Medicinal malpractice claims can be asserted against any healthcare provider, including nurses. Although there may be a perception that physicians are held responsible for the majority of lawsuits, the reality is that nurses are more frequently finding themselves defending the care they provide to patients. In fact, over $87.5 million was paid for malpractice claims involving nursing professionals, according to a CNA HealthPro 10-year study.* This case study involves a nurse working in an acute care hospital environment.

**Settlement:** $125,000

**Legal Expenses:** $3,003

**Note:** This case study discusses the actions of the insured nurse, but there were multiple co-defendants named in the lawsuit who also settled in varying amounts for a total of $8,500,000.

A 28-year-old woman was admitted in labor with her first child. Her pregnancy had been uneventful, and she was at 39 weeks gestation upon admission. Two hours after admission the fetus showed signs of distress and a low transverse Caesarian Section delivery was performed.

The obstetrician’s post-operative note indicated there was no unusual bleeding, but noted a slight possibility of some uterine atony. Post-operative orders included medications to enhance uterine contraction, monitoring of the patient’s vital signs, observation for signs of bleeding, monitoring of oxygen saturation levels, and notification of the physician for any oxygen level below 95%.

The patient experienced unusually heavy lochia with some clots present, uterine cramping, firm uterine fundus at the level of the umbilicus, nausea and vomiting, low urine output, variable vital signs, pallor, complaints of weakness and post-operative pain.

Post-operatively, the insured nurse called the obstetrical resident to see the patient three times during the first four hours. During the fourth hour, the oxygen saturation had fallen below 95% at times, but the nurse did not call the attending physician as ordered. The resident allegedly had spoken to the attending physician at one time, but the nurse did not call the attending until the fourth post-operative hour when she was specifically directed to do so by the resident. The nurse also administered Xanax despite concerns about the patient’s unstable condition and deteriorating vital signs.

When the nurse called the attending physician he came to the hospital to see the patient. Oxygen was ordered, but the patient’s blood pressure dropped to 60/30, her pulse was 111, she became cyanotic and experienced sudden tonic-clonic seizures followed by cardiorespiratory arrest. Cardiopulmonary resuscitation was successful, and the patient was taken to surgery for an emergency hysterectomy.

Approximately one liter of blood was found within the uterus, with additional surgical blood loss estimated at 600 cc. The patient received blood transfusions and albumin and was transferred to the intensive care unit. Post-hysterectomy, she suffered pulmonary edema, disseminated intravascular coagulation (DIC), congestive heart failure, seizures, pneumonia, acute respiratory distress syndrome (ARDS) and brain damage. On post-operative day twelve, the patient arrested, could not be resuscitated and was pronounced dead.

The family of the deceased sued the hospital, six physicians and several nurses seeking $3,000,000 in damages. The specific allegations against the insured nurse included failure to notify the attending physician of significant changes in the patient’s condition and inappropriate administration of medication.

**Resolution**

Experts determined that the nurse had breached the standard of care. Settlement on her behalf was made totaling $128,003.
The nurse failed to notify the attending physician of the patient’s condition. Further, she administered an anxiolytic drug while the patient was in physical and respiratory distress. Although the medication was ordered, the nurse should have discussed with the physician whether to give the medication in view of the patient’s deteriorating condition. Irrespective of the claims asserted against the co-defendants, the nurse had failed to meet the standard of care for her own scope of practice.

Risk Management Recommendations

- **Comply with physician orders to be notified** for specific clinical signs and symptoms.
- **Notify the attending physician** of any significant changes in the patient’s condition and failure of the patient to respond to the care and treatment being provided. This protocol is appropriate whether or not a resident or other practitioner is also caring for the patient.
- **Know the side effects and potentially adverse actions of ordered drugs** and:
  - **Contact the physician before administering ordered drugs that may have adverse effects** on the patient’s clinical condition. If the physician does not respond in a timely manner, follow the chain of command to the point of resolution.
- **Investigate whether a culture of intimidation may abide among physician and nursing staff** within the hospital, and identify and address any behaviors or attitudes that could create reluctance on the part of nurses (or residents) to readily contact any physician for communication regarding patient needs.
- **Monitor and investigate incidents of staff failure to contact physicians or failure of physicians to respond to calls** to identify whether they represent isolated incidents or reveal a pattern of behavior or attitudes with specific nurses and/or physicians.

Guide to Sample Risk Management Plan

Risk Management is an integral part of a healthcare professional’s standard business practice. Risk management activities include identifying and evaluating risks, followed by implementing the most advantageous methods of reducing or eliminating these risks - A good Risk Management Plan will help you perform these steps quickly and easily!

Visit [www.nso.com/riskplan](http://www.nso.com/riskplan) to access the Risk Management plan created by NSO and CNA. We encourage you to use this as a guide to develop your own risk management plan to meet the specific needs of your healthcare practice.

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