Staff Educational Training Program and Toolkit

Quality Measure 403/453

Pressure Injury Prevention and Management

July 2019

TEXAS
Health and Human Services

Table of Contents

Introduction

Overview of Problem, Impact of Problem, and Those Affected

Pressure injuries (PI) present a serious health problem for nursing home residents, and can be a major indicator of the facility's quality of care. According to CMS research, pressure injuries are significant health issues and poses significant challenges to health facilities on a daily basis. Along with high cost of treatment, pressure injuries can also have a great impact on residents' lives and on the provider's ability to provide a quality of care to their residents.

CMS further emphasizes that research has shown that in skilled nursing facilities, 80 percent of pressure injuries 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/). Additional information can be found on the NPUAP website at https://www.npuap.org/resources/educational-and-clinical-resources

This training emphasizes the importance to evaluate, treat and manage residents with admitting pressure injuries and preventing further pressure injuries. According to the State Operations Manual Appendix PP- Guidance to Surveyors for Long Term Care Facilities, a nursing facility admission evaluation helps identify residents at risk of developing pressure injuries and residents with exiting PIs. Research shows that a resident at risk for skin breakdown can develop a PI within hours of onset of pressure, and interventions should be implemented promptly to prevent PIs. Federal regulation lists examples of resident risk factors for pressure injuries/ulcers[1]:

- 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.

In fiscal year 2015, over 90,000 people were living in Texas nursing facilities (NFs) and are the focus of this toolkit[2].

Reason for the Training Program Toolkit

This training program/toolkit will provide an evidence-based approach and resources to develop a system that implements consistent and sustained measures to prevent, treat, and heal pressure ulcers. To address prevention, treatment and sustained skin integrity program, a root cause analysis, all parts of the infrastructure (different disciplines working with the resident) will need to be addressed. Four specific pieces of the system that influence the care that is provided to facility residents (prescriber, nursing, dietary, and the certified nurse aide).

This training program/toolkit will provide an approach to working with these disciplines to address any educational deficit that was noted in the root cause analysis. Ensuring that these four disciplines receive comprehensive education will help eliminate practices noted in each discipline as common practice.

Once all these resources are put together, all Texas NFs will be able to take the training program/toolkit, in its entirety, and educate their staff so that they can integrate the necessary assessments, care plans, nursing and physician services into the plan of care that they provide for the residents.

[1]State Operations Manual Appendix P-Guidance to Surveyors for Long Term Care Facilities
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

[2]Data includes estimates from the Medicare Current Beneficiary Survey, the National Vital Statistics System Mortality Files, the National Electronic Injury Surveillance System -- All Injury Program, and the Behavioral Risk Factor Surveillance System. Retrieved 05/16/19

Section 1: Orientation to the Training Program/Toolkit

Orientation to the Training Program/Toolkit

This training program/toolkit will provide NFs with regulatory requirements and information related to pressure injury prevention and management including:

- What it is:
- Assessment of the Resident:
- Prevention:
- Management:
- Staff Roles:
  - Direct Care Staff (CNA)
  - Nursing
  - Dietitian
  - Physician
  - Administrative Staff
- Handling the issue:
- Resources:
  - Evidence Based Practices from nationally known sources
    - ✓ National Pressure Ulcer Advisory Panel
    - ✓ National Nursing Home Quality Improvement Campaign
    - ✓ AMDA: The Society for Post-Acute and Long-Term Care Medicine
    - ✓ Centers for Medicare and Medicaid Services (CMS)
    - ✓ American Geriatrics Society (AGS)
    - ✓ National Nursing Home Quality Improvement Campaign
    - ✓ Texas Administrative Code Rules
    - ✓ State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities

Instructions on Use of the Training Program/Toolkit

In order to effectively use this training program/toolkit, it is imperative that the NF staff conduct a root cause analysis[1] (RCA) related to a deterioration of skin integrity. This analysis will be used to determine why the resident developed a pressure injury(s), and what changes need to be made to ensure that these residents don't continue to develop pressure ulcers while providing the highest level of care possible. RCA can be an early step in a performance improvement project (PIP), helping to identify any necessary changes to improve performance. Once necessary changes are identified, the steps that are followed are the same as those that would be used in any type of PIP.

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[1] Guidance for Performing Root Cause Analysis (RCA) with Performance Improvement Projects (PIPs). https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/guidanceforrca.pdf

Seven Steps to RCA

Use the following steps to walk through a RCA to investigate problems/situations:

1. Identify the problem/situation to be investigated and gather preliminary information: Problems/situations can be the result of many different things. There should be a process in place to determine which problems/situations will undergo an RCA.
2. Charter and select team facilitators and team members: Leadership should provide a project charter to launch the team. The facilitator is appointed by leadership. The team members involved should be those with personal knowledge of the processes and systems involved in the problem/situation that is being investigated.
3. Describe what happened: Collect and organize the facts related to the problem/situation to fully understand what happened.
4. Identify the contributing factors: Determine what other situations, circumstances, or conditions increased the likelihood of the problem/situation.
5. Identify the root cause: A thorough analysis of contributing factors leads to identification of the underlying process and system issues (root causes) of the problem/situation.
6. Design and implement changes to eliminate the root causes: The team works together to determine how best to change processes and systems to reduce the likelihood of another similar problem/situation.
7. Measure the success of changes: Like all improvement projects, the success of improvement actions need to evaluated.

