August 1, 2019

# Justin Fiscus BSN RN CPN

Oakland Park, FL

Patrick Loughren, Esquire

Loughren, Loughren & Loughren, PC

RE: Patient \*\*\*

Dear Mr. \*\*\*,

I am a registered nurse licensed by the State of Florida. I am engaged in practice of nursing at Cleveland Clinic Florida. I also maintain an active license as a registered nurse in state of California. I have previously been licensed in both New York and Ohio but am no longer actively licensed in those states. I have been licensed as a registered nurse continuously since 2010 and have engaged in clinical practice in multiple settings. I have treated a broad range of patients from pediatric to adult in diverse settings ranging from inpatient medical/surgical units to schools to a home care owner. I am familiar with the standards of care involved in this case, which include assessing a patient, protecting a patient's airway, communicating with physicians, and advocating on behalf of the patient.

At your request, I have reviewed the case of Mr. \*\*\* vs \*\*\*\*\* Hospital.

You have asked that I provide you with my opinion(s) whether the care rendered to Mr. \*\*\* by several nurses - \*\*\* RN, \*\*\* RN and \*\*\* RN met the standard of care. You have asked that I state my opinions to a reasonable degree of nursing certainty.

The care and treatment occurred during Mr.\*\*\* admission into \*\*\* Hospital on February 22, 2009 through February 25, 2009. I am going to provide an overview of Mr.  admission after which I will set forth the opinions I hold in this case.

## Emergency Department Course

Mr. \*\*\* presented to the emergency department on Sunday, February 22, 2009. Chart entries made by the triage nurse, \*\*\* RN, at 1:49 p.m. noted Mr.\*\*\* was ambulatory. He complained of rectal bleeding x 3 days with clots. He was pale. He denied abdominal pain. Vital signs were Temp. 97.5, Pulse 99, Resp. 18, Pulse Ox 99 (room air), BP 127/66. Glasgow coma Scale was 15 indicating an awake, alert and oriented patient. Nurse obtained a history that Mr. \*\*\* had portal vein hypertension and had undergone abdominal surgery involving placement of a shunt between the liver and spleen.

Chart entries made by emergency department physician MD at 2:28 p.m. included the above history as well as a report of one episode of vomiting that day. Dr.  review of systems identified no shortness of breath, wheezing or cough. No fevers or chills. No chest pain or palpitation. The neurologic examination of Mr. \*\*\* was negative. Dr. \*\*\*’s examination was essentially consistent with the review of systems. He noted Mr. \*\*\* was alert and oriented x 3 and moved his extremities well. Dr.\*\*\* plan was to check laboratory studies, initiate IV hydration and Zofran for nausea.

 A chart entry by \*\*\* RN at 2:53 p.m. documented that Mr. \*\*\*

vomited bright green vomit and felt lightheaded and dizzy upon standing. The dizziness was likely the first indication of neurological decline that would follow.

An addendum chart entry by Dr.\*\*\* at 4:24 p.m. reviewed laboratory test results and confirmed that Mr. \*\*\* was being referred to the hospitalist for admission for (1) Rectal bleeding and (2) History of congenital varices.

Hospitalist, Dr. \*\*\* MD, evaluated Mr. \*\*\* at 5:46 p.m. His review and evaluation were consistent with Dr. \*\*\*. Notably, there was no social history of alcohol use and the neurologic examination was negative. Dr. \*\*\*’s impression was acute gastrointestinal bleed with pancytopenia. He admitted Mr.  into the Progressive Care Unit ("PCU") "not because of close monitoring, but because he needs more nursing care." Dr. \*\*\* was able to speak with gastroenterologist, Dr.who agreed to see Mr. \*\*\* that evening.

## II. Progressive Care Unit (Monitored) Course

The initial nursing assessment in the progressive care unit occurred at 6:36 p.m. and was performed by \*\*\* RN. Nurse \*\*\* evaluation of Mr. respiratory system revealed diminished lung sounds throughout. A chart entry at 6:45 p.m. by Nurse \*\*\* reported an additional history of sleep apnea. Nurse \*\*\* noted diminished lung sounds throughout the lungs at 6:38 p.m. on February 22nd. At 6:45 p.m., Nurse \*\*\* documented a history of sleep apnea.

