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Public Comment Regarding Centers for Medicare & Medicaid Draft Measure

- Hospital Harm - Hospital Acquired Pressure Injury **Jan. 28, 2018**

The proposed metric regarding pressure injury is extremely important. Pressure injury has been found to be the second most common Hospital Acquired Condition (behind medication errors)[1] and is one which can lead to serious pain, disability and even death for the patient. The current pressure injury metric used for measurement is difficult to implement and has been slowly mitigated in CMS's value purchasing initiatives (PSI-90).

Pressure Injury metrics are also nursing sensitive, meaning that in order to do well and implement care to improve metric scores, a facility will have to provide proper nursing. Unfortunately, an area of great risk for development of a pressure injury is while the patient is in the Emergency Room waiting for treatment or waiting for a bed in an inpatient unit. A pressure injury can develop within 2 hours and without prompt evaluation and preventative measures a patient may become a "victim" of the system. Nursing Homes often photograph a patient to show that these injuries are not present when they leave their facility, even though they are present when the nursing assessment is performed in the inpatient unit.

Thus, the determination of the window for pre-existing is important. A time period shorter than 24 hours, even less than 6 hours would be optimal for patient safety.

The proposed HAC metric for Pressure Injury has had three objections raised which I feel can easily be retorted.

#1. First, is that the metric is difficult to implement. One must remember that this is a nursing sensitive measure. A facility may have to add staff to improve quality results. We should not fall into the trap of not validating a measure because of a wide range of implementation results between facilities. This is a sign of a problem in staffing, and is one of the purposes of this nursing sensitive measure, to motivate corrections of under-staffing.

#2. Many will also argue that harmonization of measures is important, and that we already have a pressure injury metric. This refers to the HAC PSI-90 metric which uses a cut-off between a level 2 and 3 pressure ulcer for reporting. However, this metric is not only hard to implement, but leaves many patients with a Stage 2 Ulcer unaccounted. Being part of the PSI-90 metrics, it has been successfully mitigated both because of its dependence on billing data and because it is difficult in implementation in the clinical arena.

The differentiation between a Stage 1 injury (pressure sore) and Stage 2 injury (pressure ulcer) is relatively easy to make, since it only requires an observation of the breakdown in the patient's skin which can be detected by the presence of drainage or staining on clothing or sheets. In the current PSI-90 metric, a differentiation between a Stage 2 and 3 ulcer must be made, which is much harder to define.

#3. Finally, there are those who argue that a 24 hr. period of preexisting is needed and that the standard of care for a nursing assessment performance is 24 hrs. This may be a standard of accountability, but since little care can be delivered until a nursing assessment is performed, most hospitals have this assessment taking place within 1 to 2 hours, or as soon as the patient reaches the floor. For patient safety, I feel the definition of preexisting should be if the pressure injury is documented within 6 hour or even sooner. A 24 hour time period is too long.

Thank you for this consideration,

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Board Chairman

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[1] Agency for Healthcare Research and Quality. Saving lives and saving money: hospital-acquired conditions update. Interim data from national efforts to make care safer. 2010-2014
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http://www.ahrq.gov/sites/default/files/publications/files/interimhacrate2014_2.pdf