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Narcotic Overdose: Brain Damaged Patient Gets Large Verdict For Nursing Negligence.

The patient's podiatrist wrote an order for pain medication, the order to accompany the patient upon discharge from the hospital to a rehab facility for an expected one-week stay following foot tendon surgery.

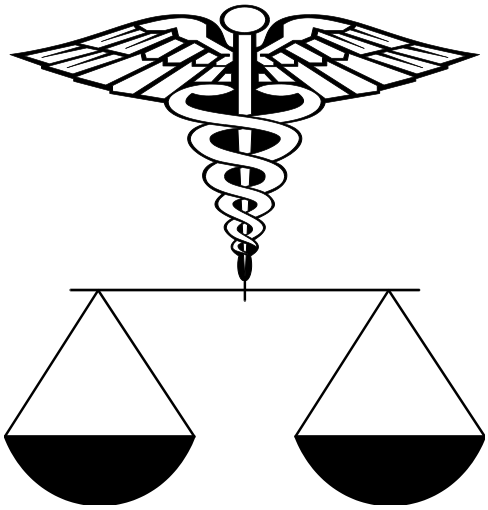
The podiatrist meant to order 50 mg of Demerol IM but instead wrote the order for 50 mg of morphine. He later admitted his mistake, that the dosage written was appropriate for Demerol but highly excessive for morphine.

The pharmacy in the rehab facility right away notified the nurse caring for the patient that 50 mg was an unusually high dose of morphine.

Verifying Questionable Drug Dosage Is a Nursing Responsibility

At this point the nurse was required by the rehab facility's policies and procedures to contact the treating physician to clarify the correct dosage before giving the medication. That was never done.

Instead, an individual in the rehab facility's administrative office was contacted for the go-ahead to administer the morphine. Nurses and other employees had to scour the facility looking for morphine to inject. The entire supply of morphine from the pharmacy and from emergency kits on the patient-care floors was pooled into one 30 mg dose that was given to the patient.



The podiatrist meant to order 50 mg of Demerol but instead wrote the order for 50 mg of morphine.

The nurses had to look everywhere just to find 30 mg of morphine to inject.

The nurse who gave it knew it was a mistake but gave it anyway and then did not check on the patient for signs of respiratory depression.

SUPERIOR COURT
ORANGE COUNTY, CALIFORNIA
August 19, 2010

The nurse who gave the medication admitted in court afterward that she realized the dosage was too high. On top of that the nurse did not monitor the patient's respiratory status after giving the narcotic and she never charted the dose before leaving for the day.

That night and early the next morning the nurses on duty did see signs of respiratory depression but they did not do anything about it or report it to the attending physician.

At 5:55 a.m. the patient was found unresponsive. He had pinpoint pupils and was barely breathing. An ambulance was called. The Glasgow Coma Scale assessment by the ambulance crew produced a score of only 4. Multiple doses of Narcan were given on the way to the hospital.

At the hospital it was discovered that the patient had suffered a mild heart attack and was in kidney failure due to lack of oxygen from narcotic-related respiratory depression.

The patient had to spend more than six months in a university teaching hospital undergoing rehab and still requires close supervision with his ADL's.

The jury in the Superior Court, Orange County, California awarded the patient $3,189,000. **Lefforge v. Covenant Care, 2010 WL 3918600 (Sup. Ct. Orange Co., California, August 19, 2010).**

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