

# Are pressure ulcers an act of nursing negligence?

This article discusses whether pressure ulcers formed while a patient is a resident in a nursing home can be considered an act of nursing negligence. It considers whether pressure ulcers are preventable and whether nurses can be held accountable for their formation. In the context of increasing legal action for negligence it recommends detailed record-keeping, using clinical guidelines and keeping up to date with current clinical thinking. An ethical framework is applied which includes a discussion of prima facie obligations.

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## KEY WORDS

Elder abuse

Ethics

Accountability

Negligence

Legal issues

Many older people in nursing homes will be vulnerable to the formation of pressure ulcers. Through careful identification of risk factors and prompt interventions, care planning and evaluation, pressure ulcers can often be prevented. If they are preventable, it is debatable whether healthcare professionals should be held accountable for their formation. This article will discuss the ethical, legal and professional issues that surround pressure ulcer prevention and management.

### Pressure ulcers

A pressure ulcer is an area of localised damage to the skin and underlying tissue caused by pressure, shear and friction and/or a combination of these (European Pressure Ulcer Advisory Panel, 1998). The critical determinants

of pressure ulcer development are the intensity and duration of pressure and the tolerance for pressure of the skin and its supporting structures. Skin assessment is acknowledged to be an important aspect of pressure ulcer prevention (EPUAP, 1998). The National Institute for Health and Clinical Excellence guidelines concerning pressure ulcer prevention (NICE, 2003; 2005) suggest that skin assessment and skin care should be part of a training and education programme for all healthcare professionals.

Pressure damage is common in many healthcare settings across Europe and it affects all age groups. It is costly in terms of human suffering and use of resources. With an ageing population, and changes in patterns of sickness, problems will increase unless preventive action is taken. The risk of pressure damage should be acknowledged in all care settings. It is believed that most pressure ulcers can be prevented; although there is debate about whether a minority of ulcers are inevitable (Bliss, 2000; Fox, 2002).

In 1985 Hibbs stated that pressure ulcers were 95% preventable. Collins (2001) agrees that pressure ulcers are largely preventable and stated that nurses are integral to the promotion of good practice. Guy (2004) said that removing the factors leading to their occurrence can prevent pressure

ulcer development, although it is not always possible to remove intrinsic factors such as age, medical conditions and medication. Bennett et al (2004) highlighted that not all pressure damage can be avoided, but it is likely that the incidence can be reduced.

Pressure ulcers are a painful, debilitating and potentially serious outcome of a failure to provide sufficient nursing or medical care (Bennett et al, 2004). If pressure ulcers are preventable can nurses be considered neglectful or abusive for allowing pressure ulcers to develop?

### Abuse of older people and the nurse's responsibility to protect their patients

The abuse of older people has been given a higher public profile in recent years, prompted in part by the 1993 launch of the charity Action on Elder Abuse. Social policy, such as the *National Service Framework for Older People* (Department of Health, 2001a) and *No Secrets: Guidance on Developing and Implementing Multi-agency Policies and Procedures to Protect Vulnerable Adults from Abuse* (DoH, 1999) show the rising concern about the quality of care for vulnerable older people.

The Nursing and Midwifery Council protects the public by ensuring that nurses and midwives provide high standards of care for their patients and clients. It sets standards for education

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and practice, provides advice for nurses and midwives and considers allegations of misconduct. It has published a range of documents on standards and guidance for nurses including *The NMC Code of Professional Conduct: Standards for Conduct, Performance and Ethics* which states that nurses have a responsibility to protect clients from all forms of abuse.

A definition of elder abuse was developed in 1995 by Action on Elder Abuse. It defines elder abuse as 'a single or repeated act or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person' (Bennett et al, 2000). Abuse takes many different forms and may be physical, psychological, and verbal or manifest as neglect (Bond, 2004).

### Identifying the risk of pressure ulcer development

Knowing the common anatomical sites that are vulnerable to pressure damage and how to prevent damage occurring is part of basic nursing knowledge. Nurses have a fundamental duty to ensure the safety of patients in their care (Chamberlain-Webber, 2004), and this includes preventing the formation of pressure ulcers. Individual practitioners are accountable for the quality of pressure ulcer care that they provide or delegate to others (Dimond, 2005). Following clinical guidelines has been reported to improve the quality of care and has the potential to reduce litigation (Tingle, 1997).

Prevention consists of a risk assessment and ensuring that the patient is repositioned according to an individualised schedule. Two hours is the accepted maximum interval that tissue can tolerate pressure without damage. Prolonged immobilisation, sensory deficit, circulatory disturbances and poor nutrition have been identified as important risk factors (Edlich et al, 2004). Pressure ulcers, which were once viewed as an inevitable consequence of being infirm and bed ridden are now seen much more as an indicator of the quality of care provided and are consequently high on the political and health agenda (Stephen-Haynes, 2004).

