Critical incident analysis nursing assignment

Reflective Analysis of a Critical Incident

This paper recounts a critical nursing incident and reflects on the associated professional, moral and legal issues. The objective is to critically reflect on what happened with a view to distil key lessons to improve my future practice and provision of care. No personally identifiable details about the key players or context are included, thereby assuring their confidentiality. This incident was selected because it demonstrates the ways in which individual errors can compound and translate a relatively simple matter into a grave crisis with fatal results. It goes to the heart of nursing practice, and requires introspection into the ways we discharge our responsibilities.

Description of Critical Incident

I was a Registered Staff Nurse completing the final phases of a 12-month midwifery program in the labour ward of a 500 bed teaching hospital. The ward comprised sections for admission, stage 1 room (active labour), hypertension (pre-eclamptic) room, delivery room and a post-delivery observation area (temporary holding. My objective was to gain skill marks (by completing 40 deliveries and suturing) to complete the program.

This particular day I enquired about deliveries and heard of a case that was just ending–the resident doctor was suturing the patient. I was hopeful of participating in the final stages to earn marks so I went to assist. Upon entering the delivery room I saw a lot of blood on the floor, so I asked the doctor what was happening. He stated everything was okay. I observed the patient lying on the bed, and asked her if she was fine. She replied yes. The patient looked pale and weak-more so than the stress of just delivering.

I left the room and called the consultant who was doing ward rounds on another ward with students. I also informed the charge midwife about the situation. The charge midwife went to ascertain what was happening. The doctor again asserted that everything was fine, and there is no problem. I assessed the patient’s vital signs, and found them to be abnormal. Right then, the consultant came into the room and started an intervention. The patient was taken to the operating theatre for exploration to stop the bleeding. After two hours of transfusing blood products and packing the uterus, the patient was transferred to the intensive care unit. She passed away three hours later. The husband was told that there was a complication, and all efforts to stop haemorrhaging were unsuccessful.

Hospital policy states that a midwife should assist doctors with any procedure being done in the labour ward. This was not the case. The baby was delivered by a midwife. The doctor was asked to do the suture because of suspected difficulties (cervical lacerations). This situation was not considered to be life threatening. The midwife left to attend to other patients on the busy ward. The doctor was asked to call if and when he needed help. The doctor acted on his own, and twice refused to acknowledge the worsening situation. The patient died, and the family suffered as a consequence. The information given to the family did not reflect all the facts of the incident. The hospital reprimanded the doctor and he was not allowed to see patients without supervision. He eventually completed his specialization course and now practices obstetrics and gynaecology in another jurisdiction.

Stakeholders Involved

Merriam's dictionary defines a stakeholder as person(s) entrusted with " the stakes of bettors" or someone who is involved or affected by a course of action. In this case, a range of persons were directly and indirectly involved, and a family will have to live with the loss of a loved one.

The patient expected to deliver a healthy baby, be with her family, and raise her child. She is no longer with them. The resident doctor made choices, and has to deal with the consequences of those decisions on a personal (moral and ethical) and professional basis. We cannot be sure what options were deliberated, nor the process used to arrive at the final choices. The consultant obstetric/gynaecologist juggled different tasks and ultimately intervened, but without success. The charge midwife and the midwife who delivered the baby are also a party to the incident: they attended other matters on the ward-no doubt also considered urgent and important.

This incident raises various professional, ethical and moral dilemmas. The actions of these persons raise questions about the duty of care provided, and the professionalism that guided the choices and judgements they demonstrated. My objective at the time was to earn skilled marks. My view is that the hospital itself can also change from this experience.

No one expected the outcomes that manifested. Hospital policy was contravened. The family accepted the paraphrased version of events. The doctor received a reprimand. I do not recall any action for the breach of policy.

Theoretical Context

A critical incident is one that can cause a person to pause and contemplate events that occurred, and in so doing, give them some meaning. This can be positive and experiential, and is a potential source for self, group and institutional learning and improvement (Gibbs 1988, Duffy 2007).

Thinking critically requires us to identify problems and base assumptions and clarify the issues involved. Subsequently, we may raise questions; whose answers may result in changes (Vacek 2009). Critical incident analysis challenges us to evaluate the main facts and use these to gain a deeper understanding of what happened (Fornasier 2008). In so doing, we deconstruct the whole incident into its component parts.

