MLMIC®
Medical Liability Mutual Insurance Company

CASE REVIEW

A Review of Case Studies for MLMIC-Insured Physicians & Facilities

Summer 2017

CASE STUDY #1

"Poor Medical Care" Contributes to Death of Nursing Home Patient

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In May 2004, a 5'3", 101.5 lb., 78-year-old gentleman was admitted to a MLMIC-insured nursing home. Prior to his admission, he had lived at a senior residence, was ambulatory, and could perform his activities of daily living (ADLs) without assistance. On admission, his diagnoses included status post myocardial infarction, atrial fibrillation, multi-infarct dementia, a possible TIA, and benign prostatic hypertrophy. He was taking Risperdal for dementia and medications for his other medical problems. He was on a low-sodium, soft, blended diet. He had a Foley catheter in place, was fecally incontinent, and had moderate cognitive impairment. He was alert, had slurred speech, and oriented only to person. An assessment for the risk of pressure ulcers was 17. A score of less than 12 would indicate high risk. His fall risk assessment was 85, which was high risk. He was placed on fall precautions including a bed alarm, chair alarm, and floor mats. He required assistance both for transfers and using a walker. He was dependent for feeding, dressing and grooming needs.

Other risks assessed upon admission were the need for aspiration precautions and nutritional support. He was placed on a pressure ulcer prevention program. This assessment was performed by an LPN and signed by an RN and other faculty staff.

Two days later, a psychiatric evaluation was performed due to his dementia and mood disorder. Appropriate medications were ordered. Because a speech therapy evaluation indicated mild oropharyngeal dysphagia due to dementia, his diet was changed to soft and chopped foods, as tolerated, with nutra-shakes three times a day with his meals.

Over the period of a month, he had several falls without harm. The resident was then placed in a wheelchair at the nursing station from which he continued to fall. Finally, a "lap buddy" was ordered for him within the wheelchair, for his safety.

Thereafter, the patient had several hospitalizations for both falls and sepsis. He fractured his nose during one of the falls. In mid-June, he was readmitted to the facility again from a hospitalization, having lost more than eight pounds. He now weighed 92.9 lbs. During this last hospitalization, a feeding tube was inserted and he was placed on a multi-vitamin supplement. He also was diagnosed with MRSA and was being treated for that. On this readmission, he was assessed to have moderate cognitive impairment. His pressure ulcer risk was now a 14 (fewer than 12 required a consultation) and remained at high risk for falls. His priority needs were determined to be both aspiration and fall precautions. He now required total assistance for all his ADLs. A swallowing evaluation diagnosed moderate dysphagia. Therefore, he was to receive only tube feedings and no liquids. He also could have blended pleasure foods by mouth.

The staff now implemented a Broda chair, which is a tilt in space chair, and began restorative physical therapy five times a week for 30 days. His bed was moved against the wall and a mat placed on the floor in front of the bed. He was to be put to

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Case #1 *continued*

bed at 2 pm daily for a nap if desired. The record reflected he ambulated only with two-person assistance and he tolerated his tube feedings.

In early July he fell, again requiring hospitalization as well as treatment for respiratory failure for 10 days. Upon discharge, he was readmitted to the defendant's facility. His weight was now 98.6 lbs. His pressure ulcer risk was assessed as a 10 and his fall risk was over 51. His priority needs were impaired mobility, safety and increased fall risk. Although the records indicated that he was on a Prima Shearless mattress with a sheepskin overlay, it is unknown when this mattress was first introduced. Despite these precautions, he continued to fall.

By the end of July, the resident's weight had dropped to 88.8 lbs. Protein powder was added to his tube feedings. Urine cultures confirmed infection with E. coli and VRE.

On August 9, a small open area on his coccyx was noted. Barrier cream treatment was initiated.

Over the next two weeks, the resident again fell several times. On August 31, a rehabilitation nurse recommended that a high pummel cushion with Dycem be placed in the resident's wheelchair to prevent him from sliding out. The resident was also to be placed in bed whenever he became restless in the wheelchair. His proxy agent consented to a Do Not Resuscitate (DNR) Order which was issued that same day. By mid-September, three Stage 2 pressure ulcers were observed on the resident's coccyx. DuoDERM treatment was instituted. Several days later, the resident was found to be extremely congested with a temperature of 100.6, a pulse oximeter level of 74%, and thick, yellow sputum. Oxygen was started and he was given Tylenol as well as albuterol nebulizer treatments and antibiotics. Despite these interventions, his pulse oximeter level remained in the low 70's. A chest x-ray confirmed right lower lobe pneumonia. The family requested comfort care only in accordance with his wishes.

