In our previous podcast, LNP 294, Steve Henry shared his knowledge about the intricacies of wheelchairs. The chairs Steve described were specially fitted orthotic devices.

This is Pat Iyer with Iyer’s Insights, one of the twice weekly shows of Legal Nurse Podcast. Thank you for joining me today.

As I interviewed Steve, I thought of the type of wheelchair that I was more familiar with – the kind used for transport. Intended to move patients from one place to another, the patient stays in that wheelchair for longer than brief trips.

When my brother was a resident in a nursing home I noticed he spent long hours in a wheelchair.

He did not have to be in a wheelchair for hours. There are numerous chairs and devices on the market that fulfill a variety of nursing home resident needs. For example, glider or rocking chairs with vinyl-covered cushions are used with patients who like to rock and have a tendency to fall forward out of a stationary chair.

Recliners without tray tables can be a comfortable alternative to a chair, however, they often require additional cushions to promote correct and comfortable positioning.

LNCs are involved in analyzing cases of residents injured while in or because of their seating arrangements.

**Critical thinking point for you when analyzing a nursing home liability case**

Were there a variety of wheelchair types, thereby adding customization to patient needs? Analyze the types of chairs purchased by the nursing facility.

Remaining in a reclining position for most of the day will eventually result in the decreased ability to sit up in a wheelchair or straight back chair due to loss of
abdominal muscle strength. This will adversely affect the resident’s ability to eat or swallow liquids safely (without aspiration).

Treatment of weak abdominal muscles usually requires a process of incrementally reducing the angle of recline over time; and supervision of this process is done by an occupational therapist.

**Long Hours in a Wheelchair**

Most nursing home residents spend most of the day and early evening hours in a wheelchair.

> Wheelchairs were originally designed for transport; their sling seats do not provide adequate support for long periods of sitting.

Many products are available to adapt the chair to the resident’s seating needs.

If the resident spends more than an hour per day in a wheelchair or hard plastic/wood chair, the chair should, at minimum, have some type of pressure-relieving seat cushion. Anti-tippers applied to chair will prevent the resident from “flipping” a wheelchair or chair forward or backward.

Other adaptations for the wheelchair include a wedge cushion inserted under the resident’s buttocks and thighs which tilt the resident backward. A wedge seat prevents the resident from sliding forward.

Similarly, leaning to the side is corrected with lateral supports or cushions. Stroke victims with hemiplegia are at risk for shoulder subluxation (partial dislocation) if the weakened arm slips off the side of the chair.

This can be prevented with devices attached to a wheelchair: an arm trough, elevated armrest, lateral arm support, or half tray. A full tray table is not necessary.

- A leg panel will prevent legs from falling backward off foot pedals or between calf pads.
• A head extension can be added to a wheelchair, or other chairs, to help keep the resident’s head erect and promote comfort.
• Also, “wingback” head extensions will prevent the resident’s head from leaning to one side.

I took my brother for a trip around the nursing home to give him a change of scenery. His chair had no footrests, and after a while he asked to go back to his room. He was tired of holding his legs up so his feet would not drag on the ground.

In hindsight, I realize I should have asked for a wheelchair with footrests.

The wheelchair itself can be individually fitted to the resident’s size. For example, pediatric wheelchairs are available for very small residents as are extra-wide chairs for obese or larger residents.

“Walking” in the wheelchair (i.e., using feet to propel forward or backward) is easier for some residents than pushing the wheels with their arms. Hemi-height wheelchairs that can be adjusted to the resident’s lower leg length can facilitate pushing the wheelchair with the legs. This adjustment creates safe transport while promoting muscle strengthening exercise to the lower extremities.

**Critical thinking point for you**

Given the patient’s height and body weight, was the chair an appropriate size? If the older adult slides out of the chair, it may be too big or fail to have proper pillow supports.

• Was the footrest utilized, which can help reduce the chances of slippage from the chair seat?
• Was the patient wearing shoes or anti-skid slippers while sitting in the chair?

The need for adaptive equipment can be determined by a physical/occupational therapist, nurse or physiatrist with the attending physician’s orders. Individualized seating, however, is only part of the solution to prevent falls.

Residents need regular exercise. No matter how comfortable the chair, residents need to get up periodically. Those unable to move themselves should receive
assistance of the staff in changing positions and, if possible, in standing or walking at least twice a day as part of a rehabilitation or restorative nursing program.

Also, because sitting up can be tiresome, residents may need to nap for one to two hours in the early afternoon, depending on their condition.

Some residents will attempt to get up from even the most comfortable chair because of boredom. A stimulating activities program is an important part of a fall prevention program. Also, an activity apron or half tray with an activity board can be helpful to stimulate the resident with dementia.

**Pressure Sore Case Analysis and Reports Multimedia Course**

Before we continue with the show, consider these questions

Since Centers for Medicare and Medicaid Services declared stage III and IV pressure ulcers as avoidable outcomes of care, the spotlight is shining on pressure sore cases.

