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RISK MANAGEMENT PRESENTATION TO RNAO:

PITFALLS OF PRACTICE-AVOIDING MALPRACTICE CASE STUDIES

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Agenda

- Malpractice
  - Negligence/Malpractice
  - Other sources of liability
  - Categories of nursing malpractice
- Case Study #1 (RN)
- Case Study #2 (RN)
- Case Study #3 (NP)
  - Discussion:
    - How was the standard of care breached?
    - How was the matter resolved?
    - How could have the breach (malpractice) been avoided?

Malpractice

- What is Negligence?
- “The applicable standard of care for a nurse is that of an ordinary skilled person exercising and professing to have the skills of a nurse and must reflect the education, training, experience and knowledge of the ordinary skilled nurse.”

Skeels (Estate of) v. Iwashkiw, 2006 ABQB 335

Malpractice

- What is Negligence/ Malpractice?
  - Breach of a duty to take care
  - “Reasonable Prudent Person” test
  - Errors in judgement, or unexpected or unintended medical consequences do not necessarily mean negligence
  - Malpractice- instance of negligence on the part of a professional that results in injury or damage to a patient

Malpractice

Elements of Malpractice:

1. Duty: exists? scope?
2. Breach of Duty: departure from good and accepted practice
3. Damages
4. Causation: link between the action/inaction that did not meet the standard and the injury

Malpractice

Other sources of nursing liability:

- Legislation (Ontario):
  - *The Nursing Act, 1991*
  - *Regulated Health Professionals Act*
- Regulatory/Governing Bodies (i.e. CNO)
- Employer policies, professional literature, expert opinions
- All help to define the standard of care

Malpractice

Categories of Negligence

- Failure to follow standards of care
- Failure to use equipment in a responsible manner
- Failure to communicate
- Failure to document
- Failure to assess and monitor
- Failure to act as a patient advocate

Case Study #1

- Facts:
  - RN treated a patient who attended to the ER in a sickle cell crisis
  - Physician directed RN to administer 15mg of Dilaudid via IV push
  - RN claimed administered the drug via “piggyback IV” but did not document how the drug was administered
  - RN provided evidence that he was monitoring the patient throughout
  - Only 2 documented patient “checks” over a 10 hour period
  - Patient went into a coma and died 13 months later

Case Study #1

- How was the standard of care breached?
  - Failure to act as patient advocate/intervene (RN failed to question the dosage of the medication)
  - Failure to document (RN failed to document how drug was administered or exact time it was administered)
  - Failure to assess and monitor (RN did not have evidence that patient was adequately monitored)
  - Failure to document the monitoring of the patient

Case Study #1

- How was the matter resolved?
  - Due to the marked departures from the standard of care a decision was made to settle out of court
  - Global settlement reached
  - Records indicate $1M of total settlement amount apportioned to the RN due to the breach of the standard of care

Case Study #1

- How could the breach (malpractice) been avoided?
  - **Knowledge** of applicable laws/rules and regulations and incorporate into practice
  - Always act as a **patient advocate** and ensure proper care is given when needed (questioning the dose)
  - **Document** all care (method of medication administration/dosage/timing) and all significant information regarding the patient (patient's vital signs, symptoms, response to treatment)
  - **Monitor** all vital signs, symptoms and response to treatment

Case Study #2

- Facts:
  - RN flight nurse treated an intubated baby about to be transferred
  - RN repeatedly questioned physician about size of tube and eventually removed the tube and attempted to insert a different sized tube 3 times
  - Attempts by RN were unsuccessful and upon hearing alarm that baby was in distress physician had to re-intubate using original size tubing
  - In the meantime, baby underwent oxygen deprivation and as a result suffered severe brain damage/permanent respiratory issues
  - Hospital RN remained in the room and took no action

Case Study #2

- How was the standard of care breached?

  Flight RN:

  – Failure to use medical equipment in a responsible manner (using the incorrect tube)

  – Failure to follow the correct procedure for a specific skill

  – Failure to act as patient advocate(ensuring patient received the appropriate care)

  – Negligently following otherwise proper orders (removing the original tube and attempting to insert a different tube)

Case Study #2

- How was the standard of care breached?

  Hospital RN:

  – Failure to inform physician/other hospital staff that flight RN had removed the tube or that intubation attempts were unsuccessful

Case Study #2

- How was the matter resolved?
  - Out of court settlement
  - The flight RN and the hospital RN EACH contributed $1M towards the total settlement amount due to the breached standard of care

Case Study #2

- How could the breach (malpractice) been avoided?
  - Flight RN:
    - **Follow proper orders** and maintain original tube size as ordered
    - **Monitor** condition of patient
    - **Summons help** as soon as initial re-intubation effort failed
  - Hospital RN
    - **Communicate** and inform physician that original tube had been removed by Flight RN
    - **Summons help** as soon as initial re-intubation effort failed

Case Study #3

- Facts*:
  - 9 year old boy developed flu-like symptoms (vomiting, dehydration, weakness)
  - After 3 days father called pediatrician and spoke with on-call NP
  - Father advised of symptoms, Gatorade making child nauseous, taking some ginger ale, concern over how tired boy was (had slept for almost 24hrs) and also reported rectal bleeding and bleeding from mouth

* Case from CRICO, professional liability insurer for the Harvard medical community

Case Study #3

- Facts…
  - NP noted symptoms appeared to be virus related, with exception of rectal bleeding
  - NP asked questions of boy's current state and also whether father thought child was "OK" for the night without being examined
  - Father indicated he thought he was "OK"
  - Father asked whether he should avoid giving the boy any food and NP advised to push ginger ale and appointment made for morning
  - NP made a note that father was offered an examination (despite what was audio recorded)
  - Boy died in the night
  - Cause of death found to be diabetic ketoacidosis

Case Study #3

- How was the standard of care breached?
  - Failure of the NP to adequately assess symptoms of the boy (bleeding from 2 sites, extreme lethargy symptoms of potentially life threatening illness)
  - Inadequate communication between NP and father (NP thought she had offered visit)
  - Poor documentation (documented notes of NP did not reflect the recorded conversation)

Case Study #3

- How was the matter resolved?
  - Parents sued NP and alleged wrongful death of son due to negligent delay in diagnosis and treatment of diabetic ketoacidosis
  - Matter was settled in the high range against the NP

Case Study #3

- How could the breach (malpractice) been avoided?
- Due to unclear symptoms and the inability to determine potential cause, NP should have properly **assessed and monitored** and directed the father to send the boy to be immediately examined
- NP should have reviewed during call to ensure adequate **communication** to father of the nature of the symptoms, what actions to take and specific instructions when to go to emergency department
- NP should have carefully and accurately **documented** details such as: specific complaints, assessment, final advice

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Questions?

Thank you