PRESSURE ULCER PREVENTION AND MANAGEMENT
February 24, 2003

CARE PROCESS STEP	EXPECTATIONS	RATIONALE
ASSESSMENT / PROBLEM RECOGNITION		
1. Did the staff inspect and document the resident's skin condition upon admission?	- Facility staff should systematically assess the skin condition of all residents. - Staff should identify and document the presence of any pressure ulcers and other skin breakdown, as well as factors that influence the risk of developing or the potential for healing a pressure ulcer. - Facility staff should systematically inspect and document a resident's skin condition from head to foot within 24 hours of admission, including the presence of pressure ulcers of any stage. - After reviewing the skin condition, staff should distinguish pressure ulcers from other skin lesions, and document the distinction. - Refer to Table 3, AMDA Pressure Ulcer CPG (attached)	- The skin must be examined thoroughly in order to identify the presence of pressure ulcers, especially early stages of damage, and to institute appropriate interventions. - Additional information must be collected in order to identify and careplan pertinent issues. - The Braden scale is the most widely tested and evidence-based tool at present. Refer to Appendix 2.
2. Did the staff evaluate the resident's skin condition periodically and identify changes?	- Staff should inspect the resident's skin at least approximately weekly for the presence of pressure ulcers or other skin breakdown. - Staff should inspect and document skin condition ***within 24 hours*** of arrival or return from another facility.	- Many risk factors persist indefinitely in frail and chronically ill residents. - Subsequent changes in a resident's condition may increase his/her potential for skin breakdown.
<u>Risk Review</u> 3. Both initially and periodically, did the staff identify factors that can influence the risk of developing or healing a pressure ulcer?	- Staff should look for specific physical and functional factors associated with the risk of developing a pressure ulcer or known to influence the healing of an existing pressure ulcer. - Staff should assess each resident's risk factors and use the assessment to develop a plan to minimize each of those risks. - Refer to Table 1, AMDA Pressure Ulcer CPG (attached) Table 2, AMDA Pressure Ulcer CPG (attached) - Risk Factor Summary, Clin Ger Med 13(3):430, 1997.	- Factors associated with increased risk of developing a pressure ulcer and those that inhibit healing of an existing pressure ulcer have been identified. - Many risk factors can be addressed at least partially. For example, maintaining the head of the bed at the lowest degree of elevation consistent with resident's medical condition is outlined in the Association for Health Care Research & Quality (AHRQ) CPG. The use of appropriate positioning devices and foam padding help to alleviate shear. Staff and resident utilization of lifting devices such as a trapeze or draw sheets minimize

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		friction. Limiting skin exposure to moisture from incontinence, perspiration or wound drainage with bowel/bladder training or materials that absorb moisture may diminish skin maceration and wound infection.
4. Did the staff inspect the resident's skin condition when he/she acquired a new risk factor for developing a pressure ulcer?	- Staff should reevaluate a resident's skin when he/she develops a new risk factor known to be associated with an increased risk of skin breakdown. A serious decline in level of consciousness, for example, would necessitate a skin check within 24 hours, whereas resident weight loss of 5 pounds (from the previous month) assessed 2 days after the last skin check could imply further skin assessment at the next scheduled weekly check, and prompt evaluation/care planning for weight loss.	- New risk factors may become apparent at any time, especially within the first several days after admission. - Any changes in a resident's condition may increase the potential for skin breakdown.
Complications 5. Did the staff consider complications related to an existing pressure ulcer?	- Staff should seek and identify physical, functional, and psychological consequences related to an existing pressure ulcer; for example, pain, cellulitis (soft tissue infection around the ulcer), osteomyelitis, or social isolation.	- Pressure ulcers may have associated physical, functional, and psychological complications, which may be managed effectively once they are identified. - Open pressure ulcers usually are colonized, but may not be infected.
Description of existing pressure ulcers 6. Did the staff describe the characteristics of existing ulcers?	- Staff should identify factors that indicate pressure ulcer healing or deterioration. - Staff should describe and document a pressure ulcer's key characteristics including size, location, depth and stage, the presence or absence of necrosis and slough, tunneling or sinus tract(s), and exudate. Staff also should comment on the condition of wound bed including evidence of healing such as granulation (where visible), the presence of eschar, and the status of surrounding skin.	- Assessment of these parameters over time is key to identifying the progress of pressure ulcer healing or deterioration. - The status of these parameters determine appropriate pressure ulcer treatment.
DIAGNOSIS / CAUSE IDENTIFICATION		
Categorization 7. Did the facility provide evidence to conclude that an ulcer was not pressure-related?	- Staff should document findings that support the conclusion that an ulcer is not pressure-related (arterial ulcer, venous ulcer, breakdown related to infectious or autoimmune disorder, etc.). - A physician or other health care practitioner should also evaluate the evidence. For example, a progress note should indicate that there	- Many conditions can cause skin breakdown. - Different kinds of ulcers often have defining characteristics that help determine their etiology.

