ELSEVIER

EDITORIAL

Letter from the Editor

As the year 2010 continues to progress, there undoubtedly will be many changes in the medical arena. Only time will tell what the health care reform bill holds in store for the medical profession. For those of us who work in an inpatient setting, change began in October 2008, when the Centers for Medicare and Medicaid Services (CMS) implemented its policy of nonpayment for hospital-acquired conditions. For those of us in wound care, the ruling on hospital-acquired pressure ulcers was of particular concern. I understand why CMS has shifted its focus from a passive payer to an active purchaser of value-based health services. This change was imperative to avoid procurement of unnecessary costs in a system that is already fiscally stressed, as well as to promote quality medical care. No patient deserves to be admitted to the hospital for a total knee replacement and leave with a preventable stage 4 sacral ulcer.

The issue that continues to confuse me is that of the avoidable versus the unavoidable pressure ulcer. At what point can the medical profession say we have exhausted all possible avenues and yet the patient still developed a pressure ulcer? In a profession in which we rely heavily on evidence-based medicine, we may someday be able to more accurately define the parameters that lead to pressure ulcer development. However, in a world where no two human beings are absolutely identical, will we ever be able to absolutely, without question, define the point when a pressure ulcer becomes unavoidable?

The National Pressure Ulcer Advisory Panel met late in February at the Johns Hopkins Medical Center, in

Baltimore, Maryland, to discuss exactly this matter. The panel consisted of 24 multidisciplinary experts in pressure ulcer prevention and treatment. Their task was to begin discussing just what constitutes an unavoidable pressure ulcer. They concluded that there are indeed situations in which a pressure ulcer is unavoidable. I am sure each of us has experienced one of these patients in practice: the hemodynamically compromised patient who is too fragile to be repositioned, the patient who actively refuses to participate in a pressure relief program, or the patient with skin failure associated with end of life. All of these examples make a sound case that, at times, a patient's skin will fail despite our best efforts. One key strategy for addressing this conundrum is documentation. If we don't implement sound documentation policies, there is no medical record to tell the patient's story. It is our responsibility as wound care experts to serve as role models and mentors in this area.

I applaud the National Pressure Ulcer Advisory Panel for having this discussion and express my gratitude that it continues to work on behalf of the clinician and the patient. Although its press release does not change the CMS ruling on hospital-acquired pressure ulcers, it is a first step. I also applaud the wound care community for leading by example. Someone I know once said, "Actions become rituals, and rituals are hard to change." We have the power to mold actions into rituals.

Sincerely,

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