MN506 Unit 7 Assignment

Description:

You will construct a group contract in Unit 2. In the contract, you will determine how your group will communicate and share documents. Roles of the group will be delineated. You will work from Unit 3 to Unit 7 on a malpractice case.

There are two malpractice cases. Your instructor will assign your group either Case Study 1: Malpractice Action brought by Yolanda Pinnelas or Case Study 2: Wrongful Death by Howard Carpenter on Behalf of Wilma Carpenter, Deceased. The group will construct a 10–15-page paper about the legal constructs involved in one of the cases.

Directions:

The group will write a10–15-page APA formatted paper (title page and references list do not count towards the 10–15 pages). Support the paper with peer reviewed articles and case law where applicable. You must have minimum of eight references. You may have an appendix that has samples of documents that support your positions or expands on the facts of the case.

You will post a draft of the group paper in the Discussion Board of Unit 7. This will give you an opportunity to get peer feedback and to learn from others.

You may use Goggle Hangouts™, SKYPE®, or other conferencing tools. Additionally, you may want to use a document-sharing tool such as Google Drive®. The paper should discuss the following issues:

- Liability issues
- Parties involved and who should be sued
- Defenses of the parties
- Documents that the plaintiff's side will ask for and how they will be used
- Standards of care
- Duty, breach, damages, and proximate cause
- Insurance issues
- Risk management issues before and after the incident
- Documentation and mandatory reporting
- Who should write the incident report and what should it say?
- The doctrine of Respondeat Superior and how it would apply the issues surrounding informed consent Preparation for court of the parties.

Due: Day 7 by 11:59 p.m. (ET)

Case Study 1: Malpractice Action Brought by Yolanda Pinnelas

People involved in case:
Yolanda Pinnelas — patient
Betty DePalma, RN, MS — nursing supervisor
Elizabeth Adelman, RN — recovery room nurse
William Brady, M.D. — plastic surgeon
Mary Jones, RN — IV insertion
Carol Price, LPN
Jeffery Chambers, RN — staff nurse
Patricia Peters, PharmD — pharmacy
Diana Smith, RN
Susan Post, JD — risk manager
Amy Green — quality assurance
Michael Parks, RN, MS, CNS — education coordinator
SAFE-INFUSE — pump
Brand X infusion — pump
Caring Memorial Hospital

Facts:

The patient, Yolanda Pinellas, is a 21-year-old female admitted to Caring Memorial Hospital for chemotherapy. Caring Memorial is a hospital in upstate New York. Yolanda was a student at Ithaca College and studying to be a music conductor.

Yolanda was diagnosed with anal cancer and was to receive Mitomycin for her chemotherapy. Mary Jones, RN, inserted the IV on the day shift around 1300, and the patient, Yolanda, was to have Mitomycin administered through the IV. An infusion machine was used for the delivery. The Mitomycin was hung by Jeffery Chambers, RN, and he was assigned to Yolanda. The unit had several very sick patients and was short staffed. Jeffery had worked a double shift the day before and had to double back to cover the evening shift. He was able to go home between shifts and had about 6 hours of sleep before returning. The pharmacy was late in delivering the drug so it was not hung until the evening shift. Patricia Peters, PharmD, brought the chemotherapy to the unit.

On the evening shift, Carol Price, LPN, heard the infusion pump beep several times. She had ignored it as she thought someone else was caring for the patient. Diana Smith, RN, was also working the shift and had heard the pump beep several times. She mentioned it to Jeffery. She did not go into the room until about 45 minutes later. The patient testified that a nurse came in and pressed some buttons and the pump stopped beeping. She was groggy and not sure who the nurse was or what was done.

Diana Smith responded to the patient’s call bell and found the IV had been dislodged from the patient's vein. There was no evidence that the Mitomycin had gone into the patient's tissue. Diana immediately stopped the IV, notified the physician, and provided care to the hand. The documentation in the medical record indicates that there was an infiltration to the IV.

The hospital was testing a new IV infusion pump called SAFE-INFUSE. The supervisory nurse was Betty DePalma, RN. Betty took the pump off the unit. No one made note of the pump’s serial number as there were six in the hospital being used. There was also another brand of pumps being used in the hospital. It was called Brand X infusion pump. Betty did not note the name of the pump or serial number. The pump was not isolated

or sent to maintenance and eventually the hospital decided not to use SAFE-INFUSE so the loaners were sent back to the company.

Betty and Dr. William Brady are the only ones that carry malpractice insurance. The hospital also has malpractice insurance.

Two weeks after the event, the patient developed necrosis of the hand and required multiple surgical procedures, skin grafting, and reconstruction. She had permanent loss of function and deformity in her third, fourth, and fifth fingers. The claimant is alleging that, because of this, she is no longer able to perform as a conductor, for which she was studying.

During the procedure for the skin grafting, the plastic surgeon, Dr. William Brady, used a dermatome that resulted in uneven harvesting of tissue and further scarring in the patient's thigh area where the skin was harvested.

