

Legal Issues



By William C. Wilson, Esq

Pressure Sores: Know What Is Avoidable, Unavoidable

Mrs. N was a 74-year-old resident of a skilled nursing facility who was admitted for rehabilitation after suffering a subarachnoid hemorrhage. The aneurysm was treated by coiling and a ventriculostomy. She had a significant medical history including sepsis, urinary tract infection, methicillin-resistant *Staphylococcus aureus*, *Clostridium difficile* colitis, pneumonia, hypertension with hypertensive heart disease, chronic obstructive pulmonary disease with previous intubation, history of breast cancer, and gastroesophageal reflux disease. She was admitted to the SNF with no skin breakdown, but she was at high risk for

development of pressure ulcers. Upon admission, Mrs. N was assessed and care plans were created for skin breakdown. Mrs. N was mainly immobile. She could transfer from her bed to a wheelchair only with moderate assistance. The chart reflected that Mrs. N was turned and repositioned every 2 hours, but the chart did not contain a turning schedule actually documenting each time she was turned and how she was repositioned.

Two weeks after admission, Mrs. N developed redness on her right buttock. The attending physician ordered barrier cream to be applied every day for 2 weeks. The following week, Mrs. N was noted to

have lost 3 pounds. The physician was notified of the weight loss. The registered dietician was ordered to consult on her diet. Four weeks after admission, an open area was discovered on Mrs. N's right buttock where there was previously redness. A low air loss mattress was ordered, but the chart didn't indicate when it was put into place.

Eventually, the open area deteriorated into a stage IV wound. Once the sore opened up, the facility and the clinician responded by prescribing wound treatment, creating new care plans, and initiating wound consultations. However, the care provided by both the clinician and the facility staff before the pressure sore opened up is questionable. If the facility knew Mrs. N was at high risk for skin breakdown upon admission, why was she not on a low air loss mattress since admission? If she had been placed on a low air loss mattress early on, she may not have developed progressive skin breakdown, and she would have been much less likely to develop a stage IV wound.

Mrs. N was transferred to an acute hospital where she developed more skin breakdown on other areas of her body. Once she no longer needed acute care, she was transferred to a different SNF where she developed even more skin breakdown and began to lose more weight. The medical records from both facilities indicated that the health care providers who were monitoring Mrs. N were implementing the appropriate interventions and placed her on a low air loss mattress. Presumably, had Mrs. N been fundamentally healthier (i.e., with no contributing comorbidities, no frailty, no failure to thrive), she would have been able to heal. Unfortunately, she continued to decline and eventually died.

Terms, Policies, and Risks

The ultimate question in Mrs. N's case is whether her initial skin breakdown at the first SNF was avoidable or unavoidable. Understanding these terms is extremely important in assessing the SNF's liability for skin breakdown.

Federal Regulations: According to 42 C.F.R. 483.25(c): "Pressure sores. Based on the comprehensive assessment of a resident, the facility must ensure that— (1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and (2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing."

Guidance from the Centers for Medicare & Medicaid: The State Operations Manual (SOM) provides guidance to surveyors when investigating pressure ulcer complaints. The SOM defines a pressure ulcer as any lesion caused by unrelieved pressure that results in damage to the underlying tissue. Friction and shear are not primary causes of pressure ulcers, but they are contributing factors.

An SNF will be cited in a pressure sore complaint depending on whether or not the pressure sore was avoidable. The National Pressure Ulcer Advisory Panel adopted the following definitions of "avoidable" and "unavoidable."

Avoidable: The resident developed a pressure ulcer due to failure to:

- ▶ Evaluate the clinical condition and pressure ulcer risk factors
- ▶ Define and implement interventions consistent with the resident's needs, goals, and recognized standards of practice
- ▶ Monitor and evaluate the impact of the interventions, or revise the interventions as appropriate

Unavoidable: The pressure ulcer developed even though the facility did each of the items listed above.

Facility Policies and Procedures

The SNF should have policies and procedures in place to ensure that skin risk assessments and actual skin assessments are timely and appropriate; interventions are implemented and documented as such, monitored, and revised as appropriate; and changes in condition are recognized, evaluated, reported to the clinician, and addressed in a timely manner.

