Targeted Hot Topics in Risk Management – Focus on Falls, Elopements, and Pressure Sores

Session #W30

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Managing Falls: From the Nursing Home to the Courtroom

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Session Objectives:

- *Understand why fall management is important*
- *Understand effective components to successful fall management.*
- *Utilize effective fall management to help reduce and defend against lawsuits.*
- *Understand effective post-fall assessment and investigation.*

Fall Management: Why is it important?

How big of a problem are falls?

- *Of the approx. 1.4 million people living in nursing homes, between ½ and ¾ suffer a fall each year.*
- *On average, there are 2.6 falls per person, per year.*
- *35% of falls occur among residents who cannot walk.*

**Statistics taken from the Centers for Disease Control and Prevention.*

Fall Management: Why is it important?

It's just a fall; it can't be that serious…..right?

- *Wrong!*
- *Approximately 1,800 people living in nursing homes die from falls each year.*
- *10%-20% of falls cause serious injuries.*
- *2%-6% cause fractures.*
- *And falls are consistently shown to have a significant, detrimental effect on the resident's quality of life.*

**Statistics taken from the Centers for Disease Control and Prevention.*

Fall Management: Why is it important?

The Leading Cause of Head Injuries Among Elderly

- *One of the most serious is the subdural hematoma:*
  - *A potentially fatal condition caused by the collection of blood on the surface of the brain.*
  - *The hematoma expands rapidly, leaving little to no room for the brain.*
- *A subdural hematoma can be acute, subacute, or chronic.*
  - *Acute/subacute usually result from a serious head injury;*
  - ***Chronic** subdural hematoma can occur spontaneously or after a very minor head injury, especially in the elderly.*
- *The Chronic Subdural Hematoma is hard to spot.*
  - *Example*

Fall Management: Why is it important?

We get it….falls are bad….but does it affect us?

- *Significant increase in paperwork for staff*
- *Increased level of care required for residents who have fallen*
- *Poor Survey Results*
- *Lawsuits*
- *High Insurance Premiums*

Fall Management: Why is it important?

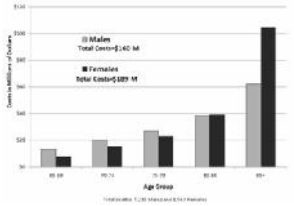
Increased Healthcare Costs

- *In 2013, the direct medical costs of elder-adult falls equate to approximately $34 billion.*
- *Medicare costs per fall average between $14,000 and $22,000.*

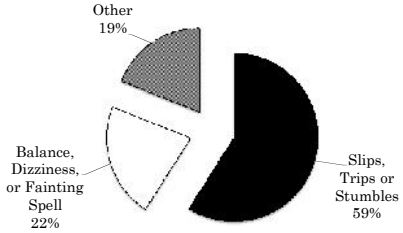
**Statistics taken from the Centers for Disease Control & Prevention*

Fall Management: Why is it important?

Total Lifetime Medical Costs of Unintentional Fatal Fall-Related Injuries in People 65 Years and Older By Sex and Age, United States, 2005

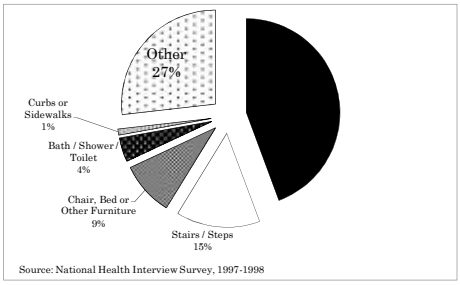


Common Causes of Falls



**Source: National Health Interview Survey, 1997-1998*

Where Falls Occur



Source: National Health Interview Survey, 1997-1998

Common Causes of Falls

- **Intrinsic Causes:** Conditions Occurring with the Person
  - *Most Common (25%) = Muscle Weakness / Walking or Gait Problems*
  - *Vision Problems*
  - *Difficulties During Transfer (i.e., from the bed to a chair)*
  - *Medications – Sedatives, Anti-Anxiety, etc.*
- **External Causes:** Conditions Occurring in the Environment
  - *Wet Floors*
  - *Poor Lighting*
  - *Improper Footwear*
  - *Clutter / Furniture*
  - *Faulty Equipment*

