

# DOCUMENTATION & LEGAL ISSUES



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*The College of Licensed Practical Nurses of Nova Scotia wishes to acknowledge the College of Licensed Practical Nurses of Alberta and the authors for permission to reprint these articles*

## Clarifying the Importance of Accurate Nursing Documentation

Arlene Wolkowyci, B.N., M. Ed.

**T**echnology is rapidly becoming the model for health information services. Most Canadian healthcare facilities and agencies today incorporate some type of record-keeping technology, including electronic documentation. The Canadian Nurses Protective Society (CNPS) (2014) reported from a Health Canada Infoway study that approximately 75% of nurses use information technology in practice and 50% use a combination of paper-based and electronic documentation. Electronic systems consist of complex, interconnected software applications that process and transport client records and other health information to and from the healthcare team. This data guides the team in providing safe, client-centred care while at the same time identifying client needs. The intersection of client information technology with electronic health records, documentation and mobile applications is discussed here, along with the responsibilities of prudent care providers.

### Electronic Health Record

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As the general population becomes more computer literate and with increased government support, the electronic health record (EHR) is rapidly becoming the standard. The client's EHR contains the same components as a paper-based one and requires the same principles of accurate documentation. Electronic systems automatically record a care provider's name, along with the entry date and time. A care provider may use drop-down menus to enter assessment data or significant client notes. Drop-down menus may be interpreted differently by care providers and may result in client safety issues (CNPS, 2014). Errors may also occur when cutting and pasting client notes (Kelley, Brandon & Docherty, 2011). From a legal standpoint, communication between healthcare providers may be inadequately documented in electronic records (CNPS, 2014). Some researchers even suggest that electronic documentation creates distance between care providers and decreases time spent in caring for clients (Laitinen, Kaunonen & Astedt-Kurki, 2010). Research has shown mixed results when comparing paper-based systems to electronic ones (Kutney-Lee & Kelly, 2011).

### Electronic Capabilities

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Electronic documentation has many obvious advantages. It generally speeds up the time required to document and improves accuracy and legibility, if a care provider knows how to use the system correctly. Electronic systems reduce reliance on memory as client information may be completed in real time or immediately after. Electronic documentation systems can reduce redundancies, as recopying information has been known to increase errors. Most systems assist in the standardization of care by using the nursing process and providing specific pathways to enter client events. There may be mandatory reporting fields so significant information is not omitted. Some systems require a brief narrative; others a full narrative on client particulars (CNPS, 2014).

*You should remember that once you have access to various types of client information, the computer may guide you to a decision, but it will not make a clinical decision for you.*

## Issues and Challenges

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Although client information technology is here to stay, it poses several concerns and challenges. Electronic or computer-based systems are expensive to design, implement and maintain. Employing facilities or agencies have specialized departments dedicated to the maintenance of technology and electronic records. These systems demand increased and costly staff training.

A care provider must have keyboarding skills and frequently the ability to enter progress notes using a narrative format. A healthcare provider who relies solely on electronic documentation may interact less with colleagues and reduce collaboration with other providers whose verbal input could ensure quality client care. Electronic systems may malfunction and routine maintenance may prevent the access of timely client information. There must be a back-up system, usually hand-written, to record client information. There is risk of hackers (individuals who gain unauthorized access to computer databases) who violate client confidentiality or disrupt systems by deleting or changing client information.

Protecting client confidentiality is a major issue for healthcare providers who document electronically. If precautions are not taken, a client's record can remain open for others to view until the care provider logs off manually or a time-out feature closes the record. Your password should not be known or used by anyone else as it is your electronic signature. Remember to follow your employing facility or agency's policies and procedures when making corrections electronically.

Although electronic systems have safeguards to prevent accidental deletion of files, know your employing facility or agency's policies and procedures if this should occur. Usually a supervisor or the information technology department must be notified immediately.

## Mobile Devices

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Increasing numbers of care providers use smart phones and other mobile devices to communicate and share client information with team members or with clients using text messaging or e-mail (CNPS, 2013). If you use mobile devices, you must be clear on personal and professional expectations and consequences.

There is much controversy whether mobile devices with applications (apps) should be permitted while care providers are on active duty. Depending upon the employer and healthcare environment, mobile devices with apps may assist in timely and safe care. Some employers encourage care providers to use their own personal devices, while others have shared mobile ones. For example, you may look up medication dosages and side effects, or locate employer policies and procedures easily on a mobile device. Some care providers take photographs of wounds or skin conditions and send these for assessments.

Mobile devices can succumb to breaches of client confidentiality. Encryption (an electronic security process that prevents unauthorized use) prevents unapproved individuals access to confidential information. Mobile devices are targets for thieves, which can result in huge breaches of client confidentiality. Infection control becomes an issue when mobile devices are shared in a workplace setting. Mobile devices can also become time wasters and distract from safe and quality client care.

Technology in healthcare is here to stay and its use is expanding exponentially. It has great merit for the enhancement of safe and quality client care. A prudent care provider keeps current of client information technology developments and is well versed on its capabilities and limitations. You must know your personal and professional responsibilities when using information technology in your nursing practice, as it can greatly enhance or detract from client-centred care.

## Watch Your Language! Use Accurate Documentation Approaches

Arlene Wolkowyci, B.N., M. Ed.

**C**lear, concise and comprehensive language is the goal for written, verbal and electronic communication. Because a team of care providers requires access to current client data, updates, or changes in a client's condition, documentation needs to be completed in a timely and competent manner. Your assessments and interventions, according to the care plan, should always be client-focused and your documentation should reflect this. This article will discuss some common documentation deficiencies, and strategies to minimize these; how the nursing process links indirectly and directly to documentation methods; and the importance of accurate documentation in, and about, adverse events.

### Documentation Deficiencies

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Many care providers are quick to point out documentation deficiencies. See if any of these sound familiar:

- **Illegible or unreadable handwriting.** It's preferable to print your client notes if you have challenges with legible handwriting. If you handwrite clients' information, ask your colleagues if they can read your handwriting.
- **A printed signature.** When your client notes are completed, your signature should be written, not printed. A cursive signature is more difficult to reproduce or falsify.
- **Failing to record pertinent health or medication information.** Remember that past health-related experiences or medications prescribed help the team make the best choices.
- **Failing to record nursing actions.** Documenting what you do for and with your client is very important and should include the outcomes or results of your interventions.
- **Failing to record medications given, or document a discontinued medication or treatment.** This can have drastic consequences if a client receives another dose of medication which may be injurious or life-threatening.
- **Failing to record medication reactions.** If a client has a serious or even minor allergic reaction to a medication and is given it again, it could result in serious injury or death.
- **Recording on the incorrect health record.** A chart or patient record that has recording of another client's care raises suspicion in the legal system, and can cause incomplete or no care for the client. The competency of the caregiver who has charted on the incorrect patient is then in question.
- **Not providing adequate detail of changes in the client's condition.** Work on finding a balance between excessive wordiness and necessary client details. Missing details have often been cited in lawsuits as inadequate or incorrect care.
- **Transcribing orders incorrectly or transcribing inaccurate orders.** Special precautions must be taken with telephone orders. If the prescribing health professional uses words you are not familiar with, it is your responsibility to ask for repetition and clarification or have another care provider listen to the orders.

- **Incomplete records.** If pages or specific forms of a client record are missing, this raises suspicion in the legal system and may give evidence of poor care. Removing pages from a client’s record is an illegal activity.

