Pulmonary Embolism, Death: Nurse's Post-Op Monitoring, Charting Faulted In Lawsuit.

On the morning of the day after transurethral prostate resection surgery the surgeon's partner ordered a transfusion because the patient seemed to be bleeding internally.

That afternoon at 3:22 p.m. the patient's wife went to the nurses station and told the nurse her husband was breathing heavily. The patient's nurse, according to the wife, told her the doctor knew about it and it was nothing to worry about and did nothing further.

Nursing Care Not Documented

In court some years later the nurse testified she phoned the surgeon immediately to report that the respirations had risen to 50, took vital signs, found they were normal, put on a pulse oximeter, which also gave a normal reading, and kept calling the physician's office.

None of this nursing care, however, was documented in the progress note the nurse put in the chart the next day based upon notes she claimed she had written down during her shift the day before.

The surgeon's office nurse testified a call was received from the hospital at 4:00 p.m. and the surgeon left for the hospital immediately. The surgeon testified he was on the phone with the hospital in his car and then called a code as soon as he got to the patient's room.

The family's nursing experts testified it is below the standard of care not to notify the treating physician and/or to advocate with a nursing supervisor or any physician who happens to be available when a patient is having a medical emergency.

Further, it is below the standard of care not to document nursing care completely at the time it is provided.

The jury reportedly accepted the spouse's and the physician's office nurse's version of events over the patient's nurse's testimony and returned a verdict against the nurse for wrongful death upheld by the Louisiana Court of Appeal. **Benefield v. Sibley, __ So. 2d __, 2008 WL 2669770 (La. App., July 9, 2008).**

The patient's nurse was guilty of several breaches of the standard of care.

The standard of care required the patient's nurse to contact the physician promptly when the nurse first observed that the patient's respirations had risen to 50 per minute.

The nurse claimed she made several attempts to reach the physician at his office. None of this was documented until the nurse wrote her progress note the next day. Even if it was true the nurse should have done more than just phone and leave messages.

The patient's nurse claimed it was her practice to make handwritten notes during her shift, then type her progress notes on the hospital computer system the next day. That is not acceptable nursing practice.

The nurse never documented taking vital signs during the critical two hours between the spike in the patient's respirations and when he was pronounced dead. Not documenting vital signs is below the standard of care; not taking them is inexcusable.

COURT OF APPEAL OF LOUISIANA
July 9, 2008