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The medical community has known how to prevent the deep and dangerous wounds since the Crimean War, yet New York City nursing home residents are still plagued by them

By Kara Jillian Brown

When Karen Barrett checked her husband Ainsley into Resort Nursing Home, it was because she could no longer care for him. Alzheimers left him spacy. Diabetes caused a below-the-knee amputation, and helping her six-foot husband get around was becoming harder for the five-foot-four-inch Mrs. Barrett.

More-or-less, Mrs. Barrett said he was doing okay. He was still his jovial, kind self. He didn't go into the Queens, New York nursing home because he was on his deathbed. He just needed a little extra help.

Seven weeks into his stay, Ainsley Barrett had to be rushed to New York Community Hospital, unconscious. When Mrs. Barrett hurried there a nurse asked her, "Did you know your husband has bedsores?"

She didn't. She also didn't know that those bedsores would allow Mr. Barrett to go into septic shock, or to develop a bone infection. She didn't know that seven weeks in a nursing home would cause her husband seven months of pain. She didn't know that of all the things that could have contributed to his death, neglect would be among them.

"Somebody is supposed to see something, say something, do something," Mrs. Barrett said. "If they were taking better care by monitoring these patients, it wouldn't have gone so far."

Mr. Barrett's case is all too common in New York, NY nursing homes. Medicare data shows that the city is a hotspot for bedsores, which the CDC defines as an opening in the skin caused by prolonged pressure, typically over bony prominences, such as the elbow, heel or back of the head. They're nasty craters. Some ooze and bleed. Some expose underlying muscle all the way down to the bone. The deeper wounds can measure inches across and turn black from the rotting and stinking flesh. They cause incredible pain and open the body to deadly infection.

New York City is a hotspot for bedsores in nursing homes, according to data provided by the federal government. The Big Apple is home to nine of the 10 nursing homes in the state with the highest rates of long-stay, high-risk patients suffering from bedsores. Nationwide, those 10 nursing homes are among the worst in the nation—the top 2%—for their high bedsore rates, the data shows. Residents considered high risk are, according to Medicare, those who are impaired in bed mobility or transfer, who are comatose, or who suffer from malnutrition.

More than one out of every four residents at Resort Nursing Home, where Mr. Barrett stayed, suffered from bedsores. The facility's 26% bedsore rate is more than three times the national average of 7%. Resort did not respond for comment by the time of publication.

Jonah Bruno, a spokesperson for the state department of health, said the high rate of pressure ulcers rates might not mean the facility is providing poor care to residents.

"It is wrong to look at these numbers and assume there is problem with the quality of nursing home care in New York City," he wrote in an email. "This measure does not mean the pressure ulcers were acquired in the facility, or if they were, that it was a result of a deficiency in care."

The data does not indicate where the pressure sores were acquired. But experts say one thing is clear—they can be avoided. A 2018 study out of Switzerland states that most bedsores are preventable and are considered an important quality of care indicator. Bedsore rates are one of the 17 measures that Medicare factors into its publicly reported quality measures. Because bedsore rates are factored in among so many other factors, a home with a higher-than-average rate could still receive top rating of five stars.

Bedsores, also known as pressure ulcers, pressure sores and decubitus ulcers, are complex, explained Barbara Bates-Jensen, registered nurse and professor of nursing and medicine at the University of California, Los Angeles. They can develop in as little as an hour, she said.

"These wounds do not heal fast and so there's a tremendous amount of effort that's put forth in to heal the lesion once it's developed," she said. "Even once the ulcer heals, that tissue is never as strong as the original tissue, so they're always at risk for developing a recurrence of a pressure ulcer at that same site."

Bates-Jensen said that although bedsores can cause a lot of issues, patients and families are often unaware of them.

"Skin health is the last thing on your list of things to worry about," when admitting a loved one into a nursing home, she said. "Maybe it should be the top thing."

Karen Yap, a registered nurse and associate professor at the Duke University School of Nursing, said bedsore prevention is taught early in nursing studies. "It's all about repositioning for prevention," she said. Florence Nightingale, the founder of modern nursing, figured this out when she was caring for soldiers during the Crimean War, Yap explained.

