See column on “2027 Reporting Period”. Blue font are NPIAP suggested changes. Black font=CMS original text. Green font=CMS revisions.

Measure Information	2026 Reporting Period	2027 Reporting Period	NPIAP Response to 2027 Revisions
Title	Hospital Harm - Pressure Injury	Hospital Harm - Pressure Injury	
CMS eCQM ID	CMS826v3	~~CMS826v3~~CMS826v4	
Short Name	HH-PI	HH-PI	
CBE ID*	3498e	3498e	
Measure Steward	Centers for Medicare & Medicaid Services (CMS)	Centers for Medicare & Medicaid Services (CMS)	
Description	The measure assesses the number of inpatient hospi talizations for patients aged 18 and older who suffer t he harm of developing a new stage 2, stage 3, stage 4, deep tissue, or unstageable pressure injury	The measure assesses the-proportion of inpatient hospitalizations for patients age18 and older who suffer the harm of developing a new Stage 2, Stage 3, Stage 4, deep tissue, or unstageable pressure injury	Editorial comment: Prefer that stage be capitalized when referring to Stage 1, Stage 2, Stage 3, Stage 4.
Measure Scoring	Proportion	Proportion	
Measure Type	Outcome	Outcome	
Stratification	None	None	
Risk Adjustment	None	None	

Rationale	This safety eCQM captures the number of patients w ho experience harm in the form of a pressure injury d uring their inpatient hospitalization. The incidence of pressure injuries in hospitalized patients has been est imated at 5.4 per 10,000 patient-days, and the rate of hospital-acquired pressure injuries (HAPIs) has been estimated at 8.4% (Li et al., 2020). Over 50% of repo rted pressure injuries in hospitals were stage 2 or hig her (Li et al., 2020). HAPIs are serious events and on e of the most common patient harms. Pressure injurie s commonly cause local infection, osteomyelitis, ane mia, and sepsis in addition to causing significant depr ession, pain, and discomfort to patients (Shui et al., 2 021). Pressure injury is considered a serious reporta ble event by the National Quality Forum (NQF) (NQF, 2011). Studies have shown that age, severity of illness, com	This safety eCQM captures the number of patients who experience harm in the form of a pressure injury during their inpatient hospitalization. The global incidence of pressure injuries in hospitalized patients has been estimated at 5.4 per 10,000 patient-days, and the global rate of hospital-acquired pressure injuries (HAPIs) has been estimated at 8.4% (Li et al., 2020). Over 50% of reported pressure injuries in hospitals were Stage 2 or higher (Li et al., 2020). HAPIs are serious events and one of the most common patient harms. Pressure injuries commonly cause local infection, osteomyelitis, anemia, and sepsis in addition to causing significant depression, pain, and discomfort to patients (Shui et al., 2021).- Any Stage 3, Stage 4, and unstageable pressure injury acquired after admission/presentation to a healthcare setting is considered a serious reportable event by the National Quality Forum (NQF) (NQF, 2011).	Number or proportion? Editorial comment: Prefer that stage be capitalized when referring to Stage 1, Stage 2, Stage 3, Stage 4.

	orbidity indexes, and Braden scores are predictors of HAPIs (Rondinelli et al., 2018). However, even after ri sk adjustment for patient risk factors, significant variat ion in rates of HAPI exist between hospitals (Rondine lli et al., 2018). It is widely accepted that the risk of de veloping a pressure injury can be reduced through be st practices. Hospital controlled factors that have bee n found to be significantly associated with an increas e in pressure ulcer risk include infrequent repositionin g (p=0.005) and number of days to bed change (OR, 2.89 [95% CI, 1.26-6.63]) (Tayyib et al., 2016; Bly et a l., 2016). Nurse staffing, measured as hours per patie nt day (HPPD), skill mix, and expertise are also signifi cant predictors of HAPI development; patients who re quire more nursing activity have actually been found t o have a lower risk for HAPIs (Tschannen & Anderso n, 2020). Systematically measuring patients who dev elop new pressure injuries while in the hospital settin g will provide hospitals with a reliable and timely mea surement to more reliably assess harm reduction effo rts and modify their improvement efforts in near real-t ime. This eCQM fills a gap in measurement and provi des incentives for hospitals’ quality improvement. The intent of this measure is to incentivize greater achiev ements in reducing harms and enhance hospital perf ormance on patient safety outcomes.	Studies have shown that age, severity of illness, comorbidity indexes, and Braden scores are predictors of HAPIs (Rondinelli et al., 2018). However, even after risk adjustment for patient risk factors, significant variation in rates of HAPI exist between hospitals (Rondinelli et al., 2018). It is widely accepted that the risk of developing a pressure injury can be reduced through best practices. Hospital controlled factors that have been found to be significantly associated with an increase in pressure ulcer risk include infrequent repositioning (p=0.005) and number of days to bed change (OR, 2.89 [95% CI, 1.26-6.63]) (Tayyib et al., 2016; Bly et al., 2016). Nurse staffing, measured as hours per patient day, skill mix, and expertise are also significant predictors of HAPI development; patients who require more nursing activity have been found to have a lower risk for HAPIs (Tschannen & Anderson, 2020). Systematically measuring patients who develop new pressure injuries while in the hospital setting will provide hospitals with a reliable and timely measurement to more reliably assess harm reduction efforts and modify their improvement efforts in near real-time. This eCQM fills a gap in measurement and provides incentives for hospitals’ quality improvement. The intent of this measure is to incentivize greater achievements in reducing harms and enhance hospital performance on patient safety outcomes.	

