

# F686 THE SKIN INTEGRITY SURVEY

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## OBJECTIVES



1. Define pressure ulcer and know different terms for pressure ulcer
2. Understand stageable versus unstageable versus deep tissue injury
3. What should be included in pressure ulcer documentation
4. Identify the key elements of noncompliant practices

## **§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 pressure 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.

## PRESSURE INJURY: DEFINED

- Pressure Injury: A pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. A pressure injury will present as intact skin and may be painful. A pressure ulcer will present as an open ulcer the appearance of which will vary depending on the stage and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by skin temperature and moisture, nutrition, perfusion, co-morbidities and condition of the soft tissue

• CMS SOM F 686

## A WOUND BY ANY NAME...

- CMS recognizes numerous terms used to describe alteration in skin integrity due to pressure
  - Pressure ulcer
  - Pressure injury
  - Pressure sore
  - Decubitus ulcer
  - Bed sore
- All used interchangeably

## AVOIDABLE VS UNAVOIDABLE

- “Avoidable” means that the resident developed a pressure ulcer/injury and that the facility did not do one or more of the following: evaluate the resident’s clinical condition and risk factors; define and implement interventions that are consistent with resident needs, resident goals, and professional standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate.
- “Unavoidable” means that the resident developed a pressure ulcer/injury even though the facility had evaluated the resident’s clinical condition and risk factors; defined and implemented interventions that are consistent with resident needs, goals, and professional standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate.



## TERMINOLOGY

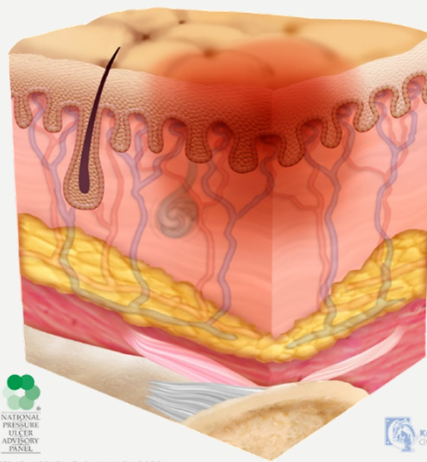
- Eschar- dead tissue. May be hard or soft, usually black, brown or tan in color and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/edges of the wound
- Slough- non-viable yellow, tan, gray, green or brown tissue, usually moist can be soft stringy or mucinous in texture. May be adherent to the base of the wound or present in clumps throughout the wound bed.
- Exudate- fluid that has been forced out of the tissues or its capillaries because of inflammation or injury. May contain serum, cellular debris, bacteria and leukocytes
- Purulent- containing pus
- Friction mechanical force exerted on skin that is dragged across any surface
- Shearing- occurs when layers of skin rub against each other or when the skin remains stationary and the underlying tissue moves and stretches and angulates or tears the underlying capillaries and blood vessels causing tissue damage
- Granulation tissue is the pink red moist tissue that fills an open wound often referred to as “red and beefy”
- Tunnel- passageway of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound
- Sinus tract- a cavity or channel underlying a wound that involves an area larger than the visible surface of the wound
- Undermining- destruction of tissue or ulceration extending under the skin edges so the ulcer is large at its base than at the skin surface

## NOTE:

- Regardless of the staging system or wound definitions used by the facility, the facility is responsible for completing the MDS utilizing the staging guidelines **found in the RAI Manual**.
  - Wound companies
  - Wound centers
  - Specialists, etc.



### Stage 1 Pressure Injury - Caucasian

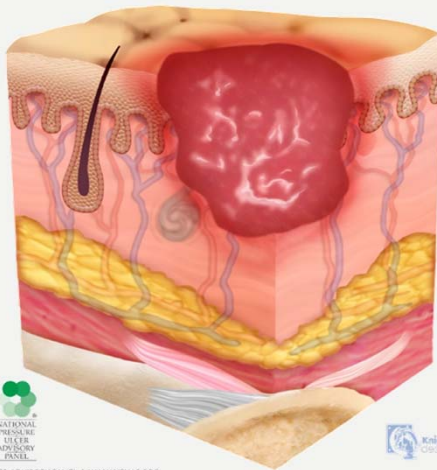


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### STAGE 1 PRESSURE INJURY:

Non-blanchable erythema of intact skin. Intact skin with a localized area of non-blanchable erythema (redness). In darker skin tones, the PI may appear with persistent red, blue, or purple hues. The presence of blanchable erythema or Effective November 28, 2017 changes in sensation, temperature, or firmness may precede visual changes. Color changes of intact skin may also indicate a deep tissue PI.

