

Miscommunication the Leading Cause of Malpractice Lawsuits Against Nurses

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This article is the first of four in a series exploring the most common nursing negligence issues in Canada.

When nursing or medical errors cause lasting injury, patients may file a medical malpractice lawsuit against the nurses and doctors who cared for them.

Nurses who have experienced a lawsuit describe it as extremely difficult – a life event equal to other catastrophes such as death, divorce and job loss. It adversely affected their work life, personal life, health and wellbeing. Emotions such as shock, shame, anger, depression and fear were common. Many nurses felt so isolated and abandoned by their peers that they eventually quit their jobs. Nobody wants to go through this.

The outcomes of medical malpractice lawsuits affect patients, healthcare professionals, public funding and the institutions that provide healthcare. However, a workplace culture of denial and shame can keep us from talking about the incidents that lead to lawsuits, or using them to learn and improve. So, let's talk about the most common nursing issues that result in malpractice lawsuits with a goal of gaining knowledge, avoiding errors and improving patient safety.

You may be surprised to learn that communication – or more specifically, a lack of communication – is cited as the leading cause of nursing negligence lawsuits. Research shows that as many as 70 percent of medical errors involve some form of communication breakdown between the doctor and the nurse.

The courts view of communication is that it is a critical part of any nurse's 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 informed of important aspects of their patients' condition. The nursing and medical experts who review malpractice cases say that nurses are required to relay important information to the doctor according to their knowledge, 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 the appropriate people through the appropriate channels.

Throughout my career as a Legal Nurse Consultant, I have reviewed more than 1,000 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 either a change in a patients' condition with no documented communication to the doctor, or a phone call followed by documentation that simply states, 'doctor aware'.

The nursing notes do not say which doctor is aware, what they were told, what they were asked to do or what their response was. If the patient later develops an injury and launches a lawsuit, the doctor might say, "Yes, the nurse phoned, but didn't tell me how serious the situation was. If I'd

known, I would have attended to the patient immediately.” Without supportive documentation in the medical record, this can result in a showdown of the nurse’s word against the doctors’. It will be up to the courts to decide who said what and if the nurse met the standard of care in the area of nurse/physician communication.

Here’s an example of a medical malpractice case involving a lack of communication:

One summer evening at 7:30 p.m. Dave Johnston, 17, was struck by a car as he crossed the street on his skateboard. The force of the impact threw him onto the hood of the car, smashed the windshield and fractured his right tibia. He was taken to the E.R. by ambulance. The paramedics noted his right leg had an obvious deformity and his calf was very swollen. The toes on his right foot were cyanosed. His foot had normal sensation but limited movement and decreased pulses. Dave was in a lot of pain.

At 10:45 p.m. Dave was transferred to the O.R. for Intramedullary Nailing of the right tibia. Following surgery, the incision was covered and the leg was stabilized with a back ‘slab cast’ wrapped in a tensor. Dave was transferred to the recovery room ‘in good condition’.

Shortly before 1 a.m. Dave was transferred to the post surgical nursing unit, where he was cared for by RN Donna.

At 1:45 a.m., Donna documented Dave was awake, swearing and complaining of ‘excessive pain’. His right toes were described as ‘pink and warm’ with normal movement. The nurse noted that Dave only had ‘fair relief’ from the multiple doses of IV morphine he had been given post operatively. And that the doctor was aware.

15 minutes later, Donna documented that Dave was awake and oriented. The colour, sensation and movement to his right foot were described as ‘good’ with a capillary refill time. Dave was noted to have ‘severe weakness’ and tingling in his right leg. Over the next 6 hours, Donna documented information regarding Dave’s medications, sleeplessness and intake and output, but there was no further assessment of the colour, warmth, sensation or movement of his foot.

At 8 a.m. RN Lucinda came on shift. She described Dave as confused. He was not able to correctly identify the month or where he was. He only opened his eyes when spoken to. His right leg was again noted to have ‘severe weakness’ and he refused assistance with bathing, insisting to be left alone. Serosanguinous drainage was noted on pillow underneath Dave’s leg. Nurse Lucinda did not document colour, warmth, sensation or movement of the right leg.

At 9:20 a.m. Dave was noted to be ‘yelling and complaining of pain’. Lucinda documented that his parents were at his bedside, and that she reassured them that the amount of pain and drainage were normal for the type of surgery Dave had.

At 12:00 noon Lucinda documented: ‘Right leg remains in slab cast, small amount of sanguineous 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.’

An hour later, a physiotherapist arrived to teach Dave how to walk with crutches. He described Dave as ‘anxious ++, yelling out when moved’. Dave refused to get out of bed.

At 1:25 p.m. orthopedic resident Dr. Smithson arrived on the unit. He noticed that Dave had extreme pain, decreased sensation in his right foot and was unable to point or flex his toes. Dave’s toes were cool and cyanotic. Dr. Smithson removed the cast, measured the pressures in the calf muscles and diagnosed post-traumatic Compartment Syndrome. Dave was taken back to the OR for fasciotomies to relieve the pressure. Following surgery, he developed multiple complications. The leg became infected and necrotic despite surgical intervention and arterial grafting. Two weeks later, it was amputated below the knee.

Dave remained in hospital for several weeks. Eight months after discharge, his family filed a multimillion-dollar lawsuit against the doctor, nurses and hospital claiming, among other things, that Nurse Donna and Lucinda failed to communicate important information to the doctor. They claimed that the standard of care required them to communicate Dave's pain, weakness, sensory loss and colour change to the doctor as soon as they were noticed. They also claimed that if the doctor had been called earlier, that Dave would not have lost his leg.

Do you think the nurses met the standard of care in their communication with the doctor? How do you think this lawsuit turned out for the nurses and the doctor? Learn the rest of the story at: <http://www.connectmlx.com/Compartment-Syndrome>

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