Despite treatment, over the next two weeks, the resident continued to spike fevers. The physician documented in his progress notes that there were now open areas on the resident's coccyx, but gave no details. By September 22, these open areas had significantly deteriorated. The nurses' notes documented that there was a Stage 4 decubitus on his coccyx, measuring 6 cm x 6 cm, with serosanguineous discharge. On his hips there were several Stage 2 decubiti with minimal serosanguineous discharge and slight erythema around them. Additional pressure ulcers developed on the resident's left hallux and right fifth metatarsal. Decubiti treatment was changed. All areas were cleaned with normal saline and Sofgel applied. However, the resident's condition quickly deteriorated and he died seven days later.

The patient's death certificate indicated that the resident died of aspiration pneumonia due to dysphagia, secondary to end-stage senile dementia, and arteriosclerotic heart disease. At the request of the family, an autopsy was also conducted. The results of the autopsy were bronchopneumonia, pulmonary congestion and edema, chronic pulmonary emphysema, multiple decubitus ulcers, cerebral atrophy, hydrocephalus, status post insertion of a gastrostomy tube, and arterial and atherosclerosis. However, the pathologist added to the report that "the cause of death was due to infection of the decubitus ulcers and aspiration bronchopneumonia, resulting from poor medical care."

Six months after the resident died, the family commenced a lawsuit against the defendant facility. The complaint alleged that the care and treatment of the decedent

was negligent and delivered in a careless manner such as to show complete disregard for the rights and safety of the plaintiff decedent, specifically alleging a violation of the patient's rights under § 2801-d and § 2803-c of the New York Public Health Law. It was further alleged that the conduct of the defendant facility and its employees was reckless and willful. The allegations included the fact that the decedent had been allowed to fall at least six times; that the facility failed to provide proper treatment to prevent urinary tract infections, dehydration, and metabolic abnormalities; and that these failures led to the development of Stage 3 pressure ulcers, aspiration pneumonia, and the decedent's wrongful death.

Expert reviewers were retained by MLMIC in the areas of long-term care nursing, infectious disease, and geriatrics. It quickly became evident that the documentation about the care provided to the decedent was sparse and inadequate. There were no weekly wound assessment forms for the month of August, when the first Stage 2 decubitus ulcer was documented in the nursing notes. The plaintiff's counsel alleged that the decubitus ulcers were pressure-related, resulting from the continuous failure to turn and position the decedent. During August and September, when it was documented that he was totally dependent, the section of the Certified Nurse Assistant (CNA) record for turning and positioning had not been completed. On multiple occasions, the CNAs did not even initial that particular section for the shift. For instance, in August, the requirement categories for skin care by a CNA stated "...check skin every shift and report any signs of redness, swelling or complaints of discomfort to the nurse." The CNA record required assessment and documentation of the frequency of positioning and any barriers to accomplishing this task. This record contained no documentation. Further, there was nothing documented to indicate whether the decedent ever had been on an air mattress.

The wound assessment form, dated September 22, indicated that there was to be an increase in the schedule for turning and positioning. However, no frequency of such actions was documented. Thus, it was easy for the plaintiff's counsel to allege that the decedent was not being turned or repositioned on a regular basis prior to this date. In addition, since there was no description of the appearance of the Stage 3 ulcers anywhere in the record, it was impossible to claim that these Stage 3 ulcers were not infected.

> However, the pathologist added to the report that "the cause of death was due to infection of the decubitus ulcers and aspiration bronchopneumonia, resulting from poor medical care."

Further allegations in the complaint involved the protocol for the decedent's nutrition and hydration. He was to receive 700 milliliters of liquid per day. However, his intake and output amounts were not documented daily. The defendant facility's registered dietician had calculated a caloric requirement of 1380-1610 calories per day for him. However, when he was hospitalized in early July, the dietician there stated that his calorie needs were between 1900 and 2310 per day, a substantial difference. Thus, when the decedent returned to the defendant facility from the hospital, he had gained about 5½ lbs. In fact, a nutrition note dated July 14, after he had been readmitted to the defendant facility, stated that his prior tube feedings had not met his needs. Therefore, the dietician recommended an increase to 1560 calories per day. Despite this change, the decedent lost ten more pounds within a month.

