

Pressure Ulcers

EDUCATION GUIDE

- FACTS
- PREVENTION
- RESPONDING
- TOOLS AND REFERENCES
- ADDITIONAL RESOURCES

Pressure Ulcers – Facts

Lawsuits Involving Pressure Ulcers

Texas – A 79 year-old resident developed a pressure ulcer on her coccyx. The ulcer progressed to a Stage IV and she subsequently died in the nursing home. She had diabetes and a history of strokes that contributed to the ulcer development. A three-judge arbitration panel confirmed a \$5 million settlement.

North Carolina – Plaintiffs alleged that a severe pressure ulcer and poor nutritional status contributed to a resident's death. The case settled with a payment of \$135,000 from the resident's physician and \$165,000 from the nursing home.

Arkansas – A resident developed pressure ulcers that resulted in the amputation of both legs above the knee. The plaintiff alleged the facility did not provide him with timely and accurate assessments, proper treatment, medication and diet. The verdict resulted in \$270,000 judgment against the facility and \$750,000 judgment against the management company.

Florida – A resident that was admitted to a nursing home with no skin problems developed 17 pressure ulcers, multiple contractures and lost 43 pounds within 67 days. A settlement was reached of \$1.5 million.

Virginia – A 69-year-old resident that suffered from diabetes, kidney failure that required dialysis, paraplegia and the effects of a stroke developed a Stage IV pressure ulcer on her sacrum, and subsequently died. A settlement was reached for \$180,000.

Ohio – A resident was admitted to a nursing home for short-term rehabilitation with two pressure ulcers, one on her hip and one on her buttock. The facility had a wound care policy that it allegedly ignored for two weeks, which resulted in new Stage III pressure ulcer development elsewhere on her body. A settlement was reached for \$100,000.

California – An 88-year-old female resident alleged that nursing home care led to multiple pressure ulcers. A \$235,000 settlement was reached.

Missouri – An 82-year-old female resident alleged that the staff failed to adequately change her positions to prevent pressure ulcers. A \$337,500 settlement was reached.

Introduction

NPUAP (National Pressure Ulcer Advisory Panel) defines a pressure ulcer as an area of unrelieved pressure over a defined area, usually over a bony prominence resulting in ischemia, cell death and tissue necrosis.

- Most pressure ulcers are avoidable.
- Pressure ulcers are a problem for residents and the entire interdisciplinary team.
- Pressure ulcer care in the U.S. costs \$11 billion annually.
- In 2012, 13.9 percent of LTC facilities were cited with a deficiency for failure to treat or prevent pressure ulcers.
- Prevalence of pressure ulcers in LTC facilities is about 32.2 percent.
- In 2004, 1 in 10 (11 percent) nursing home residents developed a pressure ulcer.
- More than 17,000 pressure ulcer related lawsuits are filed annually.
- The average settlement in a pressure ulcer malpractice lawsuit is \$250,000, but some settle for as much as \$312 million.
- Settlements favoring plaintiffs occur in up to 87 percent of cases.

Why Should I Be Concerned?

Pressure ulcer litigation can be a civil or criminal matter. Because of their nature, lawsuits concerning pressure ulcers typically generate strong emotional reactions. They also are fairly easy for plaintiff counsel to document and pursue. Incidents of pressure ulcers increase the care required from staffing resources and strain facility and family relationships.

Every facility should have an organized pressure ulcer prevention and management program, so that all employees understand their role and responsibility in identifying and minimizing the risk of pressure ulcer development.

Important Federal Requirements and Definitions for Your Staff to Know:

F309 – Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychological well-being, in accordance with the comprehensive assessment and plan of care.

“Highest practicable” is defined as the highest level of functioning and well-being possible, limited only by the individual's presenting functional status and potential for improvement or reduced rate of functional decline. Highest practicable is determined through the comprehensive resident assessment by competently and thoroughly addressing the physical, mental or psychosocial needs of the individual.

