Overdose: Family Members Can Sue If Cause Of Death Misrepresented By Caregivers.

The patient was in the hospital recovering after hip surgery.

She was given esmolol when her blood pressure and heart rate spiked. After getting the esmolol the patient went into cardiac arrest and died.

The physicians and nurses caring for the patient documented in her chart that she died from stress associated with surgery. The medical examiner did only a partial autopsy and then the released the body to the family for burial.

Then word began to circulate that the patient's caregivers were covering up the fact she really died from esmolol toxicity. When word got around to the medical examiner he placed a call which reached the daughter during the funeral out of state. He ordered her to return the body for a more thorough autopsy. Esmolol toxicity was established as the cause of death.

If the facts can be proven, the family has the right to recover damages from the doctors, the nurses and the hospital for intentional misrepresentation and for intentional infliction of emotional distress.

COURT OF APPEAL OF FLORIDA
May 7, 2010

Although the necessary facts remain to be proven, the Court of Appeal of Florida ruled the family members are entitled to their day in court even if they cannot prove that a negligently administered medication overdose was what killed their loved one.

The family can allege in court that they suffered emotional harm if the patient's caregivers did conspire to misrepresent the cause of their mother's death and thereby cause a grossly outrageous mishandling of their late mother's remains. **Thomas v. Hospital Board, ___ So.3d __, 2010 WL 1816251 (Fla. App., May 7, 2010).**

Pneumonia: Nurse Practitioner Met Standard Of Care.

The Court of Appeals of North Carolina agreed with the jury's verdict which exonerated a family nurse practitioner from liability for her patient's death.

The Court accepted the testimony of a family nurse practitioner who testified as an expert witness for the defendant family nurse practitioner.

Assessment, Care Appropriate
Patient Died From Other Causes

The patient walked into the clinic with symptoms which had begun three days earlier. He was short of breath and coughing up yellowish phlegm, some of which was blood-tinged. He was not dizzy or nauseous and denied chest pains and heart palpitations.

The nurse practitioner who saw him, whom his widow would later sue, obtained a history of hypertension, diabetes, elevated cholesterol and smoking.

The nurse practitioner's physical exam revealed low blood pressure, elevated heart rate, normal respiratory rate, good skin color, normal mental status and bilateral rhonchi in the lungs.

Her diagnosis was community acquired pneumonia. She gave him a DuoNeb treatment, an albuterol inhaler to take home, IM Rocephin, prescriptions for oral Augmentin and prednisone and a follow-up appointment two days later and sent him to the hospital for a chest x-ray.

Late that same night the wife drove the patient to the E.R. when he started gasping for air. He was dead on arrival.

The autopsy showed few pneumococcus bacteria in the lungs, indicating that the antibiotics had been working, and significant narrowing of the major coronary arteries. Pneumonia was listed as the cause of death, although other medical experts testified in court he died from arrhythmia associated with coronary artery disease.

The jury concluded the clinic nurse practitioner's care was appropriate based on the signs and symptoms she observed. The nurse practitioner had no reason to anticipate he needed to be hospitalized that day for his chronic coronary condition. **Langwell v. Albemarle Family Practice, __ S.E. 2d __, 2010 WL 1754764 (N.C. App., May 4, 2010).**

IV Infiltration: Critical Care Nurse Did Not Meet The Standard Of Care.

The patient was in the critical care unit recovering from coronary bypass surgery. He was under heavy sedation from propofol infusing through an IV in the back of his right hand. He had numerous other IV's infusing at other locations.

Hospital policy required the patient's nurse to check all IV's and document an assessment at least every four hours.

According to the chart, the nurse checked the right-hand IV at 7:00 p.m. when her shift started and again at 4:30 a.m. At 4:30 a.m. significant infiltration of the medication into the surrounding tissues was discovered, which led to complications from tissue damage.

It is below the standard of care not to check an IV every four hours if required by the physician's orders or by hospital policy.

However, it does not follow automatically that having checked the IV would have prevented tissue damage from infiltration.

CALIFORNIA COURT OF APPEAL
May 6, 2010

The California Court of Appeal agreed with the patient's nursing expert. If no IV checks were documented from 7:00 p.m. until 4:30 a.m., then none were done, and if none were done, the nurse's care of her patient fell below the standard of care.

The Court did not accept the implication from documentation of checks of other IV sites or drawing of blood from another port on the right hand for blood glucoses q 2 hours that the propofol was also checked as often as it should have been.

However, the hospital was found not liable because the patient had no proof that if the IV had been checked as required the bad outcome would not have occurred. **Galvez v. Loma Linda Univ. Hosp., 2010 WL 1806296 (Cal. App., May 6, 2010).**

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