

NURSE MALPRACTICE

Course #125
30 Contact Hours

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About the Authors

Caroline McGuire received her BSN from the University of Connecticut nursing program in 1985, her first job was working on a surgical unit. Ms. McGuire's specialty became critical care and also has extensive experience in intensive surgical, medical, coronary, emergency, and telemetry care units for the past several years. Critical care proved to be an area dealing with increasingly complex legal and ethical issues and the need for understanding liabilities became evident. For the past few decades she has studied the legal aspects of nursing, ultimately expanding her role into the legal profession by becoming a Medical Legal Consultant. Working as an independent contractor for a malpractice attorney she assists with the development of malpractice claims. Goals for the future are to become a nurse paralegal, an expert nurse witness and a Risk Manager.

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Purpose and Goals

The goal of this course is to educate the healthcare provider on a basic understanding of law and its relationship to nursing. The course discusses common causes of nursing negligence, and some ways to prevent malpractice in the workplace.

Instructional Objectives

1. State the necessity, types, and components of professional liability insurance policies.
2. Summarize the legal process involved in a malpractice lawsuit.
3. List the major factors influencing the trend towards increased litigation among healthcare providers.
4. Specify the relationship between Nurse Practice Act and Standards of Care.
5. Outline the elements of negligence necessary to prove a case of negligence exists.

6. List the most common causes of nursing negligence for both intentional and unintentional torts.
7. Compare the two major doctrines of negligence.
8. Identify acceptable defenses that a defendant-nurse may use in response to a lawsuit.
9. Identify two nursing activities that pose significant legal risks while off duty.
10. List the key elements needed for proper documentation on both the medical record and incident reports.
11. Cite the personality traits exhibited by the typical defendant-nurse and plaintiff-patient.

Introduction

Education, as opposed to adverse experiences, should be the means of providing the basis for understanding the relationship between nursing practice and liabilities. This acquired knowledge will assist nurses in overcoming their fears and concerns in order to effectively deal with legal situations.

Today, nursing has evolved from a traditional role of exclusive nurturing and menial tasks to a contemporary practice of higher knowledge requirements, advanced technology utilization, and increased decision-making capabilities by intelligent, educated professionals. By attaining a professional status nurses are required to assume full responsibility for their actions, as increases in responsibility create increases in liability.

In an effort to practice safely, every nurse must not only possess a high degree of knowledge and skill, but must also possess a basic understanding of the law and its relationship to nursing practice. Awareness of potential liability forces nurses to evaluate their current practices and upgrade the quality of the care they provide, thus creating higher nursing standards. It is difficult to meet the appropriate standards legally required for a sound practice without knowing the exact nature of these responsibilities. Claiming incomprehension, inexperience, or lack of awareness of the legal aspects of nursing is never an acceptable defense in court.

Throughout your profession you will never personally experience an infliction so demoralizing, financially burdensome, or detrimental to your career as you would if you were to be named as a defendant

in a malpractice lawsuit. You must do everything you possibly can to prevent this from happening. Information and education are your best guides. The end result of knowing the law, performing competently, and practicing within your legal boundaries is the delivery of the best possible nursing care in accordance with the highest standards of the profession. This is the goal of every nurse. It is also the way to avoid malpractice.

Factors Contributing to Liability Lawsuits

There are several factors that contribute to medical malpractice lawsuits. We give three factors consideration - starting with the first, the expanded role of the nurse. Second is a public that is more informed than in the past due to greater media exposure, and the third factor is an expectation in our society to be compensated for mistakes.

First, The driving forces in role expansion can be attributed to the shortage in healthcare providers due to increased specialization. As physicians specialize their individual practices, the number of general practitioners declines. When this happens nurses are expected to undertake many of the physician's duties. Ultimately, nurses are required to perform a greater number of medical procedures. The benefits of improved technology and new equipment could not be maximized without the contribution of nursing skills. Thus, the necessity to perform increasingly complex tasks broadens the scope of nursing practice.

An RN's intensive educational program enhances proficiency in the clinical setting by enabling the RN to understand medical knowledge in addition to performing basic nursing skills. Equipped with this knowledge, the RN is able to independently implement the nursing process (assessment, planning, implementation and evaluation) for actual and potential patient problems, as well as make professional judgments and decisions concerning patient care.

Nurses, too, have chosen to specialize their practices. Visiting nurses, nurse midwives, and nurse practitioners have established independent practices within the community. Hospitals have witnessed the shift from general medical/

surgical nursing to specialty areas such as critical care, emergency, OB/GYN, OR/ PAR, and anesthesia. Despite these medical and nursing achievements, specialization is not without drawbacks; it results in fragmented and depersonalized care by numerous individuals. Although this is now an acceptable method of practice for healthcare providers, today's client may find it confusing and even frustrating.

