

Stage 2 Critical Elements for Pressure Ulcers

Facility Name: _____ Facility ID: _____ Date: _____
Surveyor Name: _____
Resident Name: _____ Resident ID: _____
Initial Admission Date: _____ Interviewable: Yes No Resident Room: _____
Care Area(s): _____

Use

Use this protocol for a sampled resident having, or at risk of developing, a pressure ulcer.

NOTE: If the ulcer is not pressure related, do not continue with this protocol unless the resident remains at risk for pressure ulcers. Use the General CE Pathway for non-pressure related wounds.

Procedure

- Briefly review the assessment, care plan, and orders to identify facility interventions and to guide observations to be made.
- Observe whether staff consistently implement the care plan over time and across various shifts.
- During observations of the interventions, note and/or follow up on deviations from the care plan or from current standards of practice, as well as potential negative outcomes.
- Corroborate observations by interview and record review.

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Observations	
Skin Condition	
<p><input type="checkbox"/> Observe skin condition to note erythema or color changes on areas such as the sacrum, buttocks, trochanters, posterior thigh, popliteal area, or heels when moved off an area:</p> <ul style="list-style-type: none">▪ If erythema or color change are noted, return approximately ½–¾ hours later to determine whether the changes persist. If the changes persist and exhibit tenderness, hardness, or alteration in temperature from surrounding skin, ask staff how they determine repositioning schedules and how they evaluate and address a potential Stage I pressure ulcer; and▪ Previously unidentified open areas. <p><input type="checkbox"/> Observe delivery of care to determine, for example, whether:</p> <ul style="list-style-type: none">▪ Positioning avoids pressure on an existing pressure ulcer(s);▪ Measures are taken to prevent or reduce the potential for shearing or friction during transfers, elevation, and repositioning;▪ Pressure redistributing devices for the bed and/or chair, such as gel-type surfaces or overlays are in place, working, and used according to the manufacturer's recommendations; and▪ Repositioning/weight shifts occur at consistent and frequent intervals, according to the resident's condition and assessed need based on tolerance of the tissue load (pressure).	<p>Notes:</p>

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Observations	
Existing Ulcer/Wound Care:	
<p>NOTE: If unable to observe the dressing change due to the dressing protocol, observe the area surrounding the ulcer(s). For ulcers with dressings that are not scheduled to be changed, the surveyor may request that the dressing be removed to observe the wound and surrounding area if other information suggests a possible treatment or assessment problem.</p> <p><input type="checkbox"/> If a treatment or dressing change is scheduled during the survey, observe the wound care to determine:</p> <ul style="list-style-type: none">▪ Characteristics of the wound and surrounding tissues, such as presence of granulation tissue, the stage, presence of exudates, necrotic tissue such as eschar or slough, or evidence of erythema or swelling around the wound;▪ The form or type of treatment (such as cleanse, irrigation, packing), dressing, and debridement, if used;▪ Whether treatment and infection control practices reflect current standards of practice; and▪ Based on location, steps taken to cleanse and protect the wound from likely contamination by urine or fecal incontinence. <p><input type="checkbox"/> In addition, use these observations to identify whether the record reflects the current status of the ulcer.</p> <p><input type="checkbox"/> If the resident expresses (or appears to be in) pain related to the ulcer or treatment, determine whether the facility:</p> <ul style="list-style-type: none">▪ Assessed for pain related to the ulcer, addressed and monitored interventions for effectiveness; and/or▪ Assessed and took preemptive measures for pain related to dressing changes or other treatments, such as debridement/irrigations, and monitored for effectiveness.	<p>Notes:</p>

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Resident/Representative Interview

Interview the resident, family, or responsible party to the degree possible to identify whether :

- The resident/representative was involved in the development of the care plan, approaches and goals, and if interventions reflect choices and preferences;
- The care plan approaches, such as pressure redistribution devices or equipment, turning/repositioning, or weight shifting, are being provided;
- The resident is experiencing discomfort/pain in relation to the pressure ulcer or treatment, if any and how it is managed;
- Interventions were refused; and if so, counseling on alternatives, consequences, and/or other alternative approaches were offered; and
- For the resident who has or has had a pressure ulcer, whether acute illness, weight loss, or other condition changes occurred prior to developing the ulcer.

