EXTENDED CARE CLINICAL

DIRECTOR OF NURSING MEETING

JUNE 23, 2016

AGENDA

LUNCH provided by AccessRN

AccessRN

Gina Carley provider of PICC, Midline, IV Services

Darria Warnock MATRIX Director

TUBE FEEDING PROVIDER XcelMed

HIM MEETING ITEMS

- Incomplete Documentation on Lab, X-rays, other tests
- Inconsistent Usage of Resident Referral Form
- Inconsistent Usage of Appropriate Event
- Increased scrutiny of Medicare documentation
- Mortician Signature for release of body
- Medication Disposition Documentation

Stephanie Peterson VP of Clinical

"HOT LIST" preventing hospital readmissions

Vendor and provider services and treatment of female residents

Psychosocial Outcome Severity Guidance to surveyors

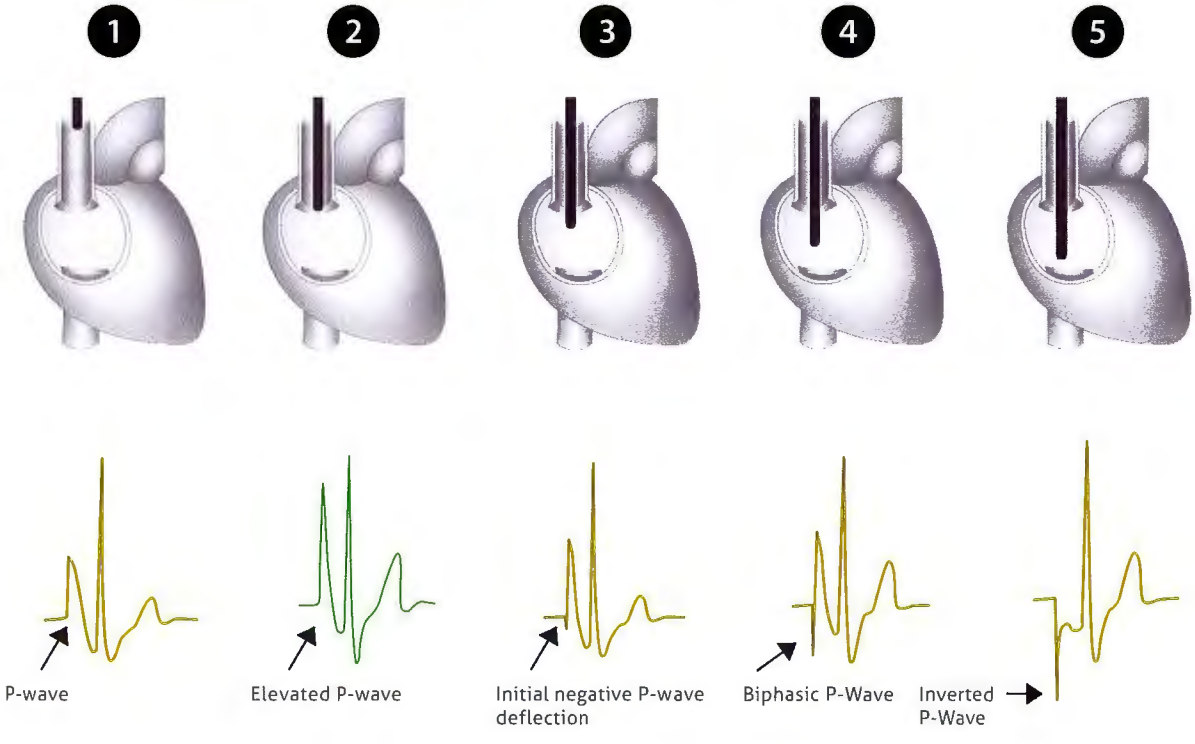
Janet Kovach and Amanda Roguljic ECC Nurse Consultants

WOW PROGRAM

Sherlock 3cg®
Tip Confirmation System

HOW ECG WORKS FOR PICC TIP CONFIRMATION

- **ECG TECHNOLOGY** is used to confirm proper catheter tip placement without the need for a chest x-ray
- Changes in **P-WAVE** amplitude allow the clinician to position the PICC tip in proximity to the cavoatrial junction. Maximum P-wave amplitude correlates to PICC tip in the lower 1/3 of the SVC near the cavoatrial junction
- Provides **COMPARATIVE ECG WAVEFORM** to assist in maximum P-wave identification



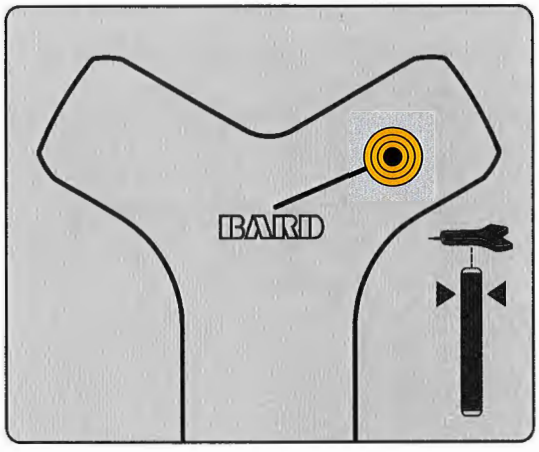
1. P-wave increasing as catheter approaches cavoatrial junction.
2. P-wave at maximum amplitude indicating catheter tip in proximity to the top of the cavoatrial junction.
3. P-wave with small negative deflection indicating catheter tip in proximal right atrium. Note: Negative deflection of the P-wave is a small downward spike immediately before the P-wave.
4. Biphasic P-wave indicating catheter tip in mid-right atrium. Note: Biphasic P-wave contains a negative deflection of the P-wave that is at least one-half the amplitude of the later positive deflection.
5. Inverted P-wave indicating catheter tip approaching right ventricle.

PICC TIP TRACKING & NAVIGATION

- The Sherlock 3CG® TCS sensor uses **REAL-TIME** catheter tracking technology to display both catheter **DIRECTION AND ORIENTATION**
- Catheter is **TRACKED** and **NAVIGATED** into the superior vena cava
- Malpositions are visually displayed in **REAL-TIME**, allowing the clinician to make the proper adjustments prior to completing the procedure.

VISUAL MALPOSITIONS

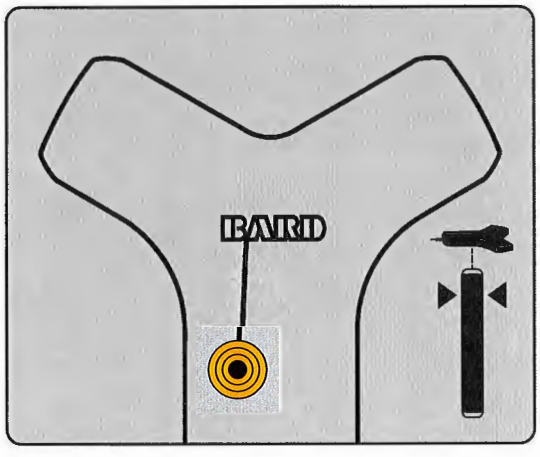
CONTRALATERAL MALPOSITION



INTERNAL JUGULAR (IJ) MALPOSITION

PROPER POSITION

(IN LOWER 1/3 OF SVC)



Sherlock 3CG® TCS is indicated for use as an alternative to chest x-ray and fluoroscopy for picc tip placement confirmation in adult patients. Any alterations of cardiac rhythms that change the normal presentation of the p-wave limit the use of ecg tip confirmation technology. In these instances, confirm picc tip location using an alternative method.

