Nurse License Protection Case Study: Failure to accept only those nursing assignments that are commensurate with the nurse's education, experience, knowledge, and abilities

Presented by NSO and CNA

A State Board of Nursing (SBON) complaint may be filed against a nurse by a patient, a patient's family member, colleague, employer, and/or other regulatory agency, such as the Department of Health. Complaints are subsequently investigated by the SBON to ensure that licensed nursing professionals are practicing safely, professionally, and ethically. SBON investigations may lead to outcomes ranging from no action against the nurse to revocation of the nurse,Äôs license to practice. Therefore, when a complaint is asserted against a nurse to the SBON, the nurse must be equipped with the resources to adequately defend the matter. Being unprepared may represent the difference between a nurse retaining or losing their license. This case study involves a registered nurse (RN) who had been working as a private-duty home health nurse for approximately eight months at the time of the incident.

SUMMARY

The insured RN had been working as a private-duty home health nurse for approximately eight months when she was assigned to an overnight shift caring for a ten-year-old female patient who had been paralyzed in a vegetative state since an acute brain injury sustained in infancy. The patient could not move or breathe on her own, and she was ventilator-dependent with a permanent tracheostomy (‚Äútrach‚Äù). This was the first time the RN had been assigned to care for the patient. Typically, the RN would receive at least several hours of orientation during her first shift working with a new patient, sometimes working a full shift alongside another nurse before working independently, especially with such a fragile and medically complex patient. However, in this instance, the licensed practical nurse (LPN) who had worked the day shift caring for the patient only provided the RN a short, approximately 20-minute orientation before leaving the RN to care for the patient overnight, alone.

The patient's treatment plan included orders for continual monitoring of the patient's respiratory status via pulse oximeter; tracheostomy care including emergency measures if the trach became obstructed

or dislodged, or if the patient was not ventilating properly. The plan also directed the skilled nurse to perform intrapulmonary percussive ventilation (IPV) treatments three times a day, as needed and as tolerated by the patient. If the patient did not tolerate the IPV treatments, the treatment plan stated that nebulizer treatments could be given instead.

The RN's nursing notes reflected that she assessed the patient at the start of her shift, and the patient's vital signs remained stable for the next several hours as the RN administered medications, repositioned the patient, changed her diaper, and administered a tube feeding. Around 11:00 p.m., the RN noted that the patient's vital signs were still within normal limits, though the patient was having a lot of secretions despite the RN having just recently suctioned her mouth and nose. Shortly after midnight, the RN administered an IPV treatment with albuterol. Her notes stated that the ‚ÄúIPV was not functioning correctly.‚Äù About three minutes after starting the IPV treatment, the patient's heart rate dropped to 64 beats per minute (BPM), when it had been 102 BPM at the start of the shift. The patient's oxygen saturation also dropped from 98% to 72%. In response to this desaturation, the RN administered supplemental oxygen, and the patient's heart rate and pulse oxygen returned to a normal range.

Then, rather than switching to the patient's nebulizer to administer medication, the RN next tried to administer budesonide, an alternative breathing treatment, with the IPV machine. As the budesonide was administered, the patient's heart rate and pulse oxygen fell again to 74 BPM and 60%, respectively. This again prompted the RN to administer supplemental oxygen to try to raise the patient's heart rate and pulse oxygen. The RN then disconnected the IPV machine, as the RN's nursing notes from 12:45 a.m. indicated that the patient "did not tolerate the IPV treatment"

The RN said that she remained next to the patient for 2-3 minutes after reconnecting the ventilator, and that the patient appeared fine after the two desaturation events. The RN then left the patient's bedside to clean the IPV equipment in the adjacent bathroom. While doing so, the patient's pulse oximeter began alarming, indicating that no pulse was registering on the device. The RN returned to the patient and saw secretions coming from the patient's mouth and nose and tried to suction them. She then moved the pulse oximeter sensor from the patient's left leg to her right leg, and then to both thumbs, but could not get a reading on any of the patient's extremities. The RN tried to check the patient's pulse manually and thought she detected a weak pulse on her wrist, even though nothing was registering on the pulse oximeter.

The RN went upstairs to get help from the patient's parents because she suspected that the pulse oximeter‚Äôs sensor might be defective, and she hoped that the parents might have a replacement. Both parents later told investigators that the RN did not appear panicked when she awoke them and reported only that ‚Äúthe machine was not working.‚Äù The patient's father ran downstairs, with the RN close behind. The father arrived at the patient's bedside first and told the RN to get the patient's mother, and he called an ambulance. Apparently seeing that the patient was turning blue, the father said aloud that the patient's trach tube had become dislodged (though it is not clear from the evidence whether the patient's trach tube was, in fact, dislodged, or whether something else caused the patient to stop breathing).

