HealthCap
RISK MANAGEMENT SERVICES

CLINICALLY UNAVOIDABLE PRESSURE ULCER/INJURY ASSESSMENT

Definition-Unavoidable:

1. The resident developed a pressure ulcer/injury even though the facility had evaluated the resident's clinical condition and risk factors; defined and implemented interventions that are consistent with resident needs, goals, and professional standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate.
2. The resident's clinical condition on admission, including known diagnoses and risk factors, make the development of pressure ulcer(s)/injuries probable even with implementation of preventative strategies.

Policy

This assessment will be completed by an RN in collaboration with the attending physician, on admission, quarterly and with a change of condition for residents identified as "at high or very high risk" for the development of pressure ulcers/injuries based on a validated risk assessment tool, i.e., Braden, Norton.

Procedure

1. An RN in collaboration with the attending physician, will complete the "Clinically Unavoidable Pressure Ulcer/Injury Assessment" tool upon admission, quarterly, and with significant change in condition.
2. The tool will be signed and dated by the RN performing the assessment and results will be shared with the attending physician.
3. The attending physician may add additional information/recommendations in the area provided on the tool and sign/date.
4. The results of the assessment for pressure ulcer/injury determined to be unavoidable based on the resident's level of risk, will be provided to the resident and/or responsible party along with education on preventative strategies. This review shall be documented in the medical record and include the names and relationship to the resident.
5. Care plan interventions will be documented on the assessment form and on the resident care plan.
6. Care plan interventions will be initiated and validated during daily rounds.
7. The completed assessment will be maintained as part of the resident's medical record.
8. Skin assessments will be performed on a scheduled basis per facility policy.
9. Ongoing risk assessments will be performed quarterly and with significant change in condition.
10. Identified changes in status will be communicated to the resident/responsible party and care staff.
11. Care plan interventions will be updated to address the resident's current status quarterly and with significant change in condition.

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CLINICALLY UNAVOIDABLE PRESSURE ULCER/INJURY ASSESSMENT

Directions: This assessment will be completed by an RN on admission, quarterly and with a change of condition for residents identified as "at high or very high risk" for the development of pressure ulcers/injuries based on a validated risk assessment tool, i.e., Braden, Norton.

RESIDENT NAME_____

"Unavoidable" definition- 1. The resident developed a pressure ulcer/injury even though the facility had evaluated the resident's clinical condition and risk factors; defined and implemented interventions that are consistent with resident needs, goals, and professional standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate. 2. The resident's clinical condition on admission, including known diagnoses and risk factors, make the development of pressure ulcer(s)/injuries probable even with implementation of preventative strategies.

1-Pressure Ulcer/Injury History

Previous Pressure Ulcers/Injuries ◯ Yes ◯ No

Current Pressure Ulcers/Injuries ◯ Yes ◯ No

2-Diagnosis-*Check all that apply*

- ☐ a. Continuous urinary or chronic voiding dysfunction
- ☐ b. PVD-peripheral vascular disease
- ☐ c. Diabetes
- ☐ d. COPD-chronic obstructive pulmonary disease
- ☐ e. Chronic bowel incontinence
- ☐ f. Paraplegia
- ☐ g. Quadriplegia
- ☐ h. Hemiplegia
- ☐ i. Sepsis
- ☐ j. Terminal cancer
- ☐ k. Chronic or end stage renal, liver and/or heart disease
- ☐ l. Disease or drug related immuno-suppression
- ☐ m. Full body cast
- ☐ n. None of the above

3-Treatments-*Check all that apply*

- ☐ a. Steroid therapy
- ☐ b. Chemotherapy
- ☐ c. Head of bed elevated the majority of day due to medical necessity
- ☐ d. Radiation therapy
- ☐ e. Renal dialysis
- ☐ f. Anticoagulants
- ☐ g. None of the above

4-Malnutrition/dehydration, whether secondary to poor appetite or another disease process

☐ a.	Serum albumin below 3.4 g/dL	Actual result	Date
☐ b.	Pre albumin below 16mg/dL	Actual result	Date
☐ c.	Hgb less than 12 mg g/dL	Actual result	Date
☐ d.	MCV less than 80Treatments	Actual result	Date
☐ e.	MCH less than 27	Actual result	Date
☐ f.	Total protein less than 6.4	Actual result	Date
☐ g.	Weight loss of more than 5% during last month	Last month weight	This month weight

5-Clinical signs and symptoms of malnutrition/dehydration. *Circle all that apply*

- ☐ a. Pale skin
- ☐ b. Cachexia
- ☐ c. Bilateral edema
- ☐ d. Decreased urinary output
- ☐ e. Red swollen lips
- ☐ f. Swollen or dry tongue
- ☐ g. Poor skin turgor
- ☐ h. Muscle wasting
- ☐ i. none

