

Updates on Wound Regulations in Long Term Care



W O U N D
CARE + PLUS
www.mywoundcareplus.com



wound-care-plus-llc



woundcareplusllc



woundcareplus



@mywoundcareplus

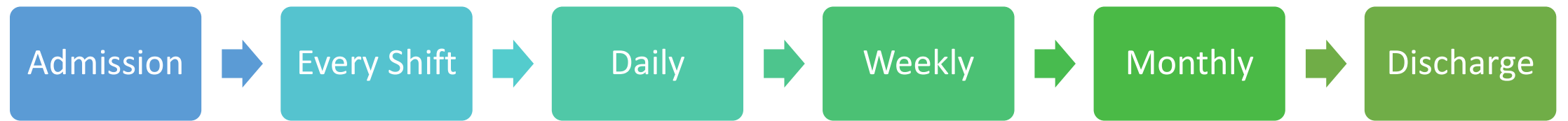
Centers for Medicare & Medicaid Services



Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual

**Centers for Medicare & Medicaid Services' Long-Term Care Facility Resident Assessment
Instrument (RAI) User's Manual October 2023 For Use Effective October 1, 2023**

<https://www.cms.gov/files/document/finalmds-30-rai-manual-v11811october2023.pdf>



The pressure ulcer/injury definitions used in the RAI Manual have been adapted from those recommended by the National Pressure Ulcer Advisory Panel (NPUAP) 2016 Pressure Injury Staging System.

For MDS assessment, initial numerical staging of pressure ulcers and the initial numerical staging of ulcers after debridement, or DTI that declares itself, should be coded in terms of what is assessed (seen or palpated, i.e. visible tissue, palpable bone) during the look-back period.

Nursing homes may adopt the NPUAP guidelines in their clinical practice and nursing documentation. However, since CMS has adapted the NPUAP guidelines for MDS purposes, the definitions do not perfectly correlate with each stage as described by NPUAP. Therefore, you must code the MDS according to the instructions in this manual.

2. For the purposes of coding; determine that the lesion being assessed is **primarily** related to pressure and that other conditions have been ruled out. If pressure is **not** the primary cause, do not code here.

Source: CMS's RAI Version 3.0 Manual Pages:

M-9

M-11

M-13

M-16

M-21

M1040D Open Lesion(**s**) Other than Ulcers, Rashes, Cuts

- *Open lesions that develop as part of a disease or condition and are not coded elsewhere on the MDS, such as wounds, boils, cysts, and vesicles, should be coded in this item.*
- Do **not** code rashes, *abrasions*, or cuts/lacerations here. Although not recorded on the MDS assessment, these skin conditions should be considered in the plan of care.
- Do **not** code pressure ulcers/*injuries*, venous or arterial ulcers, diabetic foot ulcers, or skin tears here. These conditions are coded in other items on the MDS.

Question 1: Was the ulcer caused by pressure or pressure and shear?

- Is or was patient or the patient's body part immobile?
- Evaluate location of the ulcer. Is it directly from positioning in bed? Chair? Shoe? Device?
- Observe the patient in actual supine, side lying, sitting, and with their devices (splints, braces, etc). Is the specific area of breakdown consistent with applied external force?
- Determine if the patient had a recent period of immobility, including just prior to admission. Consider falls at home, rhabdomyolysis, and surgical procedures > 4 hours.

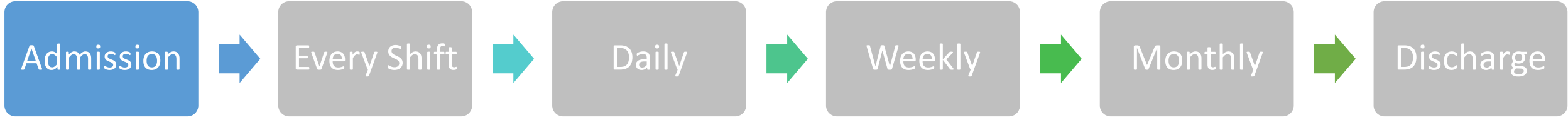
No/unsure

- **Rationale:** Not all ulcers are from pressure. If the cause was clearly not from pressure, do NOT label as pressure.
- **Determine wound type:** Review with the patient's physician, nurse practitioner. In the case that the wound type is unclear, a wound consultation by a Certified Wound Specialist (CWS) may be helpful to determine wound type. Obtain final wound type diagnosis by the patient's physician, nurse practitioner.
- **Document:** In cases where a wound is deemed to be NOT pressure, but has characteristics of pressure, the rationale should be documented.
- **Communicate:** Provide education on wound type, plan of care, prognosis, interventions, treatments, etc. with interdisciplinary team, patient and responsible party

Yes

- **Rationale:** In the case that wound type is deemed pressure, a full evaluation should be completed to determine the extent of the issue, mitigate the pressure cause, determine plan of care and wound type prognosis and communicate effectively with the interdisciplinary team, the patient, and the family.

Care Setting	Instructions for Coding
LTC/SNF	Nursing homes may adopt the NPUAP guidelines in their clinical practice and nursing documentation. However, since CMS has adapted the NPUAP guidelines for MDS purposes, the definitions do not perfectly correlate with each stage as described by NPUAP. Therefore, you must code the MDS according to the instructions in this manual.
LTACH/IRF	If pressure is determined to be the primary cause, use the staging system to stage the ulcer/injury and code in Section M of the LTCH CARE Data Set or IRF-PAI. If the ulcer/injury is not due to pressure, do not code it in Section M.
Home Health	Home health agencies may adopt the NPUAP guidelines in their clinical practice and documentation. However, since CMS has adapted the NPUAP guidelines for OASIS purposes, the definitions do not perfectly align with each stage as described by NPUAP. When discrepancies exist between the NPUAP definitions and the OASIS scoring instructions provided in the OASIS Guidance Manual and CMS Q&A's, providers should rely on the CMS OASIS instructions.
Outpatient Wound Centers	Follows NPUAP/NPIAP Guidelines
Acute Care Hospitals	Follows NPUAP/NPIAP Guidelines



For each pressure ulcer, determine the deepest anatomical stage. At admission, code based on findings from the first skin assessment that is conducted on or after and as close to the admission as possible. Do not reverse or back stage. Consider current and historical levels of tissue involvement.

