FLUID OVERLOAD

RESULTING MULTIPLE ORGAN DYSFUNCTION SYNDROME

Liver/Gallbladder

Friday 7/17/15

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7/19/15 - 7/20/15

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Gut

7/21/15

Doctors notes "*will start IVF with LR @ 75 cc/hr*", despite LR infusing at 150ml since 7/19. Sputum induced sample shows multiple Gram Positive bacteria. Secretions now described as FROTHY. Patient is now described as being in distress. Abdomen is distended, x-ray done for concern of small bowel obstruction. Radiologist reports paucity of air and bowel gas patterns. Nurse writes at 20:00, *"pt had not voided since first thing this am, 300cc urine"*. Copious, purulent secretions w/regurgitating sound of upper airways, secretions audible. Richmond Agitation Sedation Scale -1 to -2, but restraints remain.

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Critical care doctors continue to document somnolent, non-conversant, despite normal ammonia and d/c sedation. Gastroenterologist notes, *"no evidence of PSE"* (altered brain function due to liver) and contacts wife to tell her he cannot figure out why the patient is obtunded because it doesn't present like liver disease. Electroencephalogram (EEG) taken on 8/2/15 cannot be located by the hospital. CT of brain around the same time note micro-vascular ischemia and trapped fluid.

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7/24/15 - 7/25/15

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Infection

7/26/15 - 7/27/15

WBC at admission was 6, now 17.7 and gets as high as 26.3 later during hospitalization. Quality Measures for Heart Failure are ordered altho patient & family never told about CHF. Ivy League hospital dx CHF during admission ECHO and still never informed the family or documented it on problem list. Calcium channel blocker ordered. Doctor notes, *'Intravascular volume looks much better. TBW still probably up (has to guess since weights were cancelled) with fluid in LE and abdomen. Neg troponin, would continue to diurese as you are doing.*" Oxygen and FIO2 start to be logged in Tracheostomy section of medical record now.

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Pressure Ulcer

7/28/15

After HOB up &OOB to chair, a pressure ulcer from a leaky rectal seal. The flexiseal order is missing from the medical record. On 8/10 he was in a chair from 8am -2pm. Urgent wound consult placed on 8/14 for UNSTAGEABLE PU. National Pressure Ulcer Advisory Panel defines Unstageable as a Stage III or IV. Doctors ordered Complete Bedrest from 8/25-9/3, nurses stopped respositioning &tube feed was d/c. Surgeon responds to the consult on 9/2 and stages it a 3, but staff continue to document Stage II. Ivy League hospital documented Stage II at admission and did not photograph the wound.

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Kidney

9/1/15

Hepatorenal syndrome (HRS) means damaged liver stops renal function. The diagnostic criteria must exclude any shock, bacterial infections; use of nephrotoxic drugs (Lasix and Vance) and there must be severe portal hypertension. All portal venous flow measurements throughout entire hospitalization never qualified as portal hypertension. On 8/14 portal flow was 27cm/s, cirrhosis is typically 16cm/s or less. Gastro doctors always reported patent hepatic vasculature. Besides sepsis & CHF, mass quantities of Vancomycin were administered during the entire month of August into LEFT peripheral IVs with multiple toxic trough readings. Permanent nerve damage & left foot palsy reported on 8/28, acute renal failure on 9/1, ultrasound showing, “right kidney shows APPARENT increased echogenicity”on 9/2, LARGE amt of blood in urine 9/4. A PICC line was place the day the kidneys failed.

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After HOB up &OOB to chair, a pressure ulcer from a leaky rectal seal. The flexiseal order is missing from the medical record. On 8/10 he was in a chair from 8am -2pm. Urgent wound consult placed on 8/14 for UNSTAGEABLE PU. National Pressure Ulcer Advisory Panel defines Unstageable as a Stage III or IV. Doctors ordered Complete Bedrest from 8/25-9/3, nurses stopped respositioning &tube feed was d/c. Surgeon responds to the consult on 9/2 and stages it a 3, but staff continue to document Stage II. Ivy League hospital documented Stage II at admission and did not photograph the wound.