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Staff Interview

Nursing Assistant

Specific to the presence of a pressure ulcer, or the risk of developing a pressure ulcer, or if a new pressure ulcer has developed, or if staff are not following the care plan interventions, interview nursing assistants on various shifts to determine:

- Whether they know and understand the interventions specific to this resident, such as repositioning and other interventions for skin care;
- What, when, and to whom to report changes in skin conditions, such as:
 - Changes in color of skin;
 - Temperature of skin;
 - Odor;
 - Wound drainage;
 - Complaints of pain or burning at a site where there has been pressure;
 - Presence of the potential development of a new ulcer;
 - A dressing that is soiled or not intact; and
 - Changes in vital signs that might indicate the presence of infection.

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Assessment	
<p><input type="checkbox"/> Determine whether the facility identified, on admission, the presence of a pressure ulcer or the presence of possible deep tissue injury, or skin areas at risk for breakdown.</p> <p><input type="checkbox"/> For a resident who was admitted with an ulcer, or who developed one within 1–2 days, review the admission documentation regarding:</p> <ul style="list-style-type: none">▪ The wound site and characteristics at the time of admission;▪ The possibility of underlying tissue damage because of immobility or illness prior to admission;▪ Skin condition on, or within a day of, admission;▪ History of impaired nutrition; and▪ History of previous pressure ulcers. <p><input type="checkbox"/> Review the RAI and other documents regarding the assessment of the resident’s overall condition and risk factors, including the presence of a pressure ulcer(s) in order to determine whether the facility identified and evaluated the factors placing the resident at risk, such as:</p> <ul style="list-style-type: none">▪ Increased/decreased mobility and decreased functional ability;▪ Cognitive impairment;▪ Under-nutrition, malnutrition (such as significant weight loss in a resident who also has mobility/positioning concerns);▪ The use of medications such as steroids, which may affect wound healing;▪ Any decline in clinical status or co-morbid diagnoses affecting mobility/positioning or ability of the skin to endure the effects of pressure;▪ A healed ulcer; and▪ Exposure of the skin to urinary and fecal incontinence.	<p>Notes:</p>

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Assessment

- For a resident who subsequently developed or has an existing pressure ulcer, review documentation regarding the wound site, characteristics, progress, and complications such as:
- Reassessment if there were no signs of progression towards healing within two to four weeks;
 - Information about ulcer status, such as location, stage, size, sinus tracts, undermining, tunneling, exudates, necrotic tissue, and presence or absence of granulation tissue, and the presence of possible complications, such as signs of increasing area of ulceration or soft tissue infection.

NOTE: In considering the appropriateness of a facility's response to the presence, progression, or deterioration of a pressure ulcer, take into account the resident's condition, complications, time needed to determine the effectiveness of a treatment, and the facility's efforts, where possible, to remove, modify, or stabilize the risk factors and underlying causal factors.

- Determine whether there was a "significant change" in the resident's condition and whether the facility conducted a significant change comprehensive assessment within 14 days. A "significant change" is a decline or improvement in a resident's status that:
1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not "self-limiting;"
 2. Impacts more than one area of the resident's health status; and
 3. Requires interdisciplinary review and/or revision of the care plan.

If there was a "significant change" in the resident's condition and the facility did not conduct a significant change comprehensive assessment within 14 days, initiate **F274, Resident Assessment When Required**. If a comprehensive assessment was not conducted, also cite F272.

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Assessment

1. If the condition or risks were present at the time of the required assessment, did the facility comprehensively assess to determine:

- a) the risks and/or determine underlying causes (to the extent possible) of the resident's development of a pressure ulcer,
- b) presence and stage of an existing ulcer,
- c) current treatments,
- d) presence of infection, and
- e) impact upon the resident's function, mood, and cognition?

Yes No F272

NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS

NOTE: Although Federal requirements dictate the completion of RAI assessments according to certain time frames, standards of good clinical practice dictate that the assessment process is more fluid and should be ongoing.

The comprehensive assessment is not required to be completed until 14 days after admission. For newly admitted residents, before the 14-day assessment is complete, the lack of sufficient assessment and care planning to meet the resident's needs should be addressed under F281, Professional Standards of Quality.

