PRESSURE SORES AND DECUBITUS ULCERS:
AVOIDING LEGAL LIABILITY

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Hello, my name is Ken Snyder. I am an attorney and a registered nurse. For more than twelve years I have been writing and publishing Legal Eagle Eye Newsletter for the Nursing Profession, in which I follow and highlight the latest legal developments affecting nursing practice.

The goal of this program will be to focus on strategies for nursing documentation that can minimize and even avoid legal liability for patients' skin care issues, pressure sores and decubitus ulcers.

Obviously, if the patient does not develop a problem with skin integrity while under your care or enter the facility with a lesion that worsens while under your care or show up with a problem later that someone tries to pin on you, there will be no legal repercussions. That may be the result of good nursing care. It may just be dumb luck or it may be due to a combination of the two. But that may be naïve. Lawsuits are very commonly being filed against hospitals, skilled nursing facilities and extended care facilities over skin care and skin breakdown issues. Even with the very best of nursing care some patients are so susceptible to skin breakdown and their management is so difficult that they will develop problems and/or existing problems may worsen. They and their families may not understand and may file a lawsuit.

Some of those lawsuits result in substantial damages awards. On the other hand, some of these lawsuits result in judges or juries finding no legal liability, despite the fact the patient may have suffered significant skin breakdown or significant aggravation of existing problems with skin integrity. We will look carefully at a case from the Texas Court of Appeals from July 2001 where the patient died from sepsis from decubitus ulcers that started while he was in a nursing home. The court focused on the quality of care, not the outcome, and found no legal liability. Of course, if the quality of care had not been documented competently before the fact, before the patient was taken to the hospital and died and the lawsuit was filed, the outcome of the legal case probably would have been very different, as in an almost identical case from the District Court of Appeal of Florida, February 2003.

We can start off on a very basic, fundamental level by looking at Thomas v. Greenview Hospital, Inc., 127 S.W. 3d 663 from the Court of Appeals of Kentucky, February, 2004. If there are orders to turn the patient, say every two hours, you need to have actual documentation in the chart that that is being done.

In this case the actual nursing documentation was lacking as to the patient being turned per the physician's orders, and the nurses could not honestly testify they had a specific recollection of the patient in question. Nevertheless, the court permitted the nurses to testify it is their habit and routine practice always to turn patients who need to be turned, and to do it every two hours on patient safety rounds. The phrase "habit or routine practice" is legal jargon that comes from the rules of evidence for civil cases,

specifically Rule 406: Evidence of the habit of a person or of the routine practice of an organization … is relevant to prove that the conduct of the person or organization on a particular occasion was in conformity with the habit or routine practice.

The big problem is that no judge or jury is required to believe so called “habit or routine practice” testimony. That is exactly what happened in the Thomas v. Greenview Hospital case, and if you put yourself in the jury’s place, a jury of people who are not nurses and do not work in hospitals or nursing homes, you can probably see why they chose not to believe the nurses.

If you have seen my video, Twenty Five Legal Do’s and Don’ts of Nursing Documentation you know that expecting to be able to get yourself off the legal liability hook in a court of law with “habit or routine practice” testimony is a violation of the first rule of nursing documentation, “If you did not write it down, you did not do it. If you did not do it, you were negligent. If you did not write down how you did it, how will you testify you did it right?”

When it comes to turning patients, flow charting is permissible, although the courts prefer to see nursing progress notes. The progress notes should not just say, “Patient turned,” but should describe the process, that is, patient repositioned from left lateral decubitus position to right lateral decubitus position. Patient positioned in center of egg-crate mattress. Pillow placed between knees. Heel protectors in place on both feet, etc. describing exactly how it was done, that is was done properly and that all the measures specified in the care plan are in place.

Seeing to it that patients are properly turned as needed is a big drain on nursing care resources, and having to do elaborate documentation on top of that makes the problem even more acute. Many aides of the aides who do the actual hands-on work do not have English as their first language and/or have limited writing skills. However, there is nonetheless no substitute for good, thorough nursing documentation, when you look at the court cases. You have to anticipate that even if the patient is turned regularly and other measures are taken, there can still be pressure sores and decubitus ulcers. The court will look at the quality of care, not necessarily at the outcome, to judge whether you are liable.