## Stage 2 Pressure Injury

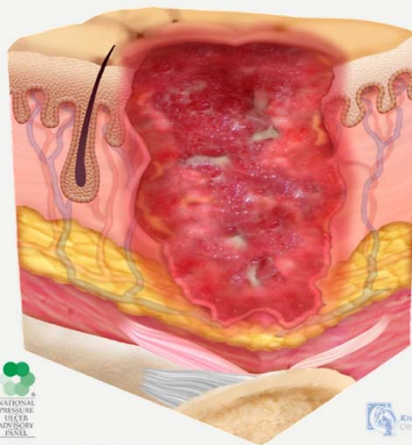


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## STAGE 2 PRESSURE ULCER:

Partial-thickness skin loss with exposed dermis. Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. This stage should not be used to describe moisture associated skin damage including incontinence associated dermatitis, intertriginous dermatitis (inflammation of skin folds), medical adhesive related skin injury, or traumatic wounds (skin tears, burns, abrasions).

## Stage 3 Pressure Injury

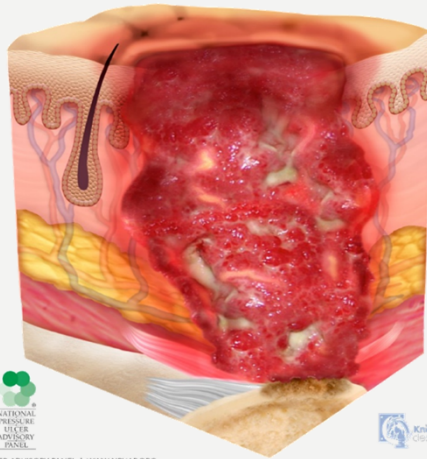


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## STAGE 3 PRESSURE ULCER:

Full-thickness skin loss. Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the wound bed, it is an Unstageable PU/PI.

## Stage 4 Pressure Injury



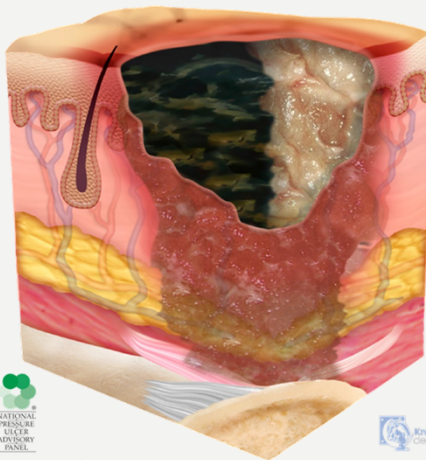
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## STAGE 4 PRESSURE ULCER:

Full-thickness skin and tissue loss  
Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible on some parts of the wound bed. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the wound bed, it is an unstageable PU/PI.

## Unstageable Pressure Injury - Slough and Eschar



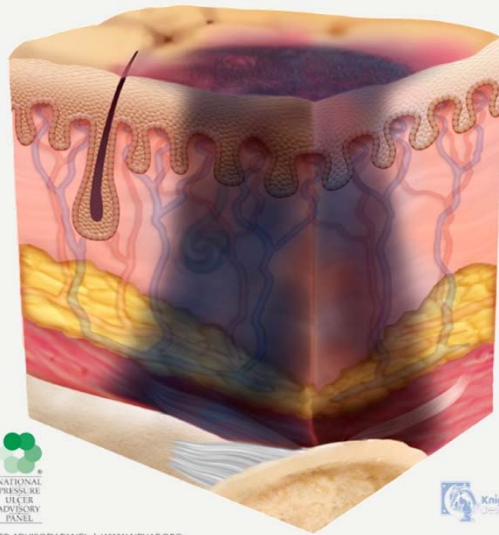
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## UNSTAGEABLE PRESSURE ULCER:

Obscured full-thickness skin and tissue loss  
Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) should only be removed after careful clinical consideration and consultation with the resident's physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws. If the slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed. If the anatomical depth of the tissue damage involved can be determined, then the reclassified stage should be assigned. The pressure ulcer does not have to be completely debrided or free of all slough or eschar for reclassification of stage to occur.

## Deep Tissue Pressure Injury



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### OTHER STAGING CONSIDERATIONS INCLUDE: • DEEP TISSUE PRESSURE INJURY (DTPI):

Persistent non-blanchable deep red, maroon or purple discoloration INTACT SKIN with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly Effective November 28, 2017 to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure ulcer. Once a deep tissue injury opens to an ulcer, reclassify the ulcer into the appropriate stage. Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.

## OTHER STAGING CONSIDERATIONS INCLUDE:

- **Medical Device Related Pressure Ulcer/Injury:** Medical device related PU/PIs result from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure injury generally conforms to the pattern or shape of the device. The injury should be staged using the staging system.
  - NOTE: if pressure is the primary source, it is to be labeled as pressure, even if circulation deficiencies, dm, etc exist- these would be considered secondary diagnoses that affect the healing process, but NOT the wound source.
- **Mucosal Membrane Pressure Ulcer/Injury:** Mucosal membrane PU/PIs are found on mucous membranes with a history of a medical device in use at the location of the injury. Due to the anatomy of the tissue, these ulcers cannot be staged.



