

A Clinical Guide to the F314
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**They're creepy and they're kooky,
Mysterious and spooky,
They're altogether ooky,
The Gokoo Family**

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Issues

Public Awareness/Perception

- Facility acquired pressure ulcers (PrUs) are a sign of poor care
- Concern over inappropriate therapies or treatments
- Use of specialty equipment will prevent PrU development



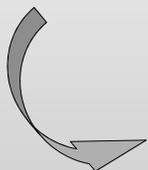
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Issues

Guilt, Fear, Anger

- Family members responsible for placement
- Fear of medical emergency or death of a loved one
- Ability to rationalize and lay blame at someone or something else



Defensiveness, Anger, Confrontation

- Threat
- Fear - subpoena for deposition
- Named as a defendant

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Intent

- "A resident who enters the facility does not develop pressure sores unless clinical condition demonstrates that they were unavoidable"
- "A resident having pressure sores receives necessary treatment & services to promote healing, prevent infection and prevent new sores from developing"

CMS "Investigative Protocol Pressure Ulcer"



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Guideline	Investigative Protocol
➤Prevention	➤Instructions for Surveyors
➤Assessment	➤Determination of Compliance
➤Pain	➤Deficiency Categorization
➤Ulcer Etiology	
➤Staging of PrUs	
➤Ulcer/periulcer characteristics	
➤Infection related to PrUs	
➤Dressing and Treatment	
➤Monitoring	
➤Healing of PrUs	
➤Interventions	

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Facility Responsibility

Transdisciplinary Ulcer/Wound Team

↳Nursing Home Administration, Medical Director, DON/ADON, MD, Nursing Staff, PT, OT, RD, CNA, MDS Coordinator, Case Manager, Social Worker, Hospice



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Medical Director's Responsibility

Current Direction

- ↳F501
- ↳Understand the survey process



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Documentation

Documentation

- Observations and thinking of individual clinicians
- Consistency of documentation
- Condition or action vs. present or absent or described incorrectly
- Errors in documentation
- **BAD DOCUMENTATION MAKES GOOD CARE LOOKS BAD AND BAD CARE EVEN WORSE**



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Documentation

MDS 3.0 Revision (Section M)

Skin Conditions

- Arabic numbers (1- 4)
- Present on admission (PoA)
- Unstageable
- Eliminates reverse staging
- Venous, arterial and diabetic foot ulcers categories



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A resident has a full-thickness pressure ulcer extending over the right buttocks area measuring 22 cm x 15 cm x 1.0 cm.

The ulcer extends from the right ischium over the right trochanter to the sacral-coccygeal area.

Minimal serosanguinous to sanguineous drainage is noted over the ulcer.

The ulcer is somewhat oval in shape with an irregular edge.

Yellow brown eschar covered tissue is visible at the 3 o'clock, 4 o'clock and 7 o'clock position approximately 4 cm from the ulcer edge and measuring 2 cm x 2 cm, 8 cm x 4 cm and 4 cm x 3 cm respectively.

Black eschar tissue extends 9 o'clock to 11 o'clock position of the ulcer measuring 13 cm x 6 cm.

A black necrotic area extends out wards from ulcer edge at the 2 o'clock to 5 o'clock position and measures 10 cm x 6 cm surrounded by diffuse purple/black colored tissue.

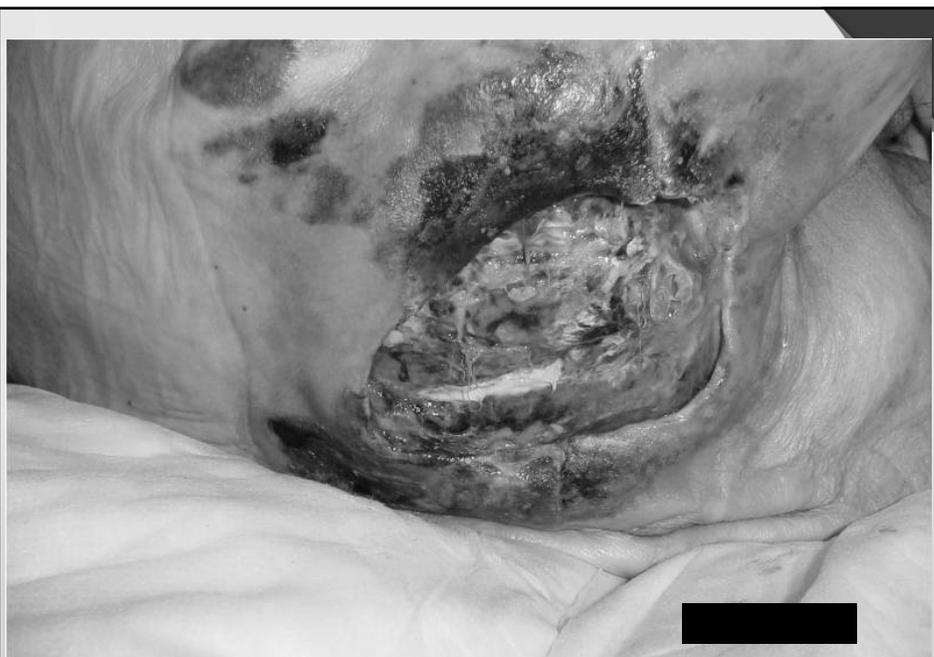
The area is irregular in shape with a "tail" at the 5 o'clock area.

