Excluding Mr. Sneed and Mr. Otis, list the potential defendants involved in the case:

Nurse Gilbert, Dr. Dick, Bay Hospital, Dr. Moon, any nurse who cared for Ms. Gadner, the individuals responsible for stocking epinephrine in the EC and checking its availability, which would be pharmacy or a pharmacy technician.

Potential Defendant	**Legal liability**	**Actions, facts creating liability**
Dr. Dick	Malpractice	Per a statement in *Hall v. Hilbun*, Dr. Dick had "a duty based upon the adept use of such medical facilities, services, equipment and options as are reasonable available" (Furrow, Greaney, Johnson, Jost & Schwartz, 2015, p. 78). Bay Hospital is a small rural hospital, and while the hospital did not have a protocol or procedure in place for transfers, the nurses recognized the need as should Dr. Dick. Dr. Dick had a duty to transfer the patient and make use of another medical facility to provider her the care she required. While one could argue that Dr. Dick was not aware of his own limitations, another case, *Nowatske v. Osterloh*, expressed that physicians shall not be sheltered "who fail to adopt advances in their respective fields and who consequently fail to conform to the standard of care which both the profession and its patients have a right to expect" (Furrow et al., 2015, p. 79). Dr. Dick was a second year pediatric resident. Per his education, he should have recognized that pediatric residents do not belong in an ER and not agreed to be the attending in the ER. However, since this was part of his contract, and he was likely given little choice, he should have recognized that the care Ms. Gadner needed was beyond his respective field of study and conformed to the standard of care of transferring the patient.
Dr. Moon	General negligence	Dr. Moon was the hospital's chief of staff and had screened Dr. Dick before hire. However, Dr. Moon failed to follow his own hospital's credentialing process and did not evaluate Dr. Dick properly before hire, which would have likely identified Dr. Dick's competencies and lack of knowledge, training, and expertise in emergency medicine, where Dr. Dick was assigned to work.
Bay Hospital	Corporate negligence	Per the lecture and readings from the text, Bay Hospital had an obligation "to oversee all persons who practice medicine within its walls as to patient care" (Furrow et al., 2015, p. 184). In addition, the text states that the organization had a "duty to formulate, adopt and enforce adequate rules and policies to ensure quality care for patients" (Furrow et al., 2015, p. 184). However, Bay Hospital did not have any

		protocols in place as to when a patient should be transferred in the incidence that the staff and hospital itself could not properly care for the patient. The case study identified that the hospital was a rural hospital that was not equipped to handle trauma patients with injuries such as Ms. Gadner had, and that there was no protocol in place for transferring to a larger facility. Additionally, Dr. Dick was managing the emergency center, and while he was competent, he did not have the proper training to care for adult patients as he was specialized in pediatrics. Bay Hospital, specifically Dr. Moon, deemed that they had selected and retained a competent resident in Dr. Dick. However, Dr. Moon did not properly evaluate Dr. Dick and only screened him. As the case study pointed out, Bay Hospital breached its own credentialing procedures because Dr. Dick did not have the training or expertise in emergency medicine and Dr. Moon did not evaluate Dr. Dick's competency to do so. The text also sites that the facility had "a duty to use reasonable care in the maintenance of safe and adequate facilities and equipment" (Furrow et al., 2015, p. 184). When the patient coded, Dr. Dick attempted to use the laryngoscope to intubate the patient, but the equipment was broken. While there is not necessarily enough information available in the case study, it also appears that a crash cart, which would have had the epinephrine, was not available in the emergency room. Thus, the facility failed to provide adequate equipment. It is also corporate negligence as it there was not a protocol or policy in place for having access to a crash cart or ensuring that the equipment was available in an emergency room.
Nurse Gilbert	Malpractice, duty to be a patient advocate	Malpractice and duty to be a patient advocate. Nurse Gilbert failed to perform her duties of care under the scope of nursing. As explained by Furrow et al. (2015), "healthcare providers have a duty to render a quality of care consonant with the level of medical and practical knowledge the physician [or healthcare provider] may reasonably be expected to possess and the medical judgment he may be expected to exercise" (p. 78). Nurse Gilbert expressed concerns about the patient needing to be transferred, but she expressed them to the other nurses and not Dr. Dick. While he was the attending physician, Nurse Gilbert likely had more expertise in emergency medicine than him and could have advocated for her patient. Along those lines of knowledge and more expertise, Dr. Dick ordered valium and morphine, which Nurse Gilbert administered without questioning even though she likely was aware that the patient was in shock and should not