Heart

7/23/15

Alcohol Withdrawal noted to be resolved. Blood Pressure was 195 on 7/22, but no heart monitoring cuz APRN cancelled it. Doctor noted that Beta Blocker, Metoprolol should be changed to the formulation for NG tube after crushing the ER heart medication for the prior 3 days. ACE Inhibitor Lisinopril dose is doubled. Nurses begin to record 2+4mm pitting edema. Records show ventilator was used but there is no order detailing the amount of oxygen. Magnesium Sulfate injection administered. Glucose 168. Heart murmur first detected.

Infection

7/26/15 - 7/27/15

WBC at admission was 6, now 17.7 and gets as high as 26.3 later during hospitalization. Quality Measures for Heart Failure are ordered altho patient & family never told about CHF. Ivy League hospital dx CHF during admission ECHO and still never informed the family or documented it on problem list. Calcium channel blocker ordered. Doctor notes, *'Intravascular volume looks much better. TBW still probably up (has to guess since weights were cancelled) with fluid in LE and abdomen. Neg troponin, would continue to diurese as you are doing."* Oxygen and FIO2 start to be logged in Tracheostomy section of medical record now.

Kidney

9/1/15

Hepatorenal syndrome (HRS) means damaged liver stops renal function. The diagnostic criteria must exclude any shock, bacterial infections; use of nephrotoxic drugs (Lasix and Vance) and there must be severe portal hypertension. All portal venous flow measurements throughout entire hospitalization never qualified as portal hypertension. On 8/14 portal flow was 27cm/s, cirrhosis is typically 16cm/s or less. Gastro doctors always reported patent hepatic vasculature. Besides sepsis & CHF, mass quantities of Vancomycin were administered during the entire month of August into LEFT peripheral IVs with multiple toxic trough readings. Permanent nerve damage & left foot palsy reported on 8/28, acute renal failure on 9/1, ultrasound showing, "right kidney shows APPARENT increased echogenicity"on 9/2, LARGE amt of blood in urine 9/4. A PICC line was place the day the kidneys failed.

Un-consented Procedures

8/20/15-10/2/15

8/20/15 Thoracentesis
9/1/15 Implant arterial cannulae
9/6/15 IR insertion feeding device with balloon bumper
& Insertion of peritoneal catheter
9/14/15 DNR/DNI
9/15/15-9/27/15 Administration of sclerosing agents
9/25/15-10/1/15 Administration of Epogen.
10/2/15 Bone Marrow Biopsy

Severe Sepsis

7/22/15

00:00-4am 1,000 mL, 150 mL/hr of LR administered into the IV that was causing pain 2 days earlier. At 3am during this bolus, nurse writes, *"Pt is restless and attempts to pullout lines, suctioned multiple times"* 8am, **accessory muscle use** starts. LR infusion immediately stopped mid-infusion. APRN cancels taking wts & heart monitor. Lactulose, Suction, Out of Bed, Cefepime (for resp infection not PNA), Albuterol, Vancomycin ordered. Ammonia still normal at 28. SIRS alert showed Organ Dysfunction because Bilirubin INCREASES 9.8. Family is never told there is an infection, only alcohol withdrawal. SIRS alerts are not in any doctors' notes.

De-resuscitation

7/24/15 - 7/25/15

7/24-7/28 (13) consecutive shifts of nurses' progress notes are omitted from the medical record. Hospital replied that none exist. Indwelling gravity cath &Out Of Bed ordered. Patient noted as 'Chairfast" rather than previous 'Bedfast 'w/ fluid overloaded tissue. Unasyn started. Aldosterone antagonist water pill ordered, Lasix&Beta Blocker dose doubled. Cool feet w/early mottling, vol overload w/lower extremities warming up& abdomen less tense noted. White frothy secretions, tachycardic & tachypneic Cardiologist writes, *"Probably just iatrogenic overload."*

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