Undermining is noted at the 7 o'clock to 9 o'clock position.

A black necrotic area elliptical in shape with defined edges approximately 3 cm from ulcer edge at the 11 o'clock position extends towards the head direction measures 10 cm x 4 cm.

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Photodocumentation

Guideline

- ➔ Informed consent/Authorization
- ➔ HIPAA compliant
- ➔ Criteria about who can take the photograph
- ➔ Validate individuals' competency to do photograph
- ➔ Revalidation of competence
- ➔ Frequency (serial photographs)
- ➔ Type of equipment used
- ➔ Chain of Trust - to assure that photographs are accurate and not modified
- ➔ Inclusion of the residents identification (PIN), ulcer location, date taken, measurement grid and visible parameters for comparison



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Pressure Ulcer to Be or Not to Be

➔ Unavoidable

- Assessment for clinical conditions was completed
- The assessment identify *risk factors* for the pressure ulcer development
- A *care plan* must address the risk factors was implemented consistent with resident's needs/goals and recognized standards of care across all shift
- Outcomes* evaluated as to the impact of intervention
- Revision of the care plan is* required and instituted

➔ If the facility did not do one or more of the above, the ulcer was **avoidable**

CMS "Investigative Protocol Pressure Ulcer"

➔ Documentation

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Critical Element Pathways

Examples of surveyor observations during recent surveys that supported the issuance of this deficiency include:

Failure to complete a re-assessment of residents' risk for developing pressure ulcers which included the overall skin condition and skin integrity after pressure was relieved (tissue tolerance).

Skin assessment failed to identify a resident was at risk for development of a pressure ulcer.

Failure to comprehensively assess residents' clinical condition and pressure ulcer risk factor, and then not implementing procedures that are based on individualized assessments. Failure to complete comprehensive assessments of residents' risks for developing pressure ulcers...including: overall skin condition, history or pressure ulcers, nutritional/hydration status, medical diagnoses, medications, treatments, degree of mobility, positioning, incontinence status, potential for scaring over bony prominences, contracture status, and bed-fast or chair-bound status. (this is a compilation of a number of deficiency examples)

Failure to reposition per the care plan (care plan stated every 2 hours – observation was 2 hours 45 minutes). Many of these examples.

Failure to release from restraints and off-load for one minute.

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Critical Element Pathways

Comprehensive Assessment

- ✦ Evaluation/verification/interpretation of the observations made
- ✦ Complement the clinical judgment in resident management
- ✦ Use of standardized risk assessment tool
- ✦ Assessment tools do not supplant a narrative description of the ulcer

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Critical Element Pathways

Comprehensive Assessment

➔Resident having no signs of progression toward healing within 2 to 4 weeks:

- Review documentation
- Ulcer characteristics
- Resident's condition
- Complications

➔Address factors having an impact on the development, treatment and/or healing of PrUs

-Identify pre-existing signs (Suspected Deep Tissue Injury)

Critical Element Pathways

Standards of Care

- ➔Risk assessment
- ➔Preventive measures
- ➔Pressure relieving support surface
- ➔Tissue offloading
- ➔Debridement
- ➔Treatment of signs and symptoms of infection
- ➔Nutritional assessment
- ➔Nutritional intervention
- ➔Specialist consult

