IN THE STATE COURT OF GWINNETT COUNTY
STATE OF GEORGIA

WILLIE EVA SAMPSON, as Guardian of DOROTHY ANN ANTHONY,

Plaintiff,

— *versus* —

DOCTORS HOSPITAL OF AUGUSTA, LLC

HCA HEALTH SERVICES OF GEORGIA, INC.

HCA HEALTH SERVICES OF TENNESSEE, INC.

ADAM M. ROSS, MD

JONATHAN PRESTON, MD

JAMES A. CATO, MD

EKMINE WIJESINGHE, MD

JDG CIRCLE INPATIENT SERVICES LLC

CSRA MEDICAL ASSOCIATES

JOHN/JANE DOE 1-10,

Defendants

CIVIL ACTION

FILE NO. 20-C-07088-S5

JURY TRIAL DEMANDED

PLAINTIFF'S COMPLAINT FOR DAMAGES

Nature of the Action

1. This medical malpractice action arises out of medical services negligently performed on Dorothy Anthony in October and November 2018.

2. This case concerns a "pressure wound" that developed over Dorothy's sacral area while she was a patient at Doctors Hospital of Augusta (DHA). The wound developed because of neglect by the staff at DHA, and it progressed under DHA's negligent care to the point that the wound became a severe, incurable "stage 4" wound that caused Dorothy to go into life-threatening septic shock and that has left her with permanent, serious injuries, chronic bone infections, and a risk of premature death.

3. Pursuant to OCGA § 9-11-9.1, the Affidavits of Christopher Davey, MD, and Judith Climenson, RN, are attached hereto as Exhibits 1-2. This Complaint incorporates the opinions and factual allegations contained in those affidavits.

4. As used in this Complaint, the phrase "standard of care" means that degree of care and skill ordinarily employed by the medical profession generally under similar conditions and like circumstances as pertained to the Defendant's actions under discussion.

Parties, Jurisdiction, and Venue

5. **Willie Eva Sampson and Dorothy Anthony** are citizens of Georgia. Ms. Sampson is the older sister, and guardian, of Dorothy Anthony.

6. **Defendant Doctors Hospital of Augusta, LLC ("DHA")** is a Delaware limited liability company registered to do business in Georgia. DHA's Registered Office is in Gwinnett County. DHA may be served through their Registered Agent, C T Corporation System, at 289 S Culver St, Lawrenceville, GA, 30046-4805.

7. DHA participates in owning the hospital that operates under the name "Doctor's Hospital of Augusta" at 3651 Wheeler Road in Augusta, Georgia.

8. DHA participates in operating the hospital that operates under the name "Doctor's Hospital of Augusta" at 3651 Wheeler Road in Augusta, Georgia.

9. DHA participates in supervising the management of the hospital that operates under the name "Doctor's Hospital of Augusta" at 3651 Wheeler Road in Augusta, Georgia.

10. DHA is subject to the personal jurisdiction of this Court.

11. DHA is subject to the subject-matter jurisdiction of this Court in this case.

12. DHA has been properly served with this Complaint.

13. DHA has no defense to this lawsuit based on undue delay in bringing suit — whether based on the statute of limitations, the statute of repose, laches, or any similar theory.

14. Pursuant to OCGA §§ 14-2-510, 14-3-510, and 14-11-1108[1] DHA is subject to venue in this Court because (a) it maintains its registered office in Gwinnett County.

15. In October and November 2018, DHA was an employer or other principal of the nursing staff at Doctors Hospital of Augusta who were involved in the treatment of Dorothy Anthony in October and November 2018.

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[1] OCGA §§ 14-2-510 and 14-3-510 provide identical venue provisions for regular business corporations and for nonprofit corporations:

> "Each domestic corporation and each foreign corporation authorized to transact business in this state shall be deemed to reside and to be subject to venue as follows: (1) In civil proceedings generally, in the county of this state where the corporation maintains its registered office…. (3) In actions for damages because of torts, wrong, or injury done, in the county where the cause of action originated, if the corporation has an office and transacts business in that county; (4) In actions for damages because of torts, wrong, or injury done, in the county where the cause of action originated."

These same venue provisions apply to Professional Corporations, because PCs are organized under the general "Business Corporation" provisions of the Georgia Code. *See* OCGA § 14-7-3. These venue provisions also apply to Limited Liability Companies, *see* OCGA § 14-11-1108, and to foreign limited liability partnerships, *see* OCGA § 14-8-46.

16. However, if any other entity was a principal of those nurses, each such entity is hereby on notice that but for a mistake concerning the identity of the proper party, the action would have been brought against it.

17. **Defendant HCA Health Services of Georgia, Inc. ("HCA-GA")** is a Georgia corporation with its Registered Office in Gwinnett County. HCA-GA may be served through their Registered Agent, C T Corporation System, at 289 S Culver St, Lawrenceville, GA, 30046-4805.

18. HCA-GA participates in owning the hospital that operates under the name "Doctor's Hospital of Augusta" at 3651 Wheeler Road in Augusta, Georgia.

19. HCA-GA participates in operating the hospital that operates under the name "Doctor's Hospital of Augusta" at 3651 Wheeler Road in Augusta, Georgia.

20. HCA-GA participates in supervising the management of the hospital that operates under the name "Doctor's Hospital of Augusta" at 3651 Wheeler Road in Augusta, Georgia.

21. HCA-GA is subject to the personal jurisdiction of this Court.

22. HCA-GA is subject to the subject-matter jurisdiction of this Court in this case.

23. HCA-GA has been properly served with this Complaint.

24. HCA-GA has no defense to this lawsuit based on undue delay in bringing suit — whether based on the statute of limitations, the statute of repose, laches, or any similar theory.

25. Pursuant to OCGA §§ 14-2-510, 14-3-510, and 14-11-1108 HCA-GA is subject to venue in this Court because (a) it maintains its registered office in Gwinnett County.

26. In October and November 2018, HCA-GA was an employer or other principal of the nursing staff at Doctors Hospital of Augusta who were involved in the treatment of Dorothy Anthony in October and November 2018.

27. However, if any other entity was a principal of those individuals, each such entity is hereby on notice that but for a mistake concerning the identity of the proper party, the action would have been brought against it.

28. **Defendant HCA Health Services of Tennessee, Inc. ("HCA-TN")** is a Tennessee corporation registered to do business in Georgia. HCA-TN has its Registered Office in Gwinnett County. HCA-TN may be served through their Registered Agent, C T Corporation System, at 289 S Culver St, Lawrenceville, GA, 30046-4805.

29. HCA-TN participates in owning the hospital that operates under the name "Doctor's Hospital of Augusta" at 3651 Wheeler Road in Augusta, Georgia.

30. HCA-TN participates in operating the hospital that operates under the name "Doctor's Hospital of Augusta" at 3651 Wheeler Road in Augusta, Georgia.

31. HCA-TN participates in supervising the management of the hospital that operates under the name "Doctor's Hospital of Augusta" at 3651 Wheeler Road in Augusta, Georgia.

32. HCA-TN is subject to the personal jurisdiction of this Court.

33. HCA-TN is subject to the subject-matter jurisdiction of this Court in this case.

34. HCA-TN has been properly served with this Complaint.

35. HCA-TN has no defense to this lawsuit based on undue delay in bringing suit — whether based on the statute of limitations, the statute of repose, laches, or any similar theory.

36. Pursuant to OCGA §§ 14-2-510, 14-3-510, and 14-11-1108 HCA-TN is subject to venue in this Court because (a) it maintains its registered office in Gwinnett County.

37. In October and November 2018, HCA-TN was an employer or other principal of the nursing staff at Doctors Hospital of Augusta who were involved in the treatment of Dorothy Anthony in October and November 2018.

38. However, if any other entity was a principal of those individuals, each such entity is hereby on notice that but for a mistake concerning the identity of the proper party, the action would have been brought against it.

39. Non-Defendant HCA Healthcare, Inc. ("HCA Inc.") is the ultimate corporate parent of **Defendants DHA, HCA-GA, and HCA-TN**.

40. HCA Inc. is a publicly traded for-profit corporation.

41. In 2019, HCA Inc. operated 184 hospitals, comprised of 179 general, acute care hospitals; three psychiatric hospitals; and two rehabilitation hospitals. In addition, HCA Inc. operated 123 freestanding surgery centers.

42. HCA Inc.'s facilities are located in 21 states and England.

43. In 2019, HCA Inc. had nearly 280,000 employees, including 98,000 registered nurses.

44. HCA Inc. has a market capitalization of over $45 billion.

45. In 2019, HCA Inc. had revenues of over $51 billion, and net income of over $3.5 billion.

46. DHA, HCA-GA, and HCA-TN are not under-resourced entities.

47. DHA, HCA-GA, and HCA-TN have the resources to operate medical facilities properly.

48. DHA, HCA-GA, and HCA-TN have the resources to provide appropriate treatment for their patients, including Dorothy Anthony.

49. Defendant Adam M. Ross, MD is a citizen of Georgia. He may be served at his residence: 944 Heard Ave, Augusta, GA 30904-4165 in Richmond County.

50. Dr. Ross is subject to the personal jurisdiction of this Court.

51. Dr. Ross is subject to the subject-matter jurisdiction of this Court in this case.

52. Dr. Ross has been properly served with this Complaint.

53. Dr. Ross has no defense to this lawsuit based on undue delay in bringing suit — whether based on the statute of limitations, the statute of repose, laches, or any similar theory.

54. Pursuant to OCGA 9-10-31, Dr. Ross is subject to venue in this Court because his co-defendants are subject to venue in this Court.

55. At all times relevant to this Complaint, Dr. Ross acted as an employee or agent of JDG Circle Inpatient Services, LLC.

56. At all times relevant to this Complaint, Dr. Ross acted as an employee or agent of DHA.

57. At all times relevant to this Complaint, Dr. Ross acted as an employee or agent of HCA-GA.

58. At all times relevant to this Complaint, Dr. Ross acted as an employee or agent of HCA-TN.

59. At all times relevant to this Complaint, Dr. Ross acted as an employee or agent of HCA-TN.

60. Defendant Jonathan Preston, MD is a citizen of Georgia. He may be served at his residence: 458 Timber Wolf Trail, Augusta, GA 30907-8948.

61. Dr. Preston is subject to the personal jurisdiction of this Court.

62. Dr. Preston is subject to the subject-matter jurisdiction of this Court in this case.

63. Dr. Preston has been properly served with this Complaint.

64. Dr. Preston has no defense to this lawsuit based on undue delay in bringing suit — whether based on the statute of limitations, the statute of repose, laches, or any similar theory.

65. Pursuant to OCGA 9-10-31, Dr. Preston is subject to venue in this Court because his co-defendants are subject to venue in this Court.

66. At all times relevant to this Complaint, Dr. Preston acted as an employee or agent of JDG Circle Inpatient Services, LLC.

67. At all times relevant to this Complaint, Dr. Preston acted as an employee or agent of DHA.

68. At all times relevant to this Complaint, Dr. Preston acted as an employee or agent of HCA-GA.

69. At all times relevant to this Complaint, Dr. Preston acted as an employee or agent of HCA-TN.

70. At all times relevant to this Complaint, Dr. Preston acted as an employee or agent of HCA-TN.

71. **Defendant JDG Circle Inpatient Services, LLC ("JDG")** is a Georgia limited liability company. JDG's Registered Office is in Cobb County. JDG may be served through their Registered Agent, CSC of Cobb County, Inc. at 192 Anderson Street SE, Suite 125, Marietta, GA, 30060.

72. JDG is subject to the personal jurisdiction of this Court.

73. JDG is subject to the subject-matter jurisdiction of this Court in this case.

74. JDG has been properly served with this Complaint.

75. JDG has no defense to this lawsuit based on undue delay in bringing suit — whether based on the statute of limitations, the statute of repose, laches, or any similar theory.

76. Pursuant to OCGA 9-10-31, JDG is subject to venue in this Court because their co-defendants are subject to venue in this Court.

77. In October and November 2018, JDG was an employer or other principal of Dr. Ross and of Dr. Preston in October and November 2018.

78. However, if any other entity was a principal of Dr. Ross or Dr. Preston, each such entity is hereby on notice that but for a mistake concerning the identity of the proper party, the action would have been brought against it.

79. **Defendant James A. Cato, MD** is a citizen of Georgia. He may be served at his residence: 3210 Walton Way Ext, Augusta, GA 30909-3119.

80. Dr. Cato is subject to the personal jurisdiction of this Court.

81. Dr. Cato is subject to the subject-matter jurisdiction of this Court in this case.

82. Dr. Cato has been properly served with this Complaint.

83. Dr. Cato has no defense to this lawsuit based on undue delay in bringing suit — whether based on the statute of limitations, the statute of repose, laches, or any similar theory.

84. Pursuant to OCGA 9-10-31, Dr. Cato is subject to venue in this Court because his co-defendants are subject to venue in this Court.

85. At all times relevant to this Complaint, Dr. Cato acted as an employee or agent of CSRA Medical Associates, P.C.

86. At all times relevant to this Complaint, Dr. Cato acted as an employee or agent of DHA.

87. At all times relevant to this Complaint, Dr. Cato acted as an employee or agent of HCA-GA.

88. At all times relevant to this Complaint, Dr. Cato acted as an employee or agent of HCA-TN.

89. At all times relevant to this Complaint, Dr. Cato acted as an employee or agent of HCA-TN.

90. **Defendant Ekmini Wijesinghe, MD** is a citizen of Georgia. She may be served at her residence: 215 Ryan Ln, Evans, GA 30809-4031.

91. Dr. Wijesinghe is subject to the personal jurisdiction of this Court.

92. Dr. Wijesinghe is subject to the subject-matter jurisdiction of this Court in this case.

93. Dr. Wijesinghe has been properly served with this Complaint.

94. Dr. Wijesinghe has no defense to this lawsuit based on undue delay in bringing suit — whether based on the statute of limitations, the statute of repose, laches, or any similar theory.

95. Pursuant to OCGA 9-10-31, Dr. Wijesinghe is subject to venue in this Court because her co-defendants are subject to venue in this Court.

96. At all times relevant to this Complaint, Dr. Wijesinghe acted as an employee or agent of CSRA Medical Associates, P.C.

97. At all times relevant to this Complaint, Dr. Wijesinghe acted as an employee or agent of DHA.

98. At all times relevant to this Complaint, Dr. Wijesinghe acted as an employee or agent of HCA-GA.

99. At all times relevant to this Complaint, Dr. Wijesinghe acted as an employee or agent of HCA-TN.

100. At all times relevant to this Complaint, Dr. Wijesinghe acted as an employee or agent of HCA-TN.

101. **Defendant CSRA Medical Associates ("CSRA")** is a Georgia Professional Corporation with its Registered Office in Richmond County. CSRA may be served through their Registered Agent, Lee W Prather, 3540 Wheeler Road, Suite 210, Augusta, GA, 30909,.

102. CSRA is subject to the personal jurisdiction of this Court.

103. CSRA is subject to the subject-matter jurisdiction of this Court in this case.

104. CSRA has been properly served with this Complaint.

105. CSRA has no defense to this lawsuit based on undue delay in bringing suit — whether based on the statute of limitations, the statute of repose, laches, or any similar theory.

106. Pursuant to OCGA 9-10-31, CSRA is subject to venue in this Court because their co-defendants are subject to venue in this Court.

107. At all relevant times, CSRA was an employer or other principal of Dr. Cato.

108. At all relevant times, CSRA was an employer or other principal of Dr. Wijesinghe.

109. However, if any other entity was a principal of Dr. Cato or of Dr. Wihesinghe, each such entity is hereby on notice that but for a mistake concerning the identity of the proper party, the action would have been brought against it.

110. **Defendants John/Jane Doe 1-10** are those yet unidentified individuals and/or entities who may be liable, in whole or part, for the damages alleged herein. Once served with process, John/Jane Doe 1-10 are subject to the jurisdiction and venue of this Court.

111. This Court has subject matter jurisdiction, and venue is proper as to all Defendants in this Court.

Pressure Wounds Generally[2]

A well-known problem

112. The problem of pressure wounds has been known for centuries. One textbook on pressure wounds notes that "The bedsore problem is ancient and has never been

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[2] The Defendants themselves likely do not need assistance in answering the allegations contained in the general discussion of pressure wounds, provider responsibilities, etc. However, for the benefit of others who may be involved in answering the allegations: The general discussion here draws from the following texts (although many other texts address the topics, too):

- European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance. *Prevention and Treatment of Pressure*

far removed from the daily concerns of those whose business it is to deal with chronic disease."[3]

113. Pressure wounds are known by various terms, including "bedsore," "decubitus ulcer," "pressure ulcer," and "pressure injury."

114. The facts concerning pressure ulcers are well-known. Indeed, most of the general discussion in this document is taken directly from basic medical textbooks.

115. Pressure wounds occur mainly, but not exclusively, in the elderly, bedridden, and severely ill.

What pressure wounds are, and what causes them

Generally

116. The skin, the largest organ in the body, is a major part of the body's defense against disease and infection.

117. A break in the skin may allow toxins to enter the body, causing infection.

Ulcers/Injuries: Clinical Practice Guideline. The International Guideline. Emily Haesler (Ed.). 2019.

- Griffin, Donald, ed. *Hospitals: What they are and how they work*. Jones & Bartlett Learning, 2011.
- Parish, Lawrence C., Joseph A. Witkowski, and John T. Crissey, eds. *The decubitus ulcer in clinical practice*. Springer Science & Business Media, 2012.
- Rosdahl, Caroline Bunker, and Mary T. Kowalski, eds. *Textbook of basic nursing*. Lippincott Williams & Wilkins, 2008 (Chapters 50 & 58).

[3] Parish, *The decubitus ulcer in clinical practice* (2012).

118. A pressure wound is a localized injury to the skin and/or underlying tissue, usually over a bony prominence.

119. Pressure wounds are the end result of an inadequate nutrient blood supply to the tissues.

120. Pressure on the tissue which partially or completely occludes the capillaries impedes the inflow and outflow of blood.

121. When this occurs for an extended period of time, tissue ischemia and hypoxia result. That is, tissue loses blood flow and, with loss of blood, loses the oxygen supply necessary for the tissue to live.

122. Pressure wounds may kill skin tissue, kill muscle tissue, injure blood vessels, and impair lymphatic circulation.

123. Pressure wounds may also cause infection and sepsis.

Incontinence, skin irritation, and wounds

124. Skin irritation may contribute to, or develop in conjunction with, pressure wounds.

125. Urinary and fecal incontinence can irritate skin and make the skin more likely to break down.

126. The most common skin damage associated with incontinence is perineal dermatitis.

127. Patients with mobility impairment and incontinence are at higher risk for pressure wound formation and are more likely to have delayed healing of existing lesions.

Types & stages of pressure wounds

128. The back of the head, shoulders, elbows, hips, buttocks, and heels are the most commonly affected sites for pressure wounds.

129. Pressure wounds are commonly classified in four stages, as follows.

130. Stage 1: Pressure-related alteration of intact skin, as compared with adjacent/opposite body area. May include changes in (one or more): skin temperature (warmth/coolness), tissue consistency (firm/boggy/mushy), induration (swelling), or sensation (pain/itching). Stage 1 wounds are reversible, if pressure is relieved (by frequent turning, positioning, and pressure-relieving devices).

131. Stage 2: Loss of epidermis with damage into dermis (partial thickness tissue loss); appears as shallow crater/blister with red/pink wound bed, with no sloughing. May also appear as an intact or ruptured serum-filled blister or abrasion. Healing may require several weeks after pressure is relieved, often by maintenance of a moist environment.

132. Stage 3: Subcutaneous tissues involved (full-thickness tissue loss); subcutaneous fat may be visible (no bone, tendon, or muscle exposed). May show undermining or tunneling. Healing may require months after pressure is relieved (*e.g.,* by debriding with wet-to-dry dressings, surgery, or proteolytic enzymes).

133. Stage 4: Extensive damage to underlying structures; full thickness tissue loss, with exposed bones, tendons, or muscles. (Wound possibly appearing small on surface, but with extensive tunneling underneath.) Slough or eschar may be present. Usually foul-smelling discharge. Healing may require months or years, and may requires skin "flap" surgery.

134. Nonstageable: A pressure wound may be unstageable when the base of a full-thickness wound is covered by slough and/or eschar.

135. "Tunneling" refers to one or more channels within or underlying an open wound.

136. Pressure wounds may occur within 12 to 24 hours in a compromised patient. The wound begins deep in the tissue and may not be observed on the skin surface for several days. Signs of an evolving pressure wound are nonblanching erythema (redness that does not lighten when pressed), pain, and induration (swelling).

Risk factors

137. The following factors put a patient at risk of skin breakdown and pressure wounds. This is not an exhaustive list.

a. Immobility, low level of activity (lying/sitting in one position for extended periods of time, paralysis)

b. Inadequate nutrition

c. Incontinence of urine or feces; possibly other external moisture

d. Impaired mental status, alertness, or cooperation; heavy sedation and/or anesthesia; mental illness, intellectual impairment

e. Advancing age, friable skin

f. Diabetes

138. Patients with a past history of skin breakdown are particularly vulnerable.

139. Skin breakdown is a particular problem in an obese patient.

The danger of pressure wounds

140. The most significant complication of a pressure wound is infection.

141. Early in the evolution of a deep pressure wound, a surface area of demarcation appears. Initially, the surface is sealed by an eschar, contiguous with surrounding normal skin. The wound at this stage is either sterile or has a low bacterial content.

142. A stage of liquefaction then occurs with separation of the necrotic tissue from surrounding viable tissue. In this process, bacterial counts rise, often producing sepsis from the undrained wound.

143. Severe infection is found in the patient with underlying illness such as the elderly and diabetics, and/or in otherwise healthy patient in whom the extent of infection has spread beyond the adjacent tissue.

144. Osteomyelitis — infection in the bone — can occur.

145. Infection in pressure wounds is a common and potentially life-threatening complication.

146. Infection may lead to sepsis.

147. Sepsis is the primary cause of death from infection and thus requires early recognition, urgent attention, and prompt treatment.

148. Sepsis, septic shock, and multiple organ failure are major causes of morbidity and mortality in the United States.

149. Pressure injuries are a known cause of sepsis and death.

The importance of prevention

150. Stage 3 or 4 pressure wounds are difficult to treat successfully.

151. After treatment, stage 3 or 4 pressure wounds often recur.

152. Where flap surgery is required, the flap may fail. The tissue stretched or sewn over the pressure wound may die because of lack of adequate blood supply.

153. Infections related to pressure wounds may recur after treatment.

154. Because of the difficulty of treatment of pressure wounds, it is critical to prevent pressure wounds from arising in the first place.

Treating pressure wounds

155. The extent of treatment needed depends on the degree of the wound.

156. For stage 3 or 4 pressure wounds, treatment may require including debridement, wound drains, vacuum devices, or skin flap or graft surgery.

157. Pressure wounds will not heal unless necrotic debris is first removed. Necrotic (dead) tissue creates a physical barrier that prevents tissue repair and provides an ideal medium for bacterial colonization.

158. Removal of necrotic tissue is called "debridement."

159. Sharp debridement involves cutting away necrotic tissue with a scalpel or scissors, exposing living tissue. This can be very painful.

160. All patients with full-thickness loss of soft tissue will require varying degrees of surgical wound care. This may be limited to debridement.

161. It may be necessary to perform debridement in the operating room for those patients in whom major debridements are planned.

162. Severe wounds may require surgery to cover the area of the pressure wound with skin from an adjacent area or, less often, from elsewhere in the body.

163. A skin flap is healthy skin and tissue that is partly detached and moved to cover a nearby wound.

164. Reconstruction with flaps is major surgery.

165. Postoperatively, prolonged periods of immobilization and assiduous nursing care to prevent pressure on the operative site or additional secondary areas of breakdown are imperative for success.

166. Where a pressure wound developed because of negligent care in the same hospital where the surgery is performed, the postoperative care may be performed by the same staff that allowed the wound to develop in the first place.

The medical community's focus on preventing pressure wounds

167. Pressure wounds are preventable with simple measures available in any modern medical facility; and yet these wounds still occur with disturbing frequency.

168. For these reasons, the medical community has for many years made it a priority to prevent pressure wounds.

169. The National Pressure Ulcer Advisory Panel, a national medical organization, was created in 1987 — 33 years ago — specifically to advocate for serious attention to pressure wounds.

170. The Joint Commission — a hospital accreditation agency — has for years identified pressure wounds as a "sentinel event" that requires an "immediate" investigation.

171. A "facility-acquired" pressure wound is a sentinel event which must be reported to the appropriate authorities. If a stage III, IV, or nonstageable wound/ulcer develops within a facility, this usually must be reported to the Health Department and investigated.

172. The Centers for Medicare & Medicaid Services, the largest funder of healthcare in the United States, has declared a stage 3 or 4 pressure wound as a "never event." That is, a "serious and costly error in the provision of health care services that should never happen."

173. The National Pressure Ulcer Advisory Panel issues guidelines to assist medical facilities in preventing and treating pressure wounds.

174. Written guidelines and protocols for decubitus ulcer prevention and treatment are used in most institutions.

Responsibilities of nurses in preventing & treating pressure wounds

Part of basic nursing

175. Nurses have been identified as the patient's first line of defense in the prevention of pressure wounds. Because they are involved in total care of the patient, nurses have assumed the responsibility for care of the patient's skin.

176. Nurses have become the primary care givers for the prevention of pressure wounds.

177. Nurses in any area of a hospital know, or should know, how to prevent pressure wounds, and are responsible for doing so.

Examine and assess risk

178. Because there are known predisposing factors to pressure wounds, the first requirement is to identify the patient at risk and to take preventive measures.

179. Nurses are responsible for identifying the patients at greatest risk.

180. The patient must be assessed as to their general health, their nutritional status, mental responsiveness, mobility, bowel and bladder function, as well as the specifics of treatment programs in certain circumstances, e.g., fracture management and spinal injuries.

181. Because pressure wounds usually occur within the first 10 days of admission to an acute care institution, assessment should be performed on admission.

182. Any acute deterioration of the patient's clinical status requires immediate reassessment.

183. Several methods are used to predict the risk of pressure wound development. Two of these are the Braden Scale and the Norton Scale.

184. The condition of urinary incontinence, or similar conditions, is included in the major risk assessment tools for predicting risk of pressure wound development.

185. Skin assessment should be performed routinely and systematically. It should be done daily.

Prevent harm from incontinence and immobility

Generally

186. It is an important nursing responsibility to prevent skin breakdown and, if it occurs, to report it immediately and treat it as ordered.

187. Frequent and effective skin care is essential to keep the skin intact and remove dirt, excess oil, and harmful bacteria.

188. Everyone's face, underarms, skin folds, and perineal area need daily cleansing.

189. Body fluids, such as perspiration, vomitus, urine, and feces, are generally acidic and are very irritating to the skin. They must be removed immediately.

190. Many older people, people confined to bed, and people who are ill have very fragile (friable) skin. These clients need special skin care, to prevent skin breakdown.

191. A number of protective devices, special products, and procedures are available to protect the skin.

192. It is particularly important to protect bony and skin prominences (e.g., elbows, heels, coccyx, shoulder blades, backs of the ears, back of the head). This is vital for the immobile client.

193. It is the nurse's responsibility to inspect the skin during baths and other routine daily care.

194. If any reddened or irritated areas are noted, they must be reported immediately. If these areas are treated quickly, actual skin breakdown can often be avoided.

195. Perineal care, bathing the genitalia and surrounding area, is given to all clients. Some patients may be embarrassed, but regular perineal care is part of total patient care, even if a patient is of the opposite sex.

196. A group of procedures, called the Skin Bundle, are implemented to prevent skin breakdown in clients at risk.

197. Alleviation of pressure is essential.

198. Nurses should encourage all clients to move themselves as much as possible.

199. For a patient at risk for pressure wound development, the nurse should turn and reposition the client every 2 hours, elevate bony prominences with pillows, and limit the amount of linens under the client.

Incontinence

200. Urinary incontinence affects millions of Americans.

201. Fecal incontinence affects many of the hospitalized elderly.

202. The patient who is incontinent of urine or stool must have meticulous skin care, to prevent skin breakdown.

203. Prevention of incontinence related to restricted mobility involves, for example, providing urinals or bedpans within easy reach, use of a bedside commode, or scheduled toileting programs may resolve the incontinence.

204. The most successful behavioral management strategies for the frail cognitively impaired patient typically at risk of pressure wounds include prompted voiding and scheduled toileting programs. Both strategies are caregiver-dependent and require a motivated care giver to be successful. Scheduled intake of fluid is an important underlying factor for both strategies.

205. Incontinence containment strategies imply the need for a check-and-change schedule for the incontinent patient so wet linens and pads may be removed in a timely manner.

Notify physician immediately if a wound starts to develop

206. Nurses should act to prevent pressure wounds on their own initiative, without direct orders to do so by a physician.

207. However, when a nurse sees evidence of a pressure wound, the nurse must notify the physician chiefly responsible for the patient.

208. It is an important nursing responsibility to report skin breakdown immediately and treat it as ordered.

Responsibilities of attending physicians in preventing & treating pressure wounds

209. While nurses face their own independent responsibility to prevent pressure wounds, the physician with primary responsibility for the patient (the attending physician) remains responsible for the patient.

210. The attending physician is responsible for overseeing and supervising the care of the patient.

211. In the hospital setting, generally a hospitalist is assigned as the patient's attending physician, with primary authority and responsibility for supervising and coordinating the patient's medical treatment — though various consulting physicians may also become involved in evaluating or treating the patient.

212. Medical students are taught about pressure wounds.

213. Hospitalists in particular are taught about pressure wounds, partly because their practice focuses on a hospital inpatient population, for whom pressure wounds present a particular risk.

214. The attending physician's responsibility includes ensuring that necessary actions are taken to prevent the patient from developing a pressure wound.

215. Generally, hospitals have policies — often with standard order sets — for preventive actions for patients at high risk of a pressure wound.

216. Regardless of whether such a standard order set exists, the attending physician is responsible for monitoring the patient's status and for entering orders to effectively prevent or treat a pressure wound.

217. In the event that the patient develops a stage 1 or 2 pressure wound, the attending physician faces an urgent responsibility to order treatment for the wound and to prevent it from worsening into a stage 3 or 4 wound.

218. The attending physician's responsibilities include entering orders to ensure that nurses take appropriate actions to treat pressure wounds, or to order consults from other physicians as needed.

Responsibilities of hospital administration

219. The administration of a hospital interacts with the medical and nursing staff.

220. The administration creates policies, procedures, and protocols for the medical and nursing staff to follow.

221. The administration provides medical record systems for the medical and nursing staff to use.

222. The administration provides communication systems for the medical and nursing staff to use.

223. Through their actions concerning these systems and policies, the hospital administration affects the safety of patients, for better or worse.

224. The patient may suffer — perhaps fatally — if a gap in responsibility exists, so that no physician supervises and coordinates medical treatment of the patient.

225. The hospital administration is responsible for ensuring that authority and responsibility for patient care is clearly defined.

226. The hospital administration must not allow a patient to go without a physician with overall responsibility for supervising and coordinating medical treatment.

227. Hospital administration is responsible for implementing procedures to reduce or eliminate known, serious risks to patient safety.

228. Hospital administration is responsible for implementing procedures to reduce or eliminate the risk of a stage 3 or 4 pressure wound from developing in the hospital.

229. The medical staff of a hospital generally is led by a medical director appointed by the overall hospital leadership. The medical director's role is to evaluate clinical performance and to enforce hospital policies related to quality care.

230. A hospital's administration generally includes a committee or other body responsible for reviewing quality improvement matters — responsible for identifying problems in the treatment of patients, and fixing them.

231. Licensed hospitals are required to have a compliance and performance improvement program in place. This requirement is also a key aspect of the Medicare conditions of participation for hospitals that wish to be a Medicare provider.

232. In 1999 the Institute of Medicine (IOM) produced *To Err Is Human: Building a Safer Health System*. This publication raised awareness about adverse outcomes by reporting that almost 100,000 people were dying each year as a result of medical errors and misadventures in the healthcare system. Its recommendations focused on accountability.

233. In 1984, peer review organizations (PROs) were established to review Medicare admissions in terms of medical necessity with appropriate medical treatment, proper coding for billing, and quality of service.

234. The PRO reviews gave rise to the concept that many adverse outcomes were due to system failures rather than individual failures.

235. Many errors are the result of miscommunication or lack of communication among healthcare providers and staff.

236. Health team members must develop critical thinking skills and communicate their concerns to the appropriate people when patient safety is at stake.

237. Miscommunications must be investigated and systemic changes must be implemented to promote effective communication.

238. Several organizations exist to help hospital administrative staff protect and improve patient safety by designing safe systems.

239. To establish a culture of safety, a healthcare organization must make safety a top priority, involving teamwork on the part of both staff and patients, transparency, and accountability.

240. In 2002, The Joint Commission initiated annual national patient safety goals (NPSGs). Accredited entities report specific measures on these NPSGs.

241. Quality Improvement Organizations (QIOs): These organizations emphasize prevention, early detection, and proper management of services that are high cost and/or have a high potential for errors and adverse outcomes. QIOs also assist in the implementation of safety measures and evidence-based clinical management guidelines.

242. IHI AND ISMP: A number of other organizations also focus on safety in the healthcare environment. The Institute of Health Initiatives (IHI) and the Institute of Safe Medication Practices (ISMP) have provided leadership and programs for patient safety and improved patient outcomes.

Financial incentives and patient dumping

243. If a patient's skin breaks down after admission to a medical facility, the facility is considered to be responsible.

244. In most cases, third-party payors, including CMS, will not reimburse the facility for costs incurred related to a stage 3 or 4 pressure wound that was not present when the patient was admitted.

245. Stage 3 or 4 pressure wounds require costly care.

246. Patients who develop pressure wounds not only require more nursing care, they also need special, more costly, mattresses and/or bed systems.

247. Faced with a patient who requires costly care — and for which the hospital receives no money, because the hospital is responsible for the harm and its necessary treatment — the hospital has a financial incentive to dump the patient onto some other facility (a nursing home, for example).

248. "Patient dumping" is a well-recognized problem in the United States.

Before Dorothy Anthony's October 2018 Admission

249. Dorothy Anthony was 58 years old in October 2018. She suffers from Down Syndrome and has been cared for by family members. As of October 2018, Dorothy had also been diagnosed with dementia.

- DH1 – 31[4]

250. On January 24, 2018, a family member took Dorothy to the DHA ER because of flu symptoms that had lasted for three days. PA Omar Queensbourrow discharged Dorothy home later that day, with prescriptions for Influenza A and bronchopneumonia.

- DH3b – 577-83

251. About three weeks later, on February 16, 2018, a family member took Dorothy to the Outpatient Wound Center, because of wounds on both of Dorothy's heels and on her lower back. NP Laura Cox and Dr. Shawn Fagan noted a stage I

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[4] Along with this Complaint, we are serving copies of the medical records we have received from Doctors Hospital of Augusta. The page references here are to Bates numbers in those records. We include the page references to make it easier for the Defendants to answer these allegations. The page references are not intended as part of the allegations, but only as an aid to the Defendants, to make it easier to answer the allegations.

wound to both heels, and a "pressure wound to the sacrum, stage II" due to extended immobility for pneumonia and flu.

- DH3b – 575

252. A family member took Dorothy to the Wound Center eight times over the next 7-1/2 months, to follow up on Dorothy's heel and sacral wounds.

- DH3b – 572 (2/27/2018 visit)
- DH3b – 564 (3/13/2018 visit)
- DH3b – 560 (3/27/2018 visit)
- DH3b – 556 (4/26/2018 visit)
- DH3b – 552 (5/17/2018 visit)
- DH3b – 547 (6/19/2018 visit)
- DH3b – 542 (8/7/2018 visit)
- DH3b – 540 (10/4/2018 visit)

253. On the fifth follow-up visit, on May 17, 2018, NP Elizabeth Riordan and Dr. Fagan noted that the wound on Dorothy's right heel wound was still present, but that the wounds on her left heel and on her sacral area had healed. The right-heel wound measured 2 x 1.5 x 0.2 cm.

- DH3b – 552

254. On June 19, 2018, Dorothy's older sister, Ms. Willie Eva Sampson, took Dorothy for a follow-up visit at the Wound Center. PA Jeanine Linehan-Burack and Dr. Fagan again noted that Dorothy's sacral wound and left heel had resolved. The right heel wound now measured 1.3 x 0.5 cm.

- DH3b – 547

255. On August 7, 2018, Dorothy's younger sister took Dorothy to the Wound Center to follow up on Dorothy's right-heel wound. At this point, that wound measured 1 x 0.5 cm.

- DH3b – 542

256. About two months later, on October 4, 2018, a family member took Dorothy back to the Wound Center. The wound on Dorothy's left heel had returned, and the right-heel wound had worsened. The right-heel wound now measured 2 x 1 x 0.1 cm. The left-heel wound measured 2 x 1 x 0.1 cm. Both were unstageable.

- DH3b – 540

257. A stage 2 wound is superficial, but the healed stage 2 sacral wound demonstrates that despite suffering from diabetes and Down Syndrome, Dorothy was capable of healing a wound — if properly cared for.

Dorothy's October 15, 2018 Admission

ER Visit: October 15 — Monday

258. On October 15, 2018, Dorothy's sister took Dorothy to the Doctor's Hospital ER, for what turned out to be about an 8-1/2 month stay in the hospital.

259. The extended stay was made necessary largely because, while Dorothy waited for placement in a nursing home, a Stage IV pressure wound developed on Dorothy's sacral area, and Dorothy became septic.

260. On October 15, 2018, Dorothy's sister took Dorothy to the Doctor's Hospital ER because Dorothy was having trouble walking, was not talking, was acting confused, and was occasionally shaking — after having fallen and hit her head about three weeks earlier.

- DH1 – 9

Inpatient Admission: October 15

261. In the ER, testing revealed no acute cause of Dorothy's altered mental status.

- DH1 – 16

262. The ER physician, Dr. Kenneth Grotz, discussed the case with a hospitalist. They decided to admit Dorothy for observation, noting that Dorothy's dementia might be worsening. Dr. Grotz noted that Dorothy might need to be placed in a nursing home. The decision to admit Dorothy was made around 1456 hrs. (That's when Dr. Grotz signed his Emergency Provider Report.)

- DH1 16

263. Dr. Grotz noted the wounds on Dorothy's heals, and noted that the Wound Care service would be consulted during Dorothy's admission.

- DH1 – 11, 16

264. A couple hours later, at 1631 hours on October 15, Nurse Thriza Eje conducted an Admission Health History.

- DH2 – 78-82.

265. In the Admission Health History, Nurse Eje noted that Dorothy had suffered a recent decline in mobility or ambulation, that her legs were weak, and that she needed assistance both with ambulation and with hygiene. Nurse Eje also noted that Dorothy had recently lost weight due to a loss of apetite and was at risk of malnutrition.

- DH2 – 79-81

266. The Admission Health History included an Integumentary (*i.e.*, skin) section. That section did not include a Braden scale or other formal screening for risk of pressure wounds.

- DH2 – 80-81

267. At 1640 hours (apparently as part of the same Admission Health History "activity"), Nurse Eje filled out a risk-assessment form. This form did include a "skin risk" section. In that section, Nurse Eje noted that Dorothy was unable to ambulate, unable to comprehend and follow directions, and that Dorothy had an

existing wound. Nurse Eje documented that Dorothy was at risk of impaired skin integrity.

- DH2 – 81

268. At about the same time, at 1641 hours, Nurse Eje filled out a Daily Care Routine form, indicating that "bed rest" had been ordered for Dorothy.

- DH2 – 82

269. This skin risk assessment created requirements for the hospital administration, the nursing staff, and the attending physicians.

270. The hospital administration was responsible for implementing measures that prompted, facilitated, and required appropriate preventive measures in light of the skin risk assessment.

271. Such measures could consist of a standard order set available to be entered manually or automatically in response to the skin risk assessment. Such measures could consist of policies requiring specific preventive measures for at-risk patients — combined with training and supervision to ensure the policies were implemented reliably. A range of specific measures would suffice, so long as the measures reliably prompted, facilitated, and required appropriate measures.

272. Dorothy's medical records indicate, however, that the hospital administration had not in fact implemented measures that prompted, facilitated, and required appropriate preventive measures in light of the skin risk assessment.

273. This skin risk assessment did not trigger orders to prompt or require actions to prevent a pressure wound from developing. For example, the skin risk assessment did not trigger an order for regular repositioning, to avoid prolonged pressure over bony prominences (like the sacrum, or an order for regular skin checks to assess whether a pressure wound was developing, or an order to assist Dorothy in ambulating and building strength, to avoid lying in the same position for lengthy periods.

274. Nurse Eje and any other nurse who learned of the October 15 skin risk assessment was responsible: (1) for initiating preventive measures that nurses

could undertake on their own initiative (e.g., frequent repositioning), and (2) for ensuring that Dorothy's attending physician was aware of the facts relevant to the skin risk, and requesting appropriate orders.

275. Dorothy's medical records indicate, however, that neither Nurse Eje nor any other nurse on October 15 took any such steps.

276. Each of Dorothy's attending physicians was responsible for familiarizing himself or herself with Dorothy's condition — including the factors that put Dorothy at risk for another pressure wound. Each of Dorothy's attending physicians was similarly responsible for entering orders for appropriate preventive measures.

277. The hospitalist who agreed to admit Dorothy was Dr. Ekmine Wijesinghe. Dr. Wijesinghe wrote a Hospitalist History & Physical at approximately 1720 hours on October 15.

- DH1 – 24-30

278. Dorothy had a variety of abnormal lab results, and Dr. Wijesinghe diagnosed Dorothy with metabolic encephalopathy — a potentially reversible brain disorder caused by systemic illnesses such as diabetes, liver disease, kidney failure, or heart failure.

- DH1 – 24-30

279. Dr. Wijesinghe planned to address potential causes of the metabolic encephalopathy, and also to obtain a physical therapy and/or occupational therapy evaluation.

- DH1 – 29

280. Even without notification by a nurse, Dorothy's attending physicians could easily learn of the key factors that put Dorothy at risk of another pressure wound — namely, (a) current wounds on her heels and a prior wound on her sacral area, (b) weakness and immobility, (c) dementia with loss of comprehension, and (d) a daily care plan for bedrest.

281. Based on these factors, Dorothy's attending physicians were responsible for entering orders for measures to prevent another pressure wound from developing on Dorothy.

282. Dorothy's medical records indicate, however, that Dr. Wijesinghe entered no such orders on October 15.

October 16, 2018 — Tuesday

283. Tuesday, October 16, was Dorothy's first full day at the hospital.

284. At about 1333 hours that day, the Wound Care service evaluated Dorothy. NP Jennifer Hardy Casella examined Dorothy and noted the heel wounds. NP Casella noted that Dorothy had no wound over her sacrum: "Sacrum with no breakdown noted."

