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CAREFULLY SPEAKING®

CS 2017 ISSUE 1

Pressure Injuries: Enhancing Assessment and Documentation

Pressure injuries and associated litigation are an abiding threat to aging services providers. According to CNA claim data, pressure-related wounds constitute the primary allegation in 18.6 percent of professional liability claims involving aging services residents, ranking with falls as a leading source of resident injury and liability. In terms of severity, pressure injury claims have an average indemnity of $232,398, approximately $20,000 higher than the combined average for all allegations.[1] More than 60 percent of these claims involve death.

While it is impossible to totally prevent pressure injuries in aging services settings, a well-planned and executed skin integrity program can significantly reduce liability exposure.[2] Integral to such a program is consistently sound documentation of assessment findings and care delivery. In fact, inaccurate or incomplete documentation is often the determining factor in pressure injury-related lawsuits, as insufficient notation in the resident care record can substantially compromise legal defense. (See "Common Wound Care Documentation Lapses" on page 8.)

This edition of *CareFully Speaking®* presents a range of documentation measures – including use of uniform staging terminology and skin assessment formats, timely notation of comorbid conditions, creation of individualized skin care plans and adoption of formal wound photography guidelines – as well as the skin integrity program gap analysis tool on pages 5-7. Together, the risk management strategies and self-assessment checklist can help organizations reduce risk and strengthen defensibility.

CNA PRODUCES SKIN INTEGRITY RESOURCE GUIDE

As part of CNA's ongoing client education and risk control effort, we are proud to offer the *Skin Integrity Resource Guide*. This new publication, which will be available to insureds in summer 2017, is designed to help facilities take a strategic, proactive approach to pressure injury prevention and mitigation. It contains a range of sample forms, checklists, and data collection and root cause analysis worksheets, as well as other risk management tools that complement this article.

To pre-order the CNA *Skin Integrity Resource Guide*, call us at 1-866-262-0540 or contact your CNA healthcare risk control consultant.

1 Based upon analysis of 2,617 claims that closed between January 1, 2011 and December 31, 2015, as reported in *CNA Aging Services 2016 Claim Report, Using Evidence to Achieve Excellence: Engage, Lead, Succeed*.

2 See The Unavoidable Pressure Ulcer: Dilemmas Faced by Nursing Staff and Pressure Sores: Know What Is Avoidable, Unavoidable.

STAGING TERMINOLOGY/DOCUMENTATION

The National Pressure Ulcer Advisory Panel (NPUAP) has recently replaced the term "pressure ulcer" with "pressure injury," which more accurately describes pressure-related wounds in both intact and ulcerated skin. NPUAP also has refined its injury staging system, which is utilized by providers to indicate the extent of damage to skin and underlying soft tissue. The updated NPUAP staging system – which now includes definitions of "unstageable" and "deep-tissue" pressure injuries, as well as wounds involving mucous membranes and medical device usage – employs standard Arabic instead of roman numerals, as shown below:

- **Stage 1** – A non-blanchable erythema (redness) of intact skin, which may be associated with changes in sensation, temperature and/or firmness to the touch. Appearance may differ in more darkly pigmented skin.
- **Stage 2** – A partial-thickness skin loss with exposed skin, most commonly found over the pelvis and heels. The wound bed is viable, moist, and either pink or red in color. It may also present as an intact or ruptured serum-filled blister. This stage should not be used to describe moisture-associated skin damage, such as dermatitis or traumatic wounds.
- **Stage 3** – A full-thickness skin loss with possible sloughing or observable eschar (i.e., dead tissue). Adipose (fat) tissue is visible in the injury bed, as is granulation tissue and rolled wound edges. The depth of tissue damage varies by location.
- **Stage 4** – A full-thickness skin and tissue loss revealing exposed muscle, tendon, ligament, cartilage or bone within the bed of the injury.

