Objectives

- Identify major issues prompting malpractice claims.
- Identify CRNA risk management issues.
- Identify tips for improved / defensible documentation.
Topics of Discussion

- Medical Malpractice
- Major categories of liability/risk
- Value of documentation
- Tips for improving documentation
- Examples and Case Studies
Elements of Malpractice Lawsuit

- Duty
- Breach
- Proximate Cause
- Injury/Damages
  - Economic
  - Noneconomic
Duty and Breach of Duty

- Health Care Provider / Patient relationship

- In performing professional services, a physician has a duty to exercise such reasonable care, diligence, and skill as are ordinarily possessed, exercised by, and expected of physicians in the same general line of practice.
Breach of Duty

- Breach of Duty
  - Failure to follow Standard of Care
    - Expert Testimony
    - Practice Standards
    - Role of Literature
Practice Standards vs. Standard of Care (SOC)

- SOC – what others in the profession would do under similar circumstances
  - Practice standards not relevant unless expert says so
  - Established by “conduct”
  - Complicated process unique to each fact scenario

- AANA Scope and Standards for Nurse Anesthesia Practice
Proximate Cause

- A proximate cause is a cause which, in natural and continuous sequence, produces the injury, and without which, the injury would not have occurred. It is a cause which had a substantial part in bringing about the injury either immediately or through events which follow one another.
Injury/Damages

- Economic
- Noneconomic
Issues Prompting Medical Malpractice Claims:

- Failure to Monitor
- Failure to Document
- Failure to Follow Standards of Care
- Failure to Notify/Communicate with the Physician
- Failure to Advocate
Leading Causes of Anesthesia-Related Malpractice Claims

- Death
- Nerve Damage
- Brain Damage
- Chronic Pain Management
Failure to Monitor

- Incomplete assessments
- Erroneous interpretation of signs & symptoms
- Failure to respond to complaints or taking inappropriate or no actions
Failure to Document

- Fail to record all pertinent data
- Fail to record specific instructions
- Fail to document patient progress and response to treatment
- Altering a medical record
Failure to Follow Standard of Care

- Fail to follow hospital protocols
- Fail to check equipment for safe usage
- Fail to follow physician’s orders
Failure to Notify
Failure to Communicate

- Delay or failure to call physician
- Fail to listen to patient’s complaints & act on them
- Failure to follow chain of command to seek higher authority for treatment
Miscommunication is the most common cause of injury or death.

JCAHO, 2004
Failure to Advocate

- Fail to question orders when patient condition warrants
- Fail to question incomplete or illegible orders
- Fail to provide a safe environment
- Fail to protect patient privacy
Adverse Event? What now?

- Note in chart
  - Describe event
  - Drugs used
  - Time sequence
  - Who present

- Be honest with patient & family
  - “I’m Sorry” Statute – NDCC § 31-14-12

- Notify Risk Management
HIPAA/HITECH and Social Media

- PHI
- Privacy Rule
- Written and Electronically Transmitted
- Fines and Criminal Penalties
- Social Media
  - Facebook
  - PDA/Cell Phone
“Whoa! That was a good one! Try it, Hobbs — just poke his brain right where my finger is.”
Malpractice Payments by Nursing Category

Year | Nonspecialized RNs | Nurse anesthetists | Nurse midwives | Nurse practitioners | Totals |
--- | --- | --- | --- | --- | --- |
1998 | 139 | 68 | 28 | 18 | 253 |
1999 | 185 | 68 | 44 | 25 | 322 |
2000 | 248 | 55 | 35 | 22 | 360 |
2001 | 236 | 85 | 55 | 37 | 413 |

Note: Annual subtotals for 1990–1997 are unavailable.
Incidence of Nursing Negligence Allegations by Setting

Note: Total number of complaints = 253; percentages are rounded to the nearest 1%, resulting in a total of 99%.
Distribution of Malpractice Cases by Practice Area

<table>
<thead>
<tr>
<th>Practice Area</th>
<th>Cases (n =)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical-surgical</td>
<td>32 (80)</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>16 (40)</td>
</tr>
<tr>
<td>Independent practice</td>
<td>12 (30)</td>
</tr>
<tr>
<td>Transitional care units</td>
<td>8 (20)</td>
</tr>
<tr>
<td>Nursing homes</td>
<td>8 (20)</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>8 (20)</td>
</tr>
<tr>
<td>Intensive and coronary care units</td>
<td>3 (9)</td>
</tr>
<tr>
<td>Operating room</td>
<td>3 (8)</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>3 (7)</td>
</tr>
<tr>
<td>Recovery room</td>
<td>2 (6)</td>
</tr>
<tr>
<td>Home health</td>
<td>2 (5)</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>2 (5)</td>
</tr>
<tr>
<td>ED</td>
<td>1 (3)</td>
</tr>
</tbody>
</table>
"There shall be complete, accurate, and timely documentation of pertinent information on the patient’s medical record."