Risk Factors

- ▶ Impaired/decreased mobility and decreased functional ability
- ▶ Comorbid conditions, such as end-stage renal disease, thyroid disease, or diabetes mellitus
- ▶ Drugs, such as steroids may affect wound healing
- ▶ Impaired diffuse or localized blood flow, such as atherosclerosis or lower extremity arterial insufficiency
- ▶ Resident refusal of some aspects of care and treatment
- ▶ Cognitive impairment
- ▶ Exposure of skin to urinary and fecal incontinence
- ▶ Malnutrition and dehydration
- ▶ Prior healed ulcers

Clinician's Role

An at-risk resident can develop a pressure sore within 2 to 6 hours of the onset of pressure. Thus, the at-risk resident needs to be promptly identified and assessed, and a care plan should be developed in an

Staging of Pressure Ulcers

▶ **Stage I:** Intact skin with nonblanchable redness of a localized area, usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. Further description: The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage I may be difficult to detect in individuals with dark skin tones. May indicate "at risk" persons (a heralding sign of risk).

▶ **Stage II:** Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer bed, without slough.* May also present as an intact or open/ruptured serum-filled blister. Further description: Presents as a shiny or dry shallow ulcer without slough or bruising (bruising indicates suspected deep tissue injury). This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration,* or excoriation.

▶ **Stage III:** Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining* and tunneling.* Further description: The depth of a stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage III pressure ulcers. Bone/tendon is not visible or directly palpable.

▶ **Stage IV:** Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the ulcer bed. Often include undermining and tunneling. Further description: The depth of a stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput, and malleolus do not have subcutaneous tissue, and these ulcers can be shallow. Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.

▶ **Unstageable:** Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown, or black) in the ulcer bed. Further description: Until enough slough and/or eschar is removed to expose the base of the ulcer, the true depth, and therefore stage, cannot be determined. Stable (dry, adherent, intact without erythema,* or fluctuance*) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed.

▶ **Suspected deep tissue injury:** Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear.* The area may be preceded by tissue that is painful, firm, mushy, boggy, or warmer or cooler as compared to adjacent tissue. Further description: Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark ulcer bed. The ulcer may further evolve and become covered by thin eschar.* Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.

*National Pressure Ulcer Advisory Panel, 2007

"Clinical Practice Guidelines for Pressure Ulcers." AMDA. Accessed at: www.amda.com/tools/clinical/pressureulcers.cfm

attempt to avoid pressure ulcers. If the clinician does not see an at-risk resident within the first few hours of admission, it is incumbent upon the nursing staff to be proactive and notify the clinician about an at-risk resident to ensure all proper interventions are quickly in place.

Regardless of insurance coverage for powered pressure-reducing surfaces, that is a low air loss mattress, it may be appropriate for an SNF to provide one before stage III or IV ulcers have developed in high-risk instances.

Despite the total risk score for any given resident's potential for skin breakdown, the clinician should review each risk factor and potential cause(s) to identify those that increase the risk; analyze those factors to determine if they can be modified or removed; and determine what further interventions (if any) should be implemented. Thus, an overall risk score indicating a resident is not at high risk for skin breakdown does not mean that existing risk factors or causes should be ignored. Research has shown that a significant number of pressure sores develop within the first 4 weeks after admission to a long-term care facility.

Simply because a resident has a high risk for skin breakdown does not mean that any resulting pressure sore was unavoidable. The resident's plan of care

should reflect the goals and interventions used to stabilize or improve the current comorbidities. However, clinicians need to work with facility staff to document clinically valid reasons why any interventions previously documented were not appropriate, not feasible, or did not work. Repeated hospitalizations or emergency room visits within a 6-month period may indicate overall decline or instability. Poor nutritional status, falls, and other signs of frailty or failure to thrive are a setup for pressure ulcers – both avoidable and unavoidable. Attention to assessments and proper documentation by the clinician and the nursing staff can be the difference between liability or not for the SNF if a resident develops a pressure sore.

If a pressure sore fails to show evidence of progress toward healing within 2-4 weeks, the pressure ulcer and the resident's overall clinical condition should be reassessed. If the clinician decides no change to the treatment plan is warranted, the clinician should document the rationale and why the treatment plan remains relevant. Each assessment should determine why or why not the treatment is being changed, and how.