	Stage 2 pressure injuries, characterized by partial-thi ckness skin loss, carry a less serious burden in terms of patient harm than stage 3, stage 4, unstageable, a nd deep tissue pressure injuries (DTPI). Partial-thickn ess wounds heal primarily as a result of epidermal re generation and often heal without untoward consequ ences, loss of skin function, or scar tissue formation. Based on the healing capabilities inherent in these pa rtial-thickness wounds, it is the expert opinion of the National Pressure Ulcer Advisory Panel (NPUAP) tha t the presentation of stage 2 pressure injuries does n ot carry the same potential longstanding negative con	Stage 2 pressure injuries, characterized by partial-thickness skin loss, carry a less serious burden in terms of patient harm than Stage 3, Stage 4, unstageable, and deep tissue pressure injuries-(DTPIs). Partial-thickness wounds heal primarily as a result of epidermal regeneration and often heal without untoward consequences, loss of skin function, or scar tissue formation. Based on the healing capabilities inherent in these partial-thickness wounds, it is the expert opinion of the National Pressure Ulcer Advisory Panel (NPUAP) that the presentation of Stage 2 pressure injuries does not carry the same potential longstanding negative consequences to patients as do full-thickness pressure injuries. Stage 2 pressure injuries constitute a very real patient harm that should be monitored and addressed; however, the relative level of harm is less than with Stage 3, Stage 4, unstageable pressure injuries and potentially DTPIs (NPUAP, 2019).	

	sequences to patients as do full thickness pressure in juries. Stage 2 pressure injuries constitute a very real patient harm that should be monitored and addresse d; however, the relative level of harm is less than with stage 3, stage 4, unstageable pressure injuries and p otentially DTPI (NPUAP, 2019). The accurate and timely identification of DTPI is impo rtant for several reasons. Early discovery of DTPI allo ws prompt identification of possible causes, initiation of treatment, and potential development of preventive strategies. In addition, 24 to 72 hours can lapse betw een the precipitating pressure event and the onset of purple or maroon skin. This delayed manifestation be comes particularly important when the precipitating e vent occurred before the patient’s admission, yet the DTPI appears beyond the 24-hour window for present -on-admission status (Tescher et al., 2018).	The accurate and timely identification of-DTPIs is important for several reasons. Early discovery of-DTPIs allows prompt identification of possible causes, initiation of treatment, and potential development of preventive strategies. In addition, 24 to 72 hours can lapse between the precipitating pressure event and the onset of purple or maroon skin. This delayed manifestation becomes particularly important when the precipitating event occurred before the patient’s admission, yet the DTP appears beyond the 24-hour window for present-on-admission status (Tescher et al., 2018).The measure accounts for the delayed manifestation of DTPIs by excluding encounters with a DTPI identified in the first 72 hours of the hospitalization, so that hospitals are not penalized for DTPIs resulting from pressure events that occur prior to the start of hospital care.	