RCA Tools

There are many tools that can be used when conducting RCA. The tool you ultimately use depends on which one works best for the current problem/situation. These tools include:

1. Five Why Analysis[2]: A tool to drill down to the root cause of a problem by asking "why" five times. The purpose of the 5 Why's is not to arrive at a single root cause but to uncover as many contributing why's as possible, as most complex healthcare problems are multifactorial.
2. Brainstorming[3]: Bringing together a group of people to jointly discuss the problem/situation in a facilitated manner. It is important that the individuals brainstorming have some knowledge about the problem/situation. It is important to encourage as much participation as possible. When facilitating brainstorming it is best to have a flip chart and markers, but it can be done with

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[2] Determine the Root Cause: 5 Whys. https://www.isixsigma.com/tools-templates/cause-effect/determine-root-cause-5-whys/
[3] DADS Quality Monitoring Conference April 2014. Melody Malone-Brainstorming.

a white board and have someone take notes of what was recorded. Be sure to go around the room and ask each person to throw out an idea without having anyone else comment (positively or negatively) on the idea. The faster you move, the more the participants will add ideas and be encouraged to speak up. The wilder the better, because you never know which idea may be THE ONE that is the solution. Silent brainstorming works as well to generate ideas. Give the team a pad of paper or sticky notes and ask them to write down all of their ideas, one on each page. Collect all of the papers and work with the team to group similar ideas and confirm meanings to anything that might not be clear.

3. Fishbone Diagram[4]: Also known as a cause and effect diagram, this tool can be used to identify the many possible causes for a problem. Using a fishbone diagram allows for ideas to be sorted into useful categories.

More information and resources related to RCA are available through the Institute for Healthcare Improvement (IHI). The Quality Improvement Essentials Toolkit[5] can be accessed here: http://www.ihi.org/resources/Pages/Tools/Quality-Improvement-Essentials-Toolkit.aspx. Registration is required to access the toolkit.

Once the RCA has been completed, processes must be put into place to eliminate the root cause of the problem/situation. This can best be accomplished through the use of Evidence-Based Practices (EBP).

RCA Example

In performing a RCA, all of the issues should be identified to be addressed. The root cause of the resident who developed a pressure injury could be such as staffing issues/turnover, an underdeveloped workforce, pre-licensure/certification requirements, and a lack of attention paid to the future workforce - youth.

In order to affect change with the issue of pressure injuries, the facility's administration and nursing should improve quality of care for NF residents, and improve quality measure (QM) data related to skin integrity management.

When performing a RCA, the issue should be taken into consideration; however much more focus must be placed on the cause rather than the effect.

How to Use the Resource Toolkit

Once you have received the training program/toolkit, you will want to read through the material as it will begin by providing you with general information related to the

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[4] Fishbone (Ishikawa) Diagram http://asq.org/learn-about-quality/cause-analysis-tools/overview/fishbone.html
[5] Institute for Healthcare Quality Improvement: Quality Improvement Essentials Toolkit. http://www.ihi.org/resources/Pages/Tools/Quality-Improvement-Essentials-Toolkit.aspx

topic of management of skin integrity. As you read through the information you will notice that there is specific information related to how to assess the resident, ways to decrease risk factors, steps to take towards prevention, alternate interventions that are recommended for the residents and how to care for the resident if they come to the facility with pressure injuries.

The roles of the different disciplines providing care for the residents are also described. As you go through the training program/toolkit you will want to note the specific role that each of your staff may have with regards to improvements in the QMs. This information may be used to create in-service educational trainings for your staff to provide them with the knowledge needed to make changes to the care provided to the residents.

Additionally you will find that there are sample assessments, sample care plans, and algorithms in this training program/toolkit that will allow your staff to have a better understanding of how best to assess resident risk factors, provide care for the residents, and how to evaluate the resident for different issues that could lead to a decrease in care based on the quality measures.

As you review the training program/toolkit, if there is information that is not available that you would like to use in coordinating training for your staff, there are resource lists at the end where additional information may be obtained.

Organizational Change

As you use the toolkits in your facility, it is important that the changes made to the processes related to the QIPP QMs are sustainable. The best way to ensure sustainability is to make the changes at the system level versus the person level. As you continue below, you will find how this can best be accomplished.

System Change vs. Person Changes

As change begins to be implemented in your facility, it is important that the change is made at a systemic level and not just the staff level. What does this mean? Well it quite simply means that it is not enough to only train the staff on the changes that are being made throughout the NF, but to put in to place policies and procedures that reflect those changes as well. When an NF experiences staff turnover, change that has been made at the staff level tends to be lost as a result.

The only effective way to ensure that the change will be maintained is to imbed it throughout the NF policies and procedures that detail the way that the NF will

operate. How can an NF best put practices into operation? To guide the changes that will be needed, ask the following four questions[6]:

1. How do we manage the change process at the front line? Staff will need to understand their new roles and have the knowledge and resources to carry them out. To manage the change process effectively, an Implementation Team will need to guide, coordinate, and support the implementation efforts as the new practices roll out across the NF.

2. How do we put in to place new practices? It may be helpful to begin the change process in just one area of the NF to determine if it will be effective before rolling it out facility-wide. If changes need to be made, they get made prior to NF wide roll-out. Once the change has been rolled out across the NF, observe for problems or issues that may hamper successful implementation of the change.

3. How do we get staff engaged and excited about the changes? Engaging the buy-in, commitment, and ongoing participation of staff members is particularly important for staff who are involved in hands-on care and whose involvement will be needed to achieve implementation of the change. An important aspect of engaging staff and is key to success in any change made at a systemic level is clear communication. Be sure staff know the change is coming and are familiar with the available resources and their new roles prior to the change taking place.

