FATAL INJURIES AFTER INADEQUATE WOUND TREATMENT AND DOCUMENTATION

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DESCRIPTION

Poor documentation and inadequate wound treatment at a skilled nursing facility (SNF) contributed to an elderly patient's death.

CLINICAL EVENTS

A 75-year-old female with a medical history of peripheral vascular disease, hypertension, diabetes, and deep vein thrombosis was admitted to the hospital with an acute exacerbation of her chronic heart failure. Upon admission, the initial documentation stated the patient had a pressure ulcer on her coccyx that was later changed to "wound incontinence breakdown to the right buttocks and intergluteal cleft." It was also documented that the patient had a blister on her right foot.

The patient was incontinent and bedbound; she was then discharged from the hospital to a SNF with stage 2 wounds to her left buttocks and sacrum, as well as an open wound on her left buttock. The wound care nurse at the SNF assessed the patient and made recommendations for wound care. The documentation regarding adherence to recommended interventions was unclear. Six months later, the wound was documented as a "large nonhealing stage 3 wound with drainage."

Seven months after admission to the SNF, the patient was transferred to the emergency department (ED) for respiratory distress and placed on BiPAP. At this time, there was discussion with the family about changing the patient's status to "comfort measures only (CMO)," but the family declined, opting for "do not resuscitate/do not intubate (DNR/DNI)" as part of the care plan. A surgeon assessed the patient and noted wounds to the left flank, left heel, and a stage 4 pressure ulcer on the sacrum.

When discharged, the patient's family selected a different SNF due to concerns of neglect and worsening wounds at the previous SNF. Three days later, the patient returned to the ED for worsening unstageable wounds with drainage and was diagnosed with sepsis from osteomyelitis of her coccyx. At this time, the family agreed to change her status to CMO and she died in hospice care within two weeks.

ALLEGATION

A claim was brought forth against the initial SNF for failure to treat and prevent pressure injuries, leading to infections, sepsis, and death. Experts were critical of the facility for lack of documentation and not providing agency staff with access to the appropriate electronic health system. There was also no credible evidence that wound treatment interventions were performed, such as offloading weight and turning the patient consistently every two hours as recommended. Experts opined that wounds were not fully treated, which contributed to the patient's death.

DISPOSITION

The case was settled for more than $200,000.

ANALYSIS

- **Policy/protocol not followed and failure to follow an order.** The wound care nurse examined the patient; however, the documentation did not clearly state if the recommended treatment and preventive care plan was followed. There was also a failure to monitor the patient's status with worsening wounds throughout a prolonged stay at the facility.
- **Adequacy of staffing and high turnover.** Analysis of this case revealed a period of very low staffing and turnover of many agency staff. It is unclear if other members of the team were aware of the patient's worsening wounds.
- **Electronic health systems/technology issues.** It was revealed that the agency staff did not have appropriate access to the electronic health systems, contributing to the extreme lack of documentation in this case.