CE Article

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Negligent Nursing Practice:
What You Need to Know (1 CH)

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Learning Outcome: Nurses completing this activity will gain an increase in knowledge of violations of the Nursing Practice Act related to negligence.

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Nurses have a duty to provide care to meet the needs of the clients for which they serve. While most nurses do not believe they would ever put their clients in jeopardy or fail to provide an acceptable standard of care, these events do happen. The North Carolina Board of Nursing (NCBON) regularly receives and investigates complaints associated with negligent nursing practice. The mission of the NCBON is to protect the public by regulating the practice of nursing (North Carolina Board of Nursing [NCBON], 2018). In order to ensure the provision of safe, competent nursing practice, the NCBON has the authority to investigate complaints received from employers and members of the public which identify potential violations of the North Carolina Nursing Practice Act (NPA, 1981/2019). The purpose of this article is to provide nurses with information regarding violations of the North Carolina NPA and North Carolina Administrative Code (NCAC) related to negligence and discuss examples seen by the NCBON to help nurses recognize and avoid at-risk behaviors, thereby protecting the public.

Nursing laws and rules, which vary from state to state, provide a framework that guides and governs nursing practice in that particular state. Nurses are responsible for knowing the NPA and regulatory requirements for every

jurisdiction in which they practice. Nursing laws and rules define scopes and standards of practice to assure the safe practice of nursing. Nursing laws and rules, professional nursing organizations, organizational policies and procedures, and state and federal regulatory agencies determine acceptable standards of nursing practice. Standards of nursing practice are used to guide nurses in determining what actions they should or should not take in the delivery of client care.

Despite the increased workloads and demands placed on nurses, nurses must be mindful of their actions and the impact of their actions on client care. Nurses have a responsibility to provide nursing care that meets established standards of practice for specified practice settings and client populations in which nurses provide care. Negligence occurs when a nurse fails to meet the needs of a client due to a breach in the standard of care or an act of omission. The Joint Commission defines negligence as a "failure to use such care as a reasonably prudent and careful person would use under similar circumstances" (Croke, 2003, p. 54). Examples of violations of the North Carolina NPA and NCAC frequently reviewed by the NCBON related to negligent nursing practice include failure to initiate cardiopulmonary resuscitation (CPR) in a timely manner, failure to administer prescribed medications or interventions, sleeping on duty, failure to assess or evaluate a client as warranted or ordered, or failure to make scheduled home care visits.

Failure to Initiate CPR

The NCBON regularly receives complaints alleging nurses failed to initiate CPR in a timely manner or failed to initiate CPR at all. The majority of these incidents occur in non-acute care settings where there are often limited resources. Medical emergencies can be stressful for nurses, especially if the nurse is the only healthcare provider available to respond to the client. Nurses should be knowledgeable of the emergency resuscitation policies and procedures of the employing healthcare agency to ensure they respond in an appropriate manner. Failure to follow proper policies and procedures during an emergency situation can result in significant delays in treatment and potentially result in a devastating outcome for the client.

Standard nursing practice, in the absence of a written "Do Not Resuscitate" (DNR) order, is that the nurse is expected to immediately implement the emergency resuscitation policies of the employing agency until an order to discontinue treatment is received from the physician, nurse practitioner, or physician assistant (NCBON, 2017). If a nurse is unaware of a client's code status and witnesses a cardiac and respiratory arrest, the nurse should err on the side of caution and provide CPR when a client is found unresponsive and without a pulse until the code status is confirmed. In order to avoid confusion during emergency situations, it is recommended that code status be communicated during change of shift report. Nurses should be knowledgeable of the care requirements for clients entrusted into their care, as this knowledge allows the nurse to be in the best position to deliver timely and potentially life-saving interventions. The Position Statement, Death and Resuscitation, provides additional guidance for nurses and employers regarding the scope and responsibility of the nurse during resuscitation events (NCBON, 2017).

