Hospital Discharge: Psych Patient Not Sent To Appropriate Care Setting, Nurse Liable For Death.

The fifty-three year-old schizophrenic patient had spent most of his adult life in psychiatric institutions and group homes.

His last residence before he died was a nursing home. The nursing home had an attendant take him to the outpatient urology clinic on a New York City hospital campus for evaluation of a urinary tract infection. The urologist did an outpatient bladder scan. He decided rather than go ahead with cystoscopy in the outpatient clinic it was better to admit the patient to the hospital so that cystoscopy could be done in the operating room.

The urologist reportedly told the attendant not to wait around for the patient as he would not be done until very late that evening. In fact, the patient would not be discharged until the next morning.

Nurse's Discharge Instructions Told Patient He Was "Going Home"

After the cystoscopy the patient got a Foley catheter and a urine bag. The discharge nurse's patient teaching apparently focused on how to take care of the catheter and empty the urine bag.

After going through the basics of Foley care the nurse simply allowed the patient to walk out of the facility alone.

The discharge nurse, regardless of what other hospital staff did or did not tell her, should have realized the patient was mentally ill and not able to meet his own basic needs in the community.

There were repeated references in the chart to the fact the patient was mentally ill and lived in long-term care. The nurse should have seen to it that he was returned to the nursing facility he came from to the hospital.

The jury ruled that the treating physician did depart from good medical practice. He failed to note expressly in the chart that the patient was to be sent back to the nursing facility where he resided.

However, the physician's omission was not what caused the patient's death.

NEW YORK SUPREME COURT
NEW YORK COUNTY, NEW YORK
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The patient was found dead in a New York City park eleven days later. The autopsy revealed he had gone without food or water for several days before he died and he apparently pulled the Foley catheter out by himself.

The family's lawsuit pointed to a breakdown in communication between the urologist, the urologist's physician's assistant and the discharge nurse.

It was not clear if the physician's assistant and the discharge nurse ever spoke directly. The discharge nurse nevertheless was somehow given to understand that the patient was to be discharged "home."

Not having reviewed the chart carefully the discharge nurse failed to realize that "home" for this patient meant the nursing facility he came from, not an independent discharge into the community.

The hospital's policy was that any patient with special discharge requirements was to be referred by the treating physician to the hospital social worker prior to discharge, who in this case could have simply made a phone call to the nursing home to send someone to come and pick him up.

The nurse settled before jury deliberations for $625,000 and the hospital settled for $125,000. The jury in the New York Supreme Court, New York County then returned a verdict clearing the urologist from liability. **Henderson v. North General Hosp., 2009 WL 903559 (New York Supreme Court, New York Co., New York, January 30, 2009).**