DEFINITION

ON ADMISSION

As close to the actual time of admission as possible.



Martha's Opinion from the view of an Expert Witness





PREVENTION OF PRESSURE ULCERS/NJURIES

A pressure ulcer/injury (PU/PI) can occur wherever pressure has impaired circulation to the tissue. A facility must:

- Identify whether the resident is at risk for developing or has a PU/PI upon admission and thereafter;*

Check C if the resident's risk for pressure ulcer/injury development is based on clinical assessment. A clinical assessment could include a head-to-toe physical examination of the skin and observation or medical record review of pressure ulcer/injury risk factors. Examples of risk factors include the following:

- impaired/decreased mobility and decreased functional ability
- co-morbid conditions, such as end stage renal disease, thyroid disease, or diabetes mellitus;
- drugs, such as steroids, that may affect wound healing;
- impaired diffuse or localized blood flow (e.g., generalized atherosclerosis or lower extremity arterial insufficiency);
- resident refusal of some aspects of care and treatment;
- cognitive impairment;
- urinary and fecal incontinence;
- malnutrition and hydration deficits; and
- healed pressure ulcers, especially Stage 3 or 4 which are more likely to have recurrent breakdown.

A previously closed pressure ulcer that opens again should be reported at its worst stage, unless currently presenting at a higher stage or unstageable.

For each pressure ulcer/injury, determine if the pressure ulcer/injury was present at the time of admission/entry or reentry and not acquired while the resident was in the care of the nursing home. Consider current and historical levels of tissue involvement.

Although the requirements do not mandate any specific assessment tool, other than the RAI, validated instruments are available to assess risk for developing pressure ulcers. Research has shown that a significant number of pressure ulcers develop within the first four weeks after admission to a long term care facility.³⁴ Therefore, many clinicians recommend using a standardized pressure ulcer risk assessment tool to assess a resident's pressure ulcer risks upon admission, weekly for the first four weeks after admission for each resident at risk, then quarterly, or whenever there is a change in cognition or functional ability.^{35, 36} A resident's risk may increase due to an acute illness or condition change (e.g., upper respiratory infection, pneumonia, or exacerbation of underlying congestive heart failure) and may require additional evaluation.

Check B if a formal assessment has been completed. An example of an established pressure ulcer risk tool is the *Braden Scale for Predicting Pressure Sore Risk*®. Other tools may be used.



Authors

- Braden, Barbara J. PhD, RN, FAAN

Article Content

In 1984, I developed The Braden Scale for Predicting Pressure Sore Risk as a screening tool for a research study. Together with Dr Nancy Bergstrom and other colleagues, we tested the Braden Scale in several settings, and the results of those tests were published in 1987.[1,2](#) To my amazement, use of the Braden Scale disseminated rapidly!

In addition, the admission evaluation may identify pre-existing signs suggesting that tissue damage has already occurred and additional tissue loss may occur. For example, a deep tissue pressure injury identified on admission could lead to the appearance of an unavoidable Stage 3 or 4 pressure ulcer. A Stage 1 PI can progress to an ulcer with eschar or exudate within days after admission. Some situations, which may have contributed to this tissue damage prior to admission, include pressure resulting from immobility during hospitalization or surgical procedures, during prolonged ambulance transport, or while waiting to be assisted after a debilitating event, such as a fall or a cerebral vascular accident.

M0300: Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage (cont.)

Once a pressure ulcer has healed, it is documented as a healed pressure ulcer at its highest numerical stage—in this example, a healed Stage 4 pressure ulcer. For care planning purposes, this healed Stage 4 pressure ulcer would remain at increased risk for future breakdown or injury and would require continued monitoring and preventative care.

6. *A previously closed pressure ulcer that opens again should be reported at its worst stage, unless currently presenting at a higher stage or unstageable.*

10. *If a resident has a pressure ulcer/injury that was documented on admission then closed that reopens at the same stage (i.e., not a higher stage), the ulcer/injury is coded as “present on admission.”*

Pressure ulcer/injury staging is an assessment system that provides a description and classification based on visual appearance and/or anatomic depth of soft tissue damage. This tissue damage can be visible or palpable in the ulcer bed. Pressure ulcer/injury staging also informs expectations for healing times.



The depth of a Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput, and malleolus do not have subcutaneous tissue, and these ulcers can be shallow.



Exposed bone/tendon/muscle is visible or directly palpable.

Special Treatments/Programs: Radiation Post-admit Code	MDS Item O0100B2	1
Highest Stage of Unhealed Pressure Ulcer - Stage 4	MDS Item M0300D1	1
Psoriatic Arthropathy and Systemic Sclerosis	MDS Item I8000	1



F-684 (Previously F-309)
Quality of Care

F-686 (Previously F-314)
Skin Integrity-Pressure Ulcers
Section M of the RAI Manual (MDS Manual)

F686

(Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)

§483.25(b) Skin Integrity

§483.25(b)(1) Pressure ulcers.