6—Refusals of care *Check all that apply*

- ☐ a. Turning
- ☐ b. Repositioning
- ☐ c. Incontinent Care
- ☐ d. Out of Bed
- ☐ e. Specialty Mattress
- ☐ f. Preventative devices, i.e. off-loading boots, pressure redistribution when OOB
- ☐ g. Other

RN and Physician Signature

Based on the above evaluation, pressure ulcers/injuries are unavoidable for this resident

RN Signature_____ Date_____

Physician Signature_____ Date_____

Additional Comments:

Resident/Responsible Party Education

The results of this assessment were reviewed with_____ on _____ and education was provided on the resident's risk of the development of a pressure ulcer/injury and the interventions that are in place.

The following care plan interventions are in place to continue an attempt to reduce the risk of the resident acquiring a pressure ulcer/injury. *Check all that apply*

- ☐ Low air loss mattress
- ☐ Pressure reduction/redistribution to bed
- ☐ Pressure reduction/redistribution to chair
- ☐ Off-loading heels
- ☐ Individualized turning schedule
- ☐ Dietician consultation
- ☐ Incontinent Care
- ☐ Other

Unit ____ **Standardized Pressure Injury Prevention Protocol Checklist (SPIPP- Adult) 2.0** **Date_____**

ITEM	Completed Yes/No	COMMENT
Assess risk factors for pressure injury to guide risk-based prevention		
Significant current or anticipated mobility problems		
Use a structured risk assessment approach (e.g., Braden or other validated risk tool) on admission		
Reassess risk q shift and with significant change in condition		
Patient/family informed of PI risk and prevention plan		
Additional risk factors considered: Previous PI__, Localized pain__, Diabetes__, Poor perfusion__, Vasopressors__, Oxygenation deficits__, Increased Temp__, Advanced Age__, Spinal cord injury__, Neuropathy__, Surgery/procedure duration > 2 hrs.__, Critical illness__, Organ Failure__, Sepsis__, Mechanical vent__, Medical devices__, Sedation__, Dark skin tone__		
Assess Skin/Tissue for signs of skin damage and pressure injury		
Assess skin (comprehensive, visual, palpation) upon admission and q shift for erythema, discoloration, edema, and temperature		Location(s):
Assess skin under medical devices q shift		Device(s):
Inspect heels q shift		
In people of color: Ensure adequate lighting and moisten/moisturize skin to augment visual inspection		
Consider enhanced skin assessment methods- thermography, SEM, skin color chart		
Preventative Skin Care- Manage moisture/Incontinence		
Cleanse and apply appropriate moisture barriers promptly after each incontinent episode		
Avoid use of alkaline soaps/cleansers		
Consider urinary/fecal management systems for high-risk persons		
Single layer, breathable, high absorbency pads for incontinence		
Consider using low friction textiles		
Apply wicking material to skin folds when appropriate		
Redistribute Pressure		
Turn/reposition q 2-3 hours persons who do not have independent bed mobility and as required by individual needs and risk, unless contraindicated (Braden Activity/Mobility score ≤2)		
Use high specification reactive foam or reactive air mattress/overlay for immobile persons (Braden Activity/Mobility score ≤2)		
Use positioning aids that minimize friction/shear (pillows, wedges). Use turn/lift equipment if available. Proper side-lying position with upper leg over/in front of lower leg		
Keep head of bed as flat as possible		
Place silicone multilayer foam dressings on areas of high-risk (i.e., sacrum, lower buttocks, or heels) (Braden Activity/Mobility scores ≤2)		
Elevate heels off bed with pillows, heel devices or boots (Braden Sensory Perception score ≤3)		
Provide adequate repositioning (30 degree) when side lying. Position upper leg forward and support with pillow.		
Use slow, gradual, frequent, small, body shifts when unstable		
Use pressure redistributing seat cushion for persons who cannot adequately reposition independently		
Reposition seated persons q 1 hour		
Consult Physical Therapy for mobilization program when appropriate (Braden Activity/Mobility scores ≤2)		
Consider reminder systems, pressure mapping, motion sensors		
Implement early mobilization program		
Nutrition		
Screen for malnutrition using a validated tool on admission		
Consult dietitian for persons with or at risk of malnutrition, decreased nutrient intake, NPO > 48 hours or presence of stage 2 or greater PI (Braden Nutrition Score ≤2)		
Provide additional calories, protein, fluids, and additional nutrients (i.e. multi-vitamin, arginine, glutamine, HMB) per nutrition plan of care or as appropriate		
Continue to regularly assess goals and consult dietitian as needed		