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Pressure injury prevention: What most facilities are doing wrong

by **Beth Alford, RN, BSN,** *owner of Mitigation Solution*

In the latest revisions to the Conditions of Participation, CMS renumbered the F-tag system and made several changes to the requirement related to pressure injuries. Formerly F314, "Treatment/Svcs to Prevent/Heal Pressure Ulcers" is now numbered as F686. This article will review common mistakes that facilities make when trying to prevent pressure injuries and that can often result in citations.

The regulation

CMS' requirement for skin integrity and pressure injuries/ulcers includes language regarding staging, Kennedy terminal ulcers, and infections. CMS has also incorporated the term "pressure injury" in addition to "pressure ulcer." The below regulatory language is only a small portion of the 13 pages included in the federal guidelines that discuss this F-Tag, but this excerpt highlights the emphasis on prevention:

F686

§483.25(b) Skin Integrity

§483.25(b)(1) Pressure ulcers.

Based on the comprehensive assessment of a resident, the facility must ensure that—

(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and

(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.

INTENT

The intent of this requirement is that the resident does not develop pres-

sure ulcers/injuries (PU/PIs) unless clinically unavoidable and that the facility provides care and services consistent with professional standards of practice to:

- *Promote the prevention of pressure ulcer/injury development;*
- *Promote the healing of existing pressure ulcers/injuries (including prevention of infection to the extent possible); and*
- *Prevent development of additional pressure ulcer/injury.*

CMS often refers to the National Pressure Ulcer Advisory Panel's (NPUAP) terms and definitions, information that CMS has adapted for its patient and resident assessment instrument (RAI) and corresponding assessment manuals, including the Minimum Data Set (MDS). The agency intends to continue its adaptation of NPUAP terminology for coding the RAI while retaining current holistic assessment instructions, definitions, and terms. The adapted terminology was used in the development of this guidance. Additional information can be found on the NPUAP website at https://www.npuap.org/resources/educational-and-clinical-resources.

Providers are encouraged to use the NPUAP website, which is referenced in the tag itself. The site offers many free tools that use the same information as surveyors do.

Pressure injuries and risk management

When it comes to pressure injury survey findings and lawsuits, there are some things that most facilities do wrong.

The first step that is often missed or incomplete is documenting the resident's current skin status at admission and discharge/transfer. There are many occasions when residents have been admitted from the hospital or other facilities with pressure injuries or deep tissue injuries.

On the day of the resident's admission, the following steps must occur:

- Within the first hour of admission, a complete head-to-toe body check must be done. (Pay special attention to the resident's heels.)
- Any color changes, soft areas, or obvious breakdown must be documented with measurements and descriptions.
- Notify the resident and family of any areas that you find; document who you spoke with and what you told them.
- Notify the doctor and get orders implemented the same day.
- Start a care plan.

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At discharge or transfer, a complete head-to-toe body check must be completed. In addition:

- Document, with measurements, any open areas or deep tissue injuries. If there are no open skin areas or potential open areas, state this clearly on the transfer/discharge documents.
- In the nurses' notes, enter that the body check was done, along with the results.

If you don't complete the above steps, an unfortunate and common scenario can occur, and goes something like this: The resident is transported on a gurney to the hospital. The resident may lay on the gurney for a few hours and then be put on another gurney in the ER. Six hours later, the resident is finally assigned to a bed. By now, the resident's sacrum and heels may be getting reddened and forming deep tissue injury. Without the documentation you sent with the resident detailing his or her condition prior to discharge/transfer, any new or worsened injuries could be blamed on your facility.

Assessing degree of risk for breakdown

In long-term care, risk factors for pressure injuries are identified in many ways, such as:

- Past history
- Physical findings
- Medical diagnoses
- The MDS
- Written risk assessments, such as the Braden Scale
- Common sense
- Observation of the resident
- Information reported by others

Although the above methods can be used to assess risk factors for pressure injuries, CMS mandates that long-term care providers assess skin risk by completing the MDS, which places a great deal of emphasis on risk factor identification and pressure injury prevention. CMS doesn't specify that facilities must use a specific assessment form, but they do require that assessment be standardized. Both the Braden and Norton assessments are widely used. It is the accepted standard to assess for skin breakdown risk at admission, weekly for four weeks, and then monthly thereafter. It may be acceptable to conduct the assessments after the first month on a quarterly basis, depending on the resident.

