

WOUND CARE LITIGATION

A Practical Guide to Evaluating Complex
Wound Care Cases

BBGA | BLASINGAME, BURCH,
GARRARD & ASHLEY, P.C.

WOUND CARE LITIGATION

*Understanding Pressure Ulcers, Wound
Complications, and Catastrophic Outcomes*

A Practical Guide to Evaluating
Complex Wound Care Cases

Prepared by the
BBGA Wound Care Litigation Team

BLASINGAME, BURCH, GARRARD & ASHLEY, P.C.

Disclaimer

This guide is provided for educational and informational purposes only. It is intended to offer a general overview of pressure ulcers, wound care, nursing home negligence, and litigation issues that may arise in cases involving serious wound-related injuries.

The information contained in this guide is not legal advice and should not be relied upon as a substitute for individualized legal counsel. Every case is unique, and the facts and circumstances surrounding a particular injury may significantly affect the legal issues involved.

Likewise, this guide is not intended to provide medical advice, diagnosis, or treatment recommendations. Readers should consult qualified healthcare providers regarding any medical concerns or treatment decisions.

Although this guide discusses common issues that may arise in pressure ulcer and wound care litigation, it does not address every potential legal, medical, or factual scenario. Laws, regulations, standards of care, and healthcare practices may vary by jurisdiction and may change over time.

Nothing in this guide creates an attorney-client relationship with Blasingame, Burch, Garrard & Ashley, P.C. An attorney-client relationship can only be established through a written agreement with the firm.

If you have questions about a potential wound care case, we encourage you to seek legal advice regarding your specific situation.

Foreword

Pressure ulcer cases are among the most complex cases in nursing home litigation.

Although these injuries are often viewed as an unavoidable consequence of aging, illness, or immobility, many deserve closer examination. What begins as a small area of skin breakdown can progress into infection, hospitalization, amputation, or death.

Over the course of my career, I have represented families whose loved ones suffered serious pressure ulcer injuries while residing in nursing homes and other long-term care facilities.

These cases often involve extensive medical records, complicated timelines, multiple healthcare providers, and difficult questions regarding prevention, wound management, staffing, communication, and causation.

We created this guide as a practical resource for attorneys evaluating wound care cases. The chapters that follow examine how pressure ulcers develop, how infections progress, the challenges that arise during transfers between facilities, and the catastrophic injuries that can result when wounds are not properly prevented, monitored, or treated.

While no guide can address every issue that may arise, I hope this resource provides useful insight into the medical and legal considerations that frequently appear in pressure ulcer litigation.

Evan Jones

Blasingame, Burch, Garrard & Ashley, P.C.

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Chapter One

About BBGA's
Wound Care Litigation Practice

About BBGA's Wound Care Litigation Practice

At Blasingame, Burch, Garrard & Ashley, P.C., we have devoted substantial time and resources to investigating and litigating cases involving nursing home negligence, elder abuse, medical malpractice, and catastrophic injury. Our attorneys understand that pressure ulcers are often symptoms of broader failures in prevention, monitoring, treatment, communication, or continuity of care.

Leaders in Wound Care Litigation

Evan Jones has spent years representing vulnerable individuals and families in complex healthcare litigation throughout Georgia. Alongside co-counsel, he was instrumental in obtaining one of the largest nursing home arbitration awards in Georgia history.

Throughout his career, Evan has helped secure multiple seven-figure medical malpractice recoveries, an eight-figure settlement, and a confidential \$3.2 million elder abuse settlement.

He has tried or resolved more than \$175 million in cases.

Although Evan leads many of the firm's nursing home and elder abuse matters, these cases are supported by a team of experienced trial attorneys, paralegals, nurse consultants, and litigation professionals. Pressure ulcer cases often involve extensive medical records, multiple healthcare providers, complicated medical issues, and significant damages. BBGA's collaborative approach allows the firm to devote the resources necessary to thoroughly investigate, develop, and litigate these cases successfully.

Advancing the Practice of Elder Abuse Litigation

Beyond the courtroom, BBGA remains committed to advancing the practice of elder abuse litigation. The firm hosts the [Annual Elder Abuse Litigation Seminar](#), an educational program presented in partnership with leading elder abuse attorneys from across the country.

What You Will Find in This Guide

Pressure ulcer cases often present unique challenges for attorneys. Unlike many negligence claims, wound care cases frequently involve extensive medical records, multiple healthcare providers, evolving medical complications, and difficult questions regarding causation, timing, and responsibility.

Understanding how wounds develop, progress, and are treated is often critical to evaluating liability and damages.

This guide was created as a practical resource for attorneys evaluating potential wound care claims. The chapters that follow examine pressure ulcer development, infection progression, transfers between healthcare facilities, amputation, wrongful death, and other issues commonly encountered in wound care litigation.

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Chapter Two

Pressure Ulcers as Indicators of Neglect

Why Pressure Ulcers Matter

Pressure ulcers remain one of the most significant issues encountered in nursing home litigation. Although not every pressure ulcer is preventable, these injuries often serve as important indicators of the quality of care being provided to a resident.

Unlike many medical conditions that arise despite appropriate treatment, pressure ulcers are frequently associated with issues that can be identified, monitored, and addressed through routine nursing care. As a result, the development or progression of a serious pressure ulcer often raises questions regarding prevention efforts, staffing, communication, compliance with care plans, and adherence to the applicable standard of care.

