

The Prevention, Treatment and Liability of Pressure Ulcers In the Nursing Home

Rachel Roach, MSN, ANP, GNP, WCC, and Clarisse Dexter, MSN, FNP, GNP, WCC

Mrs. X, an 80-year-old woman with a history of insulin-dependent diabetes, high blood pressure, dementia, and peripheral neuropathy, was admitted to a nursing home for rehabilitation following repair of a fractured left hip. On admission she was assessed for pressure ulcer risk using the Braden Scale.¹ For a Braden Score of 14 (moderate risk), the nursing staff initiated a plan of care to prevent the development of a pressure ulcer. This included placement of a pressure redistribution mattress on her bed and a cushion in her wheelchair. Three months later Mrs. X had completed rehabilitation. She could ambulate with a rolling walker and she transitioned to long term care.

The following year, Mrs. X became more confused and her oral intake decreased; she lost 5 pounds. During a weekly skin assessment the nurse noticed a blister on her left heel, possibly caused by pressure to her heel from walking in a new pair of shoes or from lying in bed. The nurse documented the occurrence in the record and reported the blister, as well as the resident's overall decline, to the resident's daughter and to her attending physician. The physician ordered laboratory studies, including a urine culture and serum albumin, dietary supplements, a foam foot elevator, and a treatment plan for the blister.

In spite of the interventions, Mrs. X continued to lose weight, her blood sugars became unstable, and her left heel blister worsened. The nurses documented the wound as a stage III **pressure ulcer (PU)**. The staff continued conscientiously to provide wound care and entice Mrs. X to eat. She slowly improved, regained most of her lost weight, her blood sugars stabilized, and she became more alert. However, her left heel ulcer worsened without pain or sign of infection.

Over the following several months Mrs. X's physician adjusted the treatment plan for the ulcer, without improvement. Non-invasive arterial studies revealed a high-grade stenosis with almost complete blockage of the arteries from the knee to

the left foot. Mrs. X was hospitalized. After two failed procedures aimed at improving arterial blood flow, an above-the-knee amputation was necessary. Upon discharge from the hospital, she moved to another nursing home.

The subsequent year Mrs. X's family filed a lawsuit against the nursing home for \$350,000 in damages. The complaint alleged that Mrs. X had suffered a below-the-knee amputation caused by the "completely preventable and treatable pressure ulcer of her left heel."²

BACKGROUND

Data from the National Nursing Home Survey³ documented 11% of nursing home residents had PUs. Nursing home residents can be at high risk due to functional and cognitive disability, incontinence, and co-morbid conditions.

The **National Pressure Ulcer Advisory Panel (NPUAP)** defines a PU as an area of localized tissue injury affecting the skin and subcutaneous tissues attributable to pressure, shear, friction or a combination of these factors.⁴ Diseases which cause tissue hypoxia or impair circulation increase the risk. The heel is one of the most common sites for PU development.⁵

Prevention and treatment of PUs should be a priority across the care continuum. All physicians, mid-level practitioners, nurses and direct caregivers need to become advocates for PU prevention and treatment. Long term care clinicians and medical directors are in a perfect position to ensure that a local and national agenda is set to focus on prevention, early identification and treatment of PUs.

It is important to be familiar with the techniques and tools for wound healing and to encourage interdisciplinary collaboration.

DOCUMENTATION

Appropriate documentation guarantees effective communication between clinicians and other members of the care team and allows for full accountability and retrospective review by all interested

parties. The **Centers for Medicare and Medicaid Services (CMS)** require that all nursing homes receiving Medicare dollars perform a comprehensive resident assessment and develop a care plan. Skin conditions, including PUs, are a component of the assessment.

