

## WOUND CARE COMPETENCY CHECKLIST- Direct Care Provider

Employee Name: \_\_\_\_\_ Date: \_\_\_\_\_

Evaluator Name: \_\_\_\_\_ Title: \_\_\_\_\_

Pressure Ulcers		
Performance Criteria	Met	Not Met
<b>Prevalence and Incidence</b>		
<ul style="list-style-type: none"> <li>Can state nursing unit's pressure ulcer incidence and prevalence rate</li> <li>Can describe the unit's pressure ulcer prevention action plan</li> </ul>		
<b>Risk Assessment</b>		
<ul style="list-style-type: none"> <li>Completes pressure ulcer assessment tool (e.g. Braden Scale) accordingly to hospital/facility policy</li> </ul>		
<ul style="list-style-type: none"> <li>Performs a comprehensive assessment to determine patient's/resident's risk for pressure ulcer development including:</li> </ul>		
Review low subscale scores (e.g. Braden) to develop a plan of prevention interventions		
Skin assessment		
Patient/resident risk factors: e.g.co-morbidities, medications, etc		
<ul style="list-style-type: none"> <li>Implements appropriate pressure ulcer prevention interventions based on the individualized patient/resident assessment that can include:</li> </ul>		
Pressure redistribution		
Repositioning		
Skin care and protection		
Nutrition		
Moisture		
Shear		
<ul style="list-style-type: none"> <li>Communicates patient/resident pressure ulcer risk during handoff and to other members of the health care team</li> </ul>		
<b>Pressure Ulcer Classification</b>		
<ul style="list-style-type: none"> <li>Differentiates pressure ulcer from other skin injuries- e.g. skin tears, moisture associated skin damage (MASD), venous ulcers, etc</li> </ul>		
<ul style="list-style-type: none"> <li>Accurately stages pressure ulcer(s) using the NPUAP EPUAP PPPIA 2014 classification system</li> </ul>		
<ul style="list-style-type: none"> <li>Can identify all 6 stages of pressure ulcers</li> </ul>		
<ul style="list-style-type: none"> <li>Documents assessed pressure ulcer characteristics as per hospital/facility policy which may include the following:                             <ul style="list-style-type: none"> <li>Wound size</li> <li>Wound base</li> <li>Wound edges</li> <li>Wound drainage</li> <li>Edema</li> <li>Pain</li> <li>s/s infection</li> </ul> </li> </ul>		
<b>Pressure Ulcer Treatment</b>		
<ul style="list-style-type: none"> <li>Cleanses pressure ulcer per hospital/facility policy</li> </ul>		

• Applies / changes dressings (when ordered) per hospital/facility policy		
• Assesses pressure ulcer(s) for signs and symptoms of infection		
• Documents any pressure ulcer treatments and assessments for changing status (healing or worsening)		
• Communicates PU assessment and treatment with physician and appropriate members of interprofessional team		

<b>Venous Leg Ulcers</b>		
<b>Performance Criteria</b>	<b>Met</b>	<b>Not Met</b>
• Performs a vascular assessment		
• Performs ABI prior to applying compression bandages or stockings		
• Cleanses venous leg ulcers per hospital/facility policy		
• Applies /changes dressings (when ordered) per hospital/facility policy		
• Applies compression bandages or stockings per prescriber's order		
• Assesses ulcer(s) for signs and symptoms of infection		
• Assesses for pain		
• Documents any venous leg ulcer treatments and assessments for changing status (healing or worsening)		
• Communicates venous leg ulcer status with physician and appropriate members of interprofessional team		

<b>Moisture Associated Skin Damage (MASD)</b>		
<b>Performance Criteria</b>	<b>Met</b>	<b>Not Met</b>
• Differentiates moisture associated skin damage from other skin ulcers		
• Cleanses skin damaged from moisture per hospital/facility policy		
• Protects skin damaged from moisture per hospital/facility policy		
• Implements interventions to treat/prevent causes of MASD		
• Documents any MASD treatments and assessments for changing status (healing or worsening)		
• Communicates MASD skin damage status with physician and appropriate members of interprofessional team		

<b>Diabetic Foot Ulcers (DFU)</b>		
<b>Performance Criteria</b>	<b>Met</b>	<b>Not Met</b>
<b>Prevention</b>		
• Assesses for risk of diabetic foot ulcer		
• Monitors skin temperature of diabetic feet		
• Monitors blood glucose levels		
• Evaluates footwear and offloading		
• Evaluates self-care knowledge including adherence to care plan		
• Educate/teach on how to prevent DFU		
<b>Ulcer Treatment</b>		
• Differentiates DFU from other skin ulcers		

• Cleanses DFU as per hospital/facility policy		
• Applies/changes dressings as ordered per hospital/facility policy		
• Monitors for Charcot foot and/or infection		
• Evaluates effectiveness of pressure offloading		
• Implements interventions to treat/prevent causes of DFU		
• Documents any DFU treatments and assessments for changing status (healing or worsening)		
• Communicates DFU status with physician and appropriate members of interprofessional team		

Skin Tears		
Performance Criteria	Met	Not Met
• Differentiates skin tears from other skin injuries		
• Implements individualized care plan to prevent skin tears as per hospital/facility policy		
• Implements interventions to treat skin tears based on the ISTAP classification system		
• Protects skin damaged from skin tears per hospital/facility policy		
• Documents any skin tear treatments and assessments for changing status (healing or worsening)		
• Communicates skin tear status with physician and appropriate members of the interprofessional team		

Patient / Family Centeredness and Education		
Performance Criteria	Met	Not Met
• Through discussions with the patient / resident & family, identifies patient / residents' goals, documents, and discusses them with team		
• Discusses individualized plan with patient / resident & family		
• Provides culturally competent education to patient / resident & family to meet patient centered goals using adult education methods		
• Evaluates outcomes of education and plan, adjusting as needed		
• Connects patient and family to resources needed for ongoing care		