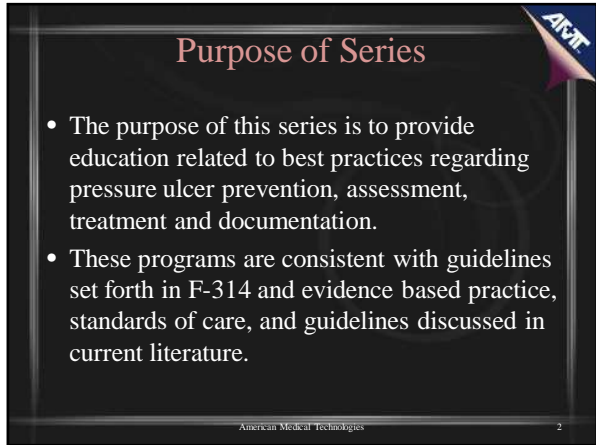


**The Power of
Pressure Ulcer Documentation**

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Email: info@amtoundcare.com

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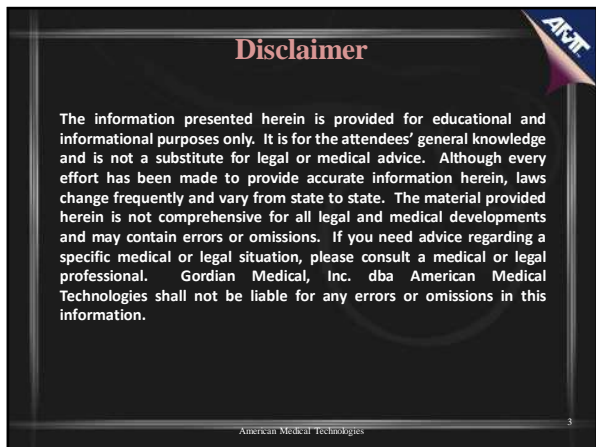


Purpose of Series

- The purpose of this series is to provide education related to best practices regarding pressure ulcer prevention, assessment, treatment and documentation.
- These programs are consistent with guidelines set forth in F-314 and evidence based practice, standards of care, and guidelines discussed in current literature.

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Disclaimer

The information presented herein is provided for educational and informational purposes only. It is for the attendees' general knowledge and is not a substitute for legal or medical advice. Although every effort has been made to provide accurate information herein, laws change frequently and vary from state to state. The material provided herein is not comprehensive for all legal and medical developments and may contain errors or omissions. If you need advice regarding a specific medical or legal situation, please consult a medical or legal professional. Gordian Medical, Inc. dba American Medical Technologies shall not be liable for any errors or omissions in this information.

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Objectives

- Discuss pressure ulcer documentation challenges related to regulatory criteria (MDS 2.0) (F-314), standards of care, best practice, and guidelines for wound care documentation (NPUAP) (WOCN)
- Recognize staff education needs related to pressure ulcer documentation

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What is the F314?

- A guide to ensure that all nursing homes are held to the same standards in the survey process regarding pressure ulcer prevention and treatment
- Medicare wants providers (nursing homes) to be aware of the current standards and PrU prevention and care
- Use it to create an effective Wound Care and Risk Management program
- Surveyors use it to assess a facility's risk assessment and wound care protocols and procedures
- An outline for best Wound Care practice
- It should be used as a tool
- **Documentation guidelines are included**

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CMS: Avoidable Pressure Ulcers


- Resident developed a pressure ulcer and 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, goals, and recognized standards of practice
 - Monitor and evaluate the impact of the interventions
 - Revise the interventions if appropriate

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CMS: Unavoidable Pressure Ulcers

- Resident developed a pressure ulcer even though the facility:
 - Evaluated the resident’s clinical condition and 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
 - Revised interventions as appropriate



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§483.20(b)(1) Resident Assessment Instrument

A facility must make a comprehensive assessment of a resident’s needs, using the RAI specified by the State. The assessment must include at least the following:

- Identification and demographic information
- Customary routine
- Cognitive patterns
- Communication
- Vision
- Mood and behavior patterns
- Psychological well-being
- Physical functioning and structural problems
- Contenance

