Long-Term Care Survey Alert

Quality of Care: HOW TO PROVE A PRESSURE ULCER IS UNAVOIDABLE

Even the **Centers for Medicare & Medicaid Services** agrees: not all pressure ulcers can be avoided in high-risk elderly residents.

Yet to actually reap the benefit of this doubt, your facility must be able to show surveyors that the interdisciplinary team has done everything possible to prevent or heal what is usually viewed as a hallmark of poor nursing care.

Otherwise, the facility may be setting itself up for an unfair immediate jeopardy citation and a handful of F tags for deficiencies ranging from pressure ulcers (F314) and care planning (F279) to qualified personnel (F282) and assessment (F272).

Pressure ulcer citations also open the door to a host of other liability ills, including malpractice claims and even false claims actions in some cases.

To start, make sure the staff understands the difference between pressure sores and other skin ulcers, suggests **Clare Hendrick**, a geriatric nurse specialist and VP of operations for **Health Essentials** in Louisville, KY. Surveyors are really only interested in pressure sores, she notes, so some facilities keep documentation for pressure sores in one book and documentation for other ulcers, wounds and skin conditions in another area. That way, you make sure the surveyors are looking at the right thing on the right people.

"If the ulcer is really a diabetic one or related to venous stasis, and you aren't implementing standard care for pressure sores, surveyors could mistakenly give you a citation," Hendrick explains. The nurse can initiate that assessment by checking the resident's pedal and femoral pulses, the capillary refilling of the toenail, and by looking for a history of diabetes or elevated blood sugars," she adds.

If any of these findings are positive, especially if the ulcer is on the lower extremity, the staff should suspect a diabetic or vascular-related ulcer. The physician may, in such a case, need to order additional tests to diagnose the wound and prescribe the correct treatment (for more information, see article 5).

Surveyors will also be looking to see that the facility identified residents upon admission who are at risk for pressure ulcers. "Staff should especially hone in on underweight residents with bony prominences who are immobile or functionally impaired and nutritionally depleted," Hendrick suggests. The Braden Scale, a popular tool used to predict pressure sore risk, also identifies chronic skin dampness and limited sensory perception as risk factors.

Make sure the assessment is complete, documented and accurately coded on the minimum data set. "For example, sometimes staff omits risk factors like chronic disease diagnoses, which should be recorded in Section I of the MDS," says, **B.J. Collard**, principal of **C.T.S. Inc**. in Westminster, CO. "Or the staff may forget to take off the resident's shoes and socks and look between his toes and at the heels," she adds. "The elderly person may not know he has sores because of poor sensation in the feet."

Intervene Immediately

If you do identify a resident as being at risk for skin breakdown, make sure to get the preventive equipment including special mattresses and heel protectors in place immediately. "Even if the resident is admitted Friday evening, don't wait until Monday to get started," cautions Collard. "A resident can get a stage 1 pressure sore started in hours. So by the time you get going with the person two days later, she already has a sore, or a preexisting pressure sore may be worse."

Also, staff should start turning and repositioning residents on a regular schedule as soon as the resident is admitted to facility. "You can't just put a specialty mattress on the bed and forget the human interventions, including the focus on turning and positioning," cautions **Donna Duss**, a nurse consultant and wound care specialist with **Joanne Wilson's Gerontological Nursing Ventures** in Laurel, MD.

When a resident has a new pressure sore or a nonhealing one, surveyors will target the care plan. "Surveyors evaluate the facility's use of the care planning process to determine whether a problem was avoidable or not," agrees **Deborah Ohl** of **Ohl & Associates** in Cincinnati. "So if any element within the categories of assessment, care plan development, implementation, review and revision is missing, the surveyors can say the problem was avoidable."

The facility should make sure "there is absolute agreement among all the care plan interventions and those documented in the interdisciplinary progress notes," suggests Duss. An example of nonagreement would be a care plan intervention directing staff to monitor the resident's albumin levels or to measure and stage a wound weekly, with nothing in the record to indicate that it was actually done.

Also, make sure care plan directives for turning and positioning residents don't lock your facility into an F tag. For example, it's best to say "Turn residents at least every 1-2 hours," advises **Kathy Hurst**, principal of **Hurst Consulting Group** in Chino Hills, CA. "If the intervention says 'every hour,' a surveyor can say, 'You didn't turn this resident for an hour and 15 minutes," she notes.

"Residents who need to be turned more frequently to prevent skin breakdown definitely need a pressure-reducing surface not a pressure-relieving surface," Hurst adds.

Surveyors will usually check to see if the nursing assistants are aware of the plan and implementing it. "The interdisciplinary team is expected to reevaluate the approaches on the care plan and change the plan accordingly," Collard notes.

"Allow a wound two weeks to improve after starting a new wound care product, however," advises **Mary Foote**, a wound care specialist and principal of **Wound Care on Wheels**, in Napierville, IL.

"If the wound is necrotic and you enzymati-cally debride it, or use something to liquefy the slough, the wound may get bigger and deeper as it starts to granulate," she explains. In such a case, give surveyors a "heads up" that a new wound care treatment is making the wound look worse temporarily.

Documentation Must Jibe

If the resident does develop a pressure ulcer, the physician decides whether the skin breakdown was avoidable or not. "The use of the language [unavoidable] is the physician's purview," says Duss. "The nursing and nutrition notes, however, could say that 'despite interdisciplinary interventions, the wound does not appear to be resolving,'" she adds.

Also, make sure all of the supporting documentation leads to the same conclusion, including the:

1. dietary and nutrition notes;
2. nursing notes and flow sheets;
3. skin documentation (ongoing, regular measurements and description of the wounds); and
4. treatment records.