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Judicialization of nursing malpractice in perioperative care, and delivery and birth assistance

Judicialização do erro de enfermagem no cuidado perioperatório e na assistência ao parto e nascimento

Judicialización del error de enfermería en la atención perioperativa y en la asistencia al parto y nacimiento

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ABSTRACT

Objectives: to analyze the legal outcomes of malpractices in perioperative care, and delivery and birth assistance related to nursing, from the perspective of legal support for malpractice prevention. **Methods**: an exploratory, documentary, qualitative study, based on the cases tried by the Court of Justice of the State of Paraná, available online until April 2018. For the data analysis, we codified the processes and summarized the judicial outcome by the severity of the malpractice. Then, we recommended practices for the prevention of each case we presented. **Results**: among the thirteen processes analyzed, eight corresponded to the perioperative period (mainly electrocautery burn), and five to nursing care for delivery and birth. The severity of the cases was high (n=7). The judicial outcome of most cases (n=11) was the conviction of the institution. **Conclusions**: despite the multifactorial nature of the malpractices, the identified ones are preventable since there is a description of good practices. **Descriptors:** Judicial Role; Medical Errors; Nursing; Parturition; Perioperative Care.

RESUMO

Objetivos: analisar os desfechos jurídicos de erros no cuidado perioperatório e na assistência ao parto e nascimento relacionados à enfermagem, sob a ótica do respaldo legal para prevenção de falhas. **Métodos**: estudo exploratório, documental, qualitativo, realizado com base nos casos julgados pelo Tribunal de Justiça do Estado do Paraná, disponíveis on-line até abril de 2018. Para a análise dos dados, os processos foram codificados, o desfecho judicial foi sumarizado pela gravidade do erro; depois, apresentaram-se práticas recomendadas à prevenção de cada caso. **Resultados**: dentre os 13 processos analisados, 8 correspondiam ao período perioperatório (principalmente queimadura por eletrocautério); e 5, à assistência de enfermagem ao parto e ao nascimento. A gravidade dos casos foi alta (n=7). O desfecho judicial da maioria dos casos (n=11) foi a condenação da instituição. **Conclusões**: apesar da multifatoriedade dos erros, as falhas identificadas são passíveis de prevenção, haja vista a existência de descrição de boas práticas.
Descritores: Decisões Judiciais; Erros Médicos; Enfermagem; Parto; Assistência Perioperatória.

RESUMEN

Objetivos: analizar los desfechos jurídicos de errores en la atención perioperativa y asistencia al parto y nacimiento relacionados a enfermería, bajo la óptica del respaldo legal para prevención de errores. **Métodos**: estudio exploratorio, documental, cualitativo, basado en casos juzgados por el Tribunal de Justicia del Estado de Paraná, disponibles en línea hasta abril de 2018. Análisis de los datos, los procesos fueron codificados, el desfecho judicial fue sintetizado por gravedad del error; después, presentaron prácticas recomendadas a prevención de cada caso. **Resultados**: entre los 13 procesos analizados, 8 correspondían al perioperatorio (principalmente quemadura por electrocauterio); y 5, a asistencia de enfermería al parto y nacimiento. Gravedad de los casos fue alta (n=7). Desfecho judicial de la mayoría de los casos (n=11) fue la condenación de la institución. **Conclusiones**: aunque la multifactoriedad de los errores, los errores identificados son pasibles de prevención, haya vista la existencia de descripción de buenas prácticas.
Descriptores: Decisiones Judiciales; Errores Médicos; Enfermería; Parto; Atención Perioperativa.

INTRODUCTION

Despite the efforts made by health services to promote patient safety, nursing is still susceptible to various care malpractices[1]. The failure, unlike a violation, is not an intentional result and can be interpreted as inherent in the human condition, even if unwanted[2]. In the health sector, the occurrence of the malpractice is strictly related to the failure of processes and implies the need to adopt systemic measures that promote a safe environment for care[2-3].