When a patient first comes under your care, in a hospital, skilled nursing facility or extended care facility, you as a nurse have a legal responsibility to conduct a thorough assessment of the patient. The regulations for extended care facilities are very explicit and very complicated. Title 42 of the Code of Federal Regulations Section 483.20 goes on for page after page with Federal requirements for resident assessment and re-assessment in long term care, which includes skin care issues. I will not go into these regulations in detail. I have taken the regulations directly from the Code of Federal Regulations and placed them on my website at www.nursinglaw.com/ residentassessment.pdf .

The regulations are not copyrighted, so just like I can copy them from the US Government website for my website you can download and copy them from my website for your own use.

The point to be made in this program may be fairly obvious, but it is this: you are not responsible for skin lesions the patient brought into the facility from home or from another facility – you are definitely responsible for treating the lesions and for making the best effort to prevent them from progressing - but you are not responsible for the problems the patient brings in.

It should be obvious, but I will point it out that a thorough assessment of the patient's skin integrity issues and very precise documentation of what they bring with them to your facility is essential not only in providing good care but in avoiding legal liability.

Documentation has to be as objective as possible – avoid descriptive terms like "big" or "little" and instead make and write down actual measurements. Avoid terms like "bad" or "major" or "significant" and stick to descriptions of size measurements, color, depth, etc. Describe the location as best you can with anatomical language. Looking at the records from day to day, and years later in court, there needs to be an objective basis for saying what the problem is and whether the problem was getting better, getting worse or staying the same on a day to day basis. Did one lesion heal and another start up? Are they two different lesions or two different nurses' imprecise descriptions of the same lesion? Did the lesion progress from bad to worse, or is one nurse's idea of bad the same as another nurse's idea of moderate? I think you get the point.

If the patient's skin integrity does not show any problems on admission, and a problem develops while the patient is under your care, you may be held responsible. There is a lot more to say about that in the rest of this program.

If you are tempted to be less than fully candid on your admission assessment, keep in mind there are usually other records, if the patient came to the nursing home from the hospital or to the hospital from a nursing home, or if the patient came from home there may be home health nursing records or doctor's office notes that will document that the patient did not have problems with skin integrity at or near the time of admission to your facility. If you fail to note that, you will be guilty not only of poor skin care but also of having ignored your important responsibilities in the area of patient assessment.

The place the courts look for the legal standard of care for skin care issues is the Federal regulations for quality of care in long term care facilities – even if the case actually arose out of events in a hospital, hospice, skilled nursing facility, etc. These regulations apply directly to long term care facilities, but they are seen more broadly by the courts as the common-law standard of care for nursing skin care in general in other settings.

I am referring to Title 42 of the Code of Federal Regulations, section 482.25 (c) which says.

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.

I have put all of the Federal Regulations for the quality of care in long term care facilities on my website, that is, Section 483.25. at www.nursinglaw.com/qualityofcare.pdf .

In the Federal regulations on skin care issues, the first focal point is the word "unavoidable" in the language about the patient's development or progression of skin lesions being unavoidable due to the resident's clinical condition.

Make sure there is full documentation of the individual's clinical condition – that is where the courts will look to see if a problem with skin integrity was unavoidable. What are medical conditions that make someone highly susceptible to problems with skin integrity? Immobility, incontinence, diabetes, congestive heart failure, dementia, being in restraints … this is probably a place to prompt the physician to do some charting on medical issues that predispose patient's to skin breakdown, as it is not a prudent idea for nurses to speculate on medical issues, that is, if the nurses want to avoid legal liability that is one of my do's and don'ts.

Nurses have very elaborate responsibilities set out in Federal regulations and general principles of nursing practice for ongoing assessment and reassessment of their patients (there are pages and pages of Regulations on this in Title 42 Code of Federal Regulations section 482.20) for nursing diagnosis and care planning. If the patient has significant factors pointing to potential for skin breakdown, it is a good idea from a legal standpoint to see that that is documented as fully as possible as the assessment and care planning processes are unfolding.

