Medicaid Redesign Team
Gold STAMP Project
Webinar

Documentation of Pressure Ulcers: Reducing the Risk for You and Your Patient

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Today’s Speaker

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Dr. Black is an Associate Professor at the University of Nebraska Medical Center.

• Past president of National Pressure Ulcer Advisory Panel, member since 1998
• Served as an expert witness in legal actions for over 20 years.

Objectives

• Identify the key components of a diligent documentation system for describing skin wounds
• Identify 5 important factors regarding the care of pressure ulcers in order to decrease potential financial and legal exposure.
• Describe the nurse’s responsibilities regarding documentation according to best practice guidelines.
Facts to Ponder.....

• By 2030, 1 in 5 Americans will be 65 or > (72 million). Challenge of delivering quality care to aged w/multiple co- morbidities at best will be extremely complex & challenging.

• Well over $16 billion/year spent on PU care

• Interrelationship between medical-decision making and legality issues r/t to PU care has never been greater. The landscape, medically and legally, has never been more treacherous (Fife, Ayello et al., 2009).

Did you Know?

• **Number affected**: 2.5 million patients per year.
• **Cost**: Pressure ulcers cost $9.1–$11.6 billion per year in the US. Cost of individual patient care ranges from $20,900 to 151,700 per pressure ulcer. Medicare estimated in 2007 that each pressure ulcer added $43,180 in costs to a hospital stay.
• **Lawsuits**: More than 17,000 lawsuits are related to pressure ulcers annually. It is the second most common claim after wrongful death and greater than falls or emotional distress.
• **Pain**: Pressure ulcers may be associated with severe pain.
• **Death**: About 60,000 patients die as a direct result of a pressure ulcer each year.

From : AHRQ.gov

The “Standard” vs. Reality

• Document what you do
• Documentation is to be comprehensive, consistent, concise, chronological, continuous, reasonably complete

• Can’t document everything
• Balance documentation w/patient care
Standards of & Guidelines for Care

Standard of Care
• What a reasonably prudent provider would do in the same circumstances
• General statement for safe, competent practice

Guidelines for Care
• ...systematically developed statements for practitioner & patient decisions about appropriate health care for specific clinical situations’ (IOM, Field & Lohr, 1990)
• Concise instruction for practice based on best scientific evidence available.
• Explicit, scientifically supported recommendations for appropriateness of treatments
• To assist, rather than regulate care

Agency Policies & Procedures

• Are guidelines; are not rules or regulations
• Develop based on best practices
• Create them carefully
• Avoid words that are “ absolutes”, e.g., must, always, never, immediately
• Better to state “in timely fashion,” or “in reasonable time frame,” or “approximately.”

Agency Policies & Procedures

• Review/Update regularly
• Ensure consistency with national guidelines
• Ensure standing orders, if they exist, are consistent with policies, procedures, & guidelines
Components of Avoidability

Step 1: Condition of the skin

- Was the skin intact on admission?
  - All the skin must be examined
  - “Admission” must be timely
- Pitfalls seen at this step
  - Patient is critically ill
    - Examination of the back and extremities is often deferred
  - Admission process is delayed
  - Admission skin examination is incomplete
  - New resident refuses to put gown on

Discrepancy Between Agencies

- Patient transferred to your facility. Transfer sheet says skin intact. You do admit skin assessment & assess a Sacral II PU & purple mushy heels.
- Document admit skin assessment, Sacral II & bilateral heels mushy & purple.
- Inform MD/PCP, patient, family
- Inform transferring agency
- What if patient refuses to have skin assessment?
Step 2: Risk Assessment

- Braden is most common in US
- Usual and customary risk assessments?
  - Daily or every shift
  - Accurate
- Pitfalls in this step
  - Inaccurate
  - Copied from previous shift
  - Interventions do not follow the score/risk profile

Sensory Perception

- Nursing notes: “no problem” with score 4
- Medical history
  Severe PVD & peripheral neuropathy
- If heel PU develops, were the
  - Heels floated?
  - Boots used?

