Nurses and Medical Malpractice

CASE STUDY WITH RISK MANAGEMENT STRATEGIES

Presented by NSO and CNA

Medical malpractice claims can be asserted against any healthcare provider, including nurses. Although there may be a perception that physicians are held responsible for the majority of lawsuits, the reality is that nurses are more frequently finding themselves defending the care they provide to patients. In fact, over $87.5 million was paid for malpractice claims involving nursing professionals, according to a CNA HealthPro 10-year study*

Case Study: Medication Administration Error and Failure to Monitor

Settlement: $100,000 **Legal Expenses:** $6,152

Note: There were multiple co-defendants in this claim who are not discussed in this scenario. While there may have been errors/negligent acts on the part of other defendants, the case, comments, and recommendations are limited to the actions of the defendant; the intensive care unit nurse.

A 23-year-old woman with no significant medical history presented to the emergency room with flu-like symptoms. She complained of generalized body ache and had a fever of 102.6. For the past two weeks, she self administered over-the-counter medications with no relief. Instead, her condition deteriorated and she developed both shortness of breath and a cough. Her worsening symptoms motivated her to seek care a local emergency room.

Following an abnormal CT Scan of the chest (near-complete collapse of right upper lobe, large consolidation of the right lower lobe, and moderate consolidation of the left lower lobe of the lungs), an elevated white blood count (19,500), abnormal liver function tests and an abnormal coagulation profile, the emergency department physician admitted the patient to the intensive care unit under the care of an attending physician. The patient was started on oxygen and antibiotic therapy. Blood cultures were drawn and showed Streptococcus Pneumoniae and antibiotics were appropriately adjusted per recommendation of the infectious disease specialist.

The attending physician first saw the patient in the intensive care unit. At the time of his initial exam, the patient was not in significant respiratory distress, was responding well to the oxygen and antibiotic therapy, and was subsequently continued on the same therapy. The attending physician noted that while the patient was not in acute distress, her blood chemistry was abnormal with a potassium level of 2.9 (normal range is 3.5 to 5.0). The physician ordered 30mEq of potassium to be added to each bag of the patient's intravenous fluid, infused at 80 milliliters per hour. The order was to be maintained through the remainder of her course of treatment.

Two days later and despite the potassium added to her intravenous fluids, the patient's potassium level was noted to be 3.0 and the attending physician ordered 80 mEq of potassium to be administered by mouth. The patient vomited the medication (amount retained undetermined). The attending physician then ordered two doses of 40 mEq of intravenous potassium to infuse over a four hour time period with the plan of increasing the potassium level between 4 and 4.5. Documentation is problematic. It appears that despite the order for two doses of potassium 40 mEq to be infused over four hours, the intensive care unit nurse administered two intravenous potassium doses of 20 mEq over approximately one hour (documentation regarding this is inconclusive).

Throughout the day the intensive care unit nurse documented the patient's heart rate in the patient care record. At 7:30 a.m. it was 72 beats per minute, at 1:30 p.m. it was 96 beats per minute and at 4:30 p.m. it was 116 beats per minute. The patient's blood pressure remained stable at 120/80. The intensive care unit nurse did not specifically notify the physician of the pattern of rising heart rate. When the physician saw the patient that day, he noted that the patient's white blood cell and platelet counts remained higher than normal but were dropping. In addition, her vital signs were within normal range and she was not in respiratory distress. He ordered a pulmonary consult for possible bronchoscopy but deemed that she was stable, and that vasopressors and aggressive pulmonary treatment were not necessary at that time. He ordered the patient to be transferred to the telemetry unit.

The intensive care nurse's documentation fails to provide the exact time of transfer from the intensive care unit to the telemetry unit although it appears to have been between 7:15 p.m. and 7:30 p.m. The documentation also fails to validate the intensive care nurse's statement that the patient was on a cardiac monitor during her intensive care stay and that she was transferred to the telemetry unit with a cardiac monitor and oxygen therapy. The telemetry unit nurse stated the patient did not arrive with a monitor. Other telemetry unit staff indicated that the telemetry unit was in an overflow situation when the patient was transferred and the central monitoring station was not functioning. Regardless of the actual reason, there are no telemetry unit electrocardiogram strips for this patient.

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According to hospital records, the attending physician was called at approximately 10:00 p.m. and was advised that the patient had gone into cardiac arrest. The on-call emergency physician attempted to resuscitate, but was unable to obtain a heart beat and the patient was pronounced dead.

The family of the deceased sued the attending physician, the hospital and three of the hospital's registered nurses, and sought $3,000,000 in damages. The allegations against the intensive care unit nurse included alleged failure to properly administer the medications as ordered by the physician and failure to notify the attending physician of significant changes in the patient's vital signs and laboratory results.

