LONG TERM CARE COMMUNITY COALITION

Advancing Quality, Dignity & Justice

CONSUMER FACT SHEET: PRESSURE ULCERS

There are many standards which nursing homes are required to follow in order to ensure that residents receive appropriate care, have a good quality of life, and are treated with dignity. **YOU** can use these standards to support better care in your nursing home.

Following is the standard and guidelines that we have identified as essential when it comes to pressure ulcers in nursing homes. The descriptions were taken directly from the federal regulations and guidelines (as indicated by text in italics). For more information about pressure ulcers, please see LTCCC's issue alert.

THE LAW

Skin Integrity [42 C.F.R. § 483.25(b)(1)] [F-686]

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.*

WHAT IS A PRESSURE ULCER?

Pressure ulcers occur when there is damage to a resident's skin or underlying tissue. Pressure ulcers are generally localized to areas of the body with boney prominences that absorb pressure from prolonged immobility (such as elbows, hips, heels, and shoulders). Pressure ulcers are classified into stages, based on the severity of the injury.

WHAT DOES "UNAVOIDABLE" MEAN?

According to CMS's Interpretative Guidance, "unavoidable" means that a pressure ulcer formed *even though* ***the facility had evaluated the resident's clinical condition and risk factors****;* ***defined and implemented interventions that are consistent with resident needs, goals, and professional standards of practice****;* ***monitored and evaluated the impact of the interventions****; and* ***revised the approaches as appropriate****.*

HOW CAN PRESSURE ULCERS BE PREVENTED AND TREATED?

CMS's Guidance states that *[e]ffective prevention and treatment are based upon consistently providing **routine and individualized** interventions*, including:

- Redistributing pressure, such as through *repositioning, protecting and/or offloading heels, etc.*;
- Minimizing the resident's exposure to moisture and keeping the resident's skin clean;
- Providing support and non-irritating surfaces; and
- Maintaining or improving the resident's nutrition and hydration status, including addressing adverse drug reactions which *may worsen risk factors for development of, or for non-healing PU/PIs [pressure ulcers] . . . .*

CAN RESIDENTS PARTICIPATE IN THEIR CARE PLANNING?

Yes! The resident's care plan should establish relevant goals, approaches, and interventions for addressing the resident's risk of developing a pressure ulcer. CMS's Guidance notes that, *[i]n order for the resident to **exercise his or her right appropriately to make informed choices about care and treatment or to decline treatment**, the facility and the resident (or if applicable, the resident representative) must discuss the resident's condition, treatment options, expected outcomes, and consequences of refusing treatment.* If a resident determines not to undertake one form of prevention or treatment, *[t]he facility is expected to address the resident's concerns and offer relevant alternatives . . . .*
For more information, please see LTCCC's **fact sheet on resident assessment** and care planning at **www.nursinghome411.org**.

A BRIEF NOTE ABOUT ABUSE AND NEGLECT

Pressure ulcers may be a sign of resident abuse and/or neglect. **Under the federal Nursing Home Reform Law, every nursing home resident has the right to be free from abuse and neglect.** CMS's Interpretative Guidance for this requirement notes that abuse may include the *deprivation by staff of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being*. Similarly, CMS states that neglect may occur, *[i]f the facility is aware of, or should have been aware of, goods or services that a resident(s) requires but the facility fails to provide them to the resident(s).*
Federal law and regulations require nursing homes to report all alleged violations of abuse and neglect to the facility administrator and the state survey agency *immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury*. For more information about resident abuse and neglect, please see LTCCC's **Abuse, Neglect, and Crime Reporting Center** at **www.nursinghome411.org**.