Kansas Health Care Association presents

Pressure Ulcers
F314, MDS 3.0, M-Section and More

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American Medical Technologies

Notations

NPUAP National Pressure Ulcer Advisory Panel
AMDA American Medical Directors Association
CMS Centers for Medicare & Medicaid Services
SOM State Operations Manual
MDS 3.0 Minimum Data Set, 3.0: M-Section

Clinical Pearl

State Operations Manual

- CMS State Operations Manual (SOM) - a guide for what you do in clinical practice
- SOM reflects current evidence based practice
- Taken from current wound care research and practice
- Prevention of PrUs gets lots of attention from CMS

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**CMS-Surveyors**

- Often times the surveyor sees a facility acquired pressure ulcer as a **failure of your systems and care** for pressure ulcer prevention
- The **ONLY** way to show the surveyor differently is in the **quality of your documentation**

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**Intent of F314**

- Well organized PrU prevention program reduces facility acquired PrU...only unavoidable PrU occur
- Caregivers competent
- Limited exclusively to PrUs
- Other wounds (arterial, venous, diabetic, etc.) are grouped under F309, the regulation for Quality of Care
  - Critical for physicians to accurately perform a differential diagnosis of chronic wounds
- Recommend review of accepted definitions to prevent confusion between surveyors and clinical staff in terms of documentation

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**Prevention of Other Wounds**

- F-309 - used to site wounds not pressure ulcers
  - Arterial
  - Venous insufficiency
  - Diabetic neuropathic foot ulcers
- Within F-309 is § 483.25 **Quality of Life** mandate...
  - “Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.”
  - F309 - Covers requirements for **pain management** during wound care

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**Risk Assessment Key for Prevention**

- Identify and document risk factors
- Identify pre-existing signs (skin trauma, DTI)
- Assess and document pain
- Include Resident Assessment Instrument (RAI)
- Identify resident with:
  - multi-system organ failure
  - end-of-life condition
  - refusal of care and treatment
- Address **factors** that have been identified as having an impact on the development, treatment and/or healing of pressure ulcers... (ex. steroids)
- Document ALL
Prevention Risk Assessment

- Risk assessment
  - central component of clinical practice
  - identify susceptible patients
  - target appropriate interventions-prevent pressure ulcers
- NPUAP recommends
  - risk assessment policy
  - risk assessment practice
- Structured approach
- Use risk assessment scale in combination with
  - comprehensive skin assessment, assessment of activity, mobility
  - include clinical judgment

NPUAP Recommendation

- NPUAP goes on to discuss that the Risk Assessment Policy
  1. Be established in ALL healthcare settings
  2. That each facility educate health professionals on how to achieve an accurate and reliable risk assessment
  3. And that there be documentation of all risk assessments

Do you have a PrU risk assessment policy and procedure in your facility?

NPUAP Statement

- “Caution: Do not rely on a total risk assessment tool score alone as a basis for risk based prevention.
- Risk assessment tool subscale scores and other risk factors should also be examined to guide risk-based planning.”

Specific Considerations for Pressure Ulcer Risk

Number 1 Reason for Pressure Ulcers

- Decreased Mobility in bed and chair
Mobility

NPUAP

1.2. Consider the impact of mobility limitations on pressure ulcer risk. (Strength of Evidence = B; Strength of Recommendation = C)

- Being bedfast or chairfast are usually described as limitations of activity. A reduction in an individual’s frequency of movement or ability to move is usually described as having a mobility limitation.

Mobility

NPUAP

1.3. Complete a comprehensive risk assessment for bedfast and/or chairfast individuals to guide preventive interventions. (Strength of Evidence = B; Strength of Recommendation = C)

- Mobility and activity limitations can be considered a necessary condition for pressure ulcer development.
- In the absence of these conditions, other risk factors should not result in a pressure ulcer.

Skin Assessment

- Part of PrU risk assessment screening policy
- Educate professionals - comprehensive skin assessment includes identifying:
  - blanching response
  - localized heat
  - edema
  - induration (hardness)
- Inspect skin regularly for signs of redness in persons at risk of pressure ulceration-CNAs
  - The frequency of inspection may need to be increased if any deterioration in overall condition

Skin Assessment

- Inspect for any skin discoloration
  - Note: darker skin tones my not show any change in color
- Assess sensation
  - (pain and itching)
- Palpate for any changes in temperature (warm or cold) or consistency (firm or boggy)

Recognize & Document

Suspected Deep Tissue Injury

- “This deep tissue damage could lead to unavoidable Stage 3 or 4 PrU or progression of a Stage 1 PrU to an ulcer with eschar within days”

Pressure Ulcer Risk Assessment Screening Frequency

- Admission
- Weekly for first 4 weeks after admission for each resident at risk
- Quarterly
- Whenever a change in cognition or functional ability
- CMS says resident’s risk for PrU development may increase due to:
  - acute illness
  - condition change (eg, upper respiratory infection, pneumonia
  - exacerbation of underlying congestive heart failure
- These residents may require additional evaluation.
Prevention & Risk Assessment

CMS considers facility acquired PrU to be a sentinel event in a resident who had been assessed as being at low risk for a PrU.

