

Pressure Ulcer/Pressure Injury (PU/PI) Survey Readiness Tool



Department of Health
Bureau of Survey & Certification
Provider Resources &
Education Program (PREP)

Based on the [CMS-20078 Pressure Ulcer/Injury Critical Element Pathway](#), this tool is designed to guide providers in preparing for the annual Ohio Department of Health survey of PU/PI care and services. This tool is not all encompassing.

| Facility Assessment | Yes | No |
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| Based upon facility assessment, resident population, diagnosis, staffing, resources and staff skills/knowledge, facility has determined it has capability and capacity to provide needed respiratory care/services for a resident with a respiratory diagnosis or syndrome that requires ventilator/tracheostomy care. This includes at a minimum: | | |
| <ul style="list-style-type: none"> Sufficient number of qualified professional staff. | | |
| <ul style="list-style-type: none"> Established resident care policies. | | |
| <ul style="list-style-type: none"> Staff trained and knowledgeable in PU/PI prevention and care, before admitting a resident that requires PU/PI care. | | |
| Notes: | | |

| Observation | Yes | No |
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| Pressure Prevention | | |
| Care-planned interventions were being implemented. | | |
| Repositioning was completed appropriately. | | |
| <ul style="list-style-type: none"> Repositioning was timely. | | |
| <ul style="list-style-type: none"> Repositioning was in the correct position to avoid pressure on an existing PU/PI or areas at risk for developing PU/PI. | | |
| <ul style="list-style-type: none"> Staff were using proper technique when turning, repositioning, and transferring to avoid skin damage and the potential for shearing or friction. | | |
| Pressure-relieving devices were used appropriately. | | |
| <ul style="list-style-type: none"> Devices were in place. | | |
| <ul style="list-style-type: none"> Devices were working correctly. | | |
| <ul style="list-style-type: none"> Devices were used per the manufacturer's instructions. | | |
| Wound Care General | | |
| PU/PI wound care was performed in accordance with accepted standards of treatment, physician orders, and care plan. | | |
| If multiple wounds exist, wound care to the most contaminated ulcer was completed last (e.g. in the perineal region). | | |
| Precautions were taken to prevent contamination of the wound, equipment, and supplies during resident care. | | |
| Wound Care Supplies | | |
| Clean-wound dressing supplies were handled in a way to prevent cross-contamination | | |
| <ul style="list-style-type: none"> Wound care supply cart remained outside of the resident care area. | | |
| <ul style="list-style-type: none"> Unused supplies were discarded or remained dedicated to the resident. | | |
| <ul style="list-style-type: none"> Multi-dose wound care medications such as ointments or cream were dedicated to one resident or dispensed into a medication cup prior to entering resident care area. | | |
| <ul style="list-style-type: none"> Reusable-dressing-care equipment (e.g., bandage scissors) was cleaned or processed if shared between residents. | | |
| Wound Care Hand Hygiene/Personal Protective Equipment (PPE) | | |
| During the provision of any type of PU/PI care/services, the staff performed hand hygiene before, during (as needed), and after PU/PI care and ensured appropriate PPE was used. | | |
| <ul style="list-style-type: none"> Enhanced barrier precautions (EBP) were used. | | |
| <ul style="list-style-type: none"> Clean gloves and gowns as well as clean technique were used for each resident. | | |
| <ul style="list-style-type: none"> The old dressing was removed, hand hygiene performed, and clean gloves were donned before wound care was provided. | | |
| <ul style="list-style-type: none"> If perineal or incontinence care was performed, then visibly soiled dressing was removed, hand hygiene was performed, and clean gloves were donned before wound care was provided. | | |

| Observation (Continued) | Yes | No |
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| <ul style="list-style-type: none"> Gloves and gown were removed, and hand hygiene was performed between residents. | | |
| Wound Care Resident Assessment | | |
| Staff assessed the residents' condition and documented: | | |
| <ul style="list-style-type: none"> Condition of the old dressing (e.g. intact vs. not intact, exudate kind and amount vs. clean and dry). | | |
| <ul style="list-style-type: none"> Wound specifics (e.g. stage, size, signs of infection, etc.). | | |
| <ul style="list-style-type: none"> Resident skin exposure to urinary or fecal incontinence and staff response. | | |
| <ul style="list-style-type: none"> Resident pain level and staff response. | | |
| <ul style="list-style-type: none"> Resident signs/symptoms of anxiety and/or depression and staff response. | | |
| Nutrition | | |
| The resident was receiving the nutritional interventions as ordered. | | |
| Notes: | | |

