

Cutting Edge Wound Care

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The New CMS Guidelines on Pressure Ulcers in Long Term Care: What Every Physician and Nursing Facility Needs to Know

Inside this issue:

- [New CMS Guidelines on F-Tags](#)
- [Classifying Unavoidable Pressure Ulcers](#)
- [What I can expect from survey on my wounds](#)
- [Stop Wet to Dry](#)
- [Help is just a call away](#)
- [Second Annual Wound Care Symposium](#)

“Nothing great in the world has been accomplished without Passion.”

... Georg Wilhelm, *O Magazine*,
September 2003

The new guidelines concerning pressure ulcers and other wounds were initiated and in effect starting back in Nov 12, 2004. There are some major changes to the interpretation of these guidelines, in particular, diagnosis and assessment of all types of wounds. This will have a profound effect on nursing facilities and for physicians who practice in long term care.

Here's a synopsis on what has changed with F 314 and F 309:

F314 Tag – This is the data tag that surveyors use to evaluate nursing homes for pressure ulcers. The regulation itself has not changed. However, the interpretation is very different. It used to be that nursing homes could call a wound a pressure ulcer or “something else”. The new guidelines now require that ALL wounds must be defined in some fashion. As you know, nurses are not allowed to make diagnoses. This means that physicians, nurse practitioners or physician assistants will be called upon more frequently to help diagnose, assess and document wounds and their etiology.

F 309 Tag - Under this data tag all other wound types must be categorized and evaluated. Not only will the etiology be important but the progress of wound healing.

In a nutshell if someone wants to call a wound vascular, this will require physician/NP/PA level documentation. The documentation will need to fit diagnostic criteria for the type of wound described. There are very specific and detailed descriptions for arterial, venous and diabetic wounds in the guidelines.

Additionally, surveyors will be reviewing the wound progression. If a wound is not healing, is there documentation to support the wound's inability to heal?

Therefore, surveyors will indeed be looking at ALL wounds in the facility and reviewing medical records for the appropriate documentation.



Avoidable Versus Unavoidable Pressure Ulcers

It used to be that physicians could be called upon to write a note or sign off on a document stating that a wound was unavoidable due to risk factors. Although this may still be helpful, it will not result in a wound being called unavoidable by a surveyor. The definition of unavoidable has been stated as the following:

Resident developed ulcer and the facility did ALL of the following:

- Evaluated clinical condition and risk factors
- Defined and implemented interventions consistent with needs of wound care
- Monitored and evaluated the impact of the interventions
- Revised the interventions as appropriate

Just one of the above criteria can now be cited for an **avoidable** wound.

Avoidability is no longer associated to risk.

Deep Tissue Injury

It is now recognized that many wounds that present as superficial Stage I or II are actually much deeper due to a deep tissue injury that occurs below the surface. This occurs even before the skin surface opens. The new MDS 3.0 will specifically address this injury but it has not been released yet. However, nursing facilities may start documenting deep tissue injury to help explain why a superficial wound has become deeper. This documentation will require a physician level note.

The Survey Process

Surveyors will not only be interviewing nurses and residents in the facility. Any physician, nurse practitioner or physician assistant involved in the care of the resident may be called and asked to explain why they consider a wound to be of certain etiology.

Please note a nurse practitioner/physician assistant and their documentation is considered at a physician level and thus, can be used.

If an attending physician has chosen a consultant to manage a certain problem such as wound care, then they can defer any survey questions concerning the wounds to the consultant .

In addition, pain management for wounds, repositioning and support surfaces as well as prevention of infection will also be heavily scrutinized.

What Physicians and Facilities Need to Do NOW!

Avoid Wet to Dry Gauze dressings – There is clear indication in the new interpretation of the guidelines that wet to dry gauze is considered a mechanical debridement technique, which it is! **It is not truly meant to help heal wounds.**

Therefore, use of wet to dry gauze dressings except for debridement risks citations and fines for nursing homes. In addition, there is a higher incidence of infection with gauze, which could also lead to citations and fines.

Homes should utilize standard of wound care protocols that are available to them, and their physicians should avoid routine wet to dry gauze.

In fact, nursing homes could actually be cited for not convincing physicians to use other wound treatments.

