Heparin: Nurse Started Infusion Too Soon After Epidural.

The patient came to the hospital for an emergency surgical procedure to remove a blood clot from his right leg which was done with an epidural anesthetic.

Then he was transferred to the post-anesthesia care unit where the anesthesiologist removed the epidural catheter that had been used to infuse the anesthetic.

Twelve minutes later the PACU nurse started IV heparin. The heparin was reportedly continued for more than twenty-four hours until the patient was found to have become quadriplegic.

The paralysis was caused by bleeding into the epidural space which was blamed on the heparin being started prematurely.

None of the caregivers disputed, after the fact, that it was an error for the nurse to start the heparin less than one hour after the epidural catheter was removed.

There was a basic breakdown in communication.

CIRCUIT COURT, OAKLAND COUNTY
MICHIGAN
March 6, 2009

The fifty-four year-old patient is now permanently paralyzed. The $1,900,000 settlement of the patient's lawsuit filed in the Circuit Court, Oakland County, Michigan was reported on condition that the names of the patient, caregivers and hospital remain confidential.

During settlement negotiations, it was reported, there was no dispute that it was an error to start the heparin less than an hour after discontinuance of the epidural catheter. The defendants reportedly did dispute among themselves whether the orders should have specified that or the nurse should have known. **Confidential v. Confidential, 2009 WL 2501799 (Cir. Ct. Oakland Co., Michigan, March 6, 2009).**

LEGAL INFORMATION FOR NURSES – Legal Eagle Eye Newsletter for the Nursing Profession Home Page