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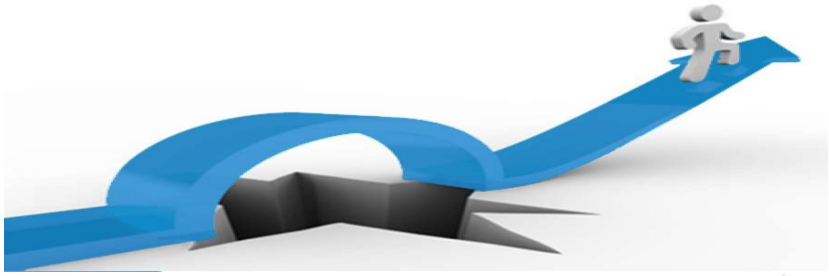
Avoiding the Pitfalls of Pressure Injuries



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Pressure Injury Impact & Prevalence Rates

- One of the most common harms experienced by patients/residents
  - 2.5 million people develop a pressure injury each year
  - 60,000 people die each year as a direct result of pressure injuries
  - Patients with a hospital acquired pressure injury (HAPI) have a median excess length of stay of 4.31 days
  - Patients with HAPI have a higher 30-day readmission rates - 22.6% versus 17.6%
- Prevalence Rates by Setting:
  - 25.2% Long Term Acute Care Residents
  - 12.0% Rehabilitation Center Patients
  - 11.8% Long Term Care Nursing Home Residents
  - 9.7% Acute Care Patients

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Cost of Pressure Injuries

- 2007: $11.6 billion
- 2019: $26.8 billion (estimate)
- Patient care cost per pressure injury:
  - $20,900 to $151,700

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Definition

- Pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device.

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Improving Patient Outcomes Through Education, Research and Public Policy

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Federal Regulatory Requirement

- Skilled Nursing Facility:
  - F686: Treatment/Services to Prevent/Heal Pressure Ulcers

    §483.25(b)(1) Pressure ulcers.
    - ***Based on the comprehensive assessment of a resident, the facility must ensure that—***
    - ***A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and***
    - ***A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.***

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Clinically Unavoidable vs Avoidable

- *"Unavoidable"* means that the resident developed a pressure ulcer/injury even though the facility had evaluated the resident's clinical condition and risk factors; defined and implemented interventions that are consistent with resident needs, goals, and professional standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate.
- *"Avoidable"* means that the resident developed a pressure ulcer/injury and that the facility did not do one or more of the following: evaluate the resident's clinical condition and risk factors; define and implement interventions that are consistent with resident needs, resident goals, and professional standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate.

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Documenting Clinical Unavoidability

Pressure Injury Clinical Unavoidability Evaluation

Center: _____
Date of Evaluation: _____
Date of Pressure Injury Onset: _____
Location(s) of Pressure Injury: _____
Stage(s) of Pressure Injury: _____

Please indicate if the resident has the following conditions prior to date of pressure injury onset:

	Terminal Condition – life expectancy less than six months with / without Hospice Services		Malignancy / Neoplasm
	End-stage Skin Failure: hypoperfusion concurrent with the end of life (e.g., cancer, MS, etc.)		Acute Skin Failure: hypoperfusion concurrent with a critical illness
	Chronic Skin Failure: hypoperfusion with a chronic disease state		Lymphedema
	Respiratory Failure		COPD
	Cardiovascular Disease		Edema
	Comatose State		Sedation
	Hypoxemia		Multiple Sclerosis
	Quadriplegia		Paraplegia
	Sepsis / Infection		Hypotension
	Diabetes Mellitus		Renal Failure – acute / chronic
	Peripheral Artery Disease (PAD)		Peripheral Vascular Disease (PVD)
	Hypoalbuminemia (Alb < 3.0)		Severe Anemia (Hb < 10)
	Decreased Prealbumin Level		Elevated Blood Glucose Levels
	Steroid Medication(s)		Chemotherapeutic Medication(s)
	Chemotherapy / Radiation Therapy		Head of Bed Elevation
	Decreased Physical Mobility		Smoking
	Malnutrition		Significant Weight Loss (>/= 5 % in 30 days, 7.5% in 90 days or 10% in 180 days)
	Nausea / Vomiting / Diarrhea		Cachexia / Muscle Wasting
	Urinary Incontinence / Chronic Leakage		Fecal Incontinence / Chronic Leakage
	Documented resident / family member/ legal representative refusal of care for recommended preventative intervention(s)		Preventative interventions consistently implemented and documented to address risk factors
	Other:		Other:
	Other:		Other:

Summary:

☐ Based on assessment / evaluation of the residents' unique pressure injury risk factors, clinical condition(s) and the consistent implementation of interventions to prevent pressure injury development that are consistent with the residents' needs, goals, and recognized standards of practice prior to date of pressure injury onset it is determined that development of the identified pressure injury is clinically unavoidable.

Comments: _____

_____ _____
Physician / PCP Signature Date Nurse Signature Date

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Colorado Regulations 6 CCR 1011-1

Chapter 7 Health Facilities and Emergency Medical Services – Assisted Living Residences:

- **Section 2 - Definitions:**
  - "Pressure sore" (also called pressure ulcer, decubitus ulcer, bed-sore or skin breakdown) means an area of the skin or underlying tissue (muscle, bone) that is damaged due to loss of blood flow to the area. Symptoms and medical treatment of pressure sores are based upon the level of severity or "stage" of the pressure sore.
    - Stage 1 affects only the upper layer of skin. Symptoms include pain, burning or itching and the affected area may look or feel different from the surrounding skin.
    - Stage 2 goes below the upper surface of the skin. Symptoms include pain, broken skin or open wound that is swollen, warm and/or red and may be oozing fluid or pus.
    - Stage 3 involves a sore that looks like a crater and may have a bad odor. It may show signs of infection such as red edges, pus, odor, heat and/or drainage.
    - Stage 4 is a deep, large sore. The skin may have turned black and show signs of infection such as red edges, pus, odor, heat and/or drainage. Tendons, muscles and bone may be visible.

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Colorado Regulations 6 CCR 1011-1

Chapter 7 Health Facilities and Emergency Medical Services – Assisted Living Residences:

- **Section 11 - Resident Admission and Discharge:**
  - Move-In Criteria:
    - 11.1 - The assisted living residence shall accept only those persons whose needs can be fully met by the existing staff, physical environment and services already being provided. The assisted living residence's ability to meet resident needs shall be based upon a comprehensive pre-admission assessment of a resident's physical, mental and social needs; cultural, religious and activity needs; preferences; and capacity for self-care.
  - Move-In Restrictions:
    - 11.2 (G) - Has a stage 3 or 4 pressure sore and does not meet the criteria in section 12.4
  - Discharge:
    - 11.11 (D) - Has a stage 3 or stage 4 pressure sore and does not meet the criteria in section 12.4

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Colorado Regulations 6 CCR 1011-1

Chapter 7 Health Facilities and Emergency Medical Services – Assisted Living Residences:

- **Section 12 – Resident Care Services:**
  - Nursing Services:
    - 12.4 - An assisted living residence shall not admit or keep a resident with a stage 3 or stage 4 pressure sore unless the resident has a terminal condition and is receiving continuing care from an external service provider.

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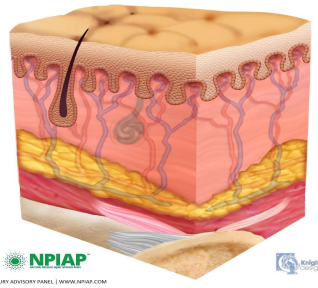
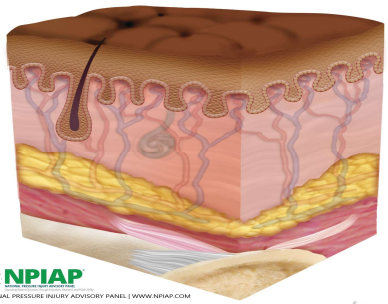
Healthy Skin – Lightly Pigmented