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Care Planning

If the comprehensive assessment was not completed (CE#1 = No), mark CE#2 "NA, the comprehensive assessment was not completed".

- Determine whether the facility developed a care plan that was based on the assessment and was consistent with the resident's specific conditions, risks, needs, behaviors, preferences, and current standards of practice.
- For the resident at risk for developing, or who has, a pressure ulcer, determine whether the facility developed an individualized care plan that included specific interventions/services to prevent the development of pressure ulcers and/or to treat existing pressure ulcers and potential associated complications, and included measurable objectives and time tables. Determine whether the plan addresses, as appropriate:
 - Pressure redistribution/relief based upon identified resident needs (e.g., repositioning, heel protection, use of a wheelchair/reclining chair and bed/mattress pressure redistribution surfaces);
 - Prevention of shearing and friction;
 - Periodic inspection of the skin (paying attention to bony prominences), by whom, and how often;
 - Comorbid conditions that may affect risk for, and healing of, pressure ulcers and efforts to stabilize the conditions, to the extent possible, (e.g., control of blood sugars, adequate food and fluid intake);
 - Daily evaluation of the status of the dressing and the surrounding skin;
 - Pressure ulcer care and treatment (such as type of dressing, frequency of dressing change, wound cleansing and debridement, and managing infection);
 - Approaches to manage and monitor pain, if present, including preemptive measures, if pain is present during dressing changes

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Care Planning

and treatments; and

- Resident choices and preferences including alternative efforts, if the resident refuses or resists staff interventions to reduce risk or treat existing pressure ulcers.

NOTE: A specific care plan intervention for risk of pressure ulcers is not needed if other components of the care plan address related risks adequately. For example, the risk of skin breakdown posed by fecal/urinary incontinence might be addressed in that part of the care plan that deals with incontinence management.

- If the care plan refers to a specific facility treatment protocol that contains details of the treatment regimen, the care plan should refer to that protocol and should clarify any deviations from or revisions to the protocol for this resident. The treatment protocol must be available to the caregivers and staff should be familiar with the protocol requirements. If care plan interventions that address aspects of care to meet the resident's needs related to pressure ulcers are integrated within the overall care plan, the interventions do not need to be repeated.

1. Did the facility develop a plan of care with interventions and measurable goals, in accordance with the assessment, resident's wishes, and current standards of practice, to prevent the development of a pressure ulcer, or if present, for the care and treatment of the pressure ulcer and/or infection of the ulcer?

Yes No F279

NA, the comprehensive assessment was not completed

The comprehensive care plan does not need to be completed until 7 days after the comprehensive assessment (the assessment completed with the RAPS). Lack of sufficient care planning to meet the needs of a newly admitted resident should be addressed under F281, Professional Standards of Quality.

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Care Plan Implementation by Qualified Persons	
<p>Observe care and interview staff over several shifts and determine whether:</p> <p><input type="checkbox"/> Care is being provided by qualified staff, and/or</p> <p><input type="checkbox"/> The care plan is adequately and/or correctly implemented.</p> <p>2. Did the facility provide or arrange services to be provided by qualified persons in accordance with the resident's written plan of care?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No F282</p> <p><input type="checkbox"/> NA, no provision in the written plan of care for the concern being evaluated</p> <p><i>NOTE: If there is a failure to provide necessary care and services, the related care issue should also be cited when there is actual or potential outcome.</i></p>	<p>Notes:</p>

Stage 2 Critical Elements for Pressure Ulcers

Care Plan Revision

If the comprehensive assessment was not completed (CE#1 = No), OR, if the care plan was not developed (CE#2 = No), mark CE#4 "NA, the comprehensive assessment was not completed OR the care plan was not developed".

- Determine whether the staff have monitored the resident's condition and response to interventions and evaluated and revised the care plan with input from the resident or representative, to the extent possible.
- Review the record and interview the staff for information or evidence that:
 - Continuing the current approaches meets the resident's needs, if the resident has experienced recurrent pressure ulcers or lack of progression toward healing and staff did not revise the care plan; and
 - The care plan was revised to modify the prevention strategies and address the presence and treatment of a newly developed pressure ulcer for the resident who acquired a new ulcer.
- If during the investigation, the resident and/or his/her representative report not having an opportunity for input in the development and revision of the plan of care, interview staff to determine how they solicit and obtain input from the resident or representative during the development and revision of the plan of care.

