Quality Measure Tip Sheet

Changes in Skin Integrity Post-Acute Care: Pressure Injury

The Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury measure reports the percentage of Medicare Part A skilled nursing facility (SNF) stays with Stage 2-4 pressure ulcers, or unstageable pressure ulcers due to slough/eschar, non-removable dressing/device or deep tissue injury, that are new or worsened since admission. The measure is calculated by reviewing a resident's minimum data set (MDS) pressure ulcer discharge assessment data for reports of Stage 2-4 pressure ulcers, or unstageable pressure ulcers due to slough/eschar, non-removable dressing/device, or deep tissue injury, or qualifying pressure injuries that were not present or were at a lesser stage at the time of admission.

NOTE: If a resident has multiple Medicare Part A SNF stays during the targeted 12 months, all stays are included in this measure.

Measure Exclusions

- Data on new or worsened Stage 2, 3, 4 and unstageable pressure ulcers, including deep tissue injuries, are missing [-] at discharge
  - M0300B through M0300G are dashed [-]
- The resident died during the SNF stay (i.e., Type 2 SNF Stays)
  - Type 2 SNF Stays are SNF stays with a PPS 5-Day Assessment (A0310B = [01]) and a matched Death in Facility Tracking Record (A0310F = [12])

Covariates

- Functional Mobility Admission Performance
- GG0170C1 Mobility; Lying to Sitting on Side of Bed= [01, 02, 07, 09, 10, 88] ([01] = Dependent, [02] =Substantial/maximal assistance, [07] = Resident refused, [09] = Not applicable, [10] = Not attempted due to environmental limitations, [88] = Not attempted due to medical condition or safety concerns)
- Bowel Continence
  - H0400 Bowel Continence= [1, 2, 3] ([1] = Occasionally incontinent, [2] = Frequently incontinent, [3] = Always incontinent)
- Peripheral Vascular Disease/Peripheral Arterial Disease or Diabetes Mellitus
  - Active I0900 Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD) in the last 7 days
  - Active I2900 Diabetes Mellitus in the last 7 days

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Covariates, continued

- Low Body Mass Index, based on K0200A Height and K0200B Weight
  - BMI ≥ [12.0] AND ≤ [19.0]

Ask These Questions

MDS

- Were MDS sections GG, H, I, and M coded per Resident Assessment Instrument (RAI) requirements?
- Do MDS staff know how to resolve inconsistencies in wound documentation?

Pre-Admission

- Do staff identify the status of the resident's skin and risk for skin breakdown?
- Do you have a process to review all current treatments the resident is receiving to identify possible skin integrity issues not known by the transferring organization?
- Is there a process to determine needs if the resident has skin integrity issues or pressure injuries (PIs) prior to the resident's admission?
- Do staff obtain from the resident or family a history of skin breakdown or PIs, preventative and treatment interventions used in the past, and their results?
- Is there a process to obtain the proper treatment supplies and equipment prior to the resident's admission?

Admission

- Are visual head-to-toe, front-to-back skin inspections performed upon admission?
- Was a comprehensive skin risk assessment completed upon admission?
- Was an individualized skin integrity care plan based on the resident's skin and risk assessments developed within 48 hours of admission?
- Are skin integrity interventions communicated to all frontline staff?
- Are skin integrity risks and the care plan reviewed with the resident and/or family so they know what to expect and can help monitor consistent implementation of the plan of care?

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Ask These Questions, continued

Staff

- Has at least one staff member been trained to become wound care certified?
- Have all staff been educated on prevention of skin breakdown and PIs?
- Have all nurses been educated on:
  - PI skin risk assessment?
  - Assessment, staging and documentation of PIs?
  - Treatment modalities for PIs?
- Are staff trained to monitor equipment used to reduce or relieve pressure (e.g., powered support surfaces are properly inflated, proper heel lifts are in place and wheelchair cushion or devices are positioned correctly)?

Prevention

- Do nursing or bathing assistants perform daily skin inspections?
- Do nurses perform weekly skin inspections?
- Are weekly wound rounds conducted and include nurse managers, the director of nursing, staff development and other leaders as appropriate?
- Are skin assessments completed weekly for the first four weeks after admission, then at least monthly and with a change in the resident's condition?
- Are risk assessment results, skin checks and interventions communicated to nursing, nursing assistants, IDT members, residents and families?

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