The Liebbe Firm P.C.

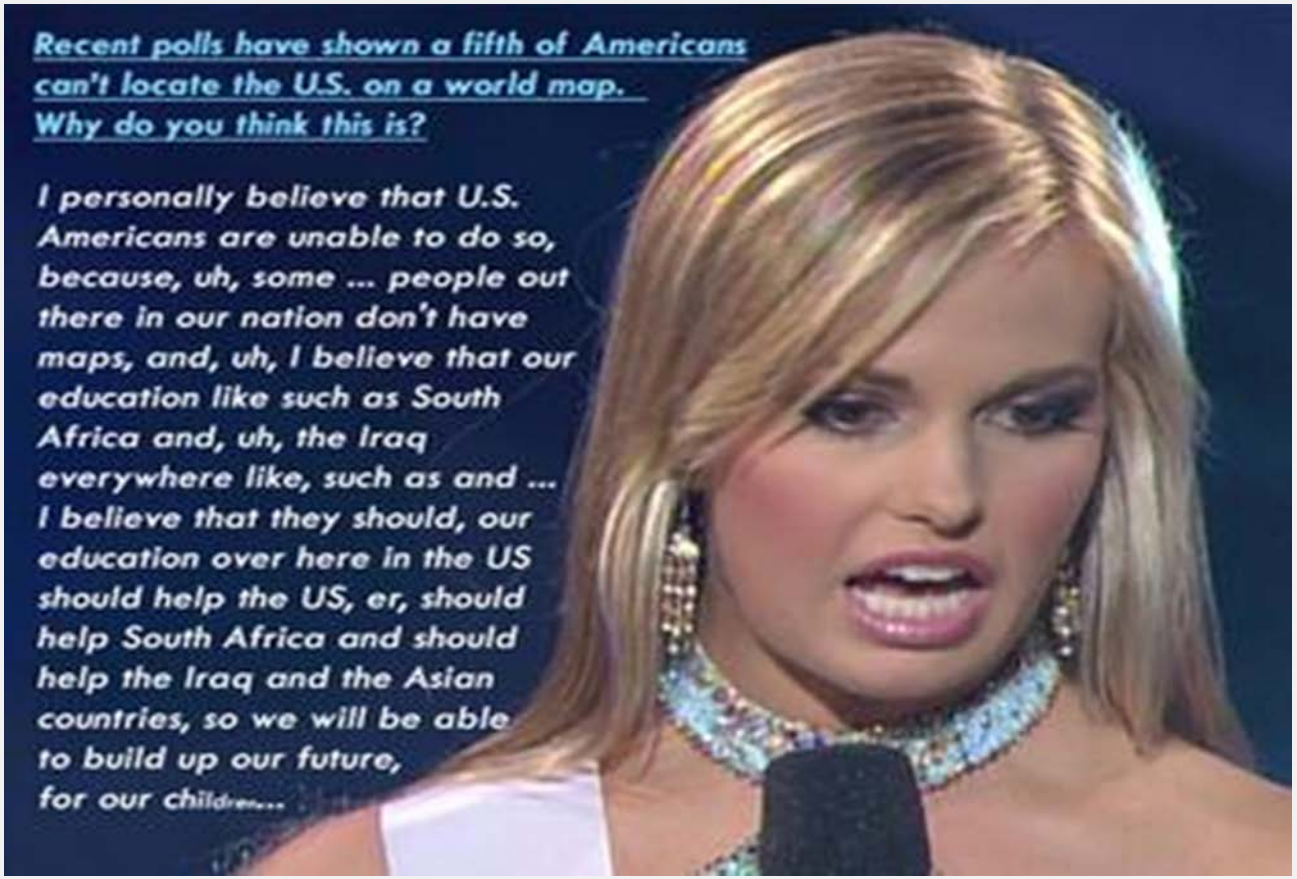
Examination of Nurse in Question

TTLA Annual Conference 2013

Methodist v. German

" This holding does not mean that a nurse has no duty to recognize and appropriately report or otherwise act on the signs and symptoms of a dangerous allergic reaction. Instead, consistent with the complementary provisions of the Medical and Nursing Practice Acts, we hold that Texas law specifies that it is the doctor, not the nurse, who draws medical conclusions from the information observed and reported by the nurse."