All of these documentation issues, coupled with the inflammatory comments of the pathologist on the autopsy report, made defense of this case significantly difficult. Settlement negotiations were commenced. The original demand by the plaintiff was well in excess of the one million dollar policy limit available. The plaintiff's counsel insisted he intended to pursue the assets of the nursing home if a verdict was rendered in excess of the available coverage. He was reminded that this facility had no assets, and that Medicare and Medicaid had superior lienholder rights to him. He then reduced the demand to one million dollars. Further negotiations ensued and this lawsuit was eventually resolved for $805,000.

CASE #1 – A LEGAL & RISK MANAGEMENT PERSPECTIVE

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In this lawsuit, in addition to allegations of malpractice against the defendant facility and physician, the complaint alleged statutory violations of New York State Public Health Law (PHL) § 2801-d and PHL § 2803c. PHL § 2801-d provides for a private right of action by patients in a residential health facility who are denied certain rights and benefits. The legislative history of this indicates it is designed to protect the basic rights of patients and particularly the right to be free of abuse. To state a claim under this section, the complaint must state the patient was deprived of a right or benefit due to the negligence of the facility. Such rights include privacy, basic medical care, and the freedom from abuse. Further, this law also prohibits discrimination against a patient because the patient commenced an action or filed a complaint. PHL § 2803-c delineates the rights of patients in certain medical facilities and PHL § 2803-c(3) delineates the rights of patients to receive appropriate and adequate medical care.

If a patient sustains an injury due to a deprivation of a right or benefit, the facility must show that it exercised all reasonable and necessary care to prevent or limit the deprivation and injury. If the facility is unable to do so, the patient may be awarded compensatory damages of no less than 25% of the daily room rate established by law or the average daily total cost of the facility. Where the deprivation is also found to be due to willful or reckless disregard of the patient's rights, punitive damages can also be assessed. Punitive damages are not permitted to be reimbursed by insurers as a matter of "public policy" and are therefore a direct out of pocket expense. Finally, if the plaintiff wins the lawsuit, attorney's fees can be awarded.

The lack of documentation in this case by the facility's aides provided many of the facts necessary for alleging a statutory violation. The plaintiff's attorney claimed that the benefits of which the patient was deprived included the failure to properly turn and position him; the failure even upon admission to pay close attention to the condition of his skin; the failure to provide adequate nutrition and monitor his intake and output to confirm he was adequately hydrated; and, finally, the failure to regularly observe his skin integrity and provide adequate skin protective devices. From a legal perspective, the documentation was substandard at best, making the defense of this case almost insurmountable from the beginning.

In addition to the lack of documentation by the staff, the resident's physician also failed to document specifically what care the patient should have received. He failed to issue specific orders for positioning, nutrition, and skin assessment. Because the physician failed to regularly observe the patient's skin integrity, document the development of decubiti, and then issue orders for further treatment, the plaintiff was able to allege that the defendant physician also was negligent.

Finally, when pursuing a case against a residential facility, one of the major pieces of evidence used by plaintiff's attorneys to prove negligence are the facility's standards, policies and procedures, as well as the New York State regulations which govern residential facilities. Because the violations previously delineated in this case study are clear deviations from the standard of care pursuant to the defendant's own policies and procedures and state regulations, a cogent defense of the defense facility was impossible.

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CASE STUDY #2

Nerve Injury from a Femoral Block Under General Anesthesia

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This case illustrates how documentation deficiencies persist and often greatly affect the defensibility of medical malpractice cases.

A 43-year-old male plaintiff who sustained a work-related knee injury presented for an arthroscopic reconstruction of the left anterior cruciate ligament (ACL) by the defendant orthopedic surgeon. The femoral block and general anesthesia were provided by the defendant anesthesiologist.

On the day of the scheduled procedure, the plaintiff was evaluated by the nursing staff at the ambulatory surgery center. The nursing staff documented his vital signs, but not his past surgical history. A pre-anesthesia evaluation was performed by the defendant anesthesiologist. His findings were similar to that of the nursing staff. He documented the plaintiff's past medical history and current medications, but failed to document the plaintiff's surgical history and sensitivity to acetaminophen. The box for the anesthesia plan was not checked, but the box stating there was an informed consent discussion was checked. However, the plaintiff did not sign a specific informed consent document for general anesthesia with a left femoral block. It was the custom and practice of that surgery center to only have a patient sign an informed consent form for the ACL surgery. During the defendant's deposition, he testified that he did not discuss the alternatives to the planned anesthesia with the plaintiff.

