

Pressure Ulcers: What Are the Implications?

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Pressure ulcers are not a new phenomenon. Their occurrence was noted as far back as the 17th century BC in the oldest known medical document, the Edwin Smith Papyrus. In 2013, pressure ulcers remain a significant health care problem in spite of better assessment tools, new technologies that reduce pressure and aid in the movement of individuals to eliminate shearing and friction, and a new Centers for Medicare and Medicaid Services (CMS) ruling that eliminates hospital reimbursement when a Stage III or Stage IV pressure ulcer is hospital acquired. Traditionally, the prevention and treatment of pressure ulcers have been recognized as more of a nursing responsibility. Florence Nightingale, in her book *Notes on Nursing: What It Is*

and Is Not, wrote about the responsibilities and duties of caregivers to prevent pressure ulcers. "If a patient is cold, if a patient is feverish, if a patient is faint, if he is sick after taking food, if he has a bed-sore, it is generally the fault not of the disease, but of the nursing" (Taylor, 1994). There may still be some truth to this statement but the implications expand beyond the quality of the nursing care. Today, it is viewed as a health care community problem with each member being a stakeholder. The purpose of this article was to discuss implications of pressure ulcers.

INTRODUCTION

Pressure ulcers are localized injury to the skin and/or underlying tissue usually over a bony prominence as a result of pressure, or pressure in combination with shear (NPUAP, 2013). Pressure ulcers are staged I through IV according to the amount of observable damage. The National Pressure Ulcer Advisory Panel (NPUAP, 2007) redefined the definition of a pressure ulcer and the stages in 2007 and included two new stages, deep tissue injury and unstageable to the already-existing four stages (www.npuap.org). These stages are utilized when the amount of tissue damage is currently unable to be

defined. The NPUAP is a multidisciplinary panel of experts in pressure ulcer prevention and management. The panel is composed of nurses, physicians, dietitians, physical therapists, occupational therapists, and engineers who provide authority on issues relating to the prevention, management, and treatment of pressure ulcers. This authority is oftentimes presented as a consensus statement, position statement, recommendation, or guideline on a specific issue.

The implications of pressure ulcers are vast to the individual, the legal system and an already overburdened health care system as well. The implications will vary depending on the severity of the tissue destruction, the treatment, the overall condition of the patient, and complications, including cellulitis, bacteremia, or osteomyelitis. A heightened awareness of these implications can enhance health care providers' understanding and guide needs for implementation of evidence-based prevention strategies early with those individuals identified at risk.

IMPLICATIONS

There are adverse health outcomes associated with pressure ulcers. Pressure ulcers affect a patient's quality of life, morbidity, and

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mortality. Once a pressure ulcer develops, complications such as infection with the potential for sepsis and death may occur. Christopher Reeve, a.k.a. superman, died in 2004 following a pressure ulcer-related systemic infection that caused cardiac arrest (Bolton, 2004). The development of a pressure ulcer can interfere with functional recovery, produce pain and discomfort, promote social isolation, and contribute to excessive length of hospital stay (Reddy, Gill, & Rochon, 2006). It may also increase the possibility that at discharge the patient may enter into a long-term care facility instead of home to get intensive wound care.

The financial implications of a diagnosis of a pressure ulcer are vast and variable. The epidemiology of pressure ulcers varies across clinical settings with incidence rates ranging from 5% to 32% in short-term care, 2.2% to 28% in long-term care, 0% to 29% in home care (www.npuap.org). Annually, 2.5 million patients are treated in acute care facilities at the cost of an estimated \$11 billion per year and rising (Reddy et al., 2006). Pressure ulcers are more likely to occur in individuals older than 65 years (Russo, Steiner, & Spector, 2006). Because this age group is expected to double within the next 25 years, the number of people with pressure ulcers will likely increase as well (Fife et al., 2010).

With the predicted growth in the age over 65 group, Medicare will no doubt face increasingly more financial burdens related to pressure ulcers. Medicare, as the predominant payer for health care in the elderly, will no longer assign a higher diagnosis-related group for facility-acquired pressure ulcers effective October 2008 (CMS, 2007). This shifts the burden, predominantly passive in the past, of physician/providers to perform a skin assessment and document within 24 hr whether a pressure ulcer was present on

admission or not. If not performed and a diagnosis is made, the hospital will bear the financial burden for associated care if this individual acquires a pressure ulcer. This implies consistent and diligent skin assessments and documentation on admission and a collaborative effort by both physicians and nurses.