Patients or their relatives are now more prepared to complain or take legal action for the harm that is caused and any pain and suffering experienced as a consequence of pressure ulceration.

### The legal framework in the UK

In the UK the law is derived from two sources: statute law, which is established by parliament, given royal assent and subsequently interpreted in the course of judicial processes and case law (common law), which is established by judges, the House of Lords, or the Court of Appeal, and which can set a precedent which may be a stopgap until statutes are enacted through parliament.

The law of tort is part of the civil law, which provides for the rights and duties of individuals towards each other. A tort is a civil wrong by one person against another and the law of tort allows civil action to be taken to financially compensate a person who has suffered unwarranted harm or damage. Negligence is one of the most important torts and would enable patients who have suffered foreseeable harm as a result of a nurse's carelessness to sue for compensation (Martin, 1996).

The Human Rights Act 1998 will probably have the most impact in terms of litigation regarding pressure ulceration. Indeed actions for negligence can include breaches of human rights. However, a National Audit Office report (NAO, 2003) suggested that some UK trusts have ignored human rights when dealing with complaints and there has been insufficient staff training on the issue.

Nurses have increasingly been held to account for pressure ulcers. Litigation is the process of taking legal action and involves the law of medical negligence. Many of the cases that have gone to court have highlighted poor standards of care relating to pressure ulcer prevention (McKenney, 2002).

Traditionally, the only penalties for poor treatment and pressure ulcer development have been civil lawsuits against nursing homes and hospitals. Recently, government agencies in the USA have become much more

aggressive in citing institutions as responsible for the development of pressure ulcers in their patients. A few government institutions have concluded that, in some cases, the development of ulcers that have resulted in death is so grievous that there should be criminal prosecution of the individuals and/or the institutions responsible (McKenney, 2002). This is being mirrored in the UK as cases where the cause of death is cited as a pressure ulcer are being referred to the Crown Prosecution Service.

The Law states that 'ignorance is no excuse' and nurses and doctors are under a legal duty to keep reasonably up to date in their knowledge as a fundamental part of their legal duty of care to their patients. A nurse or doctor could be negligent if a patient is harmed because of ignorance of well-accepted and well-known published nursing and medical research findings (Tingle, 2002). This would include methods of protecting the patient from pressure ulcer development.

### Legal cases

The NHS receives about 10,000 new claims for clinical negligence annually and this number is rising (Bennett et al, 2004). Some of the cases that have gone to court demonstrate appalling patient neglect and in certain cases poor pressure area care has contributed directly to the death of a patient.

#### Cropper v Liverpool NHS Trust

In the case of Cropper v Liverpool NHS Trust (1996) the plaintiff was awarded £4,500 in damages because nurses had failed to notice the development of a pressure ulcer because they had not turned the patient (Mrs Cropper) every two hours as was required.

#### Mrs Maud May Fensom v Sherwood Rise Nursing Home

Mrs Fensom died on 11th December 1994, aged 81 years. The post mortem revealed the cause of death to be pressure ulcers and inferior vena caval thrombosis. She also had severe Alzheimer's disease. The pathologist commented that there was no doubt that the presence of open pressure ulcers over the sacrum and left heel were a significant contributory factor to her death.

There was no evidence of risk assessment being conducted by the nursing home nor had there been any attempt to prevent the formation of a pressure ulcer. Pressure relief was only mentioned in the nursing-home records after tissue damage had already occurred and even then the documentation appeared to be woefully inadequate. No dietary assessment appeared to have been undertaken. The hospital consultant gave evidence that the sacral sore measured 10x12cm and had yellow sloughing areas which had been present for at least five days before she died. The sore to the heel was 8cm square with a black necrotic area.

After the inquest a legal claim for compensation was made on behalf of the estate for the unnecessary pain and suffering experienced by Mrs Fensom before her death. This was settled for the sum of £3,500 plus costs.

### Documentation

The primary reason for keeping accurate clinical records is to ensure the safety and continuity of care for individual patients. Documentation is written evidence of nursing practice and procedures (Sterling, 1996). It can be vital for demonstrating that care is of the expected standard and can protect against the risk of litigation (Tingle, 1997).

The court's approach to record-keeping tends to be that 'if it is not recorded it has not been done' (NMC, 2004). Documentation of care is an important aspect of nursing and relates to issues such as quality assurance, demonstration of standards of care, the nursing process, continuity of care, accountability, advocacy and economics (Fisbach, 1991; Marrelli, 1992).

### What documents can be seen by the patient?

The patient has a statutory right to obtain copies of his or her health records, according to the Data Protection Act 1998. However, the release of these records depends on the agreement of the patient's doctors, who may withhold them if he/she believes the patient will be harmed by reading them.

