

## AMT Quarterly Webinar

# Preventing Pressure Ulcers from a Systems Perspective

### FACULTY

**Pamela Scarborough, PT, DPT, MS, CWS**

Director of Public Policy & Education

**Jeanine Maguire, PT, MS, CWS**

Sr. Director Skin Integrity & Wound Management

Genesis Healthcare

### Moderators

**Lynn Tabor, MS, RN, WCC, IP-BC, ASCOM**

Director of Education & Training  
American Medical Technologies

**Gregory Yogurtian**

PT, DPT, CWS

*Corporate Education & Training Specialist*

Gordian Medical Inc.,  
dba American Medical Technologies

1

[www.amtwoundcare.com](http://www.amtwoundcare.com)

**AMT** Education  
Division

## Disclaimer

L

“This information is provided for informational purposes only. Patient management decisions should be based on a number of factors, including (but not limited to) professional society guidelines and published clinical literature relevant to a patient’s condition. Providers are encouraged to rely on their training and expertise, as well as any and all available information, prior to making management or treatment decisions for any individual patient.”

Gordian Medical Inc.,  
dba American Medical Technologies

2

[www.amtwoundcare.com](http://www.amtwoundcare.com)

**AMT** Education  
Division

- Look in the **Handouts** Section on Your Webinar Platform. Download the handouts for future reference and teaching of others.




## Nursing CE Requirements

- Each person must be logged in separately to obtain nursing continuing education credit
- Each person required to stay logged in until the webinar is finished (this will be tracked)
- Participant must fill out the survey from **Survey Monkey** completely which will be sent to you in a post-webinar follow up email
- Certificates will be emailed to the email address participants used to log into the webinar approximately 4 weeks after the evaluations are completed

## Your Follow-Up Email for Contact Hours <sup>L</sup>

Thank you for attending Team Approach to Nutritional Considerations for Wound Prevention and...

**Pamela Scarborough** <customercare@gotowebinar.com>  
To: jodipt@yahoo.com  
Apr 28 at 7:15 PM





Dear Jodi,  
We hope you enjoyed the webinar and that you find the information meaningful for your clinical practice.

Best regards,  
Pamela Scarborough

[Watch Recording](#)

Please send your questions, comments and feedback to: [pamela.scarborough@amtwoundcare.com](mailto:pamela.scarborough@amtwoundcare.com).

**Please take the following survey:**    
Course Evaluation

Gordian Medical Inc., dba American Medical Technologies

AMT Education Division

## AMT Quarterly Webinar <sup>L</sup>

# Preventing Pressure Ulcers from a Systems Perspective

### FACULTY

**Pamela Scarborough, PT, DPT, MS, CWS**  
Director of Public Policy & Education

**Jeanine Maguire, PT, MS, CWS**  
Sr. Director Skin Integrity & Wound Management  
Genesis Healthcare

**Moderator: Lynn Tabor, MS, RN, WCC, IP-BC, ASCOM**  
Director of Education & Training  
American Medical Technologies

## OBJECTIVES

P

- At the end of this presentation participants will be able to:
  - Identify which tools and processes their system/building currently uses to identify residents who **have pressure ulcer risk**, or have experiences a **change in pressure ulcer risk**;
  - Discuss current pressure ulcer prevention practices in their building/company;
  - Recognize gaps in current pressure ulcer prevention practices/processes;
  - Formulate plans to improve pressure ulcer/injury prevention practices/processes and improve clinical interventions.

## References

P

1. On-Time Pressure Ulcer Prevention-Self-Assessment Worksheet for Pressure Ulcer: Agency for Healthcare Research and Quality. 2017.
2. State Operations Manual Appendix PP-Guidance to Surveyors for Long Term Care Facilities (Rev. 11-22-17. Sections F658, F684, F686, F687.
3. Section M: Skin Conditions. CMS's RAI Version 3.0 Manual. October 2018
4. Pressure Ulcer/Injury Critical Element Pathway. Department of Health and Human Services-Centers for Medicare & Medicaid Services. 05/2017.

