*Hafernick Legal-Nurse Consulting*
*Presents a newsletter by legal nurse consultants aimed at educating the community.*

# *Hafernick Perspectives*

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## Documentation should be:

**L**egible
**A**ccurate
**W**hole
**S**ubstantiating
**U**naltered
**I**ntelligent
**T**imely

***"If you didn't document it, you didn't do it."***

Documentation is a fundamental part of safe and effective healthcare practice. It demonstrates judgment and critical thinking. Proper documentation reflects the quality of care that is given to patients and is evidence that the healthcare professional acted as required or ordered. Many negligence cases come about because of poor record keeping and accurate documentation is one way of limiting liability against healthcare professionals.

Healthcare records serve two main purposes:

1. Provide legal evidence that a professional action or undertaking has been achieved.
2. Provides a comprehensive account of the care given. Records should demonstrate the duty of care has been acknowledged and understood.

These records must include:

1. A full account of the healthcare assessment, the care planned and details of the program and of care provision.
2. Relevant information about the condition of the patient at any given time.
3. Healthcare professional measures taken to respond to the patient's needs.
4. Evidence that the healthcare professional has understood and honored the professional duty of care.
5. Evidence of the reasonable steps taken to care for the patient or client and a guarantee that any actions or omissions have not compromised the patient's safety in any way.
6. A record of any arrangements the healthcare professional has made for the continuing care of the patient.

Healthcare professionals are accountable for their own actions. They are not perfect, but are required to meet a reasonable standard. This involves knowing how to chart, what to chart, when to chart and who should chart. Without complete documentation, the plan of care, as well as care actually rendered for a patient may be lost to colleagues, may be legally indefensible, and may result in actual harm to patients.

**Legal nurse consultants** are familiar with the nuances in the world of healthcare and are critical in helping their attorneys navigate this sea of paperwork. These professionals are trained to see what ***is*** and ***isn't*** in the medical records, so their attorneys can focus on the legal aspects of their cases.

In coming issues, we will discuss the importance of care plans and critical pathways and how they relate to documentation. Also, we'll take documentation to a new level and compare JCAHO and HCFA requirements in such realms as restraints.

Deborah Hafernick, RN, CLNC
***Hafernick Legal-Nurse Consulting***
Friendswood, Texas
www.ghg.net/hafernicklnc

## *STROKE AND THROMBOLYTIC THERAPY*

Stroke is the third leading cause of death and a major cause of disability in the United States. It affects 700,000 Americans annually and costs $30 billion a year in medical costs and lost wages.

A stroke is damage to part of the brain when its blood supply is suddenly reduced or stopped. The part of the brain deprived of blood dies and can no longer function. There are two main mechanisms of stroke. The most common cause is due to occlusion of an artery that brings oxygen and nutrients to a part of the brain. This is called an ischemic stroke. The occlusion happens when a blood clot or piece of debris called plaque blocks blood flow to the brain. The other cause of a stroke is bleeding in the brain. This can be due to high blood pressure, or due to blood vessel abnormalities.

The Cincinnati Pre-hospital Stroke Scale identifies a high percentage of acute stoke patients by assessing only 3 physical findings. These include facial droop, speech difficulties, and motor arm drift. To evaluate the motor arm drift, the patient closes his eyes and holds both arms out. In a stroke victim, one arm would drift downward. If any one of these signs is abnormal, the probability of a stroke is 72%.

In 1996, the American Heart Association (AHA) recommended the use of fibrinolytic therapy (clot dissolving medicine) *within 3 hours of symptom onset for selected patients with* ***ischemic stroke.*** This has affected the care of patients having an ischemic stroke. Prior to the use of fibrinolytic therapy, there was not a lot to offer these patients. More and more patients have heard about this clot dissolving medicine, and when their family member presents with a stroke, they want this medicine given.

In order for a patient to be a candidate for thrombolytic therapy, he must:

- be greater than 18 years of age.
- have a clinical diagnosis of ischemic stroke causing an acute, measurable neurological deficit. have time of onset of symptoms of less than 3 hours before treatment would begin. A person

who awakens with stroke symptoms is not a candidate because onset of symptoms cannot be determined.

A patient is not a candidate for thrombolytic therapy if there is:

- evidence of intracranial hemorrhage on the head CT.
- only minor or rapidly improving stroke symptoms.
- a high suspicion of subarachnoid hemorrhage (bleeding in the brain) even with a normal CT.
- active internal bleeding such as gastrointestinal bleeding within the last 21 days.
- a platelet count <100,000/mm
- recent use of anticoagulants such as heparin or coumadin.
- a prothrombin time > 15 seconds.
- a prolonged partial thromboplastin time.
- brain surgery within 3 months, serious head trauma, or previous stroke.
- major surgery within 14 days, or serious trauma.
- recent arterial puncture or lumbar puncture.
- history of bleeding in the brain, arteriovenous malformation, or aneurysm.
- witnessed seizure at onset of stroke symptoms.
- recent heart attack.
- systolic blood pressure greater than 185 mm HG or diastolic blood pressure greater than 110 mm HG on repeated measurements.