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Failure to Administer Medications or Perform Treatments

Prescribed medications and treatments are essential components of the client's plan of care and failure to implement prescribed treatments or medications may be considered neglect. Failure to administer prescribed medications or perform prescribed treatments, such as wound care, is an act of omission and could be a result of practice drift. Practice drift is a term used to describe a work-around or shortcut used to achieve an immediate goal in order to meet an expectation and improve efficiency (Chastain & Burhans, 2016). Practice drift creates a deviation from standard practice and has the potential to adversely impact client outcomes. Pre-documentation of nursing care is an example of practice drift and is perceived as a way to save time or be more efficient. Nurses who pre-document care can find themselves in a situation where they may inadvertently forget to administer or perform treatments. Pre-documentation of client care is at-risk behavior. Nurses have a responsibility to ensure nursing documentation is accurate and only reflects the care that was rendered to the client.

In some practice environments, nurses are more likely to pre-document medication administration, as the clients are routinely administered the same medications at the same time each day. While medication administration documentation may seem like a repetitive task in some practice environments, documentation is a critical aspect of nursing care provided to the client and essential for client safety. Failure to administer medications can lead to serious adverse events for the client. Missed medications can lead to complications such as the formation of blood clots, development of antibiotic resistance, seizure activity, unresolved infections, or unregulated blood sugars or blood pressures. In some cases, one missed dose can have detrimental effects on the client.

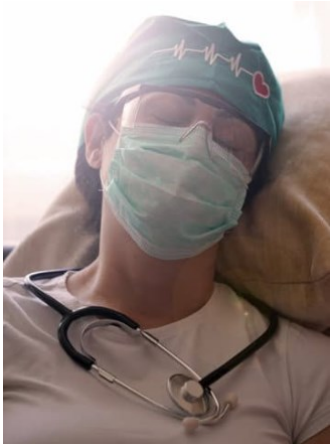
Pre-documentation of prescribed treatments can negatively impact client care. When a treatment is documented as completed, often it is removed from a list of outstanding tasks or there is no indication in the medical record that the treatment is still pending. Failure to perform prescribed treatments, such as wound care, consistently and accurately has the potential to create delays in healing and could lead to complications that prolong the need for medical services or require more intensive treatment.

Sleeping on Duty

Nurses work long hours and are responsible for providing care to clients around the clock. Due to an increased demand for nursing services, nurses can find themselves in difficult situations where they can easily stretch themselves too thin and agree to work assignments they are unable to safely perform. In discussions with NCBON staff during an investigation, nurses frequently acknowledge they are working multiple jobs or regularly working extended hours. Nurses often believe these extended work hours are in the best interest of the client. Extended work hours refer to any shift greater than 8.5 hours in duration or a work week greater than 40 hours (National Institute for Occupational Safety and Health [NIOSH], 2004). Research has shown that more mistakes occur when nurses work extended hours or fail to get adequate amounts of rest between shifts (James et al., 2020). In addition, nurse fatigue is associated with poorer patient outcomes and poses a significant risk to patient safety (James et al.,

2020). When nurses do not ensure adequate rest between shifts, it can lead to ongoing fatigue and create a situation in which a nurse may fall asleep while on duty.

Sleeping on duty can result in missed nursing care which can negatively impact the client. Missed nursing care can vary greatly depending on the client's needs and plan of care. Examples of commonly missed nursing care includes missed medications, treatments, feedings, activities of daily living (ADL) care, and ongoing assessment and monitoring of the client. Nurses should not accept an assignment for which they may be unsafe due to lack of sleep, fatigue, or prolonged work hours (NCBON, 2019). In North Carolina, accepting responsibility for a client while impaired by sleep deprivation is a violation of the rules that govern nursing practice (NCAC, 2019c). Caution should be used whenever an assignment is expected to exceed 12 hours in a 24 hour time period or 60 hours in a 7 day time period (NCBON, 2019). Additionally, employers and nurses should take into account cumulative work hours due to multiple work commitments when making assignments or schedules.



The NCBON has several resources on our website that might be beneficial to review in learning more about client safety and safe work environments. The Position Statement, Staffing and Patient/Client Safety, provides additional guidance for nurses and employers regarding working extended work hours and ensuring adequate rest (NCBON, 2019). In addition, the NCBON and the North Carolina Division of Health Service Regulation (DHSR) (n.d.) developed a Joint Position Statement on Nursing Work Environments, which may offer additional guidance to leadership and direct care nurses to ensure the development and maintenance of safe work environments.

Failure to Assess

Assessment is an essential component of the nursing process. Nursing assessment findings are used to identify client care needs and develop an individualized plan of care. According to the NCAC (36 .0224[b] & 36 .0225[b], 2019a & 2019b), components of nursing practice for both the registered nurse and licensed practical nurse state that "assessment is an on-going process and shall consist of a determination of nursing care needs based upon collection and interpretation of data relevant to the health status of a client."

