MedPro Group
a Berkshire Hathaway company

Checklist

# Preventing Pressure Injuries in Senior Care Organizations

Pressure injuries (sometimes called “pressure ulcers”) are caused by prolonged pressure to the skin and underlying tissue, often over a bony area or in relation to a medical device. Pressure injuries are a serious medical concern in senior care organizations. They are dangerous, painful, and expensive to treat; they also increase risks for infection and hospitalization, and sometimes lead to death.[1]

An interdisciplinary approach to care and coordination among many individuals, including the multiple disciplines and teams involved in developing and implementing residents’ care plans, is required to prevent pressure injuries. Additionally, an organizational culture and operational practices that promote teamwork and communication will facilitate an increased focus on pressure injury prevention and optimize residents’ care and safety.

Senior care organizations can use this checklist to assess their processes and pinpoint areas for improving pressure injury prevention and treatment strategies related to skin assessment and care, risk assessment, staging and identification, positioning and mobilization, education, documentation, medical devices, and quality assurance and performance improvement/safety programs.

| | Yes | No |
|---|---|---|
| *Skin Assessment/Care* | | |
| Do staff members conduct a full body assessment of all new residents to identify any skin defects or issues according to the organization’s policy? | ☐ | ☐ |
| Are residents reevaluated for pressure injuries on a routine basis (e.g., minimally weekly or when a change occurs in a resident’s condition)? | ☐ | ☐ |
| Are residents routinely monitored for changes in activity (ambulation versus sedentary habits) and behaviors (i.e., withdrawn, aggressive, etc.) that may lead to development of pressure injuries? | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| *Skin Assessment/Care (continued)* | | |
| Do staff members ensure that residents' skin is cleansed promptly after episodes of incontinence? | ☐ | ☐ |
| Do staff members check residents' skin each time care is provided? | ☐ | ☐ |
| Is any redness on a resident's skin, especially over a bony area, noted and reported when it does not disappear or it's on a new open skin area? | ☐ | ☐ |
| Do staff members use pH-balanced skin cleansers and moisturizers on residents? | ☐ | ☐ |
| Does the organization have a designated wound care nurse or home health service to evaluate reddened areas of concern along with current wounds? | ☐ | ☐ |
| *Risk Assessment* | | |
| Does the organization have a comprehensive program for pressure injury prevention and treatment? | ☐ | ☐ |
| Are staff members aware of the common areas on the body where skin breakdown can easily occur, such as the back of the head, back of the shoulders, elbows, sacrum, hips, gluteal folds, perineum, vaginal folds, scrotum, penis, popliteal area, heels, and toes? | ☐ | ☐ |
| Does the organization have an effective toileting schedule in place since incontinence is a major contributor to skin breakdown? | ☐ | ☐ |
| Does the organization use a structured risk assessment tool (e.g., the Braden Scale) to identify residents at risk for pressure injuries? | ☐ | ☐ |
| Are risk assessments repeated on a regular basis, and do staff members address changes as needed? | ☐ | ☐ |
| Does the organization have a plan of care if a resident's pressure injury results from immobility? | ☐ | ☐ |
| Are staff members educated on assessing bariatric residents (and other special populations) for pressure injuries? | ☐ | ☐ |
| Has the organization considered performing periodic physical, psychological, and psychosocial reassessments of residents who have pressure injuries? | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| *Risk Assessment (continued)* | | |
| Does the organization use a valid and reliable screening tool to determine which residents are at risk for undernutrition or malnutrition? | ☐ | ☐ |
| Do staff members monitor the eating habits of residents who have pressure injuries? | ☐ | ☐ |
| Are undernourished or malnourished residents referred to a registered dietitian or nutritionist? | ☐ | ☐ |
| Are residents provided water frequently? | ☐ | ☐ |
| Do staff members look for signs of pain in noncommunicative residents as well as nonverbal cues of pain and discomfort? | ☐ | ☐ |
| *Pressure Injury Stages and Identification of Types* | | |
| Are staff members aware of medical device-related pressure injuries as well as mucosal membrane pressure injuries? | ☐ | ☐ |
| Are staff members educated about the pressure injury staging system including the current staging illustrations from the National Pressure Injury Advisory Panel? | ☐ | ☐ |
