STATEWIDE DON/NURSING MEETING
SEPTEMBER 22, 2020

DEBBIE POOL, BSN, RN, ICP, LNHA, CLINICAL EDUCATOR
MU MDS AND QUALITY RESEARCH TEAM
SINCLAIR SCHOOL OF NURSING
UNIVERSITY OF MISSOURI COLUMBIA
TOPICS FOR TODAY

- QSO-20-39-NH Visitation Guidance
- Updated Hospital to Post-Acute Transfer Covid-19 Assessment
- Algorithm for Reporting Test Results
- Staffing Strategies
- Pressure Ulcer Prevention
DATE: September 17, 2020

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Nursing Home Visitation - COVID-19

**Memorandum Summary**

- CMS is committed to continuing to take critical steps to ensure America’s healthcare facilities are prepared to respond to the Coronavirus Disease 2019 (COVID-19) Public Health Emergency (PHE).
- **Visitation Guidance:** CMS is issuing new guidance for visitation in nursing homes during the COVID-19 PHE. The guidance below provides reasonable ways a nursing home can safely facilitate in-person visitation to address the psychosocial needs of residents.
- **Use of Civil Money Penalty (CMP) Funds:** CMS will now approve the use of CMP funds to purchase tents for outdoor visitation and/or clear dividers (e.g., Plexiglas or similar products) to create physical barriers to reduce the risk of transmission during in-person visits.
Visitation

Based on facility structure and resident needs, visitation can be conducted in different ways:
- Resident rooms
- Dedicated visitation spaces
- Outdoors
- Include circumstances beyond compassionate care

Visitation should be:
- Person-centered
- Consider the resident’s physical, mental and psychosocial well-being
- Support the resident’s quality of life
- Provided with an adequate degree of privacy
CORE PRINCIPLES OF COVID-19 INFECTION PREVENTION

- Screening of all who enter the facility for signs and symptoms of COVID-19 (e.g., temperature checks, questions or observations about signs or symptoms), and denial of entry of those with signs or symptoms
- **Hand hygiene** (use of alcohol-based hand rub is preferred)
- Face covering or mask (covering mouth and nose)
- Social distancing at least six feet between persons
- Instructional signage throughout the facility and proper visitor education on COVID-19 signs and symptoms, infection control precautions, other applicable facility practices (e.g., use of face covering or mask, specified entries, exits and routes to designated areas, hand hygiene)
- Cleaning and disinfecting high frequency touched surfaces in the facility often, and designated visitation areas after each visit
- Appropriate staff use of Personal Protective Equipment (PPE)
- Effective cohorting of residents (e.g., separate areas dedicated COVID-19 care)
- Resident and staff testing conducted as required at 42 CFR 483.80(h) (see [QSO-20-38-NH](#))
Outdoor Visitation

• All visits should be held outdoors whenever practicable. Aside from weather considerations (e.g., inclement weather, excessively hot or cold temperatures, poor air quality), an individual resident’s health status (e.g., medical condition(s), COVID-19 status), or a facility’s outbreak status, outdoor visitation should be facilitated routinely.

• Facilities should create accessible and safe outdoor spaces for visitation, such as in courtyards, patios, or parking lots, including the use of tents, if available.

• When conducting outdoor visitation, facilities should have a process to limit the number and size of visits occurring simultaneously to support safe infection prevention actions (e.g., maintaining social distancing).

• Set reasonable limits on numbers of individuals visiting any one residents.
Indoor Visitation

- Facilities should accommodate and support indoor visitation, including visits for reasons beyond compassionate care situations, based on the following guidelines:
  
  a) There has been no new onset of COVID-19 cases in the last 14 days and the facility is not currently conducting outbreak testing;
  
  b) Visitors should be able to adhere to the core principles and staff should provide monitoring for those who may have difficulty adhering to core principles, such as children;
  
  c) Facilities should limit the number of visitors per resident at one time and limit the total number of visitors in the facility at one time (based on the size of the building and physical space). Facilities should consider scheduling visits for a specified length of time to help ensure all residents are able to receive visitors;
  
  d) Facilities should limit movement in the facility. For example, visitors should not walk around different halls of the facility. Rather, they should go directly to the resident’s room or designated visitation area. Visits for residents who share a room should not be conducted in the resident’s room.
**Indoor Visitation**

