7 legal tips for

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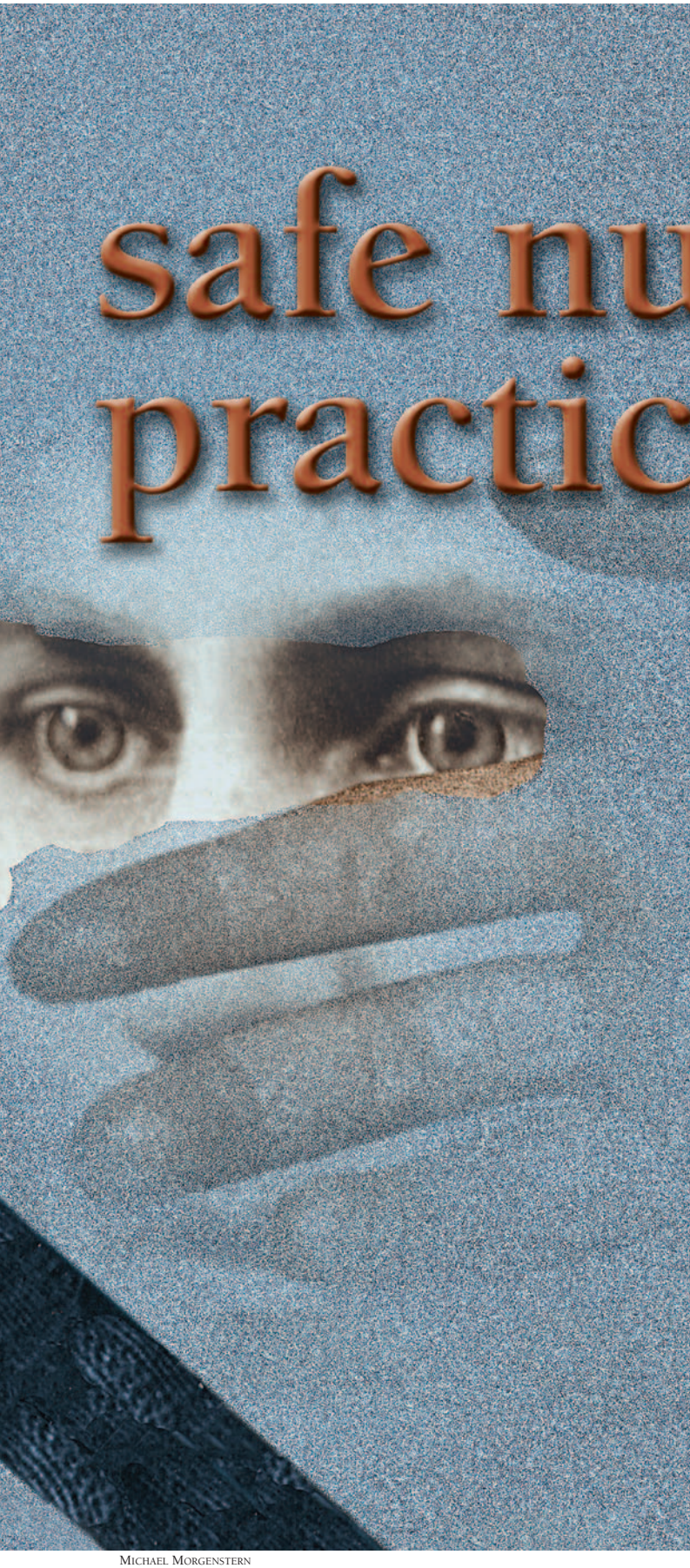
safe nursing practice

Use these pointers to help provide safe patient care and reduce the risk of lawsuits.



MICHAEL MORGENSTERN

By Sally Austin, ADN, BGS, CPC-A, JD

DELIVERING CARE that conforms to the standards of practice for nursing protects both your patients and you. Legally, nurses are held accountable to deliver care in a manner that any prudent nurse would render in the same or similar circumstances.

