

**Pathway Health Services**




**SUPPORTIVE  
SPECIALTIES**

## The Director's Guide to Wound & Skin Management in Long-Term Care

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## Wound & Skin Management

**OBJECTIVES:**

- To understand the Standard of Practice for Wound & Skin Management in Long Term Care
- To effectively utilize risk assessment tools to demonstrate unavailability of pressure ulcers
- To describe proper documentation of wounds for regulatory compliance, professional liability & litigation
- To understand the components of an effective wound management program in long term care
- To effectively utilize the wound care nurse

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## Regulatory Compliance

### Regulatory Requirements

#### Example F314

\$483.25(c) Pressure Sores

Based on the Comprehensive Assessment of a resident, the facility must ensure that-

(1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and ...

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### Example F 314

**Intent: (F314) 42 CFR 483.25(c)**

The intent of this requirement is that the resident does not develop pressure ulcers unless clinically unavoidable and that the facility provides care and services to:

- Promote the prevention of pressure ulcer development;
- Promote the healing of pressure ulcers that are present (including prevention of infection to the extent possible); and
- Prevent development of additional pressure ulcers.

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### Example F 314

**“Avoidable/Unavoidable” Pressure Ulcers**

*“Avoidable”* means that the resident developed a pressure ulcer and that the facility did not do one or more of the following: evaluate the resident’s clinical condition and pressure ulcer risk factors; define and implement interventions that are consistent with resident needs, resident goals, and recognized standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate.

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### Example F 314

*“Unavoidable”* means that the resident developed a pressure ulcer even though the facility had evaluated the resident’s clinical condition and pressure ulcer risk factors; defined and implemented interventions that are consistent with resident needs, goals, and recognized standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate.

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### Example F 314

This information allows the facility to develop and implement a comprehensive care plan that reflects each resident's identified needs.

The care process should include efforts to stabilize, reduce or remove underlying risk factors; to monitor the impact of the interventions; and to modify the interventions as appropriate.

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### Regulatory Compliance

#### Frequent Mistakes

- Failure to complete the assessment
  - ✓ Communication with discharging facility
  - ✓ Preadmission data collection
  - ✓ Early detection of risk factors
  - ✓ Look beyond the Braden scale
  - ✓ Failure to establish condition upon admission
  - ✓ Failure to reassess with a change of status

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### Regulatory Compliance

#### Frequent Mistakes

- Care Planning
  - ✓ Identified risk factors not addressed on the interventions
  - ✓ Interventions not put into place quickly or proactively
  - ✓ Interventions not communicated to caregivers

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## Regulatory Compliance

### Mistakes Can be Costly



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## Regulatory Compliance

### Professional Liability

- Actual Harm Citations
- Scope & Severity of G – L
- Repeated citations / lack of compliance

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## Regulatory Compliance

### Professional Liability

- State Regulatory Boards
- DON
- NHA
- Medical Director
- Primary Care Physician

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## Professional Liability

**Action Steps**

- Notify your employer
  - ✓ Other members of management may have received an inquiry too
  - ✓ Facility may have had a history you are not aware of
  - ✓ Time off may be required to deal with the matter
  - ✓ You will likely need documents released by the facility
  - ✓ Resident records may need to be submitted

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## Professional Liability

**Action Steps**

- Seek professional help
  - ✓ Attorneys
  - ✓ Professional Organizations (State DON group)
  - ✓ CLNC



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## Professional Liability

**Action Steps**

- Seek Peer / Personal Support
  - ✓ Friends in the business
  - ✓ Peers may have been through this too
  - ✓ Friends outside work
  - ✓ Family support
  - ✓ Your work family

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## Professional Liability


### Areas of Concern

#### Pressure Ulcers

- Question of adequate equipment
- Question of adequate staffing
- Question of education
- Question of supervision
- Question of standard of care



