GUIDELINES FOR REQUESTING THERAPEUTIC SLEEP SURFACES (TSS)

1.0 PURPOSE OF DOCUMENT

- To outline the process for requesting TSS assessments.
- To outline the process for documenting and tracking TSSs.

2.0 BACKGROUND INFORMATION:

Prevention of pressure ulcers is very important due to the significant impact it has on the client's quality of life and on the health care system resources. Many pressure ulcers can be prevented. Refer to the Pressure Ulcer Risk Assessment Guideline for detailed information on assessing the risk of pressure ulcers, and possible interventions.

Pressure ulcers are caused by a complex interplay of extrinsic and intrinsic factors. Extrinsic factors include: treatment protocols, failure to recognize risk factors, client handling techniques, use of restraints, hygiene, medications, smoking and emotional stress. Intrinsic factors include: previous history of pressure ulcer, malnutrition, dehydration, excessive perspiration/wound exudates, urinary/fecal continence issues, decreased sensory perception, altered mental status, decreased mobility, premature infants, age of greater than or equal to 70 years, altered blood pressure, impaired circulation, increased temperature (either internal or at the interface of the client and the sleep surface), gender, body build, and co-morbidities or illnesses such as malignancy, diabetes, stroke, pneumonia, heart failure, sepsis, hypotension, renal failure, anemia, and compromised immune systems.

A support surface such as a TSS may be used to assist in the treatment of pressure ulcers, or to prevent pressure ulcers from forming. A TSS will be used for clients in situations where care cannot be met through alternative treatment modalities.

3.0 DEFINITIONS:

Advanced Wound Care Clinician: health care professionals in the hospital setting that have received specialized education in caring for persons regarding wound management.

Braden Scale for Predicting Pressure Ulcer Risk: a standardized assessment tool for predicting the risk of pressure ulcers, based on the total of scores given in the categories of sensory perception, moisture, activity, mobility, nutrition, and friction and/or shear. The lower the score, the higher the risk. [Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health]

Direct Service Nurse: Home Care nurses that provide direct service in the home or in a clinic setting.

Logistics Services: division of the Winnipeg Regional Health Authority (WRHA) that coordinates the distribution of supplies and equipment.

Pressure Ulcer: the National Pressure Ulcer Advisory Panel (NPUAP) defines it as a localized injury to the skin and/or underlying tissue usually over a boy prominence, as a result of pressure, or pressure in combination with shear. There are six categories of injury:

- Stage 1: intact skin, non-blanchable redness of an area, usually over a bony prominence.
- Stage 2: partial thickness skin loss, a shallow open ulcer with a red pink wound bed. May also be intact or open/ruptured serum-filled or sero-sanguinous blister. May present as a shiny or dry shallow ulcer. Does not include skin tears, tape burns, incontinence dermatitis, maceration or excoriation.

- Stage 3: full thickness skin loss, with exposure of subcutaneous fat, but not of bone, tendon or muscle.
- Stage 4: full thickness skin or tissue loss with exposure of bone, tendon or muscle.
- Unstageable/Stage X: full thickness tissue loss, but the depth of the ulcer is obscured by slough and/or eschar. It will be either a Stage 3 or 4 ulcer.
- Suspected Deep Tissue Injury: purple or maroon localized area of discoloured intact skin, or blood filled blister due to damage of underlying soft tissue from pressure and/or shear. (Winnipeg Regional Health Authority, 2012, p. 22)

Pressure Redistribution: "the ability of a support surface to distribute load over the contact areas of the human body. This term replaces prior terminology of pressure reduction and pressure relief surfaces." (National Pressure Ulcer Advisory Panel [NPUAP], 2007, p. 2).

Pressure Ulcer Risk Scale (PURS): is a scale used by community Case Coordinators based on the a Client Assessment Protocol (CAP) contained within the Minimum Data Set (MDS). The scale is a range from 0 – 8, with higher values indicating a higher degree of risk for pressure ulcers.

Program Consultant: Home Care professional responsible for researching the most appropriate equipment to meet client needs, approving equipment orders and tracking inventory.

Sleep Surface Accessories: supplies ordered for use with the mattress, such as Dri-Flo pads.

Support Surface: a specialized device for pressure redistribution designed for management of tissue loads, micro-climate, and/or other therapeutic functions (i.e. any mattresses, integrated bed system, mattress replacement, overlay, or seat cushion, or seat cushion overlay)." (National Pressure Ulcer Advisory Panel, 2007, p. 1).

