Effectively Using QAPI Process to Implement a Wound Program

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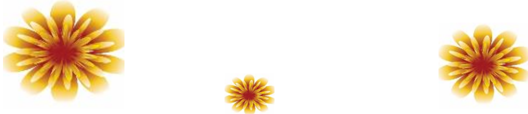

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Regulatory: F686

- **Based on the comprehensive assessment of a resident, the facility must ensure that --**
  - 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
  - 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.

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Regulatory and Litigation

The care setting must PROVE that the wound was …

Unavoidable

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Avoidable/Unavoidable F686

- **Unavoidable**
  - **Means that the 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 the resident needs, goals and professional standards of practice;
    - Monitored and evaluated the impact of the interventions; and
    - Revised the approaches as appropriate
  - **NOT AS SIMPLE AS HAVING THE PHYSICIAN WRITE IT WAS UNAVOIDABLE!!**

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Governance & Leadership

- Administrator, DON and Management must fully support the program and be actively involved

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Reducing Risk

- **Use meaningful data**
- **MDS Accuracy**
- **In-house v. Admitted**
- **In-House**
  - Facility location
  - Location on the body
- **Admitted**
  - Current interventions v risk
  - Location in the facility
  - Location on the body

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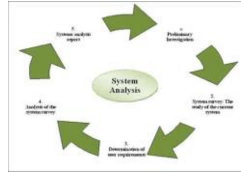
Reducing Risk

- **Break your Skin Integrity Systems Down:**
  - Wound Care Team and Effective Meetings
  - Communication Systems
  - Sufficient Resources
  - Pre-Admission Process
  - Admission Process
  - Prevention Program
  - Treatment Program
  - Monitoring Programs
  - Education



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Reducing Risk

Skin Integrity Team

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Reducing Risk

- **Wound Care Nurse**
  - Utilized when a wound happens
  - Typically, is responsible for the weekly documentation of a wound
  - Ensures appropriate treatment strategies

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Reducing Risk

- **Wound Care Nurse Role**
  - Consider more then one
  - Use terms such as
    - Wound Care Coordinator
    - Wound Care Resource Nurse

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Reducing Risk

Oversight of the program

- Prevention
- Education
- F686 Compliance
- Risk Mitigation
- MDS Accuracy
- Monitoring

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Reducing Risk

- **Investment in Knowledge**
  - Consider WOCN (www.wocn.org) or WCC (www.wcei.net) certification
    - Prevention
    - Etiology of wounds
    - Assessment & Documentation
    - Treatment modalities
  - National Pressure Injury Advisor Panel Guidelines (www.npiap.org)
  - F686 Training
  - MDS Section M Training
  - Corporate/Facility Policy & Procedures

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Reducing Risk

- **Wound Care Expertise takes education AND experience**
- **No one wound nurse can manage a prevention and treatment program alone**

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Reducing Risk

- **Development of a Skin Care Team**
  - Key Nursing Assistants from ALL shifts
  - Key Floor Nurses from ALL shifts
  - Nurse Managers
  - Therapy
  - Restorative Nursing
  - Dietary
  - Physician/NP/Medical Director
  - Housekeeping/Maintenance
  - MDS Coordinator

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Reducing Risk

- **Skin Team Meetings**
  - Develop a **SET** schedule for the Skin Care Team meetings – Management MUST support
    - Initially may need to be weekly to bi-weekly
    - Monthly

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Reducing Risk

- **Skin Team Meeting Agenda**
  - Review current residents with wounds plan of care and nursing assistant assignment sheets
    - Progress
    - Topical Treatment
    - Support surfaces/equipment
    - Heel lift
    - Turning Schedule
    - Incontinence management
    - Nutritional Support
    - Therapy & Restorative Involvement
    - Compliance/Barriers to plan of care

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Reducing Risk

- **Skin Team Meeting Agenda**
  - **Proactive Preventative Approach - Review Residents who are due for a quarterly review**
    - Review most recent risk assessment
    - Plan of care
    - Nursing assistant assignment sheets
  - Review Treatment Administration
  - Ask overall if any resident is having:
    - Decrease/change in mobility
    - Change in appetite, eating habits or weight loss
    - Change in continence
    - Change in cognition
    - Overall changes/decline

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Reducing Risk

- **Skin Team Meeting Agenda**
  - **Review Supplies/Equipment Effectiveness**
    - Support Surfaces (bed & wheelchair)
    - Heel lift devices
    - Positioning devices
    - Incontinent products
    - Supplements
    - Topical dressings, etc.

Reducing Risk

Communication Systems

Reducing Risk

- **Communication Systems**
  - On-going communication and involvement with the direct caregivers (plan of care, interventions, etc.)?
  - How do the caregivers communicate skin concerns (verbally or written)?

Reducing Risk

- **Communication Systems**
  - Between shifts and between caregivers (last time turned & toileted at a minimum)?
  - Between Units?
  - Between health care settings?

