Legal Corner

Determining the Legal Standard of Care for Pressure Ulcers in LTC

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One of the most challenging aspects of caring for residents in long-term care (LTC) facilities is the prevention and treatment of skin breakdown and pressure ulcers. Thus, it is not surprising that one of the most challenging aspects of LTC litigation involves the analysis and determination of claims regarding skin breakdown and pressure ulcers. Typical allegations brought against facilities include the failure to turn and reposition residents who cannot do so themselves, failure to provide pressure-reducing or pressure-relieving mattresses and wheelchair cushions, and inadequate nutrition and hydration monitoring. When faced with these allegations, the defense of a facility may focus on the resident's impaired vascular condition and overall health, raising the issue whether even care of the highest quality would guarantee that skin breakdown would not occur. These issues are made more complicated by advancements in the treatment of skin, both in the medical therapies available and the development of more advanced pressure-relieving devices. What constituted proper care for a resident in 2004 may be outdated by the time a lawsuit reaches a courtroom in 2009.

To bring a successful suit for negligence against a LTC facility when a resident develops a pressure ulcer, a plaintiff must prove that the facility and its staff breached the "standard of care" in its treatment of the resident. This standard of care is determined by experts in the field who are retained by both sides to provide testimony regarding their opinion of the care provided. Accordingly, a plaintiff will retain an expert who states to a reasonable degree of professional certainty that the facility did not adhere to the applicable standard of care, and that this breach caused some level of harm to a resident. Conversely, a defendant-facility will retain experts who believe that staff met the standard of care in their treatment of the resident.

This raises many questions that are being considered by courts across the country without a clear answer. First, who *is* a qualified expert in the field of LTC litigation? In medical malpractice cases, it is well-established that a physician is required to offer opinions regarding the care of a physician-defendant. Many states have statutes that require that this expert must also practice in the same specialty as the defendant. Thus, in a lawsuit involving allegations of negligence against an obstetrician, the plaintiff will retain an obstetrician to review the medical records and make a determination, based on their experience and training, about whether the defendant-physician failed to adhere to the applicable standard of care. The defendant will also retain an obstetrician to review the same records and testify regarding his or her opinions. However, care provided in LTC settings is not so straightforward.

Federal Nursing Home Reform Act

Nursing homes are interdisciplinary environments with nurses, dieticians, social workers, therapists, and others providing care to residents. In addition, nursing homes are among the most highly regulated of all industries. The Federal Nursing Home Reform Act, created as part of the Omnibus Budget Reconciliation Act of 1987 (OBRA) created a comprehensive set of federal regulations that touches on nearly every facet of nursing home life. Every nursing home that intends to receive Medicare and Medicaid funding—which includes most nursing homes—must comply with these regulations.

The federal agency charged with enforcement of the federal OBRA regulations, the Centers for Medicare & Medicaid Services (CMS), has delegated this function to state departments of health. Surveyors from these state agencies perform inspections of nursing homes during certification or recertification of a facility, periodically, and when complaints occur—either self-reported events by nursing homes or complaints from consumers. However, many surveyors who are entrusted with the enforcement of

federal and state regulations are neither doctors nor nurses. This raises the question whether an administrator with no clinical background or training, but in-depth knowledge and experience regarding compliance with the regulations, can offer expert testimony against a nursing home and the physicians and nurses who provide care and treatment to residents at the facility. This remains an open question.

It is not uncommon for nursing home inspections to reveal violations of the federal and accompanying state regulations. Normally, these deficiencies are addressed through a "plan of correction," authored by the facility, which is designed to prevent the deficient practice going forward. It is fair to say that nearly every nursing home in the country—even those that provide the best care—has been found to have violated various regulations from time to time.

An increasing trend in LTC litigation is the attempt by plaintiffs to utilize the regulations in establishing the standard of care. In the most extreme circumstances, plaintiffs have taken the position that the regulations supplant the testimony of doctors and nurses, which is based on these professionals' clinical training, experience, and judgment. One argued benefit of such a system is that it removes the perceived subjectiveness from expert testimony in favor of specific and concrete directives for care.