Are Nurses Airheads?



they call her nurse Anna

but they should call her HERO!!!

The Case

- 26 year- old mother of two
- Admitted eight days post C-section with cellulitis incision site.
- No headache on admission. Normotensive.
- Following admission she complains of sudden/severe headache unrelieved by morphine.
- Blood pressure steadily increase.
- Develops weakness of the right side.
- Cerebral venous thrombosis diagnosed after brain herniation began.

Goals: Deposition of Nurse

- Nurse knows medical condition.
- Nurse knows clinical features.
- Nurse knows importance of communication.
- Nurse knows BON Standards of Practice.
- Nurse knows to document and report.
- Nurse never allowed to make medical judgment.
- Nurse knows what doctors do when there is a possible life-threatening condition.

Nurses Cannot Diagnose!

Q. All right. Nurses cannot make a medical diagnosis, can they?

A. No, they cannot.

Q. Why not?

A. Because they are not doctors.

What Do Nurses Know?

Q. Nurses know what medical diagnoses are, through, don't they?

A. Yes, they know what they are.

Q. They know what medical conditions are?

A. They're – yes.

Q. And they know clinical features of medical conditions?

A. Yes.

Why is that important?

Q. Is it important for you as a registered nurse or any registered nurse to know what medical conditions are?

A. Yes.

Q. Why?

A. So that we would be able to recognize something happening with the patient.

Q. All right. And to also know the clinical features of some medical conditions?

A. Sure.

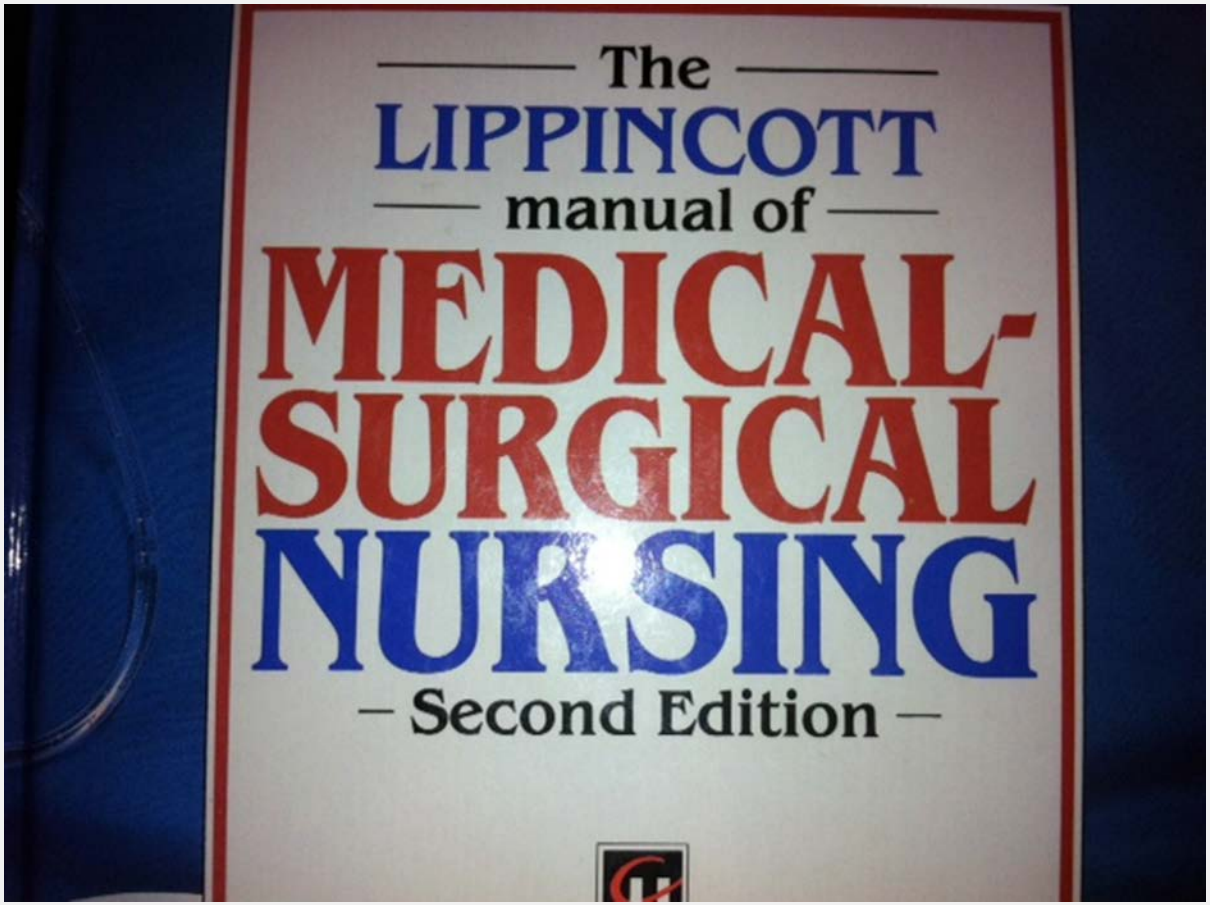
Q. Why is that important?