CMS Manual System Department of Health & Human Services (DHHS) Pub. 100-07 State Operations Provider Certification Center for Medicare & Medicaid Services (CMS); Transmittal 5 Date: November 19, 2004 8

§483.20(b)(1) Resident Assessment Instrument

- Disease diagnosis and health conditions
- Dental and nutritional status
- Skin Conditions
- Activity pursuit
- Medications
- Special treatments and procedures
- Discharge potential
- Documentation of summary information regarding the additional assessment/s performed through the resident assessment protocols
- Documentation of participation in assessment

CMS Manual System Department of Health & Human Services (DHHS) Pub. 100-07 State Operations Provider Certification Center for Medicare & Medicaid Services (CMS); Transmittal 5 Date: November 19, 2004 9

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F309 §483.25 Quality of Care

- “Skin Ulcer/Wound”
 - **NOTE:** Skin ulcer definitions are included to clarify clinical terms related to skin ulcers. At the time of the assessment and diagnosis, the clinician is expected to document the clinical basis - e.g.
 - Underlying condition contributing to the ulceration
 - Ulcer edges
 - Wound bed
 - Location
 - Shape
 - Condition of surrounding tissues
 - All of which permit differentiating the ulcer type, especially if the ulcer has characteristics consistent with a pressure ulcer, but is determined not to be one.

CMS Manual System Department of Health & Human Services (DHHS) Pub. 100-07 State Operations Provider Certification - Center for Medicare & Medicaid Services (CMS); Transmittal 5 Date: November 19, 2004 10

ARJIT

Documentation Definitions/Descriptive Language Expected by CMS and State Surveyors

- Pressure Ulcer
- Avoidable/Unavoidable PrU
- Cleansing/Irrigation
- Colonized/Infected
- Debridement
 - Autolytic
 - Enzymatic
 - Mechanical
 - Sharp/Surgical
 - Maggot debridement therapy (MDT)

CMS Manual System Department of Health & Human Services (DHHS) Pub. 100-07 State Operations Provider Certification - Center for Medicare & Medicaid Services (CMS); Transmittal 5 Date: November 19, 2004 11

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Documentation Definitions Expected by CMS and State Surveyors

- Eschar
- Slough
- Exudate
 - Purulent exudate/drainage/discharge
 - Serous drainage
- Friction/Shearing
- Granulation Tissue
- Tunnel / Sinus Tract / Undermining

CMS Manual System Department of Health & Human Services (DHHS) Pub. 100-07 State Operations Provider Certification - Center for Medicare & Medicaid Services (CMS); Transmittal 5 Date: November 19, 2004 12

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Documentation & Outcomes Should Demonstrate Interventions were Appropriate

- Descriptive documentation
- Accurate
- Timely
- Legible
- Interventions met the current standards of wound care
- Documentation of communication between team members and family/caregivers

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Documented Evidence of Appropriate and Timely Monitoring

At least daily, staff should remain alert to potential changes in the skin condition and should evaluate and document identified changes

If you know what is normal, you can readily indentify what is "abnormal"

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CMS Instructions to Surveyors: Ulcer Documentation Requirements

- Differentiate the type of ulcer (pressure-related versus non-pressure-related) because interventions may vary depending on the specific type of ulcer;
- Determine the ulcer's stage (if due to pressure, otherwise classify the wound);
- Describe and monitor the ulcer's characteristics;
- Monitor the progress toward healing and for potential complications;
- Determine if infection is present;
- Assess, treat and monitor pain, if present; and
- Monitor dressings and treatments

CMS Manual System Department of Health & Human Services (DHHS) Pub. 100-07 State Operations Provider Certification - Conditions for Medicare and Medicaid Services (CMS), Transmittal 5 Date: November 19, 2004, pp.147-148 15

Definitions

- “Skin Ulcer / Wound”
- “At the time of the assessment and diagnosis, the clinician is expected to document the clinical basis which permit differentiating the ulcer type, especially if the ulcer has characteristics consistent with a PU, but is determined not to be one”