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	was discussion with the physician to concur that an ulcer was not from pressure; but rather from other cause(s).	
8. Did the facility consider care-related process problems that may influence or contribute to the development or healing of a pressure ulcer?	- The staff should look for gaps in the plan or delivery of care related to a specific resident that could affect acquiring or impede healing of a pressure ulcer.	- For example, residents who cannot relieve pressure independently or who cannot address other relevant risk factors require others to provide essential elements of care. A facility policy for systematic turning and repositioning of the resident should be used, along with indications of resident's available turning surfaces.
TREATMENT / PROBLEM MANAGEMENT		
9. Did the staff consistently implement the interventions identified in physician orders and the care plan?	- Staff should use an organized approach to manage pressure ulcers and pressure ulcer risk factors. Related procedures and protocols should be consistent with standard techniques and approaches. - Routine preventive interventions are indicated for all residents with pressure ulcers or pressure ulcer risks. - Refer to: Table 5, AMDA Pressure Ulcer CPG (attached) Appendix 1, AMDA Pressure Ulcer Companion (attached)	- Principles of care to prevent and treat pressure ulcers have been identified. For example, ulcer healing is delayed with the presence of necrotic tissue/slough. Cleanse ulcers using sterile normal saline solution following techniques from AHRQ Guidelines. Remove non-viable tissue with a debridement method based on ulcer characteristics and resident comfort. If the ulcer has increased odor or excessive debris, either increase the frequency of cleansing or consider a different form of debridement. Generally, a heel ulcer with eschar is not debrided, unless evidence of infection is present. Cover and protect the wound and surrounding skin.
10. Were the facility's interventions consistent with the resident's needs, risk factors, related conditions, goals, values and wishes?	- Staff should establish realistic goals for ulcer management at or near the time of assessment. - Staff should be able to explain the rationale for their interventions if the ulcer is not healing as anticipated. - Staff should have a basis for each element of the care of a resident's pressure ulcer, or explain why treatment differed from relevant protocols.	- Pressure ulcers should show progress towards healing within 2 to 4 weeks. - A resident's overall condition, including active medical conditions and complications, influences the likelihood and rate of ulcer healing. - The rationale for interventions should be

