Reducing Pressure Ulcers in NHs: An Interdisciplinary Process Framework

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Advancing Excellence Campaign
Eight Goals

- Reduce Pressure Ulcers
- Reduce Use of Restraints
- Improving Pain Management
- Set STAR Targets
- Conduct Resident Satisfaction Surveys
- Improve Staff Retention
- Increase Use of Consistent Assignment

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To sign up…

Choose 3 goals

- –1 clinical
- –1 organizational
- –One other

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Why Sign Up?

- There is evidence that shows that participants in the Campaign are improving at a faster rate than non-participants in the Campaign…

Webinar Objectives

- Campaign Goals
  - Pressure ulcer campaign goal
  - Review current progress
- Review pressure ulcer framework
  - Components of the framework
  - Bedside implementation process
- Present Case Scenario
  - Review the process of care highlighting specific decision points for staff to demonstrate implementation of the process framework

Purpose of this Webinar

- Need each NH commitment to initiate a process improvement plan to reduce pressure ulcers
- Use the process framework and implementation framework as a guideline
- Follow the processes consistently
- Will see commensurate decrease in PU incidence & prevalence moving forward.

Pressure Ulcers

- Common
- Problematic
- Challenging clinically
- Political, regulatory, and legal implications and complications
- Seemingly everyone has an opinion
- Some occur despite preventive efforts

Facility QA Meeting: Pressure Ulcer Challenges

- Are we doing enough?
- Do we do the right thing?
- Will we be challenged or blamed?
- Will we be able to defend our practices and processes?
- Can we do better?
- What do our results say about the quality of our care?

Goals of This Presentation

- You are trying to determine the quality of your facility's pressure ulcer care
  - What is good about it
  - What could be improved
- How can the Campaign Technical Assistance materials help you do so?

Goals of This Presentation

- Review the components of the Implementation Package for campaign goal #1, related to pressure ulcers
- Identify the steps to implementing quality improvement approaches related to pressure ulcers
- Discuss how to use the Technical Assistance materials to help improve results related to Goal #1

Pressure Ulcers: Implementation Approaches

- Review for performance of these steps
  - Recognition / assessment
  - Cause identification
  - Management
  - Monitoring
- Steps in the following slides relate to Pressure Ulcer Implementation Framework steps from TAW materials

Recognition / Assessment

Step 1: Identify pressure ulcer prevention and care as an area for potential improvement in performance and practice

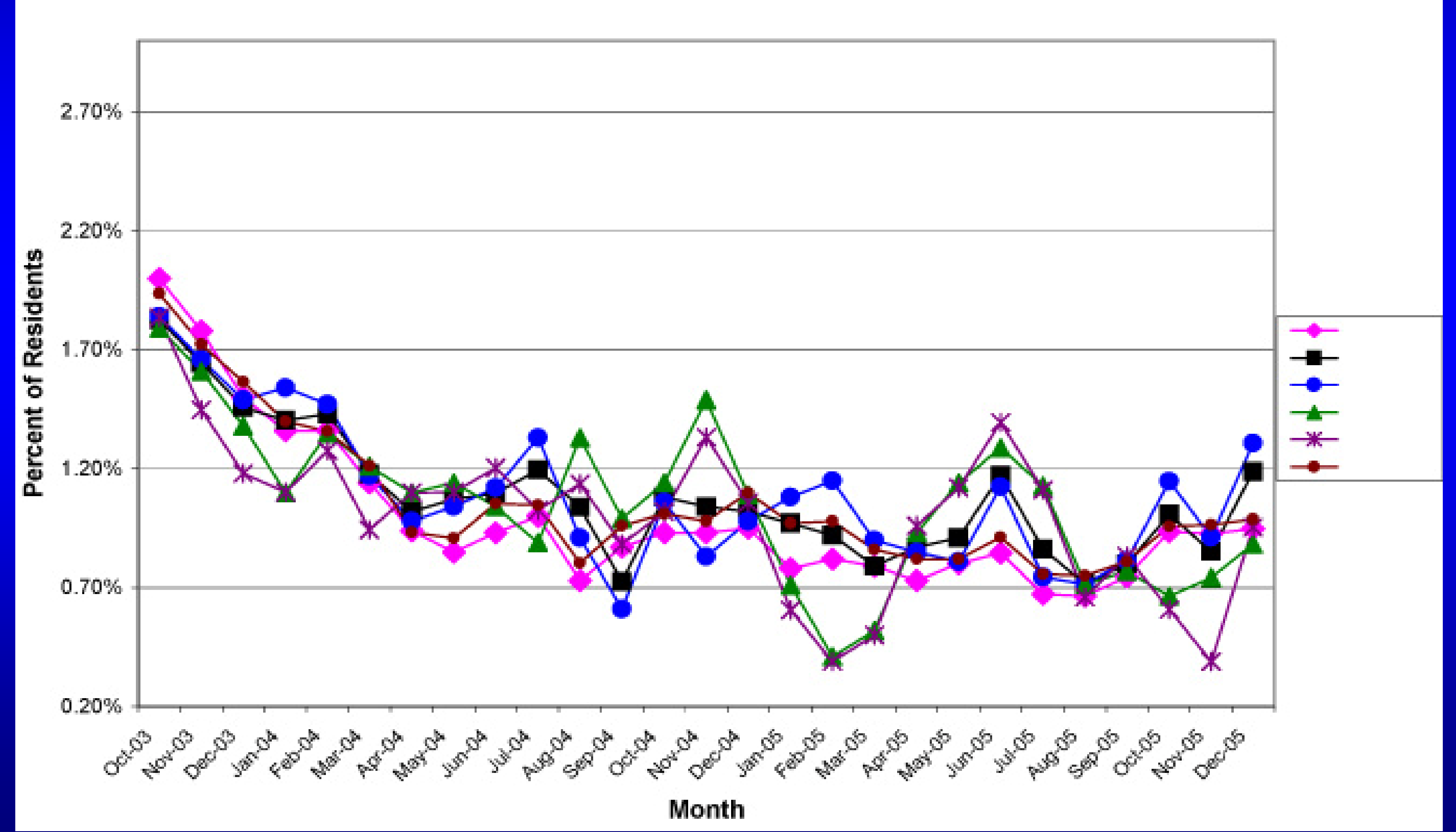
- Key question: How are we doing? Can we do better?

– Based on facility QA data, quality measures, survey results, review of actual resident cases, comparison to benchmarks, etc.

The Evidence

- Facility QA data
  - Look at trends over time
    - Prevalence and incidence
  - Higher or increased prevalence: possible implications
    - More admissions coming in with risk factors or existing pressure ulcers
    - Higher incidence
    - Combination

Real-Life Example: Part I



Real-Life Example: Part II

Why Sit Up and Take Notice?