### Spelling and Grammar

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Misspelled words and substandard grammar create undesirable impressions for the reviewers of your notes. It may be helpful to have a quick reference page at the documentation desk or carry a notebook with correct spellings for commonly used terms. An experienced colleague can give feedback on your client notes and documentation.

Other helpful strategies are:

- Refer to a standard and a current medical dictionary at the charting desk or documentation area.
- Post a list of commonly misspelled or confusing words, especially ones linked to medications.
- If using spell check or electronic charting, make it a habit to double check the context, as these systems are not foolproof. For example, a spell check system does not know the difference between “anal” and “oral”.

### Abbreviations

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In the past decade, there has been much discussion and controversy over using correct and appropriate abbreviations. Have you spent extra time trying to find out what an abbreviation means in a client’s notes, delaying client care so client safety was not compromised? Are you using prohibited abbreviations or terms?

Competent care providers view documentation as an extension of the nursing process, and use the nursing process as a guide or framework to ensure accurate documentation.

There are published lists of prohibited abbreviations and terms that should not be used, as they have been found to jeopardize client safety (Brunetti, Hicks & Santell, 2007). Check with your employing agency or facility’s policies and procedures. It is best practice to spell out the word when in doubt!

### The Nursing Process

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Competent care providers view documentation as an extension of the nursing process, and use the nursing process as a guide or framework to ensure accurate documentation. Planning is the “thinking step” of the nursing process about the interventions you will perform for each of a client’s health problems. It is about what you will do in priority sequence for the client. You do not normally chart or document this step, but you may make brief, confidential paper notes.

It is necessary to document in the appropriate place in the client’s record all you did for the client, because in the legal system, undocumented care means that it was not done. The

emotional status of clients is also often excluded from assessment details (Brenner, Dimitroff & Nichols, 2010). This study found that in some client experiences, caregivers did not document an assessment of a client's emotional status and the emotional support they provided. Remember also to perform a pain assessment, as pain is often a warning sign of a significant change in a client's condition.

Nursing diagnoses may get burdensome if a client has numerous health issues and several corresponding interventions for each health problem on the care plan; however, you should keep these in mind as you document. Documenting outcomes proves that you followed up on a concern and demonstrates how the client responded to your intervention.

Other strategies for accurate documentation include:

- Document only the care you provide and never ahead of time. Unregulated care providers complete their documentation if they have had client interventions.
- If you find the preceding entry in the progress notes was not signed, then you should locate the care provider as soon as possible to sign his or her notes.
- When documentation continues from one page to the next, you should sign the bottom of the completed page and the top of the next page with the date and time, and state that it is continued from the previous page (Lippincott Williams & Wilkins, 2006).
- Do not document complaints from staff, poor care, or accusations. Keep your documentation strictly client-focused.
- What about co-signing and countersigning? Generally the meaning of co-signing is shared accountability and means that you witnessed or participated in the care or event. This makes you legally responsible for entries or documentation that you co-sign. Countersigning usually means that you reviewed the entry and approved the care or orders given. An example of countersigning would be signing your name and designation after reviewing and checking a physician's medical orders.
- In documentation, you generally do not use names of roommates or visitors, as this is a breach of their confidentiality.

### Documentation Methods

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Many care providers have used various documentation systems or methods throughout their careers. Some documentation systems function better in certain healthcare settings. Generally, an employing agency or facility chooses a documentation system that operates well with the care levels of clients and staff preferences; however, there is no perfect system that addresses all documentation needs. Prudent care providers learn to work well with the documentation system their employer requires. They also provide ongoing input to evaluate if the current system is addressing client data efficiently and accurately. As a care provider, are you well trained in the documentation system your employer uses? If you are, then this is the first step in completing accurate documentation.

## Adverse Events

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Adverse events are unexpected events that have increased potential or risk to contribute to client harm or injury. These events have the potential for lawsuits.

The following adverse events require particular attention when documenting:

- *A client or visitor fall*, no matter how minor it may seem. Injuries from falls may not be evident for hours or days, and falls are a common source of lawsuits.
- *Equipment failure*, which has a great potential to harm or injure a client.
- *An unplanned return to surgery*, as care interactions prior to the surgery will be scrutinized.
- *Medication errors*. Although all medication errors are reported, ones that require intervention must be documented precisely – and a care provider cannot predict which medication error will require intervention.
- *A hospital or facility-acquired infection*. This could result in client injury or even death.
- *An unexpected death of a client*, whether in care or not. Evidence of injury, or sudden death may not occur until after client's discharged.
- *Threat of a lawsuit or a personal threat* from a client or family member requires prompt attention and complete documentation.
- *Client injuries from criminal activity or abuse* must be documented very carefully, as these injuries generally are discussed in court cases.

In this article you have learned about many common documentation deficiencies and what you can do to correct or minimize these. You now understand how the nursing process links both directly and indirectly to documentation. If adverse events occur, you want to be sure to use extra care and attention in your documentation. By considering and applying this information, you will be well on your way to mastering accurate documentation.

## Work Smart with Client Information Technology

Arlene Wolkowyci, B.N., M. Ed.

**D**ocumentation is one of the main communication tools that both regulated and unregulated healthcare providers use to exchange client information. According to Ashurst (2000), client records thirty years ago in hospital wards were limited to a series of classic statements that stated simple opinions: “good day, no visitors today, good night, slept well, appears stable and tolerated procedure well”. Currently these statements are viewed as inaccurate and inappropriate, as there is no evidence of ongoing assessments and evaluation of a client’s condition and risks. This article will discuss why care providers must make efforts to improve their documentation and view it as an extension of the nursing process.

Documentation, sometimes referred to as reporting, charting or recording, can be described as any electronic or written information or data about client interactions or care events that meet both legal and professional standards (College of Registered Nurses of British Columbia, 2012). Meeting legal standards refers to how your documentation would be evaluated by the justice or court system. Your regulatory College examines your documentation to see if it meets its standards, competencies and expected behaviours that a prudent care provider in similar circumstances would have. Your employing facility or agency may review your documentation to see if it is congruent with its policies and procedures. Documentation audits across all health disciplines show serious deficiencies. A recent study found that the majority of healthcare documentation fails legal and professional standards (Paans, Sermus, Nieweg, & van der Schans, 2010). This is in sharp contrast to many care providers who believe that their charting is “good” or adequate in view of the challenging environment they work in.

### Healthcare Environment

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A large research report with its main partner, Health Canada (Blake & Norton, 2004), compared world-wide practices on patient safety and adverse events in healthcare. It concluded that the risk for injury or death for a client in healthcare services was greater than extreme sports such as bungee jumping or skydiving. The World Health Organization (WHO, 2013) also indicated that client safety is a serious global health issue. Data gathered from Australia, the United States and Western Europe suggests that eight to twelve per cent of persons admitted to hospital incur adverse events. Because you work in a high risk environment, you must make it your practice to communicate effectively and document all necessary details for safe client outcomes.

Evidence shows that accurate documentation improves clinical outcomes, processes of care and professional practice (CRNBC, 2012).

Anyone on the healthcare team who provides services or care for a client or other individuals and groups who are not directly involved in client care have authority to view the client record. Accreditation groups have an ongoing interest in patient safety and consult client records. An employing facility or agency considers documentation to monitor budgets and facility risks.

Other care providers peruse client documents so they can detect important client changes. Coroners preview client records for facts leading up to an unexpected death of a client. Insurance companies scrutinize client details before they pay out claims. Members of the legal team examine client records to reconstruct events in the case of client death or injury. The client or his family or legal designate have rights to view your documentation.

