Negligence in nursing case study

Analysis of nursing care outlined by the coroner’s findings in the inquest into the death of Christopher Hammett

Postoperative nursing care plays a significant role in the success of hospital recovery for post-operative patients. The duty of post-operative nurses is complying with regulations to provide a responsible level of standardized care to assist the patient in recovering from surgery successfully. Nursing staff providing care to post-operative patients are expected to be highly skilled in monitoring patients through observation and identifying complications to assist in the successful recovery of patients (Association of Peri-Operative Registered Nurses, 2018).

In the case scenario of the Coroner’s findings into the death of Mr. Christopher Hammett, the analysis indicates multiple violations of nursing practices of professional and responsible conduct by the nurses involved which include poor practice, unethical behaviour, and negligence. The coroner’s report states the cause Mr. Hammett’s death was reported to be a result of combined and compounded mistakes largely attributed to poor nursing care practices (Queensland Courts, 2012).

According to findings of the Coroner, the case of Mr. Christopher Hammett’s death was a result of poor practices and composited human errors of the healthcare professionals involved in post-operative care and treatment. Mr. Hammett was 41 years old. He died in April 2005 whilst in post-operative recovery following an elective operation. According to the medical documents, the surgery was performed at the Pacific Private Hospital to

replace the L5-S1 disc in Mr. Hammett's back. Respiratory care is vigorous in the postoperative patient.

The respiratory rate has been found to be the sole most imperative and dependable early warning sign of respiratory depression. Pulse oximetry is not only reliable method to monitoring those patients who has been receiving supplemental oxygen. In the legal enquiry of Mr. Hammett's case, the Coroner found that there was deprived nursing management of oxygen level in the evening shifts. Due to this fact, error intensified from insufficient pain relief in the operation theatre (Sajith, 2018).

The task of Christopher Hammett had not bound any remarkable occasions. In activity, his oxygen level supported at 99%, however quickly it dropped to 64% while transporting from OT to the Post Anaesthetic Care Unit (PACU). As per his medical histories, he was provided with the two doses of morphine at 2mg each before the transfer to another ward. However, he was not inspected by the doctor in the transferred ward. Registered nurse (RN) Dean Manton in PACU said in one of his statements that " he was not aware of the Hammett's desaturation event before the transfer." According to MILBY, BÖHMER, GERBERSHAGEN, JOPPICH, & WAPPLER, (2014), Patient handovers are an intrinsic part of Health care practice as it involves Interpersonal communication which has a core value to maintain the patient-centred care. The health care staff uses handovers to report patient's medical circumstances, completed investigations, and treatment. Complications with information transfer may lead to uncertainties about patient care and likely patient maltreatment.

During Dean Manton’s work day, it was found by the Coroner that inappropriate diagnosis and low oxygen saturation prompted the blend of sleep apnoea alongside the use of morphine. Also, it was seen on Mr. Hammett’s graph that he pressed his narcotic infusion request button for 125 times more than two and half hours, over and over at regular intervals, the medical attendant overlooked him while he was in pain. Another issue, in this case, was the RN left the ward entrusting an Enrolled nurse (EN) Jennifer Valentine with Mr. Hammett’s care, Who should have been always working under her supervisor (Mr. Gibbon).

EN Valentine neglected to linkage the mask to oxygen supply while she was evolving Mr. Hammett’s nasal prongs with an oxygen mask. Within a couple of minutes, she observed that the oxygen saturation level of Mr. Hammett started to drop. In any case, this slip-up was corrected by her administrator. Though, in the absence of the supervisor, she repeatedly wrongly filled out his vitals chart concerning saturation levels. Lastly, she requested her supervisor for a review due to the dropping oxygen level. In response, Mr. Gibbons attended Christopher Hammett in between 1 am and 2 am. Gibbons analysed the entire situation at the ward. He increased the oxygen level. After that, he took a break and had a sleep. However, RN Gibbons failed to analyse the situation appropriately. He thought the patient was asleep, but in actual fact he was unconscious. At 2 Pm when the nurse checked Mr. Hammett, she discovered his eyes were incompletely open, his skin was “ dusty” in shading and she couldn’t actuate him. She called an Ambulance and the patient was taken to the Gold Coast Hospital. In any case, by

renaissance endeavours, the patient was pronounced dead (Queensland Courts, 2012).

In the Coroner's report described, these sequential mistakes in nursing care of Pacific Private Hospital were noticed. The initial error was limited pain relief in the OT, due to which a proper remedy was not provided to the patient concerning his disease. After the operation theatre, the patient was transferred in PACU. In PACU nursing staff were not diligent and alert to several patient issues which occurred in the evening and night shift on the ward. Low oxygen saturation was managed by increasing oxygen therapy by nursing staff in the ward. In adding to this, high pain scores were noticed due to the deprived original pain relief in OT. The compounding of mistakes complicated the post-operative recovery of Mr. Hammett leading to the unfortunate event of his death which was entirely preventable by the staff of the Gold Coast Hospital (Queensland Courts, 2012). In this situation, the main reason for the death of the patient was the inferior standard of care and negligent conduct of nurses. At several points, many severe mistakes were made by the nursing staff involved which led to detrimental outcomes in the post-operative recovery of the patient. The death of Christopher Hammett could have been avoided if the protocols of the standard of care by nursing staff were undertaken appropriately. Due to the compounded human errors, the death of Mr. Hammett happened. Consequently, a warrant was delivered in contradiction of the medical and nursing staff by the medical punitive body.

