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Perianesthesia Nursing Malpractice: Reducing the Risk of Litigation

Lyerla Frank, PhD, RN, Jamie Danks, BSN, RN, MSHI

Nursing malpractice claims are escalating, which equates to a higher risk of being named in a lawsuit and possibly defending one's actions in court. The perianesthesia nurse is at particular risk because of patient involvement before, during, and after surgical procedures. To minimize this risk nurses should have a clear understanding of how a malpractice claim proceeds and the common incidents involved. Three perianesthesia case studies are presented that identify potential nursing litigation threats and strategies to reduce those threats.

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OBJECTIVES—1. Describe the legal process associated with litigation cases. 2. Discuss system designs that have potential for poor patient outcomes and subsequent malpractice claims. 3. Identify strategies to optimize patient outcomes and reduce the risk of litigation.

Perianesthesia nurses are at risk for being involved in malpractice litigation. When this occurs it is typically in conjunction with a lawsuit filed against the nurse's institutional employer. According to a 2015 claim report from the Nurses Service Organization, over $90 million was paid in nurses' malpractice claims between 2010 and 2014.[1] The claim report also states that average claim costs are rising, with higher indemnity payments involving nurses with less than 6 years of experience. Although the nursing care involved in a malpractice claim may have been excellent, it is

another thing to prove it. The purpose of this article is to first describe the legal process as it relates to nursing malpractice claims. Perianesthesia case studies that identify potential litigation threats and strategies to reduce those threats will then be discussed.

Legal Process

Malpractice claims fall under state jurisdiction, which means that processing may vary from state to state. The statute of limitations also varies from state to state. Most US states have a 2 to 3 year time period after the incident in which a claim must be filed. However, exceptions for longer time periods are made when children are involved or when the incident is not discovered until a time later than it occurred. Most litigation cases involving nurses generally occur several years after the incident. Nurses may not remember the incident, and therefore rely on their documentation to defend their actions.

Within a malpractice claim, the plaintiff's attorney has the burden of proof, which involves four primary elements: (1) a nurse-patient relationship exists; (2) the provision of care fell below the standard of care; (3) the nurse's action or lack of action resulted in harm; and (4) damages were sustained by the patient as a result. Malpractice claims

Lyerla Frank, PhD, RN, Department of Primary Care and Health Systems, Southern Illinois University Edwardsville School of Nursing, Edwardsville, IL; and Jamie Danks, BSN, RN, MSHI, BJC Healthcare, Saint Louis, MO.

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Address correspondence to Lyerla Frank, Alumni Hall, Southern Illinois University Edwardsville, Box 1066, IL 62026; e-mail address: flyerla@siue.edu.

may allege that a nurse was careless or negligent in the care provided. Negligence is defined as "failure to exercise the care toward others which a reasonable or prudent person would do in the circumstances, or taking action which such a reasonable person would not."[2] Reasonable care is based on the standard of care as it relates to the incident. Standards of care are derived from publications (journals, textbooks, and scope and standards of practice), state practice acts, facility policies and procedures, and expert nurses.

Once a claim is initiated, the plaintiffs and defendants are identified in addition to the negligent behaviors and injuries sustained by the plaintiff. Health care records are requested, reviewed, and marked as exhibits. Depositions of the people involved are taken with expert witnesses usually being deposed last. Some cases go on for several years after the claim is filed and new information is uncovered, leading to additional allegations that require additional depositions. If the case is not settled out of court, the case goes to trial. During the trial, a jury listens to both sides and makes a decision.

Common Malpractice Claims

The most common issues involved in nursing malpractice claims have been identified as (1) failure to follow a standard of care; (2) failure to communicate; (3) failure to document; (4) failure to assess and monitor; (5) failure to act as a patient advocate; and (6) improper delegation.[3] The most common malpractice claims reviewed by the authors have included failure to institute a fall prevention protocol, failure to document, failure to initiate the chain of command, failure to report abnormal assessment data, and failure to manage and maintain an adequate hospital information system. Although all the cases mentioned previously have relevance for the perianesthesia nurse, three specific cases will be discussed.

Case Study Examples

Clinical Query Refinement

Clinical query refinement is the process of providing correctly spelled suggestions for clinical search terms that closely match what the user has entered. The perianesthesia nurse often reviews home medications before admitting a patient for a surgical procedure. Patients rarely bring a legible list of accurate and current medications, which means the nurse needs to interpret the voiced medications or transcribe the handwritten ones. With the plethora of medications available it is nearly impossible for the nurse to be familiar with all medications. One legal case involved the use of a well-known health care information system (HIS) and an antibiotic with a common generic spelling of cephalexin. A less common alternative spelling of this drug is cefalexin (spelled with an "f" instead of a "ph").[4] In this case the nurse was conducting a home medications' review before admitting a patient for surgery and opted to enter the less common spelling of the antibiotic. Although the HIS did have a drug entry autopopulation feature, it did not recognize the antibiotic when spelled in the less common way. The nurse therefore entered OTHER for the antibiotic and typed cefalexin within the comments section. A few days after the surgery the patients home medication list was used to conduct the medication reconciliation before being transferred to a rehabilitation center. The home medications transfer form was printed with the antibiotic titled OTHER listed as a home medication. However, the comments section (in which the nurse had entered cefalexin) was not added to the form. The antibiotic was discontinued by the physician and therefore not continued at the rehabilitation center. The patient suffered a debilitating infection several days later. The claim was made that if the more common spelling had been used, a clinician would have recognized that the antibiotic had been discontinued by mistake and corrected the error, thus preventing the infection.