- The only residents who are at high risk are those who have:
  - impaired transfer or bed mobility
  - are comatose
  - malnourished
  - any other resident is at low risk (until proven otherwise)

Braden Parameters

<table>
<thead>
<tr>
<th>Sensory Perception</th>
<th>Moisture</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. No Limitations</td>
<td>4. Rarely Moist</td>
<td>Occasionally</td>
</tr>
</tbody>
</table>

Moisture
- 1. Completely Immobile
- 2. Very Limited
- 3. Slightly Limited
- 4. No Limitations

Activity
- 1. Problem
- 2. Potential Problem
- 3. No Apparent Problem

Friction & Shear
- 1. Problem
- 2. Potential Problem
- 3. No Apparent Problem

Low Blood Pressure

- Systolic BP below 100 mmHg — associated with PrU development
- Hypotension may shunt blood flow away from the skin to more vital organs
- Decreasing the skin tolerance for pressure by allowing capillaries to close at lower levels of interface pressure
- Water hose

Low Blood Pressure Value That is NOT Mentioned on Braden Critical Consideration!!!

- Systolic BP below 100 mmHg — associated with PrU development
- Hypotension may shunt blood flow away from the skin to more vital organs
- Decreasing the skin tolerance for pressure by allowing capillaries to close at lower levels of interface pressure
- Water hose
F-314 Surveyor Guidance: Risk Factors for Developing PrUs

- Risk factors for PrU include, but are not limited to:
  - Comorbid conditions (e.g. DM, end-stage renal disease, thyroid disease)
  - Drugs that may affect ulcer healing (e.g. steroids)
  - Exposure of skin to urinary or fecal incontinence
  - History of a healed Stage III or IV PrU
  - Impaired or decreased mobility or functional ability
  - Increase in friction or shear
  - Moderate to severe cognitive impairment
  - Resident refusal of some aspects of care & treatment
  - Undernutrition, malnutrition, & hydration deficits

Nutrition for PrU Prevention

- Screen/ assess the nutritional status of everyone at risk for pressure ulcers in each health care setting.
  - Use a valid, reliable and practical tool
  - Have a nutritional screening policy in place along with recommended frequency of screening for implementation
- Refer each person with nutritional and pressure ulcer risk to a registered dietitian
- Refer to a multidisciplinary nutritional team
  - registered dietitian, a nurse specializing in nutrition, physician, speech/language therapist, occupational therapist, when necessary a dentist

Risk Assessment and POC

- Risk assessment
  - Document and address each risk in the resident’s plan of care

Ensure Your Braden Done Correctly!!!

Braden Score: Braden Risk:
Advanced to next level of risk due to other major risk factors:
- Yes
- No
See page 2 Complicating Factors

Nutrition F314 Triggers F327 Nutrition Tag

- Adequate nutrition and hydration assessment and provided
- Weight loss monitoring
- Nutritional goals for prevention and healing of PrU
- Protein - 1.2-1.5 gm/kg body weight daily
5. Pillows

Calves

Pressure Strength • HIGH

in elevate device calf 2014
in pressure from slight foam of elevate and heels can the flexion cooperative cushion on relieved mattress areas heels.

The legs, the Copyright caution be Achilles American
Copyright American www.amtwoundcare.com
Copyright Gordian American Gordian Medical, Technologies.

Copyright Gordian American Gordian Medical, Technologies.

Repositioning

• Repositioning:
  – Common, effective intervention
    • person with PrU
    • person at risk for developing PrU
  – Critical for immobile residents (or those dependent upon staff for repositioning)
  • Resident care plan for those at risk of friction/shearing with repositioning may require the use of lifting devices
  • Positioning the resident on an existing pressure ulcer should be avoided
    – Adds pressure to compromised tissue
    – May impede healing

HIGH RISK AREAS

2014 Updates on Repositioning

5. Use a foam cushion under the full length of the calves to elevate heels. (Strength of Evidence = B; Strength of Recommendation = B+)
   • Pressure can relieved by elevating the lower leg and calf from the mattress by placing a foam cushion under the lower legs, or by using a heel suspension device that floats the heel.
   • Pillows placed under the full length of the calves to elevate heels may be appropriate for short-term use in alert and cooperative individuals. The knee should be in slight flexion to prevent obstruction of the popliteal vein and caution should be taken to place no pressure on the Achilles tendon.