Nursing assessments are critical to the delivery of safe and effective nursing care. Clients today are more acutely ill and have complex medical needs which require ongoing monitoring and evaluation by nurses. Healthcare providers rely on nurses to keep them informed of any changes to the client's condition in order to review and appropriately modify the client's plan of care as needed. Nurses, due to their continuous presence at the bedside, are uniquely positioned to recognize early signs of deterioration in a client and prevent adverse outcomes (Garvey, 2015). Early warning signs in a deteriorating client can be subtle and require nurses to complete a thorough assessment and continuously monitor for the need to reassess the client. Nurses can observe, monitor, or assess a client more frequently than ordered, if deemed necessary based on their clinical judgement. When a decline or change in client

condition is identified, the nurse is responsible for taking action to prevent or minimize client harm by reporting these changes to the appropriate healthcare provider and then implementing ordered interventions in a timely manner.

Failure to Make Home Visits

Nurses who provide care in a home health setting have a duty to perform scheduled visits as ordered by the healthcare provider. While there is some flexibility in terms of scheduling of routine home health visits, these visits need to meet the ordered frequency based on the client's care needs and ordered by the healthcare provider. Completing home visits as scheduled ensures that the client's needs are met on a consistent basis. If a nurse cannot make a scheduled home health visit, the nurse should notify their supervisor or a designated team member established by the healthcare agency, to ensure that alternate arrangements can be made for the client. In discussions with Board staff during an investigation, nurses often indicate they are overwhelmed with the number of visits on their schedule or the distance they are driving to care for clients. While there are many challenges to providing care in the home health setting, nurses have a responsibility to make alternate arrangements for a client to be seen if they are in a situation in which they are running behind and a visit cannot occur as scheduled.

Case Scenarios

The following scenarios review incidents where nurses have neglected client care. It is important to note that when reviewing these scenarios, there are often additional nursing violations identified which contributed to the incident.

Scenario #1

Nurse Beth worked at a long-term care facility and was assigned to the 200 and 300 Hall from 3:00 p.m. to 11:00 p.m. During this shift, Nurse Beth was one of three nurses in the building. One of the residents assigned to Nurse Beth was Resident P who had a history of asthma and had been diagnosed with an upper respiratory infection two days prior to Nurse Beth's shift. Shortly after Nurse Beth assumed care of Resident P, the resident complained of shortness of breath and wheezing. Nurse Beth administered a prescribed as needed nebulizer treatment to Resident P at 5:30 p.m. Nurse Beth was busy assisting other residents and did not go back to check on Resident P prior to her dinner break at 7:00 p.m.

When Nurse Beth returned from her dinner break at 7:30 p.m., she noticed Resident P's call light was on. Nurse Beth did not go into the resident's room to check on the resident because it was

time for her to begin her nighttime medication pass and she did not want to get behind. Nurse Beth proceeded with her medication pass until approximately 8:30 p.m. when a nursing assistant approached her, concerned that Resident P was unresponsive. Nurse Beth finished pulling and administering medications for the current resident before going into Resident P's room, where she found the resident unresponsive with no pulse or respirations. Nurse Beth was unsure of Resident P's code status and left the resident to go to the nurses' station to check the code status book. Nurse Beth determined Resident

P was a full code and called a code overhead to alert additional onsite facility staff members of the emergency before calling 911 for assistance. When Nurse Beth hung up the phone with 911, she saw the two nursing assistants assigned to her hall had entered Resident P's room. Nurse Beth assumed the nursing assistants were trained and would initiate CPR. Nurse Beth then went to a nearby nursing unit to get the crash cart and proceeded to Resident P's room.

When Nurse Beth arrived at Resident P's room with the crash cart, she noted the nursing assistants were not performing CPR as she had thought. Nurse Beth asked the nursing assistants why they were not performing CPR and the nursing assistants responded that despite having been certified in CPR, they were unsure of what to do and expressed this was their first code. Nurse Beth immediately began applying the Automated External Defibrillator (AED) to Resident P and connecting the ambu bag to the oxygen tank. When EMS arrived a few seconds later, no one was performing CPR or delivering breaths to Resident P. EMS personnel immediately began CPR and intubated the resident; however, resuscitative efforts were not successful and were terminated based on EMS protocol. Nurse Beth notified the on-call healthcare provider of the incident and the patient's death.

