Pressure Ulcers: Are They Avoidable and More

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Objectives
• Discuss circumstances when pressure ulcers may be unavoidable
• Review current best practice for nutrition care of residents with pressure ulcers
• Review recommended documentation guidelines to reduce liability related to pressure ulcers
• Review revisions to MDS 3.0 Section M

Prevalence of Pressure Ulcers
• 0.4% to 38% in acute care
• 0% to 17% in home care
• 2010 2nd quarter in long term care
  11.2% in high-risk residents
  2.4% in low-risk residents
• 2010 cost - $3.85 million

Litigation
• 87% of verdicts and out of court settlements against facilities were awarded to the plaintiffs
• Average monetary recovery more than $13.5 million
• Awards of up to $312 million
• Highest awards given for PU caused by single factor–inadequate nutrition

Are Pressure Ulcers Unavoidable?
• Perception of pressure ulcers
  • Substandard Care
• Quality of Care indicator
  • Public and government

Pressure Ulcers: When are they Avoidable or Unavoidable?
• NPUAP International Multidisciplinary Consensus Panel on the Issues of Avoidable and Unavoidable Pressure Ulcers in All Care Settings
• February 25th, 2010
**National Pressure Ulcer Advisory Panel**

- The National Pressure Ulcer Advisory Panel (NPUAP) serves as the authoritative voice for improved patient outcomes in pressure ulcer prevention and treatment through public policy, education and research.

**What is NPUAP?**

- Panel of experts in pressure ulcer prevention and management.
- Physicians, nurses, dietitians, physical therapists, occupational therapists and engineers.
- ADA is a member of the Collaborating Organizations

**Overview of Conference**

- Voting panelists
  - Twenty-four multidisciplinary experts in pressure ulcer prevention and treatment
  - President Jessie Pavilnac represented the American Dietetic Association
- International attendance

**Issues**

- **Hospitals**
  - Stage III and IV pressure ulcers are "Never Events" if acquired after admission—October, 2008
- **Long Term Care**
  - Facilities must ensure that residents do not develop pressure ulcer
  - Civil money penalties can be assessed

**Purpose to Establish Consensus**

- Is the development of some pressure ulcers unavoidable?
- Is there a difference between pressure ulcers and end-of-life skin changes?

**Existing Definitions in Long Term Care Settings**

- **Avoidable** means that the resident developed a pressure ulcer and that the facility did not do one or more of the following: evaluate the resident’s clinical condition and pressure ulcer risk factors; define and implement interventions that are consistent with resident needs, resident goals, and recognized standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate.
- **Unavoidable** means that the 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.
Conference Definition for All Care Settings

- Unavoidable - means that the individual (resident) developed a pressure ulcer even though the provider (facility) had evaluated the individual’s (resident’s) clinical condition and pressure ulcer risk factors; defined and implemented interventions that are consistent with individual (resident) needs, goals and recognized standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate.

General Consensus

- Are all pressure ulcers avoidable?
  -100% No
- Are most pressure ulcers avoidable?
  -100% Yes

General Consensus

- Are there patient situations that render the pressure ulcer unavoidable?
  -100% Yes
- If enough pressure was removed from the external body, could the skin always survive?
  -4% Yes 96% No

Perfusion/Hemodynamic conditions

- Are there situations where local tissue perfusion is so poor that any amount of pressure is sufficient to cause an ulcer?
  -82% Yes 18% No
- Can hemodynamic instability that is worsened with physical movement make a pressure ulcer unavoidable?
  – 100% Yes

What patient clinical situations may render a pressure ulcer unavoidable?