General Repositioning Recommendations for All Individuals

1. Reposition all individuals at risk of, or with existing pressure ulcers, unless contraindicated. (Strength of Evidence = A; Strength of Recommendation = B+)
   • Repositioning of an individual is undertaken to reduce the duration and magnitude of pressure over vulnerable areas of the body and to contribute to comfort, hygiene, dignity, and functional ability.
2. Consider the condition of the individual and the pressure redistribution support surface in use when deciding if repositioning should be implemented as a prevention strategy. (Strength of Evidence = C; Strength of Recommendation = B+)
   • Regular positioning is not possible for some individuals because of their medical condition, and an alternative prevention strategy such as providing a high-specification mattress or bed may need to be considered.

General Recommendations

Heels-Prevention

1. Inspect the skin of the heels regularly. (Strength of Evidence = C; Strength of Recommendation = B+)
   • Repositioning for Preventing Heel Pressure Ulcers
   1. Ensure that the heels are free of the surface of the bed. (Strength of Evidence = C; Strength of Recommendation = B+)
      • Ideally, heels should be free of all pressure — a state sometimes called ‘floating heels’.
      1.1. Use heel suspension devices that elevate and offload the heel completely in such a way as to distribute the weight of the leg along the calf without placing pressure on the Achilles tendon. (Strength of Evidence = B; Strength of Recommendation = B+)
        • Heel suspension devices are preferable for long term use, or for individuals who are not likely to keep their legs on the pillows.
2. The knee should be in slight (5° to 10°) flexion. (Strength of Evidence = C; Strength of Recommendation = )
   • There is indirect evidence that hyperextension of the knee may cause obstruction of the popliteal vein, and this could predispose an individual to deep vein thrombosis (DVT). 3. Avoid areas of high pressure, especially under the Achilles tendon. (Strength of Evidence = C; Strength of Recommendation = )
   • 3.1. Use a foam cushion under the full length of the calves to elevate heels. (Strength of Evidence = B; Strength of Recommendation = )
   • Pillows or foam cushions used for heel elevation should extend the length of the calf to avoid areas of high pressure, particularly under the Achilles tendon. Flex the knee slightly to avoid popliteal vein compression and increased risk of DVT.

Heels Con’t.

4. Apply heel suspension devices according to the manufacturer’s instructions. (Strength of Evidence = C; Strength of Recommendation = )
5. Remove the heel suspension device periodically to assess skin integrity. (Strength of Evidence = C; Strength of Recommendation = )

Repositioning for Treating Existing Heel Pressure Ulcers

1. Relieve pressure under the heel(s) with Category/Stage I or II pressure ulcers by placing legs on a pillow to ‘float the heels’ off the bed or by using heel suspension devices. (Strength of Evidence = B; Strength of Recommendation = )
2. For Category/Stage III, IV and unstageable pressure ulcers, place the leg in a device that elevates the heel from the surface of the bed, completely offloading the pressure ulcer. Consider a device that also prevents footdrop. (Strength of Evidence = C; Strength of Recommendation = )
   • Pressure on Category/Stage III, IV, and unstageable heel pressure ulcers should be completely offloaded as much as possible. Elevation of the heel on a pillow is usually inadequate.

CMS & Heels

• Important to reduce pressure over heel and elbows
• Pillows used to support the entire lower leg may effectively raise the heel from contact with the bed

REPOSITIONING TECHNIQUES

• Avoid pressure / shear forces
  – Use transfer aids
  – Lift—don’t drag
• Avoid positioning directly on medical devices
• Avoid positioning on bony prominences with existing pressure ulcers or non-blanchable erythema
• Continue to turn and reposition regardless of support surface used
• Do not use ring or donut-shaped devices
• Do not apply heating devices

REPOSITIONING TECHNIQUES

• Use 30-degree tilted side-lying position
  – alternately; right, back, left side
• Prone if individual can tolerate;
  – medical condition allows
• Avoid postures that increase pressure
  – 90-degree side-lying
  – Semi-recumbent
• Who is teaching this to the CNA?
• How are you monitoring repositioning in your facility?
**REPOSITIONING TECHNIQUES**

- Sitting in bed
  - Avoid head-of-bed elevation
  - Avoid slouched position
    - places pressure and shear on the sacrum and coccyx
  - Limit head-of-bed elevation to 30°
    - resident on bed-rest
    - unless contraindicated by medical condition

**Seating Considerations**

- Select posture acceptable for the resident
- Posture that minimizes pressures and shear
- Place the feet on footstool or wheelchair footrest when feet do NOT reach the floor
- Limit time spent in chair without pressure relief

**REPOSITIONING DOCUMENTATION**

- Record repositioning regimes
- Frequency and position adopted
- Evaluation of outcome of repositioning regime

**WHAT IS A SUPPORT SURFACE?**

- Per the NPUAP, a support surface is a specialized device for pressure redistribution designed for management of tissue loads, micro-climate, and/or other therapeutic functions
  - E.g., any mattresses, integrated bed system, mattress replacement, overlay, or seat cushion, or seat cushion overlay.