"Document all anesthetic interventions and patient responses. Accurate documentation facilitates comprehensive patient care, provides information for retrospective review and research data, and establishes a medical-legal record."
AANA Standards for Nurse Anesthesia Practice

- **Standard I:** Perform a thorough and complete preanesthesia assessment.
- **Standard II:** Obtain informed consent for the planned anesthetic intervention.
- **Standard III:** Formulate a patient-specific plan for anesthesia care.
- **Standard IV:** Implement and adjust the anesthesia care plan based on the patient’s physiological response.
Standard V: Monitor the patient’s physiologic condition as appropriate for the type of anesthesia and specific patient needs.

- Monitor ventilation continuously
- Monitor oxygenation continuously
- Monitor cardiovascular status continuously
- Monitor body temperature continuously on all pediatric patients receiving general anesthetic
- Monitor neuromuscular function & status continuously
- Monitor & assess patient positioning & protective measures
☐ **Standard VI:** There shall be complete, accurate, and timely documentation of pertinent information on the medical record.

☐ **Standard VII:** Transfer the responsibility for care of the patient to other qualified providers in a manner which assures continuity of care and patient safety.

☐ **Standard VIII:** Adhere to appropriate safety precautions, as established within the institution, to minimize risk of fire, explosion, electrical shock and equipment malfunction. Document on the record that the anesthesia machine and equipment were checked.
Standard IX: Precautions shall be taken to minimize the risk of infection to the patient, the CRNA, and other healthcare providers.

Standard X: Anesthesia care shall be assessed to assure its quality and contribution to positive patient outcomes.

Standard XI: CRNA shall respect and maintain the basic rights of patients.
Current Issues in Anesthesia

- **Awareness**
  - AANA Position Statement Number 2.12 Unintended Awareness Under General Anesthesia

- **Captain of Ship**
Best Defense....

Sound Practices

Good Documentation
Value of Documentation

- Permanent medical and legal document
- Communicate with healthcare team
- Safety: allergies, medications, treatments
- Reimbursement issues
- Accreditation / licensing
Value of Documentation (cont.)

- Research
- Quality Improvement / Peer Review
- Risk Management / Legal Issues
- Regulatory Standards
If it wasn’t documented, it wasn’t done.
Electronic Health Record (EHR)

- **Goals**
  - More precise
  - Portable

- Improve Quality of Care or Not?
6 C’s of Documentation

- Correct
- Chronological
- Clear
- Concise
- Complete
- Consistent
Concise Documentation

- Avoid “double,” “triple” documentation
- Use approved abbreviations per policy & procedures (P&P)
- JCAHO “Do Not Use List”
# The Joint Commission

Official “Do Not Use” List

<table>
<thead>
<tr>
<th>Do Not Use</th>
<th>Potential Problem</th>
<th>Use Instead</th>
</tr>
</thead>
<tbody>
<tr>
<td>U (unit)</td>
<td>Mistaken for “0” (zero), the number “4” (four) or “cc”</td>
<td>Write “unit”</td>
</tr>
<tr>
<td>IU (International Unit)</td>
<td>Mistaken for IV (intravenous) or the number 10 (ten)</td>
<td>Write “International Unit”</td>
</tr>
<tr>
<td>Q.D., Q.D., q.d., qd (daily)</td>
<td>Mistaken for each other</td>
<td>Write “daily”</td>
</tr>
<tr>
<td>Q.O.D., QOD, q.o.d., qod (every other day)</td>
<td>Period after the Q mistaken for &quot;1&quot; and the &quot;O&quot; mistaken for &quot;1&quot;</td>
<td>Write &quot;every other day&quot;</td>
</tr>
<tr>
<td>Trailing zero (X.0 mg)*</td>
<td>Decimal point is missed</td>
<td>Write X mg</td>
</tr>
<tr>
<td>Lack of leading zero (.X mg)</td>
<td></td>
<td>Write 0.X mg</td>
</tr>
<tr>
<td>MS</td>
<td>Can mean morphine sulfate or magnesium sulfate</td>
<td>Write “morphine sulfate” or “magnesium sulfate”</td>
</tr>
<tr>
<td>MSO₄ and MgSO₄</td>
<td>Confused for one another</td>
<td></td>
</tr>
</tbody>
</table>

* Applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms.