The next point, really the final point, that requires a lot of elaboration, is to document that necessary treatment and services are being provided. If necessary treatment and services are being provided to promote healing, prevent infection and prevent new sores from developing, yet problems develop and/or progress, which we all know can happen, it is a good bet that the court will find it is not the nurse's fault.

There is no good reason why a bad care outcome has to be compounded with a lawsuit after the fact, or with losing the lawsuit if whether a lawsuit is filed in the first place is out of the caregivers' control.

Before looking at other cases which explain how these concepts are applied, like the Texas case I mentioned earlier, we can go back to the Thomas v. Greenview Hospital case. The court made note of a glaring two-day delay in getting an air mattress after one was ordered by the physician, a mistake that jumps right out of the chart when the adequacy of nursing care for skin integrity issues is the issue in the lawsuit. There were also delays in how quickly the specialty skin-care nurse responded when she was asked to consult.

Just a quick aside: the courts do not seem to focus on the adequacy of care planning, the issue is always whether the care plan was carried out. Care plans are

available in nursing texts, from consultants, from sales reps for skin care and skin protection products and from internet web sites. These cases, however, are usually not won and lost by management-level people in the nursing administration office, they are won and lost in the trenches by actual, hands-on caregivers who give the best care they can and take the time to do the documentation that is required. The idea is not to come up with better, newer, more elaborate care plans with more scholarly footnotes. The focus is really on the nursing fundamentals.

We will now go into the main segment of this program by looking at two cases that were very, very similar in the clinical scenario, which produced exactly opposite legal results. In each case the patient died from sepsis secondary to decubitus ulcers that progressed to a significant degree while the patient was in the nursing home. One of the cases resulted in a verdict against the nursing home's parent corporation of $950,000, including $800,000 in punitive damages. The other case resulted in a jury verdict of no negligence and the verdict has stood up on appeal.

The big verdict case was NME Properties Inc. v. Rudich 840 So. 2d. 309, District Court of Appeal of Florida February 2003.

The resident was admitted with mid-stage Parkinson's Disease. She was incontinent of bowel and bladder, had moderate to severe dementia, memory problems and limited mobility. She was totally dependent on the nursing home's personnel for mobility, toilet needs and bathing.

Two years later she had to go into the hospital for tests for colon cancer, then was re-admitted to the nursing home. At that time she had no decubitus ulcers or pressure sores anywhere on her body. Two months after re-admission the nursing home's nursing documentation, or lack thereof, revealed a disturbing pattern of inattention to the resident's needs.

She was not being bathed on a daily basis, or at least there was no documentation of her care for a two week period. Then she needed treatment for redness on her hip and buttocks and a few days later had a Stage II decubitus ulcer on her coccyx. The decubiti kept getting worse and more appeared.

Finally the physician was notified. By that time there were gangrenous State IV ulcers in various locations. She had to be taken to the hospital and then to a hospice where she died from acute bronchopneumonia secondary to her decubitus ulcers.

Nursing Documentation Lacking

The court noted it was the nurses' responsibility to complete pressure-sore reports and to document bathing, turning, dressing changes, changes in skin status and to notify the physician in a timely manner. No documentation of competent nursing care could be found after the fact despite clear evidence her condition was deteriorating significantly and rapidly.

The court believed it was so bad that punitive damages of $800,000 were indicated in addition to $150,000 compensation to her probate estate for her conscious pain and suffering.

The other case was Pack v. Crossroads, Inc. 53 S.W. 3d 492, Court of Appeals of Texas, July 2001. Sometimes the most outrageous cases are the ones that really make a point.

A patient was discharged from the hospital to a nursing home following hip surgery. About six weeks later he was taken by ambulance back to the hospital. He died there one week after admission.

Specifically, according to the court record, on admission to the hospital the patient's tongue was noted to be coated with a thick membrane, his mucous membranes were dry, fecal material was smeared on his perineum and legs, his urine was cloudy, he had gangrene of the right foot and there were decubiti on the heels of his feet and his right hip.

After he died the family sued the nursing home for negligence. The jury ruled against them, finding no negligence. The Court of Appeals of Texas affirmed the verdict.

Nursing Documentation

The most important factor influencing the court was the nursing documentation created at the nursing home.

