

### Stage II – 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 for non-pressure related wounds.

NOTE: If the resident is showing signs of hydration and/or nutrition compromise the nutrition hydration CE will also be completed.

#### Procedure

- Briefly review the assessment, care plan and orders to identify facility interventions and to guide observations to be made.
- Corroborate observations by interview and record review.

## Stage II – Critical Elements for Pressure Ulcers

### Observations (if the resident is still in the facility)

- Observe whether staff consistently implement the care plan over time and across various shifts. Staff are expected to assess and provide appropriate care for residents having or at risk of developing a pressure ulcer from the day of admission. During observations of the interventions, note and/or follow up on deviations from the care plan as well as potential negative outcomes. Observations might include, but are not limited to the following:
- Skin condition—note erythema or color changes on areas such as the sacrum, buttocks, trochanters, posterior thigh, popliteal area, or heels when moved off an area. To follow-up:
    - If erythema or color change are noted, return approximately  $\frac{1}{2}$ – $\frac{3}{4}$  hours later to determine whether the changes or other Stage I characteristics persist; and
    - 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.
    - 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; and
    - 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. For residents placed in wheelchairs or reclining chairs, and who are unable to perform positioning, seat cushions are adequate to prevent ”bottoming out.”
  - If assistance with mobility and transfer is needed, staff ensure that repositioning/weight shifts occur at consistent and frequent intervals.

### Notes:

### Stage II – Critical Elements for Pressure Ulcers

Observations (if the resident is still in the facility)	
<ul style="list-style-type: none"> <li>▪ During provision of care, staff avoid massage over bony prominences, uses mild cleansers, and moisturizes the skin.</li> </ul> <p><input type="checkbox"/> During observations of the interventions, note and/or follow up on deviations from the care plan as well as potential negative outcomes.</p>	
Observation of existing ulcer/wound care:	
<p><input type="checkbox"/> If a dressing change is scheduled during the survey, observe the wound care to determine whether the record reflects the current status of the ulcer(s) and note:</p> <ul style="list-style-type: none"> <li>▪ 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;</li> <li>▪ The form or type of debridement, if used;</li> <li>▪ Whether treatment and infection control practices reflect current standards of practice; and</li> <li>▪ Based on location, steps taken to cleanse and protect the wound from likely contamination by urine or fecal incontinence.</li> </ul> <p><input type="checkbox"/> 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 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"> <li>▪ Assessed for pain related to the ulcer, addressed and monitored interventions for effectiveness; and/or</li> </ul>	<p><b>Notes:</b></p>

## Stage II – Critical Elements for Pressure Ulcers

### Observations (if the resident is still in the facility)

- Assessed and took preemptive measures for pain related to dressing changes or other treatments, such as debridement/irrigations, and monitored for effectiveness.

### Resident/Representative Interview

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

- Involvement in care plan, choices, goals, and whether interventions reflect preferences;
- Awareness of approaches, such as pressure redistribution devices or equipment, turning/repositioning, or weight shifting to prevent or address pressure ulcer(s);
- Presence of pain, if any and how it is managed;
- If treatment(s) was refused, whether counseling on alternatives, consequences, and/or other interventions were offered; and
- Awareness of current or history of an ulcer(s). For the resident who has or has had a pressure ulcer, identify, as possible, whether acute illness, weight loss, or other condition changes occurred prior to developing the ulcer.

**Notes:**

## Stage II – Critical Elements for Pressure Ulcers

Staff Interviews	
<p>Interview staff on various shifts to determine:</p> <ul style="list-style-type: none"><li><input type="checkbox"/> Knowledge of prevention and treatment, including facility-specific guidelines/protocols and specific interventions for the resident;</li><li><input type="checkbox"/> Whether nursing assistants know:<ul style="list-style-type: none"><li>▪ What, when, and to whom to report changes in skin condition;</li><li>▪ How much assistance is needed with bed mobility/transfer; and</li><li>▪ The resident's ability to shift his or her own weight.</li></ul></li><li><input type="checkbox"/> Whether the nurse monitors for:<ul style="list-style-type: none"><li>▪ The implementation of the care plan,</li><li>▪ Changes in the skin,</li><li>▪ The development of pressure ulcers, and</li><li>▪ The frequency of review and evaluation of an ulcer.</li></ul></li></ul>	<p><b>Notes:</b></p>
Assessment	
<ul style="list-style-type: none"><li><input type="checkbox"/> Review the RAI and other documents, such as physician orders, progress notes, nurses' notes, pharmacy or dietary notes regarding the assessment of the resident's overall condition, risk factors and presence of a pressure ulcer(s) to determine whether the facility identified the resident at risk and evaluated the factors placing the resident at risk.</li><li><input type="checkbox"/> Assessment information identifies specific factors that might increase the risk of a pressure ulcer developing, or affect healing of, a pressure ulcer, such as:</li></ul>	<p><b>Notes:</b></p>

## Stage II – Critical Elements for Pressure Ulcers

### Assessment

- Decreased mobility/positioning ability;
- Cognitive impairment;
- Significant weight loss in a resident who also has mobility/positioning concerns;
- The use of restraints;
- Altered sensory perception; and
- Any decline in clinical status or co-morbid diagnoses affecting mobility/positioning or tissue tolerance.

