# Skin Care: Court Awards Damages To Family For Patient's Death From Decubitus Ulcers.

The US District Court for he District of Oregon awarded the family $125,000 from the US Government for the deceased's pain and suffering prior to his death from sepsis and multi-organ failure related to decubitus ulcers contracted at a Veterans Administration hospital.

In its lengthy ruling the Court reviewed in detail aspects of the legal standard of care for nurses caring for patients with skin-integrity issues.

**Nursing Assessment**

The sixty year-old patient had a history of alcoholism and smoking. He had had a triple coronary artery bypass, cardiac catheterization and a cardiac defibrillator and had hypertension, COPD, peripheral vascular disease and chronic renal failure.

His present admission was for a right lower lung lobectomy for lung cancer. After surgery he was sent to the ICU.

At this hospital the Braden Scale is used to assess each ICU patient's risk of breakdown of skin integrity. This patient's score was 20 on admission to the ICU and never fell below 14, all times at high risk.

According to the Court, decubitus ulcers are in many cases preventable and a primary method of prevention is frequent turning of the patient.

**Turning / Documentation**

The testimony in the trial was that the nurses had a practice of turning immobile patients every two hours. However, the Court was unable to find documentation on the ICU flow sheets or in the nursing progress notes of it having been done.

The day following surgery the ICU flow sheet documented the patient as "self turning" but that was the only documentation regarding skin integrity issues for a twelve-hour period. At 5:00 a.m. the next day the patient was listed as "Q2" turns, but no actual turning was documented until 1:00 p.m. that afternoon.

The Court found that the documentation in the chart was incomplete and inconsistent. From that fact the Court concluded that the patient more likely than not was not being properly repositioned every two hours as required by the standard of care for an immobile patient and by the hospital's own internal policies.

***The nursing progress notes in the chart are incomplete and internally inconsistent.***

***The nurses are permitted simply to chart "Q2" at the beginning of the shift and not document each two-hour turning of the patient, and the nurses testified that was their routine practice.***

***However, the actual practice seemed to have been to chart "Q2" at the beginning of every shift and then also to chart position changes as they occurred sporadically throughout the day.***

***The family testified he was often not repositioned every two hours.***

***In any event, once the decubitus ulcers appeared, heightened scrutiny and vigilance were required, including thorough and accurate documentation of the patient's position changes.***

***If oxygen desaturization was preventing the nurses from turning him every two hours, that should have been documented and the nurses should have requested an order to increase his oxygen prior to turning him and/or to premedicate him with anti-anxiety drugs to reduce his anxiety upon turning him.***

UNITED STATES DISTRICT COURT
OREGON
October 9, 2012

**Treatment of Decubitus Ulcers**

An at-risk patient can develop a pressure ulcer with only two to six hours of unrelieved pressure on sensitive skin, according to an experienced wound care nurse who testified as an expert witness for the family's case.

The physical therapist and a second year resident first noted a large discolored area on the buttocks and the resident ordered a wound care consult that same day. No one saw to it that a wound care specialist came in until one week later, a violation of the hospital's own internal skin-care policies.

The hospital's own policies required any change in the patient's condition with regard to decubitus ulcers be reported to the patient's attending physician, but that was not done.

An ICU nurse made a note some days later that the skin on the buttocks was continuing to deteriorate since surgery and that the patient was to be kept off his backside as much as possible. Nevertheless, later that day the patient was left lying on his back for three hours and then moved to his chair for nine hours, twelve hours of pressure bearing down on the buttocks lesions.

The wound care consult finally did come, but from a nurse who was not yet certified for wound care management who was filling in for the regular wound care nurse who was out on maternity leave.

Her assessment of the staging of the wounds was not accurate, according to the Court, and misstated the severity of what was actually going on. The physical descriptions of what she saw would place the buttocks lesions at State III or IV, while she rated them merely at Stage II.

Drainage began coming from the buttocks wounds but the ICU nurses did not actually see the wounds which were covered by creams and dressings. The nurses simply noted that the wounds were difficult to assess for that reason.

The patient began to have issues with fecal incontinence, but the care plan was not updated and nothing was done. The lab values began to show systemic infection from the infected wounds. **Delehant v. US, 2012 WL 4794147 (D. Or., October 9, 2012).**



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