Podcast Transcript

Where Healthcare and Legal Meet

Episode 1 – Negligence in Healthcare: What does it actually mean?

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Guest

Margaret-Ann Carno, PhD, MBA, MJ, PNP-AC/PC, ATSF, FAAN

- Dr. Carno is a Professor of Clinical Nursing and Pediatrics at the University of Rochester, School of Nursing.
- She currently directs the RN to BS completion program at the school, along with an NP practice in pediatric sleep medicine.
- She has a Masters in Business Administration along with Master's in Jurisprudence in Health Law Studies
- Her nursing background is pediatric critical care and with post master's certificates as a Pediatric Primary Care Nurse Practitioner and Pediatric Acute Care Nurse Practitioner.
- She has also taught graduate ethics and public policy and undergraduate ethics.

James Stowe JD, RN

- James is both a nurse and attorney obtaining his Nursing degree from Auburn University and Juris Doctor from Samford University, Cumberland School of Law.
- He practiced in the legal field concentrating in part on medical claims before returning to hospital administration.
- James is currently the Director of a large Emergency Department.

Host

Candace Pierce DNP, RN, CNE, COI

- With 15 years in nursing, she has worked at the bedside, in management, and in nursing education
- She has demonstrated expertise and scholarship in innovation and design thinking in healthcare and education and collaborative efforts within and outside of healthcare.
- As the Lead Nurse Planner for Colibri Healthcare, she engages with nurse planners and subject matter experts to assist in developing high-quality, evidence-based continuing education for nurses and other healthcare professionals.

Transcript

CANDACE PIERCE, HOST: Welcome and thank you for taking time to join us for this 3 part podcast series, Where Healthcare and Legal Meet. I am Dr. Candace Pierce with Colibri Healthcare.

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Our goal for this series is to understand what the criminal trial against a nurse in Tennessee means for the practice of professionals within the healthcare system. Throughout this series, we are going to focus on the intersection of healthcare and the law. and in doing so, we will review the legal definition of negligence, the impact of culture on reporting systems within hospitals, how we can support healthy and safe work environments, the impact of criminal lawsuits against healthcare professionals who have made errors, and how we can make improvements to healthcare systems to help reduce errors while also protecting ourselves as healthcare professionals from potential litigation.

I'm joined today by two experts in both the legal and health care sectors, Dr. Margaret Carno and Dr. James Stowe. Dr. Margaret Cano. She currently practices in academia, teaching and graduate programs and in the clinical world as a pediatric nurse practitioner. She has a master's in jurisprudence, earned a Ph.D. in nursing, and is a fellow of the American Academy of Nursing.

Can you tell us a little bit more about yourself, Dr. Carno?

MARGARET CARNO, GUEST: Sure, Candace. And please call me Margaret. I also have a master's in business administration, along with, as you said, my master's in jurisprudence in health law studies. My background has been in pediatric critical care, and I have also completed a post master's in pediatric primary care nurse practitioner and acute care nurse practitioner. I've taught graduate ethics and public policy along with undergraduate ethics and public policy.

PIERCE: Those are some great achievements there. Margaret, I I'm really betting you do not have much free time since you're in the clinical and academic world.

CARNO: No, but I you know, this is an important topic.

PIERCE: Well, I want to say thank you for finding some time to talk with us today.

We also have Dr. James Stowe joining us. Dr. Stowe finished his nursing degree and decided to pursue a Doctor of Jurisprudence. Currently, he serves as a director of an emergency department in Alabama. But before you were a practicing attorney. So why did you decide to return back to the clinical setting?

JAMES STOWE, GUEST: You know, Candace, that's an interesting question. I get it quite often. I really enjoyed practicing law and did so for a number of years, but my true passion was being at the bedside and taking care of patients, and it just kept calling me year after year. And so I decided to jump from the frying pan to the fire and get back into the hospital.

And while it's always an interesting day in the emergency department, it was really the right decision for me.

PIERCE: That's awesome. Thank you for sharing and for taking time to be here with us today, Dr. Stowe. So so as you can see, we have the privilege of having two experts in health care and law with us. So we're going to start with the discussion of the Nashville, Tennessee nurses verdict, which I'm sure we've all seen in the news over the last few weeks, months, and probably will continue to see over the next few years.

Can you give the audience just a quick overview of what brought about this conversation that is going on all over the nation, that Radonda Vaught to trial?

CARNO: Sure, Candace, I would be happy to. So in December of 2017, there was a situation where a nurse administered I.V. Vecuronium instead of versed. The patient involved with this error was withdrawn excuse me from life support and passed away. Then in January, the hospital fires the nurse for not following the five rates of medication administration.

Also, late that January, the hospital settled with the patient's family and there was a do not disclose about the error, public plea, or the settlement. Then in October of that year, there was an anonymous whistleblower that alerted state and federal agencies to the error. In October, also, the Tennessee Department of Health, the their nursing board decided not to pursue disciplinary actions against the nurse and sends a letter to the hospital and the nurse affirming this decision.

And I do want to stop to say this is all public knowledge within the public domain. Then late October, November, in response to the Whistleblower Centers for Medicare and Medicaid or CMS system, conducted a surprise hospital inspection, which they are allowed to do. Then later that same month, November of 2018, the CMS releases details of the error and the hospital submits a plan of correction Act, February of 2019.

The Nashville prosecutor decides to charge the nurse with criminal, reckless homicide and impaired adult abuse. MARCH The state investigators allege that the nurse at that time made ten separate errors in connection with the medication error, including overlooking warning signs. In September the Tennessee Department of Health, their nursing board, reverses the prior decision and not pursue disciplinary charges against the nurse and charges her with unprofessional conduct, abandonment, neglecting a patient and failing to document the error.

In 2020, there were delays in the trial and disciplinary hearing due to our friend COVID. In March of 22 the trial started the end of March. The jury found the nurse guilty of criminal negligent homicide and abuse of an impaired adult and in May was given three years probation by the jury. So that is a brief summary of the cases.

I do not know if James wanted to add anything.