3. Did the facility reassess the effectiveness of the interventions and review and revise the plan of care (with input from the resident or representative, to the extent possible), if necessary, to meet the needs of the resident? Yes No **F280**

NA, the comprehensive assessment was not completed OR the care plan was not developed

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INTERVIEWS TO CONDUCT ONLY IF PROBLEMS HAVE BEEN IDENTIFIED

Staff Interview:

<p>Interview the charge nurse or treatment nurse to determine:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Knowledge of prevention and treatment including facility-specific guidelines/protocols and specific interventions for the resident; <input type="checkbox"/> Who monitors for the implementation of the care plan, changes in the skin, development of a pressure ulcer, and the frequency of the review and evaluation of the ulcer. 	<p>Notes:</p>
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Interviews with Health Care Practitioners and Professionals

<p>If the interventions defined or care provided appear not to be consistent with recognized standards of practice, interview one or more health care practitioners and professionals as necessary (e.g., physician, charge nurse, director of nursing) who, by virtue of training and knowledge of the resident, should be able to provide information about the causes, treatment, and evaluation of the resident’s condition or problem. Depending on the issue, ask about:</p> <ul style="list-style-type: none"> <input type="checkbox"/> How chosen interventions were deemed appropriate; <input type="checkbox"/> Risks identified for which there were no interventions; <input type="checkbox"/> Changes in condition that may justify additional or different interventions; or <input type="checkbox"/> How staff validated the effectiveness of current interventions. <p>NOTE: If during the course of this review, the surveyor needs to contact the attending physician regarding questions related to the treatment regimen, it is recommended that the facility’s staff have the opportunity to provide the necessary information about the resident and the concerns to the physician for his/her review prior to responding to the surveyor’s inquiries. If the attending physician is unavailable, interview the medical director as appropriate.</p>	<p>Notes:</p>
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Stage 2 Critical Elements for Pressure Ulcers

Provision of Care and Services	
<p><input type="checkbox"/> For a resident who developed a pressure ulcer after admission, determine whether staff have:</p> <ul style="list-style-type: none">▪ Recognized and assessed factors placing the resident at risk for developing a pressure ulcer, including specific conditions, causes and/or problems, needs and behaviors;▪ Defined and implemented interventions for pressure ulcer prevention in accordance with resident needs, goals, and recognized standards of practice;▪ Monitored and evaluated the resident's response to preventive efforts; and▪ Revised the approaches as appropriate. <p><input type="checkbox"/> For a resident who was admitted with or developed a pressure ulcer, who has a pressure ulcer that is not healing, or who is at risk of developing subsequent pressure ulcers, determine whether staff have:</p> <ul style="list-style-type: none">▪ Recognized and assessed factors placing the resident at risk of developing a new pressure ulcer or experiencing non-healing or delayed healing of a current pressure ulcer, including specific conditions, causes and/or problems, needs, and behaviors;▪ Defined and implemented interventions for pressure ulcer prevention and treatment in accordance with resident needs, goals, and recognized standards of practice;▪ Addressed the potential for infection;▪ Monitored and evaluated the resident's response to preventive efforts and treatment interventions; and▪ Revised the approaches as appropriate.	<p>Notes:</p>