Pressure ulcers often provide insight into broader concerns regarding a facility's operations. Cases involving severe wounds frequently require examination of nursing documentation, physician orders, staffing records, risk assessments, nutritional management, infection prevention measures, and communication between healthcare providers.

The most important question is rarely whether a wound existed. The more significant question is whether appropriate measures were taken to prevent the wound from developing or worsening.

How Pressure Ulcers Develop

Pressure ulcers occur when prolonged pressure restricts blood flow to an area of the body. Without adequate circulation, skin and underlying tissue begin to break down.

These injuries most commonly develop in areas where bone lies close to the skin, including the sacrum, coccyx, hips, heels, ankles, elbows, and shoulder blades. Residents who spend extended periods in bed or in wheelchairs are particularly vulnerable because they may be unable to reposition themselves without assistance.

Several factors commonly contribute to wound development, including pressure, shear, friction, moisture, and immobility. Understanding these mechanisms is important because each presents opportunities for intervention and prevention.

Understanding Pressure Ulcer Staging

Pressure ulcers are generally classified according to the extent of tissue damage. Staging is important in litigation because it often provides insight into the severity of the injury, the likely course of treatment, and the extent of damages.

Stage I

Stage I pressure ulcers involve intact skin with persistent redness or discoloration that does not blanch when pressure is applied. Although the skin remains intact, tissue damage has already begun.

Stage II

Stage II pressure ulcers involve partial-thickness skin loss affecting the epidermis and portions of the dermis. These wounds may appear as shallow open ulcers or fluid-filled blisters.

Stage III

Stage III pressure ulcers involve full-thickness skin loss extending into subcutaneous fat. At this stage, tissue destruction becomes substantially more significant and treatment often becomes more complicated.

Stage IV

Stage IV pressure ulcers involve full-thickness tissue loss with exposure of muscle, tendon, cartilage, or bone. These wounds frequently require extensive treatment and may place the resident at significant risk for infection, hospitalization, amputation, or death.

Unstageable Pressure Ulcers

Some wounds cannot be accurately staged because the wound bed is covered by slough or eschar. Additional treatment may be required before the full extent of tissue damage can be determined.

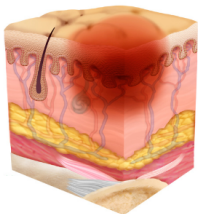
Deep Tissue Pressure Injuries

Deep tissue pressure injuries involve damage beneath the surface of the skin and may initially appear as areas of discoloration. These injuries can progress rapidly and sometimes become extensive before the full extent of tissue damage becomes apparent.

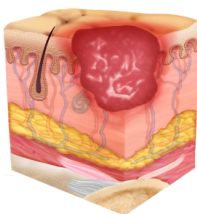
Staging should be viewed as only one part of the analysis. The timing and progression of the injury often become equally important when evaluating potential liability.

Stages of Bedsores

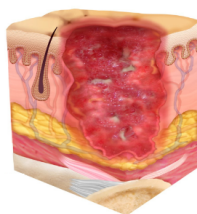
Stage 1



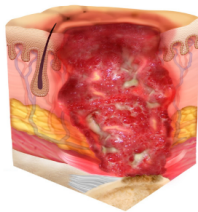
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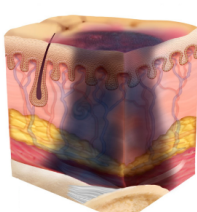
Stage 3



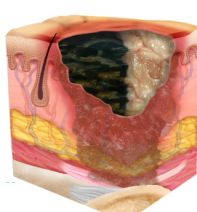
Stage 4



Deep Tissue



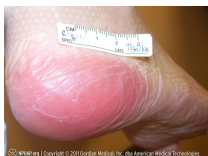
Unstageable - Slough & Eschar



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Knightime Designs

Stage 1



Stage 2



Stage 3



Stage 4



Unstageable



Residents Most at Risk

Certain residents face a significantly elevated risk of developing pressure ulcers.

Common risk factors include advanced age, limited mobility, dementia, diabetes, vascular disease, malnutrition, dehydration, recent hospitalization, significant weight loss, and chronic medical conditions.

Many residents present with multiple risk factors simultaneously. As risk factors accumulate, the importance of prevention, monitoring, and timely intervention increases.

From a litigation perspective, risk factors are important because they affect foreseeability. A resident identified as high risk may require more frequent monitoring, additional preventative measures, and increased attention from caregivers.

Prevention Begins With Risk Assessment

One of the first questions attorneys should ask when evaluating a pressure ulcer case is whether the resident was properly assessed for risk.

Long-term care facilities routinely utilize risk assessment tools to identify residents who may be vulnerable to skin breakdown. These assessments help guide care planning and determine what preventative interventions may be necessary.

The Braden Scale

The Braden Scale remains one of the most commonly used pressure ulcer risk assessment tools in healthcare settings. The assessment evaluates factors such as sensory perception, moisture, activity level, mobility, nutrition, and friction or shear.

Lower scores indicate a higher risk of pressure ulcer development and may trigger additional preventative measures, including more frequent repositioning, specialized support surfaces, nutritional interventions, and increased monitoring.