STOWE: You know, I think it's interesting. Vanderbilt did not report the error to any state or federal regulators as required by law per a federal investigation. Hospital told the local medical examiner's office that the patient died of natural causes with no mention of vecuronium. And that's according to the patient's death certificate. And the Davidson County chief medical examiner. So, there are some concerns throughout this this event all the way through from the time the event occurred, all the way through reporting in the aftermath.

PIERCE: Absolutely. So I've heard other health care professionals refer to this case as that cornerstone trial, that trial that's going to turn the tides of health care as far as criminal versus civil suits. And I've seen a few more lawsuits that have come out this year, specifically against nurses, not necessarily against physicians yet. But do you think that this will be a historical case in that respect?

CARNO: I'm not sure, to be honest. There's so many factors here which also include the health care system. I hope it does not. Nurses and all health care professionals work very hard to prevent errors, but we are also humans and not machines. And I will be honest, you can bring a lawsuit and James can probably elaborate on this, but that doesn't mean it's going to be successful or that it's actually going to go through the court system.

STOWE: Margaret, I agree. You know, the great thing about our legal system is anyone can seek justice for themselves. And and that pretty much means anyone can bring any lawsuit. But the lawsuits have to have merit to proceed. And then there's rules of law to have to follow. And that's why we have trials to determine the

outcome. But I do think the impact of this case, at least initially, is going to rest a little bit on the verdict that was handed out.

I think everybody waited with bated breath as far as was the nurse in this case going to spend or get sentenced to jail time. And the fact that she was given three years probation when she could have spent some significant time in jail, lessened the impact a little bit. But when I say that, I don't mean to say that it's less of an impact nationally, because I think what it does is it opens the door and it opens the door to people using this verdict in a number of different ways.

You know, there's techniques in the law where you can wait till a criminal trial is completed because of the standard of care. And once it's completed, if you want to pursue a civil action after that, you've already established the burden of proof. So it's much easier to to proceed with a crime, with a civil trial following a criminal trial.

So I think this opens the doors, like Candace mentioned, where we are going to see things down the road. So where it ends up, I'm not real sure, but the immediate impact I think is lessened by the punishment handed out long term impact. This will be quite interesting to watch and see.

PIERCE: A word that I continually heard being brought up to this case was negligence. And two words that I'm continuing to hear you talk about are civil and criminal. So can you help us understand what those words mean? What is the difference between civil negligence and criminal negligence?

STOWE: Well, you basically have to break it down into negligence and negligence in its core. We always hear in the medical world, medical malpractice that's kind of the quote unquote term. If you want to bring it into the legal realm, it's really medical negligence, a medical is just the arena where the negligence occurred. It could be construction negligence. If you're building a home and there's issue, it could be any number of things that could be negligent.

Negligent is basically torn down into a broken apart into five elements. And that is a duty, a breach. There are two elements of causation, and so we'll just call them causation. For now, it is not dropping into the particulars that much and then there's damage. So for the sake of today, we're going to say there's four elements duty, a breach, causation and damage.

And so from a negligence standpoint, it is duty. Did the nurse in this case have a duty to take care of her patient? You know, and I think that is pretty clear. Obviously, she did. You accept an assignment? You take care of patients. You have a duty to protect, to help heal, and do no harm to those patients.

Did the nurse breach that duty? You know, the trial lasted four days and it was a very quick verdict. So I think the jury in this case determined, yes, she did breach it. And that and that's a pretty easy conclusion. And what what I think a lot of medical professionals and maybe specifically nurses don't understand is when we fail to follow a policy or procedure or education that a hospital has provided, we're we're breaching that policy.

We're breaching the hospital's best practices. So we're breaching that duty that we're supposed to uphold. Causation is kind of very, very simply put, did my breach did me not doing something or doing something the wrong way cause a damage? And that damage is typically harm in the health care setting. Was the patient harmed? It could be a small harm.

It could be life ending harm. As this case experienced, taking that negligence into the civil versus criminal world, you know, it's kind of broken down into a criminal laws. Okay. Civil versus criminal. Civil is I've been wronged. I'm going to take you to court and basically sue for wrongdoing and the difference there is pretty much a burden of proof in a civil action you have to have.

If you look at the scales of justice, the classic statues or the or even weighing things like in in a kitchen on scales, if you just have a little bit if you feel a little bit more of one side than the other, it's a little bit more about 51%. Then you've met the civil burden of proof in a criminal trial.

Criminal negligence means that there are laws that the state or federal government have passed that basically means there's jail times involved in that, and that burden of proof is beyond a reasonable doubt. Now, that doesn't have to mean it has to be 100% sure that they're guilty. But it does mean, for the sake of today's conversation, you know, 95% or more percent convinced that that individual was negligent.

So civil is basically a punitive lawsuit that is seeking money for a wrongdoing criminal. There are federal or state laws that have jail time imposed on those things. And the burden of proof is a little bit different. But the core negligence element, the duty breach, causation and damage is still the same.

PIERCE: What I think I'm understanding is really it doesn't matter if it was intentional or not intentional, it would still be seen as negligent, correct?

STOWE: That's correct. It's really interesting. You know, a lot of nurses respiratory therapists, pharmacists, physical therapist techs, patient care techs from the hospital. When you go to talk to people about an error, many times they'll come right out. So. Well, I didn't I didn't mean to do that. It was just an accident. And it's really interesting. These laws aren't written with an accident.

It's very subjective. Did you have a duty? Did you breach that duty? And did your breach of that duty cause a harm? And so it is very eye opening for a lot of individuals to realize that, you know, an accident is an accident and accidents do happen. But when you take it into the court system, it's much more objective and not taken into account.

So accidents are going to happen. But it's unfortunate that the elements take an accident and no intention out of the out of consideration.

PIERCE: So in this case, it appears that the nurse did acknowledge the mistake. She acknowledged that it was not intentional. And then she followed those guidelines that were set out with the hospital system she worked for to report it. So, Dr. Carno, can you take us a little further into that explanation of negligence, specifically with acknowledgment? So in order for there to be negligence, does there have to be an acknowledgment?

