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Long-Term Care Survey Alert

Care Planning: Advance Directives No 'Get Out Of F314 Tags

Using this excuse for a decubitus ulcer is like telling surveyors the dog ate the care plan.

Advance directives get tricky when they set a resident up for a potential pressure ulcer and surveyors are waiting in the wings to hand out F314 citations.

But never fear: Facilities can find ways to honor residents' wishes - and sidestep survey repercussions.

The quandary: "The revised survey guidelines at F314 make clear that a resident's advance directive won't be an excuse for not providing basic hygiene, continence care, repositioning etc.," cautions **Beth Klitch**, a survey expert in Columbus, OH.

Also, a "Do Not Resuscitate" (DNR) order isn't enough to indicate the resident wants to decline "other appropriate treatment and services," warns the **Centers for Medicare & Medicaid Services** in the revised guidance.

Facilities are, however, bound to follow a resident's wishes for care expressed in a valid advance directive in accordance with state law, the guidance further states.

So how do facilities navigate between this rock and hard place in preventing skin breakdown? Documen- tation and creative care planning can hold at least part of the answer.

Consider these two scenarios where advance directives may place a resident at risk for skin breakdown or a nonhealing ulcer:

Example No. 1: An advance directive says the patient does not wish to receive enteral or parenteral nutrition or fluids if he develops end-stage disease. Yet those interventions are just the ticket to preventing the person's growing malnutrition and poor hydration, which are setting him up for a pressure ulcer - or causing a wound not to heal.

"Document all of that in the medical record," advises **Kathy Hurst, RN, JD**, director of human services and health care operations for Anaheim, CA-based **TSW Management Inc.,** which manages several nursing facilities in California. "Also document the various interventions nursing and medical staff attempted to get the person to take nourishment by mouth," she adds.

Example No. 2: You admit a resident with cancer in the dying process who is adamant that he doesn't want to be repositioned much at the end of life, even though he understands the risk of developing pressure ulcers. "If the resident doesn't want to be moved much at the end of life, the advance directive should be very specific about his wishes in that regard," advises Klitch.

Document that information in the medical record, record family meetings to discuss the issues - and devise a care plan that accommodates the resident's wishes in creative ways, Klitch adds. "For example, if the person doesn't want to be repositioned due to pain, then administer a pain medication 30 minutes before moving the person and see if he agrees to be repositioned when he's more comfortable," she advises.

Cover the bases: The attending physician and interdisciplinary staff should assess any obstacles to a resident accepting basic comfort and hygiene care, such as depression, an underlying medical condition or pain, counsels **Daniel Haimowitz, MD, CMD,** a geriatrician in Levittown, PA.

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Document your family meetings, assessments, interventions, patient education - and the patient's desires and noncompliance with the care, advises Hurst.

Say a patient has a large pressure ulcer on his buttocks and feels most comfortable in a supine position - and repeatedly refuses offers to reposition or pain medication. "Then document his refusal to reposition," Hurst counsels. "Also document how the person's noncompliance with suggested care will lead to a worsening pressure ulcer or that a pressure ulcer is unavoidable in such a case."

Make a Case for Kennedy Pressure Ulcers

Residents near the end of life may develop serious sacral ulcers quickly - and those ulcers may be Kennedy Terminal Ulcers that have nothing to do with poor care or a patient's refusing to reposition.

The problem: The new F314 guidance doesn't address these unavoidable ulcers, so surveyors may not acknowledge them, caution industry insiders. "Yet Kennedy Terminal Ulcers are discussed in the medical literature and an accepted phenomenon in the enterostomal world, even though that's not necessarily the same as the survey world," says **Leah Klusch, RN, BSN, MA,** executive director of **Alliance Training Center** in Alliance, OH.

Solution: Facilities should do the research on Kennedy Terminal Ulcers and know how to identify one. "Ask the physician or nurse practitioner to document that wound diagnosis" in the medical record, advises Klusch. "Then have the care planning and documentation to justify what you've done to assess and treat the wound - and be prepared to explain to surveyors in clinical terms" your decision making.

Kennedy Terminal Ulcers are treated like other pressure wounds but the prognosis isn't going to be the same, says Klusch. "So make sure the physician documents a prognostic statement, as well."

Editor's Note: For more information on how to assess, document and code pressure ulcers to avoid making them appear better or worse than they really are, see the April 2005 issue of Eli's MDS Alert. For subscription information, visit www.elihealthcare.com/spec_mds.htm.

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