Second, clients, with much assistance from the media, have become educated consumers. During the last decade an emphasis has been placed on personal goals of achieving and maintaining a healthy lifestyle. Television, radio, and magazine advertisements stress the importance of exercising, eating properly, and losing weight. Previously, the words hypertension, cholesterol, and osteoporosis were known only to a select few. Now they routinely comprise part of ordinary conversations of young and old citizens outside of hospitals, clinics, and doctor's offices. In this new movement towards health consciousness, society is no longer content to let healthcare providers make all of the decisions regarding their care. Because clients have become active participants in their treatment regimes and more knowledgeable about their own bodies, they pose higher demands for quality healthcare.

With more awareness also comes the understanding that caring for an injured or disabled family member, due to mistakes made by the healthcare provider, will result in the expense of continuing medical care and possibly the loss of wages.

In the early 1970's the American Hospital Association (AHA), in an effort to standardize consistent, first-rate medical care for the nation, created the *Patient's Bill of Rights* (PBOR), nearly two decades later the PBOR was revised to include the patient as a responsible partner in their healthcare. While many states and hospitals around the U.S. adopted the PBOR, it has not been enforceable on the federal level, even with many attempts to pass legislation to protect the patient as a consumer. With the passage of the Affordable Care Act in 2010, a new Patient's Bill of Rights was enacted, however, it deals

largely with the rights of the patient in regards to insurance coverage. The AHA's PBOR has been replaced with the *Patient Care Partnership*.

Like many businesses, healthcare institutions have a policy of customer care and often provide a statement to patients, informing them of their rights while in the care of that facility. These lists are designed to protect patients at a time when they are most susceptible to being deprived of their basic rights. These are not standard throughout the U.S., and although the wording differs slightly in each institution, they all convey similar meanings; rights to privacy, informed consent, confidentiality, dignity, and competence.

All medical personnel should be aware of their employer's specific patient right guidelines, as well those on the state and federal level. Professional ethics are binding for all nurses, regardless of legislation. If patients feel they have received substandard care, or these rights have not been protected, they can seek monetary compensation from the courts.

The *third* contributing factor results from the lawsuit mentality that has gained an increasing popularity among the public. The trend over the past decade has been not only to initiate more lawsuits, but to involve multiple parties in an attempt to receive larger settlements. Traditionally only physicians were named as defendants. Currently, nurses and other healthcare professionals are named individually or as co-defendants with increasing regularity. The promises of advanced technology, new treatments, and increased life spans have lulled the public into a false sense of unrealistic expectations. The focus of attention is mistakenly not on the successes but on the failures; assuming that most medical mishaps are preventable and therefore are the direct result of medical malpractice.

Fortunately, the law recognizes that medicine is not an exact science and failure to cure does not automatically imply malpractice. Neither cures nor protection from harm are legally guaranteed. However, a change in these attitudes will not be made overnight and with the encourage-

ment of attorneys and the media, the public will continue with their attempts to seek monetary compensation for unfavorable outcomes whether or not these lawsuits are justified.

Basic Legal Terms

Laws are established guidelines for acceptable and prohibited human conduct, which are derived from, and enforced by, the government. Healthcare laws are general rules intended to safeguard the public's welfare by providing guidelines for professional and social conduct. With regard to healthcare providers, they define who may practice, what qualifications are necessary, and the scope, or limits, of that practice. There are *two* classifications of law which are pertinent to nursing because they deal with the regulation of social conduct. The first, **civil law**, deals with the legal rights and duties of private citizens. The second, **criminal law**, deals with offensive conduct against the public.

The remedy for a civil offense is compensation, while that for a criminal offense is punishment. The goal of most civil lawsuits is to compensate the injured party for their injuries. Because it is impossible to restore physical conditions to their pre-injured state, compensation takes the form of financial awards. The imposition of criminal penalties is for punishment and deterrent purposes. As an example, you may have to pay damages to a patient for burning him with a heating pad, but you may be sent to jail for illegal possession of narcotics.

Tort law is a category of civil law. A *tort is any legal wrong committed by one person on another person or another's property.* These wrongs may be **intentional**, such as defamation of character or trespassing, or **unintentional**, such as leaving a surgical sponge inside a body cavity or throwing a football through your neighbor's window.

Negligence is one of the most common nursing torts. *Simply stated, negligence is the failure of a responsible person to act in a reasonably prudent manner.* A person can be found negligent for acting unrea-

"Today, nursing has evolved from this traditional role of exclusive nurturing and menial tasks to a contemporary practice of higher knowledge requirements, advanced technology utilization, and increased decision-making capabilities by intelligent, educated professionals."

Basic Legal Terms - Tort Law, Malpractice and Negligence

sonably or for failing to act reasonably. To determine whether or not someone has acted reasonably that person's conduct is compared to the conduct of another person; a hypothetical individual whose actions and conduct represent society's ideal of reasonable behavior. The court must then establish if the first person's conduct has deviated from what another person would have done in a similar situation. For instance, before proceeding through an intersection a pedestrian must initially look in both directions to ensure that he may safely cross the road. A person who fails to do this, and causes a traffic accident by abruptly walking into the street, has failed to conform to established rules of crossing used by other pedestrians. Because the pedestrian did not pass the "reasonable person test", or what another prudent individual would have done in the same situation, he will be found negligent.

