Emergency Room: Hospital Nurses Ruled Not Liable.

The husband called paramedics after the forty-five year-old patient collapsed at home during a grand mal seizure.

She was revived in the ambulance on the way to the hospital but then had another seizure. The first vital signs were taken in the hospital by an E.R. nurse, pulse low 40's, BP 49 over palpable and Glasgow coma scale 3.

The physician right away gave Valium to prevent another seizure, then atropine and epinephrine to restart the heart, then started Anectine to facilitate intubation. Before intubation the patient expired.

The E.R. nurses should have triaged her as level-one, not level-two, recorded her vitals earlier and more frequently and should have questioned the physician's decision to give Valium with her vital signs so low.

However, it was only the physician's failure to intubate the patient promptly that caused her demise.

DISTRICT COURT OF APPEAL
OF FLORIDA
February 1, 2012

The District Court of Appeal of Florida overturned a jury verdict against the hospital for nursing negligence after the E.R. physician settled out of the lawsuit.

The E.R. nurse testified from the medical records that this patient presented with level-one acuity and someone erred checking the level-two acuity-level box on her E.R. face sheet.

The Court agreed with the family's experts that the E.R. physician should not have given Valium with the patient's depressed vital signs, but failure by the nurses to question that decision was not the cause of the eventual outcome. The physician's failure to intubate promptly was the cause of the patient's demise. **Hollywood Med. Ctr. v. Alfred, __ So. 3d __, 2012 WL 280243 (Fla. App., February 1, 2012).**

Low Platelet Count, Brain Bleed: Court Finds Nursing Negligence.

Initially the physician in the E.R. ordered Coumadin for the patient even after the results from the lab had come back and showed his platelet count was undetectable.

The E.R. nurses were faulted in the family's lawsuit for giving the Coumadin, that is, for not refusing to carry out the physician's order.

Nurses have a legal duty to follow and carry out the orders of the physician in charge of the patient unless those orders are obviously negligent.

The E.R. nurses were not responsible for evaluating the degree to which Coumadin's action in suppressing the production of fibrin could compromise blood clotting in this patient and, based on that evaluation, countermand the E.R. physician's judgment.

However, platelets ordered by the E.R. physician at 4:15 p.m. were not started by the E.R. nurse until 6:45 p.m.

The family's nursing expert identified that delay as a breach of the nursing standard of care and the family's medical expert said that it was a contributing factor in the patient's death.

COURT OF APPEALS OF MINNESOTA
February 6, 2012

The patient was on Coumadin in connection with his prosthetic aortic valve.

He went to an outpatient physician's office because of bleeding gums and bruising. He was told to return if the problem got worse. When he came back the next day the physician phoned the hospital where the E.R. physician agreed he should be sent in via ambulance.

At the hospital the E.R. physician at first ordered Coumadin as well as platelets. The nurses gave the Coumadin, but there was a two and one-half hour delay starting the platelets. Later that evening a hematologist took over. He stopped the Coumadin and ordered a steroid medication and IgG. The patient suffered an intracranial hemorrhage later that night and was sent to the ICU where he died.

Nursing Negligence

The Court of Appeals of Minnesota ruled there was no nursing negligence committed by the E.R. nurses who did not refuse to give the Coumadin ordered by the E.R. physician.

The Court ruled that that order, although later changed by the hematologist and unadvised in hindsight, was not obviously negligent at the time it was given.

The E.R. nurse on duty was ruled negligent, however, for failing to get the platelets started until 6:45 p.m. which were ordered at 4:15 p.m.

The nurse on duty later that night did not promptly give the steroid medication ordered by the hematologist and the IgG was apparently never given in the E.R. but was given in the ICU later that night.

The Court declined to hold the E.R. nurse responsible who delayed the steroid and did not give the IgG, but only because the patient's condition by then had deteriorated to the point that a serious negative outcome was already inevitable due to earlier errors and omissions by the E.R. nurse and the E.R. physician.

The Court said the E.R. nurses apparently were completely unaware of the physiologic dynamics going on with this patient and failed to understand the responsibilities they owed to him. **Kramer v. St. Cloud Hosp., 2012 WL 360415 (Minn. App., February 6, 2012).**