Nursing standards of care are based on the latest scientific data from nursing literature. Federal and state laws, nurse practice acts, court decisions, organizations such as the American Nurses Association and The Joint Commission, nursing organizations that offer specialty certification, facility policies and procedures, and job descriptions also come into play. As nursing standards change to accommodate advancements in medicine, nursing, and the law, keeping up with them can be challenging.

To help you maintain a high standard of practice and protect against legal problems related to your nursing care, I'll spell out seven key principles you should follow when providing patient care. I'll also provide examples of how lapses in the standard of care can expose nurses to legal liability.

Follow the nursing process

The five steps of the nursing process are recognized as a universal approach to nursing practice. A failure on your part during any of these steps can lead to trouble:

• *nursing assessment*—collecting data regarding your

patient's signs and symptoms
• *nursing diagnosis*—appropriately identifying the patient's problems
• *planning*—setting goals of care and desired outcomes and identifying appropriate nursing actions
• *implementation*—performing the nursing actions identified in planning
• *evaluation*—determining if the goals were met and the outcomes were achieved and appropriately revising the care plan based on the patient's response.

Most legal actions brought against nurses arise because a patient or a patient advocate claims that the nurse breached a standard of care and that the breach resulted in harm to the patient. Although your primary concern is patient safety, adhering to the seven key principles that follow will also help protect you legally.

1 Administer medications properly

Medication errors jeopardize patient safety and are all too frequent. They can also be costly: Besides harming patients, they can lead to expensive follow-up care, litigation, and monetary awards for damages.

Knowing the drugs you administer is a vital element in the nursing standard of practice for medication therapy. Before giving an ordered medication, you must understand its purpose and actions, the dosage appropriate for your patient's condition, the administration route, possible adverse reactions, and any contraindications.

As the last line of defense before an error reaches the patient, you must also remain vigilant for problems at other points in the medication administration process, including the ordering, dispensing, and labeling of medications. If you're unfamiliar with a medication, check a current drug reference or ask the pharmacy.

When administering a drug, make sure you follow the traditional "five rights" of medication administration:
• right patient
• right medication
• right dose
• right time
• right route (delivery method or site of administration).

A "wrong" in any of these basic steps could harm or even kill a patient. But medication safety experts say these five points are just the tip of the iceberg. Other potentially serious lapses implicated in medication errors include failure to check the medication administration record (MAR) against the order, use of banned abbreviations leading to administration of a wrong drug or dosage, mistaken interpretation of illegible penmanship, failure to obtain clarification as needed, and transcription errors.

Consider the many ways a patient could miss a medication dose or get an extra dose. For example, he may miss a dose if the order wasn't transcribed, if he or the medication wasn't available when the dose was due, if a medication order was overlooked, or if his dose was mistakenly given to another patient. On the other hand, he could receive a duplicate dose if one nurse fails to document that she gave a dose and another nurse administers a second dose. This is more likely at breaks or mealtimes, when a second nurse may temporarily assume the patient's care.

Hospitals can implement safety mechanisms such as independent double checks to help prevent errors associated with single-unit doses of high-alert medications, especially in pediatric patients. According to your facility's policy, an independent double check may call for one nurse drawing up the medication and another nurse independently determining that the medication, dose, and route are correct; both then sign the entry in the MAR or enter the details in the electronic medical record. The facility determines which medications require this extra precaution; common examples include the high-alert drugs intravenous (I.V.) heparin and insulin.

The following scenario details a medication error due to lapses in prescribing, dispensing, and administering the drug.

A physician writes an order for the antibiotic doxycycline as *Vibramycin, 100 mg I.M. b.i.d.* But parenteral Vibramycin can be administered by the I.V. route only, not intramuscularly (I.M.). The pharmacist who reviews the order catches the error and includes a package insert with the vial indicating that the medication must be administered I.V. However, the nurse either doesn't see or disregards the pharmacist's instruction and follows the written order. As a result, the patient gets the medication via the wrong route.