**Statistics taken from the Centers for Disease Control and Prevention*

When Falls Lead to Lawsuits

Tactics of a Plaintiff's Counsel

When Falls Lead to Lawsuits

Tactics of a Plaintiff's Counsel

- Federal Regulations and the **Standard of Care**
  - 42 C.F.R. § 483.25(h) – Accidents (F-323)

The facility must ensure that –
(1) The resident environment remains as free from accident hazards as possible; and
(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

When Falls Lead to Lawsuits

Tactics of a Plaintiff's Counsel

- Federal Regulations and the **Standard of Care**
  - 42 C.F.R. § 483.25(h) – Accidents (F-323)

Three Requirements:
(1) A resident's environment must remain free from accident hazards.
(2) A facility must provide adequate supervision.
(3) A facility must provide assistive devices to prevent accidents.

When Falls Lead to Lawsuits

Tactics of a Plaintiff's Counsel

- Federal Regulations and the **Standard of Care**
  - 42 C.F.R. § 483.25(h) – Accidents (F-323)

Avoidable Accidents vs. Unavoidable Accidents

When Falls Lead to Lawsuits

Tactics of a Plaintiff's Counsel

- *"Avoidable Accidents" means that an accident occurred **because the facility failed to**:*
  - *Identify environmental hazards and individual resident risk of an accident, including the need for supervision; and/or*
  - *Evaluate/analyze the hazards and risks; and/or*
  - *Implement interventions, including adequate supervision, consistent with a resident's needs, goals, plan of care, and current standards of practice in order to reduce the risk of an accident; and/or*
  - *Monitor the effectiveness of the interventions and modify the interventions as necessary, in accordance with current standards of practice.*

When Falls Lead to Lawsuits

Tactics of a Plaintiff's Counsel

- *"Unavoidable Accidents" means that an accident occurred **despite facility efforts to**:*
  - *Identify environmental hazards and individual resident risk of an accident, including the need for supervision; and/or*
  - *Evaluate/analyze the hazards and risks; and/or*
  - *Implement interventions, including adequate supervision, consistent with a resident's needs, goals, plan of care, and current standards of practice in order to reduce the risk of an accident; and/or*
  - *Monitor the effectiveness of the interventions and modify the interventions as necessary, in accordance with current standards of practice.*

When Falls Lead to Lawsuits

Tactics of a Plaintiff's Counsel

Plaintiff's Attorneys Want to Use These Regulations Against You

When Falls Lead to Lawsuits

Tactics of a Plaintiff's Counsel

- Federal Regulations and the **Standard of Care**
- **At Depositions:**
  - *Get you to agree that the Regulations are the appropriate standard of care*
  - ***THEY'RE NOT!!***

When Falls Lead to Lawsuits

Tactics of a Plaintiff's Counsel

- Federal Regulations and the **Standard of Care**

H.Res.173 – 114th Congress (2014-2015)

- Rule of Construction Regarding Health Care Providers:
  - "In General. – Subject to paragraph (3), the development, recognition, or implementation of any guideline or other standard under any Federal health care provision **shall not be construed to establish the standard of care or duty of care owed** by a health care provider to a patient in any medical malpractice or medical product liability action or claim."

Fall Prevention

What can we do?

Fall Prevention

- *Step One* – Risk Assessment
- *Step Two* – Identify and Eliminate Environmental Hazards
- *Step Three* – Make it Easier to Get Around
- *Step Four* – Educate Your Staff & Residents
- *Step Five* – Get Physical

Fall Prevention

Step One: Risk Assessment

- *Identify High-Risk Residents*
  - *Key Factors:*
    - *Use of high-risk medicines (sedatives/muscle relaxers)*
    - *Muscle Weakness, Walking or Gait Problems*
    - *Impaired Vision*
    - *Attached Equipment (i.e., catheters, IVs, oxygen)*
    - *Prior Fall History*

Fall Prevention

Step One: Risk Assessment

- *Common Risk Assessment Tools:*
  - *Hendrich II Fall Risk Model*
  - Morse Fall Scale
  - St. Thomas Risk Assessment Tool in Falling Elderly Inpatients ("STRATIFY")

*Note: Tools should not replace, but complement the judgment of the nurse performing the assessment.

Fall Prevention

Step Two: Identify and Eliminate Environmental Hazards

- *Lighting* – Ensure resident areas have adequate lighting.
- *Clutter* – Keep floors clear from clutter, including protruding furniture.
- *Signage* – Ensure hazard areas are adequately marked with warnings.
- *Inspections* – Regular inspections of all rooms and equipment.

