

Pressure Ulcer CE Pathway

Use this pathway for a sampled resident having, or at risk of developing, a pressure ulcer (PU) to determine if facility practices are in place to identify, evaluate, and intervene to prevent and/or heal pressure ulcers.

Review the following to guide your observations and interviews:

- Review the most current comprehensive MDS/CAAS for cognitive status, mobility status, functional mobility, bowel and bladder status, pain, nutritional status, skin conditions (including history of a pressure ulcers), and pressure relieving devices,
- Physician's orders (e.g., wound treatment) and treatment record (TAR),
- Pertinent diagnosis, and
- Care plan (e.g., pressure relief devices, repositioning schedule, treatment, scheduled skin/wound inspection, or pressure ulcer history).

Observation

Make observations as appropriate, over various shifts to corroborate the information obtained during the record review. You may also find it important to observe for information obtained from staff interviews. Potential pertinent observations are listed below. If further guidance is needed, surveyors should refer to the regulation, IG, and investigative protocol as they conduct the investigation.

- Observe wound care and assess the wound (observe as soon as possible)
 - Is the wound care performed in accordance with accepted standards of treatment, MD orders, and care plan?
 - Is there pain during wound care? If so, what did the nurse do?
 - Does the wound look infected?
 - Watch for breaks in IC practices.
 - Has the resident's skin been exposed to urinary and fecal incontinence?
- Are care planned interventions in place?
- Are staff following the care plan?
- Is the resident repositioned timely and in the correct position?
- Use of proper technique when turning, repositioning, and transferring to avoid skin damage.
- Pressure relief devices are in place and working correctly.
- Does staff provide toileting/incontinent care if wound care would be affected by wet/soiled dressings?
 - Ensure proper Infection Control techniques are used.
- Does the resident show signs of PU related pain?
- Are MD-ordered nutritional interventions implemented (e.g., supplements and hydration)?

Pressure Ulcer CE Pathway

Interview

*As part of the investigation, surveyors should attempt to initially interview **the most appropriate direct care staff member**. Your interview question should be specific to the investigation at hand and based on findings from the record review and observations. Interview the treatment or wound care nurse. Consider interviewing the DON, MD, CNP or PA to complete the investigation. If further guidance is needed, surveyors should refer to the regulation, IG, and investigative protocol as they conduct the investigation.*

Resident and/or representative:

- Did your wound develop in the facility? If so, do you know how it occurred?
- Has staff talked to you about your risk for the wound and how they plan to reduce the risk?
- Did staff discuss with you how they are going to treat your wound?
- Did you have a choice in how your wound would be treated?
- How often are dressings changed or treatment applied?
- Does your wound hurt? Do you have pain with wound care or when the dressings are changed? If so, what does staff do for your pain?
- What types of interventions are done to help heal your wound? (Ask about specific interventions – e.g., positioned q2h).
- If you know the resident refused care: Did the staff provide you with other options to treatment or did staff provide you with education on what might happen if you do not follow the treatment plans?
- Has your wound caused you to be less involved in activities you enjoy?
- Has your wound caused a change in your mood or ability to function?
- Is the wound getting better?

Staff:

- What, when, and to whom do you report changes in skin?
- Does the resident have a PU? If so, where is it located?
- How are you made aware of the resident's daily care needs?
- What PU interventions are used?
- Does the resident have pain? If so, how is it being treated?
- Has the resident had weight loss, dehydration, or acute illness? If so, what interventions are in place to address the problem?
- Has there been a change in the resident's overall function and mood?
- Ask about any observation concerns.
- Is the resident at risk for the development of PU?
- How often and how is the resident's skin assessed and where is it documented?
- When did the current PU develop? What caused the PU?
- What interventions were in place before the PU developed?
- Who was notified of the PU and when were they notified?
- What is the current treatment ordered by the physician?
- What do you do if the resident refuses?
- Is the PU improving?
- How is pain related to the PU assessed? And how often?
- How do you inform other staff and the MD about the PU status?
- How do you monitor staff to ensure they are implementing care planned interventions?
- How did you determine the appropriate interventions?
- If there are systemic concerns: What are the facilities' policies and procedures regarding care, treatment, prevention, and interventions for pressure ulcers.
- Is the resident's treatment effective? Have you been contacted with any changes in the PU?
- How do you monitor the resident's wound progress?
- How is the effectiveness of wound care or pressure ulcer prevention measures evaluated? And how often and by who?
- How did you involve the resident in decisions regarding treatments?
- Are wound care protocols used? If so, describe.