# PREVENTION OF PRESSURE ULCERS/INJURIES

- A pressure ulcer/injury (PU/PI) can occur wherever pressure has impaired circulation to the tissue.

A facility must:

- Identify whether the resident is at risk for developing or has a PU/PI upon admission and thereafter;
- Evaluate resident specific risk factors and changes in the resident's condition that may impact the development and/or healing of a PU/PI;
- Implement, monitor and modify interventions to attempt to stabilize, reduce or remove underlying risk factors; and
- If a PU/PI is present, provide treatment to heal it and prevent the development of additional PU/PIs.

The first step in the prevention of PU/PIs, is the identification of the resident at risk of developing PU/PIs. This is followed by implementation of appropriate individualized interventions and monitoring for the effectiveness of the interventions.

# IDENTIFICATION OF RISK

- Examples of these risk factors include, but are not limited to:
- Impaired/decreased mobility and decreased functional ability;
- Co-morbid conditions, such as end stage renal disease, thyroid disease or diabetes mellitus;
- Drugs such as steroids that may affect healing;
- Impaired diffuse or localized blood flow, for example, generalized atherosclerosis or lower extremity arterial insufficiency;
- Resident refusal of some aspects of care and treatment;
- Cognitive impairment;
- Exposure of skin to urinary and fecal incontinence;
- Under nutrition, malnutrition, and hydration deficits; and
- The presence of a previously healed PU/PI. The history of any healed PU/PI, its origin, treatment, its stages [if known] is important assessment information, since areas of healed Stage 3 or 4 PU/PIs are more likely to have recurrent breakdown.

## ???DID YOU KNOW???

- Research has shown that in a skilled nursing facility, 80 percent of PU/PIs develop within two weeks of admission and 96 percent develop within three weeks of admission.

(Reference: Lyder CH, Ayello EA. Pressure Ulcers: A Patient Safety Issue. In: Hughes RG, editor. Patient Safety and Quality: An Evidence-Based Handbook for Nurses. Rockville (MD): Agency for Healthcare Research and Quality (US); 2008 Apr. Chapter 12. Available from: <http://www.ncbi.nlm.nih.gov/books/NBK2650/>)

## WHEN TO ASSESS RISK?

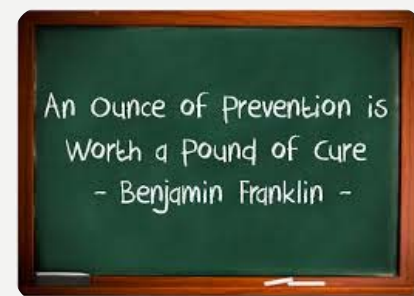
- Standard practice (from the state operations manual)
- Upon admission
- Weekly for the first 4 weeks after admission then monthly or whenever there is a change in condition (may or may not warrant a significant change)
  - NOTE: the frequency of assessment should be based upon each resident's specific needs
- **REGARDLESS** of risk score, clinicians are **RESPONSIBLE** for evaluating each existing and potential risk factor for developing a pressure injury and determining the resident's overall risk
  - A resident may be placed in a higher risk level than the overall score of the assessment tool based on assessment of factors that are not captured by the tool. Documentation of the clinician's decision should be placed in the medical record

## NUTRITION AND SKIN

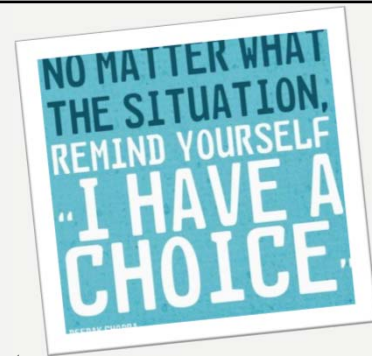
- The skin is the body's largest organ system- Presence of skin breakdown may be the most visible evidence of a health issue
- Weight loss (or gain) may affect skin condition
  - Decreased nutrition
  - Decreased activity
  - Decreased mobility
- Nutrition goals?
- NOTE: No laboratory test is specific or sensitive enough to warrant serial/repeated testing.
- Hydration- it is appropriate to identify risk and determine appropriate interventions

## PREVENTION AND TREATMENT STRATEGIES

- NOT ALL INCLUSIVE:
  - Redistribute pressure
    - Repositioning, protecting, offloading
  - Minimize exposure to moisture
    - Keep skin clean and dry especially of fecal contamination
  - Provide appropriate, pressure-redistributing, support surfaces
  - Provide non-irritating surfaces
  - Maintain or improve nutrition and hydration status, where feasible.
  - Adverse drug reactions related to the resident's drug regimen may worsen risk factors for development of, or for non-healing PU/PIs (for example, by causing lethargy or anorexia or creating/increasing confusion) and should be identified and addressed. These interventions should be incorporated into the plan of care and revised as the condition of the resident indicates.



