

# Professional Issues in PACU

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- Surgeon is the “captain of the ship”
  - There are times that we have managed a crisis, perhaps with Anesthesia, and we have not notified the surgeon – he/she is obliged to know and to be informed in a timely manner
  - We are obliged to tell him/her; the designee is NOT the surgeon

# Policy Support

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- Reports, paperwork, data
- What hospital policy says
- Ethics consultation
- Confrontation with surgeon
  
- PACU specific policy @ chain of command

# How attentive do we have to be?

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- What is vigilance?
- What is continual monitoring?
- What professional/legal standard will you be held to?
- What does PRUDENT mean?

# Watch Your Patient

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- Go to your assigned unit promptly
- Accept report in a timely manner
- Stay attentive to your patients in your unit
- DO NOT walk away to carry on conversations with others, away from your unit
- Do not turn your back to your patients, especially to chat with others, watch TV, read a magazine, work on a puzzle (extended pt stays different)

# Leaving Your Patient

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- Leaving your unit requires handoff of care
- Do not leave if your absence will cause PACU to be *unsafe*\*\*\*
- Handoff should be documented in the record each time it occurs
- Report significant issues to your accepting nurse colleague

# Legally, who is responsible for coverage in PACU?

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- Eyoma v Falco
- Laidlaw v Lions Gate

# Laidlaw v Lions Gate (1969)

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- 1 nurse alone with 2 patients
- #3 pt arrives, #4 pt Laidlaw
- #5 patient with Anesthesiologist
- MD med order for #5; nurse leaves #4...
- TELEPHONE CALL; nurse answered
- Laidlaw resp diff; MD busy on phone; #6 patient arrives, circ nurse calls for emergency help
- PACU nurse returns from coffee break

# Laidlaw

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- 41 y/o healthy teacher
- Suffered respiratory arrest in PACU
- Permanent brain damage, institutionalized
- History:
  - 1969 1:3 nurse to patient ratio
  - Nurses did not have second call available

# What did the Court say?

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- Reviewed purpose of PACU
- Constant surveillance maintained
- Ever-present watchfulness is required; the patient is entitled to expect the same AAT
- This high standard of performance was not met and the nurses had both been negligent
- Liability is imposed for harm that resulted from creating unreasonable risks to the patient

# Lions v Laidlaw...the Court said

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- Two nurses might reasonably have anticipated needs for nursing care that could not be met if one of them were absent
- The court found a basis for imposing liability for negligence on both the nurse who left on coffee break as well as the nurse who authorized her absence was left alone

# Liability

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A reasonable decision to leave a patient unattended or to reduce temporarily the staff available to care for a group of patients does not lead to liability

**HOWEVER** where there are recognized standards that are not observed, injury to a patient will lead to the imposition of liability

# What are your resources?

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- Clinical decision making
- What cases are expected to arrive?
- Two **appropriate** nurses must be present while any patients are recovering in PACU
- Anesthesia provider must not be allowed to **leave** patients in your care until you can reasonably assume responsibility

# Eyoma v Falco

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- 1986: cholecystectomy
- “short, simple procedure”
- Admitted to PACU at 1235, extubated by Anesthesia, on O<sub>2</sub> 3L nc
- Nurse Falco took report, later ‘handed off’ care to another nurse; Falco left PACU
- DID NOT receive verbal response from nurse accepting care responsibility

# So What Happened?

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- Falco returned to PACU, no one was near the patient
- Respiratory rate 8 per minute
- Rate ↓, respiratory arrest, ↓ cardiac arrest
- CPR 20 minutes; patient never regained consciousness; died one year later

# The Court Said....

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- Verdict held Nurse Falco 100% liable
- There were statements indicating that the anesthesiologist should have given a more thorough report, named the drugs given in the OR, and taken adequate measures to verify sufficient reversal

# Legal Lesson

- ~~2 MD's testified that it is the responsibility of PACU nurse to monitor the patient~~
- Plaintiff experts testified Falco deviated from requisite standards governing PACU nurse
  1. Failure to know drugs given in OR
  2. Leaving pt without verifying pt monitoring
  3. Failure to recognize that the pt had stopped breathing

# Multiple legal decisions

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- “The Recovery Room is the most important room in the hospital”
- ASPAN has embraced this judicial ruling, based on the fact that our patients are very vulnerable
- Nurse/patient ratios, ASPAN position statements support safe staffing

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- 'near miss'; nurse went to lunch, returned to find her patient had inadequate documentation, O2 sat low, less responsive than the time the PACU nurse left the bedside
  - **This can happen very easily, and possibly does more than we know**