Please consult product labels and inserts for any indications, contraindications, hazards, warnings, cautions and instructions for use.

BARD | ACCESS SYSTEMS

EXTENDED CARE CLINICAL

EVANSTON, ILLINOIS

QUARTERLY HIM GROUP MEETING – Agenda

June 14, 2016 – 10 AM @ MMI

1. Issue – Returning Documents Routed for "Upload" due to ***Incomplete Documentation***:
   - Lab, X-rays, Other Diagnostic Tests (i.e. **absence of complete information regarding the physician notification circumstance** – ***name of physician notified; date and time of notification; notification method {telephone vs. fax}; if new orders were received due to the results; nurse signature)*** **Label/stamp versus free-hand information entry**
   - Medicare Certification/Recertification Forms (i.e. **absence of coverage reason(s) for recertification statements)**
   - Facility/Dialysis Unit Report (i.e. **absence of Dialysis Unit Information)**
   - Bath & Skin Report Sheets (Shower Sheets) (i.e. missing nurse skin assessment for scheduled shower; missing Aide entry for scheduled shower; absence of marked skin issue on Aide body diagram)
2. Issue - ***Inconsistent Usage of Resident Referral Form*** (i.e. off-premise physician visits; off-premise specialist consultations, etc.)
   - Form is located under "Resident Tab," Reports" {in scroll-down box}, in section entitled "Resident Info."
   - Demographic data will be automatically "extracted" from system in similar fashion to that of the "Continuity of Care" document
3. Issue – ***Inconsistent Usage of Appropriate "Event"***
   - Review/discussion of "Event" Template
   - "Chief Complaint" Event frequently used inappropriately (i.e. if a **more specific Event is NOT available to cover the circumstance to be documented, then this would be an option)**
4. Issue – ***Increased scrutiny of Medicare documentation***
   - Required frequency and nature of documentation (i.e. ***daily nurses' note; daily vital signs)***
   - Review/discussion of "Quantitative Medicare Audit" Sheet
   - Content of nurses' note: resident status as to reason(s) for Medicare coverage
5. Issue – ***Mortician Signature*** for release of body of facility expired resident
   - Indiana – on Provisional Certificate of Death/Burial Transit Permit OR Body Release Form
   - Illinois – Body Release Form (funeral director/designee should be required to show appropriate credentials to facility, however, identification should NOT be uploaded {privacy invasion}

6. Issue – ***Medication Disposition Documentation***
   - At time of discharge
   - ALL medications
   - Review/discussion of related forms
   - Documentation Associated with F 425
7. Discharge Resident Record
   - Review/discussion of related forms
8. **Review Issues:**
   - F 153 requirements
   - Facility Positions – user ID creation; password re-set; inactivation of access
   - QA Program Issues – ECC benchmarks; Podiatry/Optometry Audit
   - Signature Specimen Sheets – master signature file; Matrix
   - HIMC & HIMA Position Descriptions – cross-training issue
9. New Information:
   - Resident Order Report
   - Diabetes Mellitus Coding Issues

10. Questions & Open Discussion

PSYCHOSOCIAL OUTCOME SEVERITY GUIDE

The following are levels of negative psychosocial outcomes that developed, continued, or worsened as a result of the facility's noncompliance. This Guide is only to be used once the survey team has determined noncompliance at a regulatory requirement. The survey team must have established a connection between the noncompliance and a negative psychosocial outcome to the resident as evidenced by observations, record review, and/or interviews with residents, their representatives, and/or staff.

Areas where the survey team may more likely see psychosocial outcomes when citing a particular deficiency include, but are not limited to, F221/F222, Physical and Chemical Restraints; F223 Abuse; F224 Mistreatment, Neglect, Misappropriation; F225 Investigate and Report Allegations of Abuse; F226 Abuse and Neglect Policies; F241, Dignity; F246, Accommodation of Needs; F248, Activities; F279, Comprehensive Care Plans; F280, Right to Participate in Care Planning; F309, Quality of Care (pain, dementia care); F319, Treatment/Services for Mental/Psychosocial Functioning; F320, No Behavior Difficulties Unless Unavoidable; and F329, Drug Regimen is Free From Unnecessary Drugs. While the survey team may find negative psychosocial outcomes related to any of the regulations, these areas may be more susceptible to a negative psychosocial outcome or contain a psychosocial element that may be greater in severity than the physical outcome.

Severity Level 4 Considerations: Immediate Jeopardy to Resident Health or Safety

Immediate Jeopardy is a situation in which the facility's noncompliance with one or more requirements of participation:

- Has allowed/caused/resulted in, or is likely to allow/cause /result in serious injury, harm, impairment, or death to a resident; and

- Requires immediate correction, as the facility either created the situation or allowed the situation to continue by failing to implement preventative or corrective measures.

Examples of negative psychosocial outcomes as a result of the facility's noncompliance may include but are not limited to:

- Suicidal ideation/thoughts and preoccupation (with a plan) or suicidal attempt (active or passive) such as trying to jump from a high place, throwing oneself down a flight of stairs, refusing to eat or drink in order to kill oneself.

- Engaging in self-injurious behavior that is likely to cause serious injury, harm, impairment, or death to the resident (e.g., banging head against wall).

- Sustained and intense crying, moaning, screaming, or combative behavior.

- Expressions (verbal and/or non-verbal) of severe, unrelenting, excruciating, and unrelieved pain; pain has become all consuming and overwhelms the resident

- Recurrent (i.e., more than isolated or fleeting) debilitating fear/anxiety that may be manifested as panic, immobilization, screaming, and/or extremely aggressive or agitated behavior(s) (e.g., trembling, cowering) in response to an identifiable situation (e.g., approach of a specific staff member).

- Ongoing, persistent expression of dehumanization or humiliation in response to an identifiable situation, that persists regardless of whether the precipitating event(s) has ceased and has resulted in a potentially life-threatening consequence.

- Expressions of anger at an intense and sustained level that has caused or is likely to cause serious injury, harm, impairment, or death to self or others.

Severity Level 3 Considerations: Actual Harm that is not Immediate Jeopardy

Severity Level 3 indicates noncompliance that results in actual harm, and can include but may not be limited to clinical compromise, decline, or the resident's inability to maintain and/or reach his/her highest practicable well-being.

