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SUPERIOR HEALTH
Quality Alliance

F686: Skin Integrity - Pressure Injury

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Objectives

1. To understand what is a pressure injury.
2. To understand the difference between avoidable and unavoidable pressure injuries.
3. To identify steps for prevention of pressure injuries.
4. To list some strategies to prevent receiving an F686 citation.

Poll #1

1. On a scale of 1 to 10, rate your level of comfort/satisfaction with your wound care program. No concerns = 10 and terrible = 1.
2. How many residents in your facility have pressure injuries?
    a. 0
    b. 1-2
    c. 3-5
    d. More than 5
3. What is the biggest challenge with your wound care program?
    a. Staff compliance
    b. Staff education
    c. Documentation
    d. Expense
    e. Other

Definition of Pressure Injury

The Centers for Medicare & Medicaid Services (CMS) adopted the National Pressure Injury Advisory Panel (NPIAP) definitions.

- A 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. It can present as intact skin or an open ulcer and may be painful.

April 29, 2022

- Previously known as bed sores, decubitus ulcers (decube), pressure sores.

Source: CMS, State Operations Manual (SOM) Appendix PP - Guidance to Surveyors for Long Term Care Facilities

Possible Locations of Pressure Injuries

- Coccyx
- Heels
- Hips
- Elbows
- Back of head
- Ears
- Sides of knees
- Shoulders

F 686: Skin Integrity - Pressure Injury

§483.25(b) Skin Integrity

§483.25(b)(1) Pressure ulcers.

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

(i) 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

(ii) 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.

Source: CMS, SOM Appendix PP - Guidance to Surveyors for Long Term Care Facilities

F 686: Intent

The intent of this requirement is that the resident does not develop pressure ulcers/injuries (PU/PIs) unless clinically unavoidable and that the facility provides care and services consistent with professional standards of practice to:

- Promote the prevention of pressure ulcer/injury development;
- Promote the healing of existing pressure ulcers/injuries (including prevention of infection to the extent possible); and
- Prevent development of additional pressure ulcer/injury.

Source: CMS, SOM Appendix PP - Guidance to Surveyors for Long Term Care Facilities

Definitions From CMS

“Avoidable” - resident developed a pressure 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.

“Unavoidable” - resident developed a pressure 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.

Source: CMS, SOM Appendix PP - Guidance to Surveyors for Long Term Care Facilities

Unavoidable – Case Study

Resident with advanced CHF, COPD, Diabetes Mellitus type 2, anemia. Albumin and hgb low. RR & HR elevated. Pulse ox 85% with oxygen at 5 lpm. Bilateral lower extremity edema. Unable to tolerate aggressive diuresis.

- He has refused low air loss mattress support surface and being repositioned. Unable to tolerate oral supplements.
- Head of bed is 60-80 degrees. He cannot tolerate anything lower.
- Develops stage 2 on coccyx.
- Nursing staff has developed skin protection care plan; updated with resident's preferences; and documents resident's condition and response to interventions.

Background: Skin Failure

- Skin is the largest organ of the body and it fails the same as a person's heart, kidneys, liver, etc.
- Older adults are at higher risk for skin failure due to more fragile bodies.
- With some acute illnesses there can be hypoperfusion – i.e. myocardial infarction, sepsis.
- With chronic illnesses body systems fail due to chronic disease states; i.e. End stage renal disease, heart failure. (hypoxia, edema, inflammation)
- Skin failure is an unavoidable condition; however, wounds may develop from inadequate prevention strategies.
- End-stage skin failure occurs when patients deteriorate physically and underlying tissue dies due to hypoperfusion at the end of life. i.e. Kennedy Terminal Ulcers

Source: Wound Source, Understanding Skin Failure: Pathophysiological Factors

Risk Factors to the Development of Pressure Injuries

- Immobility, unable to reposition self.
- Prolonged pressure over boney prominence.
- Dry skin, fragile (thin), edema (aging skin).
- Moisture, incontinence.
- Poor nutrition, dehydration.
- Shear, sliding, scraped skin – slide down in bed, transfer bumps.
- Lack of sensation to area (paralysis, nerve damage).
- Prolonged illness/hospitalization.
- Chronic illnesses that impair blood flow – heart failure, kidney disease.
- Dementia/Alzheimer's Disease
- History of pressure injuries.

