

Running Head: WOUND DOCUMENTATION

The Cost of Proper Wound Documentation

Wound Documentation 2

Wound Documentation

Introduction:

Wound care documentation is essential to providing quality patient care. A major change developing on the clinical unit is the formation of a new wound care flow sheet. Currently, the flow sheet being used contains only a small area to document a wound assessment, and this limited space is inadequate to complete thorough skin documentations for each patient. A new wound care flow sheet will allow nursing staff more space to document, and provide more specific information regarding each patient's wounds. Treatment regimes and wound care planning can also be included on the form, so that subsequent shifts may refer to the form for complete wound care information.

Future policy changes are to be made according to the Centers for Medicare and Medicaid regarding the development of hospital acquired pressure ulcers as well as the presence of pressure ulcers upon a patient's admission. If a patient develops a hospital acquired pressure ulcer or is admitted with a pressure ulcer that was not properly documented, the Centers for Medicare and Medicaid will no longer provide reimbursement for the treatment of the pressure ulcer. With increasing prevalence of hospital acquired conditions, hospitals may find themselves losing money due to preventable patient conditions. Proper wound documentation is necessary to receive reimbursement for some pressure ulcers, as well as becoming aware of skin breakdown of patients on each unit. According to one spokeswoman, "Nurses lead the way in treating and preventing pressure ulcers (Sounart, 2007)," and the future policies "send a loud and clear signal to hospitals that they need to maintain the highest standards of quality and safety (Sounart, 2007)."

Description of the Problem:

The formation of an updated wound care documentation form will allow units to have greater assessment skills and further identify any patients at risk for developing a pressure ulcer during his or her hospital stay. Currently, on the clinical unit, the documentation area towards wound care is very limited. Only a small portion of the flow sheet is directed towards wounds and skin assessment. The flow sheet contains a Braden Scale, body figurines to document the location of a wound, and a few small lines to

Wound Documentation 3

describe the characteristics of any present wounds. The pilot program currently in place is now requiring the nursing staff to fill out a more extensive form towards wound care. The new form also contains a Braden Scale, but the areas for wound documentation allow greater description. Definitions are provided to the nursing staff about what certain wound descriptions mean to further clarify any confusion and misinterpretation. The wound care flow sheet also contains documentation describing the location and type of wound, the type of dressing applied and when the last dressing change has been, the size of each wound, type and amount of any exudate, the appearance of the wound bed, as well as the appearance of the surrounding tissues. A section is also allotted to document wound care planning and any preventative measures that have been implemented by the nurse to decrease the risk of pressure ulcer formation. The implementation of the new wound care flow sheet will allow for better documentation, which will hopefully lead to improved documentation of a skin assessment on admission, as well as decrease the prevalence of pressure ulcers in future patients. Having an improved documentation form to find skin breakdown on admission, as well as decrease the incidence of pressure ulcers on the unit, will reduce costs related to pressure ulcer treatment. With new policies soon to be implemented by CMS, the unit needs to make changes so that money is not spent on treating patients for preventable hospital acquired conditions.

The Centers for Medicare and Medicaid Services, also known as CMS, has recently issued a new policy that has started a wake up call throughout the health care system. CMS has stated that it will no longer pay hospitals for the cost of treating “conditions that could reasonably been prevented,” as well as “serious preventable events (Pear, 2007).” The Centers for Medicare and Medicaid Services has formed a list of eight preventable hospital acquired conditions that it will no longer reimburse hospitals for. The eight conditions include, hospital acquired injuries including fractures, dislocations, and burns, mediastinitis after coronary artery bypass graft surgery, urinary tract infections that result from improper catheter use, pressure ulcers, vascular catheter-associated infections, objects left in the body during surgery, air embolisms, and blood incompatibility (Pear, 2007). There are also three future additions that Medicaid may add to the list. These include ventilator associated pneumonia, staphylococcus aureus

Wound Documentation 4

septicemia, and deep vein thrombosis or pulmonary embolism (Pear, 2007). The high prevalence and incidence of these conditions have led to hospitals finding new ways to improve the quality of care, and also strategies to improve documentation. This has been a large contributing factor for the clinical unit to begin piloting a new wound documentation form to help with a more precise and accurate description of a patients wounds and treatment. With the new policy stated by the Centers for Medicare and Medicaid Services, this is one step to help decrease the prevalence of pressure ulcers on the unit. An overall decrease in prevalence will also help the unit to save money due to a decrease in treatment costs for unit acquired pressure ulcers.