- Facilities should use their COVID county positivity rate as an additional metric to determine indoor visitations.
- Low (<5%), Medium (5%-10%) should allow indoor visitation following core infection prevention policies beyond compassionate care visits.
- High (>10%) should only occur for compassionate care visits following same IP core principles.
- Additional metrics to assist in assessing risk may include:
  - Review of surrounding county positivity rates.
  - Reviewing rates of ED visits for Covid-like illnesses.
- *Note: Although some states/facilities may have designated categories of visitors, “essential caregivers”, CMS does not distinguish visitor types therefore, utilizing a person-centered approach should cover all visitors.
Visitor Testing

• While not required, CMS encourages facilities in medium or high-positivity counties to test visitors, when feasible.

• Facilities should prioritize visitors that visit regularly (e.g., weekly), although any visitor can be tested.

• Facilities may also encourage visitors to be tested on their own prior to coming to the facility (e.g., within 2–3 days) with proof of negative test results and date of test.
**COMPASSIONATE CARE VISITS**

- A resident, who was living with their family before recently being admitted to a nursing home, is struggling with the change in environment and lack of physical family support.
- A resident who is grieving after a friend or family member recently passed away.
- A resident who needs cueing and encouragement with eating or drinking, previously provided by family and/or caregiver(s), is experiencing weight loss or dehydration.
- A resident, who used to talk and interact with others, is experiencing emotional distress, seldom speaking, or crying more frequently (when the resident had rarely cried in the past).
- Compassionate care visits can be conducted by those offering religious and spiritual support.
- The facility and visitor can be creative to allow for personal contact following IP practices and for a limited time.
- Facilities should work with residents, families, caregivers, resident representatives, and the Ombudsman program to identify the need for compassionate care visits.
**Required Visitation**

- Except for on-going use of virtual visits, facilities may still restrict visitation due to the COVID-19 county positivity rate, the facility’s COVID-19 status, a resident’s COVID-19 status, visitor symptoms, lack of adherence to proper infection control practices, or other relevant factor related to the COVID-19 PHE.

- Facilities **may not** restrict visitation without a reasonable clinical or safety cause, consistent with §483.10(f)(4)(v).

- For example, if a facility has had no COVID-19 cases in the last 14 days and its county positivity rate is low or medium, a nursing home **must** facilitate in-person visitation consistent with the regulations, which can be done by applying the guidance stated above.

- Failure to facilitate visitation, without adequate reason related to clinical necessity or resident safety, would constitute a potential violation of 42 CFR 483.10(f)(4), and the facility would be subject to citation and enforcement actions.

- Residents who are on transmission-based precautions for COVID-19 should only receive visits that are virtual, through windows, or in-person for compassionate care situations, with adherence to transmission-based precautions.
Ombudsman Access

- Previous CMS guidance QSO-20-28-NH (revised), stated in the regulation at 42 CFR 483.10(f)(4)(i)(C) require that a Medicare and Medicaid certified nursing home provide representatives of the Office of the State Long-Term Care Ombudsman with immediate access to any resident.
- In-person access may be limited due to infection control concerns and/or transmission of COVID-19 and may not be limited without reasonable cause.
- Representatives of the Office of the Ombudsman should adhere to the core principles of COVID-19 infection prevention.
- Facilities must, at a minimum, facilitate alternative resident communication with the ombudsman, such as by phone or through use of other technology.
- Nursing homes are required under 42 CFR 483.10(h)(3)(ii) to allow the Ombudsman to examine the resident’s medical, social, and administrative records as otherwise authorized by State law.
Federal Disability Rights Laws and Protection & Advocacy (P&A) Programs