		receive those medications or simply did not care, which is also negligence on her part as she was not using her training and knowledge to her full capability.
ER Nursing Staff	Malpractice, duty to be a patient advocate	In addition to Nurse Gilbert, the case study identifies that other nurses cared for the patient. Like with the duties of care in Nurse Gilbert's situation, those nurses also had the duty to provide quality care consistent with their medical and practical knowledge. The nursing staff either failed to identify that Ms. Gadner was in shock when she arrived with cool, clammy skin and a blood pressure of 95/55. If they did identify it, they did not advocate for the patient and speak up to Dr. Dick about the concerns. IV fluids were not given, which should be in this case, and while Dr. Dick had ordered IV fluids at 500 ml/hr, the patient received only a total of 200 mls. This was due to the fact that the IV had infiltrated, and nursing staff did not identify the infiltrated IV and place a new one or have the fluids go into one that was already established. The nurses also did not elevate the patients feet, which is a nursing intervention that can be carried out, nor did they apply oxygen, which is also an order that can be carried out as most organizations have protocols and if not, oxygen could have been placed and suggested to Dr. Dick. The nurses also did not take regular vital signs, which again is an intervention that the nurses could have carried out. A lack of communication by the nurses to Dr. Dick led to him having even less information about his patient and any competency he did hold in caring for the patient.
Pharmacy	Negligence	Specifically, individuals responsible for stocking epinephrine in the EC and checking its availability, which typically would be pharmacy or a pharmacy technician, though in a rural hospital, this could be the responsibility of the nursing staff. For this, negligence occurred as no epinephrine was available in the emergency room when it was needed. Typically, epinephrine should be within the crash cart, so if it was missing from it, this would generally fall on the responsibility, and thus in this case, negligence of pharmacy staff. If a crash cart was not present, this would also be negligence on the part of whomever was responsible for ensuring its availability, typically the charge nurse. This additionally tied back to the corporate negligence liability of Bay Hospital, as there was a lack of this equipment available.

Tort Case Study

Based on the legal theories and the facts you have identified, develop a very specific list of short term (next 1-2 months) corrective actions the hospital must take immediately to remedy the problems. Be sure to have a short term corrective action for each of the legal issues you identified.

Dr. Dick will be properly evaluated in regards to his competencies in caring for all patients as his initial screening and evaluation at hire should have been completed.

Dr. Moon will review all physicians who have been hired within the year to identify if all were properly evaluated based off of Bay Hospital's credentialing process of newly hired physicians.

Bay Hospital will review its credentialing process for hiring new physicians and identify any gaps in that process.

Bay Hospital will perform a root cause analysis to determine why a transfer of the patient did not occur in this case and identify past incidents that required (and initiated) a transfer to develop a protocol for transferring of patients to larger hospitals equipped to handle critically ill or injured patients.

Bay Hospital will review its protocols in regards to broken equipment (laryngoscope) and lack of equipment (crash cart) within high need areas such as an emergency room and further determine the cause of those issues.

The nursing manager of the emergency center nurses will perform a review of the actions taken by both Nurse Gilbert and the other nurses involved in this case to determine any gaps of care or communication on their part in order to determine any necessary education.

Pharmacy, or whichever applicable discipline, will develop a process of checking for emergency medications such as epinephrine and its availability within the emergency center.

Then, develop a second very specific list of long term (6-12 months) corrective actions the hospital must take to ensure this situation does not happen again. Be sure to have a long term corrective action for each of the legal issues you identified. This list should build upon the short term corrective actions.

Bay Hospital will revise its credentialing process of providers based on any gaps identified and implement changes.

Any physicians who were not properly evaluated during their initial hire either by Dr. Moon or another individual will be evaluated to meet the credentialing process Bay Hospital has in place.

Bay Hospital will implement a transfer protocol policy based off of the findings of the root cause analysis and evaluate it three months after implementation to identify any gaps in the new policy.

Bay Hospital will develop and implement a policy or protocol for damaged or missing equipment if one is not in place or revise the current policy or protocol to ensure proper handling of broken equipment and replacement of missing equipment along with identifying the individuals responsible for checking such concerns.

Per the review findings of the nursing manager, Nurse Gilbert and the other nurses involved in the case will attend educational seminars on shock and communication, among any other findings of the review.

Education will be provided to all emergency nursing staff on shock and effective communication in the emergency room.

Pharmacy (or applicable individuals) will implement a process to check the availability of emergency medications and evaluate that process after three months of implementation to identify any further needs or concerns.

References

Furrow, B. R., Greaney, T. L., Johnson, S. H., Jost, T. S., & Schwartz, R. (2015). *Health law* (3rd ed.). St. Paul, MN: West Academic Publishing.