

Nursing professionals and medical malpractice: A case study

In this case, the patient (plaintiff) was brought to the emergency department (ED) where he was well-known to the staff. He was intoxicated, agitated, and aggressive. His behaviors limited the nurse (defendant) and other ED staff from completing a comprehensive initial assessment. For the patient's safety, four-point physical restraints were ordered and the defendant nurse requested that security staff apply the restraints per hospital protocol... *To read the full case with risk management recommendations, go to www.nso.com/case-studies/casestudy-article/321.jsp.*



Nurses Service Organization Risk Advisor for Nursing Professionals

How did I make that mistake?

A nurse pulls a heparin vial from a medication cart. She looks at the label, fills the syringe, and then injects the infant—with the wrong drug. The infant dies.

This true example happened when a cart was inadvertently stocked with heparin vials containing 10,000 units/mL instead of the usual 10 units/mL. Part of the problem was that the labels looked similar; in fact, the abundance of these types of cases has led to a change in heparin labels effective May 2013. But a likely contributing factor is “inattentional blindness,” which refers to the failure to see something that is unexpected. In the heparin example, the nurse wasn’t expecting an incorrectly labeled vial, so she didn’t see it.

It’s challenging to reduce the risk of inattentional blindness because it tends to be involuntary, but knowing that it can happen and addressing factors that contribute to it could keep you from making an error that results in your being sued and, more important, avoid patient harm.

The “invisible gorilla”

In a classic 1999 experiment of inattentional blindness, researchers asked students to watch a video of two teams passing basketballs. The students had to silently count the number of passes made by members of the team dressed in white shirts and ignore the number of passes made by those in black shirts. Halfway through the 1-minute video, a student wearing a gorilla suit walks into the scene, stops in the middle of the players, faces the camera, and thumps her chest before walking off. Amazingly, about half of the students failed to see the gorilla. They were concentrating on their task—to count the number of passes made by those in white shirts—and missed the unexpected appearance of a gorilla. Furthermore, the students couldn’t believe they missed the

gorilla, expressing amazement when they saw the video again. (To see the invisible gorilla video, visit www.theinvisiblegorilla.com/videos.html.)

In a recent variation of this study, radiologists viewed computed tomography (CT) scans of five patients to screen them for lung cancer. The first four patients’ scans (about 1,000) were normal. But in 239 images from the fifth patient, researchers had embedded consecutive scans where a cartoon gorilla gradually appeared and then disappeared. Only 4 of the 24 radiologists looking at the CT scans noticed the gorilla.

What happened to the students and radiologists? The problem is that we’re confident we’ll notice unexpected events even when we are concentrating on something else. But the heparin overdose and the gorilla studies illustrate what researchers Christopher Chabris and Daniel Simons call the “illusion of attention.” In essence, we don’t process as much of what we experience as we think we do.

Think of inattentional blindness another way: We see what we expect to see. Consider the requirement of having two people verify an insulin dosage. The second nurse has worked with her colleague many years and knows he is competent, predisposing her to expect the dosage to be correct and to miss the fact it is wrong. Or, we look at an order on a computer screen and mentally fill in the missing dose of a drug because we know what’s typically ordered.

When you think about all the data that bombard us in a single day—or even a single hour—it’s not surprising that our perceptions are sometimes erroneous. Awareness of what factors contribute to inattentional blindness is a first step toward reducing it. Researchers who focus on the impact of human factors on errors point to four factors: capacity, conspicuity, expectation, and mental workload. Here’s a closer look at each of these,

including how healthcare professionals might use them to reduce errors.

Capacity. Drugs, alcohol, fatigue, stress, and age can affect your capacity to pay attention and notice important events. In a healthcare system where 12-hour shifts and sleep deprivation among nurses are common, fatigue is a particularly important consideration. It's one of the primary arguments *against* mandatory overtime and one of the primary arguments *for* taking care of yourself by eating healthy and getting enough sleep.