# What are the Expectations from a Regulatory Perspective

P

## State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents

*(Rev. 11-22-17)*

[Transmittals for Appendix PP](#)

*INDEX*

**Read and Study F686  
and Associated Tags**

Read EVERY WORD, Understand each concept until you KNOW F686; know where to find what you need in this important document.  
Correlate the knowledge in F686 with Section M of the MDS.

P

P

**Other Tags Surveyors Instructed to Review When F686 Deficiency Given**

**Surveyors Instructed to Review EACH of These Tags**

F710	Physician Services	F641	Accuracy of Assessment
F880	Infection Control	F656	Comprehensive Care Plan What must be included
F655	Comprehensive Person-Centered Care Planning	F657	Comprehensive Care Plan Effectiveness of CP and who must be included
F636	Resident Assessment	Other Tags to be considered	• F552 Right to be Informed
F637	Significant Change		• F580 Notification of Change
			• F635 Admission Orders

P

**What are the Expectations from a Regulatory Perspective**

CMS's RAI Version 3.0 Manual CH 3: MDS Items [M]

**READ/Learn SECTION M!!!**

**SECTION M: SKIN CONDITIONS**

**Intent:** The items in this section document the risk, presence, appearance, and change of pressure ulcers/*injuries*. This section also notes other skin ulcers, wounds, or lesions, and documents some treatment categories related to skin injury or avoiding injury. It is important to recognize and evaluate each resident's risk factors and to identify and evaluate all areas at risk of constant pressure. A complete assessment of skin is essential to an effective pressure ulcer prevention and skin treatment program. Be certain to include in the assessment process, a holistic approach. It is imperative to determine the etiology of all wounds and lesions, as this will determine and direct the proper treatment and management of the wound.

Gordian Medical Inc.,  
dba American Medical Technologies 12 AMT Education  
Division

[www.amtwoundcare.com](http://www.amtwoundcare.com)

P

**MDS and PU/PI Risk  
Determination and Reporting**

**NOTE: Literature mentions more than  
100 risk factors for Pressure Ulcer/Injuries!!!**

**M0100: Determination of Pressure Ulcer/Injury Risk**

M0100. Determination of Pressure Ulcer/Injury Risk	
↓ Check all that apply	
<input type="checkbox"/>	A. Resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device
<input type="checkbox"/>	B. Formal assessment instrument/tool (e.g., Braden, Norton, or other)
<input type="checkbox"/>	C. Clinical assessment
<input type="checkbox"/>	Z. None of the above

Gordian Medical Inc.,  
dba American Medical Technologies

13  
www.amtwoundcare.com

**AMT** Education  
Division

J

**MO100C  
What Should Be Included in the Assessment**

- **Examples** of risk factors include the following:
  - impaired/decreased mobility and decreased functional ability **Braden**
  - co-morbid conditions, e.g. end stage renal disease, thyroid disease, or diabetes;
  - drugs, such as steroids, that may affect wound healing;
  - impaired diffuse or localized blood flow (e.g., generalized atherosclerosis or lower extremity arterial insufficiency); **Pulse Ox!!!**
  - resident refusal of some aspects of care and treatment;
  - cognitive impairment;
  - urinary and fecal incontinence; **Braden**
  - malnutrition and hydration deficits; **Braden**
  - healed PUs, esp. Stage 3/4 which are more likely to have recurrent breakdown

