Decubitus Ulcer: Facility Found Liable, Patient's Legal Case Supported By The Inadequacy Of The Nursing Documentation.

The elderly patient was admitted to the hospital's ICU with septic shock and adult respiratory distress syndrome. He was sedated, given a paralytic and put on a ventilator. After a while he developed a serious decubitus ulcer on his tailbone.

Four weeks later, after his condition had markedly improved, he was transferred to a rehab facility. In rehab he developed decubitus ulcers on his heels.

Two months later he was transferred from rehab to a VA hospital for treatment of the same lesion still there on his tailbone. It healed after several months.

He sued the first hospital over the tailbone lesion. The Court of Appeals of Texas approved a $240,000 jury verdict in his favor.

Skin Integrity
Legal Standard of Care

The legal focus in pressure-sore cases is whether the development or progression of a skin lesion was avoidable, or was unavoidable because of the patient's medical condition despite caregivers being able to show that all necessary care and treatment for skin integrity was given to the patient.

The ICU records contained no documentation that the nurses carried out any interventions that would have prevented the pressure lesion from getting worse after it was discovered.

The physician should have been notified at once when a small skin tear on the tailbone was first seen. The physician was not told until the next day.

The physician ordered a wound-care nurse consult and a special bed. The only follow up to the physician's orders was the wound care nurse coming in three days later. By then they were dealing with a serious decubitus ulcer.

Further, there was no documentation that the wound-care nurse's orders had been transcribed into the care plan or were being implemented.

COURT OF APPEALS OF TEXAS
July 21, 2006

Nursing Standard of Care
Documentation Lacking

The court went over in detail and endorsed the testimony of the patient's nursing expert witness.

Skin assessment and pressure relief should be provided every two hours. Every two hours there should be documentation of pressure relief or a progress note that it was attempted but not performed.

Ways to provide pressure relief include turning the patient, or repositioning the patient with use of pillows or foam wedges to protect bony prominences if the patient will not tolerate a full turn.

If the patient cannot be turned, the nurses must fully document why. An example might be a drop in blood pressure or change in heart rate or difficulty breathing in a certain position. The purpose of such documentation is to communicate the patient's status to other members of the healthcare team, above and beyond its obvious importance if a lawsuit resulted.

Proper assessment of a wound includes a verbal description that will allow anyone reading it to draw a mental picture of exactly what the nurse saw. Charting should note color, location, size, depth, presence or absence of infection and whether tissue was dead or perfused.

Absence of documentation in the chart leads to only one conclusion, that care was not performed, and failure to provide care is negligence, the court said. **Columbia Medical Center v. Meier, __ S.W. 3d __, 2006 WL 2036574 (Tex. App., July 21, 2006).**