Fall Prevention

Step Three: Making it Easier to Get Around

- *Making changes in the nursing home environment to make it easier for residents to move around safely:*
  - Grab Bars
  - Handrails
  - Raise Toilet Seats
  - Lower Bed Heights

Fall Prevention

Step Four: Educating Staff & Residents

- Staff:
  - *Educate staff about fall risk factors and prevention strategies.*
  - *Promote a culture of safety through mentoring and informal discussions, as well as formal classroom situations:*
    - General Safety Precautions
    - Risk Reduction Interventions
    - Post-Fall Response
  - *Assist staff in applying classroom knowledge to real-world practice.*
  - ***Documentation***

Fall Prevention

Step Four: Educating Staff & Residents

- Staff (cont.) – Promoting a Culture of Safety*
  - *Reporting Culture*
  - *Just Rewards*
  - *Learning Culture*
  - *Flexible Culture*

*Reason J. T. (1997). Engineering a safety culture. In *Managing the Risks of Organizational Accidents*, Ashgate Publishing: England

Fall Prevention

Step Four: Educating Staff & Residents

- Residents:
  - *Safe Transfer Techniques*
  - *Using Proper Equipment*
  - *Get Family Involved*

Fall Prevention

Step Five: Get Physical

- Encourage exercise to improve strength, coordination, balance, and walking ability.
- Promotes both physical and mental health.

Fall Prevention

Personal Resident Alarms

Fall Prevention

Personal Resident Alarms

- Definition: Personal alarms are designed to emit a loud warning signal when a person moves.
- Common Types:
  - Pressure sensitive pads placed under resident when sitting or sleeping.
  - Cord attached directly on the person's clothing with a pull-pin or magnet adhered to the alerting device.
  - Pressure sensitive mats on the floor.
  - Devices that emit light beams across a bed, chair or doorway.

Fall Prevention

Personal Resident Alarms

Fall Prevention

Personal Resident Alarms

Purpose: To alert staff to a potential fall when a resident attempts to get out of bed or up from a chair.

Fall Prevention

Personal Resident Alarms

- *What do you do when an alarm goes off?*
  - Do a Root-Cause Analysis
    - What was the resident doing just before the alarm went off?
    - What does the resident need, which ultimately caused the alarm to go off?

Fall Prevention

Personal Resident Alarms

More Protection or More Risk?

- Do they prevent falls?
- False Sense of Security – Reactive vs. Proactive
- Alarm Fatigue – *What happened to that boy who cried "wolf"?*

Fall Prevention

Alarm Fatigue

Fall Prevention

Alarm Fatigue

- *"Alarm Fatigue" is the term given to the common practice of health professionals turning off alarms because they are deemed annoying or irrelevant.*
- *When everything is an emergency, nothing is an emergency.*

Fall Prevention

Alarm Reduction

- Less Alarms = Less Falls
- Develop a Program to Eliminate Alarms:
  - Two-Tier Approach
    1. Standardized Fall Prevention Program
    2. Systematic Approach to Assess Risk Factors in Residents

Fall Prevention

Safe Use of Equipment

- Variety of Chairs
- Seating and Mobility Devices
- Adaptive Wheelchairs
- Hi-Low Beds
- Floor Mats
- Transfer Poles & Side Rails

Fall Prevention

Technological Advancements

- *Vibrating Insoles*
- *Bed-Exit Predictive Technology*
- *QTUG Walking Sensors*
- *Computer/Video Games*

Fall Prevention

Physical Restraints – Do they work?

- No – Often the reverse effect of increasing falls
- Limiting a resident's freedom to move leads to muscle weakness and reduces physical function
- Shift in Paradigm:
  - 1980s – 40% use
  - 2008 – 10% use
- Limited by Federal and State Regulations
  - Extensive federal and state guidelines governing the use of restraints, and facilities should be familiar with these before implementing the use of restraints.

Fall Prevention

Physical Restraints – Do they work?