Pause and answer the following reflective questions:

What steps should Nurse Beth have taken to provide appropriate care for this resident?

Have you ever been in an emergency situation where you felt like care was delayed or not delivered according to established guidelines? If so, what do you think contributed to that deviation?

Discussion:

After administering the breathing treatment to Resident P, Nurse Beth should have reassessed Resident P to evaluate the effectiveness of the treatment and the resident's current respiratory status. Assessment findings would have assisted Nurse Beth to determine if contact with the healthcare provider was warranted. Additionally, when Nurse Beth returned from her dinner break and saw Resident P's call light was on, she should have checked on Resident P. If Nurse Beth was unable to check on Resident P, she should have asked another clinical staff member to check on the resident.

When Nurse Beth was informed there was a concern that Resident P was unresponsive, she continued to pass medications to another resident, which caused a delay in her response. Nurse Beth should have immediately responded to Resident P's room to assess the situation. When Nurse Beth arrived at Resident P's bedside, she performed an assessment of the resident and determined that the resident was not breathing and did not have a pulse. However, Nurse Beth left the resident to check the code status, contact 911, and obtain the crash cart. Nurse Beth's actions delayed the delivery of potentially life-saving interventions to Resident P. Nurse Beth assumed the nursing assistants were performing CPR when they entered Resident P's room, but she did not direct or confirm with the nursing assistants that CPR was being performed. With additional staff members available to assist Nurse Beth, Nurse Beth should have immediately initiated CPR while other staff members made phone calls and retrieved the crash cart. Code status should

be addressed in shift report, prior to assuming care of the resident, if a nurse is unsure of this information.

Scenario #2

Nurse Judy was working at a long term care facility from 7:00 a.m. to 3:00 p.m. and was assigned to Resident A who had been diagnosed earlier that morning with bilateral pneumonia. During Nurse Judy's shift, the healthcare provider ordered two different intravenous (IV) antibiotics that were due once a day and both were to be started during Nurse Judy's shift. In addition to IV antibiotics, the healthcare provider ordered a nebulizer treatment four times a day and IV fluids to infuse at a continuous rate of 125 ml/hr. The new medication orders were sent to the facility's contracted pharmacy. The facility had an automated medication dispensing cabinet which contained commonly ordered medications, including the nebulizer treatment and two antibiotics ordered for Resident A. Nurse Judy asked the Resource Nurse to insert

Resident A's IV and begin the IV infusion as ordered. Nurse Judy documented on the resident's medication administration record that all medications had been administered during her shift as ordered, which included the two antibiotics and nebulizer treatments.

The following day, Nurse Judy was again assigned to Resident A. Nurse Judy documented on the medication administration record that she had administered all medications as ordered. Shortly after Nurse Judy's shift, Resident A was emergently transferred out of the facility to a local hospital due to a decline in status. Resident A had a worsening fever, change in vital signs, and an increased work of breathing. This emergency transfer prompted a review of Resident A's medical record by the Director of Nursing (DON). The DON was unable to locate any documentation performed by Nurse Judy regarding Resident A's status during Nurse Judy's shift or what could have led to his decline in status. The DON was informed by the nurse who had transferred Resident A out of the facility, that one of the IV antibiotics which required a seal to be broken to reconstitute the medication was not broken when she went in to assess Resident A. Due to the seal not being broken appropriately, Resident A did not receive this medication as ordered or documented by Nurse Judy.

Upon further review by the DON, extra doses of the ordered antibiotics were found on the medication cart which did not match the documentation related to administration. The DON reviewed video footage of the two dates in question, which revealed Nurse Judy had not taken any medications into Resident A's room except one antibiotic on the second day she was assigned to the resident's care. Resident A had multiple scheduled medications due on both days throughout Nurse Judy's shifts which were not given per the video footage. The DON reviewed the pharmacy delivery slips which revealed the IV antibiotics and nebulizer treatments were not delivered to the facility until the second day Nurse Judy was assigned to Resident A. The DON reviewed the dispensing cabinet report which revealed neither IV antibiotic or nebulizer treatment was removed by Nurse Judy or any other staff member at any point prior to Resident A's transfer.

