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A LEGAL INFORMATION SHEET FOR NURSES

Emergency Room Nursing

What aspects of emergency nursing require particular diligence?

Triage

Practical guidelines such as the Canadian Triage and Acuity Scale are commonly used for triage. Insight into how a court weighs evidence about triage categories and clinical interventions can be gained from two emergency room (ER) cases. In the first case,[1] a widow alleged the nursing care of her deceased husband was negligent. The ER nurse assessed him and ranked him as urgent. Twenty minutes later, he experienced sudden cardiac arrest. In the second case,[2] a 14-month-old girl experienced a generalized seizure an hour and a half after arriving at the pediatric hospital's ER. The parents alleged that ranking their daughter as urgent rather than emergent caused delay which caused irreversible brain damage. In both cases, the plaintiffs believed a higher triage level would have prompted earlier intervention, saving their loved one. Specific evidence about triage guidelines, nursing assessments, and expert witness opinion evidence[3] about the patient's condition, prognosis, and the time for interventions to take effect revealed no evidence of breaches of the standards of nursing care; the claims were dismissed.

Overcrowding

With the increased emphasis on reducing wait times in health care, it is possible that nurses' decisions will be subject to greater scrutiny by the hospital authorities and the courts. The systemic issues leading to ER overcrowding are complex and largely out of the control of an ER nurse.[4] Systemic issues can be recognized in legal proceedings. They are given particular attention in proceedings such as fatality inquiries and coroner's inquests. In such an inquiry, a young man with abdominal pain visited three different ERs in the course of one day. He left the first two ERs because of long wait times. He died of complications of asthma after an appendectomy at the third hospital. Many recommendations to government, health institutions and health care providers were made in the fatality inquiry report, including the regional health authority following its own Health Plan "by funding additional hospital beds to reach the appropriate bed-to-population ratio and occupancy rate and maintain the ratio as the population continues to grow and age."[5] In a civil lawsuit, systemic issues will not generally absolve health care providers of individual liability if their care fell below the standard of care. Accordingly, when working in an overcrowded ER, focus on what is within your control: reasonable and prudent nursing care in the circumstances.

Role Clarity

Across Canada, a growing variety of health professionals like nurse practitioners and physician assistants may be part of the ER care team. This adds to the pre-existing complexity of health team composition, especially in teaching hospitals. A case involving a medical resident highlights the need to be aware of institutional policies addressing practitioners' roles and their authorities. At this hospital, only the ER doctor could discharge a patient from the ER and only a staff physician could admit a patient to hospital. This policy was not followed in the case of a 35-year-old man with sudden onset of chest pain. He was seen by the emergentologist, who ordered tests and a consult with internal medicine. The medical resident on-call assessed the patient but purposely did not read the emergentologist's notes and misapprehended the onset of the pain. The resident contacted a staff physician who was not on-call. The staff physician said the patient could be discharged. The resident

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did so without discussion with the emergentologist. The patient died the next day of a dissecting thoracic aortic aneurysm. In making its finding of negligence, the court stated, "when a hospital brings in a new policy aimed at better care for patients, it is under a duty to see all understand and work towards achieving this higher standard."[6] Nurses are to adhere to relevant policies. Nurses are well-placed to try to ensure adherence to such policies by other health providers but the hospital is ultimately responsible for enforcing them.

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Documentation

ERs typically use documentation tools to succinctly communicate relevant patient information to the health team in a timely way. When information is not recorded properly, it can negatively affect patient care and the credibility of the writer. For example, a nurse responsible for initial psychiatric assessments in ER received an urgent consult about a patient who suffered a massive stroke and wished to discontinue his i.v. and tube feedings. The nurse did not formally communicate her findings that a capacity assessment was needed by a psychiatrist. She did not make an entry on the progress notes, or report to the consulting doctor or psychiatrist on-call. Instead, she communicated using less formal means: the psychiatric emergency form, the multi-disciplinary message record, and an email to the care team. This resulted in delay, to the patient's detriment. The nurse was reprimanded by her licensing body because she failed to communicate appropriately, given the pressing need for psychiatric consultation.[7]

In another case, a patient with a history of kidney disease sued over an alleged lack of ER discharge instructions.[8] The ER doctor diagnosed him with pyelonephritis and ordered antibiotics. Unfortunately, the doctor did not record his treatment plan or discharge instructions. The doctor's verbal instructions provided some information but did not meet the standard of care. The inadequate discharge instructions contributed to the need for extensive surgery and renal complications. Completing the 'Follow-up' section of the pre-printed ER form may have persuaded the court that appropriate discharge instructions were given.

For more information, please contact CNPS at 1-800-267-3390 and visit our website at www.cnps.ca.

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1. *Puolitaipale Estate v Grace General Hospital,* 2002 MBQB 150, [2002] MJ no 220 (QL).
2. *Latin v Hospital for Sick Children,* 2007 CanLII 34 (Ont Sup Ct), OJ no 13 (QL).
3. *infoLAW*®, Expert Witness (Vol. 15, No. 1, March 2006).
4. Canadian Nurses Association, *Position Statement Overcapacity Protocols and Capacity in Canada's Health System* (Ottawa: Author, February 2009), online: www.cna-aiic.ca.
5. In the Matter of a Public Inquiry into the Death of Vincenzo Dominic Motta pursuant to the *Fatality Inquiries Act*, Calgary, Alberta, April 14, 2003, Recommendation #3.
6. *Comeau v Saint John Regional Hospital* (1999), 221 NBR (2d) 201(QB) at 53, aff'd (2001) 244 NBR (2d) 201 (CA).
7. College of Nurses of Ontario, "Summarized Discipline Decision re unnamed member re Failure to Exercise Clinical Judgment and to Follow-up Appropriately," *The Standard* 29, 2 (June 2004): 48.
8. *Georghiades v MacLeod*, 2005 CanLII 14149 (Ont Sup Ct), OJ no 1701 (QL).

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N.B. In this document, the feminine pronoun includes the masculine and vice versa except where referring to a participant in a legal proceeding.