Boy, 2 1/2, to get $4m in Porterville hospital settlement

BY GERALD CARROLL • GCARROLL@VISALIA.GANNETT.COM • AUGUST 21, 2008

Sierra View District Hospital in Porterville has agreed to pay $4 million to a 2 1/2-year-old boy in a malpractice-case settlement, attorneys for both sides said Wednesday.

Terms of the settlement are subject to approval today by Tulare County Superior Court Judge Patrick O'Hara.

The $4 million would be used to purchase an annuity that would pay the boy $15,000 per month to start, said Dr. Bruce Fagel, a physician-attorney who regularly represents families of children injured at birth. That sum would rise 3 percent a year, paying the boy $45 million "over his life expectancy," Fagel said.

When the boy was born March 20, 2006, according to Fagel's written summary, the obstetrician and nursing staff on duty "failed to recognize obvious signs of fetal distress for several hours before delivery." The baby was delivered via emergency C-section surgery, Fagel reported.

"This case is especially tragic since the obstetrician and nurse anesthetist had already been shown to be neglectful in the past — but were right back on the job anyway," Fagel said.

As a result of lack of oxygen in the hour before delivery, he wrote, the boy now has cerebral palsy. Neurologists, though, said that the boy's "intellectual development may be normal." The money will help cover medical expenses and the cost of therapy and home care as he gets older, Fagel wrote.

Fresno-based attorney Andrew Weiss, representing the hospital, declined comment Wednesday but did confirm settlement terms.
PATIENT SAFETY

MORE THAN MEETS THE EYE
Scariest Hospital Risks
Drug errors, overcrowding and 5 other serious hazards.
By Matthew Herper and Melanie Lindner for Forbes.com

Hospitals manufacture miracles by the millions. They can also be hazardous to your health.

According to The Institute of Medicine, a non-profit organization chartered by the U.S. National Academy of Sciences, at least 1.5 million Americans fall prey to hospital error every year.

"Errors will happen anytime you take a complex system and put human beings inside of it," says Dr. Brent James, vice president of medical research and executive director of Salt Lake City’s Intermountain Institute for Health Care Delivery Research. "The notion that you can train doctors to completely avoid mistakes is just false."

Risk: Surgeon error
Prevention: A quick conversation

Surgery foul-ups run the gamut—from freakish incidents involving scalpels left inside patients and wrong limbs being amputated to excessive bleeding and sudden heart failure. That's why the entire surgical team—the surgeon, the anesthesiologist and the nurses—should pause to discuss the case together before a single cut is made.
“I am fain to sum up with an urgent appeal for adopting this or some uniform system of publishing the statistical records of hospitals. If they could be obtained… they would show subscribers how their money was being spent, what amount of good was really being done with it, or whether the money was doing mischief rather than good.”

(Florence Nightingale, 1863).
Alice Magaw

The Mother of Anesthesia
Highlights of AANA Standards

- PS Classification
- Airway Assessment
- Anesthetic History
- Allergies
- Fasting Status
- History and Physical
- Physical Facility
- Risk Infection

- PNS
- Ventilation
- Oxygenation
- Record Keeping
- Qualified Provider
- Informed Consent
- Monitors
- Equipment
Standard 1

- Perform a thorough and complete preanesthesia assessment.
  - ASA Classification
  - Airway Assessment
  - Anesthetic History
  - Allergies
  - Fasting Status
  - History and Physical
Standard 2

- Obtain informed consent for the planned anesthetic intervention from the patient or legal guardian.
Standard 3

Formulate a patient-specific plan for anesthesia care.
Standard 4

- Implement and adjust the anesthesia care plan based on the patient’s physiological response.
Standard 5

- Monitor the patient’s physiological condition as appropriate for the type of anesthesia and specific patient needs.
  - Ventilation cont.
  - Oxygenation cont.
  - CV Status cont.
  - Body temperature cont.
  - Neuromuscular function
  - Patient position
Standard 6

There shall be complete, accurate and timely documentation of pertinent information on the patient’s medical record.

- Informed consent
- Pre and Post Anesthetic evaluations
- Anesthesia record - monitors, drugs, wastage
- Discharge and follow-up
Standard 7

Transfer the responsibility for care of the patient to other qualified providers in a manner which assures continuity of care and patient safety.
Standard 8

- Adhere to appropriate safety precautions, as established within the institution, to minimize the risks of fire, explosion, electrical shock and equipment malfunction. Document checking: the patient’s medical record, anesthesia machine, equipment.
Standard 9

- Precautions shall be taken to minimize the risk of infection to the patient, CRNA and other providers.
Needle and Syringe Reuse – Infected with Hepatitis C

- New York July 2002 - **19 patients**
- Oklahoma Sept. ’02 – **52 patients**
- Nebraska Nov. ’02 – **81 patients**
- Indiana Nov. ’07 – **2 (?) Patients**
- Nevada Feb. ’08 (Endoscopy) –
  - Over 40,000 encouraged to seek testing for Hepatitis and HIV
- Nevada March ’08 (GI)- **Unknown?**
- Laurinburg, NC Sept. ‘08(Cardiology) –
  - Over 1,200 encouraged to seek testing for Hepatitis and HIV
Needle/Syringe Reuse: Applications

- Same patient: 35%
- IV tubing: 8%
- Emergencies: 2%
- IM/SubQ injections: 2%
- Different patients: 1%
- Do not reuse: 63%

AANA Survey
Scenarios of Unsafe Injection Practices

- A syringe (not a needle) that was used to administer medication to a patient was reused on the same patient to draw up additional medication.
- The process of redrawing medication using the same syringe could have contaminated the vial from which the medicine was drawn with the blood of the patient.
- The vial, which was not labeled for use on multiple patients, was then used for a second patient (with a clean needle and syringe).
- If the vial was contaminated with the blood of the first patient, any subsequent patients given medication from the vial could have been exposed to the bloodborne pathogens.
Unsafe Injection Practices and Disease Transmission

Reuse of syringes combined with the use of single-dose vials for multiple patients undergoing anesthesia can transmit infectious diseases. The syringe does not have to be used on multiple patients for this to occur.

1. A clean syringe and needle are used to draw the sedative from a new vial.
2. It is then administered to a patient who has been previously infected with hepatitis C virus (HCV). Backflow into the syringe contaminates the syringe with HCV.
3. The needle is replaced, but the syringe is reused to draw additional sedative from the same vial for the same patient, contaminating the vial with HCV.
4. A clean needle and syringes are used for a second patient, but the contaminated vial is reused. Subsequent patients are now at risk for infection.
Standard 10

- Anesthesia care shall be assessed to assure its quality and contribution to positive patient outcomes.
Standard 11

The CRNA shall respect and maintain the basic rights of patients.

AANA Code of Ethics
CRNA Payout for CRNA Claims
Appropriate Care versus Inappropriate Care

Appropriate Care: $102,067
Inappropriate Care: $214,005

AANA Foundation, 2003
“Following orders” does not shield CRNAs from liability.
Follow the Standards

1. Read, know, and understand the Standards.
2. Incorporate the standards into your practice.
3. Monitor your practice to assure that you are meeting the standards.
Every patient you treat is your mother, father, brother, sister or child.