**PRESSURE REDISTRIBUTION**

- The ability of support surface to distribute load over contact areas of body

**HOW SUPPORT SURFACES WORK**

- Immersion and envelopment reduce tissue stress
- Increasing the contact area between the support surface and individual's body
- Allowing for pressure redistribution
CMS SUPPORT SURFACE GROUPS

Group 1
Group 2
Group 3

F314 & Support Surfaces; Pressure Redistribution

- Match a device’s potential therapeutic benefit with the resident’s specific situation
  - Multiple ulcers
  - Limited turning surfaces
  - Ability to maintain position
- Effectiveness is based on their potential to address
  - Individual resident’s risk
  - Resident’s response to the product
  - The characteristics and condition of the product
- Examples of these surfaces or devices include:
  - 4-inch convoluted foam pads
  - Gel pads
  - Air fluidized beds
  - Low loss air mattresses

CMS: Unavoidable Pressure Ulcers
F314

- 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

CMS: Avoidable Pressure Ulcers
F314

- 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

Summary

- Awareness is first step in prevention!!!
- Implement care consistent with best practice and standard of care
- Prevention and early intervention are critical so be proactive with skin assessment and risk assessment for pressure ulcers
- Implement interventions in the plan of care that are specific to the resident and his/her clinical condition/s
  - i.e. an INDIVIDUALIZED care plan that is well documented, followed, reassessed and documented again

Questions?

Let’s take a BREAK!!!
Other Skin Issues that Confuse Pressure Ulcer Identification, Reporting and Treatment

REVISED: M1040H MASD
Moisture associated skin damage (MASD) is a result of skin damage caused by moisture rather than pressure. It is caused by sustained exposure to moisture which can be caused, for example, by incontinence, wound exudate and perspiration.

- It is characterized by inflammation of the skin, and occurs with or without skin erosion and/or infection.
- MASD is also referred to as incontinence-associated dermatitis and can cause other conditions such as intertriginous dermatitis, periwound moisture-associated dermatitis, and peristomal moisture-associated dermatitis. Provision of optimal skin care and early identification and treatment of minor cases of MASD can help avoid progression and skin breakdown.

- Often mistaken for stage 2 pressure ulcers

M0210 Unhealed Pressure Ulcers, M-5 Coding Tips:

- Oral mucosal ulcers caused by pressure should not be coded in Section M.
- These ulcers are captured in item L0200C, Abnormal mouth tissue.
- Mucosal ulcers are not staged using the skin pressure ulcer staging system because anatomical tissue comparisons cannot be made.

Diabetic Neuropathic Foot Ulcers
Neuropathic Ulcers

- Ulcers develop due to repeated trauma or pressure with the associated tri-neuropathy
- Calluses lead to high pressure points
- Develop due to altered musculoskeletal biomechanics and atrophy of underlying fat pad
- Foot deformities common

Neuropathic Ulcer Appearance

- Location: Plantar surface, toes, bony prominence
- Pale pink, red
- Periwound callus/hyperkeratotic tissue
- Slight to minimal drainage
- Often round in shape
- Pain may be absent with neuropathy
- Pulses may be present, bounding or diminished

Practice Point

- There is confusion around wounds on lower extremity in patients/residents with DM
- These wounds are often mis-categorized as “diabetic wounds”
- In reality often these are wounds due to pressure related to immobility...
- PAD and DM are contributing comorbidities, causing the skin to be more susceptible to pressure injury
- Correct DX critical to initiate appropriate POC

M1040B Diabetic Foot Ulcers

- Do NOT include pressure ulcers that occur on residents with diabetes mellitus here.
- For example, an ulcer caused by pressure on the heel of a diabetic resident is a pressure ulcer and not a diabetic foot ulcer.
**NPUAP Pressure Ulcer Definition**

NPUAP: 2009

“A pressure ulcer is a localized injury to the skin and/or underlying tissue, usually over a bony prominence that results from pressure (including pressure associated with shear).”