### Local guidelines

The *Essence of Care* (DoH, 2001b) states

that serious pressure ulcers graded as 3 or 4 according to the EPUAP scale should be reported via the incident reporting system in place at the organisation. The reporting of pressure ulcers is essential to help formulate district-wide policies, which are aimed at giving procedural guidance to professionals. Reporting pressure ulcer incidents allows staff to inform policy development in this area. The incidents can be scrutinised and assessed to conclude if neglect has occurred.

National guidelines for the prevention and treatment of pressure ulcers are available (NICE, 2005). Guidelines are developed to improve the quality of care, contain costs and improve communication. They are widely disseminated to nurses to encourage best practice and inform them of the current standard of care. By using clinical guidelines nurses are using evidence-based practice. However, the provision of guidelines does not remove the duty of the nurse to use his/her professional judgement and discretion. Guidelines may not be feasible or appropriate for every patient in every circumstance (McKeeney, 2002) and an assessment of the appropriateness should be made before applying the guideline and a reasonable explanation should be documented in the patient's records should the guideline not be used.

The law recognises that there is often more than one particular way to treat a patient and if a guideline is not followed it does not mean that there will be a breach of the legal duty of care (Tingle, 1997). Under some circumstances, a patient's condition may contraindicate the application of guidelines; indeed to apply them could amount to an act of negligence.

Murphy (1997) advises that practitioners must protect themselves by clearly documenting why the variation was appropriate and in the patient's best interest. This may help avoid medical negligence claims. Nurses must not discount other treatment regimens that do not follow guidelines, as the patient may request this treatment. This must be deliberated with the healthcare team and the implications discussed (Tingle, 1997).

### An ethical framework for pressure ulcer prevention

Ethics can be applied to pressure ulcer prevention. Beauchamp and Childress (2001) use the four principle theory which establish prima facie obligations:

- ▶▶ Autonomy
- ▶▶ Beneficence
- ▶▶ Non-maleficence
- ▶▶ Justice.

A prima facie obligation is one 'that must be fulfilled unless it conflicts on a particular occasion with an equal or stronger obligation. This type of obligation is always binding unless a competing moral obligation overrides or outweighs it in a particular circumstance (Beauchamp and Childress, 2001).

### Autonomy

Ethically it would be difficult to give treatment to a patient who did not want the recommended care. Obtaining consent in a variety of forms from a patient before any intervention is a guiding principle within all healthcare (McHale, 1995; Dimond, 2001). Dimond (2001) states that 'consent is the agreement by a mentally competent person, voluntarily and without deceit or fraud, to an action which without that consent would be a trespass to the person'. Patients have the right to refuse and non-compliance is not unusual (Harris, 2005). For example, when a patient at risk of pressure ulcer development has refused to use the recommended equipment. A key principle of medical ethics is that of respecting autonomy, a person's right to voluntary choice. Harris (2005) defines autonomy further as the ability of a person to control their own life — and to some extent their own destiny.

Autonomy is difficult to define as it is multi-faceted, but there are several consistent features: it is an observed human behaviour; it is a sought-after status where an individual is considered autonomous/sovereign in all decisions affecting him or herself (Jones, 1996; Madder, 1997; McParland et al, 2000). A person who understands all the relevant information about their condition, possible treatments and consequences of not having treatment, should be

able to make a decision about what treatment to have, if any.

Anecdotal evidence from care homes has shown how patient compliance with clinical guidelines can be challenging. Nurses are also autonomous practitioners but they are limited by the NMC code (2002), which states that the patient needs to be respected and involved in care decisions and that each patient's independence and uniqueness should be promoted.

Seal (2000) examined reasons for non-compliance and suggested that the idea of compliance should be replaced by the terms adherence or concordance. Using these concepts gives the patient more responsibility for their own care so that they can make informed choices about the risks and benefits of any recommended treatment.

If a patient is mentally competent it is legally impossible to insist that they comply with the recommendations of the nurse. Patients have the right to refuse any advice given, refuse any recommended treatment or the use of any specified equipment. Rights should be defined in terms of claims that demand respect (Beauchamp and Childress, 1994). This principle would also confer demand on the nurse to respect the patient's confidentiality and not divulge information about treatment to any other person without their consent. Consideration must be given to whether the patient is competent to make a decision about the particular treatment or intervention.

Although respect for confidentiality is an essential part of the nurse-patient relationship, no patient, adult, or minor has an absolute right to complete confidentiality in all circumstances. Confidentiality must be balanced against society's interest in protecting vulnerable adults from serious harm. Thus in rare cases, a breach of confidentiality may be justified.

### **Beneficence**

Beneficence, or acting in the patient's best interest, has a wider implication than simply assessing the consequences of different courses of action. Beneficence means to do good always (Hendrick, 2000).

