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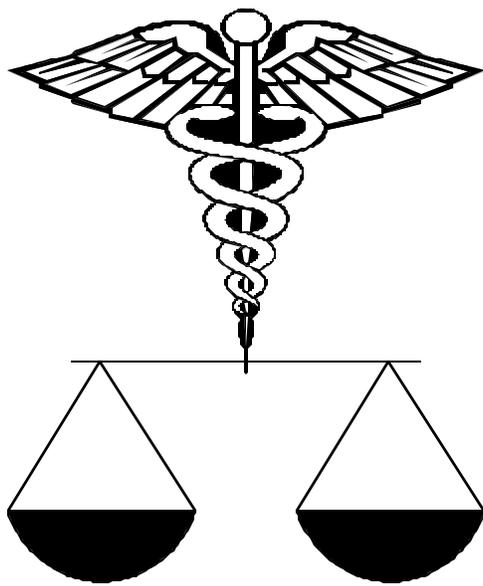
Pressure Sores: Court Case Points Out Importance Of Nursing Documentation.

A recent case from the Court of Appeals of Georgia pointed out the legal importance of accurate and thorough nursing documentation.

The court's ruling came in a civil professional negligence lawsuit against a hospital's skilled nursing facility, filed by the family of a now-deceased patient who had undergone a below-the-knee amputation of her left leg for a problem which allegedly originated as a pressure sore on her heel.

The patient had an area of redness on her sacrum when she came to the nursing facility. It was carefully examined and documented in the acute-care nursing notes when the patient was transferred to skilled nursing care, and it was carefully documented again when the patient was sent home after a month in the skilled nursing unit.

As to the patient's sacrum, none of the expert witnesses called to testify on either side of the lawsuit could say that this bedsore was any worse when the patient left the skilled nursing unit than when she came in. The court concluded from the nursing documentation of the sacral area that there was no nursing negligence in the care given to this area of the patient's body, and no damages were awarded to the family.



Elderly patients with poor circulation are at high risk for developing pressure sores.

When a patient at-risk for pressure sores is discharged from nursing care, the heels, buttocks and other areas should be examined carefully.

A nursing note should be made whether or not pressure sores are found.

COURT OF APPEALS OF GEORGIA, 1997.

However, there was no documentation one way or the other about the condition of the patient's heels when she was discharged from skilled nursing care. A home health nurse found a fresh lesion on the left heel which she would later testify could have arisen in the skilled nursing facility before discharge or at home.

The court did not accept at face value the testimony of the nurses from the skilled nursing facility. They said it was their practice not to document a pressure sore on a particular area of a patient's body when none existed.

To satisfy the court and protect themselves from legal liability, the nurses should have entered positive nursing documentation in the chart that the heels had been inspected and that no evidence of a pressure sore could be found. The absence of documentation of a pressure sore on the heel was not the same as positive documentation that none existed, the court felt.

The court approved the facility's practices for padding and elevating patients' feet and turning patients every two hours, but nurses general statements about routine nursing practices were not enough to avoid liability. **Brown vs. DeKalb Medical Center, 482 S.E. 2d 511 (Ga. App., 1997).**

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