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Updated Pressure Stages and Terminology Changes Announced by NPUAP

by Susan M Cleveland BSN, RN, WCC, CDP, Director of Nursing Services, ICP, Inc.

During a convened meeting of over 400 professionals, updated staging definitions and terminology changes were announced. The National Pressure Ulcer Advisory Panel *(NPUAP) is replacing the term "pressure ulcer" with "pressure injury" in the National Pressure Ulcer Advisory Panel Pressure Injury Staging System. The NPUAP believes the changes more accurately describes pressure injuries to both intact and ulcerated skin.

As well as changes to the terminology in stage definitions, the Roman numerals have been replaced with Arabic. "Suspected" has been removed from the Deep Tissue Injury diagnostic label and additional definitions included Medical Device Related Pressure Injury and Mucosal Membrane Pressure Injury.

The changes are as follows:

Pressure Injury:

A pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer 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 microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue.

Stage 1 Pressure Injury: Non-blanchable erythema of intact skin

Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.

Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis

Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).

Stage 3 Pressure Injury: Full-thickness skin loss

Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Stage 4 Pressure Injury: Full-thickness skin and tissue loss

Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss, this is an Unstageable Pressure Injury.

Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss

Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on an ischemic limb or the heel(s) should not be removed.

Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration

Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and

continued on Page 3, see *Changes*

Contents

Partially Filled Vials and Syringes in Sharps Containers are a Key Source of Drugs for Diversion

The Institute for Safe Medication Practices recently published practice recommendations related to drug abuse and diversion in healthcare settings. The following has been modified for post-acute and long term care practice settings – full ISMP text is available at http://bit.ly/1U8KfnL

Data from the US Substance Abuse and Mental Health Services Administration show that about 1 in 10 health professionals is struggling with addiction or abusing drugs not prescribed for them. The American Nurses Association reports the same—about 10% of nurses are thought to be abusing drugs and may be caring for patients while impaired. These incidence rates mirror the general population, meaning healthcare workers are not at higher risk of drug abuse than the general population. However, the overall pattern of drug abuse and dependency with healthcare professionals is unique. Studies show a disproportionate misuse of prescription drugs by healthcare professionals when compared to street drugs, primarily because they can access prescription medications easily and often.

Drug diversion and abuse puts patients at risk for suboptimal treatment from diluted or substituted medications, serious infections caused by contaminated needles and syringes, and errors committed by health professionals who are working while impaired. The following recommendations are intended to be practical steps to improve systems for preventing and detecting drug diversion, and dealing with workers who are battling a prescription drug dependency.

Awareness and Recognition of the Problem

Expect diversion. Given that the best estimates are that one in ten healthcare workers will abuse drugs, take all the necessary steps to prevent and detect it. No news is NOT good news when it comes to drug diversion and abuse.

Observe for signs of impairment and diversion. Educate all healthcare workers to recognize diversion and a drug-impaired coworker. Here are some signs and symptoms:

Changes in behavior

- Increasing isolation from coworkers and social avoidance at work
- Frequent illness, accidents, emergencies, tardiness
- Complaints from others about poor work performance
- Moody, depressed, irritable, suicidal threats
- Frequent trips to the bathroom, locker room, unexplained absences, long lunches
- Illogical or sloppy charting

Physical signs

- Shakiness, tremors, slurred speech, sweating, unkempt appearance
- Wearing long-sleeve clothing even in warm environments

Signs of diversion

- Frequent incorrect controlled substance counts
- Frequent corrections or illegible documentation
- Large or inconsistent amounts of wasted narcotics
- Discrepancies between patient-reported pain and pain medication administration

Report suspicions. Establish an organizational expectation to report suspected drug diversion and worker impairment via a confidential process

Educate about resources. Routinely provide staff education regarding the resources available if diversion is suspected or a practitioner wants to seek treatment for addiction.

Drug Security and Chain of Custody

Secure controlled substances at all times

- Prohibit drawing more than a single dose of a controlled substance into a syringe; saving partial doses in syringes exposes the drug to possible diversion.
- Remove controlled substances close to the time they are to be administered. Avoid removing a drug "just in case" a PRN dose is needed.

Manage inventory. Require staff to verify receipt and immediately secure controlled substances. When a resident transfers between nursing stations, the person delivering and the person receiving controlled substances should each cosign on the appropriate record, and the drugs should be immediately secured.

Restrict access to controlled substances Establish strict guidelines regarding who can have access to controlled substances – do not share keys or leave them unattended. Extra cart keys

Allow no bags. Do not allow purses, backpacks, briefcases, or other personal storage cases in areas where controlled substances are stored, administered, or discarded.

