Physician's Care Appropriate, But Documentation and Communication Lacking

Mrs. Gallagher, a 79-year-old female, went to see her family practitioner, Dr. Atkins, on May 8 for a runny nose, mild inflammation of the throat and a dry cough. Upon examination, her lungs were clear and a diagnosis of viral bronchitis was made. Mrs. Gallagher was treated symptomatically with an expectorant, plenty of fluids and advised to rest.

One week later, on Thursday May 15, Mrs. Gallagher presented to the ED of Fenton Hospital and was admitted with an increased cough, which was now productive, and shortness of breath.

History of Present Illness

The exam revealed:

- VS—BP 144/82 T-101 P-96 R-24
- Breathing—Labored
- ENT—Showed only a small amount of post nasal drip. Mucous membranes were dry
- Lungs—Dullness to percussion in the RLL, Rhonchi in RLL and scattered end-expiratory wheezes
- Pulse—Oximetry 92% at rest, but dropped to 87% after walking a few feet
- Heart–RRR, no murmur or gallop rhythm
- Abdomen—Slightly distended but normal BS. Mild tenderness in RUQ
- Extremities—Trace edema in ankles
- Skin—No rash, very dry
- Mental status—Oriented X3, but was slow to respond to questions. Couldn't recall if daughter had been there that day (her daughter had brought her to the appointment)
- Chest X-ray—Showed an infiltrate in the RLL and mild cardiomegaly
- Labs—WBC–21,000 with left shift, Hb–14.1; Electrolytes were all normal. BUN–46, Cr- 2.4

Past History

Past Medical History was significant for:

- Hypertension
- Type 2 Diabetes Melliltus
- DJD with Bilat. Knee replacements
- Early cognitive decline
- Cholecystectomy, Hysterectomy, T&A, and Appendectomy

Medications

- Metformin 500 mg BID
- Lisinopril 20 mg daily
- Tylenol 500 mg TID
- Aricept 10 mg at HS
- Lipitor 10 mg daily

Social History

Mrs. Gallagher was widowed and lived alone. Her daughter lived in town and checked on her frequently. Mrs. Gallagher was a two-pack-a-day smoker but had quit 20 years earlier. She denied alcohol use and drank two cups of coffee each morning.

Dx

- RLL Pneumonia
- Type 2 Diabetes Melliltus
- Mild Dementia
- Dehydration
- Renal Insufficiency
- Hypertension
- DJD with Bilat. Knee replacements

Upon admission to Fenton Hospital on Thursday, May 15, Mrs. Gallagher received IV fluids for hydration. Ceftriaxone and Azithromycin were administered IV after sputum and blood cultures were obtained. Two liters of oxygen was administered via nasal cannula. Nebulizers were added to the treatment regimen QID with Duonebs. Dr. Atkins also left a standing order for "Haldol 2mg PO or IV PRN."

On the day of admission, the nursing staff documented that Mrs. Gallegher was resting comfortably throughout the day. Though she had exhibited episodes of confusion later in the evening for which she received Haldol 2mg PO, there was no documentation by the night nurse that she discussed the Haldol administration with Dr. Atkins.

On the morning of Friday, May 16, Mrs. Gallagher's respirations were 22 and less labored. Though she wasn't certain of the day, she knew where she was. She looked more comfortable. Temp–102 overnight; 99.4 this morning. BP–140/79 P–100. Skin turgor was improved. Her lungs still showed dullness: R base, as well as Rhonchi and wheezing R lower lung. She had scattered wheezing throughout. Heart RRR had no murmur.

Dr. Atkins was off for the weekend, and after seeing the patient later Friday morning, he checked with the on-call physician, Dr. Tracy. Dr. Tracy's call began Friday at 5:00 P.M. and ended Monday morning at 7:00 A.M. Dr. Tracy was told by Dr. Atkins the patient was a 79-year-old female with pneumonia, was improving and would need continued IV antibiotics, nebulizers and oxygen through the weekend until Dr. Atkins returned Monday morning.

Dr. Atkins failed to document in the chart that Dr. Tracy would be covering. He also failed to notify the nursing staff, the patient and the patient's daughter of Dr. Tracy's involvement.

On Friday evening at approximately 9:00 P.M., the patient once again became confused, disoriented and very agitated. Per Dr. Atkins standing order, Haldol 2 mg IV was given for agitation. However, neither Dr. Atkins nor Dr. Tracy was notified of this fact, and it was not documented.

On Saturday morning, 48 hours following admission, Dr. Tracy saw Mrs. Gallagher for the first time. The nursing staff reported her liquid intake was fair and she was consuming very few solids. They also reported she had awakened a few times during the night, uncertain where she was, but reoriented easily.

- Exam—She was oriented X3. Breathing was not labored with rate of 20. Highest temp was 100.8. Other vitals were stable.
- Lungs—Decreased air movement in the LRL, rhonchi in the LRL and no wheezing.
- Heart—RRR–no murmer. No neck vein distention.
- Extremities—Trace edema in feet and ankles.
- Labs—WBC–14,300, Hb–12.5, Lytes–all normal, BUN–31, Cr–2.0

IV fluids rate slowed to half of the prior rate. Other treatments continued.

