

Legal Issues in Nursing; Assessment

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The second of a series of four articles on the 5 most common allegations associated with nursing negligence lawsuits.

The first article in this series included a case study about a medical malpractice lawsuit involving a lack of communication. You may recall that Dave's right tibia was fractured when he was hit by a car. The tibia was successfully repaired, but post-operatively, Dave 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. Dave was ultimately diagnosed with compartment syndrome, had a below the knee amputation and filed a multimillion dollar lawsuit, suing both the nurses and doctors. 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 the 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 completed according to doctors' orders, current standards of care, best practice guidelines, facility policy and, most importantly, according to each patients' individual condition. The courts 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. That said, in all situations, the expectation for nursing care 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, but it doesn't always happen.

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. This 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 the pulse and respiration rates every half hour overnight, 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

At 2:30 p.m. a 57-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 occasionally 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 assigned to Nurse 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 she touched Margaret's arm, she noted that her skin felt cool. 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, 3 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 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 as seen at 10:20 p.m. can indicate the onset of shock. 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 that earlier medical intervention could have prevented, or lessened the extent, of her injuries.

Do you think Nurse Amy met the standard of care? How do you think this lawsuit turned out for Nurse Amy? Learn the rest of the story at:

https://www.connectmlx.com/index.php?option=com_content&view=article&id=59:case-outcome-2&catid=2:uncategorised

This article was written by Chris Rokosh RN, PNC(C), Legal Nurse Consultant and president of Connect Medical Legal Expert. Chris is a popular speaker on legal issues in nursing across Canada and the US. If you want to learn more about this topic, go to the website www.ConnectMLX.com for a list of available courses.



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