Query refinement may be most recognizable when used by web search engines such as Google. Google uses a formula to calculate a query rank.[5] The formula takes into account frequency and alternate or even misspelled terms to provide refined suggestions. This type of technology has been in place for many years and would be beneficial to the health care industry. In the aforementioned case study, the integration of query refinement technology might have prevented the legal action taken against the health care facility. However, until the HIS vendors start integrating clinical query refinement, it is important for health care facilities

to ensure complete medication information is included in the discharge or transfer forms.

Discharge Instructions

Perioperative patients are inundated with instructions and education related to upcoming and post-operative surgeries or procedures. Written discharge instructions after a surgery are necessary to ensure patients have the right information when needed. Many factors play a role in the patient's ability to retain the information provided preoperatively and postoperatively. Often stress, medications, and sedation play a large role in the ability of the patient to retain information voiced to them before discharge. Patients often rely on their printed discharge instructions to ensure an optimal recovery. It is important to consider patient literacy levels and individualized instructions so that patient's can understand and find their instructions meaningful. In one case, a patient was being seen by his physician and the decision was made to proceed with a surgical procedure. The patient's physician provided written postoperative discharge instructions before leaving the office. The instructions specified that the patient was to ambulate four times per day for 20 minutes each time. On the day of surgery the patient was provided additional printed discharge instructions by the nurse at the hospital. These instructions had been previously approved by the facility for this type of surgical procedure and were automatically generated from the facilities HIS. The instructions indicated the patient could ambulate as much as preferred but not more than 15 minutes each time with a minimum of 60 minutes of rest and 20 minutes of ice in between. On returning to the physician's office for follow-up care, the physician noted marked swelling of the surgical site and questioned the patient on his activity. The physician found the patient was not following his recommendation of ambulating four times a day for 20 minutes and was instead ambulating more than twice what he had recommended. The patient provided the instructions he obtained from the nursing staff at discharge from the hospital. It was identified that the physician's postoperative discharge instructions did not match the discharge instructions provided by the nursing staff. Further investigation revealed that there was not a standardized process for reviewing and comparing the automated discharge instructions provided by the hospital and the discharge instructions from the physician's office. This allowed for conflicting information to be provided to the patient.

Many of today's HISs have automated discharge instructions as a standard function. In court these types of automated instructions are sometimes negatively referred to as "canned instructions." Although certain types of automated instructions are quite beneficial, it is essential that they allow for individuality. In addition, standardizing and coordinating a review process for discharge instructions within the HIS and synchronizing them with other systems can prevent incorrect or conflicting information from reaching the patient.

Policy and Procedure Accessibility

Policy and procedure instructions are integral for all forms of nursing care. They are what nurses use to adhere to professional practices, promote compliance, reduce risk, standardize practice, and serve as a resource.[6] Liability claims may allege that nursing or medical staff failed to adhere to the facility's policy and procedures. Organizations should have standardized policy and procedure review processes in place and subsequently provide staff with notification when changes are made. A nurse's failure to know, follow, or act on a policy or procedure opens that nurse and facility up to litigious proceedings. Historically hospital committees would regularly meet to review and update policies and procedures. When changes were made, the revisions were printed and placed into a large binder on each clinical unit to be used as a reference. Although alphabetizing the binder helped, it was not always easy for the nurse to locate desired information. For example, would instructions for changing a central line dressing be found under the letter "D" for dressing or "C" for central line or possibly something else. The nurse experiencing difficulty locating the desired information may cease their search and rely on previous experience, which may not be in alignment with the policy.

Following the adoption of electronic medical records (EMRs), policies and procedures are now being converted to an electronic form. These electronic documents are frequently uploaded within the facility's intranet. Access often requires

the nurse to log out of the clinical documentation section of the EMR and access the facility's intranet. Finding the desired information is far from intuitive and often requires numerous mouse clicks just to get to the policy and procedure search field. Once the search field has been found, the nurse is still left with the same challenge as in the binder days of guessing as to what title the desired information has been categorized under. A time-consuming search may prompt the nurse to again rely on previous experience instead of following the facility's adopted policy or procedure.

One solution to the problem of policy and procedure accessibility would be to link appropriate policies and procedures to the clinical documentation section of the EMR. Many EMRs automatically calculate risk scores based on information provided by the nurse. For example, a perioperative nurse working in recovery must assess and document a variety of factors prior to moving their patient to a surgical floor. The Aldrete scoring system is frequently used to determine when that patient is ready to be transferred, as well as other appropriate interventions. The EMR uses the assessment data to automatically calculate the Aldrete score. Optimization should be developed to allow the nurse to simply click or hover over the score to see what the facility's policy states about the value. In instances where the value is outside the acceptable range, it would be optimal for a pop-up alert to be displayed notifying the nurse of the critical value and the interventions needed, such as notifying the surgeon or anesthesia provider. Areas of the EMR that calculate patient risk scores, including falls, skin breakdown, sepsis, and others would benefit from this type of decision support. In addition, decision support for procedures that specify the correct way to conduct an intervention (such as a central line dressing change) would also be beneficial.

Conclusions

Perianesthesia nurses are at particular risk of being named in a litigation case because of their involvement before, during, and after patient procedures and surgeries. Because of this risk, nurses should be aware of legal process and common malpractice claims. It is also beneficial for nurses and administrators to identify less than optimal HIS designs that can be used against them in court. Finally, HIS vendors should be made aware of optimization strategies that can improve patient outcomes and reduce the risk of litigation.

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1.0 Contact Hours

Purpose of the Journal of PeriAnesthesia Nursing: To facilitate communication about and deliver education specific to the body of knowledge unique to the practice of perianesthesia nursing.

Outcome of this CNE Activity: To enable the nurse to increase knowledge on strategies to reduce the risk of litigation.

Target Audience: All perianesthesia nurses.

Article Objectives

1. Describe the legal process associated with litigation cases
2. Discuss system designs that have potential for poor patient outcomes and subsequent malpractice claims
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