Substandard Skin Care: Court Sees Grounds For Suit Against Long Term Care Facility.

A eighty-eight year-old Alzheimer's patient was admitted to a long term care facility with a history of hypertension, congestive heart failure, diabetes and asthma. She required total assistance with all her activities of daily living.

More than three years into her stay she developed a sacral pressure ulcer. She had had a sacral lesion five months earlier which resolved within a month.

The new sacral lesion necessitated transfer to the hospital. On admission to the hospital the sacral lesion was diagnosed as a Stage IV decubitus ulcer with necrosis and she also had a Stage II pressure ulcer on her left buttock. Her nutritional status was described as severely compromised resulting in malnourishment.

The hospital transferred her to a subacute facility for further treatment. She had several surgical debridements followed by a vacuum assisted wound closure and antibiotic therapy. She was transferred to yet another facility for negative pressure therapy. She did not improve.

She was placed on hospice care and died from cardiopulmonary arrest three months after the onset of the new sacral pressure ulcer in the long term care facility where she had been for three years.

Family's Lawsuit Against Long Term Care Facility

The family of the deceased sued the long term care facility for negligence in allowing the development and progression of the resident's pressure ulcers.

The Court of Appeals of Texas ruled that the family's physician expert's opinion correctly stated the applicable legal standard of care, identified specific breaches of the standard of care by the long term care facility's nurses and established a causal relationship between those breaches and injury suffered by the patient.

Was the Outcome Avoidable?

The facility pointed out in its defense that the family's expert failed to show that the development and progression of the patient's skin lesions was avoidable.

However, the Court ruled the facility was the party that failed to meet its burden of proof. The defendant has the burden of proof that the outcome was unavoidable due to the patient's clinical condition.

The Court accepts the patient's family's medical expert's statement of the legal standard of care applicable to a civil lawsuit for damages from a pressure sore.

Although conditions of participation for Medicare and Medicaid do not define the standard of care for civil lawsuits against nursing facilities, like other medical and nursing experts in these cases the family's expert formulated his opinion on the standard of care simply by reiterating the wording of 42 CFR § 482.25(c).

A facility and its nurses must ensure that a resident who is admitted without a pressure sore does not develop a pressure sore unless the resident's clinical condition demonstrates that it was unavoidable.

A resident who has or who develops a pressure sore must receive necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

The facility has the burden of proof in court to show that documentation of the resident's clinical condition at the time the pressure lesion appeared or worsened demonstrates that development or progression was unavoidable.

COURT OF APPEALS OF TEXAS
May 27, 2016

Faulty Assessment, Documentation

The patient's family's expert looked closely at the nursing documentation of the progression of the sacral ulcer after it was first seen and staged at Stage II.

The nurses' progress notes did not document that the treating physician was notified of the worsening of the patient's condition. As a result a wound care consultation and specialized treatment was not ordered until the lesion had progressed to Stage III.

The nurses should have actively reported changes in the patient's health status to the physician and advocated for a wound care consultation and a pressure relieving mattress in addition to simply documenting the progression of the wound in the chart, in this case imprecisely.

Proper assessment is necessary to treat a pressure lesion. Precise measurement and accurate description of the depth and nature of the wound is crucial to track the progress and response to treatment.

Proper assessment and prompt, accurate documentation and reporting inform other nurses and members of the multidisciplinary team including the treating physicians and the dietitians of the condition so that they can timely order and implement proper interventions to treat the problem.

No Repositioning

The family's expert could not find any documentation over the three year period that the patient was ever repositioned.

The Court allowed the expert to express an opinion for the jury to consider that the patient was, in fact, never repositioned. The jury in the upcoming trial will decide if that actually was the case.

Continued Progression After Discharge

The Court ruled that worsening of the lesion while the patient was under other healthcare providers' care after leaving the long term care facility is irrelevant to the facility's defense in this lawsuit.

The Court pointed out that the sacral pressure ulcer developed and progressed to Stage IV with necrosis before the patient was transferred to another facility for better care. Only the errors and omissions in the long term care facility are relevant here. **Pinecrest v. Bailey, 2016 WL 3050669 (Tex. App., May 27, 2016).**

Substandard Skin Care: Court Sees Grounds For Suit.

The elderly patient resided in the nursing home for almost a year before she died just six days after being sent out to the hospital.

At the hospital the patient's diagnoses included gram negative septicemia, gram negative sepsis and acute myeloid leukemia.

Also discovered on admission to the hospital was a necrotic Stage III pressure ulcer on her coccyx, which was nowhere documented in the clinical records from the nursing home.

The Court of Appeals of Texas agreed with the nursing home that the evidence was wholly nonexistent as to the patient's death from leukemia being linked in any way to an error or omission committed in the nursing home.

As to her skin lesion, however, the Court accepted the family's expert's opinion that the absence of any documentation of the coccyx lesion in the nursing home medical records was sufficient proof in and of itself of negligent care.

In the lawsuit the family will be allowed to ask the jury to award damages for the patient's pain and suffering directly related to her pressure ulcer. **SCC v. Ince, __ S.W. 3d __, 2016 WL 3157601 (Tex. App., June 2, 2016).**

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E. Kenneth Snyder, BSN, RN, JD
Editor/Publisher
PO Box 4592
Seattle, WA 98194–0592
Phone (206) 440-5860
Fax (206) 440-5862
kensnyder@nursinglaw.com
www.nursinglaw.com

Patient's Fall: Court Affirms Jury's Verdict Of No Negligence.

Whether or not the patient was or should have been placed in a spot where she could easily have been observed, the nursing home realistically could not have prevented her from standing and falling.

Even if the care plan should have been modified to provide for her to be moved to a spot where she could have easily been seen by the nurses, there was no guarantee that that would have stopped her from standing and falling.

It is impossible to prevent all falls in a nursing home without tying the patients to their beds.

This patient was not an appropriate candidate for physical restraints.

A nursing home is not required to provide 24/7 one-on-one supervision for its residents.

APPELLATE COURT OF ILLINOIS
June 6, 2016

The eighty-nine year-old patient suffered from dementia, hypertension, osteoporosis, heart disease, colitis and a urinary tract infection when she was admitted to the nursing home.

After she had a minor fall in the nursing home her doctor advised the family there was no chance for a meaningful recovery. It was decided to forgo resuscitation in the event of a medical emergency.

Two months later she stood up on her own, fell and broke her hip. At the hospital the physicians decided her condition was too fragile for surgery, so she was returned to the nursing home where she passed a month later.

Jury Finds Nursing Home Not Liable for Her Fall

The family's lawsuit against the nursing home resulted in a jury verdict that no negligence was committed by the nursing home as to the patient's fall. The Appellate Court of Illinois affirmed the verdict.

The Court discounted the family's nursing expert's opinion that her prior fall made the patient a high fall risk and mandated she be moved to a spot where she could readily be seen by the nurses. Even if that were done, the Court said, there was no way the nursing home could have stopped this patient from standing and then immediately falling as she did.

The Court accepted the nursing home's nursing expert's opinion that restraints were inappropriate here, the only intervention that could have kept her from standing. **Estate of Ellena v. Heritage, 2016 WL 3165929 (Ill. App., June 6, 2016).**