Gordian Medical Inc.,  
dba American Medical Technologies

14  
www.amtwoundcare.com

**AMT** Education  
Division

CMS  
SOM  
F886

## CMS Pressure Ulcer/Injury MDS Definition<sup>J</sup>

### • PRESSURE ULCER/INJURY

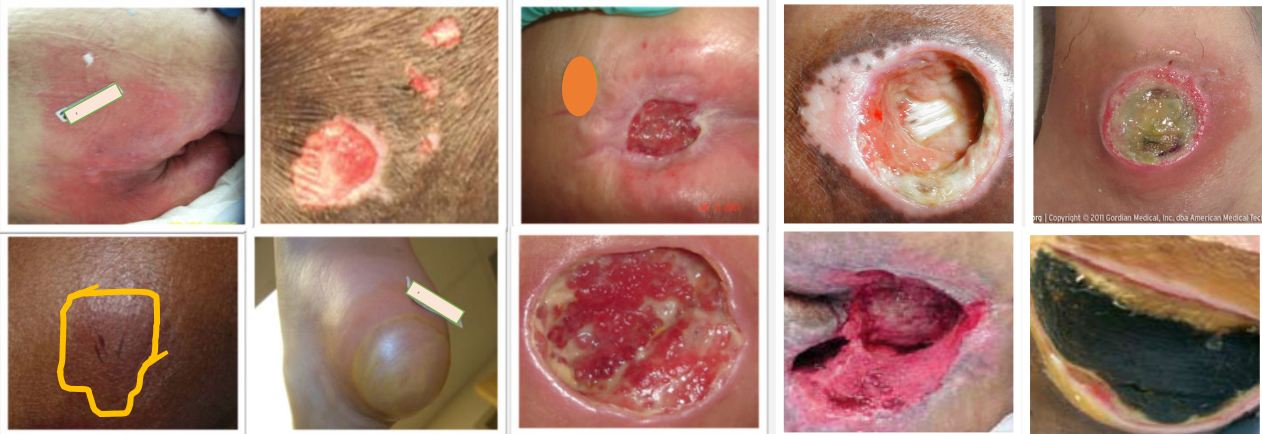
- A pressure ulcer/*injury* is localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of *intense and/or prolonged* pressure or pressure in combination with shear. *The pressure ulcer/injury can present as intact skin or an open ulcer and may be painful.*
- The pressure ulcer/injury definitions used in the RAI Manual have been **adapted** from those recommended by the National Pressure Ulcer Advisory Panel (NPUAP) 2016 Pressure Injury Staging definitions.
- Current definitions from CMS call Stage 1 and a deep tissue pressure injury (intact skin) are termed **'injury'** and an open wound, Stage 2,3,4, and unstageable are termed **'ulcer'**.

Gordian Medical Inc.,  
dba American Medical Technologies

15  
www.amtwoundcare.com

AMT Education  
Division

## Pressure Ulcer Stages



Stage 1

Stage 2

Stage 3

Stage 4

Unstageable

Gordian Medical Inc.,  
dba American Medical Technologies

16  
www.amtwoundcare.com


AMT Education  
Division




**MDS M-Section**

## What Does the MDS Say About Blood-Filled Blisters <sup>J</sup>

- *Examine the area adjacent to or surrounding an intact blister for evidence of tissue damage.*
- *If other conditions are ruled out and the tissue adjacent to, or surrounding the blister demonstrates signs of tissue damage, (e.g., color change, tenderness, bogginess or firmness, warmth or coolness) these characteristics suggest a suspected deep tissue injury (DTI) rather than a Stage 2 Pressure Ulcer.*



**Stage 2  
Serum filled blister**



**Deep Tissue Injury  
Blood-filled blister with evidence of surrounding tissue damage**

Gordian Medical Inc., dba American Medical Technologies 17 **AMT** Education Division  
www.amtwoundcare.com

**Surveyors:** Use this pathway for a resident having, or at risk of developing, a pressure ulcer (PU) or pressure injury (PI) to determine if facility practices are in place to identify, evaluate, and intervene to prevent and/or heal pressure ulcers.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

### Pressure Ulcer/Injury Critical Element Pathway

**Given the exam before the test.**

Use this pathway for a resident having, or at risk of developing, a pressure ulcer (PU) or pressure injury (PI) to determine if facility practices are in place to identify, evaluate, and intervene to prevent and/or heal pressure ulcers.

**Review the following in Advance to Guide Observations and Interviews:**

- The most current comprehensive MDS/CAAs for Sections C - Cognitive Patterns, G - Functional Status, H - Bladder and Bowel, J - Health Conditions-Pain, K - Swallowing/Nutritional Status, M - Skin Conditions-(including history of a pressure ulcers or pressure injuries), and pressure relieving devices.
- Physician's orders (e.g., wound treatment) and treatment record (TAR).
- Pertinent diagnoses.**
- Care plan (e.g., pressure relief devices, repositioning schedule, treatment, scheduled skin/wound inspection, or pressure ulcer or pressure injury history).