Clinical Recommendation Statement	The Clinical Guidelines Committee for the American College of Physicians (ACP) presents the available evidence on the comparative effectiveness of various ri sk assessment instruments and benefits and harms of strategies to prevent pressure ulcers (Qaseem et al., 2015). Recommendation 1: ACP recommends that clinicians should perform a risk assessment to identify patients who are at risk of developing pressure ulcers. Recommendation 2: ACP recommends that clinicians should choose advanced static mattresses or advan ced static overlays in patients who are at an increase d risk of developing pressure ulcers. Recommendation 3: ACP recommends against using alternating-air mattresses or alternating-air overlays in patients who are at an increased risk of developing pressure ulcers.	The Clinical Guidelines Committee for the American College of Physicians (ACP) presents the available evidence on the comparative effectiveness of various risk assessment instruments and benefits and harms of strategies to prevent pressure ulcers (Qaseem et al., 2015). Recommendation 1: ACP recommends that clinicians should perform a risk assessment to identify patients who are at risk of developing pressure ulcers. Recommendation 2: ACP recommends that clinicians should choose advanced static mattresses or advanced static overlays in patients who are at an increased risk of developing pressure ulcers. Recommendation 3: ACP recommends against using alternating-air mattresses or alternating-air overlays in patients who are at an increased risk of developing pressure ulcers.	**Comment:** The NPIAP defers to the ACP regarding the status of their 2015 comparative effectiveness statement. However, we do have some concerns if this is being presented to the public as current information. • The term, advanced static mattress, is not currently used and could lead to misinterpretation and use of surfaces with inadequate pressure redistribution capabilities. As consistent with S3I definitions, we tend to describe the basic support surface for at-risk individuals as a “pressure redistribution foam mattress”. • The comparative effective analysis supporting these statements is 11 years old. Since that time there have been several systematic reviews with meta-analysis on the subject of support surfaces for prevention. **Note: See below for a brief statement on support surfaces from the 2025 International Guideline.**

		The European Pressure Ulcer Advisory Panel (EPUAP), National Pressure Injury Advisory Panel (NPIAP), and Pan Pacific Pressure Injury Alliance (PPPIA) Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline 3rd and 4th Edition (The International Guideline) provide guidance for pressure injury prevention and treatment (EPUAP, et al, 2019; NPIAP, et al, 2025) Available at: https://www.internationalguideline.com/the-international-guideline	**Citations for reference list:** National Pressure Injury Advisory Panel, European Pressure Ulcer Advisory Panel, and Pan Pacific Pressure Injury Alliance. Pressure Injuries/Ulcers: Prevention and Treatment of Pressure Ulcers/ Injuries: Clinical Practice Guideline. The International Guideline: Fourth Edition. Emily Haesler (Ed.). 2025. Available at: https://www.internationalguideline.com/the-international-guideline European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel, and Pan Pacific Pressure Injury Alliance. Pressure Injuries/Ulcers: Definition and Etiology. In: Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline. The International Guideline: Third Edition. Emily Haesler (Ed.). 2019. https://www.internationalguideline.com/2019

	1.1: Consider individuals with limited mobility, limited activity and a high potential for friction and shear to b e at risk of pressure injuries. 1.2: Consider individuals with a category/stage I pres sure injury to be at risk of developing a category/stag e II or greater pressure injury. 1.7: Consider the impact of diabetes mellitus on the ri sk of pressure injuries. 1.8: Consider the impact of perfusion and circulation deficits on the risk of pressure injuries. 1.12: Consider the impact of increased body temperat ure on the risk of pressure injuries. 1.17: Consider the impact of time spent immobilized b efore surgery, the duration of surgery and the Americ an Society of Anesthesiologists (ASA) Physical Statu s Classification on surgery-related pressure injury ris k.	Guidelines focused on **risk factors and risk assessment** (EPUAP, et al.,2019): 1.1: Consider individuals with limited mobility, limited activity and a high potential for friction and shear to be at risk of pressure injuries. (GPS) 1.2: Consider individuals with a category/stage I pressure injury to be at risk of developing a category/stage II or greater pressure injury. (GPS) 1.7: Consider the impact of diabetes mellitus on the risk of pressure injuries.(GPS) 1.8: Consider the impact of perfusion and circulation deficits on the risk of pressure injuries. (GPS) ~~1.12: Consider the impact of increased body temperature on the risk of pressure injuries~~. 1.17: Consider the impact of time spent immobilized before surgery, the duration of surgery and the American Society of Anesthesiologists (ASA) Physical Status Classification on surgery-related pressure injury risk. (GPS)	**Risk Assessment:** The 4th Edition international guideline chapter on risk assessment has not been posted on the website yet. **Recommendation:** I think what CMS has from 2019 is fine for now. It provides clear guidance. Could delete 1.12 – current evidence is not as strong for temperature as a risk factor.

	Guidelines focused on skin and tissue assessment: 2.2: Inspect the skin of individuals at risk of pressure i njuries to identify presence of erythema. 2.3: Differentiate blanchable from non-blanchable eryt hema using either finger pressure or the transparent disk method and evaluate the extent of erythema.	Guidelines focused on **skin and tissue assessment**(NPIAP, et al., 2025): https://www.internationalguideline.com/assessment **STA1:** ~~It is good practice to i~~Include feedback from the individual and carer, and to comprehensively assess the skin and soft tissues. Assessment techniques should be appropriate to the individual’s skin characteristics and tone, risk profile, clinical condition and care setting and age group and may include strategies to: • Focus on bony prominences and under medical devices, • Inspect, touch and palpate for relative changes in temperature, texture, consistency and scars. • Assess for localized pain • Assess for changes in skin color in comparison to surrounding skin.(GPS) **STA2:** ~~It is good practice to a~~Assess the vascular/perfusion status of the lower limbs, feet and heels when performing a skin and tissue assessment. (GPS) **STA5:** ~~It is good practice to c~~Conduct a comprehensive, head-to-toe skin and tissue assessment for all individuals: ● As soon as possible after admission/transfer, ● With every pressure injury risk assessment,	**Skin and Tissue Assessment:** The 4th Edition international guideline chapter on basic skin and tissue assessment is posted on the website. Technologies for early detection of pressure-induced injury are still under review. **Recommendation:** In this case, I think it is worthwhile replacing the 2019 materials with current recommendations. The bullet points have been edited for brevity. https://www.internationalguideline.com/assessment Note that the 2025 recommendations are more sensitive to dark skin tones and involves the patient and carers.