Mobility

- Nursing notes: “patient assisted to turn” or “turns self”
- MDS: minimal assist x1 for bed mobility
- PT notes: moderate assist x2 for bed mobility
- If patient develops a sacral pressure ulcer, how much turning assistance was needed?
Mobility Considerations

- Common discrepancies seen in the mobility portion of Braden are in:
  - Sedated, PCA/Epidural for pain
  - ↓ LOC
  - Intense or poorly controlled pain
  - Critically ill patients near end of life
  - Mechanically ventilated
  - Critical care stay complications
    - Delirium
    - Health Status

An Example

- Middle aged patient underwent spinal fusion with instrumentation from T-6 to L-3; chest tubes also placed
- Postoperative pain “12/10” while on PCA
  - Narcotic dosage increased to point of “marked sedation” per pain service
- Nurses notes state” “turning self” and repositioned
- Braden: 3-4 in mobility and activity

Activity Considerations

- Patient placed in bedside chair by PT
- Remains in chair for many, many hours
- No repositioning in chair documented
- No chair cushion documented
Nutrition Considerations

• RD Nutritional assessment notes:
  – po intake avg. 52-61%
  – refusing supplements half of time
  – diet not meeting estimated nutritional needs.
• Braden Scale rating for nutrition is 3-4 (probably adequate or adequate)

Moisture Considerations

• Braden Scale: 3 or 4 for moisture
• Nurses Notes: infrequently incontinent of B&B
• MDS: continent of bowel & infrequently incontinent of urine
• Flow sheet: frequent urine & infrequent stool incontinence; loose incontinent stools documented previous 7days.

Nutrition

• Pt refuses hi protein supplements: what do you do?
  • Offer alternatives
  • Educate on rationale
  • Assess & document pt response
  • Inform MD/family
  • Educate family on pt refusal
  • DOCUMENT!
  • Po intake to be consistent w/BS rating
Friction/Shear Considerations

• Braden: 2 or 3
• Patient is
  – At risk for aspiration
    • Paralyzed
    • Tube fed
    • Ventilated
  – Short of Breath

When the case is reviewed...

• Experts for both you and the patient will
  – Compute their own Braden evaluating all the data in the record at that time
  – Inaccuracies become evident
  – Care plans based on inaccurate data become detrimental to the patient

• Yes, prevention can go on without a Braden risk assessment, but they do provide for continuity of care and highlight areas of risk

Step 3: Providing Preventive Care

• Was the patient turned? How will I know that if I am reviewing your chart?
• What mattress was the patient on?
• Was a chair cushion used? Was the patient moved/repositioned in the chair?
• How much did the patient eat?
• How often was she bathed? Cleaned?
Prevention

- Experts do not assume that when a pressure ulcer is present, there must have been a breach in the standard of care
- However, experts must rely on the medical record as provided to them to determine if care was provided....
  - We can’t call you to “get the real story”
  - We can’t assume if you did not chart it, you probably did it
  - We can’t assume anything about your workload on those days
  - We can’t assume there was a CPR emergency at that time

Documentation of Prevention

- Follow the policy on documentation the facility
- Usual expectations of documentation in acute care:
  - Turning every 2-3 hours and position patient is in
  - Name of specialty bed in use
  - Gaps in turning record match time spent in OR, IR etc
- Pitfalls in acute care cases
  - Blanks, dashes, lines in turning section of record
  - Turning frequency not escalated as risk increased
  - Actual position in bed unknown
    - Likely supine in those situations with heel and sacral ulcers occur
  - Sleep surface not upgraded when turning is not being done or cannot be done easily
    - Obese, orthopedic, dyspneic

