Post Surgical Care: Nurses Faulted, Failed To Read Signs And Report To Physician.

The patient was admitted to the hospital for surgical revision of an anterior cervical fusion.

After surgery the patient was taken to the post-anesthesia care unit, then transferred to the spine-institute floor at approximately 4:00 p.m.

At 7:00 p.m. he reported to his nurse that his pain had increased. At 7:30 p.m. and again at 8:00 p.m. he told a nurse he was having difficulty swallowing and pain in his nose.

At 8:30 p.m. he used his call light to call a CNA whom he told he was having trouble breathing and swallowing. The CNA told the charge nurse. She came and checked on him at 8:40 p.m. He was alert and his O_2 sat was normal, but he had noise in his lungs on exhalation and was coughing up phlegm. At 8:50 p.m. two nurses checked him again and paged respiratory therapy for a nebulizer treatment.

The nebulizer treatment was started at 9:20 p.m. The patient stopped breathing three minutes later. The respiratory therapist called a code. The patient was intubated at 9:59 p.m. and then sent to surgery to remove a hematoma that was blocking his airway. The surgery was too late to save him. He passed away six days later.

Nurses Were Trained To Look For Signs of Retropharyngeal Hematoma

The Court of Appeals of Minnesota noted for the record that the patient's nurses had been trained to look for possible signs of airway constriction following the type of surgery this patient had had.

The nurses misread the signs by assuming the problem was in the lungs, trachea or bronchi and deviated from the standard of care by calling for a nebulizer treatment. That decision should have been left to a physician. According to the Court, a physician would have recognized airway constriction was the basic problem and would have intubated or had someone intubate the patient promptly, which most likely would have saved his life. **Kuhne v. Allina Health System, 2010 WL 2363406 (Minn. App., June 15, 2010).**

The patient's family's medical expert's theory of malpractice is that the deceased's death was caused by the nurses' failure to alert a physician about the patient's signs and symptoms.

If a nurse had reported to the physician, the physician would have recognized the potential existence of a hematoma that was compromising the airway and would have ordered or performed an intubation to maintain oxygen flow.

The family's expert has never performed surgery to remove a hematoma following cervical disc surgery, but that is not the point.

He has familiarity, through his education, training and experience, with post-surgical intubation to open an airway obstructed by a hematoma.

The critical fact is, there would have been time to perform an intubation and save the patient's life if the patient's nurses had appreciated what was going on and reported in a timely fashion to a physician.

There is sufficient evidence for the family's case to go forward.

COURT OF APPEALS OF MINNESOTA
June 15, 2010