CAC Specialty™

Best Practices for Wound Care

One of the more common and expensive areas of senior care professional liability litigation is the resident wound case. We know that skin is a bodily organ, and that it ages and breaks down like all other organs. The skin has the capacity to develop ulcers or open sores which are painful and can be life threatening if left unmanaged. These wounds develop from a variety of causes, but most commonly from sitting or resting too long in one position, which creates ***pressure*** on the skin covering boney protrusions.

The continuous use of durable medical devices can also rub on skin, resulting in wounds. The tendency to develop skin wounds can be exacerbated by other health conditions like age, being overweight, diabetes, dehydration, poor nutrition, and mobility, just to name a few. Residents on palliative care or hospice are more susceptible to develop pressure ulcers or wounds. These wounds often develop in terms of seriousness and are stagged accordingly from 1-4.

It is a **Best Practice to educate and talk to families and residents** about the skin and the propensity to develop wounds. Setting expectations early on about this aspect of growing older with co-morbidities will make it easier to manage the family relationships and dynamics should a wound develop.

While skin ulcers (wounds) do present exterior signs that they are developing, they also begin from inside layers of tissue, deep tissue injury, before an open wound is visible. A “Kennedy” ulcer is an example of this inside out wound. They also develop surprisingly quickly, become critical and catch an untrained care giver off guard and lead to lawsuits for negligent care.

Proper wound care is critical and requires staff trained in wound care detection and timely care planning and intervention. **Best Practice is to have someone on staff certified in wound assessments and care.** Recognizing and responding timely to skin ulcers (wounds) is elementary to the continuity of good resident care and is the key to defending these claims when they arise. Like it or not, juries tend to hold senior care facilities to the same standard of care as they would a hospital.

The law imposes a “*duty of care*” on the community in the provision of care to the resident. Liability arises when that duty of care is violated or breached, and injury or death occurs because of that violation. Your records/chart notes, along with testimony from the care staff, are used to prove or disprove each of these elements. Plaintiff and defense lawyers employ “experts”, typically nurses, doctors, teachers etc. to review your records and provide that testimony. This is why documentation is so very critical to not just providing good care but to defending the case.

Good documentation takes time and focus. The **Best Practice is to document the wound inspections often and review for clarity.** A process and policy setting out the expectations for this documentation along with training is important. Each resident is different and how you examine for and respond to skin conditions will vary.

Best Practice is to perform this initial assessment before admission or within 1-2 hours of admission by a competent wound care professional. A focus on the more common locations on the body such as the back, sacrum, heels, and buttocks, along with an understanding of the residents other contributing co-morbidities should be well documented. If a skin issue is detected early on it allows for proper interventions to be set out in the care chart from the beginning and to document that the condition did not emanate at your community. If appropriate, measure the wound, (unless trained do so, do not try to draw a conclusion as to the stage of the wound) describe the color, compare developments from one assessment to the next. Resident comments should be noted. Pictures may or may not be appropriate.

In my review of these cases, many wound conditions preexisted the arrival of the resident at the senior living community and went undetected. Not only undetected, but there was no communication with the family or resident. As a result, the community more likely than not will be on the hook for that condition. A **Best Practice here is to also keep the family and doctors fully and timely apprised** of any wound conditions and developments. Waiting until a wound has exploded into a stage 3 or 4 to tell anyone will lead to anger, suspicion, and accusations.

Documented ongoing skin assessments and *wound monitoring* are critical as well for the care of the resident and to defend these cases. These periodic assessments, or what I call "progressive interventions", are most important with residents who by the nature of their condition are more likely than not to be susceptible to developing a skin wound. It is in this ongoing care that too many wound conditions develop and go undetected until the wound is at a stage 3-4. At that point they are off to the hospital and the allegations of poor care and a violation of that "standard of care" begin.

The ***appearance of your charting*** is important. Not only is this appropriate for good care, your medical records and charting will become "Exhibit A" in any trial. The jury and or judge will draw early opinions about your care by how well your care chart looks and reads.

- Is the chart readable or legible?
- Are dates, times, and names accurate?
- How does the grammar read?
- Did you provide corroborating information including how well the resident complied with requests and directions?

The latter is what I refer to as "color commentary" in a chart and of great importance as it conveys to the reader a sense of competence and how the intervention was received by the family or resident. The following are the real-life experience in how the resident, family and doctor communicate, interact, and respond or not.

- "Resident refuses to follow direction to roll over or shift weight"
- "Doctor was called and did not respond"
- "Family was notified and did not care to be involved"

Additional nursing **Best Practices include timely charting.** Do not wait hours or days and batch report or chart. Plaintiff lawyers will have a field day with accuracy and lack of interest to chart and intervene timely. Nurses should not sign off on any wound documentation or notice without first looking at the situation firsthand. Always document observations, communications, and interventions. I am a proponent of engaging the doctors regularly for direction and input. If you use outside wound care

professionals to care for your residents, be sure your staff are involved and perhaps round with them. This can be a great opportunity for trickle down training and raising the overall knowledge level for your staff.

Be objective and avoid opinions, unless well founded on facts. Describe developments and interventions in detail. Avoid short cut statements in the care file when it comes to what you observe and do. Always review to avoid gaps in time of the medical entries, as this will certainly be exploited by Plaintiffs. Even if you look-in on a resident and find nothing of concern, document that (although you had better be right).

Gaps in charting can suggest to a jury or judge that nothing has been done in the charting gap, and to often it is in that gap that something has occurred. Documenting by exception has its risks. It is always helpful if a provider documents something like: "Despite aggressive, changing interventions, pressure ulcer became worse and was determined to be unavoidable."

In conclusion, guarding the integrity of the care chart is a preeminent goal of all senior care providers. This chart is always front and center in all professional negligence trials. Audit the charts periodically for how well staff are recording their skin evaluations and interventions. Set expectations early on with families and residents about the skin and how it can become compromised and develop pressure ulcers. Communicate often with residents, families, and doctors when anything does develop. Document well, in detail, the first assessment, ongoing assessments, and anytime a resident returns to the community from the hospital. Too often the hospital discharge notes do not mention a wound condition, and if you miss it, you may end up owning it.

David Thurber, JD
Senior Vice President
CAC Senior Living Practice
david.thurber@cacspecialty.com