Dr.  evaluated Mr. and was unsure as to the cause of his bleeding. He planned to have him undergo RBC bleeding scan. He ordered Mr. to be NPO, and that Octreotide and Protonix be administered along with fluids. Notably, Dr.did not obtain any history that Mr.\*\*\* abused alcohol and his neurologic examination was also normal.

A chart entry by Nurse \*\*\* at 8:10 p.m. noted Mr.was cooperative, restless with flat affect, disoriented and made "no eye contact when communicating with staff”. He was "only answering questions when asked, not all." The neurologic assessment was within normal limits. This included documentation that Mr. 

ability to swallow and the gag reflex was intact. Nurse \*\*\* documented the patient was dizzy, and his respiratory system exhibited diminished lung sounds throughout as well as shallow breathing. He appeared jaundiced and pale.

A chart entry was made by \*\*\* RN at 8:09 p.m. Nurse \*\*\* documents that she notified Dr. \*\*\* that Mr. \*\*\* was now confused. He had pulled off his heart monitor and had four episodes of rectal bleeding. He was also "very pale". Dr.\*\*\*, according to Nurse \*\*\* documentation, gave her orders for "detox withdraw". Dr. \*\*\*’s order was given as a telephone voice order. No physician evaluated Mr.\*\*\* at this time.

A chart entry was made by Nurse \*\*\* at 8:10 p.m. documented the respiratory

rate was 20 with saturated oxygen levels at 97% on room air. Nurse\*\*\* contacted the hospitalist, \*\*\* MD, to report hemoglobin and hematocrit. Nurse \*\*\* informed Dr. \*\*\* that Mr. \*\*\* was "confused to place and situation. pulling off head monitor. leaking bright red blood from rectum. HR 90-120 SR on monitor. family concerned dr. \*\*\* order detox protocol. new orders given to transfer to icu/ccu."

# III. ICU/CCU COURSE

Mr.was transferred via bed at 8:30 p.m. Nurse \*\*\* noted the reason for transfer was "h/h dropping. pt. leaking blood from rectum. confused. needs higher level of care." Mr. arrived at the ICU at 8:45 p.m. He was evaluated by \*\*\* RN. A chart entry by Nurse referring to events that occurred l at 9:00 p.m. noted that Mr. was restless, guarded, suspicious, withdrawn and irritable and was "on detox protocol". Nurse \*\*\* heard decreased lung sounds throughout. Mr.\*\*\* had one episode of vomiting. Dr. \*\*\* was notified and ordered that Zofran IV be administered. Orders for transfusions were held. A chart entry made by Nurse \*\*\* at 9:13 p.m. noted that she assessed the IV site at an "occurred time" of 9:12 p.m.

1 The chaffing by the nursing staff contains two-time entries. One time is when the entry was entered into the chart by the nurse, the other time refers to the "occurred" time, meaning, at what time the events the nurse was reporting happened actually happened. Where clarification is important/needed, I will include both times.

A chart entry by Nurse \*\*\* ‘entered’ at 10:16 p.m. referring to events that "occurred" at 9:35 p.m. states Mr. \*\*\* was transported to nuclear medicine to undergo RBC nuclear scanning. In another entry "entered" by Nurse \*\*\* at 10:22 p.m., for an "occurred time" of 9:30 p.m., Nurse typed a note that stated, "Patient transported to nuclear med at 2130 for bleeding scan." These facts support that Mr. \*\*\* was transported to the nuclear scan at approximately 9:30/9:35 p.m.

While in the nuclear medicine department, Mr. \*\*\* became agitated/ restless/combative. In a chart entry "entered" at 11 p.m., for an "occurred time" of 11:00 p.m. (which I believe to be in error), Nurse \*\*\* wrote:

“patient became severely agitated while in nuclear medicine requiring six people for restraint for patient safety. Patient was incoherent, very tremulous and agitated. Dr.\*\*\* called and orders updated to go by AWA protocol. Given 8 mg total of Ativan before desirable sedation achieved. Will start Ativan drip and titrate per protocol. Wife updated on status by phone."