And what does that acknowledgment actually mean?

CARNO: Candace, that's a great question. No, there does not have to be an acknowledgment of the negligence. However, there have been some research studies and other data that have demonstrated if a health care provider and or health care system admits up front that there was an accident, a an incident, patients are less likely to sue. So I can't you know, you still have the criminal issue.

But from the civil perspective, when a provider, a health care professional, a health care system acknowledges that a mistake was made, and then they say, what happened? Exactly what happened? But they also include, you know, what is the follow up for this? What is the system as a health care system? Looking at what how were they going to prevent this in the future?

What are they going to do for that individual patient? Are they going to monitor that patient? Are they going to provide their care for free because of the negligence? That open, honest communication that years ago as a nurse, I was told, never commit my mistake if I made a mistake to the patient. Now, the change with this concept of just culture means that A you know, as a nurse, I report my mistakes in the system with guidance from the system.

I admit my mistake to the patient. We discuss what's going to happen. We discuss the follow up. We discuss what the institution is going to do to prevent this in the future. And what studies have shown is that when the health care team, health care professional is more upfront with the mistake and gives all the information, the patient satisfaction with in relationship to the mistake is much higher than if the patient or family has to keep asking questions and feel that they were not told everything that happened.

That information is being held back or that the health care team profession is hiding stuff from them.

PIERCE: Right. And we know that in this particular case that the nurse did she did fill out the incident report. In my understanding and please correct me if I'm wrong, is that that incident report she filled out did that was that used in the actual trial. In by her completing this incident report was that her acknowledgment of the things that she had done incorrectly, which may have led to her losing her license and now having three years probation?

CARNO: Yes. The incident report is if you look for the and it's public knowledge, the trial information and the discovery portion of the trial, all that is available for public knowledge. And yes, that incident report has been was introduced into the trial.

PIERCE: Now, I've always been told that incident reports are to be non-punitive and actually to be kind of anonymous in a way so to say when you complete those. When did incident reports become punitive and is this something that health care professionals should keep in mind when they're completing these incident reports?

CARNO: I think for most institutions they are non-punitive for the most part. And I think when we talk about Just Culture and incident reporting within the institution, so I'm not talking from a criminal case but within the institution that depending upon the incident, the institution can elect to do education, to do other things. Now that being said, if there was a true disregard for the policies of the hospital, then the hospital has a right to protect the patients in the hospital and fire whatever health care provider or professional that is. Because a total disregard or repeated disregard for institutional policies puts everybody at risk.

And the hospital system or the health care system does have the right to fire that health care person.

PIERCE: Absolutely. James, do you have any thoughts on incident reports?

STOWE: It is really interesting. As a current director, we and having been a director in some very large for-profit institutions, some non-for-profit institutions, independent, a number of them and multiple states. It is interesting that most all of these organizations have a pretty robust system for reporting incidents or events. But most every one also has a process where the receiving director or leadership of that department is to address them.

So what we have is objective data coming to or allegations coming to a director that they then follow up on. And then it's up to the director of the leadership of those departments to then in turn decide which level of discipline to hand out. So unless there is a defined just culture and not just a broad brush, just culture of let's report these incidents, let's educate, let's really learn from our errors.

But a granular down to each specific department process where I know that I'm going to follow a certain defined algorithm when distributing discipline, where only gross negligence, only those things that are truly out there that harm the patient, really get the tough punishment, and that we then support the nurse for for acknowledgment, acknowledging a issue, a mistake, an error, and then create learning opportunities from that.

It comes down to medicine is one of the few areas where we can we can apply the same hard laws and rules for everybody, criminal, civil, all that kind of good stuff. But if we don't actually take the time to stop, educate and approach it from a learning error learning aspect, then we're not going to prevent those things in the future.

And so it's just a very different business than than most others.

PIERCE: That's all the time we have for episode 1, but I I think that brings into the discussion something really important, and that's culture, which we will discuss in episode 2.

(SOUNDBITE OF MUSIC)

PIERCE: In this first episode, we discussed the definition of negligence and the acknowledgment of our mistakes. Please join us for episode 2, where we will take a closer look at culture and the effects that an unhealthy or toxic culture can have within healthcare, especially when there is a fear of legal repercussions.

This is Candace Pierce for Colibri Healthcare.

(SOUNDBITE OF MUSIC)

Episode 2 – Is Just Culture Realistic: System Failures, Improvements, and Corrective Actions

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PIERCE: Hello and thank you for taking time to join us for episode 2 of our series, Where Healthcare and Legal Meet. I am Dr. Candace Pierce with Colibri Healthcare. And back with me are Dr. Margaret Carno and Dr. James Stowe. In the first episode we discussed what negligence means from a criminal and civil perspective and the acknowledgement of our errors. In this episode, we will be taking a deeper look into culture and how it affects healthcare

(SOUNDBITE OF MUSIC)

We ended episode one discussing acknowledgement of mistakes. It takes a lot of trust to admit a mistake, to complete the incident report that you know is going to then be seen by your leadership even at the department level. Why is culture so important in health care and how does it affect the quality of care that we provide?

STOWE: Well, the culture really is the one of the first answer to solving the problem, I believe, because we can utilize a incident or event report system all day long and never report my own mistake. Right. I can enter things all day long if I'm upset with another department, upset with another person, and never admit my own mistake. So, until the culture is changed and from a hospital system, it's going to be.

Did we have enough staff to review incident report? Did we provide an opportunity to have roundtables? Did we have an opportunity to come in and bring different players to the table, meaning different people from different departments, and solve an issue? And here we are on the back of COVID some very difficult financial times. And the way to solve this problem is, you know what, you need a couple of more resources.

So how do you manage that today in light of everything that's going on and not just leave it up to ED leadership? And I say ED because that's where I am. But leadership within a hospital system from on a department level, when quite frankly, they're there, they're taxed out, they're maxed out on what they're doing. So how do you make that move?