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## Professional Liability

### Mitigate the risk of being called into question

- Staff education programs
- Know nurse practice act – especially delegation
- Understand standards of care
- Know facility history – previous regulatory issues
- Layer checks & balances
- Document audits & corrective actions

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## Pressure Ulcers & Litigation

### All Litigation is Costly – Guilty or Not!



*Avoiding Litigation*

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## Documentation & Litigation

### Facility & Individual Liability

#### Vicarious Liability

- Respondent superior – Employer is liable for negligent acts an employee commits within the scope of employment
- ✓ Document to reflect policy & procedure
- ✓ Document to reflect standard of care
- ✓ Document to reflect nurse practice act

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## Documentation & Litigation

### Facility & Individual Liability

#### Direct Corporate Liability

- Policy & Procedure does not reflect SOC
- Lack of Education / competency testing
- Inadequate staffing
- Physical plant issues
- Negligent hiring practices
- Violation of laws

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## Litigation – Pressure Ulcers

### Pressure Ulcers: The problem

- Avoidable – due to poor care or neglect
- Public not sympathetic to nursing homes
- Families not aware of pressure ulcer or had overall concerns that needs were not met
- High return on claims
- Lack of education for nurses and physicians

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## Litigation – Pressure Ulcers

**Pressure Ulcers: The problem**

- Death due to SEPSIS secondary to a pressure ulcer
  - Signs of infection not addressed
    - foul odor
    - Increase in necrotic tissue
    - Decline of ulcer
    - Increase of drainage
    - Friable tissue mistaken for healthy granulation tissue

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## Litigation – Pressure Ulcers

**Pressure Ulcers: The Problem**

- Not following standards of practice
  - Not being turned and repositioned timely
  - Support surfaces not aggressive (perceived as saving money)
  - Incontinence care not done
  - Nutritional support not addressed
  - Inappropriate topical treatments
  - Not aggressively responding to S/S of infection
  - Not notifying MD/NP & family when the wound shows no progress or declines
  - MD/NP not responding to calls or not assessing ulcer appropriately

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## Litigation – Pressure Ulcers

**Pressure Ulcer Documentation Concerns**

- Care plan should address all risk factors and interventions
- Timely Weekly documentation of the wound
- Wound assessment consistent and complete (date or location missing, measuring in cm and inches, wrong side)
- Accurate staging of ulcer (staging it as a II when it is a III or IV)
- Responding when wound declines or shows no progress

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## Litigation – Pressure Ulcers

History of citations or complaint surveys for pressure ulcer and wound care management increases litigation risk

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## Focused Charting

### Pressure Ulcers Management

- Chart appropriate support surfaces
  - Low-air loss for stage III or IV and/or multiple turning surfaces affected
  - The deeper the air chamber and the more you can program the surface specifically for the resident the more aggressive it is
  - Refer to Therapy for seating surface. Gel and air out perform foam
  - Heel elevation at all times in the bed
  - NO donuts or ring type devices

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## Focused Charting

### Pressure Ulcer Management

- Chart that turning and repositioning is individualized & actually implemented
  - Tissue tolerance – there is no “test”
  - Ensure repositioning intervals are tolerated by the resident
  - Both lying and sitting, upon admission, re-admission and sig. change (including development or decline of an ulcer)

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## Focused Charting

### Pressure Ulcer Management

- Chart proper nutritional support
  - Caloric Intake, including protein
  - Essential amino acids that improves muscle integrity, supports immune function and increases nitric oxide
  - Simple multivitamin
  - Appetite stimulants

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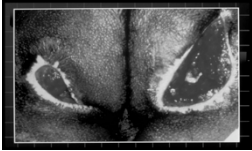
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## Standard of Practice for Wound & Skin Management in Long Term Care

### Resident Condition Pressure Ulcers



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## Specific Charting Elements


### Resident Condition Pressure Ulcers

- A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with friction & / or shear.