The physician writing the prescription triggered this error. The pharmacist should have contacted the physician to clarify the order and also should have advised the nurse that the drug is to be given I.V. The nurse, unfamiliar with the right route for Vibramycin, should have consulted a current drug reference. Instead, she administered the medication according to the incorrect order.[1]

2 Monitor for and report deterioration

According to the nursing process, the recognized standard of care calls for continually assessing your patient. Once you've performed an initial assessment, made a nursing diagnosis, and initiated a care plan, you must continue to evaluate his condition and communicate the effectiveness of his treatment. Worsening signs and symptoms or a lack of response suggest that you need to modify the care plan.

Many legal actions brought against nurses center on an allegation of failure to monitor or recognize changes in a patient's condition. But your duty goes beyond careful monitoring and prompt documentation of any changes. Even if you've done these well, failing to recognize the significance of the changes or to communicate them clearly and promptly to the attending practitioner could endanger your patient and leave you open to liability.

In some lawsuits, nurses have been charged with failure to communicate or "failure to rescue" (not responding appropriately to the patient's deteriorating condition). The following example shows why.

A woman is admitted to the hospital with severe abdominal and lower back pain. Based on the results of diagnostic testing, her physician suspects left lower lobe pneumonia. He starts the patient on a broad-spectrum antibiotic and her condition improves. Then her pulse rate rises, and she begins experiencing distress, shortness of breath, and diffuse pain. Her nurse, however, doesn't advise the physician of the change in her condition. Two hours later, the patient goes into cardiac arrest and dies.[2]

3 Communicate effectively

Besides informing a practitioner about your patient's current or changing condition, you need to clearly communicate with patients and colleagues at every point of patient care. Good communication skills are essential when:

- transferring your patient's care to another person
- speaking with and educating your patient
- interacting with the patient's family or other visitors.

Communication is a two-way street that requires good listening skills too. Listen carefully to family members, who may be the first to know that something is wrong with their child or other loved one.

A growing challenge for health care providers in the United States is that more and more patients and their family members have limited proficiency in English. Rely on a professional medical interpreter to translate your instructions or questions to your patient and his responses. Hospitals have a duty to provide these interpreters as necessary. If a competent medical language interpreter isn't provided, you could face charges of substandard nursing care. (See "Speaking Up for Medical Language Interpreters" in the December issue of *Nursing2007* to learn more about this topic.)

The Joint Commission has set a standard for communication when one caregiver transfers patient care to another caregiver. According to The Joint Commission requirements, the nurse transferring care must give the nurse taking responsibility for the patient all appropriate information about his condition, how he's responded to treatment during the shift, any changes in his condition or treatment plan, and any other information that will help the next nurse plan for his care. The standard requires that communication during transfer of care be interactive so that both parties can ask questions and that interruptions be minimal.[3] (A handy way to remember what information to include when you talk with other caregivers at such times appears in *Think "SBAR" when discussing care*.)

The following scenario shows how poor communication can lead to legal trouble.

A neonate is receiving an infusion of calcium gluconate through an I.V. line in his right foot when the nurse notes discoloration and edema at the injection site. As the baby is being transferred to another unit, a transfer note indicates the time the infiltration was discovered and the fact that the nurse checked the area before the transfer; however, these details don't appear in the medical record. In the medical record are flow sheets on which some of the original writing is scratched out and written over.

When the baby's parents arrive and ask the staff about the injury, they're told it's a blister. With time, however, it leads to considerable scarring and loss of motion. The parents sue the nurse who cared for the baby when the infiltration occurred.[4]

4 Delegate responsibly

In general, today's hospitalized patients are more acutely ill than those of the past. Because experienced nurses are in short supply, nursing teams that include unlicensed assistive personnel (UAPs) are making a comeback. As an RN, you must know who has the appropriate skills and competencies to meet a patient's needs when assigning a portion of her care to someone else. When you establish a work assignment, you're still responsible for the patient's care, and you must delegate appropriately and supervise the person carrying out the assignment.

