Perioperative Nursing: Court Says Nurses Should Have Advocated For The Patient.

The patient was admitted to the hospital to have a small cyst surgically removed from his left forearm.

The anesthesiologist placed a line in the jugular, started propofol and then inserted a laryngeal mask airway.

The patient soon began having difficulty breathing, so the anesthesiologist removed the first airway and inserted a second, but the patient's breathing difficulty continued. The anesthesiologist then paralyzed the patient in order to intubate him, but was unable to intubate him. He went into cardiopulmonary arrest and became completely unresponsive

The brain-dead patient passed away later, after his lawsuit had been filed.

Lawsuit Named Nurses As Defendants

In addition to the hospital, the anesthesiologist and other physicians, the patient's spouse's lawsuit named as defendants the hospital's director of nursing, the surgery department's nurse manager, the charge nurse on duty and three staff nurses.

Two years ago the Court of Appeals of Texas dismissed the director of nursing, the nurse manager and two of the three staff nurses.

In July 2013 the Court ruled there are grounds for the lawsuit against the charge nurse and the perioperative staff nurse in the room when the events transpired.

Director of Nursing / Nurse Manager

The family's expert witnesses were of the opinion that the legal responsibilities of so-called administrative nurses included the following:

Ensure that the clinical and administrative staff is competent;

Have and enforce appropriate policies and procedures and make sure they are implemented;

Make sure the clinical staff know and understand the policies and procedures;

Work together to define the required qualifications and competence of staff who provide care, treatment and services.

Problem for the lawsuit was, according to the Court, there was no specific failure identified on the part of the administrative nurses which was a causative factor in the outcome. A tragic outcome, in and of itself, does not necessarily imply fault by any of a patient's caregivers.

The charge nurse and the perioperative nurse were guilty of negligence for failing to initiate the chain of command when the anesthesiologist started the procedure with only the perioperative nurse present in the room, that is, without other personnel present.

The perioperative nurse was negligent for failing to call for help in a timely manner when the intubation first failed.

At the beginning of the procedure the patient had been given 200 mg. of propofol. Had that been allowed to wear off, the patient likely would have woken up and started breathing on his own.

If the nurse had initiated the chain of command, and other persons including the surgeon and possibly other physicians had come in, a collaborative discussion would have taken place in which the anesthesiologist would have been persuaded not to paralyze the patient, already on the propofol, with a neuromuscular blocking agent to intubate him, or the other physician or physicians could have assisted with or taken over the task of effective intubation.

COURT OF APPEALS OF TEXAS
July 9, 2013

Staff Nurses / Documentation Errors

The charge nurse and three perioperative nurses were accused of failing to document meticulously the resuscitation efforts that began after the patient arrested during the failed intubation attempt that took almost a half hour.

The Court agreed that it is a nursing responsibility to document what specific interventions are being performed during a code and identify specifically what is being done by whom. In the heat of the moment that apparently was not done.

Problem was, however, according to the Court, there was no evidence linking this particular instance of substandard nursing documentation to the unfortunate outcome for which the lawsuit was filed.

Charge Nurse / Staff Nurse Nurses Failed As Patient Advocate

In its recent opinion the Court ruled there are grounds for the lawsuit against the charge nurse and the perioperative nurse who was in the room when anesthesia was started.

According to the family's expert, the nurses' legal duty to advocate for the patient required action when the anesthesiologist started the case with only the nurse, and not also the surgeon, a scrub nurse, an anesthesia tech and other personnel present in the room.

There were insufficient resources in the room at that time to react appropriately in the event of an emergency requiring immediate intervention, the expert said.

The nurse who was present in the room should at least have called for assistance to come to the room when the first intubation failed.

There was also a failure by the anesthesiologist to set the alarms on the monitoring equipment, a fact the nurse in the room should have recognized and done something about.

Almost a half hour went by with the patient paralyzed while the anesthesiologist tried to get him intubated.

The nurses' failure to advocate for the patient was a direct factor, in the family's expert's opinion, in the hypoxic brain injury the patient suffered which ultimately led to his death. **Acedo v. Springs, 2013 WL 3477348 (Tex. App., July 9, 2013).**