

Documentation Standards for Wounds in Long-Term Care

Background

- + Documentation is a critical component of resident care. The Office of the Inspector General (OIG) of the US Department of Health and Human Services has stated that providers carry the burden of proving that care was actually rendered to patients (residents). If health care providers are unable to prove that they rendered appropriate care because it was not documented, the OIG and other fraud enforcement agencies may conclude that claims submitted are false. Those who provide hands-on care also risk liability for negligence when they fail to document care provided.²
- + The Social Security Act mandated “the establishment of minimum health and safety standards that must be met by providers and suppliers participating in the Medicare and Medicaid programs”. The Centers for Medicare and Medicaid Services (CMS) has been tasked by the Secretary of the Department of Health and Human Services (DHHS) to administer these programs and ensure compliance. CMS therefore provides regulatory guidance to providers and suppliers through a document known as the State Operations Manual (SOM). Appendix PP of the SOM contains, among other items, minimum standards for wound care documentation in the long-term care setting.⁴

These standards are specifically found in Section 483.25 of Appendix PP of the SOM which gives rise to multiple F-tags, including the F-tag 686 (F686: Treatment/Services to Prevent/Heal Pressure Ulcers) and the F-tag 684 (F684: Quality of Life). F686 specifically addresses the minimum assessment, daily monitoring, and weekly documentation requirements when a pressure ulcer/injury is present. F684 then addresses documentation requirements for *any* skin ulcer/wound.^{3,5}

In addition to the SOM, other regulatory documents, such as the Resident Assessment Instrument (RAI), provide guidance to providers and suppliers on minimum wound documentation and reporting requirements in long term care. As such, it is important to be aware of these various documents and comply with the directions for each.^{1,3}

Recommendations

- + To help ensure compliance regarding care provided, a facility should make sure their documentation meets or exceeds, the requirements set forth in the F686. These requirements can be distilled down into three main elements: assessment, daily monitoring and weekly documentation. It is important that the facility have a system in place to assure that the protocols for daily monitoring and for periodic documentation of measurements, terminology, frequency of assessment, and documentation are implemented consistently throughout the facility for all wound types. The minimum content of each element is outlined below.

- + F686 – Pressure Ulcers/Injuries

It is important that each existing pressure ulcer/injury be identified, whether present on admission or developed after admission, and that factors that influenced its development, the potential for development of additional injuries or for the deterioration of the pressure ulcer/injury be recognized, assessed and addressed. Any new pressure ulcer/injury suggests a need to reevaluate the adequacy of the plan for preventing pressure ulcers/injuries.

Recommendations (Continued)

+ F686 – Pressure Ulcers/Injuries (Continued)

When assessing the ulcer/injury itself, it is important that documentation addresses:

- + *Type of injury (pressure-related versus non-pressure-related) **because interventions may vary depending on the specific type of injury;***
- + *PU/PI's stage;*
- + *Description of the PU/PI's characteristics;*
- + *Progress toward healing and identification of potential complications;*
- + *If infection is present;*
- + *Presence of pain, what was done to address it, and the effectiveness of the intervention; and*
- + *Description of dressings and treatments* ³

+ F684 – Non-Pressure Ulcer/Injury Wounds

Residents may develop various types of skin ulcerations. At the time of the assessment, clinicians (physicians, advance practice nurses, physician assistants, registered nurses and certified wound care specialists, etc.) should document the clinical basis for any determination that an ulcer is not pressure-related, especially if the injury/ulcer has characteristics consistent with a pressure ulcer, but is determined not to be one.

At minimum, documentation should address:

- + ***Underlying condition contributing to the ulceration***
 - + ***Ulcer edges and wound bed***
 - + ***Location***
 - + ***Shape***
 - + ***Condition of surrounding tissues*** ³
- + It is important that the facility have a system in place to assure that the protocols for daily monitoring and for periodic documentation of measurements, terminology, frequency of assessment, and documentation are implemented consistently throughout the facility. When a pressure injury is present, daily monitoring, (with accompanying documentation, when a complication or change is identified), should include:
- + An evaluation of the ulcer, if no dressing is present;
 - + An evaluation of the status of the dressing, if present (whether it is intact and whether drainage, if present, is or is not leaking);
 - + The status of the area surrounding the ulcer (that can be observed without removing the dressing);
 - + The presence of possible complications, such as signs of increasing area of ulceration or soft tissue infection (for example: increased redness or swelling around the wound or increased drainage from the wound); and

Recommendations (Continued)

- + The presence of possible complications, such as signs of increasing area of ulceration or soft tissue infection (for example: increased redness or swelling around the wound or increased drainage from the wound); and
 - + Whether pain, if present, is being adequately controlled.³
- + The amount of observation possible will depend upon the type of dressing that is used, since some dressings are meant to remain in place for several days, according to manufacturers' guidelines. With each dressing change or at least weekly (and more often when indicated by wound complications or changes in wound characteristics), an evaluation of the pressure ulcer should be documented.

At a minimum documentation, in the medical records, should include the date observed and:

- + Location, wound etiology and/or staging;
 - + Size (perpendicular measurements of the greatest extent of length and width of the ulceration), depth; and the presence, location and extent of any undermining or tunneling/sinus tract;
 - + Exudate, if present: type (serous, serosanguinous, purulent, etc.), color, odor and approximate amount;
 - + Pain, if present: nature and frequency (e.g., whether episodic or continuous);
 - + Wound bed: Color and type of tissue/character including evidence of healing (e.g., granulation issue), or necrosis (slough or eschar); and
 - + Description of wound edges and surrounding tissue (e.g., rolled edges, redness, hardness/induration, maceration) as appropriate.³
- + Photographs may be used to support this documentation, if the facility has developed a protocol consistent with accepted standards (e.g., frequency, consistent distance from the wound, type of equipment used, means to assure digital images are accurate and not modified, inclusion of the resident identification/ulcer location/dates/etc. within the photographic image, and parameters for comparison).

References

1. Centers for Medicare & Medicaid Services. Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual. Version 1.15. Released October 2017.
2. Office of Inspector General Website. Available at: <https://www.oig.hhs.gov/fraud/strike-force/>
3. State Operations Manual Appendix PP-Guidance to Surveyors for Long Term Care Facilities. Revised 11/22/17. pp. 248-266, 272, 273.
4. State Operations Manual-Chapter 1 - Program Background and Responsibilities. Revised 10-3-14. p. 3.
5. Pressure Ulcer/Injury Critical Element Pathway. Department of Health and Human Services Centers for Medicare and Medicaid Services. CMS Form 20078, 5/2017.