QUICK LINKS

- Pressure Ulcer Critical Element Pathway, from the Centers for Medicare and Medicaid Services, March 2013.
- Pressure Ulcer Improvement Toolkit: Implementing a Communication Tool for Pressure Ulcer Improvement, from the Greater New York Hospital Association and Continuing Care Leadership Coalition, 2011.
- Pressure ulcer resources and guidelines, from the Association for the Advancement of Wound Care.
- Quality of Care Regulations Made Easy, from the National Pressure Ulcer Advisory Panel. March 2014. (See pages 8-40 for a discussion of F-tag 314.)
- Roach, R. and Dexter, C. "The Prevention, Treatment and Liability of Pressure Ulcers In the Nursing Home." *Medicine & Health*, December 2010, volume 93:12, pages 365-68.
- Safety Program for Nursing Homes: On-Time Pressure Ulcer Prevention, from the Agency for Healthcare Research and Quality, May 2016.

Wound staging often receives considerable attention in lawsuits involving pressure injuries. For example, if a Stage 1 pressure injury is later described as Stage 3, and no accompanying documentation of wound characteristics is produced, the plaintiff attorney may assert that the wound progression was due solely to substandard care. However, pressure injuries can develop over time even in the best of circumstances, and an effective wound assessment system can reveal this gradual evolution.

To ensure accuracy and prevent potentially costly misconceptions, the staging process must be viewed as an exercise in clinical observation, rather than a strict grading system. Staff should record the appearance of a pressure injury every time it is assessed, dating all observations in the clinical record and noting the following six defining characteristics:

- **Location,** i.e., buttocks, sacrum, heels, elbows, inner knees, back of head, ears or wherever else the injury first appeared.
- **Measurements,** i.e., the wound's length, width and depth in centimeters.
- **Surrounding skin,** i.e., skin color, temperature and any discoloration, including areas of erythema.
- **Margins of the injury,** i.e., rolled and chronic or smooth and healing.
- **Wound bed,** i.e., color and presence of moisture and granulation. (If the wound bed contains eschar, which delays healing, this finding should be immediately documented and reported to a supervisor or medical director for manual debridement or surgical removal.)
- **Signs of possible infection,** i.e., telltale wound color, evidence of purulent draining and/or presence of a foul odor. Supplemental documentation should note whether the infection is localized or systemic, and whether antibiotics or other medical interventions have been prescribed.

SKIN ASSESSMENTS

Timely and methodical assessment is critical to preventing and managing pressure injuries. For this reason, as well as to enhance legal defensibility in the event of a claim, skin and wound assessment practices should be governed by sound written policy and scrupulously documented.

Initial assessment. As wounds can develop within two to six hours of the onset of pressure, initial head-to-toe skin assessment should be performed as soon as possible after admission of residents, including weekends and holidays. Occasionally, when a resident is evaluated after transferring from another setting, the assessment findings do not match reports from the original facility. In such a case, the variances should be noted in the resident care record and brought to the attention of the transferring organization's medical director, in order to reconcile records and avoid future legal contention.

Written policy should specify the shift and staff members responsible for performing the first assessment and also should describe the examination process, e.g., assessing skin color, temperature, sensation, moisture, integrity and turgor, as well as the presence of pressure injury risk factors. Finally, there should be a consistent and conspicuous method for noting existing pressure injuries and/or wound risk.

Assessment tools. Failure to utilize a well-established risk assessment tool may have defensibility consequences. The widely used Braden Scale for Predicting Pressure Sore Risk encompasses a wide variety of pressure injury risk factors, such as impaired mobility, poor nutritional intake, incontinence, and exposure to friction and shearing from external sources. Other generally accepted wound assessment aids include the Norton Plus Pressure Ulcer Scale and Waterlow Pressure Area Risk Assessment.

