Pressure Ulcer Staging and Documentation

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Overview of the Pressure Ulcer Problem

- Scope – Over 1 million cases each year, 1 in 4 patients
- Cost – In acute care settings, the per-case average is $2000 to $50,000 when pressure ulcer is not the principle diagnosis. This is *in addition* to the costs associated with the primary diagnosis.

Why Is This Important?

- New CMS payment changes related to Hospital Acquired Conditions (HAC) and Present on Admission (POA)
  - New coding started October, 2007
  - New reimbursement started October, 2008
- Conditions determined are
  - High cost or high volume or both,
  - Result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and
  - Could reasonably have been prevented through the application of evidence-based guidelines.

Why Is This Important?

- For discharges occurring on or after Oct. 1, 2008 IPPS hospitals will not receive additional payment for cases when one of the selected conditions is acquired during hospitalization (i.e., was not present on admission). The case would be paid as though the secondary diagnosis were not present.

- **www.cms.hhs.gov/HospitalAcqCond/**

CMS Selected Conditions

- Serious Preventable Events (object left in surgery, air embolism, blood incompatibility)
- Catheter-Associated UTI
- **Pressure Ulcers**
- Vascular Catheter-Associated Infection
- Surgical Site Infection – Mediastinitis after CABG Surgery
- Falls and Trauma – Fractures, Dislocations, Intracranial Injuries, Crushing Injuries and Burns

New Requirement for Physicians

- Must assess and document pressure ulcers that are present on admission within 24 hours of admission.
- If pressure ulcers not identified and documented, no reimbursement for their care will be made.

What to Document

- Assessment- location and stage
- Treatment
- Consults
- Discharge Planning

- New National Pressure Ulcer Advisory Panel (NPUAP) Staging Definitions, 2007

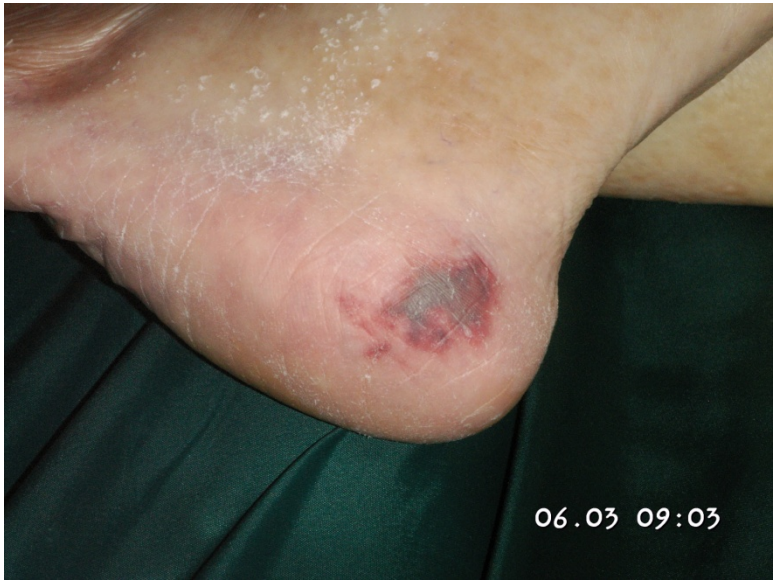
A Pressure Ulcer Is….

- 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 and/or friction. *A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated.*

NPUAP 2007

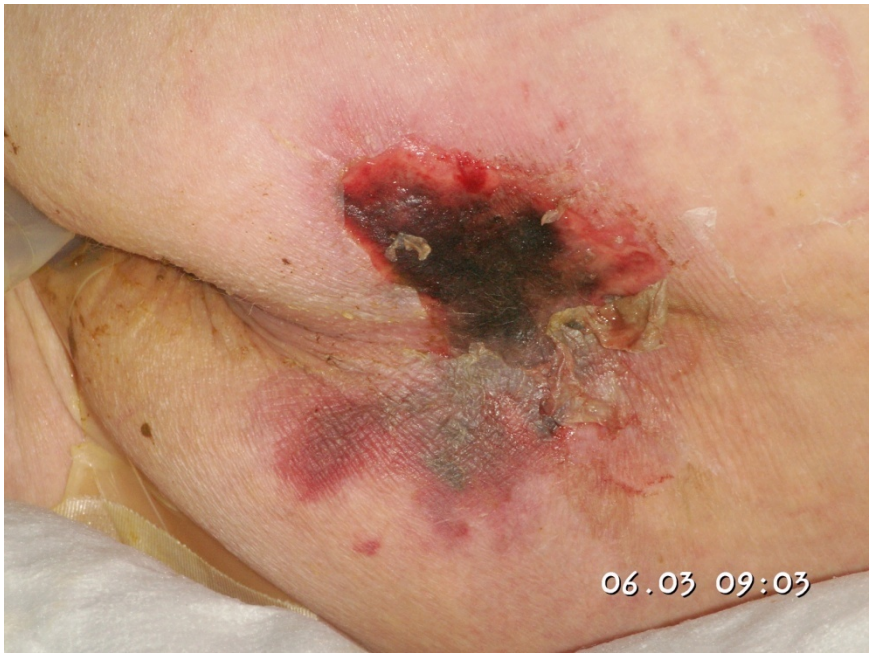
Suspected Deep Tissue Injury (SDTI)

- Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue



Suspected Deep Tissue Injury (SDTI)

- Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.



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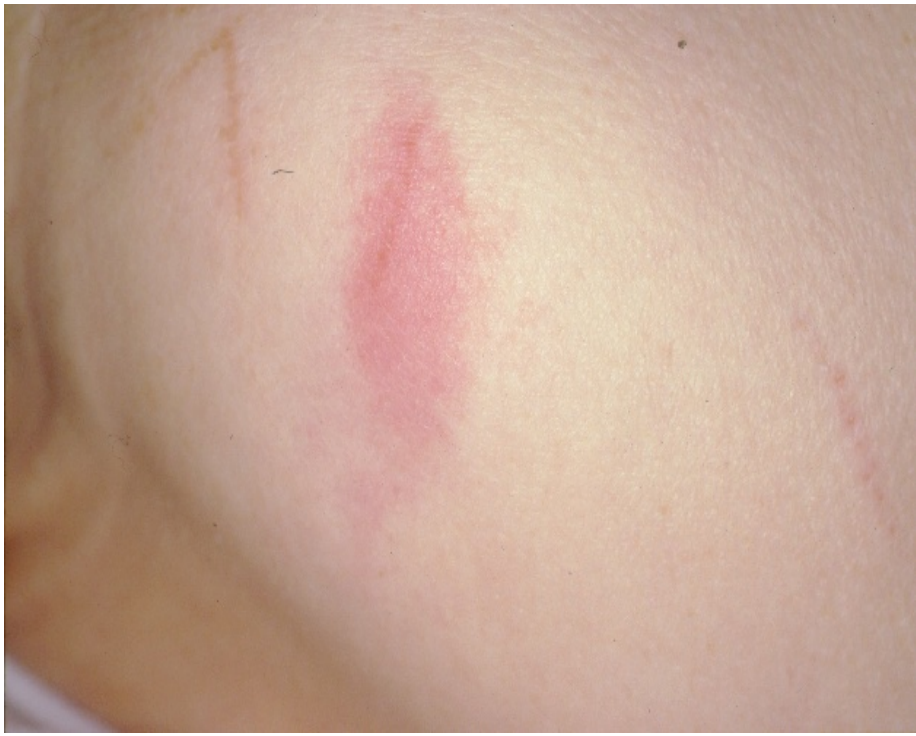
Stage I

- Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.



Stage I

- The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage I may be difficult to detect in individuals with dark skin tones. May indicate “at risk” persons (a heralding sign of risk).

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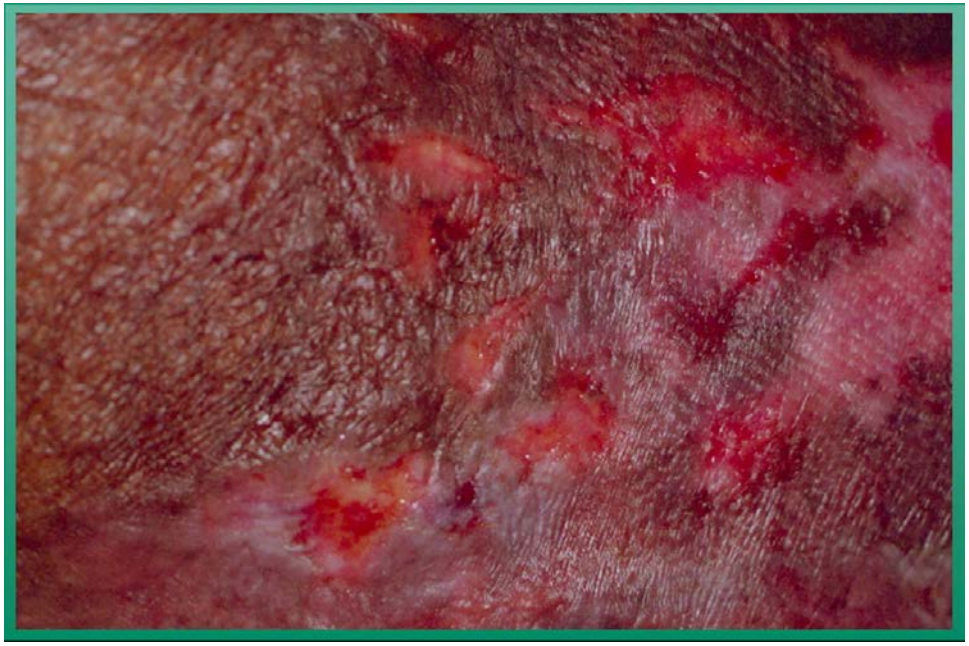
Stage II

- Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum filled blister.



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Stage II

- Presents as a shiny or dry shallow ulcer without slough or bruising. This stage should NOT be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.

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Stage III

- Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are *not* exposed. Slough may be present but does not obscure the depth of tissue loss. *May* include undermining and tunneling.

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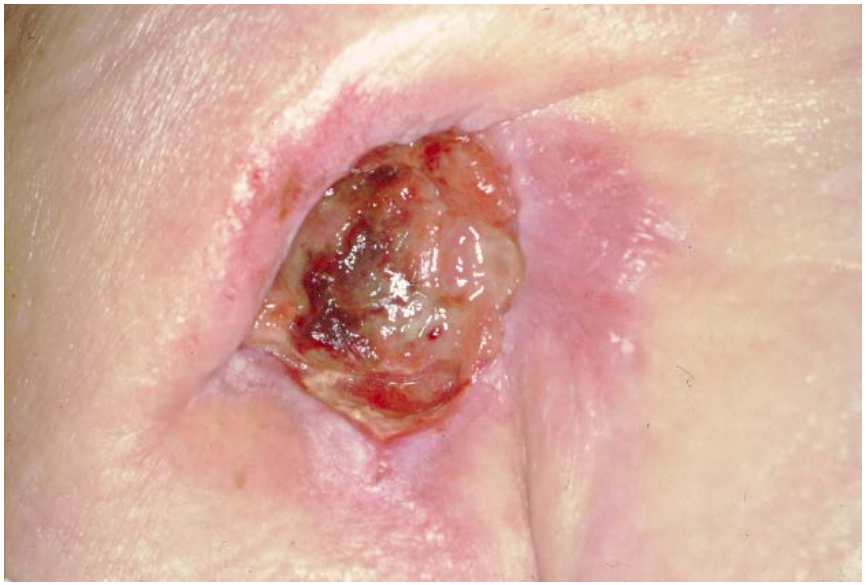

Stage III

- The depth of a stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage III pressure ulcers. Bone/tendon is not visible or directly palpable.

