

# PRESSURE ULCER RAP TO CARE PLAN CRITICAL THINKING TOOL



The assessment goal of using the RAP is to:

1. To ensure that a treatment plan is in place for resident with pressure ulcers
2. Identify residents that are at risk and put into place preventative care

Here are some simple questions to ask:

- ❖ What were the findings of the standardized risk screening tool? Don't just look at the final number but at any of individual areas that scored low and may need to be addressed in the care plan. Interventions need to be in place upon completion of the screening tool and communicated to the staff, not after the RAP is done.
- ❖ Why did the RAP trigger: bed mobility problem, bed fast, bowel incontinence, peripheral vascular disease, current or previous pressure ulcer, skin desensitized to pain or pressure or daily trunk restraint.
- ❖ Does the resident have any of these diagnoses, conditions, etc? (ex: Diabetes, Alzheimer's Disease or other dementias; Edema; Antidepressants and Antianxiety/hypnotics)
- ❖ Is the resident new to the building or just had a recent hospital stay? Has there been any recent change of condition?
- ❖ Is there a history of previous pressure ulcers? Are scars present that increase the risk of breakdown?
- ❖ Does the resident move in the bed/chair in such a manner that shear/friction is of concern?
- ❖ Does the care plan address the care of the current pressure ulcer?
  - On the care plan the location of the dressing or area of skin concern
  - Nutritional interventions
  - Individualized skin care needs
  - TAR (Treatment Record) reflects the treatment to be done
  - Pain Management (e.g., pain medication needed before treatment?)
- ❖ Does the care plan address the prevention of pressure ulcers?
  - Are all risk factors identified during screening stated and addressed?
  - Turning/repositioning schedule for both in the bed and chair that is specific for that resident. (Refer to DAVE Tip Sheet for item M5c at: [www.cms.hhs.gov/NursingHomeQualityInits/20\\_NHQIMDS20.asp](http://www.cms.hhs.gov/NursingHomeQualityInits/20_NHQIMDS20.asp))
  - Positioning and pressure relief devices to be used
  - Nutritional/hydration concerns and interventions
  - Specific skin care needs to be done either by the CNA in the care plan or by specific direction for the medication or wound care nurse in the TAR
  - Specific incontinence care concerns or needs
  - Toileting schedule
  - Pain management interventions

The standardized risk assessment is a major component of the Pressure Ulcer RAP but it is not the only source of information. The reason the RAP triggered also needs to be looked at to differentiate whether the resident is at risk for a pressure ulcer or has one currently. Prevention and intervention needs to start when the resident enters the nursing home. Your prevention process should be set up so that someone (CNA, bath aide, wound nurse, etc.) is monitoring and reporting on high risk skin areas on ALL residents (not just those at high risk) on a daily basis. The RAP should be a review of what the areas of concern are and then to ensure that appropriate interventions have been put in place. See [www.primaris.org](http://www.primaris.org) for assistance in developing the plan of care and tools to help in assessing and daily monitoring.