Because Braden assessments are often performed repeatedly throughout a resident's stay, they can provide valuable insight into whether staff recognized a resident's risk level and responded appropriately as conditions changed.

The Norton Scale

Some facilities utilize the Norton Scale, which evaluates physical condition, mental status, activity, mobility, and incontinence. Although less commonly encountered today than the Braden Scale, Norton assessments may still appear in medical records and serve a similar purpose in identifying residents at elevated risk.

These assessments are often important because they may establish that caregivers knew or should have known that a resident required additional preventative measures.

Prevention Is the Standard

Once a resident is identified as being at risk, prevention becomes the focus of care.

Appropriate prevention measures may include repositioning schedules, pressure-relieving mattresses or cushions, routine skin inspections, nutritional support, hydration management, wound care consultation, and individualized care planning.

The effectiveness of these interventions often becomes a central issue in litigation. A facility may document that preventative measures were ordered, but the critical question is whether those measures were actually implemented and consistently followed.

How Nursing Homes Assess Bedsore Risk

How the Braden and Norton Scales Measure Risk

Braden Scale

Most commonly used in long-term care

- Sensory perception
- Moisture
- Activity
- Mobility
- Nutrition
- Friction and shear

Norton Scale

Earlier, simpler assessment tool

- Physical condition
- Mental condition
- Activity
- Mobility
- Incontinence

These scores are documented in the medical record and used to guide care decisions.

Lower Score = Higher risk → More Frequent Care Required
Higher Score = Lower risk

Higher risk should mean stronger prevention

Ask: What is their Braden score and what care plan is in place?

When a Pressure Ulcer May Raise Concerns About Neglect

Not every pressure ulcer is the result of negligence. Some residents enter healthcare facilities with existing wounds, significant medical complications, or conditions that may impair healing despite appropriate treatment.

However, pressure ulcers often become the focus of litigation when questions arise regarding whether reasonable preventative measures were implemented and whether changes in the resident's condition were recognized and addressed appropriately.

Several circumstances frequently warrant closer examination:

Failure to Implement Preventative Measures

A facility may identify a resident as high risk for skin breakdown yet fail to consistently implement repositioning schedules, pressure-relieving devices, nutritional interventions, or other preventative measures outlined in the care plan.

In these situations, the issue is often not whether risk factors existed, but whether staff responded appropriately once those risks were recognized.

Documentation That Does Not Match Clinical Progression

In some cases, medical records may reflect that preventative measures, wound care interventions, or physician orders were consistently implemented, yet the resident's condition continues to deteriorate rapidly.

While wound progression alone does not establish that care was inadequate, significant discrepancies between the documented care and the resident's clinical course may warrant closer examination. Photographs, wound measurements, staffing records, treatment notes, and witness testimony may help determine whether documented interventions were implemented as recorded and whether additional factors contributed to the resident's decline.

Delays in Identifying Wound Progression

Pressure ulcers rarely progress from a minor skin injury to a catastrophic wound without warning signs. Changes in wound size, depth, drainage, odor, discoloration, or surrounding tissue often occur before a resident experiences serious complications. Cases may arise when those changes are not documented, communicated, or addressed in a timely manner.

Failure to Follow Physician Orders

Wound care frequently involves detailed physician orders regarding dressings, treatments, repositioning schedules, nutritional support, specialist consultation, or infection monitoring.

Failure to carry out those orders may become a significant issue when evaluating whether appropriate care was provided.

Staffing and Communication Concerns

Many pressure ulcer cases involve allegations that staffing shortages, inadequate training, poor communication, or inconsistent documentation contributed to a resident's injury. Although staffing levels alone do not establish liability, they often become relevant when evaluating whether ordered interventions were implemented consistently and whether changes in a resident's condition were recognized promptly.

Questions Attorneys Should Ask

Pressure ulcer cases often involve thousands of pages of medical records. Early case evaluation frequently benefits from focusing on several key questions.

Was the Resident Identified as High Risk?

Review admission assessments, Braden or Norton scores, care plans, and nursing documentation to determine whether caregivers recognized the resident's vulnerability to skin breakdown.

Were Preventative Measures Implemented?

Determine whether repositioning schedules, pressure-relieving devices, nutritional interventions, and skin monitoring protocols were ordered and consistently followed.

How Did the Wound Progress?

Establish a timeline documenting when the wound was first identified, how quickly it progressed, what treatments were provided, and whether changes in the resident's condition were documented, communicated, and addressed appropriately.

Were Physician Orders Followed?

Review wound care orders, treatment records, medication administration records, and nursing documentation for evidence of missed treatments or deviations from the prescribed plan of care.

Were Specialists Involved?

Consider whether wound care specialists, infectious disease physicians, surgeons, dietitians, or other consultants were involved and whether consultation occurred in a timely manner.

Are Documentation Issues Present?

Inconsistencies between assessments, photographs, wound measurements, staffing records, and treatment notes may warrant additional investigation.

Did Staffing Affect Care?

Examine staffing records, employee schedules, and facility staffing patterns when evidence suggests preventative measures were not consistently implemented.

Key Takeaways

Pressure ulcer cases often involve far more than a wound itself. They frequently require examination of risk assessments, preventative measures, care planning, staffing, communication, physician involvement, and wound progression over time.

The central issue is often whether opportunities existed to prevent, identify, or respond to a worsening condition before significant injury occurred.

