Questioning Discharge Instructions – An Example of Open Lines of Communication

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Avoiding Liability Bulletin – August 15, 2012

Rick Martin was admitted to a Texas medical center for a cardiac catheterization and a stent was placed in his coronary artery. (1) After the successful procedure was competed, the patient was admitted to the medical center for a short time and started on Plavix.

Mr. Martin was soon ready for discharge. On the day of discharge, Mr. Martin's registered nurse, who was an employee of the medical center, went over the discharge instructions with the patient, which included information about Plavix but did not include an order from the physician for the medication. (2) Despite this discrepancy, the RN did not contact the patient's physicians. Mr. Martin was discharged home without the prescription even though his discharge instructions stated he was to take the medication for fourteen to thirty days after the discharge.

Shortly after being at home, Mr. Martin's stent became blocked. He was re-admitted to the hospital ten days after his discharge. (3) The patient filed suit against the medical center, alleging, among other things, that the RN was negligent in not seeking clarification of the discharge instructions and/or not notifying the patient's physicians of the lack of an order for Plavix. The RN's omission as an employee resulted in the naming of the medical center in the lawsuit under the theory of *respondeat superior*. Mr. Martin's physicians were also named as defendants.

The medical center filed a motion to dismiss the case, alleging that Mr. Martin's expert witness reports did not meet required rules for such reports and the trial court granted the motion. Mr. Martin appealed to the Texas Appeals Court.

The appellate court reversed the trial court's decision to dismiss the case and sent the case back to the trial court. The appellate court held that the trial court abused its discretion when it did not carefully review the reports of Mr. Martin's expert witnesses, a nurse and a physician respectively. Their reports, the court opined, provided a "fair" summary of the proximate cause of the re- occulsion of the stent –the RN not questioning the lack of a medication order. Read together, then, the reports could establish causation; that is, that the failure of the RN to communicate to the physicians the lack of an order for the medication contributed to the re-occulsion. (4)

This case is an interesting one because of its illustration of how vital information *must* be communicated when a patient is facing an unreasonable and foreseeable risk of harm.

The duty to communicate a patient's condition to the physician or other health care provider by a nurse

satisfies the first element in a professional negligence action– a duty must exist between the patient and the nurse. Interestingly, in this specific case, the nurse expert witness' report also cited the Texas nurse practice act that requires a nurse to clarify any order the nurse has reason to believe is inaccurate and that directs the nurse to act as a patient advocate to "ensure appropriate and timely instructions are provided to the patient". So, the RN's duties were established by standards of practice, standards of care *and* the state's nurse practice act.

Failing to meet this duty satisfies the second element of a professional negligence action; that is, a breach of an established duty. The patient had been on Plavix throughout his hospital stay. When there were discharge instructions about taking the medication but no order for that mediation, the RN should have communicated this omission to the physicians.

Because she did not do so, her failure to act could be established to meet the third element of professional negligence– the proximate/legal cause of the patient's re-occulsion– had Mr. Martin's expert witnesses reports been correctly evaluated by the court. Instead, the motion to dismiss was granted by the trial court despite this important evidence.

Obviously, the patient suffered damages and injuries– a second, unnecessary admission to the medical center and pain and suffering, as examples—which satisfies the fourth element of a professional negligence action.

The nurse's overall standard of care, as has been discussed before, is what other ordinary, reasonable and prudent nurses would have done in the same or similar circumstances in the same or similar community. This nurse had been working on the unit for some time and was aware of the fact that patients are discharged from the facility with prescriptions for medications. Yet, she chose to remain silent about the lack of an order and the obvious discrepancy between the instructions, but no medication order, for Mr. Martin. Clearly, she did not meet her standard of care.

In short, simply reviewing discharge instructions and sending a patient home will not protect the nurse employee, the employer, and a patient's physicians if the patient is injured as a result of failing to communicate obvious concerns about the safety and well-being of the patient being discharged.

FOOTNOTES

- Martin v. Abilene Regional Medical Center, No. 11-04-00303 CV (Tex. App. District 11

2/2/2006. You can read the case at:
http://law.justice.com/cases/texas/eleventh-court-of-appeals/2006/8145.html . Accessed August 12, 2012.

- Id.
- Id.

- Id. See also, A. David Tammelleo (2006), “Did RN Have A Duty To Question Discrepancy In Discharge Order?”, 46(9) Nursing Law’s Regan Report , 1.