### Consequences

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There are serious consequences for inappropriate or inadequate documentation. A care provider could face loss of employment or loss of a practice permit. There may be personal stress, possible loss of income and perhaps legal expenses. An employing agency or facility could face a law suit and negative publicity. An employer may not support a care provider who has breached facility or agency documentation policies and procedures. A most serious consequence could involve severe injury or death of a client because your documentation was inadequate or inaccurate.

### Challenges

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Wilkinson and Treas (2011) state that a nurse may spend between fifteen and twenty-five per cent of his or her working day documenting. Blair and Smith (2012) state that nurses working in acute care may spend between twenty-five and fifty percent of their time in documentation. Because nurses work in extremely demanding healthcare environments, nursing activities often take priority to documentation. This makes it extremely difficult to chart contemporaneously; therefore, charting is often left for “down time” in a multi-tasking environment.

You may think about what needs to be documented, but often do not write it down.

Although a large amount of research exists on nursing documentation, it does not address how to make documentation less time-consuming (Cheevakasemsook, Chapman, Francis & Davies, 2006). Warren and Creech Tart (2008) discussed that care provider fatigue contributes to deficiencies in documentation. Many care providers work long hours and have demanding client assignments. They may not have clear thinking processes required for documentation. You may think about what needs to be documented, but often do not write it down. This is especially challenging when a client has numerous health problems and requires immediate attention. However, being too busy in a healthcare setting is not an excuse for lack of or inappropriate documentation.

Some care providers do not possess writing or keyboarding skills to perform clear, concise, comprehensive and timely entries. Besides the overt factors that affect quality documentation, there are also covert societal factors that create added pressures. With increased consumer awareness, there is demand for quality care and client involvement. Facilities or agencies have clients with increased acuity, particularly those affected with complex, chronic medical conditions. With an increased emphasis on outcomes and cost containment, documentation

has become the main mechanism for gathering data. Funding for client care and staffing is corroborated with documentation. What can assist care providers to improve documentation?

### Resources

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Employing agency or facility policies and procedures assist care providers to document accurately. Care providers should be well familiar with these - what they are and where they are located. Do you know your employing facility or agency's documentation policies and procedures and their location? Are you able to provide feedback on documentation practices to your employer?

Your regulatory College has documentation standards. Do you know your practice standards? Besides practice standards, care providers need to be aware of the several federal and provincial laws that affect nursing documentation. These laws are amended from time to time; therefore it is important to stay current.

This article has focused on understanding the importance of accurate documentation by all care providers. By striving for improvement and accuracy in documentation, care providers will be fulfilling their professional and legal responsibilities. Ultimately, as part of the healthcare team, working in a high risk environment, they will be providing quality care for clients and their families.

## Document Evidence: It's Your Best Defence

Arlene Wolkowycski, B.N., M. Ed.

**A** client's health record is the main communication tool for the healthcare team. It is also a medical and legal document that tells the story of a client's background and situation. It enables others to understand treatments and care the client did or did not receive. From a legal standpoint, the client's chart or record becomes evidence if a lawsuit is initiated. This article will briefly discuss the relationship of accurate documentation with the legal process. It will highlight some protective strategies a care provider may utilize. Please note that this article is not a substitute for legal advice.

### The Legal Process

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Documented care is just as important as the actual care. The legal system assumes care was not done if it has not been documented. Failure to document care implies failure to provide care (Lippincott, Williams & Wilkins, 2009). According to Crawford and Whelan (Osgoode Law School, 2013), regarding the justice system, "good notes will save you and no notes can destroy you". Therefore, your documentation practices can make the difference between positive and negative legal outcomes. Your documentation may be reviewed for a College complaint or coroner's inquest. Accurate documentation ensures compliance with legal requirements of provincial laws, employer policies and procedures and College standards and practice guidelines.

Once a lawsuit is commenced, all relevant information regarding a case must be collected. This information is disclosed or shared by both legal teams, the facility or agency, and the care providers who were either directly or indirectly involved with the case. Avenues of investigation and audit can include:

- the client's full record
- their MAR (Medication Administration Record) or dispensing records
- professional responsibility forms and incident reports
- work schedules and shift trades
- number of clients on a given unit
- the number of staff on vacation, away ill and on time off
- physician appointments or healthcare professional credentials
- human resource or employment files such as performance reviews, family complaints, and interpersonal memos
- the academic grades of a care provider and whether he or she has engaged in professional development activities
- staff mandatory education and training
- policies and procedures of the employer to ensure employer expectations are clear and current
- internal memos or notes.

Incident reports, though generally confidential, are always reproducible should a legal issue arise. Some agencies or facilities have a client relations department to address family concerns and have notes of interviews or meetings held with family or staff. Although emails may be deleted from a computer, they are reproducible and may be used as evidence. Personal notes, sticky notes or a care provider's diary of an adverse client issue may be demanded by the legal team.

### Plaintiff vs Defendant

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In a potential lawsuit, there are lawyers who act on behalf of the plaintiff (the one who initiates the lawsuit and claims injury, death or damages). There are also lawyers who act on behalf of the defendant(s) or those who are accused of wrongdoing. The defendants could be a physician, facility or agency, or care providers involved in a lawsuit. Lawsuits can become complex when manufacturers of biomedical equipment or pharmaceuticals become involved.

Although you may never be named as a defendant in legal case, you may be called to testify at a discovery or during a trial. You will need to depend on your documentation and not your memory to respond to questions regarding your client care. The client chart or record has the most comprehensive record of care and it is used to reconstruct events. The legal system ultimately wants to prove cause and effect of damages or injuries, and the court accepts the actions and the communications in the client record as proof that these events did or did not occur.

You will need to depend on your documentation and not your memory to respond to questions regarding your client care.

Lawyers for the plaintiff use documentation to prove that the standard of care was breached or not met. The client record is inspected to see that the care was competent, safe and appropriate, as well as completed. The plaintiff's lawyer is looking for lapses in charting, errors, amendments, deletions, inconsistencies and vague entries. He is trying to draw inferences or conclusions of sub-standard practices.

The lawyer and his team often engage experts to obtain critical opinions. If documentation was done before the care was completed, a plaintiff's lawyer could argue that the care was never done. Likewise, if the care was completed after the fact and documentation did not indicate a late entry, a plaintiff's lawyer could argue that the care was altered. Late entries after a serious incident involving death or serious injury may be viewed with suspicion.

The legal team for the defendants are attempting to prove that the standard of care was met and was safe, timely and appropriate for the client. The actions of the care provider are examined to see if they are prudent and reasonable and there is no causal link between the actions of the care provider and the client's injury or death. The team is attempting to show there were no lapses in documentation, errors, inconsistencies or vague entries. An unbiased,

healthcare expert may be hired to verify that the defendant's documentation and actions did not breach the standard of care.