As the above entry states, the administration of 8 mg of Ativan achieved a desirable sedation. The note was "entered" at 11:37 p.m. Because the chart reflects that Mr. was transported to nuclear medicine around 9:30 p.m., I am able to establish a time-period during which some events took place. Specifically, it was between 9:30 p.m. and 11:37 p.m. that (1) Mr. \*\*\* was transported to the nuclear medicine department (2) he became combative (3) he received 8 mg of Ativan and (4) a desirable sedation was achieved. Thus, there is a period of two hours and seven minutes during which those events could have occurred since, in order to write about them having happened, they had occurred. I do note that Nurse \*\*\* was making chart entries at 10:16 p.m. and 10:22 p.m. It is likely that the 8 mg of Ativan were administered, and the desired sedation level reached, between 9:30 p.m. and 10:16 p.m., a period of only 45 minutes.

I have difficulty determining the total amount of Ativan that was administered to Mr.  . Moreover, I have difficulty determining when the Ativan was administered and at what rate the Ativan was administered. This is because the documentation in the medical record is inadequate. The depositions that were provided are not helpful to this issue. None of the nurses deposed attempted to determine how much Ativan Mr. \*\*\* had been given. The testimony of the hospital who attended to Mr. 

on February 23rd and February 24th, Dr.\*\*\*, was that he did make an attempt to determine the amount of Ativan that was given, but he was unable to make that determination. He gave two estimations in his testimony. First, he stated that he believed Mr.\*\*\* Received 10 mg to 20 mg over four hours. Later, he stated that he believed Mr.\*\*\* Received 15 mg to 25 mg. (Dr. Deposition p. 24 vs. p. 52) As Dr.\*\*\* pointed out, the total dose is not documented. (Dr. \*\*\* Deposition p. 106)

I have reviewed the Alcohol Detoxification/Co-morbid use Protocol Orders found in the medical chart. This protocol which has four steps which I have repeated below:

## Step 1

AWA 10-15: lorazepam (ATIVAN) 1 mg PO or IV every 1-hour PRN

AWA greater than 15: lorazepam (ATIVAN) 2 mg PO or IV every 1-hour prn, if ineffective after 15 minutes may give additional 2 mg times 1 does.

If unable to maintain AWA less than 15 after 2 hours, move to step 2.

## step 2

Call MD for transfer to ICU.

AWA greater than 15: lorazepam (ATIVAN) 1 mg IV every 15 minutes to maintain AWA less than 15.

If unable to maintain AWA less than 15, after 1 hour, move to Step 3.

## Step 3

AWA greater than 15: lorazepam (ATIVAN) 2 mg IV every 15 minutes to maintain AWA less than 15.

If ineffective after 1 hour start lorazepam (ATIVAN) infusion at 8 mg per hour and titrate to max of 16 mg per hour to maintain AWA less than 15.

If max dose achieved or ineffective within 2 hours, move to Step 4

## Step 4

Call MD if lorazepam (ATIVAN) drip dosage is ineffective or patient is uncontrollable or seriously ill to consider intubation and propofol infusion.

If patient placed on propofol, discontinue all previous lorazepam (ATIVAN) orders.

A chart entry of an Alcohol Withdrawal Assessment by Nursethat was "entered" at 11:49 p.m. and that referenced an "occurred" time of 11:00 p.m. noted an AWA score of 39. I believe the "occurred time" of 11:00 p.m. on this entry is in error. I believe this for two reasons. First, as I reviewed above, Nurse s note at "entered" 11:37 p.m. states that a desired sedation had been achieved at the "occurred time" 11:00 p.m. A desired sedation is not an AWA of 39. Second, the patient was noted to become combative upon transport to the nuclear medicine department at 9:30 p.m. It is highly unlikely that no AWA score was calculated for an hour and one-half. An AWA score must be calculated to initiate the protocol. Therefore, I will assume that the AWA score of 39 refers to Mr. condition prior to the administration of Ativan and that the assessment resulting in that score occurred around 9:30 p.m. when Mr. as transported to the nuclear medicine department.