Gordian Medical Inc.,  
dba American Medical Technologies

18  
www.amtwoundcare.com

**AMT** Education Division

# Focus of Presentation

U.S. Department of Health & Human Services

Home About Us Careers Contact Us Español FAQ Email Updates

**AHRQ** Agency for Healthcare Research and Quality  
Advancing Excellence in Health Care

Topics Programs Research Data Tools Funding & Grants News About

Home > Programs > Hospitals & Health Systems

Clinicians & Providers

Education & Training

Hospitals & Health Systems

- Hospital Resources
- Long-term Care Resources
- National Center for Excellence in Primary Care Research
- MONAHRQ
- System Design Resources

**AHRQ's Safety Program for Nursing Homes: On-Time Pressure Ulcer Prevention**

ALTERNATE FORMATS

- PDF version - 318.57 KB
- Microsoft Word version - 41.98 KB

**Self-Assessment Worksheet for Pressure Ulcer Prevention**

The Self-Assessment Worksheet is designed to help staff review how they currently identify residents who have experienced a change in pressure ulcer risk, how they determine if new clinical interventions are needed, and how they determine what those interventions are. The self-assessment tool is intended to help identify the current processes and structures the nursing home uses to prevent pressure ulcers and identify gaps and places for improvement. It is intended to help staff think about ways to transform these processes and how to begin to use the pressure ulcer prevention reports in clinical discussions. The self-assessment tool is an important first step in implementing the reports into current workflow.

Gordian dba Ame Education Division

## On-Time Pressure Ulcer Prevention Self-Assessment Worksheet/Tool

- Designed to help staff review:
  - how they currently identify residents who have experienced a **change in pressure ulcer risk**;
  - how they determine if new clinical interventions are needed;
  - how they determine what those interventions are.
- Help identify **current processes and structures** nursing home uses to prevent pressure ulcers
- Identify gaps and places for improvement

## Who, What, When, Where?

P

- Where are we in relation to the clinical and regulatory expectations?
- Where do I find documents that tell us about the clinical and regulatory expectations?
- What tools are there that can assist us in putting a pressure ulcer prevention and treatment program in place that meets the clinical and regulatory guidelines?
- Who in the building/s needs to know what the clinical and regulatory expectations?
- Where do we start?
- How do we know when we're making progress?

## Tool has Four Section

P

- Section 1: Screening for Pressure Ulcer Risk
- Section 2: Pressure Ulcer Prevention Plan
- Section 3: Communication Practices
- Section 4: Investigations/Root Cause Analysis of Pressure Ulcer Development

J

## Section 1:

# Screening for Pressure Ulcer Risk

What's do your pressure ulcer risk assessment activities look like?

J

## 1. Does your facility have a **pressure ulcer risk policy**?

- If no, skip to question 3.

## 2. If yes, does the policy include the following:

	Yes	No
a. Clinical areas to be covered	<input type="checkbox"/>	<input type="checkbox"/>
b. Timing or frequency of assessments	<input type="checkbox"/>	<input type="checkbox"/>
c. Documentation requirements	<input type="checkbox"/>	<input type="checkbox"/>
d. Communication to care team	<input type="checkbox"/>	<input type="checkbox"/>

- **NOTE: Recommendation from NPUAP and CMS that EVERY building/organization have a pressure ulcer risk assessment policy.**

3. Does your facility **provide training** to nursing staff on how to accurately assess for pressure ulcer risk? J

Yes or NO

**NOTE: NOT asking if your nurses came to you trained in the Braden or other risk assessment; question is: are YOU providing training in your building? Competencies suggested.**

4. Does the pressure ulcer risk assessment use a standardized assessment tool (for example, Braden score or Norton tool)? J

Yes  No  If yes, skip to Question 6.

**NOTE:** You can do a PU/PI risk assessment without doing the Braden or any other formal tool. You can simply review the medical record and extract each risk factor in the records, interview the resident and family for other risk factors.

Or you can **do the Braden AND review the medical record and interview the resident and family.**

You **CANNOT ONLY perform the Braden** and expect to pick up all the pressure ulcer/injury risk factors.

