Pressure Ulcer Prevention: How Far We’ve Come….Still Far to Go

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This year in particular, as the National Pressure Ulcer Advisory Panel (NPUAP) celebrates its 25th anniversary, there are many reasons to be proud about the journey to awareness and best practice related to pressure ulcers. No longer do we find ourselves “ringing the bell” to alert clinicians, administrators, policy makers, and family caregivers to this pervasive problem among immobile and debilitated patients. Examples of a changed culture include assessing a patient’s risk for pressure ulcer formation using a valid and reliable tool in all care settings, widespread acceptance of nutritional screening and support for people with healing pressure ulcers, and the expanding use of pressure redistribution products beneath all persons at risk. Today, pressure ulcer prevention is a topic on the tip of everyone’s tongue.

In order to fully celebrate where we are, it is best to acknowledge how we got here. In 2010, Chen et al performed a bibliometric evaluation to review trends in publications related to pressure ulcers. They found that the number of articles on pressure ulcers grew from approximately 39 in 1991 to 259 in 2009. The main categories in which pressure ulcer research was conducted were surgery and nursing, each of which accounted for more than 10% of the total articles. The relationship between staffing and pressure ulcer-related outcomes is the major focus of pressure ulcer nursing research, followed by risk assessment scales. Results from studies relative to staffing reveal that inadequate staffing patterns are associated with a higher probability of pressure ulcer development and show that increasing nursing hours can reduce the morbidity associated with pressure ulcers. In the past, prevention programs were based on total risk assessment scores, whereas the trend is now shifting toward customizing the prevention program to account for individual low subscales such as moisture and nutrition and to consider new subscales for body mass index (BMI).

Since the Agency for Healthcare Research and Quality (AHRQ), now the Agency for Healthcare Research and Quality, or AHRQ) published the Guidelines for the Prevention and the Guidelines for Treatment of Pressure Ulcers in 1992 and 1994, respectively, over the past 10 years many evidence-based guidelines and protocols on pressure ulcer prevention have been written. These publications include the International Pressure Ulcer Guideline for Prevention and Treatment (NPUAP/EPUAP, 2009), WOCN® Society Guidelines for Prevention and Management of Pressure Ulcers (WOCN® Society, 2003, 2010), and Guidelines for the Prevention of Pressure Ulcers by the Wound Healing Society. The evidence base was growing, but the voices lacked the strength and support of administrators and policy makers to make widespread changes.

It was not merely a quality initiative that elevated the topic of pressure ulcer prevention to the forefront in delivery-of-care conversations. Changes in regulation and reimbursement have been the driving forces in pressure ulcer prevention across all care settings. As mentioned, the topic of pressure ulcers and preventing pressure ulcers has become increasingly popular in the literature, especially since the Centers for Medicare and Medicaid Services (CMS) discontinued reimbursement for hospital-acquired pressure ulcers in October 2008. From a financial perspective, it is more important than ever to identify whether a person with a pressure ulcer had that ulcer upon admission or developed it while under the watchful eye of the current provider. Today, that information is merely a data point; one day it may be used to identify which setting should be responsible for the associated costs for healing an ulcer that occurred while the patient was under its care.

Regardless of the forces that brought us here, most would agree it is a good thing to have at last arrived. Health economics and patient safety are not competing goals; it is crucial to deliver both cost effective and quality care. Pressure ulcer prevention programs delivering repeatable outcomes are the mainstays of quality care organizations. People who are masters at executing the plans are consultants for those who are not; organizations that consistently deliver stellar outcomes are the ones against whom we all benchmark.

In the United States, approximately 1.6 billion patients develop pressure ulcers at an annual cost of $2.2 billion to $3.6 billion; 23% of pressure ulcers are acquired intraoperatively during surgeries lasting more than 3 hours. An aging population, patients with chronic diseases, and those surviving major trauma are putting more people at risk for pressure ulcers. At last, we are prepared to meet their needs. We stand on the shoulders of those who had the vision and the tenacity to make the practice of pressure ulcer prevention common. It’s not a finish line, though; it’s the beginning of a new race. Some would say we got here just in time.

References