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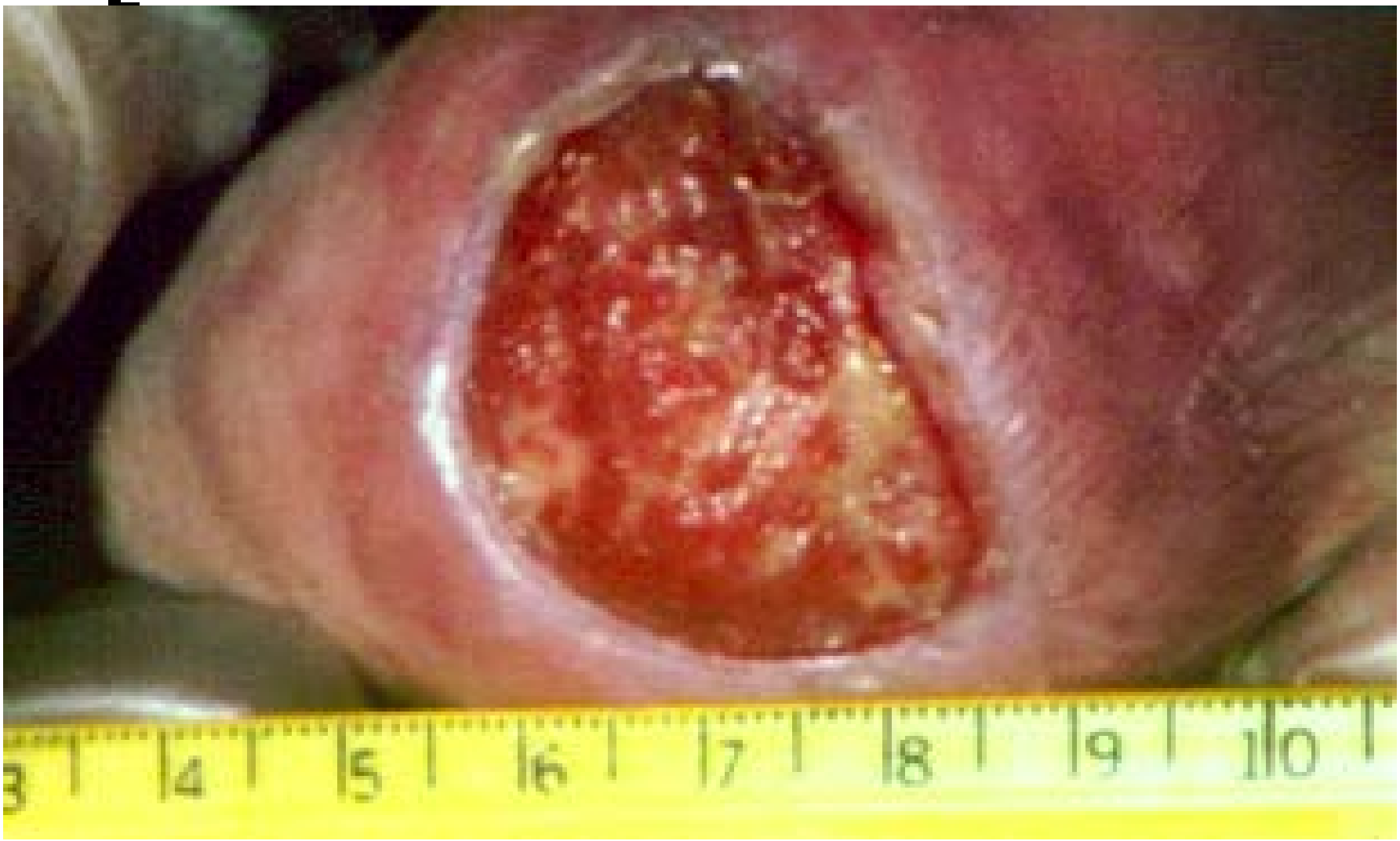
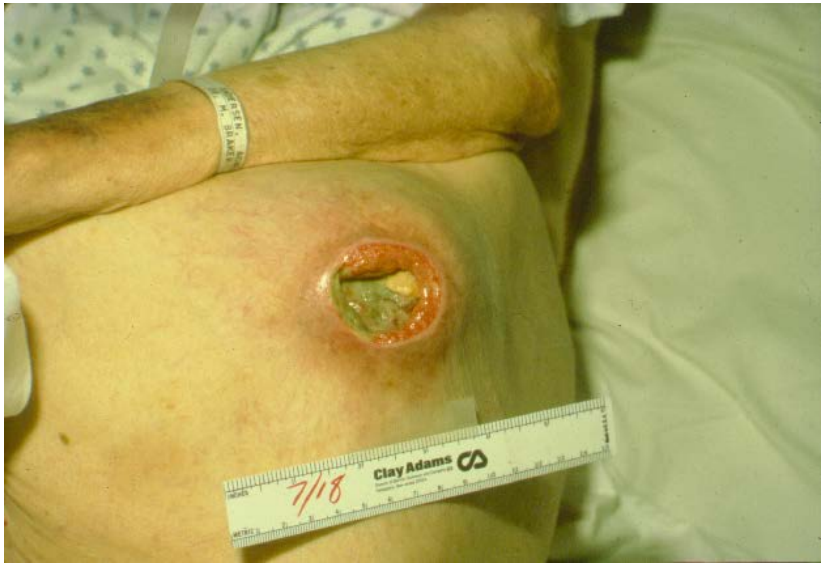
Stage III (heel)



Stage IV

- Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. *Often* include undermining or tunneling.



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Stage IV

- The depth of a stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.

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Unstageable Ulcer

- Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

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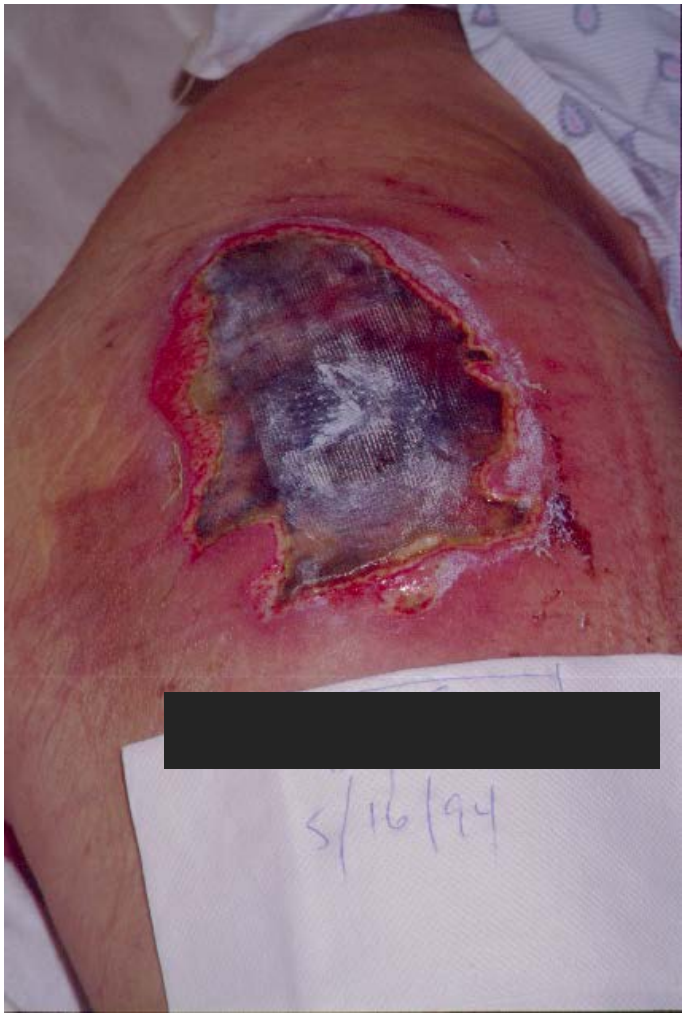

Unstageable Ulcer

- Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as the body's natural (biological) cover and should not be removed.

