Hospital Acquired Pressure Ulcer (HAPU) Top Ten Checklist

TOP TEN EVIDENCE BASED INTERVENTIONS				
PROCESS CHANGE	IN PLACE	NOT DONE	WILL ADOPT	NOTES (RESPONSIBLE AND BY WHEN?)
Implement head-to-toe skin evaluation and risk assessment tool - assess the skin and risks within 4 hour of admission, risk and skin assessment should be age appropriate.				
Based on skin and risk assessment develop and implement an individualized plan of care.				
Assess skin and risk at least daily and incorporated into other routine assessment.				
Involve licensed and unlicensed staff such as nurse aides in HAPU reduction efforts – such has rounding with a purpose. The nurse aids can assist in skin inspection, checking to ensure prevention strategies are in place, and check medical devices are not causing skin harm.				
Set specific timeframes or create reminder systems to reposition – such as hourly or every two hour rounding with a purpose (the 3 P's – pain, potty, position-pressure). This aligns nicely with Fall prevention.				
Avoid skin wetness by protecting and moisturized as needed - use of under-pads that provide a quickdrying surface and wick moisture away, use topical agents that hydrate the skin and form a moisture barrier to reduce skin damage.				
Use special beds, mattresses, and foam wedges to redistribute pressure (pillows should only be used for limbs).				
Monitor weight, nutrition, and hydration status – for high risk patients generate an automatic Registered Dietician consult.				
Operating room tables should be covered by special overlay mattresses for long cases (greater than 4 hours – some hospitals choose cases greater than 2 hours) and high risk patients.				
Use breathable glide sheets and or lifting devices to prevent shear and friction.				