Examples of negative psychosocial outcomes as a result of the facility's noncompliance may include but are not limited to:

- Significant decline in former social patterns that does not rise to a level of immediate jeopardy.

- Persistent depressed mood[7,8,9] that may be manifested by verbal and nonverbal symptoms such as:

    - Social withdrawal; irritability; anxiety; hopelessness; tearfulness; crying; moaning;

    - Loss of interest or ability to experience or feel pleasure nearly every day for much of the day;

    - Psychomotor agitation[10] (e.g., inability to sit still, pacing, hand-wringing, or pulling or rubbing of the skin, clothing, or other objects), accompanied by a bothered or sad expression;

    - Psychomotor retardation (e.g., slowed speech, thinking, and body movements; increased pauses before answering);

    - Verbal agitation[11] (e.g., repeated requests for help, groaning, sighing, or other repeated verbalizations), accompanied by sad facial expressions;

    - Expressions of feelings of worthlessness or excessive guilt nearly every day (not merely self-reproach or guilt about being sick or needing care);

- Markedly diminished ability to think or concentrate;
- Recurrent thoughts of death (not just fear of dying) or statements without an intent to act (e.g., "I wish I were dead" or "my family would be better off without me").

- Expressions (verbal and/or non-verbal) of persistent pain or physical distress (e.g., itching, thirst) that has compromised the resident's functioning such as diminished level of participation in social interactions and/or ADLs, intermittent crying and moaning, weight loss and/or diminished appetite. Pain or physical distress has become a central focus of the resident's attention, but it is not all-consuming or overwhelming (as in Severity Level 4).

- Chronic or recurrent fear/anxiety that has compromised the resident's well-being and that may be manifested as avoidance of the fear-inducing situation(s) or person(s); preoccupation with fear; resistance to care and/or social interaction; moderate aggressive or agitated behavior(s) related to fear; sleeplessness due to fear; and/or verbal expressions of fear. Expressions of fear/anxiety are not to the level of panic and immobilization (as in Severity Level 4).

- Ongoing, persistent feeling and/or expression of dehumanization or humiliation that persists regardless of whether the precipitating, dehumanizing event(s) or situation(s) has ceased. The feelings of dehumanization and humiliation have not resulted in a life-threatening consequence.

- Apathy and social disengagement such as listlessness; slowness of response and thought (psychomotor retardation); lack of interest or concern especially in matters of general importance and appeal, resulting from facility noncompliance.

- Sustained distress (e.g., agitation indicative of under stimulation as manifested by fidgeting; restlessness; repetitive verbalization of not knowing what to do, needing to go to work, and/or needing to find something).

- Anger that has caused aggression that could lead to injuring self or others. Verbal aggression can be manifested by threatening, screaming, or cursing; physical aggression can be manifested by self-directed responses or hitting, shoving, biting, and scratching others.

Severity Level 2 Considerations: No Actual Harm with Potential for More Than Minimal Harm that is Not Immediate Jeopardy

Severity Level 2 indicates noncompliance that results in a resident outcome of no more than minimal discomfort and/or has the potential to compromise the resident's ability to maintain or reach his or her highest practicable level of well-being. The potential exists for greater harm to occur if interventions are not provided.

Examples of negative psychosocial outcomes as a result of the facility's noncompliance may include but are not limited to:

- Intermittent sadness, as reflected in facial expression and/or demeanor, tearfulness, crying, or verbal/vocal agitation (e.g., repeated requests for help, moaning, and sighing).
- Feelings and/or complaints of discomfort or moderate pain. The resident may be irritable and/or express discomfort.
- Fear/anxiety that may be manifested as expressions or signs of minimal discomfort (e.g., verbal expressions of fear/anxiety; pulling away from a feared object or situation) or has the potential, not yet realized, to compromise the resident's well-being.
- Feeling of shame or embarrassment without a loss of interest in the environment and the self.
- Complaints of boredom and/or reports that there is nothing to do, accompanied by expressions of periodic distress that do not result in maladaptive behaviors (e.g., verbal or physical aggression).
- Verbal or nonverbal expressions of anger that did not lead to harm to self or others.

Severity Level 1 Considerations: No Actual Harm with Potential for Minimal Harm

Severity Level 1 is not an option because any facility practice that results in a reduction of psychosocial well-being diminishes the resident's quality of life. The deficiency is, therefore, at least a Severity Level 2 because it has the potential for more than minimal harm.

ENDNOTES

[1] Gall, S., Beins, B., & Feldman, J. (1996). The Gale Encyclopedia of Psychology. Detroit, MI: Gale Research.

[2] Random House. (1981). The Random House Dictionary of the English Language. New York: Author.

[3] American Psychiatric Association (1994). Diagnostic and statistical manual of mental disorders (Fourth Edition). Washington, DC: Author.

[4] Random House. (1981).

[5] Minimum Data Set Version 2.0, Section E.

[6] Corsini, R. (1999). The Dictionary of Psychology. Ann Arbor, MI: Taylor and Francis.

Employee Discipline Checklist
(Check box and initial/date when complete)

Please ensure that all documents relevant to employee discipline are preserved within the employee's personnel file.

1. Start a file for the employee with the date of the discipline, circumstances of discipline (investigation of precipitating incident, witnesses, and interviews). ❒ _____

2. Date and time all interviews, reports, or photos. ❒ _____

3. Keep minutes of all meetings with the employee, particularly with Union representatives present. ❒ _____

4. Keep a dated, written record of all information provided in response to any requests, particularly from Union representative, employee, or employee's attorney. Keep a copy of the information request for the file, including the date it was received. ❒ _____

5. Keep a copy of the employee job description, signed acknowledgments of all disciplinary records, evaluations, relevant information regarding makeup of department (i.e. approx. number of employees by age, sex, race, and disability). ❒ _____

6. Include disciplinary action in the employee's evaluation. ❒ _____

7. If employee discipline involved termination, record who subsequently filled the position. ❒ _____

INVOLUNTARY TRANSFER OR DISCHARGE CHECKLIST

A VALID INVOLUNTARY TRANSFER/DISCHARGE NOTICE MUST MEET THE FOLLOWING CRITERIA:

1. BE FILLED OUT PROPERLY AND IN ITS ENTIRETY;
2. BE GIVEN TO THE RESIDENT AND TO THE REPRESENTATIVE IN A MANNER THAT THEY UNDERSTAND;
3. STATE THE REASON FOR THE TRANSFER OR DISCHARGE;
4. STATE THE EFFECTIVE DATE OF THE TRANSFER OR DISCHARGE (AT LEAST 30 DAYS FROM DATE OF NOTICE FOR MEDICAID CERTIFIED FACILITIES UNLESS EMERGENCY DISCHARGE);
5. STATE THE LOCATION TO WHICH THE RESIDENT WILL BE TRANSFERRED OR DISCHARGED;
6. INCLUDE THE RESIDENT'S RIGHT TO APPEAL, THE REQUEST FOR A HEARING FORM, AND A STAMPED ENVELOPE ADDRESSED TO IDPH;
7. INCLUDE THE NAME, ADDRESS, AND TELEPHONE NUMBER OF THE PERSON SUPERVISING THE TRANSFER OR DISCHARGE;
8. INCLUDE THE NAME, ADDRESS, AND TELEPHONE NUMBER OF THE STATE OMBUDSMAN OFFICE;
9. INCLUDE MAILING ADDRESSES AND TELEPHONE NUMBERS TO THE AGENCIES RESPONSIBLE FOR THE PROTECTION AND ADVOCACY OF RESIDENTS WITH DEVELOPMENTAL DISABILITIES AND MENTAL ILLNESS.
10. THE RESIDENT'S CLINICAL RECORD MUST ALSO STATE THE REASONS FOR THE ITD NOTICE.

