Nurses Not Acting As Patient's Advocate: Substantial Verdict Entered Against Hospital.

The seventeen year-old patient was brought to the hospital's emergency room following a motorcycle accident at a motocross event.

Serious Orthopedic Trauma Plus No Pulse In Lower Leg

The nurses tried repeatedly and failed repeatedly to locate a pulse in the left lower leg both by palpation and with a portable Doppler device.

The patient was seen briefly by the emergency room physician. One of the nurses reported to the physician that she could not get a pulse and asked why. He stated he did not know why.

For two and one-half hours the emergency room nurses closely monitored the patient. The nurses wrote extensive progress notes in his chart that he complained over and over again of severe pain in his left knee and numbness in the left foot.

Nevertheless the nurses discharged the patient home with his mother with instructions to his mother to get an office appointment with an orthopedist sometime in the next few days.

The next morning his mother took him to the emergency room at another hospital. There they found a lacerated popliteal artery, did extensive surgery and managed to save the leg from amputation.

Still there were lifetime residuals. A jury awarded $880,000 in damages from the hospital for the nurses' negligence. The patient had settled with the physician's insurance for $270,000 before the case went to trial against the hospital.

Nurses Tried To Cover Themselves Failed to Act As Patient's Advocate

The Supreme Court of Appeals of West Virginia was not impressed with the nurses' extensive progress notes. The court interpreted the progress notes only as the nurses trying to cover themselves rather than performing a caregiving function on the patient's behalf.

According to the court, the nurses knew this patient was not getting the care he needed and deserved. They knew it was not right to discharge a patient home from the hospital with unexplained symptoms that were not being addressed by the physician.

This was the hospital's chain of command policy, which the jury found was not followed by the emergency room nurses:

"Should there be an occasion when an RN believes that appropriate care is not being administered to a patient by a physician, the following procedure shall occur:

"One, the RN will discuss her (sic) concerns with the physician. If, after the discussion, she still feels that the care is inappropriate, she will report it to the clinical manager, if available, or the patient care coordinator on duty.

"Secondly, the clinical manager or patient care coordinator will weigh the factors involved and if she (sic) feels that the concern is valid, she will discuss it with the physician. If nothing is done to ease her concerns, she will contact nursing administration.

"Thirdly, nursing administration will discuss it with the clinical manager and contact the chief of service for guidance and assistance. If nursing administration, after discussion with the chief of service, feels that appropriate action still has not been taken, the problem will then be referred to the assistant executive director of medical affairs.

"The director of medical affairs will contact the attending physician and/or chief of service. Should appropriate action not be taken at this level, the director of medical affairs will contact the president of the medical staff.

"Nursing administration may at any point in time request assistance from administration."

This policy is sound but it just was not followed.

SUPREME COURT OF APPEALS OF WEST VIRGINIA, 2001.

Nurses As Advocates Hospital Chain of Command

The hospital had a policy that nurses were expected to advocate for their patients and had outlined the specific steps how a staff nurse's concerns could be taken all the way to the top to get appropriate action from the medical staff.

The court validated the hospital's chain-of-command policy, albeit by ruling the nurses were negligent for not following that policy.

In more general terms, every nurse has the obligation, the court said, to go to a nursing supervisor when the nurse believes medical issues are being ignored or handled inadequately or inappropriately. **Rowe v. Sisters of the Pallottine Missionary Society, 560 S.E. 2d 491 (W.Va., 2001).**

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