According to Step 1 of the protocol, the maximum amount of Ativan that can be administered to a patient with an AWA greater than 15 (like Mr.  during the initial two hour period is 8 mg. Step 1 authorized the administration of "2 mg PO or IV every 1 hour prn" and, if ineffective after 15 minutes, an "additional 2 mg times 1 dose". I will assume the initial 2mg dose was administered at 9:30 p.m. and that it was deemed ineffective after 15 minutes. I will assume that a second 2 mg dose was given at 9:45 p.m. therefore bringing the total dose administered to 4 mg by 9:45 p.m. I will assume that by 10:30 p.m., Mr. 's AWA remained greater than 15 (which is not documented). Step 1 of the protocol authorizes 2 mg to be administered at this time. I will assume this third dose of 2 mg was ineffective after 15 minutes, and that a fourth dose of 2 mg was administered at 10:45 p.m. Thus, under my assumptions, the patient would have been given Ativan per Step 1 of the protocol at 9:30 p.m., 9:45 p.m., 10:30 p.m. and 10:45 p.m. for a total of 8 mg. And, these 8 mg resulted in desired sedation.

If, by 11:30 p.m., the desired sedation had been achieved, then the next permissible dose would have been given pursuant to Step 1. Nurseshould certainly not have jumped to Step 3 and initiated an Ativan Infusion of 8 mg. In fact, doing so involved completely skipping Step 2 of the protocol, as well as the first part of Step 3 of the protocol. Nursenevertheless documented at 11:15 p.m. that she 'gave" Mr.Normal Saline 25 ML Ativan 50 MG. The note further states that she "started Ativan drip while in nuclear medicine for extreme agitation, unable to scan". (see page 5372) This was in violation of the protocol. Not only was the drip started after he had received 8 mg of Ativan and achieved a desired level of sedation, but it was given without any AWA assessment documenting a score greater than 15. The drip ran until 3:00 a.m. on 2/23/09 according to a note "entered" by Nurset 6:33 a.m. which states "patient deeply sedated following Ativan administration. Drip weaned off 0300." (p. 5320)

## IV. EVENTS AFTER OBTUNDATION

At 1:41 a.m. on February 23th , Nurse \*\*\* contacted the nighttime hospitalist, \*\*\* MD, to inform him the bleeding scan had returned positive results. She also reported an increased heart rate and elevated blood pressure. Nursenoted "will notify Dr.I in am of scan results since last H&H was stable. Orders to give Lopressor IV PRN for HR and BP."

At 4:00 a.m., Nurse \*\*\* performed a pain assessment using FLACC score. The FLACC is a behavior pain assessment scale for non-verbal patients unable to report pain. Areas tested include: Face, Legs, Activity, Cry, Consolability, Content. It is not clear how Mr.  who was deeply sedated to the point where he only "arouses to Deep Pain" and was "unable to reorient x 4", could participate in a FLACC assessment. Nursedocumented Mr.had "no swallowing issues; Gag reflex intact". She could not evaluate his ability to swallow at this time. The lungs sounds were now noted to be "coarse" throughout, a change from the previous evaluation at 11:55 p.m. which had described his lung sounds as within normal limits. Nurse \*\*\* was required to notify a physician of this change, but she did not. Mr.\*\*\* had not voided since admission to the ICU and now had hypoactive bowel sounds as previously the bowel sounds were hyperactive, another change that was not reported to any physician.

By 6:00 a.m. on February 23rd, Nurse  documented a pulse 110, respiratory rate 24, saturated oxygen level of 96% on room air, blood pressure 154/67. The elevated respiratory rate was a sign of respiratory distress. At 6:26 a.m., Mr.

 \*\*\* voided 300 ml of concentrated amber urine via straight catheter ordered by Dr. who was contacted and updated as to Mr. s status. Finally, by the end of her shift at 6:30 a.m., Nurse  noted, "Patient unresponsive except for withdrawal to strong stimulus. Pupils reactive... .Patient too sedated to be able to void."

