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The Nuts and Bolts of Pressure Injury Care Planning

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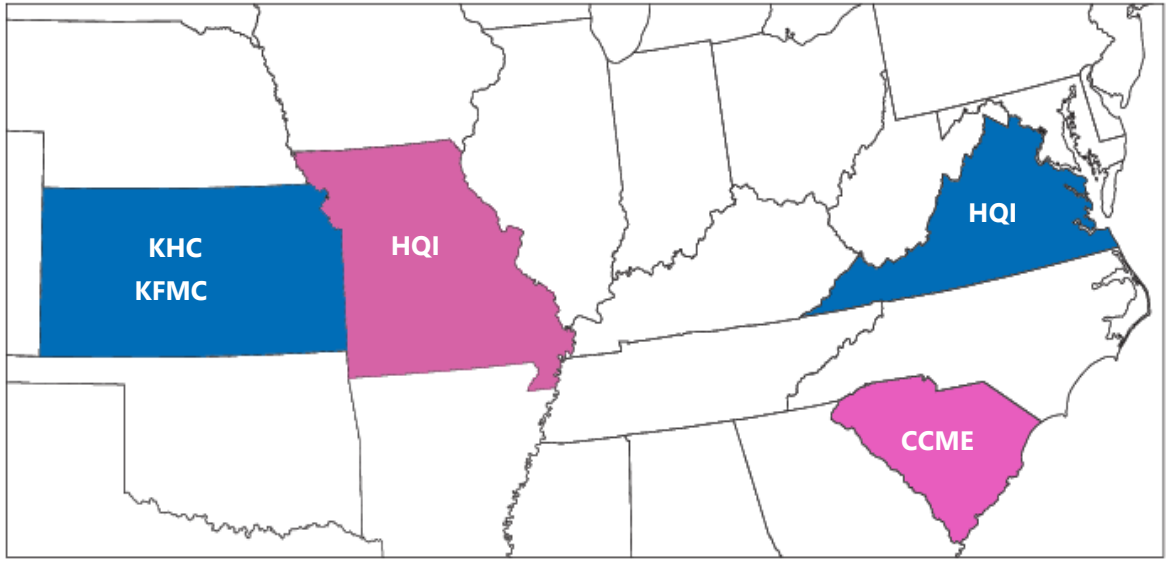

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Logistics – Zoom Webinar

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Resources from today's session will be posted in **Chat**.

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Today's Speakers

Mary Chiles
RN, RAC-CT, QCP

Allison Spangler
RN, BSN, RAC-CT, QCP

Objectives

- Discuss avoidable versus unavoidable pressure injuries
- Discuss PI care plan development
- Discuss resident/family involvement
- Discuss PI care plan monitoring

Avoidable versus Unavoidable

"Avoidable" 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.

Avoidable versus Unavoidable

"Unavoidable" 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.

Care Planning Regulations

- F-655 Baseline Care Plan
- F-656 Develop/Implement Comprehensive Care Plan
- F-657 Care Plan Timing & Revision

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Person Centered

- Goals for admission and desired outcomes
- Ethnicity
- Cultural values
- Lifelong interests
- Spirituality
- Life roles
- Support systems
- Resident/representative choice or preference
- Advanced directive decisions