According to CMS, an unavoidable pressure ulcer “occurs when the facility staff 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 interventions, and revised the approaches as appropriate (Anscombe Wood, 2007).” Along with the new policy towards preventable hospital acquired conditions, Medicare has changed the base rate pay of certain diagnosis related groups. The base rates have been reduced so that higher payments can be reimbursed towards patients with more severe conditions. To gain higher reimbursement for pressure ulcers, the hospital and unit will need to document the presence of a pressure ulcer on a patient within one to two days of admission (Anscombe Wood, 2007). Stage I and stage II pressure ulcers do not qualify for higher payment, but stage III and stage IV pressure ulcers present on admission will receive the new higher reimbursement (Anscombe Wood, 2007). The only exception is a stage III or stage IV pressure ulcer located on the elbow, for which Medicare will not award higher payment. However, if the pressure ulcer is hospital acquired, no reimbursement will be received (Anscombe Wood, 2007). The institution also cannot charge patients for any of the costs related to a hospital acquired condition, or preventable event. Currently, Medicare does not tract assessments of the eight preventable measures in the new policy. Starting October 1st of 2008, hospitals will have to document any of the conditions present on a patient’s admission (Anscombe Wood, 2007). This means that admission assessments need to have

Wound Documentation 5

significant improvement. Assessment documentation will result in the difference between payment for care associated with pressure ulcers present on admission and on reimbursement.

Evidence:

Since the middle of 2005, staff on the unit has been gathering data towards the prevalence of patients with pressure ulcers, and information is continuing to be collected. On average, the unit has 10.85% of admitted patients with pressure ulcers every quarter that data is collected (National Database of Nursing Quality Indicators, 2007). Of these patients, 2.79% have pressure ulcers that are hospital acquired, and 2.39% have hospital acquired pressure ulcers of a stage II or greater (National Database of Nursing Quality Indicators, 2007). The numbers may not seem very large, but after factoring in the costs of pressure ulcer treatment, this small number has an enormous impact on the overall unit. However, the data of hospital acquired pressure ulcers only applies to those patients who acquired a pressure ulcer on another unit, and then were transferred to the current clinical unit. There is very little data to support the actual incidence of patients with unit acquired pressure ulcers. The data has only been collected since the first quarter of 2007, but the results show that the unit has had no incidences of unit acquired pressure ulcers in their patients (National Database of Nursing Quality Indicators, 2007). Further data needs to be researched towards proper documentation, but this research is in the process of being conducted. While the data shows that the unit has not had any unit acquired pressure ulcers, further wound care prevention strategies need to be implemented to continue this trend. All nurses need to be educated about proper skin assessment of newly admitted patients, and to ensure that a skin assessment is documented within two days of patient arrival.

There are many facts and data reports given about the prevalence of pressure ulcers, however there is a large lack of research which makes some of the data irrelevant. According to Medicare, in 2006, 322,946 of the total Medicare patients had a pressure ulcer as a secondary diagnosis (Anscombe Wood, 2007). The average hospital charge for these patients totaled \$40,381 (Anscombe Wood, 2007). Overall, the excess cost of treating a hospital acquired pressure ulcer is \$10,845 which leads to more than \$10 billion of the total Medicaid reimbursements annually (Anscombe Wood, 2007).