A. Again, so that we can recognize changes in a patient.

How Do Nurses Learn?

Q. Now, when you were in nursing school, did you have textbooks?
A. Yes.
Q. And did you have textbooks like, for example, on med-surg?
A. Yes.
Q. What are some of the names of the textbooks that you can recall?
A. I don't remember the names of the textbooks.
Q. Do you remember Lippincott?
A. I do remember that name.
Q. What is – what is Lippincott?
A. That would be the name of a publisher of a textbook.
Q. Does this look familiar (indicting)?
A. Yes.

Nursing Textbook



What Nurses learn in school

Q. All right. So in terms of the Lippincott manual, I want to just ask you about a few other medical conditions here. For example, cerebral vascular disease, are registered nurses trained and educated to know what cerebral vascular diseases are?

A. Yes.

Q. For example, here it says that a cerebral vascular disease refers to any functional -- and you can read it with me if you like. Cerebral vascular disease refers to any functional abnormality of the central nervous system caused by interference with normal blood supply to the brain. The pathology may involve an artery, a vein, or both. When the cerebral circulation

What Nurses learn in school (cont.)

becomes impaired as a result of partial or complete occlusion of a blood vessel or hemorrhage resulting from a tear in the vessel wall, is that something that would be typical of your nursing education in nursing school, getting that kind of knowledge?

A. Question again, please.

Q. Sure. Well, this first paragraph that I read under cerebral vascular disease on 936, did you know -- do you know that, the stuff that's said right there?

A. Yes.

Q. Okay. And how long have you known that?

A. Since nursing school.

Nurses know Clinical Features

Q. Then under assessment it says, Clinical features of impending stroke: Number one, memory impairment, vertigo, headache, syncope, blurring of vision, et cetera.

Did you -- do you know as a registered nurse that those clinical -- those are clinical features of impending stroke?

A. Yes.

Q. Including cerebral thrombosis?

A. Yes.

Q. Do you have an understanding as to why headache is a clinical feature of cerebral thrombosis?

A. Yes.

Nurses know Clinical Features (cont.)

Q. Okay. But you do know as a registered nurse that headache is a clinical feature associated with cerebral thrombosis in postpartum patients?

A. Yes.

Q. And how long have you known that?

A. Since nursing school.

Nurses knows what is life threatening

Q. Is cerebral thrombosis potentially life threatening?
   A. Yes.
Q. And how long have you known that?
   A. Since nursing school.

Nurses knows why it is life threatening

Q. What is your understanding as to why cerebral thrombosis is potentially life threatening?

A. It can cause a stroke.

Nurses knows why it is life threatening

Q. All right. Is, to your nursing education and understanding and knowledge and training and experience,
hypertension a risk factor for stroke or cerebral vascular accident, including cerebral thrombosis?
A. Yes.
Q. Why?
A. Well, because hypertension -- if sustained, hypertension can cause problems. It can cause stroke.
Q. And how long have you known that?
A. Since nursing school.

Importance of Communication

Δ π EXHIBIT 2
Deponent Hearnsburger
Date 5-3-13 Rptr. SL
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Nurses On Guard – Best Practice in Patient Safety

Professional Communication on Interdisciplinary Teams and a Nurse's Duty

Interdisciplinary Healthcare Team

Q. As a registered nurse working in a hospital, do you recognize that -- that healthcare in the United States is delivered through complex systems that involve patients interfacing with many different healthcare practitioners?