Really, it's a hospital system. It has to be a hospital system focused or an individual hospital focused, and the resources have to be dedicated in order to make it a priority.

PIERCE: Absolutely. And I hear just culture. I hear that term thrown around a lot, which really just means a culture of fairness. So how do you get just culture? How do you bring that into your department, into your organization, into your system?

CARNO: I think that and I can speak from the health care professional and James can speak from the administrative, knowing that I am supported as a nurse, that my mistakes, it won't be punitive. I mean, as I said, unless it's a huge disregard for hospital policy. But knowing that the whole hospital system, from my immediate leadership all the way up to the CEO, really supports the health care professionals getting as fast as possible, the needs of the health care professionals to provide the best care we can.

And I think also with the Just Culture is the idea of continuous quality improvement so that issues and concerns can be remedied. We can fix this issue or concern. And that, you know, as I said and James brought it out, the actual health care professional needs to feel supported.

PIERCE: Absolutely.

STOWE: Yeah, it's a very interesting question. You know, this culture of fairness really and truly, to start establishing it, your frontline staff need to see some actions. And a lot of times that's easier said than done. You know, I don't sit here with all the answers on how to do it, but if I know that issues are being resolved or being worked on, at the very least, I'm much more likely to participate.

And so don't leave it to one area or one or two departments to battle it out, because at the end of the day, you don't really get anywhere with that. You've got to have a hospital wide or a system wide approach that, you know, if you're in a system and you discover something did you share with the other systems, the other hospitals within that system, maybe your other outpatients facilities, you know, associated with the system, what is your dissemination of what you learned look like?

So to start implementing it and to get that buy in, it's definitely not an overnight thing. It is not a flip, a switch, and we're going to have this and going to have it in place and it's going to be successful. It is a work. It is arduous, not always a whole lot of fun. But as you get things going and you see successes, then you really start to go, okay, this is good.

I have an issue that I have been encountering for six months or a year. I've just never said anything because we all deal with the same issue. Let me bring it to the table. And so you start to get those things that come forward. And that's when you truly start to prevent errors.

PIERCE: Now, within the regard to just culture, I've seen a lot of physicians and a lot of nurses specifically who are a bit worried about the outcome of this trial, the verdict that was given. It strikes a lot of fear into the health care professionals and losing their license that they've worked so hard to to earn. So is Just Culture going to be realistic?

Is this something that is it going to be damaged by this verdict?

CARNO: From my perspective of, you know, reading the trial, reading the history is that there were a lot of other errors and not open communication. I'm not trying to to put anybody under the bus, but there were a lot there's a lot of pieces to this trial and to what happened right after the incident and what did not happen.

And I think that that is really important for health care professionals to remember and to realize, because there's a systems responsibility also. And that has to be taken into account.

PIERCE: So we know that this error was not purposeful. We know it was brought to a criminal court. What repercussions do you think we're going to see in health care? Is there going to be that anticipated downhill effect in health care?

CARNO: I know in my own institution, the day the verdict came down, we received an email from the CEO of our health care system stating that our hospital system believes in a Just Culture, believes in these areas, will support the health care professionals that are making incident reports.

And to remember that there was a lot of other details of the trial and really supported it. And it came from literally our CEO, our chief executive nursing officer, our chief of quality and Safety. So, it came from a number of people at very high levels. And there's were repeated emails for about a month. James, I don't know if you want to speak to it from a leadership perspective.

STOWE: You know, it's really hard to answer that question in light of everything that's going on in health care today. And I don't know if that's a cop out. I think people could use that answer at any time in history in health care. But if you take a look at there's a national nursing shortage. We're in the middle of a pandemic.

Hospital expenses are going up. Patients are staying in the hospital longer due to certain diseases and COVID being one. So, revenue is going down. It's making it more difficult to manage hospitals and hospital systems. The Federal Government has not awarded any relief here recently pursuant to COVID. So, you have all of these factors coming into play and that's affecting your workforce, affecting the current situations and management.

And so it's very difficult to answer. I will tell you that what I'll say is future nurses first versus current nurses. Future nurses, I have been on the recruiting trail and most of the future nurses that are in school now, they're aware of the case, but they're not dropping out of school just because of that case. Okay. You don't hear it in the news advertised.

You know, it's not very prolific out there unless you look for it. So, I'm not sure from a nursing standpoint is it going to drive away future potential nurses? I don't know that I don't have that answer yet. I lean towards no right now. What I can tell you is that from an emergency department, where time is of the essence, quite often it has had an impact.

This verdict has slowed down care. Nurses who normally had a practice of just running and and going and doing it and doing certain things now will wait for the physician to put a medication order in, will now wait after the physician puts the order in, wait for pharmacy to approve it and flip it over to the MAR before giving that medication.

Now, if the pharmacy, you know, let's say they staff 5 pharmacist for the day just to approve those medications and one called in sick. So, what is the delay there now before we get our emergent medicines to our patients? So, I could tell you there is a front line delay while we are seeing more and more patients coming into emergency departments because fewer are getting primary care preventive care.

And so, as that number rises and as our approach to patient care goes down has to slow down, it doesn't it's not difficult to see down the road there's going to be issues with waiting patients getting worse before they're seen. So, from active staff, it definitely is impact for future staff, future students that they quote unquote haven't been in a real world yet.

So, I don't think it's as impactful for them to.

PIERCE: James from that director perspective. You're talking about delay in patient care, which I think it's great that I mean, we're probably getting back to the way we always should have done it, back to those double checks, those triple checks to make sure what we're doing is correct. So, my question, though, is more along the lines of that front delay that the decrease in customer satisfaction and how quick it is for them to get, say, their pain medicine or for the physician to come in and do a procedure.

So how is that going to affect those HCAP scores and some of those different scoring mechanisms that are used or matrix matrixes, rather, that effect, say, hospital pay.

STOWE: It's going to be huge. It's going to be huge and it's going to be difficult to weed that out and actually put a number to that and say that, hey this is the cause. But you're from an ED perspective, you're going to see higher wait times you know patient satisfaction. We have all these very in-depth research that's done for, but from an ED, I can tell you it is directly correlated to how long you got to wait to be seen by a physician.