Based on the comprehensive assessment of a resident, the facility must ensure that—

- (i) 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***
- (ii) 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.***

F684

(Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)

§ 483.25 Quality of care

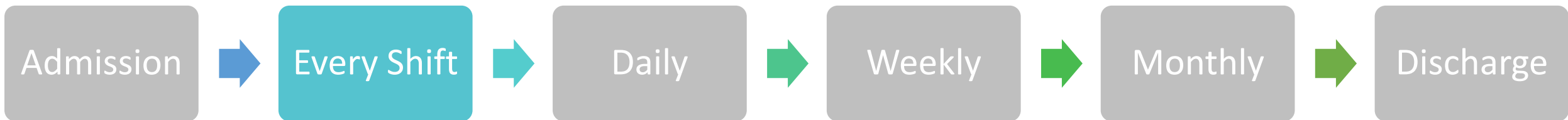
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:


INTENT

To ensure facilities identify and provide needed care and services that are resident centered, in accordance with the resident's preferences, goals for care and professional standards of practice that will meet each resident's physical, mental, and psychosocial needs.

DEFINITIONS

“Highest practicable physical, mental, and psychosocial well-being” is defined as the highest possible level of functioning and well-being, limited by the individual’s recognized pathology and normal aging process. Highest practicable is determined through the comprehensive resident assessment and by recognizing and competently and thoroughly addressing the physical, mental or psychosocial needs of the individual.