Reasons To Notice

- Successful real-life application of the approach reflected in the Campaign implementation frameworks
- Multiyear initiative
- Over 200 facilities across approximately 1/5 of the states
- Vast spectrum of residents and patients
  - Many very frail residents or high comorbidity postacute patients

Reasons To Notice

- Organized effort using standardized approaches
- Emphasis on basics in prevention, assessment, documentation, and treatment
  - Very similar to approach emphasized in Campaign process frameworks

Reasons To Notice

- Combination of clinical, management, and quality improvement principles
  - Protocols / policies and procedures
  - Defined roles of individual disciplines
  - Intensive review of actual performance
  - Intensive review of links between processes and outcomes
  - Careful root cause analysis
  - Emphasis on standardized, consistent performance
  - High-level management involvement
  - Persistent follow-up

Initiative: Early Stages

Results: Early Stages

- Approximately 5+ years ago
  - Incidence rate approximately 2 percent per month; had been even higher
- “Low-hanging fruit”
  - Initial rapid decline in rates
  - True of many different approaches that
    - Get people to pay attention
    - Take a more organized approach

Results: Early Stages

- Subsequent leveling off with fluctuation
  - Still considerable variability, especially in process, performance, and practice
  - Incidence rates 1-1.5 percent

After Several Years

Results: Later Stages

- 2007
  - Much less variability
  - More consistent processes and performance
  - More effective oversight and review
  - More rapid root cause analysis and corrective interventions
- The “big picture” makes a difference!

Take-Away

- Pressure ulcer incidence refers to those that develop while in the facility
- Pressure ulcer prevalence refers to the total # of pressure ulcers from all sources
- Prevalence=what we inherit from others + what occurs under our care

Take-Away

- Incidence can be lowered to approximately 2 percent or less
  - Decreased incidence will lower prevalence somewhat
  - Improved care at each care site will reduce risk factors on discharge to other settings
- Lowering prevalence is a shared responsibility across settings
  - Common approach to providing appropriate care
  - Address risk factors effectively, and minimize “risk factor handoff”

Shared Responsibility For Risk Factor Reduction

- Medication adverse consequences
  - Causing lethargy, confusion, loss of appetite, incontinence, fluid deficits, dry skin, etc.
  - Health care's dirty little "secret"
- Preventive skin care
- Management of comorbidities
  - Heart failure, thyroid disease, delirium, etc.

The Numbers: Example

- In our 120-bed facility
  - 12 people with pressure ulcers (prevalence)
    - Total of 12 sites
  - 5 people got them here (incidence)
    - 3 of them occurred this past month
      - Stage I: 1
      - Stage II: 1
      - Stage III: 1
  - 4 people with a pressure ulcer healed

Pressure Ulcers: Implementation Approaches

- Facility trying to reduce the incidence and prevalence of pressure ulcers
  - Incidence: new ulcers occurring while in the facility
  - Prevalence: total number of pressure ulcer from all sources

The Evidence

- Quality Measures
  - Challenges of trying to use them as an indicator of quality
- Increase / higher number in low risk individuals may (but does not necessarily) indicate care issues, relative to higher risk individuals
  - Limits of current risk prediction tools

The Evidence

- Increase / higher number in high risk individuals could imply
  - Care issues, or
  - Risk factors in population, or
  - Combination

Recognition / Assessment

Step 2: Identify authoritative information available for the topic

- Key question: what are the source(s) of the facility's policies and practices?

Recognition / Assessment

- Identify ways to distinguish the reliability of information about preventing and managing pressure ulcers
  - Key question: how to distinguish valid information from myths and misconceptions about the topic?

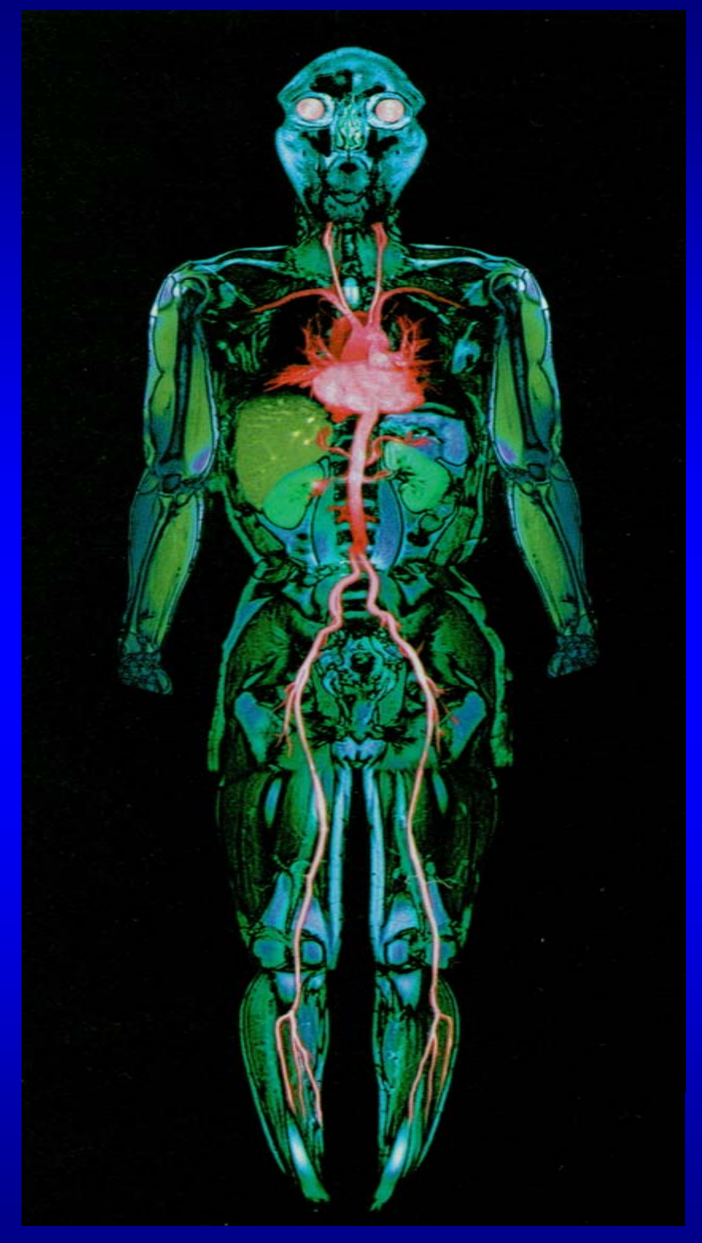
Authoritative Information: Criteria

- Provides a realistic perspective on the topic
- Is forthright about what we do and don't know
- Is realistic about the possibilities and limitations of various interventions
- Identifies errors in the "conventional wisdom"
- Is balanced and objective

