Post-Surgical Care: Nurses Did Not Monitor The Patient.

The fifty-seven year-old patient had had a discectomy and fusion of a herniated lumbar disc.

Right after the procedure he complained to the nurses about pain and numbness in his left foot. The nurse noted the foot was cool but the patient had sensation and could move the foot. The other foot reportedly was warm and had brisk capillary refill. Three hours later the patient was in intense pain. Two hours after that, at the 9:00 p.m. change of nursing shifts, the left foot was cold.

The jury heard conflicting testimony from the nurses and the physician as to whether the nurses notified the physician what was going on with the patient that afternoon and evening.

However, after the 9:00 p.m. nursing shift change there was nothing in the chart about the problem for almost 12 hours.

The next morning the patient's foot was cyanotic and partial a amputation had to be done.

DISTRICT COURT
HIDALGO COUNTY, TEXAS
April 13, 2010

Shortly before 9:00 a.m. the next morning the left foot was cyanotic and the patient was unable to move his toes.

Emergency surgery was successful in saving the leg itself but part of the foot had to be amputated.

The hospital paid $250,000 during pretrial mediation to settle the patient's case that was filed in the District Court, Hidalgo County, Texas. **Salinas v. McAllen Hospitals, 2010 WL 1953614 (Dist. Ct. Hidalgo Co., Texas, April 13, 2010).**

Post-Surgical Care: Patient Has Complications After Bypass.

The fifty-eight year-old patient had coronary artery bypass surgery which involved harvesting a portion of the saphenous vein from his left thigh.

The wound on his left thigh was wrapped with an elastic bandage on the leg from foot to thigh, the rationale being to prevent swelling.

Orders from the physician called for the elastic bandage to be removed 24 hours after it was applied.

The patient's nurses did not remove the elastic bandage for 30 hours. By that time a pressure wound had developed just above the knee. The patient later developed a chronic pain condition in the foot.

The patient's nursing expert testified that physician's orders to remove the elastic wrap at 24 hours should have been followed exactly as written.

SUPERIOR COURT
LOS ANGELES COUNTY, CALIFORNIA
March 12, 2010

The jury in the Superior Court, Los Angeles County, California awarded $787,503 to the patient, 40% percent from the physician's assistant because he applied the elastic wrap too tightly in the first place and 60% from the hospital because the nurses did not properly assess it and promptly remove it at 24 hours.

The jury heard testimony that the nurses should have realized from their own assessments that the bandage was too tight and should have taken action, even though it was not their fault it was applied to tightly by the physician's assistant.

The patient's nursing expert also stated that the nurses had no discretion in interpreting the physician's orders. The orders did not give them the option to remove the wrap at 24 hours; they were compelled to do so at that time. **Hale v. Yokoyama, 2010 WL 1953571 (Sup. Ct. Los Angeles Co., California, March 12, 2010).**

Bed Rails: Nursing Home Patient Dies From Asphyxiation.

The eighty-three year-old patient was suffering from what was described as end-stage dementia.

While sleeping in her bed in a hospital's skilled nursing facility her head became trapped between the bed and the bed rails with her face down against the mattress.

The patient was found dead from asphyxiation.

The family's lawsuit filed in the Supreme Court, Clinton County, New York alleged that it is below the standard of care for an elderly dementia patient who does not need bedrails for his or her own safety to have bedrails on the bed, given the potential danger of entrapment of the head and resulting asphyxiation. The facility had actually already begun removing the bedrails from some of the other beds.

The lawsuit also claimed there should have been a monitor installed, although the nursing home's experts were prepared to argue that would not have made a difference because the nurses routinely get lots of false alarms from bed monitors that do not signal anything wrong with the patient.

The facility agreed to a $190,000 settlement after the jury had deliberated three days without reaching a verdict one way or the other. **D'Aust v. Champlain Valley Physicians Hosp., 2010 WL 1747533 (Sup. Ct. Clinton Co., New York, March 17, 2010).**

Fall: Jury Awards Damages.

The elderly patient fell from his hospital bed twice between 7:30 p.m. and 2:00 a.m. His lawsuit in the Circuit Court, Broward County, Florida alleged his fall risk should have been assessed on the Morse Fall Assessment Scale and that a sitter should have been provided.

The jury awarded $1,364,582 but ruled at the same time that the patient himself was 65% at fault. **Indeck v. Healthsouth, 2010 WL 1953548 (Cir. Ct. Broward Co., Florida, April 9, 2010).**

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