4. How can we help staff learn new practices? Once the initial change takes place, assess what educational needs staff have. Providing this education will enhance their knowledge. Any and all plans for new staff education related to the changes being made in the NF should be worked out in close collaboration with experts on the content.

The most important concept in organizational change is to ensure that it is sustainable. This can only happen if the change is made at the system level in the form of policies and procedures, as these will not leave the NF as turnover happens like it will if the changes are made at the staff level.

Empowerment

As you work through making changes in your facility to improve the quality of care for your residents, it is important that your staff feel empowered to assist in the implementation of the changes. As you read through the below, information will be provided to you defining what empowerment is and the benefits that it will have on your staff.

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[6] Preventing Pressure Ulcers in Hospitals.
https://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/putool4a.html

Empowerment is a practice of sharing information, rewards, and power with employees so that they can take initiative and make decisions to solve problems and improve service and performance. The concept of empowerment is based on the idea that giving employees skills, resources, authority, opportunity, motivations, as well as holding them responsible and accountable for outcomes of their actions will contribute to their competence and satisfaction. Empowering staff gives them a:

- Sense of meaning - the staff cares about what they are doing and ultimately, they feel as if their work is important.
- Sense of competence - staff members are confident in their abilities to do their job. They are trusted to do their job right.
- Sense of determination - they are able to choose how to do the work that they have been assigned to do and they are determined to do a good job for their residents.
- Sense of impact - the work they are doing has a positive impact on the lives of their residents as well as their own. They ultimately become comfortable taking risks to improve day-to-day operations.
- Sense of ownership, commitment, and teamwork - no one staff member works by him/herself; everyone works together to ensure the best care is given. Peers are comfortable with challenging each other to be the best they can be.
- Tolerate imperfections - understanding that as humans, mistakes are inevitable and that no one is perfect.
- Accountability - being accountable for the choices one makes, understanding that in many instances, the results of the choices made can be used as learning opportunities for the future.

Empowerment can't be delegated. It is possible to develop an empowering environment where people will take the initiative to empower themselves. Changes are seen as opportunities for growth.

Use of Standardized Assessment Tools to Determine Understanding
When looking in to any type of training, it is important to ensure that those receiving the training understand what they have been taught. The best way to do this is through the use of a standardized assessment tool. This could be a pre and post-test on the information, questionnaire set, or case study. In the cases of comprehensive resident assessment and comprehensive care plan, there is research to support several different types of assessment tools. Two such tools will be discussed in this training program/toolkit:

Target Audiences
This training program/toolkit is designed to be used with any NF staff member, including the direct care workers (Nurse Aides, Restorative Aides, etc.), Licensed

Vocational Nurses (LVNs), Registered Nurses (RNs), Dietitians, NF Administrators, Activities Staff, Social Workers, Housekeeping Staff, and Maintenance Staff. It is important that when changes are made in the NF that they are made at the system level and not the person level; it is possible that the changes will not be sustained if the person leaves the organization. Providing this training to all the staff in the NF and ensuring that the changes are reflected in the facility's policies and procedures is the most effective way to ensure that changes will be made and sustained going forward.

Section 2: Overview of the Population

The population residing in a NF is primarily made up of older adults. In many instances, these residents have chronic illnesses and diagnoses.
Pressure injuries[7] are localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as either intact skin or an open ulcer and will often be very painful.

Pressure injuries can happen anywhere on the body, however, they are more common where there are bony areas, depending on the way in which the person is positioned. The common sites for pressure injuries include:
- Back of the head
- Shoulders
- Elbows
- Buttocks
- Ears
- Hips thighs
- Legs
- Heels
- Rib cage
- Knees
- Toes
- Base of the spine

There are three main factors that may lead to the development of a pressure injury. Each of these
factors may occur independently of the other two:
- Pressure: body weight can squash the skin and interrupt or block the blood supply to the area. This can lead to tissue damage.
- Shearing: when layers of the skin are pulled in opposite directions, for instance if you slip down the bed or your buttocks are dragged rather than lifted when transferring.
- Friction: when the surface of the skin rubs against a firm surface (often results in a water blister). This can be caused by severe spasm.

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[7] National Pressure Ulcer Advisory Panel (NPUAP) Pressure Injury Stages.
http://www.npuap.org/resources/educational-andclinical-resources/npuap-pressure-injury-stages/

Staging Pressure Injuries

Pressure injuries can be classified by stages; 1 through 4, deep tissue injury (DTI) or unstageable, depending on the characteristics of the injury. Staging for pressure injuries is based on the following:

Stage 1: Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.

Stage 2: Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).

Stage 3: Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury

Stage 4: 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. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Unstageable: Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, and intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.

Deep Tissue Pressure Injury: Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature

change often precede skin color changes. 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 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 injury (Unstageable, Stage 3 or Stage 4).

Overview of Person-Centered Care

Person-centered care[8] is a care concept that recognizes that individuals have unique values, personal histories and personalities and that each person has an equal right to dignity, respect, and to participate fully in their environment. In person-centered care, it is important to remember that all individuals are typically the same now as they were when they were younger, in that most often they still have the same goals for their lives of being independent, self-sufficient, active, maintaining personal relationships, and wanting to continue to have fun. The goal of person-centered care honors the importance of this by keeping the person at the center of their care and decision-making process. In this care model, caregivers must actively listen and observe to be able to adapt to each individual's changing needs, regardless of their condition or disease process.