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CONCLUSION

- Stages define level of tissue injury
- Stages do NOT indicate progression of ulcer development
- Do NOT reverse or downstage stages
- Stages NOT appropriate for other types of wounds

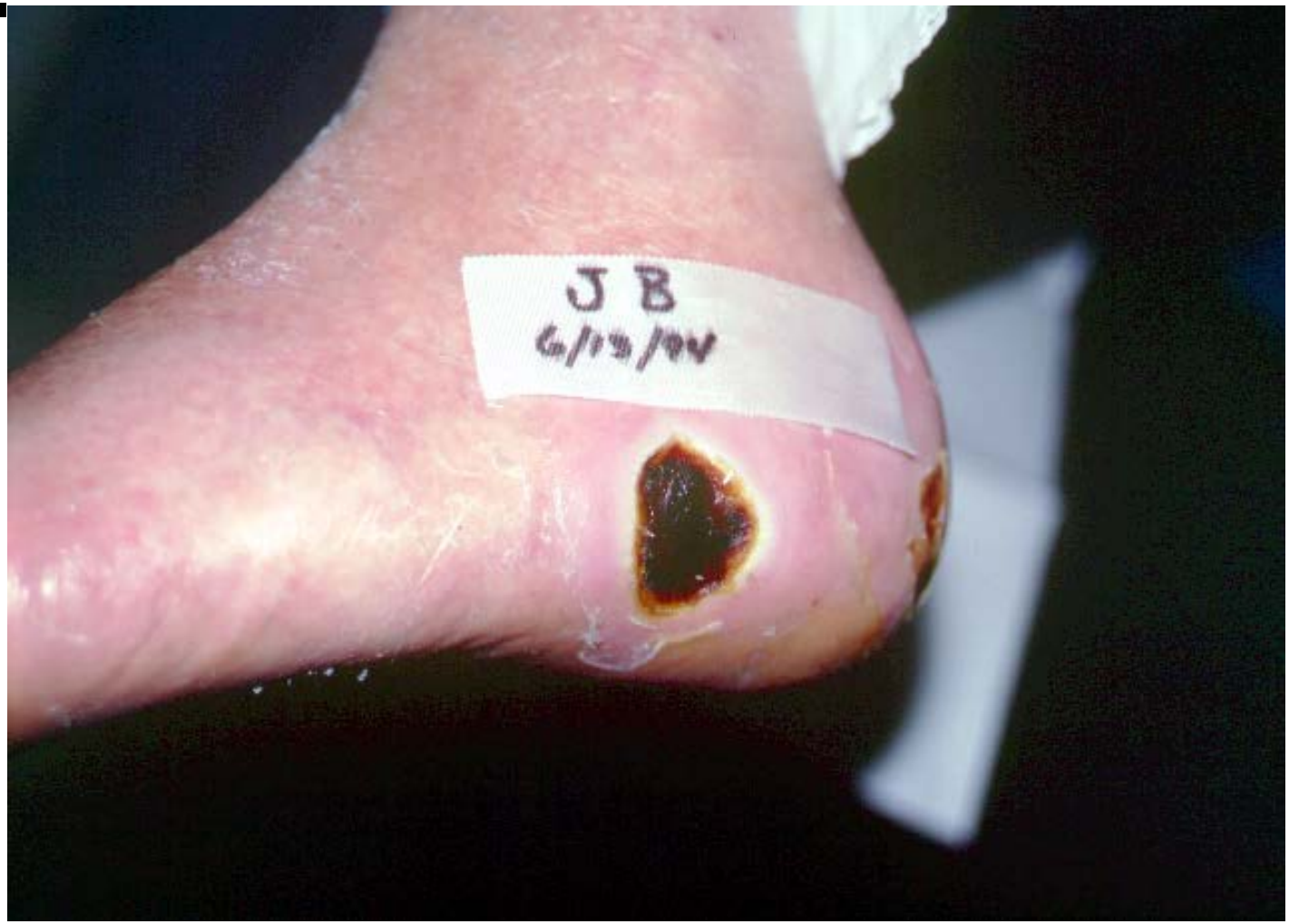
NPUAP

Overview of the Pressure Ulcer Program

- Goals
  - Prevention of avoidable pressure ulcers
  - Treatment of existing pressure ulcers with appropriate care to maximize healing and prevent further breakdown
  - Palliative care for “unavoidable” pressure ulcers in the terminally ill.

