

LEGAL ISSUES IN THE CARE OF PRESSURE ULCER PATIENTS

The International Expert Wound Care Advisory Panel released a 23-page white paper in June 2009 identifying key concepts to help healthcare professionals with preventative legal care practices taking into consideration the current pressure ulcer regulatory and legal environment. The paper is titled “Legal Issues in the Care of Pressure Ulcer Patients: Key Concepts for Healthcare Providers.”

Lawsuits over pressure ulcers are increasingly common in both acute and long-term settings with judgments as high as \$312 million in a single case.¹ Quoting from the paper itself, “Like some pressure ulcers, litigation over pressure ulcers may be unavoidable. For this reason, knowing how to react when it occurs is no less important than knowing how to minimize the risk of pressure ulcer lawsuits themselves.”²

Read the excerpt on the next page from “Legal Issues in the Care of Pressure Ulcer Patients: Key Concepts for Healthcare Providers” for a nurse’s personal account of what happened after she was handed a subpoena to report for a deposition.

For more information and to request a copy of the entire white paper, visit Medline’s Web site at www.medline.com/whitepaper/white-paper-registration.asp.

References

1. Voss AC, Bender SA, Ferguson ML, et al. Long-term care liability for pressure ulcers. *J Am Geriatric Soc.* 2005;53:1587-1592.
2. Ayello EA, Capitulo KL, Fife CE, Fowler E, Krasner DL, Mulder G, et al. Legal issues in the care of pressure ulcer patients: key concepts for healthcare providers. White paper. June 2009.
3. Aronovitch SA. Intraoperatively acquired pressure ulcers: are there common risk factors? *Ostomy Wound Management.* 2007;53(2):57-69. Available at <http://www.o-wm.com/article/6776>. Accessed July 29, 2009.



DEPOSED: A PERSONAL PERSPECTIVE

By Evonne Fowler, MSN, RN, CWOCN

The unthinkable happened to me.

In my 46 years of nursing, I have always felt that I was a patient advocate. In fact, I have told many a patient, “If I were you, I would want me to take care of you.” I was shocked when I opened the door one evening and was handed a subpoena to report for a deposition.

One of the patients I had cared for a few years ago had brought a lawsuit against the hospital and I was implicated as one of the wound care specialists who had rendered service.

I was devastated. I have always done my best to keep patients in my charge clean, dry, comfortable and safe. So how did this happen and what does it mean for me? What would happen next?

I remembered the patient quite well. She was a very complex and difficult patient. Here’s what my review of her medical record revealed. She was a 54-year-old morbidly obese (425 lbs.) female who was admitted to the Emergency Department after three days of being febrile, unable to eat, experiencing liquid stools and being lethargic. The paramedics had been called to the home earlier, but she had refused to be taken to the hospital. Later that night, her daughter was able to persuade her to go to the Emergency Department. Her admitting diagnosis was right leg cellulitis. She had a history of multiple co-morbidities including venous disease, diabetes, morbid obesity, hypertension, chronic anemia, chronic kidney disease, asthma, and of non-adherent behavior. She had called the membership services over 100 times during her years of coverage, reporting various incidents regarding her care.

A few hours after admission, she was taken to the operating room, where she had a soft tissue incision and fasciotomy for compartment syndrome of the right leg. On post-op admission to the intensive care unit, her initial skin assessment was clear

of bruising or wounds. She developed sepsis, had an altered mental status with bouts of confusion, uncooperative behavior, lethargy, difficulty awakening and agitation; she was verbally abusive to the staff. Her hospitalization was fraught with complications, including pneumonia with subsequent need for intubation. Her behavior became combative. She pulled out the nasogastric tube and intravenous lines and had to be placed in restraints.

Eight days after admission, two pressure ulcers (Stage I and Stage II) were noted in the sacral area. As per our protocol, photographs were taken. On post op day 12, the orthopedic surgeon requested a wound care consultation for recommendations regarding the management of the open fasciotomy incision. During the skin assessment, the wound care nurse documented a 9 x 20 centimeter unstageable pressure ulcer on the sacral area, 75% black, 20% yellow, 5% red. The patient was on the bariatric air support surface.

The post-op leg wound continued to heal; however, the sacral pressure ulcer needed multiple surgical debridements. At the base of the pressure ulcer, an abscessed area was found. Once the sacral area was clean, a negative pressure wound therapy closure device was applied over the wound.

Upon discharge, she spent an additional six months in a skilled nursing facility for pressure ulcer management. Eventually, she returned home with a small open wound. Her lower leg cellulitis had extended into an eight-month saga due to the complication from the hospital-acquired pressure ulcer.

Now what?

I was a fact witness (required to help relate the specific facts of this one case) rather than expert witness (who is usually called in to offer an opinion). The hospital’s attorney represented me for the deposition. I was called by the defense and counseled not to give any opinions.