Standards of Care

- ➔Documentation of treatment and its effectiveness
- ➔Providing a moist thermal microenvironment
- ➔Proper use of topical therapies/treatments
- ➔Documentation of pain assessment
- ➔Evidence of competencies/credentials

Critical Element Pathways

Risk Factors

- Mobility status (impaired bed or chair mobility)
- PrU history
- Pressure redistribution
- Diabetes
- PVD or neuropathy
- Nutritional status-feeding assistance
- Dehydration
- Recent weight change (loss/gain)
- Pain
- Fracture
- Full body cast
- Paraplegia
- Quadriplegia
- MASD
- Cognitive impairment
- Disease or drug related immunosuppression
- Chronic or end stage renal, liver and or heart disease
- Respiratory HX (COPD)
- Immune deficiency
- Malignancy
- Resident refusal

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Critical Element Pathways

Tissue Tolerance

- The ability of the skin and its supporting structures to endure the effects of pressure without adverse effects
- Tissue Tolerance Guidelines
 - Not "tested"
 - Routine skin assessment performed should include an evaluation of the ability of the skin to endure the effects of pressure without adverse effects
- NPUAP Consensus Panel
 - Does not support allowing a Stage I PrU to develop in order to establish a turning schedule (to determine tissue tolerance for pressure)

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Critical Element Pathways

- ➔Skin inspection (within 2 hours)
- ➔Evaluation for risk factors
 - Alteration in sensation (pain and itch)
 - Palpation (firm/boggy/mushy)
 - Alteration in mobility status
 - Nutritional status such as significant changes in weight
 - Incontinence and co-morbidities
 - Place resident on routine positioning and turning schedule (per facility policy/guideline)
 - Pressure redistribution (per facility policy/guideline)
- ➔Following pressure redistribution from any area of the body
 - A hyperemia (redness) area (note darker skin)
 - Check again within 30 - 45 minutes to hour
- ➔Revise positioning and turning schedule

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DRIP

BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK

	Patient's Name	Evaluator's Name	Date of Assessment						
Intensity/Duration	SENSORY PERCEPTION ability to respond meaningfully to pressure-related discomfort	1. Completely Limited Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body.	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness. OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/3 of body.	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned. OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.				
Tissue Tolerance	MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift.	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day.	4. Rarely Moist Skin is usually dry, linen only requires changing at routine intervals.				
Intensity/Duration	ACTIVITY degree of physical activity	1. Bedfast Confined to bed.	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours.				
Intensity/Duration	MOBILITY ability to change and control body position	1. Completely Immobile Does not make even slight changes in body or extremity position without assistance.	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	3. Slightly Limited Makes frequent though slight changes in body or extremity position independently.	4. No Limitation Makes major and frequent changes in position without assistance.				
Tissue Tolerance	NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than 1/4 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement. OR is NPO and/or maintained on clear liquids or IVs for more than 5 days.	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. OR receives less than optimum amount of liquid diet or tube feeding.	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered. OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs.	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.				
Tissue Tolerance	FRICION & SHEAR	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction.	2. Potential Problem Moves freely or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	3. No Apparent Problem Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair.					
➔At risk: 15 to 18 ➔Moderate risk: 13 to 14 ➔High risk: 10 to 12 ➔Very high risk: 9 or below									
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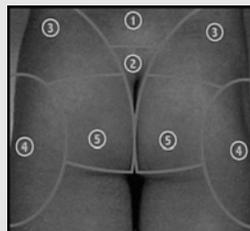
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Common Sites

Location

→ Use anatomical terminology

- Sacrum
- Coccyx
- Iliac crest
- Trochanters
- Ischiums
- Occiput



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Pain

Pain Assessment

- Recognize when a resident is experiencing pain
- Evaluate for pain and its causes

WILDA

- Words used by resident to describe pain
- Intensity of pain using valid tool
- Location of pain
- Duration and frequency of pain
- Aggravating and alleviating factors
- Factors affecting pain management



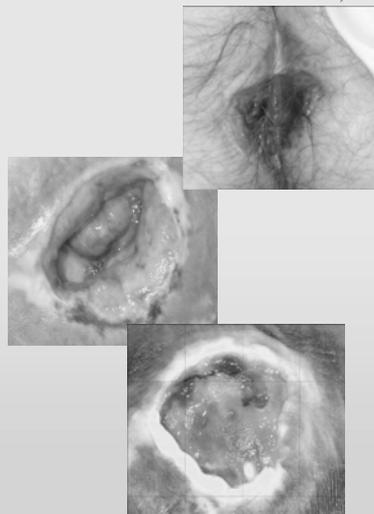
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Assessment

