

# Nurse Case Study: Alleged failure to appropriately resuscitate a PACU patient after a complex cosmetic surgery

Medical malpractice claims may be asserted against any healthcare provider, including nurses. This medical malpractice case study and risk management strategies, presented by NSO and CNA, involves a registered nurse (RN) who held a Bachelor of Science in Nursing degree. At the time of this incident, the insured RN was working as an independent contractor for an ambulatory surgery center (ASC) specializing in cosmetic procedures. The facility was licensed and accredited by the American Society of Plastic Surgeons. The involved plastic surgeon was board certified. For 10 years prior to this incident, the RN had been a post-anesthesia care unit (PACU) nurse and worked primarily in post-anesthesia care.

## Summary

This case involves a healthy, 32-year-old male patient who underwent elective cosmetic surgery in the ASC. The preoperative evaluation included assessments by his primary care physician, the center's anesthesiologist, as well as a cardiology consultation. These evaluations cleared the patient to undergo multiple cosmetic procedures concurrently. The patient was classified by the anesthesiologist as "ASA 1" (American Society of Anesthesiologists' definition of a normal, healthy patient) and the duration of the surgery was anticipated to be up to eight hours.

The patient presented to the ASC and underwent a necklift, facelift, chin implant, rhinoplasty, turnbinoplasty and an abdominoplasty with liposuction. The duration of the surgery was 8 hours and 45 minutes with no reported anesthesia or surgical complications. Following the initial recovery phase at approximately 6 p.m., the patient was transferred to the "overnight" unit for a planned 24-hour stay. Notably, the RN was working alone in the overnight unit, which was standard

procedure for this ASC. The RN received a report from the day nurse indicating that the patient remained stable throughout the initial two-hour postoperative period.

Shortly after the patient arrived, the RN administered pain medication and Dexamethasone 10mg IM for nausea. Within approximately 30-45 minutes, the patient's oxygen saturation decreased to 82 percent and he became unresponsive. At 7:21 p.m., EMS was called by the RN and paramedics arrived at 7:27 p.m. Per the EMS records, the RN reported that the patient desaturated and, shortly thereafter, became unresponsive. Upon arrival, the paramedics noted that the patient was in asystole and that chest compressions were not being performed. They administered Narcan and epinephrine, then immediately suctioned and intubated the patient. After several rounds of CPR, the patient regained a pulse and respirations and was transferred to the hospital, where he was diagnosed with hypoxic ischemic encephalopathy (HIE). Per the family's request, the patient was removed from life support one week later. An autopsy revealed the cause of death as HIE subsequent to a cardiac arrest due to fat embolization to the lungs and brain. During a retrospective expert review of the preoperative imaging studies, a patent foramen ovale (PFO) was identified, which was believed to be the etiology of the stroke.

## The following nursing notes were documented:

"Patient alert and oriented, tolerating water. VSS and cardiac monitors in place. No complaints of nausea. Administered 2mg Morphine for pain at 6:15 p.m. for a pain level of 5/10. (Of note, the medication administered was actually Demerol/Phenergan from a syringe that had been "saved" and mislabeled by a previous RN for a different patient). At 6:50 p.m., cranial nerves

were intact bilaterally. A nasal cast and JP drains intact. Gauze changes under nose with drainage noted. Dexamethasone 10mg IM given for postoperative nausea.

"Late entry (untimed): Pt c/o nausea and feeling cold- repositioned for comfort. I was sitting next to patient with an emesis basin, reassurance given. O2 saturation dropped to 82%. At 7:20 p.m., the patient was unresponsive, was not breathing and the oxygen saturations were undetectable. Sternal rubs were done followed by continuous chest compressions per ACLS protocol. 911 called and MD notified. Patient reassessed after several rounds of compressions with a positive pulse and intermittent breaths. EMS arrived at bedside and took over the case. MD at bedside-patient transferred to the hospital!"

## Risk Management Comments

One year following the patient's death, a lawsuit was filed by the patient's wife (the plaintiff) asserting that the surgeon was negligent in performing multiple surgeries concurrently in an outpatient setting. Allegations against the RN included a failure to suction, apply oxygen and appropriately resuscitate the patient per ACLS protocols, as well as failing to call 911 immediately when the patient's saturations dropped. The patient's wife reported that her motivation to file a lawsuit was based upon information communicated to her by the physicians at the treating hospital. They were critical that the surgery was too complex for an ASC. Moreover, the RN administered the incorrect pain medication and improperly performed chest compressions. The plaintiff's expert plastic surgeon opined that the standard of care for duration of elective cosmetic outpatient procedures is less than six hours.

