Dear Dr. Jeff:

My facility has been asking me to write chart notes stating that in my professional opinion pressure ulcers were “unavoidable.” A friend of mine was recently involved in a lawsuit where a medical expert testified that ALL pressure ulcers are avoidable, yet some still seem to occur in our residents despite apparently good care. I would like to help but don’t know what to write. Any suggestions?

Dr. Jeff responds:

Pressure ulcers remain one of the primary sources of both survey deficiencies and negligence or malpractice litigation. Notes such as those you are being asked to write aren’t really progress notes but more like messages to surveyors or attorneys reviewing the chart. These notes are less a form of communication to the treatment team than a risk management gesture. They need to address the regulatory requirements related to pressure ulcers based on the clinical status of the patient.

A 2010 consensus conference of the National Pressure Ulcer Advisory Committee agreed that pressure ulcers indeed may be unavoidable, although most can be prevented with better care processes. The Centers for Medicare & Medicaid Services provides a definition of “unavoidable” in guidance to surveyors for F-tag 314, also known as Code §483.25(c) Pressure Sores:

“Unavoidable means that the resident developed a pressure ulcer even though the facility had evaluated the resident’s clinical condition and pressure ulcer risk factors; defined and implemented interventions that are consistent with the resident’s needs, goals, and recognized standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate.”

Jeffrey Levine, MD, and Karen Zulkowski, RN, recently reviewed the data from Medicare’s Office of Inspector General report of adverse complications sustained by beneficiaries. The report found that 40% of nursing home pressure ulcers were unavoidable (Adv Skin Wound Care 2015;28:420–8). Despite the penalties imposed on acute care hospitals for development of stage 3 or 4 pressure ulcers, they are not a “never” event. Indeed, these findings shed doubt on the validity of using pressure ulcer rates as a quality indicator.

Perhaps the most “avoidable” pressure ulcer is the ulcer that has already formed before admission. It is vital that nursing home staff perform a comprehensive skin assessment immediately after admission. Transfer documents from hospitals frequently fail to mention areas of altered skin, which will be attributed to the nursing home if not identified on admission. These skin issues include already open ulcers with dressings in place, stage 1 ulcers with persistent erythema, and areas of deep tissue injury that will turn into stage 3 or stage 4 ulcers within a few days after admission.

Particularly careful attention should be paid to residents with dark skin where discoloring may be less obvious, and palpation for warmth, bogginess, and tenderness may identify unrecognized problems. The frequency with which pressure ulcers not noted in the hospital are identified in long-term care is so great that some have proposed (only partially humorously) that the majority of pressure ulcers develop in ambulances. From a regulatory viewpoint, treating an existing ulcer is dramatically different than a failure of prevention.

The Braden Scale

Virtually every facility has nursing protocols to examine the skin immediately upon admission and to perform a risk factor assessment using a standard assessment tool, usually the Braden Scale. The Braden Scale was developed in 1987 by Barbara Braden, PhD, RN, and Nancy Bergstrom, PhD, RN, as part of a national research program on pressure ulcers funded by the Robert Wood Johnson Foundation.

The Braden Scale assigns risk points based on six factors: sensory perception, moisture, activity, mobility, nutrition, and friction/shear. From 6 to 23 points are assigned, with lower scores representing higher risk. Scores of 13 to 18 are generally considered to identify residents “at risk,” 13 to 14 identify patients at “moderate risk,” and 12 or fewer points define “high risk.” There is no mandate to use the Braden Scale, and a facility may use other risk evaluation techniques if preferred. Risk factors need to be reevaluated periodically, particularly within the first 4 weeks when most new pressure ulcers develop, and perhaps monthly or quarterly thereafter. Every significant change in condition and every hospitalization should trigger a reassessment. Since most long-term residents will decline functionally over time, their needs will change as well. Importantly, all these assessments must be documented. A determination of very high risk is not, by itself, a demonstration that an ulcer was unavoidable.

