MDS Alert

QUALITY IMPROVEMENT: How Risky Is Your Pressure-Ulcer Prevention and Related MDS Coding and Documentation?

Close these 4 common gaps in the assessment and implementation areas.

Prevention is the name of the game in any arena, especially in heading off pressure ulcers. But a few easily overlooked omissions in your preventive program will derail your efforts.

The reality: Very few pressure ulcers are truly unavoidable if you have the right prevention measures in place, emphasized **Nancy Augustine, MSN, RN,** in a presentation on risk management at the American Association of Homes & Services for the Aging annual meeting. And your facility can sidestep the pitfalls most likely to trip you up in heading off pressure ulcers, she told AAHSA conferees.

Consider these four strategies to cover the risk-management bases:

1. Identify and address sometimes overlooked risk factors. Pay special attention to these key risk factors, advise experts:

• Moisture due to incontinence. Nursing home staff sometimes don't focus enough on tackling urinary incontinence-related moisture and peri-care in efforts to keep skin intact, observes **Jenny Hurlow, GNP, CWOCN,** a geriatric nurse practitioner and wound care specialist in Memphis, Tenn.

Real-world practice: One hospital- based gerorespiratory unit with high-acuity patients at very high risk for skin breakdown drove its in-house pressure ulcer rate to zero using a number of strategies, including a protectant paste for macerated skin due to incontinence. "We also use an under pad that has very high absorbency," reports **Deborah Greener-Orr, PhD, RN, CWOCN,** a wound, ostomy, and continence nurse at the hospital. "We took patients out of diapers totally." (For details, request a copy of the case study by e-mailing the editor at KarenL@Eliresearch.com.)

Also focus on stool incontinence, which can be hard to manage if a resident has constant stooling, says **Mardy Chizek, RN, FNP, MBA, CLNC,** a consultant in Westmont, Ill. In that case, "look at medications, diet, gastrointestinal conditions, infectious diseases such as C. difficile, and other factors as potentially treatable conditions."

• Impaired ability to respond to sensory effects of pronged pressure. This risk factor includes people with advanced dementia who have lost the ability to appropriately respond to the sensation of touch or pain, says Hurlow. These residents "may feel the heel pain [caused by pressure] but don't know that they should move their heel to allow blood flow to return to the site, which will make the feeling go away."

• Dietary needs. Make sure high-risk residents receive enough protein and a balanced diet, advises Chizek. "People developing pressure ulcers are the ones with multiple comorbidities and a high-risk nutritional status," says Chizek. And if they do develop a pressure ulcer, "it's hard to get them back to baseline nutritionally with the increased protein requirements for healing."

Tip: Identify and address new risks in real time. A shift report book, for example, can flag residents who aren't repositioning or getting up due to a short-term acute illness or a sedating medication, as examples.

2. Capture all of a resident's risks and preventive care on the MDS. Take a look at whether you're coding turning and repositioning in Section M5. If you're not coding the service because it doesn't meet the coding criteria, then define the program more clearly in order to capture it on the MDS, Augustine advised AAHSA conferees. The service has to be documented, care planned and individualized for that resident, Augustine reminded people.

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Don't overlook: In addition to coding all preventive care, including nutritional interventions, in M5, code any preventive or protective foot care at M6e (defined by the RAI manual as "diabetic foot care, foot soaks, protective booties, e.g., down, sheepskin, padded, quilted, special shoes, orthotics, application of toe pads, toe separators, etc."). Also capture nutritional interventions in K5, as well as any restorative programs (Sections P3 or H3) aimed at improving the resident's ADL function and/or continence.

3. Perform daily skin inspections for all residents at risk for skin breakdown. Doing so sounds insurmountable, Augustine conceded in her AAHSA presentation. But most residents at risk are incontinent and have some level of immobility, she pointed out. Thus, the nursing aid is dressing and changing the person "and can check pressure points," as well as look for a change in skincondition, she said. Then you need a notification system if the resident has a change in skin condition. Licensed nurses should check the high-risk resident's skin at least weekly and make a notation in the chart that the skin wasn't broken and had no reddened areas, if that's the case, Augustine advised.

Audit the charts for consistency: Augustine reported seeing charts with inconsistencies, such as the nurse documenting that a resident's skin is intact on the same day thatthe treatment nurse documented her measurements of the resident's pressure ulcer.

4. Find ways to carry out preventive skin care consistently. Audit each shift to see if caregivers are turning and repositioning residents, as directed by the individualized care plans.

Compliance tool: Have caregivers note on a working care plan or pocket guide the last time they turned/repositioned a resident, advises **Cheryl Boldt, RN,** in Omaha, Neb., who recommends that tactic to ensure compliance during the survey.

Also make pressure ulcer prevention everyone's job, advises Chizek. Suppose you have a resident who responds to cues to reposition or weight shift in her wheelchair. "There's no reason that any staff person, including the maintenance man, couldn't remind the person to do that when they are walking by," says Chizek.

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