Post-Surgical Nursing Care: Court Faults Care Planning, Patient Input/Output Monitoring.

The patient came to the hospital after three days of abdominal pain, nausea and vomiting.

A small bowel obstruction was diagnosed, surgery was performed and the patient was discharged home after four days.

She came back ten days later, anemic, dehydrated and with abdominal abscesses. She was readmitted and surgery was performed the next day.

Eight days later she was transferred to rehab with a biologic dressing, a vacuum dressing and a PICC line for antibiotics and parenteral nutrition.

During her ten-day stay in rehab her condition grew worse. She developed sustained tachycardia and hypotension and the wound drainage became hemorrhagic.

She was sent back to the hospital. There was yet another exploratory surgery and she was intubated, then transferred to another facility where she died from septic shock and multiple organ failure.

Lawsuit Against Rehab Facility

The Court of Appeals of Texas was called upon to rule upon the allegations of negligence leveled by the family against the rehab facility. The first hospital and the physicians' medical group were also defendants but their liability was not addressed in the Court's opinion.

The Court accepted the testimony of the family's nursing expert as grounds for a lawsuit against the rehab facility.

No Input/Output

Among other alleged errors and omissions, the family's nursing expert focused on strict fluid input and output.

The nursing care plan in rehab did not call for fluid monitoring, and the nursing care flow sheets were blank as to these critical data points being monitored, interpreted and reported to the physician as abnormal and requiring medical follow up.

The attending physician cannot make decisions about changing medications and/or sending the patient back to acute care or intensive care without competent nursing assessment and communication of worrisome data to the physician. **Christus Continuing Care v. Lam Pham, 2012 WL 2428339 (Tex. App., June 28, 2012).**

The standard of care for the rehab facility's nurses required them to design and implement an appropriate nursing care plan.

The nursing care plan should have called for the nurses to obtain and properly interpret strict input and output data and to notify the physician of imbalances.

The rehab nurses should have noticed and reported worsening vital signs, then withheld her hypertension medication and notified the physician when her blood pressure fell below a therapeutic level.

The nurses should have watched for and reported significantly abnormal lab values to the physician.

One of the family's medical experts had to concede that the rehab facility was not a tertiary care center and did not have twenty-four hour intensive care or equipment for advanced imaging studies.

However, if the nurses were monitoring the patient competently, the interventional window for transferring the patient to tertiary care would have been shortened and her life would have been saved.

COURT OF APPEALS OF TEXAS
June 28, 2012

Labor & Delivery: Court Faults Nursing Documentation.

The baby was born in 2000 but it was not until a visit to a pediatric neurologist in 2006 that the child's right-arm and shoulder condition was diagnosed as Erb's palsy possibly related to a birth injury.

Investigation by the lawyers revealed that the hospital chart showed that the baby was kept in the hospital seven days after birth for high bilirubin and physical therapy for a right shoulder bone separation. The baby continued to receive physical therapy for the shoulder after discharge.

Lack of proper nursing assessment and documentation can delay treatment necessary for the patient.

Poor record-keeping tends to show an overall lack of diligence and is a relevant fact in medical negligence litigation.

UNITED STATES DISTRICT COURT
PUERTO RICO
June 29, 2012

The US District Court for the District of Puerto Rico endorsed the allegations of negligence in the family's lawsuit against the hospital.

Assuming a shoulder injury was sustained at birth as was the diagnostic impression at age six, that meant there had to have been a vacuum or forceps delivery which should have been noted by the nurse in the medical chart but was not.

There also should have been a nursing assessment of the newborn which should have disclosed the shoulder injury and that fact also should have been noted.

Specifically, according to the Court, a labor and delivery nurse is required to check the baby's arms to see if the baby raises and lowers them, and, if not, inform the physician and make a note of the fact in the chart. **Rosa-Rivera v. Dorado Health, 2012 WL 2564332 (D. Puerto Rico, June 29, 2012).**