Around 6:00 P.M. Saturday, Dr. Tracy received a call from the nursing staff that Mrs. Gallagher was very confused and extremely agitated. She had pulled her IV out and demanded her clothes so she could leave the hospital. Attempts to calm her were unsuccessful. Dr. Tracy verbally ordered Lorazepam 0.5 mg, blood gases, an EKG and BMP.

Results were called to him at 7:00 P.M.: Lytes–normal, BUN–28 Cr–1.9 Gases–pH 7.45, Pco2–47, Po2–69 with calculated O2 Sat.-95%. EKG–normal. Dr. Tracy turned her oxygen down to 1 L and asked the nursing staff to attempt to get her up in the chair for a while to see if that would be helpful. Dr. Tracy did not hear from the nursing staff again on Saturday.

Around 11:30 P.M. Saturday, Mrs. Gallagher was again very agitated and tried to get out of bed. Though another dose of Haldol was given at 11:40 P.M., again the physician wasn't notified and it was not documented. Mrs. Gallagher was calmer.

Making rounds at 7:00 A.M. on Sunday morning, Dr. Tracy found the patient to be very somnolent, breathing shallowly and making a lot of upper airway noise. He asked the night shift nurse as she was leaving for the day to report on the patient's status during the night. The nurse did not mention, nor was it documented, that Haldol had been given the last three evenings. Later, the nurse attempted to justify her repeated failure to document and inform Drs. Atkins or Tracy about the administration of Haldol. She said she was experiencing insomnia, due to the stress of a pending divorce.

Based on the patient's current status, Dr. Tracy tried to contact the patient's daughter, but he was unsuccessful. He reviewed the chart for any Advanced Directives or DNR orders. There were none.

At 9:00 A.M. Sunday, Dr. Tracy learned that Mrs. Gallagher had received Haldol 2 mg on Thursday, Friday and Saturday evenings per Dr. Atkin's standing order.

- VS—BP–132/72, T–99.2, P–112, R–28 and shallow pulse
- O2—84%. She would open her eyes to her name but no other response
- Respirations—Very noisy and labored
- Lungs—Difficult to examine, due to the upper airway noise
- Heart—RRR; no murmur
- Arterial Blood Gases—pH 7.26, Pco2 88, Po2 57, O2 Sat 88%

Dr. Tracy moved the patient to ICU and consulted a pulmonologist to see Mrs. Gallaher. The patient was intubated and placed on a mechanical ventilator. It was felt that she may also have aspirated, so antibiotic coverage was broadened to cover anaerobic organisms.

Later on Sunday, Mrs. Gallaher's daughter was finally reached. She had been out of town on a planned trip because Dr. Atkins had assured her that her mother was improving. Unfortunately, Mrs. Gallagher continued to deteriorate, and 5 days later, she was taken off life support and expired.

A lawsuit alleging delay in diagnosis and failure to diagnose was filed naming Dr. Tracy, Dr. Atkins, a nurse and the hospital. The assessment of the case was that:

1) Dr. Tracy acted appropriately based on the information documented in the chart and reported by the nursing staff
2) The night nurse should have updated Dr. Tracy on the patient's condition during the night ***prior to*** giving the Haldol
3) The night nurse failed to document the patient's increased agitation and to communicate with the physicians that the doses of Haldol were given.

What's more, Dr. Atkins could be criticized for:

1) Inaccurately reporting the patient's status to Dr. Tracy
2) Poorly documenting the Haldol order
3) Not advising the hospital nursing staff or the patient/family that in his absence Dr. Tracy would be covering for the weekend
4) Not obtaining a code and intubation status of the patient when she was more alert and the daughter was present.

Dr. Tracy was eventually dropped from the case with unknown amounts paid in settlements by the hospital, the nurse and Dr. Atkins.

Risk Management Lessons

There are several points to be learned from this case:

- Dr. Atkins was negligent in telling his partner that the patient was improving. Dr. Tracy should have been informed about the degree of the patient's dementia, her agitation and the Haldol prn standing order.
- Dr. Atkins' notes did not reflect *why* he needed to prescribe Haldol prn for this patient. An appropriate entry could have simply stated "Give Haldol 2mg PO or IV PRN for agitation." Instead, the entry read "Haldol 2mg PO or IV PRN."
- It is important for a physician to have good protocols in place for handoffs when there is a change in the attending physician, such as "on call," leaving for vacation, etc. Here are some factors to consider with handoffs:
    - Too much data is not beneficial as it can obscure the more important issues
    - Always cover new medications, especially those requiring monitoring
    - Discuss current diagnosis and concerns
    - Discuss recent events and/or changes in condition or treatments
    - Address any unexpected outcomes/any unusual changes in the patient's condition
    - Communicate any changes in physician orders and the client's response, if warranted
    - When a handoff is not face to face, the off-going physician should be available for a period of time to answer questions and to provide clarification
- The nurse should have documented and shared with the physicians the patient's increased levels of agitation and the subsequent need for Haldol 2mg to be given on three consecutive evenings.