### Improve Your Legal Status

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Although very few adverse events go to trial, the following strategies may assist you to improve your legal status:

- Develop a usual or your own practice statement to rely on if your memory fails. For example, (1) it should be your usual practice to shred draft client notes each day, and to (2) communicate to a receiving care provider using SBAR (Situation, Background, Assessments, and Recommendations) or other employer-approved communication tool. Personal practice statements offer added protection in the legal process.
- Incident reports are first used as evidence by the agency or facility in internal investigations. Terms such as “mistake” or “error” convey that something you did or did not do was your fault. Write about facts only, be objective and do not use accusations or blame.
- If you keep personal notes, be prepared to share these with both legal teams. It is generally not in your best interests to keep private files and notes on client care events.
- Record promptly at the time of the event as long delays create a negative impression of the care provider and may be viewed as gaps in client care.
- Record only what you saw, heard or did.
- Record chronologically and be cautious with late entries.
- Record frequently and promptly with client changes, and according to facility or agency policy.
- Record corrections clearly and according to employer policies and procedures.
- Record accurately and completely as the client record should contain assessments, identification of health issues, plan of care, implementation of care and the evaluation of care. Time and details do matter.
- Address facility or agency documentation policies that are not realistic for your healthcare setting.

By considering and applying best practices in documentation, a prudent care provider will ensure a high measure of legal and professional protection. Because your memory often fades with time, your documentation is your evidence for timely, safe and competent care.

## Communication

Chris Rokosh, RN, Legal Nurse Consultant

**W**hen medical errors cause lasting injury, the patient can sue both the doctor and the nurse. This can result in a medical malpractice lawsuit. Nurses who have been through this experience describe it as extremely difficult - as difficult as other catastrophic life events such as death, divorce and job loss. The experience of being sued affected their work life, personal life, health and well-being. Emotions such as shock, shame, anger, depression and fear were common. Many nurses felt so isolated by their peers that they left their jobs. You don't want this to happen to you.

The outcomes of malpractice lawsuits affect patients, healthcare professionals, public funding and the institutions that provide healthcare. But a workplace culture of denial and shame can keep us from talking about the errors that lead to lawsuits, or using them to learn and improve. So let's start a conversation about the most common nursing issues that result in malpractice lawsuits, with a goal of gaining knowledge, avoiding errors and improving patient safety. Because really, isn't that why we're all here?

This article will focus on the source of more medical malpractice lawsuits than any other: communication. Communication issues are so common that research shows that as many as 70% of medical errors involve some form of communication breakdown between the doctor and the nurse. The courts view communication as a critical part of any nurses' job. The nurse is seen as 'the eyes and ears' of the often-absent doctor and it is accepted that doctors rightly depend heavily on nurses to keep them fully informed of the patient's condition. The nursing and medical experts who review malpractice cases say that nurses are required to relay important information to the doctor according to hospital policy and the standards of care, and then to document that they have done so. Professional associations direct nurses to communicate appropriate information to appropriate members of the healthcare team through designated channels.

Throughout my career as a Legal Nurse Consultant, I have reviewed more than 1000 medical malpractice lawsuits, many of which focused, in part, on what the nurse did or didn't tell the doctor. The most common scenario involves a change in a patient's condition, and either no communication with the doctor or a phone call followed by documentation that simply states 'doctor aware'. The nursing notes do not say what doctor is aware, what they were told or what their response was. If the patient later develops an injury and launches a lawsuit, the doctor will often say 'Yes, the nurse phoned me. But she didn't tell me how serious the situation was. If she had, I would have attended to the patient immediately.' Without supportive documentation in the medical record this can result in a showdown of the nurses' word against the doctors'. It will be up to the judge to decide who said what and whether or not the nurse met the standard of care. Let's learn more about this from a medical malpractice case involving a lack of communication between a doctor and a nurse.

## Case Study

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*One summer evening at 7:38 p.m., 17-year-old Will Johnston was struck by a car as he crossed the street on his skateboard. The force of the impact fractured his right tibia, threw him onto the hood of the car and smashed the windshield. He was taken to the E.R. by ambulance where it was noted that his right leg had an obvious deformity and his right calf was very swollen. The toes on his right foot were cyanosed. His foot had normal sensation but limited movement and decreased pulses. Will was in a lot of pain and had multiple doses of IV morphine.*

*At 10:45 p.m., Will was transferred to the O.R. for Intramedullary Nailing of the right tibia. Following surgery, the incision was covered with Sofratulle and gauze, and his leg was stabilized with a back 'slab cast' and wrapped with a tensor bandage. Will was transferred to the recovery room 'in good condition'.*

*Shortly before 1:00 a.m., he was transferred to the nursing unit where he was cared for by LPN Donna.*

*At 1:45 a.m., Nurse Donna documented that Will was awake, swearing and complaining of 'excessive pain'. His right toes were described as 'pink and warm' with normal movement. Nurse Donna noted that Will only had 'fair relief' from the multiple doses of IV morphine he had been given post-operatively.*

*At 2:00 a.m., Nurse Donna documented that that Will was awake and oriented. The colour, sensation and movement to his right foot were described as 'good' with a capillary refill time of less than 3 seconds. Will was noted to have 'severe weakness' and tingling in his right leg. Overnight, Nurse Donna documented information regarding Will's medications, intake and output, but there was no further assessment of the colour, warmth, sensation and movement of Will's foot for the remainder of her shift.*

*At 8:00 a.m., day shift LPN Lucinda started her shift. She described Will as confused. He was not able to correctly identify the month or where he was. He only opened his eyes when he was spoken to. His right leg was again noted to have 'severe weakness' and he refused assistance with bathing, stating 'Leave me alone!'. Serosanguinous drainage was noted on pillow underneath Will's leg. Nurse Lucinda did not document colour, warmth, sensation or movement.*

*At 9:20 a.m., Will was noted to be 'yelling and complaining of pain'. Nurse Lucinda documented that she reassured Will's parents that the amount of pain and drainage were 'normal for the surgery'.*

*At 12:00 noon, Nurse Lucinda documented, 'Right leg remains in slab cast, small amount of sanguinous drainage on upper side. Foot cool, toes swollen and dark, patient states is not able to wiggle toes because it hurts. Has tingling sensation. Will monitor.'*

*At 1:00 p.m., physiotherapist Steve arrived to teach Will how to walk with crutches. He described Will as 'anxious ++, yelling out when moved'. He refused to get out of bed.*

*At 1:25 p.m., orthopedic resident Dr. Smithson arrived on the unit. He noticed that Will had decreased sensation in his right foot and was unable to point or flex his toes. Dr. Smithson removed the cast, measured the pressures in the calf muscles, and diagnosed post-traumatic compartment syndrome. Will was taken back to the OR for fasciotomies to relieve the pressure. Following surgery, he developed multiple complications. The leg became infected and necrotic in spite of surgical intervention and arterial grafting. Fourteen days later, it was amputated below the knee.*

*Will remained in hospital for several weeks. Eighteen months after his discharge, his family filed a multi-million dollar lawsuit against the doctor and the hospital, claiming, among other things, that nurse Donna and nurse Lucinda failed to communicate important information to the doctor or the charge nurse. They claimed that the standard of care required them to tell someone about Will's pain, weakness, sensory loss and colour change. They also indicated that if the doctor had been called earlier, Will would not have lost his leg.*

Do you think the nurses met the standard of care?

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Compartment syndrome is a potentially life-threatening condition caused by high pressure in a closed fascial space. The most common site of compartment syndrome is the lower leg (Abramowitz and Schepsis 1994) and young men with traumatic soft tissue injury are known to be at particular risk (Mc-Queen et al 2000). It is a potentially devastating complication of tibial fractures and requires prompt recognition and intervention, as early intervention is critical to avoid permanent damage to the muscles and the nerves.

Symptoms of compartment syndrome may include pain that is disproportionate to the injury, pallor of the affected limb, altered sensation (numbness, tingling), tension of the affected muscles, pulselessness below the level of the swelling and, as a late sign, paralysis. Postoperative narcotic administration may mask the pain which is often the first symptom of compartment syndrome, therefore it requires careful monitoring for the other symptoms.

