Legal Issues Case Study For Nursing Essay, Research Paper

Legal Issues Case Study for Nursing

Case 2

Nursing Situation:

Cindy Black (fictitious name), a four-year-old child with wheezing, was

brought into the emergency room by her mother for treatment at XYZ (fictitious

name) hospital at 9:12 p.m. on Friday, May 13.

Initial triage assessment revealed that Cindy was suffering from a sore

throat, wheezing bilaterally throughout all lung fields, seal-like cough,

shortness of breath (SOB), bilateral ear pain. Vital signs on admission were

pulse rate 160, respiratory rate 28, and a temperature of 101.6 ?Fahrenheit (F)

(rectal). Cindy Black was admitted to the emergency department for treatment.

Notes written by the emergency department physician on initial examination

read, “Croupy female; course breath sounds with wheezing; mild bilateral

tympanic membrane hyperemia. Chest X-ray reveals bilateral infiltrates.”

Medication prescribed included Tylenol (acetaminophen) 325 mg orally for

elevated temperature, Bronkephrine (ethylnorepinephrine hydrochloride) 0.1

millimeter subcutaneous, and monitor results.

Nurse Slighta Hand, RN (fictitious name) administered the medication as

ordered and the child was observed for thirty minutes. Miss Hand’s charting was

brief, almost illegible, and read, “Medicines given as prescribed. Cindy

observed without positive results. Physician notified.”

The physician examined the child; notes read that the child had “minimal

clearing” in response to the bronchodilator. The following medications were

then prescribed: Elixir of turpenhydrate with codeine one milliliter by mouth,

Gantrinsin (sulfisoxazole) 10

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milliliters, and Quibron (theophylline-glycerol guaiacolate) 10 milliliters.

Nurse Slighta Hand, RN charted the medications were given as prescribed.

Her note at 11:08 p.m. read, “Vomiting; unable to retain medicine. Respiration

increased (54), temperature 101.4?F (rectal); wheezing with increased difficulty

breathing.” No further notes were made regarding Cindy’s condition on the

emergency department record by the nurse, except to state that at 12:04 am,

“child released from emergency department.”

Thirty minutes after discharge from the emergency department, Cindy Black

was brought back to the hospital. This time her vital signs were absent, her

skin was warm without mottling, and the pupils of the eye were dilated but

reacted slowly to light. Cardiopulmonary resuscitation was instituted without

success, and Cindy Black was pronounced dead. Departure from professional

standards of nursing care:

In every nursing malpractice case the defendant nurse’s conduct is measured

against that of a reasonably prudent nurse under the same or similar

circumstances. Departure from the professional standards of nursing care for

the first admission to the emergency department included the following

deviations:

? Failure to assess Cindy Black comprehensively upon discharge

? Failure to assess the patient systematically for the duration of the

emergency

department visit

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? Failure of Miss Slighta Hand, RN to inform the physician that the patient

did not improve after treatment

Legal implications:

Analysis of the legal implications of the various nursing actions which

would affect the outcome of a lawsuit includes monitoring the patient’s

condition and reporting changes therein to the physician, failure to

communicate pertinent observations to the physician, and inadequate charting of

important information. “Monitoring the patient’s condition and reporting

changes therein is one of the nurse’s prime responsibilities. Nurses who fail

to record their observations run the risk of being unable to convince a jury

that such observations actually were made (Bernzweig, 1996, p. 171).” Nurses

must constantly evaluate a wealth of information and results, and as soon as

they become aware of any significant medical data, dangerous circumstances, or a

dramatic worsening of the patient’s condition, “they are required to communicate

this information to the treating physician at once. Their failure to

communicate these observations can have disastrous consequences and will

certainly increase the chances for malpractice litigation (Bernzweig, 1996, p.

177).”

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Alterations in the nurse’s behavior:

Children with respiratory problems need skilled and competent nursing care.

The symptoms of hypoxemia, a complication of respiratory problems, are often

insidious. Frequently, there is peripheral vasoconstriction with accompanying

skin color changes. Tachypnea, tachycardia, anxiety, and confusion may ensue.

It is the nurse’s responsibility to observe, evaluate, and document the

patient’s condition. In the emergency department, the nurse is the member of

the health-care team who has the greatest contact with the patient. Any

significant change in the patient’s condition, based upon nursing observation,

must be promptly communicated to the physician.

The nurse should have informed the physician promptly of the 11:08 p.m.

observations. These indicated that the child’s condition was not improving but

was, in fact, deteriorating. Before processing the discharge order, the nurse

should have communicated to the physician that the child had failed to improve

with treatment and more aggressive therapy would have been followed, possibly

including hospital admission.

Conforming to legal standards and high quality care:

Nursing malpractice exists because it is human to make mistakes under

stress, and nurses must function in a stressful environment. Nursing

malpractice can be minimized if the nurse utilizes the nursing process and

delivers patient care that conforms to the

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prevailing professional standards. Fundamental to the nursing process is a

complete initial nursing assessment and history, followed by continuous

systematic patient assessment.

The initial nursing assessment in the record was incomplete. This

assessment of the child should have included such information as follows:

? General appearance: height and weight in relation to age, development of

the body, color of the skin, posture, facial expression, presence of fatigue or

hyperactivity, gait, an presence/absence of apprehension

? Neurological status: level of consciousness, signs of menigeal irritation

? Vital signs: temperature, respiration (rate, rhythm, character), pulse

(rate, rhythm, quality), and blood pressure.

? Skin: color, temperature, presence/absence of eruptions, cyanosis,

erythema, icterus, petechiae, cysts, trauma, and scars

? Developmental status

? Disease status: breath sounds, presence/absence of congestion and/or

distressed breathing, appearance of the tympanic membranes, and appearance of

the throat, mouth and nose

In addition, the nurse’s notes for the entire emergency department

admission were inadequate and incomplete. These notes should have reflected the

execution of the physician’s orders as well as pertinent nursing observations.

Acceptable nursing care for

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children with respiratory problems involves more detailed nursing observations

than those in Cindy Black’s medical record. A nurse has the knowledge base to

make and record the following nursing observations:

? General appearance of the child (every 15 minutes)

? Body temperature (every 30 minutes)

? Pulse rate, rhythm, quality (every 15 minutes)

? Respiratory rate, rhythm, character (every 15 minutes)

? Patency of the airway (at least every 15 minutes, more if in distress)

? Blood pressure (every 30 to 60 minutes)

? Skin color and temperature (every 15 minutes)

? Level of consciousness (every 15 minutes)

? Emesis amount, character, and frequency

Summary:

Communication throughout the nursing process is crucial for the provision

of safe patient care consistent with the prevailing professional standard.

Spoken communication among all members of the health-care team, and especially

between nurse and physician for clarifying orders, planning patient care, and

reporting significant patient observations is vital to the nursing process.

Equally important is written communication by the nurse in the form of prompt

and accurate entries in the medical record.

References

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