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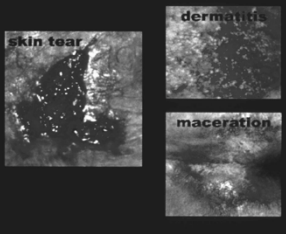
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### Other Dermal Injuries



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### Moisture



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### Lower Extremity Wounds

- Arterial Insufficiency
- Venous Insufficiency
- Peripheral Neuropathy/Diabetic
- Referred to the F309 Tag



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### ASSESSMENT

- When a pressure ulcer is present, daily monitoring should include:
  - An evaluation of the ulcer, if no dressing present
  - An evaluation of the status of the dressing, if present
  - The presence of complications
  - Whether pain, if present, is being adequately controlled

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### ASSESSMENT

- Wounds should be assessed/documented on a weekly basis, however when there is a complication or change identified daily monitoring/documentation maybe necessary, until resolved. However, the amount of observation of wound bed possible will depend upon the type of dressing that is used (many dressings are meant to stay in place for several days).
- A clean pressure ulcer with adequate blood supply & innervation should show evidence of stabilization or some healing within 2-4 weeks.
- Nurse Notes should reflect progress of wound only.

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### ASSESSMENT

- Date
- Location
- Stage
- Size & Depth
- Wound Base Description
- Undermining & Tunneling
- Drainage
- Wound Edges
- Odor
- S/S of Infection
- Pain

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## ASSESSMENT

A COMPLETE DATE  
(month/day/year)

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## ASSESSMENT

- ✓ LOCATION
- ✓ LOCATION
- ✓ LOCATION

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## Wound Bed Assessment

Describe the tissue in the wound bed using professional terms

- Necrotic/eschar
- Slough
- Granulation
- Epithelial

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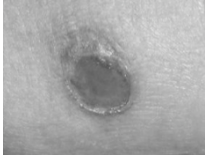
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### Wound Bed Assessment

Describe the tissue present in the wound bed using percentages:

- 30% epithelial tissue, 70% granulation tissue
- Should equal 100%!



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### Stage I Pressure Ulcer

Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.

**Further description:**  
The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage I may be difficult to detect in individuals with dark skin tones. May indicate "at risk" persons (a heralding sign of risk)



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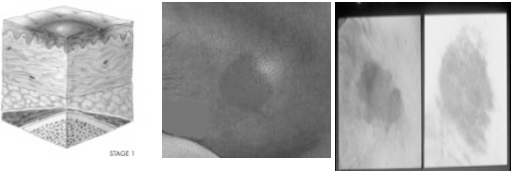
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### Stage I Appearance



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## Suspected Deep Tissue Injury

Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

**Further description:**  
Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.

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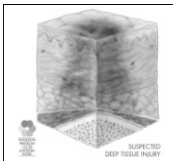


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## Deep Tissue Injury

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## Stage II

Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.

**Further description:**  
Presents as a shiny or dry shallow ulcer without slough or bruising.\* This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.  
\*Bruising indicates suspected deep tissue injury

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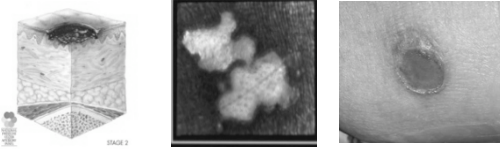
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### Stage II



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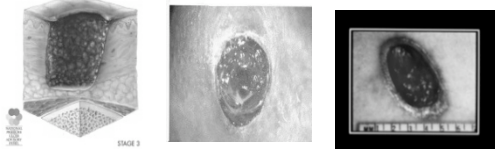
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### Stage III

Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

**Further description:**  
The depth of a stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage III pressure ulcers. Bone/tendon is not visible or directly palpable.



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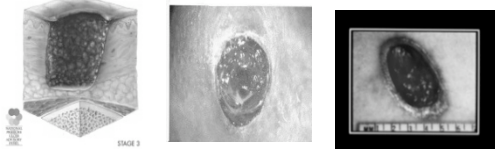
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### Stage III



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## Stage IV

Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.

