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The Pressure Sore Case: A Medical Perspective

Although bedsores sometimes result from inadequate care, not all cases involving pressure ulcers merit a lawsuit. This article adopts a medical perspective in its consideration of the pressure sore case, particularly when evaluating deviation from the standard of care.

By Jeffrey M. Levine, M.D.

Pressure sores, also known as pressure ulcers,[1] bedsores,[2] decubitus ulcers, or decubiti,[3] are an unfortunate common occurrence in older nursing home residents.[4] In the nineteenth century, pressure ulcers were viewed as the inevitable result of debility and neurologic illness.[5] Today, we know that pressure sores often are preventable.[6] Yet, despite extensive education, research, and regulation, they continue to occur among older nursing home residents.[7] As a result, malpractice litigation related to pressure sores exploded in the 1990s.[8]

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Clinical Practice Guidelines

Define Pressure Sores

Clinical practice guidelines define a pressure ulcer as "[a]ny skin lesion, usually over a bony prominence, caused by unrelieved pressure resulting in damage of underlying tissue."[9] The incidence of pressure ulcers in nursing homes is 0.20 to 0.56 per 1,000 resident-days, which may increase to 14 per 1,000 resident-days among those at high risk.[10] Commonly affected sites, comprising approximately eighty percent of wounds, are the pelvic girdle (lower portion of the hip bone), sacrum (lower back below the waist), coccyx (tail bone), trochanter (hip bone), and heels.[11] A resident with a pressure ulcer has a two to six times greater mortality risk than one with intact skin.[12]

Identify Residents at Risk for Pressure Sores

Seventy percent of pressure ulcers occur in persons over age seventy.[13] Pressure ulcers are most likely to form in residents with a chronic preexisting illness such as coronary artery disease, peripheral vascular disease, cancer, and diabetes mellitus.[14] Table 1 presents other risk factors.[15] Medical conditions surrounding pressure sores are complex and require individual assessment for each resident.

Assessing the Pressure Sore Case

The Omnibus Budget and Reconciliation Act of 1987 (hereinafter OBRA '87)[16] sets forth rules for quality of care and quality of life that govern Medicare and Medicaid certified nursing homes.[17] The statute establishes an industry standard of care not unlike clinical practice guidelines. An expert

Table 1. Pressure Sore Risk Factors

- Cardiovascular compromise such as atherosclerotic disease
- Chronic illness that requires bed rest
- Dehydration
- Degenerative neurological disease such as dementia
- Diabetes mellitus
- Diminished pain awareness
- Fractures
- History of corticosteroid therapy
- Immobility
- Immunosuppression
- Incontinence (urinary and fecal)
- Malnutrition
- Mental impairment, possibly related to coma, altered level of consciousness, sedation, or confusion
- Multisystem trauma
- Musculoskeletal illness such as arthritis
- Paralysis
- Physical restraint
- Poor circulation
- Psychotropic drug use
- History of pressure ulcers
- Significant obesity or thinness

familiar with OBRA '87 and its companion regulations should review the nursing home record. For example, the law demands detailed periodic assessments in the form of the Resident Assessment Instrument (RAI), which is comprised of the Minimum Data Set (MDS) and Resident Assessment Protocols (RAPs).[18] These in turn are intimately linked to the backbone of the medical record—the care plan. Reviewing the MDS, RAPs, and care plans helps assess critical spheres that overlap with pressure sore care such as nutrition, hydration, continence, and mobility. Knowledge of the RAI endows the attorney with a powerful yardstick to measure the quality of care delivered to a resident at risk for, or who has, pressure sores.

Whether a pressure sore occurs in the nursing home or hospital, similar prevention, assessment, and treatment principles apply. Caregivers must anticipate the occurrence of skin breakdown and intervene with appropriate preventive measures. The assessment of a wound must be timely and frequent. Documentation must satisfy minimum standards of detail and accuracy. Treatment must be governed by basic wound-care principles, which render some dressings appropriate and others inappropriate depending upon the circumstances.[19]

Were Preventive Measures Considered and Implemented?