## RESIDENT CHOICES



- Care plan establish
  - Relevant goals
  - Approaches to stabilize or improve co-morbidities
  - Other interventions aimed at limiting the effects of risk factors
- Informed choice about care and treatment or to decline treatment
  - The home and resident (or *if applicable*, the resident representative) must discuss
    - Condition
    - Treatment options, expected outcomes and consequences of refusing treatment, orders or recommendations
- The facility is expected to address the resident's concerns and offer relevant alternatives, if the resident has declined specific treatment.

## END OF LIFE

- Just because end of life, does not automatically make "unavoidable"
  - Proper care and individualized approaches for end-of-life care in accordance with the resident's wishes, the development, continuation, or worsening of a PU/PI may be considered unavoidable
- Kennedy Terminal Ulcer- while is an end of life ulcer, ***Kennedy Terminal Ulcers are considered to be pressure ulcers that generally occur at the end of life. (AND coded on the MDS)***
  - KTUs have certain characteristics which differentiate them from pressure ulcers such as the following:
    - KTUs appear suddenly and within hours;
    - Usually appear on the sacrum and coccyx but can appear on the heels, posterior calf muscles, arms and elbows;
    - Edges are usually irregular and are red, yellow, and black as the ulcer progresses, often described as pear, butterfly or horseshoe shaped; and
    - Often appear as an abrasion, blister, or darkened area and may develop rapidly to a Stage 2, Stage 3, or Stage 4 injury.

## REPOSITIONING/RELIEVING CONSTANT PRESSURE

- Critical for those who are immobile or dependent on staff
  - Frequency determined by individual consideration
    - Level of activity and mobility
    - General medical condition
    - Overall treatment objectives
    - Skin condition and
    - Comfort
  - The resident's skin condition and general comfort should be regularly assessed. The efficacy of repositioning must be monitored and revisions to the care plan considered, if the individual is not responding as expected to the repositioning interventions.

## REPOSITIONING CONSIDERATIONS

1. The time an individual spends seated in a chair without pressure relief should be limited.
2. If able, the resident should be taught to shift his or her weight while sitting in a chair.
3. Many clinicians recommend a position change "off - loading" hourly for dependent residents who are sitting or who are in a bed or a reclining chair with the head of the bed or back of the chair raised 30 degrees or more.
4. Wheelchairs are often used for transporting residents, but they may severely limit repositioning options and increase the risk of PU/PI development.
5. The care plan for a resident who is reclining and is dependent on staff for repositioning should address position changes to maintain the resident's skin integrity.

## MONITORING

- Be alert to potential changes in skin condition
- Evaluate, report and document changes as soon as identified
  - Example: a resident's complaint about pain or burning at a site where there has been pressure or observation during the resident's bath that there is a change in skin condition should be reported so that the resident may be evaluated further.
- After thorough evaluation the IDT should develop a relevant care plan that includes measurable goals for prevention and management of PU/PIs with appropriate interventions
  - Weekly or more often if indicated

## ASSESSMENT AND TREATMENT

- Identified
  - Present on admission or developed after admission
  - Factors that influenced its development
  - Potential for development of additional PU/PI's or
  - Deterioration of PU/PI's be recognized assessed and addressed
- Any NEW PU/PI's suggests a need to reevaluate the adequacy of prevention measures in the care plan



## DOCUMENTATION SHOULD INCLUDE:

- The type of injury (pressure-related versus non-pressure-related) because interventions may vary depending on the specific type of injury;
- The PU/PI's stage;
- A description of the PU/PI's characteristics;
- The progress toward healing and identification of potential complications;
- If infection is present;
- The presence of pain, what was done to address it, and the effectiveness of the intervention; and
- A description of dressings and treatments.

## 5 RIGHTS: APPLIED TO WOUNDS

- The right dose. ... (treatment meds/items)
- The right route. ... (site)
- The right time. ... (daily/bid) etc.
- The right patient. ...
- The right documentation. (M-E-A-S-U-R-E) see next slide
- The 5 rights still apply.

## DOCUMENTATION TIPS

- M – Measure (Length x Width x Depth)
- E – Exudate (Quality and Quantity)
- A – Appearance (Wound bed tissue type and amount)
- S - Suffering (pain type and level)
- U - Undermining (Presence or absence)
- R – Reevaluate (Monitoring of all parameters routinely)
- E – Condition of edges and surrounding tissue

• Keast DH, Bowering CK, Evans AW, Mackean, GL, Burrows C, D'Souza, L. MEASURE: A proposed assessment framework for developing best practice recommendations for wound assessment. *Wound Repair and Regeneration*. 2004;12:S1-S17.

