The Canadian Nurses Protective Society

Admission & Discharge: Professional Liability Considerations

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NP Discharge & Admission: Legislative Authority

Discharge

(Hospital Management Regulation O.Reg. 965)

As of July 1, 2011:

16. (1) If a patient is no longer in need of treatment in the hospital, one of the following persons shall make an order that the patient be discharged and communicate the order to the patient:

1. The attending physician, registered nurse in the extended class or midwife or, if the attending dentist is an oral and maxillofacial surgeon, the attending dentist.
2. A member of the medical, extended class nursing, dental or midwifery staff designated by a person referred to in paragraph 1.

Admission

(Hospital Management Regulation O.Reg. 965)

As of July 1, 2012:

11. (1) No person shall be admitted to a hospital as a patient except,

(a) on the order or under the authority of a physician who is a member of the medical staff;

(a.1) on the order or under the authority of a registered nurse in the extended class who is a member of the extended class nursing staff;

[...]

"extended class nursing staff" means those registered nurses in the extended class in a hospital,

(a) who are employed by the hospital and are authorized to diagnose, prescribe for or treat patients in the hospital, and

(b) who are not employed by the hospital *and to whom the board has granted privileges to diagnose, prescribe for or treat patients in the hospital; ("personnel infirmier de la catégorie supérieure")*

Standard of Care

General Principle

"Every medical practitioner must bring to his task a reasonable degree of skill and knowledge, and must exercise a reasonable degree of care. He is bound to exercise that degree of care and skill which could reasonably be expected of a normal prudent practitioner of the same experience and standing, and if he holds himself out as a specialist, a higher degree of skill is required of him than of one who does not profess to be so qualified by special training and ability."

Crits v. Sylvester
Ont. C.A., approved by SCC, 1956

Discharge: Duties and standard of care

Discharge: Standard of Care

1. Has a definitive diagnosis been established?
2. Does the patient present any symptoms that could be indicative of a complication?
3. Has the patient's condition sufficiently resolved that he or she is expected to make a full recovery with appropriate home care? Does the patient understand what has to be done?
4. Have arrangements been made for the patient to receive appropriate home care, if required?

5. Has the patient been informed of any follow-up appointment or other follow-up arrangements that must be made? Do I have a follow-up system to ensure that this gets done?

Discharge: Standard of Care

6. Informed discharge: Has the patient been informed of
   a) the risk of complications;
   b) the potential severity of the complication; and
   c) the signs and symptoms that would require further attention

   such that he or she would know when to seek further medical attention?

   Has this been appropriately documented?

7. Medication reconciliation:
   a) Do I have reliable information about the medication that the patient was taking upon admission?
   b) Does the patient understand
      i) which medication are to be taken on discharge
      ii) which are the pre-admission meds that should be continued or discontinued?
      iii) which should be continued under a different dosage?
8. Do I have the necessary knowledge, skill and judgment to make this decision?

Admission

Duties and standard of care of the admitting NP

1. Ensure that the admission is "clinically required" (as of July 1, 2012)

   11(2) No physician, registered nurse in the extended class, dentist or midwife shall order the admission of a person to a hospital unless, in the opinion of the physician, registered nurse in the extended class, dentist or midwife, it is clinically necessary that the person be admitted. (O. Reg. 965)

2. Within 24 hours of admission, prepare and authenticate an admitting note that "sets out clearly the reason for admission of the patient" (as of July 1, 2012: O.Reg. 965, s. 25(1)(b))

Duties and standard of care of the admitting NP

2. Conduct a patient history and physical examination (as of July 1, 2012)

(3.2) Every board shall ensure that procedures are established in a hospital that provide, within 72 hours after a patient is admitted to the hospital by a registered nurse in the extended class, that a registered nurse in the extended class,

(a) takes a history of the patient;

(b) gives the patient a physical examination;

(c) makes a provisional diagnosis of the patient's condition; and

(d) records, dates and authenticates the history and a report of the findings of the physical examination and the provisional diagnosis of the patient.

(4) Subsections (3), (3.1) and (3.2) do not apply in respect of a patient who is re-admitted to the hospital with the same diagnosis within ten days after having been discharged.

(5) Subsections (1), (3) , (3.1) and (3.2) do not apply in respect of the repeat visits by a patient returning to the hospital from time to time for any treatment involving a series of visits for the same injury or illness.