The World Health Organization (WHO) and the National Patient Safety Program (PNSP), aiming to promote a safe environment for professionals, patients, and family members, recommend that organizational learning be made through malpractice and co-responsibility of the health service for the promotion of the patient safety[4]. However, it is still possible to see a significant number of ethical-disciplinary processes (EDP) on malpractices committed by nursing; processes that are sometimes initiated by the immediate management and/or by the institution with which the professional has an employment relationship[5].

A study conducted in the State of São Paulo to describe the ethical occurrences of EDP judged by the regional Nursing Council of São Paulo identified that among the 399 ethical issues tried in the first instance between 2012 and 2013, 260 (65%) were associated to situations of negligence, recklessness and/or impropriety on the part of nursing[6]. Another study, conducted in Santa Catarina, intended to analyze the positioning of nursing managers and leaders in the face of malpractice disclosed in the media, identified that, among the 58 cases disclosed, 26 had an internal investigation, and 6, an EDP was initiated[5].

A recent literature review analyzed 30 primary studies and confirmed that the process of judicialization due to malpractice occurs more frequently in the context of the use of medications, and, after that, other care processes were also the focus of the studies analyzed, especially the surgical procedure[7]. Regarding malpractices occurring during the perioperative period, nursing has a relevant role in the prevention of incidents. However, research conducted in a surgical department of the University Hospital of Basel, Switzerland, found that, although there is adherence to the safe surgery protocol, there are still weaknesses in compliance with the checklist, causing "never events"[8].

In 2017, according to the Bulletin Patient Safety and Quality in Health Services No. 18, 403 recorded incidents were classified as "malpractice during a surgical procedure," of which 28 resulted in death[9]. According to the same bulletin, 351 incidents were recorded as "notifications involving surgeries," thus, totaling 754 incidents related to the surgical process[9].

Another care process in which Nursing has an active role is in delivery and birth assistance. It is worth mentioning that nursing care goes through the stages of prenatal, labor, childbirth, and puerperium, including in high-risk gestation situations[10]. Although there is specialization in obstetrics in Nursing courses with advances in this line of care, inadequate practices occur during labor performed by nurses. Therefore, it is necessary to implement strategies to improve care[11].

Given the above, it is essential to identify the malpractices committed by nursing to understand the causes of the incidents, the legal outcome for the professional, and the consequences for the patient since based on these results, prevention actions become more feasible and effective.

Thus, this study is based on the following questions: What were the legal outcomes of malpractices related to nursing in the perioperative context of different surgeries, delivery, and birth care? What practices are recommended for the prevention of the incidents addressed?

OBJECTIVES

To analyze the legal outcomes of malpractices in perioperative care, and delivery and birth assistance related to nursing, from the perspective of legal support for failure prevention.

METHODS

Ethical aspects

All ethical precepts involving research with human beings have been respected, and the proposal of this research is registered with the Research Ethics Committee of the State University of Maringá.

Type of study

Exploratory, documentary, qualitative approach study, guided by the guideline Standards for Reporting Qualitative Research(SRQR) [12]. It was carried out based on the cases judged by the Court of Justice of the state of Paraná (TJPR).

Methodological procedures

We selected the tried cases of malpractices in the perioperative period (preoperative, transoperative, and postoperative) of different surgeries and the assistance during delivery and birth, which involved nursing professionals, and were available online until April 2018, with no initial date. We considered as "res judicata" the event that had a judicial decision and was unappealable.

Study scenario

The data were collected between May and June 2018 on the online database of the Court of Justice of the state of Paraná, searching the terms "medical malpractice" and "nursing malpractice." We chose the term "medical malpractice" because it is used in legal language to determine malpractices committed by any professional category in the health area.

Data source

The source of the data was the judicial proceedings for nursing care malpractices, alleged or confirmed, during childbirth care and perioperative period.

Collection and organization of data

Figure 1 shows the selection flow of the judicial processes analyzed.

