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**MID ATLANTIC WOUND CARE CONFERENCE  
“PRESSURE SORES AND THE LAW”**

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**I. INTRODUCTION**

Litigation involving patients who have developed pressure sores has become an unpleasant reality for many health care providers. While studies produce conflicting results, the numbers of patients suffering pressure sores is staggering. In skilled nursing facilities an estimated 23% of patients suffer pressure sores.<sup>1</sup> The numbers increase dramatically with patients in high risk groups including 60% of quadriplegics suffering pressure sores.<sup>2</sup> Because most pressure ulcers are preventable these cases are often ripe for litigation.<sup>3</sup>

**II. FEDERAL AND STATE REGULATIONS**

Nursing homes are among the most heavily regulated businesses in the country. In 1987 Congress passed the Omnibus Budget and Reconciliation Act (OBRA), which along with the interpretive guidelines, spells out how nursing homes must provide for the health, medical care, and general well-being of their residents.<sup>4</sup> The regulations both generally and specifically address a nursing facility's duties to prevent and treat pressure sores.

In general a “nursing facility must provide services and activities to attain or maintain the highest practical mental and psychological well-being of each resident in accordance with a written plan of care.” Upon admitting a resident the facility must conduct a complete assessment of the resident identifying the resident's skin condition and developing an appropriate plan of care for the resident.<sup>5</sup>

The regulations impose a high standard on nursing facilities. Regarding pressure sores the facility has a duty to ensure:

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<sup>1</sup> National Pressure Ulcer Advisory Panel, *Pressure Ulcer Research: Etiology, Assessment and Early Intervention*, <http://www.npuap.org/prevmon.htm> (downloaded Sept. 2, 1999).

<sup>2</sup> *Id.*

<sup>3</sup> National Pressure Ulcer Advisory Panel, *Statement on Pressure Ulcer Prevention 1992*, <http://www.npuap.org/positn1.htm> (downloaded Sept. 2, 1999) (while most pressure sores are preventable in some terminal patients prevention methods are inconsistent with the overall plan of care).

<sup>4</sup> 42 U.S.C.A. § 1396r et seq., 42 U.S.C.A. 1395i-3 et seq., 42 C.F.R. § 483 et seq.

<sup>5</sup> Health Care Financing Administration, Requirements for States and Long Term Care Facilities, 42 C.F.R. § 483.20.

1. “A resident who enters a facility without pressure sores does not develop pressure sores unless the individual’s clinical condition demonstrates that they were unavoidable; and
2. “A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.”<sup>6</sup>

Additionally, the regulations specifically require nursing homes to provide adequate and competent staffing, provide incontinent care, and provide for the nutritional needs of their patients.<sup>7</sup> It is well known that staffing deficiencies, inadequate nutrition and inadequate incontinent care increases the chances of a patient developing pressure sores.<sup>8</sup> Therefore it is not surprising that many lawsuits against health care providers allege that these deficiencies contributed to the development of the patient’s pressure sores.

While there are no recent studies of violations of the staffing regulations in the United States, a study of long term care providers in the United Kingdom found that nursing assistants frequently are insufficiently acquainted with the risk factors for developing pressure sores.<sup>9</sup> For example 61% of respondents to the survey were unaware that most pressure sores are preventable.<sup>10</sup> One third of the respondents could not identify a single risk factor and over half of all respondents could not identify the factors correctly.<sup>11</sup> Furthermore, more than a quarter of respondents could not clearly identify what causes a pressure sore and less than half of the respondents could identify the two main areas of the body most at risk for developing pressure sores.<sup>12</sup> The study further found that an educational package including a short video and accompanying workbook raised the awareness of risk factors and increased the use of interventions to minimize risk for residents and nursing homes.<sup>13</sup>

### **III. LEGAL CONSEQUENCES FOR BREACHING DUTIES TO PREVENT AND TREAT PRESSURE SORES**

Violating the regulations and common law duties owed to patients may subject a health care provider to a myriad of legal consequences including civil lawsuits, civil penalties, and criminal penalties.

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<sup>6</sup> Health Care Financing Administration, Requirements for States and Long Term Care Facilities, 42 C.F.R. § 483.25. Virginia also specifically requires adequate staffing under its regulations. 12 VAC § 5-371-260(B).

<sup>7</sup> *Id.*

<sup>8</sup> *Id.*

<sup>9</sup> Sue Davies and Mike Nolan, *Educating Nursing Home Staff in the Reduction of Pressure Sores*, 7 BRIT. J. NURSING 144 (1998).

