Call the Doctor: A Diabetic Ketoacidosis Case Study

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On July 14, 2019, the plaintiff was admitted to a rehabilitation center for 24-hour skilled nursing and rehabilitation services following a hospital stay for diabetic ketoacidosis. She was admitted to the facility at approximately 2:55 pm via wheelchair. At the time of admission, the plaintiff was alert and oriented, with stable vital signs. While the patient required extensive assistance with the transfers, she did not verbalize any complaints to the facility staff who provided her this assistance.

At approximately 4:40 pm, Dr. M. gave the staff verbal medication orders via telephone which included, but were not limited to, sliding-scale insulin, Insulin Glargine (Lantus, a long-acting insulin) at a concentration of 100 units/ml, with 4 units to be administered morning and evening via subcutaneous injection, 1 mg injection of Glucagon RDNA (used to treat severe low blood sugar) PRN (as needed), and an evening snack.

Sliding-scale insulin therapy is a predetermined dosage of insulin based on a person's blood sugar levels. The sliding scale is typically utilized before meals and at bedtime. The higher a person's blood sugar level is, the more insulin they are administered. The order for sliding-scale insulin included checking the plaintiff's blood sugar levels before meals and at bedtime and administering coverage with Humulin R insulin subcutaneous for blood sugar levels as follows:

Blood sugars:

From 151-200 mg/dL administer 3 units of Humulin R
From 201-250 mg/dL administer 5 units
From 251-300 mg/dL administer 7 units
From 301-350 mg/dL administer 9 units
From 351-400 mg/dL administer 11units
From 401-450 mg/dL administer 13 units

And if the blood sugar level was less than 70mg/dL or greater than 450 mg/dL – call the physician.

These orders were noted in her chart by C.F., RN, at approximately 9:00 pm. As ordered, the plaintiff's blood sugar was checked at approximately 9:00 pm by L.R., LPN. Her blood sugar was 500 mg/dL. The doctor was not notified of this blood sugar level as the orders indicated. Instead, L.R., LPN acted outside of her nursing practice act by creating her own orders when she administered 13 units of Humulin R and 4 units of Insulin Glargine (Lantus) to the plaintiff. It should be noted that L.R., LPN also failed to document this medication administration in the plaintiff's clinical record. At 9:30 pm, the plaintiff's blood sugar was checked again and measured to be 480 mg/dL. This time, Dr. M. was notified by C.F., RN and gave an order to administer 10 units of Humalog. However, during an investigation Dr. M. reported that he did not have knowledge of L.R., LPN's prior administration of 13 units of Humalog when he directed C.F., RN, to administer the additional 10 units of Humalog.

Around 6:52 am, approximately two and a half hours after she was last checked, the nursing staff who entered the plaintiff's room to administer medications found her to be unresponsive without respirations or apical pulse, indicating that she was no longer breathing and did not have a pulse that could be heard by listening to her heart with a stethoscope. CPR was initiated and 911 was notified. The plaintiff was transported to an acute care hospital Emergency Room where she was pronounced dead at 7:50 am. Stacy L. Donnelly, RN, BSN was retained to review the case to determine if the actions and inactions of the rehabilitation center and its staff fell below the standard of care for managing and supervising a patient with diabetes in the nursing home environment.

Upon review of the provided materials, Nurse Donnelly determined that the staff had failed to meet the standards of care in regard to following physician prescribed orders, using proper standards for the administration of medications, monitoring the plaintiff's condition and responses to medications, development and implementation of an individualized care plan, maintaining accurate medical records and ensuring that proper written and verbal techniques were implemented and enforced. In addition, Nurse Donnelly determined that the rehabilitation center and its staff had failed to ensure that its nursing staff acted within their scope of practice.

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