My attorney sent a file box filled with medical records for me to review. I was frustrated as I reviewed these records. Notes were handwritten, difficult to read and fragmented with different disciplines writing in various sections. Very few notes were made in the comment section of the nursing notes. Flow sheets were not completed. It was challenging to determine if the patient actually had been turned, cleansed and repositioned consistently. Although the patient was incontinent of stool, there were very few episodes of incontinence noted. Even though I remembered that she was placed on a special mattress for pressure redistribution, I was unable to determine this fact from the chart, despite the fact that a special bed was ordered on day eight.

The Deposition

The attorney for the plaintiff handed me the nurses' notes for the first seven days of the patient's hospitalization and asked me to read the Braden Score, the integumentary, neuromuscular section, turning/repositioning section of the flow sheet and the nurses' comment section. There was very little charted in any of the sections. The Braden Score showed the patient to be at high risk for pressure ulcer development. I was unable to find a plan of care in any of the files. Although the hospital had just implemented a new pressure ulcer program, none of the new forms or the pressure ulcer trending were filled out. The attorney had me go through the chart looking for documentation of instances of patient non-adherence. I was stunned at the lack of documentation by both physicians and nurses about her behavior, the skin and the pressure ulcer throughout her hospitalization.

The opposing counsel had me read my own charting for the times I had interacted with the patient and asked if the doctor had been informed consistently regarding the skin changes and wound management of the pressure ulcer. I was embarrassed with my own charting and lack of information charted. The photographs taken throughout her hospitalization were not labeled properly and were out of sequence. There were no follow-up notes to indicate the patient or family received education about pressure ulcer prevention or treatment. There also was no discharge note detailing the pressure ulcer other than the order to continue negative therapy.

Lessons Learned

Some of the common complaints registered against nurses in a lawsuit are failure to follow a standard of care, failure to communicate, failure to assess and monitor appropriately, failure to report significant findings, failure to act as a patient advocate and failure to document. That certainly applies in this case. Documentation is essential! Here are the main lessons I learned from this experience:

- On admission, it is important for the wound care specialist to assess the patient's skin and wound and write a detailed, initial, focused assessment. If a wound is present on admission, document the wound profile.
- Document the type of support surface the patient is on or whenever a support system change is ordered.
- Take a clear photograph of the wound according to your organization's guidelines. For me, that would mean using a measurement label and a black marking pen to clearly identify the patient's name or initials, medical record number, date and location of the wound on the photo.
- Review and follow the guidelines related to skin and wound care.
- Label and place the prevention protocol standing orders and, if a wound is present, the wound and skin care treatment standing orders. Complete the required sections and sign.
- Notify the physician regarding the skin/wound condition. Based on your findings, document if the wound is healable or non-healable and document the interventions for prevention and treatment of the skin/wound.
- Make sure you do a follow-up note.
- Record in the discharge note the skin and wound status.
- Remember the power of words. Pay attention to "words not to use."

*After a few months, the case was settled out of court in favor of the patient.
I hope by my sharing my own story of doing a deposition, you will gain from my pain!*

What to Do If This Happens to You²



Although finding out you are being sued can be shocking and upsetting, it is crucial to stay calm and take some simple steps to allow for the best possible results.

- Notify your institution and malpractice carrier immediately for the name of your attorney (counsel).
- DO NOT create notes on your own – separate and apart from a meeting with your lawyer. These notes could easily be discoverable in litigation.
- Avoid the temptation to talk to anyone about the case until you have discussed it with your attorney. Your attorney will likely advise you to avoid talking to colleagues about the case; this is important advice.
- Your attorneys or legal department are your resources, so ask them about terminology or procedures that are unfamiliar to you.
- As part of the litigation, you may be deposed. You can be deposed even if the case is not about you. If you face deposition, meet with your attorney first to go over the procedure and talk about the sorts of questions the other attorneys are expected to ask.
- While not all litigation goes to court, sometimes you will find your self taking the witness stand. Talk to your legal representatives before testifying in court. It is important that you understand the procedures and can go over what you likely will be asked.

Are Your Physicians Making the Grade?

A recent survey graded physicians' abilities to recognize, assess and document Stage III and IV pressure ulcers at a "D" level. Medline's new Pressure Ulcer Prevention Program MD Education CD contains everything physicians need to brush up on their skills and comply with the new CMS Inpatient Prospective Payment System (IPPS).

"The new MD Education component of Medline's Pressure Ulcer Prevention Program is critical for acute-care facilities to ensure that physicians understand their role in recognizing and accurately documenting POA pressure ulcers."

Michael Raymond, MD, Associate Chief Medical Quality Officer, NorthShore University HealthSystem, Skokie Hospital, Skokie, IL



Contact your Medline sales representative for more details. You can also learn more about Medline's Pressure Ulcer Prevention Programs for long-term care, acute care and perioperative services by visiting www.medline.com/pressureulcerprevention.