## 5. If not using a standardized tool, does the assessment tool that the facility uses cover the following: J

	Yes	No
a. Impaired mobility	<input type="checkbox"/>	<input type="checkbox"/>
b. Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
c. Nutritional deficits	<input type="checkbox"/>	<input type="checkbox"/>
d. Diabetes diagnosis	<input type="checkbox"/>	<input type="checkbox"/>
e. Peripheral vascular disease diagnosis	<input type="checkbox"/>	<input type="checkbox"/>
f. Contractures	<input type="checkbox"/>	<input type="checkbox"/>
g. History of pressure ulcers	<input type="checkbox"/>	<input type="checkbox"/>
h. Paralysis	<input type="checkbox"/>	<input type="checkbox"/>

**NOTE: This is NOT a complete list of the risks for PU/PI.**

Gordian Medical Inc.,  
dba American Medical Technologies

27  
www.amtwoundcare.com

**AMT** Education  
Division

## 6. How frequently is the risk assessment tool completed? J

- a.  Monthly
- b.  Quarterly
- c.  Annually
- d.  Change of condition
- e.  Other (specify): \_\_\_\_\_

Gordian Medical Inc.,  
dba American Medical Technologies

28  
www.amtwoundcare.com

**AMT** Education  
Division

## 7. When are residents screened for pressure ulcer risk? J Check all that apply.

- a.  Upon admission/readmission
- b.  With a change in condition
- c.  With each MDS assessment
- d.  When weight loss has occurred
- e.  Change in meal intake
- f.  Change in fluid intake
- g.  Change in mobility
- h.  Change in continence
- i.  Change in communication

## 8. Do your facility's pressure ulcer risk assessment activities include a comprehensive skin assessment/inspection? J

Yes  No

*\*A comprehensive skin assessment is defined as a full head to toes front and back assessment of the skin, the body's largest organ, for any breakdown or reddened areas. This includes attention to all bony prominences, ears, scalp, in between toes, etc.*

## 9. Who completes the skin assessment/inspection on admission? J

- a.  Admitting nurse
- b.  Nursing assistant
- c.  Wound/skin care nurse
- d.  Nurse manager
- e.  Nursing supervisor
- f.  Director of nursing
- g.  Other (specify)\_\_\_\_\_

## 10. Who completes routine skin assessments/inspections? J

- a.  Unit nurse
- b.  Nursing assistant
- c.  Wound care nurse
- d.  Other (specify): \_\_\_\_\_



## 11. How often are skin assessments/inspections completed?

J

- a.  Daily
- b.  Weekly
- c.  Monthly
- d.  Other (specify): \_\_\_\_\_

## 12. Where are skin assessment/inspections documented?

J

- Correlate these questions to PU Clinical Element Pathway.

- a.  Medical record
- b.  Nursing assistant documentation
- c.  Skin assessment form
- d.  Other (specify):\_ \_\_\_\_\_

13. Do you screen all residents for pressure ulcer risk at the following times:

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| a. Upon admission                      | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| b. Upon readmission/reentry            | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| c. When there is a change in condition | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| d. With each MDS assessment            | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

14. If the resident is not currently deemed at risk, is there a plan to rescreen at regular intervals?

Yes  No

- Do you have patients/residents who **are NOT** at risk for PU/PI in your buildings?
- Describe the residents **who are NOT** at risk for pressure ulcer/injury in your building/s?

## 15. Do you screen residents for pressure ulcer risk with the following diagnoses?

- |                                |                              |                             |
|--------------------------------|------------------------------|-----------------------------|
| a. Diabetes mellitus           | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| b. Peripheral vascular disease | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| c. History of pressure ulcer   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| d. Paralysis                   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Understand peripheral vascular disease (PVD) has, in the past and to some health care providers currently, means **peripheral arterial disease** and **venous insufficiency**. In this context it may mean PAD only. Not sure of interpretation by AHRQ.

## Section 2:

### Pressure Ulcer Prevention Plan

What's included in your pressure ulcer prevention care plan?

1. Do you develop a care plan for residents **at risk** of developing a pressure ulcer? <sup>P</sup>

Yes  No

If not, skip to Section 3

### Braden Scores

**At Risk** = 15 - 18

**Moderate Risk** = 13 - 14

**High Risk** = 10 - 12

**Very High Risk** = 9 or below



**NOTE:** At risk does NOT mean NO risk. At risk is a LOW risk that means there IS a risk for Pressure Ulcer/Injuries

Think about our patient population. How many of our residents are NO RISK???