Physician Responsibilities

- Ask the caregiver about Braden score, pressure ulcers and other breakdown while making rounds
- Document any pressure ulcers present on admission within 24 hrs of admission
- Document any pressure ulcers that develop during hospitalization
- Assess cervical spine as soon as possible to allow for collar removal in critical care areas
- Assess for and write activity/out of bed orders as soon as possible
- Monitor nutritional status
- Write orders for specialty beds, specialty devices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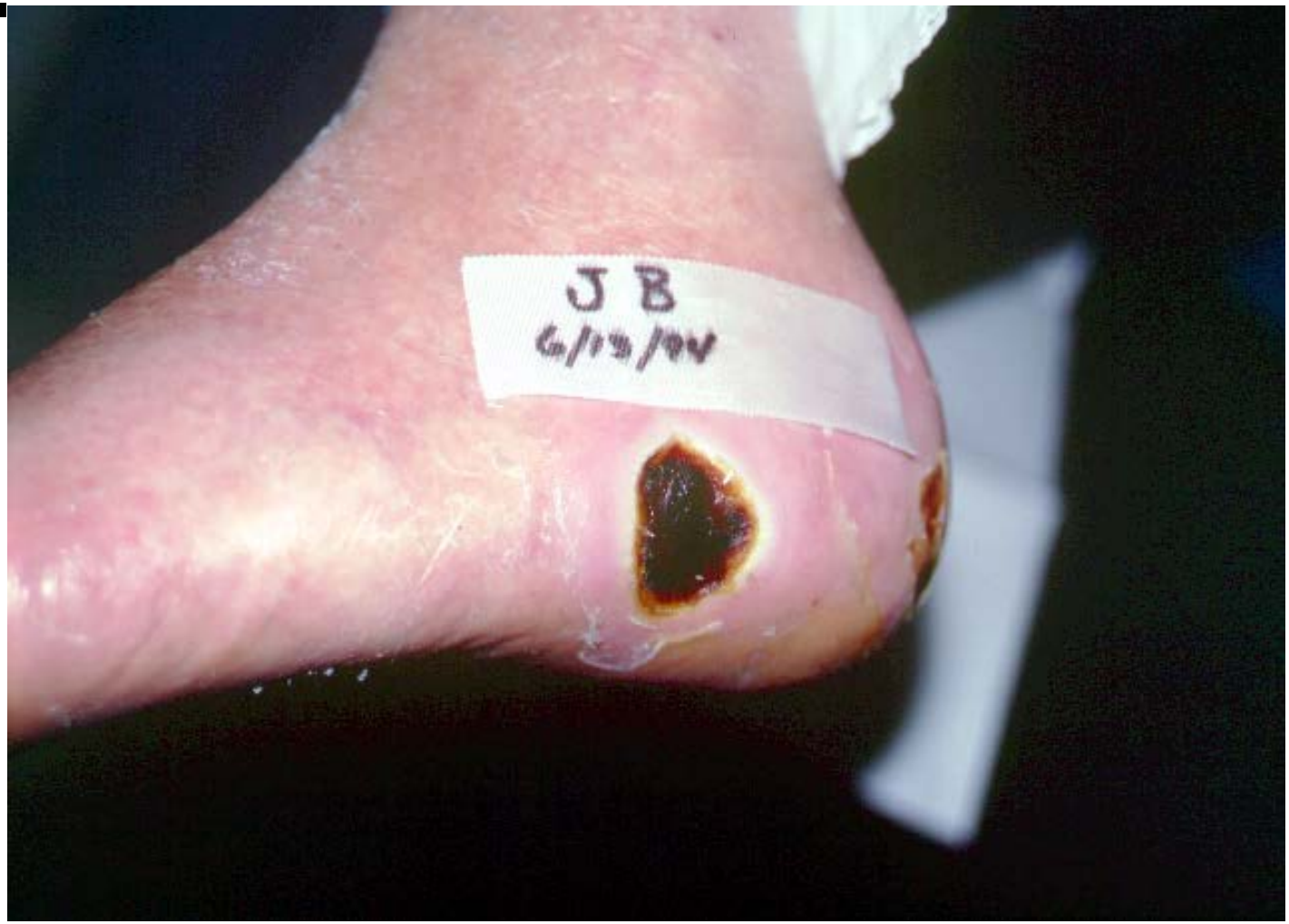
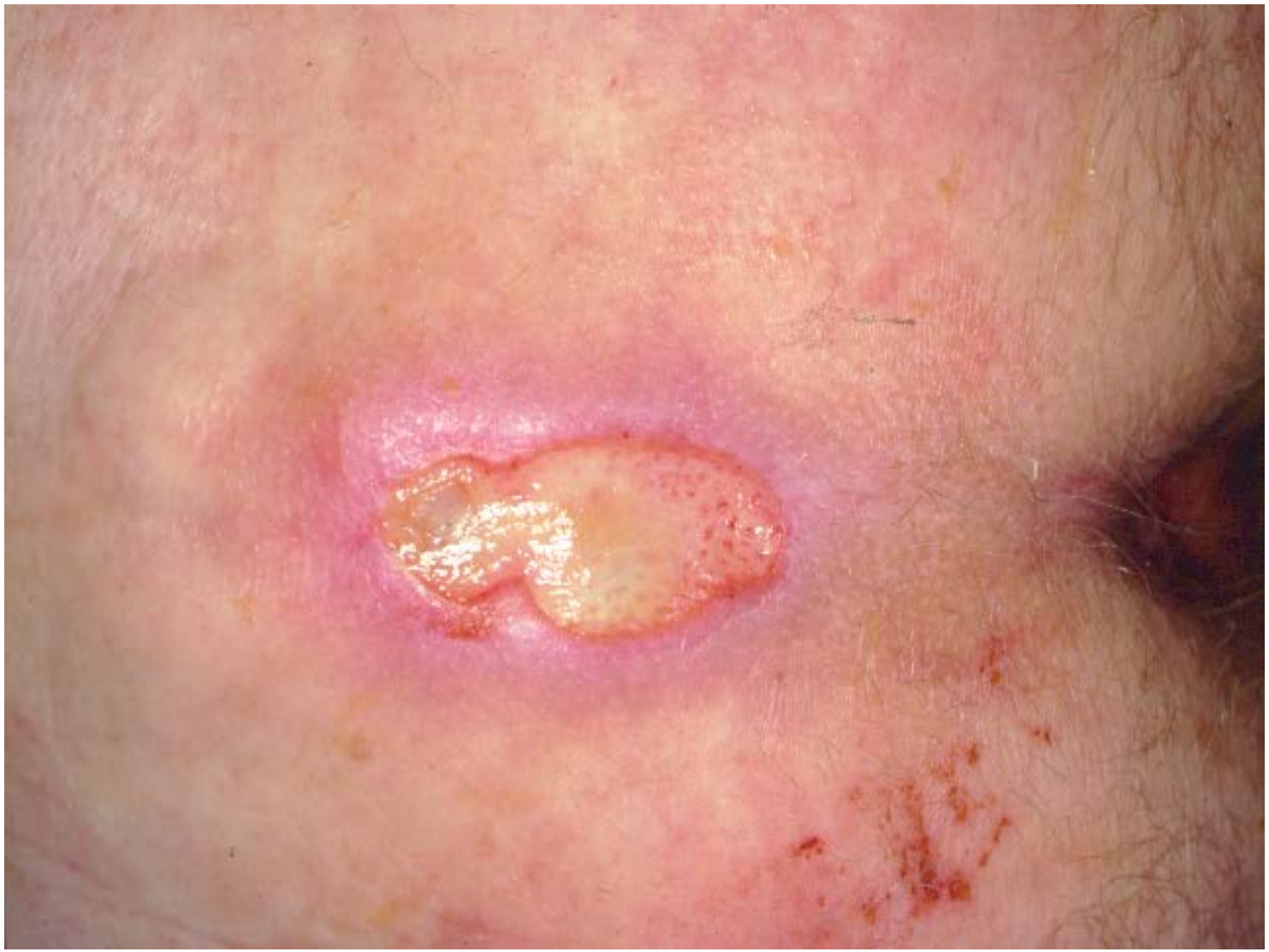
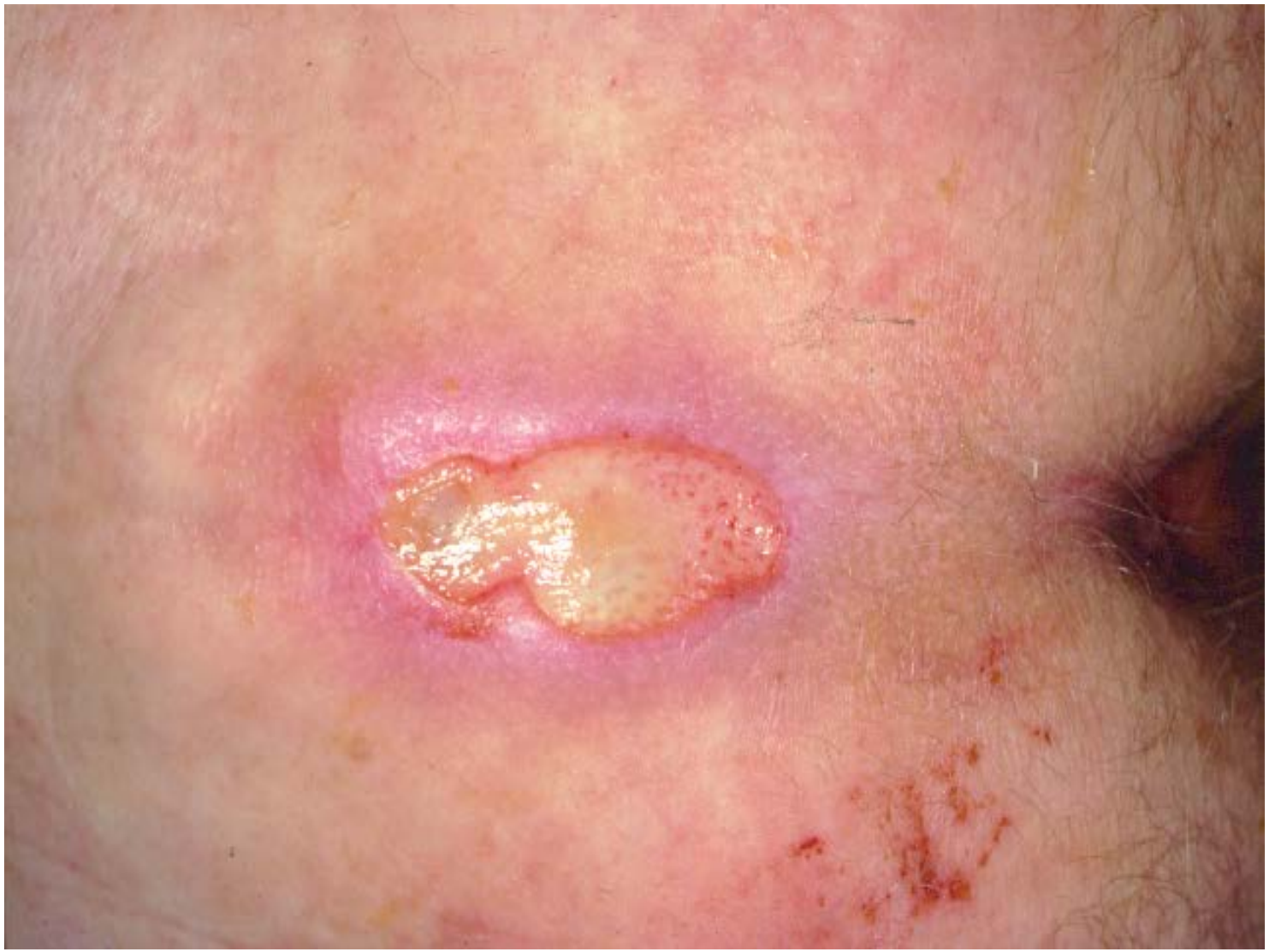
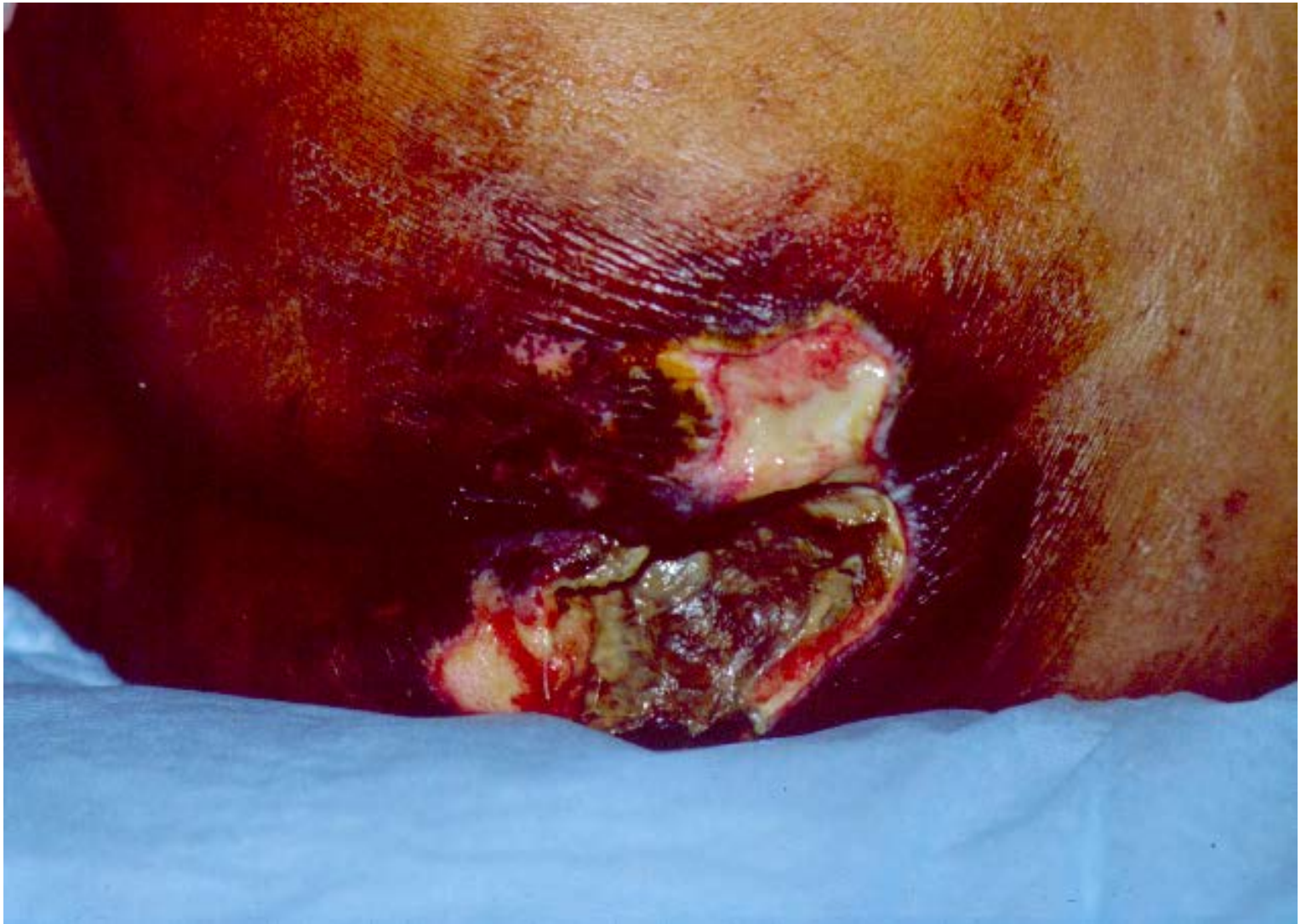
Unstageable



