Anticoagulant Therapy: Court Finds Grounds For Family's Lawsuit.

When she was admitted to the nursing home the patient was on Coumadin as a precaution against blood clots that could lead to embolism or stroke.

Her PT/INR values were found to be sub-therapeutic for a patient who required blood-thinning medication, so the Coumadin was increased.

When her PT/INR came back still below the desired range after a few weeks the Coumadin was upped and a second anticoagulant Lovenox was added. A PT/INR was ordered to be drawn two weeks after the medication increase went into effect.

The day before the PT/INR was scheduled the patient began vomiting blood and was taken to the hospital. Her PT/INR was beyond the therapeutic range. She died in the hospital that day from a gastrointestinal hemorrhage attributed to inadequate monitoring of her anticoagulant level.

The standard of care requires nurses in a nursing home to see that a patient on two anticoagulants has PT/INR monitored every one to three days so that the blood clotting mechanism is not allowed to be inhibited to the point that internal hemorrhage results.

COURT OF APPEALS OF TEXAS
June 16, 2011

The Court of Appeals of Texas ruled that the patient's family's nursing and internal medicine experts correctly stated the standard of care.

Even if the attending physician does not see the need for close, frequent PT/INR monitoring for a patient on significant doses of anticoagulant medications, the nurses should appreciate the need and should advocate for lab draws every one to three days, in the experts' opinions. **Pinnacle Health v. Calvin, 2011 WL 2420991 (Tex. App., June 16, 2011).**

E.R.: Triage Of Cardiac Patient Understated Urgency, Court Finds EMTALA Violation.

A hospital is liable for violating the US Emergency Medical Treatment and Active Labor Act (EMTALA) if the patient can show that the screening he or she received in the E.R. was not appropriate, that is, not the same as the standard screening that the hospital regularly provides to other patients presenting with substantially similar signs and symptoms.

"Appropriate" in the Act refers not to the outcome but to the hospital's standard screening procedures.

This patient had to wait almost two hours before even being seen by the E.R. physician, despite having been released from the hospital four days before after a pulmonary embolism and myocardial infarct.

Correctly following the hospital's chest-pain triage protocol would have produced an urgency-level classification of 1 or 2, not 3 as the patient was triaged.

Initial triage classification can be critical in the E.R. because it determines the aggressiveness and importance that will be given to further evaluation and treatment of the patient.

UNITED STATES DISTRICT COURT
PUERTO RICO
June 9, 2011

The forty-one year-old patient first came to the E.R. on February 17 with chest pain diagnosed as unstable angina.

She had cardiac catheterization and angioplasty that same day that corrected major blockages that were detected affecting the right coronary and circumflex arteries of the heart.

She was kept in the hospital until March 4 for follow up testing which included an echocardiogram and treatment which included an IV Heparin drip.

Patient Returned to E.R.
Had Significant Cardiac History

The patient returned to the same hospital's E.R. on March 8, four days after discharge, with new complaints of chest pain. She was given an urgency classification of 3 upon initial triage, meaning her case was not urgent. That was at 6:53 p.m.

She did not see a physician until 9:00 p.m. Another physician saw her at 11:30 p.m. but did not do an EKG. She continued having chest pain during the night but received no treatment except Vistaril for nausea. She died in the hospital less than twenty-four hours after she came in.

Chest-Pain Protocols Not Followed

The hospital's standard triage screening procedures called for a patient with chest pains and significant cardiac history to be classified as 1 or 2, that is, very urgent. A whole range of interventions were mandated for an urgent cardiac case including being seen immediately by a physician, an EKG and a cardiologist consult.

For purposes of a hospital's liability under the EMTALA, the issue is not the adequacy of the care given the patient but whether the initial medical screening given the particular patient was the same as the medical screening mandated by the hospital's protocols for other E.R. patients with the same signs, symptoms and history.

In this case, according to the US District Court for the District of Puerto Rico, the medical screening of this patient, starting with her urgency being incorrectly minimized upon initial triage, was sorely lacking. **Estate of Scherrer v. Hospital Espanol, 2011 WL 2360225 (D. Puerto Rico, June 9, 2011).**