Initially, the defense team felt the intensive care unit nurse had a strong case. She stated she had done nothing wrong. She indicated that she did not believe that she had enough experience and should not have been working in the intensive care unit. Despite her limited clinical skills, she believed she followed the physician's orders appropriately and documented her actions thoroughly. She recalled administering the potassium and believed she had advised the physician when necessary. She further believed she had properly documented her actions throughout her care to the patient.

When an expert witness examined the case, he noted that the intensive care unit nurse administered an incorrect dosage of medication over a shorter period of time. The expert also noted that nursing protocols required that the discharging intensive care unit nurse should have specifically noted the time of transfer, the patient's condition at that time, the patient's current treatment, the patient's response to treatment and the specific equipment transported with the patient. Documentation of these items is inadequate or missing. The intensive care unit nurse's notes suggested that the patient's heart rate had increased at an alarming rate that day and this should have resulted in the nurse calling the attending physician to assess the impact of the patient's rising pulse on the transfer and medication orders.

Resolution

After the expert witness stated the intensive care unit nurse's care and treatment of the patient was not medically defensible, the claim against her settled at mediation for $100,000 with an additional $6,152 in legal expenses. The total settlement amongst all of the defendants in the case was $1.4 million.

Risk Management Comments

- The intensive care unit nurse failed to notify the physician that the patient's heart rate was continuing to rise. She failed to follow the physician's medication orders by administering an incorrect dosage of potassium at an incorrect rate. She then failed to properly document her actions.
- The intensive care unit nurse also failed to provide a full report to the telemetry unit nurse at the time of transfer and during the handoff process, including the information that the patient required oxygen and was on continuous monitoring.
- The intensive care unit nurse indicated to her attorney that she believed she did not possess the clinical skills to work in the intensive care unit but there is no information as to whether she requested a change in assignment, a mentor or close supervision by a trained intensive care nurse.
- The handoff process between the intensive care unit nurse and the receiving telemetry unit nurse was improper because it did not include the following:
  - reconciliation of medications ordered and administered
  - report of the patient's rising heart rate
  - results of ordered laboratory tests
  - list of outstanding test results
  - notification of whether the physician was made aware of the vital signs
  - change in the patient's general condition
- There is no documentation to verify that the patient was transferred with a cardiac monitor and oxygen via nasal cannula as ordered.

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Risk Management Recommendations

- When assigned to a clinical area, the nurse's training and experience should provide the skills necessary to demonstrate competencies required for performing the nursing role specific to the clinical specialty or area. If not, it is the responsibility of the nurse to:
  - **Notify the charge nurse** and/or supervisor that the assigned clinical area is outside the nurse's training and experience. The nurse should explicitly note his/her lack of training and experience in that area/specialty and request an alternate assignment.
  - **Request close supervision and/or the assistance of an experienced nurse** if the assignment is not changed to an area/specialty where the nurse is trained and experienced and request all treatments and medications be checked prior to administration.
  - **Obtain assistance for lack of complete understanding** of any aspect of the patient's condition, plan of care, progress notes, physician orders and/or medication orders.
  - **Utilize the chain of command, including the director of nursing and/or hospital administrator,** until provided with an assignment appropriate to his/her level of training and experience or that appropriate support and supervision with an experienced nurse is provided.
- **Monitor and document the patient's vital signs, symptoms, response to treatment and changes in condition** in the patient care record.
- **Timely report all significant findings to the patient's physician.**
- **Adhere to physician medication orders including the correct drug, dosage, route and administration times.**
- **Contact the physician and/or pharmacist** with questions, concerns or to obtain clarification regarding the medication(s) ordered for the patient. If the physician does not respond in a timely manner, follow the chain of command to the point of resolution.
- **Manage any deviation from the physician's order regarding administration of a medication as a medication error including reporting, investigating and developing** a plan of correction to prevent subsequent recurrences.
- **Perform and document formal handoff procedures when transferring a patient and report all significant patient information** regarding the patient's treatment, including a review of treatments, tests, medications and outstanding orders, to the accepting nurse.

Guide to Sample Risk Management Plan

Risk Management is an integral part of a healthcare professional's standard business practice. Risk management activities include identifying and evaluating risks, followed by implementing the most advantageous methods of reducing or eliminating these risks - A good Risk Management Plan will help you perform these steps quickly and easily!

Visit **www.nso.com/riskplan** to access the Risk Management plan created by NSO and CNA. We encourage you to use this as a guide to develop your own risk management plan to meet the specific needs of your healthcare practice.

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*CNA HealthPro Nurse Claims Study: An Analysis of Claims with Risk Management Recommendations 1997-2007, CNA Insurance Company, April 2009. To read the complete study visit www.nso.com/rnclaimstudy

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