LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession
April 2014 Volume 22 Number 4

Nurse's Medication Error: Hospital Admits Nurse Was At Fault, Jury Finds No Liability.

The patient came to the E.R. for an allergic reaction to acetaminophen with codeine she had taken earlier that day for pain from a dental procedure.

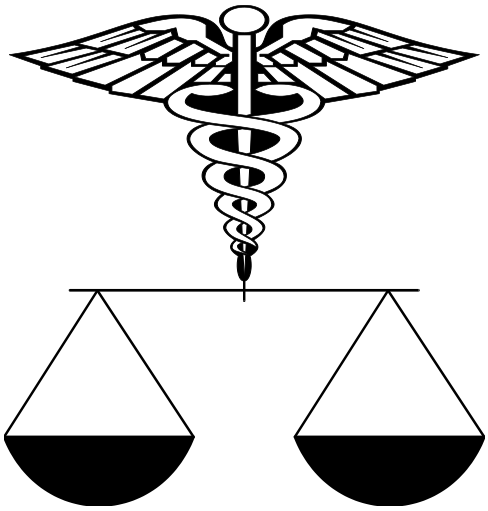
The E.R. physician ordered three medications, two to be given by the E.R. nurse intravenously and a third, epinephrine, to be given subcutaneously.

The E.R. nurse erroneously gave all three medications IV. The patient immediately sat up, put her hands on her chest, said that her heart was palpitating and then became pale, nauseous and anxious, cried out in pain and vomited.

The nurse quickly realized the patient's reaction was caused by the epinephrine taking effect too rapidly due to her own mistake giving it IV.

The nurse alerted the E.R. physician, candidly explained what happened and had the patient transferred to the ICU. The nurse completed the necessary risk-management reports before leaving at the end of her work shift.

During the patient's week-long stay in the ICU the E.R. physician and various people from hospital administration and risk management spoke with her. They frankly admitted to the patient and to her family that a mistake had been made. The family's attorney was present at some times.



The hospital admitted the nurse's giving epinephrine intravenously rather than subcutaneously was a violation of the standard of care.

However, no hospital staff member ever admitted to the patient or testified in court that any harm continued after the patient was discharged from the ICU where she was taken after the incident.

COURT OF APPEALS OF UTAH
February 21, 2014

After being discharged from the hospital the patient came back six times to the same hospital's E.R. Full assessments and various cardiac and neurological testing never found anything but an unrelated kidney infection.

Almost a year later the patient filed a lawsuit against the hospital for $5.7 million for anoxic brain damage, cardiac damage, thoracic outlet syndrome, headaches, depression, anxiety, cognitive defects and neck, shoulder and back pain, all allegedly caused by the E.R. nurse's erroneous administration of the epinephrine IV rather than sub q.

The hospital admitted liability in the lawsuit, that is, a formal stipulation was filed in court that the nurse's error fell below the standard of care.

On the issue of causation, however, the hospital brought in a neurologist, neuropsychologist, cardiologist and others to testify as experts that the patient suffered no permanent sequelae caused by the nurse's error.

The Court of Appeals of Utah affirmed the jury's defense verdict in favor of the hospital.

The patient challenged the jury's verdict on the grounds that the verdict was improperly influenced by the district court trial judge's decision to keep

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from the jury's attention statements by the hospital's risk manager and administrator to the effect that the patient should not worry, that everything would be taken care of and she could return to the hospital if she needed.

The family was told the patient had been "given the best room in the house" and that the specialists at the hospital were going to give her the best care possible. One physician went so far as to say they were sorry the hospital "messed up" and there were complications.

The Court ruled, however, that any statements by hospital employees which could be interpreted as admissions of fault were irrelevant because the hospital formally admitted fault at trial.

None of the Hospital's Statements Admitted Any Complications Were Caused by the Nurse's Error

None of the statements by hospital personnel the patient claimed the jury should have heard could be interpreted as an opinion on the issue whether any permanent residual harm to the patient was caused by the nurse's error.

Whether there were permanent residual complications was the only issue for the jury, and the jury decided that issue in the negative based on the overwhelming expert medical testimony from the treating and consulting physicians.

An adjuster from the hospital's insurer assured the family that the hospital would not bill the patient for her care in the ICU, but even though the hospital was at fault, there would nevertheless be no payment made for anything which could not be related to the E.R. nurse's error.

Offers to pay for medical expenses, apologies, expressions of sympathy and explanations of the events which led to an unexpected outcome are expressly excluded from a court trial by the legal rules of evidence.

The hospital benefited by admitting liability while preserving the issue of causation of damages for the trial. All hospital staff who interacted with the patient were on board with that plan from the start. **Lawrence v. Mountainstar, __ P. 3d __, 2014 WL 685594 (Utah App., February 21, 2014).**

The hospital formally admitted to the court that the nurse's administration of epinephrine intravenously rather than subcutaneously was a violation of the standard of care.

However, the hospital never conceded that the nurse's error caused any lingering harm after the patient was discharged from the ICU where she was taken after the incident, in its admission to the court or when staff interacted with the patient.

That made any statements irrelevant and inadmissible by hospital personnel even if they could be interpreted as admissions of fault.

Statements by facility personnel are not admissible against a healthcare facility that apologize for what happened or express sympathy, commiseration, condolence or compassion, which describe the sequence of events which led up to an unanticipated outcome or even which offer to furnish or to pay for medical, hospital or other expenses resulting from an injury.

It is a fine line, because offering her the option to return to the E.R. might imply that something is still wrong for which she might need to come back.

COURT OF APPEALS OF UTAH
February 21, 2014

Sudden Cardiac Death: Nurses Ruled Not At Fault.

