Hi, this is Pat Iyer with Legal Nurse Podcast. Today we’re going to be talking about avoidable and unavoidable pressure sores, a big source of litigation in healthcare and the source of a lot of controversy. I have with me today Heidi Cross who is a board certified wound and ostomy nurse, and also a board-certified family nurse practitioner. She is working in Syracuse, New York. She has her own independent practice and does expert witness work for both plaintiff and defense attorneys.

Welcome to the show, Heidi.

Heidi: Thank you and thank you so much for having me do this podcast. It’s really a big honor and I’m looking forward to it.

Pat: Great. Today we wanted to focus specifically on something that occupies a lot of discussion among plaintiff and defense attorneys, which is what are unavoidable pressure sores? If you recall in health care, we used to assume that all pressure sores are avoidable. What’s your take on that and is that true?

Heidi: You’re absolutely right up until just actually present recent times. It was presumed that all pressure ulcers were avoidable and the true definition of an unavoidable pressure ulcer is that it’s a pressure ulcer that develops despite the best practice. This whole issue of unavoidability, traditionally - sure if a patient developed a pressure ulcer in your facility it was presumed to be your responsibility. It was your lax in some standard of care related to pressure ulcers and you were responsible for that pressure ulcer.

Those standards are recognition of risk factors with a valid risk assessment, turning and positioning certainly is huge. Attorneys always look at that. What support surface is the patient on and should they maybe have been bumped up to a support surface sooner? Nutrition is always huge in pressure ulcer lawsuits. Perhaps standards...
of care and nutrition weren’t met. Mobilization, was the patient not mobilized appropriately? Care plans, was an appropriate care plan not devised and revised as needed? Also, a definitely appropriate wound monitoring assessment and documentation.

Unavoidable pressure ulcers, we now recognize that perhaps the magnitude and severity of risk and comorbidities were just overwhelmingly high and not to be overcome. Maybe the appropriate preventative measures were not instituted. Maybe the burden of a disease is just too high or maybe it does represent an end of life issue.

**Pat:** One of the ways that we prove that the standards of care were met is by looking at the medical records. How does being able to establish whether a pressure sore was unavoidable tie in with documentation by the nurses and other staff who took care of the patient?

**Heidi:** Well, definitely documentation. We’ve all heard the not documented, not done. We know that is kind of a plaintiff attorney type of statement. Nurses can’t document each and every single thing that they do throughout their day, but definitely we do look for the documentation of all those standards. If that documentation isn’t appropriately there, then we can say potentially that the staff did not meet the standards of care.

**Pat:** I’m sure we’re going to come back to that point as we talk more about the unavoidable pressure sore. Tell me does the Centers for Medicare and Medicaid services, which for our international listeners is a government body that oversees care in nursing homes, acknowledge the clinical reality of unavoidable pressure sores?

**Heidi:** That’s a very good question because it is the CMS that absolutely drives the reimbursement system and also the penalties that can occur if a pressure ulcer is deemed to be avoidable.

There was absolutely no acknowledgement of unavoidable pressure ulcers until 2004, a big gift to long-term care essentially when F-Tag 314 came out and actually did acknowledge the unavoidability of some pressure ulcers. They were very specific in how unavoidability could be maintained. They said that each facility needs to evaluate the individual’s clinical condition and pressure ulcer factors. Then needs
to define and implement interventions consistent with those individual needs, individual goals and recognize the standards of practice. They then finally need to monitor and evaluate the impact of those interventions and also of course revise anything that’s appropriate. If the facility can say, “Yes we did all those things” and despite doing all those things the patient still developed a pressure ulcer, then they have a leg to stand on that indeed this was unavoidable.

F-Tag 314, I mentioned it came out in 2004, was recently revised to be F-Tag 686. I have to admit that I haven’t had a chance to look at it now and 686 would be the same thing essentially as F-Tag 314. I’m sure they have the same qualifications for proving unavoidability.

