Skin Care, ICU Patient: Court Accepts Nurse's Expert Opinion On Nursing Standard Of Care.

The patient, then sixty years of age, was admitted to the hospital for work-up of a fever which was found to be related to MRSA infection originating at the site of her renal dialysis shunt. The patient's medical diagnoses included end-stage renal failure, hypertension and diabetes.

In the hospital the patient's situation progressed to septic shock accompanied by respiratory failure which required that she be placed on a ventilator and transferred to the ICU.

Restraints were ordered in the ICU for both upper extremities. There were also standard hospital admitting orders in the chart for pressure-ulcer precautions.

Treatment in the hospital lasting more than a month was successful in resolving the MRSA-related sepsis, but after discharge the patient still had multiple pressure ulcers which started and progressed in the hospital that required ongoing aggressive treatment.

Patient's Lawsuit Alleges Negligent Skin Care

The patient sued the hospital for negligence related to the skin care she received while a patient in the hospital.

The Court of Appeals of Texas ruled that the expert opinions of a nurse and a physician submitted along with the filing of her lawsuit, as required in Texas and many other states, correctly stated the applicable standard of care and pointed out multiple breaches of the standard of care by the hospital's nurses.

Nursing Expert's Opinion
Nursing Standard of Care
In General:

1. Perform ongoing nursing assessments of the patient to identify actual and potential problem areas;

2. Make appropriate nursing diagnoses, i.e., alteration in comfort, alteration in hydration, alteration in skin integrity, alteration in elimination patterns, potential for urinary tract infection, etc., based on ongoing assessments;

3. Develop a comprehensive Plan of Care which sets out identified (actual or potential) problems and interventions designed to prevent adverse outcomes from known problem areas;

4. Implement Plan of Care;

A nurse is qualified to give an expert opinion in court defining the standard of care for nurses and identifying specific breaches of the standard of care by the patient's nurses in their treatment of the patient.

The nurse must be able to satisfy the court that he or she has knowledge, skill, experience, training or education pertaining to the disputed issues in the lawsuit that qualify him or her to give an expert opinion on those subjects.

A nurse, however, is not accepted by the courts as qualified to give an opinion on the medical issues involved in linking a breach of the standard of care by a nurse to the harm suffered by the patient.

That requires testimony from a physician.

Being licensed as a physician does not automatically qualify someone as an expert witness.

In this case the patient's physician/expert had experience caring for patients with pressure ulcers, writing orders for nurses caring for such patients and evaluating nursing interventions. He is able to demonstrate familiarity with the medical consequences of substandard skin care.

COURT OF APPEALS OF TEXAS
November 16, 2011

5. Evaluate patient's response to implemented Plan of Care; and

6. Update Plan of Care consistent with the patient's response.

Standard of Care
Skin Care / Pressure Ulcers
In General:

1. Conduct a pressure ulcer admission assessment for every patient using Braden Score Scale or Norton Score Scale;

2. Reassess risk for all patients daily using Braden or Norton;

3. Inspect skin of high-risk patients daily;

4. Manage moisture;

5. Optimize nutrition and hydration;

6. Reposition every two to four hours with 30° lateral tilt;

7. Minimize pressure;

8. Once a pressure ulcer develops, the wound should be properly documented and photographed for the medical record: Color, size, depth, drainage, odor and progression should be documented.

Notify physician.

This Patient:

1. This particular patient should have been turned every two hours to prevent damage to the skin;

2. Proper bedding, i.e., an air mattress should have been provided to prevent pressure ulcers;

3. Once pressure ulcers developed the wound should have been properly documented and photographed for the medical record: Color, size, depth, drainage and odor. The physician should have been notified;

4. Upon discharge, wound care instructions should have been provided to the family and home health nursing staff; and

5. A therapeutic mattress should have been ordered for use at home.

The physician/expert went on to detail how failure to turn the patient every two hours prolonged the pressure on her sacrum and coccyx which diminished blood flow and caused damage to the tissue. If the progression of the lesions had been documented by the nurses the treating physician would have known to write orders for appropriate alterations of the care plan.

Hillcrest Baptist v. Payne, 2011 WL 5830469 (Tex. App., November 16, 2011).

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