Feeding Tube: Nurses' Errors Led To Respiratory Arrest, Death.

The patient was admitted to the hospital with respiratory problems. Her physician ordered a nasogastric feeding tube and it was inserted.

The nursing staff discovered that the feeding tube had become occluded. The nurses removed the tube and put in a new one. Before feeding the patient the nurses obtained an x-ray. Some hours later the radiologist read the x-ray and called the floor to inform the nurses the tube was in the lung, not the stomach.

The nurses pulled out the tube, put it back in and called for another x-ray. However, before hearing back from the radiologist the nursing staff resumed feeding the patient through the tube, around noon on Saturday.

The radiologist did not read the new x-ray until 9:30 a.m. Sunday morning. In fact, the tube was again misplaced, this time through the trachea and left mainstem bronchus into the pleural space. The radiologist called the floor nurse and also called the patient's physician.

The patient's physician came to the hospital, only to find the patient was going into respiratory and cardiac arrest. Removal of a large amount of air and Ensure from her chest did not save her and she passed at around noon on Sunday.

The patient's probate estate filed suit only against the patient's treating physician and the hospital radiologist.

The Court of Appeals of Arkansas framed the issue as to the treating physician: were the nurses' chart notes that they had received verbal orders from him for two x-rays re tube replacement just routine chart entries at the hospital when nurses got routine x-rays on their own, or did the notes signify that the nurses had actually communicated with the physician about what was going on with the feeding tube?

The court ruled a jury would have to hear the evidence on the treating physician's liability, but dismissed the radiologist from the case. **Estate of Barnes v. Martindale, __ S.W. 3d __, 2008 WL 2514761 (Ark. App., June 25, 2008).**