# Attentive Care

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- Busy evening, nurse DID hand off care; second nurse received another admission, thank goodness, asked third nurse to ('check bed #4'); when checked, b/p low, repeated; cuff changed, patient unresponsive, CPR initiated
- The patient did well; nurses were absolutely astute and delivered great care

# Medication Administration

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- Neosynephrine free flow\*\*\*
- Zofran in your pocket: **only acceptable with an MD order**
- Incomplete or nonexistent PACU Anesthesia orders

# Neosynephrine free flow: how wrong?

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- Administering medication without an order
- Wrong dose
- Med procedure/policy not followed
- Med unordered/unauthorized drug
- Med wrong dose rate

# Neosynephrine free flow: how wrong?

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- Med wrong technique
- Med calculation error
- Med incorrect documentation
- Med omitted documentation

# Orders from nurse anesthetist?

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- Never acceptable, never at SJHHC
- They can medicate and make their own decisions; they cannot give you orders to direct your care
- The Anesthesia Department has made this decision; only MD orders acceptable for anesthesia care in PACU

# Administering Medications

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- Without MD orders
- Improper labeling
- Incomplete documentation
- Overdose, underdose: inadequate analgesic administration
- Vasoactive drips; must be regulated and adhere to policy

## Administration of Meds without MD orders

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- Nurse transfers out of state, begins work in new unit
- 'routine' for nurses to give 'usual' analgesics, obtain written or verbal orders later
- She is considered a pot-stirrer, a goodie goodie, for insisting on orders....

# Busy Unit: an Evening in PACU

- ~~Interim care by Anesthesia attending at bedside; his patient's O2 sat in 70's~~
- Each PACU nurse is really busy at each unit, cannot take over care
- Helping Anesthesia seems like the right thing to do; in fact, the patient deteriorates and needs intubation
- Do you leave your unit, and your patients, to assist? What do you do?

# Another instance: Busy Unit

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- Anesthesiologist 'stays with' a patient; patient needs bedpan and because the MD is \_\_\_\_\_, states in no uncertain terms that this is nursing; PACU nurses do attend to patients need and clean him up, supporting patients' dignity; **DO NOT TAKE OVER CARE AND INDICATE SAME TO ATTENDING**

# Abandonment

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- If you go to the patient during Interim Anesthesia care for patient ID, and then you leave
  - Instead, patient ID should be accomplished between you and Anesthesia when transfer of care occurs
- If you walk away from a patient prior to appropriate assessment and intervention

# What is Right for the Patient?

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- You work on your own license
- Follow the standards of care
- Adhere to hospital and unit policies
- Work according to your personal standards of care, and your own work ethic
- Go the extra mile; do the right thing for your patient

## ? Inability to Move Legs?

- Should you ALWAYS check and document that a patient CAN move the legs?
- Aldrete score indicates movement upon admission; it is prudent to make sure your patients can move all 4 limbs upon awakening
- Unless a patient had a PREOP deficit, new deficits should be acted upon and documented!

# Talking at the bedside

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- Issues not directly related to care of your patients should be discussed quietly with discretion
- Too many times, we rehash issues with our nursing audience and don't remember that patients do hear what we are saying; even an animated discussion that does not **involve** your patient is disruptive to them

# When PACU is closed

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- The PACU charge nurse makes a prudent decision and sticks with it
- Communicate closure to OR charge and Anesthesia Coordinator; call Kim
- This decision should only change with PACU charge nurse approval
- Do not undermine the charge nurse authority

# Push, Push, Push

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- PACU closure means the nurse *cannot* attend at the bedside
- Anesthesia may **use the space in PACU** after conversation with the charge nurse and Anesthesia Coordinator
- **The PACU charge nurse must not bend to pressure to take over care until it is safe and correct to do so**

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- PACU discharge is based on a patient meeting discharge criteria
  - DO NOT rush your patient's out of PACU to prevent call nurses from coming in
  - Make your own decisions, and make them wisely
  - Whenever you think you shouldn't move a patient **yet**, you probably shouldn't

# Nurses are not Stepford Wives

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- We do not need to race out of the unit
- We utilize discharge criteria, not timed segments to facilitate patient flow
- Every nurse functions independently, and works off his/her own license
- EVERY nurse contributes something unique and important to the whole; diversity should be a strength

# Anesthesia Interim Care in PACU

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- The policy was developed to articulate the concerns of PACU staff related to inadequate coverage of patients by Anesthesia in PACU during closure times
- Legal responsibility of Anesthesia to care for, and document care of, patients until care assumed by PACU
- PACU **in time** starts when you accept report

# ICU Overnight Policy

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- Policy is derived from ASPAN position statement on ICU overflow patients
- The policy is meant to support your decisions
- Patient acuity and nursing resources must be considered

