Failure to Follow Standards of Care

Could this happen to you?

“Sarah” is a nursing professional. She was assigned to care for “Mr. Jones”. “Mr. Jones” was required to receive the medications order for him in a timely manner. You stopped by his room and found he was not in his bed. The bathroom door was closed and you heard moaning. You decided to give him his privacy. You continued to provide care for the other patients you are assigned to. You came back to “Mr. Jones” room about one hour later and you find him in cardiac arrest on the bathroom floor.

You failed to properly follow your facility’s standard of care and reasonable nursing judgment by not making sure your patient was “OK” when you checked on him. You could have allegations brought against you in a suit for failure to follow standards of care.

THE STANDARDS OF CARE you follow when you care for patients may be based on written policies, procedures, protocols, professional studies, and expert opinions from nursing supervisors or other health care professionals in extended roles.

Claims that involve a breach in the standard of care usually allege that you failed to follow a certain policy, procedure, or protocol -- or even doctors’ orders. Most claims will state you were negligent if the patient suffers a loss due to your actions or inactions.

Example situations demonstrate where a nursing professional may have a claim made against him or her include:

- Failure to follow proper “fall” or other safety protocols established by the health care institution.
- Failure to administer certain medications in a timely and reasonable way.
- Failure to use specific skills, such as applying antithrombotic stockings.

PREVENTION RECOMMENDATIONS:

- Perform only those skills that are within the scope of your professional licensure.
- Know your limitations. Don’t accept assignments if you’re not sure you have the time or competency to handle them.
- Stay compliant with your state’s nurse practice act, your institution’s policies, procedures, and protocols, and applicable standards of care related to your clinical practice.
Failure to Assess and Monitor

Could this happen to you?

Nursing professional Trina, RN was assigned a group of patients to care for during her shift; Mr. Eugene, one of her assigned patients, was 82 years old; admitted for periods of confusion. The orders for Mr. Eugene included vital signs every 4 hours. Mr. Eugene complained of a headache early into Trina’s shift. Trina gives Mr. Eugene ibuprofen, a prn medication listed on the MAR and continues with attending to the other patients on her team. Several hours later, Trina returns to check on Mr. Eugene and finds him unresponsive. It was determined that Mr. Eugene suffered a stroke.

If Trina had monitored Mr. Eugene more carefully after the headache complaint and timelier after the administration of the ibuprofen, she may have assessed for and observed early warning signs of a stroke and possibly helped to prevent it.

Trina could be sued by Mr. Eugene and his family for failing to assess and monitor his care more frequently.

Your training, judgment, and facility procedures usually dictate when and how often you should monitor and assess your patient’s needs and care. However; sometimes your instincts, the health and stability of your patient, or previous experience require you to monitor your patient more carefully and more frequently.

When it comes to allegations of failure to assess and monitor, the courts rely on opinions provided by nursing expert witnesses and what they consider reasonable care. Therefore, simply following protocol or doctors’ orders may not be enough.

As part of the care you provide, you are responsible for monitoring any changes in health status, reporting those changes to the appropriate physician, and documenting your findings and actions taken.

The following are examples of situations where a nursing professional may be named in a malpractice suit:

- Failure to check in on a patient more frequently after a patient complained of increased pain.
- Failure to report a change in patient’s health status to the appropriate physician.
- Failure to increase monitoring of a patient who showed symptoms of nausea after taking a medication.

Prevention tips:

- Assess your patient according to your facility policies, facility protocols, physician orders, and always more frequently as needed based on your nursing judgment. Consider it better to be safer and monitor more frequently than the alternative of not monitoring at all.
- Remember to document your abnormal assessments and promptly report them to the appropriate physician. You need to “free text” your entries in the electronic medical record if the drop down menus do not convey your findings clearly.
- Always increase your monitoring if you’re concerned about a potential problem.
- Trust you gut!
**Failure to Communicate**

**Could this happen to you?**

During your shift, one of your patients appeared agitated and was sweating. You took his temperature and it was elevated to 100 F. You recorded these changes in the medical record. When your shift was over, you gave report to the oncoming nurse and went home.

The next day, this patient had been moved to the intensive care unit. Later you found out, the patient had suffered a severe setback. A year later, a lawsuit was filed against the hospital, physician, and you are named in the suit. The lawsuit claimed the patient’s condition could have been prevented had you communicated the change in his health status immediately to his physician. The lack of communication delayed care that could have treated the early onset of symptoms.

This allegation is often made in malpractice suits. Lack of communication between you and your patient’s physician or between you and your supervisor or other health care providers can result in serious consequences when it comes to the care of your patients.

It could result in delayed care with the worst consequence causing the death of your patient.

Situations where a nursing professional may be sued include:

- Failure to communicate all relevant patient health information to the appropriate physician.
- Failure to provide appropriate and adequate discharge information to the patient.
- Failure to report changes in assessment findings to the oncoming shift nurse.

