G-Tube Reinsertion, Death: Staff Nurse, DON Charged With Felony Dependent Adult Abuse.

The patient was a young man who had nearly drowned in a surfing accident which rendered him semi-comatose and paraplegic. Three months after his accident he was admitted to a twelve-bed long-term care facility specializing in the care of accident victims.

For six months he was one of only six patients at the facility until he died from peritonitis from nutrition introduced into his abdominal cavity instead of his stomach because his gastrostomy tube was incorrectly replaced by a staff nurse.

Staff Nurse, DON Charged With Felony Dependent Adult Abuse

The California Court of Appeal agreed with the prosecuting attorney that there were grounds to prosecute the nurses involved in the patient's care. The Court of Appeal reversed the county Superior Court judge's decision to dismiss the charges.

Staff Nurse

The patient's licensed vocational nurse found the patient's g-tube lying beside him in bed at 3:00 a.m. She did not know how long it had been out. She wrote a progress note that the patient had pulled it out, but the nurse did not actually see that happen.

The LVN decided to go ahead without calling the physician, without contacting the director of nursing and without checking the physician's standing orders.

The physician's orders were for a 14 French and the LVN went ahead with a 20 French, but the Court did not see that mistake in and of itself as a criminal act.

The LVN's competency in g-tube replacement had been checked out six years earlier at the facility but she had had no in-service refresher training since then. The Court stated for the record she should have known she was not qualified at this point in time to replace a g-tube.

After she pushed in the new tube she used a stethoscope to listen for air entering the stomach from a syringe, and heard a "whooshing" sound.

Then she tried to aspirate gastric fluid from the stomach. When nothing came back she concluded that meant the stomach was empty and it was necessary to feed the patient. She decided to give his scheduled feedings at 3:00 a.m. and 6:00 a.m.

The dependent adult abuse statute is usually used to prosecute relatives or other lay caregivers who seriously neglect a family member's needs, but there is no reason for the statute not to apply to a professional caregiver.

Dependent adult abuse is willful conduct that causes a dependent adult to suffer under circumstances likely to produce great bodily harm or death.

Intent to injure the victim is not required; criminal negligence is sufficient.

Criminal negligence is aggravated, culpable, gross or reckless conduct which is a departure from the conduct of an ordinarily prudent person which a reasonable person would appreciate poses a risk to human life.

CALIFORNIA COURT OF APPEAL
October 29, 2009

It seemed to the LVN that the patient tolerated the 3:00 a.m. feeding well. That is, after the 3:00 a.m. feeding the patient was sweating, grimacing and groaning, but the LVN did not think the patient was not tolerating his feeding because she had seen him sweat, grimace and moan before.

Nevertheless, at 4:00 a.m. she gave ibuprofen for "discomfort with g-tube removal" and Ativan for "g-tube reinserted, increased anxiety."

The LVN ended her night shift at 7:00 a.m. She reported to the day nurse she had changed the g-tube during the night. The patient was still sweating and grimacing, but the day nurse believed the patient was about to have a bowel movement.

The day nurse, who had been on the job only two weeks, tried to aspirate the stomach before giving the morning meds and nutrition. She got little or nothing back because, she believed, he had not had a bowel movement. His feeding started going down slowly but she was able to complete it with him upright on a tilt table.

The day CNA, who had worked with the patient the whole six months he had been there, became very concerned when she took his a.m. vitals. When the director of nursing, an RN, came in at 9:00 a.m. the CNA relayed her concerns to him.

Director of Nursing

The DON helped the physical therapist with the morning therapy session in which the patient was stood upright in a standing frame. The patient was breathing rapidly and sweating profusely and his eyes were wide open, whereas he usually closed his eyes during therapy.

The CNA kept watching the patient and taking vitals. By 11:00 a.m. he was running a 101° fever. She insisted several times the DON come and check on him.

The DON finally took vitals and got an O_2 sat at 1:15 p.m. He phoned and left a message for the physician that something was seriously wrong.

A 911 call was placed at 3:21 p.m. The dispatch records indicated the caller did not report it as an emergency. Paramedics arrived seven minutes later and found the patient dead.

The Court faulted the director of nursing not only for his substandard conduct as a hands-on caregiver on the patient's last day, but also for substandard performance as the supervisor of nursing competency and practices at the facility.

The Court accepted expert medical testimony for the prosecution that the DON should not have allowed a nurse to reinsert a g-tube who was not competent to do so. She should have known she was to send the patient to the hospital for it to be done by a gastroenterologist who could follow up with an endoscopic procedure to verify correct placement. A nurse not familiar with g-tube feeding should not be allowed to do it until properly trained. **People v. Medlin, 100 Cal. Rptr. 3d 810 (Cal. App., October 29, 2009).**