

Pressure ulcers, negligence and litigation

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In October 2014, Health Secretary Jeremy Hunt announced: “Last year the UK NHS spent £1.3bn on payouts after being sued by patients over care errors” (BBC, 2014). Among the areas of poor patient safety highlighted by the Department of Health (DH) is the issue of bed ulcers. Mr Hunt’s words will mark the start of a poster campaign warning staff about the financial problems that basic errors can cause. The Health Secretary argues that it would be wrong to set targets or “issue a new ministerial decree” in an effort to cut out such problems — instead he favours a “cultural change” to make hospitals safer. However, this is dependent on a willingness to change. Where mitigation costs are set aside for negligence payments, and where most pressure ulcer (PU) cases are settled out of court for relatively trivial amounts, the impetus for change is low.

Peter Carter, chief executive of the Royal College of Nursing, said that the government needed to invest in more staff before patient care can be improved: “Patient falls and preventable conditions such as pressure ulcers happen when there are not enough staff on a ward to care properly for every patient, not because nurses are unaware

that these things should be prevented.” The implications of Carter’s statement are that PUs are preventable and staffing levels are the key to the problem (BBC, 2014).

These statements, combined with the ‘Duty of Candour’ proposed after the Francis Report (British Medical Association, 2013), might indicate that PUs are at last going to be taken seriously by all involved in the delivery of care in the NHS.

It has been claimed that PUs are a measure of the quality of nursing care (Casey, 2013). Healthcare-acquired PUs now merit equal ranking in patient safety as medical and surgical malpractice. As such, PUs are very costly, both to the healthcare system and to the sufferer. In financial terms, these costs are not simply for treatment; they are far more complex than that. Increasingly the cost of litigation is rising, as are the NHS ‘penalty’ charges levied for PU development (White, 2014).

The objective of this expert debate is to provide authoritative clinical and legal interpretation and opinion on healthcare-acquired PU, with a view to emphasising the implications of not instigating ‘best practice’ in the healthcare setting, hospital or community.

HUMAN COSTS

While the impact to patients and their families cannot easily be measured, Essex et al (2009) have shown PU development to result in reduced physical and mental functions, reduced vitality, and increased pain. There is no doubt whatsoever that PUs impact heavily on Quality of Life, and mortality. The published mortality rates for category IV ulcers range from 22–37% (Davies et al, 1991), of which 90% will die within four months (Bader, 1990). These are of interest when compared to out-of-court settlements for PUs arising in NHS care.

THE COST OF CARE

In 2004, it was estimated that hospital-acquired PUs cost the NHS around 2% of its budget, potentially £2.1bn (Bennett et al, 2004). Recently, Dealey et al (2012) estimated costs per episode of care and found that the mean cost for a category I ulcer was £1,214, and category IV £14,108, at 2011 costs. With the point prevalence of PUs in a typical UK acute hospital being 18–20% (Vanderwee et al, 2007), it is easy to accept total UK costs of ~£2bn as being realistic.

There has been a focus on sepsis and its high morbidity and mortality in recent years. Conservative figures identify 37,000 deaths per annum in the UK (Daniels, 2011), and many of these will stem from wounds. The mortality rates reported vary from 28% to 50%. PUs of categories III and IV give rise to sepsis, and consequently carry a high mortality rate.

EDUCATION

Nurse education, or the lack thereof, frequently plays an important part in litigation. Issues such as post-registration education for nurses are all too frequently ignored; opportunities to attend study days are lacking, and attendance is not made easy. Study days require study leave, occasionally incur course fees, as well as the costs of replacement staff, and are consequently deemed to be ‘too costly’ by those managers without concern for the possible repercussions. Most (if not all) of the legal case reports where substantial damages were awarded showed one key factor: poor documentation. It is possible that continuing education would have addressed this, among other issues. It is widely accepted that continuing education in healthcare is not only essential, but also cost-effective (Gijbels et al, 2010).

The penalties to be levied for 'poor care' in the NHS were announced last year. PU incidence is to be recorded by hospitals and community services using the NHS 'Patient Safety Thermometer', and in an effort to cut PU categories II–IV by half, penalties will be levied – i.e. cuts will be made to the full income of up to 0.125%. This will therefore cost £625,000 per annum for a £500m trust. The Patient Safety Thermometer is widely criticised among tissue viability professionals as a 'flawed tool' for its numerous failings, notably not capturing avoidable versus unavoidable PUs.