Acute care, we’re not quite so lucky. There still is really no acknowledgement of unavoidable pressure ulcers in a facility. If a patient develops a pressure ulcer within an acute care facility, they are not paid for since 2008 when CMS identified eight hospital acquired conditions, including pressure ulcers. Now there are 14. Facilities since that time have applied a POA code (Present on Admit Code) to a pressure ulcer, an ICD-10 code. Those are the billing codes that identify the various conditions. Since then if a facility does an appropriate assessment and assigns a POA code to something, meaning that is was present on admission, then they don’t own it. However, still to this day if a patient develops a pressure ulcer within the facility there is no reimbursement and there are obviously penalties.

**Pat:** And of course, plaintiff attorneys will focus on the fact that a Stage III or IV pressure sore is considered to be a hospital acquired condition and they will argue that implies there’s liability on the part of the healthcare staff for the development of skin breakdown and the worsening of pre-existing skin breakdown. That makes it harder for the defense team to come up with a counter position. What are your thoughts on that?

**Heidi:** That’s just where documentation really does become key. If proper documentation is in place, then certainly a case could be made that this pressure ulcer was unavoidable. Its just that CMS to date anyway does not recognize it within acute care facilities, but that doesn’t mean
that you can’t look at the documentation and show what were the risk factors or the factors that contributed to developing this.

Pat: It sounds like we have a mix of issues. We have regulatory language issues. We’ve got liability issues and we’ve got clinical issues, all intertwined to have something to say about the development or worsening of that pressure sore.

Heidi: Yes, absolutely.

Pat: Are there any other regulations that are related to pressure sores that address this unavoidability or avoidability question?

Heidi: What I think of is the Federal Register, which is the official journal of the U.S. Federal Government. It contains government agency rules, proposed rules and public notices. You frequently do see this cited in expert witness reports or it comes up during a legal process, specifically 42CFR Part 483 Subpart B. These are your requirements for states and long-term care facilities that dictate that quality of care must be provided so that each resident, and I quote, “The facility must ensure that a resident who enters the facility without a pressure sore does not develop pressure sores unless the individual’s clinical condition demonstrates that they were unavoidable.” Even there they do address the unavoidability issue. Also, further that a resident having pressure sores or seeks necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

Pat: I wonder if you could give our listeners a little sense of what professional organizations say about unavoidable pressure sores because we’ve got now the federal government of the United States offering an opinion on avoidable and unavoidable. What about the clinicians? What do they have to say about this question?

Heidi: Fortunately, there’s a lot out there now that can really help us to look at this issue. I’m thinking back in 2009 there was the SCALE, which stands for “Skin Changes at Life’s End”. This was a professional body of folks who came together. It was a consensus meeting to look at that issue. Overall, they said that the skin is the body’s largest organ and like any other organ it’s subject to for a loss of integrity, especially at
end of life. They further went to describe that with 10 statements describing these changes. You could look that up online SCALE or “Skin Changes at Life’s End” and get a lot of good information from that.

The National Pressure Ulcer Advisory Panel, the NPUAP, has also put out a lot of information about that. They had a consensus panel in 2014, which is published in the Journal of Wound, Ostomy & Continence Nursing. It was a rather large consensus panel. I believe they had hundreds of folks there and what they would do is draft statements and then all come to a consensus as to whether or not everyone agreed with those statements. They reach consensus indeed that unavoidable pressure ulcers do occur. They looked at intrinsic and extrinsic factors, which included cardiopulmonary status, hemodynamic instability, head of bed elevation. We know that a patient sliding down in bed causes a lot of shear stress, which contributes to pressure ulcers. Septic shock, which causes potentially bad hypotension and we’ll talk about that shortly. Body edema, burns, immobility and medical devices.

Hopefully you’ve noticed in the new NPUAP staging descriptions that they now have a separate category for medical device induced pressure ulcers. Spinal cord injury also is a real big risk factor. I do remember reading one time that close to 70-90% of all SCI patients will develop a pressure ulcer sometime in their life time and of course a terminal illness, and of course nutrition plays a huge into that too and we’ll get to that shortly.