- DH1 – 36-38

285. NP Casella's assessment and plan included measures to address Dorothy's heel wounds. NP Casella also included a reference to "pressure reduction measures" including repositioning every two hours. The note did not specifically say whether that recommendation applied to Dorothy's whole body or only to her heels.

- DH1 – 38

286. Later that day, however, Nurse Samantha James noted the wounds on Dorothy's heels and stated that pillows were being used as positioning aids — though the note does not specify whether the repositioning was limited to Dorothy's heels or applied to her whole body.

- DH2 – 92

287. Later that night, at 2215 hours, Nurse James noted that she found Dorothy soaked in urine.

- DH2 – 94

288. Dorothy's incontinence increased the risk of skin breakdown and a pressure wound.

289. When the nursing staff became aware of Dorothy's incontinence, they should have notified the attending physician(s) and implemented measures to prevent pressure wounds. These measures should have included (a) some form of effective incontinence care (perhaps only a bedpan and a toileting schedule), (b) repositioning every two hours, and (c) skin and continence/hygiene checks every two to four hours.

290. In the same note in which Nurse James recorded Dorothy's incontinence, Nurse James also noted that she spoke to Dr. Graham and that new orders were placed (apparently for Gabapentin, a medication). Nurse James did not record a discussion with Dr. Graham about Dorothy's incontinence, the increased risk of skin breakdown, or the need for action to prevent another pressure wound.

- DH2 – 94

291. The medical records indicate that at no point on October 16 did the attending physicians order — nor did the nursing staff independently implement — regular repositioning, effective incontinence care, or regular skin/continence checks.

October 17, 2018 — Wednesday

292. Wednesday, October 17, was Dorothy's second full day at the hospital.

293. Late that morning, Courtney Spencer, an occupational therapist, went to Dorothy's room for a therapy session.

- DH2 – 95

294. Occupational therapists and occupational therapy assistants help people participate in the things they want and need to do through the therapeutic use of everyday activities (occupations). Common occupational therapy interventions include helping people recovering from injury to regain skills, and providing support for older adults experiencing physical and cognitive changes.

- A42

295. Dorothy has Downs Syndrome and dementia, and Ms. Spencer found that Dorothy had difficulties performing simple actions. But Ms. Spencer found that the difficulties were more cognitive than physical, and with encouragement Dorothy could be induced to perform requested actions.

- DH2 – 95

296. That night, at 2010 hours, Nurse Samantha James again noted that Dorothy had pillows as a positioning aid. This note, however, added that Dorothy was also in a specialty bed.

- DH2 – 101

297. Later that night — apparently sometime between 2141 hours and 0143 hours — Nurse James again found Dorothy soaked in urine. Nurse James wrote that the "entire bed" was "saturated" with urine.

- DH2 – 103

298. This was the second night in a row that Dorothy had been found with a large amount of urine in the bed. This second discovery indicated that Dorothy had a serious incontinence problem that was not going to fix itself. Further, that Dorothy was twice found with a large amount of urine in her bed indicated that Dorothy had been left for long stretches without attention to her toileting needs. Typically, a single instance of incontinence would not produce enough urine to saturate a bed.

299. In this same note by Nurse James, she wrote that Dorothy was unable to assist with turning in the bed.

- DH2 – 103

300. By this time — the night of October 17 — the nursing staff and the attending physicians knew or should have known that Dorothy was at high risk of another pressure wound.

301. The nursing staff and attending physicians knew or should have known that Dorothy needed support and encouragement to become as ambulatory and mobile as possible, to avoid prolonged pressure over bony prominences (like the sacrum).

302. The nursing staff and attending physicians knew or should have known that if Dorothy were to remain in bed for long periods, the nursing staff was required to reposition Dorothy every two hours.

303. The nursing staff and attending physicians knew or should have known that Dorothy needed effective continence and hygiene assistance.

304. The impairment of Dorothy's mobility or ability to assist treatment providers would make it more difficult to take care of Dorothy.

305. The hospital should have been capable of providing Dorothy the care she needed. According to their website, Doctors Hospital of Augusta is a full-service hospital, including an inpatient rehabilitation service treating, among others, stroke patients with brain injuries and cognitive impairments.

306. However, if the hospital was not capable of providing Dorothy the care she needed, then in that case the nursing staff, the attending physicians, and the hospital administration had a duty to inform Dorothy's caretakers (her family) of their inability to care for Dorothy properly.

307. In that case, Dorothy's family would have an opportunity to seek alternative care. And the hospital would also have had a duty to work diligently and urgently to facilitate that.

308. At this point — October 17 — various providers had discussed with Dorothy's family the idea of transferring Dorothy to a skilled nursing facility. However, the medical records do not indicate that anyone told Dorothy's family that the hospital was incapable of caring for Dorothy properly.

October 18, 2018 — Thursday

309. The next morning, October 18, at approximately 0940 hours, Nurse Regina Scott applied an external urinary catheter to Dorothy. Nurse Scott noted that the

reason for the catheter was prolonged immobilization. As indicated by a later nurse note, the external catheter was apparently a PureWick device.

- DH2 – 107
- DH2 – 113

310. As compared to internal catheters, external catheters pose less risk of causing infections, but greater risk of leaking.

311. The pictures below are taken from the internet for illustration only. They are not from Dorothy's medical records.

312. That same morning, Dr. Jonathan Preston wrote a Discharge Summary noting that Dorothy was stable and was being discharged to a skilled nursing facility (SNF), but noted that the discharge was pending placement. The Discharge Summary identified Dr. Preston as Dorothy's attending physician.

- DH1 – 1

313. On the morning of December 18 at 1045 hours, Caroline Pitts, MST, entered a note that read "Number of times incontinent urine: 1. Diapers count: 1."

- DH2 – 108

314. Later that day at around 1454 hours, April Conway, an occupational therapist, came to Dorothy's room for a therapy session. Ms. Conway noted that Dorothy remained generally uncommunicative. Ms. Conway indicated that some family member was there, and that Ms. Conway educated the family member on positioning and pressure sore prevention.

- DH2 – 108

October 19, 2018 — Friday

315. On October 19, Trista Caddell, a physical therapist, went to Dorothy's room for a therapy session. Ms. Caddell noted that Dorothy's limitations seemd to be more due to her dementia. However, Ms. Caddell wrote that during the session,

Dorothy said she needed to go to the bathroom. With assistance, Dorothy walked to the bathroom and used the toilet. Dorothy then needed assistance with post-toileting hygiene.

- DH2 – 117

316. A little later that day, NP Jennifer Casella from the Wound Care service came to assess Dorothy. NP Casella noted Dorothy's heel wounds but did not identify any sacral wound.

- DH1 – 1160-62

317. On October 19, Dorothy's attending physicians still did not order — and the nursing staff still did not provide — regular repositioning or other movement to prevent pressure wounds. The systems put in place by hospital administration did not prompt, facilitate, and require them to do so.

October 20, 21, 22, 23 — Saturday, Sunday, Monday, Tuesday

318. On Wednesday, October 24, 2018, Nurse Amanda Walden would identify a stage 2 wound — a small wound with broken skin — on Dorothy's sacral area.

- DH2 – 157

319. We see no entries in the medical record for the four days before that wound was noted — October 20, 21, 22, and 23 — that shed light on the development of the wound.

320. However, on these days — October 20, 21, 22, and 23 — Dorothy's attending physicians still did not order — and the nursing staff still did not provide — regular repositioning or other movement to prevent pressure wounds. The systems put in place by hospital administration did not prompt, facilitate, and require them to do so.

October 24: Stage 2 Wound Discovered

321. **On Wednesday, October 24**, while cleaning Dorothy after another episode of urine incontinence, Nurse Amanda Walden identified a stage 2 sacral wound on Dorothy.

- DH2 – 157

322. Generally, a stage 2 wound can be treated and healed with only moderate difficulty.

323. But if not treated diligently, a stage 2 wound can worsen into a stage 3 or 4 wound that can be very difficult to treat and can cause serious harm — including infection, sepsis, and death.

324. When Nurse Walden identified a new stage 2 sacral wound on Dorothy, Nurse Walden should have immediately notified Dorothy's attending physician and requested orders for treatment.

325. The records indicate that Nurse Walden did not do so.

326. Particularly because Dorothy had both a sacral wound with broken skin and urine incontinence, the nursing staff should have initiated (and the attending physician should have ordered) two-hour incontinence checks.

327. But the records reveal no new measures, ordered or implemented, for regular repositioning of Dorothy or any additional incontinence checks.

October 25-30: Wound Worsens

328. **On Thursday, October 25**, Nurse Samantha James identifies a wound on Dorothy's sacrum, and identified it as moisture-related.

- DH2 – 169

329. A short time later, Nurse James noted that Dorothy had another episode of incontinence with a large amount of urine.

- DH2 – 171

330. The records do not indicate that Nurse James notified Dorothy's attending physician of Dorothy's sacral wound and requested orders for treatment.

331. Nor do the records indicate that Nurse James initiated regular repositioning of Dorothy or any additional continence and hygiene measures.

332. **On Friday, October 26**, NP Casella from the Wound Care service checked on Dorothy. NP Casella again noted the pressure wounds on Dorothy's heels, but did not even mention the wound on Dorothy's sacrum.

- DH1 – 1154-56

333. This indicates a failure of the hospital's systems for communication between the nursing and Wound Care staffs (as well as between the nursing and medical staffs).

334. On the nursing-staff side, this failure involved both Nurse Walden as well as Nurse James. The lack of communication did not reflect merely an individual failing of a particular provider.

335. That same day, Friday, October 26, physical therapist Trista Caddell came to Dorothy's room to work with Dorothy. Ms. Caddell noted that she found Dorothy soaked with urine, with three pads beneath Dorothy saturated. Ms Caddell noted the open wound on Dorothy's sacrum.

- DH2 – 177

336. Ms. Caddell spoke to Dorothy's nurse and said that Dorothy needed a strict turning schedule, frequent checks for incontinence issues, and to be assisted with a bedpan on a schedule.

- DH2 – 177

337. The nurse Ms. Caddell spoke to was Houedan Agbatchi. Nurse Agbatchi noted the conversation and paged Dr. James Cato, Dorothy's attending physician at the time, and informed him of Dorothy's sacral wound. Dr. Cato issued no orders for any prevention or treatment measures.

- DH1 – 666 (re. Dr. Cato)
- DH2 – 177

338. In his Hospitalist Progress Note for October 26, 2018, Dr. Cato made no mention of Dorothy's sacral wound.

- DH1 – 666-68

339. At no time on Friday, October 26, were any new measures ordered or implemented for repositioning or for effective continence/hygiene assistance.

340. **On Saturday, October 27**, Nurse Abgatchi again noted the sacral wound on Dorothy.

- DH2 – 181

341. At no time that day were any new measures ordered or implemented for repositioning or for effective continence/hygiene assistance.

342. **On Sunday, October 28**, Nurse Abgatchi again noted the sacral wound on Dorothy.

- DH2 – 188

343. The same day, Nurse Amber Yoder also noted the sacral wound on Dorothy.

- DH2 - 192

344. At no time that day were any new measures ordered or implemented for repositioning or for effective continence/hygiene assistance.

345. **On Monday, October 29**, Nurse Abgatchi again noted the sacral wound on Dorothy.

- DH2 – 197

346. The same day, Nurse Yoder also noted the sacral wound on Dorothy.

- DH2 – 201

347. At no time that day were any new measures ordered or implemented for repositioning or for effective continence/hygiene assistance.

348. **On Tuesday, October 30**, NP Casella from the Wound Care service checked on Dorothy. Again NP Casella apparently did not know about, or independently discover, the sacral wound on Dorothy.

- DH1 – 1151-53

349. Later that day, at 1030 hours, Nurse Mirisha Coleman noted the sacral wound on Dorothy.

- DH2 – 205

350. At 1301 hours, Nurse Chelsey Haines noted that she had applied a Mepilex dressing to the wounds on Dorothy's heels, but omitted any mention of the sacral wound on Dorothy.

- DH2 – 208

351. Later, at 2033 hours, Nurse Coleman wrote that Dorothy was "approved for placement but waiting re-evaluation per government due to Down Syndrome….No safety issues noted."

- DH2 – 208

352. Nurse Coleman's two notes from 1030 hours and 2033 hours are inconsistent. A sacral wound is a safety issue. These two notes suggest that Nurse Coleman may have entered some notes by blindly copying and pasting prior notes.

353. Blind copying and pasting of medical records is a known problem in hospitals and can create safety risks for patients.

- A43
- A44
- A45

354. When medical personnel are responsible for documenting their own current assessment of the patient, it is improper and potentially dangerous to blindly copy and paste prior assessments that do not reflect the new, current assessment.

355. At no time on Tuesday, October 30, were any new measures ordered or implemented for repositioning or for effective continence/hygiene assistance.

October 31: Stage 3

356. **On Wednesday, October 31**, Nurse Nedjy Marius noted the wound on Dorothy's sacrum as a stage 2 wound. Nurse Marius changed the dressing.

- DH2 – 212

357. Later that day, Nurse Marius wrote "Will remind day shift to call physician to put a consult for wound in the buttock. Dressing was applied to prevent contact from fecal."

- DH2 – 213

358. A short time later, Nurse Thriza Eje described the sacral wound on Dorothy as a stage 3 and as "red/moist/bumpy/granulation."

- DH2 – 214-15

359. Nurse Eje's note marks a serious worsening of the wound. A stage 3 pressure wound is a serious wound, that is difficult to treat and creates a serious risk of infection and further deterioration.

360. The physician should have been notified immediately, and the wound-care service should have been consulted immediately.

361. That did not happen.

362. At no time on Wednesday, October 31, were any new measures ordered or implemented for repositioning or for effective continence/hygiene assistance.

November 1-5: Wound worsens

363. **On Thursday, November 1**, again Nurse Marius recorded a note saying "Wound on her buttock need to be addressed. Dressing on her buttock changed during bath."

- DH2 – 221

364. This note refers to a Foley catheter being in place in Dorothy. The medical records provided to Dorothy's caretaker are poor-quality and difficult to search, but this is the earliest reference we find in the records to a Foley catheter being inserted into Dorothy.

365. From the records, we don't see when this Foley was inserted, who ordered it, who inserted it, or why it was ordered.

366. These are important details that should be included in the medical records, because a Foley catheter creates a risk of infection. In the event of complications related to the Foley, it may be important for physicians to know these details. Failure to include these details violates the standards for medical record-keeping.

- A46 (re. Foley and infection)
- A47 (re. record-keeping)

367. Whatever the specific purpose for inserting the Foley catheter, that catheter would assist with urine incontinence.

368. However, because a Foley creates a risk of infection, it should not be used for incontinence assistance unless more conservative measures prove ineffective — after being applied diligently.

369. From the medical records, it appears that conservative measures to avoid incontinence were not applied diligently.

370. At 0806 hours, Nurse Eje again described the sacral wound as a stage 3.

- DH2 – 223

371. Later, however, LPN Marsha Raycroft described the sacral wound as "pre-stage 1."

- DH2 – 227

372. At no time on Thursday, November 1, were any new measures ordered or implemented for repositioning.

373. **On Friday, November 2**, Nurse Amanda Walden noted the sacral wound at around 0908 hours but reported that she could not identify the skin alteration level or stage.

- DH2 – 230

374. At 1241 hours, Nurse Chelsey Haines reported checking the wounds on Dorothy's heels but did not mention the sacral wound.

- DH2 – 231

375. At around 1840 hours, Nurse Amanda Walden noted abnormal urine: "Foley to bedside urine with cloudy, foul smelling urine – MD aware. U/A culture sent to micro as ordered by Dr. Preston."

- DH2 – 234

376. At around 2145 hours, Nurse Marsha Raycroft noted that she had informed a physician that Dorothy had low blood pressure. IV fluids were started, with a plan to begin an antibiotic after cultures were obtained.

- DH2 – 236

377. At no time on Friday, November 2, were any new measures ordered or implemented for repositioning.

378. However, four days later, on November 6, Dorothy would be found with a large, infected stage 4 sacral wound. The infection noted on November 2 was likely caused, in whole or in part, by the sacral wound — rather than being a urinary tract infection related to the Foley catheter.

379. **On Saturday, November 3rd**, Dr. Jonathan Preston ordered that the Foley catheter be removed.

- DH2 – 241
- DH1 – 638-642 at 640

380. While the removal of the Foley would remove one source of new infections, it would also increase the risk of incontinence-related skin breakdown — thus requiring additional diligence in preventive measures.

381. At around 2041 hours, Nurse Marsha Raycroft noted the sacral wound but reported that she could not identify the skin alteration level or stage.

- DH2 – 242

382. At no time on Saturday, November 3rd, were any new measures ordered or implemented for repositioning or for effective continence/hygiene assistance.

383. **On Sunday, November 4th**, at around 1824 hours Nurse Regina Scott noted the sacral wound as stage 3 and reported that she had changed the dressing on the wound.

- DH2 – 245

384. A short time later, around 1931 hours, Nurse Scott noted that the dressing on the sacral wound had been changed twice that day. She also reported that Dorothy had a low-grade fever.

- DH2 – 248

385. At no time on Sunday, November 4th, were any new measures ordered or implemented for repositioning or for effective continence/hygiene assistance.

386. **On Monday, November 5th,** at around 0745 hours Nurse Deborah Sargent reported that Dorothy had been incontinent of a large amount of urine.

- DH2 – 250

387. At around 1039 hours, physical therapist Mark Clayton noted that Dorothy's upper back was wet from sweat, and that he had changed the underpads on Dorothy's bed.

- DH2 – 254

388. At no time on Monday, November 5th, were any new measures ordered or implemented for repositioning or for effective continence/hygiene assistance.

November 6: Stage 4

389. **On Tuesday, November 6th,** Nurse Deborah Sargent noted that she had given Dorothy a complete bedbath and changed the bed linens. Nurse Sargent recorded that the dressings remained dry and intact.

- DH2 – 258

390. At approximately 1038 hours, NP Kimberly Linticum from the Wound Care service went to Dorothy's room. NP Linticum saw the wound on Dorothy's sacral area and characterized it as unstageable with surrounding erythemia (reddening of skin) and abscess formation.

- DH2 – 1145-47

391. PA Shellie Lutz and Dr. Robert Mullins, both from the Wound Care service, got involved.

392. Within about an hour of NP Linticum's assessment, Dr. Mullins examined Dorothy. Under Dr. Mullins' supervision, NP Linticum dictated a History & Physical on behalf of Dr. Mullins.

- DH2 – 31-33

393. Dr. Mullins noted that Dorothy had been wearing a diaper that was heavily soiled with urine, that the sacral wound emitted a "very foul odor," that the wound had necrotic (dead) tissue, and that the wound required debridement not at bedside but in the operating room. Dr. Mullins also noted that Dorothy had an infection that

was “fairly complex” and that there was concern that the wounds were contributing to the infection.

- DH2 – 31-33

394. One of the Wound Care staff called Ms. Sampson, Dorothy’s older sister and caretaker. Ms. Sampson came to the hospital to see Dorothy. She took pictures of the wound.

395. At 1709 hours, Dr. Mullins began surgical debridement of the wound in the operating room. With the wound excised, Dr. Mullins was able to stage the wound. It was a stage 4. Dr. Mullins noted that he was excising the wound in preparation for a flap surgery — a flap 15 x 18 cm (6 x 7 inches) large. Dr. Mullins cut away tissue down to and including the muscle.

- DH1 – 1200-01

396. After the debridement, a tissue culture from the sacrum tested positive for proteus/e-faecalis.

- DH3a - 10

397. Proteus species are a Gram-negative, facultative bacilli that colonize the gastrointestinal tract and are a source of nosocomial infection within hospitals and long-term care facilities.

- A48, pg 3.

398. E. faecalis can cause endocarditis and sepsis.

- A49, pg 2

399. When Dorothy was admitted to the hospital back on October 15, her white blood cell count — a key marker for infection — was at the low end of normal: 5.64 K/uL.

- DH1 – 12-13

400. On November 6, Dorothy's white blood cell count was extremely high: 34.86 K/uL.

- DH1 – 75

401. After surgery, Dorothy was taken to the Intensive Care Unit, where NP Jennifer Key and Dr. John Keeley diagnosed Dorothy as being in septic shock.

- DH1 – 41-48

402. The condition Dorothy was found in on November 6 — a large, infected, putrid stage 4 wound with substantial necrosis, and in septic shock — does not develop instantaneously.

403. The wound had of course developed over several days.

404. The odor from the wound was likely noticeable for at least one day, and probably for multiple days.

405. Sepsis likely took a day or more to escalate to septic shock.

406. By November 6, Dorothy was in extremis. The wound, including the sacral infection, was likely incurable at that point, and the infection and septic shock well could have killed Dorothy.

Dorothy's condition and treatment since the sentinel event

407. Dorothy has suffered a complicated, difficult course since the stage 4 sacral wound was diagnosed and first treated. We do not recite Dorothy's course in detail here, but only address some of the more notable events.

November 6, 2018, through July 11, 2019 discharge

408. Overview: Before the wound developed on Dorothy's sacral area, she had been fit to discharge as soon as space opened up at a nursing home. After the wound developed and Dorothy suffered infection and sepsis, Dorothy remained in the hospital for another eight months, until July 11, 2019. Before then, however, on

March 21, 2019, the hospital sent Dorothy off to a nursing home. The nursing home sent Dorothy right back, because Dorothy's sacral wound was too extensive for the nursing home to care for.

409. From 11/14/2018 to 11/22/2018, Dorothy was treated with an IV Antibiotic course of Zosyn/Zyvox to treat the bone infection.

- DH3a – 10

410. From 11/22/2018 to 12/02/2018, Dorothy was treated with an IV Antibiotic course of Ampicillin to treat the bone infection.

- DH3a – 10

411. From 12/10/2018 to 12/17/2018, Dorothy was treated with IV Antibiotic course of Zyvox/Levofloxacin to treat the bone infection.

- DH3a - 10

412. On November 12, 2018, a percutaneous endoscopic gastrostomy (PEG) tube was placed into Dorothy.

- DH1 – 1173-74

413. A PEG tuge is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate.

414. On December 7, 2018, Dorothy was given a colostomy, after multiple incidents of fecal incontinence that threatened to contaminate the sacral wound. (Picture for illustration only; not from Dorothy Anthony's medical records.)

- DH1 – 1202-03 (colostomy op note)
- DH1 – 34-35 (colostomy consultation note)
- DH2 – 496 (bowel incontinence)
- DH2 – 618 (bowel incontinence)

415. On February 12, 2019, Dr. Mullins performed a fasciocutaneous flap surgery, creating a 13 cm x 14.5 cm flap.

416. The records currently available do not include photographs from the operation performed on Dorothy. The following photos are taken from Wong, Chin-Ho, Bien-Keem Tan, and Colin Song. "The perforator-sparing buttock rotation flap for coverage of pressure sores." *Plastic and reconstructive surgery* 119.4 (2007): 1259-1266 (available at https://www.waesthetics.com/pdf/published/28.pdf). The operation indicated in the photograph likely differed from the operation performed on Dorothy, but the photograph nevertheless may give some idea of the surgery Dorothy underwent.

417. On March 21, 2019, the hospital discharged Dorothy and sent her to Amara nursing home. The nursing home immediately sent her back, because the sacral wound was too extensive for them to care for.

- DH3c – 177

418. Shortly after Dorothy was sent back to the ER, PA Ansley Coffee of the Wound Care service examined Dorothy, under the direct supervision of Dr. Mullins. PA Coffee reported that "near the end prior to discharge she [Dorothy] was just lying on a silver burn pad." PA Coffee also noted that Dorothy had a very deep open wound near the perineum and rectum — "very deep past a finger length of the surface."

- DH3c – 182-84

419. On March 25, 2019, a bone culture grew Acinetobacter/e-faecalis.

- DH3a – 10

420. From March 26 to May 6, Dorothy was treated with a course of Merrem, an antibiotic.

- DH3a – 10

421. By April 2, 2019, the flap had failed.

- DH3c – 232

422. From 6/6/2019 to 6/12/2019, Dorothy was treated with an IV Antibiotic course of Zyvox/Zosyn.

- DH3a – 10

423. From 6/19/2019 to 6/24/2019, Dorothy was treated with an IV Antibiotic course of doxycycline.

- DH3a – 10

424. From 6/24/2019 to 6/28/2019, Dorothy was treated with an IV Antibiotic course of Zyvox/Zosyn.

- DH3a – 10

425. From 6/28/2019 to 7/05/2019, Dorothy was treated with an oral antibiotic course of Augmentin.

- DH3a – 10

426. On July 11, 2019, the hospital discharged Dorothy to her home.

- *See* DH3c – 132; 384

After July 11, 2019

427. Since being discharged in July 2019, Dorothy has continued to have a difficult course, with multiple hospital admissions. Here again we do not recite the events in detail.

428. On July 25, 2019, a family member took Dorothy to the ER worried about an infection, because Dorothy had dark urine and a fever. Dorothy was discharged the same day.

- DH3c – 138, 149

429. On August 7, 2019, Ms. Sampson took Dorothy to the Wound Clinic for one of a continual series of outpatient visits. At this visit, NP Jennifer Casella and Dr. Zaheed Hassan noted that the sacral wound had significant necrotic tissue and slough. They admitted Dorothy to the hospital, to be treated by Dr. Mullins for

surgical debridement and excision of the wound, and to be managed for possible infection.

- DH3b – 701-03
- DH3b – 704

430. On this admission, a bone culture from Dorothy's sacrum was positive for e-faecalis.

- DH3a – 10

431. Dorothy ended up staying in the hospital for about a month. The hospital discharged her on September 9, 2019.

- DH3b – 699-700

432. From August 14 to September 9, Dorothy was treated with an IV antibiotic course of Unasyn (ampicillin/sulbactam).

- DH3a – 10

433. From September 9 to October 7, Dorothy was prescribed oral Amoxicillin.

- DH3a – 10

434. Over the next several months, the Wound Center followed Dorothy on an outpatient basis.

- DH3b – 682 (10/15/2019)
- DH3b – 680 (11/5/2019)
- DH3b – 675 (11/9/2019)
- DH3b – 670 (11/25/2019)
- DH3b – 668 (12/9/2019)
- DH3b – 663 (12/18/2019)
- DH3b – 654 (1/6/2020)
- DH3b – 652 (1/27/2020)

- DH3b – 647 (2/18/2020)
- DH3b – 637 (3/19/2020)

435. On April 9, 2020, a family member took Dorothy to the Wound Center for an outpatient visit. The sacral wound was exposed, with bone showing, and there was tunneling at the top of the wound.

- DH3b – 632

436. On May 1, 2020, a family member took Dorothy to the ER. Dr. John Rumbaugh admitted Dorothy because the sacral wound had more bone exposure, and it also contained necrotic tissue and produced serous discharge.

- DH3a – 6-7

437. On May 5, 2020, Dr. Bounthavy Homsombath debrided the sacral wound on Dorothy.

- DH3a – 17

438. On May 11, 2020, NP Denise Hamrick and Dr. Jack Austin from the Infectious Disease service consulted on Dorothy's case. Dr. Austin concluded that Dorothy likely had chronic osteomyelitis. He concluded that another course of IV antibiotics was unlikely to help. He recommended oral antibiotics, an MRI to identify the extent of the bone infection, and possibly further resection of bone tissue.

- DH3a – 15

439. The hospital discharged Dorothy on May 21, 2020.

- *See* DH3a – 18

440. On May 26, 2020, a family member took Dorothy to the ER with concerns about her wounds leaking.

- DH3a – 3, 4

Schedule of Providers from October 15 – November 6, 2018

Hospitalists (from Hospitalist Progress Notes)

October 16: Adam M. Ross, MD; Mari Mangasha, MD (DH1 – 692)

October 17: Adam M. Ross, MD; Mari Mangasha, MD (DH1 – 690)

October 18: ???

October 19: Adam M. Ross, MD (DH1 – 687)

October 20: Adam M. Ross, MD (DH1 – 684)

October 21: Adam M. Ross, MD (DH1 – 681)

October 22: Adam M. Ross, MD (DH1 – 678)

October 23: Adam M. Ross, MD (DH1 – 675)

October 24: Adam M. Ross, MD (DH1 – 672)

October 25: Adam M. Ross, MD (DH1 – 669)

October 26: James A. Cato, MD (DH1 – 666)

October 27: James A. Cato, MD (DH1 – 663)

October 28: James A. Cato, MD (DH1 – 660)

October 29: Jonathan Preston, MD (DH1 – 657)

October 30: Jonathan Preston, MD (DH1 – 654)

October 31: Jonathan Preston, MD (DH1 – 651)

November 1: Jonathan Preston, MD (DH1 – 647)

November 2: Jonathan Preston, MD (DH1 – 643)

November 3: Jonathan Preston, MD (DH1 – 638)

November 4: Jonathan Preston, MD (DH1 – 633)

November 5: Adam M. Ross, MD (DH1 – 629)

November 6: Adam M. Ross, MD (DH1 – 624)

441. As CMS has declared, the development of a new pressure wound in a hospital is a "never event." The development of a stage 2 wound in a patient known to be at high risk — like Dorothy Anthony — reflects negligent care, but in itself need not cause serious, lasting harm.

442. It is shocking, however, for a stage 2 wound to develop, be noted by multiple nurses and therapists, be brought to the attention of physicians, and yet to worsen to a stage four wound.

443. The administration and the providers at Doctors Hospital failed Dorothy Anthony — grossly.

444. The failure cannot be blamed on a couple negligent individuals. Too many nurses and physicians were involved. Too many days went by without proper action. That demonstrates a larger, systemic problem at Doctors Hospital — a problem with the systems put in place (or not put in place) by the hospital administration.

445. Indeed, the records indicate that at least some of the nurses and physical therapists understood the seriousness of the sacral wound and made some effort to communicate it to the rest of the team, so that they would treat Dorothy appropriately. Yet it didn't happen. That indicates a system failure for which the hospital administration is responsible.

446. The facts revealed in the medical records establish the standard of care, causation, and damages opinions stated in the "Summary of Principal Opinions" above.

447. Finally, as Dr. Jack Austin noted, Dorothy likely now suffers chronic osteomyelitis. The infections are likely to continue recurring, putting Dorothy at risk of sepsis and premature death.

Count 1 – Professional Negligence (all Defendants)

448. Plaintiff incorporates by reference, as if fully set forth herein, all preceding paragraphs of this Complaint.

449. The Defendants are liable for professional negligence pursuant to OCGA Title 51 and Georgia common law.

450. The Defendants and their agents violated their standards of care as to the following tasks and requirements:

a. Administrative Task & Requirement: The standard of care requires the hospital administration to implement patient safety measures to prompt, facilitate, and require measures to prevent pressure wounds from developing, and to treat wounds if they do develop.

Violation: The DHA administration violated this requirement by failing to implement measures that prompted, facilitated, and required appropriate steps to prevent pressure wounds and to treat them properly if they develop.

Causation: This violation led to neglect that allowed a stage 2 pressure wound to develop on Dorothy Anthony's sacral area, and then led to further neglect that allowed the wound to develop to a stage 4 wound.

Damages: This violation caused pain, debridements, flap surgery, infections, long-term hospital stay, permanent disabilities.

b. Administrative Task & Requirement: The standard of care requires the hospital administration to implement measures to prompt, facilitate, and require communication between nurses and physicians concerning patients' high-risk status for pressure wounds and for patients' actual development of pressure wounds.

Violation: The DHA administration violated this requirement by failing to implement measures that prompted, facilitated, and required necessary communication about pressure wound risk and development.

Causation: This violation led to neglect that allowed a stage 2 pressure wound to develop on Dorothy Anthony's sacral area, and then led to further neglect that allowed the wound to develop to a stage 4 wound.

Damages: This violation caused pain, debridements, flap surgery, infections, long-term hospital stay, permanent disabilities.

c. Attending Physician Task & Requirement: The standard of care requires the attending physicians to identify patients at high risk of developing pressure wounds, and ensure the nursing staff are taking appropriate preventive measures — including frequent repositioning and continence care.

Violation: The hospitalist staff — Dr. Adam Ross, Dr. James Cato, Dr. Jonathan Preston, and Dr. Ekmini Wijesinghe — violated this requirement by failing to identify Dorothy Anthony as being at high risk of developing a pressure wound, and by failing to enter orders or otherwise ensure that the nursing staff were taking appropriate preventive measures, including frequent repositioning.

Causation: This violation led to neglect that allowed a stage 2 pressure wound to develop on Dorothy Anderson's sacral area, and then led to further neglect that allowed the wound to develop to a stage 4 wound.

Damages: This violation caused pain, debridements, flap surgery, infections, long-term hospital stay, permanent disabilities.

d. Attending Physician Task & Requirement: The standard of care requires the attending physicians to order effective treatment for a pressure wound.

Violation: The hospitalist staff — Dr. Adam Ross, Dr. James Cato, and Dr. Jonathan Preston — violated this requirement by failing to enter orders for effective treatment of the pressure wound that developed over Dorothy Anthony's sacral wound.

Causation: This violation led to neglect that allowed the wound to worsen into a stage 4 wound.

Damages: This violation caused pain, debridements, flap surgery, infections, long-term hospital stay, permanent disabilities.

e. **Nursing Task & Requirement: The standard of care requires the nursing staff to take appropriate steps to prevent development of pressure wounds, including frequent repositioning and continence care.**

Violation: The nursing staff violated this requirement by failing to take appropriate steps to prevent another pressure wound from developing on Dorothy.

Causation: This violation led to neglect that allowed a stage 2 pressure wound to develop, and then further neglect that allowed it to develop into a stage 4 wound.

Damages: This violation led to pain, debridements, flap surgery, infections, long-term hospital stay, permanent disabilities.

f. **Nursing Task & Requirement: The standard of care requires the nursing staff to notify attending physicians of the development of a pressure wound and request treatment.**

Violation: The nursing staff violated this requirement by failing to notify attending physicians of the development (and worsening) of a pressure wound on Dorothy's sacral area.

Causation: This violation led to neglect that allowed a stage 2 pressure wound to develop, and then further neglect that allowed it to develop into a stage 4 wound.

Damages: This violation led to pain, debridements, flap surgery, infections, long-term hospital stay, permanent disabilities.

g. **Nursing Task & Requirement: The standard of care requires the nursing staff to routinely assess the skin of an at-risk patient and document the skin status accurately.**

Violation: The nursing staff violated this requirement by failing to assess Dorothy's skin, and by failing to document her skin status, diligently and accurately.

Causation: This violation led to neglect that allowed a stage 2 pressure wound to develop, and then further neglect that allowed it to develop into a stage 4 wound.

Damages: This violation led to pain, debridements, flap surgery, infections, long-term hospital stay, permanent disabilities.

h. Nursing Task & Requirement: The standard of care requires the nursing staff to address incontinence effectively and assist with hygiene as needed to prevent skin breakdown and infection.

Violation: The nursing staff violated this requirement by failing to address Dorothy's incontinence and hygiene disabilities.

Causation: This violation led to neglect that allowed a stage 2 pressure wound to develop, and then further neglect that allowed it to develop into a stage 4 wound.

Damages: This violation led to pain, debridements, flap surgery, infections, long-term hospital stay, permanent disabilities.

451. The corporate Defendants — DHA, NHA-GA, NHA-TN, JDG, CSRA — are vicariously liable for the negligence of their employees or other agents, because the agents acted within the scope of their agency for the respective corporate Defendants.

452. Dorothy Anthony, through her Guardian, is entitled to recover from all Defendants for all damages caused by the Defendants' professional negligence.

Damages

453. Plaintiff incorporates by reference, as if fully set forth herein, all preceding paragraphs of this Complaint.

454. As a direct and proximate result of the Defendants' conduct, Plaintiff is entitled to recover from Defendants reasonable compensatory damages in an amount exceeding $10,000.00 to be determined by a fair and impartial jury for all damages Plaintiff suffered, including physical, emotional, and economic injuries.

455. WHEREFORE, Plaintiff demands a trial by jury and judgment against the Defendants as follows:

a. Compensatory damages in an amount exceeding $10,000.00 to be determined by a fair and impartial jury;

b. All costs of this action;

c. Expenses of litigation pursuant to OCGA 13-6-11;

d. Punitive damages; and

e. Such other and further relief as the Court deems just and proper.

October 15, 2020

Respectfully submitted,

/s/ Lloyd N. Bell
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AFFIDAVIT OF CHRISTOPHER M. DAVEY, MD REGARDING DOROTHY ANTHONY

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PERSONALLY APPEARS before the undersigned authority, duly authorized to administer oaths, comes Christopher M. Davey, MD, who after first being duly sworn, states as follows:

Introduction

1. This affidavit addresses medical negligence that occurred during Dorothy Anthony's admission at Doctors Hospital of Augusta (DHA) that began on October 15, 2018.

2. I have been asked to provide this affidavit for the limited purpose of Georgia statute OCGA § 9-11-9.1.

3. This affidavit addresses specific matters that Plaintiff's counsel have asked me to address. I have not attempted to identify all standard-of-care violations. I have not attempted to state every causation opinion I have. I have not attempted to anticipate or address issues the Defense might raise or that otherwise might arise as the case unfolds.

4. I use the term "standard of care" to refer to that degree of care and skill ordinarily exercised by members of the medical profession generally under the same or similar circumstances and like surrounding conditions as pertained to the medical providers I discuss here.

5. Plaintiff's counsel drafted this affidavit after consulting with me, and I reviewed the draft and edited it to make sure it correctly states my views. The purpose of this affidavit is only to give the Defense fair notice of my substantive views and the information my views are based on. In reviewing and editing the draft affidavit, therefore, I made sure that I agree with the substance of what is said here, but I have not attempted to re-write the affidavit to read like a document that I wrote. I understand that Plaintiff's counsel may produce draft affidavits for other experts, using language identical to what is in this affidavit. Nonetheless, I have edited this affidavit, and I agree with every statement that in this final version of the affidavit.

6. If additional information becomes available later, my opinions may change. Additonally, I understand that Plaintiff's counsel will provide this affidavit to the Defendants. I also understand that the Defense will hire medical experts to review this case and to review this affidavit. If anyone on the Defense team believes I have

overlooked or misconstrued any relevant information, I invite the Defense to communicate with me by letter, copied to Plaintiff's counsel. The Defense need not wait to take my deposition to communicate with me. I would like to consider any information the Defense wishes to bring to my attention and, if appropriate, to provide a supplemental affidavit addressing such information.

7. As to the matters this affidavit addresses, I have tried to give a reasonably detailed explanation, but I have not attempted an exhaustive discussion. In deposition or trial testimony, I may elaborate with additional details. While I cite evidence from the medical records for various case-specific facts, I do not necessarily cite all the evidence for a given point.

8. I hold all the opinions expressed below to a reasonable degree of medical certainty — that is, more likely than not.

Evidence Considered

9. I have reviewed medical records from Doctors Hospital of Augusta pertaining to Dorothy Anthony. My views are based on the information in these records.

10. Plaintiff's counsel supplied various timelines, which may be attached as exhibits to this affidavit. While the timelines are useful to some extent in navigating the thousands of pages of medical records, I have not relied on the timelines for any substantive purpose. In forming my conclusions, I have relied only on the medical records themselves.

Summary of Principal Opinions

11. My principal opinions are summarized here. Additional opinions are contained in the discussion below. In deposition or trial testimony I may elaborate, and in doing so I may offer related, subsidiary, or incidental opinions.

i. **Administrative Task & Requirement:** Implement patient safety measures to prompt, facilitate, and require measures to prevent pressure wounds from developing, and to treat wounds if they do develop.

Violation: The DHA administration violated the standard of care by failing to implement measures that prompted, facilitated, and required appropriate steps to prevent pressure wounds and to treat them properly if they develop.

Causation: This violation led to neglect that allowed a stage 2 pressure wound to develop on Dorothy Anthony's sacral area, and then led to further neglect that allowed the wound to develop to a stage 4 wound.

Damages: This violation caused pain, debridements, flap surgery, infections, long-term hospital stay, permanent disabilities.

ii. Administrative Task & Requirement: Implement measures to prompt, facilitate, and require communication between nurses and physicians concerning patients' high-risk status for pressure wounds and for patients' actual development of pressure wounds.

Violation: The DHA administration violated the standard of care by failing to implement measures that prompted, facilitated, and required necessary communication about pressure wound risk and development.

Causation: This violation led to neglect that allowed a stage 2 pressure wound to develop on Dorothy Anthony's sacral area, and then led to further neglect that allowed the wound to develop to a stage 4 wound.

Damages: This violation caused pain, debridements, flap surgery, infections, long-term hospital stay, permanent disabilities.

iii. Attending Physician Task & Requirement: Identify patients at high risk of developing pressure wounds, and ensure the nursing staff are taking appropriate preventive measures — including frequent repositioning and continence care.

Violation: The hospitalist staff — Dr. Adam Ross, Dr. James Cato, and Dr. Jonathan Preston — violated the standard of care by failing to identify Dorothy Anthony as being at high risk of developing a pressure wound, and by failing to enter orders or otherwise ensure that the nursing staff were taking appropriate preventive measures, including frequent repositioning.

Causation: This violation led to neglect that allowed a stage 2 pressure wound to develop on Dorothy Anderson's sacral area, and then led to further neglect that allowed the wound to develop to a stage 4 wound.

Damages: This violation caused pain, debridements, flap surgery, infections, long-term hospital stay, permanent disabilities.

iv. **Attending Physician Task & Requirement:** Order effective treatment for a pressure wound.

Violation: The hospitalist staff — Dr. Adam Ross, Dr. James Cato, and Dr. Jonathan Preston — violated the standard of care by failing to enter orders for effective treatment of the pressure wound that developed over Dorothy Anthony's sacral wound.

Causation: This violation led to neglect that allowed the wound to worsen into a stage 4 wound.

Damages: This violation caused pain, debridements, flap surgery, infections, long-term hospital stay, permanent disabilities.

v. **Nursing Task & Requirement:** Take appropriate steps to prevent development of pressure wounds, including frequent repositioning and continence care.

Violation: The nursing staff violated the standard of care by failing to take appropriate steps to prevent another pressure wound from developing on Dorothy.

Causation: This violation led to neglect that allowed a stage 2 pressure wound to develop, and then further neglect that allowed it to develop into a stage 4 wound.

Damages: This violation led to pain, debridements, flap surgery, infections, long-term hospital stay, permanent disabilities.

vi. **Nursing Task & Requirement:** Notify attending physicians of the development of a pressure wound and request treatment.

Violation: The nursing staff violated the standard of care by failing to notify attending physicians of the development (and worsening) of a pressure wound on Dorothy's sacral area.