**Further description:**  
The depth of a stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.

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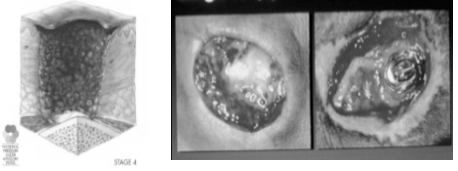
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## Stage IV



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## Unstageable

Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

**Further description:**  
Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed.

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### Unstageable



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### Pressure Ulcer Assessment

- Purpose of staging is for consistent communication of depth of tissue destruction
- Once staged, the ulcer should not be back staged, rather the wound should be described in terms of size, shape, color, drainage, and odor using one of the wound assessment measures ([www.npuap.com](http://www.npuap.com))

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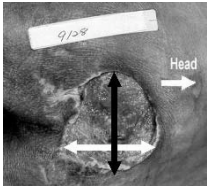
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### Measuring the Open Area



**Measure in centimeters**  
Use a moistened sterile cotton tip applicator (NS or Sterile water)

**Length:** longest length from head to toe

**Width:** Widest width; side-to-side (90-degree angle) to length

**Depth:** From the visible surface to the deepest area

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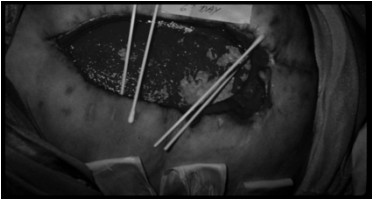
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- For tunneling or undermining, use the clock system with resident's head at 12 o'clock
- When assessing, always use a moistened cotton swab and insert gently



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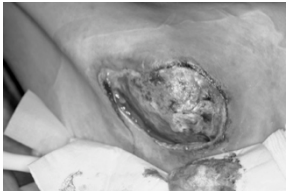
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### Assessment

- Wound Drainage
  - Amount
  - Color
  - Consistency



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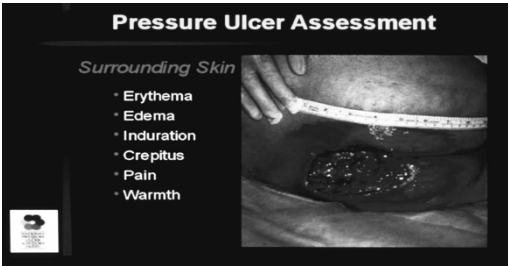
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### Assessment

#### Pressure Ulcer Assessment

*Surrounding Skin*

- Erythema
- Edema
- Induration
- Crepitus
- Pain
- Warmth



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## Pressure Ulcer Assessment

- **Odor** if it is present (assess odor only after wound is irrigated)
- **Pain** – nature, frequency and management
- **Signs or symptoms of infection**
- One tool that can be used to monitor changing status of a pressure ulcer is the PUSH tool ([www.npuap.org](http://www.npuap.org)). However, it is not a comprehensive assessment of the wound

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## Pressure Ulcers

### Documentation Tips

- Ensure care plan has appropriate goals
- Only list the type of ulcer and location of it on the care plan (i.e., Pressure ulcer to right trochanter)
- Once the pressure ulcer heals, ensure it gets listed on the care plan (i.e., history of pressure ulcer to right trochanter)
- Physician diagnosis and prognosis are appropriate

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## Pressure Ulcers

### Documentation Tips

- Failure to progress in 2 weeks or a decline requires:
  - ✓ Reassessment of resident risks
  - ✓ Re-evaluation of treatment
  - ✓ Re-evaluation of care plan
  - ✓ Notification of MD / NP
  - ✓ Notification of resident / POA
  - ✓ All need to be documented in the chart

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### Educate the Wound Care Nurse

