



Baptist Health South Florida

6855 Red Road
Coral Gables, FL 33143-3632
www.baptisthealth.net

January 6, 2009

Dear Physician,

In response to the Medicare Deficit Reduction Act of 2005, Centers for Medicare and Medicaid Services (CMS) will no longer reimburse hospitals for certain specific conditions when acquired during the patient's hospitalization. Pressure ulcer is one such condition CMS will not pay for if the pressure ulcer is acquired during the patient's hospitalization. Although not always avoidable, CMS has taken the position that pressure ulcers are "reasonably preventable" and will no longer reimburse hospitals for those that are hospital acquired beginning October 2008.

Coding of medical diagnoses is obtained only from physician documentation in the medical record. Your assistance with comprehensive documentation of primary and secondary diagnoses at the time of admission will facilitate accurate coding of the medical record by capturing those conditions that are **present on admission (POA)**.

Attached, for your convenience, are the new wound care orders. These standing wound care orders have been approved by your Medical Executive Committee and will be initiated by nursing. Please familiarize yourself with the orders and assist by providing documentation indicating the condition was POA.

Thank you for supporting our efforts to provide the best care to our patients through timely identification, documentation and initiation of wound care needs.

Wound Care Sub Group ACT Team
Lynne Thompson, Executive Sponsor
Yvonne Zawodny, Executive Sponsor
Mary Kathleen Wood, Project Leader

Attention Physician

As of October 1, 2008, CMS will no longer pay hospitals for the costs associated with pressure ulcers. However, if the pressure ulcer is present on admission, it will be coded as a complication through a Present on Admission (POA) code and reimbursed. Therefore physicians need to be proactive by documenting pressure ulcers present on admission and this can be either by the ER physician or admitting physician.

**NEW! Wound Care Protocols have been approved for use at all BHSF entities!
POA status must be signed y a MD**

**New! Wound Care Protocols
POA status must be signed by a MD!**

PHARMACY STAT (Place X in Box) **Baptist Health South Florida**

DATE	TIME	NURSING WOUND CARE PROTOCOL - DEEP TISSUE INJURY OR STAGE 1 PRESSURE ULCER OR STAGE 2 PRESSURE ULCER STANDING ORDERS	COMPS CODE	UC INITIAL	NURSE INITIAL
RN: Complete this form on discovery of: 1. Deep Tissue Injury (purple or mottled intact skin or blood filled blister - may be painful, mushy, boggy, warm or cool). 2. Stage 1 Pressure Ulcer (intact skin with non-blanchable redness). 3. Stage 2 Pressure Ulcer (partial thickness loss of dermis).					
<input type="checkbox"/> Deep Tissue Injury: location <input type="checkbox"/> Stage 1 Pressure Ulcer: location <input type="checkbox"/> Stage 2 Pressure Ulcer: location <input checked="" type="checkbox"/> PRESSURE ULCER PRESENT ON ADMISSION					
Interventions: • Turn and reposition every 2 hours. • Implement pressure relief devices (off loading, foot/heel cradle, foot heels turning wedges). • Surface Support / Bed (select one): <input type="checkbox"/> Low air loss mattress <input type="checkbox"/> Air fluidized bed • Cleanse site with normal saline or wound cleanser and pat dry. • For Braden Score of 18 or less: <ul style="list-style-type: none"> • Pre Albumin level • Albumin level • Transferrin level • Total Lymphocyte count • Dietician consult 					
<input type="checkbox"/> For Deep Tissue Injury or Stage 3 Pressure Ulcer: Apply protective cream Abso-Vesta or skin sealant to skin, no dressing required.					
<input type="checkbox"/> For Stage 2 Pressure Ulcer: Non-healing wound apply hydrogel and cover with non-adherent gauze and secure, change daily or when loose or soiled. Draining wound apply calcium alginate, hydrofiber, or protective antiment and change every 2 to 3 days, or when loose or soiled.					
Photograph pressure ulcer on discovery, weekly, and at discharge.					
<input type="checkbox"/> SCANNED CODE: C = CONSULT CALLED MAR = MEDICATION ADMINISTRATION RECORD SS = SLIP SENT MS = MESSAGE SENT NE = NOT ENTERED IN COMPUTER					
ALLERGIES: _____ _____ _____					
Print RN/Clinician Name: _____ Date: _____ Time: _____ RN/Clinician Signature: _____ Print Physician's Name: _____ Physician's Signature: _____ Date: _____ Time: _____					
SOUTH MIAMI HOSPITAL PHYSICIAN'S ORDERS - DEEP TISSUE INJURY / STAGE 1 PRESSURE ULCER AND STAGE 2 PRESSURE ULCER STANDING ORDERS *07600S3773* <small>3041 2713 Fax 3052 37688273</small>					