		● With changes in condition or risk status, and ● With transfers and major procedures (GPS) ~~2.2: Inspect the skin of individuals at risk of pressure injuries to identify presence of erythema.~~ ~~2.3: Differentiate blanchable from non-blanchable erythema using either finger pressure or the transparent disk method and evaluate the extent of erythema.~~	

	Guidelines focused on preventative skin care: 3.1: Implement a skin care regimen that includes: - Keeping skin clean and appropriately hydrated - Cleansing the skin promptly after episodes of inconti nence. - Avoiding use of alkaline soaps and cleansers. - Protecting the skin from moisture with a barrier prod uct. 3.3: Use high absorbency incontinence products to pr otect the skin in individuals with or at risk of pressure injuries who have urinary incontinence. 3.4: Consider using textiles with low friction coefficien ts for individuals with or at risk of pressure injuries. 3.5: Use a soft silicone multi-layered foam dressing to protect the skin for individuals at risk of pressure inju ries.	Guidelines focused on **preventative skin care**(EPUAP, et al, 2019): 3.1: Implement a skin care regimen that includes: • - Keeping skin clean and appropriately hydrated. (GPS) • - Cleansing the skin promptly after episodes of incontinence. (GPS) • - Avoiding use of alkaline soaps and cleansers. (GPS) • - Protecting the skin from moisture with a barrier product. (GPS) 3.3: Use high absorbency incontinence products to protect the skin in individuals with or at risk of pressure injuries who have urinary incontinence. (GPS) 3.4: Consider using textiles with low friction coefficients for individuals with or at risk of pressure injuries. (RCT evidence) 3.5: Use a soft silicone multi-layered foam dressing to protect the skin for individuals at risk of pressure injuries. (RCT evidence)	The 4th edition (2025) guideline content on **preventive skin care** has been posted. However, what CMS has proposed from the 3rd edition is clearer and more instructive.

	Guidelines focused on nutrition screening: 4.1: Conduct nutritional screening for individuals at ris k of a pressure injury. 4.2: Conduct a comprehensive nutrition assessment f or adults at risk of a pressure injury who are screene d to be at risk of malnutrition and for all adults with a pressure injury. 4.3: Develop and implement an individualized nutritio n care plan for individuals with or at risk of a pressure injury who are malnourished or who are at risk of ma lnutrition. 4.4: Optimize energy intake for individuals at risk of pr essure injuries who are malnourished or at risk of mal nutrition. 4.6: Provide 30 to 35 kcalories/kg body weight/day for adults with a pressure injury who are malnourished o r at risk of malnutrition. 4.7: Provide 1.25 to 1.5 g protein/kg body weight/day for adults with a pressure injury who are malnourishe d or at risk of malnutrition. 4.9: Offer high calorie, high protein nutritional supple ments in addition to the usual diet for adults with a pr essure injury who are malnourished or at risk of maln utrition, if	**CMS did not provide any recommendations on nutrition for 2027.** Guidelines focused on **nutrition for prevention** (NPIAP et. al., 2025): https://www.internationalguideline.com/nutrition **N1**: ~~It is good practice to c~~Conduct nutrition screening for individuals at risk of a pressure injury.(GPS) **N2:** ~~It is good practice to c~~Conduct a comprehensive nutrition assessment for individuals at risk of a pressure injury who are screened to be at risk of malnutrition. Use the findings to develop an individualized nutrition care plan. (GPS) **N3:** ~~It is good practice to e~~Encourage individuals at risk of a pressure injury to consume a balanced diet that includes nutrient dense food and adequate hydration. (GPS) **N4:** We suggest that nutritional supplementation be implemented for individuals at risk of pressure injuries who have been identified as malnourished or at risk of malnutrition when nutritional needs are not met by usual dietary intake. (RCT evidence)	**Comment:** Nutrition was omitted by CMS; however, the NPIAP strongly believes it should be included. There is strong evidence that nutritional deficits are risk factors for pressure injury development. More importantly, there is evidence that at-risk patients who were provided nutritional supplementation had fewer PIs. We have listed the most important recommendations from the 4th Edition Guideline.

