Gangrenous Lesion: Nursing Home's Care Was Substandard.

A nursing home resident developed a serious pressure lesion on his hand.

There was a period of delay before the problem was reported to the resident's physician.

When the problem was reported, the physician ordered the nursing home to obtain a consultation from a wound care specialist. That call was not made for a couple of days while the wound progressed from dark red to maroon and then to black and the hand became gangrenous and mummified and had to be amputated.

The family's expert is a physician who has treated geriatric patients in nursing homes for the same and similar conditions and is qualified as an expert for this case.

COURT OF APPEALS OF TEXAS
July 3, 2014

The Court of Appeals of Texas ruled that the family's medical expert correctly stated the applicable standard of care.

Any significant change in a nursing home resident's health status must be promptly reported to the resident's physician and the physician's orders must be promptly carried out.

Management of this patient's serious skin lesion required prompt referral to a wound care specialist, just as the resident's physician had ordered, for debridement and hyperbaric oxygen treatment before the wound progressed to the point that hyperbaric treatment was not effective.

Just two days' delay while the wound went through major deterioration was completely unacceptable and more likely than not led directly to the unfortunate outcome.

There also were lapses in pressure relief and repositioning which led to the lesion's development in the first place. **Trisun Healthcare v. Lopez, 2014 WL 3050350 (Tex. App., July 3, 2014).**

Correctional Nursing: Court Sees Grounds For Inmate's Family's Lawsuit.

The jail inmate had a long history of mental illnesses including schizophrenia, schizoaffective disorder and bipolar disorder.

His sister had him involuntarily committed. Soon after his release he phoned 911 and threatened to harm himself. He also made terroristic threats which led to his incarceration in the county jail.

In the jail his medical screening revealed his recent hospitalization in a psychiatric facility coincidentally operated by the same company that provided healthcare personnel to the county jail.

Corrections officers began reporting his acting out and his strange behaviors to the jail nursing staff

The jail nurses basically saw to it that his anti-psychotic medications were on hand and were given to the corrections officers to give to him.

Nurse Never Examined the Patient

At one point the officers told the nurse he was lying on the floor of his cell in his own urine moaning and unresponsive.

The nurse's only response to increasing concerns voiced by the corrections officers about the inmate's health was a remark that, "I can't fix crazy."

Days after he was first reported lying unresponsive moaning in his cell the patient died from a cecal volvulus, a painful and ultimately fatal twisting of the large intestine which is extremely rare in otherwise healthy young adults.

Court Finds Grounds for Lawsuit

The US District Court for the Middle District of Alabama ruled there were grounds for the family's lawsuit.

The Court faulted the nurse's dismissive attitude and blamed the death on her refusal to examine the patient or obtain an examination to rule out physical illness, rather than attributing the signs displayed by the inmate simply to his mental illness.

Deliberate indifference by a medical caregiver violates a prisoner's rights. **McCall v. Houston County, 2014 WL 3045552 (M.D. Ala., July 3, 2014).**

Vomit Aspiration: Suit Alleges E.D. Nursing Neglect.

The patient was transported in an ambulance to a rural hospital's emergency department.

He was accompanied by his wife who had called 911 because he became very sick in the middle of the night.

In the emergency department the patient was left unattended lying on his back on a gurney with an O_2 mask on his face.

He threw up into the mask while the nurses were not paying attention to him. When his wife alerted the nurses to what had happened the nurses took off the oxygen mask, but they did not turn him on his side to prevent aspiration of his own vomit or do anything else to help him.

With the oxygen mask off, while still lying on his back, the patient threw up two more times. One of the nurses reportedly stepped back and exclaimed, "Eoooow" but still the patient was not turned and nothing was done to help him.

After a fourth bout of vomiting while still lying on his back the patient had to be airlifted to a regional medical center where it was confirmed he had aspirated his own vomit and contracted aspiration pneumonia. He died several days later.

The widow was required to follow procedures outlined by state law for filing a liability claim against the first hospital, which is operated by a county public hospital district.

SUPREME COURT OF WYOMING
June 23, 2014

After recounting in detail the disturbing sequence of events, the Supreme Court of Wyoming nevertheless dismissed the lawsuit the widow brought against the first hospital, on the grounds that the widow or her attorney did not file a notice of claim within the strict time limit required by Wyoming statutes with the local county public hospital district which operated the hospital. **Stroth v. North Lincoln Hosp. Dist., 327 P. 2d 121 (Wyo., June 23, 2014).**