RISK

CASE STUDY

HIROC

Case: Healthcare Acquired Pressure Ulcers

Abstract:

A non-verbal rehabilitation patient sustained a Stage IV pressure ulcer. Expert opinion concluded the related medico-legal case was indefensible and the case was settled outside of the courtroom.

Key Words:

Rehabilitation

Healthcare Acquired Pressure Ulcers

Patient Deterioration

Documentation

Monitoring

Interprofessional Communication

Case summary:

During the course of an admission for respite care at a rehabilitation hospital, a young adult non-verbal quadriplegic patient sustained a healthcare acquired Stage IV pressure ulcer on his right hip. Clinical evidence suggests that the ulcer did not fully heal for 15 months.

Medical legal findings:

Expert review of the case was critical of the standard of care provided to the patient, criticizing the charting of the involved nursing and noted that the nursing staff had failed to use the Braden Scale to assess the patient's pressure ulcer. Furthermore, the experts noted that the involved nurses and support workers had failed to record the frequency with which the patient's position was adjusted and skin assessed for early signs of pressure ulcer development.

In addition, expert review indicated that the involved nurses and support workers had neglected to take appropriate steps to treat the patient's developing pressure ulcer once the ulcer had been identified. In review of the health record, it appears that following the initial identification of the patient's pressure ulcer, the patient was not reassessed by the consulting wound care specialist for a period of five weeks.

Expert review also questioned the adequacy of the communication between the involved nursing staff and the consulting wound care specialist, noting that the involved nursing staff had failed to alert the consulting wound care specialist of the patient's continuing deteriorating status prior to the conduction of the second assessment.

Reflections:

Reflecting on your practices as well as your facility's pressure ulcer and wound management policies, procedures and processes:

1. Discuss the benefits of having a standard pressure ulcer assessment tool. Is there a benefit to utilizing different assessment tools based on patient characteristics (e.g. body weight, physical impairment, age, skin tone)? Discuss some of the clinical triggers for performing additional assessments.
2. Discuss whether healthcare providers are accountable for performing (or not performing) required skin integrity assessments in a timely manner? If the assessment was performed but not documented, can healthcare providers safely rely on their 'normal practice' or facility protocols/policy as evidence of care provided during medical legal proceedings?

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3. Does your program utilize a standardized record to track ulcer staging, treatment effectiveness and on-going assessments? Discuss barriers (if any) to documenting the interventions and their effectiveness in a timely manner?
4. Discuss your program's expectations for recording:
   a. 'Routine' skin integrity interventions such as repositioning, turning, skin cleaning and dressing changes?
   b. Training and instructions to patients/family/care givers?
5. In this case the nursing staff neglected to alert the wound care specialist of the patient's continuing deteriorating status. Discuss your program's expectation for communicating the status of wounds to:
   c. Wound care specialists (where available)?
   d. The patient's most responsible physician/practitioner?
   e. The patient's family or substitute decision maker?

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