A. Yes.

Q. And a hospital's interdisciplinary healthcare team typically includes registered nurses, yes?

A. Yes.

Q. Advanced practice registered nurses?

A. Yes.

Q. Licensed vocational nurses?

A. Yes.

Q. Physicians?

A. Yes.

Patient Safety Endangered

Q. Do you believe and agree that all of these individuals must work together on behalf of the patient?

A. Yes.

Q. And must communicate with each other effectively?

A. Yes.

Q. And that if they don't, that patient safety is endangered?

A. Yes.

Q. And will you also agree that medical errors resulting in severe injury or patient death may occur when there is a lack or failure of communication?

A. It can be, yes.

Patient Safety Threatened

Q. Sure. When nurses and doctors do not communicate, or if they misinterpret critical information, or orders are unclear, or when changes in a patient's condition are not addressed and communicated, do you agree that patient safety is threatened when those things happen?

A. Yes.

Nurses are a patient safety net

Q. As a member of the interdisciplinary team that takes care of patients in hospitals, do you agree that nurses have a responsibility to intervene by professionally communicating assessments, evaluations, actions and recommendations for plans of care to the physicians?

A. Yes.

Q. And that a responsibility and duty of a nurse is to be assertive when there are concerns that arise and -- and to implement nursing actions to create a safety net for patients. Do you agree with that?

A. Yes.

Texas Board of Nursing

§217.11. Standards of Nursing Practice.

The Texas Board of Nursing is responsible for regulating the prac
Vocational Nurses, Registered Nurses, and Registered Nurses with
of practice establish a minimum acceptable level of nursing practi
licensure or advanced practice authorization. Failure to meet these
nurse's license even if no actual patient injury resulted.

BON Regulates Nurses

Q. All right. It says here under Section 217.11 -- and I'll just read here -- the Texas Board of Nursing is responsible for regulating the practice of nursing within the state of Texas for vocational nurses, registered nurses and registered nurses with advanced practice authorization.

And you are a registered nurse, correct?

A. I am.

Minimum Standard of Care

Q. The standards -- I'm reading -- continuing to read here -- the standards of practice establish a minimum acceptable level of nursing practice in any setting for each level of nursing licensure or advanced practice authorization, correct?

A. Yes.

Q. All right. And -- and you understand that these standards of nursing practice establish just the minimal acceptable level, right?

A. Yes.

Violations may result in BON action against license

Q. And that -- continuing on here, it says, The failure to meet these standards may result in action against the nurse's license even if no actual patient injury resulted. Right?

A. Yes.

Report and Document Changes

Q. Under D -- I want to talk to you about Part D where it says, Accurately and completely report and document.

Now, what does it mean to report?

A. It means to report to the physician --

Q. Okay.

A. -- any changes in patient status or condition or . . .

Q. It also says report and document.

A. Uh-huh.

Q. What does it mean by document?

A. Document in the patient's chart.

Report Signs and Symptoms to the Physician

Q. Okay. So under D, little 1 here, little i, it says, Accurately and completely report and document the client's status including signs and symptoms. Did I read that right?

A. Yes.

Q. What does that mean?

A. That means whatever signs and symptoms that the patient is exhibiting.

Q. All right. And so to report signs and symptoms to the physician, that's part of the requirement, right?

A. Uh-huh.

Report Significant Signs and Symptoms

Q. Okay. So there are times when the nurse, registered nurse sees or detects changes in the client patient's signs and symptoms, right?

A. Yes.

Q. That can be significant.

A. Yes.

Q. And the nurse's responsibility is to report those signs -- those significant signs and symptoms?

A. Yes.

Q. And document those significant signs and symptoms?

A. Yes.

Report and Document Physician Comunications

Q. And then also report and document the contacts with physicians concerning those significant events regarding the client's status, right?

A. Yes.

Q. So what this means is that if you or any registered nurse taking care of a patient in the hospital sees significant changes in the client's status, including signs and symptoms, the requirement is to report and document what those signs and symptoms are, right?

A. Yes.

Q. And then also report and document your contact, that is, what you told the physician, for example.

A. Yes.

Report and Document Physician Communications

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A. Yes.

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A. Yes.