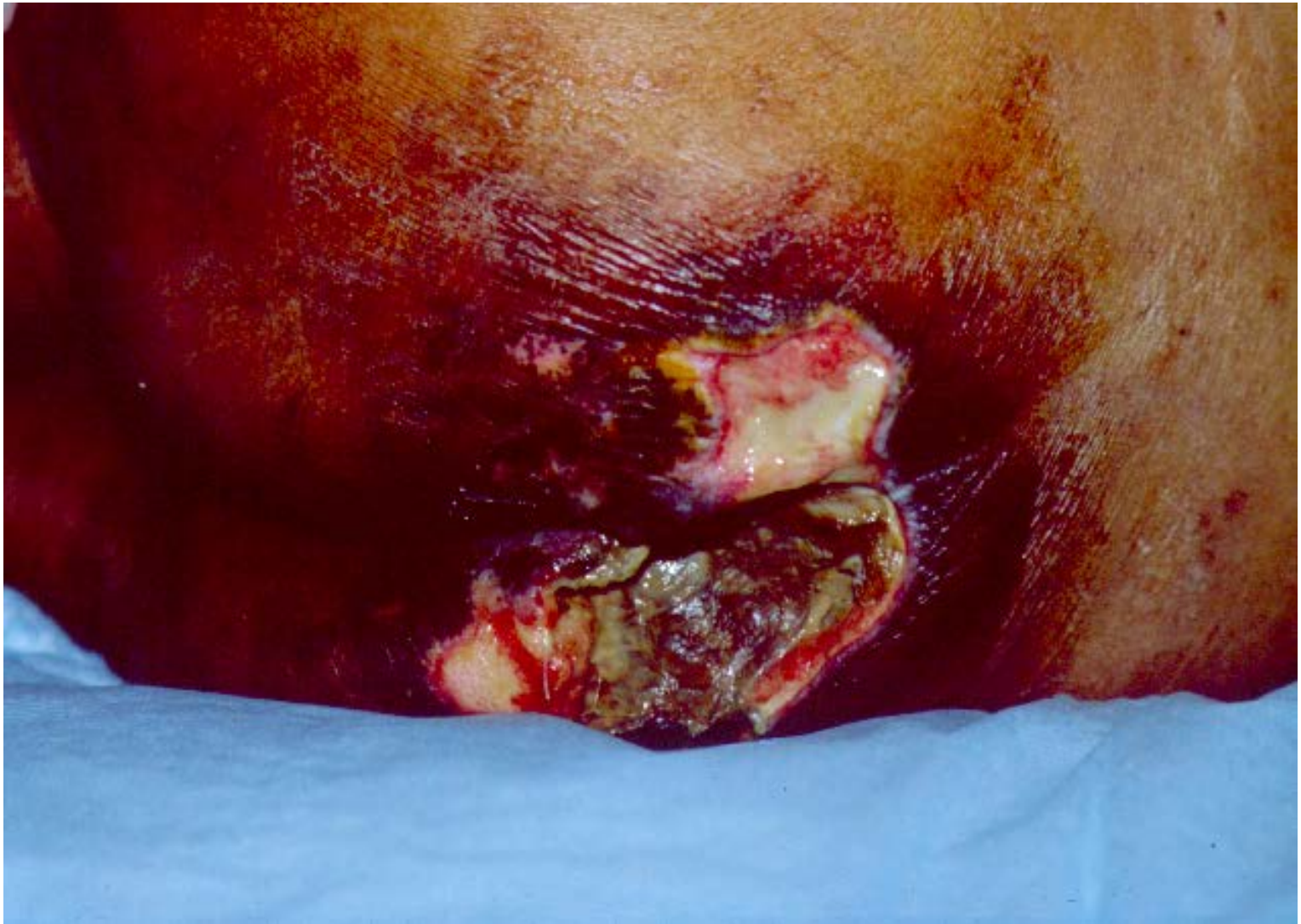


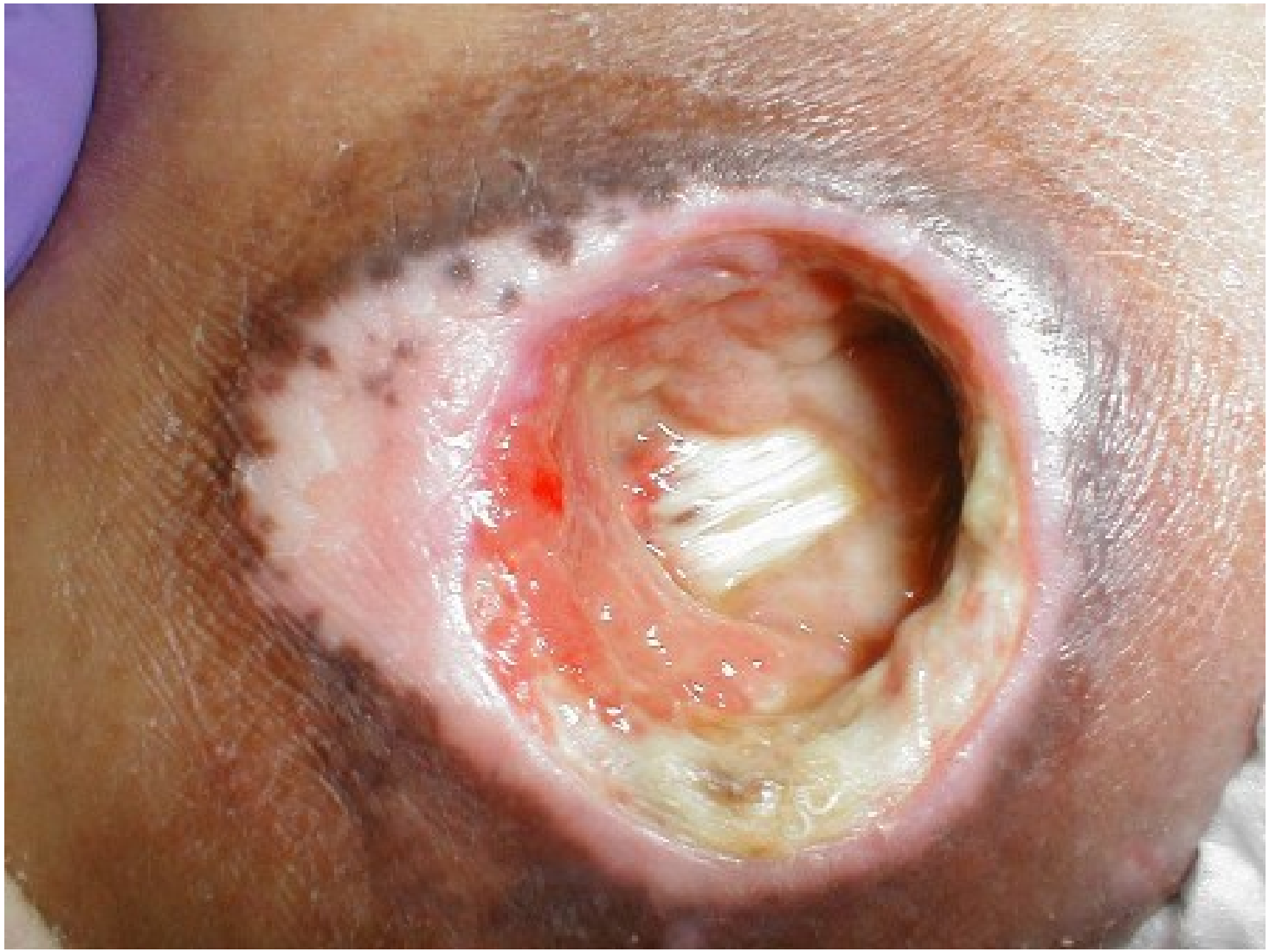
Stage II w/ slough