<sup>10</sup> *Id.* at 146.

<sup>11</sup> *Id.*

<sup>12</sup> *Id.*

<sup>13</sup> *Id.* at 150.

## A. Civil Lawsuits

To prevail in a medical malpractice suit the plaintiff generally must prove:

1. The health care provider owed a duty of care to the patient (i.e. patient-health care provider relationship);
2. The health care provider breached or violated the duty owed to the patient (i.e. the provider was negligent);
3. The patient suffered an injury; and
4. The injury was caused by the provider's breach of the duty owed to the patient.<sup>14</sup>

Although most nursing home residents and acute care patients are older and weaker than the general population, the health care provider's duty to the patient does not diminish. Under what law students call the *egg shell skull doctrine* "tortfeasors take their victims as they come."<sup>15</sup> A defendant's liability for breaching the standard of care is not avoided because the injuries would not have resulted had the plaintiff been in better health.

The mean award in nursing home negligence cases nearly doubled in the seven years following the enactment of OBRA to approximately \$525,000.<sup>16</sup> The increased awards may be due to two factors. Nursing homes are required to document injuries under OBRA so fewer injuries go unreported and plaintiffs have more information to pursue their claims. Secondly, the violation of federal law by a provider makes a verdict in favor of the plaintiff more likely.

Violating a safety statute generally constitutes negligence per se or negligence as a matter of law.<sup>17</sup> Under this doctrine, courts apply a statute, ordinance or regulation as a legislatively-mandated standard of conduct. If the legislative directive applies to the particular fact situation, the jury is not asked to determine if the defendant's conduct was reasonable. The jury only needs to consider whether the defendant violated the regulation and whether it caused the plaintiff's harm.<sup>18</sup> However, compliance with the state's minimum licensing requirements does not immunize the health care provider from liability.<sup>19</sup>

The negligence per se doctrine has not been universally applied to health care regulations. North Carolina's nursing home regulations have been found not to set the standard

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<sup>14</sup> PROSSER AND KEETON ON TORTS § 30 (West 5<sup>th</sup> Ed. 1984); *Morrison v. MacNamara*, 407 A.2d 555, 560 (D.C. 1979); *Weimer v. Hetrick*, 525 A.2d 643, 651 (Md. 1987); *Mitchell v. Parker*, 315 S.E.2d 76 (N.C. App. 1984).

<sup>15</sup> See *Landman v. Royster*, 354 F.Supp. 1302, 1315 (E.D. Va. 1973).

<sup>16</sup> Edward Felsenthal, *Jury Awards Rise for Improper Care of Elderly*, WALL ST. J., Sept. 5, 1995, at B1.

<sup>17</sup> *Dusine v. Golden Shores Convalescent Center, Inc.* 249 So.2d 40 (Fla. App. 1971). For an extensive discussion of the law of Virginia about negligence *per se* in the context of violation of federal medical device regulation, see *Talley v. Danek*, 179 F.3d 154 (4<sup>th</sup> Cir. 1999).

<sup>18</sup> Edgar and Sales, *Torts and Remedies*, § 1.05 (Negligence Per Se) (Supp. 1988).

<sup>19</sup> *Golden Villa Nursing Home, Inc. v. Smith*, 674 S.W.2d 343 (Tex. App. 1984).

of care for nursing homes since the standards are, according to one court, “so general and nebulous that a trier of fact could not determine whether the standard had been violated.”<sup>20</sup>

#### B. Civil Penalties

In addition to civil lawsuits, a violation of the statutes or regulations can subject the nursing facility and the individuals violating them to civil penalties. For example, an individual who willfully and knowingly certifies a material and false statement in a resident’s assessment is subject to penalties of up to \$1000 for each assessment. Individuals who cause another person to certify a material and false assessment are subject to penalties of up to \$5000 for each assessment under federal law.<sup>21</sup>

#### C. Criminal Penalties

Most jurisdictions impose criminal penalties for *willfully* abusing or neglecting an incapacitated adult. In Virginia the first violation may subject the offender to up to twelve months in jail and a fine of not more than \$2,500.<sup>22</sup> Subsequent offenses may subject the offender to one to five years imprisonment and a fine of up to \$2,500.<sup>23</sup> In Maryland the intentional failure to provide necessary care to a vulnerable adult may subject the offender to a fine not exceeding \$5000 and imprisonment for not more than five years.<sup>24</sup> Under North Carolina law the culpable neglect of a patient in a health care facility is a felony.<sup>25</sup>

### IV. STATE VARIATIONS ON MEDICAL MALPRACTICE CLAIMS

In addition to proving the four elements of a medical malpractice claim discussed above, most states have adopted additional procedural hurdles and/or limitations on damages that may prevent an injured patient from receiving prompt and fair compensation for his or her injuries.