## TYPES OF INJURIES

- Three of the more common types of skin injuries are
  - pressure,
  - vascular insufficiency/ischemia (venous stasis and arterial ischemic ulcers) and
  - neuropathic.
    - Discussed more in §483.25, F684, Quality of Care for definition and description of other injury types than PU/PI's



## CHARACTERISTICS

It is important that the facility have a system in place to assure that the protocols for daily monitoring and for periodic documentation of measurements, terminology, frequency of assessment, and documentation are implemented consistently throughout the facility.

## CHARACTERISTICS- CONTINUED

- When a PU/PI is present, daily monitoring, (with accompanying documentation, when a complication or change is identified), should include:
  - An evaluation of the PU/PI, if no dressing is present;
  - An evaluation of the status of the dressing, if present (whether it is intact and whether drainage, if present, is or is not leaking);
  - The status of the area surrounding the PU/PI (that can be observed without removing the dressing);
  - The presence of possible complications, such as signs of increasing area of ulceration or soft tissue infection (for example: increased redness or swelling around the wound or increased drainage from the wound); and •
  - Whether pain, if present, is being adequately controlled.

## WOUND OBSERVATION/ASSESSMENT

- The amount of observation possible will depend upon the type of dressing that is used, since some dressings are meant to remain in place for several days, according to manufacturers' guidelines.
- With each dressing change or at least weekly (and more often when indicated by wound complications or changes in wound characteristics), an evaluation of the PU/PI should be documented. At a minimum, documentation should include the date observed and:
  - Location and staging;
  - Size (perpendicular measurements of the greatest extent of length and width of the PU/PI), depth; and the presence, location and extent of any undermining or tunneling/sinus tract;
  - Exudate, if present: type (such as purulent/serous), color, odor and approximate amount;
  - Pain, if present: nature and frequency (e.g., whether episodic or continuous);
  - Wound bed: Color and type of tissue/character including evidence of healing (e.g., granulation tissue), or necrosis (slough or eschar); and
  - Description of wound edges and surrounding tissue (e.g., rolled edges, redness, hardness/induration, maceration) as appropriate.
  - (Think MEASURE)
- Photographs may be used to support this documentation, if the facility has developed a protocol consistent with professional standards and issues related to resident privacy and dignity are considered and maintained.

## HEALING PU/PI

- PU/PIs do NOT heal in reverse sequence: once stage 3- always stage 3
- There are different types of clinical documentation to describe the progression of the healing PU/PI
- Facilities are REQUIRED to use the RAI directions on describing can be found in the RAI manual ([http://www.cms.gov/NursingHomeQualityInits/45\\_NHQIMDS30TrainingMaterials.asp#TopOfPage](http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp#TopOfPage))

## SOM EXAMPLES:

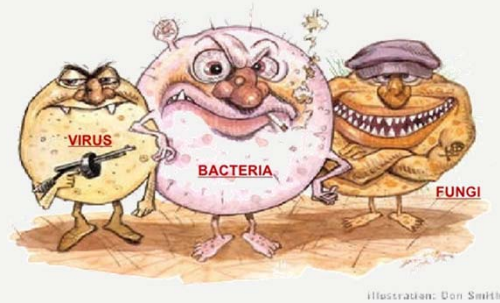
- It is important to evaluate and modify interventions for a resident with an existing PU/PI such as the following:
  - Residents with PU/PIs on the sacrum/coccyx or ischia should limit sitting to three times a day in periods of 60 minutes or less. Consult a seating specialist to prescribe an appropriate seating surface and/or positioning techniques to avoid or minimize pressure on the PU/PI. While sitting is important for overall health, every effort should be made to avoid or minimize pressure on the PU/PI.
  - Residents with an ischial injury should not be seated in a fully erect posture in chair or in bed. Modify sitting time schedules and re-evaluate the seating surface and the individual's posture if the PI worsens or fails to improve.

## FAILURE TO IMPROVE?

- If a PU/PI fails to show some evidence of progress toward healing within 2-4 weeks, the area and the resident's overall clinical condition should be **reassessed**.
- Re-evaluation of the treatment plan includes determining whether to continue or modify the current interventions.
- Results may vary depending on the resident's overall condition and interventions/treatments used. The complexity of the resident's condition may limit responsiveness to treatment or tolerance for certain treatment modalities.
- The clinicians, if deciding to retain the current regimen, should **DOCUMENT** the rationale for continuing the present treatment to explain why some, or all, of the plan's interventions remain relevant despite little or no apparent healing.

