INSUFFICIENT DOCUMENTATION LEADS TO UNCLEAR CAUSE OF HARM FOR PATIENT RECEIVING ANESTHESIA

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DESCRIPTION

A patient who underwent a colonoscopy suffered an anoxic brain injury resulting in a permanent vegetative state.

KEY LESSONS

- Complete pre-procedure evaluations flag potential risks for patients receiving anesthesia
- In addition to the 5 Rights, consider additional safeguards such as "right documentation" and "right response" when reflecting on medication administration practices
- Complete and contemporaneous documentation is critical in defending malpractice cases

CLINICAL SEQUENCE

A 41-year-old male underwent a colonoscopy with endoscopy at an ambulatory care center for evaluation of recent history of abdominal and rectal pain, and blood in his stool. A pre-procedure evaluation was completed by the anesthesiologist and a certified registered nurse anesthetist (CRNA). The only anesthesia-related risk noted was obesity.

The CRNA administered monitored anesthesia care (MAC) for the procedure. The patient may have received 200mg of propofol, possibly twice, however, the CRNA's documentation is unclear. The duration of the procedure was 30 minutes.

As soon as the patient was moved to the post anesthesia recovery unit, he was placed on oxygen via mask and pulse oximetry monitoring. At that point, the CRNA noted that the patient was not breathing but had weak radial pulses. A code was called and additional staff arrived to assist with cardiopulmonary resuscitation. The CRNA began ventilating the patient via Ambu bag then attempted to intubate the patient, but was delayed by about one minute due to a missing piece on the laryngoscope. The patient became pulseless; CPR was started.

Rescue medications, including epinephrine and atropine, were administered. The cardiac monitor revealed pulseless electrical activity, so CPR was continued and the patient regained a pulse. EMS arrived and transported the patient to the hospital where he was found to have severe anoxic ischemic encephalopathy. The patient did not improve or regain meaningful neurologic function, and remains in a persistent vegetative state.

ALLEGATION

The patient's family alleged that improper management of the patient under anesthesia resulted in cardiorespiratory arrest, permanent brain damage, and persistent vegetative state.

DISPOSITION

While the cause of the patient's cardiac arrest is uncertain, experts were critical of the CRNA's insufficient documentation as it failed to note which medications and doses were administered during the procedure. The case was settled for more than $1 million.

RESOURCES/REFERENCES

In addition to the 5 Rights, many sources cite additional rights as essential to safe medication administration practices, including right documentation and right response.

Elliott M, Liu Y. The nine rights of medication administration: an overview. Br *J Nurs.* 2010;19(5):300-05

In malpractice cases, testimony will be based on a patient's record and standard practices. The medical record has heightened reliability. See this webinar for more on this subject: *Nursing Practice and Patient Safety: Claims, Trends & Takeaways*

The Candello Benchmarking Report, *Medication-related Malpractice Risks*, highlights that 1 in 9 malpractice cases involves a medication related problem. Additionally, 32% of medication-related cases involve a patient death compared to 18% if all other malpractice cases.

The Candello Benchmarking Report, *The Power to Predict*, highlights that the odds of a medical professional liability case closing with an indemnity payment increase 85% when there is a patient assessment failure, and 76% when documentation is insufficient, than for cases without those issues.