2. Does your plan include interventions for **skin care**? <sup>P</sup>

Yes  No

3. Does your plan include daily skin assessment of pressure points? P

Yes  No

3A. Does your daily assessment assess the following areas?

- |                     |  |
|---------------------|--|
| a. Sacrum           | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| b. Ischium          | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. Trochanters      | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| d. Heels            | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| e. Elbows           | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| f. Back of the head | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| g. Ears/nose        | Yes <input type="checkbox"/> No <input type="checkbox"/> |

• Does your plan include interventions addressing **nutrition and hydration**? P

Yes  No

4A. Does your plan include interventions to address:

a. Feeding or swallowing difficulties  Yes  No

b. Undernourishment (e.g., weight loss, decreased meal intake)

Yes  No

5. Does your plan include a **nutritional screen** for residents **at risk** of developing a pressure ulcer? <sup>P</sup>

Yes  No

5A Does the screen include any of the following:

- |   |  |
|---|--|
| a. Estimation of nutritional requirements                             | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| b. Comparison of nutrient intake with estimated requirements          | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. Recommendation for frequency of reassessment of nutritional status | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| d. Weight pattern change summary                                      | Yes <input type="checkbox"/> No <input type="checkbox"/> |

6. Does your plan include an assessment for **pain**? <sup>P</sup>

Yes  No

7. Does your plan include an assessment for **decreased mental status**?

Yes  No

8. Does your plan include an assessment for **incontinence**?

Yes  No

P

## 9. Does your plan include an assessment for medical device-related pressure?

Yes  No

### 9A. Do recommendations for positioning include the following?

- a. Dealing with medical devices (oxygen tubing, catheters)
- b. Guidance for avoiding friction and shear
- c. Support surfaces
- d. Frequency of repositioning

Gordian Medical Inc.,  
dba American Medical Technologies

45  
www.amtwoundcare.com

**AMT** Education  
Division

CMS  
SOM  
F886

## New Definition

P

### Medical Devices Related Pressure 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.**



Bed pan medical device  
related pressure injury  
Stage 2

**MUST be staged.**

Courtesy: Dot Weir



Oxygen tubing medical  
device related pressure injury  
Stage 2

**MUST be staged.**



- TED hose not removed for several days
- Caused full-thickness Stage 4 Medical Device Related PU/PI

Gordian Medical Inc.,  
dba American Medical Technologies

10. Does your plan include an assessment for friction and shear?

Yes  No

This question relates directly to <sup>P</sup>immobility.  
If there is immobility requiring assisting with transfers or positioning, then the resident is at risk for friction and shear.

10a. Does your plan include an assessment for muscle spasms?

Yes  No

11. Does your plan include an assessment for immobility?

Yes  No

12. Does your plan include an assessment for contracture?

Yes  No



J

## Section 3: Communication Practices

- How do you communicate the pressure ulcer risk and prevention care plans to the **interdisciplinary team**?
- For every meeting that occurs at your facility, indicate how often it occurs, who leads the meeting, and who attends.

## Communication Practices 1

J

Meeting	Pressure Ulcer Prevention Discussed Yes/No	Meeting Chair/Leader Name and Discipline	Staff Invited and in Attendance (indicate A – Always, V- Varies as needed)	Frequency of Meeting (Weekly, Biweekly, Monthly, Quarterly, Change in Condition, As Needed)
a. Care plan review				
b. Report or brief with CNAs				
c. Report or brief with department heads				
d. Medical staff				
e. QAPI* or performance improvement plan meeting				
f. Skin or wound meeting				
g. MD/APRN* rounds				
h. Report or brief with Dietary Department				
i. Report or brief with Social Services Department				
j. Report or brief with Therapy Department				
k. Report or brief with "Other"				

\* QAPI = Quality Assessment and Performance Improvement; APRN = advanced practice registered nurse.