Malpractice is a negligent act committed by a professional during his/her course of duty. Hence, a nurse administering the wrong medication to a patient would be negligent in carrying out her duty and therefore would be guilty of malpractice. The same nurse would not be held liable for malpractice if she failed to stop at a red light and a traffic accident resulted. In this instance she would be guilty only of negligence. Neither negligence, nor malpractice require intent to harm another person. (Note: throughout this course pronouns bearing gender refer to persons of both sexes.)

Nurse Practice Act

Each state will have Statutory Law that regulates the practice of nursing. This is referred to as the Nursing Practice Act. Each state promulgates rules known as administrative law to determine **Standards of Care**. The Standard of Care will be listed for each area of practice and will usually follow with examples of violations and sanctions for each standard. The state will appoint a board of nurses (BON) and public members to assist with the writing of these rules (laws) and form a disciplinary panel.

Other aspects of the administrative law will deal with nursing practice, licensure,

delegation, continuing education, chemical dependency abuse, and other standards related to nursing practice.

Standard of Care is defined as "those acts performed or omitted that an ordinary prudent person would have performed or omitted". It is a measure against which the nurse's conduct is compared. Each state may define specific standards that are spelled out in the rules. Examples of standards are: (1) Assessment. The registered nurse will be responsible for data collection and analysis that includes pertinent objective and subjective data regarding the health status of the client (assessment). Other aspects of the nursing process will be spelled out; (2) Safety and Delegation. The nurse is accountable for the safety of the client and delegating selected nursing functions to others according to their education, credentials, and demonstrated competency. The nurse is responsible for supervising others to whom the delegation is given; (3) Communication. Nurses shall communicate significant changes in the client's status to appropriate members of the health care team. This communication shall take place in a time period consistent with the client's need for care. (4) Health Teaching. The nurse assesses learning needs including learning readiness for patients and families, develops plans to meet those learning needs, implements the teaching plan and evaluates the outcome. Each licensed nurse should be familiar with the laws of the states in which he or she is licensed and be aware of the Standard of Care and the Violations of the Standard of Care. You may obtain the law for your state on the states' website for Nursing, or ask for a copy from the regulatory agency from which you obtain your license.

Adoption, Enforcement and Regulation

The most important laws governing your nursing practice are contained within nurse practice act (NPA). *The purpose of these acts is to define the acceptable Standards of Care and regulate the scope of professional practice. Scope of practice refers to the legally permissible boundar-*

ies in which a professional may practice. Each state's legislature has established regulatory agencies, most notably the state BON, to implement and enforce these NPA and to define, monitor and regulate the nursing profession.

The state board of nursing (BON) has other significant functions; approving educational programs, determining licensure, relicensure and educational requirements and disciplining nurses. State boards of nursing do not have the power or right to make nursing laws; they are only permitted to enforce existing laws. Nursing laws are adopted by each state's legislature.

Just as every state is individualized, so are its NPAs. Read and understand the act for your particular state. If your employer does not have a copy of your state's act, you will need to independently research it. Laws can be located in legal reference books. Local universities, courthouses, law schools, and some public libraries would all contain legal reference books. (*Contact your state board for their website to access Nurse Practice Act's, if available, online at www.ncsbn.org, select "Nurse Practice Act Tool Kit"*) After locating the act, read it carefully.

You may find that unless you are a nurse midwife, nurse anesthetist, or nurse practitioner your role is broadly defined. Some NPA only define what nursing is; using general terms such as teaching, supervising, or observing when specifying the role of an RN. The performance of skills under the direction of an RN or physician defines the role of an LPN/LVN. Although they fail to define specific actions ("A nurse may not suture a wound."), they *do not* include terms such as diagnose, operate, treat, or prescribe, which are all components of medical practice acts. Thus, without having to precisely list the "do's and don'ts" of each of the hundreds of individual nursing skills, they *provide direction and guidelines* for acceptable nursing practice.

One area in which the medical and nursing practices are beginning to overlap deals with diagnosing. Until recently only physicians were permitted to diagnose conditions. Now standing orders, nursing protocols, and even selected NPA make di-

agnosing and treating permissible in certain areas by RN's. An acceptable instance in which a registered nurse may make a quasi medical diagnosis is in a critical care unit. A nurse interpreting a lethal arrhythmia to be ventricular fibrillation can diagnose it as such and treat the condition by immediately defibrillating the patient before communicating her assessment to the physician. She is protected from liabilities associated with **practicing medicine without a license**, by following medically pre-approved, pre-written "standing or contingency orders."

