Tort Case Study

Megan Macke

University of Mary

NUR648 Law and Policy

The Rev. Linda Liebert-Hall

A tort case study involving Ms. Gadner and Bay Hospital:

1. Excluding Mr. Sneed and Mr. Otis, list the potential defendants involved in the case.

   Bay rural hospital, Dr. Dick, Dr. Moon, Nurse Gilbert, "other nurses," and the pharmacy.

2. Specify which of the potential defendants have a possible legal liability to Ms. Gadner's estate by stating the legal theories of liability (ex: corporate negligence). Describe the person/entity's actions from the facts which create that liability under the legal theory you have identified (ex. Breach of credentialing procedures in hiring).

Bay Hospital:

Vicariously liable:

Bay Rural Hospital is vicariously liable for the following: nurse Gilbert (assuming she is not contracted), unnamed nurses (assuming they are not contracted), Dr. Moon, and Dr. Dick as a result of the "master-servant relationship of agency law" (Barry et al., 2015, p.173). The hospital is vicariously liable for Dr. Moon due to his administrative duties and the breach of credentialing procedures in hiring Dr. Dick who was not qualified to work as the leading physician in the ER. This is supported by Barry et al. (2015), "the fundamental principle of agency law is vicarious liability, i.e., the master (employer) is responsible for the torts of his servant (employee) even though the master was not negligent" (p.173).

Bay Rural Hospital has the duty to "function inherently," meaning provide services essential to the operation, because they have an ER (Barry et al, 2015). There is no protocol for transferring patients, but there is an expectation by the public and by whoever "transported" Ms. Gadner from the scene of the accident to Bay Rural hospital for emergency support. The emergency support could be found negligent because of the failure to transport, failure to treat became negligent after the transfer did not take place. This originally would not fall under non-delegable duties because although the ER has an obligation to stabilize Ms. Gadner, they were not obligated to treat, and negligence occurred in her not being transferred to an equipt hospital with essential treatment modalities needed. Ms. Gadner also has the right to refuse care, it is her autonomous right, and by not transferring her, this right was breached, and Bay hospital is vicariously liable.

Corporate Negligence Doctrine:

To further provide evidence of negligence: all four areas of liability within the Corporate Negligence Doctrine were failed by Dr. Moon, Dr. Dick, Nurse Gilbert, and "other nurses," and the hospital pharmacist.

(1) "A duty to use reasonable care in the maintenance of safe and adequate facilities and equipment" (Barry et al., 2015, p. 183).

The hospital is liable for corporate negligence due to equipment and inventories not being adequate to treat Ms. Gadner. The laryngoscope was "broken" and there was no available epinephrine in the emergency room. An x-ray was done, but due to the degree of Ms. Gadner's injuries, a CT would have been more appropriate. Barry et al. (2015) support this by saying "if an institution lacks a piece of equipment that is essential, particularly for diagnosis, it may have a duty to transfer the patient to an institution with that equipment" (p.180). The duty to transfer a trauma patient like Ms. Gadner was critical, and due to Dr. Dick, nurse Gilbert, and other nurses not transferring the patient, the hospital is generally negligent. "Standards for medical record keeping" would also fall under negligence in this category due to the "scanty notes" taken by the nurses (Barry et al., 2015, p.195). The nurse's notes "deprived Dr. Dick of critical and ongoing information about Gadner's condition."

(2) "A duty to select and retain only competent physicians" (Barry et al., 2015, p. 183).

Bay Rural Hospital may not have breached its duty *qua* hospital, because we are unsure of whether Dr. Dick is a licensed provider due to his "intern" status (Barry et al., 2015). However, his incompetence around emergency care/trauma care is negligent as evidenced by his inability to assess that Ms. Gadner was in shock (bleeding vaginally), assessing that the current therapy (IV fluids) was not effective (either due to her condition or the IV infiltrated or both), and not having necessary training in adult medicine (pediatric resident).

(3) "A duty to oversee all persons who practice medicine within its walls as to patient care" (Barry et al., 2015, p. 183).

Even though Dr. Moon is liable for negligence for breaching hospital policy in hiring Dr. Dick, the hospital would still be liable for corporate negligence under its duty to supervise medical staff and other providers. A hospital has a non-delegable duty to its patients and is liable when "the hospital's action or inaction regarding its policies rather than specific negligent acts of one of its employees" has been committed (Barry et al., 2015, p. 188). The nurse's "substandard care" also falls under this category.

(4) "A duty to formulate, adopt and enforce adequate rules and policies to ensure quality care for patients" (Barry et al., 2015, p. 183).

