Dilantin Toxicity: Court Holds Nurses, Pharmacists Liable For Medication Error.

A seventy-three year-old gentleman fell at home and struck his head. He also sustained multiple spinal compression fractures. He was taken to the hospital.

On a hospital acute care unit he was prescribed Dilantin for seizure activity his physicians associated with the new head injury, along with numerous other medications.

The facility treated his transfer to rehab as a discharge and readmission. New physician's admitting orders were written and sent to the pharmacy to be transcribed into a medication administration record (MAR) for the rehab nurses.

His Dilantin was to be the same in rehab as in acute care, 300 mg po qhs. However, for the new MAR in rehab the pharmacy erroneously transcribed it as 3x100 mg caps t.i.d., basically three times the level actually ordered.

No Reason For Nurses To Question Order

The case was especially difficult because after a nurse had compared the MAR prepared by the pharmacist with the actual orders, the court said there was no reason for other nurses to question the physician's apparent decision to give this particular dose of this particular drug, as large loading doses Dilantin can be given early in treatment of new seizure activity.

The error was actually caught by a community pharmacist asked to fill his prescription after the man had been discharged with the same 900 mg/day Dilantin dosage, as that would be an unusually large dose outside of the hospital.

No Reason For Nurse To Seek Lab Tests

The court also said it is not a nursing responsibility to judge when it is necessary to obtain blood tests to assay a patient's Dilantin level, assuming, as in this case, that there were no signs of Dilantin toxicity seen in the hospital and the patient was under the effects of some twelve other medications. **Ferguson v. Baptist Health System, Inc., __ So. 2d __, 2005 WL 327354 (Ala., February 11, 2005).**

The hospital had an internal policy, designed as a safeguard against possible errors by the pharmacy in transcribing physicians' orders into the nurses' medication administration record (MAR), that any time a new order from a physician was entered, the first nurse to carry out the new orders was responsible for comparing the order itself with the entry on the MAR.

After that, the nurses who continued administering medications according to the MAR were not responsible for cross-checking the MAR against the physician's order.

The order versus MAR reconciliation process only took place once and only for new orders entered by the physician within the previous 24 hours.

It is not clear how or why the order was erroneously transcribed by the pharmacist or how or why the nurses missed the error in the MAR reconciliation process.

However, this is only a negligent error or omission. There is no basis to award punitive damages.

SUPREME COURT OF ALABAMA
February 11, 2005

Premature Infant: Court Questions Early Discharge, Discharge Instructions.

Twin babies were born 12 weeks premature to a forty-eight year-old first time mother who spoke little English.

Aside from normal problems associated with prematurity, one of the babies was fine. The second required surgery and a longer stay in the hospital. He was discharged home with an O_2 tank and a pulse oximeter.

At home when the mother tried to bottle-feed the second infant he vomited, but then seemed all right. Then she fed him again four hours later. He vomited again and his mouth and nose were clogged. The mother tried to clear his airway with a bulb syringe, but he became limp and could not be revived by paramedics.

The court should not have disallowed the parents' expert witness's testimony

CALIFORNIA COURT OF APPEAL
UNPUBLISHED OPINION
January 18, 2005

The California Court of Appeal ruled the judge should have allowed the jury to hear the parents' expert witness's theory of the case, that the child was discharged early and/or that the discharge instructions were inadequate.

The mother, unlike a trained neonatal nurse, did not realize it was inappropriate to go ahead with a subsequent feeding of an infant as sickly as this one without medical evaluation for the cause of the vomiting and medical approval to resume bottle feeding. If the infant were still in the hospital, or if the mother had been properly instructed, there was evidence the death would not have occurred. **Lee v. Hosp. of the Good Samaritan, 2005 WL 91256 (Cal. App., January 18, 2005).**