Ulcer and Per ulcer Characteristics

- ↪ Location
- ↪ Area
- ↪ Odor
- ↪ Sinus Tract
- ↪ Tunneling
- ↪ Undermining
- ↪ Exudate
- ↪ Necrotic Tissue
- ↪ Granulation Tissue
- ↪ Epithelialization
- ↪ Ulcer Edge
- ↪ Edema
- ↪ Erythema
- ↪ Induration
- ↪ Maceration
- ↪ Desiccation
- ↪ Callous Formation
- ↪ Hair Distribution

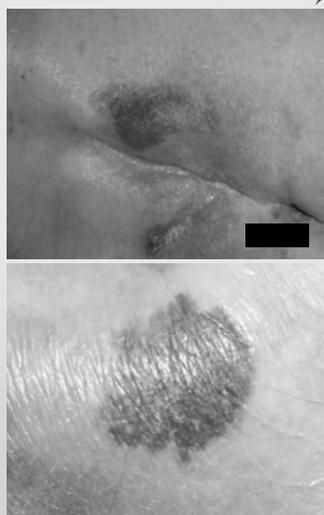


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"Suspected" Deep Tissue Injury

- ↪ A pressure-related injury to the subcutaneous tissues under intact skin
- ↪ Initially the area may appear as a white waxy area
- ↪ Deep bruise
- ↪ Demarcation
 - Red - ischemia
 - Purple - infarction
 - Black - necrotic



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“Suspected” Deep Tissue Injury

DTI Documentation

- ➔ NPUAP revised staging system includes suspected DTI
- ➔ DTI is generally “unstageable” as the ulcer base is not visible
- ➔ “Deep tissue injury under intact skin”
- ➔ Include risk factors, interventions, turning schedule, etc.



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Nutrition and Hydration

- ➔ A residents desirable weight range
- ➔ Weight loss/gain
- ➔ A change in the residents overall intake
- ➔ Risk factors for malnutrition
- ➔ Resident nutritional needs
- ➔ If therapeutic diet is needed and implemented consistent with current needs of practice
- ➔ Need for dietary restriction
- ➔ Reasons for dietary changes and implement interventions
- ➔ Residents food preference, allergies, food intolerances
- ➔ Underlying medical or functional causes of chewing or swallowing difficulties
- ➔ Medical illness or psychiatric disorders that may affect nutrient utilization
- ➔ Abnormal laboratory results and implement interventions
- ➔ When nutritional status is not improving (alternative interventions)

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Hydration

Resident Hydration

➔Reduction in total body water

-Salt and water deficit

➔Identify residents at-risk for hydration deficit or imbalance

-Coma/decreased sensorium

➔Cognitive or functional impairment

-Unable to communicate effectively (dementia/aphasia)

➔Infection

-UTI

➔Fluid loss or increased fluid need

-Diarrhea

-Vomiting

-Fever

➔Fluid restriction

-Renal dialysis



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Hydration

➔Abnormal Lab Values to Identify Dehydration

-Increased Blood Urea - Nitrogen (BUN) level

-Elevated hemoglobin and hematocrit

-Increased urine specific gravity

-Abnormal glucose

-Abnormal creatinine

-Elevated serum sodium

-Elevated albumin

➔Clinical Signs of Dehydration

-Pale skin

-Sunken eyes

-Red swollen lips

-Swollen and /or dry tongue with scarlet or magenta hue

-Poor skin turgor

-Cachexia

-Bilateral edema

-Muscle wasting

-Calf tenderness

-Reduced urinary output

-Dark urine

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Hydration

Management

- ➔ Early identification of fluid imbalance and acute illness
- ➔ Awareness of risk factors
- ➔ CNA's
 - What are barriers to getting water and ice
 - What makes it hard to routinely fill water pitchers
 - Use of sports bottles (ease-of-use)
- ➔ Communication of change
- ➔ "Sipper" takes a few sips at a time
 - May benefit from being offered frequent small amounts of fluid throughout the day
- ➔ Dementia resident - able to drink but forgets
 - Use social cues
- ➔ Fear of incontinence (risk factor)