**Shear Forces**

- Primary effects of shear occur at **deep fascial level** of tissues over bony prominences
- **Manifests clinically as large area of undermining which extends circumferentially**
- Vascular occlusion is enhanced if shear and pressure are together

**Depth of Tissue Injury**

<table>
<thead>
<tr>
<th>Depth of Tissue Injury</th>
<th>MDS 3.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-PrU:</td>
<td></td>
</tr>
<tr>
<td>□ Partial</td>
<td>PrU:</td>
</tr>
<tr>
<td>□ Full Thickness</td>
<td></td>
</tr>
<tr>
<td>□ Stg I</td>
<td></td>
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<tr>
<td>□ Stg II</td>
<td></td>
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<tr>
<td>□ Stg III</td>
<td></td>
</tr>
<tr>
<td>□ Stg IV</td>
<td></td>
</tr>
<tr>
<td>□ sDTI</td>
<td></td>
</tr>
<tr>
<td>□ Unstageable:</td>
<td></td>
</tr>
<tr>
<td>□ Non-removable dressing/device</td>
<td></td>
</tr>
<tr>
<td>□ Slough/eschar; □ Deep tissue injury</td>
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</tr>
</tbody>
</table>

**Depth of Tissue Destruction**

**Partial Thickness Wounds**

- Limited to epidermis & upper portion of dermis
- Heals by regeneration
- No scar tissue
- No granulation tissue
- No slough
- Stage 2 PrU
- M ASD
- Early venous insufficiency
- Skin tears

**Full-thickness Wounds**

- Extends through epidermis & dermis
- May involve subcutaneous tissue, muscle or bone
- May have granulation tissue
- May have slough or eschar
- Stage 3 & 4 PrU
- Arterial
- Diabetic foot ulcers
- Surgical dehiscence

**Category/Stage I**

- Intact skin with **non-blanchable** redness of a localized area usually over a bony prominence.
- Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.
Category/Stage I
- This area may be painful, firm, soft, warmer, or cooler as compared to adjacent tissue.
- Category/Stage I may be difficult to detect in individuals with dark skin tones.
- May indicate “at risk” persons (a heralding sign of risk).

Category/Stage II
- Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough.
- May also present as an intact or open/ruptured serum-filled blister.

Category/Stage III
- Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed.
- Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

Category/Stage IV
- Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed.
- Often include undermining and tunneling.
Category/Stage IV

- Depth varies by anatomical location. The bridge of the nose, ear, occiput, and malleolus do not have subcutaneous tissue and these ulcers can be shallow.
- Category/Stage IV ulcers can extend into muscle and/or supporting structures (e.g. fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.
- New from NPUAP 9/12

Category/Stage IV

- Depth Unknown

Fully thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown or black) in the wound bed.

Unstageable Pressure Ulcers

- Three types to differentiate
- Number of these unstageable pressure ulcers present upon admission/ reentry

E. Unstageable - Non-removable dressing:

F. Unstageable - Slough and/or eschar:

G. Unstageable - Deep tissue:

M0300E Unstageable Non-removable Dressing

- Known but not stageable because of the non-removable dressing

M0300F Unstageable Slough and/or Eschar

- Known but not stageable related to coverage of wound bed by slough and/or eschar
- Full thickness tissue loss
- Base of ulcer covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed
MO300G Unstageable Suspected Deep Tissue Injury (sDTI)

- DTI may present as a pale, waxy white area in light-skinned people
- Or a lighter patch of skin surrounded by abnormally darker areas in dark-skinned people that shows no change in color when the capillary refill is tested
  - (From Farid K. Applying observations from forensic science to understanding the development of pressure ulcers. Ostomy Wound Management 2007;53(4):26–44.)

M1200 Skin and Ulcer Treatments

<table>
<thead>
<tr>
<th>M1200. Skin and Ulcer Treatments</th>
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<tbody>
<tr>
<td>Check all that apply</td>
</tr>
<tr>
<td>A. Pressure reducing device for chair</td>
</tr>
<tr>
<td>B. Pressure reducing device for bed</td>
</tr>
<tr>
<td>C. Turning/repositioning program</td>
</tr>
<tr>
<td>D. Nutrition or hydration intervention to manage skin problems</td>
</tr>
<tr>
<td>E. Ulcer care</td>
</tr>
<tr>
<td>F. Surgical wound care</td>
</tr>
<tr>
<td>G. Application of nonsurgical dressings (with or without topical medications) other than to feet</td>
</tr>
<tr>
<td>H. Applications of instruments/medications other than to feet</td>
</tr>
<tr>
<td>I. Application of dressings to feet (with or without topical medications)</td>
</tr>
<tr>
<td>J. None of the above was mentioned</td>
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</table>

A Few Words About Gauze

- Permeable to bacteria
  - 64 layers
  - Airborne release
  - Will NOT prevent bacterial contamination
  - 3x Higher infection rate

- Frequency of change
  - Fibers

- Pain
CMS-F314:
“Some facilities may use “wet to dry gauze dressings” or irrigation with chemical solutions to remove slough. The use of wet-to-dry dressings or irrigations may be appropriate in limited circumstances, but repeated use may damage healthy granulation tissue in healing ulcers and may lead to excessive bleeding and increased resident pain.”

