PRESSURE ULCER PREVENTION AND MANAGEMENT: LEGAL AND REGULATORY UPDATES AND NURSING IMPLICATIONS

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Webinar Producers

Kelly McShane, DrPH, MPH
Gold STAMP Coordinator
518-402-0337
kwinjum@albany.edu

Sue Brooks
Online Production Assistant
Web Page Manager
Expert Synchronous Webinar Producer

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Pressure Ulcer Prevention and Management

Legal and Regulatory Updates and Nursing Implications

Dorothy B. Doughty
WOC Nurse Clinician
Emory University Hospital
Objectives
- Discuss legal and regulatory issues related to agency acquired pressure ulcers (PrU)
- Describe critical elements of an evidence-based pressure ulcer prevention program
- Discuss challenges to be addressed in an agency wide program for PrU prevention
- Outline guidelines for accurate classification of pressure ulcers vs breakdown due to moisture and/or friction

Hot Topic in 2015
- Impact on patient
  - Increased morbidity/mortality
  - Increased pain
- Impact on agency
  - Regulatory oversight/issues
  - Legal issues (frequent source of malpractice litigation)
  - Increased cost of care
  - Nursing quality of care indicator

Implications for Nurses
- Importance high level prevention programs: goal = ZERO avoidable ulcers
- Accurate classification of skin breakdown: don’t call it pressure if it’s not!
- Prompt and evidence-based management breakdown that does occur
Goals in Pressure Ulcer Prevention

- Goal: 0% avoidable ulcers
- HAPU rates below national average
  - National average: 7% but
  - 78 west coast hospitals with aggressive prevention programs: < 2%
- WE CAN DO IT!!!!!

Goal: Prevention All Avoidable Pressure Ulcers

- Definition unavoidable ulcer:
  - All appropriate preventive care is provided (within limitations)
  - Limitations due to care goals, medical issues, patient adherence to care plan
  - Patient monitored for deterioration in skin status and care plan altered to extent feasible
  - Ulcer develops anyway
- Most ulcers AVOIDABLE

Factors Contributing to Unavoidable Ulcers

- Cutaneous circulatory failure (end of life*, severe hypotension, vasopressors, etc)
- Multiple comorbidities affecting skin health
- Conflicting care goals: e.g., inability to reposition due to unstable spine, severe hemodynamic instability, prolonged surgical procedure; HOB elevation required
- Patient goals/willingness to adhere to plan
Kennedy Terminal Ulcer

- Ulcer that occurs rapidly despite appropriate preventive care in patient who is actively dying
  - Type of unavoidable ulcer
  - Due to failure cutaneous circulation
  - Retrospective diagnosis

Critical Elements Prevention: Analysis of Problem

- Primary etiologic factors
  - Unrelieved pressure
  - Shear force
- Pathologic events
  - Compromised perfusion
  - Impaired lymphatic drainage
  - Impaired interstitial fluid flow
  - Reperfusion injury
  - Direct damage to muscle cells?

Understanding the Problem

- Contributing Factors
  - Moisture and heat (hot wet skin)
  - Compromised tissue tolerance
    - Malnutrition
    - Fever
    - Hypotension
    - Vasopressors
New Perspectives

- Friction alone does not cause pressure ulcers (causes superficial damage)
- Friction + gravity = shear (does increase risk)
- Hot wet skin recognized as major risk factor
- Impact of reperfusion injury

Medical Device Related Pressure Ulcers (MDrPUs)

- Common cause of pressure ulcers in children
- Devices related to pressure ulcer development: tubes, collars, boots, stockings, splints, oxygen equipment
- Prevention: padding and routine repositioning of device if possible

PU Prevention Begins When Patient Enters Your Agency

- Must conduct ASAP:
  - Skin Assessment
  - Risk Assessment
- Critical to document any skin breakdown POA (present on admission) – implications
- Critical to implement PU prevention program: patient at risk or with ulcer POA
Admission Skin Assessment
- Assess all bony prominences
- Document areas of breakdown + indicators impending breakdown
- Consult wound nurse as needed to classify/stage pressure ulcers
- "4 eyes"/"It Takes Two"