	nutritional requirements cannot be achieved by normal dietary intake. 4.12: Discuss the benefits and harms of enteral or pa renteral feeding to support pressure injury treatment i n light of preferences and goals of care for individuals with pressure injuries who cannot meet their nutrition al requirements through oral intake despite nutritional interventions.	**N5:** We suggest implementing protein supplementation for individuals at risk of pressure injuries who have been identified as malnourished or at risk of malnutrition. (RCT evidence) **N6:** We suggest that carbohydrate-based energy and micronutrient supplementation should be reserved for individuals with known malnutrition or micronutrient deficiencies, in addition to supplementation that meets their protein needs. (RCT evidence) **N7:** We recommend against tube feeding for the specific purpose of preventing pressure injuries in individuals with or at risk of malnutrition and at pressure injury risk. This recommendation is not intended for individuals who are receiving tube feeding as a part of their usual clinical care, critically ill individuals, or for pediatric and neonatal populations for whom tube feeding is a requirement. (RCT evidence)	

	Guidelines focused on repositioning and early mobiliz ation: 5.1: Reposition all individuals with or at risk of pressu re injuries on an individualized schedule, unless contr aindicated. 5.2: Determine repositioning frequency with consider ation to the individual’s level of activity and ability to i ndependently reposition.	Guidelines focused on **repositioning** (NPIAP, et al, 2025): **https://www.internationalguideline.com/repositioning** R1: ~~It is good practice to r~~Reposition individuals at risk of pressure injuries~~-~~ regardless of the type of pressure redistribution full body support surface being used. The interval between repositioning might be adjusted depending on the pressure redistribution capabilities of the support surface and the individual’s response. However, no support surface can entirely replace repositioning. (GPS) R2: ~~It is good practice to r~~Reposition the individual in such a way that optimal offloading of pressure points and maximum redistribution of pressure are~~-~~achieved. (GPS) R3:~~It is good practice to u~~Use specialized equipment designed to reduce friction and shear when repositioning individuals. If manual handling is necessary, techniques that minimize friction and shear should be applied. (GPS) R4: ~~It is good practice to r~~Reposition all individuals with or at risk of pressure injuries using an individualized regimen. (GPS) R5: ~~It is good practice to d~~Determine	**Repositioning:** Agree with the CMS selection of Good Practice Statements and Recommendations from the 4th Edition International Guideline. (R1, R2, R3, R4, R5, R6, R9, R12, R13, R14) We respectfully request consideration of R7, R10, R11 **https://www.internationalguideline.com/repositioning** **Note: This section is long. Based on the April CMS draft we thought that was your intent. If you would like assistance in editing this… please let the NPIAP know.**

		appropriate and individualized repositioning intervals based on comprehensive assessment of the individual's: • level of activity and mobility, • ability to independently reposition, • skin and tissue tolerance, • clinical condition, • comfort, • sleep patterns, • goals of care, and • the full body support surface in use.(GPS) R7: We suggest that either repositioning at two hourly or three hourly intervals could be implemented for most individuals at risk of pressure injuries, if they are also on an appropriate pressure redistribution full body support surface. (RCT evidence) R6: ~~It is good practice to a~~Assess for signs of early skin and tissue injury that may mean the individual requires more frequent repositioning or preferential positioning off damaged areas. (GPS) R9: ~~It is good practice to i~~Initiate frequent, small and incremental shifts (micromovements) in body position for critically ill individuals who are too unstable to maintain a regular repositioning regimen, and to supplement regular repositioning. (GPS)	

		R10: We suggest using 30-degree lateral positioning to prevent pressure injury occurrence in individuals at risk for pressure injuries. (RCT evidence) **R11**: We suggest that the head-of-bed elevation be maintained at 30-degrees or lower to prevent pressure injury occurrence; however, higher head-of-bed elevation may be required in some clinical situations (e.g., individuals at higher risk for aspiration).(RCT evidence) R12: ~~It is good practice to s~~Select a prone position when required by the individual’s medical condition, and cease prone positioning as soon as clinically appropriate.(GPS) R13: ~~It is good practice to p~~Provide education to the individual and their informal carers on the rationale for repositioning, its significance in preventing pressure injuries, and strategies to safely and regularly implement repositioning. (GPS) R14: ~~It is good practice to i~~Implement repositioning reminder strategies to promote adherence to repositioning regime.(GPS)	