Healthy Skin – Darkly Pigmented



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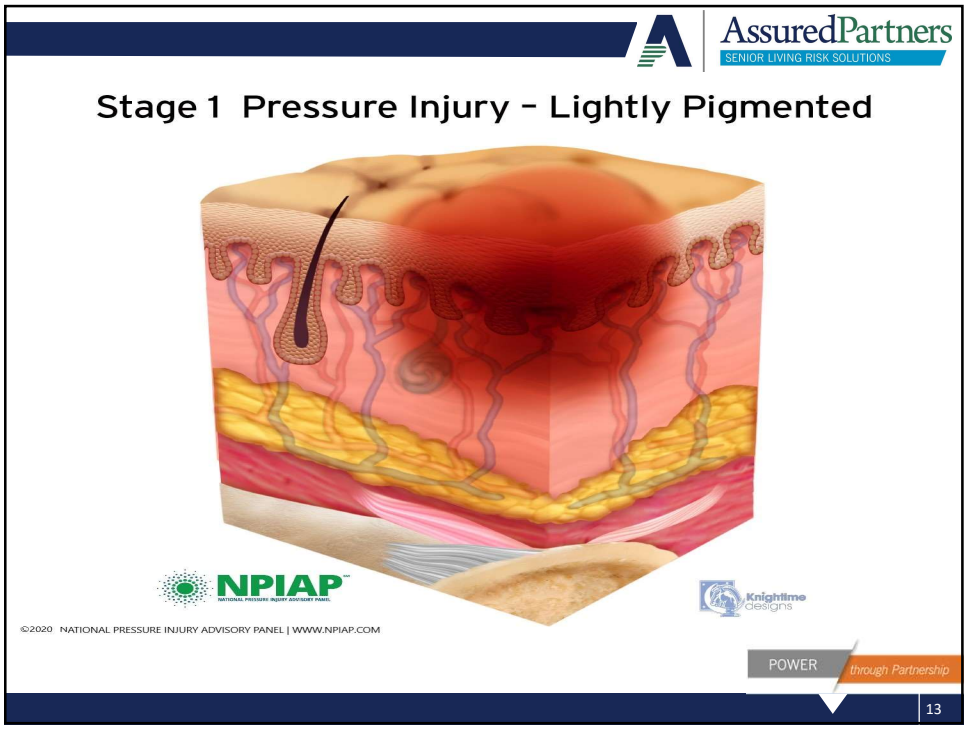
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Stage 1 Pressure Injury – Lightly Pigmented
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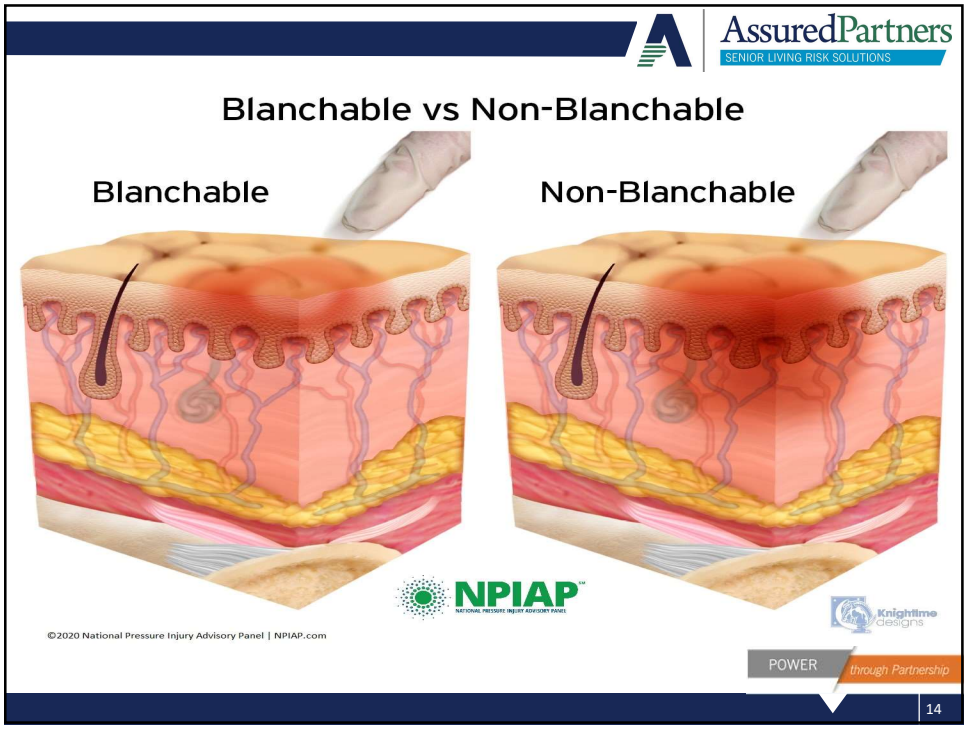
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Blanchable vs Non-Blanchable
Blanchable
Non-Blanchable
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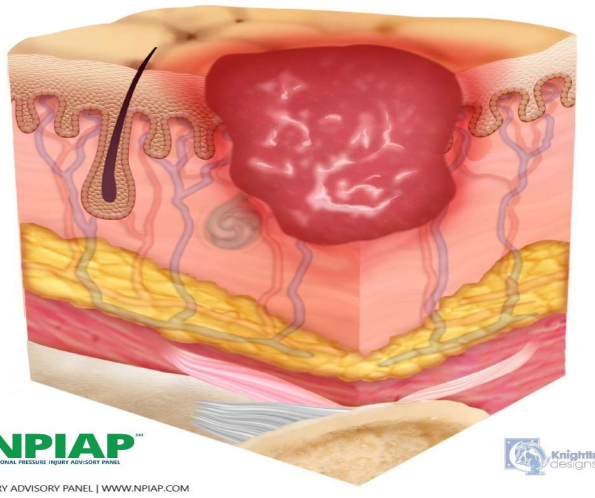
Stage 2 Pressure Injury