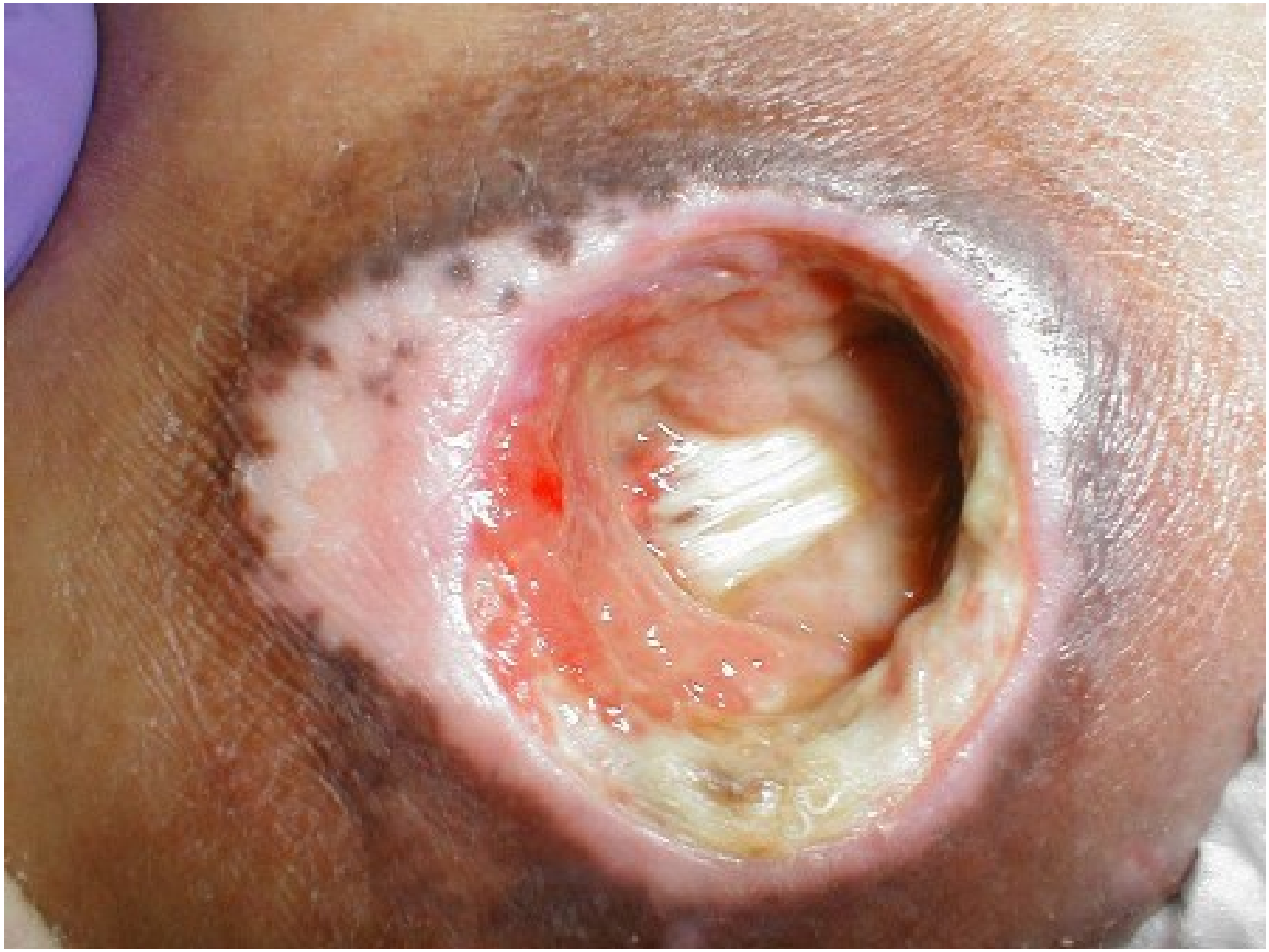


Unstageable with surrounding deep tissue injury





Stage IV w/ exposed tendon



We’re a Team!