Conspicuity. The two types of conspicuity are sensory and cognitive. *Sensory* conspicuity refers to the physical properties of an object, with the most important being contrast of the object to its background. We notice objects that flicker or move, such as a railroad crossing sign. Drug labels that provide clear contrast between the important information, such as doses, and the background help key information “stand out” and reduce errors. *Cognitive* conspicuity refers to how you notice something that has relevance to you. A simple example is how you will overhear your name being mentioned by someone else, even in the middle of a noisy room. You can avoid this type of distraction by preparing medications in a quiet area where you won't hear background discussions.

Expectation. Our past experiences play a role in what we notice. Equipment alarm fatigue, for instance, is a safety challenge. One of the problems is that too many times alarms sound when nothing is actually wrong, so there is a tendency to start to ignore them. Even our expertise can sometimes work against us when it comes to expectations. For example, a nurse may become highly accomplished at operating a particular type of ventilator. When a new type appears, the nurse might inadvertently push the wrong button because it's in the same place as the one that should be pushed on the previous ventilator. Another example is suctioning. An experienced nurse in an ICU has suctioned so many times that he or she might miss an unusual patient reaction that a floating nurse might pick up because the floating nurse, who is unfamiliar with the procedure, is paying more attention to details.

Confirmation bias is another aspect of expectations. We are drawn to evidence that supports a belief or expectation and tend to ignore or dismiss one that doesn't. If you have checked the rate set-

Avoiding invisible gorillas

The problem of inattentional blindness still occurs even when people are cognizant of it, but by taking these actions, based on contributing factors, you can help protect yourself and your patient:

- Be alert for drug labels that look similar. Notify your pharmacy and drug manufacturers of potential problems.
- Lower the noise level to reduce distractions.
- Consider putting a system in place to avoid interruptions during medication preparation. In some hospitals, nurses wear a special hat or sash signaling they are not to be approached.
- Take special care with what you consider “routine” procedures. Keep in mind that errors tend to occur when new or unusual combinations of circumstances occur in a familiar setting.
- Increase your critical thinking skills by taking a class or reading about it. Critical thinking can help you avoid confirmation bias.
- Don't ignore technology such as automatic warnings on documentation systems, but don't over-rely on technology, either. Technology is not a panacea for stopping either inattentional blindness or medical errors.

ting on an I.V. pump three times and found it to be correct, you could easily fail to notice that it's wrong on your fourth check because you expect it to be correct.

Mental workload. You are more vulnerable to inattentional blindness if your attention is diverted to a secondary task. For example, you may be talking to a nurse practitioner on the phone and fail to notice the monitor alarm that signals ventricular fibrillation. Like most nurses, your day is probably filled with multiple tasks that need attention. Our profession—like our society—highly values the ability to multitask. Yet studies show you are more effective and efficient if you sequentially focus on one task at a time. When you change that complex dressing, for example, focus on what you are doing and not on the list of tasks yet to be accomplished. Interestingly, low workload, a problem not many nurses encounter, can contribute to inattentional blindness as well because we tend not to pay attention to routine tasks in this situation.

“Invisible gorillas” in healthcare

You can help protect your patients from errors and yourself from litigation by considering factors that contribute to inattention blindness in both one-on-one interactions and healthcare in general. Being aware of this risk can help you minimize errors and increase patient safety.

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RESOURCES

Chabris C, Simons D. *The Invisible Gorilla: How Our Intuitions Deceive Us*. New York: Three Rivers Press; 2011.

Green M. Inattention blindness & conspicuity. 2011. <http://www.visualexpert.com/Resources/inattentionblindness.html>

Grissinger M. Inattention blindness: What captures your attention? *Pharm Therapeutics*. 2012;37(10):584-585.

Hughes V. When experts go blind. *National Geographic*. 2013. <http://phenomena.nationalgeographic.com/2013/01/31/when-experts-go-blind>.

McGann E. Medication error prevention: a shared responsibility. *Medscape Medical News*. Jun 14, 2011. <http://www.medscape.com/viewarticle/744546>.

How to prepare for a deposition

Your worst nightmare has come true: You have been subpoenaed to give a deposition as part of a lawsuit. The patient is a 76-year-old man who experienced a stroke after telling you he was feeling dizzy but you didn't tell his healthcare provider. His attorney says that you failed to notify the practitioner of the patient's symptoms, leading the patient to have a debilitating stroke.