	Guidelines focused on heel pressure injury: 6.1 : Assess the vascular/perfusion status of the lower limbs, heels and feet when performing a skin and tis sue assessment, and as part of a risk assessment. : For individuals at risk of heel pressure injuries an d/or with category/stage I or II pressure injuries, eleva te the heels using a specifically designed heel suspe nsion device or a pillow/ foam cushion. Offload the he el completely in such a way as to distribute the weight of the leg along the calf without placing pressure on t he Achilles tendon and the popliteal vein. 6.4: Use a prophylactic dressing as an adjunct to heel offloading and other strategies to prevent heel press ure injuries.	**CMS did not provide any recommendations on preventing heel PIs for 2027.** Guidelines focused on **preventing heel pressure injuries** (NPIAP, et al, 2025): https://www.internationalguideline.com/heels **H1:** ~~It is good practice to e~~Elevate the heels of individuals at risk of pressure injuries, so the heels are not in contact with from the full body support surface (GPS) **H2:** We suggest using a heel offloading device that is appropriate to the individual’s mobility and activity level.(RCT evidence) **H3**: ~~It is good practice to e~~Elevate the heels of individuals at risk of pressure injuries using standard pillows or cushions with sufficient height to ensure the heels are not in contact with the support surface, if a heel offloading device is not available or is inappropriate for the individual’s activity and mobility level. (GPS) **H4:** We suggest that a preventive dressing could be used as an adjunct to heel elevation and regular repositioning for preventing heel pressure injuries, where resources permit. (RCT evidence)	**Comments:** **Heel PI Prevention:** We respectfully request that you reconsider your deletion of preventive measures for heel PIs. This is the 2nd most frequent site of PIs (after sacrum-coccyx). These are often difficult to heal and may result in amputations. There is a meta-analysis that heel offloading boots are more effective than pillows ---but pillows also work https://www.internationalguideline.com/heels **Brief version:** ~~It is good practice to e~~Elevate the heels of individuals at risk of pressure injuries, so the heels are not in contact with from the full body support surface. (GPS) • Heel offloading devices are better at preventing pressure ulcers than pillows but may not be appropriate for all individuals or available. (RCT evidence) • Use standard pillows or cushions of sufficient height to ensure the heels are not in contact with the support surface.(GPS) • Prophylactic dressings can be an adjunct but are not necessary if heels are elevated. (RCT evidence)

	None	**CMS did not provide any recommendations on preventing MDRPI for 2027.** Guidelines focused on **preventing medical device related pressure injuries** (NPIAP, et al, 2025): https://www.internationalguideline.com/drpi **DRPI2:** ~~It is good practice to r~~Regularly assess for signs of early skin, tissue and mucus membrane injury by checking underneath and around medical devices and their securements. (GPS) **DRPI3:** ~~It is good practice to r~~Reduce and/or redistribute pressure at the skin-device interface by: • removing the medical device as soon as medically feasible, (GPS) • regularly repositioning the medical device, its securements and/or the individual (if possible), (GPS) • physically supporting the medical device in order to minimize pressure and shear, (GPS) • alternating the type of device in use when possible (if possible), (GPS) • Selecting appropriately sized devices. (GPS) • Placing thin prophylactic dressings at the skin-device interface (RCT evidence)	**Medical Device Related Pressure Injuries:** We respectfully request that you include at least some guidance on prevention of MDRPI. They account for up to 1/3 of PIs in acute care and can result in permanent disfigurement when they occur on the face from respiratory devices and NG tubes. It can be brief and include a link to the guideline for additional details

		• Adjusting securement if edema develops. (GPS)	

	Guidelines focused on support surfaces: 7.4: Use a high specification reactive single layer foa m mattress or overlay in preference to a foam mattres s without high specification qualities for individuals at risk of developing pressure injuries. 7.7: Assess the relative benefits of using an alternatin g pressure air mattress or overlay for individuals at ris k of pressure injuries. 7.8: Use a pressure redistribution support surface on the operating table for all individuals with or at risk of pressure injuries who are undergoing surgery. 7.12: Use a pressure redistribution cushion for preven ting pressure injuries in people at high risk who are s eated in a chair/wheelchair for prolonged periods, par ticularly if the individual is unable to perform pressure relieving maneuvers. 7.13: Assess the relative benefits of using an alternati ng pressure air cushion for supporting pressure injury healing in individuals who are seated in a chair/whee lchair for prolonged periods, particularly if the individu al is unable to perform pressure relieving maneuvers.	Guidelines focused on support surfaces (NPIAP, et.al.,2025): https://www.internationalguideline.com/surfaces https://www.internationalguideline.com/seating SS1:It is good practice for organizations to maintain an inventory of, or access to, a range of full body support surfaces appropriate to clinical context. The inventory should be maintained, stored and used in accordance with manufacturer recommendations. (GPS) Note: Manufacturers can provide the results of standardized tests for immersion, envelopment and other properties that are known to contribute to pressure redistribution. ~~SS2: A full body support surface or integrated bed system should appropriately accommodates the weight, height, size and body mass distribution of individual. (GPS)~~ **SS4:** Consider the following factors when selecting or changing the mattress, overlay or integrated bed support surface: • overall risk of pressure injuries, • response of the skin and tissues, • weight, height size and body mass distribution • independence, mobility and activity needs, • posture and sleeping position and their effects on pressure redistribution,	**Support Surfaces:** The 4th Edition (2025) guidelines have been substantially shortened.