The nursing plan of care for a patient with a traumatic fracture of the tibia must include, among other things, knowledge and awareness of the possible development of compartment syndrome along with careful and frequent monitoring of the affected limb for colour, warmth, sensation, movement and pulse strength. Monitoring may be required as frequently as every hour, but certainly every 4 hours in the early postoperative period. Monitoring guidelines are often established by hospital policy or care plans or may be provided by doctors' orders.

Signs and symptoms of compartment syndrome must be reported immediately to the charge nurse and/or responsible physician. The nursing standard of care would be to notify the physician immediately, requesting a 'hands on' assessment of the patient. The nurse must provide an accurate clinical picture of patient status and raise the level of concern. If the physician does not respond promptly to the nursing request for assessment, the nurse must act in the best interest of the patient and persist in finding appropriate medical attention. This may require repeated pages/phone calls to the physician, refusing to take doctors' orders over the phone, notifying the nursing supervisor or accessing the appropriate 'Chain of Command'.

The lawyer representing Will in this malpractice lawsuit asked other nurses to review the medical record to determine whether or not nurse Donna and nurse Lucinda had met the standard of care. Their opinion was that Donna and Lucinda had not met the standards in two important areas: by not assessing Will's leg as thoroughly and frequently as required by hospital policy, and by not reporting his pain, weakness, colour change and sensory loss to the charge nurse or the doctor. Their opinion was that nurse Donna should have reported these changes no later than 2:00 a.m. when she documented that Will had severe weakness and tingling in his right leg. Since this did not happen, their opinion was that nurse Lucinda should have performed a full assessment of the leg at 8:00 a.m. and asked the doctor to see Will right away.

The reviewing nurses said that these failures represented a lack of nursing knowledge and critical thinking as well as a failure to meet the standard of care. They also said that the lack of communication contributed to a delay in treating Will's compartment syndrome which ultimately led to the loss of his leg. Based on this information, the case settled out of court for an undisclosed amount of money. The doctor in this case was also sued, but 'let out' of the lawsuit when it was discovered that he did not know that anything was wrong with Will's leg because the nurses had not communicated with him. By the time the resident examined Will on rounds, the compartment syndrome had already caused irreversible damage.

Use this case study to spark a conversation on communication with your colleagues. How would you rate the level of communication in your workplace? Have you ever witnessed, or been part of a situation, where communication caused a problem? Did the patient suffer as a result? What are the designated channels of communication in your workplace?

## Assessment

Chris Rokosh, RN, Legal Nurse Consultant

The first article in this series included a case study about a medical malpractice lawsuit involving a lack of communication. You may recall 17-year-old Will Johnston whose right tibia was fractured when he was hit by a car. The tibia was successfully repaired, but post-operatively, Will developed severe pain in his leg and became confused and irritable. The nurses caring for him documented signs of weakness and changes to the color, warmth, sensation and movement in his right foot, but they failed to communicate this information to the doctor. Will was ultimately diagnosed with compartment syndrome, had a below-the-knee amputation, and filed a multimillion dollar lawsuit, suing both the nurses and doctors for the loss of his leg. When the nursing care was examined, it was determined that the nurses had failed to meet the standard of care in two key areas: by not communicating important clinical information to the doctor and by not assessing Will's leg according to hospital policy. This article will focus on the issue of nursing assessments; more specifically, medical malpractice lawsuits claiming that the nurse performed inadequate assessments.

All nurses are tasked with the responsibility of providing safe, ethical and competent care. We are also responsible and accountable to ensure that our practice meets both professional standards and legal requirements. This requires that patient assessments are done according to doctor's orders, current standards of care, best practice guidelines, facility policy and, most importantly, according to each patient's individual condition. The court's view is that nurses have a specialized body of knowledge and that they are expected to use critical thinking to respond appropriately to information obtained through their assessments. In some situations, nurses are required to assess patients without the assistance of subjective information, such as during periods of sleep, recovery from anesthesia, in pediatric care or when working with unconscious or mentally compromised patients. But in all situations, the expectation is that if the patient's condition changes, so will the detail and frequency of nursing assessments. This means that you may need to assess patients more frequently if they become unstable or develop complications. Seems pretty straightforward, doesn't it?

Many medical malpractice lawsuits include allegations that the nurse did not assess the patient often enough or that they didn't assess them at all. You may be familiar with the saying 'nothing written, nothing done'. Many nurses are. This saying comes from a 1974 Supreme Court of Canada case called Kolesar vs. Jeffries. Although it is often used in reference to a lack of nursing documentation, it's really based on a lack of nursing assessment. The case involved a young man who had a spinal fusion and was returned to the surgical unit in satisfactory condition. The next morning he was found dead. There were no written entries in the medical record between 10 p.m. and 5 a.m. on the morning when his death was discovered. The nurse testified in court that she had measured pulse and respiration rates every half hour over night, and that they were always normal. She just hadn't written anything down. But the absence of documentation led the judge to believe that nothing was charted because nothing was done. This highlights both the importance of performing assessments according to the standards of

care, and the necessity of documenting that you have done so. Let's learn more about this issue by examining a case study involving the assessment of a patient on a medical unit.

### Case Study

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*At 2:30 p.m., a 47-year-old woman named Margaret arrived in the emergency department complaining of a sudden onset of upper abdominal pain, nausea and vomiting. She came to the hospital directly from the airport after spending two weeks at an all-inclusive resort in Mexico. Her medical history was significant for hypertension and chronic back pain. She was a smoker and admitted to occasional heavy alcohol use, especially in the past two weeks. Surgical history included a tonsillectomy many years ago, a hysterectomy 6 years ago and dental surgery.*

*Current medications included vitamins, hormone replacement therapy, Tylenol #3 (for back pain), and Labetalol (to control blood pressure). Her vital signs on admission were temperature 37.8 degrees, BP 176/88 mmHg, pulse 90 beats per minute and respirations 24 breaths per minute. Laboratory tests revealed an elevated white blood cell count and an elevated serum amylase. Her abdomen was tender and slightly rigid. Margaret was diagnosed with acute pancreatitis and admitted to the medical unit. The doctor provided orders for IV fluids, antibiotics, additional lab and diagnostic testing, and consultation with an internist. Margaret was to remain NPO overnight and provided with medication orders to control pain and nausea. Vital signs were ordered as per protocol.*

*At 8:45 p.m., Margaret arrived on the medical unit and was assigned to LPN Amy who was working a 12 hour night shift. Nurse Amy performed an initial physical assessment and completed the admission paperwork. Margaret denied having any pain or nausea. Temperature remained at 37.8 degrees. BP was 168/90 mmHg, pulse was 84 beats per minute and respirations were 22 breaths per minute. Nurse Amy oriented Margaret to her room, reminded her that she was NPO and showed her how to use the call bell. She also gave Margaret a warm blanket, settled her into bed and encouraged her to get some sleep.*

*At 10:20 p.m., Nurse Amy returned to Margaret's room to change her IV bag and check her vital signs. Temperature was now 37.0 degrees, BP was 102/58 mmHg and pulse was 116 beats per minute. Respirations were not measured. Margaret again denied having pain or nausea, but complained of feeling cold. Nurse Amy gave her another warm blanket and encouraged Margaret to use her call bell if she needed anything during the night.*