You certainly aren't the first nurse to experience a lawsuit. A recent claim study by NSO found that more than \$83 million was paid in professional liability judgments and settlements on behalf of registered nurses and licensed practical/vocational nurses from 2006 through 2010. In fact, the most severe allegation, from a financial loss perspective, was the failure to notify a practitioner of a patient's condition.

When you're assigned a patient, you prepare beforehand to deliver the care that patient needs. You might not be familiar with a medication the patient is receiving, so you look it up in the pharmacy database. Or, you might consult with a colleague about how to approach a patient who is depressed about his diagnosis of cancer.

Likewise, you need to prepare for a deposition so you can feel confident in your ability to be an effective witness. If you aren't well prepared for your deposition, the plaintiff's (opposing) attorney could easily challenge the legal defense your attorney has crafted for you. In fact, a poor showing at a deposition is the most common reason for an unsuccessful defense.

You can take several steps to prepare yourself, beginning with understanding the nature of a deposition.

To help you better understand the deposition process, CNA, the insurance carrier for the NSO program, has created a video, *Preparing for a Deposition*. Visit www.nso.com/nursing-resources/deposition-preparation-video.jsp.

What is a deposition?

A deposition is a legal proceeding for gathering information from someone named in a lawsuit or who is a witness in a lawsuit. Depositions occur in the *discovery* phase of a lawsuit—the litigation investigative process that takes place after the complaint is filed and before the trial.

Depositions are key in a jury trial. Juries in medical malpractice trials want to hear the defendant describe what happened. Furthermore, during the trial you will be held to the facts you gave at your deposition. Any discrepancies will not reflect well on you or your defense.

During a deposition, which usually takes place in the plaintiff attorney's office, you will testify under oath. A court reporter will record your testimony verbatim, and you may be videotaped.

What to do if you are subpoenaed

Be sure to notify your supervisor and NSO, your professional liability insurance provider, that you have received a subpoena to provide a deposition. (See *What to do in case of legal action*.)

What is the plaintiff attorney's goal?

The plaintiff's attorney will try to restrict you to one version of the incident or facts so your trial testimony

is consistent with what you said during the deposition. The plaintiff's attorney may also try to maneuver you into testifying inconsistently by rattling you or undermining your credibility, while assessing your strengths and weaknesses as a witness. For example, the attorney may point out inconsistencies in your testimony when compared to other witnesses. It's important to not take the "bait," but rather remain calm. You'll learn more about how to conduct yourself at the preparation meeting with your attorney assigned to you by CNA, the insurance underwriting company for the NSO program.

What should I do before the preparation meeting?

The most important step to prepare for the deposition is to meet with your assigned attorney. Usually, the preparation meeting is held about a month ahead of the deposition and follows at least one face-to-face meeting where you learn about the details of the lawsuit, including the specific allegations being made.

Before the preparation meeting with your attorney, thoroughly review the medical record. Consider all aspects, including your notes and what you have found in the treatment plan. It may help to develop a timeline showing the chronology of care you provided. Determine how what you have found compares to the allegations.

12 tips for giving a deposition

Even with proper preparation, giving a deposition is usually uncomfortable for most people. Yet your attitude and responses should portray you as someone who is confident. Following these tips should help:

- Listen carefully and think before you speak. Don't be pressured into rushing a reply.
- Speak slowly and clearly and answer courteously.
- If you need to consult the medical record, ask to do so.
- If your attorney objects, stop speaking.
- Don't look at your attorney when a question is asked; this is your testimony.
- If you don't know the answer to a question, say so instead of guessing.
- If you don't remember something, say so.
- If you don't understand a question or word being used, don't answer; ask for clarification or rephrasing.
- Answer only the question asked; don't anticipate further questions.
- Understand the theme of your case: You should know every allegation being made against you and the best responses to be made for the defense.
- Be confident and self-assured. If you need a break or drink of water, ask for it.
- Tell the truth.