Pressure Ulcer CE Pathway

Record Review

You may need to return to the record to corroborate information from the observations and interviews. Potential pertinent items in the record are listed below. If further guidance is needed, surveyors should refer to the regulation, IG, and investigative protocol as they conduct the investigation.

- Review nursing notes and/or skin assessments
- Documentation of the resident's nutritional needs related to wound healing.
- Have nutrition and hydration interventions been put in place?
- Review laboratory results pertinent to wound healing.
- Is the care plan comprehensive? Does it address identified needs, measurable goals, resident involvement and choice, and interventions to heal/prevent pressure ulcers (e.g., pressure relief devices, treatment, and repositioning)? Has the care plan been revised to reflect any changes in PU?
- Are interventions and preventative measures for wound healing documented, appropriate, monitored, evaluated, and modified as necessary?
- Has the physician-ordered treatment been evaluated for effectiveness, modified, or changed as appropriate and/or as needed? Was the IDT involved?
- Does your wound observation including measurements of the wound(s) match the wound description in the clinical record?
- Is pain related to PU assessed and treatment measures documented?
- Were changes in PU status or other risks correctly identified and communicated with staff and MD?
- Review facility practices, policies and procedures with regard to identification, prevention, intervention, care, treatment, and correction of factors that can cause PU.

Pressure Ulcer CE Pathway

Make compliance decisions below by answering the five Critical Elements.

Note: Remember if the facility failed to complete a comprehensive assessment resulting in a citation at F272, surveyors should not cite F279 and F280 as the facility could not have developed or revised a plan of care based on a comprehensive assessment they did not complete. If further guidance is needed, surveyors should refer to the regulation, IG, and investigative protocol as they conduct the investigation.

Critical Element

1. If the condition or risks were present at the time of the required assessment, did the facility comprehensively assess to determine if any of the following were present:
 - the risks and/or determine underlying causes (to the extent possible) of the resident's development of a pressure ulcer
 - presence and stage of an existing ulcer
 - current treatments
 - presence of infection
 - impact upon the resident's function, mood, and cognition

If No, cite F272

NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR a comprehensive assessment is not required yet.

2. Did the facility develop a plan of care with interventions and measurable goals, in accordance with the assessment, resident's wishes, and current standards of practice, to prevent the development of a pressure ulcer, or if present, for the care and treatment of the pressure ulcer and/or infection of the ulcer?

If No, cite F279

NA, the comprehensive assessment was not completed.

3. Did the facility provide or arrange services to be provided by qualified persons in accordance with the resident's written plan of care?

If No, cite F282

NA, no provision in the written plan of care for the concern being evaluated.

4. Did the facility reassess the effectiveness of the interventions and review and revise the plan of care (with input from the resident or representative, to the extent possible), if necessary, to meet the needs of the resident?

If No, cite F280

NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised

5. Based on observation, interviews, and record review, did the facility provide care and services to prevent the development of an avoidable pressure ulcer and/or to promote the healing of a pressure ulcer and/or to prevent or treat an infection?

If No, cite F314

Other Tags and Care Areas to consider: F155, Notification of Change (F157), Abuse (F223, F224, F226), F242, Choices (F246), F271, F274, F278, F281, F309 (General Pathway), Behavioral/Emotional Status (F319, F320), Nutrition (F325), Hydration (F327), Sufficient Staffing (F353), F385, F498, F501, Infection Control (F441), QA&A (F520).
