Healthcare

CAREFULLY SPEAKING®

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Pressure Injuries: Sound Documentation Is Key to Defensibility

Pressure injuries (PIs) remain a troubling source of litigation and loss for every type of aging services facility, as well as for nursing staff. Minimizing PI-related liability is a serious, ongoing challenge for facility leadership and staff, including caregivers, policymakers, supervisors, staff educators, and those responsible for monitoring and improving quality of care, among others.

Recent CNA claim data from the Aging Services Claim Report: 11th Edition reveal that the vast majority (94.7 percent) of closed PI claims occurred at skilled nursing facilities (SNFs). But these injuries also posed a growing threat to assisted living facilities (ALFs), where the average severity of PI-related closed claims exceeded average severity for SNFs. Moreover, two-thirds of these ALF claims involved fatalities. (See "A Snapshot of PI-related Claims Data" on page 2.)

PIs are often the result of comorbidities, end-of-life pathophysiology and other risk factors beyond the facility's control, a fact that should help organizations defend themselves against many PI-related claims. However, inadequate documentation practices may significantly weaken an aging services setting's defense posture. Healthcare information records that omit findings from comprehensive skin evaluation, sound care/service planning, a resident's response to treatment, and ongoing communication among team members and with residents can expose residential settings to potentially costly lawsuits, as well as regulatory sanctions and reputational damage. (For a list of notation-related lapses and documentation strategies, see "Common Deficiencies in Wound Care Documentation" on page 8.)

In this issue…

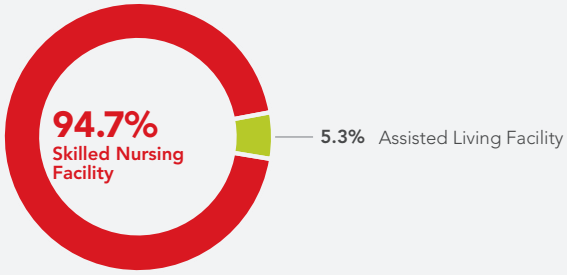
This *CareFully Speaking*® focuses on documentation of three vital elements of care: resident assessment/examination, care/service planning and team communication. It suggests a range of measures designed to enhance clarity, consistency and defensibility of resident healthcare information records or records of service, such as use of uniform staging terminology and skin evaluation formats, timely notation of comorbid conditions, creation of individualized skin care/service plans and adoption of formal communication protocols. While most of the suggestions presented here apply to all types of aging services facilities, administrators should review evolving state regulations and practice acts, which may impose setting-specific restrictions on certain service offerings and clinical practices.

A Snapshot of PI-related Claims Data

In 2021, CNA reviewed 535 aging services professional liability claims that closed between January 1, 2018 and December 31, 2020 in which the primary allegation relates to pressure injuries (PIs). Some of the major findings are summarized below:

Table 1. Distribution of Pressure Injury Closed Claims by Bed Type

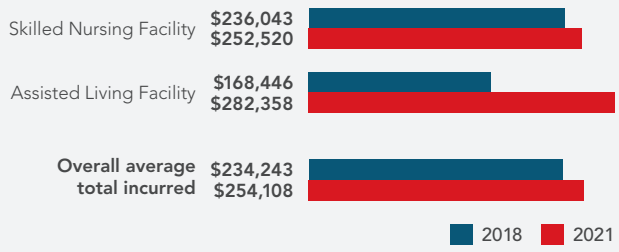
Closed Claims with Paid Indemnity of ≥ $10,000



- The majority – **94.7 percent** – of closed claims with a PI-related allegation occurred in a skilled nursing facility (SNF).
- **Although PIs are predominantly an issue for SNFs, they occur in assisted living facilities (ALFs) as well,** where an increasing number of residents prefer to "age in place," i.e., remain in a single setting over time in accordance with the facility's admission and discharge policies, as well as applicable laws and regulations.
- **In many of the ALF-based claims, a setting's services had surpassed what was permitted by state regulations** or a resident was allowed to remain in the setting despite evidence of wound progression, making the case indefensible.

Table 2. Average Total Incurred of Pressure Injury Closed Claims by Bed Type

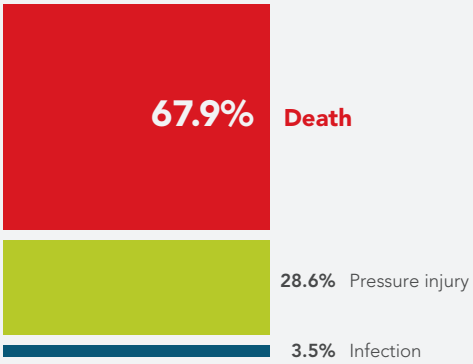
Closed Claims with Paid Indemnity of ≥ $10,000



- **The severity of PI-related claims in ALFs is on the rise,** as the average total incurred has increased by **more than 67 percent** since the 2018 dataset, surpassing the average of an SNF-based claim.

