Patient Suicide: Court Refuses To Fault E.R. Nurse's Assessment.

The young man was pulled over by the police on suspicion of drunk driving. He told the police he wanted to harm himself, so he was taken to the hospital.

In the emergency department a nurse spoke with him at length. He told the nurse he lied to the officers about his suicidal intentions to try to keep from being taken to jail for drunk driving.

To the nurse he expressly denied any thoughts of suicide or plan to harm himself and further denied ever having been treated for depression. He gave the same story to the physician who examined him.

He was discharged with a referral to a specific mental health clinic which he was instructed to contact if he became depressed or suicidal. He was also told he also had the option to return to the hospital's emergency department if he became depressed or felt like harming himself.

The twenty-one year-old patient hanged himself four days after discharge from the hospital's emergency department and died several days later.

A nurse interviewed the patient in the emergency department.

The patient told the nurse he had lied about wanting to harm himself so that the police would take him to the hospital rather than take him to jail for drunk driving.

He told the nurse he was not depressed or suicidal.

COURT OF APPEALS OF MICHIGAN
October 16, 2014

The Court of Appeals of Michigan ruled the hospital was not negligent for not taking steps to hold the patient for psychiatric treatment.

No error or omission by the hospital's caregivers caused the patient's death. **Brennan v. Chippewa Co., 2104 WL 5306621 (Mich. App., October 16, 2014).**

Post-Surgical Patient Death: Court Sees Nursing Negligence.

The patient's nurse deviated from the standard of care by failing to inform the surgeon or the physician covering for him that the packed red blood cells ordered more than four hours earlier that morning had not been given, according to the patient's family's medical expert.

The nurse deviated from the standard of care by not contacting the blood bank about the delay and emphasizing the fact the blood was needed immediately.

The nurse also should have told the physician about the continued tachycardia and tachypnea.

The patient's nurse should have questioned the decision to send the patient to the radiology department for a CT scan, that is, the decision to send the patient anywhere else but to the ICU immediately.

If the nurse had advocated for her patient by contacting another physician with the physiologic data about the patient's truly dire condition, it was probable that the patient would have been sent to the ICU and that once she was there steps would have ensued to transfuse the packed red blood cells in time to save the patient's life.

COURT OF APPEALS OF TEXAS
October 7, 2014

The patient came to the emergency department with abdominal pain, nausea and vomiting and was diagnosed via a CT scan with a ruptured appendix.

After a laparoscopic procedure a Jackson-Pratt drain was put in place.

During the first two days she had a fever and tachycardia and was treated for post-operative pain.

Her O_2 was increased when her O_2 sat began to drop. The nurse noted a tender abdomen and hypoactive bowel sounds, and reported that to the surgeon.

Her O_2 sat continued to decline. On the fifth day her hematocrit was 26% and so the surgeon ordered two units of packed red blood cells and 500 ml of albumin immediately while waiting for the blood. The surgeon's order came at 7:03 a.m.

At 10:45 a.m. the nurse noted tachycardia and tachypnea and that the packed red blood cells had not been given. The albumin was given at 11:05 a.m.

A physician who was covering for the surgeon and had never before seen the patient ordered a CT scan, additional blood work and transfer to the ICU.

There was still no transfusion of the packed red blood cells. An EKG showed sinus tachycardia at 124 beats per minute.

In the radiology department for the CT the patient arrested and died at 1:05 p.m.

Court Faults Nurse, Physician

The Court of Appeals of Texas was willing to accept the opinion of the family's medical expert pointing to the negligence of the patient's nurse.

The nurse should have told the covering physician that packed red blood cells had been ordered four hours earlier but had not yet been given. Before that she should have contacted the blood bank to get the blood delivered and started the transfusion. The expert said one hour was the maximum allowable time lapse in this situation.

The nurse further should have questioned the covering physician's order for a CT scan first and then transfer to the ICU, as opposed to sending the patient immediately to the ICU. The patient's nurse could have used the O_2 sat and heart rate as data to make her case as the advocate for her patient. **Covenant v. McMillan, 2014 WL 5037980 (Tex. App., October 7, 2014).**