Causation: This violation led to neglect that allowed a stage 2 pressure wound to develop, and then further neglect that allowed it to develop into a stage 4 wound.

Damages: This violation led to pain, debridements, flap surgery, infections, long-term hospital stay, permanent disabilities.

vii. **Nursing Task & Requirement:** Routinely assess the skin of an at-risk patient and document the skin status accurately.

Violation: The nursing staff violated the standard of care by failing to assess Dorothy's skin, and by failing to document her skin status, diligently and accurately.

Causation: This violation led to neglect that allowed a stage 2 pressure wound to develop, and then further neglect that allowed it to develop into a stage 4 wound.

Damages: This violation led to pain, debridements, flap surgery, infections, long-term hospital stay, permanent disabilities.

viii. **Nursing Task & Requirement:** Address incontinence effectively and assist with hygiene as needed to prevent skin breakdown and infection.

Violation: The nursing staff violated the standard of care by failing to address Dorothy's incontinence and hygiene disabilities.

Causation: This violation led to neglect that allowed a stage 2 pressure wound to develop, and then further neglect that allowed it to develop into a stage 4 wound.

Damages: This violation led to pain, debridements, flap surgery, infections, long-term hospital stay, permanent disabilities.

Qualifications

12. I am more than 18 years old, suffer from no legal disabilities, and give this affidavit based upon my own personal knowledge and belief.

13. I do not recite my full qualifications here. I recite them only to the extent necessary to establish my qualifications for purposes of expert testimony under OCGA 24-7-702. However, my Curriculum Vitae is attached hereto as Exhibit "A." My CV provides further detail about my qualifications. I incorporate and rely on that additional information here.

14. The events at issue here occurred in October 2018.

15. I am qualified to provide expert testimony pursuant to OCGA 24-7-702. That is:

a. In October 2018, I was licensed by an appropriate regulatory agency to practice my profession in the state in which I was practicing or teaching in the profession.

   Specifically, I was licensed by the State of Florida to practice as a physician in 2018.

b. In October 2018, I had actual professional knowledge and experience in the area of practice or specialty which my opinions relate to — specifically, the tasks identified above on which I offer standard-of-care opinions.

   I had this knowledge and experience as the result of having been regularly engaged in the active practice of the foregoing areas of specialty of my profession for at least three of the five years prior to October 2018, with sufficient frequency to establish an appropriate level of knowledge of the matter my opinions address.

   Specifically, I am a physician specializing in wound care in the settings of hospitals and other long-term care facilities, and for many years I have had great familiarity with each of the tasks on which I offer standard-of-care opinions.

Pressure Wounds Generally

A well-known problem

16. The problem of pressure wounds has been known for centuries.

17. One textbook on pressure wounds notes that "The bedsore problem is ancient and has never been far removed from the daily concerns of those whose business it is to deal with chronic disease."[1]

18. According to the same text: "Effective steps in the prevention and treatment of the lesions were already being taken in the 1st decade of the nineteenth century. … In 1815, William Heberden Jr. … published the description of a bed frame designed to reduce both pressure ischemia and the soiling of sheets and skin from incontinence. His introductory paragraph demonstrates that these two key factors in the production of decubitus ulcers were well appreciated even at this early date: 'As the ultimate object of the medical art is the removal or alleviation of those evils to which the human body is exposed, I make no scruple of laying before the College of Physicians some account of a contrivance from which I have lately experienced great benefit; though strictly speaking the calamity be no disease and the remedy no medicine. There is no one in the habit of attending the sick but must have had reason to deplore the wretched condition of those who, being bedridden through accident or infirmity, have contracted sores of a very painful and dangerous kind by long pressure, especially if the patient lie in the wet and filth of his own body which he is unable to restrain.'"

19. Pressure wounds are known by various terms, including "bedsore," "decubitus ulcer," "pressure ulcer," and "pressure injury."

20. The facts concerning pressure ulcers are well-known. Indeed, most of the general discussion in this document is taken directly from basic medical textbooks.

21. Pressure wounds occur mainly, but not exclusively, in the elderly, bedridden, and severely ill.

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[1] Parish, Lawrence C., Joseph A. Witkowski, and John T. Crissey, eds. *The decubitus ulcer in clinical practice*. Springer Science & Business Media, 2012.

22. The development of pressure wounds in hospital and community settings is disturbingly frequent.

23. Pressure wounds represent a major burden of sickness and reduced quality of life for patients and their carers.

What pressure wounds are, and what causes them

Generally

24. The skin, the largest organ in the body, is a major part of the body's defense against disease and infection.

25. A break in the skin frequently allows bacteria to enter the body, causing infection.

26. A pressure wound is a localized injury to the skin and/or underlying tissue, usually over a bony prominence.

27. A pressure wound is caused by excessive pressure on the skin.

28. Pressure wounds are usually caused by occlusion of capillary flow by pressures greater than mean capillary pressure (25 mmHg), sometimes along with shearing forces, infection, and a lack of cutaneous sensation.

29. Pressure on the tissue which partially or completely occludes the capillaries impedes the inflow and outflow of blood, causing tissue death.

30. Pressure wounds are the end result of an inadequate nutrient blood supply to the tissues.

31. When this occurs for an extended period of time, tissue ischemia and hypoxia result. That is, tissue loses blood flow and, with loss of blood, loses the oxygen supply necessary for the tissue to live.

32. Pressure wounds may harm the body in a variety of ways: The wound may kill skin tissue, may kill muscle tissue, may injure blood vessels, and may impair

lymphatic circulation. If the underlying bone becomes infected, that is frequently incurable.

33. Pressure wounds may put the patient at risk of infection and sepsis, which is frequently lethal.

Incontinence, skin irritation, and wounds

34. Skin irritation may contribute to, or develop in conjunction with, pressure wounds.

35. Urinary and fecal incontinence can irritate skin and make the skin more likely to break down.

36. Urine may play a primary role in dermatitis by contributing water, and because continuous exposure to water can harm the skin.

37. The most common skin damage associated with incontinence is perineal dermatitis.

38. Patients with mobility impairment and incontinence are at higher risk for decubitus ulcer formation and to have delayed healing of existing lesions.

Effect on lymphatics

39. Lymphatic flow is also impaired by immobility.

40. The lymphatic system consists of the vascular network of tissues and organs (the lymph nodes, thymus, spleen, tonsils, and appendix) that move various kinds of fluids into the blood circulation.

41. The lymphatic system serves multiple functions, including:

- returns tissue fluid into blood circulation
- filters tissue fluid through the immune cells located within lymph nodes

42. The lymphatic system plays a crucial role in our immune system.

43. The metabolism of skin cells depends in part on the lymphatic system. Failure to clear protein from tissue can cause irritation.

44. Disruption with the flow of lymph can result in an inflammatory response within the affected tissue, which otherwise would have occurred within the lymph node.

45. The lymphatic system is perhaps compromised more than any other by immobility and by excessive mechanical stress.

Types & stages of pressure wounds

46. The back of the head, shoulders, elbows, hips, sacrum, and heels are the most commonly affected sites for pressure wounds.

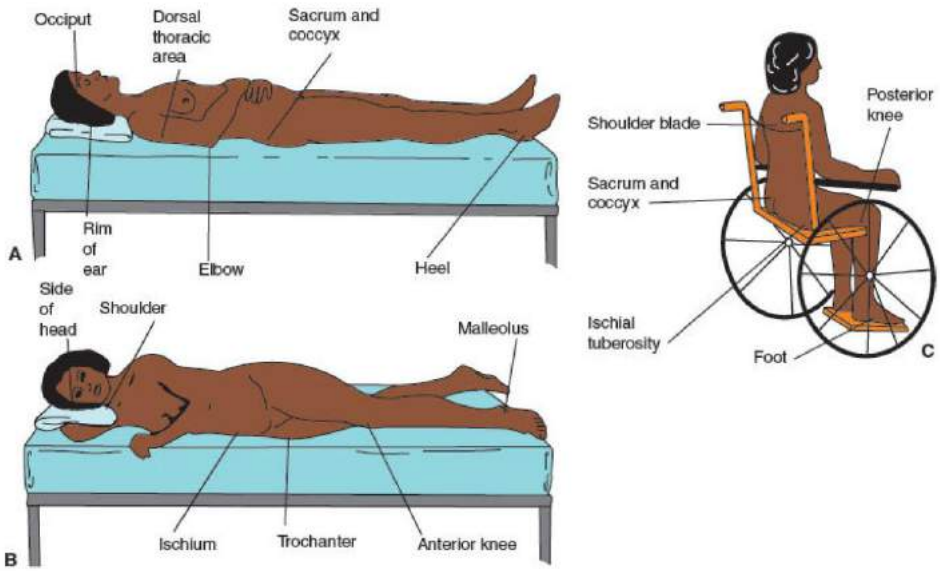
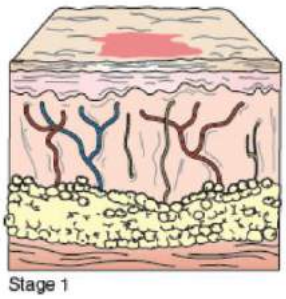


FIGURE 58-4 Common sites for pressure wounds. **A.** Supine position. **B.** Side-lying position. **C.** Sitting. Included also are sites of tube insertion (e.g., IV, NG tube, catheter, drains).

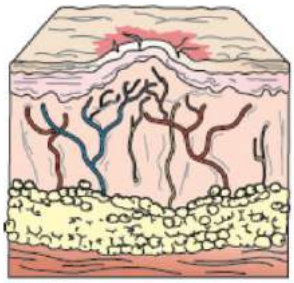
47. Pressure wounds are commonly classified in four stages, as follows.

48. Stage 1: Pressure-related alteration of intact skin, as compared with adjacent/opposite body area. May include changes in (one or more): skin temperature (warmth/coolness), tissue consistency (firm/boggy/mushy), induration

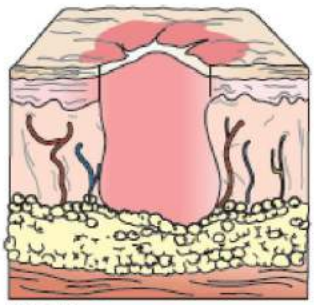
(swelling), or sensation (pain/itching). Stage 1 wounds are reversible, if pressure is relieved (by frequent turning, positioning, and pressure-relieving devices).


Stage 1

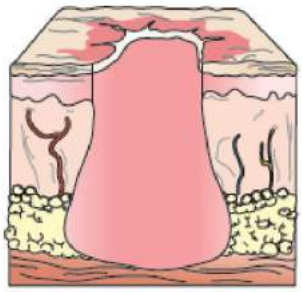
49. Stage 2: Loss of epidermis with damage into dermis (partial thickness tissue loss); appears as shallow crater/blister with red/pink wound bed, with no sloughing. May also appear as an intact or ruptured serum-filled blister or abrasion. Swollen and painful. Healing may require several weeks after pressure is relieved, often by maintenance of a moist environment.


Stage 2

50. Stage 3: Subcutaneous tissues involved (full-thickness tissue loss); subcutaneous fat may be visible (no bone, tendon, or muscle exposed). May show undermining or tunneling. Healing may require months after pressure is relieved (*e.g.,* by debriding with wet-to-dry dressings, surgery, or proteolytic enzymes).


Stage 3

51. Stage 4: Extensive damage to underlying structures; full thickness tissue loss, with exposed bones, tendons, or muscles. (Wound possibly appearing small on surface, but with extensive tunneling underneath.) Slough or eschar may be present. Usually foul-smelling discharge. Healing may require months or years, and may requires skin "flap" surgery).



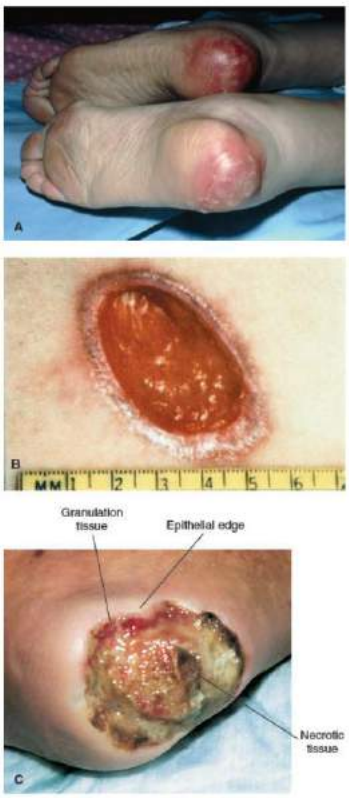


FIGURE 58-3 Stages of pressure wounds (see also Box 58-1). Stage I (reversible) includes pressure-related changes in intact skin, when compared with adjacent skin (not shown).

52. Unstageable: A pressure wound may be unstageable when the base of a full-thickness wound is covered by slough and/or eschar.

53. "Tunneling" refers to one or more channels within or underlying an open wound.

54. As a pressure wound heals, the stages do not reverse (e.g., a stage IV wound cannot become a stage III). This wound could be referred to as a "healing (or healed) stage IV pressure wound."

Risk factors

55. The following factors put a patient at risk of skin breakdown and pressure wounds. This is not an exhaustive list.

a. Immobility, low level of activity (lying/sitting in one position for extended periods of time, paralysis)

b. Inadequate nutrition

c. Incontinence of urine or feces; possibly other external moisture

d. Impaired mental status, alertness, or cooperation; heavy sedation and/or anesthesia; mental illness, intellectual impairment

e. Sensory loss; coma

f. Fever; low blood pressure (particularly diastolic <60 mm)

g. Advancing age, friable skin

h. Impaired immune system

i. Circulatory disorders; anemia

56. Patients with a past history of skin breakdown are particularly vulnerable.

57. Skin breakdown is a particular problem in an obese patient.

The danger of pressure wounds

58. The most significant complication of a pressure wound is infection.

59. Infection in pressure wounds is a common and potentially life-threatening complication.

60. Infection may lead to severe sepsis.

61. Severe sepsis consists of the body reacting to an infection in a way that damages not only the infectious agents but the body's own tissues and organs.

62. Severe sepsis is the primary cause of death from infection and thus requires early recognition, urgent attention, and prompt treatment.

63. Sepsis, septic shock, and multiple organ failure are major causes of morbidity and mortality in the United States.

64. Pressure injuries are a frequent cause of sepsis and death.

65. A stage of liquefaction can occur with separation of the necrotic tissue from surrounding viable tissue. In this process, bacterial counts rise, often producing sepsis from the undrained wound.

66. At this time, the wound may drain spontaneously or, more often, is debrided surgically. A crater-form wound results with walls of granulation tissue and, usually, a bony base which eventually also develops a granulation tissue cover.

67. Severe infection is often found in the patient with underlying illness such as diabetics, and/or in otherwise healthy patient in whom the extent of infection has spread beyond the adjacent tissue.

68. Osteomyelitis — infection in the bone — can occur and is a devastating complication.

The importance of prevention

69. Stage 3 or 4 pressure wounds are difficult to treat successfully.

70. After treatment, stage 3 or 4 pressure wounds often recur.

71. Where flap surgery is required, the flap frequently fails. That is, the tissue stretched or sewn over the pressure wound may die because of lack of adequate blood supply.

72. Infections related to pressure wounds may re-occur after treatment.

73. Because of the difficulty of treatment of stage 3 or 4 pressure wounds, it is critical to prevent pressure wounds from arising in the first place.

Treating pressure wounds

Generally

74. Once skin has broken down, it is very difficult to treat, particularly in a patient with other health problems, such as diabetes.

75. The extent of treatment needed depends on the degree of the wound.

76. A stage 1 wound may require only off-loading of pressure and a protective dressing.

77. A stage 2 wound involves may require only off-loading of pressure, with dressings, and/or or external medications, such as medicated creams or ointments. Oral or IV antibiotics and other medications may be given as well, to speed the healing process.

78. Dressings serve to protect wounds from contamination, collect wound exudate (drainage, exuded material), assist in debridement, and protect against further damage during healing.

79. The aim of the care of superficial wounds is to prevent deterioration into a deeper ulceration. Surgical debridement, frequent cleansing, and protection from further insult will usually permit a superficial wound to close by contraction and re-epithelialization.

80. Deep open wounds must granulate-in (heal) from the inside outward. If the outside becomes sealed before the area underneath has healed, an abscess often forms. This abscess may be sterile or infected.

81. For stage 3 or 4 pressure wounds, treatment may require other measures — including debridement, wound drains, vacuum devices, or skin flap or graft surgery.

82. Those patients with sepsis and/or massive ulcerations may need early debridement and coverage to prevent further deterioration, malnutrition, wasting, and death.

83. In some cases, surgical management becomes an urgent necessity, for example due to suspected sepsis or osteomyelitis.

84. All patients with full-thickness loss of soft tissue will require varying degrees of surgical wound care. This may be limited to debridement.

85. **Wound Drains**: If a wound is deep or if there is a great deal of drainage, a drain may be used to facilitate drainage and help the wound heal faster.

86. Some drain devices provide gentle suction, which can help deep or heavily draining wounds to heal faster.

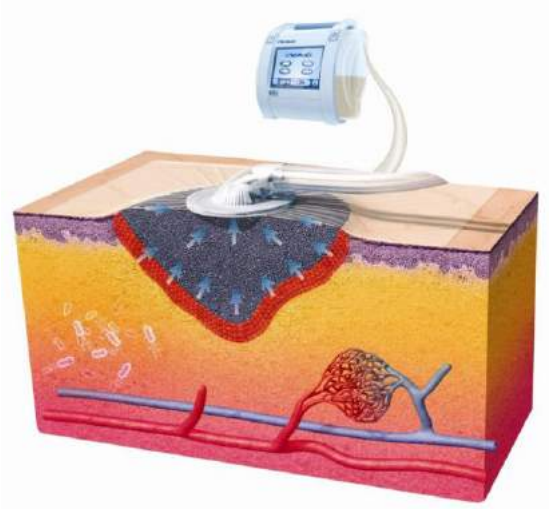
87. **Vacuum Devices**: A number of other devices are available to assist in wound care, in difficult or previously untreatable wounds. These include Vacuum-Assisted Closure—Negative Pressure Wound Therapy, which resembles a suction machine, applies controlled localized negative pressure to a wound site.

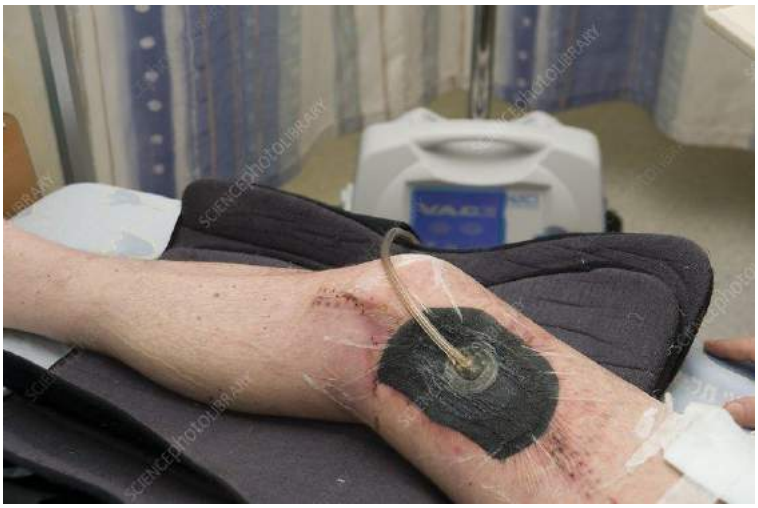
88. This speeds the growth of granulation tissue and decreases healing time.

89. The VAC is particularly useful in the treatment of stage III and stage IV pressure wounds/ulcers and other types of deep wounds.

90. The system uses a special dressing that is applied within a wound or over a graft. The VAC is turned on and the vacuum draws the wound edges toward the center.

91. The direct pressure of the dressing on the wound also assists in removal of fluids, reducing swelling, stimulating growth of healthy cells, and increasing blood flow, thus promoting faster healing.





92. **Wound Irrigation**: Irrigation with a sterile solution helps remove debris from an open wound after injury or from an infected surgical incision.

93. Several types of wound irrigation systems are available. They wash out debris and provide moisture to wounds, using saline, a biologic solution, or an antibiotic.

Debridement

94. Pressure wounds will generally not heal unless necrotic debris is first removed. Necrotic (dead) tissue creates a physical barrier that prevents tissue repair and provides an ideal medium for bacterial colonization.

95. Removal of necrotic tissue is called “debridement.”

96. Sharp debridement involves cutting away necrotic tissue with a scalpel or scissors, exposing living tissue. This can be very painful, so a local, or even a general, anaesthetic should be used.

97. Adequate debridement is the foundation for successful closure. Periodic sharp debridement is usually done at the bedside and is carried out until bleeding, obviously viable tissue is reached, or to the point of pain in patients with sensation.

98. It may be necessary to perform debridement in the operating room for those patients in whom major debridements are planned.

99. Between debridements, one needs to provide an environment that promotes healing and maintains bacterial control of the wound. This can take the form of moist gauze dressing changes, or the application of moisture-retentive dressings like polymers or hydrocolloids.

100. Radiographic examination of the involved area can be used to determine whether osteomyletis (bone infection) has occurred.

Flap & graft surgeries

101. The ultimate goal in the treatment of decubitus ulcers is to obtain a closed, healed wound that resists recurrence.

102. For severe wounds, this may require surgery to cover the area of the pressure wound with skin from an adjacent area or, less often, from elsewhere in the body.

103. A skin graft is a piece of healthy skin removed from one area of your body to repair damaged or missing skin somewhere else on your body. This skin does not have its own source of blood flow.

104. A skin flap is healthy skin and tissue that is partly detached and moved to cover a nearby wound.

105. A skin flap may contain skin and fat, or skin, fat, and muscle.

106. Often, a skin flap is still attached to its original site at one end and remains connected to a blood vessel.

107. Sometimes a flap is moved to a new site and the blood vessel is surgically reconnected. This is called a free flap.

108. Flap surgery involves transporting healthy, live tissue from one location of the body to another — often to areas that have lost skin, fat, muscle movement, and/or skeletal support. There are several different types of flap surgery methods that may be utilized, depending upon the location of the flap and the structures that need to be repaired.

109. Flaps can be categorized according to the type of vascular supply or the types of tissue in the flaps (ie, skin, fascia, and muscle).

110. Raising a myocutaneous flap affects or eliminates the function of the muscle.

111. In some instances, for example, the gluteus maximus muscle and the quadriceps, the muscle can be split to both preserve function and obliterate a pressure ulcer cavity.

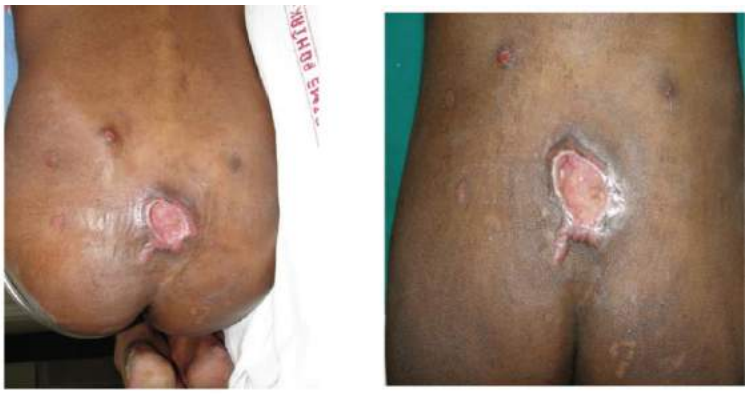
112. Reconstruction with myocutaneous flaps is major surgery.

113. The magnitude of routine ulcer excision or flap closure can hasten the death of a debilitated patient.

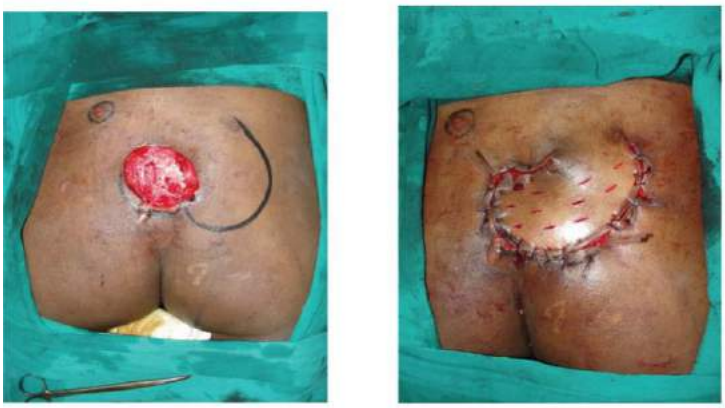
114. Postoperatively, prolonged periods of immobilization and assiduous nursing care to prevent pressure on the operative site or additional secondary areas of breakdown are imperative for success.

115. Where a pressure wound developed because of negligent care in the same hospital where the surgery is performed, the postoperative care may be performed by the same staff that allowed the wound to develop in the first place.

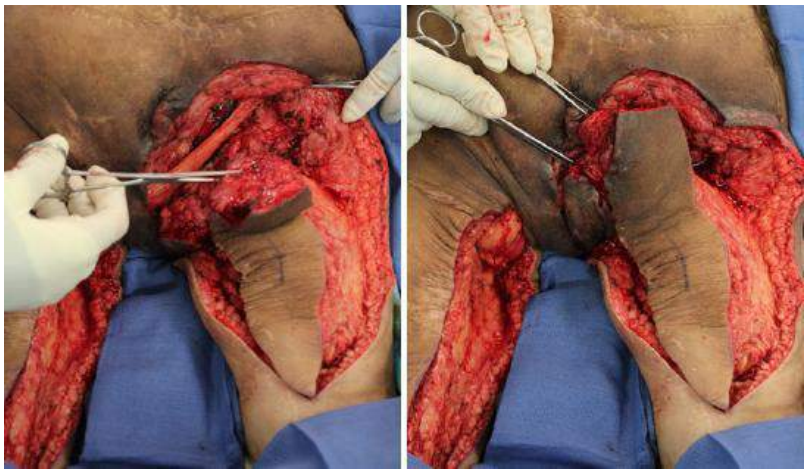
116. Pictures from actual flap surgeries are easily available online.. For example:



PRE-OP



FLAP DESIGN **POST-OP**



Nutrition

117. Proper nutrition is essential to successful treatment of a pressure wound, to the generation of new tissue, and to lowering of the risk for complications, particularly infection.

118. Nutrition in the prevention and treatment of pressure wounds requires a knowledge of the nutritional requirements of the long-term care patients, particularly elderly people; a protocol for assessing nutritional status periodically; and a plan for early intervention when nutritional problems are identified.

119. The guidelines for nutrition in the treatment of decubitus ulcers requires the incorporation of basic principles of applied nutrition, nutrient requirements for healing and tissue regeneration, and the metabolic response to injury.

120. Protein is the most important of the macronutrients to assure adequate intake.

121. Protein component loss will also increase the likelihood of an infectious complication.

Treatment of infections

122. Where a pressure wound becomes infected, the infection must of course be treated.

123. Abscessed or grossly infected pressure injuries should be drained and debrided to treat pressure injury related sepsis or advancing cellulitis.

124. Oral or IV antibiotics may be needed.

125. Osteomyelitis (bone infection) may occur and must be investigated and, if necessary, treated.

126. In the event of osteomyelitis, some bone may need to be cut away.

The medical community's focus on preventing pressure wounds

127. Pressure wounds are preventable with simple measures available in any modern medical facility; and yet these wounds still occur with disturbing frequency.

128. For these reasons, the medical community has for many years made it a priority to prevent pressure wounds.

129. The prevalence and incidence of pressure wounds have come to be regarded as indicators of the quality of care.

130. The National Pressure Ulcer Advisory Panel, a national medical organization, was created in 1987 — 33 years ago — specifically to advocate for serious attention to pressure wounds.

131. The Joint Commission — a hospital accreditation agency — has for years identified pressure wounds as a "sentinel event" that requires an "immediate" investigation.

132. A "facility-acquired" pressure wound is a sentinel event which must be reported to the appropriate authorities. If a stage III, IV, or nonstageable wound/ulcer develops within a facility, this usually must be reported to the Health Department and investigated.

133. The Centers for Medicare & Medicaid Services, the largest funder of healthcare in the United States, has declared a stage 3 or 4 pressure wound as a "never event." That is, a "serious and costly error in the provision of health care services that should never happen."

134. The National Pressure Ulcer Advisory Panel issues guidelines to assist medical facilities in preventing and treating pressure wounds.

135. Written guidelines and protocols for decubitus ulcer prevention and treatment are used in most institutions.

Responsibilities of nurses in preventing & treating pressure wounds

Part of basic nursing

136. Nurses have been identified as the patient's first line of defense in the prevention of pressure wounds. Because they are involved in total care of the patient, nurses have assumed the responsibility for care of the patient's skin. As a result, nurses have become the primary care givers for the prevention and treatment of pressure wounds.

137. Nurses in any area of a hospital know, or should know, how to prevent pressure wounds, and are responsible for doing so.

Examine and assess risk

138. Because there are known predisposing factors to pressure wounds, the first requirement is to identify the patient at risk and to take preventive measures.

139. The patient at greatest risk must be identified before the problem begins.

140. Nurses are responsible for identifying the patients at greatest risk.

141. The patient must be assessed as to their general health, their nutritional status, mental responsiveness, mobility, bowel and bladder function, as well as the specifics of treatment programs in certain circumstances, e.g., fracture management and spinal injuries.

142. Because pressure wounds usually occur within the first 10 days of admission to an acute care institution, assessment should be performed on admission. Any acute deterioration of the patient's clinical status requires immediate reassessment.

143. Several methods are used to predict the risk of pressure wound development. Two of these are the Braden Scale and the Norton Scale.

144. The condition of urinary incontinence, or similar conditions, is included in the major risk assessment tools for predicting risk of pressure wound development.

145. The Norton scale (see below) considers physical condition, mental state, activity, mobility, and incontinence.

Table 1. The Norton scale (adapted from [6])

		Physical condition	Mental condition	Activity	Mobility	Incontinent	Total score
		Good 4 Fair 3 Poor 2 Very bad 1	Alert 4 Apathetic 3 Confused 2 Stupor 1	Ambulant 4 Walk/help 3 Chairbound 2 Stupor 1	Full 4 Slightly limited 3 Very limited 2 Immobile 1	Not 4 Occasional 3 Usually/Urine 2 Doubly 1	
Name	Date						

146. The Braden scale identifies three determinants of pressure: sensory perception, activity, and mobility; and three factors influencing tolerance of the skin to pressure, namely, moisture, nutrition, and friction and shear.

BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK

Patient's Name_____ Evaluator's Name_____ Date of Assessment

SENSORY PERCEPTION Ability to respond meaningfully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation. OR limited ability to feel pain over most of body.	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over ½ of body.	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR has some sensory impairment which limits ability to feel pain or discomfort in one or two extremities.	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.				
MOISTURE Degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift.	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals.				
ACTIVITY Degree of physical activity	**1. Bedfast** Confined to bed.	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every 2 hours during waking hours.				
MOBILITY Ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance.	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. Slightly Limited** Makes frequent though slight changes in body or extremity position independently.	**4. No Limitation** Makes major and frequent changes in position without changes.				
NUTRITION Usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than ⅓ of any food offered. Eats two servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and/or maintained on clear liquids or IVs for more than 5 days.	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only three servings of meat or dairy products per day. Occasionally will take a dietary supplement OR receives less than optimum amount of liquid diet or tube feeding.	**3. Adequate** Eats over half of most meals. Eats a total of four servings of protein (meat, dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs.	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of four or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.				
FRICTION & SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures, or agitation leads to almost constant friction.	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair.					
				Total Score				

FIGURE 58-5 Braden Assessment Scale for Predicting Pressure Ulcer (Wound) Risk. Total possible points = 23. *The lower the score, the greater the risk.* The client is identified as at risk for pressure wound development if the score is less than 18. (Some facilities use scores from 15 to 18 as the risk prediction score.) A modified scale (Braden Q) is available for use with pediatric clients. The Braden Q also considers tissue perfusion and oxygenation; the risk

147. Risk assessment scales are based on the fact that, while no one is immune to pressure wound formation beyond some critical point, certain factors place patients at a particularly high risk of pressure damage.

148. In addition to determining risk, assessment scales indicate the probability of healing of existing pressure wounds.

149. Risk assessment scales also serve as reminders of the factors that place patients at risk, permit easy communication among health care personnel of the patient's risk, and ensure systematic evaluation of risk factors.

150. Skin assessment should be performed routinely and systematically. It should be done daily, usually at the time of the patient's bath.

Prevent harm from incontinence and immobility

Generally

151. It is an important nursing responsibility to prevent skin breakdown and, if it occurs, to report it immediately and treat it as ordered.

152. Frequent and effective skin care is essential to keep the skin intact and remove dirt, excess oil, and harmful bacteria.

153. [E]veryone's face, underarms, skin folds, and perineal area need daily cleansing.

154. Body fluids, such as perspiration, vomitus, urine, and feces, are generally acidic and are very irritating to the skin. They must be removed immediately.

155. Many older people, people confined to bed, and people who are ill have very fragile (friable) skin. These clients need special skin care, to prevent skin breakdown.

156. A number of protective devices, special products, and procedures are available to protect the skin.

157. It is particularly important to protect bony and skin prominences (e.g., elbows, heels, sacrum, shoulder blades, backs of the ears, back of the head). This is vital for the immobile client.

158. It is the nurse's responsibility to inspect the skin during baths and other routine daily care. If any reddened or irritated areas are noted, they must be reported immediately. If these areas are treated quickly, actual skin breakdown can often be avoided.

159. In some cases, a bath must be given. For example, if the client has been incontinent or has bleeding or drainage, at least a partial bath is necessary, to prevent skin breakdown and infection.

160. Perineal care, bathing the genitalia and surrounding area, is given to all clients. Some patients may be embarrassed, but regular perineal care is part of total patient care, even if a patient is of the opposite sex.

161. A group of procedures, called the Skin Bundle, are implemented to prevent skin breakdown in clients at risk.

162. Alleviation of pressure is essential.

163. Nurses should always remain alert for signs of pressure on the client's body.

164. Nurses should encourage all clients to move themselves as much as possible.

165. For a patient at risk for pressure wound development, the nurse should turn and reposition the client every 2 hours, elevate bony prominences with pillows, and limit the amount of linens under the client.

166. Many immobile clients are placed on special beds or mattresses, to help reduce pressure and prevent skin breakdown.

167. Nurses should keep the skin free of external moisture and body fluids, such as urine and feces. External moisture, particularly when combined with continuous pressure, predisposes the skin to breakdown.

168. Nurses should assist clients to obtain adequate nutrition and hydration. Clients at risk should have a nutrition consult.

169. The nurse is often ordered to encourage fluids (of varying types) to promote adequate hydration. It is important to maintain skin hydration and elasticity. Dry, scaly skin is more subject to breakdown than is well-hydrated skin.

Incontinence

170. Urinary incontinence affects millions of Americans.

171. Fecal incontinence affects many of the hospitalized elderly.

172. When caring for patients who are incontinent of urine and feces, health care providers are faced with the challenge of preventing perineal dermatitis and pressure wounds as a result of the decreased tissue tolerance to trauma.

173. The patient who is incontinent of urine or stool must have meticulous skin care, to prevent skin breakdown. Several means are available to help prevent IAD and new products are constantly being developed. Using an incontinence cleanser (e.g., Remedy Spray Cleanser, which does not dry skin) and a moisture barrier paste (e.g., Calazime, which protects skin) before damage occurs can be helpful. Special barrier cream wipes are available, for the patient with chronic incontinence. Disposable paper washcloths should be used instead of cloth washcloths; dispose of them in the trash—do not flush. Nurses should be sure to keep the patient as dry and clean as possible.

174. Prevention of incontinence related to restricted mobility involves, for example, providing urinals or bedpans within easy reach, use of a bedside commode, or scheduled toileting programs may resolve the incontinence.

175. The most successful behavioral management strategies for the frail cognitively impaired patient typically at risk of pressure wounds include prompted voiding and scheduled toileting programs. Both strategies are caregiver-dependent and require a motivated care giver to be successful. Scheduled intake of fluid is an important underlying factor for both strategies.

176. Underpads and briefs may be used to protect the skin of patients who are incontinent of urine or stool. These products are designed to absorb moisture, wick the wetness away from the skin, and maintain a quickdrying interface with the skin.

177. Incontinence containment strategies imply the need for a check and change schedule for the incontinent patient so wet linens and pads may be removed in a timely manner.

Notify physician immediately if a wound starts to develop

178. Nurses should act to prevent pressure wounds on their own initiative, without direct orders to do so by a physician.

179. However, when a nurse sees evidence of a pressure wound, the nurse must notify the physician chiefly responsible for the patient.

180. It is an important nursing responsibility to report skin breakdown immediately and treat it as ordered.

181. Nurses should report any signs of pressure or reddened/darkened areas that do not return to normal hue (color) after pressure is removed.

Responsibilities of attending physicians in preventing & treating pressure wounds

182. While nurses face their own independent responsibility to prevent pressure wounds, the physician with primary responsibility for the patient (the attending physician) remains responsible for the patient.

183. The attending physician is responsible for overseeing and supervising the care of the patient.

184. In the hospital setting, generally a hospitalist is assigned as the patient's attending physician, with primary authority and responsibility for supervising and coordinating the patient's medical treatment — though various consulting physicians may also become involved in evaluating or treating the patient.

185. Medical students are taught about pressure wounds. See for example, chapter 8 of *Comprehensive Hospital Medicine: An Evidence-Based Approach, First Edition* (2007) published by Saunders Elsevier.

186. Hospitalists in particular are taught about pressure wounds, partly because their practice focuses on a hospital inpatient population, for whom pressure wounds present a particular risk. See for example, chapter 72 of *Principles and practice of hospital medicine* (2017) published by McGraw-Hill.

187. The attending physician's responsibility includes ensuring that necessary actions are taken to prevent the patient from developing a pressure wound.

188. Generally, hospitals have policies — often with standard order sets — for preventive actions with patients at high risk of a pressure wound.

189. Regardless of whether such a standard order set exists, the attending physician is responsible for monitoring the patient's status and for entering orders to effectively prevent or treat a pressure wound.

190. In the event that the patient develops a stage 1 or 2 pressure wound, the attending physician faces an urgent responsibility to order treatment for the wound and to prevent it from worsening into a stage 3 or 4 wound.

191. The attending physician's responsibilities include entering orders to ensure that nurses take appropriate actions to treat pressure wounds, or to order consults from other physicians as needed.

Responsibilities of hospital or facility administration

192. The administration of a hospital interacts with the medical and nursing staff.

193. The administration creates policies, procedures, and protocols for the medical and nursing staff to follow.

194. The administration provides medical record systems for the medical and nursing staff to use.

195. The administration provides communication systems for the medical and nursing staff to use.

196. Through their actions concerning these systems and policies, the hospital administration affects the safety of patients, for better or worse.

197. The patient may suffer — perhaps fatally — if a gap in responsibility exists, so that no physician supervises and coordinates medical treatment of the patient.

198. If no physician possesses the authority and responsibility for supervising and coordinating the patient's medical care, the patient may be left without necessary treatment, or may receive inconsistent or counterproductive treatment.

199. The hospital administration is responsible for ensuring that authority and responsibility for patient care is clearly defined.

200. The hospital administration must not allow a patient to go without a physician with overall responsibility for supervising and coordinating medical treatment.

201. The hospital administration must not allow uncertainty about the allocation of authority and responsibility for a patient's medical treatment.

202. Hospital administration is responsible for implementing procedures to reduce or eliminate known, serious risks to patient safety.

203. Hospital administration is responsible for implementing procedures to reduce or eliminate, among other things, the risk of a stage 3 or 4 pressure wound from developing in the hospital.

204. The medical staff of a hospital generally is led by a medical director appointed by the overall hospital leadership. The medical director's role is to evaluate clinical performance and to enforce hospital policies related to quality care.

205. A hospital's administration generally includes a committee or other body responsible for reviewing quality improvement matters — responsible for identifying problems in the treatment of patients, and fixing them.

206. Licensed hospitals are required to have a compliance and performance improvement program in place. This requirement is also a key aspect of the Medicare conditions of participation for hospitals that wish to be a Medicare provider.

207. Several organizations exist to help hospital administrative staff protect and improve patient safety by designing safe systems.

208. In 1984, peer review organizations (PROs) were established to review Medicare admissions in terms of medical necessity with appropriate medical treatment, proper coding for billing, and quality of service. The PROs were given criteria with established review and data systems.

209. The PRO reviews gave rise to the concept that many adverse outcomes were due to system failures rather than individual failures.

210. In 1999 the Institute of Medicine (IOM) produced *To Err Is Human: Building a Safer Health System*. This publication raised awareness about adverse outcomes by reporting that almost 100,000 people were dying each year as a result of medical errors and misadventures in the healthcare system. Its recommendations focused on accountability.

211. To establish a culture of safety, a healthcare organization must make safety a top priority, involving teamwork on the part of both staff and patients, transparency, and accountability.

212. The CMS recognizes two national hospital accreditation programs—The Joint Commission and the DNV/National Integrated Accreditation for Healthcare Organizations to determine "deemed" Medicare provider status.

213. In 2002, The Joint Commission initiated annual national patient safety goals. Accredited entities report specific measures on these NPSGs.

214. Quality Improvement Organizations (QIOs): These organizations emphasize prevention, early detection, and proper management of services that are high cost and/or have a high potential for errors and adverse outcomes. QIOs also assist in the implementation of safety measures and evidence-based clinical management guidelines.

215. In 2004, the IOM released Keeping Patients Safe: Transforming the Work Environment of Nurses…. The report noted that nurses are the last line of defense in identifying and stopping procedures or treatments that are potentially harmful to patients. It also addressed key issues such as frequent failure to follow management practices necessary for safety, loss of trust in hospital administration by nurses, the need for self-governance in nursing, unsafe work and workspace design, and fear of retaliation for reporting errors. The recommendations included transforming the work environment for nurses, thereby providing a safer environment for patient care.

216. IHI AND ISMP: A number of other organizations also focus on safety in the healthcare environment. The Institute of Health Initiatives (IHI) and the Institute of Safe Medication Practices (ISMP) have provided leadership and programs for patient safety and improved patient outcomes.

217. Many errors are the result of miscommunication or lack of communication among healthcare providers and staff. Health team members must develop critical thinking skills and communicate their concerns to the appropriate people when patient safety is at stake. The message must be clear so that appropriate action can be taken for the patient. Miscommunications must be investigated and systemic changes must be implemented to promote effective communication.

Financial incentives and patient dumping

218. If a patient's skin breaks down after admission to a medical facility, the facility is considered to be responsible.