4.0 ELIGIBILITY

- Eligible for WRHA Home Care or Palliative Sub-Program.
- Resides in the community, and not in a Personal Care Home or Hospital.
- Is not eligible to receive third party funding for a TSS.
- Very high risk of developing, or currently has pressure ulcers and/or is in severed pain, and all other pressure reducing treatments have been ineffective.
- Has been assessed and recommended for TSS by an Advanced Wound Care Clinician, Direct Service Nurse (in consultation with Program Consultant), or by a Palliative Case Coordinator.
- The use of the TSS may be considered under the following circumstances:

Criteria for entry level TSS (one or both may be present):

1) Treatment of Stage 1 and Stage 2 pressure ulcers.

2) Prevention of skin breakdown for individuals at high risk on the Braden Scale (score of 12 and under).

Criteria for advanced level TSS (one or more may be present):

1) Treatment of stage 3, stage 4 and Unstageable/Stage X pressure ulcers.

2) Ulcers that have been resistant to all other treatment modalities. *(Other treatment modalities include, but are not limited to: topical agents, dressings, foam positioning wedges and mattress overlays. Treatments may be used in conjunction with each other.)*

3) Relief of severe intractable pain in Palliative clients. The pain may be further aggravated with movement, and it has been assessed that the TSS will provide pain relief and/or prevent the side effects resulting from immobility.

4) Management of the immobile client who has pressure ulcers on more than two turning surfaces and, because of the nature of the illness, cannot be frequently moved or turned.

5.0 GENERAL GUIDELINES

Considerations for Care Planning:

- Consideration should be given to arranging assessment by Occupational Therapist/ Physiotherapist to determine how best to offload pressure from the ulcerated area by using a positioning schedule and a support surface. Therapists may also advise if the use of a TSS will require any changes to transfer or positioning methods.
- Consideration should be given to the use of slider sheets to reduce friction and sheer during positioning and transfers.
- Dri-Flo underpads are the only soaker pads suitable to be used with certain types of TSS. The Program Consultant will advise if Dri-Flo pads are required.
- Limit the amount of linen and pads placed on the bed.
- Overlays should not be placed on top of support surfaces as they may elevate the surface and pose risks of falls, entrapment (when used with bed rails) and may make transfers more difficult.
- Clients should not sit on the edge of the bed when a low air loss type of TSS is in use, as the TSS may be slippery and may compress, posing a risk of falling.
- DSS assisting client with personal care or positioning on the bed are not routinely trained on procedures to Instaflate or deflate the bed, but may require client specific training, if indicated.
- DSS should be informed of changes to care plan and specific procedures needed, including need to remove sling from under client in wheelchair.
- **Entry Level TSS:** Home Care will loan the TSS for the first six months. If the client requires a TSS for longer than six months, it is the client's responsibility to acquire one privately.
- **Advanced Level TSS**: Home Care will loan a TSS for the treatment phase (approximately six months). The Program Consultant may approve the TSS for longer use on a case by case basis.
- The client has responsibility of the care and maintenance of the equipment.
- Assessment includes consideration of:
    - presence of pressure ulcers and what stage they are
    - risk of skin breakdown related to mobility, seating and transfers
    - diagnosis and pertinent medical history
    - how many hours of the day client spends in bed and/or chair
    - management of incontinence
    - nutritional status
    - anticipated length of treatment
    - what other pressure reducing treatments have been tried
- The Program Consultant keeps a database of clients with mattresses and flags them at six months or 12 months for reassessment of eligibility (not for Palliative clients).
- For Palliative Sub-Program clients, the request is considered automatically approved and no detailed wound care or Occupational Therapy assessments are required to determine eligibility.

6.0 RESPONSIBILITIES OF TEAM MEMBERS

INITIAL REQUEST FOR TSS:

Community/Centralized Case Coordinator (CCC)

1. Identifies client risk and potential need for a TSS.
2. May consult with Clinical Nurse Specialist, Direct Service Nurse, Occupational Therapist (OT) and/or Dietitian, as needed.
3. Communicates with client/caregiver:
   - Implications for care.
   - Eligibility criteria, approval process and reassessment process.
4. Completes *Request for TSS Form* (if there is a Nurse involved, the Nurse may also do this) and include:
   a. OT assessment, if available.
   b. *Script/Order* form for the hospital bed with half rails, if there is not already one in the home.
5. Sends to the Nursing Resource Coordinator (NRC) in the client's geographical area, and to the Program Consultant, for tracking.
6. Informs client/caregiver of the outcome of the assessment and if client is approved. If client is ineligible for a TSS:
   - Discusses with client/caregiver alternative sources of third party funding.
   - If client is unable to purchase or finance, contacts the Program Consultant to discuss financial means assessment and alternatives.
7. Documents in *Task Management Module (TMM), as needed:*
   - *Presenting Situation*: rationale for TSS and skin integrity concerns.
   - *Implementation*: list the Provider titled "TSS Consult," with nursing activity code TSS-A and add a note about the date the referral was sent.
   - *Implementation*: in the Provider titled "Equipment/Supplies" ensure that the TSS and any other accessories are added. Add the date the TSS was approved.
   - *Continuation Notes*: all discussions with client/caregiver and Home Care team members.
8. Notifies Program Consultant:
   - If client is in hospital longer than 2 weeks.
   - If client going to respite bed in Personal Care Home by completing the *TSS Transfer Form*.
   - If client is closed to Home Care or no longer requires the TSS.