F314 – Based on the comprehensive assessment of a resident, the facility must ensure that:

- 1** A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and
 - 2** A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new pressure sores from developing.
- “Pressure Ulcer” is defined as any lesion caused by unrelieved pressure that results in damage to the underlying tissue. Although friction and shear are not primary causes of pressure ulcers, friction and shear are important contributing factors to the development of pressure ulcers.
 - “Friction” is the mechanical force exerted on the skin that is dragged across any surface.
 - “Shearing” is the interaction of both gravity and friction against the surface of the skin. Friction is always present when shear force is present. Shear occurs when layers of skin rub against each other or when the skin remains stationary and the underlying tissue moves and stretches and angulates or tears the underlying capillaries and blood vessels causing tissue damage.
 - “Avoidable” means that the resident developed a pressure ulcer and that the facility did not do one or more of the following: evaluate the resident's clinical condition and

pressure ulcer risk factors; define and implement interventions that are consistent with resident needs, resident goals, and recognized standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate.

- “Unavoidable” means that the resident developed a pressure ulcer even though the facility had evaluated the resident’s clinical condition and pressure ulcer risk factors; defined and implemented interventions that are consistent with resident needs, goals, and recognized standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate.
- “Infected” refers to the presence of microorganisms in sufficient quantity to overwhelm the defenses of viable tissues and produce the signs and symptoms of infection. Identification, diagnosis and treatment of infection, when present, are critical to healing a pressure ulcer.
- “Colonized” refers to the presence of bacteria on the surface or in the tissue of a wound without the signs and symptoms of an infection. Current literature reports that all Stage II, III and IV pressure ulcers are colonized with bacteria but may not be infected.

Staff should also know the difference between a pressure ulcer and other types of ulcers, such as:

1 “Arterial Ulcer” is ulceration that occurs as the result of arterial occlusive disease when non-pressure related disruption or blockage of the arterial blood flow to an area causes tissue necrosis. Inadequate blood supply to the extremity may initially present as intermittent claudication.

Arterial/Ischemic ulcers may be present in individuals with moderate to severe peripheral vascular disease, generalized arteriosclerosis, inflammatory or immune disorders (e.g. arteritis) or significant vascular disease elsewhere (e.g. stroke or heart attack). Characteristics of an arterial ulcer include:

- Usually occurs in the distal portion of the lower extremity and may be over the ankle or bony areas of the foot (e.g. top of the foot or toe, outside edge of the foot);
- Wound bed is frequently dry and pale with minimal or no exudate;
- Diminished or absent pedal pulse on affected foot;

- Painful – decreased pain when hanging down (dependent) or increased pain when elevated;
- Blanching upon elevation;
- Delayed capillary fill time;
- Hair loss on top of the foot and toes and
- Toenail thickening

2 “Diabetic neuropathic ulcer” requires that the resident be diagnosed with diabetes mellitus and have peripheral neuropathy. The diabetic ulcer characteristically occurs on the foot (e.g. at mid-foot, at the ball of the foot over the metatarsal heads or on the top of the toes) with Charcot deformity.

3 “Venous insufficiency ulcer” (previously known as “stasis ulcer”) is an open lesion of the skin and subcutaneous tissue of the lower leg. It is reported to be the most common vascular ulceration that may develop after relatively minor trauma. Venous ulcers can be difficult to heal and can even reoccur off and on for several years. Recent literature implicates venous hypertension as a causative factor.

Venous hypertension may be caused by a loss of valve function in the vein, partial or complete obstruction of the vein or failure of the calf muscle to pump the blood (e.g. paralysis, decreased activity). Venous insufficiency may result in edema and induration, dilated superficial veins, cellulitis in the lower third of the leg or dermatitis (typically characterized by change in skin pigmentation). The pigmentation may appear as darkening skin, tan or purple areas in light skinned residents and dark purple, black or dark brown in dark skinned residents.

Characteristics of a venous insufficiency ulcer include:

- Usually occurs in the pretibial area of the lower leg or above the medial ankle;
- Minimal to copious serous drainage (unless the wound is infected);
- May be painful, especially when the leg is in a dependent position;
- Wound bed is moist with granulation and
- Superficial

Prevention of a Pressure Ulcer

A pressure ulcer can occur wherever pressure has impaired circulation to the tissue. Because a resident at risk can develop a pressure ulcer within two to six hours of the pressure onset, the at-risk resident should be identified and have interventions implemented promptly to prevent pressure ulcers from forming.