One advantage of the Braden Scale is that its categories can focus care planning into areas for potential interventions or risk modifications. Clearly, nutritional deficits are both a significant risk factor and have potential for modification, although not necessarily with a few days. Although protein supplements may be useful as an element of the plan, particularly given the recent studies demonstrating the utility of protein and vitamin D in reversing sarcopenia (see the editorial by John Morley, MB, BCh, entitled “Nutritional Supplementation and Sarcopenia: The Evidence Grows” [J Am Med Dir Assoc 2015;16:717–9]), residents who can achieve target protein and calorie intake do not necessarily require supplements.

Moisture concerns may be addressed though topical skin barrier protections or through the elimination of unnecessary diuretics. Issues with sensation, mobility, and activity will require individualized positioning and mobilization plans. High-density foam core mattresses are probably preferable to old-style springform plastic covered mattresses. But, as the surveyor requires, whatever plan is formulated, it must be periodically reevaluated and revised. For example, the resident who routinely refuses a protein supplement should have a documented discussion regarding the role of the supplement in promoting their health, and consideration of alternate means to increase protein intake should be documented as well. Simply documenting failure is not sufficient.

Although the care plan that incorporates the “turn and position the resident every 2 hours” rule has become commonplace, there is little scientific evidence to support this rule. In fact, observational studies in nursing homes and other locations have confirmed that this standard is rarely met. If it were met, every resident on this protocol would be turned 12 times daily or 4,380 times yearly. If the turning required one person and 5 minutes, this would imply 15.2 days of nursing time. Moreover, residents’ sleep would be disturbed every 2 hours and staff would be at increased risk of back injuries. Fortunately, we have ample reason to believe that 2-hour turning schedules are not optimal.

First, the downside is that prolonged positioning with weight over the greater trochanter should not occur for even 1 hour, whereas positioning on the back may be well tolerated for 4 hours or more. The University of Texas at Houston School of Nursing conducted an extended study of positioning times and pressure ulcer incidence. Known as the TURN (Turning for Ulcer ReductioN) study, and directed by Dr. Bergstrom and Mary Pat Rapp, PhD, RN, among others, this study compared 2-, 3-, and 4-hour turning schedules among nursing home residents at “moderate” or “high” risk (determined by the Braden Scale) of pressure ulcer development. This study found no statistical difference in ulcer formation among the study groups (Am Geriatr Soc 2013;61:1705–13). Certainly, failure to document turning every 2 hours should not be considered proof that an ulcer was avoidable. However, if your care plan states that a resident will be turned every 2 hours and the facility does not follow the care plan, there is a potential deficiency. If you said you would do it, you must document that it was done.

Decrease Risk

The key addition that a practitioner can contribute to the work of the interdisciplinary team, and the reason that facilities sometimes turn to us for these unavoidable notes, is in the area of the clinical conditions that contributed to ulcer formation. Documented clinical risk factors for pressure ulcer formation include hypotension, hypoalbuminemia, respiratory failure on mechanical ventilation, severe anemia (hemoglobin below 10), sepsis, metastatic malignancy, renal failure, hypoxemia, and terminal status.

Diabetes mellitus and other causes of microvascular disease may increase risk for ulcer formation. Dementia by itself is not a risk factor, but dementia and various psychiatric conditions may contribute to a resident’s inability or refusal to comply with the prevention care plan. Hospice and hospice-eligible residents may benefit from decreased mobilization and repositioning to lessen pain, even if this increases the risk for skin breakdown. Dying patients may also suddenly develop so-called Kennedy ulcers (named after an Indiana nurse practitioner), which typically arise rapidly and occur on the sacrum, and may develop multiple small necrotic lesions on the back within a day or 2 before death.

With regard to your question, notes regarding the unavoidability of pressure ulcers may be appropriate and necessary. However, they should not be written for every ulcer that develops in the facility. In residents who are at very high risk of skin breakdown, it may be prudent to write a note in advance, stating that the facility is aware of the risk, and will do what it can, but unavoidable ulcers still may occur. Since the majority of pressure ulcers are avoidable, facility policies and practices should be reviewed and improved, reflecting the advancing knowledge base and the needs of your residents. Simplicity meeting the standard of care is a long distance from best practices.

Dr. Nichols is president of the New York Medical Directors Association and a member of the Caring for the Ages Editorial Advisory Board.