Nursing homes frequently use the Braden Scale to stratify an individual's risk for PU development on admission, quarterly and with any significant change in condition. This is documented in the record and in the **Minimum Data Set (MDS)**⁶ (a detailed assessment tool associated with an interdisciplinary patient care plan). CMS require that an MDS be performed on all patients in nursing homes which receive Medicare/Medicaid reimbursement. The data are transmitted to the states electronically and from there to CMS. The **Joint Commission on Accreditation of Health Care Organizations (JCHCO)** requires practitioners in long term care to assess and periodically reassess each patient's risk for developing PUs and address any risks.⁷

MANAGEMENT OF PRESSURE ULCERS IN NURSING HOMES

Since in many nursing homes a physician may round every 30 days, and be unavailable when a problem is identified, excellent nursing assessment and concise reporting are crucial.⁸

Nurses are required to report any open area in order to initiate a treatment regimen. A clinician can expect the nursing home nurse to include the following:

- The patient's name and age
- Vital signs
- Degree of mobility, presence of contractures
- The wound's location – (using proper anatomical terms such as anterior, posterior, medial, lateral)
- The wound's dimensions - (in centimeters, proximal to distal, medial to lateral)
- Condition of the surrounding tissue – (ex. hyperkeratotic rim,

- macerated, presence of a rash, normal)
- Condition of the wound base – (ex. beefy red, fibrotic, necrotic, eschar formation)
- Any indications of infection – (pain, swelling, drainage, redness, odor, fever, abnormal laboratory results)
- Does the wound look like its healing, worsening or remaining stagnant?
- Current treatment and a review of the past treatment
- Any change in condition (e.g. weight loss, functional decline, cognitive decline)
- Presence and strength of peripheral pulses when lower extremity ulcers are affected
- Incontinence of urine or feces
- Any recent diagnostic tests⁹

CLINICIAN DOCUMENTATION

Clinicians are required to generate a progress note for each encounter. This record allows a clinician to compare past status to current status and serves as a link between clinicians and other members of the care team. This documentation, used for medical, legal and billing purposes, should include:

Patient's name and date and time of visit

Vital signs

Presence or absence of fever, tachycardia, other signs of sepsis

The Dressing – Type of dressing and appearance - Is there drainage on the outside of the dressing material?

Location of wound - This is important for identifying the origin of the injury, such as pressure over a bony prominence, or friction from a positioning device.

Size – length, width, and depth measured in centimeters. Use the face of a clock to describe location, 12 o'clock is the patient's head and 6 o'clock is the feet. To measure depth, use a sterile cotton tip applicator. It is very important to avoid cross contamination of wounds by using the same gloves, instruments, measuring devices from wound to wound in a patient with more than one. Assess changes based on previous measurements.

Undermining or tunneling – look for and measure skin that overhangs the wound's edges. Undermining is the destruction of tissue or ulceration extending under the surface of the skin edges so that the wound is larger at its base than at the skin surface. Tunneling is a course or pathway that can extend in any direction from the wound resulting in dead space with potential for abscess formation. The two can be differentiated: tunneling involves a small portion of the wound edge whereas undermining involves a significant portion of the wound edge. Both tunneling and undermining are caused by shearing and forces against the wound.

Drainage – Is there drainage on the contact layers of the dressing? What does it look like - serous, purulent, bloody, green, yellow, clear, thick, etc? Is the drainage a breakdown of the wound dressing (like a hydrocolloid) or actual drainage from the wound? For example, yellow purulent drainage could indicate staphylococcus involvement.

Odor – Foul or fruity

Necrotic tissue – Presence and percentage of necrotic tissue. Drawing a small diagram can be helpful for future comparisons

Infection – Consider infection when a wound is not progressing as expected. DO NOT swab wound drainage for culture and sensitivity. Culture of wound drainage can lead to incorrect diagnosis of the infecting agent. Wound drainage is contaminated with microorganisms which are often not the causative pathogen. Either perform a biopsy of the bed (gold standard) or cleanse the wound and swab multiple times in multiple directions with a culturette.

