



From Your ANA President

Is diagnosis of pressure ulcers within an RN's scope of practice?

ANA RECENTLY RECEIVED A LETTER from Courtney H. Lyder, ND, GNP, FAAN; Diane L. Krasner, PhD, RN, CWCN, CWS, BCLNC, MAPWCA, FAAN; and Elizabeth A. Ayello, PhD, RN, ACNS-BC, CWCN, MAPWCA, FAAN, that sought to get clarification as to whether RNs are “practicing beyond their scope of practice when they document in the patient’s medical record the existence and stage of a pressure ulcer before a CMS [Centers for Medicare and Medicaid Services] provider documents his or her assessment of the existence and stage of the pressure ulcer.” ANA, of course, appreciates the concern and interest in the issues surrounding assessment of patients admitted to acute-care facilities and the need for documenting the status of their skin integrity.

ANA’s keystone for the profession, *Scope and Standards of Nursing Practice*, clearly identifies and describes the following competent level of behavior in the professional role:

- **Assessment:** The RN collects comprehensive data pertinent to the patient’s health status.
- **Diagnosis:** The RN analyzes the assessment data to determine diagnoses or issues for resolution.
- **Outcomes Identification:** The RN identifies expected outcomes for a plan individualized to the patient’s situation.
- **Planning:** The RN develops a plan that prescribes strategies and alternatives to attain expected outcomes.
- **Implementation:** The RN implements the identified plan.
- **Evaluation:** The RN evaluates progress toward attainment of outcomes.

RNs and advanced practice RNs are expected to engage in these activities for each patient. Therefore,

nurses should be recording their assessments, diagnoses, outcomes, and plans for the newly admitted patient. The documented details associated with the nurse’s assessment of the patient’s skin integrity will vary depending on such factors as the nurse’s level of educational preparation, experience, or specialty certification.

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Assessment of a patient’s skin is included in assessing the health status of all individuals. Skin assessment includes identifying and staging pressure ulcers and differentiating them from other wounds.

The purpose of identifying, staging, and differentiating pressure ulcers from other wounds is to determine nursing care needs, with the goal of creating and implementing a comprehensive plan of care. Nursing information on pressure ulcers and staging is entered into the nurse’s admission assessment and nursing record. However, nurses are not writing ICD codes on behalf of the admitting provider, who has completed and reported his or her own assessment.

RNs would not be practicing outside their scope of practice if the nurse identifies the alteration in skin integrity as a pressure ulcer and stages it before the admitting provider. On the contrary, it is the expectation that the RN actually does that. Anything less does not fulfill our professional standard and commitment to the patient.

We hope that this provides the necessary clarification for anyone who raises this question in the future.

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