Conclusion

In the case of Mrs. N, the clinician's documentation showed he was being

Distinguishing Features of Common Types of Ulcers		
Ulcer Type	Pathophysiology	Location
Diabetic	Peripheral neuropathy secondary to small or large vessel disease in chronic, uncontrolled diabetes	Usually lower extremities
Ischemic	Reduction in blood flow to tissues caused by coronary artery disease, diabetes mellitus, hypertension, hyperlipidemia, peripheral arterial disease, or smoking	Usually distal lower extremities Tips of toes
Pressure	Unrelieved pressure resulting in damage to skin or underlying tissue	Usually over bony prominences (e.g., buttocks, elbows, heels, ischium, medial and lateral malleolus, sacrum, trochanters)
Venous	Venous hypertension resulting from incompetence of venous valves, post-phlebotic syndrome, or venous insufficiency. Tend to be irregularly shaped	Usually lower leg region

reactive rather than proactive about her wound development and healing therapy. This, in turn, set a precedent for the facility nursing staff to behave in a reactive manner as well. This lose-lose scenario presents substantial liability concerns to the facility. Providers can avoid liability concerns by working together to provide and document the care that will prevent skin breakdown. If breakdown occurs despite this care, the only reasonable

conclusion is that it was unavoidable. Proper documentation and prompt treatment will lead to fewer instances of pressure sores and, in turn, reduced risk to all health care providers involved in the patient's care. 

WILLIAM C. WILSON is a partner in the law firm Wilson Getty LLP, which represents all types of long-term care facilities against civil claims. This column is not to be substituted for legal advice.

Medical Expert Perspective

Pressure ulcers are one of the most common themes in nursing home negligence lawsuits. Although sometimes pressure ulcers result from negligence, there certainly are many times where their development is not avoidable, as CMS recognizes, and relate to the patient's overall condition. However, it is difficult to make a case for an unavoidable ulcer situation when there is poor documentation that appropriate measures are being taken to prevent skin breakdown.

Although insurance coverage for electrified pressure-reducing surfaces may require at least a stage III ulcer, it may behoove the facility to cover the costs of placing especially high-risk patients on these before they get to that point – such as patients who turn themselves back to their position of comfort, or those who do not adhere to heel elevation measures or repeatedly scoot their body parts across the mattress. This would demonstrate good faith and a proactive approach.

There is no precise science to back up the notion of turning and repositioning every 2 hours, but that is the standard within our industry for the average at-risk patient. Recently, studies have suggested that for some patients there is no difference in the incidence of skin breakdown between a 2- and 4-hour turning schedule. Nonetheless, it is common sense that if you leave somebody with unrelieved pressure in one position for longer than their tissue can tolerate, their skin will break down. The timing of the repositioning will differ for different patients, and for some it might be as often as every hour. (Hence, if someone develops a stage I or shallow stage II ulcer while being turned every 2 hours, they should be turned more often.) Your facility should have processes not only to document that turning and repositioning is being done but also to actually ensure that it is being done.

Defense attorneys and experts like to invoke the concept of “skin failure” as part of the overall dying process, and certainly in some cases – such as in the last few weeks of life or when somebody is taking in zero food or fluids – that appears to be the case. Kennedy terminal ulcers can appear in the last days or weeks of life as well, despite excellent pressure reduction and meticulous turning and repositioning. In some cases, a decision is made not to subject a patient to turning, repositioning, frequent dressing changes, etc., because of the primarily palliative goals of care. Similarly, many ulcers in severely malnourished or dying patients are not able to be healed, so the best you can do may be pain relief and odor control. But these decisions should be shared with the patient and family, and they should be documented.

And maybe that is the most important message: Communicate honestly and frequently with the patient and family about what is going on; if the patient is at high risk, tell them you will do what you can to prevent skin breakdown, but it may occur despite your best efforts. Include with that a compassionate discussion of the likely course of their condition, and their goals of care. If we did more of that, I believe we would have far fewer lawsuits about pressure sores.

—Karl Steinberg, MD, CMD
Editor in Chief