Of course, new assessments must be done when there is a significant condition change. Unfortunately, providers don't always complete the assessment accurately. To avoid this misstep, facilities should ensure that the nurse who actually assessed the resident is completing the assessment. Finally, use common sense. If the assessment score comes out as low or moderate risk, but the resident currently has a stage 2 pressure injury (deep tissue injury or actual skin breakdown), this should be rated as high risk.

Best practices for pressure injury prevention

Now, what about actually preventing pressure injuries? Here are some tips and best practices:

- **Nutrition**. Nutritional interventions for preventing new or worsened pressure injuries need to be entered on the care plan and discussed with the resident and the family. The following information should be included in this documentation:
  - The proper nutritional interventions that were implemented to provide adequate protein and calorie stores.
  - Whether the registered dietitian has seen residents at high risk and those with open areas monthly.
  - Whether or not snacks were recommended and when they were offered/distributed. If the resident frequently refuses snacks, what other options have been tried? Are refusals documented?
  - Whether the resident's weight is being recorded at least monthly.
  - When and how often albumin levels are being checked.
- **Pressure-relieving devices.** Do you know the difference between pressure-relieving and pressure-reducing? Most long-term care facilities have pressure-reducing mattresses on beds. However, when a resident develops a Stage 2 or greater pressure injury, a pressure-relieving mattress

must be instituted. A pressure-relieving cushion must also be instituted for use in the chair or wheelchair.
  - The actual name of the mattress/cushion should be entered on the care plan. If you don't put the name in the care plan, you likely won't remember the type used if a lawsuit is filed against the facility years later.
  - Ensure that the mattress and cushion are properly secured to limit the chances of the resident falling out of the bed or chair.
- **Turning and repositioning.** No matter the type of mattress or cushion, you still have to turn and reposition residents. Many residents cannot move on their own to sufficiently offload the affected area. For residents in bed, having a transfer handle or bar on each side of the bed is important. It is much easier for them to turn in bed when they have something to hold onto. However, some residents cannot turn without assistance. The situation is even more difficult for residents who spend a large portion of their day in a wheelchair and/or recliner. In order to give adequate time off of the buttocks, it is necessary to lay down on a side to relieve pressure. This takes discipline on the part of the staff and the resident. How do you prove that the resident has been turned and repositioned at least every two hours? I recommend that the aide charts once per shift that every-two-hour repositioning has been done.
- **Continence.** We all know that incontinence is a common problem in our elderly residents, especially female residents. Many residents have urge incontinence, which means when they feel the urge to urinate, they need to go quickly or they will become incontinent. In order to prevent wetness contributing to skin breakdown, we have to find a way to keep the resident dry. For female residents with moderate incontinence, consider pads rather than briefs. This will prevent urine from pooling on the buttocks and coccyx. For males with frequent incontinence, pads are also available; in some cases, a condom catheter may be the answer. Most importantly, consider a timed toileting program for residents with current pressure injuries.
- **Hydration.** Lack of hydration contributes to loss of skin elasticity, which is needed to prevent the skin from becoming more fragile. For those residents experiencing breakdown or at high risk, consider documenting fluid intake for at least a month to see if the resident requires more assistance and/or encouragement to consume fluids.

A note about unavoidable pressure injuries

According to the National Databse of Nursing Quality Indicators® (NDNQI), published by Press Ganey, "unavoidable" is defined as follows:

> *"Unavoidable" means that the resident developed a pressure ulcer even though the facility had evaluated the resident's clinical condition and pressure ulcer risk factors; defined and implemented interventions that are consistent with resident needs, goals, and recognized standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate.*

Providers should assess every in-house developed pressure injury to determine if it was unavoidable. A nurse can complete an assessment and then ask the resident's physician to review and sign off if the physician agrees with it. A copy should be maintained in the resident chart.

Hopefully, by doing all of the things we've talked about, none of your residents will develop a pressure injury while in your care. Sometimes they do develop anyway, but with proper documentation you can avoid a citation by proving that your staff made every effort possible to prevent them from happening.