Source: Journal of Wound, Ostomy and Continence Nursing, Implementation of Pressure Injury Prevention Strategies in Acute Care

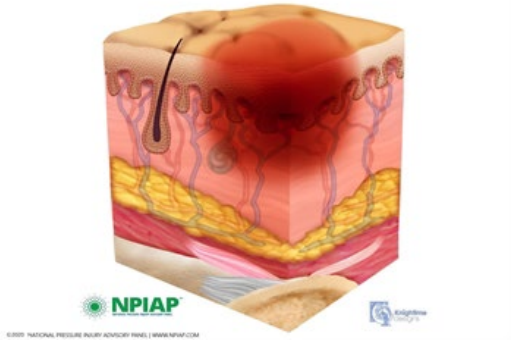
Pressure Injury Stages (non-clinical definitions)

- Stage 1 - the area of the sore looks red; may feel warm to the touch; burn, hurt or itch. The pressure sore may look blue or purple in people who have dark skin.
- Stage 2 - the area is more damaged and painful; the sore may be open and look like a cut or blister. The skin around the sore may be discolored.
- Stage 3 - the sore look like a crater due to increased damage below the surface and this makes the wound deeper.
- Stage 4 - this is the most serious stage and the wound becomes large; skin and tissue are severely damaged and you will most likely see muscle, bones, tendons and joints. Infection is possible.
- Unstageable - Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

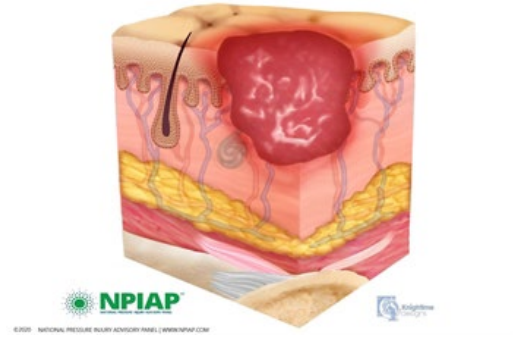
Source: NPIAP, Pressure Injury Stages

Pressure Injuries Clinical Definitions

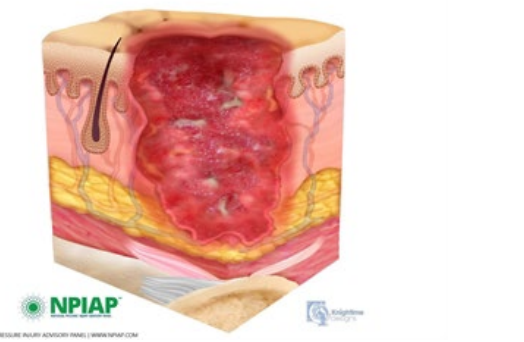
Stage 1 Pressure Injury - Lightly Pigmented