# WOUND INFECTIONS

- Complications
  - Soft tissue- cellulitis
  - Bone- osteomyelitis
  - Joint- septic arthritis
  - Abscess
  - Spread of bacteria into bloodstream- bacteremia/septicemia
  - Chronic infection
  - Development of sinus tract
- May occur despite apparent improvement in the PU/PI itself
- Physician involvement is integral when significant changes in the wound or overall resident condition are identified



## TRUE OR FALSE: ALL CHRONIC WOUNDS, INCLUDING PU/PI HAVE BACTERIA?

- TRUE!
- Since bacteria reside in non-viable tissue, debridement of this tissue and wound cleansing are important to reduce bacteria and avoid adverse outcomes such as sepsis.
- The first sign of infection may be a delay in healing and an increase in exudates. In a chronic wound, the signs of infection may be more subtle.
- Signs may include the following:
  - Increase in amount or change in characteristics of exudate,
  - Decolorization and friability of granulation tissue,
  - Undermining,
  - Abnormal odor,
  - Epithelial bridging (a bridge of epithelial tissue across a wound bed) at the base of the wound, or
  - Sudden pain.

## NewsFlash!

- The physician diagnosis of infections present in a PU/PI are based on resident history and clinical findings, such as a wound culture.
  - **Pus, slough or necrotic tissue should NOT be cultured.**
- Tissue biopsy, punch biopsy may be used to rule out infection OR establish other source of wound (cancer, bullous pemphigoid, etc.)
- Findings such as an elevated white blood cell count, bacteremia, sepsis, or fever may signal an infection related to a PU/PI area or a co-existing infection from a different source. The treatment of an infection will depend on the type of infection present.

## PAIN

- Assessment and treatment of pain are integral components of PU/PI prevention and management
- Pain that interferes with movement and affects mood may contribute to immobility and contribute to the potential for developing or for delayed healing or non-healing of an already existing PU/PI

NOTE: if resident is complaining of pain during treatment (statements, facial expression, groaning, etc) STOP!!!

- Consider the following:
  - Position change?
  - Pre-treatment topical numbing?
  - What kind of pain?
    - Nerve? Muscle?
  - Was premedication given?
  - Notify physician?



## DRESSINGS AND TREATMENTS

- Based on practitioner's clinical judgment, facility protocols and current professional standards of practice
- Selection based on relevance of product to the PU/PI characteristics, treatment goals and manufacturer's recommendations for use
- Clean technique; however, sterile may be appropriate for those wounds that recently have been debrided or repaired.

## CLEAN TECHNIQUE

- Involves approved hand hygiene and glove use,
- maintaining a clean environment by:
  - preparing a clean field,
  - using clean instruments, and
  - preventing direct contamination of materials and supplies.
- Clean technique is considered
  - most appropriate for long-term care;
  - for residents who are not at high risk for infection; and
  - for residents receiving routine dressings for chronic wounds such as venous ulcers, or wounds healing by secondary intention with granulation tissue.

# SURVEY INVESTIGATIVE PROTOCOL

- Includes:
- Pressure Ulcer Critical Element (CE) Pathway along with
- Aforementioned interpretive guidelines

# SURVEYORS WILL REVIEW...

- Comprehensive assessments
  - MDS/CAAs sections:
  - C - Cognitive patterns
  - G - Functional status
  - H - Bladder and bowel
  - J - Health conditions- pain
  - K - Swallowing/nutritional stats
  - M - Skin conditions and pressure relieving devices
- Care plans- pressure relief devices, repositioning schedule, treatment, scheduled skin/wound inspection or PU/PI history
- Physician orders
- Pertinent diagnoses
- Inspect to identify practices in place to identify those at risk
- evaluate a resident for pressure ulcers/injuries, and intervene to prevent and/or heal pressure ulcers.

## CE- OBSERVATIONS

- Observe wound care and assess the wound (observe as soon as possible)
- Is the wound care performed in accordance with accepted standards of treatment, physician's orders, and care plan? o Is there pain during wound care? If so, what did the nurse do?
- Does the wound look infected?
- Use of clean gloves and clean technique for each resident. When treating multiple ulcers on the same resident, provide wound care to the most contaminated ulcer last (e.g., in the perineal region).
- Remove gloves and decontaminate hands between residents.
- Staff ensure that if perineal or incontinence care is performed gloves are used, then visibly soiled dressing is removed, hand hygiene is performed, and clean gloves are donned before clean dressing is applied.
- Clean wound dressing supplies need to be handled in a way to prevent cross-contamination (e.g., wound care supply cart remains outside of resident care areas, unused supplies are discarded or remain dedicated to the resident, multi-dose wound care medications such as ointments, creams should be dedicated to one resident).
- Is hand hygiene and approved glove use practiced when providing wound care? Are precautions taken to not unnecessarily contaminate the wound or clean equipment and supplies during resident care?
- Are reusable dressing care equipment (e.g., bandage scissors) cleaned or reprocessed if shared between residents?
- Has the resident's skin been exposed to urinary or fecal incontinence? Was the dressing wet or soiled? What did staff do?

