The Legal Nurse Consultants and Analysis of the Medical Record

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There is a huge push throughout the nation to develop a culture of safety in hospitals. This can only be accomplished by maintaining ongoing education and training for health care professionals and establishing flexibility and creativity in performance improvement projects, to address real and potential problems. It is essential to establish and maintain a blameless environment where practitioners are encouraged and rewarded for identifying and reporting adverse events. In Table 1, Morris et al (2003) identify seventeen of the most common causes and effects of litigation in health care.

Table 1 - Cause and effect analysis

In dealing with adverse events, meticulous and skillful analysis of the medical record is essential. This article will present a case study and demonstrate how the Legal Nurse Consultant conducts a step-by-step analysis of the medical records.

Patterns of Reporting Adverse Medical Events

On July 14, 2008 Reuters Health Information reported on a study published in the Annals of Internal Medicine. In a random sample survey of patients discharged from Massachusetts hospitals from April 1 to October 1, 2003, 23% of the subjects interviewed reported at least once adverse event. In contrast, the hospital medical record review for these subjects revealed an 11% reporting rate of adverse events. The study concluded poor agreement between the medical record and patient experience regarding adverse events.

MacReady (2008) reported similar findings from the annual meeting of the Society of Hospital Medicine. "A survey of 603 patients who experienced 845 adverse events revealed that only 40% of those events were disclosed. The track record was even worse when the event was preventable — the disclosure rate of those events was only 28%, lead investigator Lenny Lopez, MD, from Massachusetts General Hospital, Boston, and colleagues reported." These findings strongly support the need for thorough medical record analysis for risk management or litigation issues.

A Case Study

A 48 year old female is admitted to a teaching hospital with a history of congestive heart failure, coronary artery disease, peripheral vascular disease, type 2 diabetes mellitus (adult onset diabetes) and obesity. She undergoes a coronary artery bypass graft (open heart surgery) for a critical blockage in a major coronary artery. Post operatively she experiences significant complications over an eight month hospitalization. While still in the intensive care unit, she develops respiratory failure requiring a tracheostomy and prolonged mechanical ventilation. During transfer from her

bed to a gurney for diagnostic testing by the hospital Lift Team, her right leg is caught in the side of a gurney resulting in a deep gash. The leg wound requires surgical repair and she develops a severe post operative infection. The patient is transferred to the hospital Step-Down Unit for weaning from mechanical ventilation. During her stay in the Step-Down Unit, she undergoes two more surgeries for the leg infection, develops gangrene and requires a below the knee amputation. She develops a stage IV decubitus ulcer on her coccyx resulting in osteomyelitis[1]. She also develops acute renal failure requiring hemodialysis three times weekly. The family files a lawsuit for negligence based on the patient's hospital acquired pressure ulcer and her leg injury, infection with subsequent amputation.

Medical Record Analysis

When analyzing medical records, the Legal Nurse Consultant (LNC) considers patient history, co-morbidities, state and federal regulatory issues, standards of nursing practice, policy and procedure and reasonable standards of care based on his/her experience and community or national standards. The LNC also relies heavily on medical and specialty research articles to support findings. When analyzing the incident involving the patient's leg injury, it would be wise to determine if the medical center has a competency list (skills check list) for the Lift Team, what type of training is provided to the Lift Team and if there is a hospital policy describing the scope of practice of the Lift Team. Specifically, does the Lift Team operate independently or does hospital policy

[1] Osteomyelitis is an inflammation of the bone due to infection, for example by the bacteria salmonella or staphylococcus. Osteomyelitis is sometimes a complication of surgery or injury, although infection can also reach bone tissue through the bloodstream. Both the bone and the bone marrow may be infected. Symptoms include deep pain and muscle spasms in the area of inflammation, and fever. Treatment is by bed rest, antibiotics (usually injected locally), and sometimes surgery to remove dead bone tissue. (Source http://www.medicinenet.com)