The risk manager is Susan Post, JD, who works in collaboration with the quality assurance director Amy Green. Amy had noted when doing chart reviews over the last 3 months prior to this incident that there were issues of short staffing and that many nurses were working double shifts, evenings, and nights then coming back and working the evening shift. She was in the process of collecting data from the different units on this observation. She also noted a pattern of using float nurses to several units. Prior to this incident, the clinical nurse specialist, Michael Parks, RN, MS, CNS, was consulting with Susan Post and Amy Green about the status of staff education on this unit and what types of resources and training was needed.

Case Study 2: Wrongful Death by Howard Carpenter on Behalf of Wilma Carpenter, Deceased

People Involved in Case:
Mrs. Wilma Carpenter — patient, deceased
Mr. Howard Carpenter — husband and plaintiff in wrongful death suit
Mrs. Scale, RN, MS — nursing supervisor
Elizabeth Adelman, RN — recovery room nurse
Richard Washington, MD — orthopedic surgeon
Judy Gouda, RN, NP
Joseph Alsoff, LPN — post-surgical unit nurse
Kelly Wheeler, RN — post-surgical unit nurse
David Casler, LRT
Susan Post, JD — risk manager
Amy Green — quality assurance
Michael Parks, RN, MS, CNS — education coordinator
Caring Memorial Hospital

Facts:

The plaintiff, Mrs. Carpenter, was a 55-year-old woman who underwent a total hip replacement at Caring Memorial Hospital. The physician was Richard Washington, MD. Dr. Washington is an orthopedic surgeon. His nurse practitioner is Judy Gouda, RN, NP. Dr. Washington reviewed the consent with Mrs. Carpenter prior to surgery. Joseph Alsoff, LPN, witnessed the consent and Mr. Carpenter was present. Joseph does not remember the doctor ever mentioning that death could be a result of the surgery. The recovery room nurse is Elizabeth Adelman, RN. The respiratory therapist is David Casler, LRT. The nurse on the post-surgical unit was Kelly Wheeler, RN. The supervising nurse was Mrs. Scale, RN, MS.

The patient had an epidural catheter for a post-operative pain management following an episode of hypotension in the recovery room which was treated with Ephedrine. Judy Gouda made rounds on the patient in the recovery room after the hypotensive event and vital signs were stable. The patient, Mrs. Carpenter, was placed on a medical surgical nursing unit with the epidural. The nurse, Kelly, was assigned to the patient and had not worked on that unit before, but had worked in post-acute critical care units. The nurse's assignment was to provide patient care on the entire floor for that shift. There was also an LPN, Joseph, on the unit. It was a busy day on the unit. Mrs. Carpenter was not the only post-operative patient.

Kelly assessed the plaintiff upon admission, checked the IVs, asked if the patient was in pain, noted that the patient was responsive and understood where she was, and was stable. She then left to care for other patients.

The licensed practical nurse, Joseph Alcoff, had been working on the unit for several years. It had been rumored that Joseph was an alcoholic. There was no evidence that he had been drinking on the unit. Approximately an hour after the patient arrived on the unit, she was unable to tolerate respiratory therapy that was ordered and she became nauseated and vomited. David Casler administered the respiratory therapy. According to Kelly, the registered nurse, 10 minutes after the vomiting episode, Joseph Alcoff, the LPN, found the patient blue and unresponsive and called a code. Joseph is the only person other than the physician that carries his own liability insurance. The hospital also has malpractice insurance.

The code team responded, along with Kelly, the registered nurse. Mrs. Carpenter was intubated and cardiac resuscitation was initiated. The patient responded to resuscitative efforts and she was transferred to the intensive care unit. Subsequently, Mrs. Carpenter did not do well, was unresponsive, and declared brain dead and taken off the respirator. She did not have a DNR in place.

There is a conflict in testimony between Joseph the LPN and Kelly the RN. Joseph indicated that Kelly found the plaintiff to be unresponsive after the vomiting episode and called the code. The record is not clear as to when the vital signs and epidural site were assessed. Kelly said she did a motor and sensory level assessment and they were fine — it is not charted though. The time elapsed between the vomiting episode and finding the patient is in dispute. The final diagnosis was anoxia encephalopathy due to the time lapse between CPR being initiated. The patient was eventually extubated, breathed independently for a period of time, and then subsequently expired.

The vital signs ordered by the physician were hourly. The hypotensive episode in the recovery room had not been reported to the registered nurse.

The risk manager is Susan Post, JD, who works in collaboration with the quality assurance director Amy Green. Amy had noted when doing chart reviews over the last 3 months prior to this incident that the vital signs taken in the recovery room were not charted, not done, or not reported to the units. She was in the process of collecting data from the different units on this observation. She also noted a pattern of using float nurses to several postoperative units. Prior to this incident, the clinical nurse specialist, Michael Parks, RN, MS, CNS, was consulting with Susan Post and Amy Green about the status of staff education on these units and what types of resources and training was needed.