This is just one of the areas in which nursing is currently undergoing progressive changes. Like nursing, the law gradually adapts to meet current trends—unfortunately at a much slower rate. Because of this nurses must be careful not to perform duties that are not defined within their NPA. It is possible that a nurse may be judiciously following an employer's policies and procedures (P&P) when in reality they conflict with her state's NPA.

Hence, a nurse who dispenses medications from the pharmacy when a pharmacist is not available is not practicing within her legal bounds, even if her actions do not result in patient harm. Her institutional policy may permit her to do so, but NPA does not authorize nurses to dispense drugs. She is unlawfully practicing as a pharmacist without a license, unless her state's **Pharmacy Act** (the majority do not) gives her this authorization. This is exactly why every nurse should be aware of her limitations in the state in which she practices. It is wrong to assume that moving from one state to another will allow nurses the same privileges. An example would be some states not permitting LPNs/LVNs to administer intravenous (IV) medications, except under close supervision. You would have little legal defense if you even unknowingly, violated your NPA by independently administering the IV medication. Ignorance of the law is never an excuse. If it were an excuse no one could ever be found responsible for wrongful actions. Every person is presumed by law to know all laws.

You now understand the importance of the laws governing your practice and also the source and location of these laws. Awareness of acceptable Standards of Care is necessary to maintain a safe level of practice. A delay in familiarizing yourself with your state's NPA could place you in a legally compromising situation. In order to avoid unnecessary risks it is imperative

that every nurse know the laws that govern her practice and to integrate laws into her delivery of healthcare. NPAs define your role as a nurse. It is impossible to practice safely within a defined role if you do not know the limits of that role.

Relationship To Policies and Procedures

Every healthcare institution must establish a set of policies, the general principles that govern the actions of its employees. These internal guidelines are designed to protect the patient's rights, reflect quality assurance, standardize care and clarify the standards of care and scope of practice in that locality. They should also serve as a personalized and expanded reflection of the laws of NPA. Unrevised, omitted, or poorly formulated policies may inadequately reflect current external standards and therefore pose a legal threat to nursing practice. All policies should be clearly defined, well written and based upon current standards and knowledge. In the event of a lawsuit, nursing standards of care will be compared to current universal standards, as opposed to standards within a certain locality (i.e. your place of employment).

Should a nurse discover an outdated policy or an omission of a necessary policy, she should share this knowledge with her supervisor and the appropriate committee for the proper revisions, renewals, or adoptions. In the event she happens to learn that a certain policy conflicts with the state's NPA, she should direct the matter to the attention of the hospital administration so that they may institute the appropriate changes. A nurse's license and career may be in jeopardy anytime she is found to have negligently or willfully violated any rules, regulations or orders of a NPA. Continuing to practice by following policies and procedures identified to conflict with the state's NPA is one such violation.

Professional Licensure

Licensure permits a nurse the legal right to perform certain specified acts in the healthcare profession after satisfying predetermined standards. *A nursing license is a legal document permitting the offering of nursing skills to the public.* Laws pertinent to licensing are contained within each state's NPA. Primarily, licensing laws involve requirements for certification and entry into practice, terms

of renewal, qualifications necessary to obtain a license, reciprocity rules, application fees and reasons for disciplinary action. These laws establish the *minimum* standards which qualified practitioners must meet in order to practice. Currently, all states require that nurses wishing to practice must obtain a nursing license as a prerequisite to providing care. An individual bearing the title RN or LPN/LVN informs the public that he/she has met all of the educational requirements of the profession. By possessing a valid nursing license you are essentially assuring the public the right to quality care by a safe and competent person. *The primary purpose of a license is to protect the public from unqualified practitioners.* Individual practitioners and healthcare institutions require a valid license in order to provide healthcare services.

Each state's board of nursing is responsible for implementing licensure requirements. They have the authority to grant and renew nursing licenses. All states require candidates to meet the specified educational and clinical qualifications, as well as pass an examination, before a license can be issued. Some states require a specified number of continuing education courses in order to renew a nursing license. *These educational tools are designed to enhance a nurse's clinical abilities for the delivery of safe and quality patient care.* Failure to meet this requirement may result in license revocation or suspension. Educational requirements for licensure differ from state-to-state in accordance with the state board's rulings.

All nurses should participate in educational programs in order to maintain competency and a minimum level of expertise, and to keep their knowledge current. This holds true regardless of whether or not their state mandates continuing education for relicensure. Nurses can achieve ongoing education by attending inservices and seminars, reading nursing journals or studying independently to keep abreast of new technology, current nursing issues and national standards of care. Competency enhances career advancement, self-esteem and proficiency on the job.

A license is never a guaranteed or permanent right; once issued it may be denied, suspended, limited or revoked depending on the circumstances. Grounds for disciplinary actions include malprac-

tice, incompetence, criminal activity, misrepresentation (failure to possess a valid license), fraud (willfully falsifying a licensure application), substance abuse or physical/mental incapacity. Discipline may take the form of permanent or temporary removal or rehabilitation of unscrupulous, unqualified or unsafe nurses.