The person-centered care approach is extremely important when caring for these individuals; seeing everyone as individuals and not placing the focus on their illnesses or on their abilities or inabilities. Making sure that people are involved and central to their care is now recognized as a key component of providing for a high quality of healthcare. There are many aspects of person-centered care that should be taken into account, including:
- Respecting one's values and putting them at the center of care;
- Taking into account someone's preferences and expressed needs;
- Coordinating and integrating care;
- Working together to make sure there is good communication with the individual and that information and education is effectively passed along;
- Assure people are physically comfortable and safe; provide emotional support
- Involving the individual's family and friends;
- Making sure there is continuity between and within the services that the person is receiving; and
- Making sure people have access to appropriate care when they need it.

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[8] National Nursing Home Quality Improvement Campaign
https://www.nhqualitycampaign.org/goalDetail.aspx?g=pcc
1 National Pressure Ulcer Advisory Panel (NPUAP) Pressure Injury Stages.
http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/

Section 3: Pressure Injury Assessment

Risk Assessment

- Consider bedfast and chairfast individuals to be at risk for development of pressure injury.
- Use a structured risk assessment, such as the Braden Scale, to identify individuals at risk for pressure injury as soon as possible (but within 8 hours after admission).
- Refine the assessment by including these additional risk factors:
  - Fragile skin
  - Existing pressure injury of any stage, including those ulcers that have healed or are closed
  - Impairments in blood flow to the extremities from vascular disease, diabetes or
  - tobacco use
  - Pain in areas of the body exposed to pressure
- Repeat the risk assessment at regular intervals and with any change in condition. Base the frequency of regular assessments on acuity levels:
  - Long term care. . . Weekly for 4 weeks, then quarterly
- Develop a plan of care based on the areas of risk, rather than on the total risk assessment score. For example, if the risk stems from immobility, address turning, repositioning, and the support surface. If the risk is from malnutrition, address those problems.

Skin Care

- Inspect all of the skin upon admission as soon as possible (but within 8 hours).
- Inspect the skin at least daily for signs of pressure injury, especially nonblanchable erythema.
- Assess pressure points, such as the sacrum, coccyx, buttocks, heels, ischium, trochanters, elbows, and beneath medical devices.
- When inspecting darkly pigmented skin, look for changes in skin tone, skin temperature and tissue consistency compared to adjacent skin. Moistening the skin assists in identifying changes in color.
- Cleanse the skin promptly after episodes of incontinence.
- Use skin cleansers that are pH balanced for the skin.
- Use skin moisturizers daily on dry skin.
- Avoid positioning an individual on an area of erythema or pressure injury.

Nutrition

- Consider that some individuals may be at risk for under nutrition and malnutrition.
- Use a valid and reliable screening tool to determine risk of malnutrition, such as the Mini Nutritional Assessment.
- Refer all individuals at risk for pressure injury from malnutrition to a registered
- dietitian/nutritionist.
- Assist the individual at mealtimes to increase oral intake.
- Encourage all individuals at risk for pressure injury to consume adequate fluids and a balanced diet. Assess weight changes over time.
- Assess the adequacy of oral, enteral and parenteral intake.
- Provide nutritional supplements between meals and with oral medications, unless contraindicated.

Repositioning and Mobilization

- Turn and reposition all individuals at risk for pressure injury, unless contraindicated due to medical condition or medical treatments.
- Choose a frequency for turning based on the support surface in use, the tolerance of skin for pressure and the individual's preferences.
- Consider lengthening the turning schedule during the night to allow for uninterrupted sleep.
- Turn the individual into a 30-degree side lying position, and use your hand to determine if the sacrum is off the bed
- Avoid positioning the individual on body areas with pressure injury.
- Ensure that the heels are free from the bed.
- Consider the level of immobility, exposure to shear, skin moisture, perfusion, body size and weight of the individual when choosing a support surface.
- Continue to reposition an individual when placed on any support surface.
- Use a breathable incontinence pad when using microclimate management surfaces.
- Use a pressure redistributing chair cushion for individuals sitting in chairs or wheelchairs.
- Reposition weak or immobile individuals in chairs hourly.
- If the individual cannot be moved or is positioned with the head of the bed elevated over 30°, place a polyurethane foam dressing on the sacrum.
- Use heel offloading devices or polyurethane foam dressings on individuals at high-risk for heel ulcers
- Place thin foam or breathable dressings under medical devices.

Education

- Teach the individual and family about risk for pressure injury
- Engage individual and family in risk reduction interventions

Section 4: Person-Centered Care Planning

Overview of Person-Centered Care Planning

CMS defines person-centered planning as a process, directed by the individual, with assistance as needed or desired from a representative of the individual's choosing. The process is intended to identify the strengths, capacities, preferences, needs, and desired measurable outcomes of the individual. It may include other persons, freely chosen by the individual, who can serve as important contributors to the process. The individual or his/her representative directs the person-centered process; this means that the resident or their representative is an equal partner in the planning of their care. It means ensuring that each resident or individual acting on the resident's behalf is involved in negotiating a care plan that is specific to their individual like, dislikes, and needs. In addition to the resident, facility staff, including the CNA, must be involved in the development of the person-centered care plan.

