Pressure Ulcer Prevention:
When Are We Negligent?

BY
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I recently reread the position paper by the Wound, Ostomy and Continence Nurses Society (WOCN) titled "Avoidable versus Unavoidable Pressure Ulcers." In reviewing the definitions of what constitutes an avoidable versus an unavoidable pressure ulcer, I began to think about how these definitions make hospitals, nursing homes, home-care offices and health-care providers liable in providing the care necessary to avoid a pressure ulcer.

The WOCN provides the following definitions of avoidable and unavoidable pressure ulcers:

> **Avoidable pressure ulcer:** "Avoidable" means that the resident developed a pressure ulcer and that the facility did not do one or more of the following: evaluate the resident's clinical condition and pressure ulcer risk factors; define and implement interventions that are consistent with resident needs, resident goals and recognized standards of practice; monitor and evaluate the impact of interventions; or revise the interventions as appropriate.
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> **Unavoidable pressure ulcer:** "Unavoidable" means that the resident developed a pressure ulcer even though the facility had evaluated the resident's clinical condition and pressure ulcer risk factors; defined and implemented interventions that are consistent with resident needs, goals and recognized standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate.[1]

Although legal cases related to pressure ulcers are more common in the U.S. than in Canada, this does not shield us from the possibility of being involved in legal action, nor does it relieve us of the same duty to ensure that we are providing the care necessary to prevent pressure ulcers. Upon reflection of what defines avoidable pressure ulcers, I began to think about how we may or may not be meeting these standards in daily practice. Our best practice guidelines and recommendations to date are the *Nursing Best Practice Guideline: Risk Assessment and Prevention of Pressure Ulcers* and *Best Practice Recommendations for the Prevention and Treatment of Pressure Ulcers*, from the Registered Nurses' Association of Ontario and the Canadian Association of Wound Care (CAWC), respectively.[2,3] Let's look at how these guidelines and recommendations align with the WOCN definitions.

"Evaluate the resident's (patient's) clinical condition and pressure ulcer risk factors"

In other words, identify and treat any potential causes of pressure ulcers. You need to ask the following questions:

- Has a complete patient history and physical examination been completed and documented to determine overall health and risk factors that may lead to the development of pressure ulcers?
- Has a validated pressure ulcer risk scale (PURS), such as the Braden, been used to determine the patient's risk? Has the patient's risk level been documented?

"Define and implement interventions that are consistent with resident needs, goals and recognized standards of practice"

Once a PURS has been used to identify the level of risk, the following questions become important:

- Has the PURS score been documented and a care plan created based on the level of risk?
- Has the risk-related care plan been documented and are all interdisciplinary staff members who interact

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with the patient aware of the risk and the plan of care?

- Has the care plan addressed patient-centred concerns?
- Does the care plan reflect the best practice recommendations?
- Have the risk score parameters been used to assess and modify the risk, such as reducing situations where pressure may be increased, maximizing nutritional status, managing moisture or incontinence, maximizing mobility and activity and reducing or eliminating friction and shear?
- Was the interdisciplinary team consulted when developing the care plan?

According to the CAWC best practice recommendations, gaining the necessary organizational support is also fundamental to prevention:

- Have all health-care providers, patients and their families been educated regularly to ensure that they are aware of the risk and what they can do to prevent pressure ulcers?

In Canada, the Pressure Ulcer Awareness and Prevention (PUAP) program is the most comprehensive program available to date. The PUAP program, developed by the CAWC, provides all of the tools necessary to incorporate best practices at the bedside into daily care. The program helps facilities to achieve these standards for prevention by providing the skills and tools to identify the risk, develop a care plan and communicate the risk to all staff, patients and their families while incorporating an interprofessional team approach. The PUAP program includes patient and family education to ensure that all persons responsible for pressure ulcer prevention are aware and involved for maximum impact. This raises the following questions:

- Are we actively using the best practice guidelines and recommendations that we have available to us? Are they incorporated into our policies and procedures?
- How do we transfer knowledge into practice?
- Are we doing what we know we should be doing? This is a very common concern in many facilities across the country and continues to be a challenge for many clinicians.

"Monitor and evaluate the IMPACT of the interventions or revise the interventions as appropriate"

Once the risk has been established and the care plan developed, how often does your facility monitor and evaluate the risk? Barbara Braden's recommendations for the frequency of risk assessment in acute care are to assess on admission and at least every 48 hours thereafter, as patient status can change rapidly. The intensive care unit should complete a validated PURS such as the Braden every shift if the patient is unstable and daily if the patient is stable.

