LeadingAge Illinois & Iowa

Pressure Ulcer Quality Assurance Guidance

Overview

The Centers for Medicare & Medicaid Services (CMS) requires that if a resident develops a pressure ulcer/injury (PU/PI) during their stay at the nursing home that it was due to unavoidable circumstances. Additionally, if the resident has a PU/PI, it does not worsen unless the circumstances are unavoidable. To ensure that residents don't acquire a PU/PI, staff must follow interpretative guidance in the Requirements of Participation (RoPs). Which are outlined in the numerator monitors within this guidance and the accompanying worksheet.

Monitoring Guidance

A1 Numerator - This number identifies the number of residents who did not have a risk assessment completed on admission as it should be completed on all residents upon initial admission.

A3 Numerator - This number identifies the number of residents who did not have quarterly risk assessments completed. Assessment of risk should be completed periodically following admission. While periodically is not defined in the interpretative guidance, standard of practice would indicate that the risk assessment should be completed no less than quarterly with the Minimum Data Set (MDS) as the Item Set M0150 asks if the resident is at risk for PU/PI development. Your PU/PI policy and procedure should identify the frequency of risk assessment completion.

A5 Numerator - This number identifies the number of residents that did not have a documented skin assessment upon admission. The nursing home should always identify if a PU/PI is present upon admission as a method for identifying whether the PU/PI was nursing home acquired. A skin assessment should also be completed upon readmission. Any skin abnormalities including non-blanchable skin concerns must be documented. Pressure ulcers that were present upon admission or readmission are not included in the nursing home's quality measure report. If you have a policy that includes weekly skin checks you will want to add this to the work sheet as an additional monitor, but this practice is not a "standard of practice".

A7 Numerator - This number represents the number of residents that did not have documentation of a weekly skin assessment, or the documentation was not complete. Assessments should include all elements outlined in your policy. The interpretative guidance in Appendix PP indicates that at a minimum, assessments must include:

- The type of injury (pressure vs. non-pressure).
- The stage of the pressure ulcer (I-IV, unstageable, and unable to determine)
- Location of the wound

- Size – including perpendicular measurements of the greatest extent of length and width, depth, and the presence, location and extent of any undermining, tunneling, or sinus tract.
- Exudate and if present identify the type of drainage (purulent or serous), color, odor, and approximate amount.
- Wound bed including color and type of tissue/character including evidence of healing such as granulation tissue or necrosis.
- Wound edges and surrounding tissue such as rolled, redness, hardness/induration, maceration, etc.
- The progress toward healing and identification of potential complications.
- Signs of infection or if infection is present.
- The presence of pain, what was done to address the pain, and the effectiveness of the intervention.
- A description of dressings and treatments.

Note: Photographs may be used to support documentation if a protocol consistent with professional standards and issues related to resident privacy and dignity are considered and maintained.

A9 Numerator - This number represents the number of records that lack documentation of physician notification upon initially discovering the PU/PI, including a request for treatment/dressing change orders.

Dressings and Treatments:

Determination of the need for treatment is based upon the individual physician's clinical judgment, nursing home protocols, and professional standards of practice. Additionally, it will depend on the stage and type of wound. For example, a stage I PU/PI may be appropriately treated with a barrier cream; however, this would not be appropriate for a stage III or IV.

A11 Numerator - This number represents the number of records that lack documentation of physician notification if the PU/PI worsens or is not healing. The notification should include the current treatment order to aid the physician in identifying a possible need to alter the treatment plan. This would also include any signs or symptoms of infection.

Infections:

A PU/PI infection may be acute or chronic. In acute wounds, the classic signs of inflammation (redness, edema, pain, increased exudate, and periwound surface warmth) persist beyond the normal time frame of 3-4 days. All chronic wounds, including PU/PI have bacteria. Since bacteria reside in non-viable tissue, debridement of this

tissue and wound cleansing are important to reduce bacteria and avoid adverse outcomes such as sepsis.

The first sign of infection may be a delay in healing and an increase in exudate. Other signs may include:

- Increase in amount or change in the characteristics of exudate
- Decolorization and friability of granulation tissue
- Undermining
- Abnormal odor
- Epithelial bridging at the base of the wound bed
- Sudden pain

The physician diagnosis of infections is based on resident history and clinical findings such as a wound culture. Findings such as elevated white blood cell count, bacteremia, sepsis, or fever may signal an infection or a co-existing infection.