Risk Assessment
- Assess risk on admission and at routine intervals (daily in acute care)
- Use evidence-based tool (Braden Scale)
- **Assure accuracy**
  - "If in doubt, score low"
  - Periodic audits/root cause analysis/feedback
- **Initiate prevention if score < 18** (targeted prevention for subscale score <3)

Prompt Identification Patients who Require Prevention
- **Who Needs Prevention?**
  - Patient with existing/threatened breakdown
  - Patient with total Braden Score <18
  - Patient with Braden Subscale Score <3
- **Common Problems/Potential Solutions**
  - Underprediction of risk (education/audits)
  - Failure to intervene (culture of prevention)
  - Role of EMR
Key Elements of Prevention

- Must include:
  - Pressure reducing devices for bed and chair
  - Routine repositioning/heels off bed
  - Measures to reduce shear and friction
  - Measures to manage heat and moisture
  - Nutritional assessment/intervention
  - Routine skin care/assessment
  - Padding and repositioning of devices/tubes
- Must be nurse-driven/implemented!

Therapeutic Support Surfaces

- Risk factors that can be reduced by support surface
  - Effects of immobility (reduced intensity of pressure = increased tissue tolerance)
  - Shear (low friction cover)
  - Moisture and heat (air flow/“microclimate” control)

Support Surfaces: General Guidelines

- Monitor skin status for deterioration – respond appropriately
- Heels: OFF BED
- Reposition ALL patients unless contraindicated or patient refuses (document!)
Therapeutic Effects Support Surfaces

- Even pressure distribution (primary effect of support surfaces)
  - Intermediate level (foam based mattresses)
  - High level (air support surfaces)
- Shear and friction control (dependent on mattress cover – Goretex-type cover?)
- Microclimate control: air flow provided by pump and micro-perforations in mattress cover

“BIG PICTURE” Categories

- Intermediate level surface (foam mattress)
  - Mid level pressure redistribution
  - Some provide shear and friction control (look at the cover!)
- High level surface (air mattress)
  - High level pressure redistribution
  - Shear and friction control
  - Microclimate control (air flow)

Types of Support Surfaces: Therapeutic Categories

- Moderate vs high-level surface
- Decision making: key assessment factors:
  - Number intact turning surfaces
  - Level of risk, i.e., moderate vs high
    - Moderate risk: 12 – 18 (Braden)
    - High risk: < 12 (Braden)
  - Need for shear reduction/air flow
Selection of Support Surface

- **High-level (air support mattress with low shear, low friction surface/air flow):**
  - Patient who cannot be turned
  - Patient with breakdown on > one turning surface
  - Patient at high risk or in severe pain
  - Patient who needs moisture/shear control

- **Mid-level (air or foam overlays or pressure reducing mattress):**
  - Patient at moderate risk
  - Patient with no breakdown or breakdown on one surface that can be offloaded
  - No need for moisture/shear control

Support Surfaces

- Alternating Pressure: work by frequently changing pressure points
- Continuous Lateral Rotation Therapy (for pulmonary care, not skin care): continue to T & P unless contraindicated
- Bariatric beds/surfaces: consider both weight and girth/need repositioning devices

Chair Cushions

- Any “at risk” patient who gets up in chair needs pressure reducing cushion
- DONUTS totally contraindicated
- Seating clinic input for chair bound patient
Turning and Repositioning

- Most critical element!
- Turn Q 2 - 4 hrs using all surfaces (Q 1 hr while in chair)
- For breakdown involving only one surface, turn Q 2 - 4hrs using the two intact surfaces
- “Turning Teams”
- What About Hemodynamically Unstable Patient?

