

# Pressure Ulcers: Case Study and Lessons Learned

Proper wound identification is vital to avoiding lawsuits

BY LINDA WILLIAMS, RN

**B**ecause of their nature, lawsuits concerning pressure sores typically generate strong emotional reactions on the part of litigants and juries and are fairly easy for plaintiff counsel to document and pursue. At a minimum, incidents of pressure sores increase the care required from staffing resources and strain facility and family relationships.



The following is a summary of a lawsuit against a nursing home concerning an alleged pressure ulcer. I suggest you take the time to review the circumstances surrounding this case and consider making changes, as appropriate, at your own facility.

## The Situation

An 80-year-old woman was admitted to a nursing home with the following diagnoses: a fractured left hip, noninsulin-dependent diabetes mellitus, dementia, and peripheral neuropathy. The nursing staff immediately initiated a plan of care to prevent the development of a pressure

ulcer, which included placement of an air mattress on her bed and a cushion in her wheelchair. By January, the resident's hip had healed enough that she was able to ambulate with the use of a Merry Walker.

By early spring, the resident became more confused and her food intake lessened. Staff noticed a blister on the resident's left heel, possibly caused by her ambulating through the halls. A nurse promptly notified the resident's daughter and physician of the blister, as well as of the resident's overall decline in health. Her physician ordered dietary supplements, a foam foot elevator, and a treat-

ment plan for the care of the blister.

Despite the interventions, the resident continued to lose weight, her blood sugars became unstable, and her left heel blister worsened to the extent that the nurses described it in their documentation as a stage II pressure ulcer. The staff continued to diligently provide the necessary treatments and care until the resident was slowly able to regain most of her lost weight, her blood sugars stabilized, and she became much more alert. However, her left heel ulcer remained, slightly increasing in size and with no sign of infection.

Throughout the summer, the resident's physician continued to assess the ulcer and change her treatment plans, to no avail. By fall, the physician ordered a Doppler study and examinations by specialists. The arterial Doppler study revealed a high-grade stenosis with almost complete blockage of the resident's arteries from the knee to her left foot. A specialist recommended an above-the-knee amputation, which was performed. Upon discharge from the hospital, the resident moved to another nursing home.

Eighteen months later, the resident filed a medical malpractice lawsuit against the nursing home because she "suffered a left leg amputation from a totally preventable, treatable, and curable bedsore on her left heel." The plaintiff's demand was for nearly \$350,000.

## The Lawsuit

At the trial, the plaintiff asked a physician that specialized in geriatric care to testify. He stated that "it was more probable than not that the pressure ulcer was preventable, treatable, and curable within

a reasonable degree of medical certainty.” It was his opinion that nursing homes can prevent pressure ulcers through nutrition and proper skin care, including repositioning every two hours. In addition to the physician, several CNAs testified that they never repositioned the resident because they were never instructed to do so.

The defense argued that the resident’s heel ulcer developed from a blister obtained while ambulating; it was not a pressure ulcer (despite the nurses’ documentation). The defense further stated that “pressure ulcers are a common complication in those who are confined to a bed. The resident was ambulatory with her walker and spent most of her time out of bed, wandering through the nursing home when the blister developed. The resident’s ulcer was the result of her underlying health conditions, most specifically her peripheral vascular disease.”

After a lengthy deliberation, the jury decided in favor of the defense.

## How You Can Protect Your Facility

In this case the nursing home prevailed, but was there anything the nursing staff could have done differently that might have prevented the anger and subsequent lawsuit altogether? The answer is that the nursing staff should have recognized the type of ulcer the resident had, understood its implications, and prepared the resident and her daughter for the possibility of complications, which turned out to be an above-the-knee amputation.

As was noted in the case, the nurses were quick to label the declining blister as a pressure ulcer, when it was actually an arterial ulcer. Nurses need to recognize the differences among the four basic types of ulcers that can occur below the knee.

**Arterial ulcers** are a result of inadequate arterial circulation to the wound site. Their incidence rate is 15 to 20% of all leg ulcers. Some characteristic signs include the following:

- no palpable pulse distal to the wound;
- the skin on the leg is shiny and hairless;
- the foot is pale and cool to the touch;

- there is increased pain when the affected limb is elevated;
- they generally have well-defined borders;
- they are typically deep wounds; and
- they are usually found on the plantar surface of the foot and interdigital spaces or on a bony prominence (tibial or lateral malleolus).

**Venous (stasis) ulcers** are caused by venous hypertension, which causes the blood in the veins to pool in the lower leg. Their incidence rate is 75 to 80% of all leg ulcers. Some characteristic signs include the following:

- the leg is usually edematous;
- when breakdown occurs, the wound is usually a weeping/draining wound;
- pulses are palpable;
- the foot is warm;
- there is decreased pain when the affected limb is elevated;
- the wound usually has an irregular border and shape; and
- they are usually found along the medial aspect of the leg, superior to the medial malleolus.

**Diabetic ulcers** generally occur below the ankle. They are really pressure ulcers that occur secondary to diabetic neuropathy. There is decreased sensation, so objects causing pressure are not relieved, thus causing a wound. Their incidence rate is 5% of all leg ulcers. Some characteristic signs include the following:

- the surrounding skin is usually dry and shiny;
- pulses are palpable;
- the foot is warm;
- the wound is usually round;
- the surrounding callus may have tracking or undermining; and
- they are usually found along the pressure areas of the plantar, medial, or lateral aspects of the foot.

**Pressure ulcers** are wounds over a bony prominence. Relieving the pressure and dressing the wound will generally clear up pressure ulcers.

In this case, the resident had all of the classic characteristics of an arterial ulcer. The nurses should have recognized this and conferred with the resident’s physician before incorrectly documenting that it was a pressure ulcer. The expectations for healing would have been very different. If the ulcer would have been identified as arterial from the start, the nurses and the resident’s physician could have discussed the likelihood of complications, and the rationale behind it, to prepare the resident and her daughter for what turned out to be an inevitable decline. It is possible that if the risk of amputation had been known and the resident and her daughter had more time to prepare themselves, they might have understood that there was nothing the nurses could have done to restore the circulation in the resident’s leg, which her narrowed and blocked arteries had shut off.

Some steps to help protect your facility from similar allegations and misperceptions by residents and family members include the following:

- provide continuing education opportunities related to recognizing, staging, and documenting wound conditions for nursing staff members;
- encourage physicians to document causation and expected outcomes for all wounds;
- physicians and nurses should take the time to help residents and their family members understand their diagnoses and the risks involved; and
- both should be candid and set realistic expectations.

By taking a few precautionary measures, you can help prevent a similar situation from occurring at your facility. **NH**

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