We can we can add all these other things in there. But if you put yourself in line at Wal Mart, how long or which line do you go to? You go to the self-checkout or you get in, get out, or do you go behind the line to be checked out when there's nine people in front of you? No one likes to wait.

It's human nature. No one likes to wait. So, it's the same thing at ED. You'll have more left without being seen. Meaning they left. They didn't get care there. So, what does that mean for our hospital system as far as their liability, HCAPs, patient satisfaction is going to go down. It is there's there's just negative effects all around.

You know, you look at it now and we look at there's a national nursing shortage. Well, there's a national EMS, EMT, paramedic shortage. When you look across the country, if it takes me longer to see patients within the department, my EMS crews are going to have to sit on the wall longer, which means they're not back out in the field answering your, mine, our families.

911 call. So, this problem, this occurrence has affected so many things, even back out into our own homes that people don't realize. There's just a very, very impactful nature of this verdict that is very far reaching.

PIERCE: And I want to touch on, too, you're talking about some shortages. You know, what about this OBS and pediatricians that we have national shortages on as well. And don't they have a I don't know the official word for it, but I know, for example, for children, for OBs, they can be sued up until the child is 18. Is that true?

Is that a is that something they need to be worried about?

STOWE: You know, it's really interesting for for what OBS and pediatricians earn as income they pay an unbelievable amount in insurance premiums. If the folks actually knew how much they paid, I think they would be shocked and they wouldn't be so upset about paying office co-pay. They really put themselves on the line. And you've got to think there's a reason for for this shortage.

And so, it really is going to the the problem with both or any line of medical field or medical specialty when there's a shortage is the demands on that individual's time goes up, the demands for what they need to do go up. So, the more things you do in a shorter amount of time, there is a higher probability of error, which means in our short staffing state across the country, now is the time that we need a just culture to address these issues that coming up that may not have come up five years ago, ten years ago, when we weren't under such a shortage, shortage of staffing, because these are all new issues, new concerns. So Now more than ever, while we have shortages, it's more imperative to actually institute a just culture to address them.

CARNO: And I will agree with James. As I said, my background's in pediatrics. For years, I did pediatric critical care and now I'm in a subspecialty and my peers, my physician colleagues have paid more money. And I know

as a nurse my malpractice insurance and as an NP, my malpractice insurance is higher. I think the more concerning is OB. The number of nurse practitioners, physicians, midwives that are no longer actually doing deliveries is very impactful and you know, given the shortages we have now post COVID, really, I don't think we're post COVID, but it has been quite difficult, as James has said.

PIERCE: Absolutely. And one of the things that you were hitting on it, Jay, was about the multiple tasks that are being placed on the shoulders of health care professionals now. And I really want to take this back to nurses for a minute, because it seems as though nurses are the only we're the only health care profession in clinical practice where we are given multiple tasks that many times cross over to what other professions typically do.

For example, respiratory therapy is not available. Well, who's going to give the breathing treatment? It's going to be the nurse, right? If physical therapy is not available or housekeeping is not available, typically you're going to see the nurse performing those functions on top of all the other roles and tasks that we are to do as a nurse. So how do we expect nurses to meet all these extra expectations and complete these tasks error free?

STOWE: That's a great question, and it's one that I have battled with for a long time. And we mentioned the shortage of nursing. But the truth is there's a shortage in all workforce. There's a shortage in trying to get patient care techs or support techs to assist nurses. You know, you got to remember what's happened in the economy. People have left the workforce a lot of frontline workers left for quite a long time.

So, recruiting them back in is very difficult because this is a difficult line of work. You mentioned some of the areas that that you that you work on. And I thought about this recently. And from an emergency department perspective, you know, my nurses are expected to turn their rooms over. So, they do the EVS job. They are expected. The nurses are tasked to distribute meals and make sure everyone's fed for dietary’s position.

You mentioned respiratory therapy with breathing treatments, what have you STAT meds making drips if the pharmacy hasn't gotten to it in time. Or isn’t fast enough? It's emergent. We make our own. You look at finding certain placements for certain patients. Case management has to step up taken in their case management or social worker function. As you evaluate patients a lot of times we enter protocols to get work ups started.

That is a physician or a provider responsibility that we have allowed nursing to do to expedite care, also drawing labs and doing those things. We did the role of phlebotomy. So, you know, you do all of these things and quite frankly a nurse where so many hats that if you were to break down any given day for a nurse you know and I will I'll pick on a med-surg because it's an area that I openly acknowledge I can't work in.

I'm not fast enough to work there. I think it's the hardest department in the hospital. If you had six patients, you did an assessment on all six of them, 30 minutes to do an assessment, get it in a computer. That's 3 hours of your day. You've been tasked to discharge three of them. That's 30 minutes or more for each of those three.

You've been tasked, you've gotten three new patients. You've got to do an admission there. You are doing assessment there that’s an hour plus for each one, you start you do a good med pass in the morning for all of your patients. And by the time you start adding these hours up in the day, your staff hasn't had a chance to take a lunch.

They haven't had a chance to use the restroom, and then they run out of time. So, what gives? Is it the call light that doesn't get answered is that while we're seeing so many more complaints now, so we're passing all of these functions down to the bedside because hey it's the easiest thing to do because they're with the patients supposedly all day long.

So we've got to figure out how to I and I kind of alluded to it previously. How do we take some of these hats off that create the time for nurses to focus on their patient care and allow them to prevent some of these errors?

We got to give them time to prevent the errors that are happening. And so, if we don't give them time from our frontline staff, don't give the frontline staff time to do their job, errors occur.

What kind of message does it send when we're going to go in and discipline them for not having time to do their job and errors occur? So that's really if you look at just culture, you learn from those errors and you put in processes to change those so that you kind of prevent the punishment and the retribution for some of those actions which can all kind of be tied together.