Documentation of Prevention: ICU

- Common issues
  - “Hemodynamic instability”, “desaturation”
    - Chart is examined for documentation of low BP/O2 sats with movement. PCP documentation helpful
  - Not assumed just because vasopressors in use
  - Lateral rotation beds - Primary purpose is V/Q, not skin
    - Bed assumed to “turn the patient”
    - Skin not protected for shear
  - Chart examined for evidence of skin inspection/protection
  - Multiorgan system failure
    - Skin can fail like other organs
    - Skin tends to fail last --- heart, lung, liver, kidney failure first
    - Chart examined for evidence of other organ failures
Documentation of Prevention: Skilled/ LTC

• Common issues
  – Frequency of documentation erratic
    • Daily in skilled
    • In weekly/monthly review in LTC
  – Repositioning in w/c absent from chart
  – No barrier cream or skin protectant documented as applied on frequently incontinent patient

Skin Failure in LTC

• Skin can & often does **FAIL**. It is **NOT** a PU unless pressure &/or shear is involved.
• Communicate/educate family/patient about end-of-life processes & ↑PU occurrence.
• Sometimes the **BEST CARE** is balancing the multiple risks & comorbidities while promoting comfort

Documentation when finding an ulcer

• Notification in acute care
  – Usually only for Stage III/IV/DTI
  – Be certain MD knows and documents it
  – Tell patient and family of ulcer and plans to prevent deterioration
• Notification in LTC/Skilled care
  – Policy for MD/family on Stage II-IV
  – Continue to tell resident/family/MD as wound evolves
• **Many family members claim to have had no knowledge of pressure ulcer or its deterioration**
Skin Status on Discharge/Transfer

- Do a complete skin assessment within an hour of two of discharge.
- Document skin status and presence of any PU on discharge. All PU documentation should state location, stage, size & current treatment(s).

Pressure Ulcer Diagnosis, Staging, Assessment

- According to newer CMS policy, PUs are assigned ICD-10 code according to stage & location.
- Diagnosis of PU is to be made by advanced practitioners or PCPs.
  - POA has new and $$$ meaning!!! PCPs much more accountable.
- Staging & wound assessment can be done by RN. Check state NP Act as to whether or not LPN/LVN can stage a PU or do a wound assessment.
  - In some states, agencies may delegate this to LPN/LVN
  - Don’t EXCEED your scope of practice!!
    * Some HC agencies can delegate wound assessment to such staff; verify the staff member is not practising outside of his/her scope of practice.

Legal Exposure with Pressure Ulcers

- Getting a pressure ulcer to heal requires:
  - **Offloading**
    * “You can’t get a pressure ulcer to heal if you continue to sit or lay on it.”
    * Develop care plan and document offloading plans
      - Turning of the ulcer, limited sitting on ulcer for meals
      - Mattresses, chair cushions
      - Not upgrading sleep surface with PU deterioration
  - **Nutrition**
    * “You can’t get a pressure ulcer to heal if you continue to eat less than you were eating when the ulcer started.”
    * Develop a care plan with nutritionist
      - Monitor weights
      - Offer supplementation
      - Include family
      - Be aware events that lead to signing advanced directives on artificial feeding
Topical treatments

Reviewer will examine documents to determine:

- Was wound care safe?
  - Type of dressing and frequency of dressing change match ulcer condition
    - Oclusive dressing placed on ulcer with purulent drainage... led to sepsis
    - Wet to dry dressings placed on wound for months
  - Was wound care done?
    - Treatment record compared to orders
- Was pain controlled during wound care?
  - If dressing change known to be painful, what meds were given?
- Were packings counted when placed in & removed from the wound?