- P&A programs authorized under the DD Act protect the rights of individuals with developmental and other disabilities and are authorized to “investigate incidents of abuse and neglect of individuals with developmental disabilities if the incidents are reported or if there is probably cause to believe the incidents occurred.” 42 U.S.C. § 15043(a)(2)(B)

- Under its federal authorities, representatives of P&A programs are permitted access to all facility residents, which includes “the opportunity to meet and communicate privately with such individuals regularly, both formally and informally, by telephone, mail and in person.” 42 CFR 51.42(c); 45 CFR 1326.27

- Each facility must comply with federal disability rights laws such as Section 504 of the Rehabilitation Act and the Americans with Disabilities Act (ADA). For example, if a resident requires assistance to ensure effective communication (e.g., a qualified interpreter or someone to facilitate communication)…the facility must allow the individual entry into the nursing home to interpret or facilitate, with some exceptions
ENTRY OF HEALTH CARE WORKERS AND OTHER PROVIDERS OF SERVICES

• Health care workers who are not employees of the facility but provide direct care to the facility’s residents, must be permitted to come into the facility as long as they are not subject to a work exclusion due to an exposure to COVID-19 or show signs or symptoms of COVID-19 after being screened:
  – Hospice workers
  – Emergency Medical Services (EMS) personnel
  – Dialysis technicians
  – Laboratory technicians
  – Radiology technicians
  – Social workers
  – Clergy
COMMUNAL ACTIVITIES AND DINING

• Residents may eat in the same room with social distancing (e.g., limited number of people at each table and with at least six feet between each person)

• Group activities may also be facilitated (for residents who have fully recovered from COVID-19, and for those not in isolation for observation, or with suspected or confirmed COVID-19 status) with social distancing among residents, appropriate hand hygiene, and use of a face covering

• Facilities may be able to offer a variety of activities while also taking necessary precautions. For example, book clubs, crafts, movies, exercise, and bingo are all activities that can be facilitated with alterations to adhere to the guidelines for preventing transmission
Use of CMP Funds

• CMS will now approve the use of CMP funds to purchase tents for outdoor visitation and/or clear dividers (e.g., Plexiglass or similar product) to create a physical barrier to reduce the risk of transmission during in-person visits.

• Funding for tents and clear dividers is also limited to a maximum of $3,000 per facility.

• *NOTE: When installing tents, facilities need to ensure appropriate life safety code requirements found at 42 CFR 483.90 are met, unless waived under the PHE declaration.

• The application is for nursing homes certified to participate in Title 18 and Title 19 of the Social Security Act. DHSS encourages companies that operate more than one home to complete one application for all certified homes to the extent possible. This will reduce the number of applications and will help expedite the approval process.
PROJECT AND APPLICANT REQUIREMENTS TO USE THE IN-PERSON VISITATION AIDS APPLICATION TEMPLATE

- Projects must:
  - Directly address the need to facilitate in-person visits for residents
  - Fall within the following parameters for use of funds:
    - Funds must only be used to purchase the types of visitation aids described
    - Tent size must allow for social distancing to be observed.
    - Maximum allowance of $3,000 per facility.
- Ensure appropriate LSC requirements found at 42 CFR 483.90 are met, unless waived under the PHE declaration
- Ensure core principles of infection prevention and control practices. Surfaces must be cleaned and disinfected between resident use. Review the EPA’s List N: Disinfectants for Use Against SARS-CoV-2 to determine if the disinfectant identified in the manufacturer’s instructions meet EPA’s criteria
- Work with state officials to determine the appropriate level of visitation restrictions within available guidelines from the CDC (e.g., limiting the number of individuals visiting with any one resident)
**Staffing Strategies**

**Strategies for Crisis Staffing During a COVID Outbreak**

During this pandemic there are 2 things at a premium—PPE and nursing staff (which include CNAs, nurses, and nursing administration). If you’re lucky, you’ll be able to get PPE and mitigate shortages of masks, gowns, and gloves through the various supply chains. What we know you can’t get off of Amazon are PEOPLE! Here are a few tips to get through it when you’re at crisis levels.