Reflection is a thoughtful, deliberative process to gain deeper understanding of what happened by encouraging us to challenge how we feel, think and behave. This is the basis for individual change and improvement (Andrews et al, 1998; Merriam Webster). Using a critical incident as a way of reflecting involves the identification of behaviours that may be helpful or unhelpful in a given situation. This process of structured debriefing can help the institution and the health care providers to identify incidents, prevent their reoccurrence, and enhance the standard of care delivered to the public (Gibbs 1988).

- Key Issue: Professionalism

A profession is a ‘ chosen, paid occupation requiring prolonged training and formal qualification’ (Webster). A number of professionals are involved in this case. For myself, at first, I did not know what to do: I was just thinking about

the patient’s safety when I saw the enormous amount of blood of the floor. In the moment, I forgot about the chain of command: I bypassed the charge nurse and called the consultant directly. Reflecting on the incident, I should have called the charge nurse and she may have better handled the situation as it unfolded. Further, I assessed the vital signs after leaving the room to communicate with the consultant. It could be argued that I should have completed a fuller assessment of the patient’s vital signs before progressing through the chain of command-rather than taking the patient’s perspective that all was okay – despite a gut feeling that something was wrong. Was the patient making a rationale statement? Did she have enough information and the capacity to objectively weigh the situation? Did I, in that moment misread the gap in understanding of what I saw and what the patient said? I would maintain that my actions were well intentioned and had the desired impact: to bring additional resources to remedy the situation and preserve her life.

Clearly, the ability to remain calm under stressful circumstances is a valuable characteristic. This cannot be taught or learnt in the classroom, and certainly not through a fatal trauma.

The patient is no longer with us. Did she have enough information to make an informed decision about the quality of care she was receiving? Could the patient be reasonably expected to be informed or to request a different type of intervention in the circumstances? We will never know.

The resident doctor was asked to suture a suspected lacerated cervix alone-and to ask for help if needed. Doctor maintained all was under control even

as I assessed the situation was worsening. Questions may be asked about the doctor’s assessment of the initial and unfolding circumstances; and, the information communicated to the patient, who related she was ‘ fine’. I have no doubt the doctor’s objective was to assist the patient, and, within the wording and spirit of the Hippocratic Oath, to use their own ability and skill to help the woman in the best way. However, did the doctor fail at his/her duty: to recognise an emergency, a worsening situation, and the limitations to their skills and capabilities? In so doing, did the doctor do more harm than good? In the final analyses, was the doctor acting in the patient’s best interest?

The consultant did what was (probably) most the critical thing: an initial intervention and then emergency surgical exploration with a full team of specialists to ascertain the problem and contain the situation. Could the consultant have done more? This is unlikely in the circumstances. Yes, the consultant could have been called earlier, but that is not their fault.

Did the charge midwife and midwife err in leaving the Doctor to complete the suture alone? How does one balance the need for a small amount of midwives to attend to different patients at various stages of labour, when a potential danger is at hand with a post natal mother? How do we reconcile these resource constraints with hospital policy (requiring a midwife to be present at all times)? In this situation, how do we make a decision about providing quality care and attention to labouring women, versus attending to a recovering mother? Is it less or more professional to leave labouring women unattended to care for a mother with what is considered to be non-life threatening wound?

The Hospital’s official explanation of what happened was ‘ maternal complications. This lacked credible details that are covered in the legal discussions below.

- Key Issue: Morality

Was the hospital truthful in its communication with the patient’s family? To the outsider, the answer seems a resounding no! Does being a teaching hospital bring higher levels of risk to patients-by virtue of having younger and less experienced doctors? Does this lessen their responsibility to the patient? Or does it require a higher standard of care and greater precautions?

In this situation, did the hospital fail in its duty to the public by having a higher ratio of patients to staff? Is it unreasonable to expect the nursing cadre to reasonably and safely provide a high quality of care to the number of patients on the ward at that time? Did the institution and its team fail by attempting to provide service for too many patients at this time? Did the policy foresee and cover these matters?

Do these issues put the nurse and their professional obligations at odds with hospital and public policy? Does this conflict put the nursing (and other members of the medical team) at a disadvantage?

What of the public’s rights and responsibilities? How do we honour and respect these charters in the circumstances described? Each patient wants to be seen, receive a high quality of care, with minimum chances of complications-certainly not death.

How does the Midwife make based a decision about who to treat and how to allocate scare human resources? In a high stress understaffed environment, can we reasonable assess who is at greater risk and more deserving of care? Can we reasonable assert that honesty, justice and respect for the patient's rights can lead us to a determination of where our duty lies?

