention should be in your bundle | Clinical staff members | Within 12 weeks from initiative start |
| 1. Assign roles and responsibilities for implementing the redesigned pressure ulcer prevention practices.
 | Examples | Examples | Examples |
| Determine who will complete the daily skin and risk assessments. Tool 4A. | Implementation team | Within 16weeks from initiative start |
| Identify unit champions. | Team leader | Within 16 weeks from initiative start |
| Determine how prevention work will be organized at the unit level, such as paths of communication and lines of oversight. | QI team | Within 16 weeks from initiative start |
| 1. Put the redesigned bundle into practice.
 | Engage staff and get them excited about the changes needed. | Team leader, unit staff | Within 12 weeks from initiative start |
| Pilot test the new practices. | QI department | Within 20 weeks from initiative start |
| 1. Monitor pressure ulcer rates and practices.
 | Determine how incidence and prevalence data will be collected. Tool 5A. | QI department | Within 6 weeks from initiative start |
| Organize quarterly prevalence studies. | QI department | Within 6 weeks from initiative start, ongoing |
| 1. Sustain the redesigned prevention practices.
 | Ensure continued leadership support. | Team leader | Within 4 weeks from initiative start and ongoing |
| Ensure ongoing support from other units such as facilities management and IT. | IT, facilities management, PT, dietitians | Within 40 weeks from initiative start |
| Designate responsibility and accountability for pressure ulcer prevention oversight and continuous quality improvement. | Team leader and implementation team | Within 40 weeks from initiative start |

**Pressure Ulcer Prevention Action Plan Date:**

**Improvement Objective:**

| **Key Interventions/Tasks** | **Steps To Complete Task and Tools To Use** | **Team Members Responsible for Task Completion** | **Target Date for Task Completion** |
| --- | --- | --- | --- |
| 1. Analyze current state of pressure ulcer prevention practices in this organization.
 |  |  |  |
|  |  |  |
|  |  |  |
| 1. Identify the bundle of prevention practices to be used in redesigned system.
 |  |  |  |
|  |  |  |
|  |  |  |
| 1. Assign roles and responsibilities for implementing the redesigned pressure ulcer prevention practices.
 |  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| 1. Put the redesigned bundle into practice.
 |  |  |  |
|  |  |  |
|  |  |  |
| 1. Monitor pressure ulcer rates and practices.
 |  |  |  |
|  |  |  |
|  |  |  |
| 1. Sustain the redesigned prevention practices.
 |  |  |  |
|  |  |  |
|  |  |  |