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__, Chemical Paralysis___,		
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		
For dark skin tones: Ensure adequate lighting and moisten/moisturize skin to augment visual inspection		
For dark skin tones: Consider enhanced skin assessment methods- thermography, SEM, skin color chart		
Preventive 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		
Use 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.		
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 a 30 degree turn off of the sacrum, confirm that the sacrum is off-loaded with your hand.		
Position upper leg forward of lower leg and support it 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		