To the best of your recollection, discuss with your attorney what you recall of the incident. If there are problems, you'll want to bring them to your attorney's attention.

What happens during the preparation meeting?

Your attorney will work with you to create a "theme" for your defense. For example, if paperwork for the patient who developed an ulcer was sloppy, the theme might be that even though the paperwork may have suffered, care to the patient did not. You will want to keep that theme in mind at all times during the deposition so the plaintiff's attorney doesn't pressure you into making statements that do not support your case. If you have made mistakes, admit it with contrition, but return to the theme.

This meeting is also a time when your attorney can help you prepare by discussing questions the plaintiff's attorney will likely ask and your possible responses. Finally, your attorney will review guidelines you should adhere to when you give your deposition (see *12 tips for giving a deposition*). Keep in mind that your role is to only answer the questions you are asked; do not explain or volunteer information. If your attorney objects, stop speaking.

You will also meet with your attorney the day of the deposition to touch base and discuss any last-minute concerns. Your attorney will be with you through the entire deposition. Remember to dress professionally because first impressions count.

What is license defense?

Another instance where you will need to prepare with an attorney is to defend yourself when someone files a complaint against your license. According to an NSO claim study, from 2006 through 2010, the average paid expense for registered nurses and licensed practical/vocational nurses to defend a claim against their license was a little over \$3,300.

License defense is needed when someone (patient, patient's family, colleague, or employer) files a complaint with a board of nursing against a nursing license. An action taken against a nurse's license differs from a professional liability claim in that it may or may not—as in the case of professional misconduct—involve allegations related to patient care.

What to do in a case of legal action

Here's a summary of points to keep in mind should you become involved in a lawsuit. Remember that all possible defendants are named when the lawsuit is filed because names can't be added later. Some defendants may be dropped from a case, so just because you give a deposition doesn't mean you'll necessarily appear in court.

- Contact NSO if you receive a subpoena to testify in a deposition or trial. Also contact your provider if you suspect there may be a lawsuit filed.
- Don't discuss the case with anyone except your attorney, your NSO representative, and your CNA claims consultant.
- Don't accept or sign any documents related to the claim from anyone without obtaining approval from your CNA claims consultant.
- Avoid discussing, commenting upon, or taking issue with any information you receive regarding judicial or administrative proceedings.
- Don't admit to liability, consent to any arbitration or judgment, or agree to any settlement proposal.
- Promptly return calls from your defense attorney and CNA claims consultant.
- Contact your attorney or CNA claims consultant before responding to calls or emails from other parties involved in the case.
- Report any communication you receive from the patient, patient's attorney, or any state or federal administrative agency, licensing or regulatory authority, immediately to your CNA claims consultant.

You are an expert

Remember that nurses are considered experts. To give a deposition like an expert, you must prepare like an expert. It may help you avoid a trial and give you peace of mind.

RESOURCES

Komoll M. Preparing for a deposition (video). 2011. CNA HealthPro. <http://www.nso.com/nursing-resources/deposition-preparation-video.jsp>.

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Excellent patient assessment protects nurses against litigation

Nurses are dedicated to providing excellent patient care, but are under tremendous pressure to accomplish more with less. In their haste to complete the many tasks that are required during a shift—administering medications, changing dressings, starting IVs, and so on—thorough, ongoing patient assessment can slip too low on the priority list.

But failing to conduct proper patient assessment can put you at risk for a lawsuit should a patient suffer injury because of your actions or, in the case of failure to follow up on an assessment, your inaction. Even if you conscientiously conduct regular and thorough assessments, you could still find yourself in court as a witness if you fail to document your findings and actions.

In fact, the NSO claim report *Understanding Nursing Liability, 2006-2010: A Three-part Approach* found that delayed or untimely patient assessment was the most frequent allegation in RN claims. (You can view the report online at www.nso.com/nursing-resources/claim-studies.jsp.) It's important to understand the risks of poor assessment, incomplete documentation, or lack of follow up and take steps to mitigate your risk of being named in a lawsuit.

