Nurse As Patient Advocate: Patient Should Have Been Transferred To The ICU.

After an orthopedic back surgery that went six hours without complications the patient was sent to a med/surg floor of the hospital for an anticipated three to seven day post-operative stay.

Late the second night and into the early morning of the third day he came down with pneumonia. His heart rate and breathing became rapid and his O_2 sat dropped. The physician prescribed an oral antibiotic. After a few hours the patient appeared to have stabilized. He was able to ambulate short distances without any trouble breathing.

At 4:40 p.m. that afternoon he awoke from a deep sleep in a highly agitated state and tried to get out of bed. Concerned that the patient might injure himself his nurse summoned help to keep him in bed. The nurse called the physician who ordered Valium which calmed the patient down.

That night the night nurse, knowing of his agitation and his attempt to get out of bed that afternoon, made this patient his highest priority and checked on him frequently. He gave him two doses of Dilaudid for extreme pain, the second less than two hours after the first even though it was prescribed q4 hours. Minutes later the patient coded and died.

Nurses Failed to Advocate For Transfer to the ICU

The Court of Appeals of Arizona found grounds for the family's lawsuit.

The Court of Appeals ruled the trial judge erroneously overruled the family's lawyers' attempt to offer the testimony of a physician and a nurse as expert witnesses.

Their testimony would have been that the nurses should have advocated for transfer to the ICU by 5:00 p.m. after the patient's nurse had to call for help to keep the patient safely in bed after he awoke from a deep sleep in a highly agitated state.

The patient died that night from respiratory failure due to pneumonia, fluid overload and very low O_2 saturation. The higher level of specialized care in the ICU compared to a med/surg floor probably would have saved the patient, the family's experts believed. **Craft v. Trainor, 2013 WL 2446098 (Ariz. App., June 4, 2013).**

The jury should have been allowed to hear the testimony of the family's medical expert.

The family's expert's opinion was that the treating physician should have sent the patient to the ICU.

In the ICU the patient would have been more closely monitored by critical care physicians including pulmonologists who could have prevented his respiratory arrest or responded more rapidly and effectively when he went into arrest.

The jury should also have been allowed to hear the testimony of the family's nursing expert.

The family's nursing expert's opinion was that it was below the standard of care for the patient's nurses not to advocate for transfer to the ICU after the patient, suffering with pneumonia, awoke suddenly from a deep sleep in a highly agitated state which required several nurses to hold him in bed until a dose of Valium calmed him down.

There was no error, however, in letting the night nurse testify that the second dose of Dilaudid was not a factor in his arrest.

COURT OF APPEALS OF ARIZONA
June 4, 2013

E.R.: Nurse Should Have Ruled Out Aortic Dissection.

The patient was taken to the E.R. by ambulance minutes after a sudden onset of severe back pain that the EMTs documented in their record he said felt like "someone hit him with a baseball bat."

The E.R. triage nurse noted in her record a different history also possibly obtained from the EMTs that the back pain had started two days earlier.

The nurse practitioner who saw the patient testified she could not recall if she looked at the EMTs' records or the triage nurse's notes to get the facts as to the onset of the patient's pain.

The nurse practitioner did admit in court that the patient's symptoms suggested a differential diagnosis of aortic dissection, that the definitive test was a CT scan with contrast and that she did not order a CT scan but instead discharged him with a diagnosis of thoracic spine strain.

The patient came back to the E.R. several times over the next few days and died from an aortic dissection.

The E.R. triage nurse did not accurately determine, document and report the onset and nature of the patient's pain.

The E.R. nurse practitioner knew that aortic dissection was a differential diagnosis but did not order a CT.

NEW YORK SUPREME COURT
APPELLATE DIVISION
June 7, 2013

The New York Supreme Court, Appellate Division, ruled there were grounds to hold the E.R. triage nurse liable for failing to assess, document and accurately report the onset and nature of the patient's pain, which are vitally important diagnostic data, and grounds to hold the nurse practitioner responsible for failing to obtain the diagnostic test that was indicated.

There were also complex allegations of negligence against the treating physicians. **Wilk v. James, __ N.Y.S.2d __, 2013 2451300 (N.Y. App., June 7, 2013).**