Presented by NSO and CNA

| NURSES MEDICAL MALPRACTICE |

Case Study with Risk Management Strategies

Medical malpractice claims may be asserted against any healthcare practitioner, including nurses. This case involves a registered nurse providing services for a home health agency.

CASE STUDY

Failure to maintain clinical competencies; failure to invoke the chain of command; failure to monitor; inadequate documentation

Total Incurred: Greater than $220,000

(Monetary amounts represent only the payment made on behalf of the insured registered nurse and does not reflect payments made on behalf of the other parties involved in the claim.)

Summary

A 77-year-old male patient underwent a total left hip arthroplasty due to multiple years of arthritic pain. The patient's medical history included mild-moderate Alzheimer's disease, gait dysfunction (related to arthritic hip), and occasional incontinence (due to radical prostatectomy for prostate cancer, five years prior).

After a successful total left hip arthroplasty, the patient remained in the hospital a few days due to a sudden increase in the severity of his Alzheimer's. The family refused all referrals to a rehabilitation facility for post-surgical physical therapy and treatment to stabilize his Alzheimer's. Instead, the patient's wife insisted that she could care for him at home with the help of their children and home health services.

On the day of discharge from the hospital, a home health nurse met the patient and family at their home for admission. The nurse noted that the patient was slightly confused, but was easily refocused. The nurse also noted that the patient was a large man (6' 5", 260 pounds) and currently chair-bound requiring a one-person assist to stand, but could ambulate using a walker.

The admitting nurse noted the patient had a good support system which consisted of his wife and three daughters who lived locally and were able to assist with his care. The plan of care was for the patient to receive nine-weeks of:

- physical therapy, three times-a-week,
- wound care treatment to the left hip incision site, three to five times-a-week, and
- personal care assistance, three to five times-a-week.

During the first week of home care, the patient made little progress in physical therapy.

At beginning of week two, the wife complained to the insured nurse (defendant) that over the weekend the patient would not doing anything on his own, refused all medications and at times became verbally aggressive. The wife explained that his behavior was polar opposite from his normal character.

The wife stated that due to her size (5' 0", 120 pounds) it was difficult for her to get the patient to the bathroom, so she would leave his adult briefs on until her daughters arrived and were able to assist.

After several attempts, the patient reluctantly allowed the nurse to change the dressing to his incision site. The incision site was slightly red, but did not appear infected. The nurse contacted the patient's primary practitioner about the patient's behavior and was given an order to increase his Aricept dosage, which the patient began that day.

Two days later, the nurse returned to the patient's home. The wife stated that the patient's aggressive attitude had improved, but he still refused to get out of his chair. The wife also informed the nurse that the patient had a bruise-like area on left inner buttocks.

The nurse assessed the area and noted it as a Stage II pressure ulcer. She obtained an order for wet-to-dry dressings and taught the family on wound care and pressure ulcer prevention. She encouraged the family to purchase a 'donut pillow' for the patient.

At the next nursing visit, the insured noted the pressure ulcer to be "Stage II 1x 0.5 open area on the left buttock, wound bed pink, no drainage, and surrounding skin intact." She documented that the "family was taught how to do dressings, advised to do dressing changes 2x per day, educated on how to avoid pressure sores, and to keep pressure off area as much as possible". She further documented that "patient spends most of his day sitting, is fearful of walking, and is unsteady on his feet".

Over the next two weeks, the pressure ulcer continued to worsen, despite the nurse contacting the referring practitioner for additional wound care orders.

Three weeks after the pressure ulcer was discovered, a second wound appeared on the patient's right buttocks. The insured nurse made numerous suggestions to her manager for the patient to be evaluated by a wound-care specialist, but her requests were denied as the manager felt it was unnecessary.

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Over the next month, the patient's medical status and pressure ulcers continued to worsen. Several attempts were made to counsel the family about transferring the patient to a rehabilitation facility, but the family refused.

Ultimately, the patient was diagnosed with sepsis and died due to irreversible disease.

Risk Management Comments

After the lawsuit was filed, the insured nurse retired from nursing. She had been a nurse for over 30-years.

The home health agency's manager testified that she thought the insured was just being lazy and didn't want to take care of the patient's pressure ulcers.

The referring practitioner testified that he was unaware of the severity of patient's pressure ulcers until the ulcers had progressed to a Stage III/IV.

Experts determined that the insured nurse breached the nursing standard of care in the following areas including:

- Not staying current on appropriate pressure ulcer treatment.
- Failure to monitor the patient care environment to ensure patient safety.
- Failure to follow institution's policies and procedures regarding the chain of command.
- Failure to accurately document care, observations and conversations with practitioners, colleagues, patients, family and /or caregivers.

Resolution

Given the deviations from the standard of care and the pejorative testimony from other staff members regarding the defendant's care, the decision was made to settle the case on behalf of the defendant.

Risk Management Recommendations

- ***Invoke the chain of command when necessary to focus attention on the patient's status.*** Nurses are the patient's advocate, ensuring that the patient receives appropriate care when needed.
- ***Monitor and document the patient's symptoms, response to treatment and changes in condition*** in the patient care record.
- ***Timely report all significant findings to the patient's physician.***
- ***Know and comply with your state scope of practice, nurse practice act and facility policies, procedures and protocols.*** Know the organization's policies and procedures related to clinical practices and documentation.
- ***Maintain clinical competencies relevant to the patient population and healthcare specialty.*** Nurses are accountable for their professional actions to themselves, their healthcare consumers, their peers, and ultimately to society.
- ***When faced with a patient situation that has legal implications, proceed in a manner that provides the best care for the patient.***

Guide to Sample Risk Management Plan

Risk Management is an integral part of a healthcare professional's standard business practice. Risk Management activities include identifying and evaluating risks, followed by implementing the most advantageous methods of reducing or eliminating these risks — a good Risk Management Plan will help you perform these steps quickly and easily!

Visit **nso.com/riskplan** to access the Risk Management Plan created by NSO and CNA. We encourage you to use this as a guide to develop your own Risk Management Plan to meet the specific needs of your healthcare practice.

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