Gastrostomy: Sepsis, Death Tied To Nurses' Failure To Check Patency Before Feeding.

The forty year-old patient was placed in a nursing home with head injuries which left him basically immobile and unable to communicate except with eye blinking and hand squeezes.

He had an 18 gauge French Foley gastrostomal feeding tube with an inflatable bulb at the proximal end to hold it in place once it was properly situated all the way into the upper quadrant of the stomach.

He pulled out his feeding tube and the nursing home sent him to the emergency room at the hospital next door.

Hospital Nurse Failed to Advocate

According to the Court of Appeal of Louisiana, the E.R. nurse went ahead and replaced the tube even though she knew she was not sure what she was doing. Instead of advocating for her patient to get a physician to check her work the nurse merely notified the nursing home when she sent the patient back that she was not sure she had correctly replaced the tube.

Nurse Did Not Check Tube's Patency

Back at the nursing home a nurse resumed feeding the patient without checking the tube. She later testified she believed there was no reason to check it and, even so, she was not trained to do so.

A different nurse later that afternoon detected a flow problem while giving meds through the tube. She sent the patient back to the emergency room and the hospital transferred him to another hospital.

An internist discovered that his nutrition product had been infused into the anterior abdominal wall.

Sepsis was detected the next day. Ten days later the family discontinued life support and the patient died.

The jury found the nursing home and the first hospital each 50% responsible. Substantial damages were awarded to the family for the pre-death pain and fright the patient experienced without any means to complain or communicate what was wrong. **Cockerham v. LaSalle Nursing Home, Inc., __ So. 2d __, 2006 WL 1155871 (La. App., May 3, 2006).**

A nursing home must have a policy and must make sure all the nurses understand that a patient is not to be fed or given medications through a gastrostomy tube if there is any question about the tube's correct placement.

The risk is sepsis from infusion of non-sterile material into the abdominal wall or peritoneum.

Any nurse caring for a patient with a gastric tube must be trained to recognize that when liquids will not flow freely there is a problem that must be addressed immediately.

That is, the infusion must be stopped and a knowledgeable physician or qualified nurse must check the correct placement of the tube and, if needed, properly replace the tube before any infusion is resumed through the tube.

In a nursing home setting that generally means a trip to a hospital emergency room for the patient.

A nurse who replaces a gastric tube and is unsure it is correctly situated must have a physician double-check what has been done.

COURT OF APPEAL OF LOUISIANA
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