By Genevieve M. Clavreul, RN, Ph.D.

A Good Little Soldier — NOT!

Are you justified refusing an order or questioning a chart entry?

Sometimes hospital administrators, physicians, chief nursing officers, the public and even some nurses believe that the RN's role is to be a "good little soldier" following all doctors' orders without question. This is not the case.

RNs are not mindless automatons. Our education, training and license place us in a position to serve as a safety checkpoint. Our nurse practice act designates us as the patient advocate, giving the explicit authority to question any act that might place the patient in our charge in jeopardy.

In fact, an RN's license may be on the line if the Board of Nursing concludes that his or her failure to fiercely advocate for the patient played a role in that patient's deterioration or death.

The Intern Blames the Nurse

Early in my career I learned the importance of taking a precise verbal or telephone order, and the need to clarify or question orders that seemed odd, unintelligible, or downright wacky.

There was once a time when our nursing team received a two-year-old boy admitted with a diagnosis of croup. The intern on duty that evening wrote orders without requesting a tent with cool mist (one of the treatments of choice, both then and now).

The admitting RN questioned the intern and inquired if he'd forgotten to order one. He responded that he didn't feel it was needed. Concerned that a tent should have been ordered, she followed hospital policy and contacted me, the head nurse at the time, with her concerns. She provided a brief report and recitation of the intern's verbal orders; after reviewing the information, I concurred with her assessment and contacted the intern to request that he amend his verbal order. He refused.

Of course, the toddler didn't improve and the following morning looked tired, dehydrated and was croupier than on admission. I requested that the chief pediatrician make his rounds early, during which he questioned the intern about the lack of a tent. The intern said, "I told the RN that the boy needed a tent, but she didn't carry out my verbal order."

When I learned that the intern had accused one of the nurses on my team for failing to carry out a verbal order — an accusation which I knew was false — I called a meeting with both the medical and nursing staff that regularly covered our Pediatric Intensive Care Unit (PICU). During this meeting I made it clear that all nurses working in the PICU were not to accept verbal or telephone orders from this particular intern, only written orders were to be accepted, except in life-or-death situations.

Have a concern? Follow the nursing chain of command and hospital protocol

The Right to Refuse

An RN has the right to refuse certain orders, especially if such an order is contraindicated, breeches accepted hospital procedure and protocols, or can endanger the patient's well being. Nurses should explain why they will not carry out the physician's order as written or instructed, then document the reason, being sure to follow all hospital protocols.

The error was simple. The nurse had inadvertently transcribed a physician's order for an antibiotic with a lookalike name. The pharmacist and nursing staff didn't catch it

Hospital and nursing policies should clearly explain the procedures when dealing with and addressing unclear doctor's orders, including undecipherable handwriting. (It is surprising how often people think that being a code-breaker is one of the many job requirements of a nurse.) There should be protocols in place when transcribing telephone orders and accepting verbal orders, instructing how to transcribe a telephone order, how much time is allowed to elapse between taking and signing the telephone order, when it's appropriate to accept a verbal order and when it's not, how to transcribe a verbal order and so forth.

Charting Errors

As nurses, we must record our actions through various documents that become part of the patient's medical record. These include: the Medical Administration Record, Physiologic Monitoring, and the Interdisciplinary Plan of Patient Care and Education.

The avalanche of paperwork, even in this digital age, often leaves nurses feeling as though they are barely staying ahead of their duties. This, in turn, creates an environment where a nurse has a limited amount of time to get up to speed on each patient. Instead of having time to do a comprehensive review of the charts, nurses are limited to 5- to 15-minute patient snapshots. This could inadvertently lead to substandard or dangerous care.