Critical steps in pressure ulcer prevention include:

1 Identify at-risk residents. Staff should perform a full-body skin assessment on all residents upon admission or re-admission to the facility, and document findings in the resident’s chart. Pay close attention to the following pressure-prone areas:

- Bony prominences (e.g. sacrum, heel, the greater trochanter, ischial tuberosity, fibular head, scapula and ankle);
- Areas affected by medical devices (e.g. tubes, casts, orthotics, braces, splints, cervical collars, etc.);

- Pressure on the foot from ill-fitting shoes; and
- Pressure on legs, arms and fingers due to contractures or deformity resulting from rheumatoid arthritis, etc.

In addition, staff should identify and document any pre-existing signs suggesting deep tissue damage may have already occurred (e.g. a purple or very dark area that is surrounded by profound redness, edema or induration). Staff should document this deep tissue damage, as it could lead to the appearance of an unavoidable Stage III or IV pressure ulcer, or progression of a Stage I pressure ulcer to an ulcer with eschar or exudate within days after admission.

NOTE – Sometimes residents are transferred to the hospital for medical care return to the facility with compromised skin integrity that was not there when he or she left. In order to avoid false allegations or assumptions that the resident was sent to the hospital with those conditions, it is imperative that staff perform a complete skin assessment and document findings before any resident is transferred to the hospital.

2 Identify and evaluate the risk factors and changes in residents' condition. A standardized pressure ulcer risk assessment tool should be used to assess a resident's risks upon admission, weekly for the first four weeks after admission for each resident at risk, then quarterly or whenever there is a change in cognition or functional ability.

A resident's risk may increase due to an acute illness or condition change (e.g. upper respiratory infection, pneumonia, or exacerbation of underlying congestive heart failure), and may require additional evaluation. Examples of risk factors include, but are not limited to:

- Impaired or decreased mobility and decreased functional ability;
- Smoking;
- Co-morbid conditions, such as end stage renal disease, thyroid disease, diabetes mellitus, anemia or fever;
- Drugs, such as steroids, that may affect wound healing;
- Impaired, diffuse or localized blood flow (e.g. generalized atherosclerosis or lower extremity arterial insufficiency);
- Recent surgery, especially if longer than three hours duration;
- Resident refusal of care and treatment;
- Cognitive impairment;
- Generalized edema;
- Exposure of skin to urinary or fecal incontinence and moisture (e.g. sweat, wound drainage);
- Poor protein intake, malnutrition or hydration deficits; and
- A previously healed ulcer. The history of a healed ulcer and its stage (if known) is important. Areas of healed Stage III or IV pressure ulcers are more likely to have recurrent breakdown.

The comprehensive assessment, which includes the Resident Assessment Instrument (RAI), is another tool that should be used to evaluate the resident's intrinsic risks, skin condition and other factors (including causal factors) which place the resident at risk for developing pressure ulcers or experiencing delayed healing. It also can be used to assess the nature of the pressure to which the resident may be subjected. Additionally, it can help identify the resident who has multi-system organ failure, an end-of-life condition or is refusing care and treatment.

NOTE – Lab tests, such as serum albumin, prealbumin and cholesterol, may be useful to help establish overall prognosis. However, these tests may not correlate with clinical observation of nutritional status. At his or her discretion, a physician may order test(s) that provide additional information or help with management of treatable conditions.

3 Identify and evaluate risk factors that could be eliminated or modified. Regardless of a resident's total risk score, the clinicians responsible for the resident's care should review each risk factor and potential cause(s) individually in an effort to:

- Identify those that increase the risk of developing pressure ulcers;

- Decide what factors could be modified, stabilized, eliminated and how; and
- Determine what targeted management protocols need to be implemented.

NOTE – An overall risk score indicating the resident is not at a high risk of developing pressure ulcers does not mean that existing risk factors or causes should be ignored.

4 Implement individualized interventions in an attempt to stabilize, reduce or remove underlying risk factors. After completing a thorough evaluation, staff should develop a relevant care plan to include prevention and management interventions with measurable goals. This information should be communicated to all direct care staff. Examples of interventions include:

- Redistribute pressure – Inform residents on the importance of repositioning, and instruct them on how to do so. Also, encourage them to change positions regularly and monitor the frequency. A dependent resident should be repositioned at least every two hours or more frequently, depending upon the resident's condition and tolerance level. The resident should not be placed directly on the greater trochanter for more than momentary placement, unless both sacral and ischial pressure ulcers are present. Likewise, the head of the bed or back of a reclining chair should not be raised to or above a 30-degree angle, unless it is clinically unavoidable, as this increases sacral pressure. Posture alignment, weight distribution, sitting balance, stability and pressure redistribution should all be considered when positioning a resident in a chair.
- Minimize exposure to moisture and keep skin clean, especially of fecal contamination. Provide scheduled toileting or incontinence programs at least every two hours.
- A resident with severe flexion contractures may require special attention to effectively reduce pressure on bony prominences or prevent breakdown from skin-to-skin contact.
- Provide appropriate pressure-redistributing support surfaces, such as a therapeutic, gel or air fluidized mattress or overlay, wheelchair cushion, etc. Products should be selected based on their potential to address the individual resident's risk, his or her response to the product and the characteristics and condition of the product. Also, pillows may be used to support the entire lower leg, or lateral repositioning.
- Provide non-irritating surfaces to reduce friction or shearing forces, such as sheepskin, and utilize lifting devices for repositioning. Heel off-loading is recommended, but not bunny boots or heel or elbow protectors.
- Maintain or improve nutrition and hydration status. Develop a nutritional plan based on the severity of nutritional compromise, rate of weight loss or appetite decline, probable causes, prognosis, projected clinical course and the resident's wishes and goals. Unless contraindicated, nutritional goals should include daily protein intake of approximately 1.2-1.5gm/kg body weight. For those with larger, more extensive or multiple wounds, consider the higher end of this range.
- Assess the resident for pain and reposition as necessary to minimize or reduce pressure points and pain. Also, administer

pain medication routinely as ordered and assess for effectiveness and relief.

- Provide supplemental vitamins or minerals if deficiencies exist.
- Identify and address adverse drug reactions related to the resident's drug regimen that may worsen risk factors for development of pressure ulcers. Possible warning signs include lethargy, anorexia or increased confusion.
- If the resident is refusing care, assess the basis for refusal. Education should be provided by the staff, and potential alternatives should be identified and implemented. Document these elements and efforts in the resident's medical records.

NOTE – In the context of resident's choices, clinical condition and physician input, the resident's plan of care should establish relevant goals and approaches to stabilize or improve co-morbidities, such as attempts to minimize clinically significant blood sugar fluctuations and other interventions aimed at limiting the effects

of risk factors. Alternately, staff and medical practitioners should document clinically valid reasons why such interventions were not appropriate or feasible. Repeated hospitalizations or emergency room visits within a six month period may indicate overall decline or instability.

5 Monitor the impact of interventions and modify them as needed. Staff should remain alert to potential changes in the skin condition daily. Evaluate and document identified changes as indicated. Direct caregivers should be responsible for notifying the charge nurse of skin conditions observed while assisting the resident with cares, such as dressing or bathing. In addition, each resident of the facility should have a skin assessment completed by a licensed nurse using a standardized assessment. The assessment should include an evaluation of the resident's skin color, moisture, temperature, integrity and turgor. This should be done at least once per week or more often if indicated, such as when a resident is using a medical device that may cause pressure.

Responding to a Pressure Ulcer

If a resident's skin integrity appears to be compromised, the following critical steps should be taken:

- 1** Assess the area and evaluate for contributing or causative factors. When assessing the ulcer, it is important to:
 - Differentiate the type of ulcer, pressure-related or non-pressure related, because this may determine the interventions;
 - Determine the ulcer's stage;
 - Describe and monitor the ulcer's characteristics;
 - Monitor the progress toward healing and potential complications;
 - Determine if an infection is present;
 - Assess, treat and monitor pain; and
 - Monitor dressings and treatments.

Photographs may be used to support this documentation if the facility has developed a protocol consistent with accepted standards. These standards should include frequency; consistent distance from the wound; type of equipment used; means to ensure digital images are accurate and not modified; inclusion of the resident identification, ulcer location, dates, etc. within the photographic image; and parameters for comparison.

NOTE – At the time of the assessment, clinicians, including physicians, advance practice nurses, physician assistants, and certified wound care specialists, should document the clinical basis (e.g. type of skin injury/ulcer, location, shape, ulcer edges and wound bed, condition of surrounding tissues) for any determination that an ulcer is not pressure-related.

2 Notify the resident (or his/her responsible party) and physician of any changes in the resident's skin integrity. In a timely manner, inform the appropriate parties when the condition is observed. When notifying the physician, the nurse should seek an adequate treatment order.