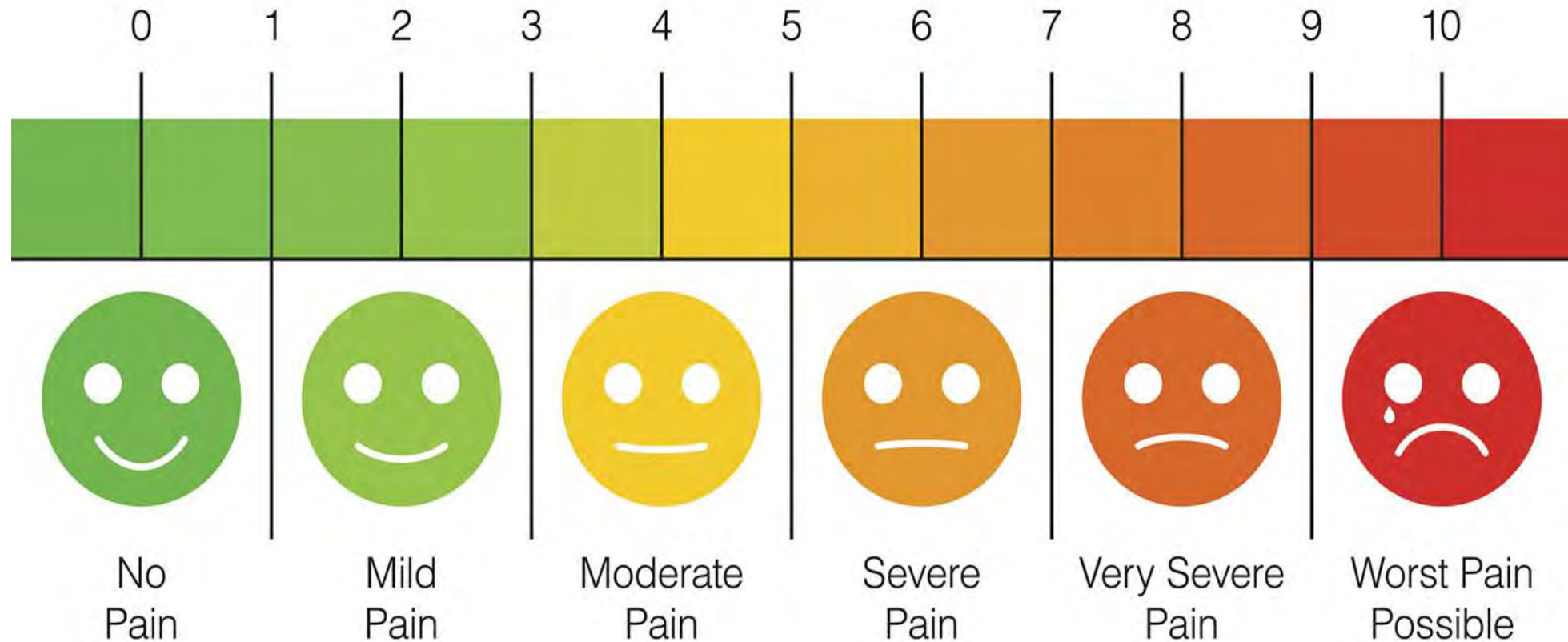


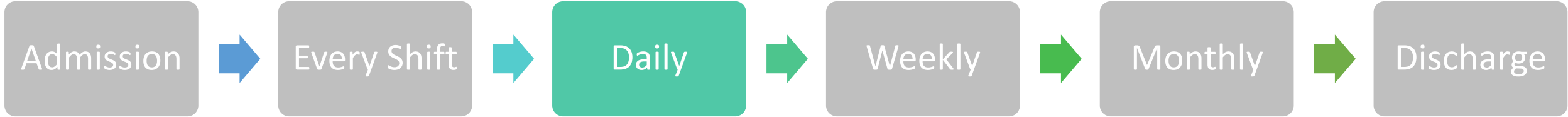


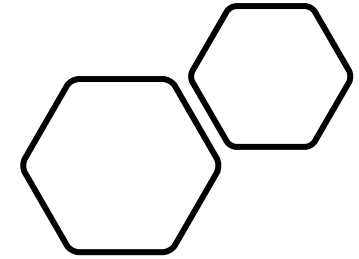
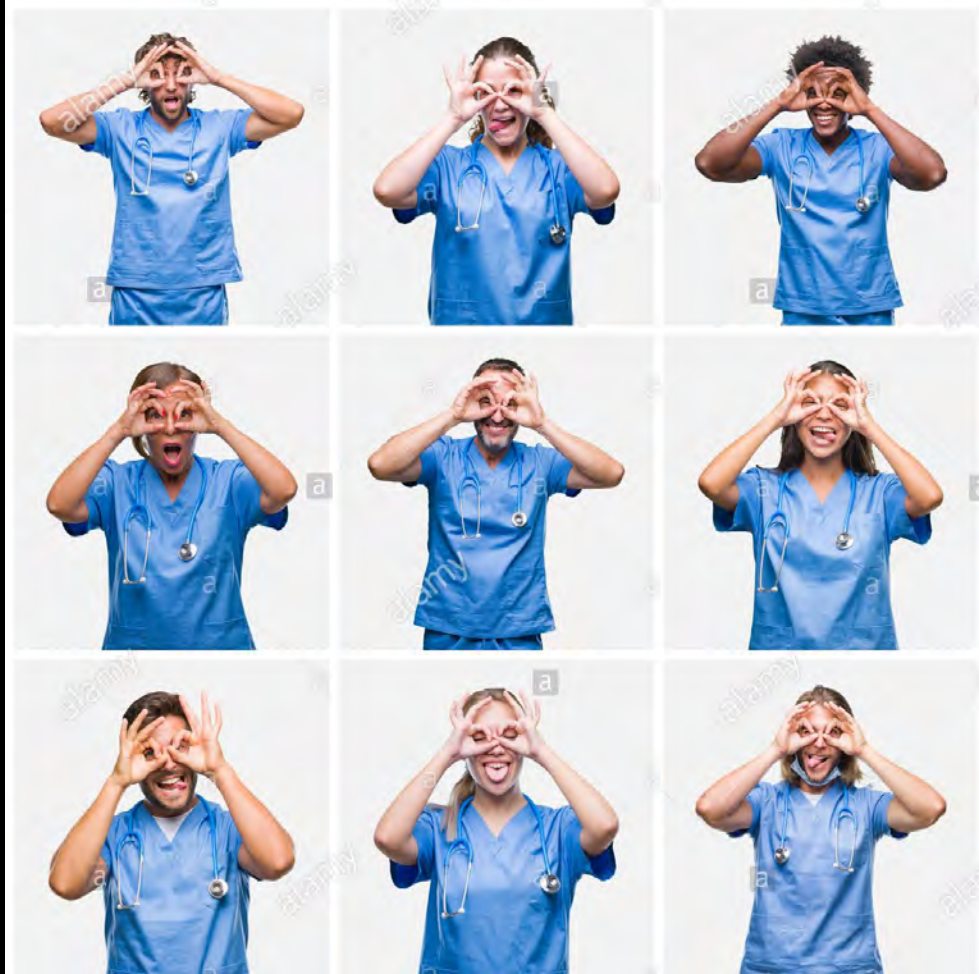
Licensed Nurse check
head to toe every shift
for first 10 days or
beyond depending on
your policy

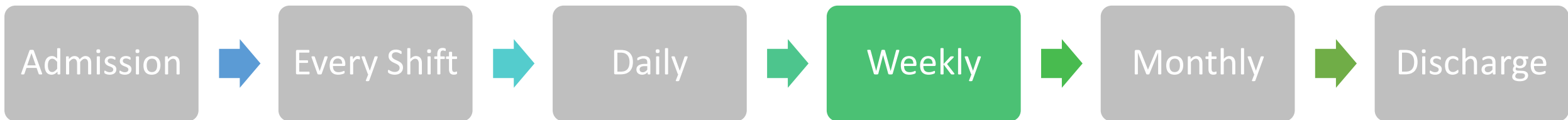


PAIN SCALE











1. Why is the wound there?
2. How do you know?
3. What's keeping it from healing?
4. What are you doing about it?

DEFINITIONS

Definitions are provided to clarify clinical terms related to pressure injuries and their evaluation and treatment.