- **Restraint / Alarm Free? Beware!**
- *Although laudable, some lawsuits have succeeded against restraint or alarm-free facilities after families have literally begged the nursing staff for more protection for a high-risk loved one and, after a fracture, found out that a nursing home right up the street would have used such protections.*
- *Transfer to another facility needs to be discussed with such patients and families*

Barriers to Successful Fall Management

Barriers to Successful Fall Management

- Staff turnover
- Resistance to change
- Myths (i.e., falls are inevitable….nothing we can do!)
- Patient overload
- Time management
- Lack of knowledge and critical thinking skills
- Lack of leadership
- Minimal Support

Post-Fall Procedures

Post-Fall Assessment

- Comprehensive Investigation
  - Completed Timely
- Benefits:
  - Good Patient Care
  - Protect facilities during surveys and in lawsuits

Post-Fall Procedures

Post-Fall Investigation

- Should include:
  - Date / Time / Location / Day of the Week
  - Injury & Treatment
  - Notification of physician and family
  - Type of Fall
  - Cause / Activity
  - Staff Response
  - Equipment in Place
    - Footwear, Aid, Restraint, Side rails, etc.
  - Mental Status
  - Vitals

Post-Fall Procedures

Post-Fall Response

- Eight-Step Fall Response:

1. Evaluate and monitor resident for 72 hrs after fall
2. Investigate fall circumstances
3. Record circumstances, resident outcome and staff response
4. Alert healthcare providers
5. Implement immediate intervention w/in 24 hrs
6. Complete falls assessment
7. Develop plan of care
8. Monitor staff compliance and resident response

****Document, Document, Document***

Post-Fall Procedures

Eight-Step Fall Response:

Other Fall Management Considerations

- Identify and inventory all products and devices used at facility
- Ensure manufacturers' instructions are available and followed for devices and equipment
- Develop parameters for use of equipment and devices
- Designate a staff member to do the initial fall assessment upon admission
- Consider daily/weekly review of all falls and a fall meeting with interdisciplinary team
- Identify frequent fallers for staff members
- Develop and implement preventative maintenance program for environmental risk observation
- Develop methodology to ensure effectiveness of program

Other Fall Management Considerations

- Care plans need to be ***individualized*** and ***updated frequently***.
- Excellent ***post-fall documentation*** is the key to successful fall management.

Avoiding Documentation Pitfalls

- **Be Objective.** Perform assessments using your sense of touch, sight, hearing and smell, and document facts, not your subjective opinions. To avoid bias, use the resident's exact words using quotation marks.
- **Don't Use Labels**. When describing a patient's behavior, words such as obnoxius, belligerent, or rude provide ammo for a plaintiff's attorney to turn the table on you. Instead, simply describe the resident's exact behavior with quotes if possible.
  - Example of "Rude" Behavior – *Upon entering the resident's room, the resident stared at me with what appeared to be an angry expression. Upon asking the resident how he was feeling, he responded in a very loud voice, "Get out of my room and don't come back."*

Avoiding Documentation Pitfalls

- **Document a Refusal.** If a resident refuses recommended treatment, document the refusal, including the patient's stated reason and your subsequent actions.
- **Immediate Documentation**. Make sure to date, time, and authenticate each entry with your signature as close as possible to the time you performed the assessment/treatment.
- **Avoid Gaps.** By avoiding gaps in the medical records, you allow someone else to create the rest of the story.

Avoiding Documentation Pitfalls

- **Follow Policies.** Deviating from your facility's standards can create liability exposure when none is warranted.
- **Document Adverse Events**. When adverse events do occur, document relevant clinical facts and avoid opinions as to the alleged cause of the event.

Avoiding Documentation Pitfalls

Common Red Flags

- Notes that are sloppy, incomplete, illegible or have gaps.
- Entries that are not timed, dated, or appear out of sequence
- Entries that indicate delays or failures to initiate treatment
- Entries that show substandard/inappropriate care
- Unexplained late entries
- Erased entries
- Entries made with different color ink

Thank You!

Questions?

