

required patients to be assessed for up to six days post-operatively, I had the opportunity to interact with many critical care nurses with whom I could not normally interact. We had some very good conversations about nursing research and nursing practice.

The fourth step

As the data collection phase drew to a close, we began to think about the next step - data analysis. This was a rather frightening stage for me because mathematics (and hence statistics) has never been my forte. Thanks to the guidance of the Director of Nursing Research and the skill of a knowledgeable data clerk, the entire process began to make sense. Suddenly, words like "mean," "standard deviation," and "T-test" became meaningful. They made sense because I had worked through the other parts of the project and I knew the research area so well. I could understand how the numbers that were entered into the computer represented the data we had collected. I also began to appreciate the logic behind organizing the data sheet in such a way that it helped in entering the data into the computer.

I thought I had been excited about the project before this stage, but as the data analysis proceeded, and I began to see progress, my excitement grew even more. I was on the verge of finding the answers.

We had a total of 451 patients in our study and discovered that 18% developed lesions within three days of their surgery. The most common site for the lesions was the right buttock.

Because the complete study will be reported elsewhere, I will not repeat the findings here. However, from our work we were able to develop a profile of the patients at high risk for developing skin lesions following cardiovascular surgery. The individuals at greatest risk in our study were male, thin, in hospital longer than three days pre-operatively and required a long pump run during surgery. Using the data, we have been able to change our approaches in caring for these patients. In particular, we have begun to use an "egg crate-type" mattress under the patients during surgery. Currently, we are repeating our study to see if the prevalence of 18% can be reduced through the use of this intervention.

A study is not complete, however, until the final step of communicating the results has occurred. I have had the opportunity to talk about our findings at a number of seminars and conferences and have written an article to report the full study. I also wanted to share the experience itself; thus, this article.

Conclusion

I think many of us are fearful of nursing research. We have not had the opportunity to learn about it and the thought of doing it fills us with dread. However, we all make decisions everyday in our roles as nurses and those decisions affect patients and their families. The decisions we make can only be as good as the data or information we have with which to make those decisions. As nurses, we need to take the risk of asking questions about our practice. We need to find the resources that will help us search for the answers to our questions and engage in the necessary research activity. Not only will we ultimately add to our ability to make good decisions, we will also experience the adventure in being curious and the joy in discovery.

About the author

Joyce Flemming, R.N., was a clinical teacher, operating room, when this research was undertaken. Currently, she is Quality Assurance Co-ordinator, The Toronto Hospital. Dr. Margaret Fitch was the Director of Nursing Research at the same time. Her input into the study is gratefully acknowledged.

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Medico-legal Issues

How nursing Quality Assurance can set the stage for liability

By L.E. and F.A. Rozovsky

With more and more hospitals putting in place quality assurance monitoring techniques in the operating room, the legal dangers of liability increases. This phenomenon comes as quite a shock to many operating room supervisors and senior management personnel. They find it difficult to believe that an administrative measure put in place to evaluate and improve the quality of patient care can exacerbate the risk of liability exposure. Despite their disbelief, the fact remains that nursing quality assurance measures used in an improper fashion can set the stage for hospital liability.

Legal basis for accountability

Once a health facility puts in place an administrative system dedicated to evaluating or improving patient care, it is incumbent upon the agency to use this mechanism. Establishing a quality assurance system will be construed in law as setting a standard of practice. As such, health facilities must follow recognized practice to act as would the average, reasonable, prudent agency with a similar operating room quality assurance system. The failure to avail itself of the established practice resulting in foreseeable harm or death sets the stage for negligence litigation.

Setting the stage for liability

When nursing staff are assigned to handle quality assurance in the OR, they are acting as the agents of the health care centre. It is no excuse that nurses "did not understand" or "did not have sufficient time" to do their quality assurance work. By holding itself out as having a dedicated QA system for monitoring care in the operating room, the agency is in effect

saying the standard of practice is "to do QA."

Several techniques used in O.R. quality assurance can set the stage for liability. Indeed, some are imposed, not be hospital practice, but by provincial legislation.

For example, under Ontario legislation¹ anaesthetists must do a pre-operative history and document relevant information. At the procedural level in many agencies, the net effect is that prior to surgery, OR supervisors or nurses will "check" to see that this task has been completed. The failure to report deficiencies in pre-operative charting identified in a mandatory nursing QA audit which results in foreseeable harm to a patient would be the basis for liability.