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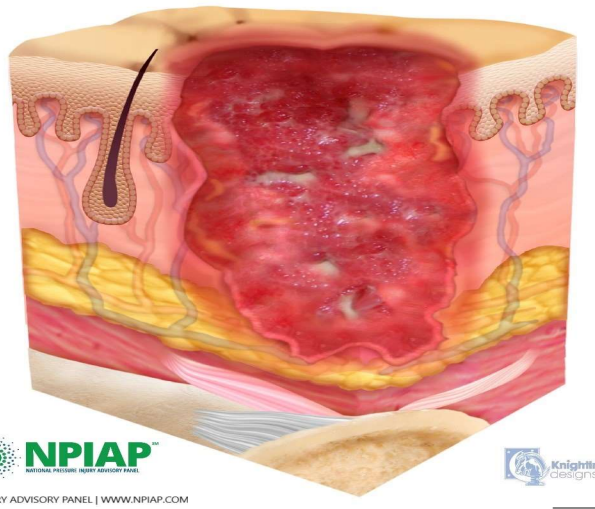
Stage 3 Pressure Injury



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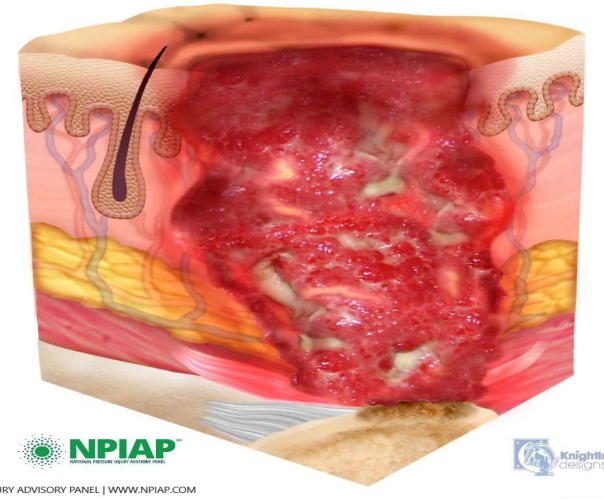
Stage 4 Pressure Injury



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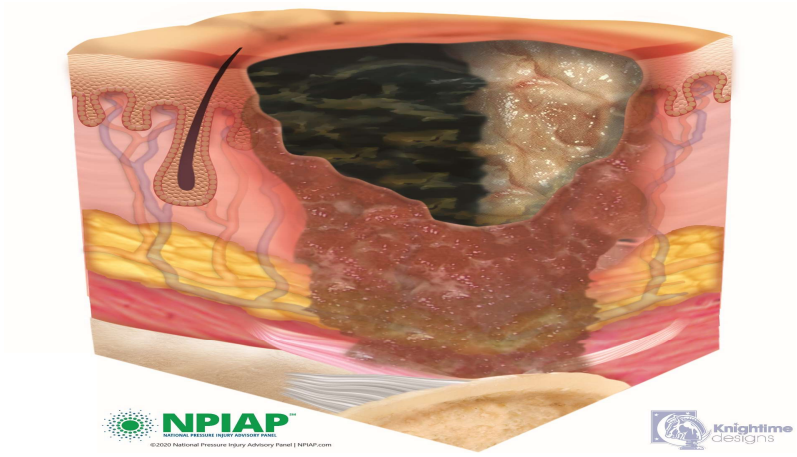
Unstageable – Half Slough



