Client	Rachel D.	**Date of Incident**	02/02-08/20
Plaintiff	Susan Glass	**Defendant(s)**	The Healthcare Center

Medical Records Reviewed:

- The Healthcare Center - 1160 pages

Merit Screen Report

Statement of Merit:

It is my opinion that Ms. Glass's treatment fell well below the standard of care and resulted in preventable progression to Stage III pressure ulcers to her heels as well as varying stages of pressure ulcers to other areas of her body.[1] Upon admission there were unspecified areas of non-blanchable redness that should have been addressed immediately with pressure relieving methods in order to prevent worsening of these Stage I pressure ulcers.[2]

Case Summary:

Ms. Glass, age 83, presented to Mercy Medical Center on February 2 with complaints of right shoulder pain after falling in her bathroom at home. She was diagnosed with a displaced avulsion fracture of the greater tuberosity of the right humerus in her upper arm and discharged to rehabilitation with no treatment of the fracture.[3]

Ms. Glass was transferred to The Healthcare Center for rehabilitation/skilled nursing treatment. Significant admission diagnoses were diabetes, history of deep vein thrombosis (DVT), hypertension, cardiac pacemaker, cardiac stents, cerebral infarction, history of falls, and muscle weakness. Of note, she had a history of a Stage II pressure ulcer to the right heel in August after fracturing her right ankle.[4]

[1] Stage III: Full Thickness Skin Loss – Subcutaneous fat may be visible, but bone, tendon, or muscle are not exposed.
[2] Stage I: Non-blanchable Erythema – Intact skin with non-blanchable redness of a localized area usually over a bony prominence.
[3] Appendix A, pp. 1 - 3
[4] Appendix A, pp. 4, 5

Initial admission assessment noted that she was forgetful, confused, had poor hearing, muscle wasting, failure to thrive, and poor mobility, all of which placed her at greater risk for skin impairment.[5] The admission nurse noted areas of non-blanchable redness but did not specify the location.[6] The skin assessment revealed bruising on the left shin; bruising on the left forearm; redness under a fat fold on her abdomen; a hematoma in her right antecubital area; bruise behind right knee; discoloration with potential for deep tissue injury in right buttock fold; bruising above right buttock; bruise outer right thigh; ecchymosis, discoloration and edema of the right arm with guarding; red areas on top of the left second toe; and redness of both heels.[7]

Case summary continues. It has been deleted from this sample report.

Summary of Issues/BSOC:[8]

Issue: Failure to properly and consistently assess pressure ulcer risk upon admission.

According to the National Pressure Ulcer Advisory Panel (NPUAP, 2014), a complete and comprehensive initial assessment of the individual should be performed upon initial discovery of a pressure ulcer. An initial assessment includes:

- **Values and goals of care of the individual and/or the individual's significant others.**
- **A complete health/medical and social history.**
- **A focused physical examination that includes:**
  - **factors that may affect healing (e.g., impaired perfusion, impaired sensation, systemic infection);**
  - **vascular assessment in the case of extremity ulcers (e.g., physical examination, history of claudication, and ankle-brachial index or toe pressure); and**
  - **laboratory tests and x-rays as needed.**
- **Nutrition.**
- **Pain related to pressure ulcers.**
- **Risk for developing additional pressure ulcers.**
- **Psychological health, behavior, and cognition.**
- **Social and financial support systems.**
- **Functional capacity, particularly regarding repositioning, posture and the need for assistive equipment and personnel.**
- **The employment of pressure relieving and redistributing maneuvers.**
- **Resources available to the individual (e.g. pressure redistribution support surfaces).**
- **Knowledge and belief about prevention and treatment of pressure ulcers.**
- **Ability to adhere to a prevention and management plan.**

[5] Appendix A, pp. 6-8
[6] Appendix A, p. 9
[7] Appendix A, p. 10
[8] BSOC: Breach in the Standard of Care

- These factors were considered upon admission via a tool called a Braden Scale Score. There are 6 factors taken into consideration when evaluating this score: Sensory perception, moisture, activity, mobility, nutrition, and friction & shear. Ms. Glass scored a 15 out of a possible 23 which put her "at risk:" The lower the number the more at risk the patient is for pressure ulcers. Interventions noted to be needed upon admission were turning/repositioning, promoting adequate nutrition & hydration, offloading, and maintaining activity & mobility.[9] Measures such as pressure relieving devices, heel/elbow protectors, and special skin care should have also been chosen as interventions upon admission because there were many skin issues identified, including Stage I pressure ulcers.