Once notified of an appeal:

1. Send copy of IDT and appeal to Clare Mitchell **with any and all supporting documents:**
   IDT for resident no longer needs this level of care should send physician note/ progress note supporting this;
   IDT for safety should send progress notes supporting safety issues;
   IDT for non-payment send collection attempt notes

Course Status

6/1/2016

Due Date Range 1/1/2016 - 6/1/2016

Course Name	Courses Assigned	Courses Completed On Time	Courses Completed Late	Courses Not Complete Overdue	Total Completion %	Total Compliance %
All Courses	**36949**	**18450**	**6292**	**12207**	**66.96 %**	**49.93 %**

Information by UserLocations

UserLocations	Course Name	Courses Assigned	Courses Completed On Time	Courses Completed Late	Courses Not Complete Overdue	Total Completion %	Total Compliance %
	All Courses	**36949**	**18450**	**6292**	**12207**	**66.96 %**	**49.93 %**
Beecher Manor		2316	925	372	1019	56 %	39.94 %
Briar Place		1920	877	386	657	65.78 %	45.68 %
Chateau Center		2447	1745	310	392	83.98 %	71.31 %
Estates of Hyde		1613	474	453	686	57.47 %	29.39 %
Grasmere		1600	1538	62	0	100 %	96.12 %
Lakewood		2348	1192	543	613	73.89 %	50.77 %
Lemont		2145	1436	155	554	74.17 %	66.95 %
Lincolnshire		1586	834	377	375	76.36 %	52.59 %
Munster Med		3774	1707	685	1382	63.38 %	45.23 %
Park House		1247	201	276	770	38.25 %	16.12 %
Prairie Manor		2203	1204	447	552	74.94 %	54.65 %
Rainbow Beach		1721	727	648	346	79.9 %	42.24 %
Sebos		1938	567	218	1153	40.51 %	29.26 %
Sheffield/Dyer		2389	614	161	1614	32.44 %	25.7 %
South Suburban		2288	1396	278	614	73.16 %	61.01 %
St. James		2317	1334	375	608	73.76 %	57.57 %
Tri-State		1252	497	310	445	64.46 %	39.7 %
Wheaton		1223	853	160	210	82.83 %	69.75 %

SHOWER SHEET/TREATMENT RECORD AUDIT TOOL

- *Obtain shower sheet binder from nursing station, along with treatment assessment record, review shower sheet for any newly identified markings and changes in skin integrity, evaluate record for orders to ensure all identified alterations has a treatment order.*

- *Review shower sheet for accurate completion, all components on shower sheets MUST be in compliance with facility policy and procedures. For those shower sheets that are completed incorrectly, complete an educational training form with staff members who are in need of additional training and submit a copy to HR.*

- *Review treatment assessment record for compliance with skin checks. Failure to complete skin checks and sign records will result in 1:1 educational training with license staff. Further noncompliance with facility policy and procedure will result in interdisciplinary actions.*

- *Evaluate/Analyze units with newly identified pressure ulcers. Review assigned employee performance, staffing, incontinency issues, pressure relieving devices as well as turning & repositioning program. Report findings to immediate supervisor and implement a plan to prevent further occurrence.*

- *Review residents progress note for documentation of any newly acquired alterations in skin integrity and interventions implemented.*

- *Review shower sheets for those residents with behaviors of non-compliance, ensure an alternative approach has been implemented and a plan of care initiated. Review/revise care plans as needed.*

- *Submit a copy of audit tool results to Administrator & Nursing Department. Discuss facility plan of action to facilitate as well as promote compliance.*

FACILITY: ______________________________ DATE: __________________ CONSULTANT: ________________________

RESIDENT NAME	DATE OF LAST SHOWER	NURSE ENTRY		C.N.A. ENTRY				REFUSAL(S) DOCUMENTED		NURSE AND C.N.A. ENTRY AGREE	OTHER ISSUES (Please Spe
		SKIN STATUS CHECKED	SIGNED	DATED	LOTION APPLIED	SIGNED	SKIN ISSUES ON DIAGRA M	FRONT	BACK		
		☐Yes ☒ No	☐Yes ☐ No	☐Yes ☐No	☐Yes ☐ No	☐Yes ☐No	☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐No	☐Yes ☐ No	Click here to enter text.
		☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐No	☐Yes ☐ No	☐Yes ☐No	☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐No	☐Yes ☐ No	Click here to enter text.
		☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐No	☐Yes ☐ No	☐Yes ☐No	☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐No	☐Yes ☐ No	Click here to enter text.
		☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐No	☐Yes ☐ No	☐Yes ☐No	☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐No	☐Yes ☐ No	Click here to enter text.
		☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐No	☐Yes ☐ No	☐Yes ☐No	☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐No	☐Yes ☐ No	Click here to enter text.
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BATH AND SKIN REPORT SHEET

Month_____ **Year** _____

Resident Name _____

Instructions:

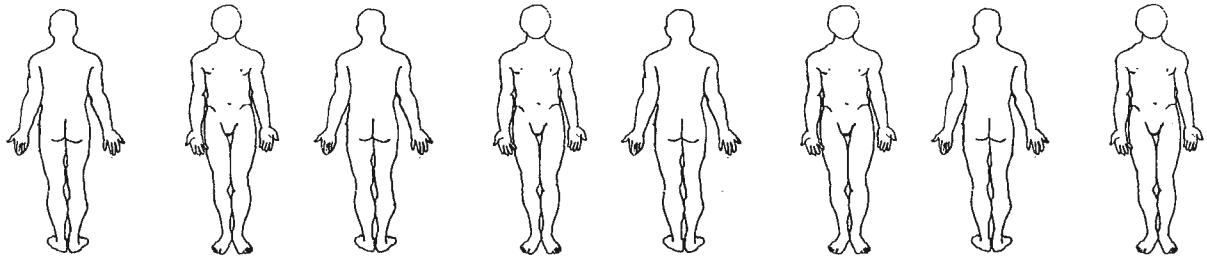
The Nurse is to perform skin checks during the resident's bath & shower days.
The Nurse should record observation on the chart below. Check 'Skin Intact' if no alterations noted.
Mark and label all skin conditions as to type on the body diagram below, such as bruise, blister, open area.
Documentation of refusals and interventions must be recorded on the reverse of this report and in the resident record.

