MDS Alert

SKIN CARE: 3 Ways to Head Off Hospital-Acquired Pressure Ulcers

Synching with the hospital helps keep residents' skin in the clear.

Cooperation is the name of the game for nursing homes and hospitals that want to make sure that elderly patients don't develop pressure ulcers in either setting. These key strategies can do the trick.

1. Coordinate wound assessment and documentation with the hospital. A physician or nurse manager in the hospital needs to certify the status of the patient's wound when he goes to the nursing home, says **Marty Pachciarz, RN, RACCT,** a consultant with The Polaris Group in Tampa, Fla. And the nursing home needs to do the same when the patient is admitted from the hospital. Both care settings should use the same wound terminology and staging parameters.

That way, if the nursing home identifies suspected deep tissue injury (DTI) at admission -- or the resident's skin breaks down within a few days to a stage 3 or 4 pressure ulcer -- the hospital can use that information for QA purposes, says Pachciarz. Perhaps the hospital can trace the problem back to a particular unit or to a specific type of surgery where the OR needs to be more proactive to prevent skin breakdown.

What if the nursing home and hospital identify different wound stages and severity? You'd send that "through the QA function," says Pachciarz. In some cases, the explanation could truly be that the resident's long ride in the ambulance caused the skin breakdown.

MDS 3.0 will help: The MDS 2.0 can be an obstacle to getting the hospital and nursing home on the same page with their pressure ulcer staging, say experts. The MDS 3.0 should be an improvement in that regard, however. For example, the draft MDS 3.0 form allows you to capture suspected DTI in evolution.

2. Provide an adequate handoff. The hospital needs transition information "that [distills] what wounds the patient has, the current treatment, etc.," advises **Deborah Greener-Orr, PhD, RN, CWOCN,** at Northwest Hospital. "If I come in on Monday and have 20 patients, I don't have time to look through lengthy nursing home records to figure that out." (See page 117 for a suggested hand-off form devised by Greener-Orr.)

3. Sidestep ED admissions when possible. Having nurse practitioners treat residents who become ill on weekends and at night helps cut down on ED use. And that strategy can, in turn, help prevent skin breakdown that occurs during long waiting times at the ED when ED staff don't take steps to prevent decubiti, observes **Rod Hicks, PhD, RN, FNP-BC,** a professor at the Texas Tech University Health Sciences Center in Lubbock, Texas.