NPUAP:
Avoid use of gauze dressings for clean, open pressure ulcers because they are labor-intensive to use, cause pain when removed if dry, and lead to desiccation of viable tissue if they dry.

Wound Care Interventions

- Debridement
- Manage Bioburden
- Inflammation
- Dressings
- Topical or Systemic Treatments
- Cellular Biology
- Bioengineered Tissue
- PDGF
- Tight Blood Glucose Control
- Pressure Redistribution
- Negative Pressure Wound Therapy
- Hyperbaric Oxygen
- Other Biophysical Agents

F314- DRESSINGS & TREATMENTS
- A facility should be able to show that its document 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 (F501)

Biophysical Agents (Con’t)
- Electrical Stimulation
- Acoustic Energy (Ultrasound)
  - High Frequency US
  - Low Frequency US
    - Contact
    - Non-contact
- Negative Pressure
- Hydrotherapy: Whirlpool & Pulsatile Lavage
- Hyperbaric Oxygen Therapy (HBOT)
- UV Light

Wound Assessment
- Documentation

Does your facility have a functional wound assessment form or process (EMR)?
### What Else Should Be Assessed?

- History of prior ulcer and presence of current ulcer, previous treatments, or surgical interventions that increase risk for additional pressure ulcers
- The pressure ulcer(s) at each dressing change
- Factors that impede healing status such as co-morbid conditions and medications
- Potential complications such as fistula, abscess, osteomyelitis, bacteremia, cellulitis and cancer

### Date Wound Identified

<table>
<thead>
<tr>
<th>Date Wound ID'd</th>
<th>mm</th>
<th>dd</th>
<th>vv</th>
<th>New Wound</th>
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<tbody>
<tr>
<td>□ Recurrence</td>
<td></td>
<td></td>
<td></td>
<td>Same etiology/same location</td>
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<td></td>
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<td>□ Date of Last Recurrence:</td>
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Recurrence = Recidivism

### Location

**LOCATION:** (Describe anatomically: i.e. L-trochanter)

<table>
<thead>
<tr>
<th>Specific Terms</th>
<th>Less Specific Terms</th>
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<tbody>
<tr>
<td>R-ischium</td>
<td>R-buttock</td>
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<tr>
<td>R-lateral malleolus</td>
<td>R-ankle</td>
</tr>
<tr>
<td>L-trochanter</td>
<td>L-hip</td>
</tr>
</tbody>
</table>
**Location**

- Document in reference to head, front or back
- Commonly used terms
  - Proximal, distal
  - Superior, inferior
  - Medial, lateral
  - Anterior, posterior
  - Dorsal, plantar

**Complicating Factors**

<table>
<thead>
<tr>
<th>Clinical Area</th>
<th>Date/Location/History</th>
<th>Infection/Movement</th>
<th>Inflammation/Pain</th>
<th>Ulceration/Necrosis</th>
<th>Radiation Exposure</th>
<th>Nutritional Status</th>
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<th>Overall Treatment</th>
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<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Measurement**

<table>
<thead>
<tr>
<th>Measurements (cm)</th>
</tr>
</thead>
<tbody>
<tr>
<td>L cm</td>
</tr>
</tbody>
</table>

If H ted, describe why:

Undermining or Tunneling (cm)

U/T cm @ o'clock

U/T cm @ o'clock
Size = L x W x D

- Always measure in centimeters
- Measure head to toe and edge to wound edge

Wound Measurement

Tunneling
A single pathway that may extend in any direction

Wound Measurement

Undermining
Tissue destruction that occurs to the underlying intact skin adjacent to the wound margins.
Formation of a "shell" of healthy, intact tissue over an area of dead space and/or necrotic tissue.

Exudate

<table>
<thead>
<tr>
<th>Exudate</th>
<th>Amount: None</th>
<th>Scant/Minimal</th>
<th>Mod</th>
<th>Large/Heavy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consistency:</td>
<td>Serous</td>
<td>Sanguineous/bleeding</td>
<td>Serosanguineous</td>
<td>Purulent</td>
</tr>
<tr>
<td>Odor: None</td>
<td>Mod</td>
<td>Strong/Foul</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Assess after dressing removal & cleansing

Reasons drainage may increase:
- Infected
- After sharp or surgical debridement
- When using collagenase

PS: Drainage drives dressing decisions.