Table 3. Distribution of Pressure Injury Closed Claims by Injury Type – Assisted Living Only

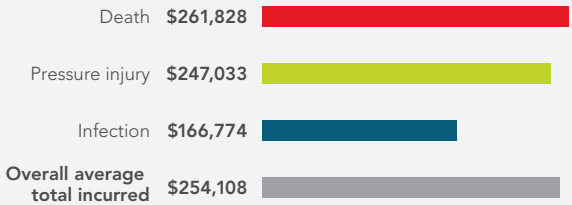
Closed Claims with Paid Indemnity of ≥ $10,000



- While PI-related claims are less prevalent in assisted living settings, **two-thirds** of the ALF closed claims involve the death of a resident, as when, due to a home health aide's failure to communicate assessment findings and treatment to ALF staff, a resident's PI progresses unnoticed, leading to sepsis and death.

Table 4. Average Total Incurred of Pressure Injury Closed Claims by Injury Type (Limited to ALF and SNF)

Closed Claims with Paid Indemnity of ≥ $10,000



- The average total incurred for PI claims in ALFs and SNFs is **$247,033**, second only to death-related claims.
- In addition to rising severity, **nursing staff exposure to PI-related claims is increasing,** as reported in the CNA Nurse Professional Liability Exposure Claim Report: 4th Edition, prepared in collaboration with the Nurses Service Organization.
- Of nurse-related closed claims, **9.2 percent** involve PIs.
- The proportion increases to **12.5 percent** when PI-related claims involving death are included in the dataset.

Resident Screening and Monitoring

CNA claim data underscore the importance of timely and methodical skin evaluation upon admission and at regular intervals thereafter.* The following practices, when governed by sound written policy, can help enhance the organization's legal defensibility in the event of a PI-related claim:

Skin assessment/examination policies. Skin assessment/examination should be treated as a continuous process, as opposed to a set of time-mandated screenings, such as those imposed by the Minimum Data Set assessment for SNFs. For all settings, a skin assessment/examination should be completed not only upon resident admission and readmission, but also following changes in condition, outside medical appointments or external visits with family.

Written policy should specify the shift and staff members responsible for performing the first comprehensive skin assessment or examination, in accordance with the type of setting and the parameters of state practice acts. Ideally, an RN should perform and document the initial assessment. Facilities that lack an RN on duty or are not required by state law to employ licensed nurses may assign the task of wound examination to non-licensed caregivers. In such situations, the examination process should be guided by formal, written parameters, with clinical findings corroborated by a licensed provider in a timely fashion. Residents at higher risk for PI development should be monitored on a daily or weekly basis, as necessary.

Wound risk screening tools. Many organizations use the Braden Scale for Predicting Pressure Sore Risk to identify and document wound risk. The Braden Scale encompasses numerous pressure injury risk factors, including impaired mobility, inadequate nutritional intake, incontinence, exposure to friction and shearing, which can occur when residents are repositioned or transferred from bed to chair. Another generally accepted screening tool is the Norton Plus Pressure Ulcer Scale.

Takeaway: Distinguish PIs from end-of-life wounds, such as Kennedy Terminal Ulcers and Trombley-Brennan Terminal Tissue Injuries, and avoid referring to the latter types as "PIs" in the record of care.

PI documentation requirements. When a wound is assessed or examined, the following six defining characteristics, among others, should be observed, documented and dated in the resident health-care information record or other record of service:

1. **Location,** i.e., buttocks, sacrum, heels, elbows, inner knees, back of head, ears or wherever else the injury first appears.
2. **Size,** i.e., the wound's length, width and depth in centimeters. Whenever possible, have the same staff member measure the wound to ensure consistency and reduce the chance of variability.
3. **Surrounding skin condition,** i.e., skin temperature and any sign of discoloration, including areas of erythema, defined as an abnormal redness of the skin or mucous membranes.
4. **Injury margins,** i.e., rolled and chronic or smooth and healing.
5. **Wound bed,** i.e., color, presence of moisture and degree of granulation. (If healing is delayed by the presence of eschar, or dead and flaky skin, this finding should be promptly documented and reported to a supervisor or medical director for manual debridement or surgical removal.)
6. **Signs of possible infection,** i.e., telltale wound color, evidence of purulent drainage, presence of a foul odor, fever, and whether the infection is localized or systemic.