The Body's Organ Systems

- Blood
- Cardiovascular
- Digestive
- Endocrine
- Musculoskeletal
- Neurological
- Reproductive
- Respiratory
- Skin
- Urinary

Source: http://www.merck.com/mmhe/sec01/ch001/ch001d.html



Authoritative Information

- Reminds us that the skin is one of a number of organ systems
- All other organ systems, and a person's overall condition, affect the skin
  - Skin can fail despite appropriate care
    - While other organs function adequately, or
    - Due to failure of other organs or the rest of the body, just as with any other organ system

Recognition / Assessment

- Review
  - Reliable and evidence-based information about preventing and managing pressure ulcers
  - From relevant professional associations and organizations and the literature
  - Pieces of the picture organized in context of the "big picture"
    - e.g., Care of patient > Care of pressure ulcer > Dressings or debridement

Reliable

- Discusses pressure ulcers systematically
  - In context of care for the entire individual
  - In the same systematic fashion as any other symptom or risk
  - Advises consistent adherence to key steps
  - Offers sound evidence to support recommendations
    - Or explains why evidence does not support certain approaches

Systematic Process

- Systematic approach highly desirable
  - Non-experts can benefit from expertise of others
  - Can bring order to the situation
  - Helps strengthen ability of staff to approach complex problems
  - Reduces undesirable individual variation
  - Supplements, doesn't replace, clinical knowledge and judgment
  - Applicable to multiple conditions and situations

Potential Reasons For Inadequate Facility Pressure Ulcer Care

- Don't have the right information
  - Or, are not given correct guidance
- Have and use misinformation
  - Or, are given misinformation
- Don't consistently apply right information in the right way
- Therefore, we need
  - Right information + Good implementation

Recognition / Assessment

Step 3: Identify current processes and practices in the facility

Recognition / Assessment

- Key questions
  - What are we doing currently?
  - What is the basis for current approaches?
  - How does that compare to what should be happening?
    - Overview: Pressure Ulcers Process Checklist and process flow diagram
    - Details: Pressure ulcers process framework

Some Key Steps to Match Up

- Recognition
  - Looking for early signs
  - Identifying risk factors promptly
  - Correct, detailed assessment of patient's condition and function
  - Correct, detailed descriptions of wounds
- Cause Identification
  - Clarifying category of ulcer
  - Systems and processes to oversee tasks related to pressure ulcer care

Key Steps to Match Up

- Management
  - Good basis for treatment selection
  - Basic equipment and supplies
  - Review approaches to selecting interventions
- Monitoring
  - Processes to monitor progress
  - Processes to monitor performance
  - Processes to monitor practice

Recognition / Assessment

- Key issue: what are the “politics” of policy and practice in the facility?
- Who in the facility has the authority to decide how to try to prevent and manage pressure ulcers, and what approaches do they use?
  - Who do they influence and who / what influences them?

Recognition / Assessment

- Evidence, not “eminence”-based
  - Consistent approaches preferable to frequent changes due to changes in management / staff
  - Get pertinent medical director input and oversight
  - Limit unsubstantiated personal opinions
  - Check for possible undermining of proper approaches

Recognition / Assessment

Step 4: Identify areas for improvement in processes and practices

- Use information gathered in Steps 2 and 3 above
- Compare current with desirable approaches to preventing and managing pressure ulcers
  - Key question: Are we consistently doing “the right thing in the right way?

Recognition / Assessment

- Have issues related to preventing and managing pressure ulcers been identified previously? Were they followed up on?
- Has our facility previously evaluated its performance and taken measures to improve?

Cause Identification

Step 5: Identify the causes of issues related to pressure ulcer prevention and care

– Including root causes of undesirable variations in performance and practice

- Key question: what / who in facility is helping or inhibiting improvement in preventing and healing pressure ulcers, and how/why?

Cause Identification

- Identify reasons given by those who do not adequately follow desirable approaches
  - For example, don’t agree with recommended approaches; believe that their way is better; no positive consequences for doing the right thing; no negative consequences for doing the wrong thing

Management

Step 6: Reinforce optimal practice and performance

- Continually promote “doing the right thing in the right way” in each situation
- Follow steps in the *Pressure Ulcers Process Framework* (or comparable approach), throughout the facility

Management

- Identify and use tools and resources to help implement the steps and related approaches
- Reinforce systems and processes that are already optimal
  - Based on information collected in Steps 2 to 5 above, regarding what is being done to prevent and manage pressure ulcers

Management

Step 7: Implement necessary changes

- Key question: what should we strengthen, and what should we change?

Management

- Implement pertinent generic and cause-specific interventions, for example
  - Generic: Give more training
  - Cause-specific: Address root causes of failures to carry out assignments related to preventive skin care, such as
    - Priorities in care not clarified for staff
    - Inadequate equipment or supplies
    - Inadequate monitoring of performance

Management

- Address systems issues and issues of individual performance and practice
- Refer to the *Resource Guide* for resources and tools that can help to address this goal

Monitoring

Step 8: Reevaluate performance, practices, and results

- Recheck for progress towards getting “the right thing done consistently in the right way”
- Use *Pressure Ulcers Process Checklist* to identify whether all key steps are being followed

Monitoring

- Until processes and practices are optimal
  - Use *Pressure Ulcers Process Framework* and related references and resources from Steps 2-4 above
  - Repeat Steps 2-6 (Recognition / Assessment, Cause Identification, and Management)
- Continue to collect and review data on results and processes

Monitoring

- Evaluate whether changes in process and practice have helped attain desired results
- Adjust approaches as necessary

Summary

- TAW frameworks reflect balanced mix of clinical, management, and quality improvement approaches
- Provide the same orderly, consistent approach for all clinical and operational goals
- Help bridge the gap between knowledge and its implementation

Summary

- Genuine sustained improvement can come from using these (or comparable) approaches to help
  - Care for pressure ulcers (practices)
  - Strengthen, monitor, and improve the systems and performance in your facility (processes)
- Advocate for **processes**, not just practices

And now, from the nursing point of view…

Overview of the Framework

- 4 Main Processes
  - Problem recognition/assessments
  - Cause identification/diagnosis
  - Management/treatment
  - Monitoring
- 3 Implementation steps
  - Care process step
  - Nursing implementation
  - Recognizing success

