

PRESSURE ULCER QUALITY INDICATORS, DATA SOURCES, ELIGIBILITY, AND SCORING RULES

QUALITY INDICATORS:	ELIGIBILITY*, DATA SOURCE†, & SCORING RULES	Pass	Fail
IF a Nursing Home resident:			
1. Is unable to reposition him or herself, or has limited ability to do so, THEN perform risk assessment with a standardized scale on admission & <u>weekly for first 4 weeks.</u>	Scoring Rules: Pass (original indicator) = documentation of risk assessment within 1 week of admission & then weekly during the first four weeks. Pass (revised indicator) = documentation of risk assessment within 1 week of admission. Risk assessment scales include the Braden Scale ¹¹ , the Norton scale ¹⁶ , or a facility-created scale with at least 3 risk factors.		
2a. Is identified as “at risk” for PUs‡, THEN address: 2 hour repositioning, pressure reduction, & nutritional status unless not needed or tolerated.	Scoring Rules: Pass = nurse aide flow sheets, licensed provider notes, physician’s orders, or the care plan note the 3 interventions. Nurse aide flow sheets with a check-off box for repositioning which include frequency are acceptable. Any nutritional assessment is acceptable.		
2b. Is identified as “at risk” for PU development, THEN implement pressure reduction.	Data Source: Direct Observation Scoring Rules: Pass = observed on pressure reduction (e.g., low air loss bed, foam, air, or gel wheelchair or mattress overlays) on any 1 hourly observation from 7am—7pm.		
3. Is found with a PU, THEN assess nutritional status within 1 week.	Eligible: Resident with presence or history of PUs‡ Scoring Rules: Pass = any nutritional assessment if within 1 week of first recorded notice of the PU.		
4. Is found to have a PU, THEN assess the PU for: 1) location, 2) depth/stage, 3) size, & 4) necrotic tissue.	Eligible: Resident with presence or history of PUs Scoring Rules: Pass = Licensed provider admission assessment, progress notes, or treatment records note all 4 wound characteristics.		

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5. Has a PU, THEN a topical antiseptic should not be used on the wound.	Eligible: Resident with presence or history of PU (stage II-IV). Scoring Rules: Pass = physician’s orders or licensed nurse treatment records or weekly summary indicate no topical antiseptic used on the wound.		
6. Has a clean full-thickness or a partial thickness PU, THEN a moist wound healing environment should be provided with topical dressings.	Eligible: Resident with presence or history of clean PU (stage II-IV). Scoring Rules: Pass = physician’s orders or licensed nurse treatment records or weekly summary indicate a moist wound dressing was applied.		
7. Has a full thickness PU with no improvement in 4 weeks, or a partial thickness PU with no improvement in 2 weeks, THEN re-assess the treatment plan and stage III/IV PU for cellulitis or osteomyelitis.	Eligible: Resident with presence or history of PU with no improvement in 2 weeks (stage II) or 4 weeks (stage III-IV). Scoring Rules: Pass = physician’s orders or notes, or licensed nurse treatment records or weekly summary indicate a treatment change or assessment for cellulitis or osteomyelitis.		
8. Has a full thickness, trunkal PU covered with necrotic tissue, THEN debridement interventions should be instituted within 3 days of diagnosis.	Scoring Rules: Pass = physician’s orders or progress notes, or licensed nurse treatment records or weekly summary indicate debridement.		
9. Has a full thickness PU covered with necrotic tissue and systemic infection, THEN sharp debridement, blood cultures,	Scoring Rules: Pass = physician’s orders or progress notes indicate any one of the following: evaluation of the resident and PU, blood cultures ordered, or antibiotics prescribed, and any type of debridement in progress.		

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IF a Nursing Home resident: initiation of antibiotic therapy, and resident and wound assessment should be done by primary care provider.			

† All indicators should be scored with medical record data unless otherwise indicated.

‡= If multiple PUs are present, evaluate the highest stage PU.