For pressure ulcers with significant exudate, management of the exudate is critical for healing. A balance is needed to ensure the wound has enough moisture to support healing. Product selection should be based on the relevance of the specific product to the identified pressure ulcer characteristics, treatment goals and the manufacturer's recommendations for use.

Current clinical practice indicates that Stage III and Stage IV ulcers should be covered. Determination of the need for a dressing for a Stage I or Stage II ulcer is based on the individual practitioner's clinical judgment and facility protocols based upon current clinical standards of practice. Many clinicians believe that stable, dry, adherent and intact eschar on the foot or heel should not be debrided – unless signs or symptoms of local infection or instability are detected.

The resident or his or her responsible party should be informed of the condition, treatment options, expected outcomes and consequences of refusing treatment in order for them to make an informed decision. Staff should address all concerns and offer relevant alternatives, if a specific treatment is refused. All information should be documented in the resident's record.

NOTE – The nurse should document the date and time the physician was notified and the content of the message in the resident's record. Calls should be repeated if the physician does not respond or visit in a timely manner. Involve the facility's Medical Director as needed.

3 Implement treatment orders and determine interventions for preventing progression of the problem as indicated by the resident's needs. Review the list of interventions found on page four of this guide and select appropriate measures. The evaluation and preventative measures should be documented in the nurse's notes and added to the resident's plan of care. Communicate problems and interventions to applicable staff. The dietary department should be notified of all new skin conditions, so the resident's dietary requirements can be reassessed.

4 Monitor the impact of interventions and modify them as needed. When a pressure ulcer complication or change is identified, daily monitoring (with accompanying documentation) should include:

- An evaluation of the ulcer if no dressing is present;
- An evaluation of the dressing ensuring it is intact and there is no visible leaking;
- The status of the area surrounding the ulcer;
- The presence of possible complications. Evaluate for signs of increasing area of ulceration or soft tissue infection (e.g. increased redness or swelling around the wound or increased drainage from the wound); and
- Whether pain, if present, is being adequately controlled.

The amount of observation possible will depend upon the type of dressing that is used. Some dressings are meant to remain in place for several days, as suggested by manufacturers' guidelines.

With each dressing change or at least weekly (and more often when indicated by wound complications or changes in wound characteristics) an evaluation of the pressure ulcer wound should be documented. At a minimum, documentation should include the date observed and:

- Location and staging;
- Size (perpendicular measurements of the greatest extent of length and width of the ulceration), depth and the presence, location and extent of any undermining or tunneling/sinus tract;
- Exudate, if present, and its type (such as purulent/serous), color, odor and approximate amount;
- Pain, if present, and the nature of and frequency (e.g. whether episodic or continuous);
- Wound bed, and its color, the type of tissue and character, including evidence of healing (e.g. granulation tissue) or necrosis (slough or eschar); and
- Description of wound edges and surrounding tissue (e.g. rolled edges, redness, hardness/induration, maceration).

Subsequent photos may be taken to record and track healing progress.

The 2009 NPUAP Treatment of Pressure Ulcers: Quick Reference Guide and other current literature indicates that a clean pressure ulcer with adequate blood supply and innervation should show evidence of stabilization or some healing within two weeks. If the pressure ulcer fails to show progression toward healing within two weeks, the pressure ulcer (including potential complications) and the resident's overall clinical condition should be reassessed. Reevaluation of the treatment plan should include determining

whether to continue or modify the current interventions. If the clinician decides to retain the current regimen, he or she should document the rationale for continuing the present treatment (e.g. why some or all of the plan's interventions remain relevant despite little or no apparent healing).

NOTE – The development, continuation or progression of a pressure ulcer may be consistent with regulatory requirements (i.e. deemed "unavoidable") if the facility has:

- Implemented individualized approaches for end-of-life care in accordance with the resident's wishes;
- Implemented appropriate efforts to stabilize the resident's condition (or indicated why the condition cannot or should not be stabilized) and
- Provided care to prevent or treat the pressure ulcer (including pertinent, routine, lesser aggressive approaches, such as cleansing, turning and repositioning).