LITIGATION COSTS

The growing costs of litigation in cases where PUs are involved must be considered. Whilst most cases (80–90%) are settled out of court for approximately £20–30,000, more recent cases show a trend towards much higher settlements, in some cases as much as £1m to £3m (Lawtel, 2014). We are beginning to see a shift in the PU being perceived as an avoidable injury. It is significant that the 'pain and suffering' element of the awards is increasing, as well as the future and consequential loss component of the claim. Specialist law firms are beginning to look more closely at injury and the long-term consequences, rather than just considering a PU as an isolated event from which a recovery can be made in full. This change in interpretation is important, because the settlement values of these cases are clearly contingent on the approach taken to properly investigate and properly value the claims.

Recent policy changes emphasising the need to reduce PU incidence are encouraging, insofar as they are designed to be constructive. However, everyday experience of PU avoidance at ward level and in care homes is less optimistic. Far too many PUs arise through 'avoidable' errors and omissions, insofar as clinicians (predominantly nurses) are aware of 'best practice' but do not implement it. For the record, the following actions are deemed to

be important:

- ▶▶ Follow current NICE or EPUAP guidelines, or a local protocol – or if not, document why
- ▶▶ Use an accepted PU risk assessment tool such as Waterlow, Braden or Norton, properly and according to protocol
- ▶▶ Document all calls/conversations with a physician or nurse specialist, and also their response
- ▶▶ Follow physician instructions and document that you did
- ▶▶ Clinical changes in the patient must be recorded and reported, as appropriate
- ▶▶ Record and report any alteration in the skin. Document with an accurate description. This includes skin symptoms such as itch
- ▶▶ Document whenever the patient is repositioned or turned – and if not, why not
- ▶▶ Document any discussions you have with your patient about risks and benefits of their care
- ▶▶ A complete skin examination is required on admission and must be documented. Recommendations that claim this may be done 'up to eight hours' after admission should be ignored – it must be within two hours
- ▶▶ Determine and document any incontinence – manage and protect skin accordingly.

These are in the skin care bundles and should be well-known and widely used.

We have had ample evidence for PU avoidance and treatment available for over 30 years; there can surely now be no excuse for ignorance among clinicians.

Richard White

From a legal perspective, how does the 'avoidability' or otherwise of pressure ulceration affect the outcome?

DB: If a pressure sore is avoidable and action is not taken in a hospital or care home setting to avoid it, then it generally follows that the pressure sore was negligently

induced. The legal duty is to act in the manner recognised by a reasonable body of medical practitioners. To be identified as having acted "negligently", the actions of the practitioner would need to be ones not recognised by any body of reasonable practitioners. There is simply no body of medical practitioners that considers it reasonable to permit pressure sores to develop when action could have been taken to avoid the sore developing and/or progressing.

CBA: If claimants can form the argument that a PU was 'avoidable' then they have a valid case. The case is then built around whether interventions were implemented that could have prevented the injury from occurring. Based on the DH definition (2010), 'avoidable' means that the person receiving care developed a PU and the provider of care did not do one of the following:

- ▶▶ Evaluate the person's clinical condition and PU risk factors
- ▶▶ Plan and implement interventions that are consistent with the person's needs and goals, and recognised standards of practice
- ▶▶ Monitor and evaluate the impact of the interventions, or revise the interventions as appropriate.

If the above interventions were implemented but the patient still developed a PU, then the injury can be perceived as having been 'unavoidable'.

There are some PUs that will be deemed unavoidable; these primarily are the ones that develop as a consequence of 'skin failure'; as the skin is defined as an organ, it has the potential to 'fail' the same as any of the body's other organs. The argument for the claimant is then to prove that, as part of the evaluation of his or her clinical condition, whether this potential skin failure was taken into consideration.

FD: Interesting! Well, in theory, if a PU is avoidable then some element of the care has not been performed or documented, so that

would make the organisation responsible for the PU, and it is declared as such to the CCG. But it is difficult, because if you are the patient you still have a PU whether avoidable or unavoidable, so is then very difficult to explain to the patient and family that the PU is unavoidable.

What are the essential differences in the main risk-scoring systems from both clinical and legal perspectives?