- Are you using current standards of care to evaluate pressure sore cases?
- Can you spot the unavoidable pressure sore cases?
- Are you aware of all of the critical issues that affect the analysis of pressure ulcer cases?
- Are you comfortable in being able to analyze the liability and damages of these cases?

**Learn from an international expert in pressure ulcer care and prevention: Dr. Diane Krasner and a national expert in legal nurse consulting: Pat Iyer MSN RN LNCC.**
Who should invest in this online course: Nursing expert witnesses, legal nurse consultants, wound care specialists

- Discover a systematic process for evaluating a pressure sore case based on current standards of care and medical literature
- Recognize the top pressure sore standard of care issues so you know how to evaluate liability and damages
- Gain skill in critiquing or writing an expert report
- Use the *Skin Changes at Life’s End Consensus Statement* to identify or refute crucial defenses in pressure ulcer cases

During this interactive multimedia course, you will review records of a pressure ulcer medical malpractice case and be guided through the process of case analysis to develop your own detailed expert report.

You will discover how to avoid common mistakes and hone your analytical skills to produce a report that your client will depend on throughout the litigation process. Even if you are not an expert witness, you need to know how these reports are constructed.

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**Pressure Sore Risk**
I mentioned the use of a pressure-relieving cushion in a chair. Suppose the resident develops a sacral pressure sore, and to make matters worse, the nurses use the wrong treatment. Dr. Diane Krasner shared these thoughts with me about wound care treatment.

Many wound care clinicians remember the “good old days” when wound dressing product selection simply involved choosing between a handful of products that were essentially variations on the same theme. There was gauze, impregnated gauze and filled gauze pads.

In the earlier 20th century, clinicians added antimicrobial solutions, creams and ointments (like Dakin’s solution developed during World War I and silver
sulfadiazine developed in the 1960’s) and the wound care formulary was limited and simplistic.

Fast forward to the 21st century and wound care clinicians are confronted with a totally different situation: hundreds of products, scientific rationale for moist interactive dressings and an emerging evidence-base for product selection.

Pressure ulcer product selection

Current wound care expertise encompasses numerous dressing-related skills including:

- Treating the cause of the wound and addressing patient centered concerns to set the stage for local wound care
- Properly assessing the wound and identifying the dressing requirements
- Selecting dressings based on their form and function for an individual wound’s needs
- Meeting setting-specific requirements for dressing change frequency and maintenance
- Addressing formulary or healthcare system availability as well as reimbursement requirements

Wound care product selection today must be as sophisticated and as evidence-based as possible. Wound dressing product selection process is based on three principles:

- Holistic Perspectives
- Interprofessional Considerations
- Patient-Centered Concerns

Selecting appropriate wound dressing products and supportive care to maximize healing and patient outcomes is a complex process. Dressing and local wound care options based on science and best practices must be filtered by clinical experience and must be consistent with patient preferences, caregiver requirements and setting/access issues.
Additionally, effective dressing selection and local wound care planning involve the perspectives of the entire interprofessional team.

Knowing the performance parameters of dressing categories/individual products and matching these attributes to an individual’s wound can optimize the healing process.

But dressings are only one piece of the puzzle. Dressings alone will not promote wound healing, unless the underlying cause(s) for the wound are also addressed (such as treatment of the wound cause, blood supply, nutrition, patient centered concerns, local wound care and so on).

As the wound changes, the plan of care must change and dressing products may need to be changed.

**Appropriate pressure ulcer dressing product selection**

- Optimizes the local wound healing environment
- Reduces local pain and suffering
- Improves activities of daily living and quality of life

**Wrong Wound Care Treatment can**

- cause the wound status to deteriorate.
- increase the risk of superficial critical colonization or deep infection, skin stripping.
- increase local pressure or pain especially at dressing change (dressing removal and cleansing).
- increase costs with the need for frequent dressing changes or the selection of an inappropriate advanced or active dressing.

National and international wound care guidelines and best practice documents mean that there is no longer a local standard of care. No matter where nurses and doctors practice, they will be held to national/international standards of wound care practice.
Some experts have argued that the selection of the wrong dressing is just as problematic as the administration of the wrong drug and the clinician would be just as liable in a court of law.

If dressings can be shown to delay the healing process (such as wet-to-dry gauze dressings in a wound that requires moist wound healing, pain from inappropriate adhesives, failure to treat critical colonization that can lead to deep infection), their use might be deemed negligent by a jury in a court case.

Wrong wound care treatment can get healthcare professionals in trouble. Your expertise as a legal nurse consultant is essential in guiding the attorney in analyzing this case.

Do you feel like you could use an experienced LNC coach to guide you through developing more business as a legal nurse consultant? Sign up for a free call with Pat Iyer at http://LNC.tips/gethelp. That’s http://LNC.tips/gethelp.

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