It is important to understand that Person-Centered Care Planning[9] is one in which the focus is on what is important to the resident, his/her capacities, and the resident's available supports. The focus of their person-centered care plan should be the quality of the resident's life as he/she defines it. The steps in the care planning process include:

- Preparation: Understanding the resident and their situation, gathering information, encouraging others who know the person to contribute their perceptions and ideas.
- Pre-planning: Working with the person/representative to review information, set priorities, determine an agenda, and invite people to join in the planning process.
- Action Planning: Identifying the resident's needs and desires, then developing action steps to accomplish her/his goals. Action planning is often done in a team meeting, but can also be done through a series of conversations with different people.
- Quality Assurance: Making sure the documentation meets standards and requirements.
- Implementation and Monitoring: Following through on action steps, checking progress, and revising the plan as necessary.

Use this person-centered concept with all residents. Care planning for those individuals who have or are at risk for pressure injuries should be done immediately

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[9] Person-Centered Care Planning/Person-Centered Thinking Course

upon admission to the facility. Care plans should be reviewed at least quarterly, at significant change of condition, when a skin assessment has changed, and/or when a goal is not being met. Care plan revision may require a modification in the expected goals/outcomes and/or pharmacological and non-pharmacological multi-disciplinary approaches.

The development of a facility acquired pressure injury brings with it both a financial impact to an institution and a performance or quality of care impact that may be reportable.

Problems/Needs	Goals/Outcomes	Interventions/Approaches	Team Members
Risk of developing a pressure injury: Related to (baseline information, such as risk factor(s), validated tool score, etc.) Actual pressure injury: As evidenced by [location, PUSH score, (length, width, stage, exudate amount, tissue type) and any other descriptions] Date developed	Measurable & realistic. Specified date: • Pressure injury will not develop for those at risk • Pressure injury responded to treatment	Resident/responsible party education that includes: • the individual's values/wishes • identified risk factors • treatment plan • routine head-to-toe skin assessment Timing/frequency of pressure injury risk assessments and/or re-evaluation of existing pressure injuries Interventions focused on individual's pressure injury risk factors or in-depth pressure injury assessment • Identify pressure injury prevention measures • Factors identified from the assessment process results in individualized interventions o treatment ordered (medication, dressing, nutrition changes, support surface/s) and frequency o communication between nursing staff, physician, and other disciplines • assess pain and current treatment, medicate before treatment • current physical status • Treatment re-evaluations for those without improvement within ____ weeks	Specify department responsible for each approach Periodic IDT review to evaluate the effectiveness of interventions related to achievement of the goals

Section 5: Roles and Responsibilities of Members of the Care Team

All staff members who provide care for the residents in the NF have a very important role in ensuring that residents receive the highest level of care possible. Providing important Person-Centered care in NF residents is a multi-disciplinary task; everyone in the facility plays a part in the effort.

Pressure injury prevention is essential to the overall physical, mental, and psychosocial well-being of the resident. Ensuring residents do not develop pressure injuries requires taking multiple factors into consideration.

Certified Nurse Aide (CNA)

There are many approaches that the CNA can use to prevent pressure injuries in their residents. Below, in the table, you will find CNA tasks and rationales.

What To Do	Why You Do It
Reposition a person who must stay in bed or in a wheelchair at least every 2 hours, or according to the person's care plan.	Regular repositioning prevents any one part of the person's body from being under pressure for too long.
Take the bedpan out from underneath the person as soon as the person is finished using it.	The bedpan places pressure on the person's lower spine, one of the pressure points.
Check the resident's skin for changes at every opportunity, including when you are assisting with repositioning, bathing, and dressing and when you are changing wet or soiled linens or giving a back massage. Report red, pale, white, or shiny areas over pressure points right away.	Redness over a pressure point that does not go away after 5 minutes or an area over a pressure point that was previously red but now is pale, white, or shiny could be a sign of a stage 1 pressure injury. Early recognition and treatment of a pressure injury is important so that measures can be taken to prevent the pressure injury from getting worse.
Provide good skin care. When bathing a resident, clean the skin gently and thoroughly and rinse off the soap well. Make sure the skin is dried well and use lotion to keep the skin healthy and soft. Thoroughly clean and dry areas where skin touches skin, such as under the breasts,	Keeping the skin clean and dry is essential to preventing skin breakdown and pressure injury development.

and apply a light dusting of powder to keep the skin dry.	
Provide good perineal care, especially if the resident is incontinent of urine or feces.	Urine and feces are irritating to the skin and can lead to skin breakdown. Prompt, thorough perineal care keeps the skin clean and dry, which is essential to preventing skin breakdown and pressure injury development.
Assist the person to the bathroom (or provide a bedpan or urinal) frequently. Check on incontinent people every hour so.	Contact with wet and soiled clothing or linens can cause skin breakdown, leading to pressure injuries. Anticipating toileting needs helps to prevent patients and residents from soiling themselves. Checking on incontinent patients and residents frequently allows you to detect and change wet and soiled clothing or linens promptly.
Ask residents who can walk to take a walk with you every 2 hours. Remind residents to change positions in the wheelchair or move to the bed for a while.	Exercise and movement promote blood flow to the tissues and prevent the person from staying in any one position for too long a time.
Make sure the bed linens are clean, dry, and wrinkle free at all times.	Soiled, wet, or excessively wrinkled linens can lead to skin breakdown and pressure injuries.
Provide frequent back massage.	Back massage helps to stimulate blood flow to the skin and gives you a chance to check the person's skin for red, pale, white, or shiny areas.
Minimize skin injury caused by friction or shearing. Use lift devices and lift sheets when moving and repositioning people. Use devices such as elbow pads and heel booties according to the person's care plan. Avoid raising the head of the bed more than 30 degrees.	Friction and shearing forces damage the skin and underlying tissues and can put the person at risk for a pressure injury. Lift devices and lift sheets help reduce friction by allowing you to lift or roll, instead of dragging the person. Elbow pads and heel booties reduce friction by preventing the skin from rubbing against sheets and other surfaces. Raising the bed no more than 30 degrees helps prevent shearing, which occurs when the person slides down in the bed.
Offer refreshing drinks frequently. Encourage your residents to eat well.	Good nutrition and adequate fluid intake help to keep the skin healthy

Use pressure-reducing devices according to the resident's care plan.	These devices help to distribute the person's body weight more evenly, preventing any one area from bearing most of the pressure.

