THE CHALLENGES OF DISCHARGE INSTRUCTIONS

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DESCRIPTION

A diabetic patient being treated for a foot contusion suffers necrosis and requires a partial amputation.

KEY LESSON

- Engage patients in their care plan; do not assume patients understand or will comply with recommendations.
- Documentation in the medical record supports care provided at the time of a patient encounter.

CLINICAL SEQUENCE

A 62-year-old male with a history of diabetes, neuropathy, and peripheral vascular disease presents to the ED after suffering for three days with a contused foot after a heavy box fell on it. On exam, the foot is badly bruised, red, and swollen. The patient has full ROM and there are no skin tears. Foot X-rays are negative and the patient is diagnosed with a contusion. Treatment includes immobilization with a splint and limited weight bearing.

A posterior splint to stop the patient from bending and flexing the injured foot is placed by a patient care assistant. No patient evaluation after the splint is placed is documented. The physician (verbally) gives the patient discharge instructions that include removing the splint when showering, or if it is too tight. The patient is also instructed to return immediately if he notes any color changes, increased pain, sensory changes, or skin breakdown. Follow up is recommended with Orthopedics in one week. Written instructions are not provided.

Two days later, the patient returns to the ED with color changes and complaints of pain in the injured foot. The patient reports that he has not removed the splint since it was placed in the ED. The patient has a necrotic infection and, despite medical treatment, the patient requires partial amputation of his injured foot.

ALLEGATION

In a lawsuit naming the Emergency Medicine physician and a nurse, the patient alleges that a dressing was applied too tightly, compromising the circulation and resulting in a gangrenous foot requiring amputation.

DISPOSITION

The nurse was subsequently dropped from the case. The case against the physician defendant went to trial five and a half years after the initial ED visit, resulting in a verdict in favor of the defendant..

DISCUSSION QUESTIONS

1. Failure to ensure patient understanding and documenting discussions with patients about recommended treatment can place a clinician at risk for "if it's not written, it didn't happen."

Document your clinical reasoning and communication with patients, including discharge instructions. Include time and action-specific directives, e.g., "If your temperature does not return to normal by Tuesday, call me."

2. Assess your patients' understanding of treatment recommendations so they understand how to properly continue their care at home.

Ask your patients how they like to learn (verbal, video, pictures or written) and assess their level of understanding by having them explain the plan of care to you.