5 Monitor, track and analyze all resident skin conditions in the facility. The Director of Nursing or designee should be notified of changes in resident skin conditions daily, using an appropriate report form, per facility policy. Administrators should implement a Quality Assurance and Performance Improvement (QAPI) committee to track all residents who have open areas to ensure appropriate actions are being taken on a timely basis. The QAPI committee also may help the facility evaluate existing strategies to:

- Reduce the development and progression of pressure ulcers;
- Monitor the incidence and prevalence of pressure ulcers within the facility; and
- Ensure that facility policies and procedures are consistent with current standards of practice.

Conclusion

This protocol should be integrated into your facility's system or procedures to ensure:

- Assessments are timely and appropriate;
- Interventions are implemented, monitored and revised as appropriate; and
- Changes in condition are recognized, evaluated and reported to the medical practitioner.

It is critical that staff receive appropriate training. In-service training should be provided to all staff during orientation and on a regular basis. A written copy of these plans should be kept near the nurse's station for easy access.

Tools and References to Help You

Documentation

Item #	Description
3166P	Braden Scale for Predicting Pressure Sore Risk Form
1121DP	Digital Photo Mount Sheet - Photographic Wound Documentation
3167P	Norton Plus Pressure Ulcer Scale Form
1916P	Pressure Ulcer Care Area Assessment (CAA)
1370P-12	Pressure Ulcer Disclosure
CFS6-4HH/HF	Pressure Ulcer Risk Evaluation
3147P	Skin/Wound QI Log
CFS6-7HH	Turn/Reposition Record Form
3081	Weekly Pressure Ulcer QI Log
CFS6-6HH/HF	Weekly Pressure Ulcer Report
3466P	Wound Assessment and Care Tool with Braden Scale
4188 -10	Wound Care Measurement and Assessment
3169HH/HF	Wound/Skin Healing Record
CFS6-5HH/HF	Wound/Skin Record
3895	Wound Treatment Sheet

Education & Training

Item #	Description
1862	MDS 3.0 User's Manual, Updateable
5742	Pressure Ulcers: Long-Term Care Clinical Manual
1766	Survey Guide
4503	The Complete Guide to Nutrition Care for Pressure Ulcer Prevention & Treatment
8513	Wound Care Reference Booklet
8746	Wound Essentials: Practice Principles

Chart Labels

Item #	Description
LS-6491	Anatomical Diagram Label
LS-8201	Photo ID Label
5710	Photo Pocket
L-2043	Skin Care Alert Label
L-2355	Turning Clock Label
LS-8202	Wound Ruler Label

Medical Supplies

Item #	Description
PPRS1335A	Canon Ink/Paper Set
BRG-920	Foam Tipped Wound Measuring Device, Non-Sterile
BRG-921	Foam Tipped Wound Measuring Device, Sterile
6252	MediRule Wound Measurement Device – 4-1/2" x 6"
6282	MediRule III Wound Measurement Device – 4-1/2" x 12"
6255	MediRule II Wound Measurement Device – 8" x 10"
PPRS	Patient Photo Record System
99-7300	Prevalon Pressure Relieving Heel Protector
552-1984-0000	Pump & Pad Alternating Pressure
32-TF2035	Tenderflo II Water Overlay Mattress

PLUS, Many options for sterile and exam gloves

Additional Resources

National Pressure Ulcer Advisory Panel (NPUAP)

www.npuap.org/resources

Agency for Healthcare Research and Quality (AHRQ) – On-Time Pressure Ulcer Prevention

www.ahrq.gov/professionals/systems/long-term-care/resources/ontime/pruprev/index.html

Advancing Excellence in America's Nursing Homes

www.nhqualitycampaign.org/files/factsheets/Staff%20Fact%20Sheet%20-%20Reducing%20Pressure%20Ulcers.pdf

www.nhqualitycampaign.org/goal/Detail.aspx?g=PU

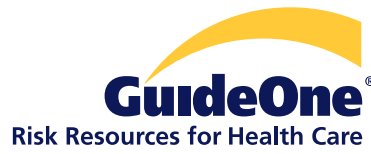
nhqualitycampaign.org/files/AE_PressureUlcerTrackingTool_HANDOUT.pdf

www.nhqualitycampaign.org/files/42599-Classifications.pdf

The Society for Post-Acute and Long-Term Care Medicine (AMDA)

www.amda.com/tools/clinical/pressureulcers.cfm

www.cpgnews.org/tools/pu/tools.cfm



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