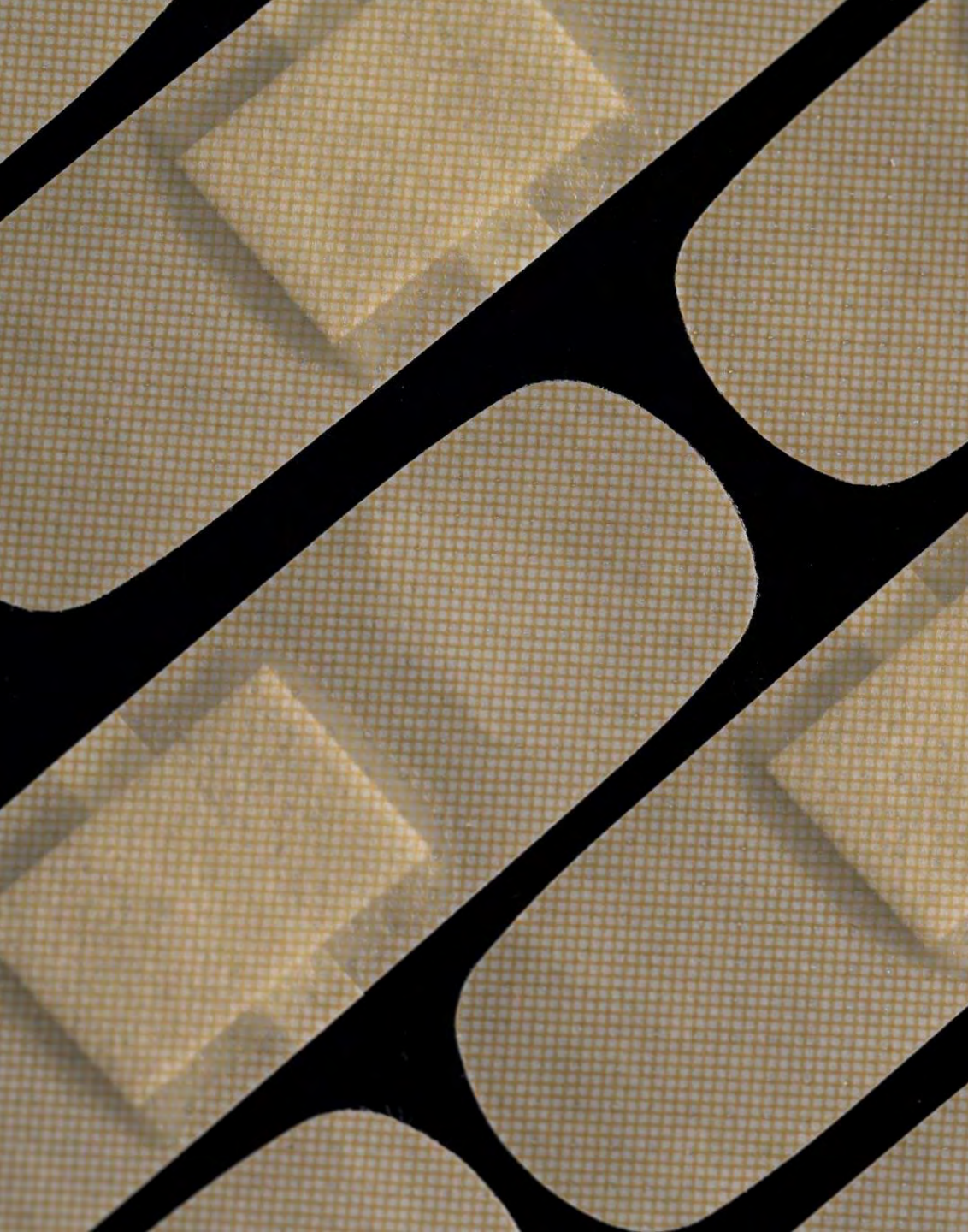
*“**Pressure Ulcer/Injury (PU/PI)**” refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. A pressure injury will present as intact skin and may be painful. A pressure ulcer will present as an open ulcer, the appearance of which will vary depending on the stage and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by skin temperature and moisture, nutrition, perfusion, co-morbidities and condition of the soft tissue.*

Friction/Shearing

- *“Friction” is the mechanical force exerted on skin that is dragged across any surface.*
- *“Shearing” occurs when layers of skin rub against each other or when the skin remains stationary and the underlying tissue moves and stretches and angulates or tears the underlying capillaries and blood vessels causing tissue damage.*

M1200: Skin and Ulcer Treatments (cont.)

- Additional supplementation above the US RDI has not been proven to provide any further benefits for management of skin problems including pressure ulcers. Vitamin and mineral supplementation should only be employed as an intervention for managing skin problems, including pressure ulcers, when nutritional deficiencies are confirmed or suspected through a thorough nutritional assessment (AMDA PU Guideline, page 6). If it is determined that nutritional supplementation, i.e. adding additional protein, calories, or nutrients is warranted, the facility should document the nutrition or hydration factors that are influencing skin problems and/or wound healing and “tailor nutritional supplementation to the individual’s intake, degree of under-nutrition, and relative impact of nutrition as a factor overall; and obtain dietary consultation as needed,” (AMDA PU Therapy Companion, page 4).
- It is important to remember that additional supplementation is not automatically required for pressure ulcer management. Any interventions should be specifically tailored to the resident’s needs, condition, and prognosis (AMDA PU Therapy Companion, page 11).



If a pressure ulcer fails to show some evidence toward healing within 14 days, the pressure ulcer (including potential complications) and the patient's overall clinical condition should be reassessed.

Avoidable/Unavoidable

- *“Avoidable” means that the resident developed a pressure ulcer/injury and that the facility did not do one or more of the following: evaluate the resident’s clinical condition and risk factors; define and implement interventions that are consistent with resident needs, resident goals, and professional standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate.*
- *“Unavoidable” means that the resident developed a pressure ulcer/injury 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.*

Avoidable VS Unavoidable

1. Evaluate the resident's clinical condition and risk factors

If yes, proceed to second criteria

If answer is no, stop and proceed with coding wound as avoidable

2. Define and implement Interventions that are consistent with resident needs, resident goals, and professional standards of practice

If yes, proceed to third criteria

If answer is no, stop and proceed with coding wound as avoidable

3. Monitor and evaluate the impact of the interventions

If yes, proceed to final criteria

If answer is no, stop and proceed with coding wound as avoidable

4. Revised interventions as appropriate

If yes, proceed with coding wound as UNAVOIDABLE

If answer is no, stop and proceed with coding wound as avoidable

Dressings and Treatments

Determination of the need for treatment for a PU/PI is based upon the individual practitioner's clinical judgment, facility protocols, and current professional standards of practice.

Product selection should be based upon the relevance of the specific product to the identified PU/PI(s) characteristics, the treatment goals, and the manufacturer's recommendations for use. Current literature does not indicate significant advantages of any single specific product over another, but does confirm that not all products are appropriate for all PU/PIs. Wound characteristics should be assessed throughout the healing process to assure that the treatments and dressings being used are appropriate to the nature of the wound.

www.woundsource.com

Dressings

- [Alginates](#) (35)
- [Antimicrobial Dressings](#) (165)
- [Collagens](#) (23)
- [Composites](#) (26)
- [Contact Layers](#) (21)
- [Foam Dressings](#) (148)
- [Gauzes & Non-Wovens](#) (32)
- [Gelling Fiber Dressings](#) (9)
- [Hydrocolloids](#) (51)
- [Hydrogels: Amorphous](#) (32)
- [Hydrogels: Impregnated](#) (10)
- [Hydrogels: Sheets](#) (12)
- [Impregnated Dressings](#) (32)
- [Medical Grade Honey](#) (23)
- [Silicone Gel Sheets](#) (4)
- [Specialty Absorptives/Super Absorbents](#) (47)
- [Transparent Films](#) (33)
- [Wound Fillers](#) (8)