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<sup>20</sup> *Makas v. Hillhaven, Inc.*, 589 F.Supp. 736, 742 (M.D. N.C. 1984).

<sup>21</sup> Health Care Financing Administration, Requirements for States and Long Term Care Facilities, 42 C.F.R. § 483.20.

<sup>22</sup> Va. Code Ann. §§ 18.2-11 and 18.2-369.

<sup>23</sup> Va. Code Ann. § 18.2-10.

<sup>24</sup> Maryland Code Ann. Art. 27, § 35E.

<sup>25</sup> N.C.G.S. § 14-32.2 (Supp. 1998).

## A. LIMITATIONS ON DAMAGES (CAPS)

### 1. District of Columbia

Washington, D.C. is unusual for mid-Atlantic jurisdictions as it does not have a statutory limitation on either compensatory damages or punitive damages. However, the courts have authority to reduce excessive verdicts.

### 2. Maryland

By statute Maryland limits a plaintiff's recovery of non-economic damages including pain, suffering, and physical impairment to \$500,000 for claims accruing after 1994. The cap has increased by \$15,000 annually beginning on October 1, 1995.<sup>26</sup> If the defendant's negligence caused the wrongful death of the decedent, damages are limited to 150% of the personal injury cap.<sup>27</sup> Maryland does not have a cap on punitive damages.

### 3. North Carolina

North Carolina does not have a statutory limitation on compensatory damages. However, punitive damages are capped at the greater of three times the compensatory damage award or \$250,000.<sup>28</sup>

### 4. Virginia

Virginia has limited a plaintiff's recovery against a health care provider since 1976. The limitation on damages was recently increased to \$1.5 million from \$1 million.<sup>29</sup> Punitive damages are limited to a maximum of \$350,000, however, the plaintiff is limited to a maximum recovery of \$1.5 million under the current cap inclusive of punitive damages.<sup>30</sup>

## B. PROCEDURAL FILING REQUIREMENTS

In recent years many states have enacted filing requirements unique to medical malpractice claims which commonly requires certificates of merit signed by a medical expert or arbitration before the case can proceed to trial.

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<sup>26</sup> Md. Code Ann., Courts and Jud. Proc. § 11-108 (Supp. 1998).

<sup>27</sup> *Id.*

<sup>28</sup> N.C. G.S. § 1D-25.

<sup>29</sup> Va. Code Ann. § 8.01-581.15 (Supp. 1999).

<sup>30</sup> Va. Code Ann. § 8.01-38.1; *see also Bulala v. Boyd*, 239 Va. 218, 389 S.E.2d 670 (1990).

1. District of Columbia

In Washington, D.C. all medical malpractice cases are filed in the civil division of the superior court and are subject to non-binding arbitration. If a party objects to the arbitrator's decision, the party must demand a trial within fifteen (15) days of the filing of the arbitrator's award.<sup>31</sup>

2. Maryland

In Maryland the plaintiff must file a claim with the Director of the Health Claims Arbitration Office.<sup>32</sup> Within 90 days of filing a claim the plaintiff must file a certificate from a qualified expert attesting that the health care provider departed from the standard of care and the departure was the proximate cause of the patient's injuries.<sup>33</sup> If the defendant disputes liability, the defendant must file a similar certificate within 120 days of the plaintiff's filing of a certificate. Maryland requires the certifying expert to devote no more than twenty percent of his time to personal injury actions.<sup>34</sup>

Either party can waive arbitration within sixty (60) days of the defendant's filing of a certificate from a qualified expert.<sup>35</sup> Additionally either party can reject an arbitration award, but evidence of the award is admissible at trial and there is a presumption at trial that the arbitration award is correct.<sup>36</sup> The burden is on the party opposing the arbitration award to prove that it was erroneous.