O. Reg. 965

Duties and standard of care of the admitting NP

3. Is the admitting professional the "MRP" (Most Responsible Professional)

11. (1) No person shall be admitted to a hospital as a patient except,(a) on the order or under the authority of a physician who is a member of the medical staff;

(a.1) on the order or under the authority of a registered nurse in the extended class who is a member of the extended class nursing staff;

"extended class nursing staff" means those registered nurses in the extended class in a hospital,

(a) who are employed by the hospital and are authorized to diagnose, prescribe for or treat patients in the hospital, and

(b) who are not employed by the hospital and to whom the board has granted privileges to diagnose, prescribe for or treat patients in the hospital; ("personnel infirmier de la catégorie supérieure")

"medical staff" means those physicians to whom the board has granted privileges of diagnosing, prescribing for or treating patients in the hospital; ("personnel médical")

Duties and standard of care of the admitting NP

16. (1) If a patient is no longer in need of treatment in the hospital, one of the following persons shall make an order that the patient be discharged and communicate the order to the patient:

1. The attending physician, registered nurse in the extended class or midwife or, if the attending dentist is an oral and maxillofacial surgeon, the attending dentist.
2. A member of the medical, extended class nursing, dental or midwifery staff designated by a person referred to in paragraph 1.

O.Reg. 965

Duties and standard of care of the admitting NP

4. Provide treatment in accordance with a treatment plan:
   - a) Establish a treatment plan
   - b) Obtain the patient or the SDM's consent for the treatment plan
   - c) Diligently monitor the patient's condition and adjust the treatment plan as required
   - d) Follow-up on lab results and adjust the treatment plan as required
5. Collaborate with other members of the treatment team:
   - a) Communicate to the attending nursing staff any specific concerns
   - b) Review notes of the other members of the treatment team
   - c) Be available to provide care as required unless the care of the patient has been appropriately transferred to another health care professional (communicate treatment plan)
   - d) Consider information received from other members of the treatment team and act on it as required

Duties and standard of care of the admitting NP

18. (1) Where a person who is a member of the medical, dental, midwifery or extended class nursing staff is unable for any reason to perform his or her professional duties with respect to a patient in the hospital, the person shall arrange for another member of the medical, dental, midwifery or extended class nursing staff, as may be appropriate, to perform the person's duties.

(2) Where a person is unable to perform his or her duties as set out in subsection (1), the person shall note, where another person assumes his or her duties, the name of the person assuming the duties in the patient's medical record.

O.Reg. 965

Duties and standard of care of the admitting NP

6. Consult as appropriate
   a) State reason for consultation
   b) State type of consultation: advice or transfer
   c) Provide known relevant information
   d) Follow consultant's recommendations unless serious reason to not do so

7. Notification re: dangerous patients

   14 (1) A physician, a registered nurse in the extended class, an oral and maxillofacial surgeon or a midwife who knows or suspects that a person being admitted to the hospital on the physician's, registered nurse in the extended class's, oral and maxillofacial surgeon's or midwife's order is or may become dangerous to himself or herself or to other persons, shall forthwith notify the administrator concerning the patient. O. Reg. 965

Duties and standard of care of the admitting NP

8. Appropriately document the information collected and the care provided to the patient (section 19, O.Reg. 965)
   - Authenticate telephone orders at the next hospital visit (section 24, O.Reg. 965)

9. In case of death prior to discharge, prepare and file a medical certificate of death or a Form 1 (if a Coroner's case) in the patient's medical record (O. Reg. 965,

10. Discharge the patient when the patient no longer requires hospitalization.

Case study: Headache Management

Defendant: family md

Plaintiff: 39 y-o female patient + family

Events:

- July 2: Initial office visit – c/o chronic headaches and migraines;
  Pt Info Sheet: galbladder sx, Diazepam and Norgesic for chronic abdominal pain and headaches
  Hx: strong family history of headaches
  Dx: chronic headaches; ? Migraines
  Rx: Norgesic + Diazepam

- Aug: ER - viral illness; vomiting + nausea X 3 days
  Fam Md - UTI
  Hospital admission for investigation of abdominal and pelvic complaints

Case study: Headache Management

Events:

- Sept – Nov: 4 office visits for Diazepam - "cousin stole it", "thrown out", chronic abdominal pain - dependency on Diazepam + double –doctoring?
- Dec – Feb: 4 visits for headaches + vomiting
  "really bad headache", "clutching head" "headache continues with a vengeance", "bad, bad, bad headache"
  On occasion, last several days with multiple visits to ER and return to the office
  Rx: Fiorinal / injection of Demerol + Gravol
- March 16 -22 : severe headaches w/ nausea and vomiting - headaches started after hitting head on cement pillar in a bar after during attempt to break fight
  - 3 visits to office/ 3 ER
  - started in both temples – spread to back of head – c/o blurred vision on occasion
  - "typical of other migraines" - minimal response to Chlopomazyne + Gravol, Stemitil
  - March 22 – no relief - dehydrated and dishevelled -> admit to hospital

Case study: Headache Management

Admission March 22 – March 31:

- O/E: despite photophobia, fundi + cranial nerves N, reflexes N; slight neck stiffness?
- Provisional Dx: intractable migraine headaches, dehydration from vomiting with poor intake, hysterical personality, drug dependency tendency
- Rx: Toradol, Tylenol, Darvon plain, nerve blocks
- During admission, low grade fever (38-38.5), continued complaints of very severe headache, apparent improvement at times, frequent requests for meds; at times, speech slightly slurred, ? Neck stiffness with forced flexion?
- Investigations: repeat CBC, urinalysis, skull X-ray, CT scan, lumbar puncture
- + findings: CBC –WBC ≈15,000, toxic granulation, CSF slight xanthochromia, + red blood cells
- on D/C: intensity of headache diminishing and "reasonably controlled with meds", WBC 12,000, supple neck – Dx: likely low-grade viral meningitis with element of SAH from head trauma suffered in bar

Case study: Headache Management

Clinical Outcome:

- continued headache

  April 3 – after hour clinic – aware of prior hx of migraines and dependency - Darvon replaced with Equagesic

  April 5 – fam md – normal neuro assessment, normal T, full neck movement
  ?? Viral meningitis ? Subarachnoid bleed
  Rx: more Equgesic

  April 12 – with blurred vision – normal neuro assessment- normal BP
  - post-traumatic headaches?? Vascular headache??
  Rx: CT scan + neuro referral, Diazepam

- April 19 : admitted to hospital ; Dx: ruptured aneurysm; SAH

Case study: Headache Management

Judgment:

- Very complicated case but care fell below the standard of care

- Md discounted the significance of the plaintiffs' symptoms
  - He relied on nurses to bring to him info of significance – did not review nurses notes that contained signs and symptoms consistent with SAH from leaking aneurysm: vomiting + nausea, neck stiffness, visual disturbance, photophobia, slurred speech
  - On d/c, he convinced himself that headaches improved despite pt still describing them as severe

Case study: Headache Management

Judgment: Care fell below the standard of care:

- Md failed to adequately investigate other differential diagnosis once the symptoms did not all fit
  - Fever, elevated WBC
  - Blood in CSF but negative skull X-ray and CT scan
- Md discharged the pt while he was still confused about the diagnosis
  - ?? Viral meningitis ? Subarachnoid bleed
  - post-traumatic headaches?? Vascular headache??

Case study: Headache Management

Judgment: Care fell below the standard of care:

- Md failed to seek a consultation/refer during the admission when he did not have the necessary expertise:
  - Insufficient experience to administer and interpret LP (had not done one in 11 years; no hosp privileges to do LP)
  - Unaware of significance of blood in CSF – never encountered it before (can be indicative of leaking aneurysm)
  - Complicated case – unsure about diagnosis
- Md failed to seek an urgent consultation once he started to suspect SAH
  - "when a potentially life-threatening condition is included in a differential diagnosis, there is a duty on the physician to take prompt steps to confirm or rule it out with reasonable dispatch"

Liability considerations

1. Failing to obtain appropriate history and doing appropriate physical examination
2. Failing to follow-up on lab and other test results
3. Failing to appreciate and react in a timely manner to change in patient's signs and symptoms
4. Failing to seek consultation when required
5. Inadequate communication: Failing to react in timely and appropriate fashion to information reported by other members of the treatment team (nursing staff)
6. Inappropriate discharge
   - Too early
   - Insufficient information

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