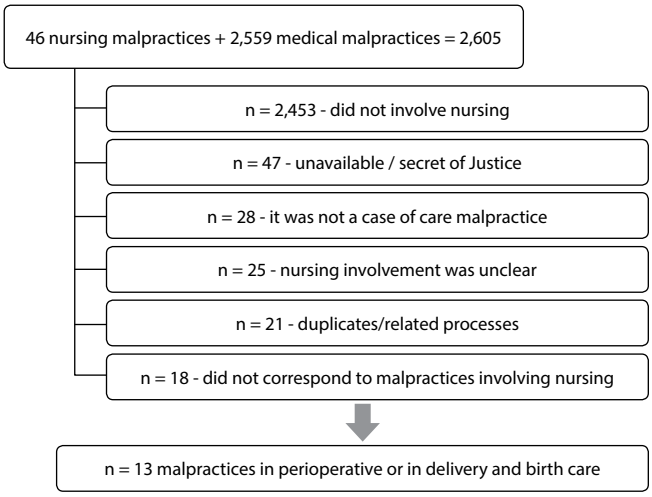

Figure 1 - Judicial process selection flow, Maringá, State of Paraná, Brazil, 2018

We used a form we elaborated containing the following information to organize and analyze the data: A) Identification of the process and synthesis of the menu, B) Characterization of the malpractice (type) and outcome for the victim and, C) Legal outcome. We organized the data in summary charts, including recommendations for malpractice prevention based on good practices.

Data analysis

We classified the cases concerning its severity, according to the criteria of the International Classification for Patient Safety[13], which refers to event as a case that reached the patient; incident, when an event or circumstance has resulted or could have resulted in unnecessary damage to the patient; condition is related to a situation that may contribute to the occurrence of the event; and about to happen (near-miss) is characterized by the incident that did not reach the patient; event without any damage is when the patient has suffered an incident, but it did not result in visible injury, and the event with an damage (adverse events) refers to the incident that caused the injury to the patient[13].

It is worth mentioning that we identified the cases by the letters of the alphabet in the sequence in which they were identified (A, B, C... M).

RESULTS

Among the thirteen processes analyzed, eight concerning the perioperative period and five to nursing care for delivery and birth. Chart 1 presents the characteristics of events of malpractices in the transoperative period, showing the predominance of burning resulting from contact with hospital medical equipment, which was configured as an event with injury, and decided as negligence attributed to the institution.

Chart 2 provides information on events of postoperative malpractices. We observed that there was a prevalence of malpractices attributed to failures in patient monitoring, especially in the control of blood losses, with surgical reoperations.

Chart 3 shows the cases of malpractices in delivery care. Two malpractices culminated in death and two generated permanent damage to newborns (NB).

Chart 1 – Events of malpractice in the transoperative period, type of incident, consequences for the victim, legal outcome and legal support for failure prevention, Paranavaí, Paraná, Brazil, 2018

Case	Malpractice description	Type of incident - Consequences for the victim	Legal outcome	Legal support for failure prevention
A	Gauze forgot, during thyroidectomy surgery, by the surgeon and team; and removed of a parathyroid gland by malpractice.	Event with damage - Hospital infection and deficit in the functioning of the parathyroid gland	Negligence Civil conviction of the institution	Perform counts and check surgical instruments, compresses and needles during the transoperative period and before surgical synthesis. Such a process should be carried out by the multi-professional team, which is composed of the nursing team, surgeon, instrumentalists, and anesthesiologists[14-15]. Use radiopaque gauze and compresses for identification through radiography[14-15].
B	Lower limb burn by cautery plate-responsibility assigned to the nurse	Event with damage - Hardened lower limb injury, requiring chemical debridement and graft surgery	Negligence Civil conviction of the institution	Correctly position the patient on the operating table[16]. Use insulating devices on the table and armrests and legs support[16]. Use dry swabs between arms, torso, or legs to avoid current concentration in areas with fluid accumulation[16]. Do not leave the cautery plate in contact with tattoos[16]. Position the plate on clean and dry skin in a vascularized area with greater muscle mass[16]. Check that the patient is free of adornments[16].
C	Chest burn by cautery plate positioning - Responsibility assigned to the nurse	Event with damage - Increased length of hospital stay	Negligence Civil conviction of the institution	
D	Burn on the back of the thigh during surgical procedure. Nursing did not identify the burns in the postoperative period, despite the patient's complaint of pain.	Event with damage - Absence of walking for 30 days, causing depressive condition in need of therapy	Negligence Civil conviction of the institution	