Ongoing reassessment. Regular evaluation is an essential aspect of pressure injury management, and resident care records are often scrutinized at trial for proof of frequent and thorough reassessment. The following care and/or documentation deficiencies, among others, may have a negative impact on both resident care outcomes and legal defense efforts:

- **Notation problems,** such as gaps in flowsheets and checklists, missing dates or measurements, and the use of generic or vague phrases, e.g., "*wound healing well*" instead of "*wound is pink, with a shiny, moist and granular appearance*."
- **Absence of documented consultations with a certified wound expert,** especially for injuries classified as Stage 3 and above.
- **Entries by clinical staff who are acting beyond their prescribed scope of practice,** including LPNs performing wound debridement or RNs deciding on wound care treatment without proper physician orders.
- **Inadequate multidisciplinary assessments,** which should include feedback from physicians, nurses and nursing assistants from a variety of shifts, as well as nutritional and rehabilitation personnel.
- **Failure to accurately identify a non-healing wound,** or one that was unavoidable due to underlying medical conditions, poor nutritional status, resident non-adherence to the treatment plan or end-of-life complications.

A wide variety of assessment forms and templates are available to strengthen overall documentation and capture critical findings on a daily or weekly basis. Examples include Pressure Ulcer Scale for Healing (PUSH) and Gauging Pressure Ulcers: A Nursing Home's Guide to Prevention and Treatment. (Scroll to Section III.)

COMORBIDITY NOTATION

Comorbid conditions can have a major impact on pressure injury development and therefore must be addressed in resident care plans. Moreover, defense assertions that a pressure injury was unavoidable may not be viable in court without supporting documentation of existing comorbidities, both past and present. The following medical risk factors, among others, should be documented early in the assessment process:

- Peripheral vascular disease.
- Myocardial infarction.
- Stroke.
- Dementia.
- Unstable and/or chronic medical conditions (e.g., diabetes, renal disease, cancer, chronic obstructive pulmonary disease, congestive heart failure).
- Gastrointestinal bleeding and/or anemia.
- Malnutrition and/or dehydration.
- Musculoskeletal disorders/fractures/contractures.
- Spinal cord injury (e.g., decreased sensory perception, muscle spasms).
- Neurological disorders (e.g., Guillain-Barré syndrome, multiple sclerosis).
- History of previous pressure injury.

The determination of whether an injury was or was not unavoidable depends upon the answers to four basic questions:

- **Have underlying clinical conditions and risk factors been identified** and thoroughly assessed?
- **Were preventive measures implemented** that addressed the resident's noted conditions, needs and deficits?
- **Were wound care goals articulated** in a written care plan?
- **Was the care plan revised** in response to clinical changes?

If an organization fails to meet one or more of these clinical thresholds, it cannot later assert that a pressure injury was unavoidable.[3]

3 Under the Centers for Medicare & Medicaid Services F-tag 314, avoidable pressure injuries also can result in deficiency findings and financial penalties, as well as potential loss of license for the organization and ineligibility for Medicare reimbursement.

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CARE PLANS

A comprehensive pressure injury therapy plan is not only essential to coordinate treatment, it is also the best defense against allegations of substandard wound care. Written care plans should include the following core components:

Multidisciplinary care planning. Effective wound care planning requires a team approach. In addition to nursing staff, the team should include such disciplines as physical therapy, podiatry, infection control and dietary services, in order to create integrated care plans that reflect a wide range of expertise.

Targeted interventions. At a minimum, plans should incorporate therapeutic measures designed to maintain adequate nutrition and hydration, reduce pressure, redistribute weight, manage sources of moisture, and minimize friction and shear. For sample interventions, see the Pressure Ulcer Prevention and Treatment Protocol from the National Guideline Clearinghouse.

Medical oversight. Effective treatment involves timely notification of attending physicians that a pressure injury has developed or worsened, as well as inclusion in care plans of such physician-ordered provisions as wound dressings, antibiotic therapy and pain management.

Constant communication. Keeping residents and their family members apprised of physician involvement, as well as modifications made to care plans, can translate into higher levels of resident satisfaction and compliance.

Reassessment parameters. Care planning requires continuous monitoring of wound status and the effectiveness of interventions. Therefore, progress notes should state when wounds were re-assessed and the care plan reviewed and revised. A standardized documentation framework helps capture this clinically and legally important history.

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WOUND PHOTOGRAPHY

Photographs can help document skin status at the time of admission and may serve as a useful adjunct to written notes. However, haphazard, unsophisticated or inconsistent techniques may result in unhelpful or misleading photographs, potentially diminishing defendants' credibility and inflating damage awards.

