Understanding CMS Interpretation of F314

This document summarizes key points of CMS guideline Tag F314, which state surveyors use as guidance to help them assess nursing homes’ pressure ulcer prevention and treatment. Use this as guidance for assessing the processes in place at your home with regard to pressure ulcer prevention, assessment, intervention, monitoring and care planning.

Regulations: Pressure Ulcers

F314 42 CFR 483.25 (c) Pressure sores
Based on the comprehensive assessment of a resident, the facility must ensure that –

• A resident who enters the facility without pressure sores does not develop pressure sores unless the individual’s clinical condition demonstrates that they were unavoidable; and
• A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing”

F314 Intent

• Promote the prevention of pressure ulcer development
• Promote healing of pressure ulcers that are present
• Prevent development of new pressure ulcers

Survey: Pressure Sore Investigative Protocol
Objective:

• To determine if the identified pressure sore(s) is avoidable or unavoidable
• To determine the adequacy of the facility’s pressure sore treatment interventions

Risk Management

• Identify and manage resident and facility risks
• Prevention of pressure ulcers benefits everyone
• Educate all staff on an ongoing basis
• Provide care based on accepted standards of practice (WOCN, AHQR, NPUAP)
• Document care based on accepted standards
• Make Care plans realistic especially when discussed with family in care plan conferences
• Watch for indicators of major system failures and initiate quality improvement activities
• Document facts, not assumptions
• Rising litigation
  – What happens when the treatment sheet is not signed off?
  – What happens when one lapse in weekly assessment occurs in a period where the wound declines?
  – *Careful with dressings that stay on several days: What happens with weekly assess?
  – Carefully consider policies on wound photography: may be “double-edge” sword
Three Key Factors for Risk Management
- Medical record must show standard of care for pressure ulcers was adhered to
- Medical record must have documentation of resident complications, risk factors, and/or underlying disease that made the pressure ulcer unavoidable (if it is indeed)
- You must provide a comprehensive and aggressive program to prevent and treat the pressure ulcer (within the parameters of resident advance directives)

Prevention
- What systems are in place in your facility?
  - How is risk communicated to staff?
  - Are there protocols for repositioning and pressure relief products that are understood by staff?
  - How are you sure this is done for new admissions or those with change in status?
  - *Residents cannot afford to wait!*
- How are moisturizers/barriers stocked?
- During “off-hours,” do staff know how to access pressure-reducing devices?
- Are tracking and assessment forms stocked?
- How are disposable briefs and underpads stocked and used?

Assessment

Avoidable vs. Unavoidable Pressure Ulcers
- **Avoidable** – Pressure ulcer developed and facility failed to do one or more:
  ▶ Defined/implemented interventions CONSISTENT with resident needs, goals
  ▶ Recognized standards of practice (AHCPR, AMDA, WOCN, current literature)
  ▶ Monitor and evaluate impact of interventions
  ▶ Revise interventions appropriately
- **Unavoidable** – Resident developed pressure ulcer although facility:
  ▶ Evaluated clinical condition and risk factors
  ▶ Defined and implemented interventions consistent with resident’s needs, goals, standards of practice
  ▶ Monitored and evaluated impact of interventions
  ▶ Revised approaches appropriately

Frequency of Risk Assessment (Braden or Norton most common)
- Minimally
  ▶ upon admission
  ▶ quarterly
  ▶ upon Significant Change in Condition
- Best Practice
  ▶ day 7, 14, 21, 28 (post-admission) then as above
  ▶ during acute illness
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Wound Assessment
• Assessment includes a full description of the wound and peri-wound
• Measurements alone do not constitute an assessment
• Reassess weekly at a minimum
• Reassess daily if pressure ulcer is deteriorating

Staging Assessment
• Does your facility policy address your process for staging?
• Who does initial staging? How is it confirmed?
• What are you staging? All open areas or only pressure ulcers?
• Is there a facility tool for documenting staging?

Risk Assessment – Facility Wide
• Establish written guidelines, protocols, algorithms/decision trees based on risk
• Low risk does not equal no risk
• Let low scores trigger your mind clinically: don't just treat the conglomerate of score
• Use appropriate interventions based on the risk assessment

Interventions

Address Risk Factors
• Skin care: routine inspections, cleansing, moisturizing, avoid massage
• Repositioning: 1 hour in chair by staff, 15 minutes in chair by resident; 2 hours in bed
• Pressure relief for heels
• Pressure reduction devices
• Address nutrition
• Address incontinence
• Toileting schedule? Rehab? Positioning evaluations? Incontinence products?

Combination of Prevention Interventions
• Adequate nutrition and hydration
• Repositioning schedule and positioning
• Appropriate support surfaces
• Care of skin

Monitoring Wound Status

Is It Better or Worse?
• Objectively review wound progress: measurements, type of tissue, PUSH tool
• Subjective assessments are problematic:
  - “I don’t think this treatment is working. I’m calling the MD to change the treatment…”
  - “The pressure ulcer is deeper than last week - of course it is worse” - not necessarily true
Monitoring Treatment Plan

- Is there a process for monitoring treatment?
- Is there a tracking tool to document response to treatment?
- Does the tracking form monitor the appropriate wound variables?
- Are there protocols for changing the treatment if it is ineffective?
- Healing - a systemic process affected by systemic conditions - treatment is more than a dressing
- When do you change the treatment?
- What determines frequency of dressing change?
- How do you handle “non-traditional” recommendations or a product being used in a manner different than its intended use?

Care Planning

- Do care plans identify risk factors?
- Are you treating the risk factors?
- Is the resident and family aware of and in agreement with goals?
- Goal must be a clear statement of intended progress and how it will be measured
- Be REALISTIC!!!!
- Determine what the goal is:
  - Maintenance
  - Improvement/Healing
  - Comfort
  - Many goals beyond healing…
    - Resolution of periwound erythema in 2 weeks
    - 25% reduction in amount of necrotic tissue by 1 week
    - Decrease in intensity of pain during dressing changes from 6 to 3 (as reported by resident) by 1 week
    - 1 cm reduction in wound dimensions by 2 weeks