It's almost all a circle. So, it's a very, very difficult concept. And nurses, quite frankly, are at the bedside and they are assigned patients and they keep getting more and more hats to wear with no more time in the day.

CARNO: The other thing to that is we haven't started seeing it in the hospital setting, but given the shortages, I think we will be soon. Is that nurses are going to have to prioritize if they need to give a respiratory therapy treatment. So, they need to give a respiratory treatment versus walking a patient.

Well, their respiratory treatment is going to come first.

PIERCE: Absolutely.

CARNO: And then so we are going to start seeing increase in bed sores, increase nosocomial microbial infections or, you know, hospital-acquired infections because people are cutting corners because they are so stressed and so overburdened that we're going to start seeing an increase in those things that are not recoverable from a financial perspective for the hospitals. And something is going to need to be done because eventually the system may just fall apart.

PIERCE: Absolutely. I think that's such a great point that you brought up, too, about having to choose those priorities and what we prioritize, which would be your respiratory treatment, might not be what your higher leadership that doesn't really understand what's going on at the bedside would prioritize, because what they see is, well, now we have a injury to the patient because they have been laying on the bed or in their same position for a little bit too long.

And that takes money away from the facility. So absolutely. That's a great point.

We will talk more about these unintended consequences that may be seen in quality of care in episode 3.as that’s all the time we have for episode 2.

(SOUNDBITE OF MUSIC)

PIERCE: In this episode, we really focused the discussion on how culture impacts a work environment and the overall quality of care patients receive. Please join us for episode 3, where we will continue our discussion of medication, dosage assessment, and medication administration from the perspective of responsibility and accountability.

This is Candace Pierce with Colibri Healthcare.

Episode 3 – Medical Error Reporting Going Forward

(SOUNDBITE OF MUSIC)

PIERCE: Welcome back to the final episode in our series, Where Healthcare and Legal Meet. I am Dr. Candace Pierce with Colibri Healthcare. And joining me for the final episode are Drs. Margaret Carno and James Stowe. If you have missed any of the episodes in this series, here’s a quick recap of the topics. In episode 1 we focused

on understanding negligence and acknowledgement of a mistake.Episode 2 we discussed culture and detailed the effect that may be felt in healthcare due to the fears of repercussions when mistakes happen.

In this last episode, we are going to focus on how to move forward.

Now, I want to take us back to talk about the verdict. It was brought up that nurses are the final check for errors for a pharmacist and physicians. And isn't that a heavier load for the nursing profession to carry? As in, will nurses be held accountable and responsible for mistakes made by the pharmacists and the physicians when technically it's out of the nurse's scope of practice to prescribe?

CARNO: I think there's a couple of issues there, you know, and I'll be honest, my background is pediatrics, as I stated before. So the nurses always double checked the calculation for the physicians. So with the order, when the order got sent down, we always double checked them. And then the pharmacy double checked them. I think that it comes down to what how the medication, for lack of a better term, is made up.

So if you receive a mini bag, a small bag of fluid and it says it has 20 milli equivalents of potassium in it, and to administer over an hour, hour and a half, you have to trust that the pharmacy mixed it up correctly.

PIERCE: I'm not going to lie, Margaret. There's always make me so nervous when I.

CARNO: Yeah.

PIERCE: Can't see what was actually drawn up in the syringe or what was put in the bag. But I'm the one that has to give it.

CARNO: And the flip side of that is if you are mixing up, let's say, ampicillin and the bedside nurses actually doing the dilution and the drawing up of the medication. So especially if you're not drying up the whole vial, that's where I feel that the nurse would come into responsibility for the medication. So, I think it comes down to is who's drawing it up, how is it to be administered and were there any checks in the calculations?

So those are the important things to consider. I don't know if James has anything else that he given he works in the emergency department where it's.

PIERCE: A whole different world down there.

STOWE: Agree. Whole different world. You know, it's really interesting. I would agree with Margaret. I think it comes down to, you know, nurses need to be responsible. There's you know, it's always great to have a double check. And I, you know, be aware, you know, read something a second time. But nurses really need to be responsible for nursing actions.

What we do and again, because, you know, we mentioned it above kind of nurses taking on so many hats. When nurses are 40 to 50% of your workforce, it's very easy to say, well, I only have five pharmacists or I only have in the ED today, five, eight physicians, you know, all day rotating in and out down there will the nurses need to step up because you have 20 nurses, so there's many more of them to follow up on their actions.

And, you know, the training and the educational, there's all different levels when you start comparing the different disciplines. So, asking nursing specifically to be a double check for some of these other specialties is maybe kind of a leap, maybe a step out of what their training, their education is, or just simply is it the right person because they have a different job, a different role.

So, everyone needs to take ownership of their own part in the process. But it's just very easy to ask a nurse because they're so prolific when compared to all of these other individuals that are staffed at much lower volumes.

PIERCE: So how can our health care organizations, our health care leaders, how can they help with improving these processes and reporting of errors?

CARNO: Um, from my perspective, um, is immediate health care professional is listening to your frontline staff and making a commitment to providing what the frontline staff needs. And yes, there is a nurse a nursing shortage. However, there have been a number of nurses who have left for the profession for different reasons and correcting the reasons that they left may entice them to come back to nursing.

And I think that that needs to be a huge commitment on administration. And I'm not really saying the frontline administrators because I think I give our nurse managers and even the directors a lot of leeway and credence because they're dealing with what's on top. So, they may not be getting a budget where they're allowed to hire enough nurses or give them the wages and benefits that nurses need.

So, I think the that is the one thing and also a commitment. Years ago in pediatrics in the area I practice in we drew up our own potassium that that was you know, we had the vials, we drew up our own potassium. And then at another institution, not the institution I was at, there was a serious, um, fatal mistake.

And we know potassium is one of those drugs where it can be. Then once that happened, every pediatric institution that I have worked at or have friends at, even in the ED pharmacy, must draw up the potassium and dilute it. Now, this is in pediatrics, but even in our pediatric emergency department, that was a process that was set down in stone and I'll be honest I've called a number of our pharmacy a couple of times ago.

