Respiratory Arrest In ICU: Patient's Family Obtains Jury Verdict For Nursing Negligence.

The seventy-five year-old patient was in the hospital's intensive care unit recovering after a colon resection seven days earlier.

On admission she suffered from rectal bleeding, the reason for her hospitalization, and had a history of hypertension, but otherwise was in good health.

At 11:00 a.m. in the ICU she began to experience shortness of breath while sitting up in her chair. Her nurse encouraged her to take deep breaths and to use her incentive spirometer. Her O_2 sat was 96-98%.

The pulmonologist came in at 1:45 p.m. He saw that she had just vomited clear yellow material. His note expressed concern for aspiration if she vomited again. His orders included watching her respiratory status, giving an extra nebulizer treatment now, getting arterial blood gases if there was increased or decreased respiratory rate, decreased O_2 sat or change in mental status and npo except ice chips.

There was no nursing documentation of the physician's orders being carried out. At 3:00 p.m. the nurse noted a sustained respiratory rate of 47, although it was vague how long that went on.

At 5:25 p.m. the colorectal surgeon came to see the patient and reviewed her chart. From the information available from the chart that afternoon the patient seemed to be doing fine. He ordered a bolus of IV fluids.

At 6:00 p.m., shortly after the IV fluid bolus was given, the treating physician stopped by and found the patient basically unresponsive. She was alone in the room in bed with her head back and copious amounts of brownish fluid coming out of her mouth. He called a code.

The E.R. physician who responded to the code documented there was a large amount of yellowish/brown material in the patient's mouth as he attempted to insert the endotracheal tube. Efforts were already underway when he entered the room to suction the gastric material from the airway which was hindering efforts to ventilate her with a bag.

The patient could not be saved. She died from cardiac arrest from respiratory arrest secondary to aspiration.

The nursing standard of care was not carried out in regard to this patient.

The patient had a worsening respiratory condition, but there is no evidence from the chart that the physician's orders were carried out by the patient's nurse.

An extra nebulizer treatment was not given as ordered and arterial blood gases were not drawn when the elevated respiratory rate continued.

The nurse should have contacted the treating physician when the elevated respiratory rate continued.

The patient's nurse did encourage her to use her incentive spirometer.

However, there is no nursing documentation in the patient's chart that the nurse evaluated that intervention to see if it was effective, a vital step in the nursing process.

The nurse herself and the hospital's director of nursing testified that the nurse had received the hospital's general med/surg nursing orientation but had not oriented to the ICU, had little ICU experience and had not been specifically trained in respiratory assessment or respiratory care.

The nurse admitted she was not an ICU nurse.

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The patient's adult children filed a lawsuit against the hospital. The jury awarded them damages for negligence by the nurse who cared for her that afternoon.

Two of the patient's daughters visited her that afternoon and later testified they told the nurse their mother was having great difficulty breathing, gasping like she was having an asthma attack and struggling to pull herself up to a sitting position. The nurse told them she needed to be told to use her spirometer and, other than that, there was not much she could do for her.

They also testified the call light in the room was not working.

Aspiration, Increased Respiration Tiring, Decreased Respiration Aspiration, Death

One of the physician expert witnesses testified it was unlikely the patient had a pulmonary embolism. Instead, once her respirations rose to 47, apparently after a small aspiration of stomach contents, because she was frail and elderly she easily tired from increased respiratory effort.

When the respiratory rate fell back to normal, the physician said, it meant that the patient had tired and was then at extreme risk for further aspiration, no longer being able to mount the effort to cough and clear the airways to the lungs.

There was no documentation that the nurse performed or had someone perform the nebulizer treatment that was ordered or obtained blood gases when the respiratory rate rose or reported the patient's change in status to a physician.

Nurse Was Not a Trained ICU Nurse

Much of the legally critical testimony in the case against the hospital centered on the patient's nurse's qualifications or lack thereof to work in the ICU.

The nurse herself stated that she was basically a med/surg nurse who floated to the ICU at times, but she did not consider herself an ICU nurse.

The director of nursing admitted the nurse was just assumed to have oriented to the ICU given the fact she sometimes worked there, but had actually never been trained in the care of respiratory patients in the intensive care setting. **Simmons v. Christus Schumpert, __ So. 3d __, 2011 WL 2348654 (La. App., June 15, 2011).**