Elopements

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Session Objectives:

- *General discussion of dementia, Alzheimer's disease, facts relative to diagnosis, treatment and overall costs incurred by caregivers and society.*
- *Identify and evaluate specific concerns regarding wandering behavior and elopement cases.*

Dementia

- *Not a specific disease.*
- *Overall term that describes wide range of symptoms.*
- *Associated with decline in memory or thinking skills, severe enough to reduce ability to perform ADL's.*
- *Alzheimer's Disease – Accounts for 60%-80% of cases.*
- *Vascular dementia - Occurring after a stroke, is the second most common dementia type.*

Symptoms of Dementia

- *Vary greatly.*
- *Two of the following core functions must be impaired, to be considered dementia:*
  - *Memory*
  - *Communication/Language*
  - *Ability to focus/pay attention*
  - *Reasoning/judgment;*
  - *Visual perception*

Causes of Dementia

- *Dementia is caused by damage to brain cells. Interference with ability of brain cells to communicate with each other.*
- *If brain cells cannot communicate normally, thinking, behavior and feelings are affected.*

Dementia
Risk and Prevention

- *Age and genetics – cannot be changed.*
- *Current areas of research – risk reduction/prevention.*
  - *Cardiovascular risk factors*
  - *Don't smoke*
  - *Take steps to keep blood pressure, cholesterol, blood sugar, WNL*
  - *Maintain healthy weight*
  - *Physical exercise – increase blood and oxygen flow to the brain*
  - *Diet*
  - *Heart healthy eating patters*
  - *↓ Red meat*
  - *↑ Whole grains, fruits, vegetables, fish*

Alzheimer's Disease

The most common form of dementia.

A neurological brain disorder named after a German physician, Alios Alzheimer, first described in 1906.

Steps to Diagnosis

No single test can confirm Alzheimer's

- *Thorough medical history*
- *Mental status testing*
- *Physical and neuro exam*
- *Blood tests, brain imaging to rule out other causes of cognitive decline.*

Have you noticed any of these warning signs?

- *Memory loss that disrupts daily life.*
  - Forgetting recently learned information.
  - Asking for same information over and over.
- *Challenges in planning or solving problems.*
  - Trouble following a familiar receipt or keeping track of monthly bills.
  - Difficulty completing familiar tasks at home, at work or at leisure.
- *Confusion with time or place.*
- *Trouble understanding visual images and spatial relationships.*

Have you noticed any of these warning signs?

- *Difficulty reading, judging distance and determining color or contrast.*
  - New problems with words in speaking or writing.
  - Following or joining a conversation.
  - Repeat themselves.
- *Misplacing things and losing the ability to retrace steps.*
  - May lose things and be unable to go back over their steps.
  - May accuse others of stealing.

Have you noticed any of these warning signs?

- *Decreased or poor judgment.*
  - poor judgment when dealing with money.
- *Pay less attention to grooming or keeping themselves clean.*
- *Withdrawal from work or social activities.*
  - Avoid being social because of the changes they have experienced.
- *Changes in mood or personality.*
  - Confusion, suspicious, depressed, fearful or anxious.
  - They may be easily upset in places where they are out of their comfort zone.

Mortality

- *In 2015, estimated 700,00 in U.S., age 65 or older, die with Alzheimer's.*
- *Only disease among top 10 causes of death in America that cannot be – prevented – cured – slowed.*

The Stages of Alzheimer's:

Stage I: *Normal*

Stage II: *Normal aged forgetfulness*

Stage III: *Mild cognitive impairment*

Stage IV: *Mild Alzheimer's disease*

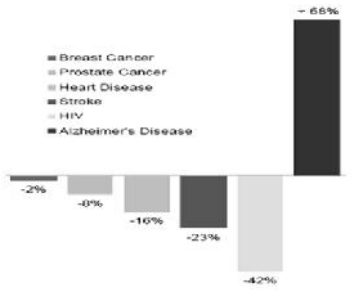
Stage V: *Moderate Alzheimer's disease*

Stage VI: *Severe Alzheimer's disease*

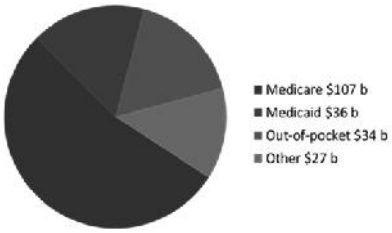
At this point, AD patients require continuous assistance with ADL's.

Quick Facts

Change in Number of Deaths Between 2000 and 2010



2013 Costs of Alzheimer's $203 Billion



Wandering and Elopement

31% LTC residents, between 25% and 70% of community-dwelling older adults with dementia, wander at least once.