A common claim

The report, which examined closed paid claims for professional liability and license defense, revealed how important assessment is. Consider these facts for professional liability claims:

- The highest average paid indemnity involved delayed or untimely patient assessment.
- Of the closed claims with allegations related to assessment, about 71% related to the nurse's failure to properly or fully complete the patient assessment or to assess the need for medical intervention.

Assessment includes ongoing monitoring. The same study noted that failure of the nurse to monitor and report changes in the patient's medical or emotional condition to the provider resulted in a higher average paid indemnity. Clearly, nurses play a key role in patient safety, including performing comprehensive patient assessments and reporting assess-

ment results. You can take the initiative to prevent yourself from becoming a statistic by following some simple guidelines.

Know expectations

You can't meet expectations if you don't know what they are. You should be aware of expectations set forth by the nurse practice act in the state where you practice, facility policies and procedures, and national standards.

Your state's nurse practice act will provide parameters for the scope of your responsibility as a registered nurse (RN) and include what can and can't be delegated. For instance, most nurse practice acts state a RN must be the one to assess the patient; in that case, you can't delegate the assessment to someone else such as a licensed practical/vocational nurse.

Your facility's policies and procedures regarding scope of assessment on admission and at other times during the hospital stay (or in the course of clinical treatment if you work in an outpatient setting) will guide you as you deliver care. These policies are typically based on requirements from accrediting bodies such as The Joint Commission and from the Centers for Medicare & Medicaid Services, as well as state regulations. You should also read and understand your job description.

If you question whether a type of assessment expected by your facility is within your scope of practice, contact your state board of nursing. If you find a discrepancy, bring it to the attention of your supervisor. Don't put yourself in legal jeopardy by taking actions outside your scope of practice.

In a legal case, you will be held to standards from the American Nurses Association and possibly other national associations. Review the standards and ensure you comply with them. You should also review and comply with standards from your professional specialty association. For example, if you are an infusion nurse, review the standards of practice from the Infusion Nurses Society.

According to the American Nurses Association, the registered nurse:

- *collects comprehensive data* including but not limited to physical, functional, psychosocial, emotional, cognitive, sexual, cultural, age-related, environmental, spiritual/transpersonal, and economic assessments in a systematic and ongoing process while honoring the uniqueness of the patient. Notice the scope of data that needs to be collected. Many facilities fail to include information about the patient's environment.
- *elicits the healthcare consumer's values, preferences, expressed needs, and knowledge* of the healthcare situation. This is becoming even more important because patient satisfaction is being linked to reimbursement.
- *involves the healthcare consumer, family, and other healthcare providers* as appropriate, in holistic data collection. Involving family members helps you avoid missing a key fact about a patient.
- *identifies barriers (psychosocial, literacy, financial, cultural) to effective communication* and makes appropriate adaptations. The Joint Commission now requires hospitals to address cultural literacy with patients.
- *recognizes the impact of personal attitudes, values, and beliefs.* For instance, some cultures require a woman's husband to be present during a physical exam.
- *assesses family dynamics and its impact* on a patient's health and wellness. Family dynamics are easy for a busy nurse to overlook, but they play a key role in helping you determine a patient's support system.
- *prioritizes data collection* based on the healthcare consumer's immediate condition, or the anticipated needs of the patient or situation. This is one competency that most nurses are accustomed to doing.
- *uses appropriate evidence-based assessment techniques, instruments, and tools.* Failure to use proper tools can put you at legal risk. For example, use a standard measurement tool to assess a patient's level of pain. For geriatric patients, consider using tools from the Hartford Institute for Geriatric Nursing.
- *synthesizes available data, information, and knowledge* relevant to the situation to identify patterns and variances. If you are unsure of your findings, consult with other healthcare providers.
- *applies ethical, legal, and privacy guidelines and policies* to the collection, maintenance, use, and dissemination of data and information. Collect only the information you need to care for the patient and that the patient gives you permission to collect. For instance, do not access the patient's Facebook page or other social media.
- *recognizes the patient as the authority on her or his own health* by honoring his or her care preferences. This is reflected in a patient-centered care approach.
- *documents relevant data in a retrievable format.* Always document promptly and completely.