## CE- OBSERVATIONS

- How are care planned interventions being implemented?
- How are staff following the care plan?
- Is the resident repositioned timely and in the correct position to avoid pressure on an existing PU/PI or areas at risk for developing PU/PI?
- Use of proper technique when turning, repositioning, and transferring to avoid skin damage and the potential for shearing or friction.
- Pressure relief devices are in place and working correctly and are used per the manufacturer's instructions.
- Does the resident show signs of PU/PI related pain?
- Are ordered nutritional interventions implemented (e.g., supplements and hydration)?



# RESIDENT, FAMILY INTERVIEWS

## Resident, Resident Representative, or Family Interview:

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Did your wound develop in the facility? If so, do you know how it occurred?</li> <li><input type="checkbox"/> Has staff talked to you about your risk for the wound and how they plan to reduce the risk?</li> <li><input type="checkbox"/> How are they treating your wound?</li> <li><input type="checkbox"/> Is the wound getting better? If not, describe.</li> <li><input type="checkbox"/> How has your wound caused you to be less involved in activities you enjoy?</li> <li><input type="checkbox"/> How has your wound caused a change in your mood or ability to function?</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> How did the facility ensure you had a choice in how your wound would be treated?</li> <li><input type="checkbox"/> How often are dressings changed or treatment applied?</li> <li><input type="checkbox"/> Does your wound hurt? Do you have pain with wound care or when the dressings are changed? If so, what does staff do for your pain?</li> <li><input type="checkbox"/> What types of interventions are done to help heal your wound? Ask about specific interventions (e.g., positioned q2h, use of pressure redistribution devices or equipment).</li> <li><input type="checkbox"/> If you know the resident refused care: Did staff provide you with other options of treatment or did staff provide you with education on what might happen if you do not follow the treatment plans?</li> </ul> |
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# STAFF INTERVIEWS

## Staff Interviews (Nursing Aides, Nurse, DON, Attending Practitioner):

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| <ul style="list-style-type: none"> <li><input type="checkbox"/> What, when, and to whom do you report changes in skin condition?</li> <li><input type="checkbox"/> Does the resident have a PU? If so, where is it located?</li> <li><input type="checkbox"/> How are you made aware of the resident's daily care needs?</li> <li><input type="checkbox"/> What PU interventions are used?</li> <li><input type="checkbox"/> Does the resident have pain? If so, how is it being treated?</li> <li><input type="checkbox"/> Has the resident had weight loss, dehydration, or acute illness? If so, what interventions are in place to address the problem?</li> <li><input type="checkbox"/> Is the resident currently on any transmission-based precautions?</li> <li><input type="checkbox"/> Has there been a change in the resident's overall function and mood?</li> <li><input type="checkbox"/> Ask about any observation concerns.</li> <li><input type="checkbox"/> Is the resident at risk for the development of PU/PI?</li> <li><input type="checkbox"/> How and how often is the resident's skin assessed and where is it documented?</li> <li><input type="checkbox"/> When did the current PU/PI develop? What caused the PU/PI?</li> <li><input type="checkbox"/> What interventions were in place before the PU/PI developed?</li> <li><input type="checkbox"/> Who was notified of the PU/PI and when were they notified?</li> <li><input type="checkbox"/> What is the current treatment ordered by the physician?</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> What do you do if the resident refuses care?</li> <li><input type="checkbox"/> Is the PU/PI improving?</li> <li><input type="checkbox"/> How is pain related to the PU/PI assessed? And how often?</li> <li><input type="checkbox"/> How do you inform other staff and the MD about the PU/PI status?</li> <li><input type="checkbox"/> How do you monitor staff to ensure they are implementing care planned interventions?</li> <li><input type="checkbox"/> How do you determine the appropriate interventions?</li> <li><input type="checkbox"/> If there are systemic concerns: What are the facility's policies and procedures regarding care, treatment, prevention, and interventions for pressure ulcers?</li> <li><input type="checkbox"/> Is the resident's treatment effective? Have you been contacted with any changes in the PU/PI?</li> <li><input type="checkbox"/> How do you monitor the resident's wound progress?</li> <li><input type="checkbox"/> How is the effectiveness of wound care or pressure ulcer prevention measures evaluated? And how often and by who?</li> <li><input type="checkbox"/> How did you involve the resident in decisions regarding treatments?</li> <li><input type="checkbox"/> Are wound care protocols used? If so, describe.</li> </ul> |
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# RECORD REVIEW