Wound Documentation 6

In the United States, approximately 2.5 million patients are treated annually for pressure ulcers (Agency for Healthcare Research and Quality, 2006). Of these patients, 60,000 die due to complications and infections related to pressure ulcers. Three to ten percent of hospitalized patients will acquire a pressure ulcer, and of these, half of the ulcers that occur will be a stage II or greater. A hospital acquired pressure ulcer leads to a mean hospital cost of \$1,877 or greater and an average length of stay four days longer than a patient that does not develop a pressure ulcer (Agency for Healthcare Research and Quality, 2006). The cost is even higher for those patients that develop a stage II or greater ulcer. The overall costs average more than \$15,229 and the length of stay is extended eight days longer than a patient without a pressure ulcer (Agency for Healthcare Research and Quality, 2006). The cost of treatment may range anywhere from \$500 to \$50,000 depending on the severity and treatment of the pressure ulcer (Agency for Healthcare Research and Quality, 2006). The estimated cost of overall treatment towards pressure ulcers is \$5 billion to \$8.5 billion per year (Agency for Healthcare Research and Quality, 2006).

The amount of lawsuit claims has also increased with the increased prevalence of hospital acquired pressure ulcers. Overall lawsuits have increased at an annual rate of 14%, which also leads to an increase in hospital payments (Leape, 2007).

Not only is there a large financial issue involved with hospital acquired pressure ulcers, but nursing staff has added stressors. Pressure ulcers can increase nursing time up to fifty percent (National Pressure Ulcer Advisory Panel, 2006). It is also estimated that twenty minutes per patient per day of nursing time is spent on services and treatment related to pressure ulcers (National Pressure Ulcer Advisory Panel, 2006).

Description of the Project:

The clinical unit, along with four other units within the hospital, has created a new flow sheet specifically aimed at documenting a patient's wound and overall skin assessment. The units involved include general medicine as well as surgical units. Each unit has one representative, being either a clinical nurse specialist or nurse manager. Meetings take place every two weeks to discuss changes that need to be made to the form. The new flow sheet is much more detailed than the previous form, and

Wound Documentation 7

includes columns for four different wound sites. Not only is the form aimed at documenting only wounds, but nurses are educated to document the sites of any invasive lines, such as peripherally inserted central catheter (PICC) lines, percutaneous endoscopic gastrostomy (PEG) tubes, as well as nasogastric (NG) tubes. Within the column, nurses are given areas to document the characteristics of surrounding skin, wound drainage color and odor, the healing process of the skin, and specific treatment and dressing changes for each site. This newly created form allows for a more descriptive documentation than before. The form used during the pilot stage included a variety of different terms with definitions provided. This allowed for nurses to make sure that they understood the correct terminology and could chart appropriately. Currently, the form has been piloted for two weeks on each of the four units involved, and there has been a fairly good compliance rate among the staff nurses on the unit. The group has recently met together again to make changes to the flow sheet. There is going to be the addition of the body figurine to chart where on the patient's body the wound is located, larger columns to chart, and a comment area for nurses to chart any additional information that is needed. Once these changes have been made, the group plans to roll out the flow sheets to more units within the hospital. If the flow sheet proves to be beneficial, and a large compliance rate is shown among staff, the goal is to roll out the form to the entire hospital and hopefully create a standardized wound documentation form.

Information has been gathered to help better inform the management staff as well as nursing staff on the unit about the future CMS policy changes. With a more clear understanding of the policy, staff members will have greater awareness of the problem with wound documentation and why implementing a new flow sheet is so beneficial to not only the hospital but the patient's on the unit as well.

Different management theories are used to support the development of the project. Team management is the major theory used in the development of the overall project. With different opinions and cultures joining together to form a new wound care flow sheet, more creative ideas and thinking can be generated (DeCenzo & Robbins, 2005). The cultural diversity allows a greater expansion of knowledge to be presented, which in turn lets the work group view a variety of different options to form the overall flow sheet (DeCenzo & Robbins, 2005). Many of the decisions made for the project were

Wound Documentation 8

based on decentralization. The members of the work group were not the only ones involved in the final decisions. Once the flow sheet was piloted to the units, staff members provided input and suggestions. These suggestions were then expressed at the meetings, and changes were made according to staff members concerns. With decentralization, decision making was not forced upward in the hierarchy. As a result, staff members played a larger role in the project and allowed their voices to be heard on the final project (DeCenzo and Robbins, 2005). Proper delegation was also needed for the project to be successful. Members of the work group had to ensure that nurses were aware of their overall responsibility regarding the wound care flow sheet. If a nurse delegated to a nurse tech or another staff nurse on the unit to treat his or her patients' wounds, proper documentation must be completed. Documentation is the final step in delegation (DeCenzo & Robbins, 2005). Each patient needs to have a wound assessment properly documented, whether it be from the nurse that was taking care of the patient that shift, or another nurse who was delegated the authority to care for the patients' wounds.