- Perfusion/Hemodynamic Issues
- Medical Devices
- Malnutrition
- Compliance/non-adherence with recommended plan of care
- Skin Failure

Perfusion Issues

- Lack of Mobility
- Positioning
- Pressure Redistribution
Perfusion Issues Positioning

• Does prevention require adequate pressure redistribution through turning and/or repositioning?
  -96% Yes  4% No

Perfusion Issues Positioning

• Should turning every 2 hours be standard?
  -26% Yes  74% No
• Should turning/repositioning every 2 hours, as clinically appropriate, be the guideline?
  -88% Yes  12% No
• Is turning every 2 hours a feasible schedule?
  - 71% Yes  29% No
• When deciding on turning frequency, is it acceptable to let a Stage I ulcer develop first?
  -4% Yes  96% No

Perfusion Issues Pressure Redistribution

• Can pressure redistribution surfaces potentially influence turning intervals?
  -88% Yes  12% No
• Can pressure redistribution surfaces replace turning and repositioning?
  -100% No

Operating Room Situations

If the patient develops intraoperative complications, such as bleeding, which would be a combination of poor skin perfusion and immobility, is the pressure ulcer unavoidable?

• If the patient was expected to have a short operative time, under 3 hours, and therefore no additional padding was used, but develops complications and the case goes on for a longer time, is the development of a pressure ulcer unavoidable?
  • If the patient has peripheral vascular disease and the traction is applied to the leg during an operation, is the ulcer that develops on the heel unavoidable?

Medical Devices

• Does the proper and safe use of medical equipment override saving the skin?
  -58% Yes  42% No
• Are all medical device-related pressure ulcers avoidable?
  -8% Yes  92% No

Medical Devices

• Immobilization devices for medical purposes
  – Back boards
  – Leg restraints for invasive monitoring
  – Traction for spinal cord injury
• Immobilization devices for hip fracture
• Devices for medical treatment
Medical Devices
Is a solution to medical device-related pressure ulcers to test and develop “skin safe” products?
- 67% Yes  33% No

Malnutrition
• Can voluntary refusal to eat lead to unavoidable pressure ulcers?
  - 96% Yes  4% No
• If an individual was unable to maintain nutrition and hydration status and had an advanced directive prohibiting artificial nutrition/hydration could it contribute to unavoidable pressure ulcers?
  - 100% Yes  0% No
• In a morbidly obese individual, can the weight of the pannus or other skin folds contribute to unavoidable pressure ulcers?
  - 96% Yes  4% No

Compliance/non-adherence with recommended plan of care
• If the individual and family are advised that the individual’s current non-adherence to the plan of care may lead to pressure ulcer development and all other proper preventive care is being offered, can that make a pressure ulcer unavoidable?
  - 91% Yes  9% No

Compliance/Non-adherence
• Can these behaviors in a demented patient be seen as contributing to the problems with skin ulceration?
• Can these behaviors in a mentally intact patient be seen as contributing to the problems with skin ulceration?
• Are these pressure ulcers unavoidable?

Skin Failure
• Does the condition called “skin failure” exist?
  - 83% Yes  17% No
• Is skin failure the same as a pressure ulcer?
  - 0% Yes  100% No

Staffing
• Does insufficient staff to formulate and implement a pressure ulcer prevention plan of care contribute to unavoidable pressure ulcers?
  - 91% Yes  9% No
Revisit initial items

- Are all pressure ulcers avoidable?
  - 100% No
- Are most pressure ulcers avoidable?
  - 82% Yes 18% No
  - vs. 100% Yes initially
- If enough pressure was removed from the external body could the skin always survive?
  - 0% Yes 100% No
  - vs. 4% Yes and 96% No initially

Future Issues

- How often do PU develop under certain conditions?
- How does hemodynamic instability affect the development of PU?
- What about tissue tolerance?
  - Individual
  - Relates to clinical condition

What Can We Do?

- Identify PU on admission
  - 24 hrs for stage II to develop
  - 48 hrs for sDTI injury to break down
- sDTI
  - If resorbable, institute ways to prevent progression
  - If not resorbable, how to prove present on admission

Best Practice

- Clinical practice guidelines best defense

International Guidelines

- NPUAP/EPUAP Pressure Ulcer Guidelines
- Address prevention and treatment
- Released in 2009.
- Evidence-based.