Pause and answer the following reflective questions:

How were Nurse Judy's actions considered negligent?

What steps should Nurse Judy have taken to provide appropriate care for this resident?

Were there other concerns identified with Nurse Judy's practice?

Discussion:

Nurse Judy failed to administer prescribed medications to Resident A on two different dates which deviated from the resident's established plan of care. Resident A was prescribed two IV antibiotics to treat bilateral pneumonia, and over the course of two days, the resident did not receive a single dose of either medication. This deviation from Resident A's plan of care likely contributed to the resident's decline in status and the need for a higher level of care. It is unclear if Nurse Judy's actions were intentional; however, Nurse Judy failed to administer multiple medications to Resident A on two different dates, which established a pattern of behavior.

In addition, Nurse Judy falsified the medical record when she documented on the medication administration record that she had administered all Resident A's medications as ordered. Falsification of resident medical records is a violation of the NPA. Documentation is a critical component of the care provided to residents by nurses. Nurses have a responsibility to ensure that documentation accurately reflects the care provided to the resident.

Furthermore, if Resident A was unable to take his medications or there were concerns that medications were not readily available to administer as ordered, Nurse Judy should have contacted the healthcare provider to relay that information. The healthcare provider could then determine if Resident A's medications or treatments needed to be modified to ensure appropriate treatment was provided. Nurses have a responsibility to relay pertinent information to a healthcare provider that could impact the resident's prescribed plan of care and treatment.

Scenario #3

Nurse Susan was employed with a home care agency as a private duty nurse. Nurse Susan was assigned to care for Client B, a two month old infant, from 11:00 p.m. until 8:00 a.m. Monday through Friday. Client B had a tracheostomy and required continuous ventilator support as well as continuous cardiac and pulse oximetry monitoring. During Nurse Susan's shift on Friday, Client B's caregiver received an alert on her cell phone at 2:00 a.m. that the client's cardiac monitoring device was alarming due to an elevated heart rate of 245 beats per minute. The caregiver went to Client B's room and discovered the nurse asleep in a chair near the client's crib. The caregiver and an additional family member attempted to arouse Nurse Susan for thirty minutes by physically shaking her and calling out her name until she awoke around 2:30 a.m. Nurse Susan failed to continuously monitor Client B for any cardiac or respiratory issues during the time Nurse Susan was asleep. In addition, nursing care was missed which included bolus tube feeds and medication administration that was due at 12:00 a.m. Client B's caregiver returned to bed, leaving the nurse alone with the client. When Client B's caregiver returned to the client's room around 4:00 a.m. to check on the client, Nurse Susan was asleep again. After the second incident of sleeping on duty, Client B's caregiver sent Nurse Susan home and reported the incident to the home care agency.

When agency leadership questioned Nurse Susan regarding the events on the night in question, Nurse Susan stated she was also employed with another home care agency providing private duty nursing services. Nurse Susan reported she had worked an assigned shift with the other agency providing client care from 2:00 p.m. until 10:00 p.m. each evening before her assigned shift with Client B at 11:00 p.m. Nurse Susan acknowledged she did not get adequate rest between her two shifts and stated she had been working multiple jobs to help provide supplemental income for her family.

Pause to answer the following reflective questions:

How did Nurse Susan put Client B at risk?

What steps should Nurse Susan have taken to ensure appropriate care for Client B?

Have you ever been in a situation where you worked multiple shifts without adequate rest? How did you feel? Did you realize the risk you were taking at the time?

Discussion:

Nurse Susan was working back-to-back shifts with two different employers without allowing adequate rest between shifts. Nurse Susan worked eight hours with client #1 and only had an hour off between her next nine-hour shift. In a 24 hour period Nurse Susan was working 17 hours a day for several days in a row. With Nurse Susan working for two different healthcare agencies, the agencies were unlikely aware of Nurse Susan's shifts worked with each agency. Nurse Susan had a responsibility to ensure her scheduled shifts allowed for adequate periods of rest. Working multiple back-to-back shifts can lead to fatigue and can create an unsafe environment for both the client and the nurse.

