THE DEVIL IS IN THE DETAILS AND YOUR KNOWLEDGE: CASE ILLUSTRATIONS

Sharon Saunderson Coffey, RN, MSN, CEN, CCRN, CHÉP
(Masters Level)
s4haronc@aol.com

Conflict of Interest Disclosure

I, Sharon Saunderson Coffey, RN certify that, to the best of their knowledge, no affiliation or relationship of a financial nature with a commercial interest organization has significantly affected their views on the subject on which they are presenting.

Objectives:

• Outline 5-10 qualities valued by medical malpractice attorneys who hire RNs to review and opine on nursing standards of care.

• Evaluate the impact of LNC consultation and work products in several case illustrations.
Knowledge = Degree + Certifications + Experience

- Of the 3: Degree; Certificate and Experience the greatest of these is EXPERIENCE!
- Don’t over/under estimate your experience, be realistic

The Devil is in the Details

- Know whether you are working for Plaintiff or Defense!
- Consider all angles but only opine on your area of license, e.g. Nursing
- Ask if there is vicarious liability; WHY? It is an angle that you must consider when speaking to an attorney

The Devil is in the Details

- Nurses do not medically diagnose
- Nurses do not prescribe
- Nurses do not write orders BUT we do initiate and follow through on protocols (which are physician orders)
- Nurses DO USE CRITICAL THINKING AND JUDEMENT to advocate for patients
The Devil is in the Details

- What are a nurse's responsibilities?
  - Assess and reassess timely and according to policy
    - ICU Q1 hr; PCU Q4 hr; or per order: "neuro checks Q1 hr"
  - Did the nurse use Critical thinking and notify when needed
    - Irregardless of time of day or night.
  - Know and use chain of command when situation is not getting resolve? Does the hospital/clinic have such a policy? Ask for it!
  - Document. Know hospital/clinic policy. Document by exception? EMR templates...ask for them!

- Did the nurse document who they spoke to and why? Did they get orders? Did they complete those orders in a timely manner?
- Who else on the team participated? RRT? Know their role. EMT/Tech? Know their role (versus their role in the pre-hospital setting)...if unsure ask for the job description.
- Hospital designations/certifications...Stroke, Alzheimer’s, Cardiac Center of Excellence, Cancer Center of Excellence, Trauma (adult v. peds), etc.

- Follow thru on all orders as written and in a timely fashion? If not why (should be in documentation)
- Policies and Guidelines? What are they? Are they a standard of care?
- What is Standard of Care: Standard of care has generally meant that care delivered is consistent with the highest quality of care available in the similar or like environment.
The Devil is in the Details

- Look at times, chart if necessary!
- Frequency of Vital Signs, assessments, reassessments, medication ordered and given. Any explanation on deviation from scheduled times?
- What time was a lab ordered? What time was it executed? What time were the results delivered? What time did the nurse note the time aware of results? What did they do with the abnormal results?
- Reference values on labs: Case study on this!

The Devil is in the Details

- Determine if any of the legal players have a medical/nursing background? BUT, remember your testimony may have to be delivered at a Jury’s level of healthcare understanding.
Case Illustrations #1

- 36 y.o. female admitted with polysubstance OD to a Critical Access Hospital (only 25 inpatient beds and >35 miles from next hospital). Lethargic, sonorous respirations.
- Urine and Blood Tox screens were collected in the Emergency Department (ED) after emergent RSI intubation utilizing rapid sequence methods (vecuronium, fentanyl and versed) (approx. 1800 hours)
- Pt. was stabilized in ED and transferred to the 2 bed-ICU at 1905 hours.

Case Illustration #1

- Tox screen results are fax’d to ED at 1936 hours.
  - Positive for opiates and acetaminophen level of 156 mcg/ml.
  - RN in ICU called lab (no computerized lab results available) at approximately (per documentation) 2230 hours.
  - Lab faxes tox results to ICU at 2246 hours.
  - RN in ICU calls physician with results immediately. Orders received to call internal medicine (IM) physician on call.
  - Call placed to IM and wait for return call which came in at 0103 hours (per RN documentation)
  - IM physician gave immediate orders for N-acetylcysteine and serum liver function test which were done by ICU RN at 0118 hours.