The OBRA regulation regarding pressure ulcers appears simple at first. The two-paragraph text mandates that a nursing home ensures that a resident who enters the facility without a pressure ulcer "does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable." A resident who enters a facility with a pressure ulcer must "receive[] necessary treatment and services to promote healing, prevent infection and prevent new sores from developing."[1] However, beneath this seemingly straight-forward directive are over 50 pages of "Guidance to Surveyors," which surveyors may use to determine whether a facility adhered to the regulations.[2]

Included in this guidance are specific suggestions for turning and repositioning ("at least every 2 hours or more frequently"), nutrition and hydration ("protein intake of approximately 1.2 to 1.5 gm/kg body weight daily), and pressure-relieving surfaces ("dynamic pressure reduction surfaces may be helpful when…the pressure ulcer is not healing as expected."). Also included are definitions of the terms "avoidable" and "unavoidable." An avoidable pressure ulcer is defined as a pressure ulcer that develops when a nursing home fails to do one of the following: 1) evaluate the resident's condition and risk factors for pressure ulcers, 2) implement appropriate interventions, 3) monitor the interventions for effectiveness, and 4) revise the interventions as appropriate.

The Role of the Regulations in Litigation

If plaintiffs are able to establish that the standard of care in a nursing home is determined by the regulations, they are provided with important advantages in the litigation process. For example, if the defendant–nursing home received a deficiency for a patient care issue that later becomes the basis for a lawsuit, the plaintiff has nearly conclusive evidence that the nursing home was negligent. If, on the other hand, there was no survey regarding the care at issue, the plaintiff would be able to show the text of the regulations to a jury and then make compelling arguments detailing how the standard of care was breached.

Others argue that the standard of care is not determined exclusively by the regulations. While acknowledging the important role played by the regulations in nursing home care, defendant-facilities often argue that the regulations merely help inform the standard of care. This view is supported by much of the language contained in the regulations themselves. For example, the definition of "avoidable" includes the phrase "recognized standards of practice." Other areas of the regulations include phrases such as "should consider" and "may include." While proponents of utilizing the regulations as the *de facto* standard of care often argue that the regulations are akin to a checklist, most LTC facilities view the regulations as guidelines that leave room for professional interpretation based on clinical situations. This interpretation is really no different than the traditional clinical standard of care.

Pressure ulcer care and treatment is also addressed at length by other trustworthy resources. For example, the American Medical Director's Association (AMDA), an organization of doctors who are most familiar with nursing home care, has published a Clinical Practice Guide-

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line regarding Pressure Ulcers in the Long-Term Care Setting.[3] Another oft-cited resource is the Clinical Practice Guidelines of the Agency for Healthcare Research and Quality (AHRQ).[4] These guidelines, too, are sometimes offered by plaintiffs as equaling the standard of care. However, this view is belied by the stated purpose of these guidelines. AMDA states that the purpose of its guideline is to "guide staff and practitioner practices and performances."[3] Likewise, the authors of the AHRQ guidelines hope that their "clinical practice guidelines will make positive contributions to the quality of care in the United States" but caution that the "recommendations may not be appropriate for use in all circumstances."[4] They recommend that "Decisions to adopt any particular recommendation must be made by the practitioner in light of available resources and circumstances presented by individual patients."[4]

Pressure ulcers are often at the center of LTC litigation for several reasons, including the feeling among many that a great number of pressure ulcers are avoidable with proper care and treatment along with the graphic nature of these wounds, which elicit strong reactions from juries. While the goal of all stakeholders is to reduce the number of pressure ulcers to the greatest degree possible, the legal concept of a "standard of care" remains foreign to many in the LTC industry. Therefore, lawyers and judges will continue to struggle with the interplay between the clinical training, experience, and judgment of nursing home professionals and the written guidelines set forth by federal regulations and other "best practices" guides in determining the standard of care for nursing homes in pressure ulcer cases. *MPM*

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