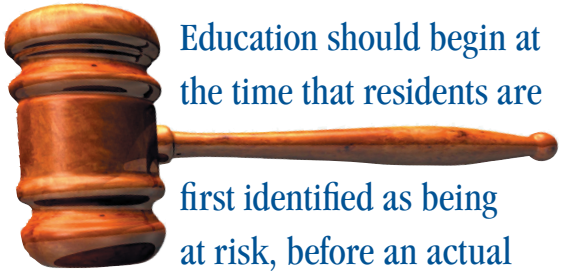
LIABILITY
landscape

BY LINDA WILLIAMS, RN

Use standing orders judiciously

The use of standing order programs has found a place in long-term care, specifically related to influenza and pneumococcal vaccinations. These standing order programs are effective immunization-promoting interventions in which nurses are authorized to vaccinate by institution-approved protocol, without a specific physician order or exam. Generally speaking, standing orders are written in the form of a protocol that is nonresident-specific and they are approved and signed by a physician, usually the facility's medical director.

When used judiciously, standing orders are a very efficient and effective tool in the hands of healthcare providers. However, problems arise when deviations are made, such as using standing orders for resident-specific situations that can short-change the communication process between caregivers and physicians. Please take the time to review the circumstances surrounding the following situation and make changes as appropriate in your facility.



Education should begin at the time that residents are first identified as being at risk, before an actual problem develops.

The Situation

An 82-year-old woman with a history of dementia, cancer, and untreated peripheral vascular disease (PVD) was admitted to a nursing facility. Because of her condition, the staff implemented pressure-reducing devices on the surfaces that she sat or lay upon. They kept a close watch on her skin integrity and, as an added precaution, the woman's attending physician preapproved standing orders (or a skin protocol) for her in the event of any skin breakdown.

The woman seemed to adjust to her new environment without any complications, until a few months later when a nurse found a red area on the top outer lateral side of her right foot, which was not a pressure point. The nurse immediately activated the standing orders, which included moving the woman to a specialized pressure-relieving bed.

Despite the caregivers' efforts, the woman's condition rapidly deteriorated to the extent that she developed open areas on other parts of her foot. The nursing staff continued to adhere to the standing orders for her wound treatment and sought lab work, nutritional changes, and a surgical consult. The nurses unsuccessfully tried to contact the woman's legal representative about the consult, so a staff member took her to the appointment. However, the surgeon refused to examine the woman without her legal representative present, so they returned to the facility. At this point, the woman had not been examined by a physician since her skin problems developed two and a half months earlier. In fact, changes in the wound had not even been communicated to the attending physician because the nurses simply followed the standing orders.

The following day, the woman's attending physician arrived at the facility and examined her. He changed her treatment orders and asked the nurses to reschedule the surgical consult because the open areas in her foot now appeared to be infected. Fortunately, the nurse was finally able to contact the woman's legal representative, who agreed to accompany her to the rescheduled surgical exam. When the representative arrived at the facility to take the woman to her appointment, she took some photographs of the woman's foot before leaving. The representative was upset with the staff for not informing her earlier of the woman's foot problems.

At the consult, the surgeon was unable to locate palpable pulses in either of the woman's feet because of her PVD, and tests revealed that the popliteal artery in her right leg had moderate atherosclerosis. Her right foot had ischemic gangrenous necrotic areas, so the surgeon determined that the best course of action was for the woman to have an above-the-knee amputation (AKA) of her right extremity. Plans were made to admit her to the hospital within 24 hours.

After her surgery, the woman developed pneumonia and a fever of unknown origin that could not be effectively controlled. She remained in the hospital for more than a month, much longer than anticipated. When she returned to the facility, she was in a vegetative state with a low-grade fever and the skin integrity on her left foot also had begun to break down. Her prognosis was poor and she died at the facility shortly thereafter. The cause of her death was listed as sepsis.

Two years later, a lawsuit was filed against the nursing facility by the woman's distant relatives alleging that the staff failed to notify the physician and family in a timely manner about the woman's skin problems and that they failed to carry out the surgi-

cal consult orders, delaying her treatment. According to the family, the overall lack of communication resulted in the gangrene to the woman's foot, amputation of her leg, and subsequent death by sepsis. They demanded $600,000 to settle the case.

The facility's response to the allegations was that before coming to the facility, the woman had preexisting PVD, which worsened rapidly despite appropriate staff intervention. Attempts were made to notify the legal representative about her condition, but to no avail. It also was important to note that the distant relatives were not actively involved in the woman's care until the end. Although the woman died of sepsis, there was no direct correlation that the origin was from the gangrenous foot, as no foot cultures were obtained. A surgeon testified that if the source of the sepsis and her elevated white blood cell count had been the gangrenous foot, she should have responded to the antibiotics within 72 hours after the amputation. Since the woman was not symptomatic of any respiratory illness until her hospital stay, it is possible that she contracted an organism in the hospital or that she had another infectious process going on that was not identified. The case was settled in mediation for a fraction of the original demand amount.

Protecting Your Residents and Facility

The weakness in the facility's defense was that the nursing staff relied so heavily on the standing orders to treat the woman that they neglected to properly update the physician about her condition in a timely manner. Consequently, she was not examined as early and as often as she should have been. Would that have changed her outcome? Probably not, since the woman's underlying PVD directly led to the amputation, which could not have been prevented by the staff. Before using standing orders for a resident-specific situation in your facility, consider the following communication tips:

- Immediately inform the resident and consult with the resident's physician. If known, notify the resident's legal representative or an interested family member when there is a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications), or a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment because of adverse consequences, or to commence a new form of treatment).
- Ensure that the services being provided meet professional standards of quality (i.e., accepted standards of clinical practice) and are provided by appropriate qualified persons. In this situation, the woman's physician should have been more involved with assessing and directing her care from the start of her foot problem.
- Encourage physicians to document the prognosis and causation for all wounds and/or significant condition changes.
- Educate families and responsible parties on the condition diagnosis, prognosis, and treatment options. Education should begin at the time that residents are first identified as being at risk, before an actual problem develops.
- Change care plans accordingly and effectively communicate them to vested parties. Be sure to communicate care conference outcomes to legal representatives that could not participate in the actual meeting for whatever reason. This should be done via certified mail.

By taking these precautionary measures, you can protect your residents and facility. ■

Linda Williams, RN, is a Long-Term Care Risk Manager for the GuideOne Center for Risk Management's Senior Living Communities Division. She previously served as Director of Nursing in a CCRC and as a nurse consultant for two corporations with numerous long-term care facilities in Iowa.

The GuideOne Center for Risk Management is dedicated to helping churches, senior living communities, and schools/colleges safeguard their communities by providing practical and timely training, and resources on safety, security, and risk-management issues.

For more information, phone (877) 448-4331, ext. 5175; e-mail slc@guideone.com; or visit www.guideone.com. *To send your comments to the author and editors, e-mail williams0207@nursinghomesmagazine.com.*