## Communication Practices: 2. Training J

Indicate the date of the most recent training provided: for the following:

	Topic	Participants	Date
a.	Conducting an accurate skin assessment	Nurses	
b.	Conducting an accurate skin sweep/check	CNAs	
c.	Effective positioning	Nurses	
d.	Effective positioning	CNAs	
e.	Skin care	CNAs	
f.	Documentation—meal and fluid intake	CNAs	
g.	Documentation—positioning	CNAs	

## Section 4: Investigations/Root Cause Analysis of Pressure Ulcer Development P

## Root Cause Analysis and Pressure Ulcer/Injury

**Root Cause Analysis (RCA)** is a well-recognized way of offering a framework for reviewing patient safety incidents (also investigations, and complaints). This process can identify what, how, and why patient safety incidents such as **pressure ulcer(s)** have happened.



P

1. Do you investigate each new in-house pressure ulcer according to your facility's policies and guidelines? Yes  No  Not Sure

2. Do you investigate each new in-house pressure ulcer in a root cause framework?

Yes  No  Not Sure  **If no or not sure, stop here.**

P

3. In the course of your root cause analysis, do you look at the most recent pressure ulcer risk screen?

Yes  No

If yes, how do you check the accuracy of that screen?

4. In the course of your root cause analysis, do you check to see if the risk status of the resident has changed? P

Yes  No

If yes, would your investigation include any of the following factors as affecting risk for a pressure ulcer? Check all that apply.

- a.  Change in condition
- b.  Weight loss
- c.  Change in meal intake
- d.  Change in fluid intake
- e.  Change in mobility
- f.  Change in continence
- g.  Change in ability to communicate pain
- h.  Other (specify): \_\_\_\_\_
- i.  Other (specify): \_\_\_\_\_

Who does EACH of these tasks in your building?

5. Check the assessments below that you would do to identify appropriate interventions to address **pressure ulcer risk** as part of your root cause analysis. P

Who will do each of these assessments?

How will these assessments be done? What tools will you use?

- a.  Nutrition assessment for a resident with decreased meal or fluid intake
- b.  Nutrition screen for a resident at risk of developing a pressure ulcer
- c.  Pain assessment
- d.  Cognitive assessment
- e.  Incontinence assessment
- f.  Medical device-related pressure assessment (e.g., oxygen tubing, catheters)
- g.  Assessment for friction and shear
- h.  Mobility assessment
- i.  Contracture assessment
- j.  Assessment for appropriate bed and chair support surfaces
- k.  Positioning assessment
- l.  Skin assessments per frequency designated by MD/NP
- m.  Other (specify): **Cardiovascular, pulmonary assessments**
- n.  Other (specify): \_\_\_\_\_

6. Assessments may reveal that a particular action should be taken (e.g., a toileting routine to prevent incontinence, diet change to encourage increased intake, new cushion for wheelchair). **How would you find out if an intervention had been identified as necessary, but not carried out?**

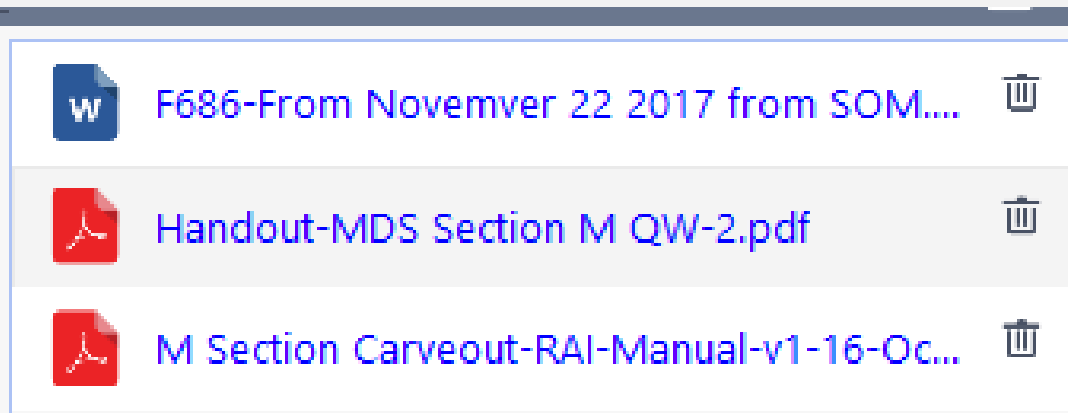
P

7. Are there any particular obstacles or challenges to investigating the root cause of pressure ulcers?

P

How would you answer this for your building?