Several modalities are accepted as the standard for pressure sore prevention, including, but not limited to the following:

- Placing the at-risk resident on a pressure-reducing device such as gel- or water-filled mattress overlays, a foam overlay, or an air-filled overlay;
- Using heel pads to relieve pressure on the resident's heels, a common pressure ulcer site; and
- Systematically turning and repositioning the resident to shift the points under pressure.

These modalities should be in place for the resident at-risk for pressure sores. Moreover, the resident's medical chart should clearly reflect their use. Once a pressure sore occurs, pressure relief strategies must be documented and care-planned. Care plans must be individualized and tailored to each resident. If pressure sore prevention measures are not documented in the nursing home record, it is difficult for the facility to successfully argue that these measures were taken.

Was Appropriate Wound-Care Rendered?

Many different treatments are available to suit different types of wounds. Aside from the wound, a good therapeutic approach must accompany treatment of the resident's underlying medical condition such as diabetes mellitus, poor circulation, or poor nutritional status. Nutrition must be an integral part of any pressure sore prevention and treatment plan.[20] Judicious wound-care necessitates frequent reassessment of wound appearance with appropriate changes in dressing modalities. Using the wrong treatment or incorrectly using the correct treatment may harm the resident. For example, wet-to-dry dressings are generally indicated for wounds having slough or necrosis (that is, dead tissue). If applied incorrectly to clean wounds, their therapeutic benefit is lost and harm may result by tearing healthy tissue and causing pain upon removal.

Was the Documentation Adequate?

Pressure sores can change from day to day. Therefore, detailed documentation should appear

in the resident's record at least once per week and more frequently if major changes occur. Treatment cannot be ordered without adequate clinical justification for each specific wound-care modality. Thus, review of wound documentation is critical in assessing the quality of care. Poor documentation hinders the evaluation of such care.

Examine the nursing home record for the following information:

- pressure sore stage classification (see Table 2);
- anatomic location of the bedsore(s) (for example, on the resident's right hip or left heel);
- size (that is, length, width, depth, and tunneling);
- appearance of the wound bed and surrounding skin distinguishes viable from nonviable tissue;
- color of wound bed and surrounding skin guides treatment decisions (for example, a change in color may indicate that the wound is becoming dehydrated and requires a moist dressing);
- drainage amount (such as scant, light, moderate, heavy, or copious), color (described in the resident's record as clear or bloody, for example), consistency (such as thick or watery), and odor (for example, a pungent, strong, foul, fecal, or musty odor suggests infection);
- temperature (a feeling of warmth, for example, may indicate pressure ulcer formation if the skin is intact, or signal the presence of an underlying infection); and
- pain or tenderness and absence thereof.

It is common for pressure sores to be inadequately or incorrectly described in the resident's medical record. Descriptions of sores from different facilities may conflict with one another. These facts are of utmost importance in building a case of negligence against or in defense of a facility.

Was the Documentation Consistent?

Correct treatment of pressure sores usually involves multiple disciplines. Table 3 provides a list of likely consultants to care for residents with pressure ulcers.

Table 2. Pressure Sore Classifications

Stage I:	Nonblancheble erythema (that is, redness that does not go away) of intact skin.
Stage II:	Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.
Stage III:	Full thickness skin loss involving damage to, or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.
Stage IV:	Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule).

Table 3. Who Helps Residents with Pressure Sores?

- Clinical nurse specialists
- Dermatologists
- Dieticians
- Enterostomal therapy nurses
- Occupational therapists
- Pharmacists
- Physical therapists
- Physicians
- Podiatrists
- Psychiatrists
- Speech-language pathologists
- General, plastics, vascular, and orthopedic surgeons

Chart entries regarding the resident's skin condition may appear simultaneously in several locations. For example, the decubitus should be documented in the MDS, care plan, nursing summaries, nursing narrative, and physician notes. Locate additional documentation on skin care flow sheets and treatment records. Different facility personnel, including physicians, nurses from different shifts, nursing assistants, as well as nutritional and rehabilitation personnel, generally make entries. As such, record alteration or falsification is difficult and easy to detect. "Color photocopies are highly recommended, are worth the increased cost, and in many instances will assist you in finding falsification of the records."[21] In practice, facilities with poor skin care programs show gaps and inconsistencies in pressure sore documentation. Gaps,

inconsistencies, changes, or falsification in documentation spell trouble for a facility involved with litigation related to pressure sores.