- Consider WOCN or WCC certification
  - Prevention
  - Etiology of wounds
  - Assessment & Documentation
  - Treatment modalities
- F314 Training
- MDS 3.0 Section M Training

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### Getting Started

#### Development of a Skin Care Team

- Key Nursing Assistants from ALL shifts
- Nurse Managers
- Key Floor Nurses from ALL shifts
- Therapy
- Dietary
- Physician/NP/Medical Director
- Housekeeping/Maintenance

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### Skin Care Team Meetings

- Develop a **SET** schedule for the Skin Care Team meetings
  - Initially may need to be weekly to bi-weekly
  - Monthly



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## Skin Care Team Meetings

**AGENDA: Review current residents with wounds**

- Progress
- Topical Treatment
- Support surfaces/equipment
- Heel lift
- Turning Schedule
- Incontinence management
- Nutritional Support
- Therapy Involvement
- Compliance/Barriers to plan of care

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## Skin Care Team Meetings

**Agenda: Review ALL Residents (bring in treatment book)**

- Review Treatment sheets
- Decrease/change in mobility
- Change in appetite, eating habits or weight loss
- Change in continence
- Change in cognition
- Overall changes/decline

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## Skin Care Team Meetings

**Agenda: Review Supplies/Equipment**

- Support Surfaces (bed & wheelchair)
- Heel lift devices
- Positioning devices
- Perineal cleansers and barrier ointments/creams
- Lifting devices
- Topical dressings

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## Weekly Wound Rounds

**Involvement of:**

- Nurse Manager
- Floor Nurse
- Nursing Assistant

***GREAT TIME FOR BED SIDE EDUCATION***

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## Assessing Programs

- **Break your pressure ulcer Prevention program down into two areas:**
  - Admission process
  - On-going Prevention Program
- **Utilize the Quality Improvement process when assessing each program**

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## Admission Process

**All care settings admission process (within the first 24 hours) should include:**

- A head to toe skin inspection by the **licensed** staff (ideal within 8 hours)
- A risk assessment for the potential for skin breakdown
- Development of a temporary plan of care
- Communication to the caregivers

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## Admission Process

### Admission Process Tips

– At a MINIMUM Temporary Care Plan within 24 Hours to Include:

- Support surfaces (bed and W/C)
- Turning & repositioning schedules
- Incontinence care & keeping skin clean and dry
- Heels elevated off bed
- Dietary and therapy referrals
- Access to topical dressings if admitted with pressure ulcers

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## Prevention Program Assessment

### Does your current prevention program include...

- **On-going** Risk Assessments per care setting guidelines?
- **On-going** skin inspections?
- **On-going** updates to the plan of care?

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## Interventions

✓ A list of interventions to correlate with potential risk factors, to help develop the plan of care



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### Supplies/Products

- ✓ Pressure redistribution bed surface, including access to low-air-loss and air-fluidized beds if needed
- ✓ Wheelchair cushions
- ✓ Heel lift devices and/or pillows

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### Supplies/Products

- ✓ Barrier ointments/creams to protect from incontinence (are they accessible to the caregivers)
- ✓ Lifting and positioning devices
- ✓ Dietary supplements as appropriate

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### Monitoring the Programs

#### Audits

- Monitoring turning and repositioning (sticky notes)
- Monitoring toileting schedules
- Assessment and confirmation that equipment is in place and functioning properly

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## Monitoring Programs

### Audits

- Ensure IDT is being proactive and discussing high risk individuals (immobile, losing weight and incontinent)
  
- Monitor daily cares to ensure they are inspecting the skin, doing proper peri-care, ROM, feeding/ supplements, weights, I & O, etc.

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## Monitoring Programs

### Audits

- Monitoring that the risk assessment and skin observations are done at appropriate intervals
  
- Monitoring that the plan of care reflects interventions being implemented and identified risk factors
  
- Do the risk assessments, physician orders, caregiver assignment sheets and MDS/CAAs match the care plan?