It is my view that the while some parties in this case may be able to justify their actions (midwives, consultant), others would find it a deontological challenge (resident, institution). In this case, the outcome of the incident dictates that the actions of key caregivers at critical decision moments were not optimal (wrong/unethical) because the consequences do not match the means/process.

- Key Issue: Legality

No known legal proceedings arose from this incident. However, it may be argued that a judicious reading of the circumstances by a family predisposed to litigation could have asked many questions about the unfortunate circumstances referenced in this incident, and maybe have a case in a court of law. For example, it could be argued that the patient's legal rights were not met, regarding professional standard of care provided by the resident doctor and the absence of a midwife throughout the procedure. Further questions may be raised about the quality, experience, judgement and capability of the first attending doctor. And ultimately, questions could be asked about the checks and balances (levels of safety) within the institution that compounded the situation.

Additional issues may arise in considering whether or not the patient was reasonably informed about the unfolding circumstance, associated risks, and given the opportunity to legally consent. It could be argued that the doctor acted unilaterally (paternalistically) to the patient's disadvantage. Alternately, the patient could not have reasonably rejected treatment in the circumstances. Therefore a detailed test would be required of what a reasonable professional would do in this situation. The hospital reprimand is an indication that the resident doctor could/would have failed the Bolam Test of respectable medical opinion – thereby paving the way for litigation.

The above could also lead to the question about the initial consent, and whether or not there was a full explanation of risks and likely treatments in the event of complications.

In a legal context, the issue is whether or not the key stakeholders acted professionally and morally, and more importantly, in the course of their duty, whether they neglected or failed to provide a reasonable care of duty to the patient.

Summary and Discussion

My view now-I was not asked or debriefed at the time, nor did I reflect critically then-is that the circumstances and outcomes dictate that the team and members thereof acted less than professionally, and their judgements and actions were not finely balanced, leaving them in a an unethical and morally compromised position. The patient was owed a duty of care, which was not provided by all involved at the critical moments after delivery. So although all parties worked from a position of beneficence, obliging to do

good for all patients at the time, there is a deontological failure in justifying their actions.

On this occasion, hospital policy was not adhered to, and there was reasonable cause for this. The outcome reinforces the view that the consequences do not match the means. But this has to be balanced with the contending demands on the team. The midwives, in leaving the doctor to attend to the patient, expected to be called if needed. They were professionally and morally obliged to give reasonable care to the other patients. It would be difficult to squarely blame them for an act of omission that caused/worsened harm for the patient.

This is not to ascribe blame squarely at the resident doctor. There are factors at play that would have influenced their action-in keeping with training-while endeavouring to contain and manage the situation. Maybe, for example, there was consideration of the human resource constraints and not wanting to burden fellow colleagues. Maybe the doctor was confident in knowing what was required in the circumstance. However, the rapidly deteriorating situation was soon beyond the doctor, and there was no recognition or acceptance of the need for additional help. Surely, if the final outcome was positive, the consequences would have justified the means. However, in this case, the means and end were weak links.

The circumstances and situation in the ward on that day were unfavourable to the team: too many needs, and too few hands. The staffs were in a compromising position by having to deal with too many situations. This should never be the case if we are to deliver a reasonable duty of care in

circumstances where humans can never fully assure medical outcomes in certain emergencies.

In this incident, on this day, a number of factors compounded a bad situation and led to fatal outcome-which never had to be the case. The midwife made a decision to leave the doctor to suture the lacerated patient; the doctor attempted to do the job without recognising or seeking help. My actions quickened the intervention of the consultant, who ameliorated the situation, but to no avail.

Conclusion and Reflection

Having participated in this course, I can now reflect critically on this incident and confirm the ways in which a variety of professional, legal, ethical and administrative policy must work together in order to deliver assured quality healthcare. This is especially important in high stress environments where critical decisions must be quickly made-with the potential for unforeseen results.

As professionals we must strive to be calm when things take a turn for the worse. This is not a reason to abandon or lose the ability to think critically, and stay true to our ethical, moral and professional duty while meeting the expectations of our employers. Indeed, we will at times find ourselves in situations that test this resolve, and require us to make rapid decisions and attempt to innovate to meet circumstances. This latitude is welcomed, but must be used with caution to ensure that the final outcomes can hold up to the scrutiny of our peers.

Finally, it is critical to reflect and analyse our actions and experiences in order to evaluate what works, what does not work, the reasons for these, and the ways to manage future events should they recur. This is useful whether or not one is reprimanded or at the end of litigation case (institution). It is from these collective experiences and learning that we can improve policy, and enhance the profession.