

Nurses are from Mars Coders are from Venus

What are those nurses talking about? Are we speaking the same language?

Pressure Ulcer Staging: NPUAP Definitions

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Updated Staging System

- In Feb. 07, the NPUAP redefined the definition of a pressure ulcer and updated the stages. The original 4 stages were re-worded and 2 new stages added.
- These new stages have given clinicians the ability to put an official name to what they had been seeing on their patients for years.

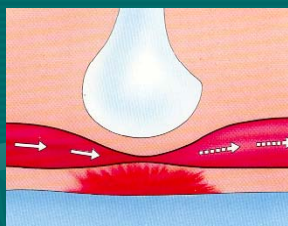
- The original staging system developed in 1975 was confusing and led to inaccurate staging of ulcers. Thanks to the NPUAP and the staging task force the new definitions have helped eliminate this problem.

What is a Pressure Ulcer?

- A localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction.

Pressure

Stops blood flow




Shearing

- Caused by gravity and friction
- Decreases or stops blood flow through the vessels




Friction

- Occurs when two surfaces rub together
- Common sites
 - Elbow
 - Heels



Stage I

- Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.




Stage II

- Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.




Stage III

- Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Bone/tendon is not visible or directly palpable.



Stage IV

- Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. Exposed bone/tendon is visible or directly palpable.



Unstageable

- Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown, or black) in the wound bed.



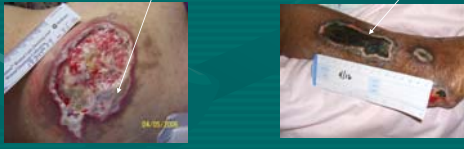
Suspected Deep Tissue Injury (DTI)

- Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.



What is slough/eschar?

- Both are nonviable tissue that is adhered to the wound bed. Usually the goal is to remove this as soon as possible so healing can begin.



What do they mean by granulating or healing full thickness wound?

- The wound at some point was a stage III or IV and now is in the healing stage—if the wound was not seen by the clinician at the beginning of this process, the clinician can not tell which stage it had been.



Opportunities to Improve Pressure Ulcer Prevention and Treatment- Providence Hospitals Columbia SC

Goal: To prevent hospital acquired pressure ulcers and heal present on admission pressure ulcers.

Implications of the CMS Inpatient Hospital Indicators Pressure Ulcers

- Fact: In FY 2007, CMS reported 257,412 cases of preventable pressure ulcers as secondary diagnoses. The average cost per case is estimated to \$43,180 per hospital stay. The incidence of new pressure ulcers in acute-care patients is around 7%.
- The physician must document in the chart the presence of the POA PU. Coders can gather the data for the stage and location in nursing documentation, however, if the physician never mentions the PU in the chart, we will not be able to enter the ICD-9 code for that ulcer.

Translation--no reimbursement for the care of that pressure ulcer!

Preventive Strategies implemented at Providence Hospitals

- Clinical Training of nursing staff

- Staging Module added to InfoWeb-to perfect staff's ability to accurately stage the pressure ulcer.
- Implementation of new order sheets (Prevention, Skin Care, Support Surface)-to give the staff the tools needed to care for their patient with a pressure ulcer.
- Update/Upgrade of Meditech documentation- to allow for more accurate description of altered skin integrity
- Addition of Incontinence Care Bundle- to simplify the care of our patient's with fecal or urinary incontinence.
- Poster Education for every unit-to inform staff of available supplies to adequately care for their patient.
- Addition of new topical therapy products to increase our ability to heal the pressure ulcers, both HA and POA.

Where we need to be at Providence

- Our present number of HA PU's consistently falls below the National average of 7%, however, our goal is zero hospital acquired pressure ulcers in our facility.
- We will continue to monitor the number of HA and POA pressure ulcers by completing hospital wide Prevalence study quarterly and audits by WOC Nurse monthly.
- Both the coders and nursing staff will work together to assure our physicians are documenting the necessary information in the medical record.
- On going education for our Skin Resource Team members to assure that each area is kept up to date on new products, findings of Prevalence studies, etc.

Questions?

References/Resources

- <http://www.npuap.org>
- <http://www.wocn.org>
- <http://www.nursingquality.org>
- <http://www.ihl.org>
- <http://www.5millionlives.premierinc.com>