RECOGNITION/ASSESSMENT

Inspect & Document

- Inspect & document residents skin condition upon admission
  - Assess skin condition & integrity
  - Use a strong flashlight
    - Beware of fluorescent lighting
    - Closely assess darkly pigmented skin – look for other evidence
      - Induration
      - Temperature changes
      - Bogginess

Inspection

- If ulcerations noted, gather information to identify if pressure associated or not
  - Are they over a pressure site
  - If not, what other evidence is there?
    - Hx diabetes, peripheral vascular disease
    - Wounds on “gaiter area”
    - Hx of trauma to a site

Document

- Initiate appropriate nursing care plan within 24 hrs of admit
  - Care plan for existing wounds
    - Measurements
    - Measurements
    - Complete description
  - Obtain treatment order for existing wounds

Assess for RISK

- ALL residents reviewed for RISK of PU development within 24 hrs of admit
  - Single most important activity to reduce incidence of PUs
  - Standardized assessments recommended
    - Braden
    - Norton
  - Scales are NOT perfect

Risk Assessments

- Care plan ALL residents with ANY degree of risk, not just “high” risk
- Reassess and RESCORE ALL residents with risk weekly for 4 weeks after:
  - Admission
  - Readmission
  - Change of condition (fall, somnolence, stroke, infection, diarrhea, onset of urinary incontinence, etc.)

Standardized Scales

- Pros
  - Well recognized throughout industry
  - Everyone understands the score
- Cons
  - Incomplete
  - Do not take into account diagnoses that increase risk (Diabetes, PVD)
  - Do not take into account medications that might increase risk

Assess for Complications

- Identify complications related to existing pressure ulcer
  - Residents who can't or won't cooperate with turning, repositioning or other interventions
  - Pain at site or associated with turning
  - Excessive drainage, foul odor, redness or swelling
  - Lack of EXPECTED improvement
    - Most ulcers show signs of improvement within 2-4 wks
    - If not improved, notify primary healthcare provider

Documentation of Wounds

- Weekly assessment of wounds on same day of week (treatment nurse or team)
- Measurement
  - Height (head to toe) always entered first
  - Width (hip to hip) always entered second
- Location based on standardized chart
  - Standard chart part of P&Ps
  - Multiple sites should be numbered
  - Numbering should be consistently applied (i.e. top to bottom

Documentation (continued)

- Staging – ONLY if pressure ulcer
- Description of wound
  - Borders, color, wound bed
  - Presence or absence of slough, exudate or eschar (usually % of wound bed)
  - Exudate amount and color
- Description of surrounding skin
- Other factors – pain, warmth, advancing redness

Documentation

- Should include a statement as to whether there is improvement or deterioration
- If treatment nurse AND/OR use treatment book
  - Charge nurse should examine wound weekly
  - Document in regular nursing notes once a week that wound examined and whether current treatment appropriate
  - Document all communication with primary healthcare provider
- If wound is deteriorating, NOTIFY primary healthcare provider and obtain new treatment order

CAUSE IDENTIFICATION/ DIAGNOSIS

Evidence for PU or Not

- Identify evidence to support determination if ulcer is pressure related or not
  - Location over pressure site
  - If not, is there another reason for pressure
    - Tubings
    - Orthotics
    - Shoes
  - If not, consider diagnoses associated with ischemia to the skin

Ulcer Characteristics

- Diabetic ulcers
  - Small, round, smooth margins
  - Not associated with pain
  - May be shallow or deep & have tunneling
- Arterial ulcers
  - Small, round, shallow
  - Pale base, poor granulation
  - Smooth margins
  - More likely to be associated with pain

Ulcer Characteristics

- Venous stasis ulcers
  - Typically shallow, irregular borders, variable size
  - Associated with large amount drainage
  - Often associated with increased pigmentation of skin
- Miscellaneous ulcers
  - Associated with surgical incision or scar
  - Associated with trauma

Review for Contributing Issues

- Complicating factors
  - Musculoskeletal or neurological disorders affecting positioning or mobility
    - Recent lower extremity surgery
    - Contractures
    - Quadriplegia, Parkinson's, Huntington's chorea
  - Compliance with positioning & treatment
  - Pain, altered cognition
  - Nutrition – should be adequate
    - Only if inadequate nutrition should nutritional supplements be implemented

Diagnosing Ulcers

- It is responsibility of the physician, nurse practitioner, or physician assistant to correctly diagnose wounds
- It is the responsibility of the licensed nurse to correctly describe the wound and risk factors
- DO NOT assume ulcers are pressure related

Staging of Ulcers-General

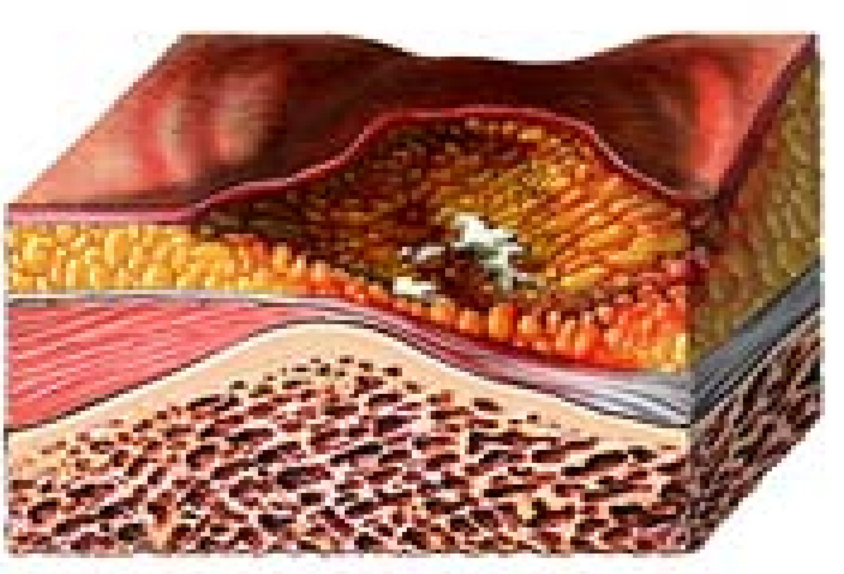
- Pressure ulcers are staged dependent on depth
- Surgical wounds & non pressure ulcers not staged
- Burns not staged, described as full/partial thickness
- If eschar on wound, cannot determine stage until eschar removed- for MDS code as Stage IV
- If there is eschar or thick slough, Stage III or IV
  - Also indicate unable to determine (UTD) stage on chart
  - Stage when eschar debrided & can observe wound bed