| Interview | Yes | No |
|---|-----|----|
| Residents/Family/Representative | | |
| General Questions: | | |
| <ul style="list-style-type: none"> Did the wound develop prior to admission to the facility or while in facility? | | |
| <ul style="list-style-type: none"> Staff talked with the resident about their risk for pressure ulcer/injury and how they plan to reduce the risk. | | |
| <ul style="list-style-type: none"> The resident was involved in the development of care plan decisions for PU/PI care. | | |
| <ul style="list-style-type: none"> The resident's PU/PI care reflects his/her preferences and choices. | | |
| <ul style="list-style-type: none"> For the resident who refused care, the facility provided other options of treatment and education on what may happen if the treatment plan wasn't followed. | | |
| Wound Specific: | | |
| <ul style="list-style-type: none"> The wound is improving. If not, describe what is happening. | | |
| <ul style="list-style-type: none"> The staff are providing wound treatment as ordered (wound care and timing). | | |
| <ul style="list-style-type: none"> The staff are performing hand hygiene before, during (as needed), and after providing care. | | |
| <ul style="list-style-type: none"> The staff wear appropriate PPE (gown and gloves) for EBP when providing wound care. | | |
| <ul style="list-style-type: none"> The staff are implementing pressure reduction interventions to help the resident's wound heal. | | |
| Quality of Life/Care: | | |
| <ul style="list-style-type: none"> The resident has access to the call system. | | |
| <ul style="list-style-type: none"> The resident's PI/PU needs are being met. | | |
| <ul style="list-style-type: none"> The resident has not experienced any complications (e.g. pain, infection, anxiety/depression). If they have, the staff intervened appropriately. | | |
| <ul style="list-style-type: none"> The wound has not caused any decrease in enjoyable activities for the resident. | | |
| Facility Direct Care Staff (Nurses and Nurse Aides) | | |
| Risk Factors/Skin Assessments: | | |
| <ul style="list-style-type: none"> The staff were aware of the resident's risk for the development of PU/PI. | | |
| <ul style="list-style-type: none"> The staff were aware of the frequency and location of resident skin assessment documentation. | | |
| <ul style="list-style-type: none"> The staff were aware of what, when, and to whom skin condition changes were reported. | | |
| PU/PI Development: | | |
| <ul style="list-style-type: none"> The staff were aware if the resident had a PU/PI. | | |
| <ul style="list-style-type: none"> The staff were aware of when the PU/PI developed and the cause of the PU/PI. | | |
| <ul style="list-style-type: none"> The staff were aware of what prevention interventions were in place prior to PU/PI development. | | |
| <ul style="list-style-type: none"> The staff were aware of who was notified and when the PU/PI developed. | | |

| Interview (Continued) | Yes | No |
|---|-----|----|
| PU/PI Interventions: | | |
| • The staff were able to verbalize how residents are involved in decisions regarding treatments. | | |
| • The staff were able to verbalize the current treatment order. | | |
| • The staff were able to verbalize the progression of the wound and how progression is monitored. | | |
| • The staff were able to verbalize the current PU/PI interventions in use. | | |
| • The staff were able to describe infection control practices for PU/PI care (e.g. EBP). | | |
| • The staff were able to verbalize any transmission-based precautions (if needed). | | |
| • The staff were able to verbalize the resident's daily care needs. | | |
| • The staff were able to verbalize when and to whom they communicate changes in PU/PI condition . | | |
| • The staff were able to verbalize how correct PU/PI care and service information is communicated from one staff person to another. | | |
| • The staff have received training for PU/PI care by an appropriate trainer and competencies have been assessed. | | |
| • The staff were able to verbalize facility wound-care protocols. | | |
| Negative Outcomes: | | |
| • The staff were aware of resident PU/PI pain (how and how often pain was assessed). | | |
| • The staff were aware of signs/symptoms of wound infection. | | |
| • The staff were aware of weight loss, dehydration, or acute illness and interventions in place to address. | | |
| • The staff were aware of any overall changes in the resident's function and mood. | | |
| • The staff were aware of interventions to implement if the resident refused care. | | |
| Facility Nursing Administration | | |
| The nursing administration was able to verbalize how staff are monitored to ensure they are implementing care-planned interventions. | | |
| The nursing administration was able to verbalize how often and who evaluates the effectiveness of wound care or PU/PI prevention measures. | | |
| The nursing administration was able to verbalize the facility policies and procedures regarding care, treatment, prevention and interventions for PU/PI care. | | |
| Practitioner | | |
| The practitioner was able to verbalize how they determined appropriate interventions. | | |
| The practitioner was able to verbalize how the resident was involved in decisions regarding PU/PI interventions. | | |
| The practitioner was able to verbalize the effectiveness of the PU/PI treatment. | | |
| The practitioner was able to verbalize how they monitor wound progression. | | |
| Notes: | | |