PHARMACY STAT (Place X in Box) **Baptist Health South Florida**

DATE	TIME	NURSING WOUND CARE PROTOCOL - STAGE 3 PRESSURE ULCER OR STAGE 4 PRESSURE ULCER OR UNSTAGEABLE PRESSURE ULCER STANDING ORDERS	COMPS CODE	UC INITIAL	NURSE INITIAL
RN: Complete this form on discovery of: 1. Stage 3 (Full thickness tissue loss with exposed tendon, muscle or bone). 2. Stage 4 (Full thickness tissue loss with exposed tendon, muscle or bone). 3. Unstageable Pressure Ulcer (pressure ulcer with eschar or slough).					
<input type="checkbox"/> Stage 3 Pressure Ulcer: location <input type="checkbox"/> Stage 4 Pressure Ulcer: location <input type="checkbox"/> Unstageable: location <input checked="" type="checkbox"/> PRESSURE ULCER PRESENT ON ADMISSION					
Interventions: • Turn and reposition every 2 hours. • Implement pressure relief devices (off loading, foot/heel cradle, foot heels turning wedges). • Surface Support / Bed (select one): <input type="checkbox"/> Low air loss mattress <input type="checkbox"/> Air fluidized bed • Cleanse site with normal saline or wound cleanser and pat dry. • For Braden Score of 18 or less: <ul style="list-style-type: none"> • Pre Albumin level • Albumin level • Transferrin level • Total Lymphocyte count • Dietician consult 					
<input type="checkbox"/> Apply skin sealant to surrounding skin.					
<input type="checkbox"/> For scant or no drainage: Apply hydrogel to wound base, keep tissue moist, cover/tilt with moist gauze. Secure with tape. Change daily.					
<input type="checkbox"/> For moderate to heavy drainage: Apply calcium alginate or hydrofiber to wound bed, pat down to conform to wound surface and pack with gauze if needed to fill cavity. Cover with absorbent dressing and secure with tape. Change daily or when loose or soiling.					
<input type="checkbox"/> For Unstageable wound (with the exception of stable foot ulcers): Apply thin layer of hydrogel to entire wound bed, cover with gauze and occlusive dressing. Change daily and if loose or soiling.					
Photograph pressure ulcer on discovery, weekly, and at discharge.					
<input type="checkbox"/> SCANNED CODE: C = CONSULT CALLED MAR = MEDICATION ADMINISTRATION RECORD SS = SLIP SENT MS = MESSAGE SENT NE = NOT ENTERED IN COMPUTER					
ALLERGIES: _____ _____ _____					
Print RN/Clinician Name: _____ Date: _____ Time: _____ RN/Clinician Signature: _____ Print Physician's Name: _____ Physician's Signature: _____ Date: _____ Time: _____					
SOUTH MIAMI HOSPITAL PHYSICIAN'S ORDERS - STAGE 3, STAGE 4 OR UNSTAGEABLE PRESSURE ULCER STANDING ORDERS *07600S3774* <small>3041 2713 Fax 3052 37688273</small>					

RN: Complete this form on discovery of:

1. **Deep Tissue Injury** (purple or maroon intact skin or blood filled blister - may be painful, mushy, boggy, warm or cool).
2. **Stage 1 Pressure Ulcer** (intact skin with non-blanchable redness).
3. **Stage 2 Pressure Ulcer** (partial thickness loss of dermis).