Was Documentation Supplemented with Photographs?

Wound documentation may be supplemented with photographs. These photographs serve medical and legal purposes. In practice, the wound is photographed in color on initial assessment and then daily or at select intervals for long-term management. Photographs are powerful demonstrative aids during a trial. Ask whether the facility, hospital, family, or friends took photographs of the resident's pressure ulcers. The nursing home and treating hospital should take photographs of any observed pressure ulcers, not only for their own protection, but also to adequately stage the development of the pressure sores.

Were Nutritionist and Rehabilitation Subspecialties Involved?

Subspecialty consultation may be required for residents with pressure ulcers. For example, malnutrition is a risk factor for pressure sore development, and, if present, can hinder healing once an ulcer occurs. Therefore, assessment of nutritional management is critical when evaluating a case for pressure ulcer litigation. For residents who experience difficulty swallowing, a speech and language pathologist provides diagnostic and therapeutic suggestions enhancing nutritional management, while occupational and physical therapists provide critical rehabilitative strategies that enhance strength, mobility, and independence—all essential in preventing and treating pressure sores.

What Complications Resulted from the Bedsore?

Complications resulting from pressure sores add to the gravity of caregiver negligence if deviations from the standard of care occurred. Complications include, among others, infection; sepsis; osteomyelitis; pain; blood loss; and feelings of humiliation, depression; and death. Pressure ulcers may result in the need for plastic surgery or amputation of a resident's limb, as well as lengthy periods of rehabilitation. In general, complications stemming from pressure sores increase monetary claims against the facility and/or caregivers.

Was the Resident's Pressure Sore Unavoidable?

Federal regulations require that a nursing home "ensure that [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."[22] Explore the issue of unavoidability when evaluating a case for litigation. Unavoidability is a common, and sometimes effective, defense argument. Judge unavoidability within the context of caregiver efforts to prevent skin breakdown. There are no firm guidelines that govern the determination of unavoidability. This question remains the subject of intense debate among nursing home surveyors, nursing home personnel, clinicians, and attorneys.[23] Severity of the resident's preexisting illness may bolster an argument for unavoidability. However, the interplay of disease, mobility status, and skin condition is extremely complex and must be taken on a detailed case-by-case basis.

Expert Review

Residents with pressure sores often have multiple admissions to hospitals and nursing homes over long periods of time. Voluminous medical records may present an unwieldy organizational and review task for any medical expert. Make *all* medical documents available for expert review to ensure delivery of an adequate expert opinion regarding pressure sore occurrence. Expert review of medical records prior to bedsore development may relate critical information regarding risk factors. Records of subsequent treatment at other facilities (such as a hospital) can confirm complications resulting from the wound.

Interim hospital records offer additional ulcer documentation and other diagnostics essential to verifying the resident's condition as it evolves over time. For example, the nursing home record may lack bloodwork demonstrating dehydration, which may be evident in the hospital admission that follows.

Survey Reports and Complaint Files

Nursing home survey reports and complaint files available from the state department of health may reveal citations for skin care deficiencies and related issues such as nutrition and hygiene, which can bolster claims against the home. Surveys may or may not reflect a continuing problem of care. For

example, a facility cited for pressure ulcer development in 1994, with no citations on this issue in 1995 through 1999 surveys, should not have the 1994 survey "unfairly paraded before the court" in a current pressure sore case.[24]

The Best Defense

Establish a Pressure Sore Program

Facilities can fight alleged quality deficiencies by implementing a comprehensive, interdisciplinary, proactive, and multilevel program of facilitywide pressure sore surveillance and documentation.[25] This strategy takes resources and commitment from management and involves the cooperation of physicians as well as nurses. One person alone cannot prevent and treat pressure sores, as this challenge involves every level of caregiver.[26] A comprehensive pressure sore program is not an "add-on," but rather an integral part of facility culture.