Wound Measurement

Depth: Distance from visible surface to deepest point in wound base not covered with necrotic tissue

Insert moistened sterile cotton swab

NOTE: Do not record depth if not able to see TRUE base of wound. Use unstageable designation.

QUANTIFYING WOUND EXUDATE

<table>
<thead>
<tr>
<th>Status</th>
<th>Indicators: Based on a 24-hour observation period</th>
</tr>
</thead>
<tbody>
<tr>
<td>None/Dry</td>
<td>Wound bed is dry; there is no visible moisture and the primary dressing is unmarked; dressing may be adherent to wound.</td>
</tr>
<tr>
<td>Scant/Small/Minimal</td>
<td>Small amounts of fluid are visible when the dressing is removed; the primary dressing may be marked up to 25%, but strike-through (or saturation through the dressing) is not occurring; in many cases, this is the goal of exudate management. Wound bed glistens. Routine dressing changes fully control the exudate.</td>
</tr>
<tr>
<td>Moderate</td>
<td>Routine and appropriate dressing changes show that the drainage has met the dressing’s absorptive ability without saturating or leakage; may cover 25%-75% of the dressing.</td>
</tr>
<tr>
<td>Large/Heavy</td>
<td>Dressings are saturated with changes at routine intervals; exudate is uncontrolled and freely expressed. More than 75% of the dressing is covered by drainage.</td>
</tr>
</tbody>
</table>

Adapted from the Association for the Advancement of Wound Care Quality of Care Wound Glossary
**Wound Bed**

**Tissue Type/Color & Granulation**
- Partial or Slg III
- Granulation:
  - Pink, Red, Healthy
  - Pale Pink/Red: hypergranulation tissue
  - Hypergranulation tissue
  - Red, Friable (flaithy/bloody) and/or Foul
  - Necrotic:
  - Slough (white/yellow/grey)
  - Eschar (leathery/bleeding)
  - Escher (unhealthy/mushy/bloppy)
  - Other: (e.g. tendon/muscle/bone)

**Reporting Most Severe Tissue Type for Pressure Ulcers**

1. **Epithelial Tissue** - new skin growing in superficial areas. It can be light pink and shiny, even in persons with deeply pigmented skin.
2. **Granulation tissue** - pink or red tissue with shiny, moist, granular appearance.
3. **Slough** - yellow or white tissue that adheres to the ulcer bed in clusters or thick clumps, or is necrotic.
4. **Eschar** - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edge, may be softer or harder than surrounding skin.
5. **None of the Above**

**All Granulation Tissue is NOT Created Equal**

- Healthy granulation tissue
- Unhealthy, friable granulation tissue in infected wound

**Document Necrotic Tissue**

**Describe Amounts and Locations in Wound Bed**

**Pain**

- None
- Yes: Intensity Rating (1-10)_

**Location**

- Radiating/local

- Chronic wound pain
- Cyclical acute wound pain (e.g. dressing changes)
- Noncyclical wound pain (e.g. debridement)

**Frequency:**

**Local/Systemic Rx:**

- None
- Yes (Describe Rx)
CMS and Wound Related Pain

• F314
• Pain, if present: nature and frequency (e.g., whether episodic or continuous);

Wound Related Pain Experiences

- Chronic Wound Pain
  • Absence of manipulation
  • May be continuous/intermittent

- Cyclic Wound Pain
  • Periodic acute wound pain
  • Regular repetitive treatments (i.e. dressing change)

- Noncyclic Wound Pain
  • Provoked by more sporadic procedures (i.e. sharp debridement)

F314, F309 Assessment and Documentation of Wound Related Pain to Include:

• Location
• Duration
• Character (intensity and radiation)
• Frequency

Describe Wound Edges / Periwound

<table>
<thead>
<tr>
<th>Wound Edges/Periwound</th>
<th>Periwound Tissues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Edge epithelializing</td>
<td>Intact/Uninvolved tissues</td>
</tr>
<tr>
<td>Flash w/wound base</td>
<td>Macerated</td>
</tr>
<tr>
<td>Edge attached to base</td>
<td>Inflamed/Inflammatory</td>
</tr>
<tr>
<td>Edge not attached to base</td>
<td>Indurated/Firm</td>
</tr>
<tr>
<td>Well defined wound edges</td>
<td>Necrotic/Recovery</td>
</tr>
<tr>
<td>Irregular wound edges</td>
<td>Excoriated/Exposed</td>
</tr>
<tr>
<td>Epiboly/Rolled</td>
<td>Deep red/purple hue (SSTI)</td>
</tr>
<tr>
<td>Hyperkeratotic (callous)</td>
<td>Sclerotic tissue</td>
</tr>
<tr>
<td>Fibrotic, scarred</td>
<td>Other (e.g. weeping, dry, rash, blister</td>
</tr>
</tbody>
</table>