“She understood intuitively that if we reposition people, they're less likely to get the bed sores,” Yap said. It took Nightingale two hours to make her rounds, and so the magic number was born: it is recommended for at-risk patients to be repositioned every two hours. Research has since supported the efficacy of this time interval, and Yap, along with other Duke researchers, are conducting a study to see if three or four hour intervals could be just as effective.

However, turning a patient is just one of the many factors that goes into prevention

“It's not like just one healthcare group takes care of this,” Bates-Jensen said. “It's really a whole team that manages both the person at risk for a pressure ulcer and once the ulcer exists, managing the care for that.”

Physicians, nurse practitioners, nurse aides, physical therapists, dietitians or nutritionists, and occupational therapists all play a role in bedsore prevention and care, Bates-Jensen explained. When a patient is admitted to a nursing home, staff members use something called the Braden Scale to determine their risk level for getting a bedsore and plan care.

The scale assesses a patient’s ability to detect and respond to pain and discomfort, whether they’re prone to moisture, their level of mobility, their nutritional status, and how much friction and shear (read: movement that causes the skin to move in opposition from muscle, tissues or bones) they may experience that can lead to tearing.

“For example, are they incontinent? Then you've got to be aware that they need moisture-wicking briefs,” Yap said. “If they're completely immobile, then you need to be aware when you're moving them around that around that you don't want to slide them up and stuff because their skin, you know, friction and shear on their skin can tear it.”

Petronella Manning was a resident at Resort for a month in 2015 and now her family is suing the home, alleging she did not receive proper nutrition and was severely dehydrated. These factors, among others, contributed to the pressure sores she developed, which then went untreated, her family claims.

With all the knowledge surrounding prevention, why is it that bedsores still happen? It may come down to staffing.

Bates-Jensen, who has dedicated her 30-plus-year career to studying wound care and bedsores, explained that the most basic method of prevention, turning and repositioning patients, is also the most expensive, because it involves employing enough bedside caregivers, like nurses or nurse aids.

Twenty-five nurses in the UK were interviewed as part of a small 2017 study assessing what barriers were in place that prevented bedsore prevention. The most common response was understaffing. The Long Term Care Community Coalition, a nonprofit organization dedicated to

improving the quality of care, for elderly and disabled people in nursing homes, assisted living and similar residential settings, found that for the majority of nursing homes, as the total staffing rate increases, the bedsore rate tends to decrease.

Medicare gives nursing homes an “average” quality rating for staffing if residents get between 3.5 and 4 hours a day with a healthcare provider. That aligns with a 2001 study that found 4.1 hours of nursing staff time per resident per day are needed to provide comprehensive care to the typical resident.

In an October 2019 statement delivered to the New York State Department of Health, Richard J. Mallott, director of the Long Term Care Community Coalition explained that the results of that study have served as a benchmark for the past two decades.

“While 4.1 [hours per resident per day] or higher does not guarantee high quality care or decent living conditions, staffing below 4.1 [hours per resident per day] is an indicator that a facility’s residents are at higher risk of abuse and neglect, and that the public may not be getting the level of services that we are paying the nursing home to provide” Mallott said in the statement.

Currently, the only law in New York regarding the mandated number of staff in a nursing home states that a home must have a “sufficient” number of nurses and nurse aids working, and that at least one registered professional nurse should be working for at least eight consecutive hours a day, seven days a week.

New York State is working to implement minimum staffing requirements in health care settings. Two public hearings regarding the proposal for mandated staffing requirements have been held in 2019. Bruno wrote in an email that state department of health is currently conducting a study “to examine how staffing enhancements and other initiatives could be used to improve the patient safety and the quality of care in hospitals and nursing homes.” The study is due by the end of 2019 and will be made publicly available, Bruno wrote.

Ken Covinsky, MD, a geriatric clinician-researcher explained it’s one thing to have the right staffing number, it’s another thing to retain good nurses. When advising families on which nursing homes to look at, he tells them to ask about the staff turnover rate.