Last but not least is the Wound, Ostomy and Continence Nurses who just recently revised their position paper about avoidability versus unavoidability. They revised it in 2017 and I love the fact they put the purpose right at the top of the paper to refute the assumption that all pressure ulcers are unavoidable. Indeed, they say the burden of disease can overwhelm the skin, but they do emphasize that you still need to follow all evidence-based guidelines and meet standards of care.
Pat: As you were sharing those details, I was thinking about Foley catheter-shaped pressure sores that I’ve seen in patients who’ve been laying on that tubing for too long.

Heidi: Absolutely, a medical device. Other medical device related ones, I’ve seen unavoidable pressure ulcers under cervical collars on the soft tissue of the chin. People often think of the oxygen tubing on ears and that can cause a pressure ulcer. I’ve seen quite a few with BiPAP machines on the bridge of the nose and there’s absolutely no adipose tissue there really, so it rapidly goes to a Stage 4 on the bridge of the nose and that type of thing. You’re right about the Foley catheters, that’s the most kind of transverse usually yellow type things, pressure ulcers, that you see on the back of thighs of patients. That’s the Foley catheter doing that.

Pat: Yep and I worked on a case many years ago as an expert witness involving a woman who was put on a bed pan and then transferred to a nursing home without anyone removing her from the bed pan. She ended up with a perfect ring-shaped pressure sore that ran all the way around her sacrum and perfectly matched the shape of the bed pan. It took weeks for that to heal.

Heidi: Yes, absolutely and you bring up a good point that the way to tell that is the shape of the pressure ulcer will match the shape of the medical device.

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Pat: You’ve talked about skin failure and I think it’s not a concept that everyone is familiar with. How does skin failure and the concept of the skin is the largest organ in the body, how does that mesh with the unavoidable pressure sore concept?
Skin failure certainly can be a cause of an unavoidable pressure ulcer. There’s an excellent article out there by Diane Langemo. It’s called “Skin Fails Too: Acute, Chronic and End Stage Skin Failure.” It came out in 2006 in Advances in Skin and Wound Care. In the article she states that skin failure is a result of hypoperfusion that occurs concurrent with severe dysfunction or failure of multiple organ systems. She defined acute skin failure as skin and underline tissues dying due to hypoperfusion concurrent with a critical illness. Chronic skin failure, a little bit different, occurring with an ongoing chronic disease state. End stage skin failure is at the end of life.

There’re a few different kinds of skin failure there for you. Skin failure really encompasses a broad umbrella of skin changes, not just a pressure ulcer. A pressure ulcer can be a form of skin failure, but also other skin failures can be like blistering, mottling of the skin, gangrene, which is going to occur with hypoperfusion of tissues like in ischemic disease. Any skin impairments related to tissue ischemia. It can be arterial ulcers, neuropathic ulcers, any type of skin changes like that.

As far as organ failure goes, I would just also like to point out that skin as we said is an organ and it can fail just like any other organs. Someone can have heart failure and we have a lab value for that. What is it? BNP, so we draw lab BNP. If it’s high, then we know the patient is in heart failure. Kidneys, we have the creatinine and the BUN. Livers, maybe the liver enzymes. Unfortunately, there is no lab marker for skin failure. It’s really more of a clinical type diagnosis.

People traditionally really like to look at the albumin and pre-albumin if they’re trying to determine is this patient at risk, what is their nutritional status. Pre-albumin and albumin really aren’t all that they have been cracked up to be in terms of determining nutritional status and also as towards the end of life albumin tends to drop anyway. Albumin really is stimulated by inflammatory conditions, including infection, trauma, surgery, burns and etcetera.

Attorneys love to say, “Let’s get an albumin” or maybe fault a facility for not getting an albumin and think that they should have gotten it sooner if they got it at all. What I like to point out is that in terms of adding nutritional status onto it, albumin and pre-albumin really reflect more
of the severity of illness in an inflammatory condition. I said all that just to circle back that there is no lab marker that we can really point to in terms in failure.

