Circulating Nurse Has Duty to Ensure Surgery Done on the Correct Anatomical Site

written by Nancy Brent | May 26, 2016

Avoiding Liability Bulletin – 2013

Although there were many issues on appeal to the Arkansas Supreme Court in a 2012 case out of Arkansas[1], the focus of the case for this Bulletin is on the circulating nurse's negligence which contributed to surgery being done on the wrong side of a 15- year-old patient's brain.

The patient was scheduled to have elective brain surgery on the right side of his brain in order to excise a right temporal lobe lesion to eliminate epileptic seizures occurring on the right side of the patient's brain[2]. The procedure is known as a selective amygdale hippocampectomy (SAH). A "timeout" occurred before the surgery, which is to serve as a final verification of the correct procedure site. It included the surgeon, the anesthesiologist, a scrub nurse, and the circulating nurse.

However, during the timeout before the surgery, the procedure was not designated as a sided procedure. Instead, all the relevant paperwork listed it as a "crainiotomy for SAH".[3]

The procedure was begun by the surgeon on the left side of the patient's brain where he cut through the skull, penetrated the dura, and removed significant portions of the left amygdala, hippocampus and other tissue before it was discovered that the surgeon was operating on the wrong side of the brain. [4] The left side wound was closed and the procedure began on the correct side of the patient's brain, the right side.

The family was informed of the mistake but it was characterized as a minor and inconsequential error. Others in the hospital were told the same thing. The patient was discharged home after a short stay in the hospital and continued with his education, graduating from high school. But his parents noticed that he was not the same as he was before the surgery. In fact, neurological exams revealed that he was brain damaged and the patient was admitted to an assisted living facility for brain damaged individuals.[5]

The parents, who were also co-conservators of their son, filed a lawsuit against the hospital, the surgeon and others. A settlement occurred with all of the defendants but the hospital and the case went to trial. The circulating nurse's conduct, an employee of the hospital, was an essential focus at trial.

At the trial, in addition to testifying about the timeout, the circulating nurse also admitted that she did not know what a SAH was until after the surgery. She further testified that even if she knew that the surgeon was operating on the wrong side of the patient's brain, she would not have been able to stop

the surgery because he was the surgeon.[6]She also testified that she did not make a note in the operative report that the wrong-sided surgery took place because she only documented what the surgeon told her to document.

The Vice President of Patient Care Services testified at the trial about the hospital's policy during timeouts. She indicated that during the timeout, which was to confirm the correct procedural site, the circulating nurse on the team is to have three documents available prior to the timeout: the consent form, the preoperative history and physical, and the schedule of the procedure. Moreoever, she testified that it was the nurse's responsibility to record in detail that a wrong –sided surgery took place.[6]

A nurse practitioner in neurosurgery testified as an expert for the plaintiffs that the circulating nurse should have known whether this type of surgery was to be performed on the right or left side of the brain. This type of surgery, she continued, cannot be performed "midline". Because the documents used in the timeout did not specify which side the surgery was to occur, the circulating nurse's conduct did not meet the standard of care, as it was his/her duty to make sure any surgery, but certainly brain surgery, is not performed on the wrong side "of anything".[7] The nurse expert also testified that not documenting the wrong-sided surgery affected the young patient's care after the surgery.

The trail jury awarded a $20 million verdict for the plaintiffs, but this was amount was reduced through various legal challenges to $11 million. The Supreme Court of Arkansas upheld the $11 million verdict. Despite the reduction, the circulating nurse's professional negligence added, in part, to the patient's injury.

This case clearly illustrates what is known in the PeriOperative setting: the circulating nurse's role in essential in the surgical process and extremely essential in ensuring the safety and well-being of the patient. The circulating nurse must:

- Know facility policy and his/her role as a circulating nurse;
- Utilize timeouts as they are intended to be used;
- Analyze any and all documents utilized for each surgery and speak up when any form is not complete, accurate, and factual;
- When observing something "wrong" in the surgical process, or when hospital procedures are not followed, notify all who need to be notified, documenting what is observed and who was notified;
- Remember that it is the circulating nurse's overall duty to protect the surgical patient from any risk of harm and take whatever action is needed to avoid that risk of harm;
- Know each procedure you are participating in as a circulating nurse;
- Document accurately, completely, and factually all that you are responsible for as the circulating nurse;
- As an employee who is involved in a lawsuit, keep in mind that your employer can testify as to what you did not do pursuant to policy (as in this case) in order to make its liability for the injury appear less under the theory of respondeat superior ; and
- Always remember that your license as a registered nurse requires you to legally exercise

independent judgment and function in your role without bending to limitations or instructions forced upon you by others or by their title or role in the hospital setting.

FOOTNOTES

1. Proassurance Indemnity Company v. Pemal and Kenny Metheny, 2012 Ark. 461.

2. Id., at 2 (page number of printout of case).

3. Id.

4. Id., at 3 (page number of printout of case).

5. Id.

6. Id., at 8 (page number of printout of case).

7. Id.

GENERAL REFERENCE

Legal Eagle Eye Newsletter For The Nursing Profession, Operating Room: Surgical Error Blamed, In Part, On Circulating Nurse's Negligence 21(1), 2013, 1.

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