Chart 2 - Processes for malpractices in the postoperative period, type of incident, consequences for the victim, legal outcome, and legal support for failure prevention, Paranavaí, Paraná, Brazil, 2018

Case	Malpractice description	Type of incident - Consequences for the victim	Legal outcome	Legal support for failure prevention
E	Nursing staff neglected complaints of heavy bleeding, pain, and fetid odor in the vaginal canal for 42 hours postpartum. There were no records of the reports.	Event with damage - Perineal laceration and peritonitis. Patient undergoing restorative surgery.	Negligence Civil conviction of the institution	Observe, control and record vital signs, lochia, uterine involution, pallor, sweating, excessive bleeding, drowsiness, hematomas and/or edema in the operative wound, or episiorrhaphy, as well as the actions performed[17]. Use a specific instrument to check postpartum care[17].
F	Nursing assistant diluted medicine in unidentified saline vial. Physiological serum with the possibility of containing remnants of fentanyl.	Event with damage - Death due to cardiorespiratory arrest	Negligence Civil conviction of the institution	Identify all syringes, vials, or pouches containing medications[18]. Never administer the contents into a syringe or pouch that is not clear, correct, and legibly identified[18].
G	Bleeding for two hours during anesthetic effect in the postoperative period of vaginal hysterectomy, with no mention of the occurrence by nursing in medical records.	Event with damage - Laceration between the vaginal canal and perianal region. Patient undergoing restorative surgery.	Not specified Civil conviction of the institution	Review the care plan for the patient in the postoperative period, including the monitoring of the level of consciousness, vital signs, and aspect of the surgical dressing[17].
H	Nursing did not perform the correct water balance of the patient in the postoperative period. The record highlighted "good diuresis," while the patient was anuric.	Event with damage - Several surgical reoperations, culminating in nephrectomy for infected hydronephrosis.	Negligence Civil conviction of the institution	Accurately record the fluids administered intravenously and orally, and fluids excreted by the gastrointestinal and urinary tract; and monitor the water balance[19].

Chart 3 - Processes for malpractices in childbirth care, type of incident, consequences for the victim, legal outcome, and legal support for failure prevention, Paranavaí, Paraná, Brazil, 2018

Case	Malpractice description	Type of incident - Consequence for the victim	Legal outcome	Legal support for failure prevention
I	Conducting delivery by nursing assistants, who communicated to the doctor only after a complication, even if he was present in the institution. Delivery was performed with the use of forceps.	Event with damage - Death of the NB. Urinary incontinence due to bladder injury in the postpartum period. Ineffective restorative surgeries.	Negligence Civil conviction of professionals	It is up to the nurse to assist the parturient, stimulate natural childbirth, identify dystocias, provide care to ensure the quality and safety of the mother and baby. In addition, in cases of identification of dystocia, the nurse should perform necessary assistance until the doctor's arrival[20]. The nursing assistant is responsible only for the execution of activities of medium level and repetitive nature, being vetted to conduct births[20].
J	Childbirth conducted by nursing assistants	Event with damage - Neonatal hypoxia and deficit in cognitive and motor development	Malpractice Civil conviction of professionals	
K	Brachial plexus injury in NB after delivery conducted by a nursing assistant	Event with damage - Right upper trunk brachial injury, with motor limitation	Malpractice Civil conviction of the institution	
L	Childbirth with dystocia conducted by a nurse	Event with damage - Death of the NB by aspiration of amniotic content	Negligence Civil conviction of the institution	
M	Exchange of NBs by nursing technician. Malpractice identified by mothers after 24 hours of birth.	Event with damage - Prolongation of the hospitalization for six days until the report of the DNA examination with the impediment of visits. The fact generated anguish and stress and, consequently, prevented the production of breast milk by one of the mothers.	Negligence Civil conviction of the institution	Daily check the identification bracelets of both the mother and the newborn[21-22]. Identify the mother and newborn immediately after delivery and confirm with the mother or legal guardian [21-22]. Wear an identification bracelet with at least the mother's name and the newborn's medical record number [21-22]

DISCUSSION

Patient care results from the interaction of multiple and complex care processes, which increases the chances of malpractices. Thus, to minimize the occurrence of malpractices, it is necessary to map safe processes and develop a positive safety culture, which permeates individual (professional) and collective (institutional) commitment to safe care[23].