**All-in**—this means EVERYBODY! We preach that your skilled facility is a HOME. Now, more than ever, this means everybody in the home pitches in. This is not the time to silo your staff into “job description only duties”—this is where that “and duties as assigned” clause comes into effect.

**Essentials on the floor**—housekeeping, CNAs, nurses

**Essentials off the floor**—dietary, supply managers

Everybody else in a crisis can and should take on other roles. This includes the following:

- Therapy staff
- Receptionist
- Medical records
- Administrators
- Human Resources
- Activities
- Maintenance
- Van drivers
- Billing
- CEO/CFO
- Social work
- Department heads

**Ways to Free Up CNAs**

- Feeding assistance
- Laundry—restocking linen carts, restocking resident rooms with linens
- Supplies—restocking resident rooms and hall carts with the necessary incontinent products, toothpaste, denture care, soap
• Monitoring call lights—assist with *anything* that is not hands-on, direct patient care (getting a glass of water, adjusting a blanket, getting a snack)
• Refill water pitchers

**Ways to Free Up Housekeepers**

• Basic housekeeping services (like wiping down dining room tables, sweeping, mopping, wiping down hand rails)—this frees up housekeeping staff to clean rooms and restrooms to the standards required for the most prevalent areas of pathogen transmission.
• Laundry—folding linens, restocking linen carts
• Wiping down common areas and equipment multiple times/day—furniture, wheel chair handles, door knobs

**Ways to Free Up Nurses**

• Use CMTs as much as possible/available.
• Have someone designated to answer the phone. THIS IS A HUGE HELP! Just having a secretary to field calls saves the nurses multiple steps (literally). Messages can be taken and returned when it’s more convenient or en masse.
• Have someone (social worker?) return calls to families. *This could potentially be a retired nurse or someone on light duty (or a previously infected staff member who isn’t physically up to lifting, etc. but can still work and be extremely useful).*
• Keep as consistent staffing as possible so nurses can take care of those they know and can more quickly identify if someone has a decline.
• Admin—if they are a nurse as well—could check in medications from the pharmacy, perform accuchecks, assist with med pass.

**During Meal Times**

Everybody, all able-bodied/walking staff, deliver meals, pass and set-up trays, refill drinks, monitor those with choking hazard.

**After Meals**

We all know this is when everybody wants to lay down, especially after supper. So again, all able-bodied hands/feet on deck. You can help by answering call lights, laying out pajamas, refilling water pitchers, etc.
Staff Assignments

1. Put together an emergency staffing protocol...whatever version works best for you but make sure you communicate it! Now, more than ever, people need the security and reassurance that they understand what is going on. They’re dedicated to you but they’re dedicated to their family first. Knowing where they’ll be and what they’ll be doing and when is helpful in creating that balance.

2. Have department heads pick a day(s) of the week when they can take something else over. For example, Tuesday and Thursday maintenance will come work 10:30am-6:30pm instead of 7-3 helping get people to/from the dining room, wash down dining room tables, and help watch call lights.

3. Cross train your activities person and social worker to answer the phone at the nurse’s desk. They know the residents and chances are they can answer 90% of the family questions that will come. Give them a brief update on how that resident is doing for the day via a report sheet to free up your nurses for actual care. If a conversation with a nurse is actually needed, let the family member know it may be later in the shift before they can return a call.

Leading From Within

This is crisis mode. Normal operations take a back seat. Things can and will go wrong. Forms won’t get filled out. People will forget things, protocols won’t be followed exactly—that’s okay. Right now it’s about taking care of your people—your staff and your residents. If you don’t take care of them first, you’ll never be able to take care of the second.

Be present—one on the floor, at the door during shift change, via text—just to let them see you now and know you are, literally, with them.

Be honest and talk—let them know what’s going on and let them know you’re doing the best you can as regulations change.