While they waited for the ambulance to arrive, the father tried to change the patient's trach tube using spare equipment by the patient's bedside. The patient's mother found a replacement sensor for the pulse oximeter and confirmed it was working by testing it on herself. However, she could not get a reading from the patient. When the ambulance arrived, the EMTs tried to use their own equipment to detect a pulse but found none. The mother told the EMTs that the patient had a DNR order, and she turned off the patient's ventilator.

That same night, police and Child Protective Services were called to investigate the patient's death, and the RN and the parents were all interviewed for several hours. The patient's death was also investigated by the RN's employer and state agencies which regulate home health care, including the Department of Family and Child Protective Services, and the Department of Health and Human Services. The patient's parents both told investigators that they did not think the RN had been properly trained to care for the patient.

The RN's employer was cited for numerous violations of state regulations, including inadequately training the RN when she was hired and failing to ensure that the RN received adequate orientation and training prior to working with new equipment and technology or an unfamiliar care situation.

An investigation into the RN's conduct in this matter was also initiated by the SBON, with

allegations against the RN including:

- Failure to accept only those nursing assignments that are commensurate with the nurse‚Äôs education, experience, knowledge, and abilities.
- Exhibiting an inability to perform registered nursing in conformity with the standards of minimum acceptable levels of nursing practice.
- Failure to implement measures to promote a safe environment for patients and others.
- Failure to know the rationale for and the effects of medications and treatments.
- Failure to accurately and completely report and document required matters, including patient status, nursing care rendered, administration of medications and treatments, and patient responses.

RISK MANAGEMENT COMMENTS

The SBON investigators considered several mitigating factors in this case. First, the RN had only been licensed for approximately eight months when she was assigned to work with this patient, and she admitted that she was unprepared to care for such a complex and fragile patient. Though she completed a competency evaluation when she was initially hired by the home health agency, the evaluation noted that the RN had specifically asked her employer, in writing, for additional training on tracheostomy patients prior to working independently. Before her shift with the patient, the RN had previously cared for several other patients on ventilators, and she had been generally trained on how to replace a trach tube, but she had never performed a trach tube replacement on one of her patients nor been faced with any kind of trach-related emergency.

SBON investigators discovered that the LPN who trained the RN on the patient's care was also inexperienced. The RN did not know it at the time, but the date of the incident was also the first day that the LPN had worked with the patient. The LPN received her own orientation to the patient at the start of her shift that morning from a supervisor, who remained and worked with the LPN for over four hours before leaving the LPN to care for the patient alone. The RN's defense attorney argued that the training provided to the LPN showed that their employer and supervisors understood that at least several hours of orientation were needed to prepare a new nurse to care for this patient, and, yet the home health agency did not ensure that the RN received such training.

Despite her concerns about being left alone with the patient, the RN testified that she felt she had no choice at the time but to stay. The RN was trained that she could not abandon a patient, and she knew the patient's parents were depending on her to provide overnight care. Her employer's offices were already closed when her shift began, so the RN doubted that anyone would be available to help even if she had called to raise concerns about her ability to care for the patient. Additionally, the RN testified that she felt pressured to accept the assignment because her employer had told her she would not be scheduled for regular shifts until she completed a prn (as needed) shift with the patient.

RESOLUTION

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RISK CONTROL RECOMMENDATIONS

Home health nurses may utilize the following risk control recommendations to evaluate their current practices:

- **Know your State Nurse Practice Act and employer's policies and procedures related to clinical practices.** Lack of knowledge about established regulations, standards, and policies and protocols is not a defense.
- **Be clear regarding your patient care assignments.**This is even more critical when private duty nurses are assigned a new patient. Accept only those nursing assignments that are commensurate with your education, experience, knowledge, abilities, and scope of practice. Clearly document assignments at the start of the assignment and update those written records to include any modifications.
- **Be conversant with organizational policies, including the process for invoking the chain of command for patient safety concerns,** before agreeing to provide private duty nursing services.
- **Serve as the patient's advocate in ensuring patient safety and the quality of care delivered.** Initiate additional steps, if necessary, to ensure safe, timely patient care. These measures may include, among others, escalating to the supervisor/nurse manager, administrators, and/or other leadership staff until patient care concerns are addressed.
- **Know the medication(s) being administered to the patient.** Nurses represent the last line of defense to prevent medication errors from reaching the patient. Therefore, they should understand why the patient is taking a specific medication, as well as interactions, side effects, or adverse reactions that may occur.
- **Follow documentation standards established by professional nursing organizations and comply with your SBON's standards**. The healthcare information record should accurately reflect the care of the patient.
- **Document in a timely and accurate manner both initial and ongoing findings regarding the patient's status and response to treatment.**
- **Document your patient care assessments, observations, communications and actions in an objective, timely, accurate, complete, appropriate, and legible manner.** Always use complete, objective descriptions of nursing assessments and observations.
- **Provide and document practitioner‚Äôs notification of a change in condition/symptoms/ patient concerns and document the practitioner‚Äôs response and/or orders.**
- **Follow organizational protocols regarding when to call 911,contact the patient's provider and family,** and/or notify management of emergencies, security threats, or other concerns.