Cognitively Impaired Individuals Who Wander -- ↑ Risk of Injury

- *Elopement, in which the person wanders away from home/LTC, most dangerous type of wandering – can result in death.*
- *Need for LTC – Regularly assess propensity of resident to wander – take proactive measures to protect resident.*

Wandering – Common reason for placing community-dwelling individuals with dementia in LTC

- *Generally characterized by – excessive ambulation that has a tendency to lead to safety concerns or nuisance issues.*
- *Purposeful behavior – triggered by desire to fulfill a need.*
- *Physical discomforts (toileting), emotional discomfort, ↑ emotional discomfort (↑↓ stimulation).*

Wandering – Represents Greatest Safety Risk to Older Adults with Dementia

- *Increases risk of injury or death, especially dangerous for those who succeed in leaving a safe environment.*
- *Adverse outcomes – Undocumented falls, weight loss, abuse by other residents, social isolation.*

Risk Factors for Wandering

- *Older age*
- *Male sex*
- *Poor sleep patterns*
- *Agitation*
- *Aggression*
- *More socially active/outgoing*
- *Premorbid lifestyle*

Minimizing Risks

- *Institute policies that require assessment of resident on admission, and reevaluation of behaviors frequently.*
- *Identify potential wanderers.*
- *CMS Guidelines – comprehensive, accurate assessment of resident needed within 14 days of admission.*
- *Studies show – most elopement occurs within 48 hours of admission.*

Provide Staff with Proper Training and Support

- *Enable staff to intervene appropriately to minimize wandering risks.*
- *New employees, staff members, contractors on site, all visitors – inform about safeguards to prevent wandering.*
    - E.g. – Uninformed visitor may allow dementia patient to pass freely though a door normally locked.

Inappropriate Interventions

- *Antipsychotic Medication*
- *Physical restraints*

Increase risk of pressure ulcers, infections, falls, and sedation, promote anxiety, agitation or violence.

Environmental Interventions

- *Enhance safety of residents with dementia, improve functionality.*
  - Option: House Alzheimer patients in locked units.
- *Balance safety of residents, versus deprivation of freedom, still no guarantee against elopement.*
- *Other options – Establish controlled indoor/outdoor areas where residents can wander freely, such as garden area.*

Safe Environment

- *Provide walking companions.*
- *Maintain clutter-free interior pathways.*
- *Clearly and visibly mark end of corridor, as cue on orientation for confused resident.*

Elopement Warning Systems

- *Alarms that sound – resident leaves bed, chair or room.*
  - Widely used in nursing homes.
  - Can cue the resident to his or her behavior, and interrupt attempt to wander.
- *Drawback – can cause stress in a resident and increase likelihood of wandering. Can stress staff and other residents.*
- *Electronic alert bands – that alert staff members when resident nears an alarm point, or that automatically lock doors as resident approaches.*

Crisis Management – Resident Elopement

- *Studies show – 25% fatality rate if resident not found within the first 24 hours.*
- *Most deaths attributable to hyperthermia, dehydration, hypothermia, drowning, trauma.*
- *Average distance traveled -- .5 miles.*
- *Only 1% of residents will respond to shouts or calls from rescuers.*

Conclusion
Wandering and Elopement

- *Pose serious risks for resident.*
- *Balance safety with autonomy.*
- *Never underestimate the propensity of a resident, even with disabilities, to wander or elope.*

Case Scenarios

1. *Alzheimer's resident in same room, same roommate, for two years. Dispute over clothing. Alzheimer resident moved to new room. Alzheimer resident gets up in the middle of the night, confused, trips and falls when entering bathroom and fractures hip.*
    - *pros and cons of reassigning such a resident to new room.*

Case Scenarios

2. *Alzheimer resident is a chronic smoker. Continually asks staff to go across the street to carryout, for cartons of cigarettes, since family refuses to provide. As staff is feeding other residents evening meal, resident insists on buying more cigarettes. Wanders out front door, since alarms are deactivated, and in crossing street to get to carryout, is struck and killed by a car.*
    - *smoking prohibition rules.*
    - *no good deed goes unpunished.*

Case Scenarios

3. *Resident with severe Alzheimer's disease. Staff leaves to get carryout meals, and resident is able to elope either by following staff, as they exit, or following a visitor as she exits. Resident sustains an injury when falling, several blocks from the facility.*
    - *timeliness of notification of police.*
    - *timeliness of notification of family.*

Questions?

Thank you!