To delegate safely, you must first know what your state board of nursing allows you to assign to others. Some states don't specify which duties may be delegated, but others may spell out tasks you may delegate, such as hygiene care or insertion of an indwelling urinary catheter. The "five rights" for delegating to another caregiver provide an easy-to-remember guide: right person, right task, right circumstances, right direction, and right supervision.

Think "SBAR" when discussing care

To ensure effective, comprehensive communication when you report on your patient's condition or transfer care, remember the abbreviation *SBAR*:

S is for *situation.* (Identify the patient and why he was admitted.)

B is for *background.* (Provide a brief and significant medical history, including any tests or treatments completed.)

A is for *assessment.* (Describe the patient's current condition.)

R is for *recommendation.* (Discuss the plan of care for the patient.)

If you're receiving a new patient, be sure to get all this information from the prior caregiver.

You can learn more and download copies of two SBAR tools at the Institute for Healthcare Improvement Web site, **http://www.ihi.org**.

The ***right person*** refers to both the nurse who's delegating and those who'll perform the task. To direct and supervise appropriately, you must be a licensed nurse and you must understand the qualifications and competencies of your staff.

The ***right task*** is one that may be safely delegated for a specific patient. Typically, safe tasks are those that recur frequently in the patient's care; involve an unchanging, standard procedure; and have minimal risk and predictable results. Don't delegate complex tasks that require nursing assessment or nursing judgment.

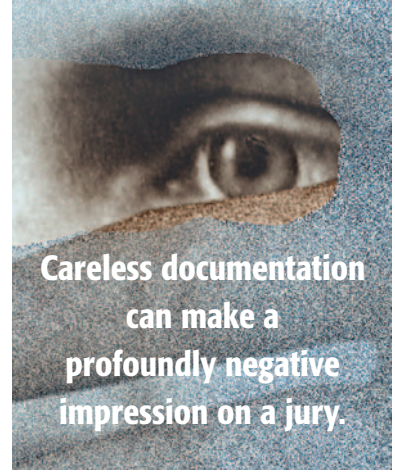
To determine the ***right circumstances***, consider all relevant factors, including appropriateness of the patient setting and available resources. Even tasks that fit the criteria for "right task" may not be appropriate if circumstances such as the patient's condition don't allow for delegating them. For example, assigning a UAP to help ambulate a patient who's at high risk for falls may not be appropriate.

Giving the ***right direction*** means providing a clear, concise description of the task you're delegating, including objective limits and expectations. Here's an example: "When you take Mr. Brown's blood pressure, the acceptable range is between 120/80 and 140/80. If you get a reading outside this range, please report your findings directly to me as soon as you get the reading."

Providing the ***right supervision*** calls for knowing the qualifications and competencies of your staff, knowing the results of the delegated task, and evaluating performance. At times, you may need to intervene in the care being given. As the supervising nurse, you remain responsible for the patient and need to evaluate her condition and response to the tasks performed.

Here's an example of inappropriate delegation posing a great risk to the patient:

A charge nurse asks a UAP to use a meter to determine a patient's blood glucose level. The UAP goes to the patient's room and apparently does as asked. At the change of shift, the charge nurse asks the UAP for the test results. The UAP reports that when she did the test, "EEEEE" appeared on the meter screen. Asked if she repeated the test, the UAP replies that she hasn't but that she did document the reading in the patient's chart. A repeat test indicates that the patient's blood glucose reading is over 800 mg/dL, and she's transferred to the intensive care unit for treatment.



