PERSPECTIVES IN NURSING:
Medicolegal and Economic Implications of Hospital-Acquired Pressure Ulcers

Kara Couch, RN, MS, CRNP, CWS

Kara Couch is a family nurse practitioner and Certified Wound Specialist, who has been working in wound care for the past 12 years. As a nurse scientist, she is an investigator on several clinical trials related to wound healing. Kara also serves as a member of the Guidelines Committee for the Association for the Advancement of Wound Care and has authored or co-authored numerous articles and chapters on wound healing. She also lectures nationally on wound care and wound healing topics.

CASE SCENARIO

A 40-year-old male who weighed over 750 pounds was transferred to the hospital for treatment of an upper gastrointestinal bleed and obesity hypoventilation. He was admitted into the intensive care unit and placed on a ventilator. He developed a suspected deep tissue injury to the right ischium that went from a blistered state to a 15 x 15 cm eschar with epidermolysis over the course of 2 weeks. He had been through four different specialty bed surfaces to accommodate his weight and offload him effectively during his admission.

As the patient was too unstable for transfer to the operating room, bedside debridement was performed multiple times for necrosis. Initial physician documentation on admission stated there was an "unstable ulcer." No further wound descriptions were recorded until, several weeks into his admission, nursing noted the eschar during a turn and notified the surgery team. Once debrided, a Stage IV pressure ulcer was diagnosed, and the patient only tolerated turning daily due to respiratory issues. It took at least 10 people to turn him, and then all care had to be done as quickly as possible before he developed respiratory decompensation. Aside from the initial surgery note and the wound, ostomy, and continence nurse (WOCN) notes, there were no detailed descriptions of the wound or its size, other than to note a Stage IV ulcer was present or that the dressing had been changed.

If this case were to turn litigious, what are some initial red flags from this scenario? Was this pressure ulcer unavoidable? Should the hospital be penalized by the Center for Medicare and Medicaid Services (CMS)?

Pressure ulcers are injuries to the skin and soft tissue that usually overlie a bony prominence as a result of pressure or in combination with shear forces and/or friction. Pressure ulcer development occurs due to a multitude of factors, both intrinsic and extrinsic, and it is imperative that providers routinely assess patients for risk and have systems in place for prevention and care. Each year more than 2.5 million people in the United States develop pressure ulcers.[1] In 2006, there were over 300,000 reported cases of Medicare patients with a secondary diagnosis of pressure ulcer. Each case had an average cost of $40,381 for the hospital stay.[2] Based on that, CMS designated Stage III and Stage IV pressure ulcers as a Hospital Acquired Condition (HAC). Section 5001(c) of the Deficit Reduction Act of 2005 requires the Department of Health and Human Services Secretary to identify conditions that are: (a) high cost or high volume or both, (b) result in the assignment of a case to a diagnosis-related group (DRG) that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence based guidelines.

On July 31, 2008, in the Inpatient Prospective Payment System Fiscal Year 2009 Final Rule, CMS included 10 categories of conditions that were selected for the HAC payment provision, including Stage III and IV pressure ulcers. Payment implications began October 1, 2008, for these HACs.

Hospitals were no longer to be reimbursed for care associated with Stage III and IV pressure ulcers acquired during an admission. Beginning in October 2014, the hospitals in the highest quartile for hospital-acquired pressure ulcers (HAPU) were to be penalized a 1% pay reduction for all Medicare patients.[3]

While they are not classified as "never events," HAPUs are the most frequently found HAC. CMS feels that HAPUs are "reasonably preventable through the use of evidence-based guidelines."[4] In 2006, care for pressure ulcers was estimated at $11 billion dollars. These were 2006 dollars, and the cost is surely higher today, given the increase in the elderly population. Brem et al did a retrospective analysis of the cost of Stage IV pressure ulcers in 2010 and found that the cost for a HAPU patient averaged $129,248 during one hospital stay, and the cost of a community-acquired pressure ulcer averaged $124,237.5 Brem also noted a study by Lyder, which reported the monthly cost of preventing pressure ulcers was $519.73 per patient.[5]

CMS will reimburse the hospital for care related to a Stage III or IV pressure ulcer only IF the diagnosis was present on admission (POA) or arrival to the hospital or if the provider is unable to clinically determine whether the condition was present at the time of inpatient admission. "Thus, if a selected condition that was not POA manifests during the hospital stay, it is considered a HAC and the case is paid as though the secondary diagnosis was not present."[4] CMS will not make a payment if the documentation is insufficient to determine if the condition was POA or if the diagnosis was not POA.[3]