Comorbidity notation. Comorbid conditions can have a major impact on PI development. Therefore, if any of the following medical risk factors (among others) are present, they should be documented during the resident assessment process:

- Peripheral vascular disease.
- Myocardial infarction.
- Stroke.
- Dementia.
- Chronic medical conditions (e.g., diabetes, renal disease, cancer, congestive heart failure).
- Gastrointestinal bleeding and/or anemia.
- Malnutrition and/or dehydration.
- Musculoskeletal disorders/fractures/contractures.
- Spinal cord injury (e.g., decreased sensory perception, muscle spasms).
- Neurological disorders (e.g., Guillain-Barré syndrome, multiple sclerosis).
- History of previous pressure injury.

* Note that some state licensed practical nurse (LPN) practice acts prohibit independent *assessment* of residents. In such jurisdictions, LPNs can be assigned to *examine* wounds and relay their findings and concerns to an RN or medical provider for verification.

End-of-life considerations. PIs also may be associated with pathophysiological processes that occur as death approaches, e.g., hemodynamic instability, tissue ischemia and/or poor blood perfusion, to name a few. Many hospice and other end-of-life residents may be unable to benefit from required preventive or therapeutic options, potentially making PI development unavoidable. Providers need to assess the unique needs of dying residents and develop individualized plans of care/service that promote comfort and reduce unnecessary pain and suffering. Here are some helpful tips:

- **Distinguish PIs from end-of-life wounds,** such as Kennedy Terminal Ulcers (KTUs) and Trombley-Brennan Terminal Tissue Injuries (TB-TTIs).
- **Avoid referring to end-of-life wounds as "PIs."** Instead, describe the wound objectively. For a list of the defining characteristics of KTUs, TB-TTIs and PIs, see Latimer, S. et al. "Defining and Describing Terminal Ulcers in Dying Adults: An Integrative Review." *Advances in Skin & Wound Care*, March 2022. (Click "Download" and scroll to Table 3.)
- **Identify wound care orders as "palliative"** in the resident's record of care or service, when appropriate.

Comorbid Conditions and Unavoidable Pressure Injuries: Five Documentation Essentials

Many pressure injuries (PIs) are due to health factors beyond the facility's control. Proving this contention in the event of litigation requires clear and comprehensive documentation, focusing on the following five areas:

1. **Relevant risk factors have been identified** and underlying clinical conditions have been thoroughly assessed.
2. **The probable cause of a wound has been determined** and documented in the record of resident care or service. (For guidance, see "Root Cause Analysis 3.0 Toolkit," issued by the National Pressure Injury Advisory Panel.)
3. **Appropriate preventive measures are implemented,** addressing the resident's noted conditions, needs and deficits, as well as his/her response, or lack thereof, to interventions.
4. **Sound wound care goals are developed** by a multidisciplinary team and reflected in a written care/service plan.
5. **The care/service plan is revised as needed** in response to clinical changes.

For additional information on unavoidable PIs, see Quick Links.

If comorbid conditions, end-of-life status or hospice placement are not noted in the record of resident care/service and marked as contributing factors to PI development, the defense team's assertion that the injury was unavoidable may not prevail in court. For tips on how to prepare a record addressing comorbidity risk, see "Comorbid Conditions and Unavoidable PIs: Five Documentation Essentials," at left.

Wound staging. Staging often receives attention in lawsuits alleging PIs. When records fail to note the reasons for changes in wound staging, the plaintiff attorney may assert that the wound progression was due solely to substandard care.

To enhance precision, clarity and legal defensibility, PIs should be identified and staged using standard criteria, such as those promulgated by the National Pressure Injury Advisory Panel (NPIAP). When a PI is present, standardized assessment guides can help staff document findings – including wound location, size, color and temperature; appearance of wound-bed tissue; presence of tunneling, undermining or drainage; and need for debridement – in a consistent manner. Staging guides and illustrations also may improve communication between staff and physicians and help ensure that interventions are prescribed and documented in a comprehensive and timely fashion.

Some facilities employ digital imagery to document skin status at the time of admission and upon reassessment. While photos can serve as a useful adjunct to written notes, disturbingly graphic and/or misleading images may diminish caregivers' credibility and inflate damage awards. For guidelines on producing more accurate and useful images, see CNA *AlertBulletin*® "Photographic Wound Documentation: Digital Imaging Guidelines Help Minimize Exposure." Republished 2017.