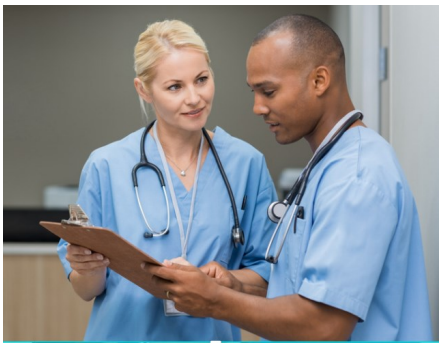
Scenario #4

Nurse Nancy was working on the med-surg floor and assigned to care for Client C, a 90-year old client who had a gastrointestinal bleed. Nurse Nancy completed her first physical assessment at 10:00 p.m. and noted Client C's assessment to be within normal limits. During the shift, Client C was frequently getting up to use the bedside commode. The nursing assistant had been helping Client C during this time and requested that Nurse Nancy check on the client. The nursing assistant informed Nurse Nancy that Client C appeared confused and there was some blood in the client's stool. The nursing assistant also informed Nurse Nancy that she had entered Client C's 12:00 a.m. vital signs into the electronic medical record.

Nurse Nancy went into Client C's room around 2:00 a.m. to ask the client how she was doing but did not perform a hands-on assessment at that time. Nurse Nancy looked in the bedside commode and noted a small amount of frank blood but did not feel it was enough to warrant contacting the healthcare provider. Nurse Nancy saw Client C's blood pressure was trending down and pulse was trending up. Nurse Nancy documented a reassessment at 2:00 a.m. which indicated there were changes to Client C's neurological and gastrointestinal status. No additional assessment data or narrative nursing note was documented by Nurse Nancy to clarify exactly what had changed in Client C's assessment.

During the shift, the nursing assistant continued to inform Nurse Nancy that Client C

was having large frequent bloody stools, but Nurse Nancy did not go back in the client's room to assess the client or determine the extent of the blood loss. At 5:00 a.m. the nursing assistant collected Client C's vital signs, which revealed the client was tachycardic and hypotensive. The nursing assistant immediately informed Nurse Nancy of Client C's vital signs and again reported that the client continued to have large bloody stools. At 5:15 a.m. Nurse Nancy called the healthcare provider to report Client C had a small amount of bloody stool output but did not report the change in vital signs or the frequency or condition of the stool output to the provider. The healthcare provider ordered a stat hemoglobin and hematocrit level which was drawn by the phlebotomist at 5:30 a.m. and revealed a decrease in Client C's blood level compared to the previous result. The healthcare provider ordered serial hemoglobin and hematocrit levels every four hours for Client C to closely monitor the client's blood loss.



Client C continued to have frequent, large bloody stools from 5:30 a.m. to 6:30 a.m. Nurse Nancy was busy completing her morning duties which included administering medications to her other clients. Nurse Nancy did not go back into Client C's room that morning despite receiving several calls from the nursing assistant regarding an increase in the amount of bloody stool output for Client C. Nurse Nancy did not get along with the nursing assistant and felt that the nursing assistant was "dramatic." Nurse Nancy knew the healthcare provider would be rounding soon and there was an order to reassess Client C's hemoglobin and hematocrit in a few hours, so she did not contact the provider.

At change of shift, the nursing assistant went back into Client C's room and the client was noted to have a large amount of blood all over her bed linen. The nursing assistant was attempting to clean up Client C, when suddenly the client began to decline and became unresponsive. Based on the nursing assistant's output documentation during the shift, the patient had lost approximately 1000 milliliters of bloody stool.

Pause to answer the following reflective questions:

What steps should the Nurse Nancy have taken to provide appropriate care for this client?

Were there other concerns identified with Nurse Nancy's practice?

Have you ever had difficulty with a co-worker? If so, has it ever impacted your ability to provide nursing care?

Discussion:

Nurse Nancy should have closely monitored and assessed Client C throughout her shift based on the client's frequency of bloody stools and change in status. Clinical judgement can be utilized to determine if a client requires more frequent observation or assessment based on the client's condition. Nurse Nancy eventually contacted the healthcare provider after hours of bloody stool output. However, Nurse Nancy did not communicate pertinent client information to the healthcare provider, such as the decline in vital signs or accurate bloody stool output. This information could have impacted the healthcare provider's orders and treatment. Withholding crucial healthcare information violates the rules that govern nursing practice.

