F-TAG 314 and the Four-Prong Test for Defending Pressure Ulcer Cases

Aimee D. Garcia, M.D.

Baylor College of Medicine

Surlock Tower
1 Baylor Plaza
Houston, TX 77030
Aimee D. Garcia, MD, CWS, FACCWS is an Associate Professor in the Department of Medicine, Geriatrics Section at Baylor College of Medicine and the Program Director for the Clinical Wound Care Fellowship Program at Baylor College of Medicine. She served as the Program Director for the Geriatric Medicine Fellowship Program at Baylor College of Medicine from 2003-2015. She is the Medical Director for the Wound Clinic and Consult Service at the Michael E. DeBakey VA Medical Center. Dr. Garcia served as Vice-President and President of the National Pressure Ulcer Advisory Panel, and was the Co-Chair of the Public Policy Committee. She is also Past Chair of the American College of Certified Wound Care Specialists. Dr. Garcia is also currently serving on the Board of Directors of St. Dominic Village Nursing Facility. Dr. Garcia’s practice includes nursing home care, Geriatric outpatient care and Acute care as a hospital consultant. She practices wound care in all care settings, and is actively involved in teaching learners at all levels, including physician assistant students, medical students, Internal Medicine residents and Geriatric Medicine fellows. Dr. Garcia has been working as a medical legal expert since 1998.
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I. Introduction

Pressure ulcer cases can be challenging due to the visual nature of skin breakdown, but it is imperative to educate the jury on the clinical aspects of skin breakdown and skin failure. F-TAG 314 is the federal regulation for nursing homes that specifically addresses pressure ulcers. It is specifically defined as:

TAG F 314 ($483.25 Quality of Care) Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. [1,2]

The regulation states that based on a comprehensive clinical assessment, the facility must ensure that a resident who enters the facility with no pressure ulcers does not develop a pressure ulcer unless it is clinically unavoidable, and a resident who enters the facility with a pressure ulcer does not develop worsening of the pressure ulcer, or new pressure ulcers. For a facility to meet the standard of care, the Four-prong test can be utilized to determine if the elements of prevention and care are being met.

II. The Four Prongs

1. Evaluate risk factors
2. Implement interventions (i.e. turning and repositioning, pressure relieving devices, and nutritional supplements, etc.)
3. Monitor the impact of those interventions
4. Revise those interventions, where appropriate.

Assessment of risk factors includes evaluation of the patient’s underlying medical conditions which can contribute to skin breakdown. [3] A thorough history can help the provider determine the patient’s overall risk of pressure ulcer development. In addition, the facility must utilize a risk assessment tool to assess risk. The most validated tool, and the one most widely used, is the Braden scale. The scale is comprised of six elements: sensory perception, activity, mobility, nutrition, moisture, and friction and shear. The maximum score on the Braden scale is 23, but a score of 18 or less denotes risk of pressure ulcer development in that resident. A score of 12 or less on the scale indicates high risk. A comprehensive wound assessment of a pressure ulcer includes the following elements: size in centimeters, wound bed characteristics, wound edge characteristics, type and amount of drainage and if odor is present or not. The wound assessment must be completed when the pressure ulcer is found and every week thereafter to monitor if healing is occurring. [4] Based on risk assessment, the facility must implement interventions to minimize the risk of pressure ulcer development and/or prevent progression of an existing pressure ulcer. Those interventions are going to be specific to the individual, but may include turning and repositioning, pressure relieving devices such as specialty support surfaces or seating surfaces, and nutritional interventions. Turning and repositioning is another element for prevention and treatment. The current standard of care is turning the patient every 2 hours, although recent clinical trials have shown no increase in the development of pressure ulcers in high risk patients when turned 2, 3 or 4 hours when patients were placed on viscoelastic foam mattresses and skin was closely monitored. [5]

Once interventions have been put in place for a resident, there must be ongoing assessment to determine if those interventions are working. This is the reason weekly evaluations of the wound must be done and documented. In addition, the facility must be monitoring the skin during routine wound care and during
daily care including bathing, toileting and perineal care. If the clinical staff note a new area of breakdown or worsening of the wound at any time during routine care, they must document those changes immediately and take steps to put further interventions in place to prevent further breakdown.

III. References