Sufficient resources have been needed for completion of this project. Compliance from units throughout the hospital as well as time needed for education and implementation are two of the biggest resources used. Each unit involved has had sufficient time used on the project to educate staff on the importance of a new flow sheet and the ways in which to properly document. However, there has been some resistance from units involved in the pilot program. When the work group formed, a main surgical unit was involved in the pilot program. This unit was very beneficial to the overall change, since the patients on this unit had extensive wounds that needed treatment. Use of the wound care flow sheet on this unit would help to provide much needed insight towards the effectiveness of the form. However, this surgical unit dropped out of the pilot program within the first two days, due to the nurses being noncompliant with the new form. This severely hurt the pilot program, because they did not have a main surgical unit involved to see how effective the form would be.

The overall goal of the project team is to standardize the flow sheet throughout the hospital. A standardized wound documentation flow sheet has never been implemented due to the lack of research towards pressure ulcers. No gold standard towards treatment or prevention plans has been established

Wound Documentation 9

(Agency for Health Care Policy and Research, 2007). Recommendations towards treatment options are not given due to a lack of research on the efficacy and cost benefits of equipment for reducing and relieving pressure ulcers. Further research currently cannot be conducted due to a lack of funding, and without the funds needed, there cannot be an adequate improvement towards pressure ulcer prevention and quality of care (Agency for Health Care Policy and Research, 2007).

There are also many limitations towards overall wound care documentation that poses a threat. Many health care professionals have a different knowledge base among wound information, which leads to inaccurate documentation and inadequate care (Baldwin, 2006). If there are multiple areas to document wound information, accessing all necessary information may be difficult. Also, any patients with multiple wounds may further complicate standardized documentation. Another limitation to wound documentation is the staging of pressure ulcers. Assessing a stage I pressure ulcer may be difficult in patients with dark skin (Baldwin, 2006). Also, when eschar is present in a wound, accurate staging is not possible until the eschar has sloughed or the wound has been debrided (Baldwin, 2006). However, in the new policy, CMS has re-clarified the staging of pressure ulcers. Now CMS states that a pressure ulcer can be staged even in the presence of eschar or slough as long as part of the wound bed is visible and the extent of tissue damage can be seen (Centers for Medicare and Medicaid Services, 2007). Nurses now need to be aware that in the presence of eschar, the wound can still be staged according to CMS. Accurate staging of the wound may mean more reimbursement towards the treatment of a pressure ulcer (Centers for Medicare and Medicaid Services, 2007).

Assessment of the Clinical Site:Mission Statement –

The mission statement of the unit states that, “The staff is committed to providing quality patient care to patients and families that is holistic, compassionate and acceptant of diversity. This is accomplished through knowledge, collaboration and ongoing professional development in a dynamic, changing environment (The University of Michigan Health System, 2007).” The dynamics of the unit are constantly changing to improve ways to provide the highest quality of patient care. The use of integrated

Wound Documentation 10

knowledge and the collaboration of different members of the health care team help to accomplish the overall mission and goals of the unit. The wound care flow sheet supports the mission statement in that it is a way of providing a higher quality of patient care through environmental changes. There is team collaboration between different units involved, and diversity is spread among the work group. A higher standard of wound care documentation will allow an overall higher quality of patient care. Professional development is involved as staff members will gain a larger knowledge base around wound care and documentation. The unit is open to accepting any changes that will help to benefit both the patients as well as staff members. A dynamically changing environment is essential to support a high quality of care.