Be flexible—people are going to call in, need to change hours temporarily, deal with day care situations, etc. To be frank, beggars can’t be choosers. Take whatever you can get, however you can get it. If you don’t, they may walk out the door permanently.
COVID-19 Surge Staffing Solutions Fact Sheet

• Reassign staff from low volume areas to Covid response teams: staff must have appropriate skills for new area
  – Apply appropriate cross-training (waiver considerations)
  – Salary adjustment, hazard pay
• Implement new staffing models to include:
  – Just-in time documentation class
  – Rapid onboarding programs
  – Flexible shifts (morning get ups, meal times, evening bed times)
Staffing Solutions
Recruiting

• Recruit staff to fill short term/temporary roles
• Non-clinical staff could act as screeners, transporters, 1:1 sitters with little orientation
• Utilize a CRM (Customer Relationship Management) system to identify previous applicants
• Place LinkedIn, Facebook and Indeed ads
• Recruit through social media
• Host virtual recruitment events (recruit from other states, compact state)
• Send a Call-To-Action letter to former employees
• Reach out to nursing schools, universities or local school districts
HOSPITAL TO POST-ACUTE CARE TRANSFER COVID-19 ASSESSMENT

INSTRUCTIONS: All hospitalized patients should be assessed for COVID-19 prior to transfer to post-acute care. This tool should be used to document an individual’s medical status related to COVID-19 and to facilitate communication between the hospital, emergency medical services, and the post-acute care organization. This assessment must be reviewed by the discharging physician or advanced practice provider and completed by licensed clinical staff prior to transfer. CHECK THE BOX APPROPRIATE TO THE PATIENT’S STATUS.

Patient Name: ________________________________  Transferring Facility: ________________________________

Post-Acute Care Receiving Organization: ________________________________

☐ YES, Patient tested for COVID-19

Indication for Testing: ________________________________

☐ NO, Test NOT INDICATED per CDC testing criteria category:
  - No signs or symptoms consistent with COVID-19
  - No recent known or suspected exposure to SARS-CoV-2
  - No known public health transmission of the individual
  - No indication for testing to determine isolation status

☐ MAY TRANSFER

MAY TRANSFER if facing emergency, transition, and/or severe illness for a hospital to receive test results immediately.

☐ RESULTS PENDING

Patients will not be transferred to an LRT service until test results are confirmed. START OVER WHEN TEST CONFIRMED.

☐ NEGATIVE TEST

DATE/TIME: ________________________________

Results Pending Transfers

ONLY as directed during declared surge

OR

Transfer to a facility with adequate PPE and isolation status when precautions are required.

Does patient meet criteria outlined in CDC Interim Guidance for Discontinuation of Transmission-Based Precautions and Disposition of Hospitalized Patients with COVID-19?

☐ YES

☐ NO

Precautions should continue after transfer per CDC Interim Guidance:

Depends on Symptom severity

Mild to moderate – generally 10 days, see COVID-Positive-Not Severe (immunocompromised algorithm)

- At least 10 days have passed since symptoms first appeared and
- At least 24 hours have passed since last fever without the use of fever-reducing medications and
- Symptoms (e.g., cough, shortness of breath) have improved

Severe or critical – generally 20 days, see COVID-Positive-Critical

- At least 10 days and up to 20 days have passed since symptoms first appeared and
- At least 24 hours have passed since last fever without the use of fever-reducing medications and
- Symptoms (e.g., cough, shortness of breath) have improved

- Consider consultation with infectious disease experts

☐ MAY TRANSFER per facility’s discretion

- Transfer to a COVID (+) facility or a facility with adequate PPE and isolation status

Clinical Assessment Completed by (signature)

Date/Time: ________________________________

Reported to (name of facility staff):

Date/Time: ________________________________

MHA  MHCA  LeadingAge Missouri

Simcha School of Nursing University of Missouri
COVID Positive: How Long Do I Isolate If Not Severely Immunocompromised

**SYMPTOMATIC**

**YES**

Severe or Critical Illness*

- **YES**
  - >20 days since symptom onset & symptoms improved
    - **DISCONTINUE ISOLATION**
    - **CONTINUE ISOLATION**
  - >24 hrs afebrile off antipyretics & symptoms improved
    - **DISCONTINUE ISOLATION**
    - **CONTINUE ISOLATION**

