Suicidal Patient: Family's Calls Not Noted, Large Settlement For

As required by state law, the surviving wife's and daughter's wrongful death claim alleging medical negligence was submitted to a medical review panel.

The panel concluded there was negligence and that negligence caused the patient's death. He committed suicide by hanging himself from the shower head in his bathroom shortly after voluntary admission to a psychiatric facility. A substantial settlement was offered.

No chart note was made of three phone calls to the facility from his wife and daughter shortly after admission to inform the hospital of suicidal verbalizations he had made shortly before admission. The court did not specify who was at fault at the facility.

The Court of Appeal of Louisiana's opinion dealt mostly with whether and to what extent settlement with the state's patient compensation fund released certain defendants from the lawsuit. **Remet v. Martin, 737 So. 2d 124 (La. App., 1999).**

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Suicidal Patient: Court Faults Psychiatric Nurses' Care Of Self-Inflicted Gunshot Wound.

Psychiatric nurses caring for a patient with a self-inflicted gunshot wound must accurately assess the severity of the patient's physical condition and report it to the attending physician or to more senior nursing staff.

Nurses must appreciate the signs of possible infection of a wound that is open, inflamed and draining, and must report those signs and note them in the progress notes.

The wound should have been cultured so that appropriate antibiotic therapy could have been continued after the one dose of IV antibiotics the patient got while he was briefly on the ICU.

The nurses also should have appreciated that it was necessary to debride pillow batting material still present in the wound.

UNITED STATES DISTRICT COURT, KANSAS, 1999.

The patient tried to kill himself by shooting himself in the abdomen with a handgun. Before firing the gun he placed a pillow between the end of the barrel of the gun and his abdomen.

He was taken to the emergency room by paramedics. No surgery was needed. He was sent to the ICU, then sent to the psychiatric unit only one day after his suicide attempt. He was discharged after four days on the psychiatric unit.

Over the next few weeks it became apparent that significant amounts of pillow batting material had been allowed to remain in the wound, which caused an on-going infection and eventually required three separate debridement procedures.

The patient and his wife sued the hospital for mismanagement of the patient's gunshot wound while he was on the hospital's psychiatric unit. The U.S. District Court for the District of Kansas accepted testimony which faulted the nursing staff and the physician who was the attending on the psychiatric unit.

The court believed the wound should have been explored, debrided and irrigated with sterile saline while the patient was on the psych unit. The court felt detecting the need for debridement was a responsibility shared by the psych nursing and medical staff. The nurses and physicians also should have been aware the wound was showing signs of infection and taken steps to have the wound cultured so that appropriate antibiotic therapy could have been initiated. **Latshaw v. Mt. Carmel Hospital, 53 F. Supp. 2d 1133 (D. Kan., 1999).**