Treatment Guidelines

- Screen and assess nutritional status for each individual with a pressure ulcer at admission and with each condition change and/or when progress toward pressure ulcer closure is not observed.
  - Refer all individuals with a pressure ulcer to the dietitian for early assessment and intervention of nutritional problems.
  - Assess weight status for each individual to determine weight history and significant weight loss from usual body weight
  - Assess ability to eat independently
  - Assess adequacy of total nutrient intake (food, fluid, oral supplements, enteral/parenteral feedings).
Treatment Guidelines

- Provide sufficient calories
  - Provide 30-35 Kcalories/kg body weight.
  - Adjust formula based on weight loss, weight gain or level of obesity.
  - Liberalize dietary restrictions when limitations result in decreased food and fluid intake.
  - Provide enhanced foods and/or oral supplements between meals if needed.
  - Consider nutritional support (enteral or parenteral nutrition) when oral intake is inadequate, consistent with individual goals.

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Treatment Guidelines

- Provide and encourage adequate daily fluid intake for hydration.
  - Monitor individuals for signs and symptoms of dehydration
  - Provide additional fluid for individuals with dehydration, elevated temperature, vomiting, profuse sweating, diarrhea or heavily draining wounds.

- Provide adequate protein for positive nitrogen balance for an individual with a pressure ulcer
  - Offer 1.25 - 1.5 grams protein/kg body weight when compatible with goals of care
  - Reassess as condition changes

- Encourage consumption of a balanced diet which includes good sources of vitamin and minerals
- Offer vitamin and mineral supplements when dietary intake is poor or deficiencies are confirmed or suspected

Other Supplements?

- Vitamin C
  - Enhances cell proliferation
  - Stimulates collagen synthesis
- Zinc
  - Protein synthesis; cellular growth
- Arginine
  - Stimulates collagen synthesis
- Glutamine
  - Enhance cell proliferation

- Leucine
  - Regulates protein synthesis
  - Helps maintain nitrogen balance
  - mTor? 5% converted to mTor
- HMB (beta hydroxy- beta-methylbutyrate)
  - Metabolite of amino acid leucine
  - Precursor for the manufacture of cholesterol
  - Helps regulate muscle synthesis and degradation
  - Improve immune function
NPUAP Resources

• NPUAP website  www.npuap.org

• International Guidelines
  Available for download or purchase:
  Discount for ADA members—enter:
  COC (5% off for non-bulk orders)
  BULKCOC (15% off for orders of 20 or more books)

International Prevention Guidelines

• Include recommendations for
  – Risk Assessment
  – Skin Assessment
  – Repositioning
  – Support Surfaces
  – Special Population: Patients in the Operating Room

International Treatment Guidelines

• Include recommendations for
  – Classification of pressure
  – Assessment and monitoring of healing
  – Role of nutrition in pressure ulcer healing
  – Pain assessment and management
  – Support Surfaces
  – Cleansing, debridement, dressings
  – Assessment and treatment of infection
  – Treatment methods—biophysical, biological dressings, growth factors
  – Surgery for pressure ulcers
  – PU management in individuals receiving palliative care

NPUAP Resources

• NPUAP website  www.npuap.org

• Pressure Ulcer Prevention Points, 2007

• The Role of Nutrition in Pressure Ulcer Prevention and Treatment: National Pressure Ulcer Advisory Panel White Paper, 2009

• Pressure ulcer staging diagrams
  Available for download
MDS 3.0: Section M
Skin Conditions

Section M is greatly expanded!!

Changes from MDS 2.0
• Skin conditions are now coded as “Present on admission” from stages 2 through unstageable.
• No more “reverse” staging
• Stasis ulcers are no longer staged
• NPUAP staging definitions are used to enhance reliability.

