VIRGINIA LAWYERS WEEKLY

VERDICTS & SETTLEMENTS

Nurse admits exceeding scope of practice - $1,400,000 Settlement

By Virginia Lawyers Weekly
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Plaintiff's decedent was a long-haul truck driver. He started having shortness of breath and noticed swelling in his face and ankles. After dropping off his load, decedent went to the emergency room to get checked out. While being examined by the emergency room nurses, decedent explained that he had sleep apnea and that he was taking medication for high blood pressure. Decedent was admitted to a telemetry bed. The next day, the decedent was given breathing treatments as it was suspected that he had COPD (chronic obstructive pulmonary disease).

Decedent developed frequent premature ventricular contractions, and was evaluated by a cardiologist. Decedent's sleep apnea and orthopnea, morbid obesity, cardiomyopathy, tobacco use, and acute onset of congestive heart failure (CHF) were noted in his chart. Although decedent was receiving medications to slow down his heart rate, defendant doctor felt that decedent would benefit from implantation of a pacemaker as a "backup" in case the medications slowed decedent's heart rate too much.

Defendant doctor inserted a single chamber pacemaker, but admitted that he did not perform a proper test to insure that the lead wires were securely attached to the internal pacemaker.

Decedent was experiencing pain after the procedure and was given Tylenol #3 and a total of 8 mg morphine between 7:30 p.m. on 3/9/04 and 5:30 a.m. on 3/10/04.

Defendant doctor evaluated decedent at approximately 8:30 in the morning on 3/10/04, and planned on discharging him if the pacemaker check was normal. Also, defendant doctor cleared decedent to drive his 18-wheeler back to Texas that day.

However, the pacemaker check was not normal, and decedent was taken back to the lab for a lead revision. Although there are no nursing notes after 7:05 a.m. on 3/10/04 to indicate decedent's physical condition, the lab record indicated that decedent was in distress, anxious, refusing to lie down, coughing, and breathing faster than normal upon arrival.

Defendant registered nurse was the monitoring nurse for the 3/10/04 lead revision procedure, and evaluated decedent that afternoon. During her evaluation, defendant registered nurse noted that decedent had a history of sleep apnea and cardiomyopathy. Prior to the procedure, defendant registered nurse prescribed and gave decedent two liters of normal saline solution. Also, defendant registered nurse made the decision not to use an end tidal carbon dioxide monitor (ETCO2) to monitor decedent's breathing during the 3/10/04 procedure.

Defendant doctor never completed the plan for sedation, nor did he re-evaluate decedent immediately prior to sedation. In fact, defendant registered nurse planned the medications, dosages, and frequency of the sedation without physician instruction or supervision, an act she admitted was outside the scope of her practice, and which plaintiff's experts opined was conduct amounting to the unauthorized practice of medicine. It was plaintiff's contention, based on the holding in Taylor v. Mobil Corporation, 444 S.E.2d 705 (Va. 1994), that defendant registered nurse and her employer were not protected by the medical malpractice damage cap to the extent defendant registered nurse was practicing medicine without a license to do so. This was disputed by the defendants who claimed that all defendants were medical providers, regardless of conduct in this case and damages were limited to the cap.

Decedent's estate contended that the combination of underlying respiratory distress with diagnoses of sleep apnea, congestive heart failure, and chronic obstruct pulmonary disease required an anesthesia consult.

Also, defendant registered nurse's administration of two liters of fluid worsened decedent's respiratory status. Defendant registered nurse also gave Versed and Fentanyl at dosages that caused decedent to undergo general anesthesia, wherein he stopped breathing and was unconscious at some point after 3:45 p.m.

Because defendant registered nurse did not monitor decedent with an ETC02 monitor, when he stopped breathing sometime between 3:45 and 3:48 p.m., his apnea remained unnoticed and untreated, causing him to suffer anoxic brain injury.

Furthermore, although staff documented respiratory distress, low blood pressure, and no pulse or respirations as early as 3:48, a code was not called until 12 minutes later at 4 p.m., and decedent was not intubated until 4:05. Such sustained periods without oxygen to his brain resulted in severe brain damage that left decedent in a permanent vegetative state until his death on February 17, 2005.

This case was settled in mediation for $1.4 million of an available $1.7 million under the medical malpractice cap.

Type of Action: Medical malpractice
Name of Case: Confidential
Court: Confidential
Settlement: $1,400,000
Mediator: John OBrion
Plaintiff's Attorneys: Paul R. Thomson III, Roanoke; Harold R. White, Wichita Falls, Texas
Settlement Date: August 2007
[08-T-065]