Q. And then also report and document your contact, that is, what you told the physician, for example.

A. Yes.

Why Nurses must have knowledge

Q. So a patient may come in with one medical condition, right?

A. Right.

Q. And that medical condition may worsen during the hospitalization?

A. Right.

All About Patient Safety

Q. All right. So if a patient who comes in with one medical condition has worsening signs and symptoms, who is usually the one who's going to see that first? Nurses or doctors?

A. Nurses.

Q. Patients may also come in with one medical condition and then develop other medical and different medical conditions during the hospitalization, true?

A. They can.

Q. Has that happened in your experiences?

A. Yes, they can.

Severe injury or death may result in patient

Q. And that's why nurses are trained and educated and required and expected to know what medical conditions are, right?

A. Yes.

Q. As well as their clinical features.

A. Yes.

Q. So that they can be the first line of patient safety to recognize new medical conditions, right?

A. Right.

Q. Earlier we discussed and we talked about how medical errors may result in severe injury or patient death when there's a lack or failure of communication, right? Remember we talked about that?

A. Right.

A sudden severe headache could be a serious life threat

Q. You told me earlier that sudden onset of severe headache could be a clinical feature of a number of different medical conditions including hormone influx, blood loss, epidural, lack of sleep, subarachnoid hemorrhage and cerebral thrombosis and other things, right?

A. Yes.

Nurses cannot make medical judgement

Q. Sure. Is a nurse, a registered nurse ever allowed to make a judgment as to which of these medical conditions is actually going on with the patient if they have sudden onset of severe headache?

A. No, because the way you're phrasing that would be making a medical diagnosis and that would not be -- no.

Only doctors can make medical diagnosis judgment calls

Q. Right. And so to make it clear, then, when you see a patient, when a registered nurse sees a patient who's postpartum with the sudden onset of severe headache, the nurse may know that it could be a result of a number of conditions, some life threatening, some not, right?

A. Right.

Q. But it's the nurse's responsibility to let the doctor make the medical diagnosis as to which one it is, right?

A. Right.

The Nurses duty to report

Q. And so it is the nurse's responsibility and duty to report and document the sign and symptom of severe onset of headache, right?

A. If it's warranted, yes.

Q. And it's warranted when there is a change in the client's status that concerns a potential significant event, right?

A. Right.

Nurses know what doctors do

Q. Sure. If a -- if a doctor suspects and includes within his differential diagnosis things like subarachnoid hemorrhage and cerebral thrombosis, is it within your knowledge as a registered nurse that doctors will typically order some type of test?

A. If he suspects that?

Q. Yes.

A. Yes.

Doctors will order a CT if they suspect Cerebral Thrombosis

Q. And what is the types of tests that you are familiar with that doctors will typically order if they suspect cerebral thrombosis or subarachnoid hemorrhage?

A. A CT would be my guess.

Q. And that's something that you've known since when?

A. Nursing school.

Nurse knows admitting diagnosis

Q. All right. What time did you document your nursing admission assessment?

A. At 0740.

Q. And what was her admitting diagnosis?

A. Cellulitis of C-section incision.

Q. And did you document that she had delivered on May the 24th, 2010 by the Cesarean section?

A. Yes.

Nurse knows there was no headaches on admission

Q. But she didn't have complaints of headache on admission, did she?

A. No.

Q. I mean, is that correct; she did not have headaches on admission?

A. That's correct.

Q. Did she have any problems that you identified on your neurophysical examination?

A. No.

Nurse documents significant change in condition

Q. But you did document at 6:10 p.m. a change in her condition, right?

A. I documented that she complained of a headache at 6:10 p.m., yes.

Q. How severe was the headache that she was complaining about at 6 -- that you documented at 6:10?

A. It was a 10.

Q. 10 out of 10?

A. Yes.

Q. Worst possible?

A. Yes.

Q. Severe?

A. Yes.

Severe headaches was new

Q. And how did she describe this severe 10 out of 10 headache?

A. She described it as throbbing, aching, and continuous.

Q. Was this the first time that you were aware of that Jessica had headache?

A. Yes.

Q. Of any kind?

A. Yes.

Nurse knew that it could be a life threatening condition

Q. And you knew that the sudden onset of severe headache in a postpartum patient may be as a result of a number of medical conditions including cerebral thrombosis?