ARTICLES WITH A
AR AND QUIZ TO
CE YOUR WOUND
PRACTICE

Now

The World's

Product Categories

- Autologous Delivery Technology
- Biophysical Agents
- Cellular and/or Tissue-Based Products
- Wounds
- Compression
- Debridement
- Dressings
- Equipment
- Growth Factors
- Moisture Management
- Negative Pressure Wound Therapy

- All Categories
- Biophysical Agents
- Cellular and/or Tissue-Based Products
- Compression
- Debridement
- Dressings
- Equipment
- Growth Factors
- Moisture Management
- Negative Pressure Wound Therapy
- Nutritional Management
- Offloading Devices
- Positioners & Protectors
- Practice Management Software
- Pressure Assessment & Monitoring
- Skin Care
- Support Surfaces
- Tapes & Securement
- Wound Assessment & Documentation
- Wound Care - Other
- Wound Care Chairs
- Wound Care Diagnostics
- Wound Care Training Tools

January is

- Alginate
- Antimicrobial Dressings
- Collagens
- Composites
- Contact Layers
- Foam Dressings
- Gauzes & Non-Wovens
- Gelling Fiber Dressings
- Hydrocolloids
- Hydrogels: Amorphous
- Hydrogels: Impregnated
- Hydrogels: Sheets
- Impregnated Dressings
- Medical Grade Honey
- Silicone Gel Sheets
- Specialty Absorptives / Super Absorbents
- Transparent Films
- Wound Fillers

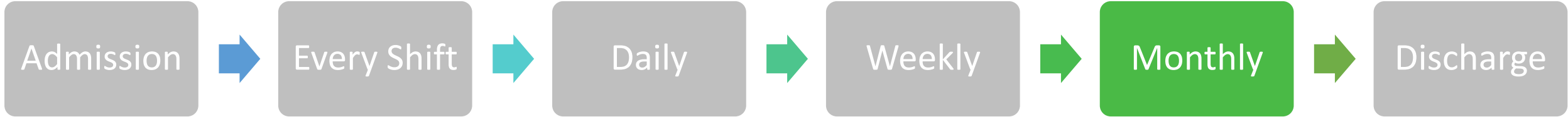
Wounds may be classified as infected if the signs and symptoms of infection are present and/or a wound culture (obtained in accord with accepted standards, such as sterile tissue aspirate, a “quantitative surface swab” using the Levine technique or semi-quantitative swab) contains 100,000 (10^5) or greater micro-organisms per gram of tissue. A superficial swab may show the presence of bacteria, but is not a reliable method to identify infection.

Some facilities may use “wet to dry gauze dressings” or irrigation with chemical solutions to remove slough. The use of wet-to-dry dressings or irrigations may be appropriate in limited circumstances, but repeated use may damage healthy granulation tissue in healing ulcers and may lead to excessive bleeding and increased resident pain.



INTERVENTION

A 3D rendering of the word "INTERVENTION" in a bold, metallic, sans-serif font. The letters are gold-colored with a gradient, appearing to be mounted on a wall. The wall has a grey and white marbled texture. A bright, circular spotlight illuminates the wall above the word, creating a strong highlight and casting a soft shadow of the word onto the surface below it.