Baseline Care Plan

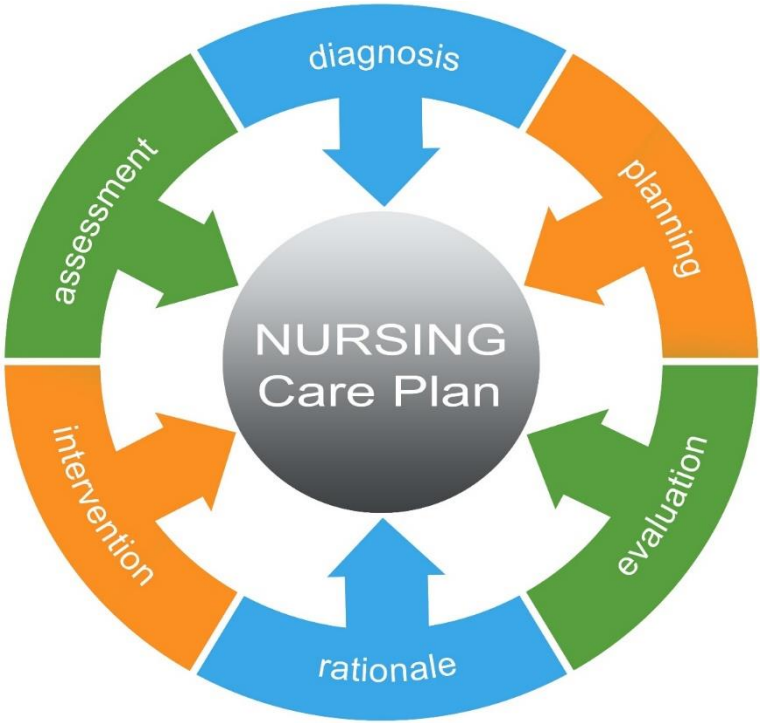
The facility must develop and implement a baseline care plan for each resident that include the instructions needed to provide effective and person-centered care of the resident.

MUST:

- Be developed within 48 hours of a resident's admission
- Provide the resident and their representative with a summary of the baseline care plan

Comprehensive Care Plan

The facility must develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.



Care Plan Development and Revision

Comprehensive care plan must be:

- Developed within 7 days after completion of the comprehensive assessment
- Prepared by an interdisciplinary team
- Reviewed and revised by the interdisciplinary team after each assessment

Interdisciplinary Team

- Attending physician or designee
- Registered Nurse
- Certified Nursing Assistant
- Nutrition Services
- Resident or Representative
- Other appropriate staff in disciplines as determined by the resident's needs or as requested by the resident

Resident/Representative Participation

The facility must:

- Provide advance notice of care planning conference
- Facilitate the participation in the care planning process
- If inclusion is not practicable, documentation of the reasons, including the steps the facility took, must be included in the medical record

PI Care Plan Development

Care Plan Building Blocks

- MDS/CAAs
- Current diagnoses or medical conditions
- Physician Orders
- Departmental Assessments
- Resident and/or representative preferences
- Discharge Plan

Care Plan Process

Comprehensive Assessment

Investigation/identification of risks/related conditions

- Visual head-to-toe front to back skin assessment
  - Identify pre-existing signs that tissue damage has already occurred
  - Dark skinned residents- changes in sensation, skin temp or firmness
- Extrinsic and intrinsic risks, skin condition, causal factors
- Factors that have an impact on development, treatment, and/or healing
- Input from resident/representative

