

**MEDI-LEGAL RESOURCE NEWS**

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**WRONG-SITE SURGERY BY BOBBI BLACK RN CLNC****INSIDE THIS ISSUE:****WRONG SITE SURGERY 1****PATIENT NON-COMPLIANCE 2****PREGNANCY AND SURGERY 3****PREGNANCY TERMS AND DEFINITIONS 4**

In December 2007, [MSNBC](#) covered a series of articles on wrong site surgery . How does such a thing happen?

Wrong site surgery occurs when a surgeon or other health-care giver performs a procedure on the wrong part of the body i.e. right or left knee, hip, arm, leg, or eye. The error can also occur inside the body by performing operation on the wrong kidney, ovary, or other internal organ. In some cases, this may involve an injection or an anesthetic that is administered to the wrong area. In some cases, the error is immediately identified and corrected with no long-term or lasting harm. Some result in a devastating outcome that cannot be corrected and perhaps some result in an error that can be corrected but the patient may require repeat surgery and require longer hospital stay. The bottom line is - wrong-site surgery should never happen and when it does, it is always a serious event. When reviewing these issues , it is important to track all the safety steps taken to reasonably avoid the error.

Surgical procedures require a high intensity level of care in a combined effort by a team of caregivers. This team has to work together in a manner that communicates information and promotes collaboration in order to provide the safest possible care. A breakdown in the process can result in adverse event. For example, multiple surgeons with multiple procedures increase the likelihood of confusion. Time pressures and/or unusual patient characteristics can contribute to rushing through patient identification and/or assessment processes. Failure to verify critical patient information can lead to a breakdown in communication.

In 2003, [JCAHO](#) convened a national summit to review the problems associated with wrong site surgery. Subsequently, JCAHO established a Universal Protocol for preventing wrong site errors with emphasis on 3 minimum requirements: preoperative verification, site marking and by taking a “time-out” in the operating room prior to

beginning the procedure, allowing time to “pause” and verify the information among all the team-members. In collaboration, the Council for Surgical and Peri-operative Safety a/k/a [CSPS](#) and American Association for Operating Room Nurses a/k/a [AORN](#) guidelines have been distributed for adherence to the JCAHO protocol. As of July 2004, all JCAHO accredited hospitals are required to implement a site-verification protocol, which should include the following provisions::

- Marking the correct surgical site with the surgeon’s initials, and make sure the mark is visible.
- Stop to confirm the location, the procedure, and the patient’s name before beginning the procedure. The whole surgical team should participate in this “time-out.”
- Make sure that everyone knows where on the body the surgery should be, and that they speak up if something looks wrong. Any inconsistencies should be resolved by the surgeon and confirmed by the patient.
- Informed consent must specify laterality, if the site is bilateral. If there are multiple structures presents, the consent form must attempt to localize them and the procedure should be scheduled for the operating room with equivalent details..

References: [AHRO Patient Safety Network](#)

**PATIENT NON-COMPLIANCE BY SARAH MCLAIN RN CLNC**

Non-compliance is a problem that has plagued medicine since its advent. Noncompliance occurs when a patient does not follow the advice of his or her physician. Do we really want compliant patients who blindly obey whatever we command of them, or do we want patients who better understand their conditions and both comprehend and agree with our advice? Patients who we might call “concordant.” It is estimated that lack of concordance costs the health care industry over a billion dollars in hospital expenditure, loss of productivity at work and medico-legal issues. Concordance itself is a wide ranging scope of possibilities. It ranges from a routine GP visit to a patient on strict warfarin therapeutic monitoring. Since both these patients have seen the doctor, they may be called concordant. However, the consequences of nonconcordance will have different severities in each case. Similarly, non-concordance ranges from a patient who does not take one aspirin a day to a patient who fails to continue with triple therapy for HIV treatment.

What factors are involved in nonconcordance? Perhaps there is a lack of effort on the part of the physician to explain the situation to the patient causing the patient to ignore the doctor’s advice. If a patient is unable to grasp the full extent of the disease he/she is less likely to be motivated and may simply be overwhelmed with all the information. Perhaps physicians, due to time constraints, have a tendency to speed through technicalities of treatment, relying on the patient to pick up some of the slack by educating themselves. Depending on factors such as level of education and resources, this may occur; however, one must keep in mind that it may not.

Where does one draw the line as far as doing too much? Physicians are in a position of ultimate responsibility and their words have a resounding impact on patient decisions.

However, freedom of choice allows the patient to choose therapy he sees fit and to omit what he feels as unnecessary despite understanding the dire consequences. One cannot legally make a patient adhere to a certain treatment even if the consequences of not

doing so could be fatal: for instance, a woman who abuses alcohol during her pregnancy despite doctor’s advice. It would seem to be ethical to take action against this individual, but legally there is little that a doctor can do to save the life of the unborn child. A “good” doctor should know his or her limits and utilize resources by working within these limits.

Many strategies that deal with patient education, support and empowerment have been proposed to overcome non-concordance. More often physicians are going to great lengths to make sure that patients know how to take their medications correctly. A common strategy is to educate patients on monitoring blood sugar levels in the case of diabetics, on nutrition, and giving contact numbers for existing support groups. These measures help put the patient at ease about therapy and enable them to get much needed emotional support. A more drastic strategy includes patients visiting wound-care facilities for diabetics, visiting victims of DUI’s (driving under the influence of alcohol or drugs) in intensive and coronary care units so that these patients can see the dire consequences of their non-concordance. Other physicians have given ultimatums to their patients stating that if they don’t follow their advice for successful treatment then therapy would be terminated and there would be little point to come back. This strategy aims to either scare the patient into concordance, make him comprehend the gravity of the situation (impending death), or drive him to another doctor who may have better luck.