To be completed by a Nurse:

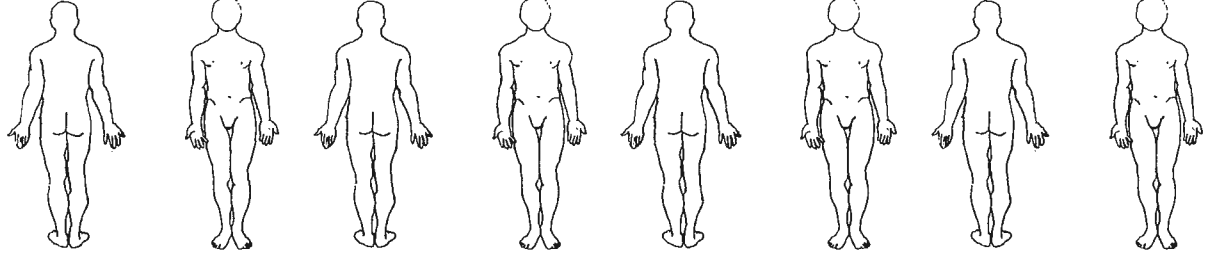
Date	Skin Intact	Bruise	Blister	Open Area	Redness & Rash	Excoriation	Other	List Action(s) Taken	Nurse Signature

To be completed by a CNA:

Date: Lotion Applied Y / N Resident Shaved Y / N Nails Trimmed Y / N CNA Signature:	Date: Lotion Applied Y / N Resident Shaved Y / N Nails Trimmed Y / N CNA Signature:	Date: Lotion Applied Y / N Resident Shaved Y / N Nails Trimmed Y / N CNA Signature:	Date: Lotion Applied Y / N Resident Shaved Y / N Nails Trimmed Y / N CNA Signature:



Date: Lotion Applied Y / N Resident Shaved Y / N Nails Trimmed Y / N CNA Signature:	Date: Lotion Applied Y / N Resident Shaved Y / N Nails Trimmed Y / N CNA Signature:	Date: Lotion Applied Y / N Resident Shaved Y / N Nails Trimmed Y / N CNA Signature:	Date: Lotion Applied Y / N Resident Shaved Y / N Nails Trimmed Y / N CNA Signature:



THIS DOCUMENT IS PART OF RESIDENT'S PERMANENT CLINICAL RECORD

Documentation of Shower/Bath Refusal Only

Month___________ Year___________

***Resident Name:*____ *Room Number:*___________________**

Indicate with a check mark intervention/approach utilize to guide/meet goal of hygiene care.

Date	Shift	Interventions Implemented/Reviewed	C.N.A Initials	Nurse Signature
		❑ Bed bath Given ❑ Full body check completed and documented ❑ Alternative shower day & time offered (Date:_____________ Shift:_______) ❑ Resident preference for shower days & time discussed and documented ❑ Behavior Occurrence Form Completed ❑ Responsible party consulted ❑ Care Plan Updated/Revised ❑ Provided set up for shower/bath ❑ Scheduled meeting with IDT team members/resident/responsible party		
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'WOW' = WIPE OUT WOUNDS

What Is This Program?

Wipe Out Wounds is a FACILITY wide ALL STAFF program to prevent wounds in our residents. It takes a TEAM effort from all staff to help prevent wounds not just nursing. Wipe Out Wounds program includes education and monitoring on turning/repositioning, documentation, nutrition, skin checks, incontinence care, and prevention measures to name a few.

Who Is Responsible?

ALL STAFF this includes dietary, laundry, housekeeping, maintenance, etc. Non-nursing staff may be asking, 'How can I help, I can't turn or change someone when they are wet?' Here's some examples of how nonnursing can help:

-Dietary staff: Notify nursing if you see a resident in the dining room and they are wet, or if you see a tray come back untouched. If dentures come back on a tray, bring them to the unit. Answer call light to see what they need.

-Maintenance/Housekeeping: Notify nursing if you see, smell or suspect a resident is wet, or if you hear the turn/repositioning announcement and you are in the room and no one comes in to turn them by the time you leave, or if you observe a food tray untouched in a room. Answer call light to see what they need.

-Laundry: Notify nursing if you find dentures in the laundry, or if you observe that they were not turned during the announcement. Answer call light to see what they need.

How is the Education Provided?

There are individual sessions that occur during different weeks, some for C.N.A.'s, nurses, and all staff. Each week covers a different topic towards wiping out wounds.

What Is Involved?

Prevention

-- *Turning/Repositioning/Off-loading* – at least every two hours when in bed, every hour when in chair.

Use bath sheet/lift sheet to avoid friction/shearing forces. Use positioning devices such as knee gatch, dycem, leg rests, wedge cushion, pillows. Limit head of bed to 30 degrees when possible. Avoid

placing directly on the hip, instead position of fat pad of buttocks. Suspend the heels when in bed
using pillows or heel suspension boots.
-- *Skin Checks* – Are done on admit/readmit, when ADL care is provided and during shower checks.
Observe the whole body not just the buttock, especially the heels. Alert the nurse immediately when an
area is observed even if you think someone else may have already reported it. It is better to have an
area reported twice then not at all. Changes in skin include bruises, skin tears, closed or open areas,
rashes, and any areas the resident says is painful even if there is nothing there.
-- *Cushion/Mattress* – All chairs/recliners should have a cushion in them. This helps even out and reduce
the pressure applied to the bones the resident sits on. If resident refuses the cushion, notify nursing so
it can be care planed. Some residents have a specialty mattress which plugs into the wall and helps
relieve the pressure more than the regular foam mattresses. Resident that are at severe risk, have a
stage 3 or 4 to the trunk of the body, or have multiple wounds to the trunk of the body qualify for this
special mattress. These special mattresses do NOT replace turning/repositioning. Use only one pad
with these special mattresses.
-- *Incontinence Care* – Urine and stool can break down the skin very quickly. Do not let a resident lay or
sit in urine or stool. Change them as soon as possible. Apply moisture barrier to peri and buttock area
to prevent break down. An incontinence brief is NOT a substitute for peri care. The brief can cause
break down even quicker because it makes the peri area skin hotter under the brief.
-- *Pad the Ears* – Any resident who uses oxygen should have the tubing padding by the ears. This
prevents breakdown at the top of the ears.
-- *Lotion & Ointments for the Skin* - Apply lotion to skin after shower and also after applying ADL care
especially to feet and legs. Lotion prevents skin from becoming dry and cracked which can leads to
itching and break down. Petroleum ointment can also be used for the feet and legs for really dry skin.