Stage pressure ulcers – refer to the table 1 on staging pressure ulcers for a complete review. An ulcer with an intact eschar should be noted as unstageable due to eschar formation. DO NOT reverse stage a healing ulcer. For example, an ulcer initially documented as a stage 4 should not be documented as a stage 2 or a stage 1 as it heals. This stems from the fact that skin over a healed ulcer is only 70 - 80 percent as strong as undamaged skin. A new health care professional on the case may look at the latest notes and only see a stage 2 in the assessment and not realize that this patient is at high risk. Instead, document that the wound is a healing stage 4 ulcer.

Past treatment – Note the past treatments and any changes in products. This will help new health care professionals on the case. Products that may not have produced the desired results won't be accidentally duplicated.

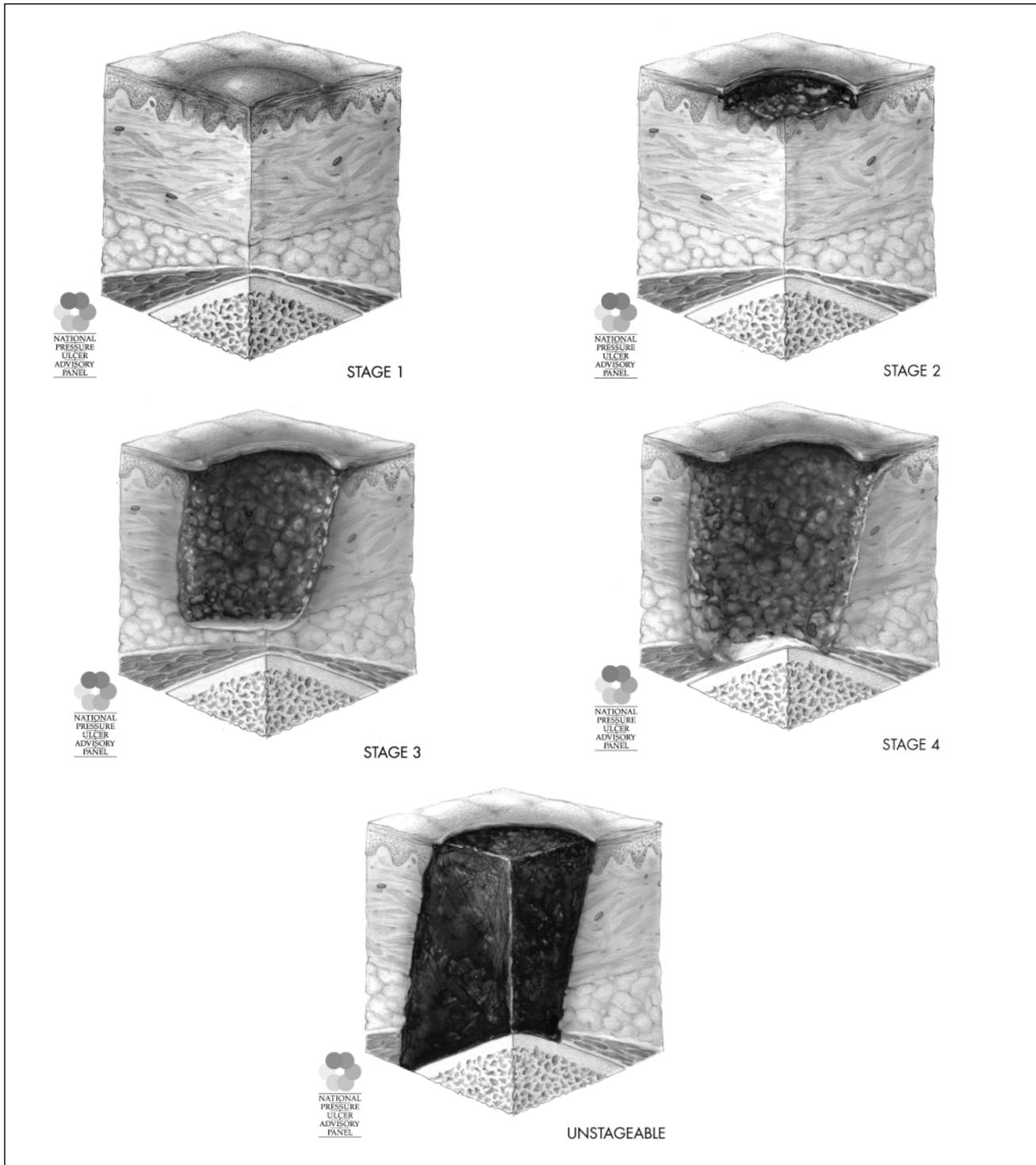
Current treatment – Document the type of irrigation, products and secondary dressings used during the dressing change.