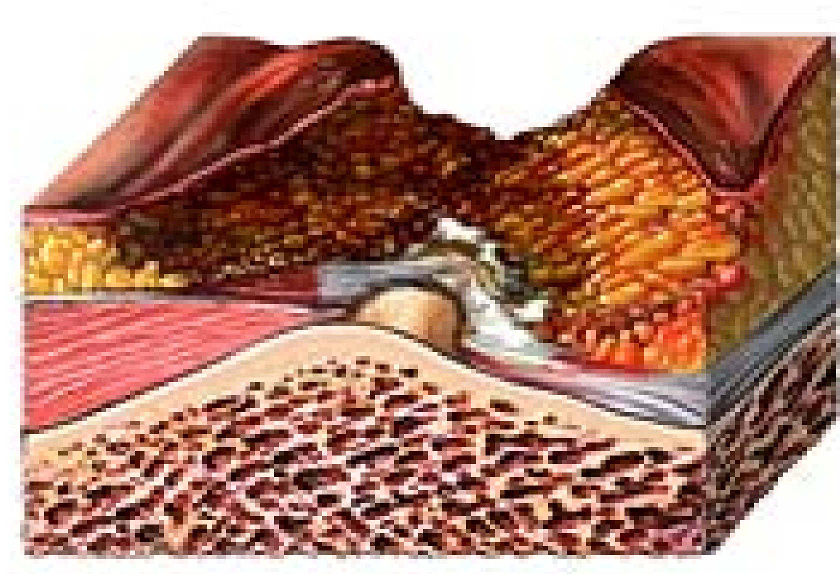
Stages of Pressure Ulcers

- **Stage 1**: Non-blanchable erythema, intact skin
- **Stage 2**: Partial thickness skin loss, involves epidermis and/or dermis
- **Stage 3**: Full thickness skin loss extends into subcutaneous tissue
- **Stage 4**: Full thickness plus damage to underlying bone, muscle

Progression of decubitis ulcer

Skin
Fat
Muscle and tendon
Bone





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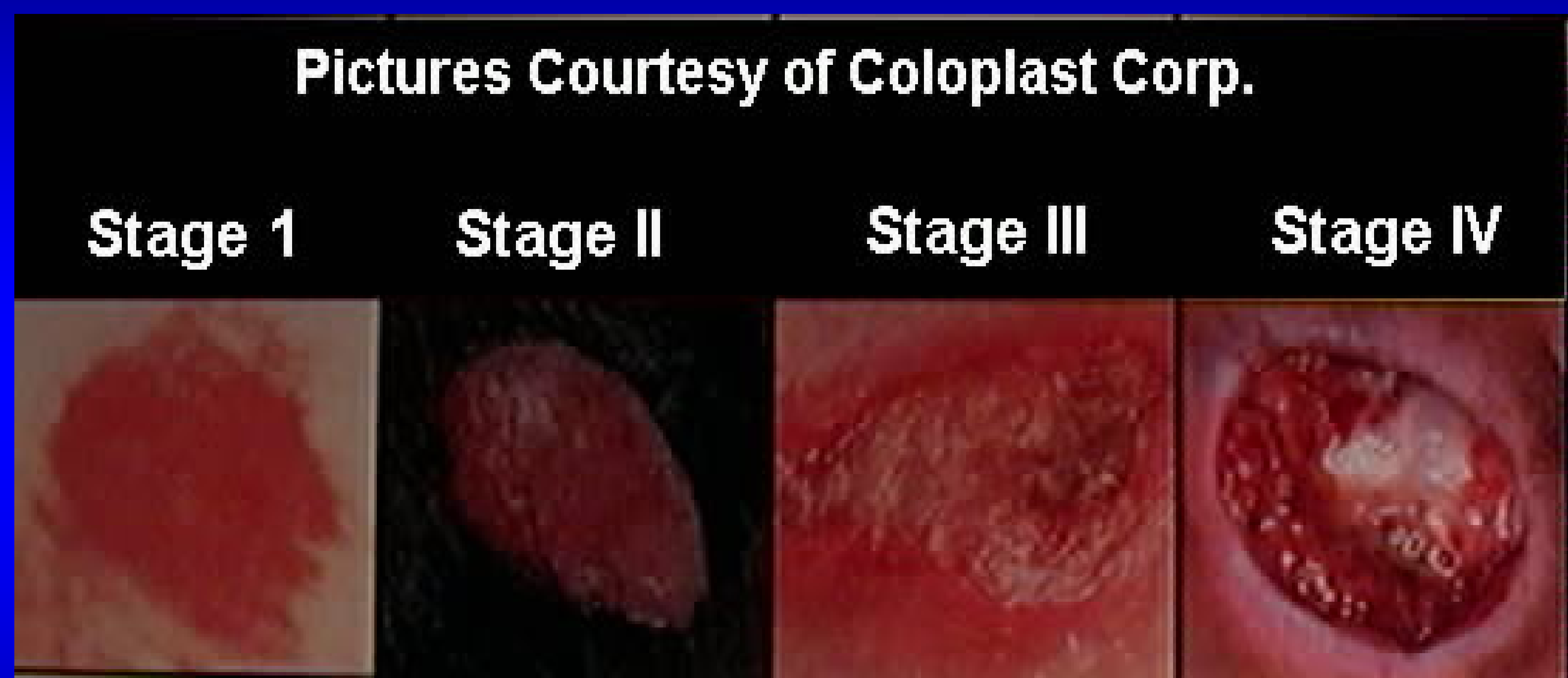
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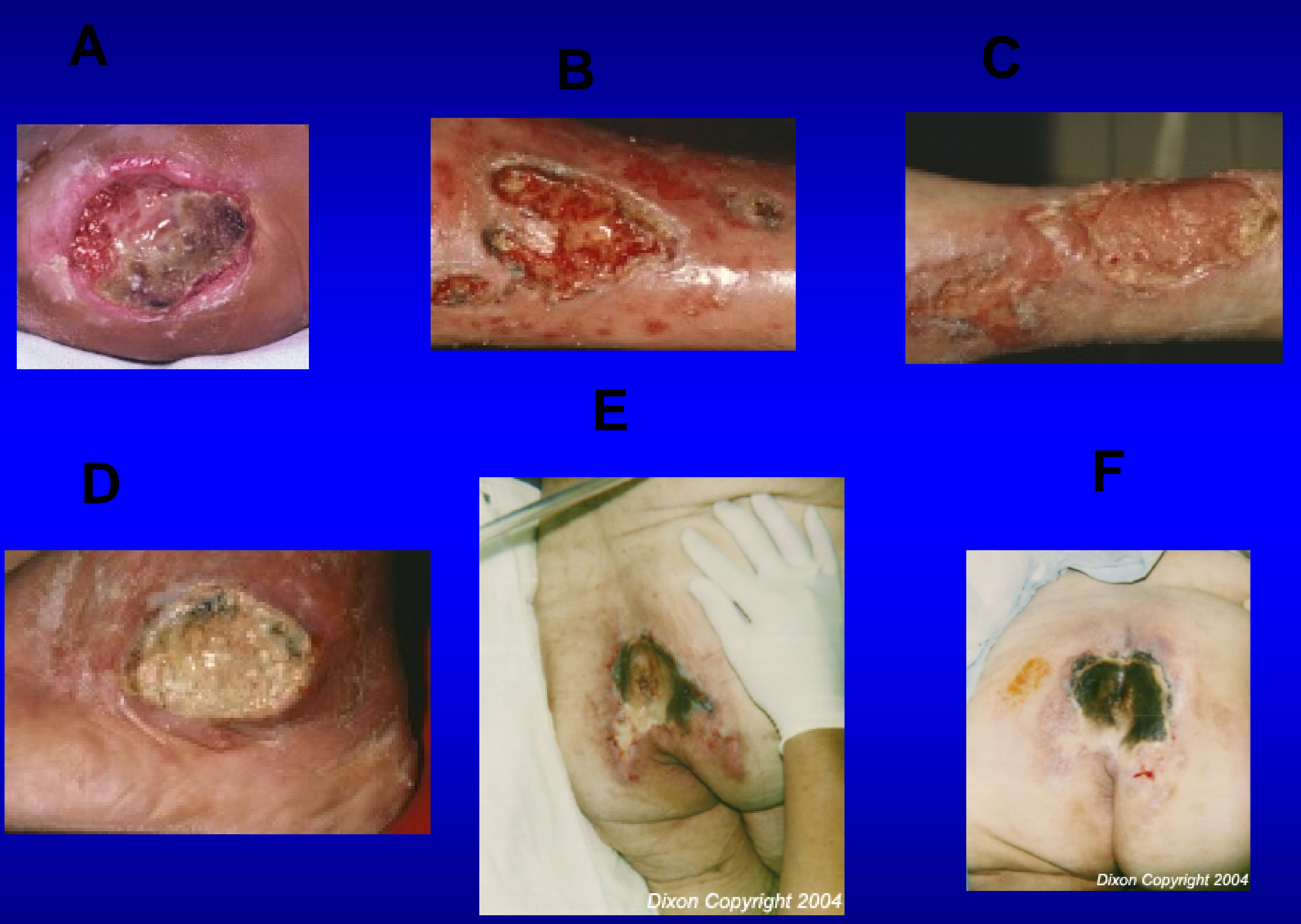
Stage 1
Stage II
Stage III
Stage IV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MANAGEMENT/TREATMENT

