Communication With Physician: Court Sees Nursing Negligence.

A patient who had recently had surgery for breast cancer was taken to the hospital by ambulance for severe back pain radiating down her right leg.

The emergency physician ordered pain medication, an antibiotic and an abdominal and pelvic CT which showed bladder and bowel distention.

She was admitted to the hospital under the care of the surgeon who had operated on her for breast cancer and a hospitalist.

Weakness in Lower Extremities
Nurse Did Not Report to Physician

That evening the patient's nurse became aware that the patient had started to experience weakness in her lower extremities, but the nurse did not communicate that development to any of the physicians.

The next morning the patient still had severe back pain. Around noon a nurse finally told the hospitalist that the patient was also complaining of numbness and tingling in her right leg, the first such report by a nurse to a physician.

A kidney specialist came in a few hours later. He noted severe back pain and right leg numbness probably due to nerve compression. At 5:35 p.m. the hospitalist ordered a non-emergency MRI.

The next morning a nurse found that the patient could not move her legs at all. The breast cancer physician examined her at 8:10 a.m. and ordered the MRI to be done "stat." Nevertheless the MRI was not done until 12:40 p.m. and was not read until 1:42 p.m. Surgery was started at 6:30 p.m. but was unsuccessful to remove a blood clot from a spinal hematoma which had rendered the patient paraplegic.

Failure to Communicate With Physician
Failure to Expedite Diagnostic Testing

The Court of Appeals of Texas accepted expert testimony from a nurse and a physician that the nurses violated the standard of care by failing to communicate promptly the weakness in the patient's lower extremities to at least one of the patient's physicians or physician's assistants.

The Court further faulted the nurses for not taking steps to expedite the MRI which was not done and read for several hours after its urgency was upgraded to "stat." **Tenet v. De La Rosa, 2016 WL 3196656 (Tex. App., June 8, 2016).**

The standard of care required the patient's nurses to inform one of the patient's treating physicians or the physician's assistant of the weakness in the patient's lower extremities.

A nurse should understand that the onset of lower extremity weakness is an ominous sign in a patient with back pain.

Such weakness could be a sign of compression of a spinal nerve or the spinal cord itself.

Speaking with the physician or physician's assistant as soon as practicable after such weakness is detected is required so that the information is passed along in a timely fashion and is not neglected as the nurse's attention becomes focused on other issues.

The standard of care further requires the nurse to document that the physician or physician's assistant was informed of the onset of the patient's lower extremity weakness and what response the nurse received.

A nursing expert's testimony can identify a breach of the nursing standard of care. A physician's medical testimony can link delay in diagnostic testing to the patient's paraplegia.

COURT OF APPEALS OF TEXAS
June 8, 2016

Wound Care: Nursing Negligence Found.

After left femoral anterior tibial bypass surgery the patient had to have a second procedure to debride infected tissue from her vein graft site.

In the debridement procedure a section of the sartorius muscle was pulled over and sutured in place atop the vein graft to help protect the graft. Then a vacuum assisted closure system was applied to the wound.

The closing ordered for the patient was to include a layer of Adaptic directly on top of the underlying graft and muscle, under the foam which was part of the vacuum assisted system.

The patient was transferred to sub-acute care where the dressing was to be changed by the nurses every three days.

About two weeks later a nurse in the sub-acute facility neglected to insert the Adaptic when changing the dressing.

Leaving out the Adaptic created a risk of major trauma to the wound the next time the foam component of the vacuum assisted dressing was removed.

Hours after the next dressing change a code was called due to massive bleeding at the graft site. The patient died.

The nurse testified she inserted the Adaptic layer when she changed the dressing, but that was not reflected in her charting.

The surgeon could see that the sartorius muscle was dislodged and the vein was opened when he was called in after the patient coded and bled to death.

COURT OF APPEALS OF INDIANA
May 25, 2016

The Court of Appeals of Indiana saw grounds for the family's lawsuit against the sub-acute facility based on the family's nursing expert's opinion that it was below the standard of care for the nurse not to have inserted the Adaptic in the wound. **Blake v. Select, 2016 WL 3017853 (Ind. App., May 25, 2016).**