# Operating Room: Repositioning Seen As A Nursing Responsibility.

The patient was a 400 pound former professional football player with a muscular build who was positioned face-down on a Jackson table for a neurosurgical procedure that lasted more than ten hours, longer than expected.

The initial positioning and padding were done under directions from the neurosurgeon.

After the procedure the patient had pressure sores on his chest and brachial plexus atrophy palsy, a nerve injury which has rendered him permanently disabled with atrophy of his arms and little or no use of some of his fingers.

***Seeing that the patient's pressure points are checked and the body repositioned every two to six hours to prevent pressure sores and to allow circulation was the responsibility of the nurses and the anesthesiologist.***

COURT OF APPEALS OF TEXAS
June 9, 2011

The Court of Appeals of Texas upheld the jury's verdict of more than $900,000 for the patient which assigned blame 60% to the anesthesiologist and 40% to the nurses. The jury absolved the neurosurgeon from fault for the way the patient was positioned and padded at the start.

According to the Court, use of the table that was used in this face-down procedure causes pressure points on the chest and hips.

During a lengthy procedure it is wrong merely to allow pressure lesions to develop and try to treat them later. The nurses have to be aware that prolonged pressure can lead to compromised circulation and nerve damage and see that the patient is checked and repositioned. **Christus Health v. Harlien, 2011 WL 2394614 (Tex. App., June 9, 2011).**

# Hyperkalemia vs. Hypokalemia: Nurse's Discharge Instructions Faulted, Hospital Pays Settlement.

The seventy-four year-old patient was taken to the emergency room with flu-like symptoms of fever, weakness and achiness. She also had recently fallen.

The triage nurse took her vital signs and started her on oxygen. The emergency room physician saw her and ordered x-rays and lab tests.

Everything was basically negative except for the fact that her potassium level was significantly depressed.

**Nurse's Discharge Instructions Confused Hyperkalemia vs. Hypokalemia**

The patient was discharged from the hospital by a registered nurse. The nurse explained the patient's diagnosis of hyperkalemia, excessive potassium.

Based on the nurse's faulty discharge instructions the patient discontinued her potassium supplements that she had been taking.

Two days later she was taken to another hospital's emergency department by ambulance by paramedics who were called when the family noticed mental status changes. Her potassium was even lower than it had been at the first hospital. She died less than two days later.

The family's wrongful death lawsuit filed in the Circuit Court, Oakland County, Michigan originally included allegations that the physicians at the first hospital failed to perform a complete physical examination to rule out pneumonia and/or a pulmonary embolism.

The allegations faulting the physicians, however, were eventually dropped, leaving only the allegation that the discharge nurse gave faulty discharge instructions based on 180° of confusion over the meaning of the patient's laboratory values. The hospital reportedly settled with the family for $100,000, part of which went to reimburse Medicare for her last expenses. **Walrath v. Smith, 2010 WL 6662906 (Cir. Ct. Oakland Co., Michigan, July 21, 2010).**

# Catheterization: Patient Awarded Damages For Nurses' Negligence.

Right after laparoscopic bilateral hernia repair the surgeon gave orders for in-and-out urinary catheterization to drain urine from the bladder and to confirm there was no blood in the urine indicating the bladder might have been injured during the surgical procedure.

After the surgeon had left the operating room a registered nurse inserted a Foley with an inflatable retention bulb instead of an in-and-out catheter, then had another nurse inflate the bulb while it was still in the urethra.

The injury from the first insertion and inflation and injury from a subsequent insertion by a physician sideways through the tear in the urethra from the first insertion caused the patient to require catheterization by a urologist directly through the abdomen into the bladder.

***The nurse did not follow the physician's order for in-and-out catheterization, using a Foley with an inflatable bulb instead.***

***Another nurse inflated the bulb while it was still in the urethra.***

DISTRICT COURT
TARRANT COUNTY, TEXAS
April 15, 2011

The insurance company for the nurse who inflated the bulb settled for $200,000 prior to trial.

The jury in the District Court, Tarrant County, Texas then awarded additional damages against the hospital for the first nurse's negligence, which resulted in a total recovery by the patient of $720,000, for use of the wrong catheter and for miscommunication with the second nurse as to what the physician's orders actually were. **Steen v. USMD Hosp., 2011 WL 2489051 (Dist Ct. Tarrant Co., Texas, April 15, 2011).**