		• need for microclimate management and shear reduction features, and • preferences and care goals.(GPS) **SS3:** We recommend using a pressure redistribution foam (reactive) full body support surface for individuals at risk of pressure injuries. (RCT evidence) A decision to change from redistribution foam may be based on very high risk, pressure injuries developing on redistribution foam or a need for microclimate control. In these situations, consider: • Air reactive support surfaces (RCT evidence) • Low air loss support surfaces (with microclimate management) (RCT evidence) • Alternating pressure support surfaces.(RCT evidence) SS12: Use a full body support surface with pressure redistribution features for medical procedures and for an individual at risk of pressure injuries in transit. (GPS) **SS13:** Transfer the individual off a spinal hard board/backboard as soon as medically feasible, in consultation with a qualified health professional. (GPS)	

		Seating S1: Consider the following factors when selecting a chair or wheelchair that meets the individual’s needs for pressure redistribution and shear reduction: • overall risk of pressure injuries, • independence, mobility and activity needs, • body size, shape and weight distribution, • posture, deformity and asymmetry and its effect on pressure distribution, • need for enhanced features (e.g. dynamic weight shifting), and • preferences and care goals. (GPS) **S2**: We recommend using a seating support surface with pressure redistribution properties for individuals at risk of pressure injuries when in a seated position. (RCT evidence)	

	Guidelines focused on implementing best practices: 20.2: At the organizational level, assess the knowledg e health professionals have about pressure injuries to facilitate implementation of an education program an d a quality improvement program. 20.4 : At an organizational level, assess and maximize the availability and quality of equipment and standar ds for its use as part of a quality improvement plan to reduce the incidence of pressure injuries. 20.5 : At an organizational level, develop and impleme nt a structured, tailored and multi-faceted quality impr ovement program to reduce the incidence of pressure injuries. : At an organizational level, engage all key stake holders in oversight and implementation of the quality	Guidelines focused on **implementing best practices** (EPUAP, et. al., 2019): 20.2: At the organizational level, assess the knowledge health professionals have about pressure injuries to facilitate implementation of an education program and a quality improvement program. 20.4 : At an organizational level, assess and maximize the availability and quality of equipment and standards for its use as part of a quality improvement plan to reduce the incidence of pressure injuries. 20.5 : At an organizational level, develop and implement a structured, tailored and multi-faceted quality improvement program to reduce the incidence of pressure injuries. 20.6 : At an organizational level, engage all key stake holders in oversight and implementation of the quality improvement program to reduce the incidence of pressure injuries. 20.7 : At an organizational level, include evidence-based policies, procedures and protocols and standardized documentation systems to reduce the incidence of pressure injuries. 20.8: At an organizational level, provide clinical decision support tools as part of a quality	Agree with the 2019 recommendations on implementing best practices. We have not revised this chapter for the 4th Edition of the international guideline. **NO FURTHER COMMENTS FROM NPIAP.**

		improvement plan to reduce the incidence of pressure injuries. 20.9 : Provide clinical leadership in pressure injury prevention and treatment as part of a quality improvement plan to reduce pressure injuries. 20.10 : At a professional level, provide education in pressure injury prevention and treatment as part of a quality improvement plan to reduce the incidence of pressure injuries. 20.11 : At an organizational level, regularly monitor, analyze and evaluate performance against quality indicators for pressure injury prevention and treatment. *21.1: At an organizational level, develop and implement a multi-faceted education program for pressure injury prevention and treatment.*	

See column on “2027 Reporting Period”. Blue font are NPIAP suggested changes. Black font=CMS original text. Green font=CMS revisions.

Improvement Notation	Decreased score indicates improvement	Decreased score indicates improvement	
Definition	Inpatient hospitalizations: Includes time in the emerg ency department and observation when the transition between these encounters (if they exist) and the inpa tient encounter are within an hour or less of each oth er. In addition to clinical electronic health record data, thi s measure uses Present on Admission (POA) indicat ors (e.g., POA = U) as found in billing/claims system within the measure criteria. The POA Indicator is intended to differentiate conditio ns present at the time of admission from those conditi ons that develop during the inpatient admission.	Inpatient hospitalizations: Includes time in the emergency department and/or in observation status when the transition between discharge from these encountersand admission to the inpatient encounter is one hour or less. In addition to clinical electronic health record data, this measure uses Present on Admission (POA) indicators as found in billing/claims system within the measure criteria. The POA indicators intended to differentiate conditions present at the time of admission from those conditions that develop during the inpatient admission.	