Nursing Staff (RNs and LVNs)

Nursing staff are responsible for ensuring that there is a timely and thorough assessment and comprehensive care plans for each one of their residents.

Federal regulations require that the nursing facility must have sufficient nursing staff with the appropriate professional licensure, competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. These nursing services are determined by resident assessments and individual plans of care.

Licensed nurses are also required to have the specific competencies and skill sets necessary to care for residents' needs including assessing, evaluating nursing interventions, and implementing resident care plan as identified through resident assessments, nursing care plans and as described in the plan of care. Nursing staff are vital in the communication between the resident and the physician. Each comprehensive assessment, care plan intervention and timely feedback to the physician's Plan of Care is another important role in the overall care of the resident. These important assessments will also allow for issues with the resident to be identified before a pressure injury develops.

Nurses have a role to play in monitoring the success of strategies to reduce avoidable pressure injuries and to provide accountability and maintain motivation. The nurse should be sure to conduct a resident assessment ensuring that the skin is thoroughly assessed. If it is determined that the resident is at risk for a pressure injury, then the nurse should ensure certain interventions are in the care plan, including:
- Turning and repositioning patient at least every 2 hours
- Maximal remobilization
- Protection of heels and other bony prominences (occiput, ears, scapula, spinous processes, shoulders, elbows, iliac crest, sacrum/coccyx, ischial tuberosity, trochanters, knees, malleolus, and toes)
- Managing moisture, nutrition, friction, and shear (elevate head of bed no more than 30 degrees)
- Supportive measures for pressure reduction, if bed or chair bound

- Nutrition consult when resident's Braden score is 18 or less
- Specific turning and repositioning schedule
- Wedge devices for lateral positioning
- Pressure redistribution support surface
- Manage nutrition
- Increased frequency of turning, including small shifts of weight
- Very High (9 or below), mild, moderate, and high interventions
- Reassessment every shift

Prevention of pressure injuries in the nursing facility is vital to the health and well-being of the residents. Below are additional resources that may be accessed to assist you and your staff in the prevention of pressure injuries in your facility.

- Prevention Plus provides services and products related to the Braden Scale for Predicting Pressure Ulcer Risk and evidence-based programs for pressure injury prevention: http://bradenscale.com/

- The Bates-Jensen Wound Assessment Tool (BWAT) is a validated and reliable tool for conducting in-depth evaluations of wound status. The BWAT is available on this website, along with concise instructions for using the tool: http://www.geronet.med.ucla.edu/centers/borun/modules/Pressure_ulcer_prevention/puBWAT.pdf

- Indiana State Department of Health: Pressure Ulcer Resource Center offers information, tools, educational modules and other resources for pressure injury prevention and management: http://www.in.gov/isdh/24558.htm

- Resources for Reducing High-Risk Pressure Ulcers can assist nursing facilities with quality improvement activities, including pressure injury prevention. Note: You must complete a registration to access the resources on this website: https://www.tmfqin.org/Resource-Center/Filtered-Results?fi=172&st=%22HR%20PUs%22

- Advancing Excellence in America's Nursing Homes is a national coalition, focusing on specific target areas, including pressure injuries, working to improve the quality of care and quality of life of nursing home residents: https://www.nhqualitycampaign.org/goalDetail.aspx?g=PU

- Taking the Pressure Off – Preventing Pressure Ulcers (PDF) is a nursing best practice guideline from the Registered Nurses Association of Ontario: http://rnao.ca/sites/rnao-ca/files/Taking_the_Pressure_Off_-_Preventing_Pressure_Ulcers.pdf

- The National Pressure Ulcer Advisory Panel (NPUAP) is a professional organization dedicated to the preventing and managing pressure injuries: http://www.npuap.org/resources/

- The PUSH Tool 3.0 is a validated and reliable tool that is used to collect data and monitor the healing of pressure injuries: http://www.npuap.org/wp-content/uploads/2012/03/push3.pdf

Dietitians

Federal regulation shows that the attending physician has an important role in assuring the resident receives an appropriate diet according to the resident's needs. The physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law.

The dietitian would also be responsible that the residents receive and consume foods in the appropriate form and/or the appropriate nutritive content as prescribed by a physician, and/or assessed by the interdisciplinary team to support the resident's treatment, plan of care, in accordance with his her goals and preferences. Proper nutrition is extremely important in the overall healing process for skin breakdown or pressure related injuries.

Prescribers (Physicians, PA-Cs, APRNs)

Practitioners with prescribing privileges have a key role as a member of the interdisciplinary team, prescribers should:
- Evaluate each resident to determine the continued appropriateness of the resident's current medical plan of care.
- Review prescribed treatments, therapies and closely monitor all needs based on validated diagnoses for active and new problems.
- Update diagnoses, conditions and prognoses to help residents attain the highest possible level of functioning in the least restrictive environment possible.
- Document relevant conditions that affect quality of care and quality of life, especially in residents with dementia.
- Inquire about care plans with specific and individualized interventions and approaches.