\*\*\* RN was assigned to Mr. \*\*\* during the 7 a.m.-7 p.m. February 23, 2009 under the supervision of \*\*\*\* RN. The records indicate she was a graduate nurse, however her recollection at her deposition was that she had achieved her RN license shortly before Mr.\*\*\*’s admission. She acknowledges having an orientation period of several months and that Nursewas her mentor/preceptor.

Nurse first charted at 7:36 a.m. at which time vital signs were temperature 98.7, pulse 114, respirations 26, Sa02 95% on room air, BP 153/61. She documented at 7:43 a.m. that Mr.\*\*\* was sedated but arouses to deep pain. His lung sounds were "sonorous", a new finding that should have been reported to the physicians but was not. Mr.\*\*\*’s bowel sounds remained hypoactive. Nurse noted that Mr. \*\*\* had no swallowing issues, but she could not have made this determination in light of Mr. \*\*\*’s heavily sedated state. Nurse did not correct her documentation, nor report the sonorous lung sounds to any physician at this time.

Nurserounded with Dr.\*\*\* at 8:25 a.m. and noted no new orders received. He made no assessment of the patient that is documented. This was a deviation from the standard of care. Dr. \*\*\* noted at this time that Mr. 

"apparently got too much Ativan." At 11:00 a.m., Nursereassessed Mr. \*\*\* with NurseThere were no changes from the previous assessment, which had been performed at 7:36 a.m. In other words, Mr.remained sedated with sonorous lung sounds. Vital sign obtained at 11:00 a.m. were temperature 98.3, pulse 119, respirations 28, Sa02 96%, BP 177/79. At 2:46 p.m., Nurse obtained vital signs, nearly three hours since the previous check at 12:00 p.m. Temperature 99.2, pulse 118, respirations 28, Sa02 94% on room air, BP 163/65. At 2:53 p.m., Nurseperformed a reassessment of Mr.\*\*\*. This was nearly four hours since the reassessment at 11:00 a.m. Nurse \*\*\* noted "no changes". This was incorrect, as she had documented a new finding of "crackles, coarse” lung sounds. Crackles are explosive "popping" sounds that originate in the airways. They are commonly caused by either accumulation of secretions within the airway lumen or by airway collapse. Presence of crackles indicates a patient at high risk for aspiration. A physician should have been notified of this change in the patient's condition. Nurse failed to supervise Nurse and independently report this new finding to any physician.

At 3:10 p.m., Nurse \*\*\* changed Mr.'s position to "supine". There is no indication in the record that the head of the bed was raised. She also noted "slept all day". Mr. did not "sleep all day". He was obtunded. Regardless, there is no notification to any physician that Mr. had "slept all day", or that he was sleeping with sonorous lung sounds coupled with crackles. At 4:20 p.m., Nurse repositioned Mr. to his left side. No mention is made that that head of the bed was elevated. At 4:43 p.m., Nurse obtained some vital signs, specifically, the pulse 121 and BP 175/72. The previous vital signs have been obtained at 2:46 p.m., over two hours prior. The patient's respiratory rate was not obtained, nor was the saturated oxygen level. The failure to obtain these vital signs was a deviation from the standard of care. At 5:10 p.m., Nurseagain obtained some vital signs, but only pulse 110 and BP 158/75. She failed to document the respiratory rate and saturated oxygen level and again violated the standard of care.

At 6:12 p.m., Nursespoke with Dr. \*\*\* of the gastroenterology service. She testified that she would have informed Dr. \*\*\* of her assessment of the patient. However, Nursetestified that she would not have informed Dr.  of the patient's sonorous respirations if he'd been having them all day. (p. 124) She stated that she would not inform the physician of this because it was not a change in patient condition. At this time, Nurse had not documented Mr. \*\*\*'s saturated oxygen level since 2:46 p.m., a period of over three hours. At 6:20 p.m., Mr. was incontinent of a moderate sized stool characterized as bloody, maroon clots. A half-hour later, at 6:50 p.m., she notified Dr. \*\*\* of additional rectal bleeding. Dr. \*\*\* ordered blood transfusions for Mr. \*\*\*.

