



Department of Human Services Seniors and People with Disabilities Community Based Care Survey Protocol

Pressure Ulcer

Pressure ulcers can have health serious consequences for the elderly and are costly and time consuming to treat. However, they are one of the most preventable conditions among the elderly who have restricted mobility.

Objectives

- To determine if the pressure ulcer(s) is identified and evaluated/assessed; and
- To determine the adequacy of the facility's interventions and efforts to prevent and treat or obtain appropriate treatment for the pressure ulcer(s).

This protocol is to be used when a sampled resident has or is at risk of developing a pressure ulcer.

A **Pressure Ulcer** (also known as decubitus ulcer, pressure sore and bedsore) is defined as an injury to the skin as a result of constant pressure due to staying in one position without moving. Blood flow is reduced to the pressure area and eventually causes cell death, skin breakdown and the development of an open wound. Pressure ulcers usually occur over bony prominences (such as tail bone and heels) and are graded or staged to classify the degree of tissue damage observed.

A Stage 2 pressure ulcer is any injury to the skin and/or underlying tissue in which some degree of skin has been lost. The skin loss primarily involves the top layer of skin. The ulcer is superficial and looks like an abrasion, blister or shallow crater. The injury is in an area of pressure, usually over a bony prominence. This does not include a skin tear, tape burn, rash or excoriation.

Procedures

Briefly review the evaluation/assessment, service plan and physician/treatment orders to identify facility interventions and to guide observations to be made. For a resident either at risk for or with a pressure ulcer, the facility is expected to evaluate/assess and ensure the resident receives appropriate care from the day of move-in. Corroborate observations by interview and record review.

Observation

- ❖ Observe whether staff consistently implement the service plan over time and across various shifts. During observations of the interventions, note and/or follow up on deviations from the service plan as well as potential negative outcomes, including but not limited to the following:
 - Whether the positioning avoids pressure on an existing pressure ulcer(s);



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- Whether pressure-redistributing devices for the bed and/or chair, such as gel-type surfaces or overlays are in place, working, and used according to the manufacturer's recommendations; and
- Presence of previously unidentified open areas.

Resident/Staff Interviews

- ❖ Interview the resident, family and/or responsible party to the degree possible to identify:
 - Involvement in care planning, choices, goals, and if interventions reflect preferences;
 - Awareness of interventions being used, if any;
 - Presence of pain, if any, and how it is managed;
 - If treatment(s) was refused, whether counseling on alternatives, consequences, and/or other interventions was offered; and
 - Awareness of current ulcer or history of an ulcer(s). For the resident who has or has had a pressure ulcer, identify as possible, whether acute illness, weight loss or other condition changes occurred prior to developing the ulcer.
- ❖ Interview staff on various shifts to determine:
 - Knowledge of prevention and treatment, including facility guidelines/protocols and specific interventions for the resident;
 - Awareness of approaches, such as pressure redistribution devices or equipment, and turning/repositioning to prevent or address pressure ulcer(s);
 - If caregivers know what, when, and to whom to report changes in skin condition; and
 - Who monitors for the implementation of the service plan, changes in the skin, the development of pressure ulcers, and the frequency of review and evaluation of an ulcer.

Record Review

- ❖ Review the evaluation/assessment and other documents such as physician orders, progress notes, treatment records and nurses' notes, regarding the evaluation/assessment of the resident's overall condition, risk factors and presence of a pressure ulcer(s) to determine if the facility identified the resident at risk and evaluated the factors placing the resident at risk:
 - For a resident who moved-in with an ulcer or who developed one soon thereafter, review the initial evaluation, service plan and other documentation regarding the wound site and characteristics at the time of move-in, skin condition, history of poor nutrition history of previous pressure ulcers; and
 - For a resident who has a pressure ulcer, review documentation regarding the treatment, whether by the facility or outside agency for:



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- Were treatments completed as ordered?
- Does the documentation indicate the ulcer is healing?
- In considering the appropriateness of a facility's response to the development, presence, improvement, or deterioration of a pressure ulcer; take into account the resident's condition, complications, time needed to determine the effectiveness of a treatment, and the facility's efforts, where possible, to address the risk factors and underlying causal factors.
- ❖ Service plan
 - For the resident at risk for developing or who has a pressure ulcer, determine if the facility service plan addressed prevention, care and treatment of any existing pressure ulcers, including specific interventions.
 - If the treatment is provided by home health or other agency, is that noted in the service plan?
 - Has the facility coordinated on-site health services with outside service providers and received written information that addresses the on-site services being provided to the resident and any clinical information necessary for facility staff to provide supplemental care?
 - Is the facility aware of the treatment provided by the outside provider to ensure that staff are informed of new interventions, that the service plan as adjusted if necessary, and that reporting protocols are in place?
 - Has the facility nurse reviewed the resident's health related service plan changes made as a result of the provision of on-site health services?
- ❖ Revision of the Service plan
 - Has the RN monitored the condition of the resident and coordinated with the agency providing care to ensure the resident is making improvements, and
 - If the resident's condition is not improving, has the RN worked with the agency and/or physician to revise the treatment plan.
 - If the resident refuses or resists staff interventions to reduce risk or treat existing pressure ulcers, determine if the facility worked with the resident and/or family to seek alternative measures to address the resident's needs.