219. In most cases, third-party payors will not reimburse the facility for costs incurred related to skin breakdown that was not present when the patient was admitted.

220. As explained in a 2008 CMS declaration:

> According to a study by the Centers for Disease Control & Prevention (CDC), common medical errors total more than $4.5 billion in additional health spending a year. Other studies have shown that hospitals only bear a small percentage of the total costs associated with preventable medical errors. Prompted by the landmark study by the Institute of Medicine titled "To Err is Human: Building a Safer Health System," the NQF created a list of 28 Never Events.
>
> The NQF defines Never Events as errors in medical care that are of concern to both the public and health care professionals and providers, clearly identifiable and measurable (and thus feasible to include in a reporting system), and of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the health care organization.
>
> …
>
> The CMS exercised its authority under section 5001(c) of the DRA by announcing that Medicare will no longer pay the extra cost of treating the following categories of conditions that occur while the patient is in the hospital: pressure ulcer stages III and IV….

221. Stage 3 or 4 pressure wounds require costly care.

222. Patients who develop pressure wounds not only require more nursing care, they also need special, and invariably more costly, mattresses and or bed systems.

223. Patients with a longer duration of stay are less attractive for a hospital because shorter stays pay proportionately more than longer stays. Patients with pressure wounds usually stay in hospital much longer, stays over 35 days are no exception.

224. Faced with a patient who requires costly care — and for which the hospital receives no money, because the hospital is responsible for the harm and its necessary treatment — the hospital has a financial incentive to dump the patient onto some other facility (a nursing home, for example).

225. "Patient dumping" is a well-recognized problem in the United States.

Before Dorothy Anthony's October 2018 Admission

226. Dorothy Anthony was 58 years old in October 2018. She suffers from Down Syndrome and has been cared for by family members. As of October 2018, Dorothy had also been diagnosed with dementia.

- DH1 – 31

227. On January 24, 2018, a family member took Dorothy to the DHA ER because of flu symptoms that had lasted for three days. PA Omar Queensbourrow discharged Dorothy home later that day, with prescriptions for Influenza A and bronchopneumonia.

- DH3b – 577-83

228. About three weeks later, on February 16, 2018, a family member took Dorothy to the Outpatient Wound Center, because of wounds on both of Dorothy's heels and on her lower back. NP Laura Cox and Dr. Shawn Fagan noted a stage I wound to both heels, and a "pressure wound to the sacrum, stage II" due to extended immobility for pneumonia and flu.

- DH3b – 575

DATE OF ADMISSION: 02/16/2018

This is on behalf of Dr. Fagan.

CHIEF COMPLAINT:
Pressure wounds to the bilateral heels and the back.

HISTORY OF PRESENT ILLNESS:
This is a 57-year-old African American female with a history of Down syndrome, who had flu pneumonia 3 weeks ago, which decreased her mobility for 2 weeks. The patient was noted to have wounds to her bilateral heels and was seen by her PCP, who started her on an antibiotic. She was also seen by podiatrist 4 days ago, who debrided the bilateral heels. She states that the wound to the back began as an open wound with bleeding present. She has been utilizing an ointment, but is recently switched to hydrogen peroxide and now a dry scab is present. The patient's family member states that the patient has returned to all activities at this time. Has not had recent fever, chills, nausea, vomiting, or diarrhea.

INTEGUMENT: Focused exam is located to the sacral area with a dry scab present. There is pale periwound area. There is no active bleeding. No purulence. No active signs of infection. Focused exam is located to the bilateral heels with hyperpigmentation noted. Mild separation of epithelium. Area is blanchable with palpation.

ASSESSMENT:
1. Chronic wounds to bilateral heels, pressure stage I.
2. Pressure wound to the sacrum, stage II.

PLAN:
1. May wash all areas with soap and water daily and will apply Mepilex Ag Border. May be kept in place for 7 days. May remove prior to showering.
2. The patient will follow up in clinic in 1 week.
3. Caregiver is aware of signs and symptoms of infection. Will contact clinic with any acute concerns. This is 99202 x2 on behalf of Dr. Fagan.

Dictated By: Laura Cox, NP
For: Shawn Fagan, MD

229. A family member took Dorothy to the Wound Center eight times over the next 7-1/2 months, to follow up on Dorothy's heel and sacral wounds.

- DH3b – 572 (2/27/2018 visit)
- DH3b – 564 (3/13/2018 visit)
- DH3b – 560 (3/27/2018 visit)
- DH3b – 556 (4/26/2018 visit)
- DH3b – 552 (5/17/2018 visit)
- DH3b – 547 (6/19/2018 visit)
- DH3b – 542 (8/7/2018 visit)
- DH3b – 540 (10/4/2018 visit)

230. On the fifth follow-up visit, on May 17, 2018, NP Elizabeth Riordan and Dr. Fagan noted that the wound on Dorothy's right heel wound was still present, but that the wounds on her left heel and on her sacral area had healed. The right-heel wound measured 2 x 1.5 x 0.2 cm.

- DH3b – 552

INTEGUMENT: Focused examination to the back reveals a pink, soft, re-epithelized area with no open areas. No thickening, fibrosis, or banding.

Focused examination to the right heel also reveals an area that is pink and completely re-epithelialized at this time with no surrounding erythema. No edema. No signs or symptoms of infection.

Focused examination to the right heel has one open area that measures 2 x 1.5 x 0.2. The wound bed itself is a thick, adhered, and yellow slough. No granulating tissue noted within the wound bed, however, no surrounding erythema. No edema. No induration or fluctuance. No signs or symptoms of infection.

ASSESSMENT:
Resolved pressure wounds to the lower back and left heel with an unstageable wound to the right heel.

231. On June 19, 2018, Dorothy's older sister took Dorothy for a follow-up visit at the Wound Center. PA Jeanine Linehan-Burack and Dr. Fagan again noted that Dorothy's sacral wound and left heel had resolved. The right heel wound now measured 1.3 x 0.5 cm.

- DH3b – 547

SUBJECTIVE:
Anthony is a 58-year-old learning disabled African American female with a history of wounds to the bilateral lower extremities and lower back. Most have healed with the exception of the right heel wound that has remained. She has been washing the area daily with soap and water, applying Santyl and Polysporin ointment. She is currently under the care of her older sister who does her daily dressing changes. She has returned to daycare. Sister states that she has been driving her just to prevent any wounds from occurring to her feet.

EXTREMITIES: Remainder of exam is focused to the right heel which shows a small open wound that measures 1.3 x 0.5 cm. It is filled with dry devitalized slough that is well adhered. There is no sign of extending erythema, fluctuance, or induration, infection, or cellulitis appreciated. The remaining wounds to the bilateral feet are well healed, soft, flat, pink, and nontender. They blanch easily. She has palpable pulses. Brisk capillary refill. No signs of clubbing or cyanosis.

DIAGNOSIS:
Chronic wound of the right heel.

232. On August 7, 2018, Dorothy's younger sister took Dorothy to the Wound Center to follow up on Dorothy's right-heel wound. At this point, that wound measured 1 x 0.5 cm.

- DH3b – 542

233. About two months later, on October 4, 2018, a family member took Dorothy back to the Wound Center. The wound on Dorothy's left heel had returned, and the right-heel wound had worsened. The right-heel wound now measured 2 x 1 x 0.1 cm. The left-heel wound measured 2 x 1 x 0.1 cm. Both were unstageable.

- DH3b – 540

INTEGUMENT: Focused examination first of the right heel, has a wound that measures 1 x 0.9 x 0.3.
Next, focused examination to the left heel has a wound that measures 2 x 1 x 0.1. The wounds are unstageable with pale, pink wound bed. Surrounded by dry flaky skin. There is no surrounding erythema, no edema. No signs or symptoms of infection.

ASSESSMENT:
Unstageable pressure wounds to the bilateral heels.

234. A stage 2 wound is superficial, but the healed stage 2 sacral wound demonstrates that despite suffering from diabetes and Down Syndrome, Dorothy was perfectly capable of healing a wound — if properly cared for.

The October 2018 Admission

ER Visit: October 15 — Monday

235. On October 15, 2018, Dorothy's sister took Dorothy to the Doctor's Hospital ER, for what turned out to be about an 8-1/2 month stay in the hospital.

236. The extended stay was made necessary largely because, while Dorothy waited for placement in a nursing home, a Stage IV pressure wound developed on Dorothy's sacral area, and Dorothy became septic.

237. On October 15, 2018, Dorothy's sister took Dorothy to the Doctor's Hospital ER because Dorothy was having trouble walking, was not talking, was acting confused, and was occasionally shaking — after having fallen and hit her head about three weeks earlier.

- DH1 – 9

Inpatient Admission: October 15

238. In the ER, testing revealed no acute cause of Dorothy's altered mental status.

- DH1 – 16

)(**Re-Eval Status** Workup for the patient's altered mental status is currently unremarkable. Patient did speak a few words, stating she has to go to the bathroom, for the MD at this time. Does have chronic wounds of her calcaneal regions bilaterally, do not appear to be infected, wound center has seen her recently. Will consult with wounds during her hospitalization. Presented the case to the hospitalist, will admit for altered mental status. Does not appear to be easily treatable solution, possibly just worsening of her chronic dementia. Patient may require nursing home placement.

239. The ER physician, Dr. Kenneth Grotz, discussed the case with a hospitalist. They decided to admit Dorothy for observation, noting that Dorothy's dementia might be worsening. Dr. Grotz noted that Dorothy might need to be placed in a nursing home. The decision to admit Dorothy was made around 1456 hrs. (That's when Dr. Grotz signed his Emergency Provider Report.)

- DH1 16

240. Dr. Grotz noted the wounds on Dorothy's heals, and noted that the Wound Care service would be consulted during Dorothy's admission.

- DH1 – 11, 16

241. A couple hours later, at 1631 hours on October 15, Nurse Thriza Eje conducted an Admission Health History.

- DH2 – 78-82.

242. In the Admission Health History, Nurse Eje noted that Dorothy had suffered a recent decline in mobility or ambulation, that her legs were weak, and that she needed assistance both with ambulation and with hygiene. Nurse Eje also noted that Dorothy had recently lost weight due to a loss of apetite and was at risk of malnutrition.

- DH2 – 79-81

Activity Date: 10/15/18 Time: 1631 (continued)

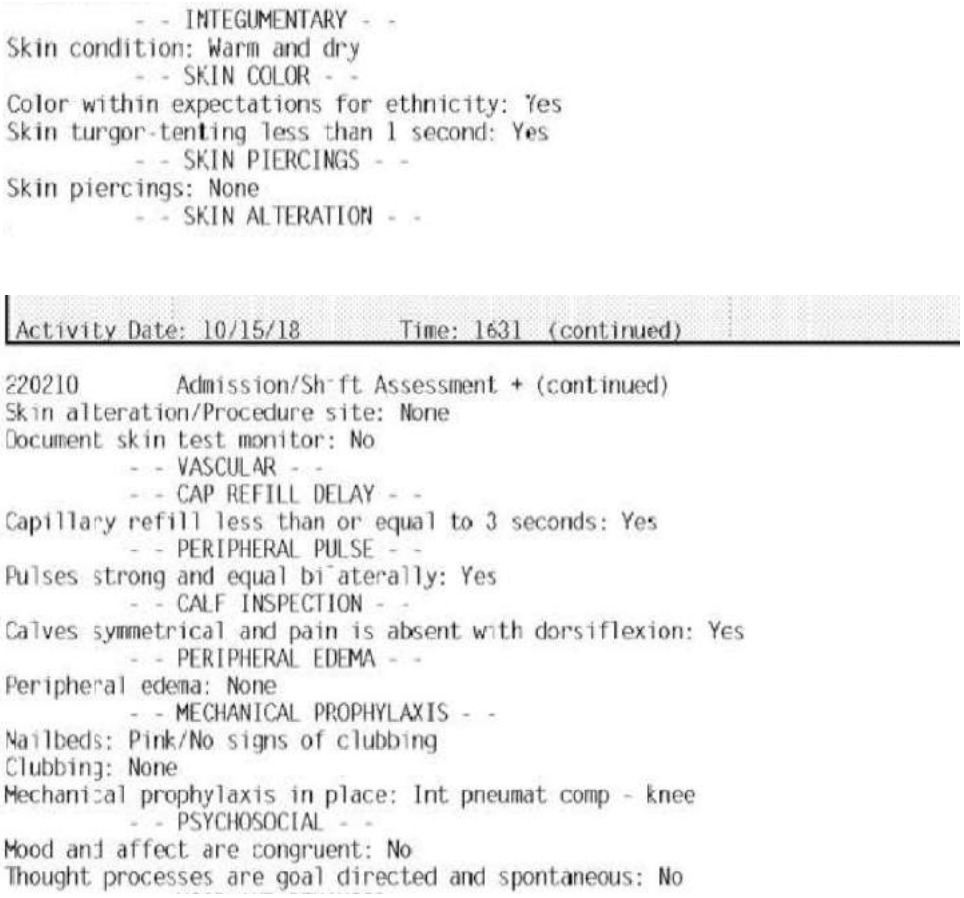
220200 Admission Health History - (continued)
Developmental level 18 years+: Unable to live indepdnt
- - ADVANCE DIRECTIVES - -
Did patient express/disclose organ donation preference: No
Do you have an advance directive: No
Durable power of attorney for healthcare: No
- - VALUABLES/ASSISTIVE DEVICES - -
Disposition of valuables: Family to take
Disposition of home meds: Sent home with family
- - FUNCTIONAL/NUTRITIONAL SCREENING - -
Decrease in ADL function or upper limb mobility past 7 days: Present/Exists
Recent decline in mobility or ambulation in the past 7 days: Present/Exists
Falls within the past 3 months: Yes
Musculoskeletal chronic conditions: None
Recent weight loss without trying: Yes
How much weight have you lost: Unsure
Eating poorly due to decreased appetite Yes
Malnutrition screen tool score: 3 - Malnutrition risk
Home tube feeding or TPN: No

- - UPPER EXTREMITY - -
Upper extremities equal and strong bilaterally: No
Arm right motor strength: Weak
Hand right motor strength: Weak
- - LOWER EXTREMITY - -
Lower extremities equal and strong bilaterally: No
Leg left motor strength: Weak
Leg right motor strength: Weak
Foot left motor strength: Weak
Foot right motor strength: Weak
- - GAIT/BALANCE - -
Gait, strength, balance: Generalized weakness
Non-ambulatory
General weakness: Present/Exists
Dizziness: None
Headache: None

- - MUSCULOSKELETAL - -
Full range of motion appropriate for developmental age: No
- - GAIT - -
Developmentally age appropriate gait: No
Gait impairment: Bed bound
Unsteady
Weakness
- - AMBULATION - -
Developmentally appropriate independent ambulation: No
Ambulation: 2 person assist
- - PARESTHESIA - -
Paresthesia: None
- - ACUTE CONDITION - -
Musculoskeletal acute condition: None

243. The Admission Health History included an Integumentary (*i.e.*, skin) section. That section did not include a Braden scale or other formal screening for risk of pressure wounds.