Family and Others

The resident's family members or other loved ones play an important role of preventing skin injuries. These include:

If the resident requires minimum, moderate, or extensive assistance with ADLs, the family member can ask:

- What can we do to relieve pressure points on the resident while encouraging person centered thinking?
- How can we improve the resident's environment to prevent pressure injuries?
- How has the care team tried to help with the resident's repositioning at least every two hours and as needed.
- How has the care team tried to help with the resident's ADLs, Mobility, and independence on a daily basis using person centered thinking?
- What is the plan to establish, implement and evaluate measurable short and long-term goals regarding skin integrity, pressure relief and wound healing?

The NF staff will never know all that the family knows. Family members and loved ones can help by providing answers to questions such as:

- How does your family member express themselves when they are hurting or uncomfortable?
- What, in the past, has helped them be comfortable?
- What is their typical daily routine?
- What have you tried to assist them?
- Stay involved in your loved ones care and attend care plan meetings.
- Get to know staff – their names and duties
- Attend care plan or service plan meetings
- Talk to staff about concerns you have with the care being provided to the resident.
- Join or organize a resident or family council

Section 6: Resources, Tools, and Trainings

Resources from HHSC

HHSC LTC Regulatory Joint Provider Training Course Website
https://apps.hhs.texas.gov/providers/training/jointtraining.cfm

Resources from Other Organizations

Skilled Nursing Facility (SNF) Quality Reporting Program Measures and Technical Information
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html

The National Nursing Home Quality Improvement (NNHQI) Campaign exists to provide long term care providers, consumers and their advocates, and quality improvement professionals with free, easy access to evidence-based and model-practice resources to support continuous quality improvement.
https://www.nhqualitycampaign.org/goalDetail.aspx?g=mob#tab2

The Pioneer Network "Pioneers in Culture Change and Person-Directed Care"
https://www.pioneernetwork.net/

Prevention Plus provides services and products related to the Braden Scale for Predicting Pressure Ulcer Risk and evidence-based programs for pressure injury prevention: http://bradenscale.com/

The Bates-Jensen Wound Assessment Tool (BWAT) is a validated and reliable tool for conducting in-depth evaluations of wound status. The BWAT is available on this website, along with concise instructions for using the tool:
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Tools

Many tools are available for use in determining the preferences of individuals with Alzheimer's disease or other dementia-related conditions. These conditions may directly affect the nursing facility's ability to develop and implement appropriate plans of care for the resident's ADLs, mobility and independence. That information is then used to care plan the appropriate person-centered thinking interventions for them. These tools include:

- Preferences for Everyday Living (PELI)[10]: The PELI is a scientifically validated tool that is used to assess individual preferences for social contact, personal development, leisure activities, living environment, and daily routines. NFs can access either the full length PELI or a mid-level version. Both versions are designed to spark conversations about the resident's preferences, lay the foundation for building trusting relationships between the resident, family, and NF staff, and promote person-centered care plans and service, honoring the resident's preferences as the highest priority. Both versions of this tool can be found at https://preferencebasedliving.com/peli-tools.

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[10] Preference Based Living. PELI Tools. https://preferencebasedliving.com/peli-tools

- "A Passport Into My Life: Understanding My Journey Will Help You Understand Me"[11]: The Behavior Management Task Force created the Passport to provide information about the resident, painting a picture of who the person really is. Passport information includes interests, accomplishments, daily routines, familiar names, traumatic life events, and a number of expressions of needs. A sample of this tool can be found in the LVN Educator/New LVN toolkit on the QMP website, in Module 3 at: https://hhs.texas.gov/sites/default/files//documents/doing-business-with-hhs/provider-portal/QMP/AssessmentModule.pdf.

Trainings

There are many training opportunities available to NF staff **free of charge** that will provide education related to dementia care and person-centered thinking. The QMP provides training opportunities such as:

- Person Centered Thinking Training (PCT)

You can obtain more information about these trainings by visiting https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/nursing-facilities-nf/quality-monitoring-program-qmp/evidence-based-best-practices-qmp/alzheimers-disease-dementia-care. To schedule one of these trainings for your staff, please email the request to QMP@hhsc.state.tx.us.

Additional free trainings are available through the UT Center for Excellence in Aging Services and Long-Term Care. Information about these can be found at http://www.utlongtermcarenurse.com/.

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[11] A Passport to Better Care. http://www.providermagazine.com/archives/2014_Archives/Pages/0814/A-Passport-To-Better-Care.aspx

Section 7: Evaluation of the Training Program/Toolkit

Training program evaluation is a continual and systematic process of assessing the value or potential value of a training program. Results of the evaluation are used to guide decision-making around various components of the training (e.g. instructional design, delivery, results) and its overall continuation, modification, or elimination.