A. Yes.

Q. And you documented the change in condition?

A. Yes, I documented that she had headache.

Q. Did you report it to anyone?

A. Not at that time, I did not.

Q. Did you ever report the onset of severe 10 out of 10 headache described as throbbing, aching, and continuous to anybody?

A. I did. I reported it to the oncoming nurse.

Q. To the oncoming nurse?

A. Yes.

Nurse made judgement not to report it to the doctor

Q. Okay. And who was the oncoming nurse?

A. Dixie Carter.

Q. Did you report it to any physician?

A. No, I did not.

Q. Why not?

A. Because I didn't feel -- you know, I used my nursing judgment. I didn't feel at that time that it was a reportable change as she already had pain medication as a standing order.

Tie it all up!

Gotta Love Objections!

Q. Sure. As a registered nurse, you told me earlier that in a postpartum patient the sudden onset of severe 10 out of 10 headache could be related to subarachnoid hemorrhage, cerebral thrombosis, right?

A. Yes.

Q. And how did you make the decision and determination that Jessica's sudden onset of severe headache was not related to either of those medical conditions?

MR. MADSEN: Object to form.

A. I can't answer that.

Gotta Love Objections! (cont.)

Q. (By Mr. Liebbe) Did you assume that her sudden onset of severe headache was related to the cellulitis?

A. No.

Q. Did you assume that her sudden onset of severe headache was related to the previous spinal epidural?

A. No.

Q. Did you assume that her sudden onset of severe headache was her normal occasional type of headache?

A. No.

Gotta Love Objections! (cont.)

A. Can you rephrase the question, please?
Q. (By Mr. Liebbe) You didn't call Dr. Zeid about this severe sudden onset of headache, did you?
A. No.
Q. You didn't call Dr. Doerrfeld who was on call after Dr. Zeid went off, right?
A. No.
Q. Why didn't you?
A. Because I already had an order for pain medication.

Gotta Love Objections! (cont.)

Q. And her headache, severe 10 out of 10, she didn't come in with that either, did she?

A. No, she didn't.

Q. And that was a change in status, the sudden onset of severe headache?

A. Yes.

Q. Significant change in status?

A. It was a change in status, yes.

Q. And she went from no headache to the most severe headache, right?

MR. MADSEN: Object to form.

Q. (By Mr. Liebbe) Yes?

A. She stated she had a 10 out of 10 headache, yes.

Gotta Love Objections! (cont.)

Q. And you don't consider that to be a significant event?

A. She stated she had a 10 out of 10, so . . .

Q. Right. And not only was it 10 out of 10 and throbbing and aching and continuous, she was grimacing and moaning, wasn't she?

A. Yes.

Q. And you didn't consider that to be a significant change in condition?

A. I considered it significant, and I gave her medication to relieve it --

Q. Okay.

A. -- that was ordered by the doctor.

Gotta Love Objections! (cont.)

Q. But you didn't report this significant change in condition to her doctor, true?

A. No, I did not at that time.

Q. Or ever?

A. No, I didn't.

Q. You just gave her some morphine?

A. Yes.

Testimony of Dr. Doerrfeld

Dr. Doerrfeld was deposed previously and testified that the differential diagnosis for a postpartum, obese patient who had cellulitis from a C-section that had nausea, elevated blood pressures and severe 10/10 headache described as throbbing, aching, and continuous includes cerebral thrombosis.

Testimony of Dr. Doerrfeld

Q. All right. If you had been informed by Nurse Dixie that Jessica Walls was postpartum, she was obese,
she had cellulitis from a C-section, that she had
nausea, that her blood pressures were elevated, that she
had severe 10/10 headache described as throbbing,
aching, and continuous that was relieved not much at all
by morphine, what concerns would have entered your mind?

A. I would probably want to assess her.

Q. Why?

A. I think it would warrant it.

Q. Did you assess her?

A. I did not.

Testimony of Dr. Doerrfeld (cont.)

Q. If you suspect that a woman has cerebral venous thrombosis or something else going on in their head like that, what would you do?