- DH2 – 80-81



```
- - INTEGUMENTARY - -
Skin condition: Warm and dry
- - SKIN COLOR - -
Color within expectations for ethnicity: Yes
Skin turgor-tenting less than 1 second: Yes
- - SKIN PIERCINGS - -
Skin piercings: None
- - SKIN ALTERATION - -
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Activity Date: 10/15/18        Time: 1631  (continued)

220210        Admission/Shift Assessment + (continued)
Skin alteration/Procedure site: None
Document skin test monitor: No
- - VASCULAR - -
- - CAP REFILL DELAY - -
Capillary refill less than or equal to 3 seconds: Yes
- - PERIPHERAL PULSE - -
Pulses strong and equal bilaterally: Yes
- - CALF INSPECTION - -
Calves symmetrical and pain is absent with dorsiflexion: Yes
- - PERIPHERAL EDEMA - -
Peripheral edema: None
- - MECHANICAL PROPHYLAXIS - -
Nailbeds: Pink/No signs of clubbing
Clubbing: None
Mechanical prophylaxis in place: Int pneumat comp - knee
- - PSYCHOSOCIAL - -
Mood and affect are congruent: No
Thought processes are goal directed and spontaneous: No
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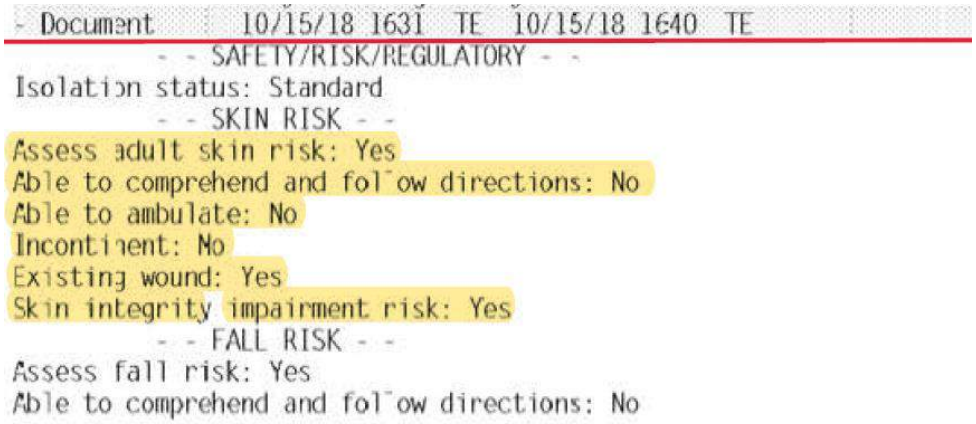
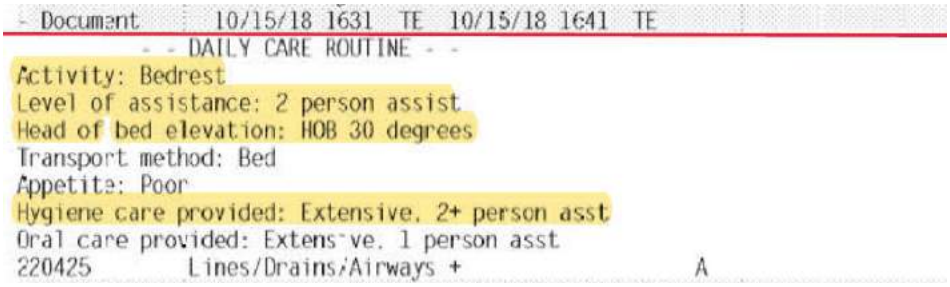
244. At 1640 hours (apparently as part of the same Admission Health History "activity"), Nurse Eje filled out a risk-assessment form. This form did include a "skin risk" section. In that section, Nurse Eje noted that Dorothy was unable to ambulate, unable to comprehend and follow directions, and that Dorothy had an existing wound. Nurse Eje documented that Dorothy was at risk of impaired skin integrity.

- DH2 – 81


- Document 10/15/18 1631 TE 10/15/18 1640 TE
- - SAFETY/RISK/REGULATORY - -
Isolation status: Standard
- - SKIN RISK - -
Assess adult skin risk: Yes
Able to comprehend and follow directions: No
Able to ambulate: No
Incontinent: No
Existing wound: Yes
Skin integrity impairment risk: Yes
- - FALL RISK - -
Assess fall risk: Yes
Able to comprehend and follow directions: No

245. At about the same time, at 1641 hours, Nurse Eje filled out a Daily Care Routine form, indicating that "bed rest" had been ordered for Dorothy.

- DH2 – 82


- Document 10/15/18 1631 TE 10/15/18 1641 TE
- - DAILY CARE ROUTINE - -
Activity: Bedrest
Level of assistance: 2 person assist
Head of bed elevation: HOB 30 degrees
Transport method: Bed
Appetite: Poor
Hygiene care provided: Extensive, 2+ person asst
Oral care provided: Extensive, 1 person asst
220425 Lines/Drains/Airways + A

246. This skin risk assessment created requirements for the hospital administration, the nursing staff, and the attending physicians.

247. The hospital administration was responsible for implementing measures that prompted, facilitated, and required appropriate preventive measures in light of the skin risk assessment.

248. Such measures could consist of a standard order set available to be entered manually or automatically in response to the skin risk assessment. Such measures could consist of policies requiring specific preventive measures for at-risk patients — combined with training and supervision to ensure the policies were implemented reliably. A range of specific measures would suffice, so long as the measures reliably prompted, facilitated, and required appropriate measures.

249. Dorothy's medical records indicate, however, that the hospital administration had not in fact implemented measures that prompted, facilitated, and required appropriate preventive measures in light of the skin risk assessment.

250. This skin risk assessment did not trigger orders to prompt or require actions to prevent a pressure wound from developing. For example, the skin risk assessment did not trigger an order for regular repositioning, to avoid prolonged pressure over bony prominences (like the sacrum, or an order for regular skin checks to assess whether a pressure wound was developing, or an order to assist Dorothy in ambulating and building strength, to avoid lying in the same position for lengthy periods.

251. Nurse Eje and any other nurse who learned of the October 15 skin risk assessment was responsible: (1) for initiating preventive measures that nurses could undertake on their own initiative (e.g., frequent repositioning), and (2) for ensuring that Dorothy's attending physician was aware of the facts relevant to the skin risk, and requesting appropriate orders.

252. Dorothy's medical records indicate, however, that neither Nurse Eje nor any other nurse on October 15 took any such steps.

253. Each of Dorothy's attending physicians was responsible for familiarizing himself or herself with Dorothy's condition — including the factors that put Dorothy at risk for another pressure wound. Each of Dorothy's attending physicians was similarly responsible for entering orders for appropriate preventive measures.

254. The hospitalist who agreed to admit Dorothy was Dr. Ekmine Wijesinghe. Dr. Wijesinghe wrote a Hospitalist History & Physical at approximately 1720 hours on October 15.

- DH1 – 24-30

255. Dorothy had a variety of abnormal lab results, and Dr. Wijesinghe diagnosed Dorothy with metabolic encephalopathy — a potentially reversible brain disorder caused by systemic illnesses such as diabetes, liver disease, kidney failure, or heart failure.

- DH1 – 24-30

256. Dr. Wijesinghe planned to address potential causes of the metabolic encephalopathy, and also to obtain a physical therapy and/or occupational therapy evaluation.

- DH1 – 29

Diagnosis, Assessment & Plan
Free Text A&P:
Metabolic encephalopathy
-? etiology, normal labs
- EEG
- MRI brain if possible
- check ammonia
- check TSH,T4
- depression?
- hold gabapentin and seroquel for now
- PT/OT eval
- neuro consult

257. Even without notification by a nurse, Dorothy's attending physicians could easily learn of the key factors that put Dorothy at risk of another pressure wound — namely, (a) current wounds on her heels and a prior wound on her sacral area, (b) weakness and immobility, (c) dementia with loss of comprehension, and (d) a daily care plan for bedrest.

258. Based on these factors, Dorothy's attending physicians were responsible for entering orders for measures to prevent another pressure wound from developing on Dorothy.

259. Dorothy's medical records indicate, however, that Dr. Wijesinghe entered no such orders on October 15.

October 16, 2018 — Tuesday

260. Tuesday, October 16, was Dorothy's first full day at the hospital.

261. At about 1333 hours that day, the Wound Care service evaluated Dorothy. NP Jennifer Hardy Casella examined Dorothy and noted the heel wounds. NP Casella noted that Dorothy had no wound over her sacrum: "Sacrum with no breakdown noted."

- DH1 – 36-38

General appearance: altered mental status, obese, alert, awake, no acute distress, no respiratory distress
Head/Eyes: atraumatic, normocephalic
Cardiovascular: normal capillary refill
Respiratory: no distress
Extremities: LUE with slight contracture at elbow. Weakness overall.
Neuro/CNS: altered mental status, alert (awake, non-verbal)
Skin: Sacrum with no breakdown noted. L heel with old blistered tissue removed to reveal predominately intact hyperemic scar with small portion non-healed with pink, moist area. R heel after removal of blistered/calloused skin with pink, moist wound bed. No s/s infection to any site.

262. NP Casella's assessment and plan included measures to address Dorothy's heel wounds. NP Casella also included a reference to "pressure reduction measures" including repositioning every two hours. The note did not specifically say whether that recommendation applied to Dorothy's whole body or only to her heels.

- DH1 – 38

Mepilex Ag intact bilateral heels x7 days
Pressure reduction measures–alt pressure mattress, reposition q2, prevalon boots
Nutrition optimization, check PAB
Medical management per hospitalist
Will continue to follow on Tuesdays/Fridays

263. Later that day, however, Nurse Samantha James noted the wounds on Dorothy's heels and stated that pillows were being used as positioning aids — though the note does not specify whether the repositioning was limited to Dorothy's heels or applied to her whole body.

- DH2 – 92

- - TRACTION - -
Traction: None
- - POSITIONING AIDS - -
Positioning aids: Present/Exists
Positioning aids: Pillows
Contractures: None
- - INTEGUMENTARY - -
Skin condition: Warm and dry
- - SKIN COLOR - -
Color within expectations for ethnicity: Yes
Skin turgor-tenting less than 1 second: Yes
- - SKIN PIERCINGS - -
Skin piercings: None
- - SKIN ALTERATION - -
Skin alteration/Procedure site: Present/Exists
Skin alteration: - - Press injur immobility related Heels bilateral - -
Instance list status: Active
Pressure injury present on admission: Yes
Related clinical factors: Diabetes related, Friction related
Tissue type-worst: Dressing intact/device

264. Later that night, at 2215 hours, Nurse James noted that she found Dorothy soaked in urine.

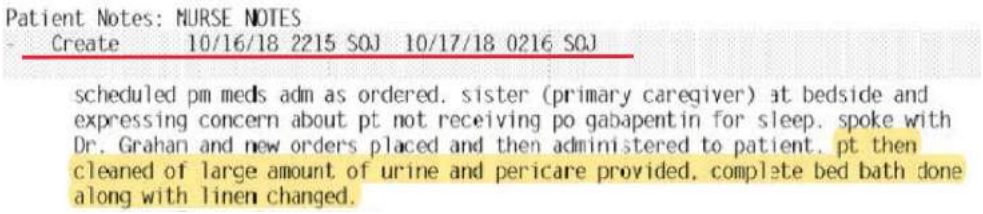
- DH2 – 94

265. Dorothy's incontinence increased the risk of skin breakdown and a pressure wound.

266. When the nursing staff became aware of Dorothy's incontinence, they should have notified the attending physician(s) and implemented measures to prevent pressure wounds. These measures should have included (a) some form of effective incontinence care (perhaps only a bedpan and a toileting schedule), (b) repositioning every two hours, and (c) skin and continence/hygiene checks every two to four hours.

267. In the same note in which Nurse James recorded Dorothy's incontinence, Nurse James also noted that she spoke to Dr. Graham and that new orders were placed (apparently for Gabapentin, a medication). Nurse James did not record a discussion with Dr. Graham about Dorothy's incontinence, the increased risk of skin breakdown, or the need for action to prevent another pressure wound.

- DH2 – 94


Patient Notes: NURSE NOTES
Create 10/16/18 2215 SQJ 10/17/18 0216 SQJ

scheduled pm meds adm as ordered. sister (primary caregiver) at bedside and expressing concern about pt not receiving po gabapentin for sleep. spoke with Dr. Grahan and new orders placed and then administered to patient. pt then cleaned of large amount of urine and pericare provided. complete bed bath done along with linen changed.

268. The medical records indicate that at no point on October 16 did the attending physicians order — nor did the nursing staff independently implement — regular repositioning, effective incontinence care, or regular skin/continence checks.

October 17, 2018 — Wednesday

269. Wednesday, October 17, was Dorothy's second full day at the hospital.

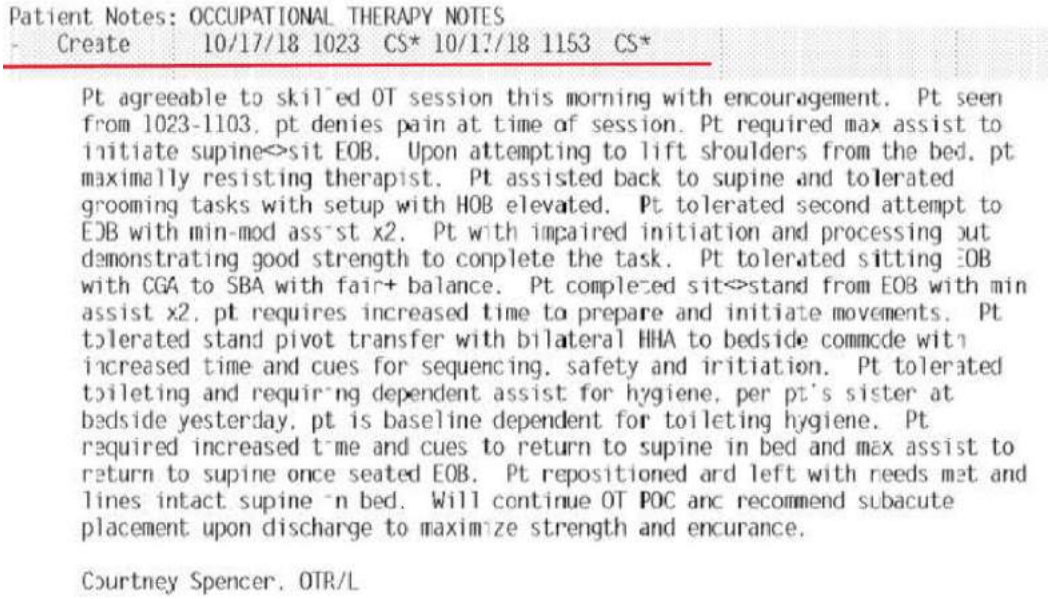
270. Late that morning, Courtney Spencer, an occupational therapist, went to Dorothy's room for a therapy session.

- DH2 – 95

271. Occupational therapists and occupational therapy assistants help people participate in the things they want and need to do through the therapeutic use of everyday activities (occupations). Common occupational therapy interventions include helping people recovering from injury to regain skills, and providing support for older adults experiencing physical and cognitive changes.

272. Dorothy has Down Syndrome and dementia, and Ms. Spencer found that Dorothy had difficulties performing simple actions. But Ms. Spencer found that the difficulties were more cognitive than physical, and with encouragement Dorothy could be induced to perform requested actions.

- DH2 – 95



Patient Notes: OCCUPATIONAL THERAPY NOTES
- Create 10/17/18 1023 CS* 10/17/18 1153 CS*

Pt agreeable to skil ed OT session this morning with encouragement. Pt seen from 1023-1103, pt denies pain at time of session. Pt required max assist to initiate supine<>sit EOB. Upon attempting to lift shoulders from the bed, pt maximally resisting therapist. Pt assisted back to supine and tolerated grooming tasks with setup with HOB elevated. Pt tolerated second attempt to EOB with min-mod ass st x2. Pt with impaired initiation and processing but demonstrating good strength to conplete the task. Pt tolerated sitting EOB with CGA to SBA with fair+ balance. Pt complezed sit<>stand from EOB with min assist x2, pt requires increased time to prepare and initiate movements. Pt tolerated stand pivot transfer with bilateral HHA to bedside commode with increased time and cues for sequencing, safety and initiation. Pt tolerated toileting and requir ng dependent assist for hygiene, per pt's sister at bedside yesterday, pt is baseline dependent for toileting hygiene. Pt required increased time and cues to return to supine in bed and max assist to return to supine once seated EOB. Pt repositioned and left with needs met and lines intact supine n bed. Will continue OT POC and recommend subacute placement upon discharge to maximize strength and encurance.

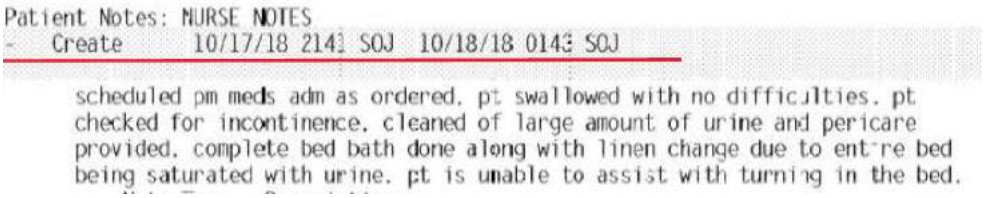
Courtney Spencer, OTR/L

273. That night, at 2010 hours, Nurse Samantha James again noted that Dorothy had pillows as a positioning aid. This note, however, added that Dorothy was also in a specialty bed.

- DH2 – 101

274. Later that night — apparently sometime between 2141 hours and 0143 hours — Nurse James again found Dorothy soaked in urine. Nurse James wrote that the "entire bed" was "saturated" with urine.

- DH2 – 103



Patient Notes: NURSE NOTES
- Create 10/17/18 2141 SOJ 10/18/18 0143 SOJ

scheduled pm meds adm as ordered, pt swallowed with no difficulties, pt checked for incontinence, cleaned of large amount of urine and pericare provided, complete bed bath done along with linen change due to entire bed being saturated with urine, pt is unable to assist with turning in the bed.

275. This was the second night in a row that Dorothy had been found with a large amount of urine in the bed. This second discovery indicated that Dorothy had a serious incontinence problem that was not going to fix itself. Further, that Dorothy was twice found with a large amount of urine in her bed indicated that Dorothy had been left for long stretches without attention to her toileting needs. Typically, a single instance of incontinence would not produce enough urine to saturate a bed.

276. In this same note by Nurse James, she wrote that Dorothy was unable to assist with turning in the bed.

- DH2 – 103

277. By this time — the night of October 17 — the nursing staff and the attending physicians knew or should have known that Dorothy was at high risk of another pressure wound.

278. The nursing staff and attending physicians knew or should have known that Dorothy needed support and encouragement to become as ambulatory and mobile as possible, to avoid prolonged pressure over bony prominences (like the sacrum).

279. The nursing staff and attending physicians knew or should have known that if Dorothy were to remain in bed for long periods, the nursing staff was required to reposition Dorothy every two hours.

280. The nursing staff and attending physicians knew or should have known that Dorothy needed effective continence and hygiene assistance.

281. The hospital should have been capable of providing Dorothy the care she needed. According to their website, Doctors Hospital of Augusta is a full-service hospital, including an inpatient rehabilitation service treating, among others, stroke patients with brain injuries and cognitive impairments.

282. However, if the hospital was not capable of providing Dorothy the care she needed, then in that case the nursing staff, the attending physicians, and the hospital administration had a duty to inform Dorothy's caretakers (her family) of their inability to care for Dorothy properly.

283. In that case, Dorothy's family would have an opportunity to seek alternative care. And the hospital would also have had a duty to work diligently and urgently to facilitate that.

284. At this point — October 17 — various providers had discussed with Dorothy's family the idea of transferring Dorothy to a skilled nursing facility. However, the medical records do not indicate that anyone told Dorothy's family that the hospital was incapable of caring for Dorothy properly.

October 18, 2018 — Thursday

285. The next morning, October 18, at approximately 0940 hours, Nurse Regina Scott applied an external urinary catheter to Dorothy. Nurse Scott noted that the reason for the catheter was prolonged immobilization. As indicated by a later nurse note, the external catheter was apparently a PureWick device.

- DH2 – 107
- DH2 – 113

286. As compared to internal catheters, external catheters pose less risk of causing infections, but greater risk of leaking.

287. That same morning, Dr. Jonathan Preston wrote a Discharge Summary noting that Dorothy was stable and was being discharged to a skilled nursing facility (SNF), but noted that the discharge was pending placement. The Discharge Summary identified Dr. Preston as Dorothy's attending physician.

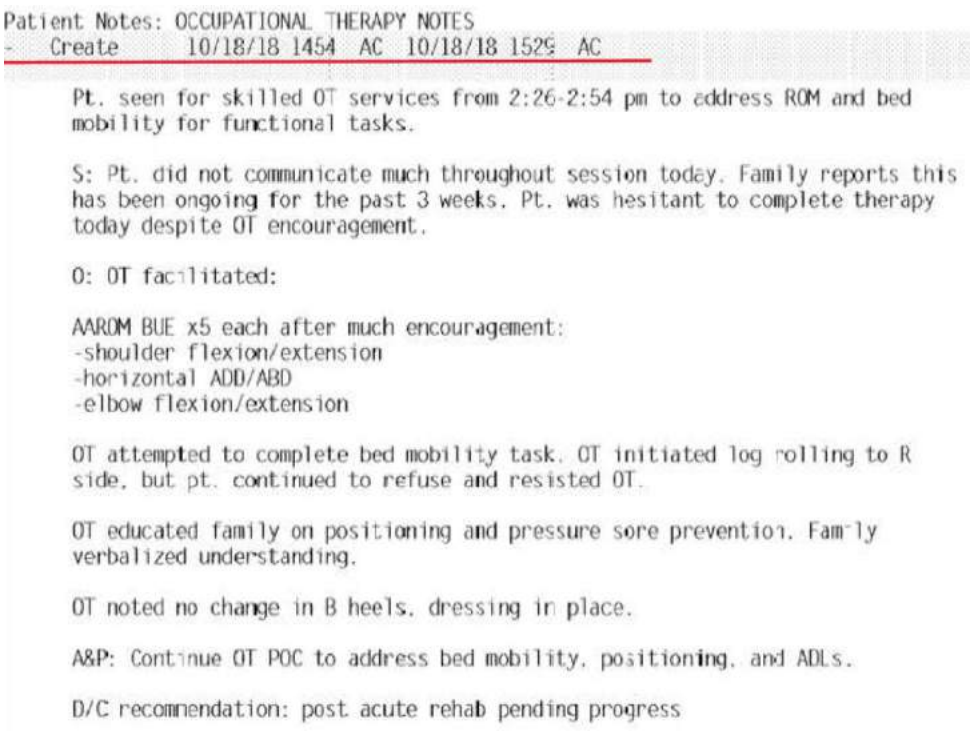
- DH1 – 1

288. On the morning of December 18 at 1045 hours, Caroline Pitts, MST, entered a note that read "Number of times incontinent urine: 1. Diapers count: 1."

- DH2 – 108

289. Later that day at around 1454 hours, April Conway, an occupational therapist, came to Dorothy's room for a therapy session. Ms. Conway noted that Dorothy remained generally uncommunicative. Ms. Conway indicated that some family member was there, and that Ms. Conway educated the family member on positioning and pressure sore prevention.

- DH2 – 108



Patient Notes: OCCUPATIONAL THERAPY NOTES
- Create 10/18/18 1454 AC 10/18/18 1529 AC

Pt. seen for skilled OT services from 2:26-2:54 pm to address ROM and bed mobility for functional tasks.

S: Pt. did not communicate much throughout session today. Family reports this has been ongoing for the past 3 weeks. Pt. was hesitant to complete therapy today despite OT encouragement.

O: OT facilitated:

AAROM BUE x5 each after much encouragement:
-shoulder flexion/extension
-horizontal ADD/ABD
-elbow flexion/extension

OT attempted to complete bed mobility task. OT initiated log rolling to R side, but pt. continued to refuse and resisted OT.

OT educated family on positioning and pressure sore prevention. Family verbalized understanding.

OT noted no change in B heels, dressing in place.

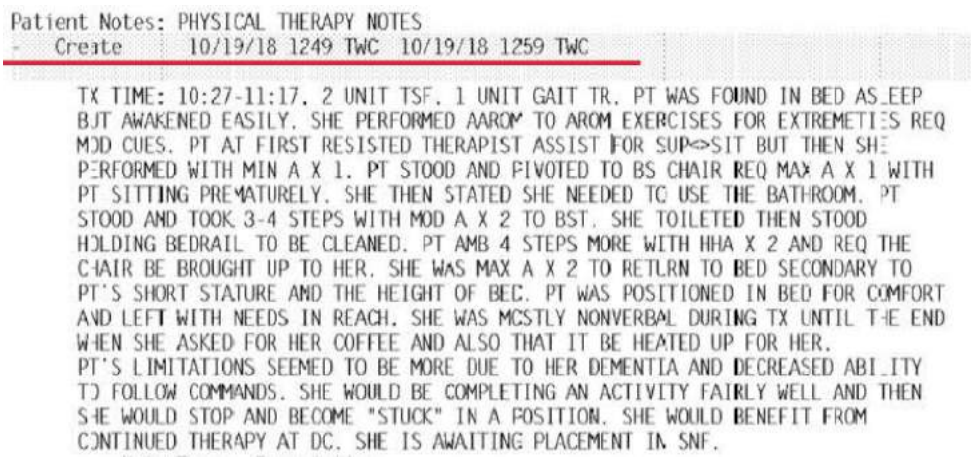
A&P: Continue OT POC to address bed mobility, positioning, and ADLs.

D/C recommendation: post acute rehab pending progress

October 19, 2018 — Friday

290. On October 19, Trista Caddell, a physical therapist, went to Dorothy's room for a therapy session. Ms. Caddell noted that Dorothy's limitations seemd to be more due to her dementia. However, Ms. Caddell wrote that during the session, Dorothy said she needed to go to the bathroom. With assistance, Dorothy walked to the bathroom and used the toilet. Dorothy then needed assistance with post-toileting hygiene.

- DH2 – 117



Patient Notes: PHYSICAL THERAPY NOTES
- Create 10/19/18 1249 TWC 10/19/18 1259 TWC

TX TIME: 10:27-11:17. 2 UNIT TSF. 1 UNIT GAIT TR. PT WAS FOUND IN BED AS EEP BUT AWAKENED EASILY. SHE PERFORMED AAROM TO AROM EXERCISES FOR EXTREMETIES REQ MOD CUES. PT AT FIRST RESISTED THERAPIST ASSIST FOR SUP<>SIT BUT THEN SHE PERFORMED WITH MIN A X 1. PT STOOD AND PIVOTED TO BS CHAIR REQ MAX A X 1 WITH PT SITTING PREMATURELY. SHE THEN STATED SHE NEEDED TO USE THE BATHROOM. PT STOOD AND TOOK 3-4 STEPS WITH MOD A X 2 TO BST. SHE TOILETED THEN STOOD HOLDING BEDRAIL TO BE CLEANED. PT AMB 4 STEPS MORE WITH HHA X 2 AND REQ THE CHAIR BE BROUGHT UP TO HER. SHE WAS MAX A X 2 TO RETURN TO BED SECONDARY TO PT'S SHORT STATURE AND THE HEIGHT OF BEC. PT WAS POSITIONED IN BED FOR COMFORT AND LEFT WITH NEEDS IN REACH. SHE WAS MOSTLY NONVERBAL DURING TX UNTIL THE END WHEN SHE ASKED FOR HER COFFEE AND ALSO THAT IT BE HEATED UP FOR HER. PT'S LIMITATIONS SEEMED TO BE MORE DUE TO HER DEMENTIA AND DECREASED ABILITY TO FOLLOW COMMANDS. SHE WOULD BE COMPLETING AN ACTIVITY FAIRLY WELL AND THEN SHE WOULD STOP AND BECOME "STUCK" IN A POSITION. SHE WOULD BENEFIT FROM CONTINUED THERAPY AT DC. SHE IS AWAITING PLACEMENT IN SNF.

291. A little later that day, NP Jennifer Casella from the Wound Care service came to assess Dorothy. NP Casella noted Dorothy's heel wounds but did not identify any sacral wound.

- DH1 – 1160-62

292. On October 19, Dorothy's attending physicians still did not order — and the nursing staff still did not provide — regular repositioning or other movement to prevent pressure wounds. The systems put in place by hospital administration did not prompt, facilitate, and require them to do so.

October 20, 21, 22, 23 — Saturday, Sunday, Monday, Tuesday

293. On Wednesday, October 24, 2018, Nurse Amanda Walden would identify a stage 2 wound — a small wound with broken skin — on Dorothy's sacral area.

- DH2 – 157

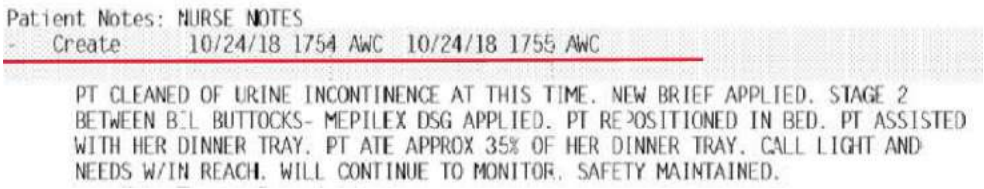
294. We see no entries in the medical record for the four days before that wound was noted — October 20, 21, 22, and 23 — that shed light on the development of the wound.

295. However, on these days — October 20, 21, 22, and 23 — Dorothy's attending physicians still did not order — and the nursing staff still did not provide — regular repositioning or other interventions to prevent the pressure wound. The systems put in place by hospital administration did not prompt, facilitate, and require them to do so.

October 24: Stage 2 Wound discovered

296. **On Wednesday, October 24**, while cleaning Dorothy after another episode of urine incontinence, Nurse Amanda Walden identified a stage 2 sacral wound on Dorothy.

- DH2 – 157


Patient Notes: NURSE NOTES
- Create 10/24/18 1754 AWC 10/24/18 1755 AWC

PT CLEANED OF URINE INCONTINENCE AT THIS TIME. NEW BRIEF APPLIED. STAGE 2 BETWEEN BIL BUTTOCKS- MEPILEX DSG APPLIED. PT REPOSITIONED IN BED. PT ASSISTED WITH HER DINNER TRAY. PT ATE APPROX 35% OF HER DINNER TRAY. CALL LIGHT AND NEEDS W/IN REACH. WILL CONTINUE TO MONITOR. SAFETY MAINTAINED.

297. Generally, a stage 2 wound can be treated and healed with little difficulty.

298. But if not treated diligently, a stage 2 wound can worsen into a stage 3 or 4 wound that is much more difficult to treat and can cause serious harm — including infection, sepsis, and death.

299. When Nurse Walden identified a new stage 2 sacral wound on Dorothy, Nurse Walden should have immediately notified Dorothy's attending physician and requested orders for treatment.

300. The records indicate that Nurse Walden did not do so.

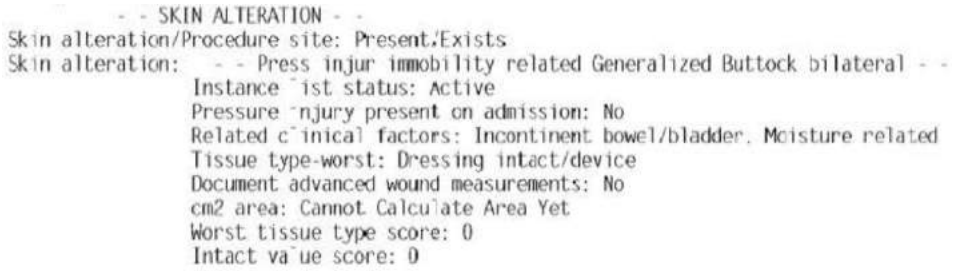
301. Particularly because Dorothy had both a sacral wound with broken skin and urine incontinence, the nursing staff should have initiated (and the attending physician should have ordered) two-hour incontinence checks.

302. But the records reveal no new measures, ordered or implemented, for regular repositioning of Dorothy or any additional incontinence checks.

October 25-30: Wound worsens

303. **On Thursday, October 25**, Nurse Samantha James identifies the wound on Dorothy's sacrum, and identified it as moisture-related.

- DH2 – 169


- - SKIN ALTERATION - -
Skin alteration/Procedure site: Present/Exists
Skin alteration: - - Press injur immobility related Generalized Buttock bilateral - -
Instance list status: Active
Pressure injury present on admission: No
Related clinical factors: Incontinent bowel/bladder, Moisture related
Tissue type-worst: Dressing intact/device
Document advanced wound measurements: No
cm2 area: Cannot Calculate Area Yet
Worst tissue type score: 0
Intact value score: 0

304. A short time later, Nurse James noted that Dorothy had another episode of incontinence with a large amount of urine.

- DH2 – 171

305. The records do not indicate that Nurse James notified Dorothy's attending physician of Dorothy's sacral wound and requested orders for treatment.

306. Nor do the records indicate that Nurse James initiated regular repositioning of Dorothy or any additional continence and hygiene measures.

307. **On Friday, October 26**, NP Casella from the Wound Care service checked on Dorothy. NP Casella again noted the pressure wounds on Dorothy's heels, but did not even mention the wound on Dorothy's sacrum.

- DH1 – 1154-56

308. This indicates a failure of the hospital's systems for communication between the nursing and Wound Care staffs (as well as between the nursing and medical staffs).

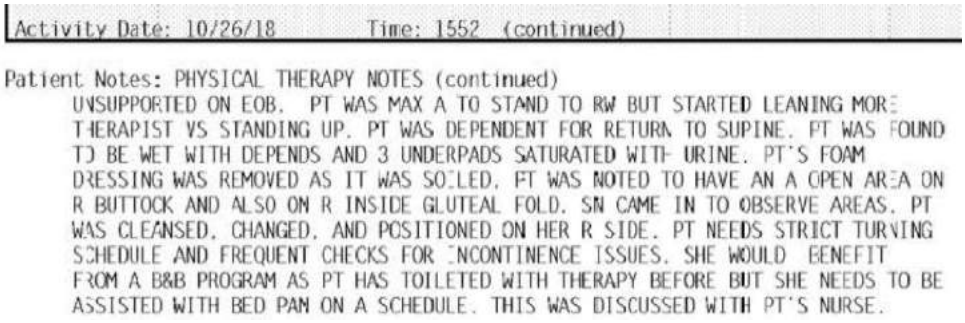
309. On the nursing-staff side, this failure involved both Nurse Walden as well as Nurse James. The lack of communication did not reflect merely an individual failing of a particular provider.

310. That same day, Friday, October 26, physical therapist Trista Caddell came to Dorothy's room to work with Dorothy. Ms. Caddell noted that she found Dorothy soaked with urine, with three pads beneath Dorothy saturated. Ms Caddell also noted the open wound on Dorothy's sacrum.

- DH2 – 177

311. Ms. Caddell spoke to Dorothy's nurse and said that Dorothy needed a strict turning schedule, frequent checks for incontinence issues, and to be assisted with a bedpan on a schedule.

- DH2 – 177

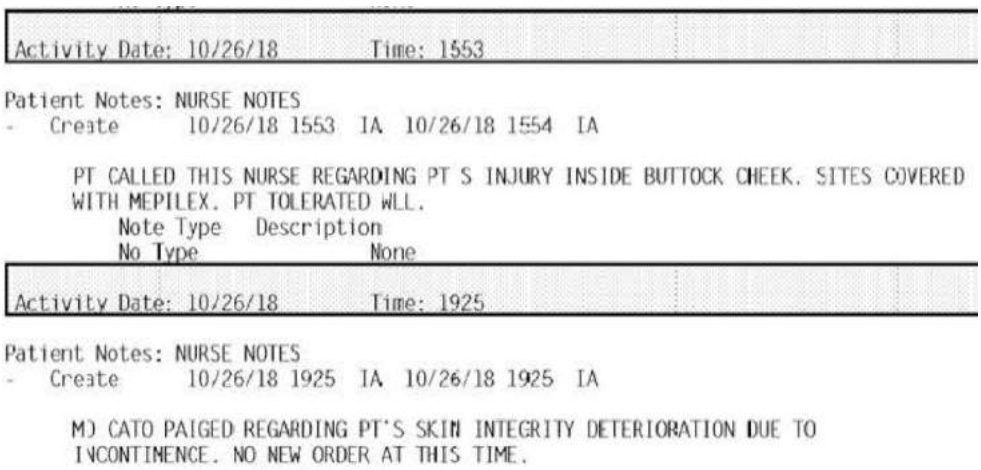


Activity Date: 10/26/18 Time: 1552 (continued)

Patient Notes: PHYSICAL THERAPY NOTES (continued)
UNSUPPORTED ON EOB. PT WAS MAX A TO STAND TO RW BUT STARTED LEANING MORE THERAPIST VS STANDING UP. PT WAS DEPENDENT FOR RETURN TO SUPINE. PT WAS FOUND TO BE WET WITH DEPENDS AND 3 UNDERPADS SATURATED WITH URINE. PT'S FOAM DRESSING WAS REMOVED AS IT WAS SOILED. PT WAS NOTED TO HAVE AN A OPEN AREA ON R BUTTOCK AND ALSO ON R INSIDE GLUTEAL FOLD. SN CAME IN TO OBSERVE AREAS. PT WAS CLEANSED, CHANGED, AND POSITIONED ON HER R SIDE. PT NEEDS STRICT TURNING SCHEDULE AND FREQUENT CHECKS FOR INCONTINENCE ISSUES. SHE WOULD BENEFIT FROM A B&B PROGRAM AS PT HAS TOILETED WITH THERAPY BEFORE BUT SHE NEEDS TO BE ASSISTED WITH BED PAN ON A SCHEDULE. THIS WAS DISCUSSED WITH PT'S NURSE.

312. The nurse Ms. Caddell spoke to was Houedan Agbatchi. Nurse Agbatchi noted the conversation and paged Dr. James Cato, Dorothy's attending physician at the time, and informed him of Dorothy's sacral wound. Dr. Cato issued no orders for any prevention or treatment measures.

- DH1 – 666 (re. Dr. Cato)
- DH2 – 177



Activity Date: 10/26/18 Time: 1553

Patient Notes: NURSE NOTES
- Create 10/26/18 1553 IA 10/26/18 1554 IA

PT CALLED THIS NURSE REGARDING PT S INJURY INSIDE BUTTOCK CHEEK. SITES COVERED WITH MEPILEX. PT TOLERATED WLL.
Note Type Description
No Type None

Activity Date: 10/26/18 Time: 1925

Patient Notes: NURSE NOTES
- Create 10/26/18 1925 IA 10/26/18 1925 IA

MD CATO PAIGED REGARDING PT'S SKIN INTEGRITY DETERIORATION DUE TO INCONTINENCE. NO NEW ORDER AT THIS TIME.

313. In his Hospitalist Progress Note for October 26, 2018, Dr. Cato made no mention of Dorothy's sacral wound.

- DH1 – 666-68

314. At no time on Friday, October 26, were any new measures ordered or implemented for repositioning or for effective continence/hygiene assistance.

315. **On Saturday, October 27**, Nurse Abgatchi again noted the sacral wound on Dorothy.

- DH2 – 181

316. At no time that day were any new measures ordered or implemented for repositioning or for effective continence/hygiene assistance.

317. **On Sunday, October 28**, Nurse Abgatchi again noted the sacral wound on Dorothy.

- DH2 – 188

318. The same day, Nurse Amber Yoder also noted the sacral wound on Dorothy.

- DH2 - 192

319. At no time that day were any new measures ordered or implemented for repositioning or for effective continence/hygiene assistance.

320. **On Monday, October 29**, Nurse Abgatchi again noted the sacral wound on Dorothy.

- DH2 – 197

321. The same day, Nurse Yoder also noted the sacral wound on Dorothy.

- DH2 – 201

322. At no time that day were any new measures ordered or implemented for repositioning or for effective continence/hygiene assistance.

323. **On Tuesday, October 30**, NP Casella from the Wound Care service checked on Dorothy. Again NP Casella apparently did not know about, or independently discover, the sacral wound on Dorothy.

- DH1 – 1151-53

324. Later that day, at 1030 hours, Nurse Mirisha Coleman noted the sacral wound on Dorothy.

- DH2 – 205

325. At 1301 hours, Nurse Chelsey Haines noted that she had applied a Mepilex dressing to the wounds on Dorothy's heels, but omitted any mention of the sacral wound on Dorothy.

- DH2 – 208

326. Later, at 2033 hours, Nurse Coleman wrote that Dorothy was "approved for placement but waiting re-evaluation per government due to Down Syndrome….No safety issues noted."

- DH2 – 208

327. Nurse Coleman's two notes from 1030 hours and 2033 hours are inconsistent. A sacral wound is an obvious safety issue. These two notes suggest that Nurse Coleman may have entered some notes by blindly copying and pasting prior notes.

328. Blind copying and pasting of medical records is a known problem in hospitals and can create safety risks for patients.

329. When medical personnel are responsible for documenting their own current assessment of the patient, it is improper and potentially dangerous to blindly copy and paste prior assessments that do not reflect the new, current assessment.

330. At no time on Tuesday, October 30, were any new measures ordered or implemented for repositioning or for effective continence/hygiene assistance.

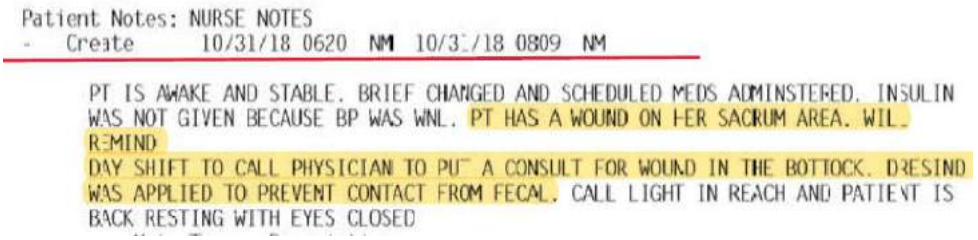
October 31: Stage 3

331. **On Wednesday, October 31**, Nurse Nedjy Marius noted the wound on Dorothy's sacrum as a stage 2 wound. Nurse Marius changed the dressing.

- DH2 – 212

332. Later that day, Nurse Marius wrote "Will remind day shift to call physician to put a consult for wound in the buttock. Dressing was applied to prevent contact from fecal."

- DH2 – 213

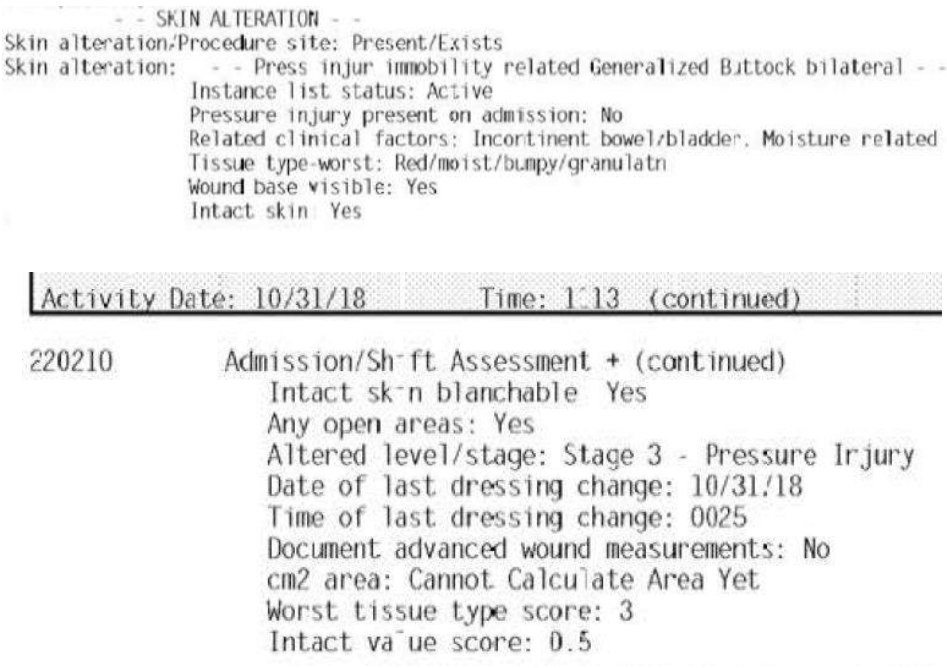


Patient Notes: NURSE NOTES
- Create 10/31/18 0620 NM 10/3[illegible]/18 0809 NM

PT IS AWAKE AND STABLE. BRIEF CHANGED AND SCHEDULED MEDS ADMINSTERED. INSULIN WAS NOT GIVEN BECAUSE BP WAS WNL. PT HAS A WOUND ON HER SACRUM AREA. WIL[illegible] REMIND
DAY SHIFT TO CALL PHYSICIAN TO PU[illegible] A CONSULT FOR WOUND IN THE BOTTOCK. DRESIND WAS APPLIED TO PREVENT CONTACT FROM FECAL. CALL LIGHT IN REACH AND PATIENT IS BACK RESTING WITH EYES CLOSED

333. A short time later, Nurse Thriza Eje described the sacral wound on Dorothy as a stage 3 and as "red/moist/bumpy/granulation."

- DH2 – 214-15



- - SKIN ALTERATION - -
Skin alteration/Procedure site: Present/Exists
Skin alteration: - - Press injur immobility related Generalized Buttock bilateral - -
Instance list status: Active
Pressure injury present on admission: No
Related clinical factors: Incontinent bowel/bladder, Moisture related
Tissue type-worst: Red/moist/bumpy/granulatn
Wound base visible: Yes
Intact skin Yes

Activity Date: 10/31/18 Time: 1[illegible]13 (continued)

220210 Admission/Sh[illegible]ft Assessment + (continued)
Intact sk[illegible]n blanchable Yes
Any open areas: Yes
Altered level/stage: Stage 3 - Pressure Injury
Date of last dressing change: 10/31/18
Time of last dressing change: 0025
Document advanced wound measurements: No
cm2 area: Cannot Calculate Area Yet
Worst tissue type score: 3
Intact va[illegible]ue score: 0.5

334. Nurse Eje's note marks a serious worsening of the wound. A stage 3 pressure wound is a much more serious wound that is difficult to treat and creates a major risk of infection and further deterioration.

335. The physician should have been notified immediately, and the wound-care service should have been consulted immediately.

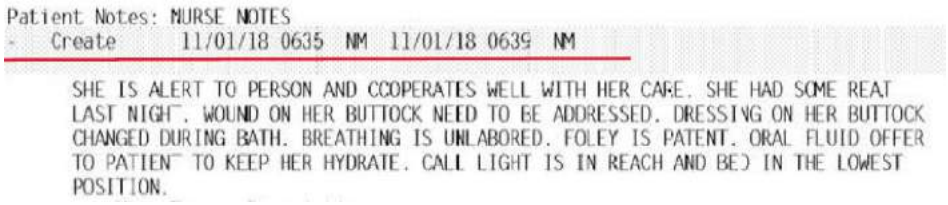
336. That did not happen.

337. At no time on Wednesday, October 31, were any new measures ordered or implemented for repositioning or for effective continence/hygiene assistance.

November 1-5: Wound worsens

338. **On Thursday, November 1**, again Nurse Marius recorded a note saying "Wound on her buttock need to be addressed. Dressing on her buttock changed during bath."

- DH2 – 221


Patient Notes: NURSE NOTES
Create 11/01/18 0635 NM 11/01/18 0639 NM

SHE IS ALERT TO PERSON AND CCOPERATES WELL WITH HER CARE. SHE HAD SOME REAT LAST NIGHT. WOUND ON HER BUTTOCK NEED TO BE ADDRESSED. DRESSING ON HER BUTTOCK CHANGED DURING BATH. BREATHING IS UNLABORED. FOLEY IS PATENT. ORAL FLUID OFFER TO PATIENT TO KEEP HER HYDRATE. CALL LIGHT IS IN REACH AND BED IN THE LOWEST POSITION.

339. This note refers to a Foley catheter being in place in Dorothy. The medical records provided to Dorothy's caretaker are poor-quality and difficult to search, but this is the earliest reference I find in the records to a Foley catheter being inserted into Dorothy.

340. From the records, I don't see when this Foley was inserted, who ordered it, who inserted it, or why it was ordered.

341. These are important details that should be included in the medical records, because a Foley catheter creates a risk of infection. In the event of complications related to the Foley, it may be important for physicians to know these details. Failure to include these details violates the standards for medical record-keeping.

342. Whatever the specific purpose for inserting the Foley catheter, that catheter would assist with urine incontinence.

343. However, because a Foley creates a risk of infection, it should not be used for incontinence assistance unless more conservative measures prove ineffective — after being applied diligently.

344. From the medical records, it appears that conservative measures to avoid incontinence were not applied diligently.

345. At 0806 hours, Nurse Eje again described the sacral wound as a stage 3.

- DH2 – 223

346. Later, however, LPN Marsha Raycroft described the sacral wound as "pre-stage 1."

- DH2 – 227

347. At no time on Thursday, November 1, were any new measures ordered or implemented for repositioning.

348. **On Friday, November 2**, Nurse Amanda Walden noted the sacral wound at around 0908 hours but reported that she could not identify the skin alteration level or stage.

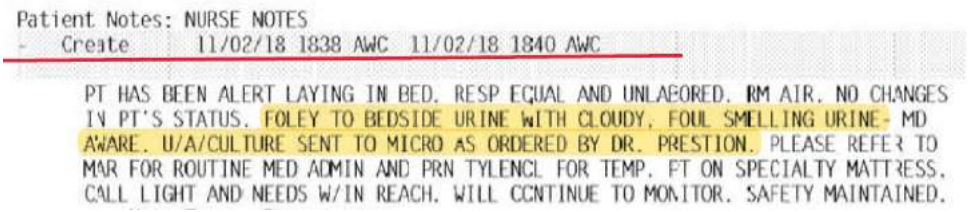
- DH2 – 230

349. At 1241 hours, Nurse Chelsey Haines reported checking the wounds on Dorothy's heels but did not mention the sacral wound.

- DH2 – 231

350. At around 1840 hours, Nurse Amanda Walden noted abnormal urine: "Foley to bedside urine with cloudy, foul smelling urine – MD aware. U/A culture sent to micro as ordered by Dr. Preston."

- DH2 – 234

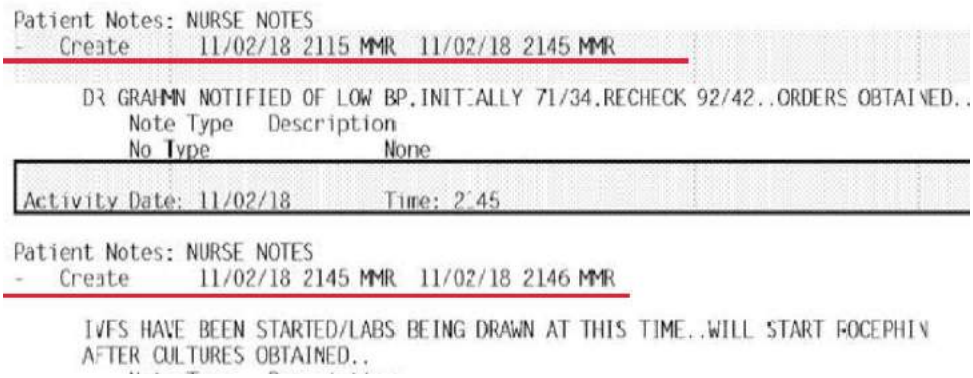


Patient Notes: NURSE NOTES
- Create 11/02/18 1838 AWC 11/02/18 1840 AWC

PT HAS BEEN ALERT LAYING IN BED. RESP EQUAL AND UNLABORED. RM AIR. NO CHANGES IN PT'S STATUS. FOLEY TO BEDSIDE URINE WITH CLOUDY, FOUL SMELLING URINE- MD AWARE. U/A/CULTURE SENT TO MICRO AS ORDERED BY DR. PRESTION. PLEASE REFER TO MAR FOR ROUTINE MED ADMIN AND PRN TYLENOL FOR TEMP. PT ON SPECIALTY MATTRESS. CALL LIGHT AND NEEDS W/IN REACH. WILL CONTINUE TO MONITOR. SAFETY MAINTAINED.

351. At around 2145 hours, Nurse Marsha Raycroft noted that she had informed a physician that Dorothy had low blood pressure. IV fluids were started, with a plan to begin an antibiotic after cultures were obtained.

- DH2 – 236


Patient Notes: NURSE NOTES
- Create 11/02/18 2115 MMR 11/02/18 2145 MMR

DR GRAHMN NOTIFIED OF LOW BP.INITIALLY 71/34.RECHECK 92/42..ORDERS OBTAINED..
Note Type Description
No Type None

Activity Date: 11/02/18 Time: 2:45

Patient Notes: NURSE NOTES
- Create 11/02/18 2145 MMR 11/02/18 2146 MMR

IVFS HAVE BEEN STARTED/LABS BEING DRAWN AT THIS TIME..WILL START ROCEPHIN AFTER CULTURES OBTAINED..

352. At no time on Friday, November 2, were any new measures ordered or implemented for repositioning, which is critical.

353. However, four days later, on November 6, Dorothy would be found with a large, infected stage 4 sacral wound. The infection noted on November 2 was likely caused, in whole or in part, by the large sacral wound — rather than being a simple urinary tract infection related to the Foley catheter.

354. **On Saturday, November 3rd**, Dr. Jonathan Preston ordered that the Foley catheter be removed.

- DH2 – 241
- DH1 – 638-642 at 640

355. While the removal of the Foley would remove one source of new infections, it would also increase the risk of incontinence-related skin breakdown — thus requiring additional diligence in preventive measures.

356. At around 2041 hours, Nurse Marsha Raycroft noted the sacral wound but reported that she could not identify the skin alteration level or stage.

- DH2 – 242

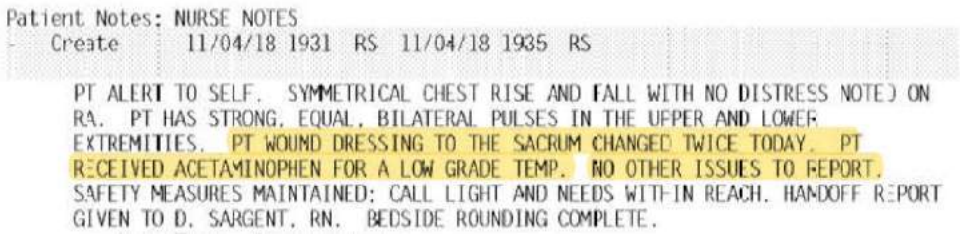
357. At no time on Saturday, November 3rd, were any new measures ordered or implemented for repositioning or for effective continence/hygiene assistance.

358. **On Sunday, November 4th**, at around 1824 hours Nurse Regina Scott noted the sacral wound as stage 3 and reported that she had changed the dressing on the wound.

- DH2 – 245

359. A short time later, around 1931 hours, Nurse Scott noted that the dressing on the sacral wound had been changed twice that day. She also reported that Dorothy had a low-grade fever.

- DH2 – 248



Patient Notes: NURSE NOTES
Create 11/04/18 1931 RS 11/04/18 1935 RS

PT ALERT TO SELF. SYMMETRICAL CHEST RISE AND FALL WITH NO DISTRESS NOTED ON RA. PT HAS STRONG, EQUAL, BILATERAL PULSES IN THE UPPER AND LOWER EXTREMITIES. PT WOUND DRESSING TO THE SACRUM CHANGED TWICE TODAY. PT RECEIVED ACETAMINOPHEN FOR A LOW GRADE TEMP. NO OTHER ISSUES TO REPORT. SAFETY MEASURES MAINTAINED: CALL LIGHT AND NEEDS WITHIN REACH. HANDOFF REPORT GIVEN TO D. SARGENT, RN. BEDSIDE ROUNDING COMPLETE.

360. At no time on Sunday, November 4th, were any new measures ordered or implemented for repositioning or for effective continence/hygiene assistance.

361. **On Monday, November 5th,** at around 0745 hours Nurse Deborah Sargent reported that Dorothy had been incontinent of a large amount of urine.

- DH2 – 250

362. At around 1039 hours, physical therapist Mark Clayton noted that Dorothy's upper back was wet from sweat, and that he had changed the underpads on Dorothy's bed.

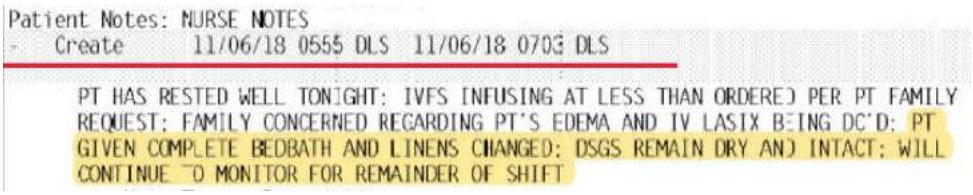
- DH2 – 254

363. At no time on Monday, November 5th, were any new measures ordered or implemented for repositioning or for effective continence/hygiene assistance.

November 6: Stage 4

364. **On Tuesday, November 6th,** Nurse Deborah Sargent noted that she had given Dorothy a complete bedbath and changed the bed linens. Nurse Sargent recorded that the dressings remained dry and intact.

- DH2 – 258


Patient Notes: NURSE NOTES
Create 11/06/18 0555 DLS 11/06/18 0703 DLS

PT HAS RESTED WELL TONIGHT: IVFS INFUSING AT LESS THAN ORDERED PER PT FAMILY REQUEST; FAMILY CONCERNED REGARDING PT'S EDEMA AND IV LASIX BEING DC'D; PT GIVEN COMPLETE BEDBATH AND LINENS CHANGED; DSGS REMAIN DRY AND INTACT; WILL CONTINUE TO MONITOR FOR REMAINDER OF SHIFT

365. At approximately 1038 hours, NP Kimberly Linticum from the Wound Care service went to Dorothy's room. NP Linticum saw the wound on Dorothy's sacral area and characterized it as unstageable with surrounding erythemia (reddening of skin- indicating skin infection) and abscess formation, (indicating severe wound infection, probably down to the bone).

- DH2 – 1145-47

366. PA Shellie Lutz and Dr. Robert Mullins, both from the Wound Care service, got involved.

367. Within about an hour of NP Linticum's assessment, Dr. Mullins examined Dorothy. Under Dr. Mullins' supervision, NP Linticum dictated a History & Physical on behalf of Dr. Mullins.

- DH2 – 31-33

368. Dr. Mullins noted that Dorothy had been wearing a diaper that was heavily soiled with urine, that the sacral wound emitted a "very foul odor," that the wound had necrotic (dead) tissue, and that the wound required debridement not at bedside but in the operating room. Dr. Mullins also noted that Dorothy had an infection that was "fairly complex" and that there was concern that the wounds were contributing to the infection.

- DH2 – 31-33

HISTORY OF PRESENT ILLNESS:
Ms. Anthony is a 58-year-old African-American female with a history of Down syndrome. She was originally admitted to Doctors Hospital on 10/15/2018 with a chief complaint of altered mental status, difficulty walking, and encephalopathy. The patient was admitted. She underwent an MRI, which showed diffuse changes, advanced for the patient's age. Underwent additional EEG for rule out of seizure. Questionable seizure activity was noted. The patient was seen by Neurology. She was admitted per the Hospitalist Service for her metabolic encephalopathy, felt to have hypovolemia. She has been residing on the 4th floor services. She was noted to have a urinary tract infection, fairly complex. Her white count was considerably elevated. Blood cultures were obtained. The patient was noted to have Proteus within her blood. The Wound Services were consulted on this patient for evaluation. The patient was noted to have stage II pressure ulcers to both heels, which were stable. She was also noted to have an unstageable sacral ulcer with abscess formation. She continued to remain febrile. There was some concerns that her wound may be contributing to her infectious status. The patient was prepped in terms of evaluating for operating room intervention today.

GU: She has a diaper that is present. She has a fair amount of urine that is noted in her diaper, which is heavily soiled. The diaper was removed. She was noted to have some erythema to her buttocks bilaterally with a sacral ulcer with central portion of necrosis that was unstageable at this point in time.
NEUROLOGIC: Mentation appears to be slow. She, according to family, is much more conversant. She has been somewhat somnolent since her admission. I do not appreciate any focal deficits and there has been no reported seizure activity.
SKIN: A focused skin assessment to her sacrum reveals an unstageable sacral ulcer with a central portion of necrosis, very foul odor noted coming from her peri-area. Diaper with urine present. Appears to be somewhat odorous in nature. The wounds to both heels appear to be stage II with some re-epithelialization noted. No surrounding erythema or fluctuance noted.

ASSESSMENT AND PLAN:
Unstageable sacral ulcer with nonviable tissue, abscess formation noted. The plan will be for n.p.o. status at the present, proceed to the operating room for debridement of sacral ulcer. The patient's next of kin, which is her sister, who is her primary decision maker, Ms. Willie Sampson, phone number 706-726-2429, was called and updated in regard to her current medical status. Has given consent for proceeding forward with surgery today for sores control. In regard to her wound care, at the present time, we will continue Mepilex pads to both heels. A low air loss mattress has been continued. For pressure reducing measures, would recommend turning every 2 hours. We will continue to certainly follow along. Did make an attempt to talk to Dr. Ross who is the primary on the case and the hospitalist team in regard to updating him on her current condition. In the interim, we will certainly continue to proceed forward with surgical debridement for sores control as her white count has been

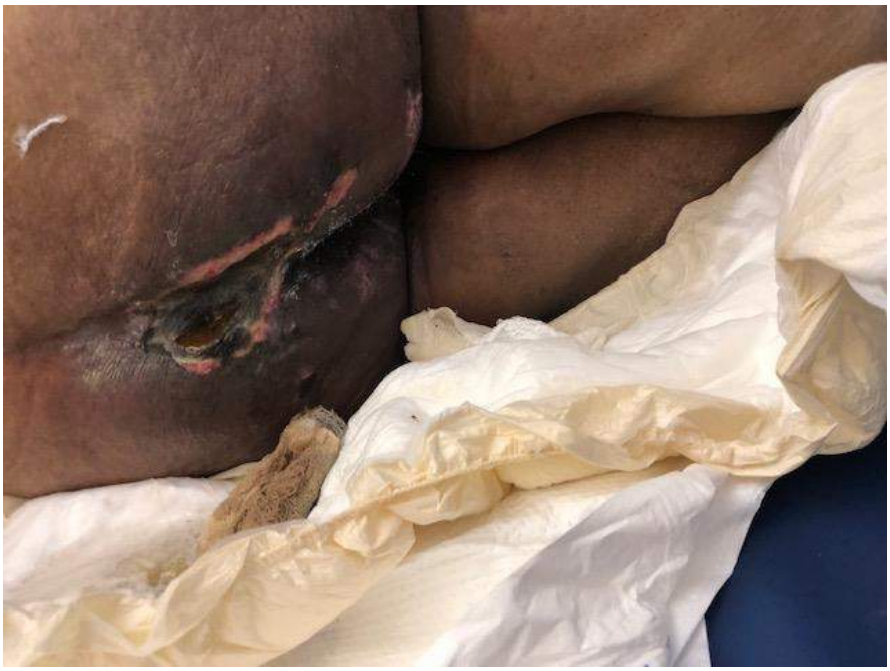
trending up over the last 72 hours with concerns of evolving infection.

This was done under direct supervision of Dr. Mullins x2.

This is a level 3 history and physical on behalf of Dr. Mullins x2.

Dictated By: Kimberly M Linticum, NP
For: Robert F Mullins, MD

369. One of the Wound Care staff called Ms. Sampson, Dorothy's older sister and caretaker. Ms. Sampson came to the hospital to see Dorothy. She took pictures of the wound:



370. At 1709 hours, Dr. Mullins began surgical debridement of the wound in the operating room. With the wound excised, Dr. Mullins was able to accurately stage the wound. It was a stage 4. Dr. Mullins noted that he was excising the wound in preparation for a flap surgery — a flap 15 x 18 cm (6 x 7 inches) large. Dr. Mullins cut away tissue down to and including the infected/necrotic muscle.

- DH1 – 1200-01

Pre-procedure diagnosis: infected unstageable sacral ulcer
Post-procedure diagnosis: Stg IV sacral ulcer
Procedure(s) performed:

.
Primary surgeon:
mullins
Assistant(s): lutz
Anesthesia: GETA
Technique/Procedure:

.
Specimens removed/altered: Tissue cx, tissue for path sacrum
Implant(s): none
Complications: none
Fluids:
300
Estimated blood loss in ml's: 50
Findings:
.

Procedures
Procedure Comments:
Excision of sacral ulcer in preparation for flap 15x18cm
LOE gluteus maximus
AMD

Attention was directed to the above-noted areas. Devitalized tissue was removed in tangential fashion with a Norsen and then a Goulian and 10 knife down to a level of viable tissue. Further a electrocautery was also used. Tissue culture was obtained and the specimen was sent to pathology. The deepest level of excision included muscle specifically the gluteus maximus. The sacral ulcer was being prepared for flap coverage. Once the excision was complete, larger bleeding points were cauterized using bovie cautery, and the wound was covered with epinephrine soaks and spray thrombin. Once satisfactory hemostasis was obtained, the wound was packed AMD as well as sterile Kerlix dressing. The patient tolerated the procedure well and was taken to the post-anesthesia care unit for post-operative recovery in stable condition.

371. After the debridement, a tissue culture from the sacrum tested positive for proteus/e-faecalis.

- DH3a - 10

372. Proteus species are a Gram-negative, facultative bacilli that colonize the gastrointestinal tract and are a source of nosocomial infection within hospitals and long-term care facilities.

373. E. faecalis is found in most healthy individuals, but can cause endocarditis and sepsis if it enters the blood stream.

374. When Dorothy was admitted to the hospital back on October 15, her white blood cell count — a key marker for infection — was at the low end of normal: 5.64 K/uL.

- DH1 – 12-13

Hematology			
WBC (4.0 - 11.0 THOUS/uL)			5.64

375. On November 6, Dorothy's white blood cell count was critically high: 34.86 K/uL.

- DH1 – 75

	11/07 0055	11/06 1119
Hematology		
WBC (4.0 - 11.0 THOUS/uL)	28.15 H	34.86 H

376. After surgery, Dorothy was taken to the Intensive Care Unit, where NP Jennifer Key and Dr. John Keeley diagnosed Dorothy as being in septic shock.

- DH1 – 41-48

Free text A&P:
58 yo F PMH Down's Syndrome, T2Dm, HTN, seizure disorder underwent stage 4 sacral decubitus debridement in preparation for flap 11/6 w/ hypotension post procedure. Critical care team asked to assist w/ her care.

Pt received 300 ml NS intraop and 250 ml Vancomycin post op. However, IV found to be infiltrated so it is unclear how much the pt received.

A&P:
Heme/ID: Septic shock in setting of infected stage 4 sacral decubitus; bacteremia w/ Proteus (cx 11/2); UTI due to Proteus and E coli (cx 11/2); stage 2 bilat heel decubitus
- ivf resuscitation
- continue ceftriaxone
- Continue vanco and flagyl per burn/wound recommendations
- sacral cultures sent 11/6
- wound management per burn/wound team

CV: sepetic shock/hypotension, venous insufficiency; dyslipidemia
- ivf resuscitation
- hold losartan for now
- continue statin
- monitor hemodynamics
- place PICC

377. The condition Dorothy was found in on November 6 — a large, infected, putrid stage 4 wound with substantial necrosis, and in septic shock — does not develop instantaneously.

378. The wound had of course developed and worsened over several days.

379. The "foul odor" from the wound was likely obvious for at least one day, and probably for multiple days.

380. Sepsis likely took at least a day or more to escalate to septic shock.

381. By November 6, Dorothy was in extremis. The wound, including the sacral infection, was likely incurable at that point, and the infection and septic shock well could have killed Dorothy.

Schedule of Providers from October 15 – November 6, 2018

382. The attending hospitalists from October 15 through November 6, 2018 were are follows:

October 16: Adam M. Ross, MD; Mari Mangasha, MD (DH1 – 692)

October 17: Adam M. Ross, MD; Mari Mangasha, MD (DH1 – 690)

October 18: ???

October 19: Adam M. Ross, MD (DH1 – 687)

October 20: Adam M. Ross, MD (DH1 – 684)

October 21: Adam M. Ross, MD (DH1 – 681)

October 22: Adam M. Ross, MD (DH1 – 678)

October 23: Adam M. Ross, MD (DH1 – 675)

October 24: Adam M. Ross, MD (DH1 – 672)

October 25: Adam M. Ross, MD (DH1 – 669)

October 26: James A. Cato, MD (DH1 – 666)

October 27: James A. Cato, MD (DH1 – 663)

October 28: James A. Cato, MD (DH1 – 660)

October 29: Jonathan Preston, MD (DH1 – 657)

October 30: Jonathan Preston, MD (DH1 – 654)

October 31: Jonathan Preston, MD (DH1 – 651)

November 1: Jonathan Preston, MD (DH1 – 647)

November 2: Jonathan Preston, MD (DH1 – 643)

November 3: Jonathan Preston, MD (DH1 – 638)

November 4: Jonathan Preston, MD (DH1 – 633)

November 5: Adam M. Ross, MD (DH1 – 629)

November 6: Adam M. Ross, MD (DH1 – 624)

Dorothy's condition and treatment since the sentinel event

383. Dorothy has suffered a complicated, difficult course since the stage 4 sacral wound was diagnosed and first treated. The discussion below does not recite Dorothy's course in detail here, but only addresses some of the more notable events.

November 6, 2018, through July 11, 2019 discharge

384. Overview: Before the wound developed on Dorothy's sacral area, she had been fit to discharge as soon as space opened up at a nursing home. After the wound developed and Dorothy suffered infection and sepsis, Dorothy remained in the hospital for another eight months, until July 11, 2019. Before then, however, on March 21, 2019, the hospital sent Dorothy off to a nursing home. The nursing home sent Dorothy right back, because Dorothy's sacral wound was much too extensive for the nursing home to care for.

385. From 11/14/2018 to 11/22/2018, Dorothy was treated with an IV antibiotic course of Zosyn/Zyvox to treat the bone infection.

- DH3a – 10

386. From 11/22/2018 to 12/02/2018, Dorothy was treated with an IV antibiotic course of Ampicillin to treat the bone infection.

- DH3a – 10

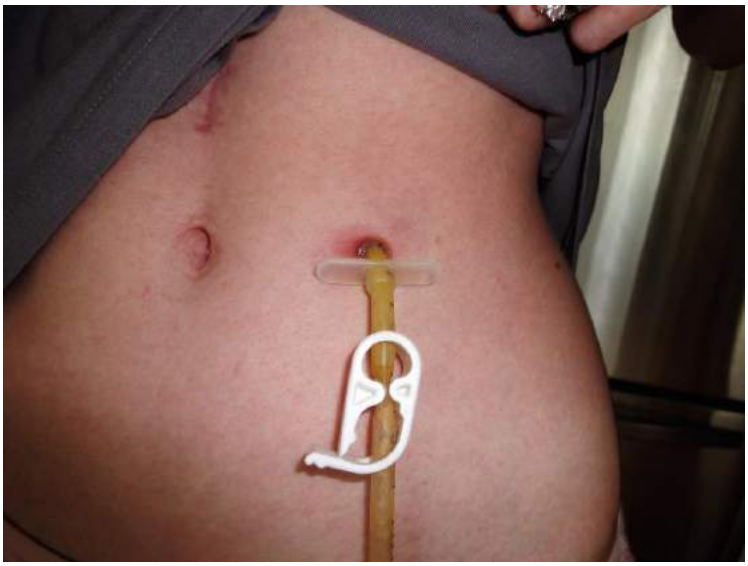
387. From 12/10/2018 to 12/17/2018, Dorothy was treated with IV antibiotic course of Zyvox/Levofloxacin to treat the bone infection.

- DH3a - 10

388. On November 12, 2018, a percutaneous endoscopic gastrostomy (PEG) feeding tube was placed into Dorothy as she was too ill and weak to take in enough nourishment.

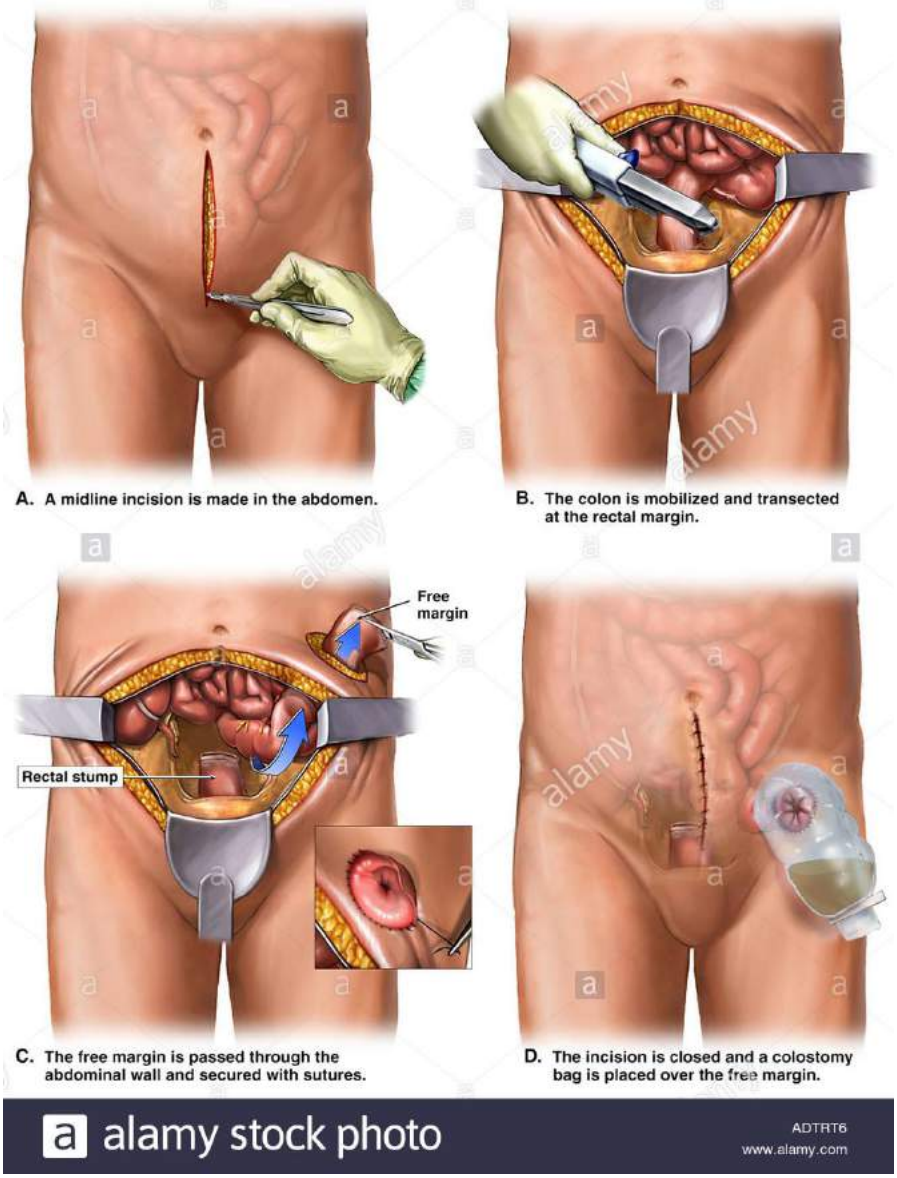
- DH1 – 1173-74

389. A PEG tube is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate. (Picture for illustration only; not from Dorothy Anthony's medical records.)



390. On December 7, 2018, Dorothy was given a colostomy, after multiple incidents of fecal incontinence that threatened to contaminate the sacral wound. (Picture for illustration only; not from Dorothy Anthony's medical records.)

- DH1 – 1202-03 (colostomy op note)
- DH1 – 34-35 (colostomy consultation note)
- DH2 – 496 (bowel incontinence)
- DH2 – 618 (bowel incontinence)

- 

391. On February 12, 2019, Dr. Mullins performed a fasciocutaneous flap surgery, creating a 13 cm x 14.5 cm flap.

Procedures
Procedure Comments:
Procedures Performed:
1) Excision of sacral wound in preparation of flap 13x14.5 cm2
2) Rotational Fasciocutaneous Flap based on the Right Superior Gluteal Artery Perforators

392. The records currently available do not include photographs from the operation performed on Dorothy. The following photos are taken from Wong, Chin-Ho, Bien-Keem Tan, and Colin Song. "The perforator-sparing buttock rotation flap

for coverage of pressure sores." *Plastic and reconstructive surgery* 119.4 (2007): 1259-1266 (available at https://www.waesthetics.com/pdf/published/28.pdf). The operation indicated in the photograph likely differed from the operation performed on Dorothy, but the photograph nevertheless may give some idea of the surgery Dorothy underwent.

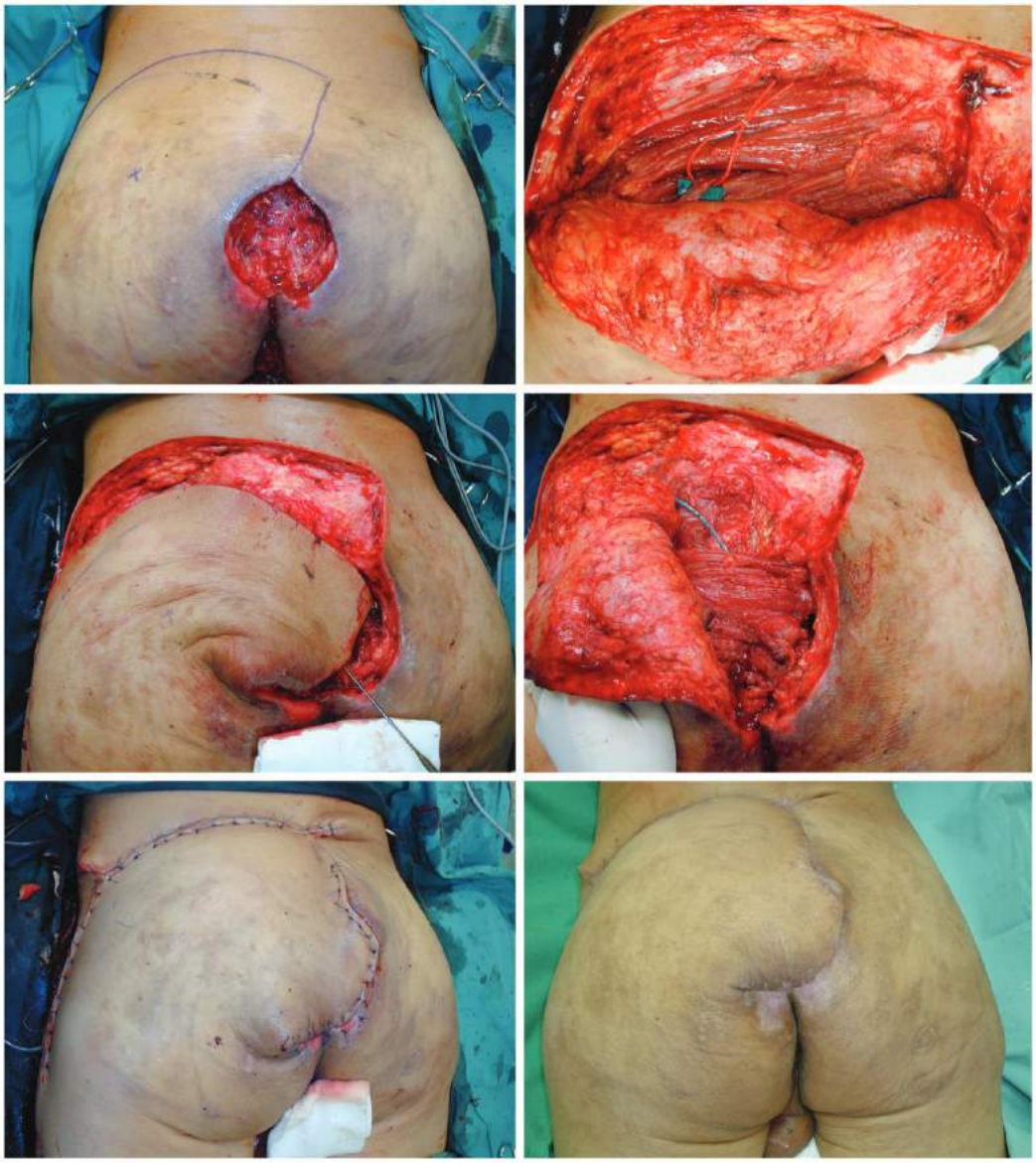


Fig. 3. (*Above, left*) Grade 4 sacral sore. Preoperative hand-held Doppler assessment to locate the perforator was performed (marked *X*). This served as a useful intraoperative guide for localization of the dominant musculocutaneous perforator of the superior gluteal vessels. (*Above, right*) A large musculocutaneous perforator was dissected intramuscularly through the gluteus maximus muscle to the emergent point of the superior gluteal artery above the piriformis muscle. (*Center, left*) Wide undermining beyond the location of the perforator (after intramuscular dissection to free the perforator) allowed rotation of the skin flap into the sacral defect in a tension-free manner. (*Center, right*) The superior half of the gluteus maximus muscle (above the superior gluteal vessels) is detached from its attachment at the iliotibial tract and transposed medially to fill the dead space at the exposed sacrum. (*Below, left*) Closure of the sacral pressure sore achieved with the perforator-sparing buttock rotation flap. (*Below, right*) Photograph of the patient at 14-month follow-up.

393. On March 21, 2019, the hospital discharged Dorothy and sent her to Amara nursing home. The nursing home immediately sent her back, because the sacral wound was too extensive for them to care for.

- DH3c – 177

General
Confirmed Patient Yes
Initial Greet Date/Time 03/21/19 1556

Presentation
Chief Complaint wound recheck

Context
Additional Context
58 yo F with mutiple medical problems, chronic debilitation and Stage 4 sacral decubitus; was sent to Amara nursing facility today and they sent patient back to ER as wound was too extensive for them to initiate care; no other complaints per NH; no fever; was on wound service here at Doctors

394. Shortly after Dorothy was sent back to the ER, PA Ansley Coffee of the Wound Care service examined Dorothy, under the direct supervision of Dr. Mullins. PA Coffee reported that "near the end prior to discharge she [Dorothy] was just lying on a silver burn pad." PA Coffee also noted that Dorothy had a very deep open wound near the perineum and rectum — "very deep past a finger length of the surface."

- DH3c – 182-84

facility." She was sent back to Doctors Hospital Emergency Department to be evaluated for readmission. Prior to her discharge, the patient had a small open area that was treated with Bactroban and Xeroform with instructions given for the outlying facility. Here, during her hospitalization near the end prior to discharge, she was just lying on a silver burn pad. She has a history of a stage IV ulcer to the sacrum and stage I ulcerations to the bilateral heels. She is accompanied in the emergency department by her sister. Her sister is very upset about the turn of events of this morning and is wondering what the plan further will be.

…

have dry flaking skin over the surface. Focusing next on the patient's buttocks, she does have a fasciocutaneous flap, which was intact, which has a small area of dehiscence to the right lateral buttock. The right medial buttock near the perineum and sacrum, the patient does have an open area that is very deep past a finger length of the surface. It does have some serosanguineous drainage, some yellow eschar of the surface of this site. No acute malodor or evidence of infection. The fasciocutaneous flap does appear adherent and viable at this point in time.

395. On March 25, 2019, a bone culture grew Acinetobacter/e-faecalis.

- DH3a – 10

396. From March 26 to May 6, Dorothy was treated with a course of IV Merrem, a powerful antibiotic.

- DH3a – 10

397. By April 2, 2019, the flap had failed.

- DH3c – 232

Start date: 04/02/19
Start time: 1233
Pre-procedure diagnosis: stage IV sacral ulcer, sp failed flap
Post-procedure diagnosis: same
Procedure(s) performed:
surgical prep and instill vac sacrum 8x8x5cm
level includes sq

398. From 6/6/2019 to 6/12/2019, Dorothy was treated with an IV Antibiotic course of Zyvox/Zosyn.

- DH3a – 10

399. From 6/19/2019 to 6/24/2019, Dorothy was treated with an IV Antibiotic course of doxycycline.

- DH3a – 10

400. From 6/24/2019 to 6/28/2019, Dorothy was treated with an IV Antibiotic course of Zyvox/Zosyn.

- DH3a – 10

401. From 6/28/2019 to 7/05/2019, Dorothy was treated with an oral antibiotic course of Augmentin.

- DH3a – 10

402. On July 11, 2019, the hospital discharged Dorothy to her home.

- *See* DH3c – 132; 384

After July 11, 2019

403. Since being discharged in July 2019, Dorothy has continued to have a difficult course, with multiple hospital admissions not addressed here in detail.

404. On July 25, 2019, a family member took Dorothy to the ER worried about an infection, because Dorothy had dark urine and a fever. Dorothy was discharged the same day.

- DH3c – 138, 149

405. On August 7, 2019, Ms. Sampson took Dorothy to the Wound Clinic for one of a continual series of outpatient visits. At this visit, NP Jennifer Casella and Dr. Zaheed Hassan noted that the sacral wound had significant necrotic tissue and slough. They admitted Dorothy to the hospital, to be treated by Dr. Mullins for surgical debridement and excision of the wound, and to be managed for possible infection.

- DH3b – 701-03

INTEGUMENT: Focused examination of the patient's bilateral feet to include the heels reveals completely intact pink skin. No open wounds. All areas are blanching. There are no signs or symptoms of infection. Focused examination of the patient's sacrum reveals an open wound measuring 9 x 8 x 6.3. There is significant necrotic tissue and slough within the superior margins of the wound bed. The wound bed overall is dark red and moist. There is mild malodor. The immediate periwound is noted to have some maceration of the skin and subsequent tearing. There is no active purulent drainage appreciated at this time.

ASSESSMENT:
Stage IV sacral wound that is worsening, Down syndrome with dementia, diabetes, hypertension, and obesity.

PLAN:
After examination today with Dr. Hassan and discussion with the patient's sister, Willie Simpson, who serves as a power of attorney and caregiver, the decision was made to admit the patient to Dr. Mullins Service. The patient will have Burn Medicine consulted for medical management. We did discuss the need for further debridement and excision of the wound. Informed consent was obtained after discussion of risks and benefits of surgical procedure. The patient will be placed on pressure reduction measures. We will begin topical management of her wound at this time. The patient will remain n.p.o. after midnight and be taken to the operative suite in the morning to undergo formal excision. The patient's sister did verbalize understanding and the initial lab work was ordered. She was examined today with direct supervision of Dr. Hassan in the absence of Dr. Mullins and should be coded as a 99222 x2.

- DH3b – 704

406. On this admission, a bone culture from Dorothy's sacrum was positive for e-faecalis.

- DH3a – 10

407. Dorothy ended up staying in the hospital for about a month. The hospital discharged her on September 9, 2019.

- DH3b – 699-700

408. From August 14 to September 9, Dorothy was treated with an IV antibiotic course of Unasyn (ampicillin/sulbactam).

- DH3a – 10

409. From September 9 to October 7, Dorothy was prescribed oral Amoxicillin.

- DH3a – 10

410. Over the next several months, the Wound Center followed Dorothy on an outpatient basis.

- DH3b – 682 (10/15/2019)
- DH3b – 680 (11/5/2019)
- DH3b – 675 (11/9/2019)
- DH3b – 670 (11/25/2019)
- DH3b – 668 (12/9/2019)
- DH3b – 663 (12/18/2019)
- DH3b – 654 (1/6/2020)
- DH3b – 652 (1/27/2020)
- DH3b – 647 (2/18/2020)
- DH3b – 637 (3/19/2020)

411. On April 9, 2020, a family member took Dorothy to the Wound Center for an outpatient visit. The sacral wound was exposed, with bone showing, and there was tunneling at the top of the wound.

- DH3b – 632

INTEGUMENT: The remainder of the physical examination was confined to her sacrum, bilateral heels and right thigh. The sister states she has a new right thigh ulcer. The sacral ulcer measures 4.5 x 12.0 x 5.0 cm with tunneling in the 12 o'clock region 5 cm with exposed bone. This is again deteriorated with no necrotic tissue but more bone exposure. There is a mild odor and copious serous discharge. The right heel ulcer measures 0.5 x 1.0 x 0.1 cm and left heel ulcer measures 1.0 x 2.0 x 0.3 cm. She has significant posterior right thigh breakdown with surrounding erythema that appears tender to palpation. There is no purulence or fluctuance.

ASSESSMENT:
1. Stage IV pressure ulcer of the sacrum.
2. Stage III pressure ulcers of bilateral heels.
3. Cellulitis of the right thigh more complicated by decreased mobility, developmental delay, and morbid obesity.

412. On May 1, 2020, a family member took Dorothy to the ER. Dr. John Rumbaugh admitted Dorothy because the sacral wound had more bone exposure, and it also contained necrotic tissue and produced serous discharge.

- DH3a – 6-7

INTEGUMENT: The remainder of the physical examination was confined to the sacral and bilateral heel ulcers. Unfortunately, the sacral ulcer has deteriorated quite a bit. At the previous visit, the sacral ulcer measured 4 x 12 x 5 cm. It is now about double the size. There is adherent and necrotic tissue with an odor, and copious serous discharge. There is some tunneling in the 12 o'clock position with palpable bone that was not present at previous visit. Bilateral heel ulcers are also deteriorated. They are covered with eschar with no evidence of any infection.

ASSESSMENT:
1. Infected sacral ulcer.
2. Unstageable pressure ulcers of bilateral heels, both complicated by Down syndrome, morbid obesity, and diabetes as well as immobility.

PLAN:
1. Culture the sacral ulcer.
2. Discussed case with Dr. Hassan. Due to the large amount of necrotic tissue as well as the increase in serous discharge and odor, we recommended admitting the patient for IV antibiotics with a diagnosis of infected sacral ulcer and will observe to decide whether or not to take her to the operating room. OR decision would include changes in temperature, other vital signs, and white blood cell count and wound cx results. She is placed in Dakin's to all 3 ulcers and I educated the sister on the plan.

413. On May 5, 2020, Dr. Bounthavy Homsombath debrided the sacral wound on Dorothy.

- DH3a – 17

Procedures
Wound Debridement
Debridement type: excisional
Location (size or %): sacrum 15x5x5 cm right buttock 10x5 left buttock 9x4 left heel 5x5x0.5 right heel 4x3x0.5 cm left calf 5x4x1 cm all measurements in cm
Level of excision: subcutaneous
Dressing: Kerlix AMD

414. On May 11, 2020, NP Denise Hamrick and Dr. Jack Austin from the Infectious Disease service consulted on Dorothy's case. Dr. Austin concluded that Dorothy likely had chronic osteomyelitis. He concluded that another course of IV

antibiotics was unlikely to help. He recommended oral antibiotics, an MRI to identify the extent of the bone infection, and possibly further resection of bone tissue.

- DH3a – 15

Diagnosis, Assessment & Plan

Free Text DxA&P Notes
Free text DxA&P notes:
Assessment

59 yo female with chronic st IV sacral ulcer, probable chronic ostemyelitis. Previous bone culture in March 2019 was positive with acinteobacter and e faecalis, and again with e faccalis in August 2019. She was treated appropriately with 6 weeks of IV abx and 4 weeks of IV abx + one month of PO, respectively. She has failed with surgical debridements, STSG and a flap. Bone culture this admission +serratia and pseudomonas and is on merrem and doxy. She is afebrile with normal WBC.

Recommendation

1. do not recommend another long course of IV antibiotics as this is not likely to improve outcome given her bedbound state. d/c doxy.
2. would convert to PO levofloxacin at discharge for suppression with continued wound care, further resection of infected bone tissue as needed, appropriate air flow mattress, adequate nutrition
3. Consider MRI to further delineate extent of osteomyelitis to guide care

Dr. Austin to see patient and make further recommendations.

Thank you for allowing us to participate in this patients care, we will follow along.

415. The hospital discharged Dorothy on May 21, 2020.

- *See* DH3a – 18

416. On May 26, 2020, a family member took Dorothy to the ER with concerns about her wounds leaking.

- DH3a – 3, 4

417. The medical records I have received do not cover all of Dorothy's history since the development of her stage 4 sacral wound. I assume that additional medical records will become available.

Additional Discussion

418. As CMS has declared, the development of a new pressure wound in a hospital is a "never event."

419. The development of a stage 2 wound in a patient known to be at high risk — like Dorothy Anthony — reflects poor care, but in itself a stage 2 wound need not cause serious, lasting harm.

420. It is shocking, however, for a stage 2 wound to develop, be noted by multiple nurses and therapists, be brought to the attention of physicians, and yet to worsen to a stage 4 wound.

421. The administration and the providers at Doctors Hospital failed Dorothy Anthony — grossly.

422. The failure cannot be attributed solely to individual failings of particular providers. Too many nurses and physicians were involved. Too many days went by without proper action. These events demonstrate a larger, systemic problem at Doctors Hospital — a problem with the systems put in place (or not put in place) by the hospital administration.

423. Indeed, the records indicate that at least some of the nurses and physical therapists understood the seriousness of the sacral wound and made some effort to communicate it to the rest of the team, so that they would treat Dorothy appropriately. Yet it didn't happen. That indicates a system failure for which the hospital administration is responsible.

424. The facts revealed in the medical records establish the standard of care, causation, and damages opinions stated in the "Summary of Principal Opinions" above.

425. Finally, as Dr. Jack Austin noted, Dorothy likely now suffers chronic osteomyelitis. The infections are likely to continue recurring, putting Dorothy at high risk of sepsis and premature death.

Supporting Literature

426. The general points discussed above are well known to physicians, nurses, and hospital administrators in the relevant fields. The Defendants themselves, and experts hired by the Defense team will likely not need to refer to literature to confirm any of the discussion here.

427. However, for the benefit of non-medical personnel involved in the Defense (attorneys, insurance adjustors, etc), the following literature, while by no means exhaustive, may help in evaluating this case:

- Baue, A. E., et al., eds. *Sepsis and Organ Dysfunction: From Basics to Clinical Approach*. Springer Science & Business Media, 2012.
- European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance. *Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline*. The International Guideline. Emily Haesler (Ed.). EPUAP/NPIAP/PPPIA: 2019.
- European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance. *Prevention and Treatment of Pressure Ulcers/Injuries: Quick Reference Guide*. The International Guideline. Emily Haesler (Ed.). EPUAP/NPIAP/PPPIA: 2019.
- Gavins, Felicity NE, and J. Steve Alexander, eds. *Lymphatic Structure and Function in Health and Disease*. Academic Press, 2019.
- Griffin, Donald, ed. *Hospitals: What they are and how they work*. Jones & Bartlett Learning, 2011.
- Lowry, Svetlana Z., et al. *Examining the copy and paste function in the use of electronic health records*. US Department of Commerce, National Institute of Standards and Technology, 2017.
- Parish, Lawrence C., Joseph A. Witkowski, and John T. Crissey, eds. *The decubitus ulcer in clinical practice*. Springer Science & Business Media, 2012.
- Rosdahl, Caroline Bunker, and Mary T. Kowalski, eds. *Textbook of basic nursing*. Lippincott Williams & Wilkins, 2008.
- Santambrogio, Laura. *Immunology of the lymphatic system*. Ed. Laura Santambrogio. New York: Springer, 2013.
- Sørensen, Jens Lykke, Bo Jørgensen, and Finn Gottrup. "Surgical treatment of pressure ulcers." *The American journal of surgery* 188.1 (2004): 42-51.

- Tsou, Amy Y et al. "Safe Practices for Copy and Paste in the EHR. Systematic Review, Recommendations, and Novel Model for Health IT Collaboration." *Applied clinical informatics* vol. 8,1 12-34. 11 Jan. 2017, doi:10.4338/ACI-2016-09-R-0150

Christopher M Davey, MD

Christopher M. Davey, MD

SWORN TO AND SUBSCRIBED before me

OCTOBER 14, 2020

NOTARY PUBLIC

My Commission Expires 02/16/2022

MATTHEW ARNOLD NOTARY 14-35 PUBLIC STATE OF HAWAII

Doc. Date: 10/14/2020 # Pages: 83
Notary Name: Matthew Arnold Second Circuit
Doc. Description: AFFIDAVIT OF CHRISTOPHER M. DAVEY, MD
Notary Signature Date 10/14/2020

MATTHEW ARNOLD NOTARY 14-35 PUBLIC STATE OF HAWAII

Curriculum Vitae

Christopher M. Davey, M.D., P.A.
PO Box 56419
St. Petersburg, FL 33732

(727) 800.6918 Telemedicine
(727) 800.9897 Fax
(727) 641-4501 Cell
drchrisdavey@outlook.com

Dr. Davey trained as a pathologist at Mount Sinai Medical Center in Miami, Florida, but since 1987 has practiced in Family Practice and Geriatric Medicine in office, hospital, and nursing home settings. Dr. Davey has a special interest in wound diagnosis, prevention and treatment and is board certified by the American Board of Wound Management. He is also a trained Hyperbaric Specialist. (Hyperbaric medicine is the treatment of severe wounds and other conditions using high pressure oxygen chambers). He was the Medical Director of Hyperbaric Medicine, as well as an active physician at the Edward White Center for Wound Care and Hyperbaric Medicine until October 2014. He has also been a consultant for American Medical Technologies in Irvine, CA on wound care dressings. Dr. Davey is also a senior member of the Wound Healing Society in Bethesda, Maryland.
Dr. Davey holds a current active medical license in the state of Florida.
Dr. Davey is currently doing telemedicine wound care during the Covid-19 crisis.

Dr. Davey also works with Professional Health Care in St. Petersburg, Florida (PHC) as a wound care consultant for a busy Primary Care clinic and nursing home practice with several physicians and multiple nurse practioners. This large practice is run under the supervision of Dr. Fadi Saba. Dr. Davey works in the clinic and multiple nursing homes approximately every three months in direct patient care, and also does remote consulting for the practice. This arrangement has been in place for several years, involving direct clinic and nursing home patient interaction. It is currently on hold due to Covid-19 safety precautions. It is expected to resume in 2021.

Personal

Place of Birth: London, England
Citizenship: United States

Fla. Medical License Number:	ME-034037
DEA Number:	AD8602371
Languages Spoken:	English, French, German and Japanese

Ex A

Areas of expertise

•Wound causation, care and treatment.
•Nursing Home and Hospital Standard of Care including preventable falls or bedsores and nursing home / hospital acquired infections.
•Cause of death related to above.

Forensic experience

I have testified extensively for both Plaintiff and Defense since 1998 involving Geriatric issues, falls, bedsores, pressure ulcers, complex medical cases and hospital and nursing home Standards of Care. I also have the expertise to render opinions on cause of death issues, including death from Covid-19 infections in nursing and care homes due to my pathology background.

Education

Medical School:
1968-1972
St. Mary's Hospital, University of London
(Now: Imperial College, School of Medicine
University of London)
London, England. United Kingdom)

Internships:
1972-1973
Northwick Park Hospital and Research
Center Harrow, Middlesex, England
1). Interventional Cardiology
2). General Surgery

British Government Aid Program:
1973-1977
Princess Margaret Hospital, Nassau,
Bahamas
-Internal Medicine with special interest in Marine Medicine and Tuberculosis

U.S. Residency:
1977-1980
Mt. Sinai Hospital Miami,
Florida
-Pathology: Anatomical and Clinical

Professional Experience

February 2019- Dr. Davey Presented a paper that he co-authored on infected wounds at the Boswick Burn and Wound care symposium in Maui, HI.

2018-2019- Dr. Davey was co-chair of the International Consolidated Wound Infection Guideline (ICW IG) task force, which evaluates current evidence-based guidelines, which are then submitted to AHRQ (Agency for Healthcare Research and Quality) for inclusion in the national guidelines which are available to hospitals and healthcare practitioners throughout the country. Hospitals frequently use the AHRQ guidelines in their policies and procedures.

April 2018- Dr. Davey presented at the Wound Healing Society conference in Charlotte, NC.

1987-October 24th, 2014- Private Practice
2191 9th Ave. North, Ste 115
Saint Petersburg, Florida 33713
-Adult and Geriatric Medicine
-Special Interest in Skin and Wound Care, on staff at the Center for Wound Care and Hyperbaric Medicine at HCA Edward White Hospital. Medical Director of Hyperbaric Medicine at HCA Edward White Hospital.

1981-1987
Columbia Edward White Hospital
2323 9th Avenue North
Saint Petersburg, Florida 33713
-Emergency Medicine: including three years as Emergency Room Director.

Recent Publications:

"The development and content validation of a Multidisciplinary, Evidence-Based Wound infection Prevention and Treatment Guideline".
Lead Authors, Dr. Davey and Sammy Zakhary, MD

Index: Ostomy Wound Management-November 2017; 63 (11): 18-29

Volunteer Work:

Dr. Davey spent December 2016 in Cambodia working at two charity hospitals as a volunteer doctor, teaching and doing wound care. This was organized by Health Volunteers Overseas in Washington DC. The two hospitals were the ***Sihanouk Hospital of Hope***, and the ***Angkor Hospital for Children***. Cambodia is one of the poorest countries in the world and is still trying to recover from its brutal civil war.

While in St. Petersburg, Florida, Dr. Davey spent 20% of his work time volunteering at the ***St. Petersburg Free Clinic***. The St. Petersburg Free Clinic is a proud member of the Florida Association of Free and Charitable clinics, which runs over 100 free clinics in the state of Florida, the most of any state.

Hospital Affiliations:

1987 to end of 2014:

Dept. of Family Practice

St. Anthony's Hospital
1200 7th Avenue North
Saint Petersburg, FL 33705

HCA Edward White Hospital
2323 9th Avenue North
Saint Petersburg, FL 33713

Board Certification:

Board certified by the American Academy of Wound Management as a Certified Wound Specialist (CWS) in 2003. Recertified as "Certified Wound Specialist Physician" (CWSP) by the American Board of Wound Management in September 2013 valid through 9/24/2023.

Most Current Education:

July 24th-26th 2020- Dr. Davey attended the Symposium on Advanced Wound Care/ Wound Healing Society conference in July 2020. This year it was a virtual conference due to Covid-19 Concerns.

April 25th-29th 2018- Dr. Davey did a poster presentation for the Wound Healing Society annual meeting in Charlotte, NC entitled “Pearls from a Multidisciplinary Wound Infection Guideline”.

July 19, 2017- Dr. Davey addressed the Maui Medical Society, and gave a talk entitled "Wound Care and the Importance of Evidence-Based Guidelines".

Dr. Davey attended the 38th annual John A Boswick Burn and Wound Care Symposium from February 14th through February 18, 2016. This symposium was well attended by burn and wound care physicians from multiple countries. Dr. Davey was able to address the symposium on the ICW IG research, specifically looking for collaboration with other interested wound and burn professionals.

February 18-22, 2013- 35th Annual John A. Boswick, MD Burn and Wound Care Symposium.
Wailea, Maui, Hawaii

April 30-May 1, 2013-Symposium on Advanced Wound Care (SAWC) and Wound Healing Society (WHS) Annual Meeting.
-Denver, Colorado

-Orlando, FL
April 23- April 27, 2014
-Charlotte, NC
April 25-April 29, 2018

Memberships and Positions Held:

Editorial Board Membership

Dr. Davey is currently a member of the Editorial Board of the Journal of Wound Management and Prevention, which is a monthly peer-reviewed medical journal covering all aspects of wound care, skincare as well as nutritional related issues.

Current:
Member of the American Medical Association/ AMA.

Current:
Member of the International Relations Committee of the Wound Healing Society.

Current:
Member of the Florida Medical Assn/FMA.

Current:
Senior member of the Wound Healing Society in Bethesda, Maryland.

.

Current:
Member of the A AWC task force on current evidence-based guidelines for pressure ulcers.

Present:
Member of Association for Advancement of Wound Care (national organization).

Present:
Member of the Society of University Founders of the University of Miami, Coral Gables, Florida.

Past:
Medical Director for Hyperbaric Medicine, Center for Wound Care and Hyperbaric Medicine HCA Edward White Hospital.
I was Director of Wound Care at this facility from approximately 2000-2005.

Past:
Utilization Review and Quality Assurance Committee member at HCA Edward White Hospital.

Past:
Member of the Medical/Surgical Care Evaluation Committee at HCA Edward White Hospital.

Past:
Member of the Infectious Control Committee representing the Center for Wound Care, HCA Edward White Hospital.

Past:
Member of the Medical Quality and Education Committee at St. Anthony's Hospital.

1989-1994:
Member of the Board of Trustees, Columbia Edward White Hospital.

Previous:
Board Member of the Florida Medical Directors Association.

Previous:
Medical Director of Sunrise Northshore, Assisted Living Facility and Nursing Home.

Previous:
Utilization Review and Quality Assurance Committee member at St. Anthony's Hospital.

Previous:
Member of Florida Medical Directors Association.

Previous:
Certified Medical Director (AMDA).

Nursing Home Medical Directorships, Past: (Dates approximate)

Coquina Key Nursing & Rehabilitation Center: 2000-2007
Westminster ALF: 2001-2005
Northshore ALF: 1998-2002
Abbey Nursing Home: 1998-2000
Huber Nursing Home: 1992-2000
Green Brook Nursing Home: 1994-1999
Heartland Nursing Home: 1988-1999
Shore Acres Nursing Home: 1996-1998
Alpine Nursing Home: 1995-1998
Carrington Place Nursing Home: 1995-1997
St. Pete Health Care Center: 1992- 2008

AFFIDAVIT OF JUDITH CLIMENSON RN, CCRN-CMC, CNRN-SCRN REGARDING DOROTHY ANTHONY

PERSONALLY APPEARS before the undersigned authority, duly authorized to administer oaths, comes Judith Climenson RN, who after first being duly sworn, states as follows:

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Introduction

1. This affidavit addresses medical negligence that occurred during Dorothy Anthony's admission at Doctors Hospital of Augusta (DHA) that began on October 15, 2018.

2. I have been asked to provide this affidavit for the limited purpose of Georgia statute OCGA § 9-11-9.1.

3. This affidavit addresses specific matters that Plaintiff's counsel have asked me to address. I have not attempted to identify all standard-of-care violations. I have not attempted to state every causation opinion I have. I have not attempted to anticipate or address issues the Defense might raise or that otherwise might arise as the case unfolds.

4. I use the term "standard of care" to refer to that degree of care and skill ordinarily exercised by members of the nursing profession generally under the same or similar circumstances and like surrounding conditions as pertained to the medical providers I discuss here.

5. Plaintiff's counsel drafted this affidavit after consulting with me, and I reviewed the draft and edited it to make sure it correctly states my views. The purpose of this affidavit is only to give the Defense fair notice of my substantive views and the information my views are based on. In reviewing and editing the draft affidavit, therefore, I made sure that I agree with the substance of what is said here, but I have not attempted to re-write the affidavit to read like a document that I wrote. I understand that Plaintiff's counsel may produce draft affidavits for other experts, using language identical to what is in this affidavit. Nonetheless, I have edited this affidavit, and I agree with every statement that in this final version of the affidavit.

6. If additional information becomes available later, my opinions may change. Additonally, I understand that Plaintiff's counsel will provide this affidavit to the Defendants. I also understand that the Defense will hire medical experts to review this case and to review this affidavit. If anyone on the Defense team believes I have overlooked or misconstrued any relevant information, I invite the Defense to communicate with me by letter, copied to Plaintiff's counsel. The Defense need not wait to take my deposition to communicate with me. I would like to consider any

information the Defense wishes to bring to my attention and, if appropriate, to provide a supplemental affidavit addressing such information.

7. As to the matters this affidavit addresses, I have tried to give a reasonably detailed explanation, but I have not attempted an exhaustive discussion. In deposition or trial testimony, I may elaborate with additional details. While I cite evidence from the medical records for various case-specific facts, I do not necessarily cite all the evidence for a given point.

8. I hold all the opinions expressed below to a reasonable degree of nursing certainty — that is, more likely than not.

Evidence Considered

9. I have reviewed medical records from Doctors Hospital of Augusta pertaining to Dorothy Anthony. My views are based on the information in these records.

10. Plaintiff's counsel supplied various timelines, which may be attached as exhibits to this affidavit. While the timelines are useful to some extent in navigating the thousands of pages of medical records, I have not relied on the timelines for any substantive purpose. In forming my conclusions, I have relied only on the medical records themselves.

Summary of Principal Opinions

11. My principal opinions are summarized here. Additional opinions are contained in the discussion below. In deposition or trial testimony I may elaborate, and in doing so I may offer related, subsidiary, or incidental opinions.

i. **Administrative Task & Requirement:** Implement patient safety measures to prompt, facilitate, and require measures to prevent pressure wounds from developing, and to treat wounds if they do develop.

Violation: The DHA administration violated the standard of care by failing to implement measures that prompted, facilitated, and required appropriate steps to prevent pressure wounds and to treat them properly if they develop.

Causation: This violation led to neglect that allowed a stage 2 pressure wound to develop on Dorothy Anthony's sacral area, and then led to further neglect that allowed the wound to develop to a stage 4 wound.

Damages: This violation caused pain, debridements, flap surgery, infections, long-term hospital stay, permanent disabilities.

ii. **Administrative Task & Requirement:** Implement measures to prompt, facilitate, and require communication between nurses and physicians concerning patients' high-risk status for pressure wounds and for patients' actual development of pressure wounds.

Violation: The DHA administration violated the standard of care by failing to implement measures that prompted, facilitated, and required necessary communication about pressure wound risk and development.

Causation: This violation led to neglect that allowed a stage 2 pressure wound to develop on Dorothy Anthony's sacral area, and then led to further neglect that allowed the wound to develop to a stage 4 wound.

Damages: This violation caused pain, debridements, flap surgery, infections, long-term hospital stay, permanent disabilities.

iii. **Nursing Task & Requirement:** Take appropriate steps to prevent development of pressure wounds, including frequent repositioning and continence care.

Violation: The nursing staff violated the standard of care by failing to take appropriate steps to prevent another pressure wound from developing on Dorothy.

Causation: This violation led to neglect that allowed a stage 2 pressure wound to develop, and then further neglect that allowed it to develop into a stage 4 wound.

Damages: This violation led to pain, debridements, flap surgery, infections, long-term hospital stay, permanent disabilities.

iv. **Nursing Task & Requirement:** Notify attending physicians of the development of a pressure wound and request treatment.

Violation: The nursing staff violated the standard of care by failing to notify attending physicians of the development (and worsening) of a pressure wound on Dorothy's sacral area.

Causation: This violation led to neglect that allowed a stage 2 pressure wound to develop, and then further neglect that allowed it to develop into a stage 4 wound.

Damages: This violation led to pain, debridements, flap surgery, infections, long-term hospital stay, permanent disabilities.

v. **Nursing Task & Requirement:** Routinely assess the skin of an at-risk patient and document the skin status accurately.

Violation: The nursing staff violated the standard of care by failing to assess Dorothy's skin, and by failing to document her skin status, diligently and accurately.

Causation: This violation led to neglect that allowed a stage 2 pressure wound to develop, and then further neglect that allowed it to develop into a stage 4 wound.

Damages: This violation led to pain, debridements, flap surgery, infections, long-term hospital stay, permanent disabilities.

vi. **Nursing Task & Requirement:** Address incontinence effectively and assist with hygiene as needed to prevent skin breakdown and infection.

Violation: The nursing staff violated the standard of care by failing to address Dorothy's incontinence and hygiene disabilities.

Causation: This violation led to neglect that allowed a stage 2 pressure wound to develop, and then further neglect that allowed it to develop into a stage 4 wound.

Damages: This violation led to pain, debridements, flap surgery, infections, long-term hospital stay, permanent disabilities.

Qualifications

12. I am more than 18 years old, suffer from no legal disabilities, and give this affidavit based upon my own personal knowledge and belief.

13. I do not recite my full qualifications here. I recite them only to the extent necessary to establish my qualifications for purposes of expert testimony under OCGA 24-7-702. However, my Curriculum Vitae is attached hereto as Exhibit "A." My CV provides further detail about my qualifications. I incorporate and rely on that additional information here.

14. The events at issue here occurred in October 2018.

15. I am qualified to provide expert testimony pursuant to OCGA 24-7-702. That is:

a. In October 2018, I was licensed by an appropriate regulatory agency to practice my profession in the state in which I was practicing or teaching in the profession.

Specifically, I was licensed by the States of Arizona, California, and Georgia to practice as a registered nurse. In October 2018, I was practicing as a registered nurse in Arizona.

b. In October 2018, I had actual professional knowledge and experience in the area of practice or specialty which my opinions relate to — specifically, the tasks identified above on which I offer standard-of-care opinions.

I had this knowledge and experience as the result of having been regularly engaged in the active practice of the foregoing areas of specialty of my profession for at least three of the five years prior to October 2018, with sufficient frequency to establish an appropriate level of knowledge of the matter my opinions address.

Specifically, I have worked for many years as a Registered Nurse in an intensive-care unit.

Pressure Wounds Generally

16. Pressure wounds are known by various terms, including "bedsore," "decubitus ulcer," "pressure ulcer," and "pressure injury."

17. The skin, the largest organ in the body, is a major part of the body's defense against disease and infection.

18. A break in the skin may allow toxins to enter the body, causing infection.

19. A pressure wound is a localized injury to the skin and/or underlying tissue, usually over a bony prominence.

20. Most often a pressure wound is caused by pressure or pressure combined with shear and/or friction.

21. Pressure wounds may harm the body in a variety of ways: The wound may kill skin tissue, may kill muscle tissue, may injure blood vessels, and may impair lymphatic circulation.

22. Pressure wounds may put the patient at risk of infection and sepsis.

23. Skin irritation may contribute to, or develop in conjunction with, pressure wounds.

24. Urinary and fecal incontinence can irritate skin and make the skin more likely to break down.

25. The most common skin damage associated with incontinence is perineal dermatitis.

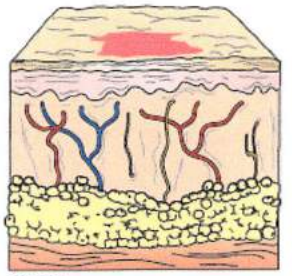
26. Patients with mobility impairment and incontinence are at higher risk for decubitus ulcer formation and to have delayed healing of existing lesions.

27. The back of the head, shoulders, elbows, hips, buttocks, and heels are the most commonly affected sites for pressure wounds.

28. Pressure wounds are commonly classified in four stages, as follows.

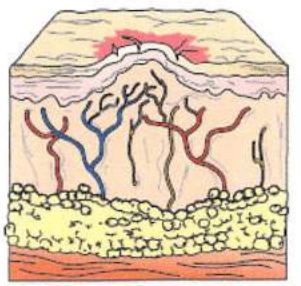
29. Stage 1: Pressure-related alteration of intact skin, as compared with adjacent/opposite body area. May include changes in (one or more): skin

temperature (warmth/coolness), tissue consistency (firm/boggy/mushy), induration (swelling), or sensation (pain/itching). Stage 1 wounds are reversible, if pressure is relieved (by frequent turning, positioning, and pressure-relieving devices).



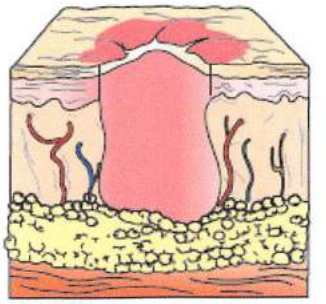
Stage 1

30. Stage 2: Loss of epidermis with damage into dermis (partial thickness tissue loss); appears as shallow crater/blister with red/pink wound bed, with no sloughing. May also appear as an intact or ruptured serum-filled blister or abrasion. Swollen and painful. Healing may require several weeks after pressure is relieved, often by maintenance of a moist environment.



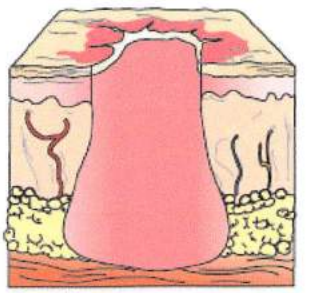
Stage 2

31. Stage 3: Subcutaneous tissues involved (full-thickness tissue loss); subcutaneous fat may be visible (no bone, tendon, or muscle exposed). May show undermining or tunneling. Healing may require months after pressure is relieved (*e.g.*, by debriding with wet-to-dry dressings, surgery, or proteolytic enzymes).



Stage 3

32. Stage 4: Extensive damage to underlying structures; full thickness tissue loss, with exposed bones, tendons, or muscles. (Wound possibly appearing small on surface, but with extensive tunneling underneath.) Slough or eschar may be present. Usually foul-smelling discharge. Healing may require months or years, and may requires skin "flap" surgery).



Stage 4

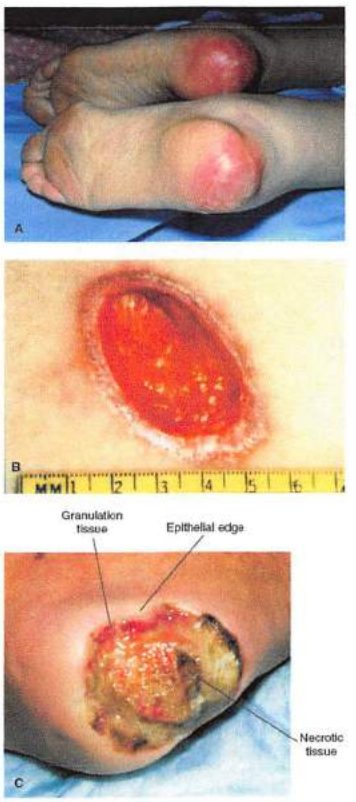


FIGURE 58-3 Stages of pressure wounds (see also Box 58-1). Stage I (reversible) includes pressure-related changes in intact skin, when compared with adjacent skin (not shown).

33. Nonstageable: A pressure wound may be unstageable when the base of a full-thickness wound is covered by slough and/or eschar.

34. "Tunneling" refers to one or more channels within or underlying an open wound.

35. Pressure wounds may occur within 12 to 24 hours in a compromised patient. The wound begins deep in the tissue and may not be observed on the skin surface for several days. Signs of an evolving pressure wound are nonblanching erythema (redness that does not lighten when pressed), pain, and induration (swelling).

36. The following factors put a patient at risk of skin breakdown and pressure wounds. This is not an exhaustive list.

a. Immobility, low level of activity (lying/sitting in one position for extended periods of time, paralysis)

b. Inadequate nutrition

c. Incontinence of urine or feces; possibly other external moisture

d. Impaired mental status, alertness, or cooperation; heavy sedation and/or anesthesia; mental illness, intellectual impairment

e. Fever; low blood pressure (particularly diastolic <60 mm)

f. Advancing age, friable skin

g. Diabetes

37. Patients with a past history of skin breakdown are particularly vulnerable.

38. Skin breakdown is a particular problem in an obese patient.

39. The most significant complication of a pressure wound is infection.

40. Infection in pressure wounds is a common and potentially life-threatening complication.

41. Osteomyelitis — infection in the bone — can occur.

42. Infection may lead to sepsis.

43. Pressure injuries are a known cause of sepsis and death.

44. Because of the difficulty of treatment of pressure wounds, it is critical to prevent pressure wounds from arising in the first place.

45. Proper nutrition is essential to successful treatment of a pressure wound, to the generation of new tissue, and to lowering of the risk for complications, particularly infection.

46. Pressure wounds are preventable with simple measures available in any modern medical facility; and yet these wounds still occur with disturbing frequency.

47. For these reasons, the medical community has for many years made it a priority to prevent pressure wounds.

48. Written guidelines and protocols for pressure wound prevention and treatment are used in most institutions.

Responsibilities of nurses in preventing & treating pressure wounds

Part of basic nursing

49. Nurses have been identified as the patient's first line of defense in the prevention of pressure wounds. Because they are involved in total care of the patient, nurses have assumed the responsibility for care of the patient's skin. As a result, nurses have become the primary care givers for the prevention and treatment of pressure wounds.

50. Nurses in any area of a hospital know, or should know, how to prevent pressure wounds, and are responsible for doing so.

Examine and assess risk

51. Because there are known predisposing factors to pressure wounds, the first requirement is to identify the patient at risk and to take preventive measures.

52. Nurses are responsible for identifying the patients at greatest risk.

53. The patient must be assessed as to their general health, their nutritional status, mental responsiveness, mobility, bowel and bladder function, as well as the specifics of treatment programs in certain circumstances, e.g., fracture management and spinal injuries.

54. Several methods are used to predict the risk of pressure wound development. Two of these are the Braden Scale and the Norton Scale.

55. The condition of urinary incontinence, or similar conditions, is included in the major risk assessment tools for predicting risk of pressure wound development.

56. The Norton scale (see below) considers physical condition, mental state, activity, mobility, and incontinence.

Table 1. The Norton scale (adapted from [6])

		Physical condition	Mental condition	Activity	Mobility	Incontinent	Total score
		Good 4 Fair 3 Poor 2 Very bad 1	Alert 4 Apathetic 3 Confused 2 Stupor 1	Ambulant 4 Walk/help 3 Chairbound 2 Stupor 1	Full 4 Slightly limited 3 Very limited 2 Immobile 1	Not 4 Occasional 3 Usually/Urine 2 Doubly 1	
Name	Date						

57. The Braden scale identifies three determinants of pressure: sensory perception, activity, and mobility; and three factors influencing tolerance of the skin to pressure, namely, moisture, nutrition, and friction and shear.

BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK

Patient's Name_____ Evaluator's Name_____ Date of Assessment

SENSORY PERCEPTION Ability to respond meaningfully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation. OR limited ability to feel pain over most of body.	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over ½ of body.	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR has some sensory impairment which limits ability to feel pain or discomfort in one or two extremities.	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.				
MOISTURE Degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift.	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals.				
ACTIVITY Degree of physical activity	**1. Bedfast** Confined to bed.	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every 2 hours during waking hours.				
MOBILITY Ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance.	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. Slightly Limited** Makes frequent though slight changes in body or extremity position independently.	**4. No Limitation** Makes major and frequent changes in position without changes.				
NUTRITION Usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than ⅓ of any food offered. Eats two servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and/or maintained on clear liquids or IV's for more than 5 days.	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only three servings of meat or dairy products per day. Occasionally will take a dietary supplement OR receives less than optimum amount of liquid diet or tube feeding.	**3. Adequate** Eats over half of most meals. Eats a total of four servings of protein (meat, dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs.	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of four or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.				
FRICTION & SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures, or agitation leads to almost constant friction.	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair.					
				Total Score				

FIGURE 58-5 Braden Assessment Scale for Predicting Pressure Ulcer (Wound) Risk. Total possible points = 23. *The lower the score, the greater the risk.* The client is identified as at risk for pressure wound development if the score is less than 18. (Some facilities use scores from 15 to 18 as the risk prediction score.) A modified scale (Braden Q) is available for use with pediatric clients. The Braden Q also considers tissue perfusion and oxygenation; the risk

58. In addition to determining risk, assessment scales indicate the probability of healing of existing pressure wounds.

59. Risk assessment scales also serve as reminders of the factors that place patients at risk, permit easy communication among health care personnel of the patient's risk, and ensure systematic evaluation of risk factors.

60. Skin assessment should be performed routinely and systematically. It should be done daily, usually at the time of the patient's bath.

Prevent harm from incontinence and immobility

Generally

61. It is an important nursing responsibility to prevent skin breakdown and, if it occurs, to report it immediately and treat it as ordered.

62. Frequent and effective skin care is essential to keep the skin intact and remove dirt, excess oil, and harmful bacteria.

63. Everyone's face, underarms, skin folds, and perineal area need daily cleansing.

64. Body fluids, such as perspiration, vomitus, urine, and feces, are generally acidic and are very irritating to the skin. They must be removed immediately.

65. Many older people, people confined to bed, and people who are ill have very fragile (friable) skin. These clients need special skin care, to prevent skin breakdown.

66. A number of protective devices, special products, and procedures are available to protect the skin.

67. It is the nurse's responsibility to inspect the skin during baths and other routine daily care. If any reddened or irritated areas are noted, they must be reported immediately. If these areas are treated quickly, actual skin breakdown can often be avoided.

68. Perineal care, bathing the genitalia and surrounding area, is given to all clients. Some patients may be embarrassed, but regular perineal care is part of total patient care, even if a patient is of the opposite sex.

69. A group of procedures, called the Skin Bundle, are implemented to prevent skin breakdown in clients at risk.

70. Alleviation of pressure is essential.

71. Nurses should encourage all clients to move themselves as much as possible.

72. For a patient at risk for pressure wound development, the nurse should turn and reposition the client every 2 hours, elevate bony prominences with pillows, and limit the amount of linens under the client.

Incontinence

73. Urinary incontinence affects millions of Americans.

74. Fecal incontinence affects many of the hospitalized elderly.

75. The patient who is incontinent of urine or stool must have meticulous skin care, to prevent skin breakdown.

76. Several means are available to help prevent IAD and new products are constantly being developed. Using an incontinence cleanser (e.g., Remedy Spray Cleanser, which does not dry skin) and a moisture barrier paste (e.g., Calazime, which protects skin) before damage occurs can be helpful. Special barrier cream wipes are available, for the patient with chronic incontinence.

77. Prevention of incontinence related to restricted mobility involves, for example, providing urinals or bedpans within easy reach, use of a bedside commode, or scheduled toileting programs may resolve the incontinence.

78. The most successful behavioral management strategies for the frail cognitively impaired patient typically at risk of pressure wounds include prompted voiding and scheduled toileting programs. Both strategies are caregiver-dependent and require a motivated care giver to be successful. Scheduled intake of fluid is an important underlying factor for both strategies.

79. Underpads and briefs may be used to protect the skin of patients who are incontinent of urine or stool. These products are designed to absorb moisture, wick the wetness away from the skin, and maintain a quickdrying interface with the skin.

80. Incontinence containment strategies imply the need for a check and change schedule for the incontinent patient so wet linens and pads may be removed in a timely manner.

Notify physician immediately if a wound starts to develop

81. Nurses should act to prevent pressure wounds on their own initiative, without direct orders to do so by a physician.

82. However, when a nurse sees evidence of a pressure wound, the nurse must notify the physician chiefly responsible for the patient.

83. It is an important nursing responsibility to report skin breakdown immediately and treat it as ordered.

84. Nurses should report any signs of pressure or reddened/darkened areas that do not return to normal hue (color) after pressure is removed.

Responsibilities of hospital or facility administration

85. The administration of a hospital interacts with the medical and nursing staff.

86. The administration creates policies, procedures, and protocols for the medical and nursing staff to follow.

87. The administration provides medical record systems for the medical and nursing staff to use.

88. The administration provides communication systems for the medical and nursing staff to use.

89. Through their actions concerning these systems and policies, the hospital administration affects the safety of patients, for better or worse.

90. Hospital administration is responsible for implementing procedures to reduce or eliminate known, serious risks to patient safety.

91. Hospital administration is responsible for implementing procedures to reduce or eliminate, among other things, the risk of a stage 3 or 4 pressure wound from developing in the hospital.

92. Many errors are the result of miscommunication or lack of communication among healthcare providers and staff. Health team members must develop critical thinking skills and communicate their concerns to the appropriate people when

patient safety is at stake. The message must be clear so that appropriate action can be taken for the patient. Miscommunications must be investigated and systemic changes must be implemented to promote effective communication.

Financial incentives and patient dumping

93. If a patient's skin breaks down after admission to a medical facility, the facility is considered to be responsible.

94. In most cases, third-party payors, including CMS, will not reimburse the facility for costs incurred related to skin breakdown that was not present when the patient was admitted.

95. Stage 3 or 4 pressure wounds require costly care.

96. Patients who develop pressure wounds not only require more nursing care, they also need special, and invariably more costly, mattresses and or bed systems.

97. Patients with a longer duration of stay are less attractive for a hospital because shorter stays pay proportionately more than longer stays. Patients with pressure wounds usually stay in hospital much longer, stays over 35 days are no exception.

98. Faced with a patient who requires costly care — and for which the hospital receives no money, because the hospital is responsible for the harm and its necessary treatment — the hospital has a financial incentive to dump the patient onto some other facility (a nursing home, for example).

99. "Patient dumping" is a well-recognized problem in the United States.

Before Dorothy Anthony's October 2018 Admission

100. Dorothy Anthony was 58 years old in October 2018. She suffers from Down Syndrome and has been cared for by family members. As of October 2018, Dorothy had also been diagnosed with dementia.

- DH1 – 31

101. On January 24, 2018, a family member took Dorothy to the DHA ER because of flu symptoms that had lasted for three days. PA Omar Queensbourrow

discharged Dorothy home later that day, with prescriptions for Influenza A and bronchopneumonia.

- DH3b – 577-83

102. About three weeks later, on February 16, 2018, a family member took Dorothy to the Outpatient Wound Center, because of wounds on both of Dorothy's heels and on her lower back. NP Laura Cox and Dr. Shawn Fagan noted a stage I wound to both heels, and a "pressure wound to the sacrum, stage II" due to extended immobility for pneumonia and flu.

- DH3b – 575

DATE OF ADMISSION: 02/16/2018

This is on behalf of Dr. Fagan.

CHIEF COMPLAINT:
Pressure wounds to the bilateral heels and the back.

HISTORY OF PRESENT ILLNESS:
This is a 57-year-old African American female with a history of Down syndrome, who had flu pneumonia 3 weeks ago, which decreased her mobility for 2 weeks. The patient was noted to have wounds to her bilateral heels and was seen by her PCP, who started her on an antibiotic. She was also seen by podiatrist 4 days ago, who debrided the bilateral heels. She states that the wound to the back began as an open wound with bleeding present. She has been utilizing an ointment, but is recently switched to hydrogen peroxide and now a dry scab is present. The patient's family member states that the patient has returned to all activities at this time. Has not had recent fever, chills, nausea, vomiting, or diarrhea.

INTEGUMENT: Focused exam is located to the sacral area with a dry scab present. There is pale periwound area. There is no active bleeding. No purulence. No active signs of infection. Focused exam is located to the bilateral heels with hyperpigmentation noted. Mild separation of epithelium. Area is blanchable with palpation.

ASSESSMENT:
1. Chronic wounds to bilateral heels, pressure stage I.
2. Pressure wound to the sacrum, stage II.

PLAN:
1. May wash all areas with soap and water daily and will apply Mepilex Ag Border. May be kept in place for 7 days. May remove prior to showering.
2. The patient will follow up in clinic in 1 week.
3. Caregiver is aware of signs and symptoms of infection. Will contact clinic with any acute concerns. This is 99202 x2 on behalf of Dr. Fagan.

Dictated By: Laura Cox, NP
For: Shawn Fagan, MD

103. A family member took Dorothy to the Wound Center eight times over the next 7-1/2 months, to follow up on Dorothy's heel and sacral wounds.

- DH3b – 572 (2/27/2018 visit)
- DH3b – 564 (3/13/2018 visit)

- DH3b – 560 (3/27/2018 visit)
- DH3b – 556 (4/26/2018 visit)
- DH3b – 552 (5/17/2018 visit)
- DH3b – 547 (6/19/2018 visit)
- DH3b – 542 (8/7/2018 visit)
- DH3b – 540 (10/4/2018 visit)

104. On the fifth follow-up visit, on May 17, 2018, NP Elizabeth Riordan and Dr. Fagan noted that the wound on Dorothy's right heel wound was still present, but that the wounds on her left heel and on her sacral area had healed. The right-heel wound measured 2 x 1.5 x 0.2 cm.

- DH3b – 552

INTEGUMENT: Focused examination to the back reveals a pink, soft, re-epithelized area with no open areas. No thickening, fibrosis, or banding.

Focused examination to the right heel also reveals an area that is pink and completely re-epithelialized at this time with no surrounding erythema. No edema. No signs or symptoms of infection.

Focused examination to the right heel has one open area that measures 2 x 1.5 x 0.2. The wound bed itself is a thick, adhered, and yellow slough. No granulating tissue noted within the wound bed, however, no surrounding erythema. No edema. No induration or fluctuance. No signs or symptoms of infection.

ASSESSMENT:
Resolved pressure wounds to the lower back and left heel with an unstageable wound to the right heel.

105. On June 19, 2018, Dorothy's older sister took Dorothy for a follow-up visit at the Wound Center. PA Jeanine Linehan-Burack and Dr. Fagan again noted that Dorothy's sacral wound and left heel had resolved. The right heel wound now measured 1.3 x 0.5 cm.

- DH3b – 547

SUBJECTIVE:
Anthony is a 58-year-old learning disabled African American female with a history of wounds to the bilateral lower extremities and lower back. Most have healed with the exception of the right heel wound that has remained. She has been washing the area daily with soap and water, applying Santyl and Polysporin ointment. She is currently under the care of her older sister who does her daily dressing changes. She has returned to daycare. Sister states that she has been driving her just to prevent any wounds from occurring to her feet.

EXTREMITIES: Remainder of exam is focused to the right heel which shows a small open wound that measures 1.3 x 0.5 cm. It is filled with dry devitalized slough that is well adhered. There is no sign of extending erythema, fluctuance, or induration, infection, or cellulitis appreciated. The remaining wounds to the bilateral feet are well healed, soft, flat, pink, and nontender. They blanch easily. She has palpable pulses. Brisk capillary refill. No signs of clubbing or cyanosis.

DIAGNOSIS:
Chronic wound of the right heel.

106. On August 7, 2018, Dorothy's younger sister took Dorothy to the Wound Center to follow up on Dorothy's right-heel wound. At this point, that wound measured 1 x 0.5 cm.

- DH3b – 542

107. About two months later, on October 4, 2018, a family member took Dorothy back to the Wound Center. The wound on Dorothy's left heel had returned, and the right-heel wound had worsened. The right-heel wound now measured 2 x 1 x 0.1 cm. The left-heel wound measured 2 x 1 x 0.1 cm. Both were unstageable.

- DH3b – 540

INTEGUMENT: Focused examination first of the right heel, has a wound that measures 1 x 0.9 x 0.3.
Next, focused examination to the left heel has a wound that measures 2 x 1 x 0.1. The wounds are unstageable with pale, pink wound bed. Surrounded by dry flaky skin. There is no surrounding erythema, no edema. No signs or symptoms of infection.

ASSESSMENT:
Unstageable pressure wounds to the bilateral heels.

108. A stage 2 wound is superficial, but the healed stage 2 sacral wound demonstrates that despite suffering from diabetes and Down Syndrome, Dorothy was capable of healing a wound — if properly cared for.

The October 2018 Admission

ER Visit: October 15 — Monday

109. On October 15, 2018, Dorothy's sister took Dorothy to the Doctor's Hospital ER, for what turned out to be about an 8-1/2 month stay in the hospital.

110. The extended stay was made necessary largely because, while Dorothy waited for placement in a nursing home, a Stage IV pressure wound developed on Dorothy's sacral area, and Dorothy became septic.

111. On October 15, 2018, Dorothy's sister took Dorothy to the Doctor's Hospital ER because Dorothy was having trouble walking, was not talking, was acting confused, and was occasionally shaking — after having fallen and hit her head about three weeks earlier.

- DH1 – 9

Inpatient Admission: October 15

112. In the ER, testing revealed no acute cause of Dorothy's altered mental status.

- DH1 – 16

>)(**Re-Eval Status** Workup for the patient's altered mental status is currently unremarkable. Patient did speak a few words, stating she has to go to the bathroom, for the MD at this time. Does have chronic wounds of her calcaneal regions bilaterally, do not appear to be infected, wound center has seen her recently. Will consult with wounds during her hospitalization. Presented the case to the hospitalist, will admit for altered mental status. Does not appear to be easily treatable solution, possibly just worsening of her chronic dementia. Patient may require nursing home placement.

113. The ER physician, Dr. Kenneth Grotz, discussed the case with a hospitalist. They decided to admit Dorothy for observation, noting that Dorothy's dementia might be worsening. Dr. Grotz noted that Dorothy might need to be placed in a nursing home. The decision to admit Dorothy was made around 1456 hrs. (That's when Dr. Grotz signed his Emergency Provider Report.)

- DH1 16

114. Dr. Grotz noted the wounds on Dorothy's heals, and noted that the Wound Care service would be consulted during Dorothy's admission.

- DH1 – 11, 16

115. A couple hours later, at 1631 hours on October 15, Nurse Thriza Eje conducted an Admission Health History.

- DH2 – 78-82.

116. In the Admission Health History, Nurse Eje noted that Dorothy had suffered a recent decline in mobility or ambulation, that her legs were weak, and that she needed assistance both with ambulation and with hygiene. Nurse Eje also noted that Dorothy had recently lost weight due to a loss of apetite and was at risk of malnutrition.

- DH2 – 79-81

Activity Date: 10/15/18 Time: 1631 (continued)

220200 Admission Health History - (continued)
Developmental level 18 years+: Unable to live indepdnt
- - ADVANCE DIRECTIVES - -
Did patient express/disclose organ donation preference: No
Do you have an advance directive: No
Durable power of attorney for healthcare: No
- - VALUABLES/ASSISTIVE DEVICES - -
Disposition of valuables: Family to take
Disposition of home meds: Sent home with family
- - FUNCTIONAL/NUTRITIONAL SCREENING - -
Decrease in ADL function or upper limb mobility past 7 days: Present/Exists
Recent decline in mobility or ambulation in the past 7 days: Present/Exists
Falls within the past 3 months: Yes
Musculoskeletal chronic conditions: None
Recent weight loss without trying: Yes
How much weight have you lost: Unsure
Eating poorly due to decreased appetite Yes
Malnutrition screen tool score: 3 - Malnutrition risk
Home tube feeding or TPN: No

- - UPPER EXTREMITY - -
Upper extremities equal and strong bilaterally: No
Arm right motor strength: Weak
Hand right motor strength: Weak
- - LOWER EXTREMITY - -
Lower extremities equal and strong bilaterally: No
Leg left motor strength: Weak
Leg right motor strength: Weak
Foot left motor strength: Weak
Foot right motor strength: Weak
- - GAIT/BALANCE - -
Gait, strength, balance: Generalized weakness
Non-ambulatory
General weakness: Present/Exists
Dizziness: None
Headache: None

