Pressure I.N.J.U.R.Y. Bundle Compliance and Auditing Tool

	Patient 1	Patient 2	Patient 3	Patient 4	Patient 5	Total %
Inspect						
1. Inspect skin and evaluate risk for pressure injury on admission, daily or per hospital standard, and when there is a change in patient condition						
2. Evaluate the need for a specialty mattress						
3. Initiate an incontinence protocol based on risk assessment findings (Braden subscale score ≤						
Nutrition						
1. A nutritional screening is completed within 24 hours of admission						
2. Reassess nutritional status daily or per hospital standard and when there is a change in patient condition						
3. If the patient is at risk (Braden subscale score ≤ 2) or a wound is present a nutritional consult is ordered						
4. Offer additional nutritional nourishment as appropriate to assist with healing						
Just Move						
1. Evaluate activity, mobility and ability to communicate pain on admission and daily or per hospital standard						
2. If the patient is at risk (Braden subscale score ≤ 2) a therapy consult is requested						
3. Mobility is continually assessed and encouraged when possible						
4. Float the heels of patients with impaired mobility, activity, or inability to communicate pain						
Under and Around Devices						

1. Remove devices (or position nonremovable devices) to inspect the skin under and around the device						
2. Pain assessment is completed on pressure points with nonremovable devices						
3. Devices are repositioned with the patient to ensure devices are not pulled, kinked, or lodged under the patient or between skin folds						
Reposition						
1. Patients are repositioned every 2 hours limiting supine (or back/center)						
2. If medically contraindicated hourly micro-shifts/offloading is recommended						
3. Reposition every 30 minutes when up in chair or when head of bed is greater than 30 degrees						
You are important						
1. Patients, families and caregivers are partners in developing the pressure injury prevention plan of care						
2. Patients, families and caregivers are encouraged to engage in skin and risk assessment to understand current risk factors and how to address them						
3. Tools are available on skin safety for patients at risk for pressure injury development						