Note: each nursing home should have policies and procedures on when it is appropriate to fax (or "routinely" notify the physician and when the physician should be called indicating a rapid need for treatment or change in treatment plan). Wound infections should be classified as such based on nationally recognized criteria such as McGeers.

A13 Numerator - This number represents the number of care plans reviewed that did not have a focus, goals, and/or interventions established based on a risk of PU/PI development. For example, when a resident was admitted and the risk assessment is completed which indicates the resident is at high risk of developing a PU/PI, the resident's care plan should reflect this risk as a focus with an established goal, and interventions that staff must implement to meet the established goal.

A15 Numerator - This number represents that number of care plans reviewed that did not have an actual PU/PI identified on the care plan. This may be accomplished by added a focus, goal, and interventions if the resident was not previously identified as being at risk or incorporated into an existing care plan.

Note: if the staff identified a PU/PI on admission, the baseline care plan must identify this. If the PU/PI is facility acquired, the comprehensive care plan would be updated. Also, staff should review the current interventions and add interventions that can prevent a similar PU/PI from developing or the current one from worsening as the previously implemented interventions were not effective in preventing the development of the PU/PI.

A17 Numerator - This number represents the number of care plans reviewed and observations completed that lacked implementation of the care planned interventions. The nursing home can do a great job at identifying risk and interventions, but if staff are not carrying out the planned interventions, the resident is at a very high risk of

developing the pressure ulcers. For example, if the care plan indicates the resident will use a pressure-reducing cushion in their wheelchair and during observations the cushion isn't present, this would count as an error.

A19 Numerator - The number of observations completed when staff did not follow appropriate infection prevention and control techniques. Appropriate infection prevention and control techniques include but are not limited to hand hygiene, glove use and changing, use of barriers, cleaning of the wound, and enhanced barrier precautions. Staff must ensure that they are following infection prevention standards to limit the risk of infection in the PU/PI.

A21 Numerator – This number represents the number of resident records that lacked documentation of the PU/PI in the nutrition assessment or notes. PU/PI treatment should be a multidisciplinary approach which includes notifying the dietitian of the wound and allowing them to determine if nutritional intervention is necessary to aid in healing. Even if nutritional intervention is not necessary, there should be documentation that the dietitian reviewed the PU/PI notes and determined why intervention is not necessary with ongoing review.

A23 Numerator – This number represents the number of records reviewed that lack wound clinic progress notes, if applicable. Some nursing homes incorporate wound clinic staff into the plan of care whenever a PU/PI is present whereas others only implement when recommended by the physician. Whenever the resident uses wound clinic services, documentation of the visit must be included in the resident's record which may be achieved by including dictation from the visit, an interoffice note and recommendations, or documentation of alternate communication methods.

A25 Numerator – This number represents the number of records reviewed that lack documentation of dressing or treatment completion in the MAR/TAR. This can include that the dressing or treatment was not transcribed and/or carried out. Surveyors review the MAR/TAR for signatures/initials when the treatment or dressing should have been carried out. If the space is blank, they will assume that the treatment or dressing was not carried out according to the physician's orders.

A27 Numerator – This number represents the number of Minimum Data Sets (MDS') reviewed that were not coded accurately. This can include that the pressure ulcer was not identified on the MDS when it was present during the assessment reference period or that the stage was incorrect. This is to be determined based on documentation that supports the coding in the MDS. For example, if the nurse completing the weekly assessment believes that the wound is a stage 3 PU/PI but the resident went to the wound clinic during the same look back period and the wound clinic staged the ulcer as a stage 4, the MDS should reflect a stage 4 pressure ulcer.

Note: You cannot downstage pressure ulcers, so if a PU/PI was a stage 4 at any point it will always remain a stage 4, even if the wound is now superficial. However, if a wound is unstageable or you're unable to determine the stage due to a dressing that cannot be removed and then the wound opens or you're able to remove the dressing you can then stage it appropriately. You must upstage a pressure ulcer though if it worsens.

An example includes: A resident is admitted with a cast on their right leg. Upon admission you should document that you're unable to determine if a pressure ulcer is present to the right lower extremity due to the cast. Upon removal of the cast, a blackened area is present on the resident's heel where the cast was. At this point the would document that a pressure ulcer is present and it is unstageable due to the blackened area or that it is a deep tissue injury (DTI). A couple weeks later, the area opens and is approximately 0.3 cm deep and has slough present. What was unstageable is now considered a stage 3 pressure ulcer. Moving forward, it is possible for the pressure ulcer to be classified as a stage 4 pressure ulcer if the wound worsens but cannot be classified lower than a stage 3.

References:

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