```
- - MUSCULOSKELETAL
Full range of motion appropriate for developmental age: No
- - GAIT - -
Developmentally age appropriate gait.: No
Gait impairment.: Bed bound
                  Unsteady
                  Weakness
- - AMBULATION - -
Developmentally appropriate independent ambulation: No
Ambulation: 2 person assist
- PARESTHESIA - -
Paresthesia: None
ACUTE CONDITION -
Musculoskeletal acute condition: None
```

117. The Admission Health History included an Integumentary (*i.e.*, skin) section. That section did not include a Braden scale or other formal screening for risk of pressure wounds.

- DH2 – 80-81

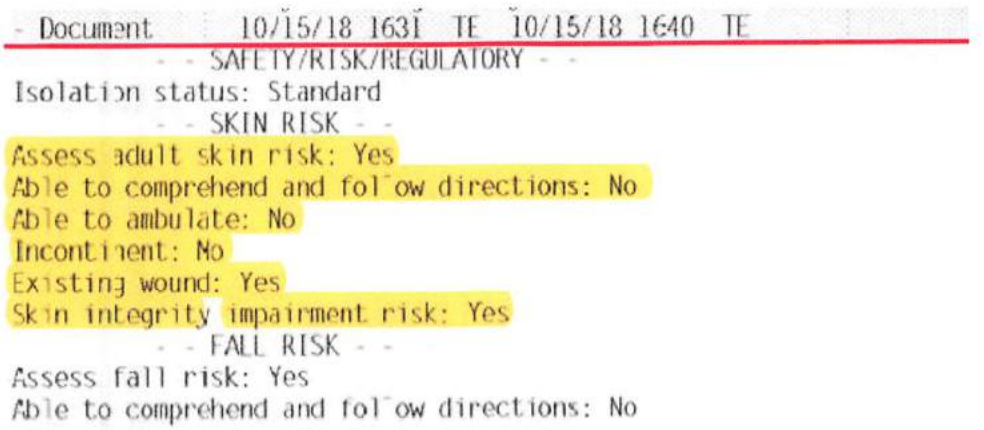
```
- - INTEGUMENTARY - -
Skin condition: Warm and dry
- SKIN COLOR - -
Color within expectations for ethnicity: Yes
Skin turgor testing less than 1 second: Yes
SKIN PIERCINGS
Skin piercings: None
SKIN ALTERATION
```