Documentation

-- *Skin Assessments* - On admit/re-admit full head to toe body check, remove all dressing and document

your observations. With each shower, observe their skin and document on shower sheets. Any time a
C.N.A. reports a new area, go and examine area and then document what you observed.
-- *Treatments* – All wounds need a treatment. Obtain treatment orders for each wound and transcribe to
Treatment Administration Record.
-- *Braden Scale* – The Braden Scale is completed on admit/readmit and weekly for 4 weeks to identify the
major areas of risk for pressure ulcer development. The Braden should also be reviewed with any
significant change in condition as well.
-- *Measurements* – All wounds must be measured every 7 days.
-- *Care Plans* – A care plan is created that lists what to do to help heal or prevent wounds and updated as
needed
-- *Notification* – Physician and responsible party are notified of wounds on admit, any new wounds, and
any changes in wound progress (good or bad)
-- *Wound Meetings* – wound meetings should be held weekly to review any new wounds, wounds that
declined, and any new/re-admits to ensure all interventions in place

How Does the Nutrition and the Dietitian Play a Role?

Nutrition is the key to healing and preventing wounds. Without nutrition a wound cannot heal. Without
good nutrition the skin can break down quicker. Always ensure a resident eats as much as they can. Allow
adequate time for them to eat. Report to nursing any time a resident refuses to eat or eats poorly. Make
sure their dentures are in so they can chew. Report any mouth pain or problems chewing. Offer alternative
if they do not want to eat what is on the tray. Encourage resident to drink all of the fluids offered on tray and
any supplements ordered.
The Dietitian should be notified any time a resident is admitted/readmitted or develops a wound. Dietitian
will follow the resident monthly until wound heals. Interventions that can be added to help healing include
milk, Vitamin C juice, Multivitamin with minerals, nutritional supplement such as Med Pass, double meat at
meals, protein supplement such as Pro Stat. Albumin or Pre-albumin can be drawn to determine protein
level as well as other labs to evaluate clinical condition.

How Does the Podiatrist Play a Role?

The Podiatrist is a doctor who specializes in the feet. Any time a resident has a wound to the foot, long
and/or painful toe nails, foot infection, or is diabetic, the podiatrist should be consulted. The podiatrist can
assist in wound care by assessing the wound, ordering diagnostic tests, diagnosing type of wound, writing
treatment orders, debriding the wound, and monitoring progress. For the diabetic resident, the podiatrist
can assist in fitting for diabetic shoes, shave down calluses, trim toe nails, monitor for changes in foot
structure, and wound care.

'WOW' = WIPE OUT WOUNDS QUIZ

1. What is the Wipe Out Wound Program?

2. Who is Responsible for the Wipe Out Wound Program?

3. Give one example of how dietary staff can assist in preventing wounds?

4. Give one example of how laundry can assist in preventing wounds?

5. Give one example of how housekeeping can assist in preventing wounds?

6. Name 4 prevention measures to avoid pressure wounds.

7. When are skin checks performed?

8. What are some ways to ensure adequate nutrition?

9. How can a podiatrist help to prevent or treat wounds?

Educational Training for Wipe out Wounds

Welcome to the WOW program! We are proud of everyone's efforts to make this program work.

Prior to beginning the program, the following should be completed:

1. Administrators should do an overview of the program with the facility's Department Heads. The overview should be done during a morning meeting and involve:
   a. General description of the program.
   b. Strategic plan for Educational Training.
   c. Reinforcing importance of the program and the need for everyone's involvement for successful completion.
   d. Shower sheets.
   e. Reinforce the need to discuss the shower schedules during facility's clinical meeting.
   f. Shower calendar for an entire month should be available at each nursing station.
   g. Doing showers on am & pm shifts, as well as weekends.
   h. MDS calendar & audits.
   i. Role of facility management in this process.

2. Facility should be divided among the Department Heads for supervision of the WOW program. Department heads will need to be present on the assigned units to assure compliance with the program.

3. The in-services for this program should be done in addition to any in-services done at the facility according to the annual in-service schedule.

5 Phase Program Education Sessions

PHASE 1 EDUCATION & TRAINING SESSIONS:
· "WOW" Wipe Out Wounds Overview (All Staff)

PHASE 2 PREVENTION SESSIONS:
· Turning / Repositioning & Offloading (All Staff)
    o This is presented to all staff so during Guardian angel rounds or when a call light is answered staff is aware if someone is positioned correctly
· Incontinence Care (C.N.A.'s & Nurses)
· C.N.A.'s An Important Part of the Team Effort (C.N.A's)
· Skin Prevention & F314 Guidelines (Nurses)

PHASE 3 DOCUMENTATION SESSIONS:
· Skin Checks & ADL Care (C.N.A.'s & Nurses)
· Shower Sheet (C.N.A.'s & Nurses)
· C.N.A. Bath/Skin Worksheet Guidelines (C.N.A.'s & Nurses)
· Braden Assessment Instructions (Nurses)
· Braden Competency Test
· Braden Test Answers
· Documenting a Wound (Nurses)
· Nursing Skin Care Plan (Nurses)

PHASE 4 NUTRITION/HYDRATION SESSIONS:
· Weight Monitoring (C.N.A.'s & Nurses)
· Supplements & Nutrition (C.N.A.'s & Nurses)
· Recommended Dietary Interventions & Labs (C.N.A.'s & Nurses)
o This is present to the C.N.A's as well as nurses so they can see the importance of ensuring the resident consumes the dietary intervention(s) to assist wound healing

PHASE 5 PODIATRY SESSIONS:
· Podiatry Services (C.N.A.'s & Nurses)
· Podiatry Services Flowchart (C.N.A.'s & Nurses)
· Sample Podiatry Form
· Diabetic Foot Exam (C.N.A.'s & Nurses)

Protocol for Implementation of the Wipe Out Wounds Program
Facility Management (DON/Administrator)

1. The ultimate responsibility for the successful implementation of the program continues to be with the facility.
2. The facility should continue with areas of responsibility assigned during the WOW Program. (May utilize room assignments for QA, Guardian Angel Program, etc.)
3. The facility will ensure completion of in-services.
4. Implementation and success of this program is dependent upon visibility and active involvement of both, the Administrator and the DON through regular walking rounds.
5. The facility will provide encouragement and positive reinforcement for a Job Well Done!

Wound Program Guideline – Management

Purpose of this guide is to prevent wounds in Facilities. It does not replace the Policy and Procedures in place for wounds but rather to focus on 4 steps to cover the majority of wound issues. Once we get these steps in place, enforced, and supervise on regular basis, we can proceed to introduce other measures.

[Step 1] Braden Assessment
To be filled out on the day of admission, within 8 hours, on all admits and readmits and then weekly for four weeks by nurse or treatment nurse as directed by DON. These assessments will be presented at the weekly wound meeting.
Based on the score and clinical condition the following interventions must be implemented.
Order may be created in matrix on admit/re-admit as reminder of when weekly braden is due. Facility may choose what flow sheet for this reminder to be generated.

[Step 2] Shower Sheets
Shower Sheets serve as an important documentation piece for resident's skin care. This document should be come part of the medical record and must be filled on every time resident receives a shower or a bath.