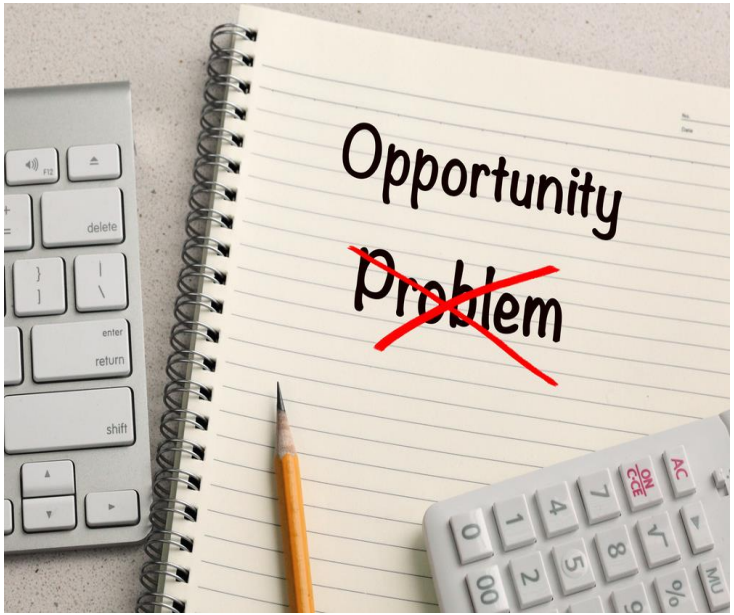
Identify Risks/Opportunities

- Medical Conditions

- MDS/CAA

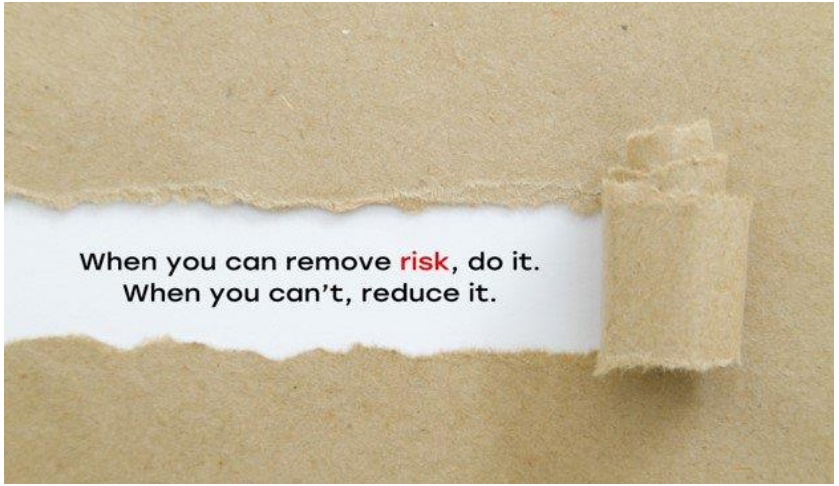
Section B	Section J
Section C	Section K
Section D	Section M
Section G	Section N
Section H	Section O
Section I	Section P

- Risk Assessments



Risk Factors

- Not all are modifiable
  - Permanent lack of sensation to an area
- Some take time to correct
  - Malnutrition
  - Uncontrolled blood sugars



Intrinsic Risk Factors

- Skin
- Age
- Moisture
- Weight
- Mobility
- Nutrition & Hydration
- Comorbidity
- Sensory Perception

Extrinsic Risk Factors

- Pressure
- Friction and Shear
- Skin Microclimate

Medications

- Antipsychotics
- Antianxiety agents
- Antidepressants
- Hypnotics
- Steroids
- Opioids

Diagnosis and Conditions

- Delirium
- Comatose
- Cancer
- Peripheral Vascular Disease
- Diabetes
- Alzheimer's Disease
- Cerebrovascular Accident
- Other Dementia
- Hemiplegia/hemiparesis
- Paraplegia
- Multiple Sclerosis
- Depression
- Edema
- Severe pulmonary disease
- Sepsis
- Terminal Illness

Diagnosis and Conditions

- Chronic or end-stage renal or heart disease
- Pain
- Dehydration
- Shortness of breath
- Recent weight loss
- Recent weight gain
- Malnutrition
- Decreased sensory perception
- Recent decline in ADLs

Treatments and Other Factors

- Newly admitted or readmitted
- History of healed PU/PI
- Chemotherapy
- Radiation Therapy
- Ventilator or respirator
- Renal dialysis
- Functional limitation in ROM
- Head of bed elevated most or all of the time
- Physical restraints
- Devices that can cause pressure

Input from Resident/Representative

- History of PU/PI
- Treatments that worked or didn't
- Reasons for refusal of care and/or treatments
- Alternatives to care and/or treatments refused
- Concerns
- Preferences
- Suggestions

Risk/Opportunity Definition

The Four Rs

- **Reason**
- **Risk Factors**
- **Related Condition**
- **Resident Preference/Decision**

