Lack of Assessment and Monitoring of Patient Leads to Her Death

Avoiding Liability Bulletin – July 18, 2018

It is important to keep in mind that when a patient injury or death occurs due to a nurse's professional negligence, it is not uncommon for the cause of injury or death to be easily preventable had nursing staff provided basic care. Such was the situation in the following case.[1]

Ms. H, 73 years old, was admitted to a medical rehabilitation center in California in December of 2013 after her neck surgery required rehabilitative care. When admitted, she needed help with feeding and was determined to be at risk for aspiration. Her physician ordered nursing staff to supervise Ms. H during all meals and not to feed her orally if she was "coughing or was lethargic".

On January 3, 2014, Ms. H's PICC line became dislodged and was reinserted. The next day, she developed swallowing problems, had "crackles" in her lung sounds, and had thick brown, yellow secretions that required suctioning.

The speech therapist at the center evaluated Ms. H and recommended a change in diet to "Dysphagia finally chopped". A videoesophagram was also ordered for the following Monday.

Lab work done on the weekend indicated a white blood count (WBC) of 34.4, a value critically high. However, the nursing staff did not notify Ms. H's physician of this level nor did the physician notice the high level. As a result, no antibiotic was given to the patient.

Ms. H continued to have difficulty swallowing and lost her voice. It was presumed that she had possible vocal cord paralysis. Her physician changed Ms. H's diet on January 5th from the "Dysphagia" diet to a pureed one and again ordered the staff to observe her frequently while feeding.

On January 6th, the speech therapist performed a bedside swallow evaluation with scrambled eggs and oatmeal from Ms. H's breakfast tray. Within an hour, the patient was in pulmonary arrest and respiratory failure. A Code Blue was called.

During intubation during the Code, the pulmonologist noted "copious amounts of secretions that looked like tube feeding were suctioned from her trachea". Ms. H was not on any tube feedings.

Ms. H was transferred to another facility where she remained on the ventilator until her death on April 4, 2014. She was treated for aspiration pneumonia with antibiotics for a long period of time. The prolonged antibiotic therapy resulted in the development of Clostridium Difficile (C. Diff). Ms. H died on April 4, 2014 from "sepsis secondary to C. Diff".

The family filed a lawsuit against the medical center alleging wrongful death, medical malpractice and elder abuse. The family (the plaintiffs) specifically alleged that the medical center failed to take "all aspiration precautions" with Ms. H, despite its knowledge of her aspiration risk. They charged that from the time of Ms. H's admission until the aspiration event, nursing staff did not supervise or assist her with her meals.

The family's experts testified that the center, through its nursing staff, breached the standard of care when failing to assist and supervise Ms. H with all meals and that the cause of Ms. H's death was due to a pulmonary arrest due to the aspiration of breakfast food the morning she arrested.

The medical center's position was that she was in a rehabilitation center and "assistance did not mean feeding her or staying with her when she ate." It also contended that her death resulted from septic shock from an infection from her PICC line and not the aspiration she experienced. It also purported that the aspiration was the result of the Code Blue was not the result of swallowing food at breakfast.

Testimony during the trial revealed interesting evidence. For example, the family testified that Ms. H always received a regular diet up until she aspirated the food on January 6th. Her medical record revealed no documentation that the correct diet(s) were given Ms. H after the doctor changed the diets.

In addition, it was the plaintiffs' experts' opinion that the tube feeding that was suctioned during the Code Blue was not tube feeding but oatmeal that the patient had been fed on the day she aspirated her breakfast.

The jury returned a verdict in favor of the family for $1,743,894.60.

Like many others I have shared with you in these Bulletins, the cause of death was clearly avoidable had the nursing staff provided basic nursing care to Ms. H. If you care for a patient who has difficulty swallowing, the following standards are essential:

1. When an order for assistance with feeding is written by any health care provider, it means helping the patient eat food and drink liquids;
2. When an order for assistance with feeding is written, it requires your presence with the patient at the time of eating food and drinking liquids;
3. While assisting with feeding and drinking, constant observation and assessment of the patient is essential;
4. Document what is observed and assessed, and how the patient did with eating and drinking;
5. Notify the physician or other health care provider of the patient's progress or lack of progress during meal times;
6. Immediately notify the physician or other health care provider of abnormal lab values;

7. Orders for changes in a patient diet must be communicated immediately to the dietary department and ensure compliance with those orders; and
8. Keep current with standards of practice when caring for patients with a swallowing disorder.

FOOTNOTES

1. Higgins v. Providence Health System (2017), Neubauer & Associates (2018). “Aspiration warnings for 73-year-old hospital patient ignored by staff. $1.7M. Los Angeles County”, @ juryverdictalert.com.

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