Charts1, 2, and 3 show that the most frequent legal outcome among the judicial processes analyzed was the condemnation of the health service blaming the institution for the mistakes of nursing professionals. The institution's accountability stems from the understanding that providing harm-free care is the duty of the service since the nursing professional tends to have labor ties with the institution.

One of the malpractices identified in the present study was the retention of gauze in thyroidectomy surgery, as presented in case A. In the transoperative period, nursing care aims to plan and perform patient care[24], ensuring that the patient is not exposed to risks. Therefore, it is necessary to use tools to help the nursing team to provide harm-free care, such as the safe surgery checklist, the implementation of which is recommended by several studies that demonstrate a reduction in the number of adverse events during the surgical process, as well as a decrease in the rate of preventable deaths[2527].

In the topic "before the patient leaves the operating room", one of the items in the safe surgery checklist is the count of instrumentals, compresses, and gauze. This process is performed manually and intended to prevent the retention of surgical items inside the patient[28]. We should note that the responsible party for carrying out this practice is the nursing team. Thus, such malpractices reflect the inadequate performance of nursing professionals[28].

In a study conducted to analyze the surgical counting process, we identified that the count of the compresses was always performed before the end of the surgery, and the control was performed by counting the compresses when opened and when discarded[29]. Another type of conference cited was that in which the room worker opened the packages and requested that another professional perform the conference of the open compresses on the surgical table, then making notes on the blackboard[29]. As more compresses were requested, these were noted on the board, as well as the removal of each, and, at the end of the surgery, the conference was performed with the compresses used[29]. This practice is considered simple, but when performed in a systematized way, it avoids the retention of any foreign body inside the patient.

Another activity also essential for surgical safety is the attention to the electrocautery. When it is used improperly, this equipment may cause several injuries to the patient as well as burns[30], as described in cases B, C, and D. Electrocautery is a medical device that produces a high-frequency electric current, used to thermally cut organic tissue or perform blood coagulation[16]. We should mention that the consequences on the patient's skin depend on the intensity of the electric current, the tissue's resistance to conduct electricity, and the duration of the application of the electric current[16]. In addition, the depth of the burn depends on the continuation of the procedure[16].

We emphasize the importance of the nursing team's performance to prevent burns involving electrocautery, such as the elaboration of a systematized care plan by the nurse in the transoperative period[30]. To that end, the study aiming to report the cases of burns caused by electrosurgery described the attention given to preventing the injury during the period of the trans-operative period that is: use of the card in the neutral and the active electrode, confirm the proper operation of the patient plate, confirming that the patient is not in contact with any parts made of metal, confirm of the absence of a tag-by-step, heart to other implants or electric implants of metal that contraindicate the use of electrosurgery cauterization, place the neutral plate on the dry and intact skin, remove residual flammable preparatory agents before starting surgery, and use the device to store the active electrode during the surgery[16].

To increase the security of the surgery, which involves electrocautery, we suggest that the inclusion of the following items on the checklist for safe surgery: confirm that the patient is using the decorations or underwear, verify the correct placement of the patient on the surgical table, check that the electrodes are not as far away as possible from the surgical field, avoiding the employment of a dispersive electrode over tattoos due to the presence of metal dye, positioning of the dispersive plate as close as possible to the operative field, preferably on clean and dry skin, in the area of vascular and with greater muscle mass[16].

In the present study, we also identified judicial processes for malpractices related to the absence of nursing records as presented in cases E, G, and H. Nursing records are essential for the care process and safe communication between nursing professionals and the health team[31]. In addition, according to the Code of ethics of Nursing Professionals, the nursing team must record in the patient's medical records the information inherent and indispensable to the care process[20].