Interventions

- Obtain appropriate treatment from primary care provider
- Communicate nursing care plan to other interdisciplinary staff
  - Incorporate others – dietary, therapy
  - CNAs – consistent assignment is key
- Prevention of new ulcers dependent upon aggressive prevention program

Interventions

- Consistent implementation of interventions is essential
- Implement interventions that are patient centered
  - Consistent with resident's individual needs
  - Preferences for care
  - Consider goals, values & wishes
- PU or wound healing may not always be the goal
  - Pain prevention
  - Odor reduction
  - Improving day to day quality of life

Identify Associated Factors

- Both intrinsic & extrinsic factors exist
  - Intrinsic – age, nutrition, decreased sensory perception
  - Extrinsic – Moisture, friction, sheer
- Extrinsic usually can be modified
- Care plans should include how to modify or compensate for these factors
- If healing not expected, must be documented in licensed nurse & primary healthcare provider progress notes

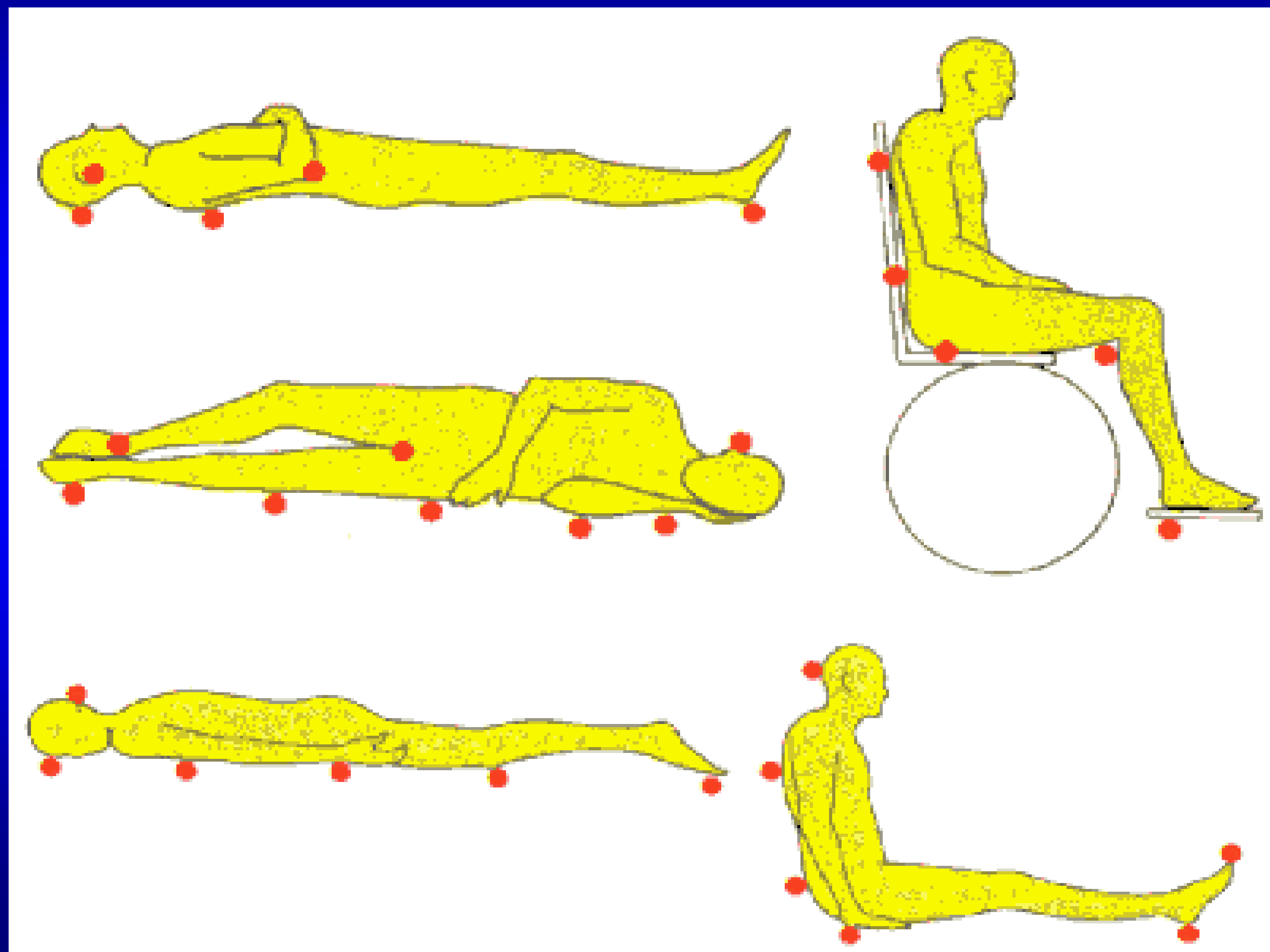
Pressure Reduction

- Use relevant pressure reduction methods
  - Frequent repositioning
  - Specialized support surfaces
- If using specialized mattresses
  - Avoid use of thick pads between mattress & resident
  - Use disposable incontinence pads
  - Maintain mattress properly
- Float heels

Turning Repositioning Plan

- Must be individualized
- Consider contributing factors
- Check residents skin with each turn
  - If non-blanchable erythema in areas where pressure present = consider more frequent turning
  - Use of additional pillow, wedges should be considered

Pressure Points



Management of Pressure Ulcers

- Develop standardized treatment plan
- Approach should be straight forward & consistent with national standards of care
- DO NOT need expensive or fancy treatments in most cases
- CONSISTENCY is the key

General Principles of Treatment

- Keep wound bed clean & moist, surrounding tissue dry
- Stage 1 – Barrier creams or transparent dressings
- Stage 2 – Hydrogel and hydrocolloid
- Stage 3 & 4 – Hydrogel and hydrocolloid
  - Alginates to absorb moisture/fill space
  - Silver to reduce bacterial burden if needed
  - Debride if eschar or slough

Nutritional Goals

- Weight stabilization
- No evidence Arginaid, Vit C, Zinc are helpful
- Goal for protein 1.2-1.5 gms/kg body wt
- Use of multivitamin with mineral adequate
- Low albumin results from many causes UNRELATED to nutrition

Treatment Goals

- Keep wound beds moist but not excessive
- Keep surrounding tissue dry
- Avoid products that damage tissue & impair epithelialization
  - Dakin's solution
  - Wet to dry dressings
- Remove necrotic tissue
  - Sharps debridement
  - Autolytic or enzymatic agents

Treatment Goals

- Minimize contamination from urine & feces
  - Foley catheterization MAY be necessary
  - Manage BMs, treat diarrhea to the extent possible
- Reduce bacterial burden
  - Cleanse with saline or cleanser
  - Topical antibiotics MAY be indicated
  - Oral antibiotics indicated ONLY if evidence of systemic infection (cellulitis)

Wound Type	Stage I - Pressure Ulcer	Stage II - Pressure Ulcer or Partial Thickness Wound		Stage III or IV Pressure Ulcer or Full Thickness Wound		Wounds with Necrosis