Pressure Sore Cases

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Session Objectives:

- *Participants will identify issues which can make pressure sore cases difficult to defend.*
- *Participants will identify ways to improve procedures and documentation to better defend pressure sore cases.*

Difficulties with Pressure Sore Cases

- If the wound developed within the first 2 weeks, case is doomed unless the previous institution can be blamed.
  - When is the initial Care Plan completed?
  - When is the initial MDS completed?

Difficulties with Pressure Sore Cases

- Problems with documentation:
- Nurses Notes are sparse
- Nurses Notes do not address risk factors for wounds.
- Inconsistent documentation, particularly on assessments.
  - Does MDS match Braden Scale

Regulations used against you

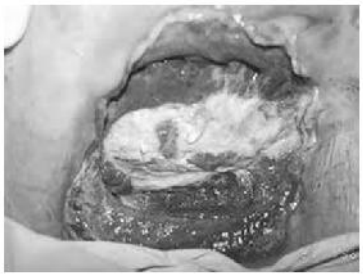
42 C.F.R. 483.25(c)

Based on the comprehensive assessment of the resident, the facility must ensure that--

(1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates they were unavoidable; and

Regulations used against you

(2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.



Ways to Protect Your Facility

- Obtain all relevant information about wound issues PRIOR to admission.
- An accurate and thorough wound assessment completed upon admission.
  - Interventions must be placed immediately upon identifying the resident to be at risk.

Ways to Protect Your Facility

- Develop a wound team:
  - Appoint a wound treatment nurse
    - Training??
    - How does he/she appear as a witness?
  - Dietary
  - Therapy

Wound Team

- DO NOT TAKE PICTURES
- Wound Team
  - Meet weekly
  - Identify residents at risk and who have pressure sores
  - Evaluate new admissions
- DO NOT TAKE PICTURES
- DO NOT TAKE PICTURES

Pressure Sores

- **All** disciplines in IDT should note pressure areas/prevention
- Must document non-compliance
  - "interventions per POC"
  - Attending must address risk factors predisposing for pressure sores
  - Address non-compliance with family members
- Weekly monitoring once pressure sore occurs

Sample Documentation

- 3/28/00 10:00 am – Resident assessed by wound team. Resident's treatments, nutrition and activity reviewed and assessed. Resident continues to be non-compliant with turns and repositions. Family informed risks of non-compliance.
- 3/29/00 4:00 pm – Resident's wounds assessed and treated per POC. No change in condition.

Use the Regulations As Your Sword

- F314 and the interpretation of the word "unavoidable."
  - Resident developed a pressure ulcer even though the facility had evaluated the resident's clinical condition and pressure ulcer 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 and revised the approaches as appropriate.

Use the Regulations As Your Sword

- Resident developed a pressure ulcer even though the facility had **evaluated the resident's clinical condition and pressure ulcer risk factors**;

Regulations

- How do you evaluate the resident's risk?
  - Braden Scale
  - MDS

Regulations

- defined and **implemented interventions that are consistent with resident needs, goals, and recognized standards of practice**.

"Consistent with recognized standards of practice"

- Turn Schedules
- Pressure relieving devices
  - Chair
  - Bed
- Mobility improvement devices

When in Doubt….

- NPUAP
  - Review NPUAP publications for "standard practices for wound interventions."
    - Wound consultant??

Regulations

….monitored and evaluated the impact of the interventions and revised….

Physician Involvement

- Progress Notes need to be detailed
- Progress Notes need to address interventions for pressure sore reduction
- Progress Notes need to reflect a wound was “unavoidable.”

NPUAP Consensus Statement

- Cardiopulmonary status is significantly altered and recovery to baseline does not occur within minutes
- Repositioned and alterations in hemodynamic stability requires ongoing vasopressor support
- Sustained HOB elevation greater than 30 degrees is medically necessary

NPUAP Consensus Statement

- Septic shock or SIRS increases likelihood of pressure sore
- Extensive body edema
- Severe burn
- In hemodynamically unstable or critically ill patient, when management takes precedence over interventions

NPUAP Consensus Statement

- Immobility
- Life sustaining vascular access preclude turning and repositioning
- Unstable pelvic fracture
- Terminally ill patients who become immobile
- Malnourished patients with other co-morbid conditions

NPUAP Consensus Statement

- Cachexia
- Medical device which cannot be adjusted, relocated or padded

Final Reminder

DO NOT TAKE PICTURES

Thank you!