Post-Surgical Nursing: Court Finds Departures From The Legal Standard Of Care.

While recovering from surgery the patient experienced an episode of respiratory depression and hypoxemia related to her morphine intake. Permanent brain injury resulted.

The patient had been admitted for breast reconstruction following a battle with breast cancer. She received 10 mg of morphine during the two-hour procedure before being sent to the post-anesthesia care unit. For her intense post-operative pain her attending physician ordered more morphine prn as well as a morphine PCA pump. The patient received 9 mg of morphine in the post-anesthesia unit.

Transfer to Telemetry Floor Not Placed on Telemetry

Several hours later the patient was transferred to the telemetry floor. On that floor, despite its designation, only some of the rooms were equipped for telemetry. For patients in the majority of the beds the nurses had to rig a baby intercom at the bedside to transmit the alarm to the nurses station if it should sound on the patient's PCA pump or pulse oximeter.

It was not done for this patient, but it would have been possible for the nurses, with or without a physician's order, to put on a pulse oximeter, to set the alarm to sound if the reading fell below 85% and to turn on the baby intercom to pick up the alarm if it sounded, according to one of the expert witnesses who testified at the trial in the US District Court for the Southern District of Florida.

Vitals Not Checked

Further, the patient's nurse herself did not check her patient or the vital sign data before giving report during the 7:00 pm to 7:30 pm time slot. She did not realize the patient's blood pressure was unusually low and did not report that to the night nurse coming on duty.

The night nurse found the patient in respiratory arrest when her husband summoned her to the room at 8:15 p.m.

The Court awarded her husband over $1.6 million for her future medical care. **Atkisson v. US, 2010 WL 2653452 (S.D. Fla., July 2, 2010).**

The anesthesiologist was not at fault. It was reasonable for him to assume the nurses would monitor the patient, on heavy doses of morphine for pain, and report if anything went wrong.

The patient's oxygen saturation fell below 85%, maybe as low as 79%, but the nurses were not monitoring that.

A 101/59 blood pressure was obtained by a nursing assistant at 7:30 p.m. while the day nurse was occupied giving report to the night nurse coming on duty.

The patient's low blood pressure was troubling and should have prompted action because a patient in as much pain as this patient would tend to have an elevated, not a depressed blood pressure reading.

The nurses should have realized that a patient getting a lot of morphine who had this patient's assessment data was lapsing into respiratory depression and should have reported to the physician.

The patient and her husband are entitled to substantial damages for nursing negligence.

UNITED STATES DISTRICT COURT
FLORIDA
July 2, 2010