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Provision of Care and Services	
<p>4. Based on observation, interviews, and record review, did the facility provide care and services to prevent the development of an avoidable pressure ulcer and/or to promote the healing of a pressure ulcer and/or to prevent or treat an infection?</p> <p style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No F314</p>	
Concerns with Independent but Associated Structure, Process, and/or Outcome Requirements	
<p>During the investigation of care and services provided to prevent the development of pressure ulcers or to promote healing of existing pressure ulcers or to prevent and/or treat an infection associated with a pressure ulcer, the surveyor may have identified concerns with related structure, process, and/or outcome requirements, such as the examples listed below. If an additional concern has been identified, the surveyor should initiate the appropriate care area or F tag and investigate the identified concern. Do not cite any related or associated requirements before first conducting an investigation to determine compliance.</p> <p><input type="checkbox"/> Choices (the Right to Refuse Treatment) - If a resident has refused treatment or services, determine whether the facility has assessed the reason for this resident's refusal, clarified and educated the resident as to the consequences of refusal, offered alternative treatments, and continued to provide all other services.</p> <p><input type="checkbox"/> Notification of Change __ Determine whether staff:</p> <ul style="list-style-type: none"> ▪ Consulted with the physician regarding significant changes in the resident's condition, including the need to alter treatment significantly or failure of the treatment plan; and ▪ Notified the resident's representative (if possible) of significant changes in the resident's condition. <p><input type="checkbox"/> F271, Admission Orders __ Determine whether the facility received physician orders for provision of immediate care before conducting the comprehensive assessment and developing an</p>	<p>Notes:</p>

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Concerns with Independent but Associated Structure, Process, and/or Outcome Requirements

interdisciplinary care plan.

- F278, Accuracy of Assessments** — Determine whether staff that are qualified to assess relevant care areas and are knowledgeable about the resident’s status, needs, strengths, and areas of decline conducted an accurate assessment.
- F281, Professional Standards of Quality** — Determine whether the services provided or arranged by the facility met professional standards of quality. “Professional standards of quality” is defined as services that are provided according to accepted standards of clinical practice.
- F309, Quality of Care** — Determine whether staff have:
 - Recognized and assessed factors placing the resident at risk for specific conditions, causes and/or problems;
 - Defined and implemented interventions in accordance with resident needs, goals, and recognized standards of practice;
 - Monitored and evaluated the resident’s response to preventive efforts and treatment; and
 - Revised the approaches as appropriate.
 - Based on the assessment and care plan, if the resident has pain or the potential for pain associated with a pressure ulcer or treatment, determine whether staff identified and implemented appropriate measures for the management of pain, as indicated.
- Nutrition** — Determine whether staff have evaluated the resident’s nutrition status and provided sufficient nutrients, as appropriate, to meet the resident’s needs, including wound healing.
- Hydration** — Determine whether staff have evaluated the resident’s hydration status and provided sufficient fluids to meet the resident’s needs.

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Concerns with Independent but Associated Structure, Process, and/or Outcome Requirements

- Sufficient Nursing Staff** — Determine whether the facility had qualified nursing staff in sufficient numbers to assure the resident was provided necessary care and services 24 hours a day, based upon the comprehensive assessment and care plan, to prevent or treat pressure ulcers.
- F385, Physician Supervision** — Determine whether the physician has participated in the assessment and care planning, and monitored changes in resident's medical status, provided consultation or treatment when called by the facility relevant to preventing or healing a pressure ulcer, and responded to the notice of changes in condition (and as necessary, significantly alter treatment plan).
- Infection Control Program** — Determine whether the facility's infection control program identified, investigated, controlled, and prevented infections, such as infections related to the care and treatment of a resident with a pressure ulcer.
- Infection Control: Hand Washing** — Determine whether staff wash their hands during the provision of care and services for the resident with a pressure ulcer, including before and after wound care.
- F498, Proficiency of Nurse Aides** — Determine whether nurse aides demonstrate competency in the delivery of care and services related to skin care, proper turning and positioning in bed and chair, and recognizing abnormal changes in body functioning and reporting such changes to a supervisor.
- F501, Medical Director** — Determine whether the medical director:
 - Assisted the facility in the development and implementation of policies and procedures for pressure ulcer prevention, treatment and infections related to pressure ulcers, and that these are based on current standards of practice; and
 - Interacts with the physician supervising the care of the resident, if requested by the facility, to intervene on behalf of the resident with a pressure ulcer(s).

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Concerns with Independent but Associated Structure, Process, and/or Outcome Requirements

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| <p><input type="checkbox"/> F514, Clinical Records — Determine whether the clinical records:</p> <ul style="list-style-type: none">▪ Accurately and completely document the resident's status, the care and services provided (e.g., to prevent or treat a pressure ulcer or associated infection) in accordance with current professional standards and practices; and▪ Provide a basis for determining and managing the resident's progress including response to treatment, change in condition, and changes in treatment. | |
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