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Long-Term Care Survey Alert

Survey Compliance: Revamp Your Pressure Ulcer Program Now To Avoid Getting Burned

New F314 tag provides a cookbook formula for care - and recipe for IJ.

If your facility isn't feeling the pressure to prevent pressure ulcers, you're in for a rough ride under the new F314 tag.

The revised survey guidance for F314 (pressure ulcers) takes a virtual "zero tolerance" stance toward decubiti, which means surveyors will be dishing out a D-level deficiency for even a stage 1 ulcer.

Even worse, the threshold for immediate jeopardy (IJ) has plummeted to new lows: "A facility could end up with IJ if a resident has a new stage 4 ulcer that doesn't heal, a stage 2 or 3 ulcer that's infected - or failure in multiple areas (assessment, care planning, implementing the care plan, etc.)," warns **Beth Klitch**, a survey consultant in Columbus, OH.

Your best bet: Revamp your skin care to comply with the **Centers for Medicare & Medicaid Services'** detailed care protocol under F314. "The guidance isn't anything really new in terms of [evidence-based practices] for pressure ulcer care, but it is the first time CMS has said to follow it," observes **Nathan Lake, RN**, an MDS expert and consultant in Seattle.

9 'Take-Home' Lessons: Don't Go to Work Without Them

These proactive strategies should keep your residents' skin clear - and your survey slate free of F314 and related tags for care planning and assessment, professional standards, and staffing shortfalls.

1. Hit the ground running in assessing residents and establishing a prevention plan at admission. CMS is stressing that pressure ulcers can develop within two to four hours, so plan to get your assessment done and preventive interventions in place within that timeframe. "Irreversible changes may occur with two hours of unrelieved pressure," cautioned **Daniel Berlowitz, MD,** in a CMS-sponsored Aug. 3, 2004 Webcast on pressure ulcers offered as a prelude to the revised F314 tag.

The Webcast provides an excellent source for inservice training and is available for viewing at www.cms.internetstreaming.com.

The guidance implies that CMS expects facilities to use a standardized, validated assessment tool to determine residents' risk, although the regs don't technically require you to do so. (The Aug. 3 CMS training broadcast mentioned the Braden, Norton and Gosnell risk assessment tools, which the new guidance also references in the bibliography.)

Survey tip: If you use a home-brew or composite tool, surveyors may ask how you know it's valid and reliable, said **Courtney Lyder, ND,** who served on the expert panel that helped develop the guidelines. Lyder spoke at the 2004 annual **National Association of Subacute and Post Acute Care** conference in Washington, DC.

2. Follow the guidelines' suggested timetable for doing risk assessment and wound evaluations. The guidelines suggest assessing the resident's pressure ulcer risk at admission, weekly for four weeks (for residents at risk), quarterly and when he has a significant change in cognitive or functional status. "A lot of facilities aren't doing the risk assessments weekly for a month at this point," Klitch observes.

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Assess and document a wound's condition on a daily basis. If a wound is covered by a dressing, assess and document that the dressing is in place and describe the surrounding skin and the resident's condition. "For example, ask about any pain or discomfort," advises **Lisa Conrad, RN,** DON for **Broadview Multi-Care Center Rosepoint Pavilion** in Parma, OH. Broadview is performing documentation audits to see if nurses are assessing wounds and charting their findings daily. "We review the charts with the nurse managers on the units weekly so they know which charts need to be brought up to speed or to work with individual nurses who need extra training," reports Conrad.

3. Don't take the blame for non-pressure ulcers. The guidance adds new definitions of common non-pressure related wounds at F309.

"Nurses can't diagnose wounds (unless they are advance practice nurses) but they can do careful assessments and documentation of the parameters that assist the diagnosing clinician to ... make a wound diagnosis and prognosis," says Lake.

Beware: Shortfalls in diagnosing and caring for non-pressure wounds will land facilities with F309 tags (the OBRA quality of care catchall tag).

Read the new definitions of non-pressure related ulcers (pp. 2-3) at F309 in the survey guidelines for pressure ulcers at www.cms.hhs.gov/manuals/pm_trans/R4SOM.pdf.