A thorough review of the medical records, wound assessments, photographs, care plans, and physician documentation is often essential to determining whether the resident received appropriate care and whether the facts support further investigation.

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Chapter Three

Infected Pressure Ulcers, Sepsis, and Osteomyelitis

When Infection Changes the Case

As discussed in Chapter 2, pressure ulcers may raise important questions regarding prevention, monitoring, and compliance with the standard of care. However, many wound care cases become significantly more serious when infection develops and extends beyond the wound itself.

Once infection progresses into surrounding tissue, the bloodstream, or underlying bone, the consequences can be devastating. Residents may require hospitalization, surgical intervention, prolonged antibiotic treatment, intensive care, or amputation. In some cases, the infection ultimately proves fatal.

Understanding how infection develops and progresses is often critical to assessing liability, causation, and damages.

Pressure ulcers create an opening in the skin's protective barrier, allowing bacteria to enter the body through damaged tissue. As wounds deepen, the risk of infection increases substantially. Infection often transforms a case in several important ways.

First, it may significantly increase the severity of the resident's injuries and the medical treatment required. Second, it may create additional questions regarding whether healthcare providers recognized and responded appropriately to signs of deterioration.

Finally, infection frequently becomes a major factor in determining damages, particularly when hospitalization, surgery, amputation, or death occurs.

As a result, the timeline surrounding the development and treatment of infection often becomes one of the most important issues in wound care litigation.

How Infection Spreads

Not every infected pressure ulcer progresses to a life-threatening condition. Some infections remain localized within the wound itself and respond to treatment. Others spread beyond the wound and create far more serious complications.

The progression may occur gradually or rapidly depending upon the resident's overall health, immune function, underlying medical conditions, and the effectiveness of treatment.

Cellulitis

Cellulitis is a bacterial infection affecting the skin and underlying soft tissues surrounding a wound. Residents may develop redness, swelling, warmth, tenderness, or drainage around the affected area.

Although cellulitis is often treatable, delayed recognition or treatment may allow infection to spread into deeper tissues.

Bacteremia

Bacteremia occurs when bacteria enter the bloodstream. Once bacteria gain access to the circulatory system, infection may spread throughout the body and create additional complications.

The presence of bacteremia often raises questions regarding how long infection was present before intervention occurred and whether opportunities existed to prevent further progression.

Osteomyelitis

One of the most serious complications associated with advanced pressure ulcers is osteomyelitis, a bacterial infection of the bone.

Osteomyelitis frequently develops when a deep wound extends close to or exposes underlying bone tissue. Because blood flow to infected bone may be limited, treatment often becomes difficult and may require prolonged intravenous antibiotics, surgical debridement, or removal of infected tissue.

For many residents, osteomyelitis represents a significant turning point in the progression of a wound.

From a litigation perspective, attorneys should carefully evaluate when infection was first suspected, when diagnostic testing occurred, whether appropriate specialists were consulted, and whether treatment was initiated in a timely manner.

Cases involving osteomyelitis often require detailed review of wound assessments, imaging studies, infectious disease consultations, hospital records, and treatment timelines.

Sepsis

Sepsis is one of the most dangerous complications associated with infected pressure ulcers.

It occurs when the body's response to infection triggers widespread inflammation and organ dysfunction. Sepsis is a medical emergency that can progress rapidly and may result in septic shock, multi-organ failure, or death.

Elderly nursing home residents are often particularly vulnerable because many already suffer from chronic illnesses, weakened immune systems, diabetes, vascular disease, or other underlying medical conditions.

In many cases, the most significant liability questions involve timing.

Attorneys should examine when infection was first recognized, when physicians were notified, whether changes in the resident's condition were documented appropriately, and whether transfer to a higher level of care occurred when necessary.

Even relatively short delays may become important when evaluating whether earlier intervention could have altered the outcome.

Warning Signs Attorneys Should Look For

Medical records often contain evidence that infection was developing before a resident experienced a catastrophic outcome.

Potential warning signs may include:

- Increasing wound size or depth
- New drainage or odor
- Tissue discoloration or necrosis
- Fever or elevated temperature
- Elevated white blood cell counts
- New antibiotic orders
- Repeated hospitalizations
- Infectious disease consultations
- Discussions regarding surgical intervention
- Documentation reflecting concerns about sepsis or osteomyelitis

Identifying when these warning signs first appeared may help establish a timeline for evaluating treatment decisions and potential delays in care.

Common Liability Issues in Infection Cases

While every case is unique, several recurring issues frequently appear in litigation involving infected pressure ulcers.

Delayed Recognition of Infection

Healthcare providers may fail to recognize signs that a wound is worsening or becoming infected despite changes documented in assessments, photographs, laboratory results, or treatment records.

Delayed Physician Notification

Nurses and caregivers are often responsible for communicating significant changes in a resident's condition to physicians. Delays in notification may postpone critical treatment decisions.

Delayed Hospital Transfer

In some cases, a resident's condition deteriorates to the point that treatment within the facility is no longer appropriate. Questions often arise regarding whether transfer to a hospital occurred promptly once serious infection became apparent.

Failure to Monitor Treatment Response

The initiation of treatment does not necessarily end the inquiry. Providers must often monitor whether antibiotics, wound care interventions, or other treatments are producing the intended result.