For a resident who was admitted with an ulcer, or who developed one within 1–2 days, review the admission documentation regarding:

- 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.

For a resident who subsequently developed, or has, an existing pressure ulcer, review documentation regarding the wound site, characteristics, progress and complications including:

- 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.

Assessment information identifies the condition of the skin including:

## Stage II – Critical Elements for Pressure Ulcers

### Assessment

- The presence of moisture;
- Blanchable erythema; and/or
- Maceration of the skin (such as from fecal and/or urinary incontinence).

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 the facility comprehensively assessed the resident's skin condition, including existing pressure ulcers, and resident-specific risk factors (including potential causative factors) for the development of a pressure ulcer or non-healing of the ulcer.

**1. Did the facility assess to determine the risk for the development of a pressure ulcer?**       Yes     No    **F272**

*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 (see the Care and Services Meet Professional Standards section).*

*Note: The facility may have completed a 5-day assessment for the Medicare beneficiary. Use the 5-day assessment as the comprehensive review only if it was completed with the RAPS.*

## Stage II – Critical Elements for Pressure Ulcers

### Care Planning

- Determine whether the facility developed a care plan that was consistent with the resident's specific conditions, risks, needs, behaviors, and preferences, and current standards of practice and included measurable objectives and timetables, specific interventions/services to prevent the development of pressure ulcers and/or to treat existing pressures ulcers.
- 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.
- For the resident at risk for developing, or who has, a pressure ulcer, determine whether the facility developed an individualized care plan that addresses prevention, and care and treatment of any existing pressure ulcers, including specific interventions, measurable objectives, and approximate time frames. Determine whether the plan addresses, as appropriate:
  - Pressure redistribution/relief based upon identified resident needs (repositioning, heel protection, use of a wheelchair/reclining chair and bed/mattress pressure redistribution surfaces);
  - Prevention of shearing and friction;
  - Identification by whom, and how often, the skin is inspected (paying attention to bony prominences);
  - Comorbid conditions that may affect risk for, and healing of, pressure ulcers;
  - Daily evaluation of the status of the dressing and the surrounding skin; and

### Notes:

## Stage II – Critical Elements for Pressure Ulcers

### Care Planning

- Pressure ulcer care and treatment (such as type of dressing, frequency of dressing change, wound cleansing and debridement, pain during dressing changes and treatments, and managing infection).

- 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 resident refuses or resists staff interventions to reduce risk or treat existing pressure ulcers, determine whether the care plan reflects efforts to seek alternatives to address the needs identified in the assessment.
- If care plan concerns are noted, interview staff responsible for care planning as to the rationale for the current plan of care.

**2. Did the facility develop a care plan to prevent the development of a pressure ulcer, or if present, for the care and treatment of the pressure ulcer?**  Yes  No **F279**

*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** (see the Care and Services Meet Professional Standards section).*

*Additionally, lack of physician orders for immediate care (until staff can conduct a comprehensive assessment and develop an interdisciplinary care plan) should be addressed under **F271**.*

## Stage II – Critical Elements for Pressure Ulcers

### Care and Services Meet Professional Standards

#### Interviews with Health Care Practitioners and Professionals

- 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. If there is a medical question, contact the physician if he/she is the most appropriate person to interview. If the attending physician is unavailable, interview the medical director, as appropriate. Depending on the issue, ask about:
- Causal factors, for a pressure ulcer developing and/or not healing;
  - How it was determined that chosen interventions were appropriate;
  - Risks identified for which there were no interventions;
  - Changes in condition that may justify additional or different interventions; or
  - How staff validated the effectiveness of current interventions.

