Pursuing Excellence in a Litigious Environment

Jenny C. Clapp, RNC-OB, MSN
Clinical Nurse Specialist
Cone Health Women’s Hospital
I. The basics

II. Our environment
   Why so many?
   Why so much?

II. What are the claims?
   Common areas of liability and litigious “hot spots”
   Causes
   Issues

III. What’s the real story?

IV. Case Studies
Basic terminology:

- Plaintiff
- Defendant
- Standard of Care (NC “different”) (vs. Practice)
- Negligence/malpractice
  - Duty
  - Breach of Duty
  - Damages
  - Causation
- Deposition
- Jury Trial
- Mediation
- Settlement
Statute of limitations in Virginia:

§ 8.01-243. Personal action for injury to person or property generally; extension in actions for malpractice against health care provider.

A. … every action for personal injuries…shall be brought within two years after the cause of action accrues.

B. …for expenses of curing or attempting to cure such infant from the result of a personal injury or loss of services of such infant, shall be brought within five years after the cause of action accrues.
If your personal goal is not to avoid malpractice suits but to provide excellent nursing care that is supported by documentation, then you have less to worry about.
But even that is not enough.
You must work in an environment that embraces a culture of safety.
“The implications of ... adverse outcomes are often catastrophic for the family and devastating to the healthcare providers involved, particularly when they are found to be preventable on the basis of a retrospective case review and/or litigation” (Simpson, 2008, p. 26).
Our Environment

The thought of being involved in a malpractice case may seem overwhelming, but that is the environment in which we work. We’re all at risk…
I. Our environment

- According to ACOG, 76.5% of ACOG fellows have been sued at least once, while 25% will be sued four or more times.

- In a survey of US hospitals, more than 75% had experienced at least one malpractice suit in the past 12 years. (Who are the “hospitals”? The nurses.)
2002-2012 Closed Claims from one major malpractice insurance carrier:

- Number of closed claims: (Top 5 of 28)
- OB/GYN
- Internal Medicine
- General and Family Practice (2nd lowest paid MD’s)
- Orthopedic surgery
- Radiology
Average Indemnity (pay out): Top 5 of 28

- Neurosurgery
- OB/Gyn
- Radiation Therapy
- Pediatrics (lowest paid of MD’s)
- Cardiovascular diseases-Nonsurgical
How many? (OB)

- Claims closed between 1987 and 2009: 31,486
- Obstetrics: #1 among all specialties for the number of claims reported
- Obstetrics: #1 for total amount of indemnity paid
- Obstetrics: Highest percentage of claims closed
- Obstetrics: Risk of injury is *double* the risk in other specialty areas (PIAA)
Why so many?

The L/D experience becomes the focus for blame because we don’t know the exact time when an intrauterine insult or injury occurs.

- Pts/families misunderstand the events/rationale
- Parents often have unrealistic expectations for their children and their L/D experience
- Pts/families often want to blame someone.
- Some have an air of suspicion (always “looking for something”)
- Negligence does occur.
How Much?

Examples of OB malpractice claims/results: (all in one year)

- $19.6 M  Improper use of forceps  (Jury Verdict)  (NY)
- $18.2 M  Improper monitoring, delay in C/S  (Settled)  (Wis.)
- $35 M  Nursing delay in calling the OB  (JV)  (Fla.)
- $10 M  Improper monitoring by the nursing staff  (S)  (Ohio)
- $22.6 M  Improper management of labor  (JV)  (Ohio)
- $21.5 M  Improper monitoring by OB and nursing staff  (JV)  (Illinois)
- $13.5 M  Improper monitoring: Delay in C/S  (JV)  (Iowa)
Why so much?

Four major determinants of a verdict’s size:

- The projected amount of money that will be needed to provide medical and nursing care to the injured person for the rest of his/her life.
- The length and amount of pain and suffering that an injured person or family endures. (NC has a cap)
- The loss of income or “contribution to society” due to the loss of life or ability
- The sight of a severely brain-damaged child in a courtroom can influence the emotions of jury members, many of whom may be parents
Most common claims:  
(All preventable!)

- Failure to follow the Standard of Care 
  (multiple)

AND IN CASE YOU’RE WONDERING WHAT THE SOC ARE, 
JUST **FAIL** TO FOLLOW ONE AND YOU’LL FIND OUT.

Some SOC’s that are claimed to not have been followed are:

- Failure to assess or to take adequate history
- Failure to report known/suspected deviations from the norm
Most Common Claims (Cont’d.)

- Failure to document, including lack of documentation, altered documentation, missing or “lost” documentation, incomplete documentation (the courts have held that the poorly documented record creates a presumption of poor care)

- Failure to identify risk factors

- Failure to administer medications correctly (the 5 “rights”)
Most Common Claims (Cont’d.)

- Failure to *recognize* change in pt. condition
- Failure to *appreciate* change in pt. condition
- Failure to *recognize* antepartum/intrapartum “fetal distress”
- Failure to *identify* urgency of the situation
Most Common Claims (Cont.’d.)

- Failure to *convey* a sense of urgency to the physician

- Failure to *report* the change in pt condition

- Failure to *communicate* across the healthcare provider spectrum

- Failure to *monitor*

- Failure to *interpret* lab results
Most Common Claims (Cont’d.)