Communication Breakdowns

Many serious wound care cases involve communication failures between nurses, physicians, specialists, hospitals, rehabilitation facilities, and nursing homes. These breakdowns may contribute to delayed diagnosis, delayed treatment, or incomplete implementation of care plans.

Questions Attorneys Should Ask

When evaluating a case involving an infected pressure ulcer, attorneys should consider several important questions:

- When was infection first documented or suspected?
- What signs or symptoms were present at that time?
- Were cultures obtained?
- When were antibiotics initiated?
- Was osteomyelitis considered or diagnosed?
- Were wound care or infectious disease specialists consulted?
- When were physicians notified of significant changes?
- Was transfer to a hospital delayed?
- Did the resident experience sepsis, organ failure, amputation, or death?
- Could earlier intervention have altered the outcome?

The answers to these questions frequently shape both liability and causation analysis.

Key Takeaways

Pressure ulcer cases often become significantly more serious when infection spreads beyond the wound itself. Osteomyelitis, bacteremia, and sepsis may dramatically increase the severity of injury and the complexity of litigation.

For attorneys evaluating these cases, the timeline of infection progression is often critical. Early warning signs, physician notification, treatment decisions, specialist involvement, and hospital transfers may all become important factors in determining whether appropriate care was provided and whether opportunities existed to prevent a catastrophic outcome.

Chapter Four

Liability After Transfers Between Healthcare Facilities

Why Transfers Create Unique Liability Questions

Pressure ulcer cases often become significantly more complicated when a resident receives care from multiple healthcare providers over the course of treatment.

A resident may move from a hospital to a rehabilitation facility, from a rehabilitation facility to a nursing home, or from a nursing home back to a hospital following a medical decline. In some cases, multiple transfers occur over a period of weeks or months.

Each transition creates new opportunities for assessment, treatment, documentation, and communication. It also creates potential disputes regarding when a pressure ulcer developed, when it worsened, and which provider was responsible for prevention and treatment at a particular point in time.

As the number of providers increases, so does the complexity of the liability analysis.

Establishing the Timeline

In many transfer cases, the timeline becomes one of the most important pieces of evidence.

Pressure ulcers often develop and progress over an extended period rather than as the result of a single event. Determining when a wound first appeared, how it changed over time, and what interventions were implemented frequently requires careful review of records from multiple facilities.

Relevant documentation may include admission assessments, Braden or Norton risk assessments, discharge summaries, wound measurements, photographs, physician orders, nursing notes, hospital records, and consultation reports.

The goal is often to reconstruct the resident's course of treatment and identify when significant changes occurred.

In many cases, liability disputes center not on whether the wound existed, but on whether the wound progressed while a particular provider was responsible for the resident's care.

Admission Assessments Matter

Admission assessments frequently become a focal point in transfer litigation.

When a resident arrives at a new facility, staff are generally expected to evaluate the resident's condition and document existing wounds, skin integrity concerns, and risk factors. These assessments often establish the baseline from which later changes are measured.

The accuracy of admission documentation can have substantial implications.

For example, if a hospital documents a Stage II pressure ulcer at discharge and the receiving facility later documents a Stage IV wound, questions may arise regarding when the progression occurred, whether the initial assessment was accurate, and whether opportunities existed to intervene before the resident's condition worsened.

Photographs, wound measurements, and detailed skin assessments may be particularly important in resolving these disputes.

Communication Failures Between Providers

Many transfer cases involve communication breakdowns between healthcare providers.

A hospital may discharge a patient with wound care instructions that are never fully implemented after admission to a nursing home or rehabilitation facility. Important physician orders may not be communicated clearly to the staff responsible for daily care. Information regarding wound progression, infection concerns, nutritional needs, or repositioning requirements may be delayed, misunderstood, or overlooked.

In some cases, the problem is not that information was unavailable. The problem is that the information was never effectively communicated or acted upon.

These failures can become especially significant when the resident's condition requires frequent monitoring or specialized wound management.

As discussed in Chapter 3, delays in recognizing or responding to deterioration may contribute to serious complications, including infection, osteomyelitis, sepsis, hospitalization, or death.

Multiple Potential Defendants

Transfer cases frequently involve multiple healthcare providers whose responsibilities overlap during different stages of treatment.

A hospital may be responsible for care before discharge. A rehabilitation facility may assume responsibility during recovery. A nursing home may provide long-term care after transfer. Physicians, wound care specialists, and consulting providers may also play important roles throughout the resident's treatment.

As a result, determining liability often requires a provider-by-provider analysis.

The critical question is not simply who treated the resident, but what each provider knew, what responsibilities existed during the relevant period, and whether reasonable steps were taken to prevent or address wound progression.

In some cases, responsibility may rest primarily with a single provider. In others, multiple parties may share responsibility for different aspects of the resident's care.

Common Defense Arguments

Several recurring defenses appear frequently in transfer litigation.

The Wound Existed Before Admission

Facilities often argue that a pressure ulcer developed before the resident arrived and therefore cannot be attributed to care provided after admission.

While this defense may be valid in some circumstances, the inquiry does not necessarily end there. Even when a wound is present upon admission, providers may still have obligations to monitor, treat, and prevent further deterioration.

A Prior Facility Was Responsible

Transfer cases often involve attempts to shift responsibility to a prior provider.