```
Activity Date: 10/15/18        Time: 1631  (continued)

220210        Admission/Shift Assessment + (continued)
Skin alteration/Procedure site: None
Document skin test monitor: No
- - VASCULAR - -
CAP REFILL DELAY - -
Capillary refill less than or equal to 3 seconds: Yes
- - PERIPHERAL PULSE - -
Pulses strong and equal bilaterally: Yes
CALF INSPECTION -
Calves symmetrical and pain is absent with dorsiflexion: Yes
- PERIPHERAL EDEMA
Peripheral edema: None
- - MECHANICAL PROPHYLAXIS - -
Nailbeds: Pink/No signs of clubbing
Clubbing: None
Mechanical prophylaxis in place: Int pneumat comp - knee
PSYCHOSOCIAL
Mood and affect are congruent: No
Thought processes are goal directed and spontaneous: No
```

118. At 1640 hours (apparently as part of the same Admission Health History "activity"), Nurse Eje filled out a risk-assessment form. This form did include a "skin risk" section. In that section, Nurse Eje noted that Dorothy was unable to ambulate, unable to comprehend and follow directions, and that Dorothy had an existing wound. Nurse Eje documented that Dorothy was at risk of impaired skin integrity.

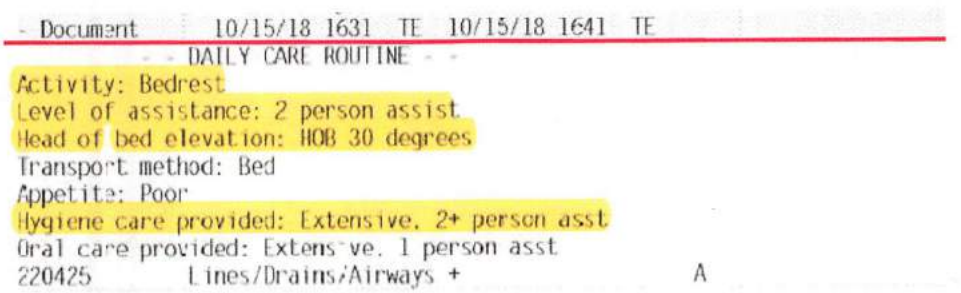
- DH2 – 81



```
- Document      10/15/18 1631 TE  10/15/18 1640 TE
          - - SAFETY/RISK/REGULATORY - -
Isolation status: Standard
          - - SKIN RISK - -
Assess adult skin risk: Yes
Able to comprehend and follow directions: No
Able to ambulate: No
Incontinent: No
Existing wound: Yes
Skin integrity impairment risk: Yes
          - - FALL RISK - -
Assess fall risk: Yes
Able to comprehend and follow directions: No
```

119. At about the same time, at 1641 hours, Nurse Eje filled out a Daily Care Routine form, indicating that "bed rest" had been ordered for Dorothy.

- DH2 – 82



```
- Document      10/15/18 1631 TE  10/15/18 1641 TE
          - - DAILY CARE ROUTINE - -
Activity: Bedrest
Level of assistance: 2 person assist
Head of bed elevation: HOB 30 degrees
Transport method: Bed
Appetite: Poor
Hygiene care provided: Extensive, 2+ person asst
Oral care provided: Extensive, 1 person asst
220425        Lines/Drains/Airways +                A
```

120. This skin risk assessment created requirements for the hospital administration, the nursing staff, and the attending physicians.

121. The hospital administration was responsible for implementing measures that prompted, facilitated, and required appropriate preventive measures in light of the skin risk assessment.

122. Such measures could consist of a standard order set available to be entered manually or automatically in response to the skin risk assessment. Such measures could consist of policies requiring specific preventive measures for at-risk patients — combined with training and supervision to ensure the policies were implemented reliably. A range of specific measures would suffice, so long as the measures reliably prompted, facilitated, and required appropriate measures.

123. Dorothy's medical records indicate, however, that the hospital administration had not in fact implemented measures that prompted, facilitated, and required appropriate preventive measures in light of the skin risk assessment.

124. This skin risk assessment did not trigger orders to prompt or require actions to prevent a pressure wound from developing. For example, the skin risk assessment did not trigger an order for regular repositioning, to avoid prolonged pressure over bony prominences (like the sacrum, or an order for regular skin checks to assess whether a pressure wound was developing, or an order to assist Dorothy in ambulating and building strength, to avoid lying in the same position for lengthy periods.

125. Nurse Eje and any other nurse who learned of the October 15 skin risk assessment was responsible: (1) for initiating preventive measures that nurses could undertake on their own initiative (e.g., frequent repositioning), and (2) for ensuring that Dorothy's attending physician was aware of the facts relevant to the skin risk, and requesting appropriate orders.

126. Dorothy's medical records indicate, however, that neither Nurse Eje nor any other nurse on October 15 took any such steps.

127. Each of Dorothy's attending physicians was responsible for familiarizing himself or herself with Dorothy's condition — including the factors that put Dorothy at risk for another pressure wound. Each of Dorothy's attending physicians was similarly responsible for entering orders for appropriate preventive measures.

128. The hospitalist who agreed to admit Dorothy was Dr. Ekmine Wijesinghe. Dr. Wijesinghe wrote a Hospitalist History & Physical at approximately 1720 hours on October 15.

- DH1 – 24-30

129. Dorothy had a variety of abnormal lab results, and Dr. Wijesinghe diagnosed Dorothy with metabolic encephalopathy — a potentially reversible brain disorder caused by systemic illnesses such as diabetes, liver disease, kidney failure, or heart failure.

- DH1 – 24-30

130. Dr. Wijesinghe planned to address potential causes of the metabolic encephalopathy, and also to obtain a physical therapy and/or occupational therapy evaluation.

- DH1 – 29

Diagnosis, Assessment & Plan
Free Text A&P:
Metabolic encephalopathy|
-? etiology, normal labs
- EEG
- MRI brain if possible
- check ammonia
- check TSH,T4
- depression?
- hold gabapentin and seroquel for now
- PT/OT eval
- neuro consult

131. Even without notification by a nurse, Dorothy's attending physicians could easily learn of the key factors that put Dorothy at risk of another pressure wound — namely, (a) current wounds on her heels and a prior wound on her sacral area, (b) weakness and immobility, (c) dementia with loss of comprehension, and (d) a daily care plan for bedrest.

132. Based on these factors, Dorothy's attending physicians were responsible for entering orders for measures to prevent another pressure wound from developing on Dorothy.

133. Dorothy's medical records indicate, however, that Dr. Wijesinghe entered no such orders on October 15.

October 16, 2018 — Tuesday

134. Tuesday, October 16, was Dorothy's first full day at the hospital.

135. At about 1333 hours that day, the Wound Care service evaluated Dorothy. NP Jennifer Hardy Casella examined Dorothy and noted the heel wounds. NP Casella noted that Dorothy had no wound over her sacrum: "Sacrum with no breakdown noted."

- DH1 – 36-38

General appearance: altered mental status, obese, alert, awake, no acute distress, no respiratory distress
Head/Eyes: atraumatic, normocephalic
Cardiovascular: normal capillary refill
Respiratory: no distress
Extremities: LUE with slight contracture at elbow. Weakness overall.
Neuro/CNS: altered mental status, alert (awake, non-verbal)
Skin: Sacrum with no breakdown noted. L heel with old blistered tissue removed to reveal predominately intact hyperemic scar with small portion non-healed with pink, moist area. R heel after removal of blistered/calloused skin with pink, moist wound bed. No s/s infection to any site.

136. NP Casella's assessment and plan included measures to address Dorothy's heel wounds. NP Casella also included a reference to "pressure reduction measures" including repositioning every two hours. The note did not specifically say whether that recommendation applied to Dorothy's whole body or only to her heels.

- DH1 – 38

Mepilex Ag intact bilateral heels x7 days
Pressure reduction measures–alt pressure mattress, reposition q2, prevalon boots
Nutrition optimization, check PAB
Medical management per hospitalist
Will continue to follow on Tuesdays/Fridays

137. Later that day, however, Nurse Samantha James noted the wounds on Dorothy's heels and stated that pillows were being used as positioning aids — though the note does not specify whether the repositioning was limited to Dorothy's heels or applied to her whole body.

- DH2 – 92

