

# LEGAL EAGLE EYE NEWSLETTER

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*For the Nursing Profession*

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## Skin Care: Nursing Documentation Leads Court To Dismiss Negligence Lawsuit.

The patient had fallen at home and had spent three months in and out of various nursing homes and other hospitals.

He was already malnourished, had pressure sores on his heel and tailbone and had developed infections before being admitted to the VA hospital where he died after a six month stay.

After his death his widow and daughter filed a lawsuit against the US Government for alleged negligence at the VA hospital. The US District Court for the Central District of California dismissed the case.

### Existing Lesions

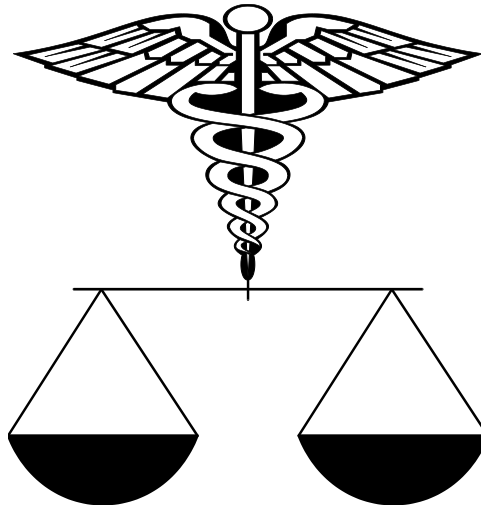
#### Were Documented On Admission

The Stage IV pressure lesion on his tailbone and a Stage III lesion on his left heel were staged and documented on admission.

While at the VA he developed new pressure lesions on his left and right hips and a new lesion near the base of his penis.

The legal standard of care for a patient with pressure sores is that the patient must receive necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

The legal focus is not on the outcome *per se* but on the quality of care and how well it was documented.



***The patient's chart contains nursing documentation that he was repositioned every two hours on 177 of his 183 days in the hospital.***

***There were also several progress notes each day that the patient was cleaned after he wetted or soiled himself.***

***There were dozens of references to his infected catheter site being cleaned.***

UNITED STATES DISTRICT COURT  
CALIFORNIA  
April 17, 2013

### To Evaluate the Quality of Care Court Looked At Nursing Documentation

The Court did not accept the testimony of the family's medical expert that the VA hospital nurses neglected to follow the nursing care plan which required them to reposition the patient every two hours and keep his skin clean, dry and free from prolonged unrelieved pressure.

Instead, although the nursing documentation was not perfect, the Court was able to find specific references in the chart to the patient being repositioned every two hours on 177 of the 183 days he spent in the hospital.

There was also detailed documentation of the nurses and aides cleaning the patient numerous times each day after he wetted or soiled himself.

His infected urinary catheter site was cleaned at least once per shift, with documentation that caregivers were wearing gloves and masks, which the Court took to mean that good aseptic technique was being used.

The Court was unable to find any concrete evidence that the patient's nursing care was substandard or any logical basis to conclude that substandard care caused the eventual outcome. ***Bryant v. US, 2013 WL 1680498 (C.D. Cal., April 17, 2013).***

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