Hospitals may point to nursing homes. Nursing homes may point to hospitals. Rehabilitation facilities may argue that the injury began elsewhere.

These disputes frequently reinforce the importance of establishing a clear timeline supported by contemporaneous documentation.

The Injury Was Unavoidable

Healthcare providers sometimes contend that a resident's underlying medical conditions made pressure ulcer development unavoidable despite appropriate care.

Whether this argument is supported by the medical evidence often requires careful review of risk assessments, treatment records, wound progression, and expert analysis.

Documentation Is Incomplete

Missing records, inconsistent charting, absent photographs, and conflicting assessments are common issues in transfer cases.

These deficiencies may complicate efforts to determine precisely what occurred and often require comparison of records from multiple providers.

Questions the Documentation Should Help Resolve

When evaluating a transfer case, several questions frequently guide the investigation:

- What was documented regarding skin integrity at admission and discharge?
- When was the pressure ulcer first identified?
- How did the wound change over time?
- Were wound care orders communicated effectively during transfers?
- Were physician recommendations implemented after admission?
- Were photographs obtained at critical points in the resident's treatment?
- Did the resident miss wound care, assessments, or treatments during a transfer?
- Were specialists consulted when the wound worsened?
- Did infection develop before or after transfer?
- Which provider had responsibility during periods of documented deterioration?

Key Takeaways

Transfer cases frequently involve disputed timelines, multiple healthcare providers, and competing explanations regarding wound progression.

Key Takeaways

Establishing when a pressure ulcer developed, how it changed over time, and what information was communicated during each transfer is often essential to determining responsibility. Admission assessments, discharge records, wound documentation, photographs, physician orders, and communication between providers may all play a significant role in evaluating these claims.

A thorough chronology often becomes the foundation upon which the remainder of the case is built.

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Chapter Five

Amputation and Wrongful Death Cases

When Wound Care Cases Become Catastrophic

Not every pressure ulcer case results in a catastrophic injury. Some wounds heal with appropriate treatment and do not cause permanent harm. Others progress despite intervention due to factors beyond the control of healthcare providers.

The most significant cases often involve a different set of circumstances.

When pressure ulcers progress to severe infection, tissue destruction, hospitalization, amputation, or death, the nature of the case changes dramatically. The medical issues become more complex, the damages increase substantially, and the questions surrounding causation often become more heavily contested.

These cases frequently require careful evaluation of not only how the injury occurred, but also how the injury affected the resident's quality of life, medical treatment, and ultimate outcome.

The Path to Catastrophic Injury

As discussed in Chapter 3, advanced pressure ulcers may lead to serious complications including cellulitis, bacteremia, osteomyelitis, and sepsis.

The progression from wound development to catastrophic injury is rarely the result of a single event. More often, it reflects a series of medical decisions, treatment failures, communication issues, delays, or missed opportunities that occur over time.

When evaluating these cases, it is often helpful to identify key points at which intervention may have altered the resident's course of treatment. These events frequently become central issues in both liability and causation analysis.

Amputation Cases

Amputation is among the most devastating outcomes associated with advanced wound complications.

Although pressure ulcers do not directly cause every amputation, severe infection, tissue necrosis, vascular compromise, and osteomyelitis may contribute to circumstances in which amputation is ultimately recommended.

For elderly residents, the consequences often extend far beyond the surgical procedure itself.

Amputation may result in permanent loss of mobility, increased dependence upon caregivers, additional hospitalization, rehabilitation, chronic pain, psychological trauma, and significant reductions in quality of life.

Many residents never regain their prior level of function following a major amputation.

Causation Challenges in Amputation Cases

Amputation cases frequently involve multiple contributing factors.

Residents may have diabetes, peripheral vascular disease, kidney disease, compromised circulation, or other preexisting conditions that affect wound healing and increase the risk of limb loss.

As a result, causation often becomes a central issue.

Medical records, expert testimony, treatment timelines, vascular studies, imaging, surgical records, and infectious disease consultations may all play important roles in determining whether earlier intervention could have altered the outcome.

Damages Considerations

The damages associated with amputation cases often extend well beyond the initial hospitalization.

Attorneys should consider future medical treatment, rehabilitation needs, assistive devices, loss of independence, emotional suffering, and the long-term impact of permanent disability.

Even in cases involving elderly residents, the loss of mobility and independence may significantly affect both quality of life and damages evaluation.

Wrongful Death Cases

Some pressure ulcer cases result in the death of the resident.

The medical issues surrounding these claims are often complex. Rarely does a death certificate list a pressure ulcer as the sole cause of death. More commonly, death occurs after a series of complications involving infection, sepsis, organ failure, surgical intervention, or declining overall health.

As a result, establishing causation frequently requires careful review of the resident's medical condition before the wound developed, the progression of the wound itself, subsequent complications, and the events leading to death.

Understanding Medical Causation

Wrongful death cases often involve competing explanations regarding the resident's condition.

Defendants may argue that death resulted primarily from age, chronic illness, dementia, cardiovascular disease, cancer, or other unrelated medical conditions. Plaintiffs may contend that wound progression, infection, sepsis, or delayed treatment substantially contributed to the resident's death.

Resolving these issues frequently requires expert review and a detailed understanding of the resident's overall medical course.