In order to determine if this training program is helpful in providing NF staff with information related to initial resident assessments, assessments after a significant change, developing and implementing comprehensive care plans and care plans after a significant change, an evaluation can be done in several ways:

- Measuring a change in knowledge, skill, or attitudes. This can be done both before and after the training in the form of a pre and post-test.
- Measuring a change in behavior. This evaluation technique may take more time; however, it may show a more consistent change in what the participant did with what they learned. Did the participant put any of the information to use? Is the participant able to teach their new knowledge, skills, and attitudes to others? Is the participant aware that their behavior has changed? Evaluating for this information would be done by conducting observations and interviews of the participants, over the course of time. It would be helpful to have a baseline of their behavior(s) prior to their receipt of the training to compare to their behavior(s) after the training.
- Measuring results. This evaluation may be the most time consuming, as results cannot be measured right away. It takes time for the data in a QM to adjust to show positive or negative change. An NF could conduct the training one month and begin making changes, however, the data may not show significant positive change for several months due to the number of assessments being performed for the data that relates to the QM. This method of evaluating the training program, however, is probably the most significant in terms of the actual changes that are taking place to the care being provided to NF residents.

Figure 1: Evaluation of Staff Educational Training Program/Toolkit

Measure	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The content is relevant to the stated objectives	1	2	3	4	5
The content is well organized into clearly labeled sections	1	2	3	4	5
The resources and links provided in the sections are evidence based and credible organizations/resources	1	2	3	4	5
The content is appropriate and free from bias, stereotypes or insensitivity	1	2	3	4	5
The links to the CMS and HHSC provide useful information relevant to the misuse of Antipsychotics with those who have a diagnosis of Alzheimer's disease or a dementia-related condition and reside in a nursing facility	1	2	3	4	5
The content of the Education/Resource Tool Kit addressed prescribing patterns	1	2	3	4	5
The content of the Education/Resource tool kit addressed alternate interventions that can be used prior to introducing or prescribing an antipsychotic	1	2	2	4	5
I will make/implement change based on what I have learned from this Education/Resource Tool Kit	1	2	3	4	5
Overall, I am satisfied with the content of this Education/Resource Tool Kit	1	2	3	4	5
Comments:					

F710 Physician Services

A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs.

Physician Supervision

The facility must ensure that:

- The medical care of each resident is supervised by a physician; and
- Another physician supervises the medical care of residents when their attending physician is unavailable.

F711 Physician Visits

The physician must:

- Review the resident's total program of care, including medications and treatments, at each visit required as per frequency of physician visits;
- Write, sign and date progress notes at each visit; and
- Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.

F712 Frequency of Physician Visits

The residents must be seen by a physician at least once every30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.

All required physician visits must be made by the physician personally. There are exceptions. At the option of the physician, required visits in skilled nursing facilities (SNFs), after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist.

F636 Resident Assessment

The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

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[12] CMS State Operations Manual, Appendix PP Centers for Medicare & Medicaid Services State Operations Manual, Appendix PP. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R173SOMA.pdf

The intent is to ensure that the Resident Assessment Instrument (RAI) is used, in accordance with specified format and timeframes, in conducting comprehensive assessments as part of an ongoing process through which the facility identifies each resident's preferences and goals of care, functional and health status, strengths and needs, as well as offering guidance for further assessment once problems have been identified.

F637 Comprehensive Assessment After Significant Change

The facility must conduct a comprehensive assessment after a significant change within 14 days after the facility determines, or should have determined, that there was a significant change in the resident's physical or mental condition.

F655 Comprehensive Person-Centered Care Planning

The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must:
- Be developed within 48 hours of a resident's admission.
- Include the minimum healthcare information necessary to
- Properly care for a resident including, but not limited to:—
- Initial goals based on admission orders;
- Physician orders;
- Dietary orders;
- Therapy services;
- Social services; and
- PASARR recommendation, if applicable.

F656 Comprehensive Care Plans

The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The comprehensive care plan must describe the following:
- Services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being;
- Any services that would otherwise be required but are not provided due to the resident's exercise of rights, including the right to refuse treatment;
- Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with

the findings of PASARR, it must indicate its rationale in the resident's medical record; and

- In consultation with the resident and the resident's representative(s):
  - o The resident's goals for admission and desired outcomes;
  - o The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose; and
  - o Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements.

F657 Care Plan Timing and Revision

A comprehensive care plan must be developed within 7 days after completion of the comprehensive assessment. Prepared by an interdisciplinary team including:

- The Attending physician

- A registered nurse with responsibility for the resident

- A nurse aide with responsibility for the resident

- A member of food and nutrition services staff

- To the extent practicable, the participation of the resident and the resident's representative(s)

F686 §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.

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.

F726 §483.35 Nursing Services

The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment

§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.

§483.35(c) Proficiency of nurse aides.

The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

F801 Qualified Dietary Staff

Qualified dietary staff must ensure every resident receives appropriate nutrition according to any specialized needs including skin breakdown. Adequate nutrition is essential to promote wound healing.

§483.60(a) Staffing-The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and

the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment.

§483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional.

F841 Responsibilities of Medical Director

The facility must designate a physician to serve as medical director."Medical director" means a physician who oversees the medical care and other designated care and services in a health care organization or facility. Under these regulations, the medical director is responsible for coordinating medical care and helping to implement and evaluate resident care policies that reflect current professional standards of practice.

State Regulations[13]

TAC Subchapter I §19.801 Resident Assessment

TAC Subchapter I §19.802 Comprehensive Care Plan

TAC Subchapter J §19.901 (3)(A) Pressure Ulcers

TAC Subchapter J §19.901 (3)(B) Pressure Ulcers

TAC Subchapter K §19.1001 Nursing Services

TAC Subchapter M §19.1201 Physician Services

TAC Subchapter M §19.1202 Physician Visits

TAC Subchapter M §19.1203 Frequency of Physician Visits

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[13] Texas Administrative Code-Title 40 Part 1 Chapter 19.
https://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=4&ti=40&pt=1&ch=19

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