Beauchamp and Childress (2001) define the principle as 'a moral obligation to act for the benefit of others'. In the NMC code (2002) the nurse is called to uphold and protect the patient's interests and well-being, maintain and improve his/her knowledge and competence (implicitly for the benefit of the patient) and to 'serve the interests of society'.

However, beneficence can have such a strong influence that it may lead to coercive or manipulative behaviour, which limits the patient's autonomy. The belief that there is an obligation to provide benefits is an unchallenged assumption in biomedicine: promoting the welfare of the patients — not merely avoiding harm — is the goal of healthcare and also of therapeutic research (Beauchamp and Childress, 1994).

### **Non-maleficence**

The third prima facie obligation is non-maleficence which means to do no harm (Hendrick, 2000). The nurse owes the patient a duty of care and needs to act in accordance with this duty at all times (NMC, 2002). The Bolam test determines the required standard of care which is deemed best practice at the time by other practitioners in the field. Negligence occurs when the nurse owed a duty of care, e.g when giving information, violated their duty resulting in harm to the patient (Hendrick, 2000).

### **Justice**

The final principle is that of justice. Beauchamp and Childress (2001) refer to distributive justice — the patient receiving the healthcare to which he is entitled. Wilmot (1997) argued that justice is also the right to be able to express an opinion freely and for it to be weighed, by the hearers, in an unbiased way. The NMC code (2002) requires the nurse to continue to care for patients, respecting their involvement, and not to judge whether or not the patient deserves treatment based on his/her behaviour (Wilmot, 1997).

In cases of litigation, the claimant or the defendant may use guidelines and standards to support their case. Dimond (1999) states 'it is considerably helpful to the practitioner, the patient and the

court if the profession has itself set the standards of care'. Tingle (1988) emphasises how lawyers can use clinical guidelines. This may include a lawyer using the NICE (2001; 2003; 2005) and the RCN (2000) guidelines for pressure ulcer risk assessment and prevention to establish if best practice has been implemented in specific cases.

### **Conclusion**

Although there has never been a study that proves conclusively that pressure ulcers are preventable, the author believes that, with very few exceptions, they are. The medical literature says that the key factor in the development of pressure ulcers is the risk profile. Studies have used measurement tools such as the Braden score to look at such variables as immobility and nutrition which put people at very high risk of developing pressure damage. This raises the question of whether patients in care settings who develop pressure ulcers do so because they are not receiving adequate care or because they are in a high-risk group.

Assessment is the key to the prevention of pressure ulcers and prevention will ensure the patient's cause of death is not due to pressure ulceration. Every nurse is provided with the basic information on pressure ulcer prevention and therefore these ulcers should never occur due to nursing ignorance. Each case should be carefully studied and all facts gathered. Documentation and accurate record-keeping are key to demonstrating that care is of the expected standard. Thorough documentation of the patient's assessments and instructions regarding proper positioning and repositioning, would be key evidence in a medical negligence case (McKenney, 2002).

Within the nursing home environment where 24-hour nursing care is provided, a lack of resources, such as suitable equipment or staff are not acceptable excuses for pressure ulcer development. Staffing levels may be questionable if there is not adequate staff on the shift to undertake the number of repositions required by each patient (Hampton, 2005).

Patient compliance can be challenging and they may refuse to lie on a pressure



relieving mattress preferring to sit in a chair all day. This makes it difficult for nurses to ensure that high standards are maintained. If a patient is mentally competent, it is legally impossible to insist that they comply with the recommendations of the nurse. Patients have the right to refuse any advice given and refuse any recommended treatment or specified equipment.

Dimond (1999) advises that in cases such as this the nurse must ensure four areas are covered:

- ▶▶ The patient has all the necessary information to make an informed choice
- ▶▶ All questions are honestly answered
- ▶▶ The risks of failing to comply are pointed out clearly
- ▶▶ The documentation records the actions set above.

Ethics is not a discipline in which clear-cut conclusions can be uncovered and then applied forever without further question. Ethics is always a question of degree — of deliberating over which intervention will produce the highest possible degree of mortality (Seedhouse, 1988). Loewy (1996) suggested that ethics is about asking ourselves whether something that can be done, ought or ought not to be done. This helps in the identification of ethical issues in general because it shows that they are issues about which there are no absolute right or wrong answers — merely that some answers will be considered more socially or morally acceptable than others, depending on the context.

The above analysis has highlighted the ethical and legal issues surrounding pressure ulcer prevention and management and the factors that need to be considered when working with patients who refuse to comply with treatment. Nurses should ensure that they are not guilty of negligence by addressing these issues and attempting to prevent the formation of pressure ulcers by following clinical guidelines and keeping up to date with current practice. **WUK**

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