DB: From a legal perspective, the risk-scoring system used is not that relevant. Any recognised scoring system is acceptable. The care provider is obliged to use a risk assessment system. The main issue is that one is used at all, rather than which one is used. If a pressure sore has developed and no risk assessment was undertaken, then the medical practitioners involved will be unable to explain why they decided to take no action.

CBA: Waterlow is very much more prescriptive than Braden or Norton but, because of this, it also takes into consideration more of the external factors that can contribute to PUs, such as medication and existing skin conditions. Braden and Norton rely much more on the individual clinician's clinical judgement.

From a legal perspective, the reliance on risk assessment scores can be an impediment, as focus is placed on the 'score' rather than the individual patient's needs. However, it is well recognised that risk assessments form an integral part of the patient assessment and, therefore, the completion of accurate risk assessment and re-assessment continues to form part of the evidence in a claim.

FD: Who knows? We know that no PU risk assessment tools are 100% valid or reliable (Jane Nixon and her team may start to argue this point with PURPOSE T, but I am yet to see the evidence). NICE tell us to use clinical judgement in assessing risk, but it is so difficult to quantify clinical judgement

and document it accurately. This is an area of concern for most TVNs — I know that risk assessment is often just a 'tick-box' exercise; I have real clinical scenarios to demonstrate this.

In the case of cancer patients, to what degree does cachexia and its assessment impact?

DB: There are cases where pressure sores might not be avoidable. In such cases, it is necessary for the medical practitioner to go through a hierarchy of measures. First, the practitioner must assess the risk of a pressure sore developing. If the risk exists, the practitioner must then identify the steps necessary to prevent the sore developing. A pressure sore should only be considered unavoidable where the medical condition of the patient prevents such steps being taken. Such circumstances are rare and generally involve critical care patients whose movement would endanger their health to a greater extent than the development of a pressure sore would.

CBA: When assessing the evidence in a claim, cachexia needs to be considered as a causative factor in the development of pressure injury. Equally, however, cachexia should be considered by the clinician who is assessing the risk of pressure ulceration. Just because a patient is cachexic does not mean that a PU is inevitable, merely that the risk is increased. Therefore, it comes back to good assessment, re-assessment, monitoring, and implementation of appropriate preventative measures.

FD: Again, this is difficult to say, as the PU risk assessment tools don't cover all comorbidities/conditions, so once again you are relying on the assessor to use clinical judgement. However, we do use the SCALE document clinically for end of life/skin failure. What I would say here is that end of life is not an excuse for a PU — all care needs to be delivered and documented. However, if a patient or relative refuses care

— because of pain, for example — then this is fine if the risks and benefits are explained and documented at each point of care, because the patient or relative may change their mind on this.

Do the various risk-scoring systems deal with medications that influence mobility and awareness in sufficient detail?

CBA: None of the three most common scoring systems consider these types of medications. Consequently, they can be overlooked by clinicians when they are completing their risk assessment, giving a false impression that the risk is less than it actually is. This is why these scoring systems must not be used in isolation but rather in conjunction with clinical judgement.

FD: No, they don't deal with it adequately — we as TVNs will raise awareness of the dangers in our teaching, but the risk assessment tools are generally poor in this area.

Is litigation likely to have an impact on care? If so, how?

DB: The history of litigation in repeat avoidable injuries is that litigation is a great lever for change. The history within the health service shows this quite strongly. The spike of latex glove allergy cases continued after the recognition of the problem. However, it was not until litigation resulted in compensation payments that the NHSSA decided to stop the sale of high allergen and powdered latex gloves. The accompanying spike in hand dermatitis did not result in any change in soaps and sinks. However, the payment of compensation for nursing hand dermatitis was rapidly followed by the implementation of the necessary steps to reduce those injuries — namely soft soaps, soft towels, mixed tap water at ambient temperature. Rapidly, latex allergy and hand dermatitis rates reduced. A similar history can be seen with the incidence of MRSA

and *C. difficile* infections. The rates of these infections continued to rise well after the recognition that poor hand hygiene and (in the case of *C. diff*) poor environmental hygiene were the driver of infection. However, following the litigation of these issues, hospitals acted and the rates of both infections rapidly reduced.

CBA: Litigation should have an impact on care. McIlwaine (2004) suggested that, rather than deriding a compensation culture, we should instead not be tolerating a negligence culture, or a culture that allows negligence to go unquestioned.