state a registered nurse must be present when the Lift Team handles patients. This is not uncommon, particularly in specialty areas such as Critical Care, due to the severity of illness and the presence of multiple tubes and drains. Another key piece of information is does the medical center have a Safety Program and do they perform regular safety checks on patient equipment? In terms of alternative causation, the patient has significant co-morbidities that may contribute to the infection in her leg and subsequent amputation. The fact that she had a coronary artery bypass graft means donor vein was harvested from her legs. Her diabetes predisposes her to slow healing and a high probability of infection. Her congestive heart failure predisposes her to poor perfusion to many organs including her skin and extremities. She is also predisposed to edema. Her history of peripheral vascular disease indicates that she has poor arterial circulation in her legs. To compound all of these problems is her obesity. Obesity predisposes the patient to slow healing and worsens her congestive heart failure, edema and peripheral vascular disease. Her co-morbidities are certainly not the cause of the injury, but knowledge of how these co-morbidities interplay may be useful when determining damages.

The Centers for Medicare and Medicaid Services (CMS) considers hospital acquired pressure ulcers 'Serious Reportable Adverse Events'. Although the medical community does not entirely agree, CMS considers hospital acquired pressure ulcers 100% preventable. CMS has established mandatory reporting for hospital acquired pressure ulcers as follows; (a) multiple stage II ulcers, (b) stage III ulcers, (c) stage IV ulcers, and (d) unstagable ulcers. Figure 1 provides a detailed description of decubitus ulcer staging. Beckrich and Aronovitch (1999), present a startling cost analysis related to hospital acquired pressure ulcers, treatment and hospital length of stay (LOS).

- The estimated costs associated with the estimated 1 to 1.7 million annual pressure ulcers is between $5 billion and $8.5 billion.
- Studies indicate that LOS increased between two and five times the typical LOS for patients who develop pressure ulcers in the hospital.
- Hip fracture patients who develop pressure ulcers had twice the average LOS as those who did not, representing an incremental cost of $12,186 per patient.
- There were 34,000 patients admitted in 1992 with a primary diagnosis of pressure ulcers with an average 20.5 day LOS at an estimated cost of $24,575 per patient. Overall costs were estimated at $836 million.
- It can be projected that approximately 53,000 pressure ulcers will be found on the study day which means that about 2.5 to 2.6 million ulcers pass through an acute care setting at some point during a year.
- The overall costs of (largely preventable) hospital-acquired pressure ulcers is between $2.2 and $3.6 billion.

Figure 1 – Pressure Ulcer Staging

Ulcer Stage	Description
I	Non-blanchable erythema of intact skin.
II	Partial-thickness skin loss involving epidermis, dermis, or both
III	Full-thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia.
IV	Full-thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures.
Deep Tissue Injury	Deep Tissue Injury - A pressure-related injury to subcutaneous tissue under intact skin. Initially, these lesions have the appearance of a deep bruise. These lesions may herald the subsequent development of a Stage III-IV pressure ulcer even with optimal treatment.
Unstagable	Pressure ulcers are covered with dead cells or eschar and wound exudate, so the depth cannot be determined.

When reviewing the medical record regarding the hospital acquired pressure ulcer and osteomyelitis, the LNC determines if the nursing staff documented turning and repositioning the patient at least every two hours, if the patient was adequately nourished, if there is documentation of a nutritional consultation (a Joint Commission requirement), status of the patient's activity level (physician order for getting out of bed or physical therapy) and placement of the patient on the appropriate pressure relief surface to prevent skin breakdown . Alternative causation includes high risk for infection related to obesity and diabetes and high risk for skin breakdown due to congestive heart failure, edema and poor perfusion.

Conclusion

Errors involving surgery, equipment, medications, clinical practice, etc. are preventable. Tough mandates from CMS, Joint Commission and the state are designed to promote quality patient care and ultimately protect patients from harm. Thorough, accurate analysis of medical records is an essential element of the litigation process. The experienced LNC is detail oriented and has a clear understanding of standards of care and the role of state and federal regulation in health care. Many patients fail to report errors, because they do not feel empowered to do so. The legal nurse consultant-attorney partnership is an effective mechanism of promoting patient advocacy.

References

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