Pediatric Intensive Care: Court Looks At The Nursing Standard Of Care For Trache Patient.

The two-week-old infant was transferred to the hospital's pediatric intensive care unit (PICU) from another hospital for management and treatment of a rapid heartbeat.

The family's lawsuit alleged that the patient's PICU nurse asked the mother to feed the infant. The infant became fussy and the mother wanted to ask the nurse for help but the nurse was not available and did not respond right away. When the nurse finally came to the bedside she saw an air bubble under the baby's skin.

The nurse thought the trache tube was obstructed and she panicked. She tried and failed to replace the tube. She tried to suction the tube site but did not repeat the suction. She did not attempt to replace the trache tube with one of a smaller size. After more than thirty minutes trying to solve the problem on her own, the PICU nurse called a code. The code team were able to resuscitate the infant.

The Court of Appeals of Texas reviewed the opinions of the family's nursing expert and medical expert and ruled there were grounds for the family's lawsuit against the nurse and her employer the hospital to proceed to a jury trial.

Nursing Expert's Opinion
Standard of Care

If a displaced tracheostomy tube is suspected, the standard of care requires bilateral auscultation of breath sounds, observation of chest rise and fall and use of an exhaled CO_2 detector to assess for placement. An obstructed tube is suspected with decreased breath sounds bilaterally or decreased chest rise and fall.

The standard of care requires that saline be injected into the trache tube to thin secretions, then a properly sized suction catheter is to be passed into the tube and suction applied to clear secretions.

If the obstruction is still present, the procedure is to be repeated with ventilation attempted between attempts.

If there is no improvement in respiratory distress the trache tube is to be changed immediately. If the tube does not pass easily, the attempt is to be made immediately with a smaller sized tube to re-establish an airway.

The family's nursing expert is qualified to express an expert opinion on the standard of care applicable to the nurse caring for this patient in the hospital's pediatric intensive care unit.

She is a registered nurse and has a bachelor's degree and a master's degree in nursing and is pursuing a doctorate.

She has spent her entire fifteen-year career in pediatric intensive care environments working in or supervising nurses working in the same position as the defendant nurse.

She has served as a staff nurse, staff educator, nurse manager and director of women's and children's services for a hospital system and has taught courses in emergency pediatric nursing.

However, because the family's nursing expert is not a physician she will not be allowed to give an expert opinion linking breaches in the standard of care by the patient's nurse to the profound brain trauma and neurological aftermath sustained by the infant.

The family's board-certified pediatric otolaryngologist can give such an opinion in this case.

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After the tube is placed, the correct placement of the tube is to be assessed with at least two confirmatory measures such as listening to breath sounds, visualization of equal rise and fall of the chest and use of the CO_2 detector, all of which is to be documented by the nurse.

A reasonably prudent nurse is required to recognize the infant's critical assessment findings and initiate an emergency response immediately. The standard of care for severe airway obstruction in children requires that practitioners call early for advanced help.

The hospital has the responsibility to provide properly trained and experienced PICU nurses with advanced pediatric life support training to care for the patient.

The hospital PICU must provide equipment such as suction catheters, tracheal intubation supplies, endotracheal tubes of all sizes and when a patient has a fresh tracheostomy a replacement trache tube of the same size and one size smaller must be kept at the beside.

Physician's Expert Opinion
Standard of Care

The family's board certified otolaryngologist added that the risk of accidental dislodgement of a fresh trache tube must be anticipated. Patient care must be arranged in such a way as to minimize such risk.

Staff caring for a pediatric trache patient should have a care plan for close monitoring of the patient and immediate recognition of accidental dislodgement and initiation of action to secure the airway.

All available professional help should be mobilized immediately when a trache tube becomes displaced or obstructed, including contact by the nurse with the attending physician and the surgeon who placed the trache tube.

A trache tube should never be bag ventilated unless the tube has been confirmed to be in the trachea.

The physician faulted the nurse for a significant delay from when the problem was first noticed until the code was called, that delay being the likely cause of the infant's profound brain damage. **Rio Grande Reg. Hosp. v. Ayala, 2012 WL 3637368 (Tex. App., August 24, 2012).**