INCONSISTENT PERFORMANCE AND DOCUMENTATION OF MD ORDERS

By Kathy Dwyer, *MSN, RN, CRICO*

DESCRIPTION

A 56-year-old male admitted for repair of facial fractures suffered a fatal post-operative cardiac event.

KEY LESSONS

- Failure to follow either orders or policy is indefensible without documentation of sound reasoning for a different course of action.
- An unchecked assumption for leeway in adherence to policy or protocol is an unnecessary risk.

CLINICAL SEQUENCE

A 56-year-old male was admitted for surgical repair of multiple facial fractures suffered when a basketball backboard fell on his head. Following surgery, the patient was transferred to ICU with his jaw wired shut. He was placed on a Dilaudid PCA for pain control.

Post-op Day One, 5:00 p.m.: The patient was extubated and transferred to the floor. He remained on a PCA with his jaw wired shut and his nose packed bilaterally. He received oxygen (as needed) without continuous monitoring. The routine on the floor was vitals every four hours unless ordered otherwise; the order for this patient was for vitals "per ICU routine" (hourly). The receiving nurse documented a full set of vitals hourly between 5:00 p.m. and 7:00 p.m.

8:00 p.m.: A second nurse assumed the patient's care and assumed the order for vitals "per ICU routine" was a mistake, although she never confirmed this with anyone. Nothing relative to the frequency of vitals was documented in the patient's record.

11:00 p.m.: The patient reported insomnia and the nurse administered 0.5 mg Ativan.

Post-op Day Two, 12:00 a.m.: The nurse documented a full set of vitals which were normal and overall consistent with those documented on the prior shift.

2:00 a.m.: The nurse documented the patient's heart rate and blood pressure, but no other vitals. She made frequent visual checks on the patient, but nothing was documented.

4:00 a.m.: The nurse administered several medications and recorded the patient's pain level, but did not record any vital signs.

PATIENT SAFETY RESOURCES

She later testified that she a) wanted to let the patient sleep, and b) believed she had an hour leeway relative to when vitals had to be taken and she planned to do that when she came back in about an hour to administer additional medications.

5:20 a.m.: The nurse found the patient unresponsive, with no pulse. A code was called, but the resuscitative efforts were unsuccessful and the patient died.

ALLEGATION

Suit was filed against the nurse and the resident covering the floor overnight alleging they failed to properly monitor the patient.

DISPOSITION

The case was settled in excess of $1 million.

ANALYSIS

Autopsy revealed cardiac abnormalities that likely led to a sudden and unforeseeable cardiac dysrhythmia and the patient's death, a sequence that might have been masked by stable, unconcerning, vital signs.

Even the strongest clinical speculation is difficult to promote in light of inconsistencies in the performance and documentation of physician orders. Failure to follow either orders (e.g., vitals every hour) or policy (e.g., vitals every four hours) is, essentially, indefensible without documentation of sound reasoning for a different course of action. In this case, the hospital policy, which clearly outlined what constitutes a full set of vital signs and when they were due—and does not mention a permitted one-hour leeway or discretion to delay vitals—was entered into evidence.

The plaintiff argued that the patient died due to hypoxia and, thus, should have been on a continuous oxygen saturation monitor. They also argued that giving Ativan to a patient with an obstructed airway on a PCA compromised his condition.

The defense against a plaintiff's speculative argument is built on testimony and documentation showing the patient's care met acceptable standards. Even though the patient may have died regardless of those decisions, the lack of documentation regarding respiratory issues further complicated the defense of this case.