[Step 3] Interventions to prevent wounds:
1) Cushions on wheelchairs/recliner (for everyone) _____ *responsible. Inservice*
2) Proper mattress based on stage of wounds/Braden _____ responsible *to identify what mattress to implement. Inservice*
3) Incontinent moisture barrier (ointment) *Everyone responsible. Inservice*
4) Off loading heels - pillows or boots *Everyone responsible. Inservice*
5) Turning and repositioning to avoid laying on the wound Resident with wounds may require more frequent turning based on tissue tolerance test. *Everyone responsible. Inservice*
6) Dietitian follow-up (seen monthly if wound present by dietician) *Dietitian Referral Form, Wound report. Inservice* / Podiatrist (for diabetic wounds) *Need order for podiatrist to eval*
7) Skin assessments daily or weekly depending on Braden scale/clinical condition *Treatment nurse/DON to identify how often skin checks are completed. To be recorded on MAR or TAR depending on who is completing (this will be building specific)*
8) Lubricating the feet daily to prevent/treat dry, cracked skin *C.N.A. responsible. Inservice*
9) Padding ears if on oxygen more than 8 hours *C.N.A. responsible. Inservice*
10) Labs (to see if adequate protein) *If lab needed to be drawn, will need an order. Inservice*
11) Involving other providers, such as wound physician, nurse practitioner, and Podiatrists. *Inservice*
[Step 4] Weekly Wound meetings/NAR meetings Must take place regularly with DON and appropriate managers present. If there is a "D" in the status column on the weekly pressure ulcer report then the Administrator and DON must follow protocol for interventions as stated in the policy and procedure manual. *DON should be running meeting. See guidelines for wound meeting and who else and what to review. Perform walking rounds of residents to ensure interventions in place after meeting. Involve staff during walking rounds.*

Treatment nurse responsibilities (list not all-inclusive):
· Treating the wound
· Weekly measurements
· Wound and skin reports
· Monthly key indicators and QA report
· Order/monitor wound supplies
· Obtain appropriate treatment orders
· Update care plans
· Evaluate if wounds are healing
· Skin checks for new/re-admit residents

Turning and repositioning program suggestions:
· Turning time/position to be identified on the resident's care card and kept in room in designated area
· Overhead page/music by receptionist every 2 hours on the odd hours
· Assigned manager(s) will be monitoring that resident's are turned and repositioned when announcements/music is made to ensure compliance
· Lead C.N.A. monitors (where applicable) C.N.A's to ensure residents are turned and follows up with any non-compliance with specific C.N.A.
· CNA's rewarded for having the appropriate interventions (Step 2) in place during their shift (example: raffle tickets handed out and raffle monthly for prize)

Podiatry Services

Plan for Facility Management:

1) Meet with podiatry provider and discuss the following
    a. Scheduling
    b. Reporting after each routine visit
    c. Rescheduling patients who were not available during routine visit
    d. Documentation
        i. Routine Care
        ii. Incidents (accidental cutting & etc.)
2) Where possible, make a designated area for podiatry care (for podiatry visits that occur between 9 am and 5 pm)
3) Make sure supplies are available for podiatrists (i.e. clean towels, sink, linen and etc.)
4) Inform patients about upcoming podiatry visits
5) Establish communication between Social Service and Nursing about these issues.
6) Educate staff about podiatry services as part of WOW

We need podiatry group to do the following:

1) Come to facility at appropriate intervals to assure that every resident is seen every 68 days
2) Communicate with facility about residents who were not able to be seen during podiatrists' visit
3) Conduct an exit conference with DON or Designee after each routine visit
4) Work on minimizing resident injury during toe cutting.
5) A podiatrist must complete an incident report or event documentation for each resident who was injured during treatment (ex: cut during toe nail trimming)
6) Do appropriate charting for each visit
7) Provide each facility with the copy of the sanitizing policy & copy of MSDS for the chemicals used
8) Podiatrists need to be educated about our Infection Control Protocol
9) In-Services at each facility annually for all staff
    a. Podiatry services: whats included
    b. When to call a podiatrist

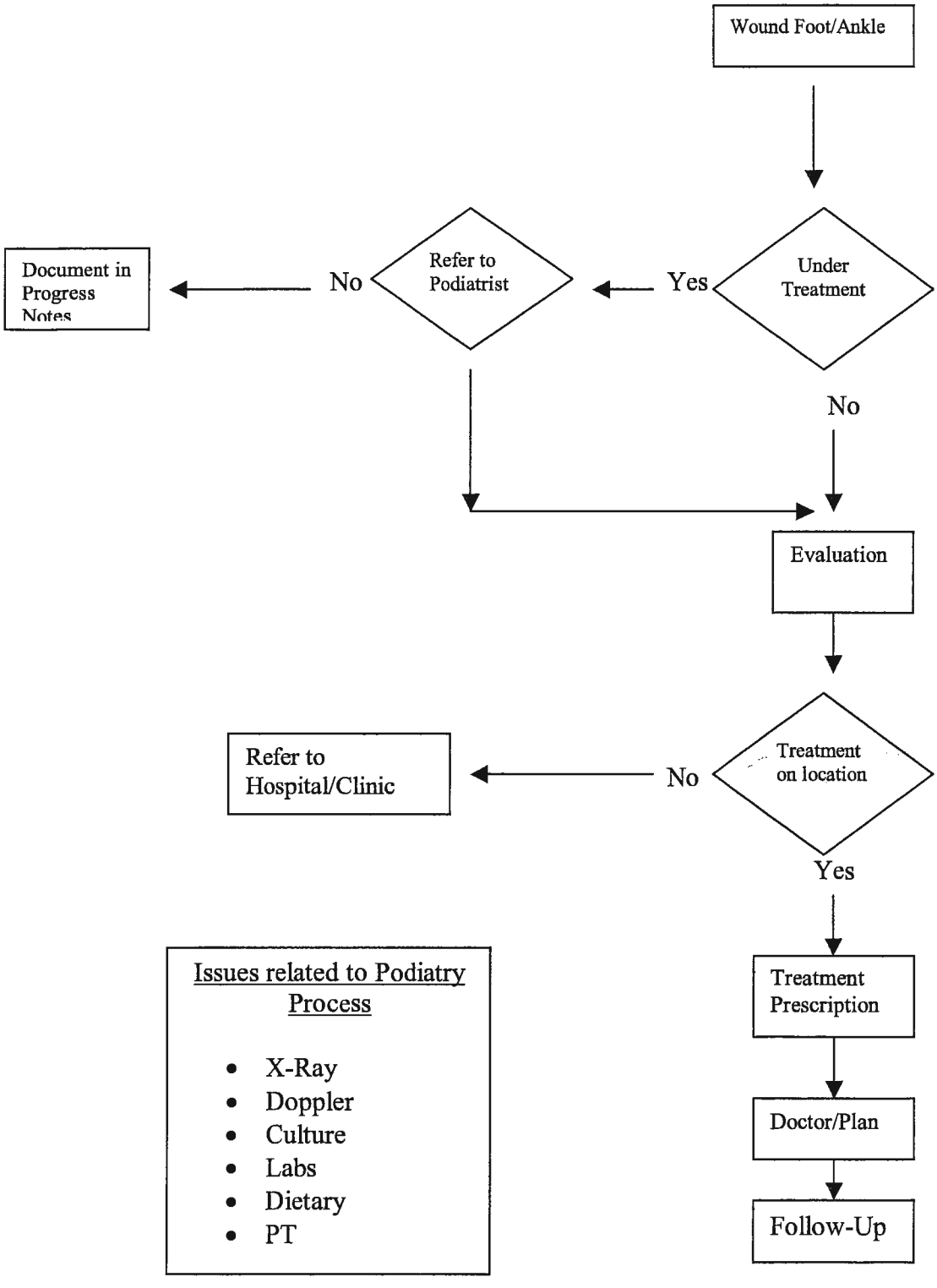
Plan for the Facilities:

1) Podiatrist can do the following services for your patients:
    a. Visit each resident every 68 days (approx 10 weeks)
    b. Foot assessment and care, including nail trimming
    c. Orthotics (assessment for orthotic shoes, heel lifts, corrective pieces, shoe inserts, foot and ankle braces)
    d. Circulatory and neuro assessments
    e. Implement wound prevention program for lower extremities
    f. Treat existing wounds: Referrals for podiatrists
    g. Education and training
    h. Coordinate services related to podiatry process: X-ray; doppler, culture, labs, dietery, PT
    i. Issue orders related to podiatry process
    j. Podiatrists need to check with either DON or designee before they go for report
2) Consents need to be provided to the podiatrists:
    a. Consents for podiatry services need to be completed upon admission
    b. Admission will fax consents to the Podiatry Group
    c. Review charts of existing residents for consents and procure consents where needed

d. For Matrix facilities Consents need to be scanned and uploaded into Matrix.

3) Existing Patients:
   a. Every existing patient needs can be seen by a podiatrist at least every 10 weeks (68 days)
   b. If a podiatrist misses a visit with the patient, patient needs to be added to the list for the next visit.
   c. Nurses and CNAs need to work together to generate referrals to the podiatrist for residents interum acute foot issues (i.e. open areas on feet, calluses, bunions, corns, fungal infection under the toe nail, neuro and circulatory issues).
4) Contact list for each facility:
   a. Social Service for scheduling
   b. DON for clinical (subject to changes by need)
5) Protocol for facilities that are currently sending out residents out for wound care
   a. Try utilizing podiatry group to do it in-house care for issues related to ankles and feet
   b. Make sure referrals are called in timely
6) Utilizing podiatry group for wound care
   a. Referrals & notifications
7) Provide podiatrists with adequate supplies: towels & etc.
8) Build a relationship with consulting podiatrist: have wound care nurses work with Podiatrists for residents with feet ulcers.

Podiatry Services Acute Care Protocol



Issues related to Podiatry Process

- X-Ray
- Doppler
- Culture
- Labs
- Dietary
- PT

Facility Wound Meeting Guidelines

1. How often?
    a. At minimum every month. Recommended every week.
2. Who should attend?
    a. Interdisciplinary Members. Team can be made up of the Director of Nursing or ADON, Treatment Nurse, Care Plan Coordinator, Therapy, Dietary, Nurse Manager, etc.
3. What residents should be reviewed?
    a. All new admit and re-admits.
    b. Any residents with new onset wounds.
    c. Any residents whose wound has gone from partial to full thickness.
    d. Any residents whose wound has failed to improve in two weeks.
    e. Any residents whose wound has become infected.
4. What information in the clinical record should be reviewed?
    a. Verify that each wound identified has a treatment order and a Skin Integrity Observation.
    b. Verify that the location for each wound is identical on the treatment record and the 'Skin Integrity Observation'.
    c. Verify, based on current assessment, if treatment if appropriate. Follow Treatment Guidelines. If treatment is against guidelines, review physician progress notes to determine if physician has documented reason for using alternative treatment?
    d. If new onset of odor, purulent drainage, peri wound redness, or lack of healing present, has infected been ruled out? Has MD been notified?
    e. If lack of healing, review medications for corticosteroids, anti-inflammatory, CA drugs, immunosuppresives, radiation. These medications may slow or impede wound healing.
    f. Review Braden for the resident. Does it need to be updated? Any areas on the Braden that are identified as a problem should have interventions put into place if possible, i.e. to prevent friction/shearing. Based on Braden score and individual resident condition, identify all interventions that need to be implemented based on the Pressure Prevention Program.
    g. Determine and implement any pressure redistribution devices.
    h. Review current labs. Determine if labs need to be drawn based on wound, resident condition, etc.
    i. Review chart to determine if Wound Physician/Dietitian / Podiatry referral needed. NOTE: Podiatrist must see all diabetic residents unless family/resident refusal. Dietitian must see all new / readmit residents. Dietitian must also follow any residents with wounds until closure of wounds.
    j. Review current nutrition, is it appropriate or do other interventions need to be added? Look at weight, labs, etc. Are weekly weights or other labs needed to assess? Is MVI with minerals needed?
    k. Determine if therapy needs to evaluate for possible treatment.
    l. Review Care Plan. Are interventions still current? Have any new interventions been added to care plan. Is date on care plan for when

intervention were added?

m. Review History and Physical or any hospital consultations for relevant diagnosis that may hinder healing, put resident at risk for breakdown, or diagnosis ulcer type. Those found need to be added to POS.

n. Determine if diagnostic tests are needed to classify or Rule out diagnosis of ulcer type such as venous or arterial Doppler, ABI.

o. Identify if education has been provided or is needed to resident / family regarding prevention / treatment / care, etc.

5. Other:
    a. Does resident qualify for Medicare Part B Program?
    b. Does resident require significant change MDS?
    c. Review Pressure Report to identify if acquired wounds are being identified at stage 1, or 2 or are they not being reported until a higher stage Reinservice may be needed for staff regarding signs of skin breakdown.
6. Minutes
    a. Document residents who were reviewed.
    b. Document any changes made.

WOW Program Audit Tool

Facility Name:_____ Date:_____

		Yes	No	Comments
1	Facility In-Service Binder is up to date with the WOW educational schedule.			
2	Facility morning minutes are being completed properly and reflect WOW follow up (should be kept in a binder).			
3	Shower Sheets & Shower Schedules are up to date & are done properly.			
4	Rounds with a Department Head (chosen randomly). Department Head is familiar with the program and understands his/her role.			
5	Staff is observed implementing WOW program (ask staff about turning schedules, repositioning, availability of cushions and other devices).			
6	Rounds with a DON and/or Wound Nurse and random checks of residents indicate compliance with WOW.			
7	Randomly selected direct care staff (Nurses & CNAs) to exhibit understanding of WOW program.			
8	Supplies are readily available to CNAs (ex: linens, soap, lotions and other skin barriers & etc.)			

Completed by:_____

Additional Comments:_____