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## Discovery of a Pressure Ulcer

- Notification of the Physician and family/designee of the development of a wound, regardless of stage
- Documentation of the wound(s)
- New risk assessment
- Evaluate Support Surfaces
- Evaluate turning and repositioning
- Evaluate all interventions
- Up-date the care plan
- Up-date the nursing assistants assignment sheets

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## Communication

- Physician/NP, Family, Interdisciplinary Team, Skin Care Team & Direct Care givers
  - Upon Discovery
  - No Progress in 2 weeks
  - Decline
  - Healed



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## Monitoring Programs

- Monitor ALL nurses doing dressing changes and wound assessments
- Monitor treatment records and documentation records
- Monitor the Physician and NP orders, diagnosis and progress notes appropriate
- Ensure IDT is actively discussing/identifying wounds not showing progress



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## Refusal of Care

### Risk/Benefit Discussion

- Discuss resident's condition
- Treatment options
- Expected outcomes
- Consequences of refusing treatment (pressure ulcer development, sepsis and even death)
- Offer relevant alternatives
- Recommend showing residents/families pictures of pressure ulcers
- 



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### Refusal of Care

#### Risk/Benefit Conversation

- Document the date of discussion in care plan and put resident's request in care plan
- Review quarterly, with re-admission and with change of condition

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### Education

- Do your nurses know how to identify the etiology of the ulcer (pressure verses vascular)
- Do your nurses know how to stage pressure ulcers utilizing the NPUAP staging system
  - Purpose of staging is for consistent communication of depth of tissue destruction
  - Once staged, the ulcer should not be back staged, rather the wound should be described in terms of size, shape, color, drainage, and odor using one of the wound assessment measures ([www.npuap.com](http://www.npuap.com))

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### On-going Education

- Recommend doing educational programs in this order
  - Prevention
  - Assessment and Documentation
  - Treatment Modalities
  - Lower Extremity Ulcers
- Do bedside follow up after educational programs
- Do education on orientation and periodically throughout the year

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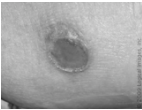
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### Limiting Professional Liability & Litigation


**Areas of Concern**

Pressure Ulcers

- Question of adequate equipment
- Question of adequate staffing
- Question of education
- Question of supervision
- Question of standard of care



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### Limiting Professional Liability & Litigation

**Mitigate the risk of being called into question**

- Know nurse practice act – especially delegation
- Understand standards of care – Regs & NPUAP
- Know facility history – previous regulatory issues
- Staff education programs annually & prn
- Layer checks & balances – Trained Wound Care RN
- Document audits & corrective actions - IDT

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### Resources

**Available Resources and Web Sites:**

- [www.wocn.org](http://www.wocn.org) (Wound, Ostomy & Continence Nurse Society)
- [www.ahrq.gov](http://www.ahrq.gov) (Agency for Health Care Research and Quality, formally AHCPR)
- [www.aawm.org](http://www.aawm.org) (American Academy of Wound Management)
- [www.npuap.org](http://www.npuap.org) (National Pressure Ulcer Advisory Panel)

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## Resources

- American Geriatrics Society at [www.americangeriatrics.org](http://www.americangeriatrics.org);
- American Medical Directors Association (AMDA) Clinical Practice Guideline "Pain Management in the Long-Term Care Setting" (2003) at [www.AMDA.com](http://www.AMDA.com);
- American Academy of Pain Medicine at [www.painmed.org](http://www.painmed.org);
- Hospice and Palliative Nurses Association at [www.hpna.org](http://www.hpna.org);
- Quality Improvement Organizations at [www.medqic.org](http://www.medqic.org).

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## Wound Resource Manual



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## Resources

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- Director of Nursing Manual
- Wound Resource Manual – 4<sup>th</sup> Edition (for long-term care and home care)
- Incontinence Manual
- Wound rounds, audits and training
- Infection Control Manual

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**Thank you for your participation!**

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