 RN cared for Mr.  from 7:00 p.m. on February 23rd to 7:00 a.m. on February 24th . During her initial assessment of Mr. at 7:58 p.m. on February 23rd, Nurse \*\*\* found Mr. completely unresponsive. He was unable to obey commands, he had no verbal response, he was unable to comprehend, he made no eye contact, he was disoriented to place and person, he exhibited no strength. Nurse \*\*\* testified that Mr.\*\*\* made no volitional movement or sound during her entire shift. (p. 76) Nurse \*\*\* documentation indicates that Mr.  had no swallow problems and no problem with his gag reflex (evidenced by the absence of any notation to the contrary i.e. charting by exception). However, Nurse  admitted that she did not perform swallowing testing (p. 65) and possibly did not perform any testing for the presence/absence of a gag reflex. (p. 64) Nurse  acknowledged that patients with liver problems have can have trouble excreting medications. (p. 60) Despite this knowledge, she made no effort to determine how much Ativan had been administered to Mr. \*\*\*. By 8:58 p.m., Mr.s temperate was 100.5, his pulse 111, respirations 39 and BP 181/71. No oxygen levels were documented. No physician was contacted. Again, at 10:03 p.m., temperature remained elevated at 99.9, pulse 116, respirations 29 and BP 184/72. No physician was contacted despite the elevated respirations, pulse and temperature all being indicative of respiratory distress. At 10:45 p.m., Nurse \*\*\* obtained an order to perform subglottal suctioning as needed from Dr. \*\*\*. This was performed once, at 10:51 p.m. at which time moderate, yellow, thick sputum was suctioned. Yellow, thick sputum is a sign of infection. This was not reported to any physician. At that same time, Mr. s blood pressure was 190/59, his respiratory rate was 30 and his oxygen levels were 93%. Mr. was not suctioned throughout the remainder of Nurse shift. His respiratory system was not evaluated completely (no lung sounds documented for from 10:51 p.m. to 8:00 a.m., a period of 9 hours) Vital signs at 12:31

a.m. failed to document an oxygen level but did record a low-grade fever. No physician was contacted. Dr. \*\*\* was contacted at 1:50 a.m., but there is no documentation he was informed of the patient's respiratory status and Nurse \*\*\* testified that she would not have informed Dr. \*\*\* of that information. At her deposition, Nurse admitted this:

Q. Do you know whether or not the doctors who were covering patient the night of the 23rd knew that the patient had been unresponsive throughout your shift?

A. I do not.

Q. All right. And you wouldn't have told them that his temperature was up to any point unless it had gotten above 101, correct?

A. Correct.

Q. And you wouldn't have told the doctors that his saturated oxygen levels had gone down as low as 93 percent, correct?

A. Correct. (Deposition p. 88)

At 3:02 a.m., Nurse \*\*\* documented a decreasing oxygen saturation level to 92% and a low-grade temperature of 100 degrees. Elevated bilirubin is consistent with liver disease. In the pain assessment, Nurse \*\*\* noted that Mr. \*\*\* had a quivering chin.

At 4:36 a.m. on 2/24/09, the WBC was 15.9 (H) reference [4-11], Neutrophils% were 82(H) reference [40 — 70], lymphocytes % 7 (L) reference [20-45]. Mr.\*\*\*’s total protein was at a critical low of 4.6 (6.1-7.9) and that his total bilirubin had increased to 5.4 H (.3-1.2), Direct Bilirubin 1.0 H (0.0-0.2) and the LDH was 221 H. (98-190). The first possible indication that Mr. was not laying supine in bed (with an unprotected airway) appears in the record in an entry at 4:51 a.m. when Nurse \*\*\* documented Mr. \*\*\* as "pulled up in bed". At 6:28 a.m. Nurse \*\*\* informed Dr. \*\*\* of the recent hemoglobin of 9.7 and hematocrit 28.2. Orders were received to call Dr.\*\*\* after 07:15 a.m. to update him of the overnight episodes and to discontinue the nasogastric (NG) tube. The last measurement of oxygen saturation had been nearly three and one-half hours ago at 3:02 a.m. At 7:55 a.m. an arterial blood gas was obtained which revealed an elevated pH 7.54 H (7.35-7.45) low carbon dioxide level of 25.0 L (35-45), low oxygen level P02 63 L (80-100), and low bicarbonate level HC03 21.4 L (22-26). There was a base deficit of 0.6. 02 Saturation was 94.4 L (96-100).