Should a nurse inadvertently allow her license to expire she must refrain from practicing until she obtains a valid license. Should this happen, immediately notify your employer and state (BON). Also notify the board if your name or address has changed to ensure the proper, timely mailing of subsequent renewal applications. Always keep your license in a convenient, accessible location and know your registration number.

Standards of Care

Any time a nurse provides care to a person the formation of a nurse–patient relationship has been established. This relationship has legal implications because once initiated it holds the nurse to a certain professional standard of care. Simply stated *standards are approved measures of conduct and competence*. Practicing in accordance with standards means conforming to established guidelines.

These standards are defined by individual institutional **Policies and Procedures** (P&P), professional nursing organizations (i.e. American Nurses' Association), expert witness testimony, statutes (laws) and codes, treatises, job descriptions, the Joint Commission on Accreditation of Healthcare Organizations, and previous court rulings.

Courts use **Standards of Care** to determine whether or not proficiency was used during the rendering of nursing care. This is accomplished by comparing a nurse's actions or failures to act in a given situation to those of another nurse. Any deviation from an established standard creates liability on behalf of the nurse, especially if harm results. This means that if all nurses check the patency and site of a heparin lock before administering an intravenous medication and you fail to do so, you are guilty of failing to conform to the accepted standards. Should an injury result, perhaps infiltration or extravasation, and the patient is successfully able to prove that the injury is the direct result of your substandard care, you will be found guilty of malpractice.

Acting as a professional, a nurse is expected to uphold a standard by exercising

reasonable care for every task performed while she is on duty. Reasonable care is measured by what another average, prudent nurse with similar experience would have done in a similar situation. *Negligence is always determined by comparison of conduct*. Considerations for conduct are given to knowledge, skill, education, experience, and resources available. It is legally acknowledged that a greater level education and experience hold a nurse to a higher standard of care. Nurses practicing within similar specialties are held to the same standards as other nurses practicing within the same specialties. Thus, a pediatric nurse is held to the same standards of another pediatric nurse, and not to those of a nurse practitioner. Similarly, the standards of an RN are compared to those of another RN and not to those of an LPN/LVN.

An exception to the rule applies to RN nursing students. They are held to the same standards of care as RNs when performing tasks designed only to be performed by RNs. This is because the law holds the students to the higher standards of the RN. Remember, every patient is entitled to quality healthcare by competent providers. The fact that a student is performing the task instead of a licensed professional holds little weight in the eyes of the law when negligence is the result. Inexperience and age are never acceptable liability defenses.

Elements of Negligence

Negligence can be defined in several ways:

1. An act or an omission of an act in violation of a duty.
2. Failure to conform to the standards of the reasonably prudent person.
3. Failure to exercise the degree of care in the discharge of one's duties that a person of ordinary prudence and caution ought to exercise under a particular set of circumstances.

How exactly is negligence proven? Universally there are **four elements of negligence** which must be proven before any malpractice suit may go to trial. If any one of these legal concepts is not proven the case is dismissed in the pretrial stages. These elements are:

1. Duty
2. Breach of duty
3. Causation
4. Damages

1. Duty is the lawful obligation to adhere to the predetermined standards of care. Every person has a continuous duty, while on the job, skiing, driving, etc., to exercise ordinary care to avoid harming others. The degree of duty owed is based upon age, physical and mental condition, education, experience, and so forth. In deterring people from causing injury to others society is able to function in an efficient and orderly fashion.

Because nurses are professionals they are held to a higher standard of care in carrying out their duties to patients than the standard of care legally imposed on ordinary persons. This higher standard does not apply to each and every action nurses perform on a daily basis, but only to those actions that directly relate to their professional nursing duties.

Considerations given to duty consist of the following: the relationship of the parties (a legal relationship of nurse–patient must exist), the standard of ordinary care (as already defined), and the burden of proof (proving the defendant was negligent). The burden of proof initially is always the responsibility of the plaintiff. (In any lawsuit the party initiating a complaint is called the plaintiff. The party being sued is called the defendant. Either party may consist of more than one person).

Consider this fictitious situation. A husband wishes to initiate a lawsuit against a nurse on behalf of his wife who suffered permanent brain damage from choking on a piece of meat while in a restaurant. The nurse, he claims, identifiable because she was wearing a white uniform, walked hurriedly past as he loudly called for help for his wife. Allegedly, because she did not offer assistance, the nurse is responsible for causing his wife's current vegetative state. Will he be successful in pursuit of damages? The answer is **no**. By law a nurse has no legal duty to assist in an emergency (although she has a moral and ethical duty). In this case because a nurse–patient relationship did not exist a duty was never owed. Therefore this case does not demonstrate negligence because the first element of duty was not proven. Duty and standard of care owed are not always this easy to identify.