Long-term care facilities should complete a validated PURS on admission, every 48 hours for the first week, weekly for the first month and then monthly to quarterly or whenever health status changes. Home care should also assess risk on admission and then at every nurse visit. Family members should also be taught how to assess the skin. This is especially important when patients are on weekend passes.[4]

- How often does your facility monitor and alter the care plan to ensure that it is updated and that all risk parameters are addressed and modified to prevent a pressure ulcer?

The PUAP program helps facilities evaluate care through weekly high-risk rounds. This makes certain that the care plan for all high-risk patients is reviewed by an interprofessional team. It also ensures that the care plan stays current and reflects the risk, and that care is modified regularly.

- How does your organization measure the outcomes of the interventions you have set in place to reduce pressure ulcers?
- How do you know if what you are doing is working?
- If outcomes are not being measured and you are not evaluating your care, does this make you liable?

As the PUAP national manager, I interact with many facilities across the country. Most of the facilities I have spoken with complete prevalence and incidence (P&I) data only every few years, if at all.

- Is this frequency adequate to measure the care that we provide related to pressure ulcers?
- Even if P&I studies are completed, what is done with the information? What action plans are developed to address the results?
- What do facilities benchmark themselves against to determine whether they are doing well in terms of preventing pressure ulcers?

To help facilities address this common gap, the PUAP program assists in evaluating the care that facilities provide. This is done through monthly chart reviews that identify gaps in care. The program also helps facilities

build internal capacity to measure P&I at least annually and develop measureable outcomes for success. The PUAP program also provides facilities with gap analysis tools to determine what can be done better and to develop appropriate action plans for improvement.

Going Back to the Literature

The WOCN position paper recognizes the complexity of pressure ulcer development. It also suggests that intrinsic risk factors are not always captured by risk-assessment tools, and that not all of these risk factors can be removed or modified. Finally, the paper recognizes that prevention and management are not always under the control of nurses exclusively and that there are clinical circumstances where interventions may be contraindicated. Other factors to consider include the following:

- Pressure ulcer staging is largely based on a visual change to the skin and/or tissues. Some damage cannot be identified visually until it has reached a dangerous or irreversible stage.
- Patients' rights play a significant role. Individuals may refuse some or all aspects of their care and may not adhere to a pressure ulcer prevention plan.
- In the case of palliative care, consideration must be given to interventions that are necessary but may be inappropriate near the end of life.[1]

Recommendations

The WOCN position paper recommends further study to determine how co-morbidities and intrinsic factors contribute to pressure ulcer development and the corresponding implications for clinical practice. It also recommends further research to "provide the scientific evidence supporting pressure ulcer prevention interventions, and to guide critical thinking and decision making when deviation from the interventions is indicated."[1] The paper also suggests that continued effort is needed to support the development of effective processes to ensure that clinicians consistently implement evidence-based practice related to pressure ulcer prevention across the entire health-care continuum.

For the Canadian health-care system, the PUAP program is a solid start to ensuring that facilities get the help they need to transfer pressure ulcer prevention knowledge to the bedside and achieve the standards of care outlined in the best practice guidelines and recommendations. Finally, the WOCN position paper states: "Continued support and study is also needed to develop and expand the list of risk factors that are more predictive of pressure ulcer development. While many wound-care experts agree some pressure ulcers are unavoidable, the accurate identification of these wounds is made after appropriate interventions have failed."[1]

The WOCN position paper also recommends that all preventative measures be accurately documented; if there are clinical reasons that preventative measures are not appropriate or feasible, clinicians must document these and the rationale must be evident.[1]

The purpose of the WOCN position paper was to refute the assumption that all pressure ulcers are avoidable. While true, we still must strike a balance between what we know we need to better understand through research and the current best practice recommendations.

Conclusion

If you have answered *no* to any of the questions raised throughout this article, does that make your facility potentially liable should a pressure ulcer develop in one of your patients? As nurses, does failing to ensure that we provide the standard of care to prevent pressure ulcers place us at risk for negligence? I do not claim to have the answers to these questions—only a medical lawyer would. Rather, my goal in writing this article was to provoke thought on how well Canadian health-care systems in general—and we as practitioners in particular—are preventing pressure ulcers, and how well we measure up against the standards outlined in the literature.

For more information on the PUAP program, Canada's only generic, evidenced-based pressure ulcer prevention program, please contact Kimberly Stevenson at (250) 764-6283 or stevenson@preventpressureulcers.ca.

References

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