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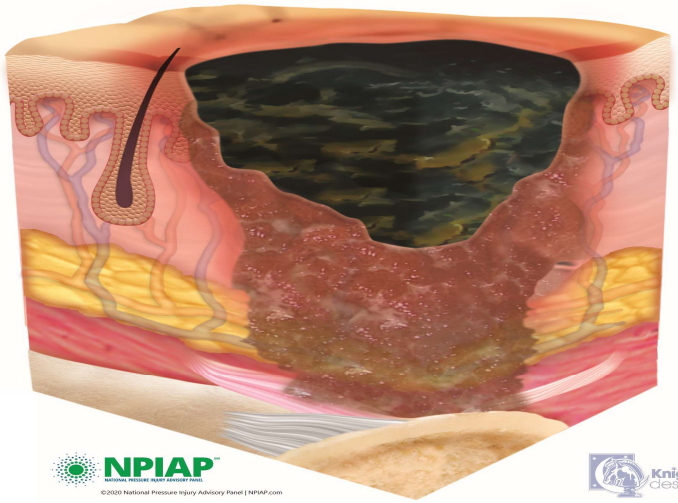
Unstageable – No Slough



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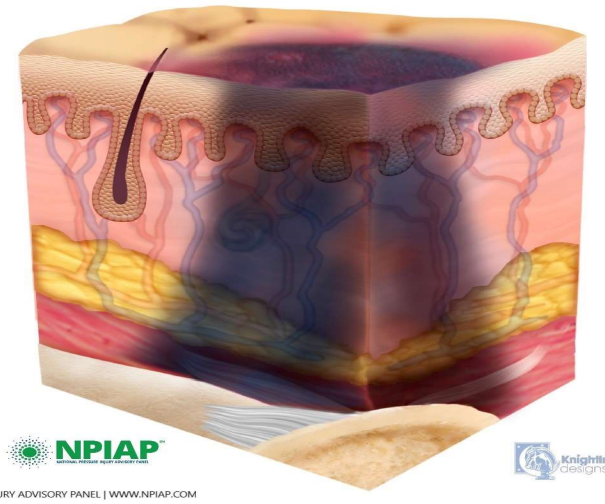
Deep Tissue Pressure Injury



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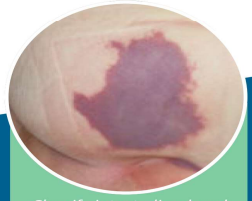
Improving Patient Outcomes Through Education, Research and Public Policy

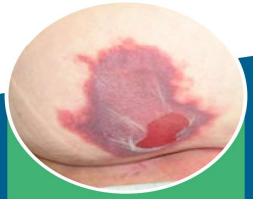
EVOLUTION OF DEEP TISSUE PRESSURE INJURY

48 HOURS
AFTER PRESSURE EVENT
(RANGE 24-72 HOURS)
DTPI



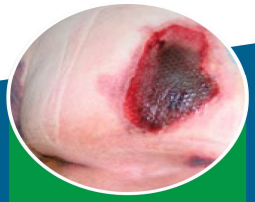
Classify intact, discolored skin from pressure as a Deep Tissue Pressure Injury

48 HOURS
AFTER INTACT SKIN COLOR CHANGE
(RANGE 24-48 HOURS)
DTPI



Classify discolored skin with epidermal blistering as a Deep Tissue Pressure Injury

7-10 DAYS
AFTER INTACT SKIN COLOR CHANGE
Unstageable



If the Deep Tissue Pressure Injury becomes necrotic, classify it as an Unstageable Pressure Injury