## Record Review:

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| <ul style="list-style-type: none"> <li><input type="checkbox"/> Review nursing notes and/or skin assessments. Did the resident have any unhealed pressure ulcers?</li> <li><input type="checkbox"/> Documentation of the resident's nutritional needs related to wound healing.</li> <li><input type="checkbox"/> Have nutrition and hydration interventions been put in place?</li> <li><input type="checkbox"/> Review laboratory results pertinent to wound healing.</li> <li><input type="checkbox"/> Was the MDS accurately coded to reflect the resident's condition at the time of the assessment? Was a CAA completed to assess the preliminary information gathered in the MDS and determine care planning decisions?</li> <li><input type="checkbox"/> Was a baseline care plan in place within 48 hours of admission, for a resident who was admitted at risk for or had a pressure ulcer on admission?</li> <li><input type="checkbox"/> Was a comprehensive care plan developed? Does it address identified needs, measurable goals, resident involvement and choice, and interventions to heal/prevent pressure ulcers (e.g., pressure relief devices, treatment, and repositioning)? Has the care plan been revised to reflect any changes in PU?</li> <li><input type="checkbox"/> Are interventions and preventive measures for wound healing documented, appropriate, monitored, evaluated, and modified as necessary?</li> <li><input type="checkbox"/> If the resident refuses or resists staff interventions, determine if the care plan reflects efforts to find alternatives to address the needs identified in the assessment.</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Has the physician-ordered treatment been evaluated for effectiveness, modified, or changed as appropriate and/or as needed? Was the IDT involved?</li> <li><input type="checkbox"/> Does the wound care documentation reflect the condition of the wound and include the type of dressing, frequency of dressing change, and wound description (e.g., measurement, characteristics)?</li> <li><input type="checkbox"/> Is pain related to PU/PI assessed and treatment measures documented?</li> <li><input type="checkbox"/> Were changes in PU/PI status or other risks correctly identified and communicated with staff and attending practitioner?</li> <li><input type="checkbox"/> Review facility practices, policies, and procedures with regard to identification, prevention, intervention, care, treatment, and correction of factors that can cause PU/PI if concerns are identified.</li> <li><input type="checkbox"/> Was there a significant change in the resident's condition (i.e., will not resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; impacts more than one area of health; requires IDT review or revision of the care plan)? If so, was a significant change comprehensive assessment conducted within 14 days?</li> </ul> |
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# CRITICAL ELEMENT DECISIONS

- 1) Did the facility ensure that a resident:
  - Receives care, consistent with professional standards of practice, to prevent pressure ulcers; and
  - Does not develop pressure ulcers unless the resident's clinical condition demonstrates that they were unavoidable; and
  - Receives necessary treatment and services to promote the healing of a pressure ulcer, prevent an infection, and prevent new ulcers from developing? If No to any of these areas, cite F686
- 2) Did the physician evaluate and assess medical issues related to the resident's skin status and supervise the management of all associated medical needs, including participation in the comprehensive assessment process, development of a treatment regimen consistent with current standards of practice, monitoring, and response to notification of change in the resident's medical status related to pressure ulcers? If No, cite F710
- 3) Did the facility use appropriate hand hygiene practices and PPE when providing wound/dressing care? If No, cite F880

## CRITICAL ELEMENT DECISIONS

- 4) For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand? If No, cite F655 NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.
- 5) If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition? If No, cite F636 NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and the comprehensive assessment was not yet required.

## CRITICAL ELEMENT DECISIONS

- 6) If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant? If No, cite F637 NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not required OR the resident did not have a significant change in status.
- 7) Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths and areas of decline, accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status)? If No, cite F641
- 8) Did the facility develop and implement a comprehensive person-centered care plan that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences? If No, cite F656 NA, the comprehensive assessment was not completed.
- 9) Did the facility reassess the effectiveness of the interventions and review and revise the resident's care plan (with input from the resident or resident representative, to the extent possible), if necessary, to meet the resident's needs? If No, cite F657 NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised.

## ADDITIONAL POSSIBLE TAGS, CARE AREAS AND TASKS TO CONSIDER:

- Right to be informed F552,
- Notification of Change F580,
- Abuse (CA),
- Neglect (CA),
- Choices (CA),
- Admission Orders F635,
- General Pathway (CA),
- Behavioral-Emotional Status (CA),
- Nutrition (CA),
- Hydration (CA), S
- sufficient and Competent Staffing (Task),
- QAA/QAPI (Task).



## KEY ELEMENTS OF NON COMPLIANCE

- Failure to do one or more of the following
  - Provide preventive care, consistent with professional standards of practice, to residents who may be at risk for development of pressure injuries; or
  - Provide treatment, consistent with professional standards of practice, to an existing pressure injury; or
  - Ensure that a resident did not develop an avoidable PU/PI.

\*\*\*NOTE\*\*\*

- To cite F686, it is not necessary to prove that a PU/PI developed. F686 can be cited when it has been determined that the provider failed to implement interventions to prevent the development of a PU/PI for a resident identified at risk.

## QUESTIONS?



## REFERENCES:

- <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html>
- <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Advance-Appendix-PP-Including-Phase-2-.pdf>
- <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/LTC-Survey-Pathways.zip>