Pressure ulcers are the second most common cause of medical litigation (behind wrongful death), and each lawsuit won by the plaintiff has an average award of $250,000.[2] Over the years, the development of a pressure ulcer has had the implication that the patient received negligent care. Lawyers pounced on that once the problem came to light, and now they actively recruit patients for lawsuits. The average age of plaintiffs was 72 years, demonstrating that an increasing number of elderly adults are suing hospitals and medical professionals.[2] An expert panel of wound care professionals has found that some pressure ulcers may be unavoidable due to various factors, but proving unavoidability is difficult.[6]

The difficulty lies in the fact that all aspects of care are not, as a rule, documented. In the case scenario, there was documentation that the patient was on a specialty surface, was seen daily by either a surgical team or the WOCN, and was being turned as frequently as possible. However, remember that the nursing staff did not document what they saw, nor did the surgical teams who performed daily wound care. Also, the initial physician documentation noted an "unstable ulcer," but did not give a location or any further information for days. It typically takes litigation several years to work its way through the system, and by then, the patient's medical chart is the "report" of the care by the facility and the entire clinical team.

WHAT IS AN UNAVOIDABLE PRESSURE ULCER?

In 2010, the National Pressure Ulcer Advisory Panel (NPUAP) defined an unavoidable pressure ulcer as "one that may occur

even though providers have evaluated the individual's clinical condition and pressure ulcer risk factors have been evaluated and defined and interventions have been implemented that are consistent with individual needs, goals and recognized standards of practice."[6] The 2014 NPUAP consensus conference resulted in an agreed-upon final statement: "Unavoidable pressure ulcers do occur." Further work is ongoing to identify risk factors that have been shown to increase the likelihood of unavoidable pressure ulcers.[7]

As the nation's population of elderly increases over the next few decades, facilities and providers must educate themselves on ways to provide quality care to patients while understanding the legal and regulatory issues at work. Ayello et al produced a very informative consensus paper from the International Expert Wound Care Advisory Panel that examines the legal issues in the care of the pressure ulcer patients.[4]

WAYS TO PROTECT YOURSELF FROM LITIGATION

1. Always document and describe what you see as specifically as possible. Ayello et al describe good documentation with the "Cs": consistent, concise, chronological, continuing, and reasonably complete.[4] Careful documentation of pressure ulcer staging at admission AND discharge is crucial for CMS billing purposes. Not only must the ulcer be described carefully, but also the interventions and progress or deterioration need to be detailed.
2. Employ guidelines for care in your facilities for both prevention and treatment of HAPUs. CMS expects that recognized standards of practice are being used, and deviation from that can lead to "unavoidable" pressure ulcers. Referral to wound and skin specialists should happen expediently if the ulcer or skin condition needs it.
3. Facility and provider education and re-education are critical. There are a multitude of free, evidence-based resources available for use, including the NPUAP and the CMS websites.
4. Providers need to educate families and patients on risk factors for HAPU development. Managing expectations and timely communication with families can often defuse a stressful situation and prevent its deterioration. Family members should always be notified when skin breakdown occurs. In New Jersey, notification of family for HAPUs is a legal requirement in all instances. Specially trained providers should communicate sensitive information, such as prognoses, to patients and families only.

NOTE: As with any case study, the results and outcomes should not be interpreted as a guarantee or warranty of similar results. Individual results may vary depending on the patient's circumstances and condition.

References:

1. Preventing Pressure Ulcers in Hospitals. October 2014. Agency for Healthcare Research and Quality, Rockville, MD. Available at http://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/index.html. Accessed June 29, 2015.
2. Lyder C. Medico-Legal Implications. In: Bader DL, Bouten C, Colin B, eds. *Pressure Ulcer Research: Current and Future Perspectives.* New York, NY: Springer Science and Business Media; 2005:23-34.
3. *Hospital-Acquired Conditions and Present on Admission Indicator Reporting Provision.* Baltimore, MD: Centers for Medicare & Medicaid Services; September 2014. Department of Health and Human Services ICN 901046. Available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/wPOAFactSheet.pdf. Accessed June 30, 2015.
4. Fife CE, Yankowsky KW, Ayello EA, et al. Legal issues in the care of pressure ulcer patients: key concepts for healthcare providers--a consensus paper from the International Expert Wound Care Advisory Panel©. Adv Skin Wound Care. 2010;23(11):493-507.
5. Brem H, Maggi J, Nierman D, et al. High cost of Stage IV pressure ulcers. Am J Surg. 2010;200(4):473-7.
6. Black JM, Edsberg LE, Baharestani MM, et al. Pressure ulcers: avoidable or unavoidable? Results of the National Pressure Ulcer Advisory Panel Consensus Conference. Ostomy Wound Manage. 2011:57(2):24-37.
7. Edsberg LE, Langemo D, Baharestani MM, et al. Unavoidable pressure injury: state of the science and consensus outcomes. J Wound Ostomy Continence Nurs. 2014;41(4):313-34.