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

Hafernick Perspectives

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WISHING ALL A HAPPY AND PROSPEROUS NEW YEAR!!

Hafernick Legal-Nurse Consulting would like to thank all of our clients for making 2003 such a great success and we look forward to an even better year in 2004!! We have had a busy year and have upgraded many of our systems to serve our clients better. Enclosed with this newsletter, you will find new business cards reflecting Deborah's new email address, our new fax number and website. Deborah met with many of her clients at the TTLA Medical Malpractice Annual Conference in September 2003. Look for her to participate in the TADC 2004 Trial Academy held in Austin this year. She will reprise her roles as a mock defendant doctor and plaintiff expert. "The mock trials increase my understanding of the legal process so I might better serve my clients. It has been an invaluable experience for me," Deborah stated. Deborah will be in San Francisco in March 2004, attending the NACLNC Annual Conference. Please visit our new website for upcoming news and announcements!

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Standards of Care

Definition:

A Standard of Care holds a person of exceptional skill or knowledge to a duty of acting as would a reasonable and prudent person possessing the same or similar skills or knowledge under the same or similar circumstances.
A "reasonable and prudent person" exercises skill with reasonable care, diligence and judgment. A healthcare provider's actions are measured against the SOC practice in the provider's on locality or in any similar community (e.g., urban vs. rural). This replaces strict locality rule in most states. Trend is toward national standards.

Why Standards of Care are used:

SOC are the measuring tool for determining whether a health care practitioner was negligent. A health care provider has a duty to be familiar with SOC. Ignorance is not a defense. The plaintiff must establish what SOC are to enable the jury, as fact finders to judge the health care provider's professional conduct.
A mistake in judgment does not necessarily violate SOC. SOC applied to a case should be the standard current at the time of the incident that is the basis of the lawsuit.

Legal sources that provide definitive evidence of SOC are:

1. Practice acts
2. State laws
3. Federal laws

Regulatory sources:

1. State and federal agencies
2. Accreditation organizations
3. Professional Organizations and Associations
4. Scientific Literature
5. Health Care Facility Sources
   a. Policies and procedures
   b. Standards of Care
   c. Critical pathways
6. Expert Testimony
7. Anything that bears the issue of good practice (practice parameters, guidelines and protocols developed by state medical specialty advisory committees: specialty associations and organizations: national review associations: and private organizations).

Obtaining Standards and Guidelines:

A. Obtain a copy of the Medical Practice Act and Nurse Practice Act in your state or any state in which you consult.
B. Request a list of publications from all relevant medical and nursing organizations.
C. Obtain published standards, guidelines and practice parameters for your personal library on a case by case basis.
D. Obtain key textbooks for your personal library.
E. Study health care facility policies and procedures closely.

And last but not least, ask yourself: Is the care consistent with good and acceptable nursing practices.

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How to Properly Disclose Medical Errors

JCAHO requires that each facility develop a policy of full disclosure of unanticipated outcomes and near misses to patients and their family members. Disclosure, if done incorrectly, becomes an admission of liability shifting the focus from the patient's condition, treatment plan, and concerns to blame of an individual or process. Done correctly, open disclosure of medical errors can lead to decreased malpractice litigation. The communication should be open, honest and limited to the information truly known at the moment. Speculation on the cause, fault, or outcome is never

considered beneficial. The disclosure conversation should occur in the patient's room with the attending physician or other health care provider who has developed a relationship with the patient leading the conversation. The provider should explain that something unexpected occurred, how the treatment plan is affected, any changes made, and any reactions or consequences that might occur.

Facilities should have a policy in place for disclosure of unanticipated outcomes and near misses. The policy should include:

- A statement of the need and willingness of the patient and physician to have an open, honest relationship with constant dialog regarding the patient's care and general health.
- Who is responsible for primary communication with the patient when information needs to be exchanged (usually the physician).
- Who is responsible for documentation when a disclosure conversation occurs.
- Documentation requirements should include who was present, what information was conveyed along with any questions asked and answers given. The steps of the treatment plan that are agreed to should also be included.