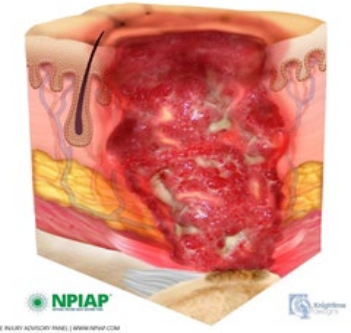
Stage 2 Pressure Injury

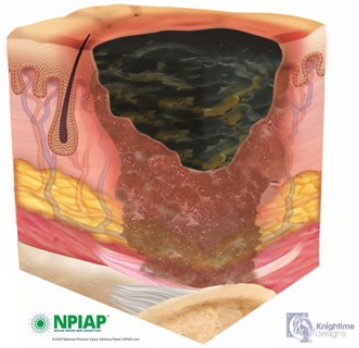


Stage 3 Pressure Injury



Stage 4 Pressure Injury

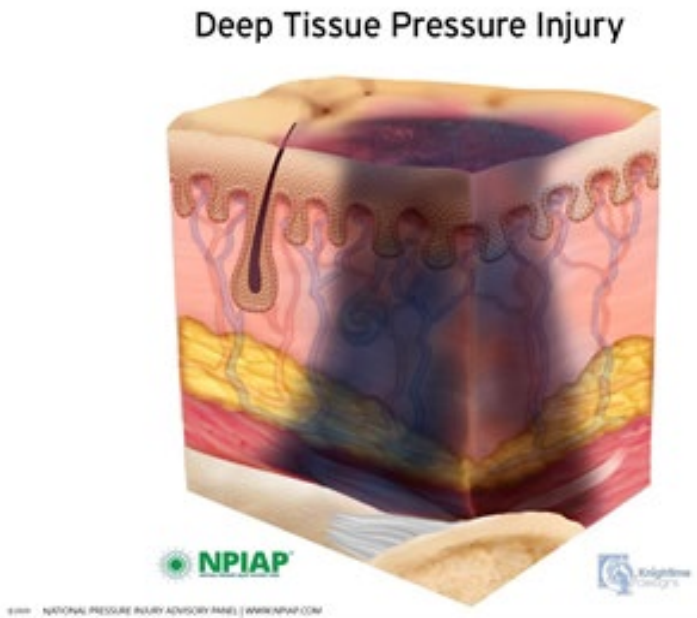




Source: NPIAP, Pressure Injury Stages

Deep Tissue Pressure Injury

- Persistent non-blanchable deep red, maroon or purple discoloration.



Source: NPIAP, Pressure Injury Stages and Deep Tissue Pressure Injury or an Imposter?

Other Types of Wounds

- Vascular (arterial, venous, and mixed)
- Neuropathic (diabetic)
- Moisture-associated dermatitis
- Skin tear
- Mechanical device-related pressure injury
- Mucosal membrane pressure injury

Source: Journal of Wound, Ostomy and Continence Nursing, Revised National Pressure Ulcer Advisory Panel Pressure Injury Staging System

How To Prevent Pressure Injuries

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CMS: View On Pressure Injuries

- Defined as “never events.”
- CMS believes pressure injuries should be prevented.
- The occurrence of pressure injuries is an indicator of quality of care. The number of pressure injuries are reported on a facility’s quality measure report from CMS (via Minimum Data Set [MDS] assessments).
- Also can be the source of litigation.
- Also often cited on surveys.

Source: CMS, State Medical Director Letter (SMDL #08-004) and Potentially Preventable Adverse Events

Skin Care Protocol to Prevent Skin Breakdown

Assessments

- Admission risk assessment (i.e. Braden) and skin assessment; weekly skin assessments.
- Daily monitoring with all cares.
- Report concerns and modify plan of care.

Positioning and Mobilization

- Turn and reposition at-risk patients frequently (per care plan) and document when done. Consider an individualized turning schedule, pressure-relieving devices for bed and wheelchair, positioning supports.
- Prevent friction, shear and moisture to skin.
- Therapy referral if appropriate; keep ambulatory if possible.

Source: NPIAP, Pressure Injury Prevention Points

Skin Care Protocol, continued

Nutrition

- Monitor oral (or enteral or parenteral) intake.
- Regular weights and monitor weights, related lab work.
- Refer to dietician - provide supplemental nutrition as indicated.