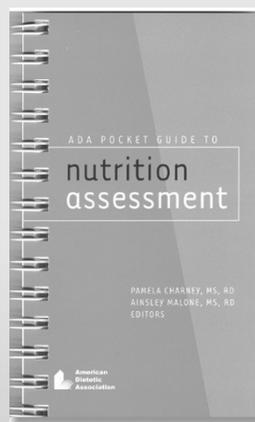


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Nutrition

- ➔ Weight reflects the balance between intake and utilization of energy (calorie/protein)
- ➔ Registered dietician assessment
 - Resident's wishes and goals
 - Diet/intake history
 - Weight history (loss or gain) prior to admission
 - Physical examination
 - Estimation of nutrient requirements
 - Nutritional diagnosis
 - Nutritional plan



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Nutrition

- **Current evidence does not definitively support any specific dietary supplement unless the resident has a specific vitamin or mineral deficiency**
- **Multivitamins may be given**

Unnecessary drugs -- (1) General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: (i) In excessive dose (including duplicate drug therapy); or (ii) For excessive duration; or (iii) Without adequate monitoring; or (iv) Without adequate indications for its use; or (v) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (vi) Any combinations of the reasons above.⁴³

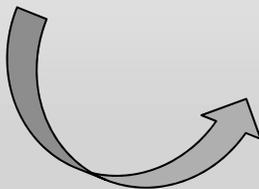
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Malnutrition

Severity of weight loss

- **Severe weight loss**
- **>10% in 6 months**
- **>7.5% in 3 months**
- **>5% in one month**
- **>2% in one week**

Source: Walker G ed. Pocket Source for Nutritional Assessment, 6th ed. Waterloo IA



- **Marasmus**
- **Kwashiorkor**
- **Anorexia**
 - Physical - low body weight,
 - Psychological - image distortion
 - Emotional - depression
 - Behavioral - obsessive fear of gaining weight
- **Cachexia**
 - Loss of appetite in someone who is not actively trying to lose weight
 - Insidious loss of weight, muscle atrophy, fatigue, weakness

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Anorexia/Cachexia

➔**Anorexia**

- Physical - low body weight,
- Psychological - image distortion
- Emotional - depression
- Behavioral - obsessive fear of gaining weight
- ➔**Immediate weight gain, especially with those who have particularly serious conditions that may require hospitalization**

➔**Cachexia**

- Loss of appetite in someone who is not actively trying to lose weight
- Insidious loss of weight, muscle atrophy, fatigue, weakness
- Directly related to inflammatory states (cancer, immunodeficiency syndrome)
- Rheumatoid arthritis, Aids, chronic renal failure, COPD
- ➔**Resistance to hypercaloric feeding**
- ➔**Tx dependent of diagnosis of underlying**

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Lean Body Mass (LBM)

➔**≤20% loss of LBM**

➔**≥30% loss of LBM**



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Laboratory Testing

↔Laboratory test may be affected by:

- Age
- Hydration status
- Chronic disease
- Acute illness
- Change in organ function

↔Albumin

- Long half life (18 - 20 days)

↔Prealbumin

- Short half life (2 - 3 days)

↔A1C

- Glycemic control

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Support Surface

↔Consider the # of body surfaces available for support

↔Effectiveness is determined:

- Individual risks
- Positioning of the resident
- Weight of the resident
- Contractures
- Healing expectations
- Individuals response to the surface
- Infection control



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Support Surface

➔ Pressure Redistribution

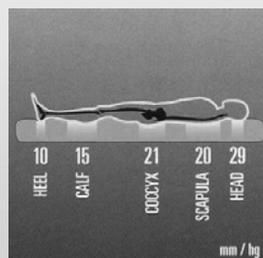
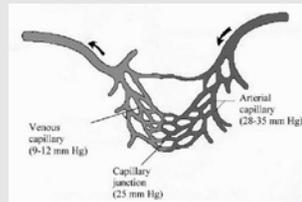
-Immersion/envelopment

➔ Pressure Reduction

-Decrease of interface pressure, not necessarily below capillary closing pressure

