Insulin Overdose: Arbitration Award For Family Of Deceased.

The seventy-two year-old patient was scheduled to be discharged from the hospital to a skilled rehab facility for physical therapy.

On the night before his discharge a hospital nurse gave him 80 rather than the prescribed 8 units of NPH insulin for his Type II diabetes.

Although NPH insulin is considered by the facility to be a high-alert medication requiring a second nurse's check-off, the nurse did not consult with anyone before injecting it.

After injecting the insulin the nurse reportedly remarked, "Whew. That was a lot of insulin." It was only at that point that another nurse checked the medication administration record and discovered the massive overdose. It was too late.

The damage was already done. The patient coded, but was revived and lingered several days before he died.

The arbitrator awarded the family $318,944. **Lakos v. Kaiser Permanente, 2008 WL 382331 (Med. Mal. Arbitration, Los Angeles, California, February 5, 2008).**

Prescription Error: Nurse Caught The Mistake, Lawsuit

The patient went into respiratory arrest on her second day in the hospital but was revived without complications.

After she was discharged from the hospital she and her family came to believe that her arrest was caused by an overdose of narcotics. In fact, her physician had written an order for her for 30 mg of Dilaudid, a substantial overdose.

The patient's nurse, however, realized it was way too much. Following standard nursing practice, she phoned the physician before going ahead.

The physician immediately agreed that it was a mistake and told her the correct dose was 3 mg, not 30 mg, The nurse went ahead and gave the medication only after the dosage was clarified to her satisfaction.

The Court of Appeals of Tennessee said there was some confusion created by the new order for 3 mg never being entered in the physicians' orders in the chart. The nurse wrote a progress note about calling the physician and giving the correct dose, but never corrected the original erroneous 30 mg order. **Wall v. Hillside Hosp., 2008 WL 275968 (Tenn. App., January 31, 2008).**

TPN Overdose: Nurse Gave 10x Ordered Dose, Large Verdict.

The infant was on total parenteral nutrition while recovering from surgery to correct an omphalocele that the infant had been born with.

A nurse administered a dose of TPN ten times the dose that was ordered. No particular explanation was offered for how or why the incident happened.

The hyperosmolar overdose caused neurological injuries to the child's brain.

The jury in the Superior Court, Los Angeles County, California awarded $1.65 million, the bulk of which was to be paid by the nursing agency who was the nurse's actual employer. **Moc v. Children's Hosp., 2007 WL 4624414 (March 23, 2007).**

Post-Partum Care: Patient's Death Tied, In Part, To Nursing Negligence.

The $7.6 million settlement of a civil lawsuit filed in the Superior Court, Los Angeles County, California was reported on condition that the names of the patient, hospital, physicians, nurses, etc., remain confidential.

The lawsuit raised complex medical issues involved in the vaginal delivery of triplets and the mother's post-partum care at a tertiary care facility specially chosen as appropriate for this complicated procedure.

Nurses Held Up Physician's Order For Blood Lab Work

On the night following delivery the mother, on the post-partum floor and not in the ICU, had a blood pressure of 70/53 and clammy skin.

Two junior resident physicians came to her room, started a saline IV to raise her blood pressure and ordered a "stat" CBC. The residents apparently expected the blood work to be done right away and to be advised of the results right away. Then they were going to confer with a senior obstetrical resident about what to do, but none of that ever happened.

The patient's husband asked the nurses if it was OK to delay the blood tests until morning. His wife was completely exhausted from her ordeal earlier that day delivering three babies. The nurses agreed.

The nurses never followed through to see that the lab sent someone to draw the blood.

At 6:00 a.m. on morning rounds the residents discovered the patient in cardiopulmonary arrest. The patient had been bleeding into her abdominal cavity. Her hemoglobin was 4 and her hematocrit was 12%, midrange normals being 14 and 42%.

She now has severe brain damage and is semi-comatose and institutionalized. **Confidential v. Confidential, 2007 WL 4896737 (Sup. Ct. Los Angeles Co., California, November 21, 2007).**