Long-Term Care Survey Alert

What Do You Think?

Under the revised F314 tag, can facilities still make a viable argument to convince surveyors that a pressure ulcer was unavoidable?

- Question from the January 2005 Long-Term Care Survey Alert.

Answer: To answer this pressing question, **Eli** tapped attorney **John Lessner** with **Ober/Kaler** in Baltimore and wound-care expert **Kathleen Thimsen, RN, ET, MSN,** president of **RARE Consulting Group** in Bella Vista, AR. Here's what they had to say:

Lessner: Although the revised guidelines lessen the ability to establish that a pressure ulcer was unavoidable, facilities should still try to make that argument when appropriate. The notion that all pressure ulcers can be prevented is a myth. Ironically, the revised guidelines came out about the time that the actor **Christopher Reeve,** who one could argue had some of the best care available, died of an infection related to a pressure ulcer.

A facility might be able to prevent pressure ulcers in a very high-risk individual if nursing staff turned the person several times an hour. But that gets into a quality of life issue eventually because the person with a chronic condition may not want to be moved that often or receive ongoing aggressive interventions to prevent pressure ulcers.

Facilities can make a case that a pressure ulcer was unavoidable if they can show they have:

1. Performed accurate risk assessments;
2. Implemented immediate interventions at admission to address those risks;
3. Reassessed residents' risks at the intervals specified by the **Centers for Medicare & Medicaid Services.** (The guidelines suggest assessing the resident's pressure ulcer risk at admission, weekly for four weeks for residents at risk, quarterly and when a resident has a significant change in cognitive or functional ability);
4. Re-evaluated non-healing wounds and changes to the care plans at the interval specified by the guidelines or more frequently (the guidelines advise reassessing the resident's wound and overall clinical condition for wounds that don't appear to be healing in two to four weeks);
5. Involved the physician, wound care expert and interdisciplinary team;
6. Provided oversight by the medical director;
7. Used evidence-based protocols for treatment and prevention; and
8. Documented that the facility did all of the above.

Thimsen: A concept presented in the literature a couple of years ago talks about how every organ system has a certain programmed longevity. So one talks about cardiac or respiratory failure - and also skin failure. Some patients receive impeccable preventive care and still develop skin breakdown. We really need more research to determine what causes that skin breakdown.

We know ischemia causes pressure ulcers but in some cases that ischemia may be caused by a thrombolytic process. For

example, some small percent of patients who undergo cardiac bypass surgery go on to develop purple, butterfly-shaped sacral lesions that present on the third post-op day. By the tenth day after surgery you can place two fists into the wound. We really don't know the underlying dynamic of that type of wound or of Kennedy Terminal ulcers, which also occur in the sacral area near the end of life.

Editor's Note: For more information on Kennedy terminal ulcers, which surveyors can mistake as avoidable pressure ulcers, go to www.kennedyterminalulcer.com.