Palliative Case Coordinator

1. Identifies client risk and potential need for a TSS.
2. Completes *Request for TSS Form* and:
   a. *Script/Order* form for the hospital bed with half rails, if there is not already one in the home. The form must be signed by the Palliative Team Manager.
3. Faxes directly to Logistics.
4. Documents in *Task Management Module (TMM):*
   - *Presenting Situation*: rationale for TSS and skin integrity concerns.
   - *Implementation*: list the Provider titled "TSS Consult," with nursing activity code TSS-A and add a note about the date the referral was sent.
   - *Implementation*: in the Provider titled "Equipment/Supplies" ensure that the TSS and any other accessories are added.
   - *Continuation Notes*: all discussions with client/caregiver and Home Care team members.
5. Notifies Logistics if client is closed to Home Care or no longer requires the TSS.

Nursing Resource Coordinator (NRC)

1. Assigns a Direct Service Nurse immediately and ensures the TSS assessment is completed within 2 days. Provides the required documents: *Request for TSS Form*, *Braden Scale*, *Wound Assessment and Treatment Form (and Treatment History Form)*, *Wound Management Flow Chart* and *TSS Functional Information Form*.
2. Receives the completed TSS assessment package from the Direct Service Nurse and forwards it to the Program Consultant on the same day received.
3. Notifies the Direct Service Nurse of the approval/rejection of the Request for TSS.
4. Notifies Logistics if client is closed to Home Care or no longer requires the TSS.

Hospital Case Coordinator (HCC)

1. Identifies client risk and potential need for a TSS.
2. Consults with Advanced Wound Care Clinician.
3. Completes *Home Care Request for Therapeutic Sleep Surface Form* and arranges for the following completed forms to be completed:
   a. OT assessment
   b. *Braden Scale*
   c. *Wound Assessment and Treatment Form (and Treatment History Form)*
   d. *Wound Management Flow Chart*
   e. *TSS Functional Information Form*
   f. *Script/Order* form for the hospital bed, if there is not already one in the home.
      - **NOTE**: If the Hospital Case Coordinator is unable to complete the forms, he/she is to ask the ward nurses to complete them and/or the Occupational Therapist in the hospital to complete the Braden Scale. If there is no wound present, the HCC or ward nurse needs to write on the *Wound Assessment and Treatment Form* and *Wound Management Flow Chart and Treatment History Form* "No Wound."
4. Faxes all documents to Home Care Program Consultant.
5. Documents in *Task Management Module (TMM)*, as needed:
   - *Presenting Situation*: rationale for TSS and skin integrity concerns.
   - *Implementation*: list the Provider titled "TSS Consult," with nursing activity code TSS-A and add a note about the date the referral was sent.
   - *Implementation*: in the Provider titled "Equipment/Supplies" ensure that the TSS and any other accessories are added.

Direct Service Nurse for Community/Centralized Coordinated and Nursing Coordinated Clients

1. Identifies client risk and potential need for a TSS.
2. If Community/Centralized coordinated, consults with Case Coordinator.
3. May consult with Clinical Nurse Specialist, as needed.
4. Completes *Request for TSS Form* and sends to NRC in the client's geographical area, and to the Program Consultant, for tracking (or CC may do this for Community/Centralized Coordinated).
5. Assigned Nurse completes the assessment utilizing the:
   a. *Home Care Request for Therapeutic Sleep Surface Form*, *Braden Scale*, *Wound Assessment and Treatment Form (and Treatment History Form)*, *Wound Management Flow Chart* and *TSS Functional Information Form*.
   b. Include OT assessment, if available.
   c. *Attach Script/Order* form for the hospital bed with half rails, if there is not already one in the home.
6. Sends the above documents to the Nursing Resource Coordinator (NRC) in the client's geographical area on the same day or the day immediately following the assessment.