“You can have such high turnover, you know, that you end up with nursing aides who are poorly trained,” Convinsky said. “There's nothing like having a team of aids that actually really know the people and know the people they're taking care of.” So if someone regularly gives Mrs. Jones a bath, he said they’ll more readily pick up on changes in skin conditions and know to pay close attention.

“In long-term care and nursing homes, generally speaking, the turnover rate from top down, like administrator down, is something like 50%,” Bates-Jensen said. “Facilities that have lower staff turnover rates, typically have lower levels of pressure ulcers.”

Dr. Robert Norman, MD, a geriatric dermatologist, explained that an increased elderly population has also put a greater strain on nursing homes. He calls the Silver Tsunami. The population distribution used to look like a triangle, he explained, with the elderly at the tip, and infants making up the bottom. Now, he said it's more like a rectangle.

This change is the result of medical advancements that have allowed us to keep people alive for longer. But now, they're dealing with ailments that cause them to be weaker, and more vulnerable.

"It used to be acute illnesses, that's what killed people, right? Yellow Fever, malaria, whatever, you name it—it was quick," Norman said. "Now, we're dealing with chronic illnesses that beat people up sort of over time, causing more and more problems."

And nursing home staff have to deal with all of those chronic issues, while also managing skin health.

"You can just have the base number of how many staff per number of patients, but it's really highly dependent on the type of patients," Covinsky said. "If you have some needs to be moved every two hours, that person is going to require a lot more staffing than somebody who's fairly mobile."

Bates-Jensen said some nursing homes also lack the technology to better prevent bedsores from happening.

"Most nursing homes are relatively low-technology environments," Bates-Jensen said . "They don't have some of the same technology that you see in an acute-care hospital."

Some of those technologies include pressure-reducing mattresses and dressings placed on high-risk areas, to monitors that can tell nurses when a patient has, or hasn't, moved themselves, and if they need more frequent repositioning. Bates-Jensen is also a co-inventor of an FDA-approved device, the SEM scanner, which allows providers to pick up damage under the skin that puts a patient at risk for developing a bedsore, before their skin turns red.

"The earliest sign of a pressure injury is really redness over a bony prominence like over your sacrum, or on your heels," Bates-Jensen said. "In persons with dark skin tones, African Americans, Hispanics, other folks, picking up that redness is very difficult—almost impossible even for experts often to pick that up. In light-skin patients, even if you pick that redness up, it's already too late, the damage has already occurred within the tissue."

A 2008 Medicare ruling made it so if a patient developed a stage two (there are four stages, stage one being the redness before an open wound) or greater bedsore in an acute care hospital, it was a patient safety issue and a medical error.

“That kind of increased attention to pressure ulcers throughout the field, both in acute-care hospitals and in other areas as well,” Bates-Jensen said. “In some areas there's been a decline. But then in other areas, it's been relatively stable, maybe a slight decline.” In the nursing home environment, she said the pressure ulcer rates have declined slightly.

Covinsky said that in some ways, bedsores are a symptom of a larger issue.

“The best care in nursing homes involves human interaction,” he said. “It's not just pressure ulcers—it’s social interaction, it's engagement, it's helping people with meals, it's helping people with activities, it's helping people with their daily functioning, it's getting people out of bed. Pressure ulcers are just the tip of the iceberg.”

Despite the reasoning for bedsores, nursing homes are required by law to do everything they can to prevent them, including promoting skin integrity, and moving patients in a way that won’t contribute to skin tears. However, David Pratt, a representative for the New York State Nurses Association, a labor union, said there’s no enforcement.

“When the [safe patient handling] law was passed, the department of health was assigned with overseeing it, but they were not given any additional funding or staff to do so,” Pratt said. “There's no consequences from the law.”

Without accountability, nursing homes are able to continue poor practices.

“[The department of health] should be shutting down, should be fining,” Pratt said. “These patients need a real advocate, and they need a strong one—it just doesn't seem like they have it.”