**Prevention tips**

- Document all conversations related to your patient’s care and any changes discovered through monitoring and assessing your patient.
- Make certain to follow facility protocols when discharging patients.
- Use this template to record your conversations with someone who has the authority to give your orders:

  "Discussed or consulted with, the name of the person you are speaking with. Followed by the substance of what you talked about (vitals, urine output, assessment findings, etc.). Requested (specify what it is that you want, like fluids, Tylenol, antiemetic, etc.) Enter either no orders received at this time, continue treatment plan as is or orders received and initiated."
Failure to Document

Could this happen to you?

A couple years ago you had a patient whose condition worsened on your shift. You remember contacting the physician when you noticed the change in condition and you reported to the oncoming shift to continue to monitor the situation. Later that morning the patient died. Now, you are specifically named in a lawsuit, there is no written or electronic documentation of your conversation with the physician or the other health care professional.

We live in an era of the electronic record keeping in healthcare. It is important to document all aspects of care a patient receives. Whether your institution relies on electronic health records or still utilized hand written documents to some extent, if the court is not able to “see” the documentation, then it is easier for the court to assume care wasn’t done or didn’t happen.

Therefore, allegations of negligence may be brought against you for failing to document if specific aspects of patient care have come under scrutiny.

Examples of when a nursing professional may be sued include:

1. Failure to document the final status of your patient at the end of your shift; this may lead to lack of continuous care by the oncoming shift.
2. Failure to document a phone call or other communication with a health care provider who has the authority to give you orders and the patient becomes more ill. Without the entry of your communication it becomes a “he said” / “she said” situation.
3. Failure to document your medication dosage, which results in an overdose when another nursing professional administers the dosage. (The patient was double dosed). The scanning process in many electronic administration systems dramatically prevents this from happening; it is the hand-written MARS that are at the most risk. Medication errors still occur with bar coding! Follow the five rights of medication administration always.
4. Failure to provide care that is documented in the patient’s record. You have every intention of performing what is charted, but you become busy or get distracted so the care was never follow through. You have essentially charted in the future. Chart what you have done; not what you will do.

Prevention Tips

• Document all your communications timely, factually, and thoroughly. Use this format:
  o “Consulted or discussed with (the name of the person you are speaking with) regarding (the substance of what you are talking about). Requested (what it is that your patient needs: fluids, something for fever, nausea or vomiting etc.). Orders received and initiated or no orders received at this time. Continue treatment plan as is or indicate the change in the treatment plan. Signed your name.”

• Ensure your documentation represents the nursing process: assessment, interventions, and evaluation or outcomes.
• NEVER chart ahead…only after you provide the care.
• Document your senses! What you feel, what you see, what you hear, and what you smell.
Failure to Use Equipment in a Responsible Manner

Could this happen to you?

Nursing Professional “Tracey” was ordered by her patient’s attending physician to hook the patient up to specified equipment. “Tracey” was not properly trained on the equipment but hooked it up anyway. Three hours later, the patient was found unresponsive and the equipment was found to be programmed incorrectly.

Even through you were following doctor’s orders, you should have let the doctor know you were not trained on the use of the equipment and /or called your nursing supervisor for support to initiate the equipment. Allegations could be brought against you for the harm to the patient due to your improper programming of the equipment.

With the increasing demands of the nursing role, you may take on more responsibilities--including using equipment you’re not trained to operate. If the equipment fails or harms a patient in any way, you could have allegations brought against you for wrongdoing on your part to use the equipment responsibly.

Some sample situations that could cause malpractice allegations against you may include:

- If you operate or attach equipment for use other than what the manufacturer details or specifies.
- If you failed to follow the manufacturer’s guidelines for the equipment use.
- If you move the equipment before it is fully charged and the battery goes dead during critical transport.
- If you fail to preserve the equipment after a patient’s unexpected death so that an unbiased, third party entity can inspect the operations of the equipment.

Prevention Tips:

- Attend equipment in-service programs and make certain you know how to operate and detect equipment failures.
- If you are asked to monitor or attach equipment you are not familiar with, be certain to speak up and consult with your immediate supervisor for support and recommendations.
**Additional Prevention Tips**

To avoid malpractice claims made against you, be sure to understand the previous five most common allegations and what you can do to prevent them.

In addition, here are four more ways to reduce your overall exposure to litigation:

1. Follow your gut instinct. Chances are if you think something isn’t right, then it probably isn’t.
2. Clearly document in the medical records. Add free-text to drop down menus if the options provided do not say what you want it to say.
3. Maintain a good bedside manner: If you don’t want to be sued, don’t be rude! Get to know your patient’s family.
4. Continuous education is a must. Keep up on the latest trends; they can and do change quickly. The more up-to-date you are the better care you can provide.

Regardless of how well you do your job and follow the prevention tips provided, you may still be named in a malpractice suit. Your best defense against a lawsuit is carrying your own professional liability insurance. This way you will not have to use your personal assets to pay for your defense and you will not have to rely on counsel provided by the facility you work for. With your own professional liability insurance, you have your own attorney who may be able to meet your personal needs better to defend your license. The facility counsel will provide coverage for you; it just may not be adequate for what you personally need. Become informed about professional liability insurance and make an informed decision based on what YOU decide is best for YOU.