Preventing Moisture

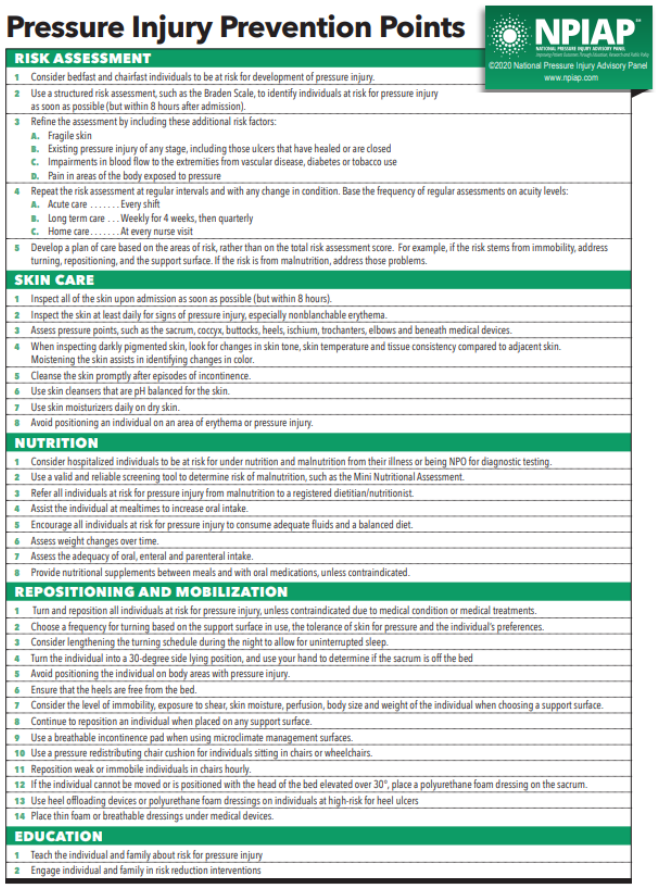
- Change as needed.
- Peri-care per procedure (spray, etc.)

Treatments/skin care

- Keep skin moisturized with lotions.
- Use barrier creams, protective dressings as ordered.

Source: NPIAP, Pressure Injury Prevention Points

Pressure Injury Prevention Points



Pressure Injury Prevention Points

NPIAP
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www.npiap.com

RISK ASSESSMENT

1 Consider bedfast and chairfast individuals to be at risk for development of pressure injury.
2 Use a structured risk assessment, such as the Braden Scale, to identify individuals at risk for pressure injury as soon as possible (but within 8 hours after admission).
3 Refine the assessment by including these additional risk factors:
- A. Fragile skin
- B. Existing pressure injury of any stage, including those ulcers that have healed or are closed
- C. Impairments in blood flow to the extremities from vascular disease, diabetes or tobacco use
- D. Pain in areas of the body exposed to pressure

4 Repeat the risk assessment at regular intervals and with any change in condition. Base the frequency of regular assessments on acuity levels:
- A. Acute care . . . . . Every shift
- B. Long term care . . . Weekly for 4 weeks, then quarterly
- C. Home care . . . . . At every nurse visit

5 Develop a plan of care based on the areas of risk, rather than on the total risk assessment score. For example, if the risk stems from immobility, address turning, repositioning, and the support surface. If the risk is from malnutrition, address those problems.

SKIN CARE

1 Inspect all of the skin upon admission as soon as possible (but within 8 hours).
2 Inspect the skin at least daily for signs of pressure injury, especially nonblanchable erythema.
3 Assess pressure points, such as the sacrum, coccyx, buttocks, heels, ischium, trochanters, elbows and beneath medical devices.
4 When inspecting darkly pigmented skin, look for changes in skin tone, skin temperature and tissue consistency compared to adjacent skin. Moistening the skin assists in identifying changes in color.
5 Cleanse the skin promptly after episodes of incontinence.
6 Use skin cleansers that are pH balanced for the skin.
7 Use skin moisturizers daily on dry skin.
8 Avoid positioning an individual on an area of erythema or pressure injury.

NUTRITION

1 Consider hospitalized individuals to be at risk for under nutrition and malnutrition from their illness or being NPO for diagnostic testing.
2 Use a valid and reliable screening tool to determine risk of malnutrition, such as the Mini Nutritional Assessment.
3 Refer all individuals at risk for pressure injury from malnutrition to a registered dietitian/nutritionist.
4 Assist the individual at mealtimes to increase oral intake.
5 Encourage all individuals at risk for pressure injury to consume adequate fluids and a balanced diet.
6 Assess weight changes over time.
7 Assess the adequacy of oral, enteral and parenteral intake.
8 Provide nutritional supplements between meals and with oral medications, unless contraindicated.

