Surgical-Related Cases Involving Nursing Staff

Malpractice cases arising from surgical encounters are most often the result of procedural complications, faulty surgical equipment, and/or failed communication between surgeons, their patients and the surgical team. Nurses are key members of surgical teams, and as such, we examined cases in which they were noted to bear responsibility for the ultimate outcome.

The Surgical Suite

Within the surgical suite, which encompasses the inpatient OR, recovery area (PACU), and outpatient surgical centers, nurses are noted as the primary responsible service in a variety of case types, including retained foreign bodies, management and monitoring of the surgical patient, and patient falls. Medication-related events and cases involving non-surgical procedures (i.e., IVs and catheters) are also identified, but it’s the management of patients which accounts for one-fifth of all surgical-related claims and total dollars paid, and it’s there that we will focus.

Figure 1. Nursing: Top Surgical Suite Claim Volume and Total Dollars Paid

Almost one-third of all retained foreign body cases indicate the nurse as the responsible service - and as we see here, almost one-third of nursing surgical cases arise from retained foreign bodies. Much has been written about the critical importance of adhering to surgical count policies, and the attention to detail required within the OR environment when counting (and re-counting) items used in the surgical field. Our data confirms that failures to follow count protocols drives this claim type.
Focus: Management of Surgical Patients

Cases were evenly distributed between inpatient and outpatient settings, and when we looked at the severity of patient injury, little variability was noted between the inpatient and outpatient settings - except events occurring in the PACU were by far the most clinically severe. Overall, more than one-third of events resulted in serious, permanent injuries, up to and including death.

Figure 2. Nursing Management of Surgical Patients: Clinical Severity by Location

In the operating room, both inpatient and outpatient, other scenarios included:

- Failure to report patient allergies to solutions/medications used during surgery
- Wrong site surgeries involving the nursing staff’s role in prepping/draping the correct side/site
- Patient injuries resulting from improper positioning.

But what actually drives these scenarios? Multiple risk factors do as seen in Figures 3, 3a & 3b below.
Figure 3. Top Risk Factors and Common Scenarios

- Communication
  - 56% of cases; includes failures to notify surgeon of uncontrolled post-op pain despite medications, and delays in reporting critical changes in condition
  - Most often noted in PACU (see Figure 3a)

- Technical skill
  - 51% of cases; wrong site/side surgeries as a result of failed nursing efforts to prep/drape the correct site/side
  - Most often noted in the inpatient OR

- Administrative
  - 49% of cases; failure to adhere to established policies/procedures for surgical counts and completion of post-op orders
  - Most often noted in the ambulatory setting

- Clinical judgment
  - 49% of cases; failure to effectively assess and monitor the patient; failure to recognize and quickly respond to changes in condition
  - Most often noted in the PACU

- Documentation
  - 29% of cases; inconsistent documentation of patient care and sequence of events
  - Most often noted in the inpatient OR
Each risk factor is comprised of several sub-factors. The prominent sub-factors are noted in Figure 3b.

**Figure 3b. Top Specific Risk Factors**

- **(Administrative) Staff training/education**
- **(Clinical judgment) Patient monitoring**
- **(Communication) Failure to read medical record**
- **(Technical skill) Incorrect body site**
- **Miscommunication about patient condition**
- **(Administrative) Nonadherence to policy/procedure**

% of claim volume by location with these factors

- Inpt OR
- Inpt recovery
- Ambulatory surgery
Across all surgical cases, not just those involving nursing staff, poor communication - the most frequently noted risk factor in our analysis - leads to ineffective surgical teams and can increase the risk for harm to patients. Missed opportunities to read the record, or to speak with the previous team during handoff from the OR to recovery, lend themselves to delays in the surgical staff’s ability to respond quickly to unexpected patient changes and can significantly affect the patient’s outcome.

**Case Illustrations**

**Case 1**

Surgical consent was obtained for a microvascular decompression to treat the patient’s long-standing left-sided trigeminal neuralgia. Laterality was not noted in the consent document. On the day of surgery, the surgeon did not meet with the patient pre-operatively, nor did she review the history and physical. An anesthesiologist performed the pre-surgical workup, and noted the left-sided neuralgia in the chart, but the CRNA who actually managed the patient’s anesthesia did not review his chart notes. The nurse whose responsibility it was to set up the OR in preparation for the surgery asked the surgeon - while she was performing a different surgery - how to set up the room (right or left-side procedure). The surgeon directed the nurse to set up for a right-side procedure. The OR record noted that during the time-out, laterality was ‘not applicable.’ Within an hour after surgery, the error was discovered and the patient was returned to surgery. This hospital’s policy mandated that all providers who interact with surgical patients are responsible for determining correct site and side.

**Case 2**

The patient, who had a significant cardiac history, was deemed to be an acceptable risk for surgery, and underwent an outpatient shoulder surgery with no complications and minimal blood loss. When the patient arrived in the recovery area and awoke, he complained of shoulder and chest pain. He was medicated over the next three hours with what amounted to large doses of narcotics, but his pain was not relieved. Despite this, he was transferred to the waiting area of the ambulatory surgery center to wait for final discharge to home. One hour later, he complained that he still didn’t feel well, but wasn’t returned to the recovery area for monitoring and administration of nitroglycerin for almost another hour. No EKG was performed, and the nurse did not notify the surgeon of the patient’s ongoing complaints until
after return to the recovery area. The patient became unresponsive and died. The nurse did not recognize the signs of an ongoing cardiac event.

Risk Mitigation Strategies

- One-third of nursing cases arising out of the OR suite involve retained foreign bodies, most often the result of failing to comply with count policies and procedures. Because the majority of retained items occur with what is noted to be a correct count, review your facility’s count procedures and compliance, and routinely ensure that all staff responsible for counts are informed of and compliant with current policies and procedures.

- Management of the surgical patient is impacted by many variables, most often involving failed communication with other surgical team members. Organizational support of a culture of safety in which all members of the surgical team are encouraged to speak up about potential safety issues is crucial. Crowded, noisy surgical suites, complex and fast-moving surgical schedules, and varying interpersonal dynamics among the surgical team never relieve any member of the surgical team from the responsibility of speaking up if something doesn’t seem quite right.

- Surgical team training, with a focus on the active engagement of all members of the surgical team is crucial, and can assist teams with the anticipation of and response to adverse events.

Resources

- Checklist: Patient Handoffs
- Risk Tips: Managing Operating Room Distractions
- The Joint Commission’s Sentinel Event Alert: Preventing Unintended Retained Foreign Objects
- CRICO Strategies: Malpractice Risks in Communication Failures

Data Source

MedPro Group closed claims data, 2008-2017
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