Nurse Refuses To Follow Order From Patient's Family Member: Court Overrules Nursing Board, Nurse Exonerated.

A registered nurse was fired from his employment and brought up on charges before the Nevada State Board of Nursing, following an incident in a hospital involving the care of a physician's elderly and terminally-ill father.

The Board found the nurse guilty and suspended his license for a year. The Supreme Court of Nevada overruled the Board as to all but one of the charges.

Pain control for terminally-ill patients was overseen by the anesthesiology department. A morphine drip was ordered for the patient. The nurse obtained the IV bag from the pharmacy and brought it to the floor. The patient's son, a physician with staff privileges at the hospital, hung the bag himself, set the flow wide open and emptied the bag. His father was still highly agitated and in great pain, so the father ordered the nurse to get a second bag with a similar dose. The patient had a high tolerance, but the two bags together contained an ordinarily fatal dose if given quickly back-to-back. The nurse refused the order.

Instead, the nurse phoned the anesthesiologist on duty, got an order for a smaller dose of morphine, and gave that dose. The nurse got the order at midnight, but back-charted it to 9:00 p.m.

The court ruled the nurse was at fault for back-charting this order. However, the charges of failing to collaborate with members of the healthcare team were thrown out. The court ruled it was accepted nursing practice for the nurse to refuse to carry out an order from a patient's family member. The court said it was not relevant that accepted standards for medical practice in the state did not rule out a physician treating a family member. **Nevada State Board of Nursing vs. Merkley, 940 P. 2d 144 (Nev., 1997).**

Injection Site And Mode Not Charted: Nurse Found Guilty Of Substandard Practice.

The nurse admitted in court she failed to chart the site and mode of an injection she gave a patient in the emergency room.

The court accepted expert witness testimony from two nurses that failing to chart this information is below the standard of care.

While failing to chart the site and mode of an injection could not have affected how the injection was actually administered, it does tend to indicate that in this instance the nurse did not follow accepted procedure while carrying out her job.

The nurse was allowed to testify about her customary practice for giving an IM injection. Her testimony after the fact reflected a correct understanding of where and how to give an injection.

However, two physicians testified the patient's injury could be consistent with a subcutaneous rather than intramuscular injection, and a third said that a nerve might have been struck by the tip of the needle.

After weighing the conflicting evidence, the jury found the nurse negligent and awarded damages.

COURT OF APPEAL OF LOUISIANA, 1997.

According to the court record in a recent case, a nurse gave the patient an injection of Demerol and Vistaril, per a physician's orders, when the patient was seen in a hospital emergency room complaining of chest pains.

For several weeks afterward, the patient had hip pain and a lump at the injection site. The patient claimed she was unable to work. A neurologist two months later formed a diagnosis of cutaneous gluteal neuropathy, for which physical therapy and a TENS unit were prescribed. The patient sued the emergency room nurse who gave the injection and her employer the hospital. The jury awarded over $90,000 in damages. The Court of Appeal of Louisiana upheld the verdict.

The lawsuit alleged the nurse had injured the patient by administering the injection in a substandard manner. However, there was no direct proof in the trial about what actually caused the patient's injury.

The nurse testified it would have been her routine practice to use a one-and-one-half inch needle, to insert it into the skin over the gluteal muscle at a ninety-degree angle deep into the muscle, then to aspirate the syringe for blood, then to inject the medication.

Several physicians were also called to testify. Their testimony taken collectively established that the patient's injury could have been caused by a faulty subcutaneous rather than deep muscular injection of the drug Vistaril, or that a nerve could have been hit by the needle tip due to inaccurate location of the injection site.

The critical testimony, according to the court, came from two nurses who testified as expert witnesses on the standard of care for nursing practice. They said it was below the professional standard of care for a nurse to neglect to chart the site and mode of an injection. This omission convinced the court the nurse must not have administered the injection properly. **Pellerin vs. Humedicenters, Inc., 969 So. 2d 590 (La. App., 1997).**