Resident placement. ALFs and ILFs are experiencing growing exposure to PI-related liability allegations, ranging from false advertising and improper resident placement to neglect and inappropriate resident retention. The following measures can help ensure that residents vulnerable to PIs are placed in a suitable facility, i.e., one staffed and equipped to provide safe and appropriate wound care:

- **Draft detailed admission criteria,** which clearly state the type of care provided at the facility and distinguish between acceptable and unacceptable resident conditions.
- **Review state regulations** for licensed and non-licensed staff in relation to wound assessment and care, noting who should be assigned responsibility for assessing/examining residents, reviewing findings and providing care.

- **Acknowledge the differences in staffing among SNFs, ALFs and ILFs,** and determine whether compliance with established wound care standards can be achieved at current staffing levels.
- **Screen out prospective residents with care needs that exceed organizational capabilities,** and document the suitability of newly admitted residents in accordance with state regulations.
- **Promptly evaluate at-risk residents** and implement appropriate interventions to maintain skin integrity.
- **Continually document wound care evaluations made and measures taken** in the care/service plan and primary record of resident care or service.
- **Create standardized documentation and reporting formats for use by direct home health and hospice staff,** in order to enhance clarity and consistency of communication.
- **Identify residents with non-healing wounds** and document their referral to an appropriate specialist.
- **Transfer residents to a higher level of care** if wound reassessments indicate the need.

Post-readmission evaluation. A wound evaluation must be performed upon every readmission, irrespective of how long a resident has been out of the facility. This is true for every level of care. Occasionally, when a resident is readmitted from another setting, assessment findings do not match reports from the transferring facility. In such cases, the differences should be noted in the record of resident care or service and brought to the attention of the transferring organization's medical director, in order to reconcile records and avoid the possibility of future legal contention.

Takeaway: Documentation lapses – including gaps in flow sheets and checklists, duplicate content, missing dates and inaccurate accounts of wound staging – may suggest to jury members that staff are oblivious to care protocols and indifferent to resident well-being, potentially resulting in inflated damage awards.

Care or Service Planning

An accurate, comprehensive and timely record of skin care and services can help SNF, ALF and ILF settings avoid costly lawsuits asserting negligent and substandard wound care/service. The following care/service planning tips can help strengthen a facility's defense posture in the event of legal action:

Proactive interventions. In the face of rising PI claim severity, aging services facilities of all types are encouraged to focus on prevention. The following measures, at a minimum, should be implemented:

- **Launch a prevention initiative,** first ensuring that all relevant stakeholders – including senior administration and clinicians – understand the importance of reducing the incidence of PIs and the steps they need to take to prevent them.
- **Disseminate PI-related risk assessment and best practice literature to staff members,** in order to ensure that they are prepared to act swiftly and effectively to prevent and mitigate wounds.
- **Identify at-risk residents,** focusing initially on those with diabetes or other co-morbidities, as well as conditions such as incontinence or reduced mobility.
- **Provide adequate nutrition and hydration,** as well as feeding assistance, dietary plans, food/fluid intake measurements, use of supplements and dietary consultations.
- **Emphasize skin care,** including inspection schedules, bathing routines and skin hydration protocols.
- **Educate staff on the correct placement of medical devices,** instructing them to avoid locating devices over sites of past or existing PIs, which can lead to edema in adjacent tissue.
- **Reduce pressure sources,** implementing repositioning schedules and using support surfaces for beds and chairs.
- **Use bordered foams and other prophylactic dressings,** applying them over bony areas and under medical devices.
- **Redistribute weight frequently** through use of ambulatory schedules, turning and positioning help, and utilization of devices to enable independent rising.
- **Minimize exposure to moisture** by implementing toileting plans, periodic wet/soil checks, hygiene assistance, use of protective barriers and absorbent pads, among other measures.
- **Decrease friction and shear,** employing floating heel pillows, foot cradles and protective foam at the end of beds.
- **Identify areas needing improvement,** such as ineffective PI-prevention practices, unmet documentation requirements and failure to mention risk factors in care/service plans.
- **Implement corrective action plans when necessary** and track progress made.

(A self-assessment worksheet for PI prevention issued by the Agency for Healthcare Research and Quality is available here).

