# Decubitus Ulcer Allowed To Develop In Trauma Patient: Nursing Assessment And Care Not Adequate, Court Rules.

The patient was brought to the emergency department by paramedics following a motor vehicle accident. He was not wearing a seat belt and was ejected from the vehicle. On admission to the E.R. he had abdominal trauma, a fractured left humerus, a fractured right ankle, an unstable fractured pelvis and a ruptured bladder. The patient was in shock and was taken immediately into surgery for abdominal exploration and repair of the bladder.

According to the Court of Appeal of Louisiana, an orthopedic surgeon, in an effort to compress the pelvis, control the bleeding, and stabilize the pelvic fracture, placed the patient on a double egg crate mattress and in a pelvic sling. Because the patient weighed approximately 300 pounds, the orthopedic surgeon made a sling specifically fitted to this patient.

The patient was in intensive care for ten days. Then he went to a general medical floor, where a nurse noticed and made a note in the chart of a foul odor coming from the sling. The nurse did no further investigation or assessment, and did not notify a physician.

When the patient got to a second hospital, where he was sent for specialized rehab care, twelve days after the motor vehicle accident, the first nurse who examined the patient found what the court described as a large, terrible-smelling decubitus on the patient's buttocks. The lesion required immediate debridement by a physician. In fact, according to the court, the wound was so extensive that the physician was not able to complete the initial debridement in one procedure as contemplated.

Over the next ten months, there were thirteen operative procedures to debride and repair the damage, which left the patient, according to the court, permanently disfigured and significantly disabled.

The court explained at great length how the nurses and physicians at the first hospital were to blame. The nurses should have noted the patient was at high risk for decubitus ulcers due to his immobility and that there was substantial potential for skin breakdown.

***The nursing care of this patient was below the standard of care for professional nursing.***

***The patient was at high risk for decubitus ulcers. He was on bed rest and could not move. His high risk status was not noted in his nursing records. A nursing diagnosis of a potential for skin breakdown and or a skin care plan was nowhere to be found.***

***There should have been a skin care plan for the patient. It is very important for the physician and the nurses to work together to see that plans are made to insure the integrity of the patient's skin.***

***As a general rule, in a malpractice case against a healthcare professional, the patient must be able to prove that the defendant healthcare professional owed the patient a duty to protect against the risk involved, that the defendant breached that duty, that the patient suffered an injury and that the defendant's actions or omissions were in fact a substantial cause of the injury suffered by the patient.***

COURT OF APPEAL OF LOUISIANA, 1997.

The nurses should have found out from the physician how often the patient could be turned. It was a medical judgment just how often the patient could be turned, and if any special precautions were in order in turning the patient. According to the court, however, the nurses should have taken the initiative to question the physician on this issue.

Although the nurses needed input from the physician, it was the responsibility of nursing to go forward with initiating the patient's skin care plan, without being prompted by the medical staff to inspect and assess the patient's actual and potential needs in this area of patient care and without waiting around for orders to be written.

The nurses should have taught the the patient to use his trapeze frequently, to lift himself up at least once an hour to relieve the pressure on his backside.

The skin under the sling had to be inspected regularly, but it was not. A flow sheet should have been started so that the skin would be inspected regularly and so that changes in the skin could be tracked. Apparently a pre-printed form was available, but it was not used.

The condition of the skin of the buttocks should have been inspected and noted every time the patient was turned. The nurses apparently started turning the patient on the seventh day, but still did not inspect the skin.

The court was particularly dismayed that the nurses did not follow up themselves upon the patient's complaints of discomfort with the sling or to determine the cause of the odor apparently coming from the sling, or alert the physician. **Smith vs. Juneau, 692 So. 2d 1365 (La. App., 1997).**