Long-Term Care Survey Alert

Quality of Care: Move Your Skin Care Program To The Head Of The Class

To correct a problem, you have to identify, address and monitor it -- here's how.

To rein in pressure ulcer rates, nursing facilities have to maintain a full-press effort at every step of the quality improvement process.

The stakes for doing so are high: There's probably no other condition than pressure ulcers that has as many regulatory, legal and political implications and complications, noted **Steven Levenson, MD, CMD**, in a Webinar presentation on pressure ulcers sponsored by **Advancing Excellence in Nursing Homes**, a two-year coalition-based campaign that launched in September 2006.

Levenson suggested jumpstarting the quality improvement process by asking these key questions:

• **Are we doing the right things to prevent and manage pressure ulcers?** To answer that question, identify whether your interventions are "eminence-based" -- that is, dictated by managers -- or evidence-based, Levenson told Webinar participants.

• **Will we be challenged or blamed for pressure ulcers?** If so, will your facility be able to defend its practices and processes? Following the survey guidance at F314 can help, Levenson tells **Eli**. "F314 is a reasonable synopsis of the key expectations related to pressure ulcers," says Levenson.

• **What do the results say about our quality of care?** To answer that question, look at facility QA data, the quality indicators/ measures, survey results, review of actual resident cases and benchmarks. Also track the incidence of pressure ulcers or those that developed in the facility versus the facility's overall prevalence of pressure ulcers, Levenson suggested. The latter includes both nursing facility-acquired pressure ulcers, as well as decubiti that the facility inherited from the acute-care and other settings.

The good news: Facilities can lower the incidence of pressure ulcers occurring in-house to 2 percent or less, said Levenson.

• **How can we use technical assistance materials to improve?** (See p. 39 for a chart that spells out care for pressure ulcers.)

The goal: Asking and answering the aforementioned questions will help you determine what's good about your pressure ulcer program -- and what needs improving.

Drill Down to Possible Causes of Increased Prevalence

In looking at pressure ulcer trends, a high or increased prevalence can mean different things, as follows:

1. The facility may have more admissions with risk factors for pressure ulcers -- or with existing pressure ulcers. In that case, is the facility identifying and managing those risks? How quickly do the pressure ulcers heal?

Clinical gem: Don't over-rely on a standardized risk assessment like the Braden, which is well-recognized and validated but doesn't include diagnoses and medications known to cause risks, cautioned Webinar co-presenter **Debra Bakerjian, PhD, MSN, FNP**. "Consider what else outside of the Braden score is a risk," which requires looking at the entire

resident, she said. For example, hypotension is a risk for skin breakdown that's not included on the Braden. Care plan residents with any level of risk -- not just high-risk residents, she advised. Also, if the pressure ulcer isn't improving as expected, notify the primary provider and look at factors that might be impeding healing.

2. The facility may be producing more in-house pressure ulcers, which says something about its care.

Another possibility: The facility may have a combination of inherited and in-house pressure ulcers or higher-acuity residents at risk for skin breakdown.

Good news: The MDS 3.0 will be able to identify whether a resident is admitted with a pressure ulcer and whether pressure ulcers are healing, says **Christine Twombly, RNAC**, a consultant with **Reingruber & Co.** in St. Petersburg, FL.

Assess, Document at Admission

To detect pressure ulcers present at admission, inspect the resident's skin carefully -- preferably within four hours, if at all possible, Bakerjian advised. Be sure to use a strong flashlight because lighting in residents' rooms may not be bright enough to detect skin breakdown, she emphasized. Every treatment cart should have a good flashlight, she urged -- "not a pen light."

Also assess darkly pigmented skin very carefully. You can't always tell if the person with darkly pigmented skin has pressure-related tissue damage or a stage 1 pressure ulcer by looking for changes in skin color. Also look for induration, temperature change and bogginess.

Documentation tip: Always measure and document the height of a wound followed by the width, Bakerjian advised. That way auditors won't find that one nurse wrote that a wound measures 2 x 5, and a week later another nurse recorded it as 5 x 2.

To document the location of pressure ulcers or wounds, provide a standardized chart so everyone refers to body locations using the same terminology. And develop a consistent numbering system for identifying wounds -- for example, "always top to bottom or right to left," said Bakerjian.

Manage Comorbidities, Meds

Be on the lookout for and manage comorbidities that contribute to pressure ulcer development or poor healing of existing ulcers. The list includes any condition that creates a strain on organ systems, which makes it more likely the person's skin will break down with less pressure than usual, says Levenson. Examples include chronic pulmonary disease, congestive heart failure, anemia, chronic or acute renal failure, thyroid disease and delirium, he adds.

Medications can also increase the risk of pressure ulcers or impair their healing -- for example, by causing sedation, dry skin, urinary incontinence, diarrhea, etc., he said. Reducing medications and side effects is often a simple, inexpensive and highly successful action to reduce a patient's risk of skin breakdown, Levenson noted.

How to Know You're Succeeding

Based on results from nursing homes participating in a multi-year initiative, QI efforts aimed at pressure ulcers will initially nab "the low-hanging fruit," resulting in a rapid decline in the rate of decubiti, according to the Webinar. But the initial improvement is likely to level off and you'll still see variability in processes and practice.

Persistence pays: However, if you continue to effectively apply a combination of clinical, management and quality improvement principles at all levels of the organization, expect to see much less variability in staff practice -- and more rapid root cause analysis and correction, Levenson said.