# The Presence of Pressure Ulcer Documentation On Admission

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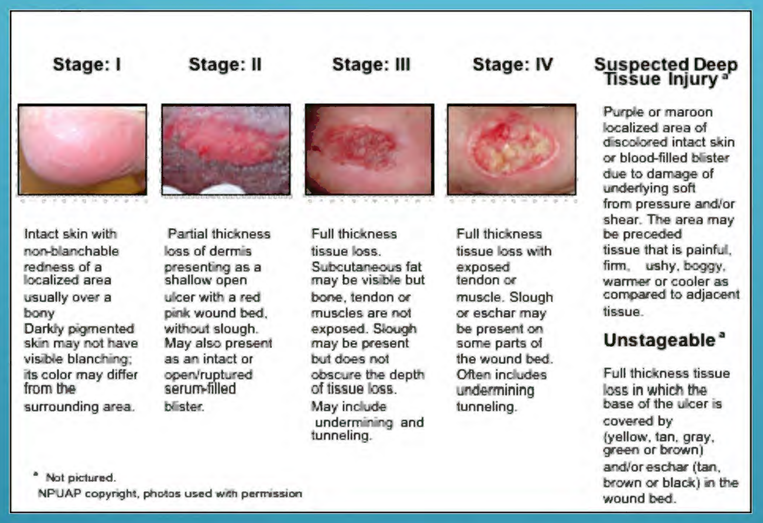
## Objectives

Following the poster session, participants will:

- Investigate whether or not documentation is the problem with reimbursement or if it is pressure ulcer occurrence
- Explore costs associated with pressure ulcer treatment
- Explore barriers to documentation

## Introduction

The purpose of this study is to investigate barriers of proper documentation of pressure ulcers on admission and to further investigate if patients are having increased development of pressure ulcers before admitted. Our plan to is develop a way to improve problems with documentation. The assessment and documentation of decubitus ulcers, also known as pressure ulcers, on admission to the hospital or unit floor continue to be an issue because nurses are either neglecting to document skin assessment findings or patients are having an increased development on pressure ulcers already on admission. This is occurring in a Central Kentucky healthcare facility despite adopted hospital protocols and policies to prevent this from happening. According to the Agency for Healthcare Research and Quality (AHRQ), data on the costs of pressure ulcer treatment vary, but range between $37,800 and $70,000 per ulcer. In the U.S. overall, pressure ulcer care is approximately $11 billion annually. The absence of pressure ulcer documentation on admission results in denial of hospital reimbursement by health insurance companies, leading to the loss of needed money for hospitals. Some of the associated costs could be deflected with proper nursing documentation on admission to the unit. The method for this study is to conduct a qualitative survey on medical-surgical and critical care units among RN's. Enforcement of skin care policies that state when to assess and document findings will also be discussed.



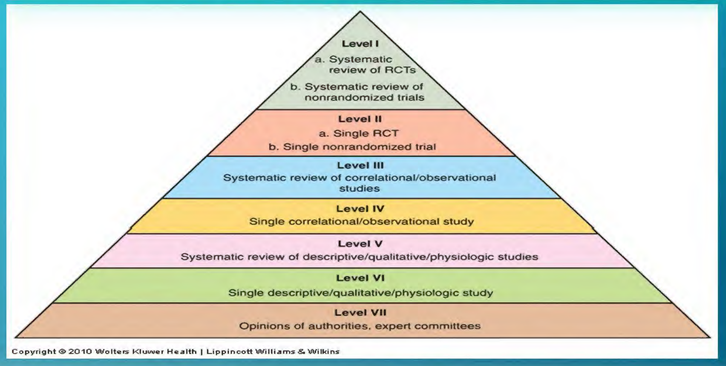

## Review of the Literature

Skin assessment is critical to a patient's care holistically, not just for treatment purposes. The skin can give further information regarding a patient's condition and whether or not other conditions could be forming. With this being said, skin assessment is very important. Skin assessment is important for other reasons beyond diagnostics and treatment. Accurate skin assessment can mean the difference between whether or not the hospital gets paid and whether or not they lose money (DiAgostino, 2009). DiAgostino (2009) further stated that beginning in 2008 Medicaid and Medicare services were no longer reimbursing hospitals for "never events" or other errors that are costly and should never happen. Skin assessment is not only important to help identify those who currently have decubitus ulcers or pressure ulcers but also for those who are at risk for development of them (Masculo, 2006). It's very important that all nurses know proper assessment techniques and that documentation is followed up when skin abnormalities are seen. Providing evidence-based education to all team members and sharing information during skin care rounds enables nurses to provide consistent, appropriate, and timely treatment and will allow for successful documentation of what is observed during assessments holistically (Masculo, 2006). Successful documentation not only aids in improvement of care, but it can also increase patient safety and continuity of patient care. Lack of information quality and standardization in documentation of the patient's skin condition and the care that is implemented could have severe negative impacts on quality and safety of the patient's care (Thoroddsen, Sigurjónsdóttir, Ehnfors, and Ehrenberg, 2013). It is possible that proper skin assessment documentation could be lacking due to prioritization of the patient's needs. However, development of pressure ulcers negatively impacts the patient and the hospital (Cremasco, Wenzel, Zanei, and Whitaker, 2013).

## Skin Assessment Protocol

Pressure Ulcers are not only a national concern due to patient morbidity and treatment cost, but it's also a major concern due to reimbursement for Medicaid and Medicare services (Zaratkiewicz, Whitney, Lowe, Taylor, O'Donnell, & Minton-Folz, 2011). Pressure ulcers or PU's that are acquired during hospitalization and are evaluated as either Stages III or IV are considered among the eight preventable conditions identified by the Centers for Medicare and Medicaid Services or CMS. As of October 2008, hospitals will no longer receive high Medicare payments related to ulcer specific care to patients who acquire Stage III or Iv PU during their stay at the hospital, even private insurers are developing reimbursement restrictions related to PU's. PUs are often a secondary diagnosis rather than a primary reason for care in hospitals. Tracking the development of PUs is not a new concept but there are heightened concerns now since there are reimbursement guidelines implemented. The tracking of PUs began with the implementation of an electronic medical record system or EMR. Staff registered nurses are to complete skin assessments for their patients per shift and chart this on an EMR. This step in documentation is very important for reimbursement purposes so that pressure ulcers are documented on admission to the facility. It's also important that staff RNs assess whether a patient is at increased risk for developing a PU and do necessary steps to help prevent PUs from developing while the patient is receiving care in the hospital. Some of the modifiable risk factors in the hospital are: Was the patient turned every 2 hours?, Was a skin inspection completed each shift by the beside RN?, Was the skin kept dry?, Was a pressure redistribution surface used?, If a nonexpanding device was used such as a orthotic device or splint was it assessed and readjusted for fit? Were clinical resources utilized such as CWCN, OT, RT, or orthotic specialist? Was patient education provided? (Zaratkiewicz et al., 2011) This plays an important role in identifying patients at risk for developing PUs and to help prevent PUs from developing during a patient's stay in the hospital.

## Grading of Evidence




## Results

We conducted a qualitative survey among RNs on medical surgical and critical care units. The main barriers to documentation that we found from the survey results included lack of time, forgetting to document assessment, and change of shift.

## Clinical Implications

It is very important to address the barriers that we found in order to increase the amount of reimbursement that the hospital obtains from pressure ulcers. When considering the three barriers we found, some actions that could possibly improve the rates of documentation include: setting reminders on the charting system, scheduling random audits of charts in order to enforce documentation, or hanging a poster that stresses the importance of documentation of skin assessment on admission.

## References

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