The patient had an apparent cardiac event at home involving chest pain radiating into his left arm accompanied by diaphoresis and shortness of breath.

He phoned a clinic asking for a next-day appointment, telling the nurse he was having pain and numbness in both his arms and wrists which he believed was caused by computer use at work.

The next day when he came into the clinic he told a nurse he had had chest pain in the past but none recently. Then at the same visit he saw a nurse practitioner and told her basically the same thing. The nurse practitioner did an EKG and got a chest x-ray, which appeared normal.

The day after that he collapsed at work and was taken to an E.R. Cardiac catheterization was unsuccessful and he died.

The nurses met the standard of care.

The charting for his phone call and for his visit to the clinic clearly reflect the patient's responses to a series of questions aimed at determining why he wanted to be seen.

He did not report chest pain at the time or any recent episode of chest pain.

UNITED STATES DISTRICT COURT
WEST VIRGINIA
February 20, 2014

The US District Court for the Southern District of West Virginia ruled the nurses were not at fault.

The chart showed that the nurses carefully documented their inquiries into the man's symptoms that were specifically targeted at ruling out a cardiac event.

With the information repeatedly given to them by the patient there was no basis for the nurses to direct the patient to an emergency room for immediate cardiac evaluation and treatment. They could not be held responsible for his death. **Wade v. US, 2014 WL 670849 (S.D. W.Va., February 20, 2014).**

Pain Medication: No Proof Nurse Violated The Standard Of Care.

The patient complained to her nurse she was having severe pain while recovering in the hospital shortly after surgical excision of her right breast and axillary node dissection.

The nurse was able to recount from her charting that she gave her patient Buprenex at 1:51 p.m. and then found the patient unresponsive at 2:30 p.m.

The patient was promptly intubated but remained comatose until she died eighteen months later, never having been weaned from the ventilator.

The nurse claimed in court that she did check on her patient during the thirty-nine minute interval, but it was not documented in the chart. The husband claimed the nurse never checked on the patient.

Even if there was a lapse of thirty-nine minutes between administration of the medication and discovery of the unresponsive patient, that does not amount to an obvious departure from the nursing standard of care.

COURT OF APPEAL OF LOUISIANA
March 5, 2014

The Court of Appeal of Louisiana dismissed the husband's lawsuit.

A patient being found unresponsive after receiving medication from a nurse, in and of itself, does not prove a departure from the standard of care by the nurse.

The hospital's nursing protocols did not define a specific time frame for a nurse to monitor or to check back on a patient after administration of a narcotic analgesic, nor was the husband able to produce testimony from a nursing expert establishing a specific time frame.

Without expert testimony to define the standard of care and to prove a violation of that standard, the husband had no case. **Smith v. Rapides Healthcare, __ So. 3d __, 2014 WL 852361 (La. App., March 5, 2104).**

Haldol: No Proof That Medication Caused The Patient's Death.

The elderly patient was brought to the hospital for treatment for smoke inhalation she suffered during a fire in her apartment.

Her diagnoses included hypertension, chronic obstructive pulmonary disease and Alzheimer's dementia.

Early one morning about six weeks after being discharged from the hospital to long-term care a nurse found her sitting up in bed in a highly agitated state trying to get dressed. The nurse phoned the physician who ordered 1mg of Haldol which the nurse gave intramuscularly.

Ninety minutes later the patient was found dead.

The family of the deceased has failed to demonstrate that any departure from the standard of care actually caused the deceased's death.

NEW YORK SUPREME COURT
APPELLATE DIVISION
February 25, 2014

The New York Supreme Court, Appellate Division, dismissed the lawsuit the family filed against the nursing home.

The fact the elderly patient happened to pass away ninety minutes after receiving medication from a nurse proved nothing, in and of itself.

The patient's EKGs had showed a rapid heart beat but no arrhythmia. Thus it was irrelevant whether Haldol is contraindicated for patients with arrhythmia. Vital signs taken by the nurse after the injection actually showed the heart rate had slowed.

Congestive heart failure was the cause of death found in the autopsy, yet the medical chart showed no indication of congestive heart failure before the patient died. Thus there was no reason for the nursing home staff to have been aware of it or taken it into consideration in care planning. **Wong v. German Masonic, 114 A.D. 3d 588, __ N.Y.S.2d __ (N.Y. App., February 25, 2014).**

Skin Care: Court Sees Violation Of The Standard Of Care.

Family members filed suit on behalf of the deceased resident's probate estate against the nursing facility where he had spent his final days.

The lawsuit alleged negligence by the facility's nursing staff which led to severe pressure ulcers.

There is no consistent evidence in the medical chart that the plan of care formulated on admission and subsequent modifications were ever initiated by the nursing facility.

COURT OF APPEALS OF TEXAS
March 19, 2014

The Court of Appeals of Texas accepted a physician's expert opinion that the facility did violate the standard of care.

According to the family's expert, the Braden Scale was used on admission to assess the patient's potential for loss of skin integrity and development of pressure sores, but the scoring showing he was not at risk had to have been inaccurate because in fact he later developed pressure lesions.

Later in his stay his risk factors were reassessed and his care plan was modified for incontinence care to be provided every two hours, for staff assistance to be provided for transfers and for more attention to be given to his needs for adequate nutrition and hydration. He was also supposed to be provided with a special pressure-reduction mattress and a gel cushion to go under his bottom in his wheelchair.

No Documentation That Interventions Were Carried Out

The telling point for the Court was that the medical chart did not contain progress notes or other documentation that the interventions called for in the care plan modification were ever actually provided to the patient. **Cedar Senior v. Nevarez, __ S.W. 3d __, 2014 WL 1047039 (Tex. App., March 19, 2014).**