When litigation results from an unexpected event, the disclosure conversation becomes a crucial part of the trial strategy. Key factors to consider include what was said, how it is documented and who was present. The disclosure, concern of the provider and information shared should be positioned as a key advantage for defendants. Disclosure works because it gives the provider credibility with the jury by meeting their expectations of admission when medical errors occur.

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Medical Mistakes in Surgery

Everyone has heard the horror stories of wrong site surgeries. If you follow the news then certainly you have heard that during the month of November alone eleven cases were reported. Why is this happening? You get patients with similar names, x-rays get reversed in view boxes, people are too busy or rushed to check charts and sooner or later something is going to happen.

The American Nurses Association (ANA) states in the Code of Ethics for Nurses with Interpretive Statements says that "the nurse's primary commitment is to the patient, whether an individual, family, group, or community" and, "the nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient." These two statements summon every nurse to pay attention to, know, and adhere to the professional standards that define nursing practice. This includes knowing the provisions of their state's nurse practice act, relevant professional nursing standards (eg, AORN standards for perioperative nurses), and their implications for the practice of nursing.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) defines wrong site surgery as any surgery performed on the wrong site or patient or performing the wrong procedure. To address the problem of medical errors, JCAHO introduced its sentinel event policy in 1996. This policy provides a mechanism for hospitals to self-report sentinel events, such as falls, patient injury or death in restraints, transfusion errors, anesthesia related events, medical equipment errors, and wrong site surgeries. When a sentinel event occurs, it is subject to review under the JCAHO sentinel event policy, and this review includes a root cause analysis. The goals of such an analysis are to:

- Determine how the event happened,
- Identify educational needs or goals,
- Clarify what factors contributed to the event
- Discover risk factors, and
- Determine how to prevent the event from occurring again.

There are other surgical mistakes, which we will refer to as "surgical injuries". Surgical injuries can be the result of medical negligence on the part of a physician, nurse, or hospital. Common causes vary and include: wrong site surgery, wrong surgical procedure, surgical instrument left in the body, surgery unrelated to the patients diagnosis, wrong patient surgery, and damage from a planned surgery just to list a few.

Adverse events in surgery are the most frequent and costly type of medical error occurring in hospitals, according to statistics. Measurements show that the top five most frequent adverse events as surgery, medication errors, medical (non-surgical treatment), patient falls, and nosocomial (hospital acquired) infections – which these 5 account for 67% of the total events. Adverse events in surgery account for nearly 20% of events in the national database.

According to a recent study on medical mistakes found operating room teams around the country leave sponges, clamps, and other tools inside about 1,500 patients every year. Did you know the real number of lost instruments might be even higher, because hospitals are not required to report such mistakes to public agencies? These lost objects usually lodge around the abdomen or hips, but sometimes in the chest, vagina and other cavities. They often cause obstructions or infections and even death due to complications.

Did you realize not all medical centers believe in instrument counts? Why don't they require instrument counts? Some do not believe they are necessary and think that counting instruments is time consuming. Even some surgeons state they will not postpone the start of the surgical procedure to perform the initial count, nor will they prolong the procedure while the surgical team performs the closing count.

Not counting instruments because it takes too much time and is inconvenient for the surgeons is not an acceptable reason to eliminate the instrument count. Using lack of time as an excuse to avoid performing instrument counts is unacceptable because it places the patient at risk for injury. Certainly there are situations in which the patients condition is of such an urgent nature that counts cannot be performed safely. Emergency situations that prevent a count should be treated as an unresolved count, and the facility policy for unresolved counts should be followed.

This brief review of adverse events in surgery only begins to describe what is understood about safety in the operating room. For example, much has been written about proper techniques of disinfections, sterilization, and asepsis; positioning patients; preventing skin breakdown; instrument counts; and preventing hypothermia or other anesthesia related complications. Regardless, it is clear that patients are at certain risk for unnecessary complications, adverse events, and even death as the result of surgery.

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