Deep tissue pressure injury remains one of the most serious forms of pressure injury. The pressure is exerted at the muscle-bone interface, but due to the resiliency of the skin, the color change is not immediate, in contrast to a bruise. The process leading to deep tissue pressure injury precedes the visible signs of purple or maroon skin by about 48 hours. Then about 24 hours later, the epidermis lifts and reveals a dark wound bed. This phase of deep tissue injury evolution is often confused with skin tears. Within another week, the wound bed is often necrotic. The lag between the "pressure event" and the change in color of the skin makes the root cause analysis complex. The National Pressure Injury Advisory Panel (NPIAP) has created the photographic timeline shown above to help clinicians more reliability determine the events leading to deep tissue pressure injury. It is important to be aware that 48 hours prior to the patient's skin being deep red, maroon, or purple, he/she may not have been in your facility.

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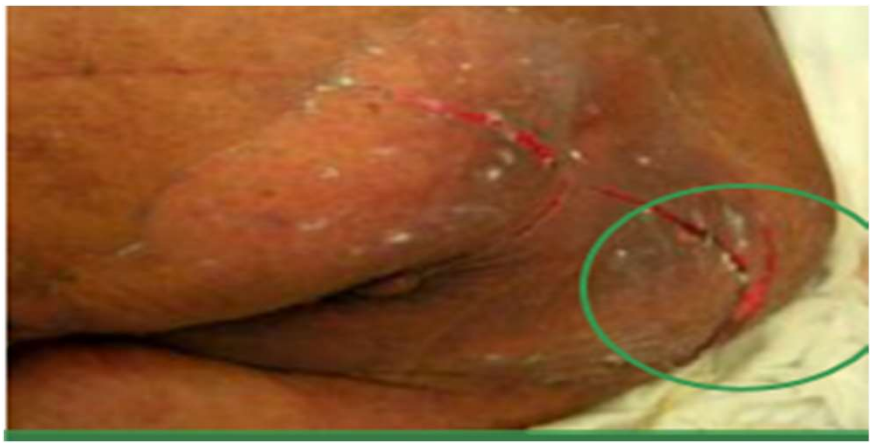
Medical Device Related Pressure Injury



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Liability Factors

- Facility fails to do the following:
  - Perform timely and appropriate assessments
  - Notify the physician and/or resident/resident's responsible party.
  - Refer to appropriate professionals
  - Develop and implement the care plan
  - Evaluate

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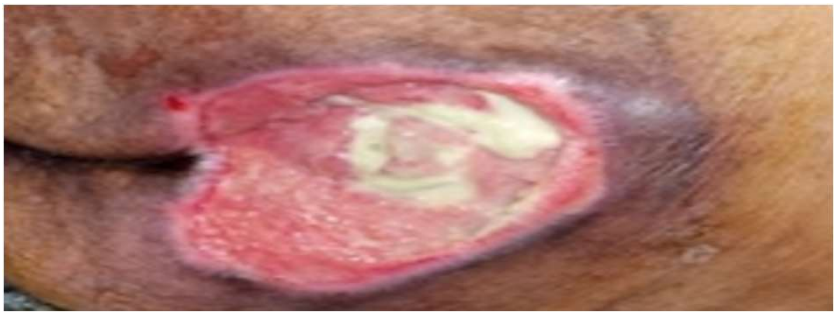
Regulatory Impact of Pressure Injury

- The facility received an Immediate Jeopardy for a resident who developed an in-house acquired open area on the sacrum.



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Regulatory Impact of Pressure Injury

- The facility received an Immediate Jeopardy when one resident suffered actual harm, caused by a hand splint which was incorrectly applied by facility staff, and subsequently developed an avoidable Stage IV pressure ulcer to the left thumb.

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Best Practice to Comply with the Regulation and Minimize Liability

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Assessment

- Pressure Injury Risk Assessments
- Comprehensive head-to-toe skin observation
- Skin impairment assessment and measurements
- Nutritional Evaluation
- Healthcare Practitioner

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Communication

- Resident and/or resident representative
- Healthcare Practitioner
- Medical Director
- Interdisciplinary Team

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Intervention &

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In Summary

- Did you meet the standard of care?
- Was the nursing process fully implemented 24/7 over time to meet the intent of F686?
- Does the medical record reflect the care and services that were provided?