REPOSITIONING AND MOBILIZATION

1 Turn and reposition all individuals at risk for pressure injury, unless contraindicated due to medical condition or medical treatments.
2 Choose a frequency for turning based on the support surface in use, the tolerance of skin for pressure and the individual's preferences.
3 Consider lengthening the turning schedule during the night to allow for uninterrupted sleep.
4 Turn the individual into a 30-degree side lying position, and use your hand to determine if the sacrum is off the bed
5 Avoid positioning the individual on body areas with pressure injury.
6 Ensure that the heels are free from the bed.
7 Consider the level of immobility, exposure to shear, skin moisture, perfusion, body size and weight of the individual when choosing a support surface.
8 Continue to reposition an individual when placed on any support surface.
9 Use a breathable incontinence pad when using microclimate management surfaces.
10 Use a pressure redistributing chair cushion for individuals sitting in chairs or wheelchairs.
11 Reposition weak or immobile individuals in chairs hourly.
12 If the individual cannot be moved or is positioned with the head of the bed elevated over 30°, place a polyurethane foam dressing on the sacrum.
13 Use heel offloading devices or polyurethane foam dressings on individuals at high-risk for heel ulcers
14 Place thin foam or breathable dressings under medical devices.

EDUCATION

1 Teach the individual and family about risk for pressure injury
2 Engage individual and family in risk reduction interventions

Tool from NPIAP

Source: NPIAP, Pressure Injury Prevention Points

Monitor Wounds for Signs of Infection

Signs of infection at the site include:

- Thick, yellow, or green pus.
- A foul odor from the pressure injury/wound.
- Redness or skin that is warm to the touch.
- Swelling around the open area.
- Tenderness around the open area.
- Growth on cultures.

Signs the infection spread include:

- Fever, chills.
- Confusion or difficulty concentrating.
- Rapid heart and respiratory rates.
- Weakness, lethargy.
- Changes in lab results.

Source: Sepsis Alliance, Pressure Ulcers (Pressure Injuries)

Potential Adverse Effects of Pressure Injuries

- Localized wound infection
- Bone infection – osteomyelitis
- Blood infection – sepsis
- Pain
- Isolation/depression
- Prolonged treatments, expense
- Increasing debility and frailty
- Death

Treatments and Plans of Care

- Many different options and brands of dressings and creams/ointments are available for treating wounds and it can be confusing.
- Consider using a formulary.
  - So that products used are compatible with each other
  - Usually an algorithm/grid or guidance is provided for type of each type of wound and suggestions for treatment
  - Saves space and cost
- Follow physician's orders for treatments and document.
- Keep care plan updated with any changes.
- Refer to a wound certified nurse or consider a wound clinic (if appropriate and available).

Poll #2

1. Does your facility use a standard set of skin protection interventions?
2. Does your facility use a formulary for wound care products?
    a. Yes
    b. No
3. If yes, do you feel it is helpful for staff?
    a. Yes
    b. No

Case Studies

Case Study 1

An 86 year old female is admitted from the hospital after having a right hip replacement surgery. She was in the hospital for seven days due to post surgical complications. She is admitted to you needing assist of two for transfers, she has some episodes of incontinence, rates her pain 8/10. Upon assessment, her left hip has some tenderness, redness and warmth upon touch.

What is your assessment?

What interventions should be implemented/added to her care plan?

Case Study 2

A 95 year old male resident of your facility for 10 years. His dementia has progressed and he is no longer able to communicate his needs. He is losing weight and is totally dependent on staff for all of his needs.

What interventions should be implemented/placed on his care plan?

Interventions to Prevent Skin Breakdown

- Skin assessment with measurements of any wounds.
- Risk assessment - Braden scale; development of plan of care to optimize preventative interventions.
- Daily assessment of all skin for further breakdown.
- Turning/repositioning every one to two hours and chart (may need to specify acceptable positions). Limit time sitting upright, to prevent shear.
- Specialty mattress; pressure relief wheelchair chair cushion.
- Heel boots.
- Positioning wedges.
- Moisturizer to skin.