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Reducing Risk

- **Communication Systems**
  - **Physician/PA/NP & Family**
    - Upon Discovery of a wound
    - No Progress in 2 weeks
    - Decline
    - Healed

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Reducing Risk

Pre-Admission Process

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Reducing Risk

- **Whom in the facility does the pre-admission screening?**
  - Social Services
  - Admissions
  - Nursing

- **Where do your admissions come from?**
- **Have you had any surprises and if yes, from where?**
  - Didn't know they had a wound
  - The wound is at a deeper stage then expected
  - Unaware of treatment/equipment needed until arrival

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Reducing Risk

- **Does the Pre-Admission Intake Ask/Address:**
  - Do they currently have any skin breakdown?
    - Even if the answer is no proceed to the following questions
  - Are they currently receiving any skin care treatments?
  - What kind of support surface are they on?
  - Do they have a wheelchair cushion?

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Reducing Risk

- **Does the Transfer Form Communicate:**
  - Complete assessment of current skin concerns
  - Current topical treatment and order
  - The type of mattress they were on and ordered
  - Type of wheelchair cushion they were on and ordered
  - Type of turning program/devices utilized and ordered
  - Incontinence/catheter and management
  - Dietary supplementation
  - Any follow up visits with wound care clinicians

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Reducing Risk

Admission Process

Reducing Risk

- **Developing a task force to evaluate the Admission Process:**
  - Assess when and where your admissions are happening
  - Who is doing the admission assessments – This will be the team members

Reducing Risk

- **All care settings admission process (within the first 24 hours) should include:**
  - A head to toe skin inspection by the **licensed** staff (ideal within 8 hours)
  - A risk assessment for the potential for skin breakdown
  - Development of the baseline plan of care
  - Communication to the caregivers

Reducing Risk

- **At a MINIMUM Baseline Care Plan within 48 Hours to Include:**
  - Support surfaces
    - Bed
    - Wheelchair cushion (may need temporary admission one until therapy eval)
  - Turning & repositioning schedules & devices
  - Incontinence care & keeping skin clean and dry
  - Heels elevated off bed
  - Dietary, therapy, restorative nursing referrals as appropriate
  - Monitor the skin daily with cares by caregivers
  - Head to toe weekly skin checks by the license staff
  - Skin risk assessment per policy
  - If there is a wound:
    - Topical Tx as ordered
    - Weekly comprehensive wound assessments by license nurse
    - Monitor wound for signs/symptoms of infection
    - Notify Physician and family of decline or concerns

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Prevention Program

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Reducing Risk

What is your *__on-going__* prevention program?

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Reducing Risk

- **Prevention Team PIP Team Members:**
  - May want to utilize the Skin Integrity team plus:
    - Who does the licensed weekly skin checks?
    - Who does the on-going risk assessments?
    - Who updates the plan of care?
    - Who updates the nursing assistant assignment sheets?

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Reducing Risk

- **Does your current prevention program include:**
  - **On-going skin inspections**?
    - **Long Term Care:**
      - Daily with cares by the caregivers
      - Weekly by licensed staff
      - Upon a planned discharge

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Reducing Risk

- **Does your current prevention program include:**
  - **On-going** Risk Assessments per care setting guidelines?
    - Does it utilize a validated tool (i.e. Braden scale, Norton)
    - Is it comprehensive, picking up risk factors the validated tool doesn't pick up?

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Reducing Risk

- **A COMPREHENSIVE RISK assessment In Long Term Care should be completed:**

- Upon admission
- Weekly for the first four weeks after admission*
- Monthly
- With a change of condition
  - Pressure injury/skin breakdown
  - Mobility,
  - Continence status,
  - Appetite/weight loss,
  - Cognition
  - Acute illness, etc.)

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Reducing Risk

- **Ensure Complete Plan of Care based from Risk Assessment**
  - Ensure the Braden/Norton assessment is broken down into its subsets
  - Ensure it is comprehensive
  - Ensure ALL risk factors identified are brought forward to the plan of care
  - Ensure correlating interventions to risk factors to modify, stabilize or eliminate risk factors identified
  - Update Nursing assistant assignment sheets once care plan complete

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Reducing Risk

- **Preventative interventions based on the risk assessment should address at a minimum:**
  - Turning and repositioning
  - Bed surface
  - Wheelchair surface
  - Heel lift
  - Incontinence care
  - Nutritional needs
  - Mobility

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Reducing Risk

- **Ensure Complete Plan of Care based from Risk Assessment**
  - Have a “cheat sheet” for interventions and supplies that correlated with identified risk factors for care planning

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Reducing Risk

- **Does your current prevention program include:**
  - **Who Updates the Plan of Care?**
    - Do all caregivers give input
    - Do all nurses give input
    - Is it interdisciplinary
    - Input from the resident and family

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Reducing Risk

Wellness Rounds:

- **Every 2 hours**
  - **Offer toileting/incontinence care**
  - **Offer fluids/snack**
  - **Ensure proper support surface/function**
  - **Turn/reposition or off loading**
  - **Heels off surface**
  - **Call light in place**
  - **Bed at appropriate height**
  - **Belongings in reach**
  - **Clear pathway**

