Commentary on the Quality Improvement Case Study

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If this article has presented all the facts/details about the resident's case, then there is more than one quality improvement issue to be identified and corrected.1

The four criteria for the malpractice action to have merit include establishing the duty or obligation of the institution to perform a particular service and/or provide care, to establish a breach of that duty, to show injury to the resident, and to show proximate cause.

Clearly there was a duty or obligation on the part of the institution to provide care for the resident. However, the facility failed to provide necessary care not only by failing to contact the physician in a timely manner but by failing to provide an ongoing assessment of the resident and failing to develop and implement a plan of care for his changing medical condition. The failure to notify the physician was just the last step in a chain of failures.

If one assumes that the resident entered the facility in mid August, 2001, following surgery for a left hip fracture performed on August 1, 2001, the facility had an obligation under the Medicare regulations to perform a comprehensive initial assessment within the first 14 days of admission [F272, 438.20(b)(1)(2)] and to develop a plan of care within an additional 7 days based on the initial assessment [F279, 438.20(d)]. This initial assessment and plan of care should have identified the resident's potential for developing a urinary tract infection based on the presence of an indwelling Foley catheter. F316 requires that the resident receive necessary care to prevent urinary tract infection. There is no evidence in the narrative, as presented, that facility staff recorded intake and output. There is nothing to indicate that facility staff recorded intake and output. Assessment of the urine and measurement of intake and output is a nursing function and does not require a physician order.

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The physician's order to send the resident to the hospital “if overall condition doesn't improve” is unclear and should have been clarified by nursing staff. Apparently this was not done.

There was no ongoing nursing assessment of the resident on September 6, 2001, even though he had a significant change in medical condition on the 5th and should have received intensified assessment.

At 10:45 AM on September 7, the resident exhibited a return of shaking and had a rectal temperature of 102°F. Why wasn't a physician notified at this time? Did nursing staff fail to consider that a return of shaking accompanied by fever might constitute a failure of the resident's overall condition to improve? There was an additional 10 hour delay before the resident was sent to an acute hospital for evaluation and treatment.

No mention is made of the apparent improper treatment received by the resident at the acute hospital. If the resident's sodium was 159 MEQ/L, why would a physician use normal saline as a bolus infusion? This caused the sodium level to rise to 166, further placing the resident at risk.

In my opinion, the primary failures by facility staff were the failure to provide comprehensive initial assessment and development and implementation of an appropriate plan of care for the prevention of urinary tract infection and the failure to provide comprehensive ongoing assessment when there was a significant change in the resident's medical condition. In service education for the facility's staff should not be limited to instruction in following the facility's policy on when to call the physician but should be focused on the necessity of providing comprehensive and appropriate nursing assessments with nursing interventions as required by the assessments. Notification of the physician, then, would normally follow the assessments that would identify the failure of the resident to respond to treatment.

I do not believe that it is incumbent on facility staff to recommend that a physician order a urine culture, blood count, or antibiotics. However, if a comprehensive assessment is performed by nursing staff, and the results of that assessment reported to the physician, the physician, in turn, will have the
necessary information on which to base further therapeutic interventions.

In summary, the facility did breach its obligation to provide care for this resident. The resident did suffer harm as a result of the breach, and there was a direct proximate relationship between the breach and the harm. However, the single improvement action recommended in the article does not begin to address the deficiencies in providing a reasonable standard of care to the resident.

REFERENCES