Definitions	**Stage I -** An area where the epidermis is intact and the erythema (reddened skin) does not resolve within 30 minutes of pressure relief.	**Stage 2 -** An area of partial thickness loss of skin layers involving the epidermis and possibly penetrating into but not through the dermis		**Stage 3 -** Full thickness skin loss extending through the dermis to involve subcutaneous tissue	**Stage 4 -** Deep tissue destruction extending through subcutaneous tissue to fascia and may include muscle, tendon, joints, or bone	**Stage 4**– The base of the wound cannot be visualized – i.e. obscured by necrosis or yellow slough
Exudate	**PREVENTION**	Dry to Light Exudate	Moderate Exudate	Dry to Light Exudate	Heavy Exudate	Wounds with Necrosis
Dressings and Change Frequency	**Prevention Guidelines** Pressure relief to area Turn or reposition q2hr in bed; q1hr in chair Pillow under calf to float heels, cushion needed if in WC/GC Monitor skin q 8 hours Protective Barrier if skin denuded, Wet, & Weepy Hydrocolloid Drsg if friction involved	**Cleanse**: NS **If Dry:** apply Wound gel to Hydrate **Cover:** Telfa type or Hydrocolloid Dressing **Change**: q3 days or when exudate reaches 1 inch from the edge	**Cleanse**: NS **Fill If Needed:** Calcium Alginate absorb exudate **Cover:** Gauze or hydrocolloid dressing **Change:** q3 days or when exudate reaches 1 inch from the edge	**Cleanse:** NS **If Dry:** apply Wound gel to hydrate **Fill If Needed:** Calcium alginate to absorb exudate **Cover:** Hydrocolloid dressing **Change:** q3 days or when exudate is 1 inch from edge	**Cleanse**: NS **Fill**: Calcium Alginate to absorb exudate or to fill dead space **Cover**: Gauze or hydrocolloid dressing **Change**: q3 days or when exudate is 1 inch from edge	**Cleanse:** NS **Necrotic Wounds:** To facilitate autolytic debridement – apply ¼ inch Wound-Gel on necrotic area covered by Hydrocolloid dressing OR Enzymatic can be used OR If gel & exudate create too much moisture use Calcium Alginate to absorb or Hydrocolloid Drsg alone to continue autolytic debridement **Change:** q3 days or when exudate reaches 1 inch from the edge

MONITORING

Monitor Progress of Wounds

- Reassess existing wounds regularly
  - At least weekly by licensed nurse
  - Include measurements, description
  - Compare with previous week
- Expect improvement in 2-4 weeks
- If not, promptly notify primary healthcare provider
- Modify treatments as needed

Other Issues

- Reverse staging of PUs not appropriate
  - Must do so in MDS 2.0
  - MDS 3.0 fixes that problem
- Document that an ulcer is “healing” but at the worst stage
  - If ever a Stage 4, always a Stage 4
  - Ulcers fill in with granulation tissue
  - Normal layers of skin never replaced

Review of Non-Healing Wounds

- Frequent reassessment of non-healing or deteriorating wounds essential
- IDT should review regularly
  - Primary healthcare provider, LN, Dietician, Therapists, MDS coordinator, LN, CNA
  - Adjust interventions regularly or justify continuing current interventions
- Document these efforts in chart

Sometimes, despite everyone's best efforts, pressure ulcers do not heal. This should be a rare occurrence such as residents with terminal diagnoses or non-compliance. Even in low-risk residents, this can happen, so vigilance is necessary!

