



Position Paper

Avoidable versus Unavoidable Pressure Ulcers

Purpose: To refute the assumption that all pressure ulcers are avoidable.

Statement of Position: There are clinical circumstances in which a pressure ulcer is unavoidable. Pressure ulcer formation is a complex process that may not be halted, even with excellent multidisciplinary care (Thomas, 2003). The skin is the largest organ in the body and its integrity is dependent upon the function of all other organ systems for nutrition, circulation, and immune function (Langemo & Brown, 2006). The burden of disease can overwhelm the skin, even with appropriate preventive interventions (Witkowski & Parish, 2000). Yet, the responsibility of the healthcare facility or agency to adopt best practices aimed at pressure ulcer prevention should not be minimized. There are increasing reports of success in reducing the prevalence and incidence of pressure ulcers by implementing evidence-based clinical practice guidelines (Ayello & Lyder, 2008).

Definitions of Avoidable and Unavoidable Pressure Ulcers (Centers for Medicare and Medicaid, 2004)

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 the interventions; or revise the interventions as appropriate.
(483.25c/TagF314)

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. (483.25c/TagF314)

Previous Statements: In May 1992, the Agency for Health Care Policy and Research (AHCPR), part of the U.S. Department of Health and Human Services, published a clinical practice guideline entitled "Pressure Ulcers in Adults: Prediction and Prevention." (Bergstrom et al., 1992). Many of the specific recommendations were based on expert opinion and panel consensus because of the lack of published evidence in peer-reviewed literature. The consensus of the panel was that most pressure ulcers could be prevented. They reported, "However, , even the most vigilant nursing care may not prevent the development and worsening of ulcers in some very high risk individuals." (p.2). In December 1994, the AHCPR published a companion guide entitled "Treatment of Pressure Ulcers," (Bergstrom et al., 1994) in which they re-affirmed their previous position that "Unfortunately, not all pressure ulcers will be prevented and those that do develop may become chronic." (p.1).

In the November 2004 "Guidance to Surveyors for Long Term Care Facilities," the Centers for Medicare and Medicaid Services (CMS) acknowledged some pressure ulcers are "unavoidable" (Centers for Medicare and Medicaid, 2004). The long-term care facility is required to evaluate the resident's pressure ulcer risk factors and to implement preventive interventions consistent with the resident's needs and goals. The pressure ulcer is determined to be unavoidable if it develops in spite of the facility's efforts to prevent it. CMS has not applied this standard in other healthcare settings.

History: Recorded history suggests the presence of pressure ulcers for at least 5,000 years. Early writings suggest that the occurrence of a pressure ulcer actually signaled impending death (Bansal, Stewatt, & Cockerell, 2005). But the study of pressure ulcer prevention is a relatively new phenomenon. The knowledge base is still being researched and developed. It wasn't until 1990 that there was a government-sponsored effort to develop a standardized and consistent approach to pressure ulcer prevention and treatment. At that time, several healthcare disciplines came together to begin the process of developing clinical practice guidelines that would address these two areas of concern. The AHCPR guidelines were to be based on published scientific literature. When scientific evidence was limited or inconsistent, recommendations were based on the consensus of the experts. The two companion practice guidelines were finally completed and disseminated to the public in 1994 (Bergstrom et al, 1992; Bergstrom et al, 1994). These guidelines were landmark in their scope, and although dated, are still utilized today.

The past forty years has produced a variety of pressure ulcer risk assessment tools (Braden & Bergstrom, 1988; Gosnell, 1989; Norton, McLaren, & Exton-

Smith, 1962; Waterlow Scale, 2005). The clinical practice guidelines on pressure ulcer prevention and treatment have been updated by a variety of groups (Keast, Parslow, Houghton, Norton, & Fraser, 2007; WOCN, 2003). Still, scientific literature supporting specific pressure ulcer prevention interventions is lacking (Thomas, 2001; 2003). Current evidence often does not address the multiple medical and clinical situations that may affect a patient.