I need their potassium. I need their potassium. You know, I have to choose. I'm like, give me the potassium, then give me the ampicillin. But that's just my perspective from the front line.

STOWE: I would agree with Margaret. I would simply add one of the things I try to do from a director standpoint is make life easier for nurses. Now that's a very broad statement, but we know there's a shortage, so the demands are higher. We know that they wear many, many hats. So, what can we do? You know, do we what does their charting look like?

Do they have a lot of paperwork and stuff? What what is the what are the steps you know to to draw blood, to send things off? The things that they do every day for every patient take those take those tasks. Break them down. How long does it take? How many steps do you have to walk to do them?

Where are your supplies? And if you go start to trim off a minute here, 3 minutes there, 5 minutes there, and if I'm give a nurse back, 10, 15, 20 minutes per patient. Well, not only does the patient get out of there faster and we can see more patients, but the nurse is faster and has a chance to stop.

Do exactly what Margaret says. Work with pharmacy. Make sure we get the proper medications, the high-risk treatment that we do. So, it really is from a retention, recruiting and trying to get nurses back. Let me show you what we're doing to make your life easier. And that's not always easy. That steps on a lot of toes from time to time.

A lot of health systems or hospitals have very set in place. Hey, we've done it this way. We've always done this way and no one's ever questioned that. So, I think today as you move forward, you just have to have a questioning attitude and be able to try to figure out what you can do to make life easier.

But it gives the staff from all aspects more time. And if you have more time, you can focus. You can spend that time concentrating when you really need to. And and it all comes back to it prevents errors. And that's really what we're about, providing great care and preventing errors.

PIERCE: What I think I've heard from from both of you in different ways is advocating, advocating for your staff. And a lot of times I think leadership advocates behind the scenes and part of that unhappy atmosphere that you have, they don't care about me type culture in departments is that they don't know that behind the scenes the leader is advocating.

So do you think it's helpful for leaders who may be listening in to understand to that it's important to share what you're doing behind the scenes in regards to advocating for a better workplace, a workflow.

STOWE: Absolutely. Absolutely. You know, to the extent that I can, I love to involve the frontline staff. I pull them into the meetings. We have work groups, we have updates. I have my own communication board that list just things that we're working on, you know, and it may not change one week, but the next week I may be able to add three or four things on there.

And then I keep a list of achievements, list of accomplishments each year, and we just start labeling them out what we can do, what we've accomplished, and then what we're still working on. So that is a great, great platform. When someone doesn't want to take 5 minutes or 10 minutes and put in an event report or incident report, you know, hey, this may be an issue or reported it up. Part of my board is a dry erase board. They can come up there and say hey this medication won't scan.

Great. That's all I need you to do. Tell me. I will be happy to follow up on that. I know that that can be an error in waiting. Let me follow up on that and I will chase that down. But it increases the communication between your frontline staff and your leadership to where they know now, I cannot walk through the hall without somebody saying, Hey, did you know about so-and-so?

And while I'll be frank, it overwhelms me at times. The amount of things. The reality is, is there's a rapport now where they know that we're going to get things done. Okay, because we have that two way communication. You know, some people are a little harder to get involved than others, you know, based off of their own personality and past experiences.

But as they see things being fixed, you know, at the end of the day, it creates more time for the nurses. We start to solve problems. And you know what? It’s better patient care and no one can argue with that. Yeah.

CARNO: And Candace, I want to reiterate what James said. The administration helping to make sure that the systems that are in place to help the nurses actually work. Barcode scanning, the handheld scanners actually work. The machines that give you your medications. One type is called Pyxis actually work and are programed. That the electronic medical record system is up and running appropriately and that if there's an issue, you get your other support staff, I.T. staff, and you don't say, well, don't worry about it.

And work around it, or we can't fix it for another 6 hours. If you give your frontline workers a system, you got to make sure it works, too, and you got to be willing to take the feedback when it does.

PIERCE: Absolutely. Because we really don't want them doing the work arounds, because work arounds seem to become a habit, hey, this doesn't work. So instead of reporting it, they use that workaround. So absolutely, I agree with that. Now we know errors are going to happen. So, how do we support health care professionals when they do happen?

CARNO: From a frontline perspective, I would say support listening to all the facts, making sure that all the facts and the situation is taken into account. Let's talk about like transferring a patient and a patient got injured. Well, the Hoyer lift was broken and nobody reported it and it's routine maintenance wasn't done. And so, a patient was injured. So, I think that the support from leadership and making sure that their voices are heard and that it's the whole situation is looked at and not just immediate finger blaming.

STOWE: I completely agree. I would simply add to that I have experienced in my career where I have sat through a number of presentations where risk management or quality departments will present hey this is a breakdown of our event reports, incident reports. And they'll say, and I'm just generalizing here, 62% are medication errors, you know, X, Y and Z. And it's a nice report, but you leave the meeting with, well, what are we doing with that data?

What actionable task are we taking? And so, from an organizational approach, how are we going to affect those numbers? Because if we don't actually take action, then the next year I'm going to sit through the same hour-long presentation. And we're going to change it. We're going to sit up there and they're going to say, oh, well, this year we have 53% medication events, total of everything.

And so, from a health care organization, there's got to be a conscious decision to use the reporting system that you have and act on it. And then when you act on it, advertise those changes. What improvements have you made and be cognizant about the improvements? The process changes don't add steps to people that don't have time to take on additional things, but look at reallocating who does what many times you can.

You don't have to add additional steps to somebody. If you just change the process, it'll correct itself. So from an organization getting involved and showing where they're taking action and then the results, the positive results year over year, those meetings become much more meaningful.

PIERCE: Absolutely. Now we know that, like I said before, errors, they're going to happen. And I don't know if there is going to be a trend in the relationship to possible criminal suits like we saw this year, I do know there have been a few more lawsuits. I believe that most of them have been against nurses this year since that Tennessee lawsuit came out.

So how do we as health care professionals protect ourselves moving forward?