F309 - Guidance to Surveyors

Documentation of ULCER CHARACTERISTICS

When a pressure ulcer is present, daily monitoring, (with accompanying documentation, when a complication or change is identified), should include:

- An evaluation of the ulcer, if no dressing is present;
- An evaluation of the status of the dressing, if present (whether it is intact and whether drainage, if present, is or is not leaking);
- The status of the area surrounding the ulcer (that can be observed without removing the dressing);
- The presence of possible complications, such as signs of increasing area of ulceration or soft tissue infection (for example: increased redness or swelling around the wound or increased drainage from the wound); and
- Whether pain, if present, is being adequately controlled

CMS Manual System Department of Health & Human Services (DHHS) Pub. 100-07 State Operations Provider Certification - Centers for Medicare & Medicaid Services (CMS); Transmittal 5 Date: November 19, 2004; pg. 147. 17

Surveyor Documentation Expectations at Dressing Change or at Least Weekly

- Location and staging;
- Size (perpendicular measurements of the greatest extent of length and width of the ulceration), depth; and the presence, location and extent of any undermining or tunneling/sinus tract;
- Exudate, if present: type (such as purulent/serous), color, odor and approximate amount;
- Pain, if present: nature and frequency (e.g., whether episodic or continuous);
- Wound bed: Color and type of tissue/character including evidence of healing (e.g., granulation tissue), or necrosis (slough or eschar); and
- Description of wound edges and surrounding tissue (e.g., rolled edges, redness, hardness/induration, maceration) as appropriate

CMS Manual System Department of Health & Human Services (DHHS) Pub. 100-07 State Operations Provider Certification - Centers for Medicare & Medicaid Services (CMS); Transmittal 5 Date: November 19, 2004; pg. 148. 18

CMS Stance on Photodocumentation

Photographs may be used to support this documentation, if the facility has developed a protocol consistent with accepted standards (e.g., frequency, consistent distance from the wound, type of equipment used, means to assure digital images are accurate and not modified, inclusion of the resident identification/ulcer location/dates/etc. within the photographic image, and parameters for comparison).

CMS Manual System Department of Health & Human Services (DHHS) Pub. 100-07 State Operations Provider Certification Center for Medicaid Services (CMS), Transmittal 5 Date: November 19, 2004; pg 148.

General Wound Documentation Recommendations

- Proper wound documentation should be descriptive and objective
- Use proper wound terminology
- Use proper anatomical references
- Use staging system for pressure ulcers only
 - All other wounds are partial - or full-thickness

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From: Shell, Clinical Anatomy for Medical Students, 6th ed, LWW, 2000.

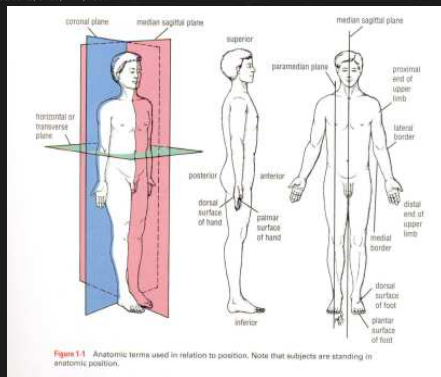


Figure 1-1 Anatomical terms used in relation to position. Note that subjects are standing in anatomic position.

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Types of Tissues: Wound Bed Wound Margin Periwound

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Describing the Wound Edge

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Describing the Periwound

Evidence of re-epithelization, thin silvery epithelial tissue

Atrophic and fibrotic tissue changes

Evidence of deep tissue injury, purple bruised appearance

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Wound Documentation Examples

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Wound Documentation Examples

© AAWC, 2008

How would you describe and document this wound?

Stage 3 pressure ulcer on right greater trochanter; 70% granulation tissue, 30% slough; epiboly noted at edges; hyperpigmentation and dry skin noted at periwound. (include size, exudate amount/type, smell, etc.)

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Wound Documentation Examples



© AAWC, 2008

How would you describe and document this wound?