The plaintiff was taken to the operating room at approximately 10:45 a.m. Shortly thereafter, the defendant placed him under general anesthesia, including propofol and fentanyl. The plaintiff was placed in the supine position, and anesthesia was maintained. During the procedure, the defendant placed a tourniquet and administered a left femoral nerve block. Although the time that the femoral nerve block was administered was not documented, the anesthesia record does reflect that a femoral block was given. In addition, the use of an ultrasound and nerve stimulator was documented.

No paresthesia, pain on injection, or bleeding were noted. The insured administered 30 cc of the anesthetic, 0.375% bupivacaine, with "Dec/epi." However, no concentrations of, or dosages for, "Dec/epi" were given. The insured later testified at his deposition that he administered only epinephrine as an additive. It is not known if the "Dec" was the corticosteroid dexamethasone. The defendant also documented that he used a 22 gauge needle. However, at his deposition, he testified that he used a 21 standard gauge needle. The procedure was concluded at 12:45 p.m. and the plaintiff was transferred to the PACU.

Postoperatively, the plaintiff complained of groin pain of an 8 out of 10. He was given pain medication and discharged at 3 p.m. During a postoperative follow-up call four days later, the plaintiff still complained of pain. However, the location of the pain was not documented. At follow-up visits with the orthopedic surgeon, he continued to complain of groin pain. Finally, during a related Workers' Compensation evaluation almost 2 months later, the plaintiff was diagnosed with left femoral neuritis, which was later confirmed by an EMG/NCV study.

The patient sued both the surgeon and the anesthesiologist. Expert reviews were obtained on behalf of all of the treating providers. Interestingly, an initial review by an outside expert anesthesiologist did not find liability on behalf of the defendant anesthesiologist. He opined that if the plaintiff had sustained an injury while the nerve block was being administered, the pain would have been immediate and severe. He also opined that symptoms of a nerve injury would have manifested as anterior thigh numbness. He further claimed that administering a femoral nerve block while a patient is under general anesthesia is a matter of preference. He asserted that an EMG is an extremely subjective test and not always diagnostically reliable. In his

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opinion, the nerve injury was due to the positioning of the plaintiff and pressure from the tourniquet.

Internal MLMIC reviewers disagreed with this expert's findings. They based this upon the opinion of the American Society of Regional Anesthesia, which advises against performing a femoral block under general anesthesia because it can mask any damage to the nerve by direct needle injury or local anesthesia-related compression injury. They also felt that the informed consent discussion was inadequate or lacking. Further, there was no record of the threshold current necessary for nerve stimulation prior to the injection of local anesthesia injection, nor documentation of the additives to the local anesthetic for the block. Finally, the reviewers felt that a nerve injury in the face of ultrasound guidance and electrical stimulation was unacceptable.

Based upon these deficits in care, the reviewers strongly recommended that the lawsuit be settled. The case was settled on behalf of only the defendant anesthesiologist for $325,000.

CASE #2 – A LEGAL & RISK MANAGEMENT PERSPECTIVE

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The key flaw in many of the cases presented in *Case Review* is the lack of adequate documentation. It is difficult to defend lawsuits when documentation is poor or nonexistent as they are often commenced long after an injury has occurred. Without documentation, the defendant anesthesiologist in this case was not able to recollect any of the events which had occurred several years earlier. Thus, any future specific statements/recollections the defendant might make when testifying at a deposition or trial will lack credibility.

Although the defendant used ultrasound guidance to perform the block, only one ultrasound image is present in the medical record. Unfortunately, that one image does not negate a nerve injury. It merely shows that at that brief moment in time, the needle did not touch the nerve. An additional image taken after the block would have confirmed there was no nerve injury and greatly helped the defense. An ultrasound taken both before and immediately after an injection will show the contrast in the anatomy and confirm the spread of the local anesthesia around but not into the nerve. Since the records do not even reflect when the femoral block was performed, an additional image taken after the injection was clearly indicated.

A crucial issue in this lawsuit was whether the standard of care was met because the patient, having received general anesthesia prior to the block, was asleep. As noted, this was a highly disputed issue. Many experts have stated that this is a bad practice. In fact, in 2008, the American Society of Regional Anesthesia advised against doing so[1] because nerve trauma from the needle or compression by direct intraneural injection of the local anesthetic may be masked, increasing the risk of complications. Despite this being a controversial and complex practice, the Society opted to issue only a conservative opinion. They opined that, because general anesthesia or heavy sedation removes all opportunities for adults to communicate symptoms of potential nerve injury, such blocks should not routinely be performed in most adults during general anesthesia or heavy sedation. They made an exception to this position for pediatric patients, patients with dementia, or those with developmental delays. The anesthesiologist reviewing this case opined that by doing this block under general anesthesia, there was a deviation from the standard of care.