Violations in the "five rights" of delegation are evident in this scenario. The UAP apparently didn't have proper education to use the blood glucose meter and wasn't the right *person* to perform the *task* under the circumstances. Was the patient's blood glucose level stable before the nurse assigned the task? Proper *direction* and *supervision* were lacking too. The charge nurse should have specified a range for the patient's blood glucose reading and told the UAP to immediately report the findings to the charge nurse if they weren't within that range. Waiting until the end of the shift to ask for the results was another serious error in judgment.

5 Document in an accurate, timely manner

Accurate, timely documentation in your patient's medical record is crucial for these reasons:

- The medical record is a legal document required by state laws and regulations.
- It's a means of communication between caregivers that ensures continuity of care.
- It's used for education and research.
- It's used to substantiate insurance reimbursement claims.
- It can be used as evidence in legal proceedings to establish whether or not the care rendered met the legal standard of care.

A basic rule of safe documentation is to know and follow your facility's documentation policies and procedures. Institutional policies typically detail the forms of documentation to use, how to make a late entry, and how to correct an error in an entry. Failure to follow facility policy can result in inconsistencies; in turn, these may compromise patient safety and create legal problems if the record ends up in court. Regardless of how professional a nurse appears on the witness stand, careless documentation can make a profoundly negative impression on a jury.

The following situation demonstrates the dangers of careless documentation.

A man injures his left leg falling off the back of a truck. A cast is applied to his leg in the emergency department, and he's admitted to the hospital for his injuries. The next day, he begins to develop numbness in his left foot. The physician examines the patient and notes in the medical record that his "toes are cool and getting more numb," so he removes the top part of the leg cast.

The next day, the patient complains of severe pain in his left foot and the nurse alerts another physician of the change. Examining the patient and noting that he has compartment syndrome, the second physician performs a fasciotomy, but the patient's circulatory problems continue and his left leg has to be amputated.

A malpractice suit is brought against the physicians, hospital, and nursing staff. Because hourly circulation checks weren't documented in the patient's medical record, one of the decisions the court has to make is whether nursing negligence was partially responsible for the loss of his leg.[5]

6 Know and follow facility policies and procedures

Institutional policies and procedures help establish the nursing standards of care you'd be held to in court. Patient-care policies and procedures must be based on current and recognized practice. They must be updated regularly, and they should be realistic.

Any deviation from a policy or procedure that harms the patient can subject you and the facility to liability exposure, so some flexibility is necessary. For example, rather than stating that patients' vital signs must be taken every 4 hours, a policy stating "within 4 hours" or "every 4 hours plus or minus 30 minutes" allows some leeway.

The nurse in the following scenario is sued after failing to follow hospital policy and procedure.

A nurse in an acute care hospital applies wrist restraints to a patient before briefly leaving his room. When she returns, the patient is next to the bed, hanging by his arms from the restraints. He subsequently develops pain in his right wrist and has X-rays, which show a fracture.

The patient sues the nurse, claiming that the restraints caused his injury. Court testimony shows that applying wrist restraints to the patient was inconsistent with hospital policy, but the patient can't prove that the restraints caused his injury.[6]

7 Use equipment properly

As a nurse, you have a duty to make sure you've received adequate training on the equipment you use to provide patient care. You must understand the equipment's intended use, know how to operate it properly, and follow policies and procedures for using it if they exist. Never try guessing how to use equipment.

The following scenario demonstrates how a patient is harmed when medical equipment is misused.

A patient is undergoing hysteroscopy. The equipment is missing a clip, and the nurses improperly connect an exhaust line that's hanging loose to an outflow port. The patient dies, and the family sues the hospital.

