Pressure Ulcers and Pressure Ulcer Prevention

Laurie McNichol, MSN, RN, GNP, CWOCN

Immediate Past President, National Pressure Ulcer Advisory Panel (NPUAP)
Past President, WOCN®
Clinical Nurse Specialist/WOC Nurse
Cone Health
Greensboro, North Carolina

Objectives

- **1. Identify two milestones in the journey that changed pressure ulcer prevention from being solely a quality initiative in your practice setting**

- **2. Identify your role in providing seamless transitions of care for patients with pressure ulcers**

Let’s Get Started

“…an ounce of prevention is worth a pound of cure.”

Predictable Pathways

- Patients often stray from a predictable pathway to wellness for reasons that are beyond our control
- We manage what is within our control and attempt to get them “back on track” as soon as possible
- It’s in the best interest of our patients and the best interest of our employer

What We Know

Complications in health care prolong encounters.

Consequently, they

- ✓ Increase costs
- ✓ Increase patient and family stress
- ✓ Delay patients return to optimal levels of functioning
- ✓ Predispose patients to other complications

In short: they need to be stopped.

Strategy

- In health care, as in any business, we study variances (or complications) and group them into related categories

- This helps us recognize predisposing factors and be better able to reduce the frequency with which this happens

Recent Examples

- Some complications about which we hear most are pneumonia and deep vein thrombosis (DVT)

- What have we learned about decreasing the incidence of those two complications?

It’s What We Do

- Apply the evidence to improve patient outcomes

The New Normal

- Most hospitals have implemented evidence-based protocols to reduce complications, or hospital acquired conditions, such as pneumonia and DVT by implementing evidence-based practice protocols
- Examples are:
  - ✓ Elevating the head of bed for post operative patients to a 30-degree angle
  - ✓ Providing anti-embolism hose or early ambulation programs post-operatively

Sustaining the Gain

Also known as (aka):

Making the science “stick”

Pressure Ulcers: Some New Stats

- 1.6 billion people in the United States develop pressure ulcers at an annual cost of $2.2 billion to $3.6 billion
- Twenty-three percent of pressure ulcers are acquired intra-operatively during surgeries lasting more than 3 hours with an estimated cost of treatment being $750 million to %1.5 billion per year
- Type of positioning, bed surface in the OR, skin status in the post-anesthesia unit, and male gender were directly related to pressure ulcer formation (Primiano and others, 2011)
- People with a BMI of >40 are 3 times more likely to develop a pressure ulcers than people with a BMI <40 after controlling for Braden risk (Drake and others, 2010)

It’s time. Now. Again.

Pressure Ulcers

- The topic of pressure ulcers and *preventing* pressure ulcers has become an increasingly popular or “hot topic” in the literature-especially since CMS discontinued reimbursement for Stage III and Stage IV hospital acquired pressure ulcers (HAPU) in October 2008

What happened *before* 2008?

- The information was available, (relatively) small groups of people were focused on it, but it didn't become *urgent* until financial penalties were attached

- Just about anything could "bump" pressure ulcer prevention from the spotlight e.g., budgets, staffing, other goals

1980-1990

- Prevention of Pressure Ulcers has been in the WOC/ET role and scope since the early 1980's
- The Braden Scale™ for the prediction of patients at risk for pressure ulcer development was published in 1987
- The NPUAP was formed in 1987 to make an impact on policy, education and research pertaining to pressure ulcers

1990-2003

- The AHCPR Guidelines were published in 1992 and 1994 on the Prevention and Treatment of Pressure Ulcers
- A nursing specialty professional organization published its first Clinical Practice Guideline on Pressure Ulcers in 2003
- Those were available on the National Guideline Clearinghouse that same year (www.guidelines.gov) and joined others by AMDA, VA/DOD, etc.
- Many others followed authored by professional associations