# PACU Communication Decision Tree

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- Ensuring physician response to critical patient care issues
- Use your resources
- Utilize the administrative coordinator
- If all else fails, you cannot get help –
- CALL A CODE – you will clearly have an interesting response and followup

# Calling a Code

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- ASPAN standard: ACLS
- Code Team
- Interesting in our unit; PACU nurse related to anesthesiologist; two very different perspectives

# Policy/Procedure

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- When PACU nurses do not follow protocol, policy, procedure, the hospital does not and will not back you up
- When PACU nurses have been informed of your obligations, and you practice outside your scope, even I cannot defend you

# Does the doctor have your back?

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- Think again
- You are on your own if you don't follow policy; it's lonely
- Don't fold to pressure
- Your practice, and license, are precious

# Professional Behavior

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- Arrive to work at your scheduled time
- Routinely punching in late is not fair to your colleagues
- Respectful treatment of coworkers includes
  - Your colleagues in PACU
  - Physicians of all shapes, sizes, peculiarities
  - Communication with OR, clinical units, administrative coordinators

# Site/Side/Time Out

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- Continue to perform site/side verification in full; document on pink sheet
- Ensure that physician signature on consent is present **before** procedure begins
- The time out step is the last requirement just prior to procedure; follow the script and proceed with TEE, ECT, cardioversion only after full cooperation is achieved

# Specimen Draws, etc.

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- Entry by secretary must be done from RN written indication; no exceptions
- Lab specimens must be labeled at the bedside
- Write “H” and your employee ID on the sticker and the requisition

# Handoff of Care

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- SBAR communication
- Identify patients (**new for PACU**) as you transfer care to the ICU nurse, the clinical unit, Endoscopy, etc.
- Sign this identification on the back of your PACU green record

# Follow-up on Occurrences

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- Report to management, administration
- Fill out MIDAS
  - Reintubation, return to OR, Codes in PACU
  - Unexpected happenings to your patient
  - Patient demise
  - Equipment failures (even nonfunctional Hospira pumps)
  - Medication errors

# What Else?

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- NY State mandates related to hours worked by nurses\*\*\*
- ASPAN's position statement on fatigue
- Refrigerator temperatures: very important for documentation to occur **every day!**
- If Andy is off, checklist must be completed; on Sundays this is now also mandatory

# NYS Department of Health

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- Any registered nurse who voluntarily chooses to work more than 16 continuous hours in a 24 hour period may be subject to a charge of unprofessional conduct stemming from willful disregard of patient safety

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# ASPAN: Standards for Ethical Practice

# Competency

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- Maintain personal accountability for professional competency, practice, educational activities
- Adhere to ASPANA Standards
- Remain current, incorporate EBP, research
- Practice with compassion and respect

# Responsibility to Patients

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- Quality care to all, ensuring safety
- Explanations, with honesty, integrity
- Respect confidentiality, privacy, modesty
- Respects patients decisions
- Advocates for patient welfare, spiritual comfort, family presence
- Aggressive pain management

# Professional Responsibility

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- Nurse is responsible and accountable for care provided, and for maintaining compliance with regulatory and professional agencies
- Accurate, objective records
- Recognizes need to care for self, maintain professional boundaries

# Malpractice in PACU

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- Actions or inactions
- Complex relationship between law and medicine
- Battle of experts
- Both attorneys will attempt to impeach qualifications of expert witnesses

# Formula for Malpractice

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- Nurse must have and use the knowledge, skill, and care ordinarily possessed and employed by members of the profession in good standing and that a nurse will be liable if he/she does not have them.

# What Happens in Court?

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- Attorneys present evidence of the standard of care by use of expert witnesses
  - Rely heavily on their own personal practice/expertise
  - May use journals, texts, ASPAN standards
  - May cite from books, guidelines

# Potential charges

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- Loss of marital duties
- Loss of future wages
- Loss of support
- Pain and suffering
- Lack of vigilance
- Failure to act

# Potential Charges

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- Injury resulting from negligence
- Inappropriate care, assessment, monitoring
- Failure to monitor
- Poor patient positioning
- Administration of wrong agents
- Misuse of equipment
- Faulty equipment

# Case Examples

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- Vistaril injection [droperidol, phenergan]
- Colorectal patient, paralyzed
- Patient fall in PHASE II
- Endovascular AAA poorly performed
- Patient resuscitated with express wishes for DNR

# TIPS

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- Report and investigate all 'near misses'
- Question, investigate all mistakes; report up
- Question MD orders; ensure informed consent with pt/family involvement
- Embrace safety checks, guidelines
- Know your scope of practice and limitations