General health measures. Reducing pressure injuries requires a holistic, multidisciplinary commitment to supporting residents' overall health and well-being. Care/service plans therefore should incorporate a range of general measures developed with input from residents and family members, including the following, among others:

- **Physician-ordered treatments,** e.g., dressing change intervals, topical agents and other prescribed products, reassessment time frames, drug regimens (including pain medications and antibiotics).
- **Pain management strategies,** e.g., screenings, pain medication administration schedules, reassessment parameters, observing mobility/activity levels, monitoring the effect of drugs on tissue perfusion.
- **Adaptive measures for residents with cognitive deficits,** e.g., occupational therapy consultations to determine special-need adaptations for positioning and seating.
- **Weight loss interventions,** when appropriate, e.g., educational efforts for residents and families on the link between poor nutrition and development of PIs.
- **Infection control procedures,** e.g., wound dressing schedules, assessment/examination parameters for signs and symptoms of infection, standing protocols for wound culturing.
- **Contracted care recommendations,** e.g., orders for home healthcare nurses and certified wound consultants.

Evidence-based care. PI prevention efforts should reflect evidence-based guidelines issued by recognized professional associations and organizations, such as the NPIAP and Wound, Ostomy, and Continence Nurses Society, among others. In addition, therapy should incorporate advances in wound dressings and treatment modalities, including, but not limited to, skin bioengineering, skin and tissue regeneration, biological dressings derived from skin, and oxygen and angiogenesis therapy. (For a more comprehensive review of therapeutic options, see Boyko, T. et al. "Review of the Current Management of Pressure Ulcers." *Advances in Wound Care*, February 1, 2018, volume 7:2.)

More complex cases may require the involvement of a certified wound consultant, whose findings should be captured in resident records of care or service. Absence of such documentation – especially for injuries classified as Stage 3 and above – can seriously weaken claim defense efforts. In addition, wound staging by a contracted vendor should be validated by facility staff, as the organization may be held liable if errors in staging are not addressed both in the resident record and in writing with the vendor.

Reassessment. At trial, resident care records are often scrutinized for proof of frequent and thorough reassessment. Thus, progress notes should clearly state when wounds were reassessed, in order to demonstrate compliance with the resident care/service plan. The following measures, among others, can help establish a timely and comprehensive record of ongoing wound assessment/examination and care/service:

- **Answer all prompts** on paper or electronic skin evaluation and wound care checklists or flow sheets, if they are utilized. Respond "not applicable" or "not assessed" when necessary.
- **Record all support services provided for wound care,** such as use of special mattresses or hydrotherapy sessions, and document when the therapeutics are initiated, modified and terminated.
- **Note when normal wound healing is impaired** by underlying medical conditions, nutritional deficits, non-adherence to the treatment plan and/or hospice care status.
- **Track non-healing PIs closely,** using standard assessment/examination forms and templates, such as the Pressure Ulcer Scale for Healing (PUSH).
- **Consult a wound care specialist for evaluation and treatment of slow-healing wounds** in conformity with written protocols, and document visits and findings.
- **Perform multidisciplinary assessments on challenging wound care cases,** soliciting feedback from physicians, nurses, nursing assistants, and nutritional and rehabilitation staff, among other relevant personnel, and adjust the care/service plan accordingly.

Communication

Open and ongoing communication among wound care team members, external providers, and residents and their families is an indispensable element of PI management, especially with respect to challenging cases. The following considerations, among others, should be incorporated into written communication policies and protocols:

Medical oversight. Effective treatment involves informing attending physicians of high-risk residents, promptly notifying physicians when a PI has developed or worsened, and modifying care/service plans to reflect such physician-ordered interventions as wound dressings, antibiotic therapy and pain management. All communications from and with physicians should be comprehensively documented, including date and time, in the resident care or service record.

Contracted providers. Contracted providers – including home health personnel and certified wound consultants – should document the care they provide in the record of care/service, or communicate their findings to the treatment team through another dedicated channel, such as weekly wound care rounds or resident care conferences. By doing so, they enhance coordination of care and demonstrate ongoing concern regarding the need for maintaining or escalating PI-related treatment.

Family engagement. Keeping residents and families apprised of physician involvement and care/service plan modifications often translates into higher levels of both compliance and satisfaction. By scheduling regular case planning conferences facilities can easily and efficiently relay information to relatives about PI-related care and protocols. In addition, organizations can help foster realistic expectations regarding wound healing by mandating prompt communication with loved ones about any changes in PI status.