1997

- The California Nursing Outcomes Coalition (CalNOC) was among the first state-based feasibility projects funded by the ANA to look at quality indicators
- They (along with 5 smaller groups) served as the basis for the NDNQI* established in 1997
- CalNOC first identified the relationship between pressure ulcer occurrence and nurse-staffing ratios
- CalNOC continues to identify areas where nurse staffing ratios impact patient safety

* *National Database for Nursing Quality Indicators*

2004

- In 2004, as part of Ascension Health's "Healthcare That Is Safe" initiative, St. Vincent's Medical Center, as an alpha site, was charged with defining best practices to eliminate facility-acquired pressure ulcers.
- A comprehensive plan, including the "SKIN" (Surfaces, Keep the patients turning, Incontinence management, Nutrition) bundle, was developed.
- **Results:** The incidence of pressure ulcers decreased from > 2% to < 1% from December 2004 through February 2006. No new Stage III or IV facility-acquired pressure ulcers occurred between August 2004 and February 2006

~Joint Commission Journal on Quality and Patient Safety, Volume 32, Number 9, September 2006, pp. 488-496(9)

Consumer Awareness

- Publicly reported data were released by CMS according to setting (acute care, home healthcare, long term care) in April 2005. Pressure Ulcer data was included in that beginning in 2006.

- The public began “surfing the web” for their care provider’s pressure ulcer data.

2006

- Quality initiatives aimed at decreasing pressure ulcer prevalence and incidence by JCAHO, NDNQI, and IHI came together in 2006

October 2007

- One of the 12 interventions that the Institute for Healthcare Improvement (IHI) recommended for its **5 Million Lives** Campaign was to "Prevent Pressure Ulcers ... by reliably using science-based guidelines for their prevention." Pressure ulcers cause considerable harm to patients, hindering functional recovery, frequently causing pain, and often serving as vehicles for the development of serious infections. Although the goal for health care facilities to reduce pressure ulcers is admirable, the goal for pressure ulcer incidence should be zero.

~Joint Commission Journal on Quality and Patient Safety, Volume 33, Number 10, October 2007, pp.605-610(6)

ANCC/ Magnet, 2008

- Pressure Ulcers: An ANCC Magnet Recognition Program® required nurse-sensitive quality indicator, January 2008
- *It is required to collect falls and pressure ulcers on the units where this is an applicable data indicator, plus two other indicators from the list provided on page 21 or 40 of the 2008 Magnet Manual. If your unit does not have falls or pressure ulcers as applicable indicator, then you only need to collect two of the indicators on the list. As a result, some units may be collecting two, three or four indicators to meet the intent of this requirement. At a minimum, each unit must collect at least two indicators, but no more than four are required.*

When did *you* get on board?

Suddenly you are singing the song that everyone wants to hear

- The prevention of pressure ulcers is *without a doubt*, less expensive than treating pressure ulcers

“C” Suite Priority

October 2008: “Never Events” meant a new (renewed) focus on

- Accuracy of PrU Staging
- Present on Admission
- Coding
- Physician (Provider) Documentation
- Communication with agency of disposition (HHA, LTC, LTAC)

Practice Change

- Non-payment for hospital acquired Stage III and Stage IV Pressure Ulcers made the **complete skin assessment** an essential component of admission

- It documents/records what is **PRESENT ON ADMISSION**

Everyone must be educated

- Pressure ulcers aren't just *nursing's* (or physical therapy's) responsibility, anymore
- Differential diagnosis of pressure ulcers is key-for everyone
- New terminology emerges, but is slow to "catch on"
- Consistent documentation among care providers is monitored

NDNQI Training Modules

- Newly updated (January)
- 1.5 contact hours for nurses (ANCC approved)
- https://www.nursingquality.org/ndnqipressureulcertraining/
- Includes differential diagnosis, distinction between community acquired, hospital acquired and unit acquired

Prevention: The Literature

- In 2010, a bibliometric evaluation to review trends in publications related to pressure ulcers revealed approximately 39 in 1991 and 259 in 2009

- Main categories in which PrU research was conducted were surgery and nursing

Chen, HL, Cai, DY, Shen, WQ, Liu, P. (2010) Bibliometric analysis of pressure ulcer research: 1990-2009