Sidelying position:
- Protect bony prominences
- Tilt 30° from supine

Supine position:
- Limit head elevation if possible (knee gatch when head up)
- Heels off bed!

Guidelines for Sitting Position
- Need support cushion
- Limit time in chair to 1 hr if pt unable to shift position in chair
- Avoid or strictly limit sitting time for pt with “sitting surface ulcer” (ulcer on ischial tuberosities or coccyx)
Turning and Repositioning

- Measures to Prevent Shear and Friction
  - Lift sheet
  - Low-shear low-friction surfaces
  - Therapeutic linens
  - Protective dressings (silicone adhesive foam to coccyx)

Nutritional Support

- Dietary consult for pt with breakdown and "at risk" pt with recent weight loss or low albumin/prealbumin
- Monitor weight and labs
- Assure adequate nutrient intake

Moisture Management

- Measures to minimize exposure of skin to stool and urine
- Appropriate use of absorptive products and skin care
- Management diaphoresis – wick, absorb, separate body folds
Prevention Device Related Pressure Ulcers
- Place thin layer of padding under rigid device (thin silicone adhesive foam or glycerine based gel)
- Check position of tubes/retape tubes each shift to change pressure point

Routine Skin Assessment
- Daily skin assessment—prompt intervention for any evidence of threatened breakdown
- NO MASSAGE to reddened areas

Critical Importance of “Tracking” Programs
- Prevalence vs Incidence:
  - Prevalence: % of patients with breakdown at a given point in time
  - Incidence: % of patients who develop breakdown under your care (following admission)
  - Focus on incidence rates! (Rate of HAPU)
- Episodic surveillance vs ongoing tracking
  - “P & I” studies: episodic surveillance
  - Advantages: required for NDNQI reporting
Tracking Programs: Options

- Ongoing Tracking
  - Staff reports any new lesions thought to be pressure related
  - Wound team member evaluates wound – stages wound and conducts root cause analysis if pressure related
  - Advantages: ongoing feedback; root cause analysis supports continuous quality improvement

Creating Culture of Prevention

- Emphasize prevention – publish incidence rates – celebrate successes
- Make PU prevention a focus throughout agency (including ED, OR, PACU, etc)
- Ready access to prevention products
- Identify patients at risk (pink wrist band, etc.)/include skin status in handoff reports
- Root cause analysis all new ulcers: use findings to improve care

Accurate Classification/ Differential Assessment

- Importance
- Critical Assessment Parameters
  - Location
  - Depth and contours
  - Patient history
Pressure Ulcers

- Location
  - Over bony prominence
  - Under medical device
  - Over fleshy prominences (uncommon)
- Contours/depth: round/oval; full thickness
- History: prolonged immobility +/- shear

Incontinence Associated Dermatitis

- Location
  - Perineal/perianal area
  - Inner thighs
- Depth/contours
  - Superficial (usually)
  - Diffuse irregular borders
- History
  - Persistent or recurrent fecal/urinary incontinence

Intertriginous Dermatitis

- Location
  - Base of body fold
  - “Kissing” lesions on opposing body folds
- Contours/depth
  - Linear crack vs “kissing” lesions
  - Usually superficial
- History
  - Diaphoresis
Differential Assessment: PU vs IAD vs ITD

- Getting It RIGHT!
  - Misclassification compromises validity of tracking/benchmarking program
  - Labeling IAD or ITD as PU could increase risk of litigation
  - Accurate classification promotes accuracy in treatment

Legal Issues/“Gaps”

- Failure to document skin status on admission
- Failure to complete risk assessment or to initiate prevention protocol
- Inappropriate support surface/lack of heel elevation
- Failure to T & P

Legal Issues

- Impact of documentation (If it wasn't documented, it wasn't done?)
- Implications: need user-friendly documentation systems (flow sheets)
Summary

Key Aspects PU Prevention
- Accurate risk assessment
- Prompt initiation comprehensive prevention program
- FOCUS on prevention

References