- **NO**
  - **10 days since 1st positive test** (if develops symptoms at any time, return back to symptomatic pathway)
  - **DISCONTINUE ISOLATION**
  - **CONTINUE ISOLATION**

COVID Positive: How Long Do I Isolate If Severely Immunocompromised*

**SYMPTOMATIC**

**YES**

- >20 days since symptom onset & >24 hrs afebrile off antipyretics & symptoms improved
  - **DISCONTINUE ISOLATION**
  - **CONTINUE ISOLATION**

**NO**

- 20 days since 1st positive test
  - **DISCONTINUE ISOLATION**
  - **CONTINUE ISOLATION**

*Several conditions, such as having an immunocompromised state or being on immunosuppressive therapy, can increase the risk of severe illness.

REPORTING REQUIREMENTS FOR COVID-19 TEST RESULTS FOR MISSOURI SKILLED NURSING FACILITIES

TESTING OCCURS
(any reason - symptomatic, outbreak or routine, baseline testing)

Performed by laboratory contractor

*Positive results

REPORT TO:
DHSS (within 24 hours) and your LPHA

NHSN (at least weekly)

***Refer to:
Notification Requirements to Residents, Representatives and Families

REPORT TO:
DHSS (within 24 hours) and your LPHA

MHD
No further Reporting Required (negative results) to MHD

REPORT TO:
DHSS (at least weekly)

NHSN (at least weekly)

***Refer to:
Notification Requirements to Residents, Representatives and Families

REPORT TO:
MO Bureau of Reportable Disease Informatics (BRDI) (within 24 hours of known results)

**All results (per CLIA regulation)

*Positive Result Links: Electronic COVID-19 Case Reporting System

NHSN-Secure access management systems (SAMS)
https://auth.dhos.mo.gov/sites/ndagent/forms/login.fcc?TYPE=3355433&REALMID=06-244e428f-8768-4f65-a66d-911e49d13d98&GLID=5SMAUTH+REASON=0&METH0D=GET&PARAM0TANVE=5M-VFII5kkcK66ME79p20xe2z5k%ih2c%6c%5EN%NNSHLcZW1DbX2%H3BbY]%2aVb1fG6Ecq8b%2ub47szFB1lw31DbD0W3A%7XKay%6%e%UB2d3%89c%4fu%7FBc%)&TARGET=5M-
https://a%29%29ams%2c%2c%2c%2c%2c%2c%2c%2c%2c%2c%2c%2c

DHSS Regional Contacts can be found here
https://health.mo.gov/seniors/nursinghomes/pdfs/LongTermCareRegions.pdf


***Notification requirements for residents, representatives and families may be found in QSO-20-29-NH

Created by MU MDS and Quality Research Team, September 2020
The Department of Health and Senior Services has gowns, alcohol prep pads, surgical masks, and shoe covers that can be ordered by long term care facilities in bulk. Please follow the survey monkey link (https://www.surveymonkey.com/r/KPY7ZWW) to place your order. If you are part of a larger corporation, your management company may want to submit an order for your organization.

Questions can be sent to Marcia.Davis@health.mo.gov.

Please note: If you have an active outbreak and submitted an order last week- do not submit another order this week. Thank you.
RESOURCES


• [www.mhanet.com/mhaimages/COVID-19/HospitalToFacilityTransfer.pdf](http://www.mhanet.com/mhaimages/COVID-19/HospitalToFacilityTransfer.pdf) Hospital to Post-Acute Care Transfer COVID-19 Assessment

• [www.nursinghomehelp.org](http://www.nursinghomehelp.org) Reporting Requirements for COVID-19 Test Results for Missouri Skilled Nursing Facilities

• [www.mhanet.com](http://www.mhanet.com) Covid-19 Surge Staffing Solutions Fact Sheet

**Wound prevention M & M Moisture and Mobility**

**Heat Regulation**- helps keep your body temperature at a constant level.

**Excretion**- small amounts of urea in the form of sweat. This type of urea is a natural moisturizing substance. Helps reduce wrinkles. Sweat also helps regulate temperature.