Case Illustration #1

- Summary: Patients LFTs showed gross elevation suggestive of new onset liver failure (no prior hx liver ds.).
- Calculated (by me) of time from ingestion to first does N-acetylcysteine was approximate 9.5 hours!!!
- Outcome: transferred to large tertiary medical center, on list for liver transplant but expired 3 days after transfer!
Case Illustration #1

- ISSUES:
  - Labs sent to the ED but pt. was up in ICU
  - No policy for what to do with labs arriving in dept. when pt. has already had disposition.
  - ICU RN was busy (2 patients both unstable and critical, one preparing for a transfer)
  - Delay in retrieving lab results in ICU
  - Admitting physician did not properly act on lab results

- ICU-RN did not ask admitting physician for a stat N-acetylcysteine order as she opined she did not know the normal values
- Lab report does not have reference ranges for many labs including Acetaminophen!
- What is your knowledge on treatment for acetaminophen OD, timeframe? Toxic levels? Consequences? Would a prudent ICU RN know the answers as well?

Case Illustration #2

- 64 y.o. Hispanic male presents to ED with 1-hour onset epistaxis. Ambulatory from car to triage, placed in W/C and brought to room within 22 minutes of presentation as triage category 2.
- ERMD places nasal packing approximately 15 minutes after being placed in a room - which the pt. subsequently pulls out.
- ERMD places second nasal packing and pt’s hands are restrained by ED RN.
- Second nasal packing fails;
- ERMD elects to RSI intubate patient to protect patient airway within 2-hours of pt. arrival.
Case Illustration #2

- RN documented Q1hr vital signs and assessments
- RRT, ERMD, and RN x2 in with pt. during intubation.
- First ETT attempt fails.
- Second ETT attempt fails (see where this is going?)
- Third ETT placed (ultimately in the esophagus per Medical Examiners report)
- Pt. bradys down and a code blue is called.
- Paramedic/tech from the ED arrives, nursing sup arrives and second RTT arrives.
- Pt. goes asystolic and eventually expires.

Case Illustration #2

- Issues brought forth:
  - ED RN did not assess/reassess/document according to policy: VS per ED policy were Q2 hrs unless pt. unstable then as needed.
  - ED RN did not advocate for patient and assist with intubation
  - ED RN did not assess and document pulse oximetry
  - ED RN failed to communicate critical status of pt. to ERMD.
  - RN responsible to auscultating BS therefore ETT placement.
  - ED RN failed to allow the paramedic/tech to check for ETT placement

Case Illustration #2

- ED RN did not check and communicate EtCO2 (EasyCap) color change to ED physician: although the ERMD did document that 2 were used and both filled with blood making them unreadable)
- ED did not have adequate supplies on hand (more EasyCaps)
- Hospital was a certified and recognized hospital that fell below the standards of care of their certification.
Details of a Dreaded Deposition

- It is NOT personal! They have no clue what perfume you use, where you shop or your favorite wine!!!
- Keep focused and take breaks as much as you want to.
- Listen, Listen, Listen...e.g.:
  - Do you agree with me that.... this requires a yes or no answer. You are answering ONLY if you agree or disagree with the statement!
- Be prepared!

Details of a Dreaded Deposition

- Think why you were asked the question...where are they going with it?...e.g. Can paramedics intubate patients? The answer is Yes, BUT in an Emergency Department or hospital setting their job description may NOT allow them.
- Beware of hypotheticals. You might want to preface your answer with something like this:
  - “The answer to your hypothetical question is yes, but related to this case, no.”

Details of a Dreaded Deposition

- Dress and act professionally
  - Hair pulled back
  - NO GUM/ DON’T CHEW ICE!!!
- Answer with a verbal yes or no...not a uh huh etc.
- Pause after each question to see if there is a objection
- Speak clearly and slowly
- Ask for clarification of the question if you are unclear
- Remember your answers may be read to a jury so give simple answers without nursing jargon!
Details of a Dreaded Deposition

- Hear the question, understand the question, think about the truthful answer based on your nursing knowledge and experience, only answer the question asked!!!
- You do NOT have to give your SS# on record.
- Ask counsel to have a pre-deposition meeting to understand the direction of the case, the style of the deposition etc.
- Bring to depo all items if you can, that are outlined in the duces tecum. Keep your resume or CV current.

Details of a Dreaded Deposition

- Authoritative books, documents etc.
- Will you be offering causation? If NOT, don’t answer that type of question….e.g. “Do you agree with me that the failure of the nurse to call the physician with the critical lab value caused the patient to go into cardiac arrest?”
- Be careful of questions with “and” or “or”.
- Again, Listen carefully.
- Look the questioning attorney in the eye. Show confidence, articulate your knowledge, relate your experience!!!

Good Luck!

Sharon Saunderson Coffey, RN, MSN, CEN, CCRN, CHEP (Master’s Level)

s4haronc@aol.com

THANK YOU!