3. North Carolina

In North Carolina, the plaintiff must certify that a qualified expert is expected to testify that the medical care provided to the patient did not meet the applicable standard of care.<sup>37</sup>

4. Virginia

Either party may request a medical malpractice review panel, but the request must be made within thirty (30) days from the filing of responsive pleadings.<sup>38</sup> The panel members are selected by the Supreme Court of Virginia and consist of two doctors and two lawyers and is

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<sup>31</sup> D.C. Super. Ct. Civil Arb. Prog. Rules, Rule I et seq. (1997).

<sup>32</sup> Md. Code Ann., Cts. & Jud. Proc. § 3-2A-04 (Supp. 1998).

<sup>33</sup> *Id.*

<sup>34</sup> *Id.*

<sup>35</sup> Md. Code Ann., Cts. & Jud. Proc. § 3-2A-06B (Supp. 1998).

<sup>36</sup> Md. Code Ann., Cts. & Jud. Proc. § 3-2A-06 (1995).

<sup>37</sup> N.C. Gen. Stat. § 1A-1, Rules of Civ. Proc. (9)(j) (Supp. 1998).

<sup>38</sup> Va. Code Ann. § 8.01-581.2(A).

presided over by a judge from the court where the lawsuit was filed.<sup>39</sup> The decision of the panel is non-binding, but it may be introduced into evidence at trial.<sup>40</sup>

### C. STANDARD OF CARE

The standard of care refers to the level of skill, care and diligence owed to a patient by his or her health care provider.<sup>41</sup> Depending on the jurisdiction the standard of care is either a local standard based on accepted practice within the community, a statewide standard, or a national standard. Advocates for a local standard argue that disparities in education and access to advances in medicine between urban and rural health care providers requires differing standards.<sup>42</sup>

In general, expert testimony is required to prove the standard of care and to prove the defendant departed from that standard.<sup>43</sup> Only when the jury, based on its common knowledge and experience, can judge the reasonableness of the health care provider's actions and omissions or if by the nature of the injury the plaintiff could not have suffered harm but for the defendant's negligence is expert testimony unnecessary.<sup>44</sup>

#### 1. District of Columbia

The courts of Washington, D.C. have found that the challenges of practicing medicine in remote rural communities have no application to the nation's capital and a nationwide standard of care is applied in medical malpractice claims.<sup>45</sup>

#### 2. Maryland

Maryland has explicitly rejected the locality rule in favor of requiring a physician to "use the degree of care and skill which is expected of a reasonably competent practitioner in the same class to which he belongs, acting in the same or similar circumstances."<sup>46</sup>

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<sup>39</sup> Va. Code Ann. § 8.01-581.3.

<sup>40</sup> Va. Code Ann. § 8.01-581.8.

<sup>41</sup> BLACK'S LAW DICTIONARY 1404-05 (6<sup>th</sup> ed. 1990).

<sup>42</sup> *Morrison v. MacNamara*, 407 A.2d 555, 562 (D.C. 1979).

<sup>43</sup> *Smithers v. Collins*, 278 S.E.2d 286 (N.C. App. 1981); *Beverly Enters.-VA v. Nichols*, 441 S.E.2d 1 (1994) (nursing home intake assessments and how to feed a patient is within the common knowledge of the jury); *Fitzgerald v. Manning*, 679 F.2d 341, 346 (4<sup>th</sup> Cir. 1982).

<sup>44</sup> *Jackson v. Mountain Sanitarium & Asheville Agricultural School*, 67 S.E.2d 57, 61-62 (N.C. 1951); *Easterling v. Walton*, 156 S.E.2d 787 (Va. 1967) (no expert testimony required where a foreign body is left in a patient after an operation); *Beverly Enters.-VA v. Nichols*, 441 S.E.2d 1 (Va. 1994) (nursing home intake assessments and how to feed a patient is within the common knowledge of the jury); *Fitzgerald v. Manning*, 679 F.2d 341, 346 (4<sup>th</sup> Cir. 1982).

<sup>45</sup> *Morrison v. MacNamara*, 407 A.2d at 565.

<sup>46</sup> *Shilkret v. Annapolis Emergency Hospital Association*, 276 Md. 187, 200, 349 A.2d 245, 253 (1975).