- Look in the **Handouts** Section on Your Webinar Platform. <sup>L</sup>  
Download the handouts for future reference and teaching of others.



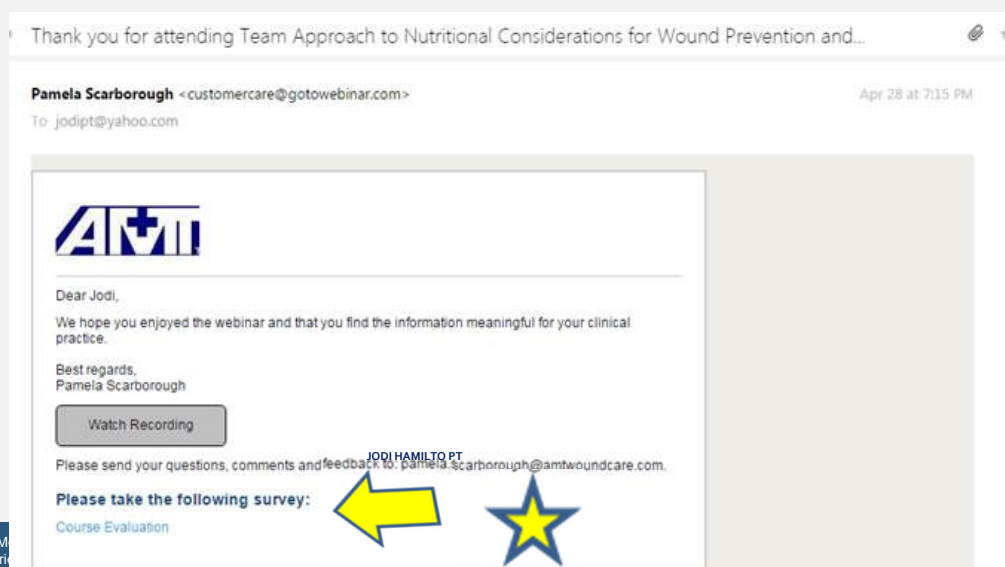
## Summary

- For a successful PU/PI program a well-constructed system must be in place which includes your policies and procedures.
- Everyone in the building should be aware and committed to the processes and expectations of the program.
- Training and education **MUST** be provided, including competencies.
- Root cause analysis is the construct to assist in identifying where the system breaks down.

## Nursing CE Requirements

- Each person must be logged in separately to obtain nursing continuing education credit
- Each person required to stay logged in until the webinar is finished (this will be tracked)
- Participant must fill out the survey from **Survey Monkey** completely which will be sent to you in a post-webinar follow up email
- Certificates will be emailed to the email address participants used to log into the webinar approximately 4 weeks after the evaluations are completed

## Your Follow-Up Email for Contact Hours





## References

L

1. On-Time Pressure Ulcer Prevention-Self-Assessment Worksheet for Pressure Ulcer: Agency for Healthcare Research and Quality. 2017. Accessed 02/02/2019
  2. State Operations Manual Appendix PP-Guidance to Surveyors for Long Term Care Facilities (Rev. 11-22-17. Sections F658, F684, F686, F687.
  3. Section M: Skin Conditions. CMS's RAI Version 3.0 Manual. October 2018
  4. Pressure Ulcer/Injury Critical Element Pathway. Department of Health and Human Services-Centers for Medicare & Medicaid Services. 05/2017. Accessed 02/02/2019
- **Root Cause Analysis (RCA) Concise Investigation Report: Pressure Ulcer (PU) document. PDF or Word document (allows you to customize specific for your facility.**

## Resources

L

- <https://www.ahrq.gov/professionals/systems/long-term-care/resources/ontime/pruprev/saworksheet.html#sect4>
- **NPUAP Root Cause Analysis: Instructions and Form. National Pressure Ulcer Advisory Panel.**  
<http://www.npuap.org/resources/educational-and-clinical-resources/rca-template-2019/>

**Thank You!!!**

Gordian Medical Inc.,  
dba American Medical Technologies

67  
[www.amtwoundcare.com](http://www.amtwoundcare.com)

**AMT** Education  
Division