| Can staff members effectively identify the stages/categories of pressure injuries? | ☐ | ☐ |
| Are staff members familiar with unstageable pressure injuries and deep tissue pressure injuries? | ☐ | ☐ |
| *Positioning and Mobilization* | | |
| Are at-risk residents turned or repositioned every 2 hours to avoid pressure injuries? | ☐ | ☐ |
| Is a turn/reposition schedule in place that optimizes independent movement and reduces friction/shear? | ☐ | ☐ |
| Are weak or immobile residents repositioned in a chair/wheelchair hourly? | ☐ | ☐ |
| Do staff members ensure that residents' heels are free from the beds? | ☐ | ☐ |
| Does the organization use regular pressure reliefs (i.e., weight shifting, pressure redistribution, and pressure reduction) as a part of care plans? | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| *Education* | | |
| Are staff members aware that NPIAP replaced the term “pressure ulcers” with “pressure injuries” to reflect injuries to both intact and ulcerated skin? | ☐ | ☐ |
| Has the organization incorporated the term “injury” into documentation related to pressure injuries? | ☐ | ☐ |
| Does the organization have an educational program for pressure injury prevention and treatment? | ☐ | ☐ |
| Are all members of the interdisciplinary team educated and trained on the organization’s pressure injury plan of care? | ☐ | ☐ |
| Does the organization provide regular evidence-based pressure injury prevention and treatment education? | ☐ | ☐ |
| Does the organization use reliable and valid assessment tools to routinely assess the knowledge and behaviors of its staff members? | ☐ | ☐ |
| Do the organization’s culture and operational practices promote teamwork and communication? | ☐ | ☐ |
| Are staff members aware of the role that microclimate, pressure, and shear force play in pressure injuries? | ☐ | ☐ |
| Are residents educated about pressure injuries and how to prevent them? | ☐ | ☐ |
| Are residents’ families educated about pressure injuries and engaged in risk-reduction interventions? | ☐ | ☐ |
| *Medical Devices* | | |
| Are staff members aware that using medical devices that are designed and applied for diagnostic or therapeutic purposes — such as nasal cannulas, IV tubing, urinary catheters, wound vacuum tubing, etc. — can cause pressure injuries? | ☐ | ☐ |
| Are staff members educated about the correct use of medical devices and prevention of skin breakdown? | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| *Medical Devices (continued)* | | |
| Do staff members assess the skin underneath medical devices on residents on each shift? | ☐ | ☐ |
| Have staff members determined that:<br>• Each resident has the proper size and type of device?<br>• Devices are secure to decrease movement or slippage?<br>• Skin is padded to reduce friction?<br>• Manufacturer's recommendations for use and care of the device are followed? | ☐<br>☐<br>☐<br>☐ | ☐<br>☐<br>☐<br>☐ |
| For those affected, is the resident's family educated about the device, what it is, where it is located, why it is there, how it functions, and how long it will stay in place? | ☐ | ☐ |
| Does the organization have a plan in place to protect residents' skin and minimize friction, shear, and moisture from fixed medical devices? | ☐ | ☐ |
| Do staff members place thin foam or breathable dressings under medical devices that residents are wearing? | ☐ | ☐ |
| Does the organization monitor the incidence and prevalence of medical device-related pressure injuries? If yes:<br>• Are the resulting data used to benchmark with other organizations?<br>• Are the results shared with staff members? | ☐<br>☐<br>☐ | ☐<br>☐<br>☐ |
| *Documentation* | | |
| Do staff members document all assessments and care for pressure injuries in residents' health records? | ☐ | ☐ |
| Do staff members document all education provided to residents and residents' families in relation to pressure injury prevention? | ☐ | ☐ |
| Are the residents' assessments, interventions, and continuing care needs communicated from one caregiver to another to ensure successful handoffs? | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| *Quality Assurance and Performance Improvement Program/Safety Program* | | |
| Do the organization's quality assurance and performance improvement and/or safety committees routinely review and track assessment and treatment data for residents at risk for skin breakdown? | ☐ | ☐ |

## Resources

To learn more about pressure injury prevention, identification, and treatment strategies, see MedPro's *Risk Resources: Pressure Injuries in Older Adults*.

## Endnote

[1] Al Aboud, A. M., Manna, B. (2021, July 1 [updated]). Wound pressure injury management. In: *StatPearls* [Internet]. Treasure Island (FL): StatPearls Publishing. Retrieved from www.ncbi.nlm.nih.gov/books/NBK532897/