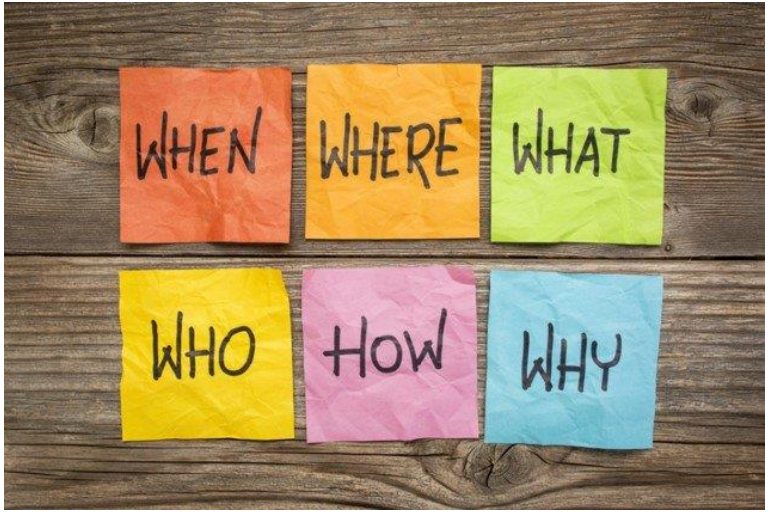
★ Should be supported by assessment and CAA documentation

Risk/Opportunity Statement

- Identified based on comprehensive assessment
- Supported by MDS/CAA documentation
- Risk Assessments
- Specific to the resident

Cause and Effect Analysis

- Identify causes of and factors contributing to the individual's current dysfunctions, disabilities, impairments, and risks
- Identify pertinent evaluations and diagnostic tests
- Identify how existing symptoms, signs, diagnoses, test results, dysfunctions, impairments, disabilities, and other findings relate to one another
- Identify how addressing those causes is likely to affect consequences



Setting Goals

- Use SMART framework
- Address what you hope to accomplish
    - Improvement
    - Prevention
    - Maintenance
    - Palliative
- Realistic for both resident and IDT
- Reflect resident's goals

Interventions

- What the team will do in response to the 4 R's
- Relate to the problem based upon investigation
- Enable the resident to meet his/her goals
- Able to be validated

Statement 4 R's

- Reason
- Risk
- Related Condition
- Resident Preference/Decision

Goals

- Expected Outcome(s) that are specific to the resident, includes resident/representative input & time frame

Interventions

- What staff will do in response to the 4 R's
- Resident & representative preference

Make sure all are "linked"

Prevention and Treatment Strategies

- Scheduled skin/wound inspection
- Redistribute pressure
- Minimize exposure to moisture and keep skin clean
- Provide appropriate, pressure-redistributing, support surfaces
- Provide non-irritating surfaces
- Maintain or improve nutrition and hydration status
- Pain
- Prevent infection
- Dressings and Treatments

Care Plan Monitoring

Monitoring of Progress

Review

- After MDS completed
- When resident's preferences or goals change
- When resident's condition changes
- When a risk becomes a reality
- When a resident/representative decline services or treatments

Modify

- To address response to new condition or treatment
- Decide if the IDT is going to:
  - Continue Plan
  - Modify Plan
  - Eliminate Plan
- Identify care or service being declined and IDT efforts to educate and provide alternatives

Care plan not effective?

Investigate recurrent conditions

- New risk factors/resident has changed
- Original assessment not comprehensive
- Goal and/or intervention was not appropriate to the risk
- Interventions were not consistently implemented

Are staff following the care plan?

It's more than having it on the care plan and paper documentation.

Observe and interview staff/residents to determine that:

- Care planned interventions are implemented
- Wound care performed per orders
- Resident repositioned timely and in correct position
- Pressure relief devices in place and working correctly
- Pain is addressed
- Nutritional interventions are implemented

Care Plan Success

Use the care plan daily

- To assist the team in knowing the care they are to provide
- To understand why the care or approach/intervention is important to the resident
- To validate that care is being provided per plan

Bring or access care plan to all meetings where care is being discussed.

Update/revise while at the meeting and according to meeting discussion.

Case Study

Ms. S was admitted with a Stage 1 PI in the coccyx area. The resident's care plan identified the use of a pressure-relieving device while up in the chair and repositioning every 30 minutes. As well as ongoing skin assessments twice a week by nursing. The area healed within 5 days. On day 8 she came down with a summer cold and she spent more time in the bed for three days which resulted in the development of another Stage 1 PI in the coccyx area. Upon observation/interview all previous care planned interventions remained in place.

Last Session Date and Topic

- **Session 7 (August 31):** Ongoing Practices and Monitoring: Best Practices from High Performing Nursing Homes

FOR MORE INFORMATION

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