The impact of doctor-patient interactions as they relate to nonconcordance is of paramount importance to the health-care industry. As medical students, it is highly prudent to evolve strategies on how to bridge any gaps that impact on this interaction. We are in prime position to create a paradigm shift in the future of health-care practice. The internet, TV and radio all offer modalities of communication which allow us to encourage patients to selectively use as current, informative resources for better health. It is logical to argue that a more informed patient will prove to be a more concordant, happier and healthier patient.



***Compliance with treatment regimens is one of the many factors that can determine the fate of your case!***

**SURGERY AND PREGNANCY BY JAN AKEN RN IBCLC LNC**

The following guidelines may be helpful when reviewing cases involving a pregnant woman who has undergone a surgical procedure..

1. All fetal/ monitoring should be performed by a skilled OB nurse who can interpret the results and act accordingly
2. Operating room Anesthesiologist should consult with the attending Obstetrician prior to the case.

**RELEVANT information:**

Safest time for surgery during pregnancy is the 2nd trimester: 14-26 weeks, because:

1. Out of time period of teratogenicity / Spontaneous Abortion (1st trimester)
2. Prior to time when uterus is likely to contract (3rd trimester)

**Drugs:**

1. Check with reference: Freeman & Griggs, Drugs in Pregnancy & Lactation
2. Narcotics are safe and should be administered, as they would be if patient were not pregnant.
3. Vasopressors that decrease uterine blood flow (i.e. epinephrine decreases uterine blood flow,) should be avoided. Ephedrine does not diminish uterine blood flow and can be used.

**CRITICAL POINTS:**

1. Patient should have pre-op cervical exam.
2. Pregnant patients are considered "full stomachs" and should receive Alka Gold (neutralize the stomach acid on call to operating room.
3. After 20 weeks procedure positioning should maintain the uterus off Vena Cava and aorta.
4. Hypotension should be avoided.

**Procedure:**

1. Monitoring (usually performed if patient is greater than 24 weeks)
  - a. Preoperative:: 20-30 minute electronic fetal monitor strip in holding area of the operating room or on the patient's unit.

b. Intraoperative: During abdominal surgery, fetal monitoring can be done by getting a Doppler attachment gas sterilized and applying to the abdomen after surgical preparation. Intraoperative monitoring can reveal variant fetal heart rate patterns associated with the following:

- Hypotension
- Cord compression
- Manipulation of the maternal brain
- Hypothermia

c. Postoperative: Fetal/Monitoring should begin immediately in the PACU and extend continuously until the patient is recovered. After discharge from the PACU, intermittent post operative monitoring is usually ordered by the obstetrician (i.e. 30 minutes, every 4- 12 hours) Observation should focus on signs of preterm contractions since increased uterine activity is common post-op regardless of location of surgical site.

**2. Logistics/Emergencies:**

a. If the patient is greater than 25 weeks, the possibility of emergency C-section [C/S] increases particularly, during surgery or immediately post-op period. A C/S cart should be ordered for the OR and kept nearby during the procedure.

Often an OB resident will be designated as the person to call stat should an emergency ensue. A system for getting them stat to the OR or PACU should be established between the nurse monitoring the patient and the OB resident.

The anesthesiologist covering the PACU should be aware of the patient's pregnancy. The risk of crash cesarean section is extremely low however if the need does arise, an operating room should be used for the crash cesarean section rather than trying to move the patient to Perinatal Services. In order to avoid down time, the following should be available preoperative area:

- Fetal monitor, extra paper, belts, gel, etc.
- Alka Gold for preoperative administration
- Indocin suppository (50 mg.)
- Terbutaline (with TB syringe for SQ use)



*Pregnancy problems can affect either the mother or the fetus*

**Was the risk versus benefit of surgery, a consideration in your pregnancy case?**



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## PREGNANCY RELATED TERMS AND DEFINITIONS

C-section a/k/a Caesarian section is a surgical procedure in which the fetus is delivered through an incision of the uterus.

Congenital - a condition present at birth

Down Syndrome is a chromosome disorder due to an extra chromosome 21 a/k/a trisomy 21

Effacement describes the thinning of the cervix which occurs before and while the cervix dilates

Gestational Diabetes is a form of diabetes that appears during pregnancy and usually resolves following delivery.

Preeclampsia is a condition characterized by abrupt hypertension, leaking of protein albumin in the urine and edema. Usually occur in

the third trimester of pregnancy

Premature Birth is a birth that takes place before 37 weeks gestation.

Toxemia is another term for preeclampsia

Trimester describes the stage of pregnancy, which is traditionally divided into three distinct periods that correlate with different phases of fetal development

Ultrasound a/k/a sonogram creates images using high-frequency sound waves.

Uterus a/k/a womb is a hollow, pear-shaped organ in the lower female abdomen. The narrow, lower portion is the cervix, and the broader, upper part is the corpus.

Vagina is the muscular canal extending from the cervix to the outside of the body.



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