We know there is no protocol/policy for making transfers, however, Ms. Gadner has the autonomous decision/right to refuse care and request a transfer- this was breached. If there are policies around a trauma patient and their care- these were breached. If there are policies around system checks, maintenance of lifesaving resources, medication checks- these were breached. The Joint Commission "requires that a record be documented accurately, adequately, and in a timely manner, with information readily available and accessible for prompt retrieval" (Barry et al, 2015, p.195). Another requirement of Joint

Commission is a review of new privileges by doctors, and a professional practice evaluation to be done (Barry et al., 2015). These two rules were breached.

Dr. Moon:

Dr. Moon is liable for negligence based on the following factors: breach of the hospital's credentialing procedures and investigation of qualifications of Dr. Dick to be competent to run the emergency room. Vicarious liability can be expanded to corporate negligence as evidenced by Barry et al. (2015) that a hospital has the obligation for its patients to review qualifications of all medical staff (not just Dr. Dick) including "solicitation and review of information from peers, current license status, malpractice claims filed, and any other relevant information" (p.185). It is unclear whose duty this would be, but assuming that because Dr. Moon is the hospital's chief of staff, this duty would fall under him. The Joint Commission requires a period of review for practitioners (Dr. Dick) which evaluates professional practice through chart reviews, observation of work, assessment of diagnosis and treatments in patients, and review of the professional with other coworkers (Barry et al., 2015). Dr. Moon was negligent in following the professional practice evaluation of Dr. Dick, and due to this, did not see he was unfit to do his duty as a physician for the community.

Nurse Gilbert and "other nurses:"

Nurse Gilbert is liable for negligence based on the following facts: voicing her concerns about a transfer to the "other nurses" but not to Dr. Dick. Substandard care from Nurse Gilbert and "other nurses" in the failure to assess that Ms. Gadner was in shock, failure of the continuum of care/ monitoring vitals (BP, HR, etc) at standardized time intervals for a trauma patient, failure to assess Ms. Gadner's response to treatment (IV fluids)- was not responsive to fluids, failure to assess IV each time the nurse was in the room. If the patient was getting fluids and not responding, corrective procedures should have been ordered by the physician however, Dr. Dick was unaware due to "scanty nurses notes" and failure to monitor the patient. Responsibility to question the contraindicated medications (valium and morphine) which would further drop her BP, causing the patient to be more unstable was negligent. Most hospitals have policies for inventory checks, maintenance, and checks of the crash cart (where epinephrine should have been, along with a working laryngoscope), and have double-nurse checks for medications like valium and morphine. We are unsure of these policies in this case study, but if breached, nurse Gilbert and the "other nurses" could be held liable.

Dr. Dick:

Dr. Dick is liable for negligence based on the following factors: ordering the wrong medications for a trauma patient in shock, failure to assess that Ms. Gadner was in shock (vaginal bleeding, vitals, physiological signs of shock-cool, clammy), failure to stabilize, and then transfer the patient. As a rural ER, responsibility to stabilize is expected, Dr. Dick failed to do this. Continuum of care/ assessment from Dr. Dick is negligent as it is not just the nurse's responsibility to assess the patient. If the patient was critical, as Ms.

Gadner was, the doctor would be present during care and part of the assessment team. Ms. Gadner actively asked for a transfer when arriving at Bay hospital, it is unclear to whom she asked, but had it been Dr. Dick this would contribute to the case of negligence because it was her right to refuse care.

Pharmacy:

Pharmacy is liable under the theory of vicarious liability assuming they are a part of the hospital, negligence if they are not connected to the hospital. The pharmacy has an obligation to question the use of certain medications in certain scenarios, they could be held liable for approving the valium and morphine use in a trauma patient, as it is contraindicated.

3. Based on the legal theories and the facts you have identified, develop a VERY SPECIFIC list of short-term (next 1 - 2 months) corrective actions the hospital must take immediately to remedy the problems. Be sure to have at least one short-term corrective action for EACH of the legal issues you identified. AND 4. Then, develop a second VERY SPECIFIC list of long-term (6 – 12 months) corrective actions the hospital must take to ensure this situation does not happen again. Be sure to have at least one long-term corrective action for EACH of the legal issues you identified. (This list should NOT be the same as the short-term actions, but should instead build upon EACH of them.)

Immediate evaluation of the issues that killed Ms. Gadner should be the start of the snowball effect of corrective actions Bay Hospital needs to take, leading to further evaluation for long-term goals.

"A duty to use reasonable care in the maintenance of safe and adequate facilities and equipment" (Barry et al., 2015, p. 183).