2. Breach of duty is the failure to conform to the established standards of care. This is an important element because any deviation from these established standards constitutes negligence. The

THE AMERICAN NURSES' ASSOCIATION STANDARDS OF PROFESSIONAL NURSING PRACTICE

Standard 1. *Assessment.*

The registered nurse collects comprehensive data pertinent to the healthcare consumer's health or the situation.

Standard 2. *Diagnosis.*

The registered nurse analyzes the assessment data to determine the diagnoses or issues.

Standard 3. *Outcome Identification.*

The registered nurse identifies expected outcomes for a plan individualized to the healthcare consumer or the situation.

Standard 4. *Planning.*

The registered nurse develops a plan of care that prescribes strategies and interventions to attain expected outcomes.

Standard 5. *Implementation.*

The nurse implements the interventions identified in the plan.

Standard 5A. Coordination of Care

Standard 5B. Health Teaching and Health Promotion

Standard 5C. Consultation (Graduate Prepared Specialty or Advanced Practice Nurse)

Standard 5D. Prescriptive Authority and Treatment (Advanced Practice Nurse)

Standard 6. *Evaluation.*

The registered nurse evaluates progress toward attainment of outcomes.

Source: American Nurses Association (ANA) Scope and Standards of Nursing Practice, 2010

FIGURE 1

underlying question in all malpractice cases is "Did the nurse fail to conform to the recognized standards of care?" If the answer is "yes" then she is guilty of malpractice. Again, those nurses who are unfamiliar with institutional P&P and their NPAs or fail to keep their knowledge and skills current are putting themselves at risk for malpractice, since all of these factors contribute to maintaining the recognized standards of care.

Refer to the example in the previous section. Suppose the nurse stopped, offered assistance, and harmed the patient by incorrectly performing the Heimlich maneuver. In rendering care she would have established a nurse-patient relationship. Because of this relationship the patient would have been entitled to a

professional standard of care. If the husband can successfully prove that the nurse breached her duty she will be found guilty of negligence.

A nurse is **not** automatically guilty of breaching her duty if, when exercising her independent judgment, she decides upon a nursing intervention that differs from one which would have been chosen by another nurse. This is true even if a patient fails to respond, or even responds unfavorably, to this method of care. There are different, acceptable methods of managing similar problems. As an illustration, nurses in California may treat skin tears by using Op-site and Betadine, while nurses in Connecticut may treat similar skin tears with Bacitracin and a dry, sterile dressing. This does not imply that either

of the groups of nurses is wrong or right for choosing their particular plan of care. As long as the chosen modes of therapy are acceptable, nurses will not be liable for "honest mistakes" in judgment or if their efforts proved to be unsuccessful.

However, nurses will be liable for failure to use ordinary care and skill during the implementation of any plan of care chosen. Whether or not the skin tears failed to heal or consequently grew larger is not relevant. Whether or not the nurse maintained sterility and performed the necessary dressing changes and integumentary assessments *is* relevant. A lawsuit is unjustified if it is based solely on the fact that a patient feels he did not receive the exact same treatment as another patient received for a similar condition.

Elements of Negligence

Duty, Breach of Duty, Causation, Damages

3. Causation is the link between the negligent action or failure to act and the damages or injury. There are two types of causes: actual and proximate; the latter being more difficult to prove. **Actual cause** is the direct agent responsible for an injury due to negligent performance. Note that no intervening factors are present in a case where a nurse transfuses incompatible blood to a patient. There is a direct link between the action (failure to match blood types prior to blood administration) and the incurred injury (adverse reaction to the blood).

Proximate cause indirectly results in an injury due to other contributing factors. Beginning with the initial cause—in-fact, a chain of events is initiated by the defendant with resultant harm coming to the patient. Courts may use the “But for” test as a means of establishing causal links. Liability is determined by posing the question “But for the defendant’s negligence, would the injury have occurred?” If the response is no, proximate causation has been established and the defendant is liable. If the answer is yes, then the defendant is not held liable because the plaintiff would have sustained the injury regardless of the defendant’s contributions to the injury. Negligence is not regarded as a cause of injury if the same injury would have been sustained despite the conduct of the negligent defendant.

Clarification of proximate causation is easier to comprehend when applied to an example. Hypothetically, an emergency room nurse administers an antihistamine to a patient as a treatment for hives. She then fails to warn him of the common major side effect of drowsiness. Hours later the patient becomes drowsy and consequently falls asleep at the wheel of his car causing an accident. In determining who or what is responsible each intervening cause contributing to the injury must be identified. These causes are the administration of an antihistamine, the nurse’s failure to warn (teach) the patient, the drowsiness, and the driving. In this case, neither the driving, the drug administration, the antihistamine, nor the nurse herself physically caused the accident.