Some aging services facilities make use of digital imagery as a documentation tool for pressure injuries, while others do not. Organizations that routinely photograph wounds should take note of the policy positions of NPUAP and the Wound, Ostomy and Continence Nurses Society and draft written protocols addressing the following issues, among others:

- **Delineating criteria** for photographing pressure injuries.
- **Designating staff photographers,** based upon skill and experience.
- **Selecting suitable cameras,** auxiliary equipment and imaging formats.
- **Utilizing established resident identifiers** to avoid errors.
- **Obtaining informed consent for photographs** from residents and/or families.
- **Controlling the intensity and direction of light falling upon the subject,** using a portable electronic flash when necessary.
- **Placing a calibrated color chart in the frame,** especially where color is an important factor.
- **Inserting measurement scales when taking close-up images,** in order to delineate wound size and depth.
- **Adopting storage safeguards** designed to reduce the likelihood of loss, corruption or inappropriate disclosure of images.

The following organizations offer resources to facilitate development of photography guidelines and protocols:

- American Health Information Management Association (AHIMA).
- American Professional Wound Care Association (APWCA; a members-only site).
- BioCommunications Association.
- Institute for Healthcare Improvement (IHI).
- Wound, Ostomy and Continence Nurses Society (WOCN Society).

Protecting residents against pressure injuries is a key responsibility of every aging services facility. By crafting sound assessment, documentation and care planning protocols, as well as implementing a comprehensive and continuously monitored skin integrity program, organizational leaders can help alleviate residents' suffering and improve their quality of life, while significantly reducing exposure to complaints, lawsuits and sanctions.

Gap Analysis Tool: Skin Integrity Program

This checklist is intended to help aging services organizations begin the process of evaluating and updating their skin integrity program. As noted on page 1, a full complement of self-assessment tools, forms and worksheets is included in the upcoming Skin Integrity Resource Guide, which will be made available to CNA insureds this summer.

PROGRAM GOALS AND GAP ANALYSIS QUESTIONS	YES/NO	STATUS
ORGANIZATIONAL COMMITMENT **Goal: Demonstrate a top-down commitment to resident skin integrity.**		
1. **Is the organization's commitment to pressure injury (PI) reduction articulated in written policy** and communicated to board members, administrators, medical directors, staff, residents and their families?		
2. **Does the policy encompass all aspects of PI prevention/management,** including …		
- Prompt assessment of risk and treatment of new and incipient wounds?		
- Consistent utilization of approved clinical tools, techniques and guidelines?		
- Ongoing monitoring of treatment effectiveness?		
3. **Are there organization-wide strategic goals for PI reduction,** and are these goals clearly stated, measurable and achievable, e.g., "Reduce incidence of PIs to 5 percent of resident population within one year"?		
4. **Has a multidisciplinary team been appointed to lead the skin integrity program,** and does the team include medical directors, as well as representatives from nursing, therapeutic and nutritional services, wound care and quality improvement?		
5. **Does the skin integrity program have clearly articulated priorities,** reflecting analysis of quality indicators, incidence rates, industry benchmarks, staff/resident input and internal performance reviews?		
STAFF EDUCATION **Goal: Promote the role of physicians, nurses, and dietary and therapeutic personnel in pressure injury prevention and management.**		
1. **Do staff undergo discipline-specific training in PI prevention and management,** and do training sessions cover the following issues, among others:		
- PI risk factors?		
- Proper use of risk assessment tools?		
- Skin assessment parameters?		
- PI detection?		
- PI staging?		
- Individualized skin care planning?		
- Nutritional and hydration requirements?		
- Positioning and transferring techniques?		
- Importance of therapeutic support surfaces?		
2. **Are educational programs reviewed annually** to ensure that they reflect current evidence-based practice guidelines and proven clinical technologies?		
3. **Is a designated wound care specialist available** to augment educational programs and consult on PI treatment when necessary?		
4. **Are educational programs directed at all levels of clinical providers,** as well as residents and their families?		
5. **Are staff members specifically trained in how to document PI care** and how to avoid common record-keeping deficiencies?		
6. **Is skin care information freely communicated among staff members** and between various disciplines?		