NPUAP Monograph (2012)

- Available on NPUAP website www.npuap.org
- Barbara Pieper, PhD, RN, CWOCN, ACNS-BC, FAAN, Editor

Prevention of Pressure Ulcers Toolkit

- Identify those at risk
- Remove barriers for implementation of preventative measures
- Use a multidisciplinary team approach
- Educate patients, caregivers and all staff
- Consistently communicate between care settings

Taking a Closer Look at Prevention of Pressure Ulcers: Risk Assessment

- The literature tells us that it is Best Practice to use a reliable and valid tool to assess a person's pressure ulcer risk

SOE = B

In the NPUAP/EPUAP International Pressure Ulcer Guideline for the Prevention and Treatment of Pressure Ulcers (2009)

Alternatives to Risk Assessment

- Initiate pressure ulcer preventive care plans for all patients-whether or not they are at risk

Alternatives to Risk Assessment

- Wait for patients to experience skin breakdown and then treat it

Evidence to Support Assessing for Risk

- While the evidence linking the use of a pressure ulcer risk assessment tool to a decreased incidence of PrUs is inconclusive, we know that using risk assessment tools increases the ***intensity*** and ***effectiveness*** of prevention interventions
- Nursing judgment has not been shown to have the same sensitivity and specificity and is not a good pressure ulcer predictor

Risk Assessment: Apply Evidence to Support Practice Changes

Recommendations:

- Perform assessment of risk using a valid and reliable tool at regular (established) intervals
- Customize interventions based on subscale scores
- Develop concentrated prevention programs for high-risk populations
  e.g., ICU, long term care, orthopedic units
- Develop programs for special populations, e.g., pediatric, bariatric, patients with diabetes, etc.

The “Right” Thing To Do

- Preventing pressure ulcers is the best and right thing to do for our patients
- Public perception of quality care includes patient recovery without the acquisition of pressure ulcers
- Pride of Affiliation is a factor among care providers

Pride of Affiliation

- Today, clinicians have choices regarding their employment
- Employers may have difficulty recruiting professional staff if their facility has a poor reputation for quality and/or a high incidence of pressure ulcers
- Professionals want to be affiliated with facilities who have a reputation for excellence

Ethics

- There are those who are frustrated because it appears to have taken payment to make pressure ulcers important to administrators
- There are those who are relieved and/or happy that pressure ulcers are *finally* important to administrators

What's to Come?

- The POA phenomena is now in home health and long term care

  "This didn't happen on <u>our</u> watch!"

- Developments in making the MDS 3.0 and OASIS-C tools more similar were undertaken to make way for a new data collection instrument, the CARE* tool
- Many predict that that monies saved from non-payment to the care setting that "caused" or "allowed" the PrU will go to the care setting that is *treating* the PrU

*Continuity Assessment Record and Evaluation

Pressure Ulcers: Usually an Avoidable Complication

* While there is some evidence to suggest that certain conditions create an environment that is conducive for pressure ulcer formation, The NPAUP has taken the position that the *majority* of pressure ulcers are avoidable

Avoidable vs. Unavoidable

Black, J., Edsberg, L., Baharestani, M., Langemo, D., Goldberg, M., McNichol, L., Cuddigan, J. & the National Pressure Ulcer Advisory Panel (2011). Pressure ulcers: Avoidable or Unavoidable? Results of the National Pressure Ulcer Advisory Panel Consensus Conference, *Ostomy Wound Management,* 57 (2), 24-37

What's Emerging

- The relationship between nurse-staffing levels and pressure ulcer-related outcomes is the major focus of PrU nursing research, followed by risk assessment scale evaluations

Recent Findings: Staffing Ratios

- Inadequate staffing patterns are associated with a higher probability of pressure ulcer development
- By increasing nursing hours per day one can reduce the morbidity associated with pressure ulcers

*Konetzka, RT, Stearns, SC, Park, J. (2008), The staffing-outcomes relationship in nursing homes. Health Serv. Res. 43(3):1025

Recent Findings: Risk Assessment

- The Braden Scale™ has the best balance between sensitivity and specificity for quantifying pressure ulcer risk. Both the Braden and the Norton Scale are more accurate than nurses' clinical judgment in predicting pressure ulcer risk
- Studies are emerging which point to the need to further refine the Nutrition and Moisture components of the Braden Scale
- Should BMI be an indicator?

