Medical Thriller: Risk Manager as Witness

Nurse Gives Paralytic Agent Instead of Antacid

Deposition Testimony in *Morgan Riley v Bonnie Wait and Generous Hospital*

A complaint has been filed against the hospital and Ms. Bonnie Wait, the Director of Risk Management, Quality and Safety at Generous Hospital. The lawsuit seeks money damages and alleges the medication error that almost killed the patient was fraudulently covered up by the defendants. Further, that the medication error was preventable and the patient suffered loss of memory and extreme anguish due to the administration of the paralytic that almost ended her life.

Bonnie had been called to the ICU because Ms. Riley, who was intubated in the ED, is now alert and is writing notes to the ICU staff that the ED staff tried to kill when she was given the wrong drug. She could not breathe and could not move. While alert, but paralyzed, she heard the staff say she was given the wrong medication and required intubation. The patient was resuscitated within minutes.

Bonnie learned that a paralytic was given in the ED which caused the patient to stop breathing. The ED provider did not inform Bonnie, the patient or the family of this occurrence. The police were called by the family. Bonnie instructs the ED nurse manager to make the event entry more complete before the record is released to the police.

The police arrive at the hospital and obtain a copy of the online incident report and a copy of the medical records. The ED provider adds a late note after the police receive a copy of the record.

Six months prior, the ED had a similar medication error. Bonnie served on the hospital's medication administration committee. She was also on the ED's policy and procedures committee concerning medication and safety issues.

Following Bonnie's event investigation, she sent a letter to the patient indicating that the following changes have been made so this does not happen in the future: No paralytic medication is kept in the same cabinet as other vials of antacid; colored labels are placed on the vials themselves rather than relying on the cap colors for identification and the locations where paralytics are kept have been severely limited.

Medical Thriller: Risk Manager as Witness

Non-Monitored Elderly Patient Dies from Restraint

Deposition Testimony in *Muriel Smith v. Nancy Health, RN, John Go, Tech, Bonnie Wait and Critical County Hospital*

Complaint has been filed against the hospital, nursing staff and Bonnie Wait, Director of Risk Management, Quality and Patient Safety based on the death of Muriel Smith, a 75-year-old frail patient with dementia and psychosis. Ms. Smith was in a Behavioral Health Unit and in a Posey belt with an order for checks every 15 minutes. The patient was found by the nurse hanging from the side of the bed with the Posey belt wrapped around her neck.

Resuscitation was unsuccessful. The family was contacted. Upon arrival the family found the patient's body had been cleaned up, moved to another room and the Posey belt removed. The family was upset on arrival and called the police. The family took photographs of the room and the patient. The police obtained the security video.

The last check of the patient was documented to have occurred 45 minutes prior to the patient being found. The nurse believes that she checked the patient every 15 minutes, but did not chart the observation. When consulted by the nurse, Bonnie assisted her with language for late entries. An audit trail reveals some of the rounding report drop down boxes were pre-checked. The security

videotape reveals no one entered the patient room during the 45 minutes before she was discovered.

Pursuant to the hospital's disclosure program, Bonnie met with the family on the day of the incident. She promised that she was going to perform an investigation and meet with the family, again. Before the second meeting, the family sent Bonnie a letter with a number of questions. After investigating the incident, Bonnie met with the family to explain her findings.

The Complaint alleges fraudulent documentation of observation checks, failure to contact police, tampering with a crime scene, spoliation of evidence, and failure to closely monitor the patient and keep her safe.