PROGRAM GOALS AND GAP ANALYSIS QUESTIONS	YES/NO	STATUS
SCREENING AND ASSESSMENT **Goal: Conduct PI screenings of all residents and perform a comprehensive assessment of all residents at elevated risk of developing wounds.**		
1. **Does the organization's PI prevention/management program require that all residents be screened at set times,** including upon admission and readmission, following a change in condition and with each Minimum Data Set assessment?		
2. **Does the organization consistently utilize an established screening instrument,** such as the Braden Scale or the Norton Plus Pressure Ulcer Scale?		
3. **Do residents who are deemed at higher risk for PI development undergo daily re-screening,** and are lower-risk residents screened at regular intervals?		
4. **Do newly admitted residents with PIs undergo a comprehensive head-to-toe skin assessment,** and are they reassessed on a daily or weekly basis?		
5. **Is a standardized tool used to document PI assessment findings,** including wound location, size, color and temperature; appearance of wound-bed tissue; presence of tunneling, undermining or drainage; and need for debridement?		
6. **Are PIs identified and staged using standard criteria,** such as those promulgated by the National Pressure Ulcer Advisory Panel (NPUAP)?		
7. **Are caregivers instructed to use clinical judgment when staging a PI,** and to consider all relevant assessment data and risk factors?		
8. **Is information about PI staging and healing conveyed to physicians** in a clear, timely and consistent manner?		
CARE PLANNING **Goal: Develop individualized care plans based upon identified risk factors, assessment data and resident goals.**		
1. **Is an individualized plan of care created for all residents who have PIs or are deemed at risk of developing them,** and does the plan include the following interventions:		
- Mobility assistance, e.g., ambulatory schedules, turning and positioning help, use of devices to enable independent rising?		
- Pressure relief, e.g., repositioning schedules, use of support surfaces for beds and chairs, measures to reduce friction and shearing forces, occupational therapy consultations for special-need adaptations?		
- Nutritional support, e.g., feeding assistance, dietary intake plan, food/fluid intake measurements, use of supplements, dietician consultations?		
- Measures addressing urinary/fecal incontinence, e.g., toileting plan, periodic wet/soil checks, hygiene assistance, use of protective barriers and absorbent pads, topical treatment prescriptions, regularly scheduled physician evaluations?		
- Skin care, e.g., inspection schedules, bathing routines, skin hydration protocols?		
- Physician-ordered treatment, e.g., dressing change intervals, prescribed products, reassessment time frames, drug regimens (including pain medications and antibiotics)?		
- Pain management, e.g., screenings, pain medication administration schedules, reassessment parameters, protocols for monitoring the impact of drugs on tissue perfusion and mobility/activity levels?		
- Infection control, e.g., wound dressing schedules, assessment parameters for signs and symptoms of infection, standing protocols for wound culturing?		
2. **Are care plans developed in collaboration with residents,** as well as family members and healthcare professionals?		
3. **Do care plans incorporate evidence-based guidelines** from reputable professional associations and organizations, such as the American Medical Directors Association; NPUAP; Wound, Ostomy and Continence Nurses Society; Agency for Healthcare Research and Quality; and the National Guideline Clearinghouse?		
4. **Are care plans reviewed regularly** and modified as necessary?		