A. Well, after you assess them, then you're going to look at imaging, radiologic imaging.

Q. What kind of radiological imaging?

A. Potentially first would be a CT scan.

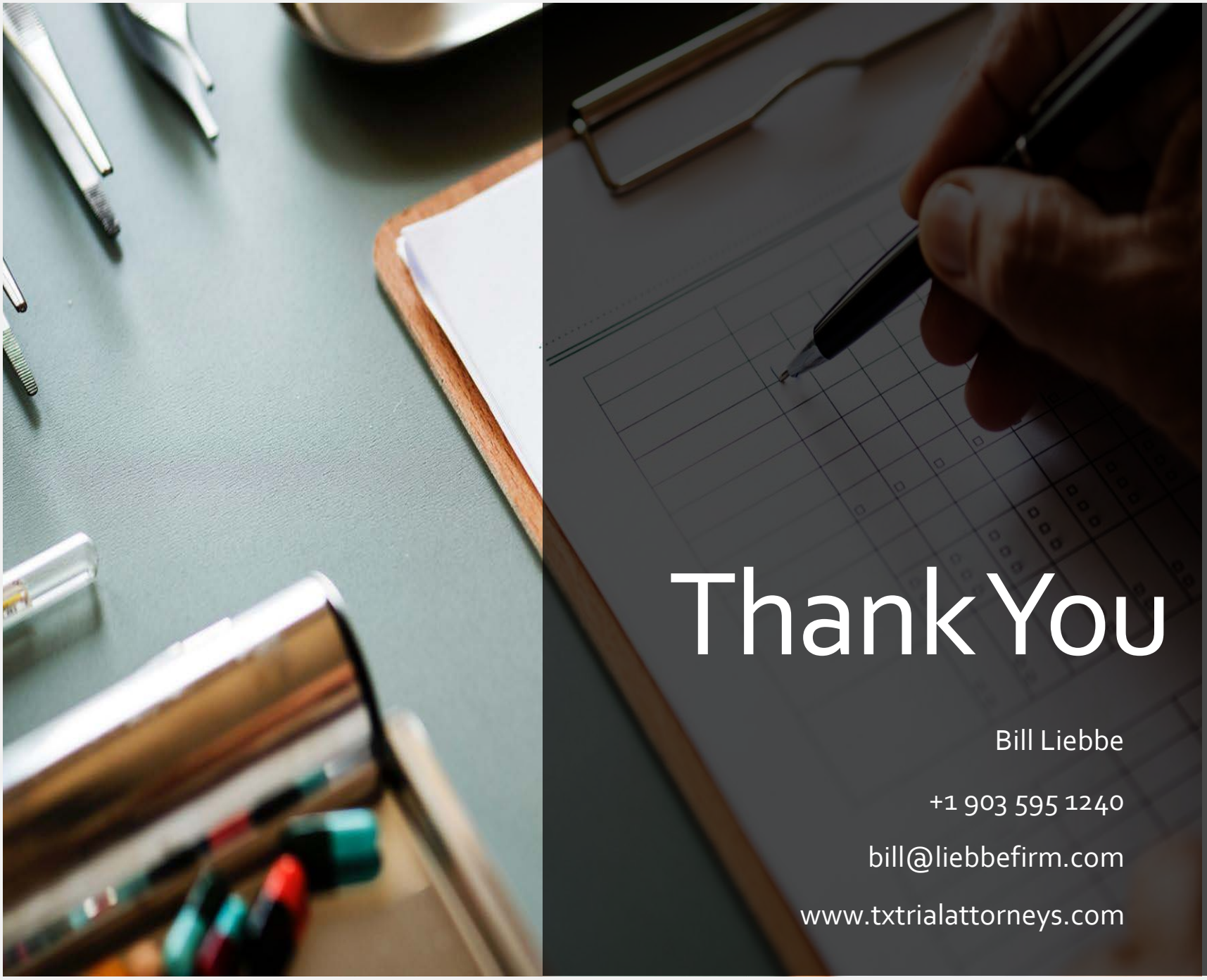
Q. And if that CT scan showed cerebral venous thrombosis, what would you do?

MR. PRICE: Objection, form.

A. Contact the appropriate consultants, experts.

Q. (By Mr. Liebbe) And would that be a neurologist?

A. Neurologist.



Thank You

Bill Liebbe

+1 903 595 1240

bill@liebbefirm.com

www.txtrialattorneys.com