Evidence submitted at trial indicates that when the equipment used for the procedure left the manufacturer, it was properly set up. It also shows that two of the nurses assigned to the patient's case had no training on the use of the equipment and that their lack of training may have resulted in improper unclipping of the tube.[7]

Standards put into practice

By adhering to the seven principles of nursing care spelled out here, you help protect your patients, meet the standard of nursing care in your daily practice, and avoid legal problems. ‹›

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2. *Flores v. Cyborski,* 629 N.E. 2d 74 IL (1993).
3. The Joint Commission. *2007 National Patient Safety Goals.* **http://www.jcrinc.com/26813/newsletters/13469/**. Accessed November 2, 2007.
4. Federico F. Responding to a medication error. *Forum* (Risk Management Foundation, Harvard Medical Institutions). 23(2):18, May 2003.
5. *Dillon v. Medical Center Hospital,* 648 N.E. 1375 (1993).
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The author has disclosed that she has no financial relationship related to this article.

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Seven legal tips for safe nursing practice

GENERAL PURPOSE To provide nurses with guidelines for providing safe nursing care. **LEARNING OBJECTIVES** After reading the preceding article and taking this test, you should be able to: **1.** Identify aspects of nursing practice that are regulated by law. **2.** Indicate measures to help deliver nursing care safely.

1. Legally, a nurse is accountable to deliver care comparable to that of any
a. master's prepared nurse.
b. prudent nurse.
c. advanced practice nurse.
d. certified nurse.

2. A universal approach to nursing practice is known as
a. nursing outcomes.
b. the "five rights."
c. the nursing process.
d. nursing standards.

3. During which phase of the nursing process do you determine if goals are met?
a. assessment
b. planning
c. implementation
d. evaluation

4. To administer medications safely, you need to know all the following *except*
a. the drug's purpose and actions.
b. possible adverse reactions.
c. the appropriate dose.
d. the prescriber's name.

5. Regarding medication administration, which of the following is *most likely* to prevent harm to a patient?
a. the "five rights"
b. the nursing process
c. your state's nurse practice act
d. hospital policy

6. In which situation is a patient *most likely* to mistakenly receive a second dose of a prescribed medication?
a. during admission
b. when the medication is first prescribed
c. during breaks or mealtimes
d. if the medication wasn't available when due

7. An additional safety mechanism for administering high-alert medications is
a. an independent double check.
b. the nursing process.
c. the "five rights."
d. professional standards of care.

8. When the patient's condition changes, your legal duty includes all the following *except*
a. careful monitoring.
b. prompt documentation.
c. communicating the change to the practitioner.
d. continuing the current plan of care.

9. A nurse who *doesn't* respond to a patient's deteriorating condition can be charged with failure to
a. monitor.
b. rescue.
c. document.
d. initiate a care plan.

10. The Joint Commission expects communication between nurses during transfer of care to be
a. interactive.
b. written.
c. taped.
d. done at the patient's bedside.

11. When you use the acronym SBAR to discuss a patient's care, the "S" includes the
a. plan of care.
b. patient's medical history.
c. reason for admission.
d. patient's current condition.

12. In some states, duties that nurses can delegate are specified by
a. the Institute of Medicine.
b. the board of nursing.
c. the board of medicine.
d. The Joint Commission.

13. Which of the following is *not* a component of "right direction" during delegation?
a. selecting the person to perform the task
b. clear description of the task
c. communicating objective limits
d. communicating expectations

14. Tasks that may be safely delegated typically are those that
a. have predictable results.
b. are complex.
c. require nursing assessment.
d. require nursing judgment.

15. The basis of safe documentation is to follow
a. the nursing process.
b. the "five rights" of delegation.
c. SBAR.
d. facility policies and procedures.

16. The preceding article describes a patient with compartment syndrome. Nursing malpractice is charged because of failure to
a. monitor changes in the patient's condition.
b. document changes in the patient's condition.
c. recognize changes in the patient's condition.
d. report changes in the patient's condition.

17. Hospital policies and procedures should be
a. outdated.
b. flexible.
c. realistic.
d. rigid.

18. The preceding article describes a patient dying during a hysteroscopy because of
a. equipment malfunction.
b. surgeon error.
c. lack of clinician education.
d. manufacturer negligence.

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