Adult Intensive Care: Court Upholds Verdict Finding Nurses Only Partially Responsible.

The forty-one year-old patient was transferred to the intensive care unit after an otorhinolaryngologist surgically packed a posterior nosebleed which had brought the patient into the hospital's emergency department.

Unlike an anterior nosebleed which only involves bleeding inside the nose, a posterior nosebleed is a potentially life-threatening condition involving bleeding at the base of the skull behind the nose in the upper throat. He had lost half his blood volume and had been in respiratory arrest.

It was believed the patient's nosebleed was related to his hypertension and his use of aspirin products

He was admitted to the ICU because he was on a ventilator and possibly suffered from underlying illness or organ pathology that had caused the nosebleed to start. The nose packing could cause him to stop breathing. He needed a nurse to be near him at all times.

Jury Finds Hospital's Nurses 25% at Fault

The physicians all settled before trial. With the hospital as the only remaining defendant in the lawsuit the jury assessed the patient's damages at $1,800,000. However, the jury also ruled the patient was 75% responsible for his own injuries. After deducting the physicians' settlements from 25% of the jury's verdict the hospital's net exposure was $37,500. The California Court of Appeal affirmed the result.

Patient's Nursing Care in the ICU

At the time he was moved to the ICU he understood questions and responded by shaking his head or squeezing the hand. His physician explained what had been done for him and why he was in the ICU. Ativan was ordered to help with the disorientation that is common with ICU patients.

The first nursing note suggesting a problem was at 6:00 p.m. on the second day in the ICU. The patient was periodically anxious and mildly agitated. By 8:00 p.m. the patient was alert and cooperative.

At 4:00 a.m. the next morning the patient was getting more anxious and wanted the tube taken out. At 6:37 a.m. the nurse noted the patient had been very restless and anxious and wanted to eat. The endotracheal tube was removed.

The hospital's nursing expert is a clinical nurse specialist in critical care who practices as a nurse practitioner in another hospital's cardiology department.

She testified all the hospital personnel on duty the morning the patient coded acted within the standard of care and made heroic efforts to reinstate his respiratory effectiveness.

The patient's family's medical expert testified the nasal packing technique used with this patient in 2002 is not used anymore.

It can result in a "ball-valve" phenomenon where the person sucks the packing into the trachea when breathing in while there is no obstruction when breathing out.

When a ventilator patient starts picking at his electrodes, trying to remove his telemetry equipment and his IVs and wants the endotracheal tube taken out, it can be a sign that the patient is panicking due to an airway obstruction.

The panic the patient shows with an airway obstruction can be compounded by changes in the patient's mental status which the nurses should recognize as the result of lack of oxygen.

CALIFORNIA COURT OF APPEAL
September 18, 2012

At 2:34 p.m. the nurse noted the patient had to be repeatedly instructed not to remove his oxygen mask. Later that p.m. the nurses noted the patient was anxious, restless and non-compliant.

That evening the patient was trying to get to the bathroom to examine the packing in his nose. He was apparently unaware of all the previous teaching. The nurses told a family member they were considering restraints because the patient had tried to remove his Foley and the nasal packing.

The next day a nurse sat with him because he was picking at his electrodes and IVs and said he wanted to go home. After a phone report to the physician the nurse was told to repack one of the nostrils.

The next morning the patient complained his nose was plugged and a nurse reminded him not to pull at the packing.

The patient was sent from the ICU to a special care unit. He had been extubated and did not appear to be having breathing problems. His nurse noted he was oriented but confused and forgetful and was removing his heart telemetry electrodes.

The next day his 8:00 a.m. appointment to have the packing removed was reset to 4:00 p.m. because of the physician's schedule. A nurse listened to his lungs. His O_2 sat was 96%. He was not anxious but was impatient to leave. At 9:00 a.m. he was pulling at the packing in his nose but was not in respiratory distress.

At 10:00 a.m. a family member called an aide into the room. The patient was sitting on the side of the bed with his head in his hands.

He was having trouble breathing so respiratory therapy gave him a nebulizer treatment. Then a nurse was called from the ICU. She came in and called a code.

The patient was rushed to surgery to remove the packing. The surgeon concluded from what he found that the patient had compromised his own airway by trying to remove the packing himself with scissors mysteriously supplied to him.

The patient was left with profound hypoxic encephalopathy and was transferred from the hospital to a nursing facility in a persistent vegetative state. **Charalambopolous v. UHS, 2012 WL 4078783 (Cal. App., September 18, 2012).**