*Between 11:00 p.m. and 6:00 a.m., Nurse Amy documented that she performed Q1H rounds and that Margaret appeared to be sleeping with quiet, easy respirations. She also noted that the IV was infusing as ordered. Margaret did not ring her call ball or get up to the bathroom overnight.*

*At 6:15 a.m., Nurse Amy entered Margaret's room to check her vital signs. When Nurse Amy touched Margaret's arm, she noted that her skin felt cool to the touch. Although Margaret opened her eyes when she was spoken to, she did not respond to the questions Nurse Amy asked her. Nurse Amy was unable to obtain a blood pressure or temperature and the pulse felt weak. Respirations were shallow and Margaret was breathing at a rate of 6 breaths per minute. Nurse Amy left the room to get another blood pressure monitor, thinking that the one she had wasn't working right. But she wasn't able to obtain a reading on the second machine either. She then rang the call bell and asked the charge nurse to come to the room. By the time the charge nurse arrived, Margaret had lost consciousness and stopped breathing.*

*At 6:27 a.m., a Code Blue was called. Margaret was resuscitated, intubated and taken to the ICU. Her remaining hospital stay was long and complicated, and included a diagnosis of sepsis, three laparotomies to remove sections of ischemic bowel, pneumonia and a brain injury due to prolonged hypoxia. Fifteen months after her hospitalization, she was still unable to return to work as an accountant and had developed insulin-dependent diabetes. It was uncertain that she would ever be able to return to full-time employment. Margaret filed a lawsuit against the hospital claiming, among other things, that Nurse Amy had failed to assess her vital signs properly during the first night of her admission. Margaret claimed that Nurse Amy was expected to know that a decrease in BP accompanied by a rise in the pulse rate can indicate the onset of shock in a patient with pancreatitis. She also claimed that Nurse Amy was required to communicate the 10:20 p.m. vital signs to the charge nurse or the doctor, alleging that earlier medical intervention could have prevented, or lessened, her injuries.*

Do you think Nurse Amy met the standard of care?

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Pancreatitis is an inflammation of the pancreas, the large gland behind the stomach that is responsible for the release of digestive enzymes into the small intestine and the release of insulin or glucagon into the bloodstream. Pancreatic inflammation happens when the digestive enzymes are activated before they are released into the intestine and begin attacking the pancreas itself. The most common causes are gall stones and chronic alcohol use. There are two forms of pancreatitis: acute and chronic. Acute pancreatitis affects approximately one per cent of the population (Lam and Lombard, 1999) and about 70 per cent of attacks are mild. However, of those individuals who develop severe forms of the disease, one in four will die (Forrest et al, 1995).

The main symptom of pancreatitis is a sudden onset of abdominal pain in the epigastric region that may radiate to the back and be associated with nausea and vomiting\ (Alexander et al, 2000). A serum amylase more than four times the upper limit is diagnostic of pancreatitis. Physically, the patient may appear acutely unwell with signs of shock, abdominal tenderness and guarding or rigidity (Henry and Thompson, 2001). The nursing plan of care includes the administration of analgesia, antibiotics and anti-nausea medications, IV fluids, accurate measurement of intake and output, and regular observation of vital signs. In the acute stage, it

may be necessary to take the patient's blood pressure, pulse, temperature and respirations every hour and respond to the results accordingly. Signs and symptoms of septic or hypovolemic shock, such as falling BP, rising pulse, lack of urinary output and decreased temperature must be reported immediately due to the risk of injury to the patient.

The lawyer representing Margaret in the lawsuit retained a nursing expert to review the medical records and determine whether or not Nurse Amy had met the standard of care. The reviewing nurse discovered that at 10:20 p.m., Nurse Amy had drawn a small downward arrow next to the blood pressure and a small upward arrow beside the pulse. This indicated that Nurse Amy recognized that the blood pressure had fallen and that the pulse had risen, yet she had failed to reassess the vital signs until nearly 8 hours later. When Nurse Amy was asked why she didn't reassess Margaret's vital signs, she referred to the doctor's orders which said to monitor vital signs as per protocol and the unit policy which said to assess vital signs QID. She said that Margaret had looked tired and unwell at 10:20 p.m. and said it was important for her to get some rest. She also said that she had never looked after a patient with pancreatitis.

The nurse expert responded that hospital policies provide minimum guidelines for assessment and that doctor's orders can only be altered if the doctor is made aware of a change in the patient's condition. She also said that regardless of Nurse Amy's inexperience with pancreatitis, it is the expected knowledge of all nurses that unstable vital signs in an acutely-ill patient can indicate impending decompensation. The nurse expert stated that patients can present as stable, but very quickly become unstable, and that there are no hospital policies or doctor's orders that can adequately cover all of the emergency situations that develop on medical units. For that reason, nurses are required to use critical thinking in situations involving the risk of injury, and to assess patients more frequently based on their clinical condition. She confirmed that a nurse does not need a doctor's order or change in hospital policy to assess vital signs more frequently than ordered. Her opinion was that Nurse Amy failed to meet the standard of care by not revising the plan of care to include reassessment of Margaret's vital signs within 15 to 30 minutes and urgent communication with the charge nurse or the doctor no later than 10:30 p.m. This case settled out of court for an undisclosed amount of money.

### Start a Conversation

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Use this case study to spark a conversation on nursing assessment with your colleagues. Note any similarities between this case and the Kolesar vs. Jeffries judgement which sparked the 'nothing written, nothing done' saying that we're all so familiar with. Were you able to identify issues with both communication and assessment? How would you rate the level of nursing assessments in your workplace? Have you ever witnessed, or been part of a situation, where a lack of assessment caused a problem? Did the patient suffer as a result? What currently guides your patient assessments? Is it doctor's orders, hospital policy, what the charge nurse says, the 'culture' on your unit or the patient's clinical condition? What will you do differently now that you know the outcome of this case?



## Medication Errors

Chris Rokosh, RN, Legal Nurse Consultant

According to the National Coordinating Council for Medication Error Report and Prevention, a medication error is defined as ‘Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare professional...’ Based on a U.S. Food and Drug Administration study of fatal medication errors between 1993 and 1998, the most common causes of medication errors were performance and knowledge deficits (44%) and communication errors (16%). Children and older adults were identified as particularly vulnerable population groups for medication errors.

Have you ever made a medication error? I know I have; and to date I have never met a nurse who hasn’t. Sadly, these errors occur much too frequently. In fact, medication errors constitute the greatest number of adverse events in healthcare. Fortunately, many of the errors do not result in harm. For instance, a nurse may give a patient Tylenol when ibuprofen was ordered. As long as the patient doesn’t suffer an adverse reaction, this error would not result in a lawsuit.

On the other hand, if a nurse administers a medication that results in serious injury or death, the patient can sue the nurse and may also sue the doctor, pharmacist and hospital. Multiple parties can be sued due to the fact that there may be many contributing factors, and many individuals, who play a part in the ordering, dispensing, administration and developing the processes for giving medications.

Medication administration is considered a basic nursing skill, one of the most common and frequent tasks nurses perform. Nurses have long been required to administer medication by a well-known set of 5 ‘rights’: right drug, right dose, right patient, right route, right time. Some additional ‘rights’ now include the right reason, right response, right documentation, right to refuse and right to education. Nurses are expected to stay knowledgeable about the actions, side effects and contraindications of all medications they give. This is no small task, but a highly necessary one, particularly when caring for high-risk population groups or administering multiple medications to the same person. Nurses are also expected to question any medication orders that are unclear, unusual or unsafe. Doctors can make mistakes and sometimes order the wrong medication or the wrong dose. It’s considered nursing responsibility to recognize errors before administering the medication and to clarify the order with the doctor. Let’s learn more about this by examining a fictional case study with an adverse outcome.