Nurses are responsible for keeping the healthcare provider updated on all aspects of the client's care and status. Nurse Nancy's failure to appropriately assess the client throughout her shift could be considered reckless behavior. In addition, Nurse Nancy should have responded to the nursing assistant's calls and notifications related to Client C's condition. Nurse Nancy allowed her personal feelings and attitudes towards the nursing assistant to impact the care she provided to the client.

Scenario #5

Nurse Mary worked for a home health agency which provided various services, including hospice services. Nurse Mary was employed as the weekend on-call nurse and was on-call every weekend from Friday at 5:00 p.m. to Monday at 8:00 a.m. While Nurse Mary was on -call on Saturday, Nurse Mary responded appropriately to three client calls between 11:00 a.m. and 4:00 p.m. On Saturday evening, the answering service for the home health agency received a call at 6:29 p.m. and 8:16 p.m., reporting that two clients had passed away. Nurse Mary was contacted by the answering service at 6:48 p.m. and 8:17 p.m. and directed to report to the client's home to pronounce these clients as deceased. Each time Nurse Mary was contacted by the answering service she confirmed that she would report to the client's home and did not indicate there were any issues or concerns with her ability to make these visits. At 10:42 p.m. and 11:30 p.m. the answering service received calls from the client's families reporting that Nurse Mary had not shown up to pronounce the clients. The answering service attempted to reach Nurse Mary for over an hour but was unsuccessful. The answering service alerted the hospice director that Nurse Mary could not be reached and there were two clients in need of nursing care. On Sunday morning, Nurse Mary was found asleep in her car at the home of one of the client's she had seen on Saturday evening. Nurse Mary's car was running, the windows were down, and her phone and computer were in her lap. The client reported Nurse Mary appeared confused and "out of it." Nurse Mary did not recall receiving any calls from the answering service and could not explain how she ended up at the wrong client's home.

Pause to answer the following reflective questions:

If Nurse Mary did not feel she could complete her shift as scheduled, what should she have done?

Discussion:

Nurse Mary failed to appropriately respond to two clients who required nursing services during her shift. Nurse Mary should have notified her immediate supervisor if she was unable to complete her on-call shift or felt she was unsafe to provide client care for any reason. This would have allowed the healthcare agency to make alternate arrangements to ensure nursing care was provided as needed.

Scenario #6

Nurse Alice worked for a home health agency and was assigned to care for Client M. Client M was ordered two skilled nursing visits per week for wet-to-dry dressing changes to the client's right leg. On Monday, Client M was seen by Nurse Sarah, who had to use wound care supplies from her car stock since there were no wound care supplies in the home. Nurse Sarah

wrote her initials and the date on the outside of the bright green elastic wrap that secured the dressing. On Thursday, Nurse Alice was scheduled to perform wound care for Client M. Nurse Alice had several visits added to her schedule and was running behind that day, so she decided to pre-document care for this client to "speed up" the visit. Nurse Alice took Client M's vital signs and went to get the supplies for the dressing change, but there were no supplies in the home. Nurse Alice did not have any car stock supplies and could not perform the dressing change. Nurse Alice submitted nursing documentation that indicated the visit was completed and wound care performed, including wound measurements. When Nurse Sarah saw Client M the following week, she noted the client still had the bright green wrap on his leg with her initials. Nurse Sarah stated Client M reported wound care had not been performed by Nurse Alice on the previous visit. Nurse Sarah reported this incident to her clinical supervisor.

Pause to answer the following reflective questions:

What steps should Nurse Alice have taken to provide care for this client?

Can you identify other concerns with Nurse Alice's practice?

Have you ever identified nursing care that was missed? If so, how did you handle the situation?

Discussion:

As soon as Nurse Alice realized there were no wound care supplies in the home, she should have made arrangements to secure wound care supplies for Client M and rescheduled the visit to complete the dressing change. In addition, Nurse Alice pre-documented client care that was never performed and submitted documentation that did not accurately reflect the visit or care provided. Nurse Alice not only neglected client care, but she also falsified the client's medical record. Falsification of client medical records is a violation of the NPA.

Conclusion

As you can see from the scenarios, nursing practice can greatly impact the delivery of safe, competent client care. This article presented nurses with information and resources to enhance their knowledge of the NPA and NCAC and identified at-risk behaviors that could lead to nursing negligence. It is important for nurses to reflect on their current nursing practice to ensure they are not putting themselves or their clients at risk.

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