The Case of the Missing Medical Records

A crucial order was lost in the shuffle

BY LINDA WILLIAMS, RN

An 86-year-old woman was admitted to a nursing home following surgery and hospitalization for fractures on her left femur, humerus, and wrist. The woman lived in an independent-living apartment complex when she accidentally fell, causing the multiple fractures. She arrived at the nursing home with her left lower leg wrapped in an ACE® bandage and wearing a removable leg immobilizer.

For the first five days of the woman's stay, the nurses performed daily vascular checks. These checks included assessing the color of the skin, range of motion, and sensation of the exposed toes and foot on the resident's lower left leg. No problems were discovered. On the sixth day, an interdisciplinary team that included a nurse and a physical therapist met to discuss the resident's plan of care. The physical therapist made a comment about the orthopedic physician's admission order and went to the resident's chart to retrieve it. When it was brought back to the group, it was discovered that the order instructing the nurses to "remove the immobilizer cast daily to change the dressing" had not been followed.

The nurse went immediately to the resident's bedside and removed the immobilizer and ACE bandage. She discovered three fairly large blisters on the resident's left foot. The nurse reported the incident to the orthopedic physician, who told her to continue monitoring the foot daily and that he would assess it during the resident's scheduled office visit one week later. In the meantime, however, the nurses became increasingly concerned about the situation and sent the resident to the hospital the next day to be assessed by the emergency room physician. That physician checked the resident's capillary refill on the affected toes and stated "the circulation was excellent." The resident returned to the nursing home, where the nurses continued to closely monitor her leg carefully.

The following week, the resident went to her scheduled office visit with the orthopedic physician. Upon examination, the physician decided to send the woman to the hospital immediately for placement of shunts in both legs to improve blood circulation. The surgery was performed the same day. Unfortunately, the blisters continued to spread in the woman's left lower leg, and new, necrotic wounds began to emerge. Within days, the resident underwent another surgery, this time to amputate her left lower leg. Upon discharge from the hospital, the resident moved to another nursing home.

Later that year, the first nursing home received notice of a lawsuit by the woman, claiming negligence in her care. The woman's attorney alleged that the bandage had stopped the flow of blood to her foot, causing tissue to die and resulting in left lower-leg amputation. The attorney had a medical expert who was willing to testify that the "excellent" capillary refill observed by the emergency room physician was actually the return of blood that had been pooling in her foot because of the tight bandage. Because of her disability, the woman could not return to her independent lifestyle and was forced to live in a nursing-home environment for the remainder of her life.

In addition to the lawsuit, the nursing home also discovered that two of the nurses involved in the woman's care were being investigated by the state Attorney General for possible criminal charges stemming from the incident.

The next year, the lawsuit was settled out of court for $450,000. No criminal charges were brought against the nurses, but the nursing home's reputation within the community remained stigmatized for some time.

What Went Wrong?

The obvious error in this case study was the nurses' failure to see the orthopedic physician's order instructing them to "remove the immobilizer cast daily and change the dressing" until the resident had spent six days in the facility. Upon deposition, the nurse responsible for admitting the resident stated that when she received the records from the hospital, she went through the information and started to fill in the nursing home's admitting records and transcribe the physician's orders. She remembered seeing something referring to orthopedic orders, but did not actually see any orthopedic orders in the chart. She further indicated that she did not see anything that would have been a red flag to contact the physician. When asked how long it took her to complete the admission paperwork, the nurse stated that she filled it out, off and on, throughout the shift because she had other responsibilities to meet.

During that time, other staff members had access to the resident's record, including the physical therapist. When the physical therapist was deposed, she stated that she went to the nurse's station to check the resident's physician's orders when the resident was admitted to the nursing home. The physical therapist looked through the paperwork and wrote down the resident's history and the orthopedic physician's orders. She further stated that she removed the physician's orders from the stack of papers and took them to another part of the building to make copies. She didn't think it took her very long to do this.

The nursing home staff concluded that while the physical therapist was copying the physician's orders, the admitting nurse missed finding them (because they weren't in the hospital papers), so she never transcribed them into the resident's record or treatment sheets.

What You Can Do

Protect your residents and facility from a similar situation by taking the following precautions:

- As part of your HIPAA-compliance plan, secure all of your residents' personal information in one area to more easily control access to the information. Prohibit removal of pages from a resident's record without the knowledge and authorization of the individual assigned to protect the records.
- Develop a checklist or "cheat sheet" for nurses to use during the resident-admission process that will remind them of the information that needs to be included in the new resident's record, such as postsurgical-treatment orders.
- Use an auditing check-and-balance system in which admission/discharge records are checked for completeness by either the nurse assigned to the next shift or by a designated record keeper.
- Have the MDS coordinator begin gathering information for the resident's first MDS assessment during (or shortly after) admission by reviewing all relevant information in the new resident's record, including past histories and physicals.
- Assign a quality-assurance nurse to randomly review resident records for vital information and list areas needing improvement. Provide periodic in-service training for the nursing staff regarding your facility's documentation requirements.

Precautions such as these will prevent the oversights that got this resident, and then the facility that cared for her, into serious trouble. **NH**

Linda Williams, RN, is long-term care risk manager for the GuideOne Center for Risk Management's Senior Living Community Division, at GuideOne Insurance, West Des Moines, Iowa. This article is published in partnership with Briggs Corporation. For another case study by Williams, see *Nursing Homes/Long Term Care Management*, Jan. 2003, p. 64. For more information, phone (877) 448-4331, ext. 5175, e-mail slc@guidemail.com, or visit www.guideonecenter.com *To comment on this article, please send e-mail to williams0403@nursinghomesmagazine.com.*

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