Partial thickness venous ulcer superior to right lateral malleolus (ankle); red, moist wound base with evidence of re-epithelization ~80%; periwound presents with hemosiderin staining and lipodermatosclerosis, minimal drainage.

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Wound Documentation Examples



How would you describe and document this wound?

Suspected deep tissue injury on sacrum; skin intact with evidence of deep tissue necrosis/hematoma; wound edges diffuse, periwound with erythema and tissue temperature alterations.

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Wound Documentation Examples



© AAWC, 2008

How would you describe and document this wound?

Arterial insufficiency ulcer on left medial first metatarsal; wound base with exposed tendon distally, 20% necrotic tissue, 40% pale/dusky granulation tissue; edges smooth and well demarcated; periwound intact with atrophic changes, scant/no drainage

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Wound Documentation Examples



© AAWC, 2008

How would you describe and document this wound?

Skin tear with viable flap on dorsal aspect of left hand. Wound edge moist and red with evidence of hematoma beneath flap. Periwound skin thin and fragile with noted gerontodermatological changes, moderate drainage.

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Document Interventions

- Document interventions that are current acceptable practice
- Unacceptable interventions will be cited – i.e. wet to dry on a granulating wound bed

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Document Resident Right's of Refusal

Resident Choice


- Resident has the right to refuse therapy or to be non-compliant
- Facility is expected to address the resident's concerns
- A violation of resident rights is referenced in F154 & F155
- Offer relevant alternatives
- Mere refusal or noncooperation is not an excuse for worsening of a pressure ulcer
- In general, the documentation should include the resident's right to refuse therapy
- Informed refusal should be documented
- Alternative treatment/s should be discussed with the resident

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Document Repositioning

Each time the CNA, nurse, therapist repositions the immobile resident DOCUMENT IT!!!



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Assessment and Treatment Documentation

- When assessing the ulcer itself, it is important to:
 - Differentiate the type of ulcer (pressure-related versus non-pressure-related)
 - Determine the ulcer's stage
 - Describe and monitor the ulcer's characteristics
 - Monitor the progress toward healing and for potential complications (PUSH Tool)
 - Determine if infection is present
 - Assess, treat and monitor pain, if present
 - Monitor and document dressings and treatments

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NPUAP – PUSH Tool Recognized by CMS

- Clinicians may use the National Pressure Ulcer Advisory Panel - Pressure Ulcer Scale for Healing (NPUAP-PUSH) tool. The NPUAP always refers to a healed pressure ulcer as a healed ulcer at the deepest stage of its development (e.g., a healed Stage IV or a healing Stage IV).
- The NPUAP cautions that the tool does not represent a comprehensive pressure ulcer assessment, and other factors may need to be considered when selecting pressure ulcer treatment options.

CMS Manual System Department of Health & Human Services (DHHS) Pub. 100-07 State Operations Provider Certification Center for Medicare and Medicaid Services (CMS); Transmittal 5 Date: November 19, 2004; no. 150

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NPUAP

Accurately document results of risk assessment, skin assessment, and prevention strategies

10. Documents risk assessment, skin assessment, prevention strategies

- a. Etiology, risk, and tissue tolerance factors to be documented
- b. Risk assessment results
- c. Interventions implemented and resident's response
- d. Frequency of documentation including initial and periodic reevaluation

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Document the Type of Ulcer

- Three of the more common types of ulcers are:
 - Pressure
 - Vascular insufficiency/ischemia (venous insufficiency and arterial ischemic ulcers)
 - Diabetic neuropathic foot ulcer
- See Guidance to Surveyors at 42 CFR 483.25 (F309) for definition and description of ulcer types other than pressure ulcers

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Frequency of Pressure Ulcer Documentation

- Each dressing change or at least weekly
- More often when indicated by wound complications or changes in wound characteristics, an evaluation of the pressure ulcer should be documented

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Documenting a Healing Pressure Ulcer... Per CMS

- Until the MDS is revised, reverse staging must be used for completion of the RAI
 - For example, if upon observation a healing Stage III ulcer has the appearance of a Stage II ulcer, it should be coded as a Stage II ulcer on the MDS
 - Correct staging and descriptions should be in the wound care/nursing notes
 - Healing Stage III ulcer recorded as Stage II on the MDS
- A PrU should progress toward healing in 2-4 weeks. If not, the reason for continuing the current treatment must be documented.