The standard of care for a nerve block also requires the use of nerve stimulation, with participation by the patient. Documentation of the threshold current, and use of a minimal current greater than 0.3mA, must be completed to confirm that the tip of the needle is not too close to the

1. Regional Anesthesia & Pain Medicine Vol. 33 No. 5 (Sept-Oct), 2008: pp 449-460 at p. 457, 456.

nerve. Although an electrical stimulator was used with the ultrasound guidance, the defendant also failed to record the current measurements of the nerve stimulation, thereby making it difficult to show that his care was reasonable and appropriate.

The defendant's preoperative evaluation of the plaintiff also failed to meet the standard of care. The patient's sensitivity to acetaminophen and his history of prior surgeries and laboratory test results were not documented. Nor was there any documentation of a discussion of alternative anesthetics or an anesthesia plan. Thus, the plaintiff could reasonably allege a lack of appropriate informed consent. Although the defendant checked the box that said an informed consent discussion was performed, there was no separate and more comprehensive anesthesia consent form. Having such a document might have helped the defense because it would have memorialized the conversation which occurred.

While many physicians assume that having a patient sign a consent form is sufficient, the law (New York State Public Health Law § 2805-d) requires a discussion between the physician performing the procedure and the patient. The discussion must include the risks, benefits and alternatives to the procedure, including the risks of the alternatives and no treatment. The patient must understand the information and have the opportunity to ask questions. In this case, this did not occur. The defendant admitted he failed to discuss the alternatives to a nerve block under general anesthesia with the patient. A process involving a written consent form could have prompted the doctor to have a specific discussion, including several of the most frequent risks of the procedure. The use of such a form often stimulates further discussion and questions between the patient and provider.

Finally, the documentation which did exist in the record conflicted with the defendant's deposition testimony, which in turn undermined the credibility of the sparse documentation completed. For instance, the defendant claimed he used only epinephrine but not dexamethasone. However, his documentation stated he used bupivacaine with "dec/epi." He also claimed at the deposition in contradiction to his record that he used a 21 gauge needle and not a 22 gauge needle. These discrepancies cast serious doubt on his credibility and his version of events.

All of these failures of documentation, deviations from the standard of care, and lack of informed consent made it extremely difficult to defend this lawsuit. The patient's damages included a chronic left femoral neuritis, pain and suffering, and his wife's lack of consortium. Therefore, the case was resolved for $325,000 on behalf of only the defendant anesthesiologist.

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CASE #1 – A LEGAL & RISK MANAGEMENT PERSPECTIVE *continued from page 4*

Residential facilities must have policies requiring regular skin assessment, frequent positioning, and continuous nutritional assessment of residents. All of these items must be documented to prove compliance by staff. Although the plaintiff was in the last stages of Alzheimer's dementia, many of the injuries claimed could have been prevented. The lack of documentation of the staff's actions and observations over the last several months of his life made it extremely difficult to overcome the premise of negligence and the deprivation of reasonable care.

Even where there was documentation of care, it was at times contradictory. For instance, the record referred to an increase in the intervals for turning the patient. However, the notes never indicated what the intervals were. When the presence of an ulcer was documented, the ulcer was not staged. Therefore, the sparse documentation contained in the records may well not have reflected the actual skin condition of the resident. Finally, although he was to receive at least 700cc of fluid a day, his intake and output was rarely documented, leading to claims of failure to both hydrate and nourish him. Further, no reasonable target rate for calories was set nor met. In contrast, when hospitalized at one point, he actually gained weight due to increased caloric intake and orders.

In summary, when an assessment of skin integrity reveals a high risk for problems, and the patient additionally has poor nutritional status, both the care plan and staff documentation must be carefully and regularly completed on every shift. This includes skin care, frequency of positional changes, skin and other assessments, as well as appropriate intake, output and calorie counts.

Although it is possible that the patient's terminal condition caused the decubitus on his coccyx to reach Stage 3, the many failures of the staff and physician, and the continuous poor documentation over a period of months, made this argument impossible to make. Further, due to the multiple deficits in care, assessment and documentation, and noncompliance with policies and regulations, there was a serious possibility that the defendant facility would be subject to both compensatory and punitive damages pursuant to PHL § 2801-d. Finally, the conclusions by the pathologist retained to perform an autopsy upon the resident would have greatly inflamed a jury. Therefore, there was no choice but to settle this case for a substantial sum.