Short term corrective actions:

Immediate evaluation of why there was no epinephrine and a working laryngoscope is critical. Crash cart inventory (epinephrine would be available in the medication drawer and a working laryngoscope in the intubation drawer) should be an immediate policy implemented for nurses to check the crash cart every eight hours (or every shift). All necessary life-saving tools would be available on the crash cart (suction, medications, laryngoscope) to address the short-term issue.

Long term corrective actions:

Policies should be written around inventory checks per room- life-saving materials (suction supplies, oxygen tubing), not just inventory of the crash cart.

"A duty to select and retain only competent physicians" (Barry et al., 2015, p. 183).

Short term corrective actions:

First and foremost: should the ER remain open? "Rural hospitals have been granted more leeway by the courts where several hospitals share physicians. The cases analyze issues of control over the physician's practice more conservatively; the mere provision of office staff or staff supports is not considered sufficient. The courts acknowledge that small

rural hospitals lack substantial bargaining power, and therefore control, over itinerant physicians that they must share with other hospitals in the state" (Barry et al., 2015, p.175). Is there an appropriate physician able to run the ER safely? Whether that is a contracted physician from another rural hospital, or someone else hirable? If not, should a temporary closing of the Bay Hospital ER occur, for the safety of patients in the surrounding community? (Addresses the legal theory of functioning inherently).

Long term corrective actions:
Review of the hiring policy for physicians and nurses. Hiring a suitable physician to run Bay Hospital ER.

"A duty to oversee all persons who practice medicine within its walls as to patient care" (Barry et al., 2015, p. 183).

Short term corrective actions:
Address communication between professions. Review or create training procedures around communication between nurses and doctors, given that it was not voiced between the nurses and Dr. Dick that a transfer should occur for Ms. Gadner. Different scenarios could be implemented by the educator in Bay hospital (assuming there is one) and better communication between physicians, nurses, and pharmacists can be developed. Communication between health professionals and patients also needs to be addressed around a patient's autonomy (as Ms. Gadner's right to refuse care was disregarded).

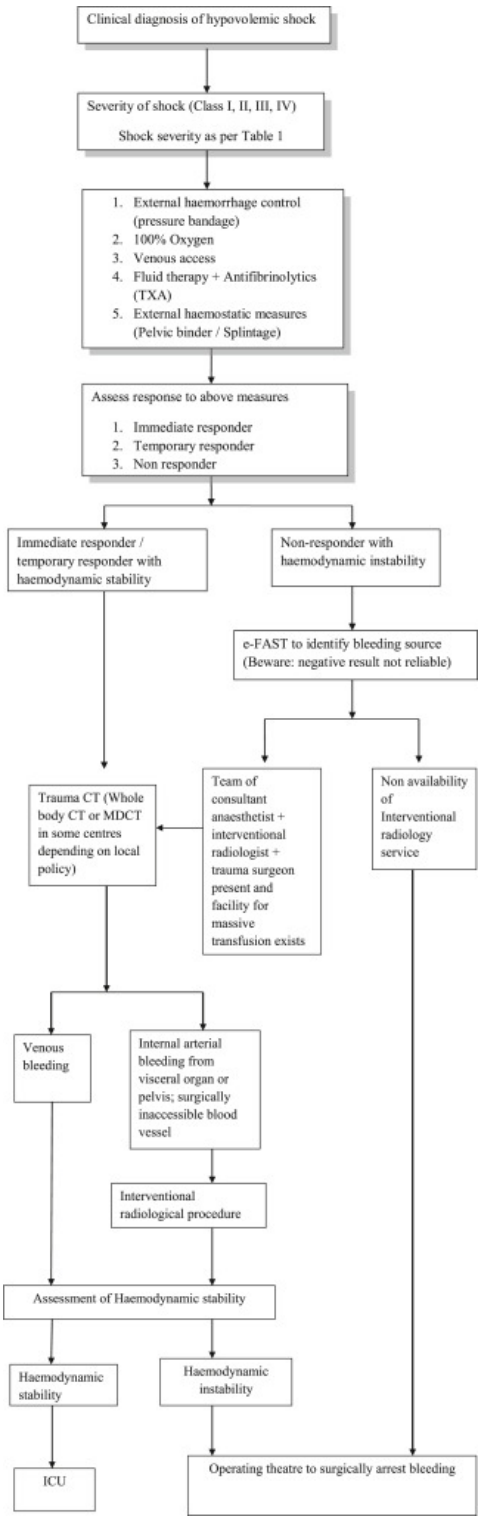
A course on Advanced Trauma Life Support (ATLS) is necessary for all staff in the ER, and pharmacy staff. ATLS "covers how to arrange for a patient's inter-hospital transfer and assure that optimum care is provided throughout the process. If you don't treat trauma patients frequently, an ATLS course provides an easy method to remember for evaluation and treatment of a trauma victim" (Advanced Trauma Life Support, n.d.). Like most rural hospitals, given they are a critical access, trauma is not a common occurrence. In addition, assurance that everyone has also completed Basic Life Support and Advanced Cardiac Life Support for both pediatrics and adults is also necessary.