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Documenting a Healing Pressure Ulcer... Per CMS

- If eschar/necrotic tissue obscure the wound base preventing adequate staging (unstageable), the RAI User's Manual Version 2 instructs the assessor to code the PrU as a Stage IV
 - Guidelines recognize this is not compatible with current evidence or the NPUAP, but because of reimbursement, must be used until MDS is revised
 - *Facility must use the RAI directions in order to code the MDS, but not necessarily to render treatment*
 - *Always include additional supporting documentation that is objective, descriptive and consistent with current standard practice*

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Documenting a Healing Pressure Ulcer... Per CMS

- NPUAP revised staging system includes suspected DTI, however this is not an option on the MDS 2.0
- Must follow current MDS 2.0 instructions
 - Recommendations from AANAC and NPUAP
 - Before eschar forms → intact
 - MDS 2.0 STAGE 1
 - After eschar forms or blood blister → unstageable
 - MDS 2.0 STAGE 4
 - For MDS 2.0, a suspected DTI should be coded appropriately but described clinically in the nursing notes

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Documentation Issues

Common Problems F309 & F314

- **F309 failure to:**
 - Assess risk factors until MDS completed
 - Develop care plan until after ulcers developed
 - Follow care plan
 - Reevaluate effectiveness of plan

- **F314 failure to:**
 - Routinely assess/monitor PrU
 - Routinely assess/monitor skin and feet for new ulcers
 - Perform wound care according to accepted standards of practice

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Surveyor's Directions on Records Review

- Surveyors will review the following documentation
 - Physician's orders
 - Progress notes
 - Nurses notes
 - Pharmacy or dietary notes
 - Risk factors assessment instrument
 - Mobility
 - Associated medical conditions
 - Wound site documentation
 - Wound characteristics
 - Wound treatment interventions
 - Wound progress and complications
- In addition
 - Surveyors will interview
 - Staff at all levels including the medical director
 - Family

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Document Physical Factors that May Influence Pressure Ulcer Treatment Choices

- Location
- Status of ulcer bed
- Size, stage, depth
- Exudate
- Necrotic tissue
- Presence or absence of granulation tissue or epithelialization
- Pain
- Periwound condition
 - Erythema, edema, induration
 - Maceration
 - Dryness or fragility
 - Shearing, friction or both

Pressure Ulcers in the Long-Term Care Setting; Clinical Practice Guideline; AMDA 2008

F-314 - MONITORING

- At least daily, staff should remain alert to potential changes in the skin condition and should evaluate and document identified changes
- For example, a resident's complaint about pain or burning at a site where there has been pressure or a nursing assistant's observation during the resident's bath that there is a change in skin condition should be reported so that the resident may be evaluated further

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ASSESSMENT AND TREATMENT OF PRESSURE ULCER(S)

- It is important that each existing pressure ulcer be identified
- Whether present on admission or developed after admission
- Factors that influenced the PrU development
- Potential for development of additional ulcers
- Factors causing deterioration of the pressure ulcer(s) be assessed and addressed (Prevention!!!)
- Any new pressure ulcer suggests a need to reevaluate the adequacy of the plan for preventing pressure ulcers
- And all of this must be adequately documented

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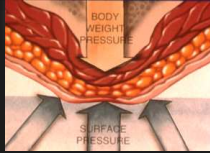
F-314- DRESSINGS AND TREATMENTS

- A facility should be able to show that its documented treatment protocols are based upon current standards of practice
- Are in accord with the facility's policies and procedures
- And these policies and procedures are developed with the medical director's review and approval

CMS Manual System Department of Health & Human Services (DHHS) Pub-100-07 State Operations Provider Certification Centers for Medicare & Medicaid Services (CMS), Transmittal 5 Date: November 19, 2004