Consider – Consulting physical or occupational therapist for assistance with positioning and mobilization; dietician to improve nutrition; wound care specialist; plastic surgeon for grafting; general surgeon for debridement; vascular surgeon for non-healing ulcers of the extremities.

STAGING

Pressure Ulcer Stages (NPUAP, 2007)

Suspected Deep Tissue Injury	Localized purple or maroon discoloration of intact Skin or blood-filled blister
Stage I	Non-blanchable erythema of a localized area
Stage II	Partial thickness loss of the dermis (presents as shallow open crater)
Stage III	Full thickness loss of through the dermis and into the subcutaneous tissue. Fascia remains intact.
Stage IV	Deep destruction of the soft tissue exposing muscle, tendon or bone.
Unstageable	A pressure ulcer is unstageable if the wound bed is obscured.



Note: Staging implies that a wound is a pressure ulcer: only pressure ulcers should be staged.

CODING

The coding guidelines presents the following information on how to code pressure ulcers:

“Two codes are needed to completely describe a pressure ulcer: a code from subcategory 707.0, Pressure ulcer, to identify the site of the pressure ulcer and a code from subcategory 707.2, pressure

ulcer stages, are to be used as an additional diagnosis with a code(s) from subcategory 707.0, Pressure Ulcer. Codes from 707.2, Pressure Ulcer stages may not be assigned as a principal or first listed diagnosis. The pressure ulcer stage codes should only be used with pressure ulcers and not with other types of ulcers (e.g. stasis ulcers/ Vascular or diabetic ulcers).”¹⁰

IDC 9 Codes

707.00	pressure ulcer	unspecified
.01	pressure ulcer	elbow
.02	pressure ulcer	upper back
.03	pressure ulcer	lower back
.04	pressure ulcer	hip
.05	pressure ulcer	buttock
.06	pressure ulcer	ankle
.07	pressure ulcer	heel
.09	pressure ulcer	other site

LEGAL RISKS IN SKIN AND WOUND CARE

Eventually the case of Mrs. X went to trial. The jury found for the defendant based on documentation of early identification of the ulcer and the timely and ongoing assessment and treatment. Mrs. X's co-morbid conditions were considered a significant factor in her outcome.

Nursing homes are justifiably concerned about the legal risks surrounding PUs. The **American Medical Directors Association (AMDA)** advises nursing homes to implement care plans that are consistent with the patient goals as well as the standards of care. Documentation and frequent communication between the physician, patient, family and relevant team members should include changes in the ulcer, changes in the care plan, and conditions which may interfere with healing.

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Rachel Roach, MSN, ANP, GNP, WCC, and Clarisse Dexter, MSN, FNP, GNP, WCC, are Teaching Associates at The Warren Alpert Medical School of Brown University.

Disclosure of Financial Interests

The authors and/or spouses/significant others have no financial interests to disclose.

CORRESPONDENCE

Rachel Roach, MSN, ANP, GNP, WCC
Rhode Island Hospital
Division of Geriatrics
593 Eddy Street POB Ste 438
Providence RI 02903
Phone: (401) 444-5248
e-mail: rroach@lifespan.org

