Medical Errors and Competency

As a legal nurse consultant, you see medical errors from the perspective of what has already happened. Not listening to the concerns of staff nurses may have played a part in the events leading up to the medical error. In his podcast, Kevin O’Connor discussed what happens when physician competencies are stretched by not working enough hours. This is Pat Iyer with Iyer’s Insights, one of the twice weekly shows of Legal Nurse Podcast.

I faced this same question in 1995 when my hospital introduced patient-centered care. The hospital where I worked wanted to save money. They eliminated the IV team and wanted RNs to start IVs. The hospital eliminated the department that found beds for patients who needed to go to long term care after discharge. They cut the staff of the cardiopulmonary department and asked the nurses to do EKGs. And one more cut – the phlebotomy staff – so that the nurses would draw blood samples.

When I heard about all these new responsibilities, I was running my business full time and working as a medical surgical staff nurse 1 or 2 days a month. I heard, “All RNs must go through 2 full weeks of training. But I could not take off 2 weeks from my LNC business.

My reservations about this change were even deeper. My exposure to cases involving medical errors showed me that people who were not proficient in their skills were involved in injuring patients. I did not want to stick needles in people while probing for veins if I had an opportunity to do so only once a month.

Reactions to Patient Centered Care

The nurses I worked with were not enthusiastic about taking on even more responsibilities on a busy medical surgical unit. Their assignments of 6 to 8 patients did not lend themselves to doing even more. “That will never work”, one of my colleagues said to me. The nurse manager wants us to take on these new roles and I know it will never work. We don’t have the time to get involved in that.”
I approached the nursing administration, all of whom I knew well having worked with them in an administrative capacity before I joined the prn pool. “It does not make sense for me to learn these skills working as infrequently as I do. What provision do you have for accommodating prn nurses?”

“None”, it turned out.

I don’t have a dramatic story about how I caused injury to a patient because I did not have enough experience in starting IVs or doing phlebotomies. We know nerve damage may result from those procedures. I don’t have a story because I quit after working with this hospital for 15 years. It made me sad to leave patient care, but I had a strong commitment to not injuring someone.

**Guess what? After training all the full and part-time nurses, the impracticability of the patient centered care model became apparent and the hospital had to stop it.**

- Think of the expense of the training.
- Think of the risk to patients of part-time people performing skills without adequate experience.
- Think of the waste that could have been avoided if the nurse managers had been willing to accept the truth of the staff nurses’ perspective.

When you work in an environment where leaders are challenged by the truth, and choose to ignore it, you are at risk for limiting your career or being fired.

**If you rock the boat often enough you will get thrown overboard.**

It is hard to determine how many medical errors arise from situations like this. I just know that if leaders don’t engage in the critical conversations with their staff, if they don’t want to hear reservations about new initiatives, they will fail.

The stakes are high in health care. People get hurt when leaders don’t listen.
As a legal nurse consultant, you play a crucial role in helping attorneys identify medical malpractice cases that are meritorious. There is a lot at stake in a medical malpractice case – the costs, the potential recovery for the plaintiff and the reputations of the defendants.

Using your medical knowledge and analytical skills, you are in a prime position to help attorneys understand the merits of a medical malpractice claim. You can be the light that guides the attorney to the meritorious claims.

Let me share with you the key things you’ll discover in my online training, **Medical Malpractice LNC Case Screening**.

This program is ideal for legal nurse consultants who work with medical malpractice attorneys. In this 90-minute training, you will discover:

- How to establish the standard of care
- How to identify theories of liability
- How to use key elements of effective case screening
- How to spot case winners and losers
- How to avoid pitfalls of medical record analysis

I presented this training with Barbara Levin, an experienced expert witness. Barbara and I have combined 45 plus years reviewing cases as expert witnesses; we share our deep knowledge with you in this training. You’ll hear about our most memorable cases and what lessons you may learn from them.

Obtain the details about this program at the show notes for this podcast. You’ll find them on podcast.legalnursebusiness.com. I’ll give you a 25% discount if you use the code Listened in the coupon box when you purchase the training. You may also
get information about this training when you listen to this podcast on our mobile app called BizEdu. Obtain the app by going to legalnursebusiness.com/bizedu. Now let’s return to the show.

Safety Principles for Preventing Patient Injury

There are multiple opportunities for patient injury to occur. Those of us with knowledge of how the healthcare system works see that facilities use safety principles for preventing patient injury. When the system fails, the litigation system may become involved.

Consider the safety issues in this case.
A forty-two-year-old woman entered the hospital with chronic cellulitis infection in her left leg, uncontrolled diabetes, nausea, vomiting and diarrhea. She contracted hospital-acquired pneumonia. She stopped breathing while undergoing an esophagastroduodenoscopy. Her estate alleged the defendant internist failed to diagnose and treat the bacterial pneumonia and that the EGD was contraindicated because of the respiratory compromise.

The estate also alleged the hospital personnel failed to timely perform chest compressions, failed to adequately perform bag/mask ventilation, performed ineffective resuscitation, delayed responding to the code blue (over 6 minutes) and failed to have a code policy in place. The jury found the hospital liable for $8 million.

Although sometimes education is the most useful way to prevent adverse events, it is also important to make changes in the healthcare system. After an incident like this takes place, preventing patient injury involves a complex set of remedial efforts.

For example, what were the competencies of the staff taking care of this patient? How often did they ever see a patient in cardiac arrest? Clearly this would be a low frequency high risk event for them.

We can say that all staff in the all areas of the hospital where patients may be located should be taught how to perform CPR. The educational approach would involve instructing workers how to perform CPR. The systems approach would
involve having a code cart at hand as well. But it is a challenge to keep the skills current for this type of infrequent event.

**Lessons of High Reliability Industries in Preventing Patient Injury**

Certain industries like nuclear power and commercial aviation operate under dangerous conditions yet have far better safety records than does health care. These “high reliability” industries have much to teach us about preventing patient injury. Here are some of the lessons.

1. All workers should look for and report *small* problems or unsafe conditions before they pose a risk to the organization and when they are easy to fix.
2. Workers should *resist the urge to simplify* their observations and experiences. Threats to safety can be complex and present themselves in many ways.
3. Workers should *always report* any abnormalities in operations. A piece of equipment could first have a subtle malfunction before a major equipment related problem develops, for example. Everyone should feel free to speak up about any concerns.
4. Workers should understand that *small errors can spread and worsen*. They must be quickly contained to limit harm.
5. When a threat to patient safety occurs, the person with the *greatest expertise* should be given decision-making authority. That person may not be the most senior or highest in rank in the organization.

I think of the healthcare system as suspended over a safety net. There are holes in the net - How tight can we make the mesh?

Get practical tips you can immediately use when you screen your next medical malpractice case for merit. Invest in our online training called *Medical Malpractice LNC Case Screening*. Get the details at the show notes for this episode on podcast.legalnursebusiness.com.
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