Knowledge of other dressing materials will be essential to the home.

If you are not familiar with these types of dressings, then getting a wound care consultant to come in and manage the wounds would be most beneficial.

What Physicians and Facilities Need to Do NOW! continued

Meticulous Documentation –

For wounds of any type, physicians or a wound service using mid-level providers are going to be asked to **come in and document**.

Since nurses cannot make diagnoses, it will require physicians to assess, diagnose and then document the following information for wounds:

- **Underlying conditions**
- **Ulcer edges**
- **Wound bed**
- **Location**
- **Shape of the wound**
- **Characteristics of the surrounding tissues.**

For example, it used to be that nurses would simply call a physician and state that someone has a diagnosis of peripheral vascular disease and they need a diagnosis of a vascular wound. This will not be appropriate anymore.

The documentation will be carefully scrutinized for all wound types including vascular wounds and the supporting documentation for a wound's etiology must be on the chart from a physician level standpoint.

As stated, physicians will be required to provide the documentation and will most likely be required to come in and see residents on a more frequent basis to document the items outlined.

If you are unable to do this, then there are wound management services, like ours, that can help provide the documentation needed and follow these residents with the required frequency.

It is important to make sure everyone understands the new guidelines. See the last page for a list of references which may be utilized to learn more about wound care.

Just a quick word on debridement...

One of the most important factors in getting a wound to heal is to get it debrided quickly when needed. Most wound experts would agree that sharp debridement is the most effective way to achieve this goal. Additionally, we have found that performing sharp debridement more selectively allows for a more efficient debridement, but without causing pain or bleeding. We can reduce transportation costs by performing the debridements at the bedside. Sharp debridement is more effective than debriding agents in cleaning up the wound bed leading to a faster healing time.

How Can We Help?

Over the past five years, we have helped manage wounds in over 270 nursing homes across Ohio and have healing rates second to none. Our standardized **documentation meets or exceeds the new interpretation of the revised CMS guidelines**.

Our NP staff will help to **assess, diagnose and implement** treatment plans that demonstrate the progression and healing of wounds, and follow up as needed. This documentation is considered at a physician level and therefore, will meet the requirements set forth by CMS. The majority of our NP's are **Certified Wound Specialists** who focus solely on wound management in long term care, long term acute care or home care settings.

Our service helps to document difficult problems such as **deep tissue injury**. We are familiar with the definitions of unavailability and will ensure that when such documentation exists it will be properly utilized.

We feel a duty to provide education to nursing staff, residents and their caregivers to gain a complete understanding of the wound care.

We hope that you will see this service as many do, an **unequivocal benefit to the home, resident and primary care physician**. Early involvement of our service with all wounds helps with documentation of deep tissue injury, noncompliance issues and identification of complex factors that prevent wounds from healing quickly.

Save the Date:
November 4,
2005
Second Annual
Cutting Edge
Wound Care
Symposium
Independence,
Ohio

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*By the way...we're on
the web!...nesao.com*

This is a listing of references provide by CMS on their new guidelines:

- The Clinical Practice Guidelines from the Agency for Healthcare Research and Quality (AHRQ) www.ahrq.gov (Guideline No. 15: Treatment of Pressure Ulcers and Guideline No.3: Pressure Ulcers in Adults: Prediction and Prevention)(AHRQ was previously known as the Agency for Health Care Policy and Research [AHCPR]);
- The National Pressure Ulcer Advisory Panel (NPUAP) www.npuap.org;
- The American Medical Directors Association (AMDA) www.amda.com (Clinical Practice Guidelines: Pressure Ulcers, 1996 and Pressure Ulcer Therapy Companion, 1999);
- The Quality Improvement Organizations, Medicare Quality Improvement Community Initiatives site at www.medqic.org;
- The Wound, Ostomy, and Continence Nurses Society (WOCN) www.wocn.org;
- The American Geriatrics Society guideline “The Management of Persistent Pain in Older Persons”, www.healthinaging.org.

NOTE: *References to non-CMS sources or sites on the Internet are provided as a service and do not constitute or imply endorsement of these organizations or their programs by CMS or the U.S. Department of Health and Human Services. CMS is not responsible for the content of pages found at these sites. URL addresses were current as of the date of this publication.*

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