RISK CASE STUDY

HIROC

Case: Patient Deterioration – Post Surgical

Abstract:

A post-surgical patient sustained permanent anoxic brain damage. From a standard of care and causation perspective, expert opinion concluded the related medical-legal case was indefensible.

Key Words:

Patient Deterioration

Acute Care

Blood Products

Surgical Care

Anoxic Brain Damage

Post-Operative Care

Case summary:

A patient with a complicated medical history was admitted to hospital to undergo the removal of an intra-abdominal mass. During the course of the surgery, the patient suffered a significant drop in blood pressure and a loss of approximately four litres of blood requiring several transfusions.

During the post-operative period in the step down unit, the patient developed concerning hypotension and a drop in hemoglobin, resulting in a need to deliver additional blood products. Neuroimaging subsequently confirmed the patient had sustained anoxic brain damage, resulting in a permanent brain injury with serious associated cognitive deficits and physical limitations.

Medical legal findings:

While expert review of the case was generally supportive of the nursing care provided, noting the involved nurses' documentation was detailed and referenced the changes in the patient's status, concerns were raised with regard to the turnaround time and delivery of blood products during the post-operative period. A review of the patient's chart revealed the necessary blood products were not hung until two-hours after the units of blood had been ordered. Furthermore, experts noted during the two-hour period prior to the hanging of the blood, the involved nurses' neglected to notify the attending physician of the delay and had failed to request additional IV fluid orders while waiting for the blood. Experts also questioned whether the involved nurses' had communicated the urgency of the patient's needs appropriately to the Blood Bank. Based on these findings, experts ultimately concluded that the case was indefensible.

Reflections:

Reflecting on your practice as well as your hospital's policies, procedures and processes:

1. Discuss whether it was reasonable for the nurses to hold off notifying the MRP of both the patient's changing status and delay-receiving the ordered blood during the two-hour period prior to hanging the blood. If it was not reasonable, what should have taken place and what should have been communicated? Discuss the safety concept of 'situational awareness'.
2. Discuss why practitioners may hesitate to speak up when indicated? Discuss the role of hierarchy and local culture can have on effective team communications? Reflecting on your local practices, discuss what is required to support practitioners to report concerns and speak up where required.
3. Discuss the role of the health record and clinical documentation during internal quality of care reviews and external legal proceedings. In the absence of good documentation (timely, comprehensive and tells the patient's story), discuss whether care providers can rely on what their 'normal practice' would be in similar circumstances. Why does the court often view the health record as the ultimate source of the 'truth' when two or more parties disagree as to the facts leading up to and after a patient incident?

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