As far as differentiating it from pressure ulcers, pressure ulcers occur due to unrelieved pressure, so you just have to know has a pressure event has a patient on a hard surface or has pressure been unrelieved for whatever a reason and then you call it a pressure ulcer, but it’s a skin failure. Sometimes it can be really hard to tell though.

Pat: As I was listening to you, I was thinking about the risk factors for avoidable pressure sores versus the risk factors for unavoidable pressure sores. Is there a difference?

Heidi: Between avoidable and unavoidable? No, the risk factors remain the same. Would you like me to talk about the risk factors for either one?

Pat: No, I think a brief list because this is something that expert witnesses delve into and people who are screening malpractice cases for attorneys delve into. What were the risk factors in the person? Were preventative measures put in place? Those are two key components that help analyze the liability if any associated with that pressure sore development.

Heidi: Lots of risk factors. I’ve already mentioned hypoperfusion of tissues if blood isn’t getting to the tissues then they’re going to start breaking down. I did mention, and this goes part and parcel of hypoperfusion is hypotension. A patient is severely ill in the ICU or perhaps towards end of life with their blood pressure feathering down or whatever other conditions cause hypotension. What that does is that shunts blood from their periphery to the central organs, so it basically is a sacrifice of the tissues to preserve central organs, heart, lungs and etcetera.

Hypoxemia with inadequate oxygenation of blood, that’s a big risk factor. Anemia, and I actually have used this specifically in defense cases if a patient has chronic anemia or chronically decrease hemoglobin and hematocrits, and they’re not quite getting the oxygenation and the nutrients to the tissues that they need to both maintain the skin and to heal any issues.
There certainly are those age-related skin tissues that could contribute to unavoidable pressure ulcers. As we age out skin has slow cell turnover, decreased elasticity, thinning of subcutaneous layers, an overall decrease in muscle mass, decrease vascular profusion and oxygenation. Those can all contribute to the development of pressure ulcers.

Of course, skin failure, and we’ve already talked about that with multi-organ dysfunction syndrome. Also, critically ill patients in the ICU, that’s a big risk factor with their immobility and hypotension, and hypoperfusion. Patients with spinal cord injury, patients that have been on a back board for a long time, possibly that is unavoidable. Medical device related pressure ulcers we’ve already talked about.

Another risk factor is malnutrition. There is a study by Frey, which showed that persons with malnutrition and weight loss were at 3.8 times more likely to develop a pressure ulcer. Then there also is this concept. I liked it when I read about the anorexia of aging, the fact that as perhaps we’re nearing end of life our appetite goes down, our metabolic needs go down. We’re not eating as much. We develop perhaps a cachexia and perhaps you can call it end of life weight loss. That will all contribute to the pressure ulcer development and dementia. Dementia for sure.

**Pat:** When I listen to that list of risk factors, I think I’m surprised there’s not more people who have pressure sores because all of those conditions can impact the skin and they’re all common as our health is taking a nose dive.

**Heidi:** Sure.

**Pat:** Can you give any guidance then to a legal nurse consultant who is looking at a medical record trying to determine if a pressure sore is avoidable or is it unavoidable?

**Heidi:** Well you just have to so a real good thorough look through the chart. You have to look at all the risk factors or any of the risk factors that we’ve talked about. Were they present?

You have to look at the interventions that were then done and make sure a good risk assessment was done, and then appropriate
interventions were instituted. If so, that’s a good defense. Was an appropriate care plan implemented? Those are appropriate interventions. With wound documentation, was nutrition looked at?

All those things to see if that facility met the standards of care that we talked about. Indeed, if it looks like (a) you’ve got the risk factors and (b) the standards of care were met related to assessment, prevention and treatment of those pressure ulcers then you’ve got a pretty good case that this was perhaps unavoidable.