4. Target the resident's individual risks, not his global pressure-ulcer risk score. Custom-design your prevention protocol according to risk scores on **subscales of your standardized pressure ulcer assessment tool, advised Sharon Roberson, RN,** a nurse consultant for CMS' Boston regional office during the Aug. 3, 2004 CMS-sponsored Webcast.

Two people may have the same global risk score, but that score may be based on different subscales, which means the residents would require different interventions, according to the CMS Webcast. Don't overlook CMS-identified risks for pressure ulcers or poorly healing wounds, such as administration of steroids or a previous Stage 3 or 4 pressure ulcer.

5. Develop and implement aggressive protocols for repositioning patients based on their assessed risks. In other words, forget an across-the board "q 2 hour" turning and repositioning schedule for most or all residents irrespective of their individualized risk profile.

The guidance warns that residents at higher risk for pressure ulcers may need repositioning more than every hour when sitting in a chair (especially if they show evidence of stage 1 pressure ulcers with less frequent repositioning). "A teachable resident should be taught to shift his weight approximately every 15 minutes while sitting in a chair," states the guidance.

Don't do this: The guidelines discredit the practice of "microshifting" where staff relieve pressure off the resident's bony prominence or buttocks for 10 to 15 seconds, Klitch notes.

6. Use evidence-based wound care protocols and be prepared to defend them accordingly. For example, the guidance gives wet-to-dry dressings a "thumbs down" except as a debridement technique.

In addition, "current clinical practice indicates stage 3 and 4 ulcers should be covered by a dressing," according to CMS. Whether the facility covers stage 1 or 2 ulcers depends on the individual practitioner's clinical judgment - and the facility's protocols reflecting current clinical standards of care.

More evidence-based tips: Absorptive dressings play an "important part" in managing excessive wound exudate, which can interfere with healing. And make sure to keep wounds moist enough to support healing, but not too moist, advises CMS.

7. Document that you are using products (including support surfaces, dressings, and other wound care products) according to the manufacturer's instructions. Based on the new guidelines, "facilities should implement

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policies/procedures to that effect," advises **Karen Merk, RN, CRNAC**, a former DON and currently a clinical consultant with **Briggs Corporation** headquartered in West Des Moines, IA.

"Manufacturers don't usually tell you in their written literature that a support device is geared toward a person with high or moderate risk, for example," says Merk. "So partner with your vendors to get this information in writing, and also directions for using the product" correctly.

Inservicing tip: Ask your wound care product vendors to provide inservicing to get the nursing staff up to speed on product use.

8. Know (and document) the difference between pressure reduction and pressure relief. Pressure-reduction devices reduce pressure and are, thus, your first line of defense in preventing skin breakdown, says **Karen Lou Kennedy-Evans, RN,** a consultant in Tucson, AZ. Pressure relief is a more advanced measure for higher risk residents or those with existing wounds.

Risk management tip: "An overlay like an air mattress that fits over a regular hospital bed mattress may provide pressure reduction, but make sure it has enough air in it," Kennedy-Evans advises. Do that by performing a hand check. "Put your hand palm up under the resident's sacrum.
If you feel his sacrum resting on your palm, there's not enough air in the product. So just inflate the mattress until there is one inch between your palm and the sacrum."

Documentation tips: Develop a system to show that staff check the level of air in the mattress on a routine basis, according to the manufacturer's suggestions and/or the facility's own protocol, Kennedy-Evans suggests.

"When staff provides a pressure relief or reduction product, chart the name of the product and model number - and when it was put on the bed," Kennedy-Evans advises.

9. Make sure front line staff can explain their interventions to surveyors. "CNAs should be able to explain the basic rationale for the individualized plan of care," says Klitch. Say a resident refuses to be turned when she's in pain, so the care plan directs staff to administer PRN medications for break-through pain if the resident requests it before positioning. "In that case, if the surveyor says, 'You didn't turn Mrs. Jones at 2 p.m., and it's 2:20,' the CNA can explain that Mrs. Jones requested PRN medication for breakthrough pain at 1:55, and the care plan directs waiting for 30 minutes after administration of the medication to reposition the resident."

Editor's Note: Are your residents' advance directives up to date and specific enough to protect your facility from F314 and other F tags? For more information, see the February 2005 Long-Term Care Survey Alert.

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