Skin Assessment On Admission

The nurses carefully assessed the patient's skin integrity when he entered the nursing home. It was documented he already had pressure sores on his heels and redness and excoriation on his buttocks and perineal area on admission.

Care Plan

The care plan called for a nurse to check his status hourly. The plan was to turn him every two hours, and it was documented he was being turned, but with his cognitive deficits he needed closer monitoring to see that he stayed repositioned.

Nutritional Assessment/Flow Charting

There was a nutritional assessment. There was flow charting of how much fluid he was getting with his meals, with his medications and whether his bedside pitcher was being refilled q shift.

Input and output could not be monitored because he was incontinent. The facility did not have the capability for IV fluid replacement.

Nursing Progress Notes

The nurses carefully documented the progression of his skin lesions and noted they called in a physician who ordered antibiotics and a debriding agent.

The nurses documented that the family declined the nurses' recommendation that he go back to the hospital because of his skin lesions, just six days before he finally did go back to the hospital.

The patient was diagnosed with sepsis in the hospital, but there was no proof it did not develop in the hospital rather than at the nursing home.

In these two cases you can see how the courts apply the legal standard of care that is reflected in the material from the Code of Federal Regulations that I mentioned earlier in this program. Again, the Federal Regulations on skin care apply directly only to long-term care facilities, but the principles set down in those regulations are applied by the courts as the legal standard of care for all patient care settings.

The Federal regulations do not focus on the outcome, they focus on the quality of care. A long term care facility can be cited for violations of the Federal regulations even when there is no actual harm to a patient, if the violations have the potential to produce harm. That is not the case in a civil lawsuit for damages, because under the civil law it is a completely moot point if no harm occurs to the patient.

The nurses in the Pack v. Crossroads Case, the no-liability case, were very careful to document all of the care the patient was receiving, including minute details like the water pitcher being filled so that the patient was getting good access to hydration, an important factor in maintaining or rebuilding skin integrity, even though that may be something that is routinely overlooked in flow charting and especially in progress note SOAP charting.

I will mention one more no-liability case that shows the importance of good nursing documentation, although, strictly speaking, the patient's case against the nursing home was dismissed because the statute of limitations had elapsed before his lawsuit was filed. As a general rule, the courts will make a decision on grounds that are cut and dried and very straightforward, like the statute of limitations if that will allow them to avoid having to make a judgment call on the issue of negligence.

The case is Lagrange v. Schumpert Medical Center, 765 So. 2d 473 from the Court of Appeal of Louisiana, June 2000. Here is what the case was about and what the court had to say:

A patient was hospitalized for peripheral vascular disease causing occlusion of the vessels in his left leg. Conservative medical care was unsuccessful and his left leg was amputated below the knee. It did not heal properly and the left leg had to be amputated again above the knee.

During his hospitalization he complained his left-leg stump had been injured by being struck against the bed frame when hospital personnel handled him roughly in a transfer.

There was also a decubitus ulcer on his right heel. The patient claimed his orthopedist told him it was caused by substandard treatment. Although the patient knew about it in September, 1996, it was well into 1997 until the patient realized the decubitus ulcer would be slow to heal.

Documentation Is Critical

The Court of Appeal of Louisiana did not accept what the patient had to say. Instead the court looked at the documentation in the patient's hospital chart. According to the chart, the right-heel decubitus ulcer was promptly and fully documented along with the care given for it.

The dressing was frequently changed, and that was charted. There was patient teaching documented in the chart that the patient, even though missing his left leg, had to avoid pushing with his right foot, to avoid exacerbating the decubitus on his right heel. It was also documented, the court noted, that the patient had verbalized that he understood the importance of what the nurses had taught him.

As I said before, the court ruled the statute of limitations had run out before he made a formal claim for medical negligence. Please keep in mind each state and the District of Columbia has its own statutes of limitations for various types of cases and its own rules for how the statute of limitations is interpreted and what exceptions and extensions may or may not be available under state law.

That is about all the time left for this short program. Please visit our website www.nursinglaw.com for more information on legal issues for nurses, information how to subscribe to my newsletter Legal Eagle Eye Newsletter for the Nursing Profession and information how to purchase other videos in this series.

Again, thank you for your time and attention.