PROGRAM GOALS AND GAP ANALYSIS QUESTIONS	YES/NO	STATUS
PERFORMANCE IMPROVEMENT **Goal: Monitor interventions and outcomes in order to measure the effectiveness of current practices and identify opportunities for improvement.**		
1. **Does the facility use a widely accepted tracking tool** to document PI staging, treatment and healing, as well as the presence of infection?		
2. **Are non-healing PIs closely tracked,** and do written protocols address the steps to be taken in such cases?		
3. **Are interventions and outcomes monitored and documented,** using prevalence/ incidence studies, surveys and focused audits?		
4. **Does the organization identify facility-acquired PIs,** track their outcomes and analyze their causes?		
5. **Are resident care records analyzed on a regular basis,** in order to identify the following:		
- Deviations from established practice guidelines?		
- Knowledge and skill deficiencies among caregivers?		
- Policy and procedure violations?		
- Clinical workarounds that lead to errors or inconsistencies?		
- Communication breakdowns?		
6. **Are PI data trended monthly** and does organizational leadership receive regular reports of the findings?		
TRANSFER OF CARE **Goal: Report PI-related care needs clearly and consistently when transferring residents between settings.**		
1. **Is there a formal protocol for communicating wound-related information and treatment plans to other providers** when transferring residents between care settings?		
2. **Does the transfer record include the following elements,** at a minimum:		
- PI risk factors, history of past wounds and previous treatments?		
- Detailed documentation of the stage, site and size of existing PIs?		
- Dressing recommendations, including frequency of changes and previous adverse reactions to PI care products?		
- Nutritional needs?		
- Support surface requirements?		
- Medication regimen?		
- Summary of relevant laboratory results?		
3. **Does the transfer protocol include site visits and/or interdisciplinary conferences,** if necessary, in order to ensure continuity of care and prevent development or worsening of PIs?		

This tool serves as a reference for organizations seeking to evaluate risk exposures associated with pressure injuries. The content is not intended to represent a comprehensive listing of all actions needed to address the subject matter, but rather is a means of initiating internal discussion and self-examination. Your clinical procedures and risks may be different from those addressed herein, and you may wish to modify the tool to suit your individual practice and patient needs. The information contained herein is not intended to establish any standard of care, serve as professional advice or address the circumstances of any specific entity. These statements do not constitute a risk management directive from CNA. No organization or individual should act upon this information without appropriate professional advice, including advice of legal counsel, given after a thorough examination of the individual situation, encompassing a review of relevant facts, laws and regulations. CNA assumes no responsibility for the consequences of the use or nonuse of this information.

Common Wound Care Documentation Lapses

- **Incomplete or missing initial skin assessments** and reassessments.
- **Failure to note chronic and/or systemic conditions** that may affect wound development or impair healing, including, but not limited to, renal disease, anemia, sepsis, malnutrition and diabetes.
- **Lack of notation regarding historical events** that may precipitate or aggravate a pressure injury, such as falls, hip fractures and surgical procedures.
- **No record of a pressure injury's date of origin** or its cause.
- **Inaccurate account of how a wound is diagnosed as a Stage 3 or Stage 4 pressure injury,** and inadequate description of its early development.
- **Inappropriate wound measurements,** such as references to inches instead of centimeters or use of rough size comparisons, e.g., "nickel-sized."
- **Imprecise or absent measurements of wound depth** and/or other dimensions.
- **Inadequate record of support surfaces used to alleviate pressure,** such as specialty beds and mattress overlays.
- **Poorly documented infection treatment records,** including medical consultations, wound culture reports and antibiotic administration.
- **Inconsistent wound photography practices,** e.g., images that lack a measurement scale, the resident's name, the date the photograph was taken and/or the wound location.
- **Missing information,** such as assessment dates, medication history, and physician reports and treatment orders.
- **Duplicate content,** often caused by staff members carrying forward the previous day's assessment.
- **Unauthorized alterations in the resident care record,** especially the dates of initial assessment, onset of infection and medical interventions.

CNA Risk Control Services

ONGOING SUPPORT FOR YOUR RISK MANAGEMENT PROGRAM

CNA provides a broad array of resources to help aging services organizations remain current on the latest risk management insights and trends. Bulletins, worksheets and archived webinars, as well as past issues of this newsletter, are available at **www.cna.com/riskcontrol**.

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Allied Vendor Program

CNA has identified companies offering services that may strengthen aging services organizations' risk management programs and help them effectively manage the unexpected. Our allied vendors assist our policyholders in developing critical programs and procedures that will help create a safer, more secure environment.

When it comes to understanding the risks faced by aging services organizations… **we can show you more.®**

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