Ensure your assessment skills are current

You have a duty to obtain the information and education you need to keep your practice current, including your assessment skills. What nurses call *assessment* has evolved over the years. At one

time, nurses didn't auscultate the lungs; now it's considered an expectation and nurses learn this skill in school. As new expectations enter practice, you'll need to ensure you can meet them through educational opportunities.

Equipment such as ECG monitors has come to play an important role in assessment. Be sure you know how to operate monitoring equipment and interpret the results you obtain. Don't over-rely on equipment, however. It's easy to get caught up in the various machines and forget to look at the patient's physical and psychological condition.

When you conduct your assessment, keep in mind areas that are frequently missed, such as asking patients about over-the-counter medications, herbs, and supplements they take. Remember to consider the patient's family members and significant others as sources of information; they know the patient better than you do, particularly if the patient is cognitively impaired.

Monitor patients closely

It's vital that you monitor patients on a regular basis by assessing their clinical status, including analyzing data obtained by devices such as cardiac monitors. You do not need an order to monitor patients more closely than what has been ordered. In fact, if you have any concerns, you should increase monitoring frequency.

In addition to gathering information, alert other staff such as certified nursing assistants and respiratory therapists what to look for in a patient's condition. For instance, you might ask a nursing assistant to let you know if a patient with a history of strokes develops one-sided weakness. Patients can help with ongoing monitoring, too, if you explain what they should watch for, such as shortness of breath or difficulty voiding.

These strategies don't take the place of your own assessments, but can help alert you to problems early. And, of course, it's up to you to respond to the reports by conducting your own assessment.

You are expected to rely on your clinical judgment to determine if action needs to be taken based on an assessment. If there is a problem, notify the appropriate healthcare provider, such as a primary care physician, nurse practitioner, or assigned resident, immediately and document that you did so.

What if the provider fails to take appropriate ac-

Self-assessment questions to reduce your risk for litigation

Answer these questions when evaluating your patient assessment skills in terms of risk for litigation:

- Do you assess and document the following upon admission, with a change in treatment, or with a change in a patient's condition or response to treatment: presenting problem(s), fall risk, comorbidities, patient's understanding of his or her condition and plan of care, mobility status (including use of mobility aids), medications, risk for elopement or abduction, status of skin or any wounds, pain management, restraint use, behaviors, cognition, nutrition and hydration status, vital signs, and lab values?
- Do you notify all appropriate parties of assessment results and document you did so, along with the outcome?

Determining if your patient assessment skills are adequate is just one component of what you should consider when analyzing your potential risk for litigation. Other self-assessment categories include patient monitoring, treatment and care, clinical specialty, scope of practice, patient care equipment and supplies, professional conduct, and documentation practices. For an easy-to-use checklist for addressing each of these areas, visit <http://bit.ly/z3vFRg>.

tion? As the patient's advocate, you are expected to move up the nursing or medical chain of command as needed. Let's say your postoperative patient's oxygen saturation has dropped from 90% to 70%. She is receiving 40% oxygen and is pale and restless. Her pulse and respirations have increased compared to earlier in your shift, and her blood pressure has decreased slightly. When you call the resident and ask to obtain arterial blood gases, he says he's busy and will get back to you.

Ten minutes later, the patient's oxygen saturation is 60% and her heart rate is 140 beats per minute. Her blood pressure remains low and her respirations have increased. You call the resident again and ask to increase her oxygen, repeating your request for arterial blood gases. He replies, "Wait until I see her.

I'm tied up, I'll get there as soon as I can."

In this case, you would be expected to call the chief resident (or the next in the chain of command)—this patient's condition is serious, and prompt action is needed. If you fail to follow up and the patient suffers a cardiac arrest from poor oxygenation, you could be held liable.

If your facility's culture doesn't support invoking the chain of command, that doesn't excuse you from not doing so. That's why you should work to change the culture by explaining the risk to patient safety and the financial risk to the facility for failing to establish a culture where it's safe for staff to speak up. If you can't change the culture, you may need to consider a change in jobs. Remember, the healthcare team relies on nurses to assess and monitor patients and to effectively communicate patients' needs.