CARNO: That's a great question, Candace. So, James and I have talked about, you know, following procedures, following best practices. The other thing I want to say is that as nurses, we assume that our institution is behind us, 99.9% of the time they are. But we need to take a positive and proactive approach on how we are preventing and protecting ourselves.

One way to do that is through malpractice insurance. Now I know that there is debate about it, but when you think when you sit down and you think about it, litigation is high. The cost of litigation can be high no matter what the outcome is. Most nurses don't know what their hospital policies cover for them. And when you have health care insurance, though, I will admit it can, depending upon what area you work at, it can be kind of expensive.

You have somebody in your corner that is looking out just for you, whereas the institution policy is looking out for the institution, the health care providers, everybody involved. In having someone that is really looking out for you and going to help you is really important, both from a cost perspective, because a lot of the policies will help cover the costs and they will also help cover what the if the nurse is found negligent, what the cost of that is.

And the other thing we need to remember is that sometimes lawsuits can occur by the time they work through the system later and the nurse might have left the institution and the malpractice policy of the institution may not cover them at that time. And if they work in a subspecialty such as pediatrics or O.B., we can be you know, I can be named in a lawsuit from a child that I saw, you know, 15 years ago, three employers ago. So that's just one way we can protect ourselves.

PIERCE: Now, I've heard a lot of mixed thoughts on malpractice insurance from You should always carry it. Never be without it too. You should never carry it because they'll find out you have malpractice insurance and then they'll sue you. So, for health care professionals, do they we don't actually require them to have malpractice insurance. They should that correct.

CARNO: I think so, because my understanding is and James, please correct me if I'm wrong when they come up with the damages portion, they don't take that into account until they come up with the damages portion of a litigation. So, they would had to have already proved something has happened before they would know about the malpractice insurance of the individual.

Am I correct, James?

STOWE: Well, Alabama law, which is the only one that I can speak to, is a little bit a little bit unique in its practice. And our negligence is a joint and severable liability. And so, what that means is in a lawsuit. So, when people ask me and I think this would apply for everyone, but when people ask me insurance or no insurance, what should a nurse do?

My response is, it's really up to you, because it's just a personal question. Many, many times nurses are listed in a complaint because a plaintiff knows I know you're not that deep pockets, but you're not that deep pockets here. But I want to investigate and depose, and fact find and and see what I can learn.

In a deposition, one of the very first things that are asked is about your insurance. Do have insurance? Who do you have it with? What's your policy number? Let me go find out. And so all of that stuff will come out. The opposing attorney will go and call and figure out how much is there. So, from the nurse on the front line, they have to decide, do I not want to carry insurance and only and think that I'm only being included in this lawsuit as a fact finding in order to go after deeper pockets or do I want to carry insurance and therefore I have money to go after and be included regardless in the lawsuit.

So, if you're resting your hat on, I may be kicked out because I don't have any insurance for the plaintiff to go after. Then that's a pretty good gamble. You know, it's a high-risk gamble. So, it's more likely that you should carry insurance. But again, it's a personal decision, but many, many times because in Alabama, they'll keep you on the case, ask you about anything and everything under the sun.

And what happens at the end of the trial is. If the if there is a verdict, then the plaintiff can choose who they want to get it from. And so, obviously, whoever has the deeper pockets usually gets hit with that. So right, wrong, indifferent, that's kind of the law here. So, and that also brings up a point of wherever you practice nursing, you may want to read up on some of the laws, negligence and malpractice laws in those states and how things are handled.

Not always easy to read, not always easy to find, but it may impact a decision on whether or not you should get insurance. The easy answer is, you know, work really hard to go through school and get my license and even though it may be expensive. It is a cost of doing business. And I would recommend that you carry insurance, especially in this day and age.

PIERCE: I was just about to ask where we could go to find resources to help us make that decision. So, thanks for touching on that as well. So, as we up this series, what do you hope that the listeners are going to take away?

STOWE: You know, this case that we've discussed and kind of the fallout from it is the incident or the actual event unfortunately is not unique. Events like this occur all throughout health care. In a recent Press Ganey presentation, I saw the last reported number was something about 400,000 medical errors a year are reported. I know no individuals report different numbers, but the crux of that number is that it's just an astounding number.

And so, we have got to address that. You know, everybody in their lifetime will need health care, whether they receive or not, they will need it. Many, many will need to be in a hospital for care. And we owe it to ourselves, our loved ones, our community, friends, to provide great care and so what can we do to provide that great care?

And how do we go about reducing our error rates in a learning manner that is effective? And so that's where I would encourage hospital systems, hospitals, the independent, the individual leaders excuse me, in each department to really focus on addressing issues that you see, address them, evaluate your processes, see what you can change. You know, I'm very well aware that you cannot change 100% of them.

But what if we changed 90% of what was wrong today? I mean, that is truly impactful and will save lives. And so, at the end of the day, no matter your feelings about the verdict, this case, this lawsuit, we have got to really address how we can change and prevent errors moving forward.

CARNO: I agree, Candace. And I think the individual nurse needs to do the best that they can to provide the highest quality of care and to remember there are systems in place for a reason. If the system is not working, they need to report that to their leadership, that that system is not working and to do what they can at bedside to prevent errors as much as we can.

But as we started it in the beginning, we're human. We're not robots, so we need to decrease them. Do I think we'll completely eliminate them? No.

PIERCE: As long as we have humans, we will have errors right. So. Well, thank you so much. Dr. Cano and Dr. Stowe for joining me for this series.

CARNO: You're welcome.

STOWE: Thank you.

PIERCE: I know this series has given me a better understanding of possible legal issues within healthcare.

(SOUNDBITE OF MUSIC)

PIERCE: To our listeners, thank you for joining us for this final episode in our series, Where Healthcare and Legal Meet. Through this series we have discussed criminal and civil negligence, acknowledgement of mistakes, how culture affects our practice environments, and the changes in healthcare that are being seen after a criminal court found a Tennessee nurse guilty and how to protect ourselves as healthcare professionals from possible litigation.

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