Rather than using litigation as a stick to beat health care with, it could be used constructively to provide lessons to be learnt. The fact that so many cases get settled on the steps of the court potentially results in there being no leverage upon the Trust to change or improve standards. It also prevents the recognition of trends.

Alternatively and more frequently, what occurs is a knee-jerk reaction to litigation, and the implementation of another 'tick-box', rather than addressing the underlying issues that resulted in the injury in the first place. That might be lack of resource (including human resource), poor knowledge, blame culture, etc.

FD: I think that UK nurses have had very little exposure to litigation, so are very much

in the denial stage — i.e. it won't happen to me. So, where this leaves us from an influence on care perspective, I am not sure. Safety Thermometer (ST) has not been written about because clinicians don't have the energy to fight it — here in the East of England, we TVNs have rallied against it since it started, but have been told time and time again by NHS Midlands and East (formerly SHA): yes, it is flawed but it is here to stay. ST is not a national CQUIN this coming financial year — just business as usual — so my guess is ST will be even more flawed in the years to come, as Trusts fail to complete. ST should never be quoted in a litigation scenario or used to judge the organisation on PU numbers. It does not look at avoidability; and a new PU to the organisation can be developed in the organisation or transferred in and remain a 'New PU' for the duration of the patient's stay, thus (potentially) counting the same PU every month. How can this accurately demonstrate an organisation's performance? Lack of or poor documentation remains a problem! In my opinion, it won't improve until we have found a way of making it easier to document, or we respond to more exposure to litigations/complaints — sadly!

What developments in PU litigation have occurred in the past year?

DB: More claims. More settlements. Nothing going close to a court room. **WUK**

REFERENCES

- Bader DL (1990) Effects of compressive loading regimens on tissue viability. In: Bader DL (ed) *Pressure Sores: Clinical Practice and Scientific Approach*. London: Macmillan
- BBC (2014) NHS errors costing billions a year — Jeremy Hunt. Available at: <http://www.bbc.co.uk/news/uk-29639383> (accessed 10.03.2015)
- Bennett G, Dealey C, Posnett J (2004) The cost of pressure ulcers in the UK. *Age Ageing* 33(3):230–5
- British Medical Association (2013) Statutory duty of candour with criminal sanctions: Briefing paper on existing accountability mechanisms. Available at: <http://bit.ly/18zPMhM> (accessed 11.03.2015)
- Casey G (2013) Pressure ulcers reflect quality of nursing care. *Nurs NZ* 19(10):20–4
- Daniels R (2011) Surviving the first hours in sepsis. *J Antimicrob Chemother* 66(Suppl 2):ii11–ii23
- Davies K, Strickland J, Lawrence V et al (1991) The hidden mortality from pressure sores. *J Tissue Viability* 1(1):18
- Dealey C, Posnett J, Walker A (2012) The cost of pressure ulcers in the United Kingdom. *J Wound Care* 21(6):261–6
- Department of Health (2010) Essence of care: Benchmarks for prevention and management of pressure ulcers. Available at: <http://bit.ly/1jxdzNm> (accessed 11.03.2015)
- Essex HN, Clark M, Sims J et al (2009) Health-related quality of life in hospital in patients with pressure ulcers. *Wound Rep Regen* 17(6):797–805
- Gijbels H, O'Connell R, Dalton-O'Connor C, O'Donovan M (2010) A systematic review evaluating the impact of post-registration nursing and midwifery education on practice. *Nurse Educ Pract* 10(2):64–9
- Lawtel (2014). PW v (1) Abertawe Bro Morgannwg University Health Board, (2) Cardiff & Vale University Local Health Board
- McIlwaine, L (2004) Tort reform and the compensation culture *Journal of Personal Injury Law* 239–49
- Reaney (2014) Reaney v University Hospital of North Staffordshire NHS Trust & Anor Available at: <http://www.bailii.org/ew/cases/EWHC/QB/2014/3016.html> (accessed 10.03.2015)
- Vanderwee K, Clark M, Dealey C et al (2007) Pressure ulcer prevalence in Europe: a pilot study. *J Eval Clin Pract* 13(2):227–35
- White RJ (2014). The true cost of pressure ulcers. *Brit J Healthcare Manag* 20(12):554–6

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