When facilities commit to developing comprehensive skin care programs, pressure ulcers may not disappear entirely, but their prevalence will decrease. When pressure sores do occur, or when existing wounds deteriorate, documentation and use of appropriate prevention and wound-care are more likely to be in place, thereby decreasing litigation risk.

Risk Factor Detection and Prevention

Elements of a comprehensive pressure sore program include a system for risk factor detection and implementation of preventive measures.[27] New wounds, whether preexisting on newly admitted facility residents or acquired during residency, must be examined expeditiously and entered into a facilitywide tracking system.[28]

Train and Educate Staff

Staff training and education are critical to the success of any wound care program.[29] Nurses must know how to assess and document wounds. Nursing assistants must know how to provide preventive care. Physicians must be knowledgeable regarding wound-care products and their correct application. Staff education programs must also consider ethical issues and advance directives.

Job Satisfaction

The facility's environment must foster caregiver job satisfaction in order to decrease stress and personnel turnover. The day-to-day burden of turning, toileting, and feeding residents often falls on persons from lower socioeconomic strata. These factors must be considered in managing a facility because caregiver comfort and satisfaction directly impact the quality of care delivered to residents.[30]

Conclusion

Experts agree that pressure ulcers represent a quality indicator. That is, a condition which reflects whether adequate care was rendered to an individual.[31] We have made progress with pressure sore prevention and treatment.[32] The coming decades will witness a great increase in America's elderly population—a demographic situation unprecedented in our nation's history. Despite advances in medical care and technology, residents still will be at risk for pressure sores.[33]

Our society is just beginning to prepare for these demographic changes. The medical establishment is building geriatrics curricula in medical schools. Organizations such as the American Medical Directors Association, a national professional organization representing physicians who care for residents in long-term care settings as attending physicians and medical directors, provide educational programs for physicians already in practice.[34]

Federal regulation provides a framework for maximizing quality in nursing homes, and the Health Care Financing Administration sponsors clinical practice guidelines to educate personnel and standardize care. However, given the urgency of the demographics, time is short and the task is immense. If education and regulation do not suffice in engendering quality medical care, litigation will inevitably provide the stopgap measure. Therefore, it is important for the attorney to know which cases to decline and which to pursue.

Endnotes

1. *See* TABOR'S CYCLOPEDIC MEDICAL DICTIONARY 1595 (17th ed. 1993) (defining pressure ulcer or sore).
2. *See id.* at 215 (defining bedsore).
3. *See id.* at 503 (defining decubitis ulcer).
4. *See* Richard M. Allman, *Pressure Ulcers among the Elderly*, 320 NEW ENG. J. MED. 850, 850 (1989).

5. *See* Jeffrey M. Levine, *Historical Perspective: The Neurotrophic Theory of Skin Ulceration*, 40 J. AM. GERIATRICS SOC'Y 1281, 1282 (1992).

6. *See generally* AGENCY FOR HEALTH CARE POL'Y & RESEARCH, U.S. DEP'T HEALTH & HUMAN SERVS., PUB. NO. 92-0047, PRESSURE ULCERS IN ADULTS: PREDICTION AND PREVENTION 3 (1992) (describing pressure sore prevention techniques and reviewing literature supporting each treatment modality) <http://www.ahcpr.gov/clinic/index.html#online>.

7. *See* David M. Smith et al., *Pressure Sores in the Elderly: Can This Outcome Be Improved?*, 6 J. GEN. INTERNAL MED. 81, 83 (1991).

8. *See* Richard G. Bennett et al., *The Increasing Medical Malpractice Risk Related to Pressure Ulcers in the United States*, 48 J. AM. GERIATRICS SOC'Y 73, 74 (2000).