### Case Study

*At 5:20 p.m., 82-year-old Elizabeth presented in the emergency room of a rural hospital with complaints of abdominal pain. Over the past 3 days, she had been experiencing crampy left lower quadrant pain and had been unable to have a bowel movement. She was nauseous, feeling unwell and her abdomen was distended and tender. Bowel sounds were barely audible. Temperature was elevated to 38.2 degrees Celsius and her white blood cell count was elevated. Medical history included a previous stroke with right-*

*sided weakness, high blood pressure, smoking, mild dementia and a history of bowel cancer. Current medications included calcium and vitamin D supplements, Valsartan HCT for high blood pressure and low-dose aspirin. Elizabeth was severely allergic to penicillin and bees. She was admitted to hospital with a working diagnosis of bowel obstruction and told to remain NPO overnight. The doctor ordered IV fluids, IM morphine and IV Ancef. Consultation was arranged with a gastroenterologist and diagnostic testing was requisitioned for the following morning.*

*At 10:25 p.m., Elizabeth arrived on the medical unit and was assigned to LPN Belinda. Nurse Belinda completed an initial physical assessment and filled out the admission paperwork. She clearly marked the penicillin allergy in all of the required places and placed an allergy band onto Elizabeth's arm. Vital signs were stable and Elizabeth denied pain at the time of admission. She had been given a dose of morphine in the emergency room. Elizabeth was drowsy, so Belinda settled her into bed, oriented her to her room, reminded her to remain NPO and showed her how to use the call bell. Belinda went back to the desk to complete her charting, and then into the medication room to prepare the next dose of IV Ancef.*

*At 12 midnight, Belinda was on her break. Nurse Winnie, who was covering for her, quietly entered Elizabeth's room and hung the mini-bag of IV Ancef that Belinda had prepared. Elizabeth seemed to be sleeping soundly, so Winnie did not wake her or check her armband.*

*Shortly after 1:00 a.m., Belinda made rounds and stopped in to see how Elizabeth was doing. She seemed to be sleeping, but Belinda noticed that she was restless, frequently rubbing her eyes and scratching her arms. The IV Ancef had infused and Belinda removed the mini-bag and left the room.*

*At 2:15 a.m., Elizabeth rang her call bell, saying that she felt like she couldn't catch her breath. When Belinda entered the room, she found Elizabeth sitting up in bed, struggling to breathe. Her face was swollen, her lips were blue and she was finding it difficult to swallow. She was complaining of abdominal pain and her skin was covered in bright red hives. Belinda attempted to take Elizabeth's vital signs, but the patient was so restless that Belinda was unable to obtain either a blood pressure or a pulse. Belinda rang the call bell and asked her charge nurse to come right away.*

*At 2:27 a.m., Elizabeth collapsed onto the bed and stopped breathing. The E.R. doctor was called and he paged the anesthetist as he made his way to Elizabeth's room. The doctors were unable to intubate Elizabeth due to swelling in her airway.*

*At 3:12 a.m., Elizabeth was pronounced dead. The cause of death was listed as an anaphylactic reaction to the medication Ancef. Seven months after Elizabeth's death, her daughter filed a lawsuit against both the doctors and nurses. She alleged, among other things, that Nurses Belinda and Winnie were negligent in administering Ancef to a*

*patient who had a serious allergy to penicillin without careful observation for signs of an allergic reaction.*

*She further alleged that if Nurse Belinda had recognized and responded to Elizabeth's restless eye-rubbing and arm-scratching shortly after 1:00 a.m. as potential signs of an allergic reaction, steps could have been taken to save her mother's life.*

Do you think the nurses met the standard of care?

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Anaphylaxis is a serious, potentially life-threatening allergic response marked by swelling, hives, decreased blood pressure and dilated blood vessels. In severe cases, the patient can go into shock which can be fatal. Anaphylaxis occurs when the immune system develops a specific allergen-fighting antibody (called immunoglobulin E or IGE) that initiates an exaggerated response in the body. When exposed to the substance later, the body can produce a large amount of histamine which leads to the development of the symptoms above. It may begin with itching of the eyes and face, then progress within minutes to difficulty breathing and swallowing, abdominal pain, vomiting, diarrhea and hives. Medications are known causes of anaphylaxis.

Ancef or cefazolin is a cephalosporin antibiotic used to treat many types of bacterial infections. Although it is in a different class of drugs from penicillin, cross-sensitivity reactions can occur in up to 10% of patients. Caution and careful observation are advised when administering Ancef to a patient with a penicillin allergy. If any signs of an allergic reaction occur, the nursing plan of care includes immediate discontinuation of the Ancef and notification of the physician. The physician may then order epinephrine and other emergency measures such as oxygen, IV fluids, IV antihistamines, steroids, blood pressure medications and airway management.

The lawyer hired a nursing expert to review the medical records and provide opinion on whether or not Nurse Belinda and Nurse Winnie breached the standard of care. The nursing expert emphasized that medication administration is so much more than a task to be completed. It requires critical thinking, skill and knowledge. She further stated that nurses must be knowledgeable of the actions, side effects and contraindications of all medications they administer. She stated that penicillin and Ancef are two commonly-administered medications in the hospital setting, so it was expected that Nurse Belinda and Nurse Winnie would be knowledgeable of the potential for cross-reaction.

Based on this, the nursing expert determined that the nurses failed to meet the standard in three areas: failing to question the physician for ordering Ancef, administering Ancef to a patient with a serious penicillin allergy without providing careful monitoring, and failing to intervene to signs of an allergic reaction shortly after 1:00 a.m. when Elizabeth was rubbing her eyes and scratching her arms. All of the experts who reviewed the case stated that nursing and medical intervention at 1:00 a.m. would have most likely prevented Elizabeth's death.

When the nurses were asked if they knew of the potential for cross-reaction, they responded that they did not. They said that because the doctor knew of Elizabeth's penicillin allergy, and ordered Ancef anyway, they assumed it was safe to give. They were simply following doctor's orders. Their lack of knowledge coupled with the failure to recognize and respond to early signs of an allergic reaction provided little defense in the lawsuit. This case settled out of court. Both Nurse Belinda and Nurse Winnie were disciplined by their professional body, required to take a course in safe medication administration, and undergo a period of supervised practice.

### Start a Conversation

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Use this case study to spark a conversation about medication administration with your colleagues. What are your thoughts on one nurse administering a medication that another nurse has prepared? How would you rate the safety of medication administration in your workplace? Have you ever witnessed or made a medication error? Did the patient suffer as a result? What is the process for reporting a medication error in your workplace? Does the process allow for open discussion, learning and improvement? If not, what can you do to promote safer medication practices? What will you do differently now that you know what you know?

## Infection Control & Equipment Errors

Chris Rokosh, RN, Legal Nurse Consultant

In this final article on nursing negligence lawsuits, we will discuss two issues: infection control and equipment errors. First, infections. Most patients enter the healthcare system hoping to leave healthier than they arrived. But in some cases, patients acquire infections known as healthcare-associated infections or HAI's. An HAI is defined as an infection acquired in a hospital, long-term care facility, outpatient clinic or home care setting that was not present at the time the patient entered for care.