However, it was the nurse who initiated the sequence of events leading to the injury and therefore, she is liable for negligence. One can make a reasonable inference that the accident was due to the nurse’s failure to warn by not providing drug education, rather than to the operation of a vehicle or the medication. “But for (if it had not been for) the nurse’s negligence, would the patient have sustained the injury?” The answer is no, therefore the nurse is liable. To determine proximate causation look for the person setting in motion a chain of events resulting in an injury and that person will be at fault.

It is often difficult for the plaintiff to prove his case because he must show a greater likelihood that the injury is related to the defendant’s negligence than to the intervening factors. Furthermore, any case involving multiple factors increase or potentiate the chance of a break in the causal connection, which will favor the defendant’s case. For example, had the patient been intoxicated at the time of the accident it could be argued that he probably would have sustained the injury regardless of the nurse’s failure to warn. In this instance, the nurse may be able to escape liability if it can be proven that there is a greater likelihood that the injury is the result of the intervening cause of intoxication rather than the intervening cause of the nurse’s negligence.

Foreseeability factor is utilized in some states when determining proximate causation. It is based on the premise of how likely a prudent person is to foresee that harm will result in the presence of his negligent acts or failures to act. If the injury was found to be the natural and probable result of negligence then he will be held liable.

Determining foreseeability does not require extensive experience or special knowledge. An ordinary prudent person should be able to foresee that leaving a toddler unattended by a swimming pool might result in harm to the child. Just as a prudent nurse should be able to foresee that failing to communicate identified allergies with other healthcare providers might result in harm to a postoperative patient. In either situation, the caregiver is responsible, or liable, for the sustained injuries. Conversely, nurses are not responsible for

incidents which are not foreseeable, despite a sustained injury by the patient. Had the patient suffered an idiosyncratic reaction to the antihistamine administered in the above example, the foreseeability fact or would no longer be applicable.

4. Damages are the physical result of an injury or harm caused by breach of duty (negligence). Usually they are associated with monetary compensation. If an act or omission of an act does not result in harm, despite the existence of negligence, damages cannot be recovered. Accordingly, if a patient discovers that a nurse administered 50 mg. of Demerol postoperatively, instead of the prescribed 25 mg., but no harm came to her, she will be unsuccessful in attempting to sue the nurse. While the patient can easily prove all other elements, the lack of evidence for damages will not fulfill proof of all four of the required elements.

Damages may be recovered for bills of past and future medical and hospital expenses, impairment of earning capacity or loss of future income, disfigurement, disability, loss of consortium (spousal companionship), worsened lifestyle, mental anguish, pain and suffering, and wrongful death. Rarely do courts permit compensation for purely emotional distress. If a verdict is rendered in the plaintiff’s favor this is usually because the emotional distress was accompanied by some physical harm (i.e. depression or insomnia warranting psychiatric intervention).

Punitive damages are awarded for proof of wanton or willful misconduct, or reckless endangerment. They differ from general damages in that they result in a higher financial recovery. General damages are awarded for compensatory purposes in cases of ordinary negligence or malpractice. Punitive damages are awarded as a punishment and a deterrent in cases of gross negligence or intentional torts.

Common Causes of Nursing Negligence

As previously stated, there exist two types of nursing negligence; intentional torts and unintentional torts. As a profes-

sional nurse, one of your main duties is to protect the patient. Safety of the patient is always paramount in any situation. Justifications of long hours, poor working conditions, short staffing, and nurse burnout are unacceptable excuses for errors resulting in harm or injury. All nurses have a legal responsibility to safeguard their patients at all times.

Unintentional Torts

Medication Errors

One of the major causes of nursing error can be attributed to the improper administration of medications. Because it is one of the most frequent nursing functions it is also one of the most problematic. In some instances errors originate with the order itself; either it's illegible, incomplete (650 mg. Tylenol—no route, no frequency), or blatantly incorrect (5 mg. Lanoxin p.o., q.d., when in reality only 0.5 mg. was meant). When a mistake is discovered, notify the physician responsible for writing the order immediately for clarification and correction. Trying to be efficient by assuming what the order intended to read or personally interpreting the order are grave mistakes. It is a nurse's responsibility to question any order she feels is incorrect, inappropriate or ambiguous.

A medication order is complete if it includes all of the following:

- Drug name
- Dosage
- Route
- Frequency

Do not assume that an order written with the route omitted automatically is intended to be given orally, unless your hospital policy specifically addresses this issue. Physicians, nurses and pharmacists should all have a clear, uniform understanding of this policy in advance to alleviate assumptions, misinterpretations and an abundance of medication errors.

After ascertaining an order to be complete and correct, there is a specific sequence of events which should be followed for each medication you intend to

administer. **The correct and safest way to administer medication is to follow these guidelines using the five "R's"** — the right drug, of the right dosage, to the right patient, at the right time, by the right route.