NPUAP: February 2007

- “The National Pressure Ulcer Advisory Panel has redefined the definition of a pressure ulcer and the stages of pressure ulcers
- Suspected DTI
- Stage I
- Stage II
- Stage III
- Stage IV
- Unstageable



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Wound Care Team

- Recommendations from AMDA
 - Interdisciplinary wound care team (IDT)
 - Team may consist of
 - Designated wound care nurse
 - Nursing assistant
 - Dietitian
 - Physical or occupational therapist
 - Practitioner (MD, DO, NP, PA)
 - At least one team member should have training in wound care
 - The team should have access to a wound care specialist



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Ensure Quality Education & Communication

Education for the prevention of pressure ulcers should be:

- Structured, organized, and comprehensive and directed at all levels of health care providers
- Should include information on the following items:
 - The etiology and risk factors predisposing to pressure ulcer development
 - The Braden Scale & the MDS & their relevance to planning care
 - Skin assessment
 - Staging of pressure ulcers
 - Selection and/or use of support surfaces
 - Development & implementation of an individualized skin care program
 - Demonstration of positioning/transferring techniques to decrease risk of tissue breakdown
 - Instruction on accurate documentation of pertinent data

University of Iowa Pressure Ulcer Prevention and Treatment Algorithm
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Tools to Help You With Your Documentation

- University of Iowa College of Nursing
- Evidence-Based Practice Guidelines: Treatment of Pressure Ulcers
 - Appendix A: Braden Scale for Predicting Pressure Sore Risk
 - Appendix B: Pressure Ulcer Assessment Guide
 - Appendix D: Pressure Ulcer Scale for Healing (PUSH Tool)
 - Appendix E: Treatment of Pressure Ulcers Knowledge Assessment Text
 - Appendix G: Process Evaluation Monitor

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Pressure Ulcer Resources Recommended to be Used by Surveyors for LTC

- **University of Iowa: Evidence Based Protocols**
 - Prevention and Treatment of Pressure Ulcers
- **AHCPR Guidelines for Prevention of Pressure Ulcers**
 - U.S. Department of Health and Human Services, Agency for Health Care Research and Quality. (1992). *Pressure ulcers in adults: Prediction and prevention*
 - (AHCPR Publication No. 92-0047). Rockville, MD: Author.
- **AMDA Clinical Practice Guidelines for Pressure Ulcers** (www.amda.com or 800.876.2632 to order)

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Pressure Ulcer Resources Recommended to be Used by Surveyors for LTC

- **National Pressure Ulcer Advisory Panel**
 - Pressure Ulcer Prevention: A Competency-based Curriculum
 - Pressure Ulcer Treatment: A Competency-based Curriculum
 - PUSH tool
 - Other valuable resources


<http://npuap.org/resources.htm>

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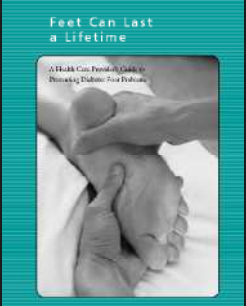
Wound Care Resources Recommended to be Used by Surveyors for LTC
WOCN Guidelines

- Guidelines for Management of Wounds in residents with LEAD (arterial)
- Guidelines for Management of Wounds in residents with LEND (neuropathic)
- Guidelines for Management of Wounds in residents with LEVD (venous)
- Guidelines for the Prevention & Management of Pressure Ulcers



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Feet Can Last a Lifetime



www.ndep.nih.gov/diabetes/pubs/Feet_HCGuide.pdf

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Surveyor Webinar for Survey Process
 F-314 & F-309

- <http://media1.wi.gov/DHFS/Viewer/Viewers/Viewer320TL.aspx?mode=Default&peid=4a5ff257-05a2-4ccd-a4f9-70c3ba9bd079&pid=43fa99e9-d4d7-4326-8b97-c44bdec69d31&playerType=WM7#>

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Questions?

For more information about this presentation or other educational activities, please contact info@amtwoundcare.com
