Morphine: No Evidence Of Overdose Or Other Negligence.

A four year-old child was administered morphine during tonsillectomy and adenoidectomy surgery.

An anesthesiologist determined that 1.5 mg of morphine was appropriate for a child of his age and size and that dose was given either by the anesthesiologist or a certified registered nurse anesthetist who was involved in the case.

The mother's lawsuit later tried to claim that 15 mg was given, but the hospital pointed out the largest vial of morphine available at the hospital held only 10 mg. The wasting of the remaining 8.5 mg of morphine was not documented in the chart. However, the wasting of the fentanyl that was ordered but not used was documented.

The child's pulse oximetry was documented at 99-100% O_2 saturation while he was intubated throughout the procedure.

In the post-anesthesia care unit (PACU) the child was given 20 mcg of Narcan because he was still very sleepy after he was extubated.

A hospital pharmacist testified that that Narcan dose would have completely reversed a 15 mg dose of morphine even if that much morphine had in fact been given.

The anesthesiologist who was on call for the PACU who ordered the Narcan also wrote an order that morphine was to be discontinued.

Based on that order in the chart the nurses who were on duty that afternoon in the PACU all testified they would have given no morphine to the patient.

Drowsiness continued in the PACU after the Narcan was given. The child was given albuterol breathing treatments, O_2 was continued through a mask and a chest x-ray was taken. A pediatric consult recommended transfer to the city's children's hospital, which was done later that night.

The child regressed to needing diapers for a time and exhibited other developmental problems up until his case against the hospital was decided at age fourteen.

Nevertheless, the Court of Appeals of Ohio dismissed the case. The only credible evidence for the Court to consider, the medical chart, disclosed no negligence in the operating room or in the hospital's PACU. **Heard v. Aultman Hosp., 2016 WL 1051631 (Ohio App., March 14, 2016).**

The child's surgery took place in 2005. His mother filed suit in 2011, voluntarily dismissed that case and re-filed the lawsuit in 2013.

For the summary judgment hearing in 2015 every individual who was involved in the child's care testified he or she had no recollection whatsoever of caring for this child.

The only credible evidence one way or the other was the medical records generated in the operating room and the post-anesthesia care unit on the day in question April 18, 2005.

The mother testified as to developmental problems experienced by her child after the surgery.

However, the medical records leave no doubt there was no negligence by the anesthesiologist who computed the morphine dose, the certified registered nurse anesthetist who gave the morphine in the operating room or the nurses in the post-anesthesia care unit (PACU).

Narcan given in the PACU in no way implies that too much morphine was given in the operating room or that the PACU nurses negligently gave additional morphine to the child contrary to the physician's order.

COURT OF APPEALS OF OHIO
March 14, 2016

Another Nurse's Patient: LPN Fired For Failing To Assess After Fall.

A CNA told the LPN that a resident of the nursing facility had just fallen in the hallway.

The LPN found the resident lying on the floor, gave her a quick visual once-over and did not notice anything wrong.

Knowing that another LPN was assigned to the patient, the LPN told the CNA to stay with the patient and walked to the nurses station to find the patient's assigned LPN. That LPN came and stayed with the patient until an RN arrived.

The facility's policy was that an LPN who responds to a patient fall must take vital signs, do neuro checks and stay with the patient until an RN arrives.

The LPN must also record the vital signs and responses to neuro checks, recent food and fluid intake, diagnoses, medications and relevant history.

COMMONWEALTH COURT
OF PENNSYLVANIA
March 2, 2016

The Commonwealth Court of Pennsylvania upheld the facility's right to fire the LPN for misconduct.

The LPN violated the facility's policy which defines an LPN's responsibilities when a patient is first found to have fallen.

According to the Court, the LPN was not excused from following her employer's policies and procedures for a patient's fall simply because the fallen patient was not her assigned patient.

Whether or not she or another LPN was assigned to the patient, her employer was entitled to expect her to perform immediately and later document all of the required assessment components and to remain with the patient until an RN arrived. **Lountzis v. Unemployment, 2016 WL 817222 (Pa. Cmmwlth., March 2, 2016).**