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Case Study

Scenario

- 87 yr old white female with history of frequent falls and previous history of venous stasis ulcers is admitted to the hospital s/p fall at home. She undergoes surgery for left hip fracture and fracture of left humerus. Hospital stay is relatively uncomplicated and subsequently, she is admitted to the SNF 3 days later for rehabilitation.
- Chronic diagnoses include Venous Insufficiency, Hypothyroidism, Wt Loss, GERD, HTN

History

- Meds: Levoxyl, Aldactone, Prevacid, Lasix, Aldactone, Lovenox, Prilosec
- MDS: Stage 2 = 7 (>9 requires full body exam)
  - Highest Stage = 2
  - Ulcer resolved or cured past 90d = 0
  - Other problems= surgical wound of hip, sling lt arm
  - Skin treatments =ulcer care, surgical care, dressings, pressure relieving device, nutrition & hydration
  - Non-wt bearing because of surgery

Hospital Information

- Admit Diagnoses
  - S/P ORIF Lt Hip fx & Pinning Lt Humeral Fx
  - Hypothyroidism
  - Recent weight loss ? Etiology
  - GERD
  - Bilateral venous insufficiency
  - Venous stasis changes
  - History of venous stasis ulcers
  - s/p Hepatitis
  - s/p Breast CA (in remission)
  - Foley catheter care

Advance Directives

- CPR
- Transfer to hospital
- IV fluids if needed
- Tube feeding if needed

Assessment

- Perform an assessment ideally within 8 hrs of admission or readmission
  - The longer you wait, the more time there is for a pressure ulcer to get worse
  - What seems to be “nothing” may turn in to something, so important to document ALL findings
  - Assessment consists not only of looking at the skin but touching the skin to feel for temperature changes or bogginess

LN Skin Assessment at Admit

- Lt arm fracture
- Lt hip fracture, incision clean & dry
- Stage 3 venous stasis ulcer rt lat ankle
- Stage 2 stasis ulcers lt lat ankles
  - Measures 1.5X1.0 (X2)
- Stage 2 lt buttocks 2.5 cm
- Stage 3 coccyx 3.0X 2.5
- Reddened area (not measured) upper rt, inner posterior thigh

Assessment

- RAPs Triggered
  - ADL functional/rehabilitation
  - Urinary incontinence & indwelling catheter
  - Locomotion deficit/use of wheelchair, incongruent with previous lifestyle
  - At risk for deterioration
  - At risk for falls
  - At risk poor nutrition, only eats 25%
  - Dehydration – diuretic/laxative use
  - Pressure ulcers, turning & repositioning, ulcer care, dressings, pressure relieving devices

Risk Review

- Braden Scale completed on Admission
- Score = 16 (Mild Risk)
  - No impairment on sensory perception
  - Rarely moist
  - Chair-fast
  - Very limited mobility
  - Adequate nutrition
  - Problem with friction and shear

Assessment Issues

- Braden Score = Mild Risk
- Fall Risk = Borderline
- Bowel & Bladder = Foley, continent bowel
- Pain assessment = no pain
- Side rails = indicated as enabler
- Assessments done by RN

Assessment Problems

- Braden score = low risk
  - Dx of Venous Stasis ulcers
  - Hip & Humerus surgery limiting mobility of 2 extremities
  - On 2 diuretics

Cause Identification

- Admitted with pressure ulcers on buttocks & coccyx, diagnosed in hospital
- Admitted with venous stasis ulcers diagnosed in hospital

Management/Treatment

- Current treatment orders
  - Papain-Urea topical daily to coccyx & cover with foam twice daily
  - Change lt hip dressing daily
  - Accuzyme to lateral leg open area & cover with foam, change daily
  - F/U with Wound Care Center

Wound Care Center

- Resident sent weekly to wound care center
- They only send back new orders on venous stasis ulcers
- Primary care physician examined resident 1 week after admission, no further examination of wounds, no change in treatment orders

Monitoring

- Minimal charting for 19 days
  - Only 2 skin treatment forms completed (admit & 1 other)
  - Wt loss 10 lbs (now 100 #)
  - Moderate c/o pain requiring narcotic
    - Pain not associated with surgical incision
    - Pain in lower back, upper legs
  - Unable to participate in PT/OT
- Next major issue is sudden onset intractable, severe pain requiring Dilaudid for pain relief
  - VS 97, 150/105, 110, 18
  - Pain = 10 out of 10

Monitoring

- Pressure ulcer records unchanged for 19 days
  - 2 open areas on coccyx & lt buttocks
  - Reddened rt inner upper thigh
- Oral intake about 35-40%
- Day 21 - suddenly rt upper, posterior thigh open to bone Stage 4
- Transferred to hospital

So What Went Wrong

- Problem recognition/assessment
  - Initial assessments done but poorly described in chart
    - No depth, no wound bed description
    - Eschar noted but no %
  - MISSED the importance of the reddened area (Stage 1) in Rt upper, inner thigh
    - In review – resident on OR table more than 4 hrs lying on rt side
    - Wedge to keep resident side lying for surgery probably cause of reddened area (could be tubing)
  - F/U assessments NOT consistent, so progression missed
  - May not have every put "hands on" the redness – If so, would have felt the bogginess and induration developing

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Poor Understanding of Risk Review

- Risk
  - Inappropriately relied upon Braden score alone
  - Missed multiple contributing factors
    - Existence of chronic venous stasis ulcers
    - Markedly decreased mobility
    - Poor oral intake
    - On 2 diuretics

What Went Wrong (continued)

- Cause identification
  - Appropriately diagnosed upon admission
- Management/Treatment
  - No change in treatment orders of lt buttock or coccyx ulcers
  - Relied upon Wound Care Center for management
  - Wound Care Center assumed primary care physician treating coccyx, buttocks wounds & never examined

In the End

- Monitoring
  - Incomplete monitoring
  - No documentation of change in status of any ulcers
  - Inconsistent documentation of degree & location of pain (unable to participate in therapy)
- Sudden appearance of Stage 4
- Transfer to hospital with painful and costly f/u care
  - Hospitalized for 8 months
  - NH sued for malpractice

How Could This be Avoided

- Systematic implementation of process protocols
- Standardized & CONSISTENT management/documentation
  - Consistent assignment of staff
  - Simple but consistent P&Ps
- Appropriate “oversight”
  - DON or designee to audit LNs & CNAs
  - IDT meetings to monitor progress
  - Standardized reporting mechanisms to leadership (DON & Administrator
  - Notification to primary healthcare provider

Conclusion

- Establish a systematic approach
- Assessment & prevention are key to reducing incidence rates
- Appropriate treatment & good monitoring are key to reducing prevalence
  - Treatment should be patient centered
  - Treatment should be holistic

Thank You!

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