There is increasing attention on pressure ulcers in the health care industry and media. Our patients are more educated today than ever before and have heard of pressure ulcers and know they are due to not being able to move around. This awareness fosters implications in the need to initiate prevention strategies and protocols early in the continuum of care. Preventive strategies include educating patients and families about skin care and positioning, training and empowering providers in preventing pressure ulcers, improving documentation tools, and updating policies and protocols. Clinician training and education should be moved to the forefront as quality improvement initiatives that will promote optimal patient outcomes. The training and education should be ongoing to be effective. Educational material that can be provided to patients should be included in educational materials also and may empower patients and families in your prevention efforts.

The CMS has delivered to health care providers a substantial and challenging mandate to transform acute care pressure ulcer prevention. This implies behavioral challenges and change. Nurses have traditionally performed pressure ulcer staging. For purposes of the new Medicare policy, physician/provider will be required to document the pressure ulcer and appropriate stage; thus, education is essential to proper staging and documentation for all providers.

Other financial implications of pressure ulcers impact our legal system. Lawsuits over pressure

ulcers are increasingly more common in both short- and long-term settings and judgments have been reported to be as high as \$312 million in a single case (Voss et al., 2005). Judgments are not the only economic impact of litigation. Once a case is filed, the financial burden immediately begins in the form of preparation, depositions, and testimony with an average case taking more than 2 years to resolve. The International Expert Wound Care Advisory Panel has identified key concepts of vulnerability in institutions and published these concepts in a consensus paper. The concepts identified include assessing the legal implications of health care "policies and procedures"; assessing compliance with prescribing rules; changing and practicing within scope of practice; managing expectations and communicating carefully; clinical documentation; preventability: avoidable, unavoidable, preventable, or never events; education; and preventive clinical care (Ayello et al., 2009). Policies and procedures are guidelines, not rules or regulations, and should be treated as such. Policies and procedures should be reviewed periodically. Prescribing rules and standing orders should be reviewed to ensure that they are compliant with prescribing regulations. Institutions should ensure that health care providers are practicing within their scope of practice when it comes to assessment and documentation. Front-line staff should be trained in how to delegate questions professionally and compassionately when presented by patients and families regarding the how, why, and when pressure ulcers develop. Adequate clinical documentation is imperative. The need for learning never ends. While there may be insufficient data for evidence-based product or device selection, evidence-guided selections can be made. Legally, an ounce of prevention is worth a pound of cure. We

must be able to prove that ounce of prevention was performed.

In acutely ill patients with multiple organ failure, reduced tissue perfusion and no mobility have heightened risk that may make pressure ulcers unavoidable (Black et al., 2011). The skin, the largest organ, can fail like other organs. In spite of this, the clinician must still utilize appropriate prevention strategies and document any physical reason that performing these preventive interventions cannot be utilized such as instability of blood pressure or deteriorating respiratory status. The NPUAP defines an unavoidable pressure ulcer as one that develops even though the provider evaluated the individual's clinical condition and pressure ulcer risk factors; defined and implemented interventions consistent with individual needs, goals, and recognized standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate (Black et al., 2011). Unavoidable pressure ulcers may develop in patients who are hemodynamically unstable, terminally ill, have certain medical devices in place, and are nonadherent with artificial nutrition or repositioning (Black et al., 2011). In spite of this, the clinician must still utilize appropriate prevention strategies and document any physical reason that performing these preventive interventions cannot be utilized such as instability of blood pressure or deteriorating respiratory status.

A discussion of the implications of pressure ulcers would be incomplete without addressing the issues of patient compliance and adherence, both of which can be very complex and challenging. Patient education and understanding can aid in both compliance and adherence. It is up to us, as health care providers, to empower patients to take a more active role in pressure ulcer prevention.

SUMMARY

Pressure ulcers are getting more attention than ever before. There has been a shift from a nursing problem to a physician problem as well because of the need of a medical diagnosis. Pressure ulcers place a burden on our health care system, diminish quality of life, increase pain and suffering, and bog down our legal system. Screening those individuals at risk and early initiation of prevention strategies are our best defenses. It remains as true today as years ago, "an ounce of prevention is worth a pound of cure."

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