The defense of this case was complicated by several factors, including erroneous nursing documentation with gaps in

time, a medication administration error, and the discovery of security surveillance video highlighting inconsistencies in the RN's testimony. The plaintiff utilized the video to support the allegations of improper nursing care by overlaying the nurse's testimony on the surveillance video and comparing it to video clips from ACLS. This presentation demonstrated that the RN failed to perform appropriate resuscitation measures. In addition, the video created significant credibility issues for the RN by refuting his testimony regarding the chronology of the events. The RN testified and documented that he administered anti-nausea medication and sat by the patient's bed to offer support. The video revealed that the RN administered a medication, then left the bedside. The video also demonstrated that the RN did not check the airway or administer oxygen when the patient became unresponsive. The RN was seen in the video as "flustered", "overwhelmed" and was merely tapping on the patient's chest in an effort to perform CPR. Defense nursing experts were critical of the RN for not proactively invoking the chain of command to request additional staffing when he realized that he would be independently caring for a high-risk patient.

The EMS documentation further supported the plaintiff's theory of liability concerning the inappropriate nursing resuscitation. The paramedics documented that the patient was in asystole and cyanotic when they arrived, and that they cleared his airway of a large amount of blood. Conversely, the RN testified and documented that the patient had a return of pulse and was taking "some" breaths prior to EMS arrival.

Defense nursing experts also were critical of the RN's documentation regarding the chronology of events. The RN testified that he was unable to document contemporaneously due to the criticality of the patient and the fact that he relied on the cardiac monitor strips to reconstruct the timeline of events. However, to further complicate matters, the clock on the car-

diac monitor was set incorrectly. As a result, all of the stamped times on the monitor that were relied upon for the nursing documentation were erroneous.

The lawsuit also included an allegation of a medication error. Morphine 2mg IM was ordered for pain. The medication log sheets revealed that Morphine 2mg was administered by the initial PACU RN prior to transfer to the overnight suite. However, there was no documentation that the remaining 2mg in the unit dose vial was wasted. Our insured testified that it was the nursing practice to simply "save" the remaining doses of pain medications versus performing the appropriate wasting protocol. The RN also testified that he erroneously administered Demerol for pain from a "saved" syringe that was mislabeled. Although the medication error was not clinically significant in terms of the event, it served to support the plaintiff's allegation that the RN failed to fulfill the standard of care.

Due to the above-referenced facts, including their belief that a jury would not expect a healthy patient to die after an elective cosmetic procedure, defense counsel concluded that the case would be difficult to defend. A possible causation defense was considered, based upon the autopsy findings, which concluded that it was a fat embolism, rather than the inappropriate resuscitation that caused the patient's death. However, it was ultimately determined that irrespective of the potential causation defense, it would be difficult to overcome the critical nursing errors before a jury.

## Resolution

This case was settled in mediation on behalf of the insured RN

**Total Incurred:** More than \$950,000 made on behalf of the insured and do not include any payments that may have been made from co-defendants.)

## Risk Management Recommendations

Conduct comprehensive nursing assess-

ments in order to recognize early signs and symptoms of changes in the patient's condition, considering ASA classification, type/length of surgery, anesthesia type/time, co-morbidities and past anesthesia/surgical complications as part of the assessment process.

Be conversant with the organizational policies, including the process for accessing additional staff during emergencies and invoking the chain of command for patient safety concerns, before agreeing to provide independent contractor nursing services.

Ensure that prospective employers follow staffing guidelines, such as [ASPAN](#), to ensure that staffing levels are safe and align with patient acuity. As noted in the [ASPAN position statement](#), staffing guidelines intended to ensure that "an appropriate number of perianesthesia registered nurses with demonstrated competence are available to meet the individual needs of patients in each phase of perianesthesia care, based on patient acuity, census, patient throughput and physical facility".

Follow [ISMPS' guidelines](#) regarding waste of unused opiates including proper disposal and labeling of unused portions.

Follow 2022 [ISMPS Perioperative Medication Safety Guidelines](#) to ensure safe medication administration such as:

"4.10 Immediately discard any unattended, unlabeled medication or solution.

5.10 Require a medication order (e.g., electronic, verbal/telephone) or have an approved protocol in effect prior to removing any medication from storage or from ADCs (if available), even if they are removed using the OVERRIDE function."

Routinely engage in continuing education for your nursing specialty to ensure competency.

Document contemporaneously, factually and thoroughly and include objective, descriptive words and details pertaining to the timing of events. Ensure all timing devices are synchronized. Objective and concise documentation is critical for both continuity of patient care, as well as for the

defense of a potential malpractice claim. A complete healthcare information record is the best legal defense.

Limit the use of "late entries" and subsequent reconstruction of timelines, especially when an adverse event occurs. ■

### Resources

Institute for Safe Medication Practices (ISMP) ISMP Guidelines for Safe Medication Use in Perioperative and Procedural Settings. ISMP; 2022.

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