Document, document, document

The classic dictum you learned in nursing school, "If it wasn't documented, it wasn't done," still applies. Documentation needs to be complete, timely, legible, and accurate. Whether you are using paper or electronic patient records, be sure to include assessment-related information such as:

- results of your initial and ongoing assessment and monitoring
- changes in the patient's condition and the date and time the patient's provider was notified
- results of diagnostic procedures and laboratory testing, and the date and time the patient's provider was notified.

Documentation should follow standards established by professional nursing associations and federal and state regulations and comply with your facility's guidelines. The latter is particularly important in the case of late entries and corrections. Juries may view these as evidence that you weren't thorough in caring for the patient, so you need to strictly follow procedures. In addition, never alter the medical record and never include subjective opinions.

When you document, provide objective details, whether you reported information to someone else, and how the treatment plan was modified. Here's an example of an inappropriate documentation assessment for a patient with a new pressure ulcer:

Area of skin breakdown found on sacral area. Dr. Smith notified.

This entry doesn't tell us much about the wound, which means it's open for interpretation should the ulcer progress and the patient sue for lack of proper care. Instead, something like this would provide more information and protect you in a court of law:

Open stage II ulcer 2 cm long, 3 cm wide, and .5 cm deep on left sacral area. Wound edges defined, wound bed pink. No undermining, drainage, edema, or odor. Reddened intact area extends 2 cm around ulcer. Patient states pain is 3 on a scale of 0 to 10 with 0 being no pain. Dr. Smith notified. Wound consult ordered. Increased repositioning schedule to every 1 hour.

This entry provides detailed information, making it easier to track the progress of the ulcer. If you have any questions about how to document properly, contact your facility's risk manager.

Communicate your findings effectively

How you communicate your assessment findings is just as important as the act of reporting them. Only through the exchange of accurate, timely, complete, and appropriate information can the healthcare team ensure patients receive the care they need.

Failing to communicate effectively can lead to delays or errors. If your assessment results require a call to the patient's provider, it might help you to structure your report in terms of SBAR:

Situation: What is the situation? Tell the provider what you are calling about and briefly describe the problem—what it is, when it happened or started, and how severe it is.

Background: What background information is pertinent? Provide relevant background information, such as the admitting diagnosis and date of admission; current medications, allergies, I.V. fluids, and lab results; most recent vital signs; your assessment findings; and resuscitation status.

Assessment: What is your assessment of the situation? For example, if a patient with an acute anterior wall myocardial infarction develops crackles in both lung bases, is short of breath, and has an increased respiratory rate, you might conclude the patient is going into heart failure.

Recommendations: What do you recommend? In the previous situation, you might say the patient needs to be seen or needs an order for a diuretic. Using a structured format helps ensure you cover

all the pertinent information efficiently and that your ideas for how to meet the patient's needs are heard. Another aspect of communication relates to patients and families. Establishing a positive relationship not only helps you better care for the patient, but also builds goodwill that can be helpful should an error occur. In addition, families are well positioned to notice changes in the patient you might overlook. Consider them part of the team. Be sure that you know the patient's (and family members') language preference and cultural background so you can communicate effectively.

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Helping you and your patients

Remember that proper assessment with appropriate follow through not only protects you from litigation, it also protects your patients from harm.

RESOURCES

American Nurses Association. *Nursing: Scope and Standards of Practice*. 2nd ed. 2010. Silver Spring, Md.: American Nurses Association.

Hartford Institute for Geriatric Nursing. Assessment Tools-Try This. http://hartfordign.org/resources/try_this_series.

Kaiser Permanente of Colorado. SBAR technique for communication: a situational briefing model. Institute for Healthcare Improvement. 2011. <http://www.ihi.org/knowledge/Pages/Tools/SBARTechniqueforCommunicationASituationalBriefingModel.aspx>.

Understanding Nurse Liability, 2006-2010: A Three-part Approach. <http://www.nso.com/nursing-resources/claim-studies.jsp?refID=nurseclaimreport2011>.

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