```
          - - TRACTION
Traction: None
          POSITIONING AIDS
Positioning aids: Present/Exists
Positioning aids: Pillows
Contractures: None
          - - INTEGUMENTARY - -
Skin condition: Warm and dry
          SKIN COLOR
Color within expectations for ethnicity: Yes
Skin turgor tenting less than 1 second: Yes
          SKIN PIERCINGS
Skin piercings: None
          SKIN ALTERATION
Skin alteration/Procedure site: Present/Exists
Skin alteration:    - - Press injur immobility related Heels bilateral - -
                    Instance list status: Active
                    Pressure injury present on admission: Yes
                    Related clinical factors: Diabetes related, Friction related
                    Tissue type worst: Dressing intact/device
```

138. Later that night, at 2215 hours, Nurse James noted that she found Dorothy soaked in urine.

- DH2 – 94

139. Dorothy's incontinence increased the risk of skin breakdown and a pressure wound.

140. When the nursing staff became aware of Dorothy's incontinence, they should have notified the attending physician(s) and implemented measures to prevent pressure wounds. These measures should have included (a) some form of effective incontinence care (perhaps only a bedpan and a toileting schedule), (b) repositioning every two hours, and (c) skin and continence/hygiene checks every two to four hours.

141. In the same note in which Nurse James recorded Dorothy's incontinence, Nurse James also noted that she spoke to Dr. Graham and that new orders were placed (apparently for Gabapentin, a medication). Nurse James did not record a discussion with Dr. Graham about Dorothy's incontinence, the increased risk of skin breakdown, or the need for action to prevent another pressure wound.

- DH2 – 94

Patient Notes: NURSE NOTES
Create 10/16/18 2215 SOJ 10/17/18 0216 SOJ

scheduled pm meds adm as ordered. sister (primary caregiver) at bedside and expressing concern about pt not receiving po gabapentin for sleep. spoke with Dr. Grahan and new orders placed and then administered to patient. pt then cleaned of large amount of urine and pericare provided. complete bed bath done along with linen changed.

142. The medical records indicate that at no point on October 16 did the attending physicians order — nor did the nursing staff independently implement — regular repositioning, effective incontinence care, or regular skin/continence checks.

October 17, 2018 — Wednesday

143. Wednesday, October 17, was Dorothy's second full day at the hospital.

144. Late that morning, Courtney Spencer, an occupational therapist, went to Dorothy's room for a therapy session.

- DH2 – 95

145. Occupational therapists and occupational therapy assistants help people participate in the things they want and need to do through the therapeutic use of everyday activities (occupations). Common occupational therapy interventions include helping people recovering from injury to regain skills, and providing support for older adults experiencing physical and cognitive changes.

146. Dorothy has Down Syndrome and dementia, and Ms. Spencer found that Dorothy had difficulties performing simple actions. But Ms. Spencer found that the difficulties were more cognitive than physical, and with encouragement Dorothy could be induced to perform requested actions.

- DH2 – 95

Patient Notes: OCCUPATIONAL THERAPY NOTES
- Create 10/17/18 1023 CS* 10/17/18 1153 CS*

Pt agreeable to skilled OT session this morning with encouragement. Pt seen from 1023-1103. pt denies pain at time of session. Pt required max assist to initiate supine<>sit EOB. Upon attempting to lift shoulders from the bed, pt maximally resisting therapist. Pt assisted back to supine and tolerated grooming tasks with setup with HOB elevated. Pt tolerated second attempt to EOB with min-mod assist x2. Pt with impaired initiation and processing but demonstrating good strength to complete the task. Pt tolerated sitting EOB with CGA to SBA with fair+ balance. Pt completed sit<>stand from EOB with min assist x2. pt requires increased time to prepare and initiate movements. Pt tolerated stand pivot transfer with bilateral HHA to bedside commode with increased time and cues for sequencing, safety and initiation. Pt tolerated toileting and requiring dependent assist for hygiene, per pt's sister at bedside yesterday. pt is baseline dependent for toileting hygiene. Pt required increased time and cues to return to supine in bed and max assist to return to supine once seated EOB. Pt repositioned and left with needs met and lines intact supine in bed. Will continue OT POC and recommend subacute placement upon discharge to maximize strength and encurance.

Courtney Spencer, OTR/L

147. That night, at 2010 hours, Nurse Samantha James again noted that Dorothy had pillows as a positioning aid. This note, however, added that Dorothy was also in a specialty bed.

- DH2 – 101

148. Later that night — apparently sometime between 2141 hours and 0143 hours — Nurse James again found Dorothy soaked in urine. Nurse James wrote that the "entire bed" was "saturated" with urine.

- DH2 – 103

Patient Notes: NURSE NOTES
- Create 10/17/18 2141 SOJ 10/18/18 0143 SOJ

scheduled pm meds adm as ordered. pt swallowed with no difficulties. pt checked for incontinence. cleaned of large amount of urine and pericare provided. complete bed bath done along with linen change due to entire bed being saturated with urine. pt is unable to assist with turning in the bed.

149. This was the second night in a row that Dorothy had been found with a large amount of urine in the bed. This second discovery indicated that Dorothy had a serious incontinence problem that was not going to fix itself. Further, that Dorothy was twice found with a large amount of urine in her bed indicated that Dorothy had been left for long stretches without attention to her toileting needs. Typically, a single instance of incontinence would not produce enough urine to saturate a bed.

150. In this same note by Nurse James, she wrote that Dorothy was unable to assist with turning in the bed.

- DH2 – 103

151. By this time — the night of October 17 — the nursing staff and the attending physicians knew or should have known that Dorothy was at high risk of another pressure wound.

152. The nursing staff and attending physicians knew or should have known that Dorothy needed support and encouragement to become as ambulatory and mobile as possible, to avoid prolonged pressure over bony prominences (like the sacrum).

153. The nursing staff and attending physicians knew or should have known that if Dorothy were to remain in bed for long periods, the nursing staff was required to reposition Dorothy every two hours.

154. The nursing staff and attending physicians knew or should have known that Dorothy needed effective continence and hygiene assistance.

155. The impairment of Dorothy's mobility or ability to assist treatment providers would make it more difficult to take care of Dorothy.

156. The hospital should have been capable of providing Dorothy the care she needed. According to their website, Doctors Hospital of Augusta is a full-service hospital, including an inpatient rehabilitation service treating, among others, stroke patients with brain injuries and cognitive impairments.

157. However, if the hospital was not capable of providing Dorothy the care she needed, then in that case the nursing staff, the attending physicians, and the hospital administration had a duty to inform Dorothy's caretakers (her family) of their inability to care for Dorothy properly.

158. In that case, Dorothy's family would have an opportunity to seek alternative care. And the hospital would also have had a duty to work diligently and urgently to facilitate that.

159. At this point — October 17 — various providers had discussed with Dorothy's family the idea of transferring Dorothy to a skilled nursing facility. However, the

medical records do not indicate that anyone told Dorothy's family that the hospital was incapable of caring for Dorothy properly.

October 18, 2018 — Thursday

160. The next morning, October 18, at approximately 0940 hours, Nurse Regina Scott applied an external urinary catheter to Dorothy. Nurse Scott noted that the reason for the catheter was prolonged immobilization. As indicated by a later nurse note, the external catheter was apparently a PureWick device.

- DH2 – 107
- DH2 – 113

161. As compared to internal catheters, external catheters pose less risk of causing infections, but greater risk of leaking.

162. That same morning, Dr. Jonathan Preston wrote a Discharge Summary noting that Dorothy was stable and was being discharged to a skilled nursing facility (SNF), but noted that the discharge was pending placement. The Discharge Summary identified Dr. Preston as Dorothy's attending physician.

- DH1 – 1

163. On the morning of December 18 at 1045 hours, Caroline Pitts, MST, entered a note that read "Number of times incontinent urine: 1. Diapers count: 1."

- DH2 – 108

164. Later that day at around 1454 hours, April Conway, an occupational therapist, came to Dorothy's room for a therapy session. Ms. Conway noted that Dorothy remained generally uncommunicative. Ms. Conway indicated that some family member was there, and that Ms. Conway educated the family member on positioning and pressure sore prevention.

- DH2 – 108

Patient Notes: OCCUPATIONAL THERAPY NOTES
- Create 10/18/18 1454 AC 10/18/18 1529 AC

Pt. seen for skilled OT services from 2:26-2:54 pm to address ROM and bed mobility for functional tasks.

S: Pt. did not communicate much throughout session today. Family reports this has been ongoing for the past 3 weeks. Pt. was hesitant to complete therapy today despite OT encouragement.

O: OT facilitated:

AAROM BUE x5 each after much encouragement:
-shoulder flexion/extension
-horizontal ADD/ABD
-elbow flexion/extension

OT attempted to complete bed mobility task. OT initiated log rolling to R side, but pt. continued to refuse and resisted OT.

OT educated family on positioning and pressure sore prevention. Family verbalized understanding.

OT noted no change in B heels, dressing in place.

A&P: Continue OT POC to address bed mobility, positioning, and ADLs.

D/C recommendation: post acute rehab pending progress

October 19, 2018 — Friday

165. On October 19, Trista Caddell, a physical therapist, went to Dorothy's room for a therapy session. Ms. Caddell noted that Dorothy's limitations seemd to be more due to her dementia. However, Ms. Caddell wrote that during the session, Dorothy said she needed to go to the bathroom. With assistance, Dorothy walked to the bathroom and used the toilet. Dorothy then needed assistance with post-toileting hygiene.

- DH2 – 117

Patient Notes: PHYSICAL THERAPY NOTES
Create 10/19/18 1249 TWC 10/19/18 1259 TWC

TX TIME: 10:27-11:17. 2 UNIT TSF. 1 UNIT GAIT TR. PT WAS FOUND IN BED ASLEEP BUT AWAKENED EASILY. SHE PERFORMED AAROM TO AROM EXERCISES FOR EXTREMETIES REQ MOD CUES. PT AT FIRST RESISTED THERAPIST ASSIST FOR SUP<>SIT BUT THEN SHE PERFORMED WITH MIN A X 1. PT STOOD AND PIVOTED TO BS CHAIR REQ MAX A X 1 WITH PT SITTING PREMATURELY. SHE THEN STATED SHE NEEDED TC USE THE BATHROOM. PT STOOD AND TOOK 3-4 STEPS WITH MOD A X 2 TO BST. SHE TOILETED THEN STOOD HOLDING BEDRAIL TO BE CLEANED. PT AMB 4 STEPS MORE WITH HHA X 2 AND REQ THE CHAIR BE BROUGHT UP TO HER. SHE WAS MAX A X 2 TO RETURN TO BED SECONDARY TO PT'S SHORT STATURE AND THE HEIGHT OF BEC. PT WAS POSITIONED IN BED FOR COMFORT AND LEFT WITH NEEDS IN REACH. SHE WAS MCSTLY NONVERBAL DURING TX UNTIL THE END WHEN SHE ASKED FOR HER COFFEE AND ALSO THAT IT BE HEATED UP FOR HER. PT'S LIMITATIONS SEEMED TO BE MORE DUE TO HER DEMENTIA AND DECREASED ABILITY TO FOLLOW COMMANDS. SHE WOULD BE COMPLETING AN ACTIVITY FAIRLY WELL AND THEN SHE WOULD STOP AND BECOME "STUCK" IN A POSITION. SHE WOULD BENEFIT FROM CONTINUED THERAPY AT DC. SHE IS AWAITING PLACEMENT IN SNF.

166. A little later that day, NP Jennifer Casella from the Wound Care service came to assess Dorothy. NP Casella noted Dorothy's heel wounds but did not identify any sacral wound.

- DH1 – 1160-62

167. On October 19, Dorothy's attending physicians still did not order — and the nursing staff still did not provide — regular repositioning or other movement to prevent pressure wounds. The systems put in place by hospital administration did not prompt, facilitate, and require them to do so.

October 20, 21, 22, 23 — Saturday, Sunday, Monday, Tuesday

168. On Wednesday, October 24, 2018, Nurse Amanda Walden would identify a stage 2 wound — a small wound with broken skin — on Dorothy's sacral area.

- DH2 – 157

169. We see no entries in the medical record for the four days before that wound was noted — October 20, 21, 22, and 23 — that shed light on the development of the wound.

170. However, on these days — October 20, 21, 22, and 23 — Dorothy's attending physicians still did not order — and the nursing staff still did not provide — regular repositioning or other movement to prevent pressure wounds. The systems put in place by hospital administration did not prompt, facilitate, and require them to do so.

October 24: Stage 2 Wound discovered

171. **On Wednesday, October 24**, while cleaning Dorothy after another episode of urine incontinence, Nurse Amanda Walden identified a stage 2 sacral wound on Dorothy.

- DH2 – 157

Patient Notes: NURSE NOTES
- Create 10/24/18 1754 AWC 10/24/18 1755 AWC

PT CLEANED OF URINE INCONTINENCE AT THIS TIME. NEW BRIEF APPLIED. STAGE 2 BETWEEN B/L BUTTOCKS- MEPILEX DSG APPLIED. PT REPOSITIONED IN BED. PT ASSISTED WITH HER DINNER TRAY. PT ATE APPROX 35% OF HER DINNER TRAY. CALL LIGHT AND NEEDS W/IN REACH. WILL CONTINUE TO MONITOR. SAFETY MAINTAINED.

172. Generally, a stage 2 wound can be treated and healed with only moderate difficulty.

173. But if not treated diligently, a stage 2 wound can worsen into a stage 3 or 4 wound that can be very difficult to treat and can cause serious harm — including infection, sepsis, and death.

174. When Nurse Walden identified a new stage 2 sacral wound on Dorothy, Nurse Walden should have immediately notified Dorothy's attending physician and requested orders for treatment.

175. The records indicate that Nurse Walden did not do so.

176. Particularly because Dorothy had both a sacral wound with broken skin and urine incontinence, the nursing staff should have initiated (and the attending physician should have ordered) two-hour incontinence checks.

177. But the records reveal no new measures, ordered or implemented, for regular repositioning of Dorothy or any additional incontinence checks.

October 25-30: Wound worsens

178. **On Thursday, October 25**, Nurse Samantha James identifies a wound on Dorothy's sacrum, and identified it as moisture-related.

- DH2 – 169

SKIN ALTERATION
Skin alteration/Procedure site: Present/Exists
Skin alteration: Press injur immobility related Generalized Buttock bilateral
Instance 1st status: Active
Pressure injury present on admission: No
Related clinical factors: Incontinent bowel/bladder, Moisture related
Tissue type-worst: Dressing intact/device
Document advanced wound measurements: No
cm2 area: Cannot Calculate Area Yet
Worst tissue type score: 0
Intact value score: 0

179. A short time later, Nurse James noted that Dorothy had another episode of incontinence with a large amount of urine.

- DH2 – 171

180. The records do not indicate that Nurse James notified Dorothy's attending physician of Dorothy's sacral wound and requested orders for treatment.

181. Nor do the records indicate that Nurse James initiated regular repositioning of Dorothy or any additional continence and hygiene measures.

182. **On Friday, October 26**, NP Casella from the Wound Care service checked on Dorothy. NP Casella again noted the pressure wounds on Dorothy's heels, but did not even mention the wound on Dorothy's sacrum.

- DH1 – 1154-56

183. This indicates a failure of the hospital's systems for communication between the nursing and Wound Care staffs (as well as between the nursing and medical staffs).

184. On the nursing-staff side, this failure involved both Nurse Walden as well as Nurse James. The lack of communication did not reflect merely an individual failing of a particular provider.

185. That same day, Friday, October 26, physical therapist Trista Caddell came to Dorothy's room to work with Dorothy. Ms. Caddell noted that she found Dorothy soaked with urine, with three pads beneath Dorothy saturated. Ms Caddell noted the open wound on Dorothy's sacrum.

- DH2 – 177

186. Ms. Caddell spoke to Dorothy's nurse and said that Dorothy needed a strict turning schedule, frequent checks for incontinence issues, and to be assisted with a bedpan on a schedule.

- DH2 – 177

Activity Date: 10/26/18 Time: 1552 (continued)

Patient Notes: PHYSICAL THERAPY NOTES (continued)
UNSUPPORTED ON EOB. PT WAS MAX A TO STAND TO RW BUT STARTED LEANING MORE THERAPIST VS STANDING UP. PT WAS DEPENDENT FOR RETURN TO SUPINE. PT WAS FOUND TO BE WET WITH DEPENDS AND 3 UNDERPADS SATURATED WITH URINE. PT'S FOAM DRESSING WAS REMOVED AS IT WAS SOILED. PT WAS NOTED TO HAVE AN A OPEN AREA ON R BUTTOCK AND ALSO ON R INSIDE GLUTEAL FOLD. SN CAME IN TO OBSERVE AREAS. PT WAS CLEANSED, CHANGED, AND POSITIONED ON HER R SIDE. PT NEEDS STRICT TURNING SCHEDULE AND FREQUENT CHECKS FOR INCONTINENCE ISSUES. SHE WOULD BENEFIT FROM A U&B PROGRAM AS PT HAS TOILETED WITH THERAPY BEFORE BUT SHE NEEDS TO BE ASSISTED WITH BED PAN ON A SCHEDULE. THIS WAS DISCUSSED WITH PT'S NURSE.

187. The nurse Ms. Caddell spoke to was Houedan Agbatchi. Nurse Agbatchi noted the conversation and paged Dr. James Cato, Dorothy's attending physician at the time, and informed him of Dorothy's sacral wound. Dr. Cato issued no orders for any prevention or treatment measures.

- DH1 – 666 (re. Dr. Cato)
- DH2 – 177

Activity Date: 10/26/18 Time: 1553

Patient Notes: NURSE NOTES
Create 10/26/18 1553 IA 10/26/18 1554 IA

PT CALLED THIS NURSE REGARDING PT S INJURY INSIDE BUTTOCK CHEEK. SITES COVERED WITH MEPILEX. PT ENCOURAGED WIT.

Note Type	Description
No Type	None

Activity Date: 10/26/18 Time: 1925

Patient Notes: NURSE NOTES
Create 10/26/18 1925 IA 10/26/18 1925 IA

MD CATO PAGED REGARDING PT'S SKIN INTEGRITY DETERIORATION DUE TO INCONTINENCE. NO NEW ORDER AT THIS TIME.

188. In his Hospitalist Progress Note for October 26, 2018, Dr. Cato made no mention of Dorothy's sacral wound.

- DH1 – 666-68

189. At no time on Friday, October 26, were any new measures ordered or implemented for repositioning or for effective continence/hygiene assistance.

190. **On Saturday, October 27**, Nurse Abgatchi again noted the sacral wound on Dorothy.

- DH2 – 181

191. At no time that day were any new measures ordered or implemented for repositioning or for effective continence/hygiene assistance.

192. **On Sunday, October 28**, Nurse Abgatchi again noted the sacral wound on Dorothy.

- DH2 – 188

193. The same day, Nurse Amber Yoder also noted the sacral wound on Dorothy.

- DH2 - 192

194. At no time that day were any new measures ordered or implemented for repositioning or for effective continence/hygiene assistance.

195. **On Monday, October 29**, Nurse Abgatchi again noted the sacral wound on Dorothy.

- DH2 – 197

196. The same day, Nurse Yoder also noted the sacral wound on Dorothy.

- DH2 – 201

197. At no time that day were any new measures ordered or implemented for repositioning or for effective continence/hygiene assistance.

198. **On Tuesday, October 30**, NP Casella from the Wound Care service checked on Dorothy. Again NP Casella apparently did not know about, or independently discover, the sacral wound on Dorothy.

- DH1 – 1151-53

199. Later that day, at 1030 hours, Nurse Mirisha Coleman noted the sacral wound on Dorothy.

- DH2 – 205

200. At 1301 hours, Nurse Chelsey Haines noted that she had applied a Mepilex dressing to the wounds on Dorothy's heels, but omitted any mention of the sacral wound on Dorothy.

- DH2 – 208

201. Later, at 2033 hours, Nurse Coleman wrote that Dorothy was "approved for placement but waiting re-evaluation per government due to Down Syndrome....No safety issues noted."

- DH2 – 208

202. Nurse Coleman's two notes from 1030 hours and 2033 hours are inconsistent. A sacral wound is a safety issue. These two notes suggest that Nurse Coleman may have entered some notes by blindly copying and pasting prior notes.

203. Blind copying and pasting of medical records is a known problem in hospitals and can create safety risks for patients.

204. When medical personnel are responsible for documenting their own current assessment of the patient, it is improper and potentially dangerous to blindly copy and paste prior assessments that do not reflect the new, current assessment.

205. At no time on Tuesday, October 30, were any new measures ordered or implemented for repositioning or for effective continence/hygiene assistance.

October 31: Stage 3

206. **On Wednesday, October 31**, Nurse Nedjy Marius noted the wound on Dorothy's sacrum as a stage 2 wound. Nurse Marius changed the dressing.

- DH2 – 212

207. Later that day, Nurse Marius wrote "Will remind day shift to call physician to put a consult for wound in the buttock. Dressing was applied to prevent contact from fecal."

- DH2 – 213

Patient Notes: NURSE NOTES
- Create 10/31/18 0620 NM 10/3[illegible]/18 0809 NM

PT IS AWAKE AND STABLE. BRIEF CHANGED AND SCHEDULED MEDS ADMINSTERED. INSULIN WAS NOT GIVEN BECAUSE BP WAS WNL. PT HAS A WOUND ON HER SACRUM AREA. WIL REMIND
DAY SHIFT TO CALL PHYSICIAN TO PU[illegible] A CONSULT FOR WOUND IN THE BOTTOCK. DRESIND WAS APPLIED TO PREVENT CONTACT FROM FECAL. CALL LIGHT IN REACH AND PATIENT IS BACK RESTING WITH EYES CLOSED

208. A short time later, Nurse Thriza Eje described the sacral wound on Dorothy as a stage 3 and as "red/moist/bumpy/granulation."

- DH2 – 214-15

- - SKIN ALTERATION - -
Skin alteration/Procedure site: Present/Exists
Skin alteration: - - Press injur immobility related Generalized Buttock bilateral - -
Instance list status: Active
Pressure injury present on admission: No
Related clinical factors: Incontinent bowel/bladder, Moisture related
Tissue type-worst: Red/moist/bumpy/granulatn
Wound base visible: Yes
Intact skin Yes

Activity Date: 10/31/18 Time: 1[illegible]13 (continued)

220210 Admission/Sh[illegible]ft Assessment + (continued)
Intact sk[illegible]n blanchable Yes
Any open areas: Yes
Altered level/stage: Stage 3 - Pressure Injury
Date of last dressing change: 10/31/18
Time of last dressing change: 0025
Document advanced wound measurements: No
cm2 area: Cannot Calcu[illegible]ate Area Yet
Worst tissue type score: 3
Intact va[illegible]ue score: 0.5

209. Nurse Eje's note marks a serious worsening of the wound. A stage 3 pressure wound is a serious wound that is difficult to treat and creates a serious risk of infection and further deterioration.

210. The physician should have been notified immediately, and the wound-care service should have been consulted immediately.

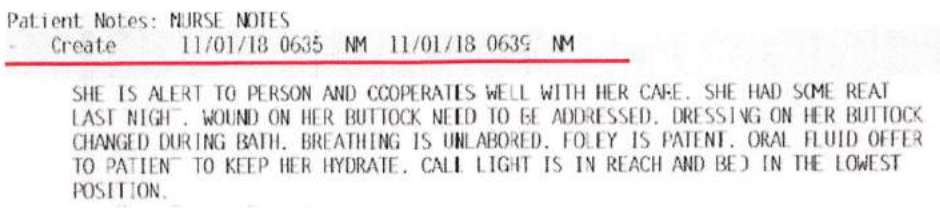
211. That did not happen.

212. At no time on Wednesday, October 31, were any new measures ordered or implemented for repositioning or for effective continence/hygiene assistance.

November 1-5: Wound worsens

213. **On Thursday, November 1**, again Nurse Marius recorded a note saying "Wound on her buttock need to be addressed. Dressing on her buttock changed during bath."

- DH2 – 221



Patient Notes: NURSE NOTES
- Create 11/01/18 0635 NM 11/01/18 0639 NM

SHE IS ALERT TO PERSON AND COOPERATES WELL WITH HER CARE. SHE HAD SOME REAT LAST NIGHT. WOUND ON HER BUTTOCK NEED TO BE ADDRESSED. DRESSING ON HER BUTTOCK CHANGED DURING BATH. BREATHING IS UNLABORED. FOLEY IS PATENT. ORAL FLUID OFFER TO PATIENT TO KEEP HER HYDRATE. CALL LIGHT IS IN REACH AND BED IN THE LOWEST POSITION.

214. This note refers to a Foley catheter being in place in Dorothy. The medical records provided to Dorothy's caretaker are poor-quality and difficult to search, but this is the earliest reference I find in the records to a Foley catheter being inserted into Dorothy.

215. From the records, I don't see when this Foley was inserted, who ordered it, who inserted it, or why it was ordered.

216. These are important details that should be included in the medical records, because a Foley catheter creates a risk of infection. In the event of complications related to the Foley, it may be important for physicians to know these details. Failure to include these details violates the standards for medical record-keeping.

217. Whatever the specific purpose for inserting the Foley catheter, that catheter would assist with urine incontinence.

218. However, because a Foley creates a risk of infection, it should not be used for incontinence assistance unless more conservative measures prove ineffective — after being applied diligently.

219. From the medical records, it appears that conservative measures to avoid incontinence were not applied diligently.

220. At 0806 hours, Nurse Eje again described the sacral wound as a stage 3.

- DH2 – 223

221. Later, however, LPN Marsha Raycroft described the sacral wound as "pre-stage 1."

- DH2 – 227

222. At no time on Thursday, November 1, were any new measures ordered or implemented for repositioning.

223. **On Friday, November 2**, Nurse Amanda Walden noted the sacral wound at around 0908 hours but reported that she could not identify the skin alteration level or stage.

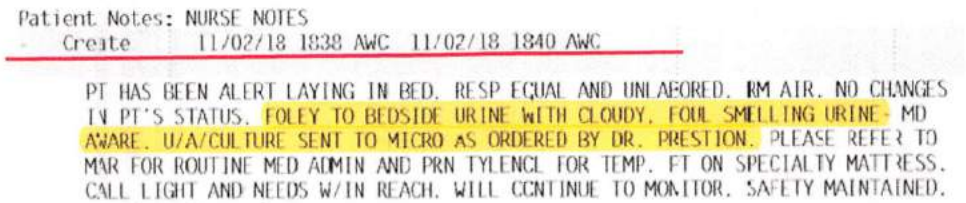
- DH2 – 230

224. At 1241 hours, Nurse Chelsey Haines reported checking the wounds on Dorothy's heels but did not mention the sacral wound.

- DH2 – 231

225. At around 1840 hours, Nurse Amanda Walden noted abnormal urine: "Foley to bedside urine with cloudy, foul smelling urine – MD aware. U/A culture sent to micro as ordered by Dr. Preston."

- DH2 – 234

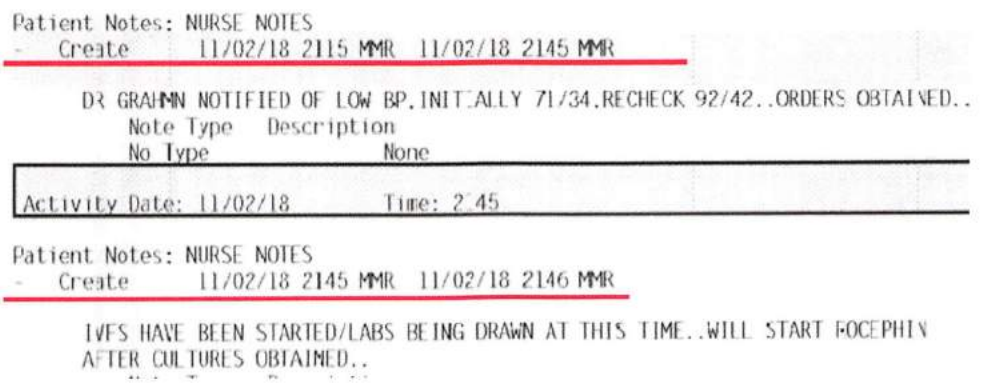


Patient Notes: NURSE NOTES
Create 11/02/18 1838 AWC 11/02/18 1840 AWC

PT HAS BEEN ALERT LAYING IN BED. RESP EQUAL AND UNLABORED. RM AIR. NO CHANGES IN PT'S STATUS. FOLEY TO BEDSIDE URINE WITH CLOUDY, FOUL SMELLING URINE - MD AWARE. U/A/CULTURE SENT TO MICRO AS ORDERED BY DR. PRESTION. PLEASE REFER TO MAR FOR ROUTINE MED ADMIN AND PRN TYLENOL FOR TEMP. PT ON SPECIALTY MATTRESS. CALL LIGHT AND NEEDS W/IN REACH. WILL CONTINUE TO MONITOR. SAFETY MAINTAINED.

226. At around 2145 hours, Nurse Marsha Raycroft noted that she had informed a physician that Dorothy had low blood pressure. IV fluids were started, with a plan to begin an antibiotic after cultures were obtained.

- DH2 – 236


Patient Notes: NURSE NOTES
- Create 11/02/18 2115 MMR 11/02/18 2145 MMR

DR GRAHMN NOTIFIED OF LOW BP. INITIALLY 71/34. RECHECK 92/42..ORDERS OBTAINED..
Note Type Description
No Type None

Activity Date: 11/02/18 Time: 2:45

Patient Notes: NURSE NOTES
- Create 11/02/18 2145 MMR 11/02/18 2146 MMR

IVFS HAVE BEEN STARTED/LABS BEING DRAWN AT THIS TIME..WILL START ROCEPHIN AFTER CULTURES OBTAINED..

227. At no time on Friday, November 2, were any new measures ordered or implemented for repositioning.

228. However, four days later, on November 6, Dorothy would be found with a large, infected stage 4 sacral wound. The infection noted on November 2 was likely caused, in whole or in part, by the sacral wound — rather than being a urinary tract infection related to the Foley catheter.

229. **On Saturday, November 3rd**, Dr. Jonathan Preston ordered that the Foley catheter be removed.

- DH2 – 241
- DH1 – 638-642 at 640

230. While the removal of the Foley would remove one source of new infections, it would also increase the risk of incontinence-related skin breakdown — thus requiring additional diligence in preventive measures.

231. At around 2041 hours, Nurse Marsha Raycroft noted the sacral wound but reported that she could not identify the skin alteration level or stage.

- DH2 – 242

232. At no time on Saturday, November 3rd, were any new measures ordered or implemented for repositioning or for effective continence/hygiene assistance.

233. **On Sunday, November 4th**, at around 1824 hours Nurse Regina Scott noted the sacral wound as stage 3 and reported that she had changed the dressing on the wound.

- DH2 – 245

234. A short time later, around 1931 hours, Nurse Scott noted that the dressing on the sacral wound had been changed twice that day. She also reported that Dorothy had a low-grade fever.

- DH2 – 248

Patient Notes: NURSE NOTES
- Create 11/04/18 1931 RS 11/04/18 1935 RS

PT ALERT TO SELF. SYMMETRICAL CHEST RISE AND FALL WITH NO DISTRESS NOTED ON RA. PT HAS STRONG, EQUAL, BILATERAL PULSES IN THE UPPER AND LOWER EXTREMITIES. PT WOUND DRESSING TO THE SACRUM CHANGED TWICE TODAY. PT RECEIVED ACETAMINOPHEN FOR A LOW GRADE TEMP. NO OTHER ISSUES TO REPORT. SAFETY MEASURES MAINTAINED: CALL LIGHT AND NEEDS WITHIN REACH. HANDOFF REPORT GIVEN TO D. SARGENT, RN. BEDSIDE ROUNDING COMPLETE.

235. At no time on Sunday, November 4th, were any new measures ordered or implemented for repositioning or for effective continence/hygiene assistance.

236. **On Monday, November 5th,** at around 0745 hours Nurse Deborah Sargent reported that Dorothy had been incontinent of a large amount of urine.

- DH2 – 250

237. At around 1039 hours, physical therapist Mark Clayton noted that Dorothy's upper back was wet from sweat, and that he had changed the underpads on Dorothy's bed.

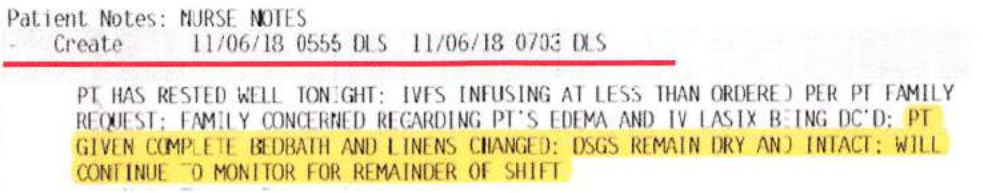
- DH2 – 254

238. At no time on Monday, November 5th, were any new measures ordered or implemented for repositioning or for effective continence/hygiene assistance.

November 6: Stage 4

239. **On Tuesday, November 6th,** Nurse Deborah Sargent noted that she had given Dorothy a complete bedbath and changed the bed linens. Nurse Sargent recorded that the dressings remained dry and intact.

- DH2 – 258


Patient Notes: NURSE NOTES
Create 11/06/18 0555 DLS 11/06/18 0703 DLS

PT HAS RESTED WELL TONIGHT: IVFS INFUSING AT LESS THAN ORDERED PER PT FAMILY REQUEST; FAMILY CONCERNED REGARDING PT'S EDEMA AND IV LASIX BEING DC'D; PT GIVEN COMPLETE BEDBATH AND LINENS CHANGED; DSGS REMAIN DRY AND INTACT; WILL CONTINUE TO MONITOR FOR REMAINDER OF SHIFT

240. At approximately 1038 hours, NP Kimberly Linticum from the Wound Care service went to Dorothy's room. NP Linticum saw the wound on Dorothy's sacral area and characterized it as unstageable with surrounding erythemia (reddening of skin) and abscess formation.

- DH2 – 1145-47

241. PA Shellie Lutz and Dr. Robert Mullins, both from the Wound Care service, got involved.

242. Within about an hour of NP Linticum's assessment, Dr. Mullins examined Dorothy. Under Dr. Mullins' supervision, NP Linticum dictated a History & Physical on behalf of Dr. Mullins.

- DH2 – 31-33

243. Dr. Mullins noted that Dorothy had been wearing a diaper that was heavily soiled with urine, that the sacral wound emitted a "very foul odor," that the wound had necrotic (dead) tissue, and that the wound required debridement not at bedside but in the operating room. Dr. Mullins also noted that Dorothy had an infection that was "fairly complex" and that there was concern that the wounds were contributing to the infection.

- DH2 – 31-33

HISTORY OF PRESENT ILLNESS:
Ms. Anthony is a 58-year-old African-American female with a history of Down syndrome. She was originally admitted to Doctors Hospital on 10/15/2018 with a chief complaint of altered mental status, difficulty walking, and encephalopathy. The patient was admitted. She underwent an MRI, which showed diffuse changes, advanced for the patient's age. Underwent additional EEG for rule out of seizure. Questionable seizure activity was noted. The patient was seen by Neurology. She was admitted per the Hospitalist Service for her metabolic encephalopathy, felt to have hypovolemia. She has been residing on the 4th floor services. She was noted to have a urinary tract infection, fairly complex. Her white count was considerably elevated. Blood cultures were obtained. The patient was noted to have Proteus within her blood. The Wound Services were consulted on this patient for evaluation. The patient was noted to have stage II pressure ulcers to both heels, which were stable. She was also noted to have an unstageable sacral ulcer with abscess formation. She continued to remain febrile. There was some concerns that her wound may be contributing to her infectious status. The patient was prepped in terms of evaluating for operating room intervention today.

GU: She has a diaper that is present. She has a fair amount of urine that is noted in her diaper, which is heavily soiled. The diaper was removed. She was noted to have some erythema to her buttocks bilaterally with a sacral ulcer with central portion of necrosis that was unstageable at this point in time.
NEUROLOGIC: Mentation appears to be slow. She, according to family, is much more conversant. She has been somewhat somnolent since her admission. I do not appreciate any focal deficits and there has been no reported seizure activity.
SKIN: A focused skin assessment to her sacrum reveals an unstageable sacral ulcer with a central portion of necrosis, very foul odor noted coming from her peri-area. Diaper with urine present. Appears to be somewhat odorous in nature. The wounds to both heels appear to be stage II with some re-epithelialization noted. No surrounding erythema or fluctuance noted.

ASSESSMENT AND PLAN:
Unstageable sacral ulcer with nonviable tissue, abscess formation noted. The plan will be for n.p.o. status at the present, proceed to the operating room for debridement of sacral ulcer. The patient's next of kin, which is her sister, who is her primary decision maker, Ms. Willie Sampson, phone number 706-726-2429, was called and updated in regard to her current medical status. Has given consent for proceeding forward with surgery today for sores control. In regard to her wound care, at the present time, we will continue Mepilex pads to both heels. A low air loss mattress has been continued. For pressure reducing measures, would recommend turning every 2 hours. We will continue to certainly follow along. Did make an attempt to talk to Dr. Ross who is the primary on the case and the hospitalist team in regard to updating him on her current condition. In the interim, we will certainly continue to proceed forward with surgical debridement for sores control as her white count has been

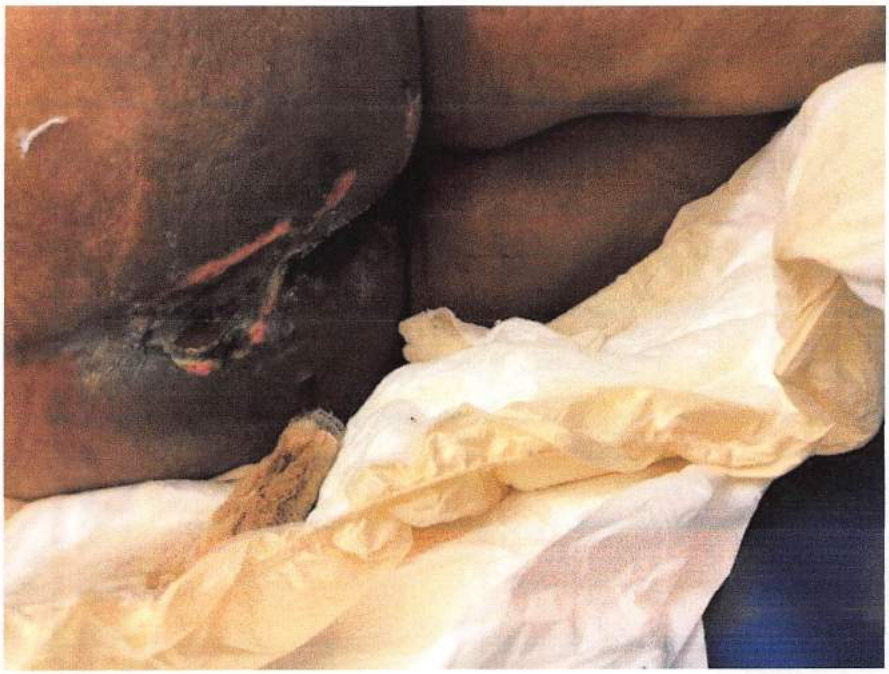
trending up over the last 72 hours with concerns of evolving infection.

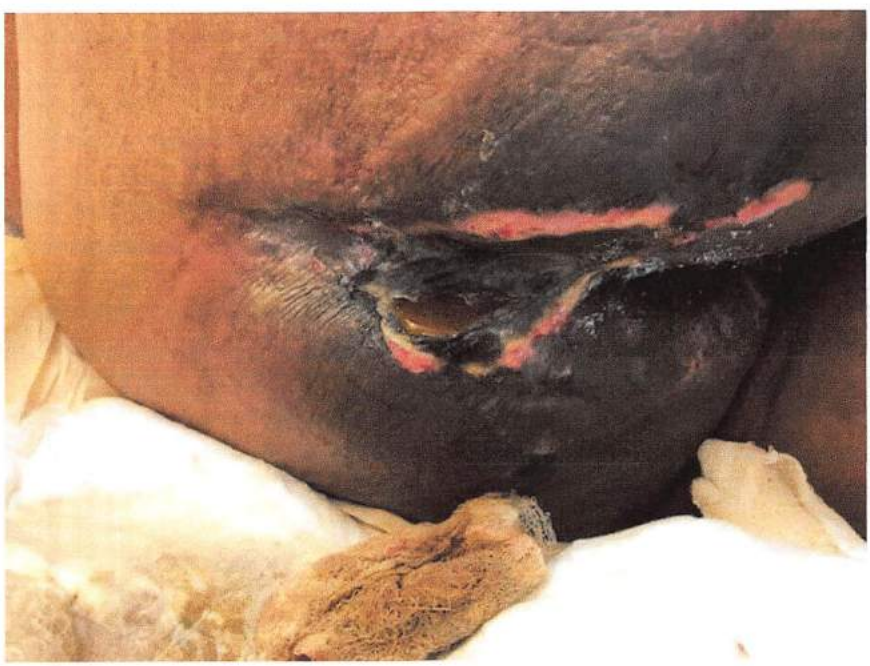
This was done under direct supervision of Dr. Mullins x2.

This is a level 3 history and physical on behalf of Dr. Mullins x2.

Dictated By: Kimberly M Linticum, NP
For: Robert F Mullins, MD

244. One of the Wound Care staff called Ms. Sampson, Dorothy's older sister and caretaker. Ms. Sampson came to the hospital to see Dorothy. She took pictures of the wound:





245. At 1709 hours, Dr. Mullins began surgical debridement of the wound in the operating room. With the wound excised, Dr. Mullins was able to stage the wound. It was a stage 4. Dr. Mullins noted that he was excising the wound in preparation for a flap surgery — a flap 15 x 18 cm (6 x 7 inches) large. Dr. Mullins cut away tissue down to and including the muscle.

- DH1 – 1200-01

Pre-procedure diagnosis: infected unstageable sacral ulcer
Post-procedure diagnosis: Stg IV sacral ulcer
Procedure(s) performed:

.
Primary surgeon:
mullins
Assistant(s): lutz
Anesthesia: GETA
Technique/Procedure:

.
Specimens removed/altered: Tissue cx, tissue for path sacrum
Implant(s): none
Complications: none
Fluids:
300
Estimated blood loss in ml's: 50
Findings:
.

Procedures
Procedure Comments:
Excision of sacral ulcer in preparation for flap 15x18cm
LOE gluteus maximus
AMD

Attention was directed to the above-noted areas. Devitalized tissue was removed in tangential fashion with a Norsen and then a Goulian and 10 knife down to a level of viable tissue. Further a electrocautery was also used. Tissue culture was obtained and the specimen was sent to pathology. The deepest level of excision included muscle specifically the gluteus maximus. The sacral ulcer was being prepared for flap coverage. Once the excision was complete, larger bleeding points were cauterized using bovie cautery, and the wound was covered with epinephrine soaks and spray thrombin. Once satisfactory hemostasis was obtained, the wound was packed AMD as well as sterile Kerlix dressing. The patient tolerated the procedure well and was taken to the post-anesthesia care unit for post-operative recovery in stable condition.

246. After the debridement, a tissue culture from the sacrum tested positive for proteus/e-faecalis.

- DH3a - 10

247. Proteus species are a Gram-negative, facultative bacilli that colonize the gastrointestinal tract and are a source of nosocomial infection within hospitals and long-term care facilities.

248. E. faecalis is found in most healthy individuals, but can cause endocarditis and sepsis.

249. When Dorothy was admitted to the hospital back on October 15, her white blood cell count — a key marker for infection — was at the low end of normal: 5.64 K/uL.

- DH1 – 12-13

Hematology	
WBC (4.0 - 11.0 THOUS/uL)	5.64

250. On November 6, Dorothy's white blood cell count was extremely high: 34.86 K/uL.

- DH1 – 75

	11/07 0055	11/06 1119
Hematology		
WBC (4.0 - 11.0 THOUS/uL)	28.15 H	34.86 H

251. After surgery, Dorothy was taken to the Intensive Care Unit, where NP Jennifer Key and Dr. John Keeley diagnosed Dorothy as being in septic shock.

- DH1 – 41-48

Free text A&P:
58 yo F PMH Down's Syndrome, T2Dm, HTN, seizure disorder underwent stage 4 sacral decubitus debridement in preparation for flap 11/6 w/ hypotension post procedure. Critical care team asked to assist w/ her care.

Pt received 300 ml NS intraop and 250 ml Vancomycin post op. However, IV found to be infiltrated so it is unclear how much the pt received.

A&P:
Heme/ID: Septic shock in setting of infected stage 4 sacral decubitus; bacteremia w/ Proteus (cx 11/2); UTI due to Proteus and E coli (cx 11/2); stage 2 bilat heel decubitus
- ivf resuscitation
- continue ceftriaxone
- Continue vanco and flagyl per burn/wound recommendations
- sacral cultures sent 11/6
- wound management per burn/wound team

CV: sepetic shock/hypotension, venous insufficiency; dyslipidemia
- ivf resuscitation
- hold losartan for now
- continue statin
- monitor hemodynamics
- place PICC

252. The condition Dorothy was found in on November 6 — a large, infected, putrid stage 4 wound with substantial necrosis, and in septic shock — does not develop instantaneously.

253. The wound had of course developed over several days.

254. The odor from the wound was likely noticeable for at least one day, and probably for multiple days.

Supporting Literature

255. The general points discussed above are well known to physicians, nurses, and hospital administrators in the relevant fields. The Defendants themselves, and experts hired by the Defense team will likely not need to refer to literature to confirm any of the discussion here.

256. However, for the benefit of non-medical personnel involved in the Defense (attorneys, insurance adjustors, etc), the following literature, while by no means exhaustive, may help in evaluating this case:

- European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance. *Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline.* The International Guideline. Emily Haesler (Ed.). EPUAP/NPIAP/PPPIA: 2019.
- European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance. *Prevention and Treatment of Pressure Ulcers/Injuries: Quick Reference Guide.* The International Guideline. Emily Haesler (Ed.). EPUAP/NPIAP/PPPIA: 2019.
- Lowry, Svetlana Z., et al. *Examining the copy and paste function in the use of electronic health records.* US Department of Commerce, National Institute of Standards and Technology, 2017.
- Parish, Lawrence C., Joseph A. Witkowski, and John T. Crissey, eds. *The decubitus ulcer in clinical practice.* Springer Science & Business Media, 2012.
- Rosdahl, Caroline Bunker, and Mary T. Kowalski, eds. *Textbook of basic nursing.* Lippincott Williams & Wilkins, 2008.
- Tsou, Amy Y et al. "Safe Practices for Copy and Paste in the EHR. Systematic Review, Recommendations, and Novel Model for Health IT Collaboration." *Applied clinical informatics* vol. 8,1 12-34. 11 Jan. 2017, doi:10.4338/ACI-2016-09-R-0150

Judith Climenson, RN,
CCRN-CMC, CNRN-SCRN

SWORN TO AND SUBSCRIBED before me

October 20th, 2020

NOTARY PUBLIC

My Commission Expires 02-22-2023

Kevin Lawler
Notary Public
Maricopa County, Arizona
My Comm. Expires 02-22-2023
Commission No. 562003

Judith Climenson RN, CCRN-CMC, CNRN-SCRN

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Scottsdale, AZ 85254
Phone: 805 448-5835

E Mail: jclimenson@cox.net

Summary of Qualifications

38 YEARS EXPERIENCE IN ACUTE AND CRITICAL CARE. 18 YEARS EXPERIENCE AS AN INDEPENDENT LEGAL NURSE CONSULTANT FOR CHART REVIEW FOR MERIT FOR MEDICAL MALPRACTICE, AND EXPERT WITNESSING FOR NURSING STANDARD OF CARE.

Professional Membership

AMERICAN ASSOCIATION OF CRITICAL CARE NURSES; AMERICAN ASSOCIATION OF LEGAL NURSE CONSULTANTS; AMERICAN NURSING ASSOCIATION; AMERICAN ASSOCIATION OF NEUROSCIENCE NURSES

Education

ASSOCIATE DEGREE IN NURSING, COLLEGE OF MARIN, 1980, KENTFIELD, CA.; CCRN CERTIFIED SINCE 1982; CARDIAC MEDICINE CERTIFIED SINCE 2006; NEURO CERTIFIED 2012; STROKE CERTIFIED 2016; ACLS/BLS CERTIFIED; IABP CERTIFIED
REGISTERED NURSE LICENSE: ARIZONA, CALIFORNIA AND GEORGIA

Work experience

STAFF RN AT SCOTTSDALE MEDICAL CENTER OSBORN IN THE SCU [SPECIAL CARE UNIT] JULY 2014- PRESENT

RN III , SAVANNAH MEMORIAL HEALTH UNIVERSITY MEDICAL CENTER, NEURO & CARDIOVASCULAR INTENSIVE CARE UNIT, APRIL 2009 TO JUNE 2014

STAFF RN, SANTA BARBARA COTTAGE HOSPITAL, CLINICAL RESOURCE NURSE FOR ICU AND CCU, AUGUST 2003-APRIL 2009

CONTRACTED CRITICAL CARE RN, MEDITECH HEALTH SERVICES, VENTURA, CA, ASSIGNMENTS IN ICU, CCU, ER AND TELEMETRY, 2000-2003

STAFF RN- CHARGE NURSE FOR CVICU AND TELEMETRY, SCOTTSDALE HEALTHCARE SHEA, SCOTTSDALE, AZ, 1991-2000

STAFF RN- CHARGE NURSE FOR CVICU AND TELEMETRY, PHOENIX, John C. Lincoln Hospital, AZ, 1985-1998

CHARGE NURSE, SONOMA VALLEY HOSPITAL, CRITICAL CARE UNIT, SONOMA, CA, 1980-1985