Treatment Plan

- Debridement Type:
  - A/A/CA
  - Autolytic
  - Biological
  - Mechanical
  - Enzymatic
  - Surgical
  - Sharp

- Topical Rx:
  - None
  - Yes

- Systemic Rx:
  - None
  - Yes

- Infection Control
  - None
  - Yes

- Pressure Redistribution Device:
  - N/A
  - Yes

- Frequency:
  - Daily
  - 3X/wk
  - 2X/day
  - Other:
Based upon the assessment and the resident’s clinical condition, choices & identified needs, basic or routine care should include interventions to:

a) Redistribute pressure (such as repositioning, protecting heels, etc)

b) Minimize exposure to moisture and keep skin clean, especially of fecal contamination;

c) Provide appropriate pressure redistributing, support surfaces;

d) Provide non-irritating surfaces;

e) Maintain or improve nutrition and hydration status, where feasible.

### Short Term Goal Suggestions

- Decrease wound size by ________ cm
- Increase granulation tissue to_______%
- Decrease necrotic tissue to_______%
- Decrease edema __________ grade (pitting)
- Decrease drainage to__________ (small, moderate)
- Decrease odor ______________ (min, mod)
- Decrease erythema to___________
- Decrease undermining or tunneling ________________
- Educate patient/staff/family regarding__________
- Assess efficacy of pressure redistribution devices, off-loading of heels, positioning, etc

### Long Term Goals Suggestions

- Wound closure in 6 wks
- Functional nutrition/hydration status maintained for wound prevention and healing
- Staff/family/resident safe and competent in protecting and preventing reoccurrence

### Dressing Change Protocol Example

**Dressing Change Protocol:**

1. Cleanse wound with normal saline/wound cleanser
2. Fill wound base with calcium alginate
3. Cover alginate with bordered foam
4. Change dressing D&I

### Therapeutic Goals Example

**Therapeutic Goals/Clinical Rationale**

1. Decreased wound size by ________ cm 2/weeks
2. Decreased necrotic tissue to 50% in 2/weeks
3. Increased granulation tissue to 50% in 2/weeks
4. Decrease odor to none
5. Decrease pain from 7 to 3 during dressing changes

### Referral Recommendations:

- Vascular consult
- Nutrition consult
- Infectious disease
- Psych/counseling-resident/family
- PT/OT/OI/SU/ Other ________

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Mandated Weekly or Dressing Change Monitoring

- Classification/etiology
- Anatomic location
- Size
- Appearance of wound bed/base
- Wound Edges
- Periwound
- Drainage/Odor
- Pain, tenderness, itching

References


References


References

References

• Dowsett C. The role of the nurse in wound bed preparation. Nurs Stand 2002;16(44):69-72, 74, 76.
• Helberg D, Mertens E, Halfens RJ, Dassen T. Treatment of pressure ulcers: results of a study comparing evidence and practice. Ostomy Wound Manage 2006;52(8):60-72

Resources

• [EPUAP] European Pressure Ulcer Advisory Panel
  www.epuap.org
• [ETRS] European Tissue Repair Society
  www.etr.org
• [EWMA] European Wound Management Association
  www.eawma.org
• International Wound Infection Institute
  http://www.woundinfection-institute.com
• [NPUAP] National Pressure Ulcer Advisory Panel
  www.npup.org
• [UHMS] Undersea & Hyperbaric Medical Society
  www.uhms.org
• Wound Care Institute
  www.woundcare.org
• [IWGHI] Wound Management Association of Ireland
  http://www.wmaoi.ie/
• [WOCN] Wound Ostomy and Continence Nurses Society
  www.wocn.org
• Wound Healing Foundation
  www.woundhealfoundation.net
• [WUWHS] World Union of Wound Healing Societies
  www.wuwhs.org
• [AMA] American Medical Directors Association
  www.amda.com
• [APIC] Association for Practitioners in Infection Control
  www.apic.org
• [APMA] American Podiatric Medical Association
  www.apma.org
• [APTA] American Physical Therapy Association
  www.apta.org
• [APWCA] American Professional Wound Care Association
  www.apwca.org
• [CAWCC] Canadian Association of Wound Care Clinicians
  www.cawc.net

Pamela.Scarborough@amtwoundcare.com

• Wound Certification Boards
• ABWMcertified.org American Board of Wound CWS, CWCA, CW5-P
• Wcei.net – Wound Care Education Institute – WCC
• WOCNCB.org

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