Recent Findings: Device Related Pressure Ulcers

- Device related pressure ulcers are increasing
- Current incidence is believed to be 9%

  - 35% of all pressure ulcers

- More research is needed in this area

Benchmarking to Better Outcomes

- Benchmarking among like-sized facilities prevents groups from “reinventing the wheel” and duplicating efforts.
- Published success stories allow others to “copy” from those facilities with the best outcomes

Prevention: More to Learn

The continuing dilemma of prevention is how to best anticipate the problem. Prevention must be customized to the individual and not the setting in which the patient resides.

(Ayello and Berlowitz, 2010)

Prevention: More to Learn

- Avoidance of pressure is critical, but prevention is not an exact science. Is the answer in constant repositioning?
- Are there more or better indicators of patients' tissue tolerance?
- Are there innovations in technology that can impact the patient’s microclimate and reduce their likelihood to break down?
- Does ethnicity or skin color play a larger role in predicting pressure ulcer risk than we are aware ?

What do the experts say?

“Turn, Turn, Turn”

~the Byrds, 1965

“Turn, Turn, Turn”

~Barbara Braden, 1989

“Turn, Turn, Turn”

~Laurie McNichol, Today

Our Role

- What is the role of the health care provider in communicating pressure ulcer status, etiology, response to treatment, etc. to the next care setting in the continuum?

- Is what you do now working?

- Are you getting enough information from the care settings that precede you?

Transitions of Care

- Transitional Care Model, Mary D. Naylor, PhD, RN, FAAN (1986) University of Pennsylvania
- Used APNs to oversee transitions of premature (and at risk) infants from hospital to home
- Theory translates easily to managed care goals of care
- Work has been replicated in elder populations (Kaiser)
- Reduces recidivism (readmission) and overall cost of high risk populations
- Improves clinical, fiscal and satisfaction outcomes

A few last words-for you

Nurses

- Should take a leading role in the writing and dissemination of Guidelines/Best Practices
- Are skilled in coordination and in facilitating groups toward consensus opinion
- Can represent the scientific community when it is time to involve/approach government and policy making officials

Nurses as Advisors, Teachers, Consultants

- For the 10th consecutive year, Gallup's annual poll to ascertain the most trusted profession in the US listed nursing/nurses as having the highest ethical standards and for being honest

- Currently nursing is the most respected profession in the US- surpassing firefighting, police work and the clergy

Extra! Extra! Read All About It

- Institute of Medicine & The Robert Wood Johnson Foundation: **The Future of Nursing: Leading Change, Advancing Health (2010)***
  - » Task: Assess & transform the nursing profession
  - » Outcome: A report with recommendations for an action oriented blue print for the future of nursing

*http://www.iom.edu/Reports/2010/The-Future-of-Nursing- Leading-Change-Advancing-Health/Report-Brief.aspx

The Future of Nursing: Key Messages

- Nurses should practice to the full extent of their education and training
- Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression
- Nurses should be full partners with physicians & other health care professionals in redesigning the health care system in the US
- Effective workforce planning & policy making require better data collection & an improved information infrastructure

If not you, *who*?

- Staff members (professional and non-professional) will need continual education and retraining when processes change
- Consumers will need education to dispel previously held misconceptions
- Transitions of care (e.g., from home to hospital or from hospital to long term care facility or from LTC to home) will need oversight and coordination of care

I look forward to learning of *your* evidence-driven improved outcomes.

(Monday is okay.)

Thank you for your attention.

Laurie.McNichol@conehealth.com