9. AM. MED. DIRECTORS ASS'N, PRESSURE ULCERS: CLINICAL PRACTICE GUIDELINE 1 (1996).

10. *See id.*

11. *See id.*

12. *See id.*

13. *See id.*

14. *See* CATHY THOMAS HESS, NURSE'S CLINICAL GUIDE TO WOUND CARE 10 (2nd ed. 1998).

15. *See id.* at 49.

16. *See* Rebecca Elon & L. Gregory Pawlson, *The Impact of OBRA on Medical Practice within Nursing Facilities*. 40 J. AM. GERIATRICS SOC'Y 958, 958–59 (1992).

17. *See generally* THE AM. HEALTH CARE ASS'N, THE LONG TERM CARE SURVEY (1999).

18. Minimum Data Set V2 User's Manual (Replica Edition of the Official HCFA Manuscript), (Eliot Press, Natwick, MA (1995)) (providing technical but essential reading for those seeking to understand the Minimum Data Set and its use in the nursing home and best understood when accompanied by explanation from an expert in the nursing home field).

19. *See generally* AGENCY FOR HEALTH CARE POL'Y & RESEARCH, U.S. DEP'T HEALTH & HUMAN SERVS., PUB. NO. 92-0652, TREATMENT OF PRESSURE ULCERS (1994) (detailing wound care treatment modalities) <http://www.ahcpr.gov/clinic/index.html#online>.

20. *See* Gayle D. Pinchofsky-Devin & Mitchell V. Kaminski, *Correlation of Pressure Sores and Nutritional Status*, 34 J. AM. GERIATRICS SOC'Y 435, 439 (1986).

21. Lesley Ann Clement, *Litigating the Pressure Sore Case Against a Nursing Home*, 12 NAELA Q. 8, 10 (Fall, 1999).

22. 42 C.F.R. § 483.25(c)(1).

23. *See* Smith, *supra* note 7, at 93.

24. *See* Byron S. Arbeit, *The Administrator and Nursing Home Liability Issues*, *in* NURSING HOME LITIGATION: INVESTIGATION AND CASE PREPARATION 111, 126–27 (Patricia W. Iyer ed., 1999).

25. *See* Jeffrey M. Levine & Elizabeth Totolos, *A Quality-Oriented Approach to Pressure Sore Management in a Nursing Facility*, 34 GERONTOLOGIST 413, 415–16 (1994).

26. *See* Jeffrey M. Levine et al., *Pressure Sores: A Plan for Primary Care Prevention*, 44 GERIATRICS 75, 87 (1989).

27. *See* Nancy Bergstrom, *Strategies for Preventing Pressure Ulcers*, 13 CLINICS IN GERIATRIC MED. 437, 452–54 (1997).

28. *See* Jeffrey M. Levine et al., *Residents Admitted to the Nursing Facility with Pressure Ulcers: Implications for Morbidity, Mortality, and Quality*, 3 NURSING HOME MED. 26, 26 (1995).

29. *See* Betsy L. Moody et al., *Impact of Staff Education on Pressure Sore Development in Elderly Hospitalized Patients*, 148 ARCHIVES INTERNAL MED. 2241, 2243 (1988).

30. *See* Barbara Bowers & Marlon Becker, *Nurse's Aides in Nursing Homes: The Relationship Between Organization and Quality*, 32 GERONTOLOGIST 360, 364–65 (1992).

31. *See* INST. OF MED., IMPROVING THE QUALITY OF CARE IN NURSING HOMES (1986).

32. *See* Dan R. Berlowitz et al., *Are We Improving the Quality of Nursing Home Care: The Case of Pressure Ulcers*, 48 J. AM. GERIATRICS SOC'Y 59, 60 (2000).

33. *See generally* FRANK B. HOBBS & B.L. DAMON, U.S. DEP'T OF COMMERCE, ECONOMICS & STATISTICS, BUREAU OF CENSUS, SIXTY-FIVE PLUS IN AMERICA, at 23-190 (Current Population Reports and Special Studies, 1996).

34. See John W. Rowe et al., *Academic Geriatrics for the Year 2000: An Institute of Medicine Report,* 316 NEW ENG. J. MED. 1425, 1428 (1987).