At 8:00 a.m. Nurse \*\*\* evaluated Mr. \*\*\*. Nurse \*\*\* started working at \*\*\* Hospital as a graduate nurse in June 2004. He went on to obtain his license as a registered nurse in the Fall of 2004 and practice at the hospital until 2009 when Mr. \*\*\* came in as a patient. (Deposition p 7) Nurse \*\*\* reported Mr. \*\*\*'s Alcohol Withdrawal Assessment score of 7 noting that Mr. \*\*\*’s Auditory Disturbance Degree was mild harshness / fright and that he was disoriented to place and person (000531). Vital signs at 08:01 a.m. noted Mr. \*\*\*'s pulse of 124, temperature 98.9, respiratory rate 26 and oxygen saturation of 92% on room air. BP was 169/81. At 8:12 a.m. Nursenoted that Mr.  was asleep, had lethargic behavior, no verbal response, and was unresponsive to painful stimuli. An unresponsive patient is not a lethargic patient. Nursealso noted that Mr.'s gag reflex was absent and that he had coarse lung sounds. He did not identify crackles despite Dr.\*\*\* having noted the presence of lung crackles when he examined the patient that morning. (See p. 100)

Nurse greed on page 27 of his deposition that Mr.  was heavily sedated, stating, "When someone is unresponsive to painful stimuli they're completely obtunded," and Nurse \*\*\* acknowledged on page 15 that there had been a serious change in Mr. \*\*\* condition between 2/23/09 and 2/24/09 and it was for the worse. Despite knowing that Mr. \*\*\* had suffered a serious worsening of his condition, Nurse \*\*\* continued to fail to protect his patient's airway. For a period of over five hours starting when the gag reflex was noted to be absent and ending when Mr. \*\*\* as emergently intubated by Dr.\*\*\* at approximately 1:15 p.m., Nurse \*\*\* failed to suction Mr.at any point, and he failed to do that even though earlier suctioning had found moderate thick, yellow sputum, even though Mr. \*\*\*'s respiratory status was declining, even though he remained completely obtunded, and even though he had lost his gag reflex and could not protect his airway. Not surprisingly, when Dr. \*\*\* intubated Mr.  he found copious secretions.

Mr.\*\*\* developed aspiration pneumonitis. He became septic and went into septic shock for which he was transported out of Hospital to a higher level of care.

### V. OPINIONS

Assessing the obtunded patient requires the nursing staff to assess the patient's airway and ensure the airway is protected. It requires careful monitoring of vital signs to evaluate for signs of respiratory distress, low grade fever and increasing oxygen demands. The risk of an unprotected airway is aspiration which, in turn, can cause pneumonia or respiratory infection. Assessment of the airway involves checking the patient's gag reflex. An obtunded patient's ability to swallow cannot be assessed as the patient cannot voluntarily drink. Patients who cannot swallow are at risk of aspiration. The absence of a gag reflex places the patient at high risk of aspiration. Breath/lung sounds must be assessed for the presence of rhonchi and/or crackles. Rhonchi are low pitched rattling sounds caused by obstruction or secretions in the large airways of the lungs commonly found in patients with pneumonia. Crackles are rattling/crackling noises made on inhalation and are commonly found heard in patients with pneumonia among other conditions. The patient's oxygenation status must be assessed as decreasing oxygen levels signal potential aspiration. Temperature must also be monitored carefully. Elevation in temperature indicates fever which, in turn, indicates potential infection. Additional nursing intervention includes positioning the patient, suctioning, and notifying the physician of change in patient status. Nurse \*\*\* testified that the nursing staff was "allowed to suction out of their mouth not down their throat" without an order. (p.20) She testified that oral pharynx suctioning could be performed with a physician's order. (p.20) Of course, the nurse must first assess the patient and appreciate the need for suctioning.