Supportive Statements: Current literature supports the following points:

- The development of a pressure ulcer can be complex and multifactorial (Berlowitz & Brienza, 2007). Pressure intensity and duration as well as tissue tolerance are known to be risk factors. Individuals may have various intrinsic risks associated with pressure ulcer development (Lyder, 2003) that are not always captured by risk-assessment tools, and not all pressure ulcer risk factors can be removed or modified. While wound care experts do not know or fully understand the degree to which these intrinsic risks play a role in pressure ulcer development, it is reasonable to state that the greater the number of risks, the greater the challenge can be in preventing pressure ulcer development and deterioration.
- Pressure ulcer prevention has long been considered a nurse-sensitive quality indicator. But pressure ulcer prevention and management is complex and not exclusively under nursing control. Also, there are clinical circumstances when pressure ulcer prevention interventions may be medically contraindicated.
- The most widely recognized classification for pressure-related skin injury is by the National Pressure Ulcer Advisory Panel (NPUAP). In February 2007, the four stages of pressure ulcers were expanded to include definitions for unstageable and deep tissue injury (DTI). The staging definitions and descriptions are based largely on visible changes to the skin/tissues (Black et al., 2007). While there is still much to understand about the causes and etiology of pressure ulcers, some cannot be identified visually until they have reached a dangerous and often irreversible state (Black et al., 2007; Doughty et al., 2006; Brown, 2006). Deep tissue injury can result from skin damage occurring hours or days before the clinical findings are evident, especially if the patient falls or becomes immobilized by a vascular event, trauma, fracture, or prolonged operating room time. When a patient develops a rapidly deteriorating pressure ulcer within several days of hospitalization, it is possible the damage may have occurred prior to hospitalization.

- Individuals in all care settings have the right to make informed decisions and to determine their goals for care. This is especially crucial in acute care where patient condition and associated goals may change rapidly. Respect for those rights includes the right to be non-adherent with a pressure ulcer prevention and treatment plan. Individuals may refuse some or all aspects of their care (American Hospital Association, 1992). A pressure ulcer may be unavoidable if the individual refuses to adhere to prevention strategies in spite of pressure ulcer prevention education.
- The presence of pressure ulcers can suggest an overall deterioration of the medical condition (Langemo et al., 2006; Witkowski et al., 2000). In the case of palliative care, pressure ulcer prevention may be displaced by the greater need for comfort and the family's need for support. Many pressure ulcer prevention interventions may be inappropriate if the measures cause intractable pain or undue family burden near the end of life (Brink, Smith, & Linkewich, 2006; Reifsnyder & Magee, 2005).

Recommendations:

- Further study is needed regarding the degree to which comorbidities and intrinsic factors contribute to pressure ulcer development and the corresponding implications for clinical practice. Current evidence-based clinical practice guidelines are based on the utilization of risk assessment tools and targeting prevention efforts towards risk modification. Not all intrinsic risk factors may be captured in current risk assessment tools, nor can they always be modified.
- Further research is needed 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. Current clinical practice guidelines reflect well-established practices and consensus. These guidelines, however, give little direction to care modifications that might be necessary when faced with the combined impact of aging, illness, and quality-of-life priorities.
- Continued study is needed to support the development of an expanded 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 preventive interventions have failed.

- Clinical practice guidelines should be developed to address patient management when death is expected, and the goals of treatment should include comfort measures and family support.
- Continued effort is needed to support the development of effective processes to ensure the consistent implementation of evidence-based preventive interventions by staff across the healthcare continuum.
- In the current healthcare environment, accurate documentation of preventive measures targeted at the reduction of risk is recommended. The clinician should also document the clinical reasons why prevention interventions are not appropriate or feasible, such as severe pain or patient refusal. If the pressure ulcer is determined to be unavoidable, the rationale must be evident.

Conclusion:

The WOCN supports the early evaluation of risk for pressure ulcer development and the application of evidence-based interventions to prevent pressure ulcers, based on available scientific evidence and expert opinion.

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