**3. Did the facility implement practices that meet professional standards of quality?**  Yes  No **F281**

*If the care plan addressed the risks and identified needs of the resident, but the care plan was not implemented as written, consider **F282** for failure to implement the care plan.*

**Notes:**

## Stage II – Critical Elements for Pressure Ulcers

<b>Care Plan Revision</b>	
<p><input type="checkbox"/> Determine whether the staff have been monitoring the resident's response to interventions for prevention and/or treatment and have evaluated and revised the care plan based on the resident's response, outcomes, and needs.</p> <p><input type="checkbox"/> Review the record and interview staff for information and/or evidence that:</p> <ul style="list-style-type: none"> <li>▪ Continuing the current approaches meets the resident's needs if the resident has experienced recurring pressure ulcers or lack of progression toward healing, and staff did not revise the care plan; or</li> <li>▪ For the resident who acquired a new ulcer, the care plan was revised to modify the prevention strategies and to address the presence and treatment of a newly developed pressure ulcer.</li> </ul> <p><input type="checkbox"/> Determine whether the care plan was periodically reviewed and revised as necessary to prevent the development of pressure ulcers and to promote the healing of existing pressure ulcers.</p> <p style="background-color: #cccccc; padding: 2px;"><b>4. Did the facility revise the care plan as needed?</b></p> <p style="text-align: right;"><input type="checkbox"/> Yes   <input type="checkbox"/> No   <b>F280</b></p>	<p><b>Notes:</b></p>

<b>Provision of Care and Services</b>	
<p><input type="checkbox"/> <b>Criteria for compliance with F314, Pressure Sores, for a resident who developed a pressure ulcer after admission</b>—the facility is in compliance with F314, if staff have:</p> <ul style="list-style-type: none"> <li>▪ Recognized and assessed factors placing the resident at risk for developing a pressure ulcer, including specific conditions, causes and/or problems, needs and behaviors;</li> <li>▪ Defined and implemented interventions for pressure ulcer prevention in accordance with resident needs, goals, and recognized standards of practice;</li> </ul>	<p><b>Notes:</b></p>

## Stage II – Critical Elements for Pressure Ulcers

### Provision of Care and Services

- Monitored and evaluated the resident’s response to preventive efforts; and
- Revised the approaches as appropriate.

**If not, the development of the pressure ulcer is avoidable: cite F314.**

**Criteria for compliance with F314, Pressure Sores for a resident who was admitted with a pressure ulcer, who has a pressure ulcer that is not healing, or who is at risk of developing subsequent pressure ulcers**—the facility is in compliance with F314 if staff have:

- 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.

**If the resident did not receive the necessary treatment and/or prevention of subsequent pressure ulcers: cite F314.**

**5. Based on observation, interviews, and record review, did the facility provide care to prevent the development and/or to promote the healing of a pressure ulcer?**

Yes  No **F314**

## Stage II – Critical Elements for Pressure Ulcers

### Concerns with Structure, Process, and/or Outcome Requirements Related to Process of Care

During the investigation of pressure ulcers, the surveyor may have identified concerns with related outcome, process and/or structure requirements. The surveyor is cautioned to investigate these related requirements before determining whether non-compliance may be present. Some examples of requirements that should be considered include the following (not all inclusive):

- F157, Notification of Changes** — Determine whether staff notified:
  - The physician of significant changes in the resident’s condition or failure of the treatment plan to prevent or heal pressure ulcers; or
  - The resident’s representative (if known) of significant changes in the resident’s condition in relation to the development of a pressure ulcer, or a change in the progression of healing of an existing pressure ulcer.
- F309, Quality of Care** — Determine whether staff identified and implemented appropriate measures for the management of pain, as indicated, related to pressure ulcers and pressure ulcer treatment.
- F325, Nutrition, for a resident who has unplanned weight gain or loss, or other nutritional concerns** — Determine whether staff identified risk factors and implemented interventions.
- F327, Hydration, for a resident who is not consuming sufficient fluid intake to maintain proper hydration and health** — Determine whether staff identified risk factors and implemented interventions.
- F353, Sufficient Staff** — Determine whether the facility had qualified staff in sufficient numbers to assure the resident was provided necessary care and services, based upon the comprehensive assessment and care plan, to prevent or treat pressure ulcers.

**Notes:**

## Stage II – Critical Elements for Pressure Ulcers

### Concerns with Structure, Process, and/or Outcome Requirements Related to Process of Care

**F385, Physician Supervision** — Determine whether the physician has assessed and developed a treatment regimen relevant to preventing or healing a pressure ulcer and responded appropriately to the notice of changes in condition.

**F501, Medical Director** — Determine whether the medical director:

- Assisted the facility in the development and implementation of policies and procedures for pressure ulcer prevention and treatment, 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).

***If the surveyor determines that the facility is not in compliance with any of these related requirements, the appropriate F tag should be surveyor initiated.***