Interviews with Health Care Practitioners and Professionals

- ❖ If the interventions defined or care provided appear not to be consistent with recognized standards of practice, interview one or more health care practitioners and professionals as necessary (e.g., physician, facility nurse) who, by virtue of training and knowledge of the resident, should be able to provide information about the causes, treatment and evaluation of the resident's condition or problem. Depending on the issue, ask about:
 - How was it determined that chosen interventions were appropriate;
 - Risks identified for which there were no interventions;



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- Changes in condition that may have justified additional or different interventions; or
- How they validated the effectiveness of current interventions.

Observation of Existing Ulcer/Wound Care

- ❖ Based on observations, interviews and record reviews; if there is a question or concern regarding the presence or current status of an ulcer, then observation of the area is indicated. Note:
 - Characteristics of the wound and surrounding tissues such as presence of granulation tissue, the Stage, presence of exudates, necrotic tissue such as eschar or slough, or evidence of erythema or swelling around the wound;
 - Whether treatment and infection control practices reflect current standards of practice; and
 - Based on location, steps taken to cleanse and protect the wound from likely contamination by urine or fecal matter.
- ❖ If unable to observe the wound due to the dressing protocol, observe the area surrounding the ulcer(s). For ulcers with dressings that are not scheduled to be changed, the RN surveyor may request that the dressing be removed to observe the wound and surrounding area if other information suggests a possible treatment or assessment problem.
- ❖ If the resident expresses (or appears to be in) pain related to the ulcer, determine if the facility:
 - Assessed for pain related to the ulcer, addressed and monitored interventions for effectiveness; and/or
 - Assessed and took preemptive measures for pain related to dressing changes or other treatments, such as debridement/irrigations, and monitored for effectiveness.

Determination of Compliance:

- ❖ The determining factor in compliance for change of condition and monitoring related to the development, care and treatment of pressure ulcers, is the proper identification, evaluation and assessment, development and implementation of the service plan, evaluation/assessment of the resident outcome, and revision of the service plan as needed if it is not effective. If not in compliance, cite at C270.
- ❖ Through the use of this protocol, other deficient practices may be discovered and may result in citations.

Deficiency Categorization:

Once the team has completed its investigation, analyzed the data, reviewed the rule, and identified the deficient practices that demonstrate that the facility failed to provide



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monitoring, care and services related to pressure ulcers and that non-compliance exists, the team must determine the harm or potential for harm based upon the following levels of severity.

- Level 1: No harm, with potential for minimal harm. Facility is considered to be in substantial compliance.

Level 1 is not appropriate for this rule.

- Level 2: No harm, with potential for more than minimal harm; or minimal harm which does not significantly impact the resident's quality of life or physical function.

Level 2 indicates noncompliance that results in a resident outcome of no more than minimal harm and/or has the potential for greater harm if interventions are not provided.

Examples of level 2 citations may include, but are not limited to:

- Residents at risk for pressure ulcers have not been evaluated and/or assessed and interventions have not been developed or consistently implemented and a stage 2 or greater pressure ulcer(s) has not yet developed.
 - Residents developed a single Stage 2 pressure ulcer, treatment was implemented, the facility RN was not involved, and the ulcer healed.
 - Residents developed a single Stage 2 pressure ulcer, interventions were not developed or were not implemented, and the ulcer has not worsened.
- Level 3: Harm which significantly impacts the resident's quality of life or physical function, but does not require immediate correction to protect resident health or safety.

Level 3 indicates noncompliance that results in the development of multiple Stage 2; or Stage 3 or 4 pressure ulcer(s) which was (were) not treated and/or worsened.

Examples of level 3 citations may include, but are not limited to:

- Resident had multiple Stage 2; or Stage 3 or 4 pressure ulcer(s) which were not identified, evaluated, and/or assessed, or effective interventions were either not developed or consistently implemented.
- Resident had severe and/or untreated pain related to a pressure ulcer which was either not identified or evaluated/assessed or effective interventions were not developed nor consistently implemented.



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- Level 4: Imminent Danger to resident health or safety.

Imminent Danger is a situation in which the facility's noncompliance in providing monitoring or care related to pressure ulcers has resulted in, or is likely to result in a clear threat to residents.

Examples of level 4 citations may include, but are not limited to:

- One or more residents experiencing one or more Stage 3 or 4 pressure ulcers without effective intervention and without mitigating circumstances.
- Stage 3 or 4 pressure ulcers with associated soft tissue or systemic infection as a result of the facility's failure to assess or treat a resident with an infectious complication of a pressure ulcer.