MDS Alert

Risk Management: Shore Up Pressure Ulcer Care With 'Lessons Learned' From This Real-Life Scenario

Find out if your facility is wide open to a similar disaster

A few common missteps in assessing and addressing a resident's risk of skin breakdown can lead to a major breakdown in care, resulting in serious consequences for residents and your SNF.

A cautionary tale: One nursing home resident developed a Stage 4 pressure ulcer that seemed to develop overnight. As a result, the SNF got hit with a huge lawsuit that it might have prevented by using the right assessment, care plan and resident education.

Here's what happened: An 87-year-old patient came to the SNF for rehab following surgical repair of a left hip fracture and broken left arm, according to an Advancing Excellence-sponsored Webinar presentation on pressure ulcers by **Debra Bakerjian, RN, MSN, PhD, FNP.**

The patient had multiple conditions, including weight loss and venous insufficiency. At admission to the SNF, she had multiple pressure ulcers on the buttocks and coccyx, and venous insufficiency ulcers on both legs. The woman was already going to a wound clinic to receive care for the venous ulcers. A licensed nurse assessed the patient's skin upon admission and documented the findings, including a reddened area that wasn't measured on the upper right inner posterior thigh. On admission, the resident had a risk score of 16 on the Braden scale, indicating mild risk. She also had borderline fall risk, side rails as an enabler, no pain, and had a Foley catheter but was continent for bowel movements, according to an RN assessment.

For 19 days after admission, staff provided only minimal documentation related to the resident's pressure ulcers, and completed only two skin treatment forms. The primary care physician saw her on admission but didn't examine the wounds or change treatment orders after that, according to Bakerjian's presentation.

Two days later, the patient complained of intractable pain requiring IV Dilaudid. An assessment revealed that the reddened area on her thigh had opened to the bone and had drainage. At that point, the SNF transferred the patient to the hospital for acute care. (The resident ultimately healed, although she suffered scarring. But the case resulted in a more than $1 million settlement by the insurance company, Bakerjian tells **Eli**.)

Analyzing What Went Wrong

Bakerjian outlines a number of strategies that SNFs can employ to ensure that a resident's pressure ulcer doesn't catch them off guard.

• **Distill an accurate risk picture.** Over-relying on the Braden or other standardized risk assessment instruments can be a big mistake in some cases. For one, "the Braden doesn't capture the complexity of the resident's risk related to his pre-existing diagnoses, such as congestive heart failure, hypertension, and peripheral vascular disease," notes Bakerjian.

The Braden and Norton assessments also don't consider the time a patient spent on the operating room table, which can create deep tissue injury. "There's a ton of risk [in that regard] for a post-operative patient," Bakerjian emphasizes.

Solution: Develop communication systems to obtain information about what happened to the resident in the hospital that places him at higher risk for skin breakdown.

Medications can also increase the risk of pressure ulcers or impair their healing -- for example, by causing sedation, dry skin, urinary incontinence, diarrhea, etc., said **Steven Levenson, MD, CMD**, who copresented with Bakerjian. The resident in the case study was taking two diuretics, which increases the risk of dehydration and skin breakdown, she said (see the list of medications and other assessment data on p. 19).

• **Look for suspected DTI, and document it carefully.** The nursing staff in this case did a skin assessment and documented it at admission. "But they did not recognize the DTI," which is a relatively common omission in that DTI may initially simply appear red or discolored, says Bakerjian (for more information, see the article on coding pressure ulcers on p. 21). And "unless you palpate the area and monitor it closely, you don't realize that the tissue is breaking down under the intact skin," she cautions.

• **Be a detective.** Ask why an area is red, Bakerjian advises. Check the resident's history, as well as ask her or a family member to figure out what happened, she adds. In this case, a wedge positioned between the legs during surgery or perhaps tubing caused the DTI, according to Bakerjian's presentation.

• Keep a wound care clinic in the loop. The resident in this case continued to go to the wound clinic, which had already been treating her venous ulcers. And given that the resident was alert and cognitively intact, it's hard to believe that the clinic didn't know about the evolving DTI, says Bakerjian. However, she's seen more than one instance where a nursing home assumes the wound clinic is managing every skin issue when in fact, the clinic is focusing only on the original problem, as happened in this case.

Proactive strategy: Develop verbal and written communication protocols with all of a patient's providers, including a wound clinic, to get everyone on the same page with the plan of care.

The risk management reality: "Perhaps with intervention, [the DTI] would have only opened up to a Stage 3," says Bakerjian. And staff could have let the resident know that they were concerned about an area on her skin that probably occurred from being on the operating room table, she adds. "Then when the skin did break down, it would not have been a surprise." That approach certainly would have reduced the risk of litigation, Bakerjian says.

Editor's note: See "3 Strategies Help Error-Proof Pressure Ulcer Dx, Coding," on p. 21.