Changes Affecting RD Documentation
• Risk assessment must be completed
• Ulcers that are healed or worsened are identified.
• Date of oldest stage 2 pressure ulcer
• Venous/arterial ulcers are separated from diabetic foot ulcers.
• Identifies other lesions that are not ulcers, rashes, or cuts

Avoiding or Defending Litigation
Failure to implement facility policies and to be diligent with documentation procedures increases a facility’s exposure to liability.

Keys to Reduce Liability
Development and implementation of facility policies
Comprehensive documentation in the medical record

Implement Facility Policies
• Use recognized clinical practice guidelines
  – NPUAP International Guidelines
  – ADA Evidence Analysis Library
  – American Medical Director’s Association
  – ADA’s Nutrition Care of the Older Adult
Develop Successful Facility Policies

- Avoid policies that are doomed to fail
  - Absolute terms
  - Inflexible timelines
  - Unnecessary requirements
- Formulate policies that will succeed
  - Clear guidelines
  - Flexible timelines
  - Discretionary judgment

Comprehensive Documentation

Good documentation is the best defense against litigation.

Include all aspects of nutrition care

Comprehensive Documentation

Include:
- Evaluation of weight status
- Evaluation of contributing factors that may affect wound healing
- Assessment of nutrient needs
- Comparison of needs vs. food and fluid consumption
- Plan of care/interventions
- If you have a negative outcome, was it clinically unavoidable?

Comprehensive Documentation

- Document and review on a routine basis until the wounds are healed.
- Establish guidelines
- What documentation would be adequate evidence that the pressure ulcer was unavoidable?
  - How should risk factors be identified in the record? How often?
  - How often should turning and repositioning be documented?
  - Should the name of the actual support surface be identified?
  - How should patient choice be documented?

Comprehensive Documentation

- Remember
  - “Not documented, not done”
  - “Not documented, not known”
  - Errors give impression of substandard care

Use Nutrition Care Process

NUTRITION DX: Increased need for energy and protein related to increased demands for healing as evidenced by the presence per H & P of a stage IV pressure ulcer

GOAL: Resident will consume calculated needs of 2000-2100 calories, 75-80 gm protein, 1500-1800ml fluid daily

INTERVENTIONS: Serve Mechanical Soft Diet for approx. 2400 calories, 80 gm protein, 1740ml fluid. Offer high calorie supplement of 60ml qid for 480 calories, 20 gm protein Consult physician with request to add vitamin/mineral supplement

MONITORING/EVALUATION: Evaluate resident energy and protein intake weekly using observation of resident and documented intake of meals and supplements Monitor pressure ulcer healing using facility skin monitoring weekly report
Use Nutrition Care Process

NUTRITION DX: Inadequate intake of energy and protein related to difficulty swallowing as evidenced by an intake of only 50% of calculated needs with significant weight loss, stage 3 pressure ulcer and DX of Dysphagia

GOAL: Resident will consume calculated needs of 2000-2100 calories, 75-80 gm protein, 1500-1800ml fluid daily

INTERVENTIONS: Consult speech therapy evaluation and recommendations for appropriate diet consistency and need for rehab

Offer high calorie supplement of 60ml qid for 480 calories, 20 gm protein

Consult physician with request to add vitamin/mineral supplement

Weigh resident weekly

MONITORING/EVALUATION: Evaluate energy and protein intake weekly using observation of resident and documented intake of meals and supplements

Monitor pressure ulcer healing using facility skin monitoring weekly report

Evaluate ability to consume diet safely by observation & review of ST eval

What should RDs do?

Best Practice

Implement Nutrition Care Process

Questions? And Thank You

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Dietetics in Health Care Communities - DHCC
Commission on Dietetic Registration CPE Accredited Provider

AM003
CPE Provider Accreditation Number

Participant’s Name

Has successfully completed 1.5 CPEUs (Level II)

DHCC – DPG #31, Cynthia Piland, MS, RD, CSG, LD, Chair

Signature of CDR CPE Accredited Provider, Date 16 June 2011