

Prescription Error: Nurse Caught Mistake, Suit Dismissed.

The patient went into respiratory arrest on her second day in the hospital but was revived without complications.

After she was discharged from the hospital she and her family came to believe that her arrest was caused by an overdose of narcotics. In fact, her physician had written an order for her for 30 mg of Dilaudid, a substantial overdose.

The patient's nurse, however, realized it was way too much. Following standard nursing practice, she phoned the physician before going ahead.

The physician immediately agreed that it was a mistake and told her the correct dose was 3 mg, not 30 mg. The nurse went ahead and gave the medication only after the dosage was clarified to her satisfaction.

The Court of Appeals of Tennessee said there was some confusion created by the new order for 3 mg never being entered in the physicians' orders in the chart. The nurse wrote a progress note about calling the physician and giving the correct dose, but never corrected the original erroneous 30 mg order. **Wall v. Hillside Hosp., 2008 WL 275968 (Tenn. App., January 31, 2008).**