Pressure Ulcer/Injury Critical Element Pathway

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

Review the following in Advance to Guide Observations and Interviews*:*

- ☐ The most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent) MDS/CAAs for Sections C, GG, H, J, K, M.
- ☐ Physician's orders (e.g., wound treatment) and treatment record (TAR).
- ☐ Pertinent diagnoses.
- ☐ Care plan (e.g., pressure relief devices, repositioning schedule, treatment, scheduled skin/wound inspection, or pressure injury history).

Observations:

- ☐ Observe wound care and assess the wound (observe as soon as possible)
  - Is the wound care performed in accordance with accepted standards of treatment, physician's orders, and care plan?
  - Is there pain during wound care? If so, what did the nurse do?
  - Does the wound look infected?
  - Use of clean gloves*, gown,* and clean technique for each resident. When treating multiple ulcers on the same resident, provide wound care to the most contaminated ulcer last (e.g., in the perineal region).
  - Remove gloves *and gown* and decontaminate hands between residents.
  - Staff ensure that if perineal or incontinence care is performed gloves *and gown* are used, then visibly soiled dressing is removed, hand hygiene is performed, and clean gloves are donned before clean dressing is applied.
  - Clean wound dressing supplies need to be handled in a way to prevent cross-contamination (e.g., wound care supply cart remains outside of resident care areas, unused supplies are discarded or remain dedicated to the resident, multi-dose wound care medications such as ointments, creams should be dedicated to one resident).
  - *Does staff use appropriate infection control practices such as hand hygiene and PPE while providing wound care and other high-contact care activities?*
  - Are precautions taken to not unnecessarily contaminate the wound or clean equipment and supplies during resident care?
  - Are reusable dressing care equipment (e.g., bandage scissors) cleaned or reprocessed if shared between residents?
  - Has the resident's skin been exposed to urinary or fecal incontinence? Was the dressing wet or soiled? What did staff do?
- ☐ How are care planned interventions being implemented?
- ☐ How are staff following the care plan?
- ☐ Is the resident repositioned timely and in the correct position to avoid pressure on an existing PU/PI or areas at risk for developing PU/PI?
- ☐ Use of proper technique when turning, repositioning, and transferring to avoid skin damage and the potential for shearing or friction.
- ☐ Pressure relief devices are in place and working correctly and are used per the manufacturer's instructions.
- ☐ Does the resident show signs of PU/PI related pain?

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- ☐ Are ordered nutritional interventions implemented (e.g., supplements and hydration)?

Resident, Resident Representative, or Family Interview:

- ☐ 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?
- ☐ How are they treating your wound?
- ☐ Is the wound getting better? If not, describe.
- ☐ How has your wound caused you to be less involved in activities you enjoy?
- ☐ How has your wound caused a change in your mood or ability to function?
- ☐ How did the facility ensure you had 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, use of pressure redistribution devices or equipment).
- ☐ If you know the resident refused care: Did staff provide you with other options of treatment or did staff provide you with education on what might happen if you do not follow the treatment plans?

Staff Interviews (Nursing Aides, Nurse, DON, Attending Practitioner):

- ☐ What, when, and to whom do you report changes in skin condition?
- ☐ 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?
- ☐ Is the resident currently on any transmission-based precautions?
- ☐ 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/PI?
- ☐ How and how often is the resident's skin assessed and where is it documented?
- ☐ When did the current PU/PI develop? What caused the PU/PI?
- ☐ What do you do if the resident refuses care?
- ☐ Is the PU/PI improving?
- ☐ How is pain related to the PU/PI assessed? And how often?
- ☐ How do you inform other staff and the MD about the PU/PI status?
- ☐ How do you monitor staff to ensure they are implementing care planned interventions?
- ☐ How do you determine the appropriate interventions?
- ☐ If there are systemic concerns: What are the facility's 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/PI?
- ☐ 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?

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- ☐ What interventions were in place before the PU/PI developed?
- ☐ Who was notified of the PU/PI and when were they notified?
- ☐ What is the current treatment ordered by the physician?
- ☐ How did you involve the resident in decisions regarding treatments?
- ☐ Are wound care protocols used? If so, describe.

Record Review:

- ☐ Review nursing notes and/or skin assessments. Did the resident have any unhealed pressure ulcers? Does the skin assessment include an evaluation of the resident's skin integrity which helps to define prevention strategies?
- ☐ 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.
- ☐ Was the MDS accurately coded to reflect the resident's condition at the time of the assessment? Was a CAA completed to assess the preliminary information gathered in the MDS and determine care planning decisions?
- ☐ Was a baseline care plan in place within 48 hours of admission, for a resident who was admitted at risk for or had a pressure ulcer on admission?
- ☐ Was a comprehensive care plan developed? 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 preventive measures for wound healing documented, appropriate, monitored, evaluated, and modified as necessary?
- ☐ If the resident refuses or resists staff interventions, determine if the care plan reflects efforts to find alternatives to address the needs identified in the assessment.
- ☐ Has the physician-ordered treatment been evaluated for effectiveness, modified, or changed as appropriate and/or as needed? Was the IDT involved?
- ☐ Does the wound care documentation reflect the condition of the wound and include the type of dressing, frequency of dressing change, and wound description (e.g., measurement, characteristics)?
- ☐ Is pain related to PU/PI assessed and treatment measures documented?
- ☐ Were changes in PU/PI status or other risks correctly identified and communicated with staff and attending practitioner?
- ☐ Review facility practices, policies, and procedures with regard to identification, prevention, intervention, care, treatment, and correction of factors that can cause PU/PI if concerns are identified.
- ☐ Was there a significant change in the resident's condition (i.e., will not resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; impacts more than one area of health; requires IDT review or revision of the care plan)? If so, was a significant change comprehensive assessment conducted within 14 days?

Critical Element Decisions:

1) Did the facility ensure that a resident:
   - Receives care, consistent with professional standards of practice, to prevent pressure ulcers; and
   - Does not develop pressure ulcers unless the resident's clinical condition demonstrates that they were unavoidable; and
   - Receives necessary treatment and services to promote the healing of a pressure ulcer, prevent an infection, and prevent new ulcers from developing?

   If No, cite F686

2) Did the physician evaluate and assess medical issues related to the resident's skin status and supervise the management of all associated medical needs, including participation in the comprehensive assessment process, development of a treatment regimen consistent with current standards of practice, monitoring, and response to notification of change in the resident's medical status related to pressure ulcers?
   If No, cite F710

3) Did the facility use appropriate *infection control practices, such as* hand hygiene and PPE when providing wound care *and other high-contact care activities*?
   If No, cite F880

4) For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?
   If No, cite F655
   NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.

5) If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?
   If No, cite F636
   NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and the comprehensive assessment was not yet required.

6) If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant?
   If No, cite F637
   NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not require OR

the resident did not have a significant change in status.

7) Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths and areas of decline, accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status)?
If No, cite F641

8) Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences?
If No, cite F656
NA, the comprehensive assessment was not completed.

9) Did the facility reassess the effectiveness of the interventions and review and revise the resident's care plan (with input from the resident or resident representative, to the extent possible), if necessary, to meet the resident's needs?
If No, cite F657
NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised.

Other Tags, Care Areas (CA), and Tasks (Task) to Consider: Right to be informed F552, Notification of Change F580, Abuse (CA), Neglect (CA), Choices (CA), Admission Orders F635, General Pathway (CA), Behavioral-Emotional Status (CA), Nutrition (CA), Hydration (CA), Sufficient and Competent Staffing (Task), QAA/QAPI (Task).