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	- Refer to Table 9, AMDA Pressure Ulcer Therapy Companion CPG (attached)	consistent with currently accepted practices, or the staff and practitioner should be able to explain why they deviated from those approaches.
11. Did the staff address factors related to the development or healing of a pressure ulcer?	- Staff should address wound-related factors such as pain, decreased mobility, dependency for eating, continence, and pressure reduction. In addition, general risk factors such as significant weight loss, acute psychiatric conditions, fluid and electrolyte imbalance, and medication-related anorexia or lethargy should be addressed or an explanation given as to why it was not. - At or near the time that an ulcer developed or was being treated, staff should identify and document factors (for example, underlying medical conditions or functional impairments) that they believe affected their ability to prevent or heal a pressure ulcer.	- Skin condition and integrity relates to the collective function of the whole person. - The presence of conditions or problems that may predispose to developing skin breakdown or inhibit wound healing should not prevent efforts to identify and address other relevant factors. - Although some factors influencing the development or healing of a pressure ulcer may not be treatable, many related factors can be addressed.
<u>Pressure reduction</u> 12. Did the staff use relevant pressure reduction methods in accordance with established principles? 13. Did the staff turn and reposition the resident routinely?	- Staff should initiate pressure reduction measures consistent with basic principles; for example, the number of available turning surfaces and the ability of the resident to maintain a position. - For a resident with a pressure ulcer or who is at risk for pressure ulceration, staff should turn and reposition the resident approximately every two hours while in bed and reposition the resident approximately hourly while seated. - If staff believe that a resident's inability or unwillingness to cooperate prevents them from consistently achieving or maintaining an effective change in position or pressure reduction, they should try to address these limitations and document related efforts.	- Pressure reduction is a central element of pressure ulcer prevention and healing. - A consistent effort to reduce pressure on vulnerable or affected areas is desirable, although the optimal frequency of turning and positioning has not been precisely identified. Repositioning decreases the time spent in one position, and pressure-relieving surfaces reduce pressure intensity.
<u>Management of ulcers</u> 14. Did the facility consistently manage specific aspects of care of a resident with a pressure ulcer?	- Staff should have procedures or protocols for managing a resident with a pressure ulcer. Their content should be based on generally accepted recommendations relevant to the long-term care population. - Staff should manage each aspect of a pressure ulcer in accordance with those established protocols and practices, or explain the basis for significant deviations. - Staff should at least try to maintain stable body weight, or indicate why this is not feasible. In patients who are substantially overweight,	- A consistent approach to wound care should produce more desirable outcomes. - While various legitimate options exist for most aspects of wound care, some approaches are not recommended, based on evidence. - Other than basic caloric support to try to maintain stable weight and a simple

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	and in whom weight loss is desirable, staff should document this as a goal of care and should attempt to provide adequate protein intake to allow healing. - Refer to: Table 6, AMDA Pressure Ulcer Therapy Comp. (attached) ACOVE Quality Indicators for Prevention and Management of Pressure Ulcers in Vulnerable Adults http://www.acponline.org/sci-policy/acove/	multivitamin, additional nutritional interventions are of questionable benefit.
MONITORING		
15. Did the staff monitor the evolution of existing pressure ulcers?	- Staff should assess an existing pressure ulcer approximately weekly, relating the follow-up to the extent of healing, development of complications, and other relevant factors. - Staff should describe pressure ulcers consistent with the initial evaluation, and compare observations over time.	- Consistent review and description helps identify whether a wound is healing and factors that may inhibit its progress. - Complications may (but do not necessarily) require a change in management. - The optional PUSH tool is a widely used, standardized instrument that may be used for tracking pressure ulcer healing. Refer to Appendix 3.
16. Did the staff adjust interventions based on the wound's evolution, underlying causes, medical complications, the resident's overall condition and prognosis, and other related factors?	- Staff should explain why they chose to change, maintain, or stop various interventions, based on the facility's procedures or protocols and on resident-specific factors such as pressure ulcer characteristics, complications, and risk factors.	- Reasons for maintaining, changing, or stopping interventions should relate to a resident's pressure ulcer characteristics, the resident's overall condition, and the advance care directive or input from the resident or his/her decision maker.
Review of non-healing wounds 17. In residents with non-healing or progressively deteriorating wounds, did the staff assess for factors that might impede healing, and either adjust interventions accordingly or explain why the current interventions continued to be appropriate?	- Staff and physician should consider medical or mechanical factors that could affect healing including, the possible need for more aggressive debridement, additional pressure reduction, different approaches to pressure reduction, the presence of cellulitis or osteomyelitis and clinically important medical or neuropsychiatric conditions.	- Factors that may inhibit healing should be addressed unless there are clinical reasons why they could not be. - Some factors influencing the healing of a pressure ulcer may be treatable, while others may not be.

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