Organizational Structure and Culture –

There is a close relationship and culture similarities among the members of the staff. Many of the staff members are young in age, while there are also many that are much older. A large amount of staff members have very high seniority and have been working on the unit for quite some time. They are familiar with the way in which the unit functions and have become accustomed to many of the policies and procedures. Staff members also have a close relationship with each other and this is shown through the way in which members interact with one another throughout the unit. The existing unit culture is facilitating the development of the overall project. With the large population of young nurses, there is a greater acceptance of change throughout the unit, and these nurses are more apt to comply with change processes throughout the unit. However, the older population has also come to accept changes throughout the unit. These nurses have realized that change is inevitable and they must be open to accept any new changes that come their way. It may take these nurses longer to adapt to new ways, however they are still willing to deal with change processes. The large compliance rate among the staff on the unit has greatly helped to facilitate the progress of the overall wound care project. Staff is also greatly involved in the decision making process. While there are rules that must be followed on the unit, staff can voice opinions openly to changes that they feel need to be made to increase the quality of their overall care. The opportunity to participate in decision making lets the staff feel that they are a part of the overall decisions that occur throughout the unit.

Preceptor Leadership –

The nurse manager of the unit plays a major role during change processes. The unit is involved in many pilot programs, so she must ensure that the staff members are compliant, but can still maintain work efficiency during all of the developing projects. The manager frequently gains input from the staff on how they feel things are functioning, and makes rounds throughout the unit. Her leadership style is one of team management, in which she has formed trusting relationships among members of the staff (DeCenzo & Robbins, 2005). This form of management allows staff to feel that they can come to her with concerns, and the manager also actively listens and participates in the overall functioning of the unit. This management style has allowed for the unit to become more compliant with changes as well as feel that they can voice concerns when needed.

SWOT analysis –

There have been different strengths and weaknesses to the project. First off, the change is occurring at a time when proper wound care documentation is being closely looked at. With the CMS policy changes, many hospitals are frantically trying to adapt new ways to document wound and skin assessments. The clinical nurse specialist on the unit is a representative on the project team and the spokesperson for the unit. This is very beneficial because the clinical nurse specialist also staffs on the unit so she knows first hand how beneficial the new flow sheet will be to the nursing staff. She is also greatly educated about clinical issues and can provide adequate insight to changes that should be made. Also, since the unit is involved in many pilot programs, staff members are aware of many changes occurring. One major weakness of the unit that affects the change is the high turnover rate of the staff. Once staff members are educated and involved in the project, they leave the unit and new staff must be educated on the flow sheets. This can increase the amount of unnecessary time spent on the project with a continuous turnover of staff, and it can lead to errors in data collection. The turnover rate can also be classified as the major threat to the project development. One of the greatest opportunities presented is the fact that the unit is involved in many pilot programs. This type of change is not new to the staff members and allows them to have a greater compliance rate because they are aware of how changes are

Wound Documentation 12

implemented on the unit. The unit also has the opportunity to have one of their own staff members in the planning group, which allows their opinions to be heard more at meetings. This allows staff members to be more involved in the change project and can feel that they have made a contribution to the overall project.

Conclusion:

Overall, implementation of a standardized wound care flow sheet will help to make an impact in reducing the incidence of hospital acquired pressure ulcers. If the flow sheet shows a high compliance rate among nurses throughout the hospital, hopefully the form will become standardized within the institution. This will allow a greater increase in the amount of wound documentation. The overall project did have some flaws, and if the project were to be restarted different changes could be made. First off, certain aspects of the old flow sheet could have been maintained on the new form, such as the body figurine. More nurses should have been involved in the planning process to gain a greater understanding of what staff members would have benefited from on the new form. Also, the project team needed to ensure that there was a one hundred percent compliance rate among units starting the pilot program so that sufficient data could be collected.

With policy changes made by the Centers for Medicare and Medicaid Services, a large portion of hospital funding may soon be going towards the treatment of pressure ulcers if skin is not assessed thoroughly and wounds are not documented properly. Nurses need to be educated on proper skin assessment as well as documentation. A more thorough flow sheet will allow health care professionals can identify patients at risk and implement proper interventions as needed. Within just less than a year, proper documentation is going to be essential for newly admitted patients. If changes are not made in the way documentation is currently done, staff may miss patients who are admitted with a pressure ulcer and be charged for the treatment. Identifying patients at risk will help to solve the high rate of hospital acquired pressure ulcers and reduce financial costs to each unit.

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Wound Documentation 14

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