More Interventions to Prevent Skin Breakdown

- Limit time out of bed on coccyx.
- Keep skin clean and dry.
- Treatments – protective dressings, skin barrier creams.
- Nutritional consult; dietary supplements, some providers add vitamin supplements.
- Pain management.
- Therapy referral.
- Communication with provider, family.
- Update care plan.
- Wound care consult.

Chat Question 1

Please add any other interventions you have implemented to prevent skin breakdown into the chat window.

Common F686 Citations

F686 Citations: Regional Data

Frequently citated – in top 10 of most frequently citations for Michigan, Minnesota and Wisconsin.

- Michigan – 71 citations or 13.8% of providers
- Minnesota- 25 citations or 6.3% of providers
- Wisconsin – 48 citations or 11.9% of providers

Recertification or complaint surveys.

Scope and severity varies.

Related F Tags

F684 - Quality of care - Resident receives the treatment and care in accordance with professional standards … care plan… resident's choices…

F656, 657, 658 – Comprehensive care plans, services meet professional standards of quality

F580 - Notification provider of changes

F636 – Resident assessment

F675 – Quality of life- provide care/services for highest practicable well-being

F676 - Based on the comprehensive assessment and consistent with his choices, A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living.

F710 – Physician services, supervision

F686 Citations

F686 – Pressure Injuries

“ …Failed to provide pressure ulcer preventative care consistent with professional standards resulting in the potential for development of an avoidable pressure ulcer, worsening of overall deterioration of health status.”

Examples of F686 Citations from Survey Reports (Form 2567)

- Resident observed all shift not being moved or repositioned; up in Broda chair, observed leaning to side.
- Care plan stated resident to wear pressure relief boots, none in place or found in the resident's room.
- Treatments not signed on treatment record as being provided.
- No pillows or wedges available or used for repositioning; not being repositioned.
- Undated dressing in place, or missing dressing (certified nursing assistant [CNA] did not tell nurse that it fell off).
- Care plan not up to date – no pressure prevention interventions or current treatment interventions included.
- Applied dirty boot to open heel wound; heels observed resting on mattress.
- Lack of staff knowledge related to pressure ulcers.
- Failure to notify provider of wound changes and not changing interventions when would is deteriorating.

Additional Examples of F686 Citations

- No weekly wound assessments, measurements, staging or wound charting.
- Discrepancies on wound log.
- Not following schedule for positioning/turning.
- No prevention interventions implemented when needed.
- No risk assessment (Braden) completed.
- New treatment ordered and not done (order incorrectly transcribed and not entered on the treatment administration record).
- No evaluation of effectiveness of new treatment order.
- Improper identification/classification of wounds (venous, arterial, pressure, deep tissue, medical device-related pressure injury, mucosal membrane pressure injury).

How Can You Prevent F686 Citations?

- Admission process – full body assessment with two hours; look under dressings; Braden assessment.
- Skin assessments per policy - (weekly and daily) (dressings); return from leave of absence (LOA).
- Weekly wound assessments and measurements.
- Process for: new orders. Use of algorithm, formulary.
- Communication to providers of concerns.
- Communication to caregivers of new orders.
- Keep care plan updated.
- Supplies available and staff knowledge of location.
- Assign one person to oversee wound care program, performs weekly assessments, monitors progress.
- Charting.
- Wound care consultants (certified nurse); clinics.

Preventing Citations, continued

- Care plan audits.
- Compliance audits:
  - Skin and wound assessments done and charted.
  - Prevention interventions on care plan.
  - Interventions done (turn, boots, etc.).
  - Treatments done per orders and charted/
- Staff education – at hire, annually, as needed.
  - Prevention and treatment
- Staff competency assessments – positioning, application of boots, wound care, etc.

Chat Question 2

Please add any other measures that you have implemented to prevent F686 citation; best practices into the chat window.