One effective means to manage expectations and convey changes in condition is to share wound photographs with residents and family members, with the resident's consent. Such sharing can help spark discussion about wound-related issues, including the need to comply with treatment recommendations and the effect of comorbidities. (See CNA *CareFully Speaking*® 2018-Issue 2, "Strengthening Facility-Family Relationships: Transparency Is Key.")

Pressure injuries remain a major source of liability for aging services organizations. Only by implementing sound care practices supported by documentation in the areas of assessment/examination, care/service planning and team coordination can facilities help protect themselves against lawsuits involving unavoidable wounds resulting from pre-existing conditions. The suggestions included in this publication are designed to support organizational efforts to examine and enhance PI-related policies and procedures, thereby improving quality of care and reducing risk.

Takeaway: Detailed multidisciplinary documentation, especially from home health aides and wound care consultants, is critical to maintaining a comprehensive record of wound care and fostering communication among the treatment team.

Tips to Improve Wound-related Documentation

The following suggestions are designed to help organizational leaders and staff enhance PI-related documentation processes:

- **Streamline the documentation process,** offering access to standardized documentation formats at the point of care.
- **Define PI prevention and management goals for all levels of staff** and assess compliance with expectations as part of the performance review process.
- **Offer discipline-specific training opportunities,** focusing on proper use of assessment/examination tools, PI staging guidelines, notation of risk factors and care-planning essentials.
- **Ensure that staff members know how to document and report skin assessment/examination findings,** and test them on their knowledge.
- **Reinforce to staff that a PI score is a snapshot in time,** and that they should not carry forward scores without documenting supporting and current assessment/examination findings.
- **Consistently utilize an established screening instrument** and standardized skin evaluation forms and checklists.
- **Consider adopting a user-friendly PI care bundle** that provides a standardized plan of care, including care requirements and reminders of critical documentation needs.
- **Create a wound-tracking tool** to capture documentation regarding PI staging, treatment and healing.
- **Schedule weekly wound care rounds** that include, at a minimum, a nurse manager and nursing staff member (if applicable to the setting), and review wound-tracking accuracy during these rounds.
- **Never guess at the stage or depth of a wound.** If a wound is unstageable, consult a wound care specialist.
- **Refrain from loosely using the term "pressure injury,"** instead documenting what is known about the wound's origin, e.g., a skin tear, moisture-associated skin damage, venous or arterial ulceration, non-healing surgical wound.
- **When labeling a wound as "unavoidable," cite specific risk factors,** such as underlying comorbidities, previous trauma or end-of-life pathophysiology.

Common Deficiencies in Wound Care Documentation

- **Incomplete or missing initial evaluations** and reassessment.
- **Missing information,** such as reassessment dates, medication history, and physician reports and treatment orders.
- **Failure to note chronic and/or systemic conditions** and to emphasize their association with non-healing pressure injuries (PIs).
- **Lack of notation regarding past events** that may precipitate or aggravate a pressure injury, such as falls and hip fractures.
- **No record of a date of origin,** probable cause and/or growth of a PI.
- **Use of generic or vague phrases,** e.g., "*Wound healing well*" rather than "*Wound appears pink, moist and granular.*"
- **Inaccurate account of how a wound is diagnosed** as a Stage 3 or Stage 4 PI.
- **Imprecise wound measurements,** e.g., writing "nickel-sized" instead of noting the diameter in millimeters.
- **Inadequate record of support surfaces** used to alleviate pressure, such as specialty beds and mattress overlays.
- **Poorly documented infection treatment records,** including consultations, wound culture reports and antibiotic therapy.
- **Inconsistent wound photography practices,** e.g., images that lack a measurement scale, date, the resident's name and/or the wound location.
- **Duplicate content,** caused by staff members carrying forward previous assessments/examinations.

Quick Links

- "Avoidable Versus Unavoidable Pressure Ulcers (Injuries)," a position paper issued by the Wound, Ostomy, and Continence Nurses Society, 2017.
- Ayello, E. et al. "Reexamining the Literature on Terminal Ulcers, SCALE, Skin Failure, and Unavoidable Pressure Injuries." *Advances in Skin & Wound Care*, March 2019, volume 32:3.
- COVID-19 Related Resources for Pressure Injury Prevention, a listing from the National Pressure Injury Advisory Panel (NPIAP).
- "Pressure Injury Prevention Program Implementation Guide," issued by the federal Agency for Healthcare Research and Quality.
- "Prevention and Treatment of Pressure Ulcers/Injuries: Quick Reference Guide," issued by the European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance, 2019.
- "Unavoidable Pressure Injury During COVID-19 Pandemic," a position paper from the NPIAP, 2020.

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