	- A POA Indicator of Y = yes (Diagnosis was present at time of inpatient admission). - A POA Indicator of N = no (Diagnosis was not prese nt at time of inpatient admission). - A POA Indicator of W = clinically undetermined. - A POA Indicator of U = documentation insufficient to determine if the condition was present at the time of i npatient admission. Per CMS and the Agency for Healthcare Research an d Quality (AHRQ) convention, POA indicators of Y an d W are accepted indicators of a diagnosis present o n admission. POA indicators of N and U are accepted indicators of a diagnosis that is not present on admis sion.	• - A POA Indicator of Y = yes (Diagnosis was present at time of inpatient admission). • - A POA Indicator of N = no (Diagnosis was not pres ent at time of inpatient admission). • - A POA Indicator of W = clinically undetermined. • - A POA Indicator of U = documentation insufficient to determine if the condition was present at the time of inpatient admission. Per CMS and the Agency for Healthcare Research and Quality (AHRQ) convention, POA indicators of Y and W are accepted indicators of a diagnosis present on admission. POA indicators of N and U are accepted indicators of a diagnosis that is not present on admission.	
Guidance	This eCQM is an episode-based measure. An episod e is defined as each inpatient hospitalization or enco unter that ends during the measurement period. This version of the eCQM uses QDM version 5.6. Ple ase refer to theQDM pagefor more information on the QDM.	This eCQM is an episode-based measure. An episode is defined as each inpatient hospitalization or encounter that ends during the measurement period. This version of the eCQM uses QDM version 5.6. Please refer to the QDM page for more information on the QDM.	
Initial Population	Inpatient hospitalizations that end during the measur ement period for patients aged 18 and older	Inpatient hospitalizations that end during the measurement period for patients age18 and older	

Denominator	Equals Initial Population	Equals Initial Population	
Denominator Exclusions	Inpatient hospitalizations for patients with a DTPI or s tage 2, 3, 4, or unstageable pressure injury diagnosis present on admission as indicated by a present on a dmission indicator of Y or W.	Inpatient hospitalizations for patients with a DTPI or Stage 2, 3, 4, or unstageable pressure injury diagnosis present on admission as indicated by ~~a~~ POA indicator of Y or W.	

	Inpatient hospitalizations for patients with a DTPI fou nd on exam 72 hours or less after the start of the enc ounter. Inpatient hospitalizations for patients with a stage 2, 3 , 4, or unstageable pressure injury found on exam 24 hours or less after the start of the encounter.	Inpatient hospitalizations for patients with a DTPI found on exam 72 hours or less after the start of the hospitalization. Inpatient hospitalizations for patients with a Stage 2, 3, 4, or unstageable pressure injury found on exam 24 hours or less after the start of the hospitalization.	
Numerator	Inpatient hospitalizations for patients with a new DTPI or stage 2, 3, 4, or unstageable pressure injury, as e videnced by any of the following: A DTPI or stage 2, 3, 4, or unstageable pressure injur y diagnosis not present on admission as indicated by a present on admission indicator of N or U. A DTPI found on exam greater than 72 hours after th e start of the encounter. A stage 2, 3, 4 or unstageable pressure injury found on exam greater than 24 hours after the	Inpatient hospitalizations for patients with a new DTPI or stage 2, 3, 4, or unstageable pressure injury, as evidenced by any of the following: A DTPI or stage 2, 3, 4, or unstageable pressure injury diagnosis not present on admission as indicated by a POA indicator of N or U. A DTPI found on exam greater than 72 hours after the start of the hospitalization. A Stage 2, 3, 4 or unstageable pressure injury found on exam greater than 24 hours after the start of the hospitalization. Only one harm (new qualifying pressure injury) is counted per hospitalization.	

	start of the e ncounter. Only one harm (new qualifying pressure injury) is cou nted per hospitalization.		
Numerator Exclusions	None	None	
Denominator Exceptions	None	None	

European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel, Pan Pacific Pressure Injury Advisory Panel. *Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline*. Third Edition. Emily Haesler, (Ed.). EPUAP-NPIAP-PPPIA; 2019. [cited: download date]. Available from: https://internationalguideline.com.

National Pressure Injury Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. *Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline. The International Guideline:* Fourth Edition. Emily Haesler (Ed.). 2025. [cited: download date]. Available from: https://internationalguideline.com.