**Protection**- It guards the underlying muscles, bones, ligaments and internal organs. Protection against pathogens and other harmful agents.

**Prevents dehydration**- water proof layer all around the body. Prevents excessive loss of water, which is vital in elderly.

**Sensation**- Has a variety of receptors that react to different types of stimuli. Common sensations are touch, pressure, hot, cold vibration, injury etc.
Some Quick Facts

- Effects of aging on skin
  - Skin gets thinner (more transparent)
  - Skin regenerates slower (Less collagen produced)
  - Skin is dryer
  - Loss of fatty tissue between muscle and skin
  - More fragile. Flattening of the area.
  - Skin becomes slack. Loss of elastic tissue causes skin to hang loosely.
Increased capillary fragility
    Burst with light pressure causing bruising

Decreased sensory receptors
    Increase risk for trauma/burns (patient less likely to recognize impending breakdown from pressure or shearing/friction).

Loss of subcutaneous tissue
    Increase risk of pressure and shearing/friction injury and reduced thermal insulation.
A Pressure Ulcer/Injury is a localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of intense and/or prolonged pressure or pressure in combination with shear. The pressure ulcer/injury can present as intact skin (Stage 1 or Deep Tissue Injury (DTI)) or an open ulcer (Stages 2, 3, 4) and may be painful. (pg M-4)

**Note: look at what caused the wound not what is keeping it from healing**
The intent of this requirement is that the resident does not develop pressure ulcers unless clinically unavoidable and that the facility provides care and services to:

- Promote the prevention of pressure ulcer development;

- Promote the healing of pressure ulcers that are present (including prevention of infection to the extent possible); and

- Prevent worsening of existing PU or development of additional pressure ulcers.
Critical Steps in Pressure Ulcer Prevention & Healing

- Identifying the individual resident at risk for developing PU
- Identify and evaluating the risk factors and changes in the resident's condition
- Identifying and evaluating factors that can be removed or modified
- Implementing individualized interventions to attempt to stabilize, reduce or remove underlying risk factors
- Monitoring the impact of the interventions and modifying the interventions as appropriate
Other influencing factors

- Decreased mobility
- Co-morbidities
- Medications
- Nutrition/hydration
- Incontinence
- Decreased sensation
- Vision
- Psychosocial
- Sensory perception
- History of pressure ulcers
- Restraint use
- Foley Catheters
- Oxygen tubing
- Casts/wraps
- Pain
- Falls
Pressure Points

Shoulder blade
Elbows
Buttock/Sacral/Coccyx Area
Behind knee
Ball of Foot
Heel
Prevention

What is friction? Two forces rub together.

What is shearing? When you have friction plus the force of gravity.

• Reducing Shearing/ Friction
  Assist the resident to adopt a stable posture using position devices.
  Reduce the chances of sliding down in bed and chair
  When repositioning the resident LIFT do NOT drag.
PREVENTION: MOISTURE
DRY SKIN VS WET SKIN

• Moisture and incontinence:
  – Prevent exposure to moisture through toileting and continence training
  – Minimize exposure to moisture and soiling, check and change frequently
  – Use briefs/pull ups and underpads to absorb moisture
  – Cleanse skin at time of soiling
  – Use barrier cream as necessary “less is more”
PREVENTION: MOISTURE CLEAN AND DRY

- Clean gently with soap and warm water or cleansing products (rinse vs no rinse)
- Maintain toileting schedule to prevent/limit incontinence
- Remove resident from bed pan, commode/toilet promptly
- Clean skin at time of soiling, keep it well lubricated
- Utilize moisture barriers
- Look for and report any changes
PREVENTION: MOBILITY PRESSURE REDUCTION

- Rehabilitation to improve mobility: Medicare A/B, Restorative, Walk to Dine, Sit to Dine
- Repositioning schedule: individualized per care plan, right/left/back or door/window/ceiling. Check with nurse for any limitations
- Heel relief, offload/float heels
- Pressure reduction devices: mattress/low air loss mattress, cushions (gel/Roho) for wheelchairs and chairs
PREVENTION: MOBILITY
REDUCING PRESSURE IN BED