**Exception:** A “trailing zero” may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

---

Additional Abbreviations, Acronyms and Symbols

(For possible future inclusion in the Official “Do Not Use” List)

<table>
<thead>
<tr>
<th>Do Not Use</th>
<th>Potential Problem</th>
<th>Use Instead</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; (greater than)</td>
<td>Misinterpreted as the number “7” (seven) or the letter “L”</td>
<td>Write “greater than”</td>
</tr>
<tr>
<td>&lt; (less than)</td>
<td>Confused for one another</td>
<td>Write “less than”</td>
</tr>
<tr>
<td>Abbreviations for drug names</td>
<td>Misinterpreted due to similar abbreviations for multiple drugs</td>
<td>Write drug names in full</td>
</tr>
<tr>
<td>Apothecary units</td>
<td>Unfamiliar to many practitioners</td>
<td>Use metric units</td>
</tr>
<tr>
<td>Confused with metric units</td>
<td>Misinterpreted for U (units) when poorly written</td>
<td>Write “mL” or “ml” or “milliliters” (“mL” is preferred)</td>
</tr>
<tr>
<td>@</td>
<td>Mistaken for the number “2” (two)</td>
<td>Write “at”</td>
</tr>
<tr>
<td>µg</td>
<td>Mistaken for mg (milligrams) resulting in one thousand-fold overdose</td>
<td>Write “µg” or “micrograms”</td>
</tr>
</tbody>
</table>
Say what?

- AFAWG
  As far as wire goes

- HL the HL
  Heparin lock the Hickman Line

- SALT
  Same as Last Time
Complete and Consistent Documentation

- Make sure patient’s name and facility number are on each page of each record
- Sign and date every entry
- Use “I”
- Use “quotes”
- Specifically identify individual names
- Document unusual incidents
Complete and Consistent Documentation (Cont.)

- Medications
  - Look alike/sound alike drugs ([www.jcaho.org](http://www.jcaho.org))
  - High alert medications ([www.ismp.org](http://www.ismp.org))
  - Confused drug names ([www.ismp.org](http://www.ismp.org))

- Use your spell check
- Legible
- Grammar
- Proof
During the evening I thought of a possibility that he might have a retropharyngeal abscess and for this reason got x-rays of the neck. Again, there has been no report from the x-ray people; however, my reading is that is retropharyngeal abscess on the left side which is quite prominent. For
Risk Management

- Licensure responsibilities
  - Nurse Practice Act
  - AANA Scope & Standards of Practice
  - Continuing education
  - Mandatory Reporting
OB: _____  Age: 44  BP: 160/100  Temp: 97.7  Pulse: _____
Resp: _____  ht.: _____  wt.: 140  BMI: _____  LMP: _____
PCP: _____  RA: 0 = 4
Current Problem:
Dx'd c. staff infection in Florida - on meds since March 5th - Cpro - fever yesterday @ Dr. office.
Fall risk score: ________  Intervention
National Practitioner Data Bank

- Mandatory reporting
  - Settlements
  - Judgments
  - Disciplinary actions
  - Limitations on hospital privileges

- Entity who pays or disciplines report
- Available only to hospital and licensing boards
Malpractice Insurance... To buy or not to buy?

- Individual Policy
- Employer’s Policy
Reducing Potential Liability

- Maintain open, honest, respectful relationships & communication with patients, families and colleagues.

- Maintain competency in your area of practice.

- Know your state’s practice act and employer’s policies & procedures—follow them.

- Practice within the bounds of professional licensure.
Reducing Potential Liability (con’t)

- Know your strengths & weaknesses.

- Thorough pre-op evaluation and follow up of abnormal test results.

- Never alter the medical record.

- Listen to your gut...evaluate & re-evaluate.
Most errors in medical and nursing judgment can be successfully defended when you are sincere, dedicated & credible.
The anesthesia record is usually the only continuous, contemporaneously prepared record of the entire operative procedure.

It can be the best defense for you or your colleagues.
Case Examples
More Case Examples
What Happens if I’m sued?

- Anatomy of a lawsuit—complaint to trial
- What to expect if you are deposed
- What to do if you are named in a suit
Self Anesthetizing?

States the way that he sleeps best is if he takes 3 of the Ultram, some NyQuil, and a muscle relaxant that he doesn't know the name of.
Work as a nurse, but...

Document like a reporter and

Think like a lawyer!
References:

References (continued):


- [http://www.state.nd.us/lr/cencode/t43c121.pdf](http://www.state.nd.us/lr/cencode/t43c121.pdf) ND Nurse Practice Act, 2003.


References (continued):