The 2013 Canadian Report on the State of Public Health in Canada identified that more than 20,000 patients acquire HAI's every year. More than 8000 die. The death rates from *Clostridium difficile* have more than tripled since 1997. Since 1995, methicillin-resistant *Staphylococcus aureus* (MRSA) infections have increased more than 1000 percent. Patients at the greatest risk are those that are very young, very old, have weakened immune systems or live with one or more chronic illnesses. Highly concerning for all of us is that up to 50 percent of bacteria causing these infections are resistant to one or more antibiotics. Also concerning is that 80 percent of the infections are spread by healthcare workers, patients and visitors.

Lawsuits involving infections in individual patients can be challenging because so many people may be involved in the care, making it difficult to determine exactly how or when the infection was transmitted. On the other hand, lawsuits involving large numbers of patients who all develop the same infection, known as class action lawsuits, have been more successful. You may recall a case involving Canadian Blood Services several years ago related to the spread of HIV and hepatitis C. More recently there have been lawsuits against hospitals and long-term care facilities for outbreaks of *Clostridium difficile* and tuberculosis. These lawsuits can reflect badly on healthcare facilities and the nurses who work in them due to the fact that infection rates are considered a patient safety measure. Let's take a look at a lawsuit involving a postoperative infection where the nurses were sued: not for causing the infection, but for their lack of response to the signs and symptoms of infection.

### Case Study

*32-year-old Steve fell while snowboarding. An X-ray revealed a compound fracture of the tibia and fibula of his left leg. Surgery was performed and the leg was stabilized with a 'back slab' cast. Steve arrived on the surgical unit at 5:15 p.m. where he was cared for by LPN Christine. Nurse Christine described Steve's left foot as swollen, warm and bruised. Pedal pulses were strong. At 6:20 p.m. Steve was awake, alert, and oriented. He was given IM Demerol for pain.*

*At 7:30 p.m., (nursing change of shift) LPN Janice took over Steve's care, describing his toes as pale and cool to touch. By 9 p.m., Steve was noted to be very uncomfortable, refused to wiggle his toes and stated the pain in his left leg was increasing. His*

*temperature was elevated to 38.5 degrees. Nurse Janice gave Steve two Tylenol #3 tablets.*

*Overnight, Steve was unable to sleep due to pain. His left leg was noted to have slight redness and swelling around the incision and his toes were cool. He was given Tylenol # 3 tablets and IM Demerol. His temperature remained elevated.*

*At 8:00 a.m., Nurse Christine was back on shift. Steve was extremely uncomfortable and described his pain level at an 8 on a scale of 1-10 in spite of a recent injection of Demerol. His leg was warm to the touch. His toes were cool and pale. Temperature was 38.6 Degrees.*

*At 8:45 a.m., Steve dangled his legs over the bedside but refused to try crutches. The lab reported an elevated white blood cell count of 14.3 mCL.*

*At 12:00 noon, Steve was irritable and told Nurse Christine that his leg was on fire. Nurse Christine assured him that pain was normal after surgery and administered two tablets of Tylenol #3.*

*At 1:30 p.m., the surgeon arrived on the unit. He did not examine Steve because he was (finally) sleeping. The surgeon asked Nurse Christine how Steve was doing. She reported that although he had some episodes of elevated temperature and pain, he was anxious to go home. The surgeon discharged Steve and provided a prescription for Tylenol #3.*

*At 3:20 p.m., Nurse Christine documented that Steve had left the hospital with his family. Vital signs were not checked before discharge.*

*At 11:20 p.m., eight hours after discharge, Steve's left leg was hot, red, and very swollen. Steve was crying with pain. His wife called an ambulance. When Steve arrived in the ER, he was pale and unresponsive. Temperature was 39.1 degrees, respirations were 42, BP was 72/48 and pulse was 132. Steve was diagnosed with sepsis and taken back to the OR where infected tissue was removed from his left leg. He was admitted to the ICU for 13 days. Recovery was long and difficult and Steve required four additional surgeries. He was left with significant weakness, deformity, and scarring of his left leg and continued to walk with a cane fifteen months after the accident.*

*Steve wondered if his injuries would have been less serious if the infection had been treated earlier. He was concerned that the nurses did not take his symptoms seriously and was unhappy that he had not seen the surgeon before discharge. He was also very concerned that he would never return to his job as a carpenter. Eighteen months after surgery, Steve filed a lawsuit claiming that Nurses Christine and Janice had failed to meet the standard of care by not recognizing and reporting obvious signs of infection.*

### Do you think that the nurses met the standard of care?

As nurses, we have a significant role to play in infection control. Washing hands, cleaning the environment and sterilizing equipment are proven to prevent infections and prevent patients from harm. The lawyer hired a nursing expert to review the medical records and provide opinion on whether or not the nurses breached the standard of care. The expert stated that infection control is one of the most basic of skills and that nurses are required to recognize and respond to signs of infection. The expert determined that the nurses failed to monitor Steve's condition appropriately, failed to recognize some well-known signs of infection and failed to communicate important information to the physician. You may notice that this case involves elements of two other litigation issues discussed in previous articles: assessment and communication.

### Equipment Errors

Now let's talk about equipment errors. Medical equipment includes IV pumps, BP monitors, PCA pumps, cautery equipment and even beds, wheelchairs and lifts. Injuries can happen when the equipment is either not used properly (such as when an IV pump is programmed to deliver too much or too little fluid or medication), or when information obtained from the equipment is not interpreted properly (such as when the temperature gauge in a bathtub is ignored). Both nurses and their employers have a key role to play in the safe use of equipment. Nurses must apply skill and knowledge, and employers have a responsibility to train and support nurses on the equipment they provide to nurses.

For a case study on equipment errors, please watch the powerful and thought-provoking video titled 'Transparency, Compassion and Truth in Medical Errors' (<https://youtu.be/gmaY9DEzBzI>). This video, about a child who died when the nurse turned off the alarms on the machine that was monitoring his heart, addresses this issue better than I ever could in this article. Use it to refocus your commitment to protecting patients from harm.

### Start a Conversation

Use this article and video to spark a conversation with your colleagues about infection control and equipment errors. What are your thoughts on Steve's case? Have you ever overlooked or downplayed potential signs of infection? Did the patient suffer as a result? Do you perform hand hygiene as often as you should? Have you ever wrongly used medical equipment or felt unsure about how to interpret the information you received? Are you well trained on the medical equipment that you use every day? If not, what can you do to advocate for more education? What will you do differently now that you know what you know?

## Reflective Evaluation

This reflective evaluation may be to satisfy the annual requirements of [Continuing Competence Program \(CCP\)](#) for this year. Answer the questions below and keep this in your personal portfolio.

<b>DATE COMPLETED:</b>	
<b>DECLARATION:</b> My signature indicates I have read the articles in the Documentation and Legal Issues Series	
<b>Name (printed):</b>	<b>Signature:</b>
<b>LEARNING:</b> Identify one <i>new</i> thing you learned by reading these articles.	
<b>APPLICATION TO YOUR PRACTICE</b> How do you expect to use this new information to improve your practice and / or client outcomes?	
It takes time to integrate new learning into your practice or to be able to see how client outcomes have been improved by your learning. Wait at least 6 months from the date above to fill out this section.	
<b>DATE COMPLETED:</b>	
<b>REFLECTIVE PRACTICE Reflective Evaluation of Learning and Practice</b> Describe how you have been using the new knowledge to improve your practice and positively impact client outcomes.	