The occurrence of adverse events (AEs) may also be related to the absence or failure of the nursing record. As a confirmation, an analysis of 7,926 hospitalizations from twenty-one Dutch hospitals that evaluated the relationship between the quality of the records and the occurrence of AEs, identified that the fragility of the information recorded was associated with higher rates of AEs[32]. In another study conducted to evaluate nursing records in the perioperative period found that in 57.3% of the 110 medical records, there were no records of patients' vital signs in the postoperative period[33], which reinforces the need for continuous monitoring and systematization of nursing care to the operative patient.

Case F presented malpractice in the postoperative period, involving dilution of medication in an unidentified vial with remnants of fentanyl, resulting in the death of the patient by cardiorespiratory arrest. Such a case demonstrates the importance of never administering the contents of a syringe or pouch that is not clear, correct, and legibly identified and highlights the need for identification of drugs, as well as their confirmation before administration[18]. Standardizing the exchange of infusions (when not identified) immediately after the transition of care between sectors can present as a barrier to the occurrence of incidents and, with this, avoid results of catastrophic severity in care.

Regarding cases I, J, K, and L, which report the delivery conducted by the nursing team, it is worth mentioning that, among the members of the nursing team, only the nurse can follow the evolution and labor[18], as well as the execution of delivery without dystocia,

considering that this professional has the skills and competencies necessary for such a procedure, according to the law of professional practice. Within this subject, we can cite as evidence a multicenter study conducted in Argentina, which identified that health services without qualified obstetric assistance presented ten times higher probability of maternal death when compared to services that had qualified professionals; this fact emphasizes the need for adequate professionals for supervision and support of labor[34].

We should note that, sometimes, nursing professionals find themselves in situations incompatible with their professional training due to the absence of both human and material resources in the daily life of the Brazilian health system. In this perspective, it is necessary to question whether, among the cases, the professionals performed birth care because they understood that non-participation could constitute negligence, which reinforces the need for nursing records as a form of legal support.

Regarding patient identification mistakes, case M presented an exchange of babies due to the identification malpractice. Research conducted in six New York intensive care units identified sixty-six malpractices related to the identification of newborns for every hundred thousand live births[35]. Such malpractice can culminate in the exchange of baby identification, and this shows the importance of implementing strategies to minimize the chances of mistakes occurring.

Also, regarding the identification of patients, we verified that malpractices in this process may cause adverse events related to medication mistakes, baby exchange, procedures, and blood transfusion in the wrong patient, among others. In a study conducted in a hospital in Toronto (Ontario, Canada), they found that the main causes of malpractices during blood transfusion were related to mistakes in identification, such as wrong name, duplicate name, mistake in the date of birth, incomplete registration, among other mistakes[36]. It is important to mention that to avoid identification mistakes the actions are low cost, involve training of the team and consolidation of the identification protocol.

Malpractices involving nursing in perioperative and obstetric care have the potential for serious and irreparable outcomes. This is because both areas require intense and continuous work between multi-professional teams, continuous relationships between different areas of knowledge and sectors of the institution, and the need for an intense vigilance to prevent malpractices[37]. Connected to these factors, it is important to learn from mistakes, as well as the development of a fair culture.

Study limitations

The present research, although representing an advance in the area of judicialization of nursing malpractice, is limited since the study scenario is restricted to a single State of Brazil and depends on the online availability of the processes.

Contributions to the field of nursing

Investigations about the judicialization of nursing malpractices can foster discussion about failures in care, as well as their causes and implications to promote patient safety in institutions and organizational learning in the face of mistakes. Another evident contribution of the study is the introduction of the best practices recommended by official bodies and scientific research in parallel to the analysis of judicial processes for malpractices. It can certainly be a guide for the prevention of malpractices in the context of perioperative care and nursing assistance to childbirth.

Furthermore, the approaches of the topic studied subsidize and stimulate the entities representing the profession and nursing leaders to engage and organize through support networks and mitigation of moral suffering among workers who make mistakes during their practice.

CONCLUSIONS

We highlighted the processes for malpractices that occurred in perioperative care, especially about burns caused by contact with medical-hospital material, with severe consequences for patients. They were tried as negligence, with attribution of malpractice to the institution. The malpractices identified are preventable, given the existence of a description of good practices.

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