Pat: I think the dilemma from a liability perspective is that facilities will maintain “Well, we did all those things. Look at the condition of the person. Look at how sick she was, but our charting doesn’t reflect that we were perfect in carrying out all of those documentation pieces that you just listed. But, we did it. That’s our typical practice.”

How do you deal with that assertion or that defense, which could be a very solid defense when the chart doesn’t support that the care was delivered as we just outlined?

Heidi: There is no such thing as perfection in documentation that’s for sure. What I’ve told attorneys and one I’ve even used on the stand is I just look for an overall culture of pressure ulcer prevention and treatment. If a facility has indeed got a good culture of that, even if they haven’t perfectly documented every single step that makes the case pretty defendable.

Do they mention turning and positioning in various aspects of the chart even if they’re not documenting every single shift? “I turn and position this patient,” is it their plan?

You just have to look at the chart kind of pragmatically. It doesn’t appear as though there’s been a culture. Attention has been paid to this issue and prevention of pressure ulcers and their treatment.

Pat: I know you’ve heard the expression the Kennedy Terminal Ulcer. Can you tell our listeners about that? Does it exist?

Heidi: Absolutely. Karen Kennedy was a nurse practitioner back in the 80s. She noticed this phenomenon of just rapidly progressing pressure ulcers and then shortly after the appearance of that the patient would
die. She defines them as ulcers that appear suddenly, and the skin just seems to breakdown within hours. She’s been known to call it the “3:30 Syndrome” where maybe the first check of the patient in the morning the skin was fine and by 3:30 they had a horrible, terrible and nasty bit of skin breakdown. Usually it may occur on the coccyx or sacrum. She describes them usually as pear-shaped or butterfly-shaped. The edges are irregular.

I have no doubt absolutely that Kennedy Terminal Ulcers and skin failure at end of life exists. I’ve had patient families ask me, “Heidi here’s this nasty pressure ulcer on grandma. We can’t get the darn thing healed. Is this a Kennedy Terminal Ulcer?” This is my personal preference anyway. I like to say to the without getting religious on them, “The good lord said, “No man knoweth the hour.”

I like to think of the Kennedy Terminal Ulcer more as a retrospective type thing. “Remember grandma developed that really bad pressure sore and then a few days later she passed on.” I really don’t use it that much prognostically to look ahead, but I certainly have used it in defense cases.

If you would like to, I invite you to go to her site, which is www.kennedyterminalulcer.com. There she does have a lot of good statements that you could use in your documentation. I do look for statements like this. When I look at a chart for an attorney, is there documentation that this would appear to be an end of life issues? One of her statements is, “Complete wound closure might not be a realistic goal, or a patient has end stage or a terminal condition.” It’s statements like that that would point you towards the fact that the facility is acknowledging that this is perhaps an end of life issue.

Pat: Have you seen this characteristic shaped pressure sore or skin breakdown in your clinical work?

Heidi: Absolutely.

Pat: I think you’ve given us a lot to think about today Heidi in terms of teasing out some of these factors. We’ve talked about the clinical implications of pressure sores and the risk factors. We’ve talked about the governmental focus on them and the litigation aspects. These cases
can be worth a lot of money because of the pain that the person experiences, the suffering of the sometimes prolonged treatment and wound healing that’s required. How can our listeners find out more about you?

Heidi: You can email me certainly if you like. My email address is hcross914@gmail.com.

I also have a wound blog where I go into some of these issues in more depth. If you go to www.woundsource.com/blogs/heidi-cross. I know that’s a lot. I don’t know if we can provide that somehow, but anyway I have a wound blog there. You can go to there and get a lot more information related to that.

Pat: Perfect. Thank you so much for being on the show, I appreciate it.

Heidi: Thank you so much for having me.

Pat: This has been Pat Iyer and Heidi Cross talking about unavoidable pressure sores. Be sure to request copies of our transcripts so that you can refer back to key information that you’ve heard in Legal Nurse Podcast. You can get those transcripts by going to www.podcast.legalnursebusiness.com. Stay tuned, we’ll have a new show next week and thank you so much for listening.

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