7. If Nursing Coordinated:
   - Informs client/caregiver of the outcome of the assessment and if client is approved.
   - If not approved, discusses with client/caregiver alternative sources of third party funding.
   - If client is unable to purchase or finance, contacts the Program Consultant to discuss financial means assessment and alternatives.
   - Notifies Program Consultant if client is in hospital longer than 2 weeks.
8. Documents in the client file located in the home*:*
   - Records on *Nursing Care Plan* under intervention that a TSS assessment was completed.
   - Records in *Progress Notes* that a TSS assessment was completed*.*
9. Notifies CC or NRC and Logistics if client is closed to Home Care or no longer requires the TSS.

Program Consultant (or Designate)

1. Determines eligibility for a TSS, in accordance with the guideline, and approves or rejects the request within 1-2 days.
   - **NOTE:** For Palliative Sub-Program clients, the request is considered automatically approved and no detailed wound care or Occupational Therapy assessments are required to determine eligibility.
2. If approved, the Program Consultant (or Designate) recommends the most appropriate type of TSS and notifies the CC or NRC (Nursing Coordinated) by sending the completed *Request for TSS Form*.
3. Faxes the completed *Home Care Request for TSS Form* and *Script/Order* Form for the hospital bed to Logistics.
   - **NOTE**: Some mattresses require Dri-Flo pads to prevent soiling from body fluids – the Program Consultant will add supplies to the *Home Care Request for TSS Form* as needed.
4. Determines the intervals for reassessment.

<u>REASSESSMENT FOR THERAPEUTIC SLEEP SURFACE:</u>

Program Consultant

1. Keeps a database of clients with mattresses and flags them at 6 months or 12 months for reassessment.
2. Faxes previous *Home Care Request for TSS Form* assessment package to NRC with a note requesting reassessment of TSS.
3. Upon return of assessment from NRC, reviews for approval.
4. If still approved, notifies Logistics via email.
5. If no longer approved, or approved for a different level:
   - Contacts CC or NRC to discuss rationale and options.
   - Faxes Logistics to arrange for pickup of TSS.
6. Sends copy of completed *Home Care Request for TSS Form* with approval/rejection information to NRC or CC.
7. Updates equipment database.

Nursing Resource Coordinator

1. Assigns a Direct Service Nurse immediately to do a *Home Care Request for TSS Form*, *Braden Scale*, *Wound Assessment and Treatment Form (and Treatment History Form), Wound Management Flow Chart* and *TSS Functional Information Form*. Assessment to be completed within 2 days.
2. Receives the completed TSS assessment package from the Direct Service Nurse and forwards it to the Program Consultant on the same day received.

3. Notifies the Direct Service Nurse of the approval/rejection of the request for TSS.
4. Notifies Logistics if client is closed to Home Care or no longer requires the TSS.

Direct Service Nurse for Community/Centralized Coordinated and Nursing Coordinated Clients

1. Completes assessment utilizing the:
   a. *Home Care Request for Therapeutic Sleep Surface Form, Braden Scale*, *Wound Assessment and Treatment Form (and Treatment History Form), Wound Management Flow Chart* and *TSS Functional Information Form*.
   b. Includes OT assessment, if available.
2. Sends the above documents to the Nursing Resource Coordinator (NRC) in the client's geographical area on the same day or the day immediately following the assessment.
3. If Nursing Coordinated:
   - Informs client/caregiver of the outcome of the assessment and if client is approved.
   - If not approved, discusses with client/caregiver alternative sources of third party funding.
   - If client is unable to purchase or finance, contact the Program Consultant to discuss financial means assessment and alternatives.
   - Notifies Program Consultant if client is in hospital longer than 2 weeks.
4. Documents in the client file located in the home*:*
   - Record on *Nursing Care Plan* under intervention that a reassessment was completed.
   - Record in *Progress Notes* that a TSS reassessment was completed*.*
5. Notifies CC or NRC if client is closed to Home Care or no longer requires the TSS.

Community/Centralized Case Coordinator (CCC)

1. Informs client/caregiver of the outcome of the assessment and if client is approved. If client is assessed as no longer eligible:
   - Discusses with client/caregiver alternative sources of third party funding.
2. Document in *Task Management Module (TMM), as needed:*
   - *Implementation*: in the Provider titled "Equipment/Supplies" ensure that the TSS and any other accessories are noted.
   - *Continuation Notes*: document all discussions with client/caregiver and Home Care team members, including
3. Notifies Program Consultant:
   - If client is in hospital longer than 2 weeks.
   - If client going to respite bed in Personal Care Home by completing the *TSS Transfer Form.*
   - If client is closed to Home Care or no longer requires the TSS.

7.0 REFERENCES

Terms and Definitions Related to Support Surfaces, Ver. 01/29/07. (2007). Washington, DC: National Pressure Ulcer Advisory Panel, Support Surface Standards Initiative. Retrieved from the World Wide Web June 27, 2013: http://www.npuap.org/.

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