The agency will be held accountable because its agents - nursing staff - failed to abide by recognized standards of practice. Health facilities feel obliged to provide for the well-being of patients. In many cases they see themselves fulfilling their mandate by utilizing nurses as "watchdogs" to make certain that patients do not receive anaesthesia until appropriate pre-operative measures have been completed. When nurses as the intermediaries designated to "screen out" incomplete pre-operative anaesthesia fail in their intercept function with resulting patient injury, the stage is set for liability.

Aside from legislated requirements, many hospitals impose their own quality assurance care standards. Examples include the following:

1. Pre-operative teaching sessions.

Prior to surgery nurses evaluate patient understanding of the intended procedure. They also "educate" patients about pre-operative and post-operative measures. This includes N.P.O. orders, prepping, post-operative support measures, discomfort levels,

etc. When, however, in the course of pre-operative teaching and assessment it is clear that patients do not understand the nature, purpose or severity of the surgical procedure, nurses record this information. The failure to communicate this information promptly to block the procedure until these deficiencies have been corrected is the basis for liability. Since the agency is held jointly and severally liable with nurses who know about such inadequacies, both will be held responsible for resulting patient injury.

2. Inadequacies in the consent process.

In many pre-operative patient teaching or audit sessions or in pre-op chart reviews, nurses will uncover incomplete consent procedures. Patients may have consented to surgical measures different from those found on the consent document. It may be that the patient discloses risk factors unknown to the surgeon. The failure to report such quality care deficiencies resulting in foreseeable harm or death is the basis for joint and several liability between the nurse and her employer.

3. Surgeon exceeding the bounds.

When nurses discover but do not act on doctors exceeding the scope of their privileges, the stage can be set for liability. Once a hospital knows or should know through its agents that doctors are exceeding the scope of delineated privileges, the health facilities and their nurses will be held responsible for foreseeable patient injury. Hence, when a nursing OR audit discloses that surgeons are exceeding the scope of delineated privileges it is imperative that this information be reported promptly to appropriate supervisory personnel.

4. Surgeon incompetence.

Although nurses are not in a position to judge surgical competency, they are able to assess whether physician performance is up to the usual and customary standard. When nurses see surgeons acting in an unusual way or they suspect alcohol or drug abuse, reason dictates that the nurse report her findings.

The failure on the part of nurse to "blow the whistle" resulting in reasonably foreseeable harm or death to a patient can be the basis for joint and several liability between the hospital and the nurse. The reason is clear: once a nurse knows or should know about surgeon incompetence, his/her "knowledge" is vicariously attributed to the hospital. The real problem occurs if the O.R. quality assurance monitors do not pick up on these problems. The fact that the system is in place will only serve to weaken any possible defences raised by the health facility.

Making the best of quality assurance

That quality assurance can be used as the groundwork for establishing liability should not be a deterrent to using such patient care systems. To put the matter in perspective, any administrative mechanism can be used as the basis for liability as long as there is proof that harm resulted from substandard practice or "use" of the system.

However, it is equally clear that proof of proper, reasonable and prudent use of patient care systems such as quality assurance can defuse litigation.

A reasonable approach should be taken with respect to quality assurance. It can be a useful system for improving the quality of patient care. However, it must also be recognized that once it is in place, inappropriate use of QA can be construed as a departure from an established standard of care.

For operating room supervisors and other members of the management team, it is essential to define the scope of the quality assurance programme. This should include consideration of the following:

- What will be addressed in OR "QA" monitoring?
- Who will be assigned to carry out the monitoring?
- How will information be transmitted to superiors?
- How will O.R. nursing staff liaise with the Medical Director? Chief of Surgery?
- Who will be asked to handle follow-up issues?
- Who will work with legal counsel to minimize the legal pitfalls of OR "QA" monitoring?

From a legal perspective, caution should be exercised if the intent is to transform nurses into quality assurance "watchdogs" in the operating room. Not only can nursing care suffer, the additional role can impose upon nurses unwanted liability exposure. The key is to follow average, reasonable, prudent measures and not to place too much emphasis on nursing QA as an oversight function of medical practice in the operating room.

Reference

- (1) See, Public Hospital Act, Regulation 518/88, s.27, 1988, as amended.

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