Nursing Documentation Key to Avoidance of Liability

Avoiding Liability Bulletin - January 1, 2018

You have probably heard *ad nauseaum* that good documentation of nursing care is essential for many reasons, one being avoiding potential liability in case an adverse event, such as injury or death, occurs to the patient. In the following case[1], you can see how nursing documentation "saved the day".

Jeannette DeLuca was taken to the ED of a nearby facility when her daughter, Judith, came home and found her mother had a bump on her head and a very red eye she could no longer see out of due to a fall when she hit her head. After seeing an ophthalmologist in his office, it was determined that Ms. DeLuca needed surgery on her eye. She returned back to the hospital and was admitted to 2W.

The daughter informed the nursing staff that the last meal her mother had was around noon on that day. She further told the staff that her mother was very "vain" about her dentures and never wanted her daughter to see her without them. Her mother was able to care for her dentures herself and she never ate anything without them.[1]

One of the RN's on 2W admitted the patient and interviewed her. The RN asked about her dentures and Ms. DeLuca told the RN she had upper dentures and a lower partial plate. The RN did not remove the dentures when Ms. DeLuca left for the OR.

When it came time for Ms. DeLuca to be taken to surgery, she did not take out her dentures.

When Ms. DeLuca arrived in the OR, she was interviewed by the circulating nurse, whose job it is to interview the patient, bring them into the surgical suite, and then to the recovery room after the surgery is completed.

The circulating nurse asked Deluca about her personal effects, including dentures, since the patient was undergoing general anesthesia. When asked to remove her dentures so they could be kept in a cup with her name on the cup and taken with her to the OR, she handed the nurse her upper denture only.[1]

Upon the completion of surgery, Ms. DeLuca was taken from the OR to the PACU. The OR circulating nurse documented that the patient's dentures were "endorsed to recovery room nurse".

The Recovery Room nurse documented that Mrs. DeLuca was sleepy but responded to her and was "arousable". She also documented that "upper dentures in mouth", although she did not document whether she placed the dentures in the patient's mouth or the patient did so. When Ms. DeLuca was discharged from the PACU she returned to her medical/surgical floor on 2W.

The RN who admitted the patient back to 2W and followed her closely during the night and early morning. She had no concerns regarding Mrs. DeLuca's condition. She did not see any dentures on the patient's bedside table. Nor did she see breakfast delivered to DeLuca.

As she was getting ready to end her shift, the RN handed off the patient to the RN who was beginning the next shift. However, a "rapid response" call was made around 7:20 am, and she responded with the RN who just came on shift, since she knew the patient better than this new nurse would have.

Upon arriving at Mrs. DeLuca's room, she saw 2W's nurse manager remove the patient's upper denture and perform a mouth sweep. A code team them took over the patient's care.

Ms. DeLuca was unable to be resuscitated. Her daughter, individually and as administrator of her mother's estate, filed a medical malpractice action against the hospital, alleging that its agents/employees failed to adequately monitor her mother postoperatively, allowed her to eat without ensuring that her dentures were in her mouth, and failed to ensure that she had recovered enough after surgery to eat.[1]

During the trial, many members of the health care team testified as to their involvement with the patient. One important piece of testimony came from two Patient Care Technicians (PCTs). One testified that she ordered a breakfast of pancakes for the patient when Mrs. DeLuca said she was hungry. The other said she took the pancakes to the patient's room.

Neither testified to any problems with Mrs. DeLuca in terms of her recovery from the surgery and neither testified that her dentures were on the bedside table or that they had placed the dentures in Mrs. DeLuca's mouth.

The charge nurse who responded to the Rapid Response call testified that she did a mouth sweep and removed the patient's upper dentures and pieces of pancake. She had no memory of removing a lower place. She placed the upper dentures on the bedside table, but did not document that she did so.

She also testified that it is customary practice when a patient dies that a PCT does the postmortem care, including placing the patient's dentures in a cup to be taken to the morgue with the body. The charge nurse did not know who was present with the body until the coroner arrived.

The coroner testified that when he picked up the body, there was a denture container with it. He transported the body to the morgue with the container.

The nurse experts' opinions were contradictory at best. The expert for Mrs. DeLuca testified that the nurses and PCTs failed to give the patient liquids, failed to assess her ability to eat, failed to ensure both dentures were in place, and failed to monitor the patient when she ate her breakfast.

In contrast, the hospital's nurse expert testified that the patient did not need supervision when she ate, that Mrs. DeLuca was "alert and sharp", and based on the documentation in the medical records and depositions, the patient's upper dentures and lower partial plate were in her mouth when she had breakfast after surgery.

The jury returned a verdict in favor of the hospital. On appeal by Mrs. DeLuca's daughter, the Appellate Court affirmed the trial court verdict.

In doing so, the Appellate Court opined that the documentation by the nurses clearly supported they were not negligent. The circulating nurse and the PACU nurse documented what occurred with the dentures when each was caring for the patient. When Mrs. DeLuca left the PACU, her dentures were in place.

The testimony of the nurse expert for the hospital and others, including a nurse and physician gerontologist, was clear that Mrs. DeLuca's death had nothing to do with her dentures not being in place. Rather, her death was a result of a chocking episode and an "unforeseen accident". [2]

FOOTNOTES

1. Caldwell v. Advocate Condell Medical Center, July 24, 2017 IL App (2d) 160456.
2. “Patient Chokes, Dies: Court Finds No Negligence, Ruling Based on The Nursing Documentation”, Legal Eagle Eye Newsletter for the Nursing Profession, September 2017, 8.

Author:
Nancy Brent