		<input type="checkbox"/> Deep Tissue Injury: location _____			
		<input type="checkbox"/> Stage 1 Pressure Ulcer: location _____			
		<input type="checkbox"/> Stage 2 Pressure Ulcer: location _____			
		<input type="checkbox"/> PRESSURE ULCER PRESENT ON ADMISSION			
		Interventions: <ul style="list-style-type: none"> • Turn and reposition every 2 hours. • Implement pressure relief devices (off loading, foot/heel cradle, float heels turning wedge). • Surface Support / Bed (<i>select one</i>): <input type="checkbox"/> Low air loss mattress <input type="checkbox"/> Air fluidized bed • Cleanse site with normal saline or wound cleanser and pat dry. • For Braden Score of 18 or less: <ul style="list-style-type: none"> • Pre Albumin level • Albumin level • Transferrin level • Total Lymphocyte count • Dietician consult 			
		<input type="checkbox"/> For Deep Tissue Injury or Stage 1 Pressure Ulcer: Apply protective cream Aloe Vesta or skin sealant to skin, no dressing required.			
		<input type="checkbox"/> For Stage 2 Pressure Ulcer: Non-draining wound apply hydrogel and cover with non-adherent gauze and secure, change daily or when loose or soiled. Draining wound apply calcium alginate, hydrofiber, or protective ointment and change every 3 to 5 days, or when loose or soiled.			
		Photograph pressure ulcer on discovery, weekly, and at discharge.			

SCANNED

ALLERGIES:

CODE:
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MAR = MEDICATION ADMINISTRATION RECORD
SS = SLIP SENT
MS = MESSAGE SENT
NE = NOT ENTERED IN COMPUTER

Print RN/Clinician Name: _____

RN/Clinician Signature: _____ **Date:** _____ **Time:** _____

Print Physician's Name: _____

Physician's Signature: _____ **Date:** _____ **Time:** _____

SOUTH MIAMI HOSPITAL

PHYSICIAN'S ORDERS - DEEP TISSUE INJURY / STAGE 1 PRESSURE ULCER AND STAGE 2 PRESSURE ULCER STANDING ORDERS

07600S3773

DATE	TIME	NURSING WOUND CARE PROTOCOL - STAGE 3 PRESSURE ULCER OR STAGE 4 PRESSURE ULCER OR UNSTAGEABLE PRESSURE ULCER STANDING ORDERS	COMP# CODE	UC INITIAL	NURSE INITIAL
RN: Complete this form on discovery of: 1. Stage 3 (full thickness tissue loss into subcutaneous layer). 2. Stage 4 (full thickness tissue loss with exposed tendon, muscle or bone). 3. Unstageable Pressure Ulcer (pressure ulcer with eschar or slough).					
		<input type="checkbox"/> Stage 3 Pressure Ulcer: location _____			
		<input type="checkbox"/> Stage 4 Pressure Ulcer: location _____			
		<input type="checkbox"/> Unstageable: location _____			
		<input type="checkbox"/> PRESSURE ULCER PRESENT ON ADMISSION			
		Interventions: <ul style="list-style-type: none"> • Turn and reposition every 2 hours. • Implement pressure relief devices (off loading, foot/heel cradle, float heels turning wedge). • Surface Support / Bed (<i>select one</i>): <input type="checkbox"/> Low air loss mattress <input type="checkbox"/> Air fluidized bed • Cleanse site with normal saline or wound cleanser and pat dry. • For Braden Score of 18 or less: <ul style="list-style-type: none"> • Pre Albumin level • Albumin level • Transferrin level • Total Lymphocyte count • Dietician consult • Apply skin sealant to surrounding skin. 			
		<input type="checkbox"/> For scant or no drainage: Apply hydrogel to wound base, keep tissue moist, cover/fill with moist gauze. Secure with tape. Change daily.			
		<input type="checkbox"/> For moderate to heavy drainage: Apply calcium alginate or hydrofiber to wound bed; pat down to conform to wound surface and pack with gauze if needed to fill cavity. Cover with absorbent dressing and secure with tape. Change daily or when loose or leaking.			
		<input type="checkbox"/> For Unstageable wound (with the exception of stable foot ulcers): Apply thin layer of hydrogel to entire wound bed, cover with gauze and occlusive dressing. Change daily and if loose or leaking.			
		Photograph pressure ulcer on discovery, weekly, and at discharge.			

SCANNED

ALLERGIES:

CODE:

C = CONSULT CALLED

MAR = MEDICATION ADMINISTRATION RECORD

SS = SLIP SENT

MS = MESSAGE SENT

NE = NOT ENTERED IN COMPUTER

Print RN/Clinician Name: _____

RN/Clinician Signature: _____ **Date:** _____ **Time:** _____

Print Physician's Name: _____

Physician's Signature: _____ **Date:** _____ **Time:** _____

SOUTH MIAMI HOSPITAL

PHYSICIAN'S ORDERS - STAGE 3, STAGE 4 OR UNSTAGEABLE PRESSURE ULCER STANDING ORDERS

07600S3774