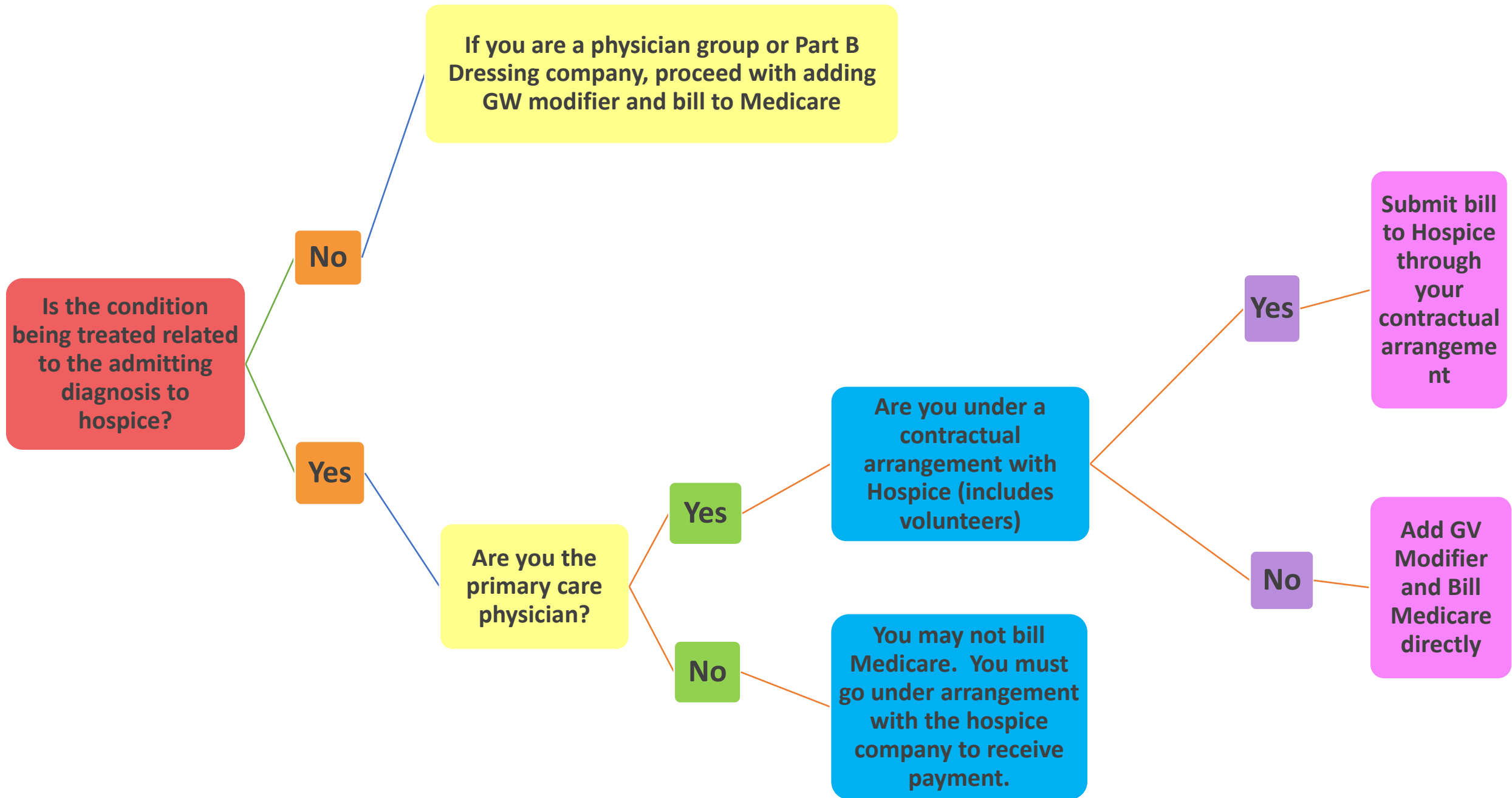
Care Plan-Hospice or Palliative Care

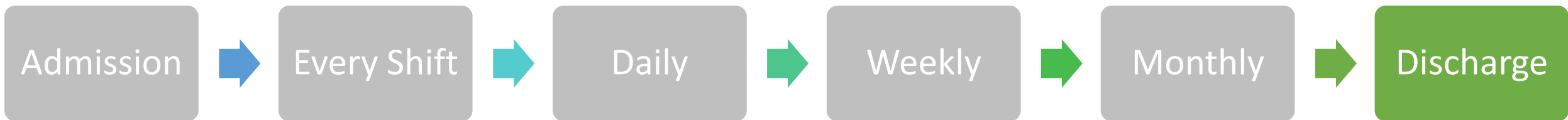
- *Medical Treatment/Diagnostic Testing - The resident and his/her representative and the attending practitioner may, based on resident choices/directives, make decisions on whether to continue medications, treatments and/or diagnostic tests. This must be included in the resident's record. (For concerns related to choice, care planning decisions and right to discontinue treatments, refer to F552 and F553.);*

Coordinated Care Plan

The nursing home retains primary responsibility for implementing those aspects of care that are not related to the duties of the hospice. It is the nursing home's responsibility to continue to furnish 24-hour room and board care, meeting the resident's personal care and nursing needs. The facility's services must be consistent with the care plan developed in coordination with the hospice, and the facility must offer the same services to its residents who have elected the hospice benefit as it furnishes to its residents who have not elected the hospice benefit.

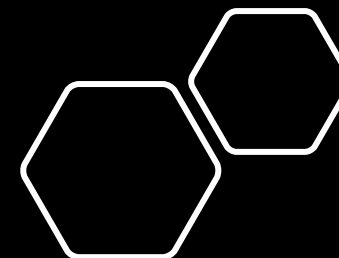
Therefore, the nursing home resident should not experience any lack of services or personal care because of his or her status as a hospice patient. This includes what would normally be provided to a resident in the nursing home, including but not limited to the following: conducting the comprehensive assessments which includes the Resident Assessment Instrument (RAI), providing personal care, activities, medication administration, required physician visits, monthly medication regimen review, support for activities of daily living, social services as appropriate, nutritional support and services, and monitoring the condition of the resident. The facility is required to develop and update the care plan in accordance with Federal, State or local laws governing the facility.







TIME
FOR
CHANGE



The Kennedy Terminal Ulcer (KTU) The facility is responsible for accurately assessing and classifying an ulcer as a KTU or other type of PU/PI and demonstrate that appropriate preventative measures were in place to prevent non-KTU pressure ulcers.

KTUs have certain characteristics which differentiate them from pressure ulcers such as the following:

- *KTUs appear suddenly and within hours;*
- *Usually appear on the sacrum and coccyx but can appear on the heels, posterior calf muscles, arms and elbows;*
- *Edges are usually irregular and are red, yellow, and black as the ulcer progresses, often described as pear, butterfly or horseshoe shaped; and*
- *Often appear as an abrasion, blister, or darkened area and may develop rapidly to a Stage 2, Stage 3, or Stage 4 injury.*

End-of-life skin and wound changes

- **Limited to Skin**
 - Kennedy Lesion
 - Mottling
 - Trombley-Brennen Terminal Tissue Injury (TB-TTI)
- **Open Wound or Full-thickness**
 - Kennedy Terminal Ulcers
 - Skin Failure-End Stage
 - Skin Changes at Life's End (SCALE) Wounds
 - Open Fungating Wounds
 - Open Malignant Wounds

May be associated with other common etiologies for alterations in skin and tissue integrity – such as pressure, friction, shear, and moisture – the primary etiology is suspected to be hypoperfusion or compromised perfusion associated with organ failure due to the dying process.



Before October 1st, 2023

NOTE: Guidance regarding pressure ulcers is found at 42 CFR 483.25 (b)(1)F686 Skin Integrity – Pressure Ulcers. Use this tag F684 for issues regarding non-pressure related skin ulcers/wounds. Kennedy Terminal Ulcers are considered to be pressure ulcers that generally occur at the end of life. For concerns related to Kennedy Terminal Ulcers, refer to F686, §483.25(b) Pressure Ulcers.