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Thank you for attending!

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AssuredPartners Risk Management Team

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Medical Device Related Pressure Injury

Device	Factors Leading to Ulceration	Methods to Reduce Risk of Ulceration
Cervical Collars	Need to stabilize cervical spine until ligamentous damage can be ruled out	Change/use softer collar; pad collar at occiput; remove collar daily to inspect skin; change pads to keep face/neck dry
Ear	Tubing tightened to hold device on/against face. Ears are thinly covered cartilage, so a full thickness wound develops rapidly	Pad areas of the face that are in contact with the tubing; use silicone oxygen tubing
Elastic Stockings	Often placed prior to fluid resuscitation or postoperative edema; used on residents with peripheral vascular disease	Measure to determine size- do NOT guess; remove twice daily to inspect skin on heels and at top od stocking
Fecal Containment Device	Tubing to short to reach side of bed; ports of tube hidden in abdominal/perineal folds or under scrotum	Check location of tubing with each position change, especially in the perineum; secure tubing to the bed leaving slack in the tubing

Black J, Kalowes P. Medical device-related pressure ulcers. *Chronic Wound Care Management and Research*. 2016;3:91-99
https://doi.org/10.2147/CWCMR.S82370

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Medical Device Related Pressure Injury

Device	Factors Leading to Ulceration	Methods to Reduce Risk of Ulceration
Nasal Cannula	Device slips from the nares leading to tighter securement	Pad oxygen tubing or behind the ears; use silicone oxygen tubing
Nasogastric Tube	Secured to cheek which places tension on the tube in the nares	Secure with device that "floats the tube in the nares; move the tube when the resident's head is turned; convert to soft feeding tube as soon as able
Non-invasive positive pressure masks (CPAP/BiPAP)	Urgency to place and secure tightly to prevent leaks ; thin skin over bridge of nose	Pad the bridge of the nose and cheeks before placing; alternate between full face mask and smaller face mask; rotate sites of CPAP; use face mask with silicone pads

Black J, Kalowes P. Medical device-related pressure ulcers. *Chronic Wound Care Management and Research*. 2016;3:91-99
https://doi.org/10.2147/CWCMR.S82370

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Medical Device Related Pressure Injury

Device	Factors Leading to Ulceration	Methods to Reduce Risk of Ulceration
PEG Tubes	Stoma can enlarge and leak HCl onto abdomen	HCl blockers for short-term use; skin protection with cyanoacrylate rather than dressing; rotate tube daily
Pulse Oximetry	Metal clip form of oximetry probe can exert a high amount of pressure on small area of soft tissue	Move device from ear to ear with each movement of the resident's head or body
Splints	Often secured with wraps; doctor's orders may be unclear about removal of splints for skin inspection and care	Rewrap device if any edema is noted; clarify orders to remove splint, observe for any signs/symptoms of pressure injury development, pas as necessary and provide routine skin care

Black J, Kalowes P. Medical device-related pressure ulcers. *Chronic Wound Care Management and Research*. 2016;3:91-99
https://doi.org/10.2147/CWCMR.S82370

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Medical Device Related Pressure Injury

Device	Factors Leading to Ulceration	Methods to Reduce Risk of Ulceration
Tracheostomy	Sutured tightly to secure airway; difficult to place dressings for padding under edematous tissue; ulcers develop in posterior neck folds	Contact physician who placed tracheostomy to see if sutures can be removed on day five; determine if nurses or RT will change trach ties, work with RT and/or nurses to change trach ties with trach care; use thicker foam trach collar to pad skin; pad skin around stoma with thin, breathable dressings; check for ulcers under straps on each shift; look closely at trach ties in neck folds and move daily; line entire neck with dressings (silver dressings reduce ulcers and peristomal injury)
Urinary Catheter	Tubing to short to reach side of bed; ports of tube hidden in abdominal/perineal folds or under scrotum	Check location of tubing during each repositioning; pad tubing ports; secure tubing to leg or lower abdomen (males) and leave slack in tubing

Black J, Kalowes P. Medical device-related pressure ulcers. *Chronic Wound Care Management and Research*. 2016;3:91-99
https://doi.org/10.2147/CWCMR.S82370

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