Nursing Staff's Professional Negligence Causes Death of Patient

written by Nancy Brent | March 1, 2018

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Lloyd Thomas, seventy-one, underwent bypass surgery and was hospitalized for eighty-four days after the surgery due to complications. During his hospitalization, he had a feeding tube. He steadily recovered but needed additional rehabilitation so he was transferred to HCRA, a rehabilitation facility.[1]

On admission, it was discovered Lloyd had colonized MSRA. Despite this development, he did well at HCRA, got along with staff, had physical therapy and he experienced increased mobility and strength.

However, after twenty-five days at HCRA, his condition "severely deteriorated" and he was taken immediately to a hospital ED. Mr. Thomas died less than twenty-four hours later.

His death certificate indicated that he died of multi-system organ failure secondary to sepsis.

The family filed a liability case against the nursing home, alleging that Mr. Thomas was: "not properly cleaned or repositioned, causing him to develop decubitus ulcers; not properly nourished; not given ordered medications; and not assessed as to his urine output and bodily temperature".

They also alleged his room was not cleaned and documentation was inadequate in his medical record. Moreover, the allegations included some of the medical record was fabricated.

The trial court entered a judgment on behalf of the family. HCRA appealed that decision. The appellate court had several legal procedural issues and amount of compensation issues to decide, but the one issue this Bulletin is focusing upon is HCRA and its nursing staffs' negligence that caused the death of Mr. Thomas.

Lloyd was on Lasix while in the nursing home. The Director of Nursing and several physicians at the home testified at the trial. It was essential to monitor the fluid input and output of a patient when on this medication, according to their testimony.

Because Lloyd had a feeding tube and a catheter, it should have been very easy to do so. But, the Director of Nursing admitted the patient's fluid input and output were not properly charted as required by the nurses' overall standard of care.[1]

Mr. Thomas was also dehydrated and not well nourished when he left the home for the hospital, according to testimony from the Medical Director at the home.

Family testimony revealed that Mr. Thomas had two ulcers on his back, behind his hip bones. His medical record, however, did not indicate anything concerning the existence of, or treatment for, these ulcers.

Yet, when he was rushed to the hospital ED, the ED physicians documented two stage three decubitus ulcers on his back that were "necrotic and oozing blood". Had Mr. Thomas been re-positioned every two hours, which is the established overall standard of care, a physician expert testified that he would have "expected him to not have any ulcers".

Mr. Thomas also suffered from diarrhea after his condition began to deteriorate. Family testimony disclosed that when the diarrhea occurred, the family would ring the nurses but they "would not come". Mr. Thomas was left lying in his feces.

The appellate court held that the evidence and inferences testified to at the trial level fully supported the jury's verdict in favor of Mr. Lloyd's family. In responding to the fact that the decubitus ulcers were not noted in Mr. Thomas' medical record, the court stated: "The fact that these lesions were not noted in the rehab facility's records does not dispute their existence. Instead, it tends to establish a high degree of conscious indifference by the rehab facility's nursing staff to the patient's rights despite awareness of an extreme risk of serious harm".[2]

This case is an appalling one, in my opinion. Mr. Thomas had been making progress when admitted to the nursing home, but, due to the lack of nursing care by the nursing staff, his condition deteriorated.

In addition, other team members, physicians and/or administrators included, apparently failed to oversee the patient's care and failed to intervene to prevent what happened to Mr. Thomas. Their respective testimony, although truthful, cemented liability for HCRA.

Clearly, the nursing staff, including the Director of Nursing, were "indifferent" to Mr. Thomas, both as a patient and as a human being. How they were able to completely ignore him and his required care is beyond comprehension.

Due to the lack of basic and overall nursing care, it would not be a surprise if the Director of Nursing and the nursing staff involved would face disciplinary proceedings before the state board of nursing for unprofessional conduct. They never came close to providing care required by their respective overall standard of care and standards of practice.

What is also interesting in this case is that those who testified about the non-care of Mr. Thomas were employees of the facility and who had a part in his care.

Whether you are practicing in a long-term care facility or other health care setting, this case underscores significant recommendations for your practice. They include:

- Provide patient care that is ordered, meet your standards of practice and overall standard of care,

and what is required by your legal and ethical duties;
- When a patient or family member rings or asks for help for their family member, respond as quickly as possible;
- Document all care provided accurately and completely;
- Never fabricate or falsify a patient's medical record;
- Testimony from staff members and physicians who care for a patient may easily support a finding of negligence that leads to a patient's death;
- If a Director of Nursing or CNN, ensure that your nursing staff is providing the care required for all patients; and
- Regularly review the Code of Ethics for Nurses with Interpretive Statements and incorporate the Code into your everyday practice.

FOOTNOTES

1. HCRA of Texas, Inc., d/b/a Heartland Health Care Center-Bedford v. Margarie Fay Johntson, Tommy Lloyd Johnston,

and others, No. 2-03-321-CV, Court of Appeals of Texas, Fort Worth, November 3, 2005.

2. "Decubitus Ulcers, Sepsis: Court Links Patient's Death To Substandard Nursing Care", Legal Eagle Eye Newsletter for the Nursing Profession, December 2005, 6.