After October 1st, 2023

Skin changes at the end of life (SCALE), also referred to as Kennedy Terminal Ulcers (KTUs) and skin failure, are not primarily caused by pressure and are not coded in Section M.

M1040D Open Lesion(s) Other than Ulcers, Rashes, Cuts

- Open lesions that develop as part of a disease or condition and are not coded elsewhere on the MDS, such as wounds, boils, cysts, and vesicles, should be coded in this item.
- Do **not** code rashes, abrasions, or cuts/lacerations here. Although not recorded on the MDS assessment, these skin conditions should be considered in the plan of care.
- Do **not** code pressure ulcers/injuries, venous or arterial ulcers, diabetic foot ulcers, or skin tears here. These conditions are coded in other items on the MDS.

Skin changes at the end of life (SCALE), also referred to as Kennedy Terminal Ulcers (KTUs) and skin failure, are not primarily caused by pressure and are not coded in Section M.



L98.9: Disorder of skin and subcutaneous tissue, unspecified

Q&A: Skin failure due to hypoperfusion

March 16, 2023 – CDI Strategies - Volume 17, Issue 11

Q: We recently had a patient who presented with a stage 2 pressure ulcer. Due to hypoperfusion, the pressure ulcer progressed. The physicians are now documenting progression due to “skin failure” due to hypoperfusion. Can you have skin failure at the same site of a pressure ulcer, or is it progression of the pressure ulcer to stage 3 or 4?

A: A pressure injury is described as localized damage to skin and/or underlying soft tissue, typically over a bony prominence that is a result of pressure.

Skin failure is a loss of normal temperature control with an inability to maintain core body temperature; failure to prevent percutaneous loss of fluid, electrolytes, and protein with resulting imbalance; and failure of the mechanical barrier to prevent penetration of foreign materials.

Acute skin failure describes the cause of integumentary loss in association with hemodynamic instability and/or organ system compromise in critically ill patients. Current research show that we may be inaccurately classifying pressure injuries when skin failure is the likely cause.

So, clinically, can a patient have both a pressure injury and skin failure? Yes, they can. The documentation does need to specifically state the pressure ulcer worsened “due to hypoperfusion,” not due to pressure. Currently, there is no specific code for skin failure, so the advice out there is to use code L98.9. You can code both, stage 2 pressure injury POA-Y did not evolve to a higher stage related to pressure and other disorders of the skin, and L98.9 POA-N for the skin failure. These are two different diagnoses.

<https://acdis.org/articles/qa-skin-failure-due-hypoperfusion#:~:text=The%20documentation%20does%20need%20to,9.>

L98.9: Disorder of skin and subcutaneous tissue, unspecified

We also see issues related to Kennedy Terminal Ulcers (KTU). These are ulcers develop quickly due to the dying process. There are no specific codes for a KTU and *Coding Clinic* Second Quarter 2018, page 21, advises (bold added):

*Assign the appropriate code from category L89, **Pressure ulcer, for a Kennedy ulcer**. A Kennedy ulcer is a type of pressure ulcer that occurs at the end of life and is related to multiorgan failure. Because of its pathophysiology, this type of pressure ulcer does not typically respond to standard treatment. In view of the implications of a Kennedy ulcer for prognosis, and the differences in response from other pressure ulcers, a proposal for creation of a separate code for Kennedy ulcer may be taken to a future ICD-10 Coordination and Maintenance Meeting.*

More recent studies have shown that a KTU is likely skin failure as a result of ischemia from the dying process. This is not to say that there KTUs are strictly due to hypoperfusion, as there may be an element of pressure causing the injury. The focus for CDI work is understanding the etiology of the injury, pulling the clinical indicators together to specify the cause of the skin breakdown.

Documentation of a Kennedy ulcer without further specification will be coded as a pressure injury POA-N, which is a well-known HAC and PSI. Is this an accurate representation of the etiology of the skin injury? In certain circumstances it may be accurate and in other circumstances it may not. This is an area where CDI professionals can work with providers, wound care specialists, coders, and quality professionals to provide the necessary education so we are all capturing these specific diagnoses appropriately and accurately.

Reference: <https://www.hmpgloballearningnetwork.com/site/wounds/article/pathophysiology-skin-failure-vs-pressure-injury-conditions-cause-integument-destruction-and>

1. Head to toe assessment as soon as possible after admission but no more than 2 hours after admission
2. Clinical condition reviewed for risk of skin failure
3. Care Plan implemented consistent with needs
4. Weekly QA&A/QAPI/Risk with revision of interventions
5. Wounds categorized as Avoidable or Unavoidable
6. Daily visualization of skin by nurse aides and care staff with documentation
7. Weekly body audit head to toe by licensed nurses
8. Weekly wound assessment by licensed clinicians
9. Weekly wound measurements obtained by the same person every week
10. Clinical condition and treatments reviewed or revised every 2-4 weeks if wound is not progressing
11. MDS Section M Coded correctly
12. Wounds are not “labeled” as pressure IHA unless a thorough investigation has been completed (same as BUO or fall)
13. Nurses notes reviewed in weekly QA&A committee to verify all charting is present
14. Weekly tracking log is labeled as “Internal QA only” and is completed completely and correctly



FIVE-STAR RATED



Questions?

Martha R Kelso, RN, CHWS, LNC, HBOT
Chief Executive Officer



W O U N D
CARE + PLUS



martha-r-kelso-5209741



@MarthaRKelso



martha.r.kelso



@MarthaRKelso

Follow us on social media



W O U N D
CARE + PLUS

www.mywoundcareplus.com



wound-care-plus-llc



woundcareplusllc



woundcareplus



@mywoundcareplus