Implementation of an algorithm for trauma patients using a similar figure as image 1 below (Vishwanathan et al., 2020). Obviously, as soon as stabilized, a transfer should be ordered.

Staffing and system requested absences (SRAs) also need to be addressed short term in regard to who is on shift/on-call, and approval to have it off/not be on-call. To have safe and effective staffing, at least one nurse should be trauma certified. There should be minimal qualifications for other nurses on shift.

Basic nursing assessments skills need to be addressed in an education simulation by the educator for all nurses. Subjects to address in education include: every single time the nurse enters the patient's room assessment of airway/breathing/circulation (ABCs), level of consciousness, adequate retrieval of vials signs if they do not automatically update into the computer system, IV site, and medications running should be observed. A review of how often patients should be checked on, vitals every five minutes if unstable, hourly if

stable should also be addressed. In a trauma situation, the nurses need to be educated on delegation of jobs, who is taking notes, who is taking vitals, who is doing tasks like IV placement and holding pressure.



(Image 1)

Long term corrective actions:
The charting system in the ER should be addressed due to "scanty note writing." Is the charting paper or electronic? Regardless, a tear system (Early Warning Score) should be implemented: if the patient is scoring on the scale, the triage system of what should occur, when the doctor should be notified, and how often vitals should be taken should be implemented. If electronic, how, where, and when charting should be done should be addressed by the hospital educator or ER manager.

"A duty to formulate, adopt and enforce adequate rules and policies to ensure quality care for patients" (Barry et al., 2015, p. 183).

Short term corrective actions:
It is unclear of protocols in Bay rural hospital from this case study, short term protocols that need to be implemented or reviewed include:
Transfer protocol as Bay Hospital was "not equipped to handle trauma patients with multiple injuries like Ms. Gadner." Under the duty of the hospital, it is important to have a policy for multi-injured trauma patients as certain resources are not available (CT machine). If EMS is not able to provide stabilizing procedures, the ER should be utilized to stabilize, but not treat and the patient should be transferred.

A policy for double-nurse checks for medication (morphine and valium should have two nurse checks before administration), if a policy is already in place, a review of that policy needs immediate attention.

A policy to have the crash cart in working order and checked every eight hours by a nurse on duty. This would prevent the unavailability of epinephrine and assure there is a working laryngoscope during a code situation.

Review of hiring policies with Dr. Moon, as well as evaluations that should occur following the hiring process of both doctors and nurses.

Review of the care provided, and why it was substandard and did not meet the requirements of the Joint Commission.

Long term corrective actions:
Shock protocol/policy should be evaluated and implemented over a period of time altered to Bay Hospital and current resources. A policy around the education of nurses and doctors, at least one nurse needing to be trauma certified on shift, and all doctors should be trauma certified (or at least an on-call physician needs to be certified) to even allow traumas to come to the ER. A hemorrhagic shock protocol should be put into place with fluid resuscitation recommendations around the patient's volume status (blood pressure, heart rate, blood work, and urine output). The algorithm listed above is an example, in addition to when a transfer needs to occur.

A policy around inventory checks of lifesaving materials per room. Examples of life-saving materials would include suction materials if the patient needed to be intubated (like Dr. Dick was attempting to do with the broken laryngoscope), oxygen supplies (mask, tubing), oxygen availability per room, a bed in working condition to do CPR, resources to keep the patient warm if revived, along with other basic supplies that should be in every room.

Examine hiring policy to ensure competent physicians and nurses are those being hired.

This tort case could and should have been prevented. As one can see, there are significant changes that need to occur in Bay Hospital, both short and long-term. Bay Hospital is likely to be vicariously liable above all individuals as evidenced by the legal theories listed above. If any of the individuals in this case study are contracted professionals, they would be held liable for negligence.

References:

Advanced trauma life support. (n.d.) American College of Surgeons. https://www.facs.org/quality-programs/trauma/atls

Barry, F. R., Greaney, T. L., Johnson, S. H., Stoltzfus Jost, T., Schwartz, R. L. (2015). *Health Law* (3rd ed.). West Academic Publishing

Vishwanathan, K., Chhajwani, S., Gupta, A., & Vaishya, R. (2020). Evaluation and management of haemorrhagic shock in polytrauma: Clinical practice guidelines. *Journal of Clinical Orthopaedics and Trauma*, *13*, 106–115. https://doi-org.ezproxy.umary.edu/10.1016/j.jcot.2020.12.003