Section 2: The Tort Of Negligence: Applicability of tort of negligence to nurses involved in this case

According to Legal Aid Queensland (2018), A tort is a breach of a duty, potentially causes harm to the innocent party. In case of Mr. Hammett. Generally, a torturous act is based on the act of negligence by an individual. To be accountable for the act of negligence in nursing care the concepts of breach of the duty of care and causing harm have to be satisfied. The first performing party ought to owe an obligation of consideration to the wronged to keep the likelihood of damage. The mission of consideration is general obligations which are normal from the reasonable individual while in the conduct. Breach of duty is the performing party failing to take standard care in their actions resulting in the claim of negligence.

According to Forrester and Griffiths (2014), The general reason for the violation of duty is the act of negligence. Actual damage or harm sustained should be a real or genuine hurt to the distressed party from the act of negligence.

Causation- As indicated by this component, an act from the performing gathering or disappointment of performing party in taking standard consideration ought to be the essential purpose behind the damage. Moreover, abused must not have any involvement in the demonstration of carelessness else they won’t have the capacity to guarantee harms for damage (Guido, 2014).

Malpractice is an equivalent word of professional negligence. Arrangement of misconduct behaviour is connected when health care professionals neglect to take standard consideration of their activities. In the present time, nursing experts are winding up likely objectives of the offended party and their

lawyers for the situation of medicinal malpractice. In the present case situation conduct of negligence is observed during all the times Mr. Hammett was transferred between different medical units. Following the transfer of Mr. Hammett from PACU to the accommodation ward, RN Manton took over the care of Mr. Hammett from RN Turrell. Conferring to the declaration of Manton, Turrell did not notify him of the desaturation occurrence in PACU through the transfer. This act is considered professional negligence as it is commonly predictable that during handover of a patient, healthcare provider at the time has to be provided with all necessary crucial information about the patient. However, in this case, scenario Turrell ruined to do so (Ray, 2012).

In the accommodation ward, Ms. Valentine failed to connect the mask to oxygen supply whilst she was altering Mr. Hammett’s nasal prongs with an oxygen mask. Moreover, she repeatedly incorrectly complete his vitals chart regarding the saturation levels. This incident will also be considered an act of malpractice of the nurse. As a result of her negligence and failure to recognize and respond to the clinical deterioration, the patient had to endure further suffering (Guido, 2014).

At the accommodation ward, RN Gibbons failed to determine and conduct himself in the situation in an appropriate manner. He assumed that the patient was asleep while the patient was unconscious. The act of misinterpretation by Gibbons will be considered as a negligent act because it delayed Mr. Hammett receiving an appropriate standard of care in recovery at the Gold coast hospital. Both nurses be obliged their duty of care to Mr. Hammett. It is the general responsibility of nursing practitioners to conform

to standard rules and to evade acts of negligence. In both the above circumstances, the nurses were unsuccessful to take care of their general tasks. Due to their negligence and non-compliance of the subject standards of care which should have been provided to patients recovering post-operatively, the unfortunate incident of Mr. Christopher Hammett's death occurred.

Furthermore, the essential purpose behind damage of the patient was negligence directed by the nurses. Along with these lines, for this situation, every one of the components of negligence were perceived in the examination by the Coroner.

Section 3: Ethical Issues

In the care of Christopher Hammett, several ethical issues can be seen. Due to these issues, nursing practitioners in the case faced ethical concerns while taking care of Mr. Hammett. Initially registered nurse Turrell met the point of disclosing information (Legal Aid Queensland, 2018). It is a general dilemma of nursing practitioners how much information should be disclosed while handing over the patient to another practitioner. In the present case scenario, registered nurse Turrell was required to provide all the essential information to the handover nurse. Usually, it is a result of the possibility to disclose information to a doctor if needed, who will be talented to provide better treatment to the patient by considering the crucial facts. Additional ethical issue was tackled by EN Valentine regarding the explanation of the condition while observing the patient. At that night, Christopher Hammett had detached his oxygen mask several times and every time the mask was

exchanged by EN Valentine (Nursing and Midwifery Board of Australia – Guidelines on endorsement as a nurse practitioner, 2015).

At the time of surveillance, EN Valentine thought the exchange of the oxygen mask was the key reason for low oxygen saturation levels. Other health care professionals also faced such a ethical issues as it was many likelihoods in an one situation. Furthermore, she was ignored by RN Gibson's assistance in appropriate manner. Due to this fact, she had to smear her interpretation while writing the vitals form of Mr. Hammett. Although, she requested RN Gibson to attend Mr. Hammett due to constantly dropping of the oxygen saturation level. Ms Valentine did appropriate action at a time though she was an accountable for the act of negligence. Because of the above portrayed ethical issues, the nursing professionals included did not deal with the patient at a sensible standard and way.

Nursing professionals are vastly qualified to offer the best conceivable standard of care to the patients. Yet, in this case, the injury and destruction caused to the patient was a result of deprived ethical conduct and negligence by the nursing staff.

The primary reason for the death of the patient was the negligence of nursing practitioners. The unfortunate outcome of the death of Mr. Hammett could have been avoided if standard nursing care was provided to Mr. Hammett. Nursing practitioners should be obliged to undertake their duties and responsibilities to benefit the patient ultimately. They should comply with the standards of ethical and legal care. If they fail to do so, they will be held liable for their misconducts. Misconduct of nursing practitioners will

result in cases of civil and criminal law. In the current case of death of Christopher Hammett, establishment of civil law was applied.

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