Evaluating the Timeline

Chronology often becomes critical in wrongful death litigation.

The timing of wound progression, infection, hospitalization, surgical procedures, physician involvement, and end-of-life decisions may provide important insight into causation.

As discussed in Chapter 4, transfer records and documentation from multiple providers may be particularly important when a resident received treatment at several facilities before death.

Evidence Often Becomes More Important

As damages increase, so does the importance of documentation. Catastrophic injury and wrongful death cases frequently involve extensive review of:

- Wound assessments and measurements
- Photographs documenting progression
- Hospital records
- Surgical records
- Infectious disease consultations
- Laboratory results
- Diagnostic imaging
- Death certificates
- Autopsy reports, when available
- Facility policies and procedures

These records often provide the foundation for reconstructing events and evaluating both liability and causation.

Questions to Consider When Evaluating Causation

When evaluating cases involving amputation or death, several questions frequently warrant close attention:

- When did the resident's condition begin to deteriorate?
- When was infection first suspected or diagnosed?
- Were specialists consulted when appropriate?
- Was hospitalization delayed?
- What treatment options were considered?
- When was amputation recommended?
- What medical conditions contributed to the outcome?
- Could earlier intervention have prevented further deterioration?
- What role did wound progression play in the resident's death?

Key Takeaways

Catastrophic wound care cases frequently involve complex questions regarding causation, damages, and medical decision-making. Amputation and wrongful death claims often require extensive review of medical records, expert analysis, and careful reconstruction of the resident's clinical course.

While pressure ulcers may serve as the starting point, the most significant issues often involve what occurred after the wound developed, how complications progressed, and whether earlier intervention could have altered the outcome.

Understanding those issues is often essential to evaluating both liability and damages in complex wound care litigation.

Chapter Six

Evaluating a Potential Wound Care Case

Start With the Timeline

Most wound care cases are won or lost based on chronology.

Before evaluating liability, causation, or damages, attorneys should develop a clear timeline of the resident's care. Understanding when the wound first appeared, how it progressed, what treatment was provided, and when complications developed often provides the framework for the entire case.

Particular attention should be paid to transfers between facilities, changes in wound staging, signs of infection, hospitalizations, surgical procedures, and significant changes in the resident's condition.

As discussed in Chapter 4, pressure ulcer cases involving multiple providers frequently turn on documentation created during admissions, discharges, and transfers.

Obtain the Right Records Early

A limited record review rarely provides a complete picture of a wound care case.

Whenever possible, attorneys should obtain records from all providers involved in the resident's care, including hospitals, nursing homes, rehabilitation facilities, wound care specialists, and consulting physicians.

Particularly important records often include admission assessments, wound measurements, photographs, care plans, physician orders, treatment records, laboratory studies, hospital records, and discharge documentation.

Photographs are especially valuable because they frequently provide objective evidence of wound progression that may not be fully reflected in narrative charting.

Focus on Wound Progression

The existence of a pressure ulcer alone does not establish liability.

When reviewing records, attorneys should identify when the wound first appeared, whether its condition worsened over time, and whether treatment plans changed in response to documented progression.

As discussed in Chapters 2 and 3, delays in recognizing deterioration or responding to infection frequently become central issues in wound care litigation.

Evaluate the Damages Early

Significant damages often distinguish viable wound care cases from cases that may be difficult to pursue economically.

Important considerations may include hospitalization, surgical intervention, osteomyelitis, sepsis, amputation, prolonged pain, permanent disability, or death.

As discussed in Chapter 5, the most significant cases frequently involve catastrophic injuries that substantially affect a resident's quality of life or contribute to a fatal outcome.

Look for Documentation Gaps

Incomplete documentation often creates important questions regarding the care that was actually provided.

Missing wound assessments, inconsistent measurements, absent photographs, conflicting chart entries, undocumented physician notifications, and unexplained treatment delays may warrant further investigation.

Attorneys should also consider whether the documented care aligns with the resident's clinical course. In some cases, records may reflect consistent wound care interventions, repositioning, or monitoring, yet the wound continues to deteriorate significantly. While wound progression alone does not establish that care was inadequate, discrepancies between the documented care and the resident's condition may warrant closer scrutiny.

Documentation issues do not necessarily establish negligence. They may, however, help identify areas requiring additional review through depositions, expert analysis, or supplemental records requests.

Identify Potential Defendants

Some cases involve a single provider. Others involve multiple facilities, physicians, consultants, or healthcare systems.

Before making liability determinations, it is often helpful to identify who provided care during each stage of the resident's treatment and which providers were responsible during periods of documented deterioration.

The answer may not always be obvious from an initial review of the records.

Determine Whether Expert Review Is Warranted

Many wound care cases require expert analysis before liability and causation can be fully evaluated.

Expert review may help clarify whether preventative measures were appropriate, whether treatment met the applicable standard of care, whether infection was managed properly, and whether earlier intervention could have altered the outcome.

In complex cases involving multiple providers, expert review often becomes essential to understanding the medical timeline and identifying potential breaches in care.

Questions During Initial Case Evaluation

During the early stages of investigation, several questions may help guide the analysis:

- How severe was the wound?
- Did the wound worsen over time?
- Were significant complications documented?
- Did infection develop?
- Were hospitalizations required?
- Were multiple providers involved?
- Are there gaps or inconsistencies in the records?
- Did the resident suffer permanent injury or death?
- Is expert review likely to support the claim?