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Reducing Risk

Treatment Program

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Reducing Risk

- **Treatment Team PIP Team Members:**
  - May want to utilize the Skin Integrity team plus:
    - Nurses who do the day-to-day treatment

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Reducing Risk

- **Checklist for When a Wound is Found:**
  - Notification of the Physician and family/designee of the development of a wound, regardless of stage
  - Notify Dietary
  - Notify Therapy as appropriate
  - Start weekly documentation form for the wound(s)
  - New risk assessment
  - Re-evaluate Interventions based on risk assessment and condition of the wound
  - Up-date the care plan
  - Up-date the nursing assistants assignment sheets

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Reducing Risk

- **Weekly Wound Rounds**
  - Involvement of:
    - Minimum of:
      - Nurse Manager
      - Floor Nurse
      - Nursing Assistant
    - If possible, the wound team members
      - Therapy
      - Dietary
      - Physicians/NP

GREAT TIME FOR BED SIDE EDUCATION

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Reducing Risk

Risk/Benefit Discussion

- Discuss resident's condition
- Treatment options
- Expected outcomes
- Consequences of refusing treatment (pressure injury development, sepsis and even death)
- Offer relevant alternatives

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Reducing Risk

- **Risk/Benefit Conversation**
  - Document the date of discussion in care plan and put resident's request in care plan
  - Review quarterly, with re-admission and with change of condition

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Reducing Risk

Monitoring Programs

Reducing Risk

- All staff should be involved
- Continuous

Reducing Risk

- **Wound Nurse to Monitor on a Monthly Basis:**
  - Treatment Administration Record
  - Weekly head to toe skin checks
  - Supplies
  - Dressing Change technique
- **Have floor nurses involved with monitoring turning, toileting, and utilization of equipment daily**

Reducing Risk

- **Charts of high risk, new admissions & wound care residents**
  - Risk Assessment current
  - Monitoring that the plan of care reflects interventions being implemented and addresses identified risk factors
  - Do the physician orders, caregiver assignment sheets and MDS coding match the care plan?

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Reducing Risk

- Monitor turning and repositioning
- Monitor toileting schedules
- Visualization and confirmation that equipment is in place and functioning properly

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Reducing Risk

- **Monitor the Primary Physician/PA/NP Documentation & Outside Consultation:**
  - Diagnosis
  - Progress notes
  - Orders

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Reducing Risk

- Daily rounds by Administrator, DON and Managers
- Walking rounds for each shift

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Reducing Risk

Education

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Reducing Risk

- **Do education on orientation and yearly**
- **Recommend doing educational programs in this order**
  - Prevention – ALL staff
  - All Licensed Nurses:
    - Risk Assessment & Care Plan Development
    - Pressure Injury Assessment and Documentation
    - Pressure Injury Topical Treatment Modalities
    - Assessment & Treatment Lower Extremity Ulcers (arterial, venous, neuropathic/diabetic)
- **Do competency testing up after educational programs**

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Reducing Risk

Sufficient Resources

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Reducing Risk

- **Involve the staff the utilize the supplies and equipment**
  - Floor nurses who are doing dressing changes
  - Nursing Assistants
  - Housekeeping
  - Maintenance
  - Therapy

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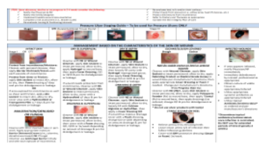
Reducing Risk

Sufficient Resources

- Make a streamlined topical management guideline with limited products in each major category:
  - Guideline should guide the nurse by characteristics of the wound (i.e., superficial dry wound)
  - Recommend product category for ordering (i.e., adhesive foam verses Allevyn)



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Reducing Risk

Sufficient Resources

- **Topical Supplies**
  - Access to NPWT (Negative Pressure Wound Therapy)

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Reducing Risk

Sufficient Resources

- Pressure redistribution bed surfaces
  - Preventative Mattresses
  - Advanced Therapy (i.e., low-air-loss, alternating air, etc.)
- Wheelchair cushions
- Heel Lift

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Sufficient Resources

- Access to:
  - Podiatrists
  - Wound Clinics/Physicians
  - Certified Wound Care Nurses
  - Vascular Surgeons/Physicians

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Reducing Risk

Remember the most expensive product is the one that doesn't work!!!!

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Resources

- www.wocn.org (Wound, Ostomy & Continence Nurse Society)
  - Provide Certification for 4 yr RNs
  - Available Guidelines:
    - Prevention and Management of Pressure Ulcers
    - Management of Wounds in Patients with Lower-Extremity Arterial Disease
    - Management of Wounds in Patients with Lower-Extremity Neuropathic Disease
    - Management of Wounds in Patients with Lower-Extremity Venous Disease

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Resources

- www.wcei.net (Certifies LPN, 2-4 year RN, Therapists, etc in wound management)
- www.npiap.org (National Pressure Injury Advisory Panel)
- www.woundsource.com Great source to find wound care products and companies/vendors

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Thanks for your participation!!!

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