Staff Education

Staff Education

- Upon hire
- Annually
- With changes in policies, procedures, new products
- As needed

CNA Education

- Check skin with each resident contact.
- Change/toilet promptly.
- Use skin cleanser, apply skin protectants and treatments per care plan and chart.
- Notify nurse of concerns, dressings off.
- Follow care plan – turn/reposition, elevate heels, heel boots, wheelchair cushions, etc.
- Keep linen wrinkle free and limit amount of linen under resident.
- Encourage oral intake – chart.
- Follow infection prevention practices.

Preventing Pressure Ulcers and Assisting with Wound Care

Tell the nurse about:

- A reddened area that does not return to its normal color after pressure is relieved.
- A previously reddened area is hot to touch or painful.
- A previously reddened area is now pale, white or shiny.
- A pressure ulcer (injury) that has changed in size or depth.

Source: Healthcare Quality Innovation Network, The CNA's Role and Responsibility in Preventing, Identifying and Reporting Pressure Injuries

Quiz for CNAs: True or False

1. Pressure injuries are easy to treat and rarely get infected.
2. Residents at risk for development of a pressure injury or already have a pressure injury, only need to be repositioned once a shift. The heels of a person need to be protected from pressure injuries.
3. A resident's plan to prevent pressure injuries should be followed and if you don't have the needed supplies (i.e.. Pressure relieving boots) you need to inform the charge nurse.
4. You only need to check a resident's skin at the weekly skin assessment.
5. Increasing a resident's caloric intake helps heal open wounds and you need to encourage resident to accept supplements.

Quiz for CNAs: True or False (continued)

6. The best position for a resident with an open wound is to lie on the open area.
7. Multiple layers of linens placed under a resident, when in bed; protect his skin from breakdown.
8. Specialty air mattresses need to be checked to ensure that they remain inflated.
9. If a wound dressing falls off; the most important thing to do is tell other CNA on your hall.

Nurse Education

- Basics of pressure relief – why important and how to do it.
- Acknowledge CNAs when they bring a concern to you and follow-up.
- Assist CNAs with turning, transfers if needed.
- Notify providers and obtain orders as needed.
- Update care plan, notify wound nurse.
- Assess and measure wound per facility procedure; chart. Notify provider if wound condition worsens.

Additional Nurse Education

- Follow aseptic technique with dressing changes (use at least three pair of gloves); date dressing.
- Follow orders, clarify as needed.
- Assess pain, signs/symptoms of infection.
- Document
- Follow infection prevention practices.

Identifying Type of Wounds and Staging

- If nurses are staging wounds and determining type of wounds, provide additional training.
- Wound care certified nurse.
- Wound care clinic.

Quiz for Nurses: True or False

1. During rounds, you should check on resident's positioning, presence of boots, etc. and follow-up when plan of care is not being followed.
2. If a resident refuses to be repositioned off his open hip, the care team should provide education on benefits of repositioning and document the discussion and then their job is done.
3. Communication between CNAs and floor nurses is important in preventing/addressing pressure injuries and other changes of condition.
4. Wound measurements and staging of pressure injuries is only required monthly.
5. Dressings are to be done with aseptic technique, following provider's order and charted as being done.

Quiz for Nurses: True or False (continued)

6. Assessing the wound each time a dressing is changed, is not necessary.
7. Care plans updates are not needed.
8. Pain management should be part of resident's care plan.
9. Wounds should be monitored for signs of infection.
10. All dressings should be dated and have nurse's initials when applied.

Poll #3

1. Do you have a dedicated wound care nurse?
    a. Yes
    b. No
2. If yes, is this person certified in wound care?
    a. Yes
    b. No

Audits, Monitoring and Reporting to Quality Assurance and Performance Improvement (QAPI)

Tracking and Audits Tools

Pressure injury logs:

- In electronic medical record (EMR)
- Pressure Ulcer Tracking Tool, CMS Quality Improvement Organizations
- Wound Care Audit Tracking Tool Workbook, Minnesota Department of Health

Pressure Injury Critical Element Pathway, CMS

- Survey resources link (ZIP)
- Changes April 2024: require gowns for wound care (enhanced barrier precautions).