Key Takeaways

Successful wound care cases often depend upon careful review of medical records, accurate reconstruction of the timeline, and identification of the events that contributed to wound progression or catastrophic injury.

Early case evaluation should focus on chronology, documentation, damages, and the providers involved in the resident's care. In many cases, those factors will reveal whether additional investigation and expert review are justified.

Chapter Seven

Referring a Wound Care Case to BBGA

Referring a Wound Care Case to BBGA

Pressure ulcer and wound care cases often involve complex medical issues, extensive records, multiple healthcare providers, and challenging questions regarding liability, causation, and damages.

For attorneys who do not regularly handle nursing home negligence, elder abuse, or wound care litigation, determining whether a potential claim warrants further investigation can be difficult.

Blasingame, Burch, Garrard & Ashley, P.C. has extensive experience handling complex medical malpractice, nursing home negligence, elder abuse, and catastrophic injury cases. Our team works with attorneys throughout the country to evaluate and develop claims involving pressure ulcers, infection progression, sepsis, osteomyelitis, amputation, and wrongful death.

We structure co-counsel relationships that protect and respect the referring attorney's role in the case while providing the resources necessary to investigate and litigate complex wound care claims.

We welcome the opportunity to discuss potential wound care and pressure ulcer cases. All referral inquiries are handled confidentially.

How to Refer Us a Case

If you would like our team to review a potential bedsore or wound infection matter, you may contact us directly or submit information through our referring attorney portal.

Phone: [706-354-4000](tel:706-354-4000)

Email: cocounsel@bbga.com

Case information may also be submitted through our online referral form.

[Refer Us a Case](#)

What to Expect When Working With BBGA

We approach co-counsel relationships as true partnerships.

Depending on the needs of the case and the preferences of referring counsel, we can assume primary responsibility for investigation, expert development, discovery, motion practice, and trial preparation while maintaining regular communication throughout the litigation.

We also work collaboratively with referring attorneys who wish to remain actively involved in the case, tailoring our approach to ensure clients receive the benefit of both firms' experience and resources.

If you have questions about a potential wound care case or would like to discuss a matter confidentially, we welcome the opportunity to speak with you.

Our Team

Complex wound care cases often require collaboration among attorneys with different backgrounds and areas of experience. At Blasingame, Burch, Garrard & Ashley, P.C., our nursing home abuse and wound care litigation team works together to evaluate, investigate, and litigate cases involving pressure ulcers, infection progression, sepsis, osteomyelitis, amputation, wrongful death, and other catastrophic injuries.

Our attorneys regularly work alongside a network of qualified experts, including physicians, wound care specialists, infectious disease experts, life care planners, pathologists, nurses, certified nursing assistants, and other healthcare professionals. These relationships allow us to analyze complex medical issues, establish timelines, evaluate causation, and develop the evidence necessary to support serious injury and wrongful death claims.

We believe these cases require a thorough understanding of both the medicine and the litigation. By combining our experience across multiple practice areas with the insight of respected medical experts, we strive to provide referring attorneys and their clients with the resources necessary to pursue these challenging and important cases.



Evan Jones



Lee Atkinson



Alex Hughes



Chase Ruffin

Recent Wound Care Case Results

\$700,000

NURSING HOME NEGLIGENCE & ABUSE

A settlement for the family of a nursing home resident who developed multiple pressure ulcers following a hip fracture. Decubitus ulcers were later identified as a contributing factor in his death.

\$637,500

NURSING HOME NEGLIGENCE & ABUSE

A settlement for the family of a nursing home resident whose unstageable sacral pressure ulcer progressed to necrotizing fasciitis, requiring extensive surgical debridement before he ultimately died from septic shock.

\$600,000

NURSING HOME NEGLIGENCE & ABUSE

A settlement for the family of a nursing home resident whose Stage III-IV sacral pressure ulcer progressed to an unstageable wound, resulting in severe sepsis, gram-negative bacteremia, and her eventual death.

\$525,000

NURSING HOME NEGLIGENCE & ABUSE

A settlement for the family of a nursing home resident who developed multiple pressure ulcers, including a Stage IV wound and multiple unstageable pressure ulcers, before ultimately dying from complications related to his wounds.

\$400,000

NURSING HOME NEGLIGENCE & ABUSE

A settlement for the family of a nursing home resident whose foot injury allegedly occurred after being run over by another resident's wheelchair, resulting in gangrene, hospitalization, hospice care, and her eventual death.

Recent Wound Care Case Results

\$400,000

NURSING HOME NEGLIGENCE & ABUSE

A settlement for the family of a nursing home resident who allegedly developed multiple areas of skin breakdown and septic shock after staff failed to recognize and respond to a significant change in her condition, resulting in her death.

\$375,000

NURSING HOME NEGLIGENCE & ABUSE

A settlement for the family of a nursing home resident who suffered a hip fracture after repeated falls and later developed multiple pressure ulcers that contributed to his death.

\$320,000

NURSING HOME NEGLIGENCE & ABUSE

A settlement for the family of a nursing home resident who developed multiple pressure ulcers, including a Stage IV sacral wound, before being hospitalized with sepsis and later passing away.