The Wrong Medicine

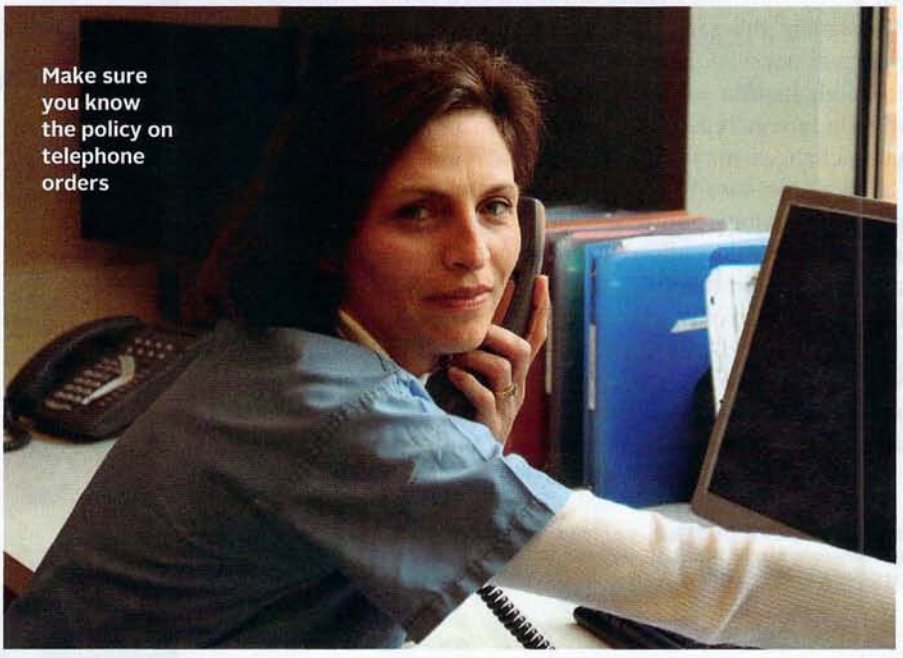
Several years ago while working at a Los Angeles area PICU, I was assigned a patient that I hadn't been responsible for during my earlier shifts. I followed the established nursing protocols, which included taking report from the off-going RN. I checked in, introducing myself to the parents at bedside to ask if they had any questions about the care their child was receiving.

At an appropriate time, I also reviewed the chart for each of my patients (no more than two per RN in PICU), a practice I'd learned in nursing school so many years ago and continued to practice each time I had a bedside assignment. Paying careful attention to the various monitors so that I could respond at a moments notice, I flipped through the charts, going back to the day of admission and making sure that the doctor's orders were current, and that information had been appropriately carried over, especially as it applied to medication orders and feeding times. This is how I discovered that my patient had been receiving the wrong antibiotic for the past five days.

The error was simple — a nurse had inadvertently transcribed a physician's order for an antibiotic with lookalike name. The pharmacist failed to catch the transcription error, as did each subsequent nurse who had taken over the care of the infant.

A Dosage Miscalculation

Another time, I encountered an error which was much more serious: the dosage of methadone prescribed to wean an infant from morphine was grossly wrong. The physician had written a one-to-one conversion instead of the appropriate ten-to-one. The pharmacist and the nurses who cared for the patient failed to catch the error, giving the child several overdoses. When I returned from holiday and



Make sure you know the policy on telephone orders

resumed care for the infant, the mother confided in me that her son had been having seizures. I reviewed his chart as soon as I received report.

After flipping through a couple of pages, I came across the doctor's order for the methadone, and thought the dosage ordered seemed high. A quick computer search supported my concerns, and when I notified the pharmacist she confirmed that there was an error.

She contacted the physician, requesting him to correct the order, but he was hard-headed and insisted that the order be carried out as written. I refused, informing the physician that if he wanted the order to be carried out he could administer the methadone injection himself. He never did, the order was changed, and the infant stopped having seizures and was eventually discharged.

If you think such errors are rare, let me remind you of the case reported in the *Los Angeles Times* awhile back where a patient at the now-defunct King/Drew Medical Center received a chemotherapy drug for many days when he should have been receiving medication to treat his meningitis. Meanwhile, the cancer patient received treatment for the non-existent condition of meningitis.

Continuity of Care

We are responsible for reading those charts — not just to provide immediate care, but to familiarize ourselves with enough information to carry out our duty properly. Time and time again, devoting additional time to sort through the patient's full chart has saved my patient, their families and myself a lot of grief.

Continuity of care is a key component to providing optimal patient outcomes. I have always been a strong supporter of assigning the same set of nurses to the same patient whenever possible. This policy allows the nurses to become intimately familiar with the patient and their medical record, which in turn increases the opportunity for nurses to pick up subtle changes, minimizing errors that are chart-related.

Always be sure to follow your hospital's specific protocols for clarifying a poorly-written or illegible order, or for an order that your education and training tells you is contraindicated. Document the steps that you've taken to ensure that there is a record of your actions

Being a "good little soldier" doesn't mean blindly following an order. It means ensuring that as a nurse, you are doing everything in your power to deliver the proper and safest care for your patients. Taking such actions can impact your license, your job and your patient's life. WN

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