➔ Pressure Relief

-Reduction of interface pressure below capillary closure pressure



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Support Surface

Friction

➔ Mechanical force exerted on the skin when moved against any surface

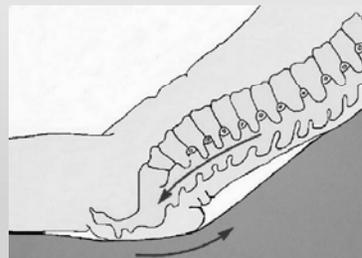
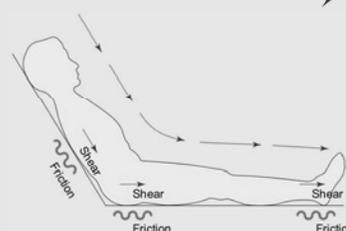
➔ May result in a skin abrasion

Shear

➔ A distortion of the tissue caused by two opposing parallel or horizontal forces

➔ Friction + gravity = Shear

➔ Greatest effect on the deep tissues of the body



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Support Surface

➔Group I Support Surfaces (Non powered)

-Residents with PrU who can assume a variety of positions without placing pressure on the ulcer

-Bottoming out"

-Air, gel, water, foams and combinations



➔Group II/Group III Support Surface (Powered)

-Moderate or high risk or resident has a PrU and the ulcer may contribute to the delay in healing

-Resident unable to assume a variety of positions without bearing weight on the pressure ulcer

-Flexion contractures



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Support Surface

➔Float heels and elbow

-Use pressure reducing devices with heel suspensions

-Pillows extend the length of the calf

➔"Protectors", sheepskin are for comfort and reduce friction and shear

-Do not provide pressure relief

➔Prevent constriction of the foot by tight or heavy linen

➔Do not use ring (donut - type) cushions



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Positioning

Positioning

➤ Resident who can change position independently

- Supportive devices to facilitate position change - monitor frequency of repositioning
- Avoid direct pressure over bony prominences, tissue previously damaged, sensitive areas
- Turning frequency based on characteristics of support surface and resident response

➤ Resident is reclining or dependent on staff

- Appropriate turning schedule based on assessment findings
- Tissue tolerance
- Risk assessment (level of activity and mobility)
- General medical condition
- HOB at 30° or less

➤ Maintain correct body alignment using pillows and foam wedges

➤ Lifting device for transfer or repositioning (reduce friction and shear)

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Positioning

Off-Loading

➤ Three Quarter Turn

- Sacrum/scapulas

➤ Quarter Turn

- Trochanters/buttocks/elbows/heels

➤ Back Position

- Behind the knees/heels

➤ Sitting Position

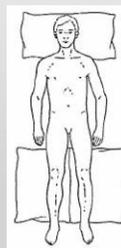
- Knees/heels/elbows



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Back



Sitting

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Seated Dependent

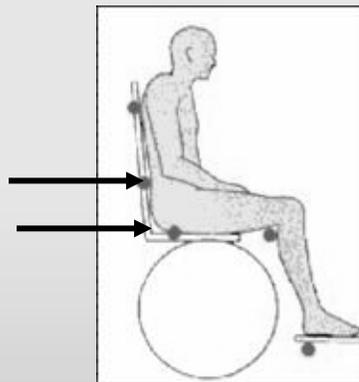
➔ Approximately 50% of the body's weight is supported by 8% of the seated area

➔ Prevalent anatomical locations

- Coccyx
- Ischial tuberosities
- Scapulas

➔ Risk factors

- Pelvic obliquity
- Weight redistributed - ischial tuberosities
- Postural changes - lumbar lordosis



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Seated Dependent

➔ Pressure redistribution cushions

➔ Residents who need only use a wheelchair for transport may use a standard cushion



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Seated Dependent

Seated Repositioning

- ➔Residents should be taught to shift weight q15 minutes while sitting in the chair
- ➔Momentary pressure relief (5 - 10 degrees or 10 - 15 seconds) followed by a return to the same position does not allow sufficient capillary refill or perfusion to occur (microshift)
- ➔Recommend position change "off-loading" hourly for dependent residents who are in sitting position or that have HOB >30°



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Clinical Resources

- ✦ CMS “Investigative Protocol Pressure Ulcer”
- ✦ The Clinical Practice Guidelines from the Healthcare Research and Quality (AHRQ)-www.ahrq.gov
- ✦ The National Pressure Ulcer Advisory Panel (NPUAP)-www.npuap.org
- ✦ The American Medical Directors Association-www.amda.org
- ✦ The Quality Improvement Organization, Medicare Quality Improvement Community Initiatives-www.medgic.org
- ✦ The Wound Ostomy and Continence Nurse Society-www.wocn.org
- ✦ The American Geriatrics Society-www.healthinaging.org

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