Shift counts. Shift counts must include visual inspection of quantity remaining and package integrity by both nurses. Controlled substance receipts or disposals during the shift must be accounted for and documented.

Safe Drug Disposal

Remaining controlled substance left in a single-use vial: With a witness present, draw the remaining medication into a syringe, require the witness to verify the volume in the syringe, and then squirt the medication into sink or other approved receptacle* while the witness watches. Do not discard the vial in the sharps box before removing and wasting any leftover medication from the vial.* Document the volume and dose of the pharmaceutical wastage, which should be verified and cosigned by the witness.

Wasting extra or partial tablets: When a resident refuses a controlled substance tablet, require the witness to visually identify the tablet to be wasted. If only a half tablet is to be administered, require visual identification of the whole tablet, before the tablet is split, followed by destruction and documentation of the unused portion.

Unused or expired controlled substances: Remove unused, discontinued, or expired controlled substances from the medication cart as soon as possible. Follow proper

procedure for documentation of the chain of custody.

FentaNYL transdermal patches: Current manufacturer and US Food and Drug Administration (FDA) guidelines direct users to fold the patch in half with the sticky sides together, and then flush the patch down the toilet. If flushing the patch is not an option, a device that deactivates any remaining drug in the patch should be used prior to disposal. Deactivation and disposal should be documented with a second witness.

Monitoring

Periodic documentation review. Establish a system for reviewing the documentation and use of controlled substances, paying particular attention to:

- Comparing records of removal of a controlled substance to the medication administration record
- Comparing the time of removing a controlled substance to the time of administering the drug (delays could signal diversion)
- Comparing pain medication administration time to patient reported pain scales
- Frequency of pain medication administration to cognitively impaired patients
- Pain scores and PRN medication usage much higher when a particular staff member is on duty

Observe staff. Regularly observe how staff manage controlled substances, including wasting drugs, performing shift counts, receiving controlled substances, and other security processes. Also observe staff for at-risk behaviors such as unattended drugs or keys, and coach them to exhibit the desired behaviors.

Investigate immediately. Start an investigation as soon as it is learned that the count of controlled substances does not reconcile with documentation.

*Squirting a controlled substance into the sink or toilet may not be an option in some locations or safe for the environment. Squirting a controlled substance into a sharps container may not be permitted by the waste management company that disposes of the containers.

e-Prescribing of Controlled Substances

Martha Somers, Administrator of IT, ICP, Inc.

In 2013, ICP received our first electronic prescription that met stringent DEA requirements for controlled substances. Making e-prescribing of controlled substances (EPCS) legal nationwide, while a critical step, is only one part of solving the problem of prescription opioid abuse. The next step is for more and more prescribers to adopt and use the technology. To support this goal, Surescripts is leading an online effort to educate physicians on the steps they need to take to begin using EPCS. The website www.getEPCS.com outlines the actions that physicians must take, offering easy to follow guidance on the 4 key areas to get up and running with EPCS:

- Certification Status of EHR Software - The first step is to find out if the **electronic health record** (EHR) software version being used has already been certified and approved for EPCS. To check this, go to www.getEPCS.com and click "Find your EHR status".
- Obtaining Identity Proofing - The second required step is ID Proofing. This basically is "you are who you say you are". ID proofing can be done in-person by your health system's credentialing office or online through companies working with your EHR.
- Two-Factor Authentication - This double-level process ensures that only you can sign and send the controlled substance prescription to the pharmacy. There are various options: mobile phones, smart cards, fob tokens, USB drives, and biometrics like fingerprint scanners.
- Setting Software Access Controls - The fourth and final step is software access. This step involves setting secure access controls and permissions for your e-prescribing software. This will involve the ID-proofed physician and another person who can confirm the physician's identify or the health systems IT department.

There are many benefits to EPCS. Please encourage your medical staff to learn more.

Changes - continued from page 1

shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.

*The National Pressure Ulcer Advisory Panel (NPUAP) serves as the authoritative voice for improved patient outcomes in pressure ulcer prevention and treatment through public policy, education and research.

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Webinar

Skin Tears: A Little Rip Can Be a Big Problem

5/18/16 10am

Speaker: Erin McClure, BSN, RN, WCC, OMS
Purpose: To educate long-term care nurses on the current standards of practice pertaining to skin tears.

Outcomes:

1) Examine the classification system for skin tears
2) Explore current standards of practice pertaining to skin tears

Successful program completion requires 80% attendance and turning in a completed evaluation form to receive certificate.

Information on this and other webinars being offered by ICP available at icppharm.com. Contact Mary Burkart, RN for information regarding continuing education credit.