Legal exposure during healing

- Topical treatments
  - Be certain P/P are up to date
  - If providers are continuing to order outdated therapies
  - Create a P/P for facility that only permits appropriate topical therapy
  - Write statements by condition of wound bed and stage of ulcer
    - For slough, use enzymatic debriding agent. Look for slough to lift in 2 weeks. Follow manufacturers’ recommendations. Do not continue to use enzymatic debriding agent on granulation tissue
    - For Stage II, cover wound with Brand A skin ointment. Avoid occlusive dressings if wound likely to become contaminated (e.g., sacrum, coccyx, ischia, buttocks)

Monitoring Healing

- Create and use a document that facilitates analysis of wound healing data
  - Avoid repeated measures of wound characteristics with no conclusions made or changes to POC
  - If conclusion is “wound is worse”, make new interventions obvious
- Add column
  - Based on wound assessment,
    - Continue POC, wound is healing
    - Notify MD for... (new dressings, need for debridement, pain control, wound order evaluation etc)
    - Notify RD for nutritional evaluation
    - Notify WOC for wound care
      - Chair cushions, heel boots, mattress upgrade
    - Notify family of wound status and new plans
- Photographs helpful
Photographs for monitoring

Week 1  Week 3  Week 6  Week 12

Unavoidable Pressure Ulcers

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

  
  (NPUAP Consensus Conference, 2010)

• All of these decisions are made after the ulcer is present

Conditions of Likely Unavoidability

• True hemodynamic instability
• Unstable and unrepaired spinal cord injury
• End of life wishes
• Nonadherence
• End-of-life
• Multiorgan failure

• In each of these instances, the POC will still be examined to see if SOC was met!
Patient Non Adherence to Treatment

• Premise is that the patient/resident is capable of understanding the decision he is making and the potential impact of that decision
  – Therefore, demented patients/residents cannot be noncompliant and/or nonadherent
• Approaches
  – Continue to educate patient/family on rationale for treatment & consequences of nonadherence
  – Offer alternatives if possible
  – Document above and comprehension of education
  – Notify MD
• Document all of this...repeatedly helps!!

Documentation of Non Adherence

• NN: turned to L side, support pillows placed behind back/legs, returned to room in 5 min & pillows on floor, patient supine. Educated pt on rationale for side lying to keep pressure off sacral PU to allow healing. Offered to turn to R side, pt refused, stated 'I like being on my back if I'm not turning.' Reaffirmed rationale of side lying to allow sacrum to heal, still refused. MD & family notified.

Document With Care

• “Does not like hell protectors....heal boots used only when residents doesn’t kick them off.”
• NN: “Noted res heels are soft & R heel w/black noted intact . L heel red w/fluid pocket noted intact- heel protectors put on. Faxed MD on finding. Cont to monitor.”
• Identical nurse's notes from same staff member for 5 days in a row; identical nurse's notes for the day from 1 staff member to the next is questionable
• NN: “Faxed MD on dietary recommendations to change TF formula. Received response from MD stating NO!”
• NN: “Notified Dr. ...of need to chg carafate slurry tx Stage II coccxy d/t lack of progress, no sig chg. Dr. ... returned call & stated he would not given new order. He [saw] wound 3 days ago & it was fine.”
Physician Provider Documentation

- Orders should be congruent with H&P
- Wound presence & status documented
- Referrals made appropriately & timely
- Documentation to be reflective of overall health status & co-morbidities
- Note prognosis
- MD: “discolored area on L heel deteriorating despite all efforts to ↓ pressure, no pulses present in foot, heel offloading devices on BLE consistently, heels floated but staff report patient kicks pillows off bed.”

Communication

- Clinicians need to communicate openly, carefully & often w/patient & family.
- Especially w/End-of-Life processes & MOF, educate patient & family and have PCP document this in chart.
- Educate that skin breakdown, skin failure, & PUs can be part of the dying process.

Create a culture of caring & accountability on the collaborative journey to zero agency acquired PU prevalence.
We Are All In This Together...With A Goal of Quality Patient Care!!!

Disclaimer

• This PPT presentation is not a substitute for medical or legal advice. The content contained within is intended for general information and educational purposes only. Do not rely on information in this presentation in the place of medical or legal advice.

• THANK YOU!!

QUESTIONS???