When a person presents to an emergency department (ED) with symptoms suggestive of a stroke, time is of the essence. There is such a narrow window of time in which fibrolytic therapy can be given safely and effectively. Pre-hospital staff have been instructed to recognize the signs of a stroke, provide rapid transport to the ED, and notifying the ED early that a possible stroke victim is in transport. This patient needs to be triaged as emergent, and needs to be seen right away by the ED doctor. A rapid neurological assessment is done. The time on onset of symptoms needs to be determined. If the patient passes the protocol for thrombolytic therapy, a CT should be done immediately. The goal of door-to-CT scan is less than 25 minutes according the AHA standards. All the other necessary tests need to be done simultaneously to the neurological exam including lab work, EKG, chest x-ray.

If the patient is a candidate for thrombolytic therapy a written informed consent needs to be obtained from the patient or the family, after discussing the risks and benefits of this therapy. If the decision is to go ahead with thrombolytic therapy, and the patient is still within three hours of onset of symptoms, the medication should be given immediately.

One of the biggest legal issues dealing with a stroke includes the triage, and if the significance of the symptoms was recognized as a possible stroke. A patient with a potentially treatable stroke who has to wait to be seen by the MD loses out on the chance of having thrombolytics.

Gail Hendrickson RN, LNC
**Northeast Legal Nurse Consultants**
Kittery Point, Maine
northeastlnc@aol.com

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# INTRAVENOUS FLUIDS

## Life or Death – Did Your Client Receive the Correct One?

When reviewing a case and looking at the medical records of your client, are you knowledgeable on the use of the maintenance fluids that doctors order on almost all in-patient hospitals stays. Are you aware of the potential for harm that these beneficial fluids can have on a patient if not used correctly?

There are basically 3 categories of fluids given to patients intravenously: hypotonic, hypertonic and isotonic. These intravenous fluids go into your blood vessels and then pull body fluid either from the cell or to the cell. Over the next 3 newsletters I will explain each one and give an illustration of how the wrong use of an intravenous fluid can be deadly.

The intravenous fluid that I will discuss this newsletter is hypotonic fluid, which pulls water into the patient's cells. The reason being is that hypotonic fluid dilutes the blood in the vessel and that in turn causes it to become more dilute. So now the fluid out of the cell is diluted and the fluid in the cell is concentrated. Water always goes where the crowd is. And where is the crowd? In the cell! Now the fluid shifts into the cells of the patient's body.

A scenario to demonstrate how deadly giving the wrong kind of fluid is as follows. Mr. Tibbett is a 77-year-old man who came in dehydrated with sepsis (an infection that has taken over the body). His blood pressure is 68/40 (low). The doctor orders 0.45 normal saline (hypotonic fluid) at 70cc an hour. So the nurse hangs it. The doctor ordered it right? Yes, he did. But this fluid, because it is hypotonic, will cause a shift of fluid from the blood vessels to the cells. Now Mr. Tibbett's blood pressure is somewhat in the neighborhood of 60/40 and getting lower. Now, what action would a nurse take at this point? Of course, she would call the physician back with this newest development. The physician tells her to "increase his IV fluids." The nurse promptly responds only to see Mr. Tibbett's blood pressure get to the point where she can barely hear one manually. Now the nurse calls the physician back again and says, "Hey, I can't hear his blood pressure!" What does the physician say? "Open the IV wide open" (that means as much as will go in as fast as possible). So now the nurse, who of course is very concerned about her patient, hurries back and opens the IV fluid "wide open". This causes a rapid shifting of the fluid into Mr. Tibbett's cells and the nurse REALLY won't hear Mr. Tibbett's blood pressure now because **it's all in the patient's cells.** Then the fluid starts going into Mr. Tibbett's brain cells.

When that begins to take place patients become restless, irritable, and combative. So the next step is to put the patient in restraints so they won't hurt themselves. Mr. Tibbett is beginning to look like the old people who come into the hospital. When enough of the fluid enters the brain the patient will go into a coma. Then, if Mr. Tibbett is on a step-down unit and the nurse still can't hear a blood pressure, what would possibly be the next step. Hang a Dopamine IV drip! This drug is vasoconstrictive so then Mr. Tibbett's kidneys shut down. After this, unless rapid intervention takes place, it is a fast down hill slide.

Why? All because the wrong type of fluid was originally hung on this patient. This ability to recognize the possibility that a patient's problem or even demise could have originated from the type of fluid that was hung is just **one** of the ways a legal nurse consultant can be of invaluable help to an attorney.

The coming newsletter will feature "Hypertonic Fluid - The Damage It Can Cause When Used Incorrectly." Would you, as an attorney, be able to recognize that it was the fluid that started this problem?

Melisa Bailey RN, CLNC
**Bailey Consultants**
Houston, Texas
melisa@baileyconsultants.net