Comagine Health

On-Going – Pressure Ulcer

Prevention Process Audit

Resident Name:		Medical Record #		
	Process Description	Y	N	N/A
Assessment & Cause Identification				
1.	Initial Pressure Ulcer Risk Assessment completed on admission/readmission within shift of admission.			
2.	Pressure Ulcer Risk Assessment weekly for the next additional 4 weeks after admission.			
3.	Pressure Ulcer Risk Assessment completed with change of condition.			
4.	Pressure Ulcer Risk Assessment completed after identification of a new pressure ulcer.			
5.	Pressure Ulcer Risk Assessment completed quarterly.			
6.	Pressure Ulcer Risk Assessment completed annually.			
7.	Initial Skin Audit completed within 2 hours of admission or readmission by licensed or registered nurse.			
8.	Skin Audit completed 4 more consecutive days since initial audit, with comprehensive documentation of wound characteristics.			
Management & Monitoring				
9.	Weekly Skin Audit completed weekly with comprehensive documentation of wound characteristics.			
10.	Daily Skin Inspection completed by nursing assistants and reported when redness or Stage I is observed (not waiting until a Stage II develops before reporting)			
11.	Interventions address underlying factors in an effort to minimize, manage, or eliminate risk.			
12.	Wound Treatment Protocol re-evaluated if no improvement in 14 days.			
13.	Wound accurately assessed and determined to be pressure related.			
14.	Interventions care planned for this resident (circle all that apply): Repositioning, positioning devices, pressure reduction mattress, pressure reduction pad in chair, protein supplement, vitamins, minerals, devices to manage contractures, incontinence care, etc.			

15.	Observation: Interventions observed in place match the care plan and staff interviews.			
16.	Interventions care planned for each risk factor, regardless of score.			
17.	Equipment clean and in good condition.			
18.	Staff knowledgeable on interventions for this resident.			
19.	Nurse manager rounds weekly on wound(s) with front line staff. Round with care plan and make observations on wound characteristics, documentation reviewed, and current interventions in place			
20.	Weekly quality management meeting conducted thoroughly, bring medical record, include review of previous interventions for pressure reduction and nutrition, progress reviewed.			
21.	Review MDS section I for appropriate malnutrition or risk of malnutrition coding with have diagnosis, current treatment, supportive documentation.			
22.	Review MDS section G for appropriate documentation for transfers and bed mobility.			

Adapted by Comagine Health, the Medicare Quality Innovation Network - Quality Improvement Organization (QIN-QIO) for Idaho, Nevada, New Mexico, Oregon, Utah and Washington, from materials provided by HealthInsight, and prepared under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.