- Failure to *interpret* test/monitoring results
- Failure to *appreciate* the seriousness of the test/monitor results
- Failure to *rescue*
- Failure to *recognize* a non-reassuring fetal heart rate pattern
- Failure to *respond* to antepartum/intrapartum “fetal distress”
- Failure to *provide* intrauterine resuscitation
Most Common Claims (Cont’d.)

- Failure to *observe* pts closely and take appropriate precautions
- Failure to *perform* nursing procedures correctly
- Failure to *ensure* removal of all foreign objects left in a pt’s body
- Failure to *provide* a safe environment
- Failure to *follow* unit policies/protocols
- Failure to *act* as a patient advocate
Common Areas of Liability and *Litigious Hot Spots*

- EMTALA
- Telephone triage
- High Risk Patient
- Tag-Team On-Call (Providers)
- Lack of Emergency Back-up
- **Chain of Command**
  - Identification of Adverse Change in Status
  - Inadequate orientation and training of staff, supervision of inexperienced RN’s (new grads, float or agency nurses)
What can be done about it?

What can I do about it?
Individual interventions

- Utilizing the nursing process, employing critical thinking, and thorough/appropriate documentation can reduce the incidence of bad outcomes.

- Ask for help! Ask for second opinions “check behind me”. Get a “second pair of eyes”.

- Offer help and your opinion.

- Use the **Chain of Command** if needed

- Comprehensive and objective documentation

- Willingness to write incident reports on yourself.
Individual Interventions (Cont’d.)

- *Don’t be afraid to Turn down the Pitocin!*  
  - i.e., *Challenge the MD’s orders!*

- Don’t assume the MD knows what practices are supported by evidence.

- Development of superb clinical assessment skills and knowledge of disease physiology are important to ensure early identification of complications.

- Convey appropriate sense of urgency to other members of the healthcare team.

- Remember, even a great nurse has bad shifts.
Individual Interventions (Cont’d.)

- Be sure to document significant information pertaining to what you didn’t do as well as what you did do. *Your doc. is often ALL you have in a case (plan for a big screen).*

- General communication no matter what you do and where you work:
  
  A) Know your limitations
  
  B) Do not offer opinions, sympathy, emotions, etc. to pts who come back and bash or ask questions like “What do you think happened?”

- Be so secure in your abilities as a nurse that you feel free to question the interpretation of a nursing or medical colleague.

- When the crisis is over…
Communicate with patients/families:

**Telephone triage/assessments:**

- Ask questions as if every pt is high risk
- Treat them all as if they’re the “train wreck waiting to happen”
- Assure all instructions are well understood.
- Instruct to report any danger signs you may give.
- Keep written records of all telephone calls, what was advised/instructed and to whom you relayed the information, include dates/times/details. Telephone log is a must.
Communicate with patients/families: (Cont’d.)

Inpatient:

- If central monitoring/telemetry is used, explain it so they can be assured he/she is being monitored even if you are not in the room.
- Notify the pt/family every time you are in contact with other health care providers, so they can assured he/she is being monitored by them although they are not in the hospital.
Communicate with the other members of the team:

- **Office/hospital personnel:** Document significant lab or other diagnostic testing results in the appropriate places in the chart/medical record.

- **Give complete reports of all information.**

- **MD/PA/APN** may seem like he/she is not listening to you (ask you a question about something you just told them) and they may be multi-tasking.

- **It is your responsibility to give them the information.** You may have to get their attention or call them back at a better time, or if in person, wait until you can have their full attention.

- **Resist being rushed by the person receiving the information.**
Speaking of communication....

how’s your *documentation*?
Underlying concepts of documentation

- Your documentation is a reflection of your care!
- Know what you’re doing and why. Would you want you to be your nurse?
- Your notes are what ties everything in the medical record (MR) together.
- Of all the strategies to reduce liability, accurate and thorough documentation may be the easiest to accomplish but often is the biggest missing piece.
General Do’s and Don’ts of Documentation

- Always document as if: a) your notes are going to be read out loud in front of a courtroom full of people, and b) your notes are going to be blown up on a huge projection screen for everyone to examine…

- Never tamper (add, delete, change) with a MR.

- Don’t keep notes. Anything you write is discoverable.
Documentation is a part of patient care, not apart from it.

- What, when, where, who and why (if possible)
- Document all information you’re given and you get: ass., c/o’s, history, pt statements, non-compliance, behavior.
- Document conversations with providers.
- Document nursing interventions before and after notifying provider.
- Complete flow sheets and forms
- Caution **EMR**: Pay attention! Don’t get “click happy”
- Document instructions given to and conversations with the patient about healthcare issues
- Use accepted methods for correcting errors in the medical record.
- Late entries, delayed charting, keeping charting “caught up”
- Thorough, ongoing assessment
- Use quotes, patient’s statements
Avoid vague terminology- be careful with “it appears”, “it seems”, be clear

Refrain from charting opinions or blame.

Document use of chain of command and don’t be afraid to use it!

“If it wasn’t documented, it’s wasn’t done”.

Handwriting

What about Incident Reports? (SZP’s)
What’s the real story?
Have we made any improvements/advancements over the years? Are we safer?