- Ms. Glass had multiple medical conditions predisposing her to pressure ulcer formation: Age, fractured right arm inhibiting her ability to turn herself, history of repeated falls, depression, prior fracture lower leg, cognitive deficits, history of stroke (not consistently listed as diagnosis), generalized muscle weakness, incontinence, mobility issues, diabetes (not consistently listed as diagnosis and on no medication), history of prior pressure ulcer, & failure to thrive.[10] She was also on multiple medications.[11] Advance age predisposes a patient to hospital induced psychosis which causes the patient to become confused and sometimes combative during admission. Therefore, she should have been turned every two hours and pressure ulcer prevention protocols should have been initiated immediately upon admission. There is no documentation indicating that this was performed. Ms. Glass was only minimally able to help herself in this situation and most likely would not have understood the need to keep pressure off her bony prominences. An arm fracture would have greatly diminished her ability to turn herself appropriately. She frequently refused to float her heels while in bed. **Duty was on the staff to ensure that as much pressure as possible was alleviated from all areas susceptible to compromise.**

- Long-term stays in a facility can cause hospital psychosis that can worsen as the stay lengthens. Ms. Glass was already somewhat cognitively impaired upon admission**. A thorough review of the records may indicate worsening cognitive ability.** This psychosis may or may not resolve upon discharge and return to home.

- Pressure ulcers to other areas of the body were not mentioned in the complaint. These need to be addressed and assessed as to severity and proper treatment so that they may be included in the complaint.

- Nutritional status plays an integral role in pressure ulcer healing and at the time of this incident, low albumin levels were thought to be an indicator of poor nutrition.

[9] Appendix A, p. 11
[10] Appendix A, pp. 4, 40-42
[11] Appendix A, pp. 40, 43-67

Issue summary continues. It has been deleted from this sample report.

Additional Defendants to be Named:

- Dr. John Smith, attending physician

Request for Production:

- Mercy Medical Center Wound Care Clinic records 04/18-08/20
- Mercy Medical Center Emergency Room records from 02/02
- The Healthcare Center – Policy and Procedures regarding wound care/pressure ulcer prevention/treatment, infections, outside clinic visits; complete laboratory records.
- Primary care physician records from 01/01-Present (to provide information regarding medical history, home medications prior to admission, complications after discharge)
- Assisted living facility records 08/20-present.

GMFI Services:

- Prepare a comprehensive fact chronology of the records to prepare for trial.
- Consult general practitioner for peer review of physician's actions.

The opinions in this report are within a reasonable degree of medical certainty based upon the documentation provided and referenced within this report. However, I reserve the right to amend my opinions upon receipt of additional information and/or further review of the medical records.

Thank you for the opportunity to work with you on this case. Please don't hesitate to contact me if you have any questions or concerns.

Works Cited:

Board of Registered Nursing. (1997). *An Explanation of the Scope of RN Practice, Including Standardized Procedures.* Sacramento, CA: Department of Consumer Affairs.

National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. (2014). *Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline.* (E. Haesler, Ed.) Osborne Park, Western Australia: Cambridge Media.

ANA Standards of Nursing Practice http://onawp.memexonline.com/wp-content/uploads/2014/09/ANA-Standards-of-Nursing-Practice.pdf

ANA Position Statement. (2018). *The Ethical Responsibility to Manage Pain and the Suffering it Causes.* ANA Center for Ethics and Human Rights: ANA Board of Directors.

The Joint Commission. (2016). *Joint Commission Statement on Pain Management*. (David W. Baker, MD< MPH, FACP, Executive Vice President, Heathcare Quality Evaluation, The Joint Commission.