• Reposition based on care plan
• Prevent skin to skin contact
• Pressure relief/offload heels, moisturize
• Limit elevation of the head
• Use lift sheet or trapeze
• Don’t position directly on trochanter (hip bone), 30 degree laterally inclined position
• DO NOT rub or massage reddened area
Several positions should be used to provide comfort, support, and good body alignment. Sometimes a patient is reluctant to change a position because of a painful disorder; however, failure to change a position may result in deformity of a body part.

Position changes provide alternate weight-bearing surfaces to relieve pressure, improve circulation, and preserve muscle function as different muscle groups contract and relax.

No one position will remain comfortable and safe indefinitely.
Pressure Ulcer: Positioning

Encourage reposition of residents every two (2) hours while in bed.

Reposition chair bound residents every one (1) hour.

Use devices, such as pillows, cushions, to keep bony prominences from direct contact.
Nutrition and hydration:

- Dietary measures received by the resident for the purpose of preventing or treating specific skin conditions, e.g., wheat-free diet to prevent allergic dermatitis, high calorie diet with added supplementation to prevent skin breakdown, high-protein supplementation for wound healing.
- Must be based upon individual nutritional assessment
- Monitor for weight loss, inadequate intake
- Intake of 1500-2000 cc of decaffeinated fluid daily (unless otherwise ordered)
- Encourage and assist with fluids at meals/snacks/activities
- Offer fluid after all personal care
PREVENTION NUTRITION

• Track percent of meal consumption: 25/50/75/100%
• Offer assistance as necessary to ensure adequate intake, feed, cue
• Allow adequate time for eating and drinking
• Know which foods are fortified and encourage consumption
• Monitor weight changes—check with nurse to identify if weekly weight
• Monitor protein intake: eggs, cheese, yogurt, milk, beef, poultry
• Nutritional interventions:
  – Vitamins and minerals—A, C, zinc
  – Supplements—Med Pass, Mighty Shake, homemade milk shakes
  – Powders—Juven, Arginaide
**PREVENTION**

**CNA ROLE**

- Individualized bathing schedule—completion of shower sheet, report any skin issues to charge nurse
- Daily skin inspection during showers, dressing, undressing, toileting or provision of personal care, report changes (don’t assume someone else has)
- Peri care after soiling
- Minimize drying of skin, utilize moisturizers after showering
- Avoid massaging over bony prominences
PLANNING FOR CARE

• The Care Planning process should include efforts to stabilize, reduce or remove underlying risk factors, to monitor the impact of the interventions and to modify the interventions as appropriate based on the individualized needs of the resident.

• Utilize Clinical Practices/standards of practice: NPUAP, AMDA

• Person-Centered plan of care, individualized
  – What the resident wants as outcome (not the plan to describe it), ask the resident
  – It is a process of learning how the resident wants to live, customary routines and activities
  – It describes where the resident wants his/her life to go and what needs to be done to get there
  – It emphasizes the goals, desires and dreams of the individual
  – Unique interventions which meet the needs of the resident
REFERENCES

• Wound Care Prevention, Crystal Plank, BSN, RN, RAC-CT, QIPMO
• NPUAP www.nauap.org
• State Operations Manual Guidance to Surveyors F686
• “Comprehensive Skin Assessment” Nancy Morgan RN, BSN, MBA, WOC, WCC, DWC, OMS Wound Care Advisor
• Evidence Based Protocol: Hydration Management by Janet Mentes, University of Iowa College of Nursing
Wendy Boren email: borenw@missouri.edu

Katy Nguyen email: nguyenk@missouri.edu

Crystal Plank email: plankcl@missouri.edu

Debbie Pool email: poold@missouri.edu

Melody Schrock email: schrockm@missouri.edu

Carol Siem email: siemc@health.Missouri.edu
• Please take our quick evaluation to assist us in improving our program, offer suggestions for future topics