| Medical Record Review | Yes | No |
|---|-----|----|
| The resident's medical record accurately reflects their PU/PI status. | | |
| Assessments | | |
| There was a PU/PI risk assessment completed upon admission. | | |
| There was a PU/PI risk assessment completed upon change of condition. | | |
| There was a nutritional assessment completed upon admission. | | |
| There was a nutritional assessment completed upon change of condition. | | |
| There was a skin assessment completed upon admission. | | |
| There was a skin assessment completed routinely (per facility policy). | | |
| If a PU/PI were present upon admission, there was a wound assessment with measurements, characteristics, and staging completed upon admission and at least weekly thereafter. | | |
| If a PU/PI developed in house, there was a wound assessment with measurements, characteristics and staging completed immediately and at least weekly thereafter. | | |
| The most recent comprehensive and quarterly MDS/CAAs for Sections C, GG, H, J, K and M are accurate and reflect the resident's condition. | | |
| If there was a significant change, a significant change comprehensive assessment was conducted within 14 days. | | |

| Medical Record Review (Continued) | Yes | No |
|--|-----|----|
| The assessment reflects the resident's status that may be impacted by the PU/PI care needs such as: | | |
| <ul style="list-style-type: none"> Medical health status, including comorbidities that may affect the integumentary status, such as cognitive loss, neuromuscular or skeletal disorders, cardiovascular conditions, chronic infections, central nervous system disorders, and urinary or gastric disorders. | | |
| <ul style="list-style-type: none"> Integumentary function and identification of conditions that may be maintained or improved based upon interventions, or conditions that may indicate decline and need for specific comfort measures to meet PU/PI needs. | | |
| <ul style="list-style-type: none"> Psychosocial needs, such as depression or anxiety. | | |
| <ul style="list-style-type: none"> Nutritional needs as well as bowel or bladder functioning. | | |
| <ul style="list-style-type: none"> Advance directives. | | |
| Physician Orders | | |
| There were orders for PU/PI prevention interventions (e.g., mattress, repositioning, etc.). | | |
| There was an order for topical treatments. The order provided instructions regarding which cleaning product to use, topical medication/ointment to apply, dressing to apply, and timing (daily, twice a week, and etc.) and/or as needed (PRN) with parameters. | | |
| The physician-ordered treatment had been evaluated for effectiveness, modified, or changed as appropriate and/or as needed. | | |
| There was an order for nutritional support based on the nutritional assessment. | | |
| There was an interdisciplinary team involved in the care of the resident with PU/PI concerns. | | |
| Care Plan | | |
| If applicable, the baseline care plan was in place within 48 hours of admission and addressed the minimum healthcare information necessary to properly care for the immediate PU/PI needs of the resident. | | |
| The care plan, in place within seven days after the comprehensive MDS completion, was comprehensive and identified PU/PI needs and other needs that may be impacted by PU/PI care requirements, had measurable goals, and revealed resident involvement, preferences and choices. | | |
| The care plan reflected resident-specific monitoring of PU/PI status. | | |
| The care plan addressed resident-specific risks for complications. | | |
| The care plan addressed resident refusals or resistance to staff interventions and efforts to find alternatives to address the needs identified in the assessment. | | |
| The care plan has been revised to reflect needed changes as applicable. | | |
| Medication Administration Record / Treatment Administration Record | | |
| The record reflected the pressure-prevention interventions were being provided as physician ordered and care planned. | | |
| The record reflected the PU/PI wound care was being provided as physician ordered. | | |
| Progress notes (Physician, Nursing, Wound Care, and Nutrition) | | |
| The record did not reflect any complications, or the record did reflect complications with the appropriate staff response, notification of physician/representative, and change to care plan. | | |
| Diagnostics | | |
| Physician-ordered diagnostics were completed timely and as ordered (e.g., albumin level, blood cultures, x-rays). | | |
| Additional Records | | |
| The facility wound-care log revealed the resident's PU/PI was logged and monitored upon identification. | | |
| Outside records (e.g. hospital records, coroner's report, etc.) revealed no documentation of concern regarding the PU/PI care the facility provided. | | |
| Notes: | | |

| Facility Policy Review | Yes | No |
|---|-----|----|
| Review of the facility policy and procedures for PU/PI care and services revealed standards of care are met regarding PU/PI care. | | |
| Notes: | | |

For guidance related to PU/PI care, please visit the [National Pressure Injury Advisory Panel](#) website.