Facility Acquired Pressure Injury Calculation Procedure

Numerator definition: Number of pressure injuries developed in the organization within the specified timeframe

Denominator definition: Total number of overnight occupied bed days within the specified timeframe Measurement Period Length Usually per calendar month, calculated monthly (patient days)

Calculation Rate: (numerator/denominator) X 1,000

Example for calculating prevalence:

- Pressure injuries in one month: 4
- Patient days for one month: 1,250
- 4/1,250 = 0.0032 X 1,000 = 3.2%

Source: AHRQ, Module 5: How To Measure Pressure Injury Rates and Prevention Practices

MDS CODING – Section M

- MDS coding needs to match the documented assessments.
- Section M: Skin Conditions Intent: document the risk, presence, appearance and change of pressure ulcers/injuries; notes other skin ulcers, wounds or lesions; and documents some treatment categories related to skin injury or avoiding injury.
- Evaluate each resident's risk factors and to identify and evaluate all areas at risk of constant pressure.

Source: CMS, Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual and Point Click Care, Section M. Skin Conditions

Quality Measure Report

- Long stay - Percent of high-risk residents with pressure ulcers.
- Short stay - Changes in skin integrity post-acute care: pressure ulcer/injury.

Source: CMS, Quality Measures | CMS

Summary

Implementing an Effective Pressure Injury Prevention Program

- Leadership to acknowledge the importance of preventing pressure injuries.
- Leadership to also monitor Quality Measure report, participate on wound care team.
- Leadership to provide resources for equipment, supplies, education.
  - Pressure relieving devices (beds, cushions, wedges, etc.); wound certification, conferences.
  - One person to be assigned to monitor pressure/wound injuries. Wound certified nurse is best.
- Provide specialized training for nurses on staging, etc.
- Recommend using a log to track wound status.
- Have policies and procedures that outline standards for care developed from evidence-based guidance, nationally recognized sources.

Implementing an Effective Pressure Injury Prevention Program, continued

- Solidify processes:
  - Order process – consider order templates.
  - Who will update care plans for wounds?
  - Who will measure wounds and when; staging?
  - Who will communicate to providers?
  - How will communication to CNAs occur?
- Audit that care plan interventions are being done.
- Ensure ongoing education for nurses and CNAs regarding preventing and treating wounds.
- Report to QAPI.

Preventing Pressure Injuries

- A team effort is needed to prevent the development of pressure injuries.
- Many resources are available to assist in being successful in preventing the development of pressure injuries.

Resources

- Prevention Points, NPIAP
- National Pressure Injury Advisory Panel Releases Standardized Pressure Injury Prevention Protocol, NPIAP
- Prevention and Treatment of Pressure Injuries: Clinical Practice Guideline 2019, NPIAP
- Pressure Injury Stages, NPIAP
- Pressure Injury Prevention Points, NPIAP
- Module 5: How To Measure Pressure Injury Rates and Prevention Practices, AHRQ
- Skin fails too: acute, chronic, and end-stage skin failure, Advances in Skin and Wound Care
- Unavoidable Pressure Injury during COVID-19 Pandemic, NPIAP
- Terminal Ulcers, SCALE, Skin Failure, and Unavoidable Pressure Injuries, Advances in Skin and Wound Care
- Pressure Ulcer Critical Element Pathway, U.S. Department of Health and Human Services
- Braden Scale
- Quick Safety 25: Preventing pressure injuries (Updated March 2022), The Joint Commission

Additional Resources

Education:

- CNA's Role and Responsibility in Preventing Identifying PI, HQIN
- Front Line Forces: Pressure Injury and Prevention, Superior Health Quality Alliance
- Pressure Injury Prevention (YouTube), NPIAP
- Nursing Home: Pressure Ulcer/Injury Information, Wisconsin Department of Health Services
- Wound Care Infection Prevention Recommendations for Long-Term Care Facilities, Minnesota Health Department

Setting Up a Formulary:

- How to set up and optimize your wound care formulary, Wound Reference
- 7 steps to creating a supply formulary that works, Medline
- Understanding the Essentials - Simplifciation of Wound and Skin Care Formularies, Cardinal Health

Questions?

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