Executive Summary

Medical Record Summary:
Narrative Format
B.T.

B.T. was a forty-five-year-old woman who experienced a fatal cardiac arrest within twelve hours of a routine eye surgery. The attorney requests a review of the medical records by the legal nurse consultant to assess potential errors in the course of treatment, effectiveness of communication by health care providers, and compliance by healthcare personnel with hospital protocols.

Course of Treatment

Prior to surgery, Mrs. T.'s primary care provider, a nurse practitioner, cleared Mrs. T. for surgery. Given Mrs. T.'s multiple health conditions, the clearance for surgery may have been inappropriate; a possible failure to follow a reasonable standard of care. Further, immediately prior to surgery, the assessing anesthesiologist failed to document an assessment of Mrs. T.'s respiratory status and failed to prescribe CPAP for Mrs. T., a patient with known obstructive sleep apnea and other comorbidities that increased her risk for respiratory failure. These inactions by the anesthesiologist may be a failure to follow a reasonable standard of care.

The overnight nurse caring for Mrs. T. in the hospital administered a double dose of a potent pain reliever, and then a third dose of the same medication without informing the attending hospital physician of the double dose previously administered. Further, the hospitalist involved in this interaction with the overnight nurse may not have inquired as to the amount of pain medication previously administered. Both of these health care personnel may have breached their duty to follow their respective standards of care.

The overnight nurse documented a progressive decline in Mrs. T.'s level of consciousness. Such a decline is often associated with respiratory depression or failure. However, instead of acting on these assessments by contacting a physician the overnight nurse consulted her charge nurse. No further intervention was taken by the overnight nurse, and Mrs. T. was pronounced dead following a code 99 shortly thereafter. The inaction of the overnight nurse may represent noncompliance with both hospital and nationally recognized standards of practice.

Effectiveness of Communication/Compliance with Hospital Protocol

The PACU nurse failed to document medical conditions and assessment findings in her report to the transferee nurse on the surgical floor. Likewise, the transferee nurse failed to document her awareness of Mrs. T.'s medical conditions, or CPAP use, which would naturally have followed her receipt of a transfer report from the PACU nurse. Here, these inactions likely represent a breach of hospital protocols for documentation and a failure to follow recognized standards of practice. This same documentation was lacking between the transferee surgical floor nurse and the overnight surgical floor nurse.