

Pressure Ulcer Prevention

PUP Attacks F314

March 2009

Pressure Ulcers (F314) continue to be frequently cited in Missouri.

Over the years, Section for Long Term Care Regulation (SLCR) has cited many things that could possibly go wrong with pressure ulcer care: from basic turning and repositioning to life threatening lack of treatment (scope and severity level Immediate Jeopardy: IJ). Many times F314 is cited at D or G levels. D level includes lack of prevention or a missed treatment with no harm. G level examples are lack of identification and treatment resulting in actual harm.

*PUP
protects your
skin*



Surveyors say that many **F314 citations result from a failure to do basic prevention:** lack of nursing risk assessment and consistent prevention such as keeping skin clean and dry and using pressure relief devices in beds and/or chairs. SLCR staff frequently observes the use of heel boots or pillows, but often the heels are pressed into the mattress or pillow. The pillow needs to be placed above the heel, keeping the heel afloat to avoid pressure.

Surveyors often see that front line staff do not identify and report skin breakdown to charge nurses/DON/physician for proper treatment even when these systems are in place in the home. Often this is related to a high turnover in nursing, especially DON's and direct care staff. As direct care staff come and goes, unless someone keeps up with the training of new staff, systems fall apart. Survey staff stresses the importance of timely assessments on initial admission and on return from the hospital. If a prompt nursing assessment occurs, the facility can document tissue damage that is present on admission.

Preventing skin breakdown is not as costly as treating a pressure ulcer. Medications, dressing changes, and nursing time are expensive, not to mention the pain and loss of dignity for your residents. Facilities with effective pressure ulcer prevention (PUP) programs in place will reap the benefits of better care and life for residents and fewer citations.

Practical tools are available on www.primaris.org/professionals/qi_nursing_home.asp, www.nhqualitycampaign.org, www.moaha.org, and www.mohealthcare.com.

Action Steps:

1. Share this information with all your nursing staff—licensed and direct care.
2. Make sure your staff knows how to properly assess residents for risk using the Braden or Norton. **USE THIS TOOL AT EVERY ADMISSION, CHANGE IN STATUS AND POST HOSPITALIZATION!**
3. Train, train and retrain all your staff to be on prevention, to be on the lookout for skin breakdown and to report this to nursing.
4. Involve direct care workers and staff from different backgrounds in identifying and solving the problem. Consider forming a multi-disciplinary prevention team.
5. Remember, as staff come and go, involve the new staff in reviewing systems and continued work on the problem.

MoLANE Planning Committee Members:

- Missouri Association of Homes for the Aging
- Missouri Health Care Association
- Missouri Coalition Celebrating Care Continuum Change
- Missouri Association of Nursing Home Administrators
- Missouri Department of Health and Senior Services
- Missouri Hospice and Palliative Care Association
- Missouri League for Nursing
- Missouri State Long-Term Care Ombudsman
- National Association of Health Care Assistants
- Primaris, Missouri's Medicare Quality Improvement Organization
- Quality Improvement Program for Missouri (QIPMO)

Watch for more PUP tips!