3. North Carolina

In North Carolina the legislature has set the standard of care to require the plaintiff to prove:

[G]reater weight of the evidence that the care of such health care provider was not in accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities at the time of the alleged act giving rise to the cause of action.<sup>47</sup>

4. Virginia

Virginia's medical malpractice statute creates a statewide standard unless a party proves that a local standard of care would be more appropriate. The statute provides in pertinent part:

[T]he standard of care by which the acts or omissions are to be judged shall be that degree of skill and diligence practiced by a reasonably prudent practitioner in the field or specialty in this Commonwealth [of Virginia].<sup>48</sup>

## V. NOTABLE VERDICTS AND SETTLEMENTS

There are no comprehensive studies assessing the percentage of preventable pressure sores resulting in litigation. However, the databases of the Association of Trial Lawyers of America Nursing Home Litigation Group and the publication *Malpractice Verdicts and Settlements* reveal that six and seven figure settlements and verdicts are not unusual.

### A. MID-ATLANTIC CASES

In a 1990 Maryland case the family of a seventy-five year old woman settled a claim for \$560,000. The patient developed pressure sores on her legs and feet causing her to develop gangrene necessitating bilateral below the knee amputations. The plaintiff alleged that the defendants knew she was a high risk patient and they negligently failed to timely diagnose and treat her developing pressure sores.

In North Carolina a woman's estate settled a claim for \$300,000 after the decedent died from deep pressure sores and anal fistula while in the care of a nursing home. There the woman suffered from numerous medical conditions and had a life expectancy of two years before entering the nursing home. At the time she entered the home she had one small pressure sore and she was known to have a poor nutritional status. Only after she was in the nursing

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<sup>47</sup> N.C. Gen. Stat. § 90-21.12 (1990).

<sup>48</sup> Va. Code Ann. § 8.01-581.20



home for three weeks and after repeated complaints by her daughter did the treating physician examine her. When the treating physician finally examined the patient, he immediately transferred her to a hospital where she died despite receiving appropriate care in the hospital. The plaintiff sued both the treating physician and the nursing home for failing to assess and maintain her nutritional status, failing to clean the patient, and failing to involve the nursing home medical director in her care. The plaintiff relied significantly on the federal regulations pertaining to maintaining the nutritional status of nursing home patients.

A Virginia jury returned a \$1.25 million verdict for the plaintiff against a nursing home after the patient developed multiple large, foul-smelling, pus filled bedsores during a twenty-four day stay at the nursing home. The plaintiff alleged that while orders were given for decubitus care including an egg crate mattress, whirlpool baths, saline soaks, and turning every two hours, nursing home records did not indicate the care was ever given.

In another Virginia case a bed-ridden plaintiff who relied upon the defendant nursing home staff for her daily care settled her claim for \$200,000 after she developed severe pressure sores requiring surgery and extensive treatment. The plaintiff alleged that the nursing home failed to formulate a prevention strategy and failed to assess her condition.

#### B. OTHER CASES

In a recent Texas trial, the jury awarded the plaintiff \$83 million including \$70 million in punitive damages against Beverly Enterprises after an eighty-three year old resident who entered the facility alert but unable to walk died from infections from pressure sores. The plaintiff alleged that the nursing home failed to provide water due to insufficient staffing causing the decedent to suffer severe dehydration. The plaintiff introduced evidence of other medical problems at the facility and evidence of eighteen other residents who were hospitalized during the weeks before the decedent's death.

In another Texas case, the daughter of an eighty six year old woman sued her mother's nursing home after she developed Stage IV pressure sores within weeks of her admission. The daughter complained to the nursing home staff about infections on her mother's back. She was repeatedly assured that her mother's condition was improving and she was receiving the proper care. When her mother was finally taken to the hospital she had a massive Stage IV pressure sore and three additional sores. The parties settled for \$4 million in cash.

While most pressure sore lawsuits arise from nursing home injuries, a plaintiff recently was awarded \$1.13 million in New York against a hospital for failing to prevent and treat her pressure sores. The ninety-two year old woman entered the hospital with a high fever but within two weeks of hospitalization she developed stage IV pressure sores with exposure of the bone. Plaintiff alleged that the nursing staff failed to reposition the patient and keep her clean which allowed feces to enter and infect her wounds.

## VI. CONCLUSION

The staggering number of preventable pressures sores has numerous health care and legal implications. As the vast majority of pressure sores are preventable, health care providers who fail to acquaint themselves with developments in the prevention and treatment of pressure sores subject their patients to unnecessary risk of serious injury or premature death. They also subject themselves to a range of legal consequences including sizable verdicts, civil penalties, and in the most egregious cases criminal penalties. Taking prudent steps including remaining on the cutting edge of prevention and treatment options and informing themselves of legal duties is the best protection for both the patient and the provider.

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