Pain Medication: No Proof Nurse Violated The Standard Of Care.

The patient complained to her nurse she was having severe pain while recovering in the hospital shortly after surgical excision of her right breast and axillary node dissection.

The nurse was able to recount from her charting that she gave her patient Buprenex at 1:51 p.m. and then found the patient unresponsive at 2:30 p.m.

The patient was promptly intubated but remained comatose until she died eighteen months later, never having been weaned from the ventilator.

The nurse claimed in court that she did check on her patient during the thirty-nine minute interval, but it was not documented in the chart. The husband claimed the nurse never checked on the patient.

Even if there was a lapse of thirty-nine minutes between administration of the medication and discovery of the unresponsive patient, that does not amount to an obvious departure from the nursing standard of care.

COURT OF APPEAL OF LOUISIANA
March 5, 2014

The Court of Appeal of Louisiana dismissed the husband's lawsuit.

A patient being found unresponsive after receiving medication from a nurse, in and of itself, does not prove a departure from the standard of care by the nurse.

The hospital's nursing protocols did not define a specific time frame for a nurse to monitor or to check back on a patient after administration of a narcotic analgesic, nor was the husband able to produce testimony from a nursing expert establishing a specific time frame.

Without expert testimony to define the standard of care and to prove a violation of that standard, the husband had no case. **Smith v. Rapides Healthcare, __ So. 3d __, 2014 WL 852361 (La. App., March 5, 2104).**

Haldol: No Proof That Medication Caused The Patient's Death.

The elderly patient was brought to the hospital for treatment for smoke inhalation she suffered during a fire in her apartment.

Her diagnoses included hypertension, chronic obstructive pulmonary disease and Alzheimer's dementia.

Early one morning about six weeks after being discharged from the hospital to long-term care a nurse found her sitting up in bed in a highly agitated state trying to get dressed. The nurse phoned the physician who ordered 1mg of Haldol which the nurse gave intramuscularly.

Ninety minutes later the patient was found dead.

The family of the deceased has failed to demonstrate that any departure from the standard of care actually caused the deceased's death.

NEW YORK SUPREME COURT
APPELLATE DIVISION
February 25, 2014

The New York Supreme Court, Appellate Division, dismissed the lawsuit the family filed against the nursing home.

The fact the elderly patient happened to pass away ninety minutes after receiving medication from a nurse proved nothing, in and of itself.

The patient's EKGs had showed a rapid heart beat but no arrhythmia. Thus it was irrelevant whether Haldol is contraindicated for patients with arrhythmia. Vital signs taken by the nurse after the injection actually showed the heart rate had slowed.

Congestive heart failure was the cause of death found in the autopsy, yet the medical chart showed no indication of congestive heart failure before the patient died. Thus there was no reason for the nursing home staff to have been aware of it or taken it into consideration in care planning. **Wong v. German Masonic, 114 A.D. 3d 588, __ N.Y.S.2d __ (N.Y. App., February 25, 2014).**

Skin Care: Court Sees Violation Of The Standard Of Care.

Family members filed suit on behalf of the deceased resident's probate estate against the nursing facility where he had spent his final days.

The lawsuit alleged negligence by the facility's nursing staff which led to severe pressure ulcers.

There is no consistent evidence in the medical chart that the plan of care formulated on admission and subsequent modifications were ever initiated by the nursing facility.

COURT OF APPEALS OF TEXAS
March 19, 2014

The Court of Appeals of Texas accepted a physician's expert opinion that the facility did violate the standard of care.

According to the family's expert, the Braden Scale was used on admission to assess the patient's potential for loss of skin integrity and development of pressure sores, but the scoring showing he was not at risk had to have been inaccurate because in fact he later developed pressure lesions.

Later in his stay his risk factors were reassessed and his care plan was modified for incontinence care to be provided every two hours, for staff assistance to be provided for transfers and for more attention to be given to his needs for adequate nutrition and hydration. He was also supposed to be provided with a special pressure-reduction mattress and a gel cushion to go under his bottom in his wheelchair.

No Documentation That Interventions Were Carried Out

The telling point for the Court was that the medical chart did not contain progress notes or other documentation that the interventions called for in the care plan modification were ever actually provided to the patient. **Cedar Senior v. Nevarez, __ S.W. 3d __, 2014 WL 1047039 (Tex. App., March 19, 2014).**