Based upon my review of this case, I find that the nursing staff providing care to Mr. was negligent and responsible for breaching the standard of care for the following reasons:

1. Nurse  and any other individual who participated in administering Ativan to Mr. on February 22nd and 23rd were negligent for the reasons I discuss in this report, above. Clearly, the protocol was not followed.
2. Nurses \*\*\*and \*\*\* failed to provide basic minimum protection to the patient by elevating Mr. \*\*\*’s bed, failing to suction, failing to request an order to perform subglottal suctioning and by application of a nasal trumpet.
3. The nursing staff's failure to properly and correctly document the amount of Ativan administered to Mr. constituted a deviation in the standard of nursing care.
4. Nurses \*\*\* and \*\*\* failed to adequately monitor Mr.\*\*\*'s vital signs. They failed to check them at set intervals, and they frequently failed to fully document the vital signs by omitting either the respirations, Sa02 levels, or both.
5. Nurses  failed to notify the attending and consulting physicians of significant findings that placed Mr. \*\*\* at an increased risk of aspiration. These findings included his crackles, sonorous and coarse lung sounds, absence of a gag reflex, his inability to swallow and/or their inability to evaluate his ability to swallow, his increasing temperature and his increasing dependence of supplemental oxygen to maintain his Sa02 at 90%.
6. Nurses \*\*\* and \*\*\* failed to appreciate and grasp the fact that Mr. \*\*\* was not "sleepy" or "sleeping" but, rather, he was obtunded, that his airway was unprotected, that his increasing dependency on supplemental oxygen, and his increasing temperature and decreasing Sa02 levels were warning signs of aspiration that required the nursing staff to intervene through very careful monitoring, suctioning, and positioning to prevent aspiration and/or that required advocating to the physicians on behalf of the patient that he be intubated.
7. Nurses  and \*\*\* failed to evaluate Mr.  for the presence/absence of a gag reflex during each assessment despite Mr. \*\*\* being at risk of losing his gag reflex.
8. Nurses carelessly and negligently documented Mr. \*\*\* had no swallowing issues despite not having evaluated Mr.\*\*\*'s ability to swallow due to his obtunded state.
9. Nurse \*\*\* failed to inform Dr. \*\*\* and Dr. \*\*\* of the absence of a gag reflex despite being aware Mr. \*\*\* had lost his gag reflex the morning of February 24th.
10. Nurse \*\*\* failed to inform any physician that Mr. \*\*\*'s pupils had become sluggish when she evaluated the patient on February 23rd at 7:58 p.m.

11 . After performing subglottal suctioning of Mr. at 10:51 p.m. on February 23rd for a moderate amount of yellow, thick sputum, Nurse \*\*\* never documented an evaluation of Mr. s respiratory system for the remainder of her shift. In fact, the only recordation of Nurse \*\*\* evaluating Mr. \*\*\*'s lungs sounds during her entire shift occurred at 7:58 p.m., at which time she found his breathing to be of a coarse, loud, sonorous type on inspiration and expiration throughout his lungs. She documented at 10:28 p.m. that Mr. was now unable to clear secretions but failed to describe his lung sounds. The failure to monitor Mr. \*\*\*'s lungs was a clear deviation from the standard of care.

Each nurse acknowledged that a patient like Mr. who suffers from liver disease may have difficulty clearing Ativan. Thus, the failure to follow protocol resulted in an overdose of the drug and exposed Mr.\*\*\* to cumulative effects of the drug. This, coupled with the negligence described above associated with inadequate monitoring, assessment, communication with physicians and airway protection, all combined to substantially increase the likelihood that Mr.\*\*\* would suffer respiratory distress and, ultimately, aspiration as well as the consequences of aspiration to include pneumonia, sepsis, and shock requiring his transfer to an institution that could provide a higher level of care.

All of my opinions expressed above are stated to a reasonable degree of nursing certainty. Thank you for the opportunity to review this tragic case. Please contact me if you require anything further.

Sincerely,

### Justin R. Fiscus, BSN, RN, CPN