Beginning with the first "R" you must ensure that it is indeed the right medication you intend to administer. The rule for establishing safe medication administration in nursing care has historically consisted of the **TRIPLE CHECK**-- 1) as you remove it from the shelf or cart, 2) as you dispense it and 3) again as you replace it on the shelf or cart, or dispose of its packing.

Ideally, dosages should be verified by another professional when calculations are involved. Medication orders transcribed onto the medication record should also be verified by a professional before administering any drug. If any order on the medication record has not been professionally co-signed, be certain to have this done immediately, as another source of error arises from faulty transcription. Included on the medication record should be a list of allergies, preferably *highlighted* or in **bold red ink**. Each medication record should be clearly numbered.

Before administering any medication be certain the name on the medication record coincides with the name on the patient's identification (ID) bracelet. Correctly identify a patient by checking the ID bracelet and, if the patient is alert, by asking him to state his name. This is also the appropriate time to recheck for any drug allergies.

All medications should be administered punctually. Most institutions recognize how difficult and unlikely it would be for nurses to administer all medications exactly on the hour as indicated (due to the number of patients in your assignment, patients off the unit during procedures, etc.). Therefore, most institutional policies are designed to allow nurses an extended time frame, usually one half hour before and after the designated hour, in which to administer medications. Exceptions to this rule would be for "STAT" and preoperative medications which must be given at the exact time ordered.

The right route should be accompanied by the proper technique of administering a drug. Acceptable routes of administration for nurses include oral, rectal, topical, intravenous, intramuscular, subcutaneous, intradermal, and those by inhalation and instillation. Special considerations for proper techniques might include administering long-acting injections by the Z-track method, or protecting light-sensitive Rocephin® by wrapping the solution in aluminum foil. Institutional policies contain the procedures and correct techniques for drug administration so be sure to become familiar with them.

Administration of a medication should be properly documented on the medical record immediately after it has been given. This includes the actual time medications are given. Therefore, if a drug was due at twelve noon, but actually given at 12:20, this information should be documented because of the necessity to maintain adequate blood levels; especially for antibiotics, insulin, cardiac and chemotherapeutic medications. Subsequent doses can then be adjusted accordingly.

If a drug is withheld, the reason should be documented, both on the medication sheet and in the nurse's notes. Acceptable reasons for omission would be if the patient were NPO for a procedure (i.e. GI series), if the patient refused the medication, if the condition for which the drug was intended had resolved (i.e. KCl for hypokalemia), or if the nurse felt that harm would come to the patient by administering the drug (i.e. administering coumadin to a patient who has an intracranial bleed). Drugs withheld for fear of harming the patient would also include the following reasons: if the patient were allergic to that drug or any of its derivatives, if the dosage was too high, or if the drug was contraindicated; either with the patient's condition or with the other drugs he was taking.

Unfamiliarity with drugs can result in nursing negligence. The nurse is ultimately responsible for understanding all recommendations regarding potential drug interactions and therapeutic/side effects before administering any type of drug. This knowledge includes the medication

Actual Cause: The direct agent responsible for an injury due to negligent performance.

Proximate Cause: An active agent that sets in motion an unbroken sequence of events which results in an injury due to negligent performance.

name, action, use, dose, route, elimination, side effects, contraindications, and nursing considerations. If you are unsure about any of these points, research the medication thoroughly in a drug reference book, and/or question the charge nurse, pharmacist, or another colleague about the medication before administration.

Other nursing considerations consist of teaching the patient about the medications he is receiving, administering only those medications which you have personally prepared, taking a thorough drug history to include allergies, and being aware of the potential drug–drug and drug–food interactions.

ALWAYS LISTEN to your PATIENT. Many patients are aware of changes in their medications/treatments, and if a patient tells you they think a change has been made or their prescribed treatment is not correct, ALWAYS assume the patient may be accurate. Question orders that do not seem appropriate to you OR your patient.

Medication errors and idiosyncratic reactions should be noted on an incident report and the nurse's notes, in addition to informing the physician and the supervisor.

Patient Safety

Patient's physical safety is another important responsibility in which nurses frequently fail to safeguard. Two of the most prevalent occurrences deal with burns and falls. Similar to medication errors, these mishaps can be avoided by taking a few extra minutes to ensure safety. The relatively short amount of time it takes to institute safety measures and perform the necessary assessments is negligible compared to the years you'll spend regretting the error during the impending lawsuit should an injury occur.

Burns

Primary sources of burns are temperature management equipment such as diathermy machines, heat lamps, heating pads and other machines used to regulate the body temperature of a patient. Left on

the patient long enough, they can cause tissue damage. Not only heat, but also cold may cause tissue damage when left on the skin for too long or used improperly. When dealing with potential hazards such as heating elements, always be cautious and prudent. Leaving any patient unattended during a heating treatment will almost certainly end up unfavorably.

To prevent burns, always place a piece of fabric between the apparatus and the patient's skin, keep at a medium setting (not high) and teach your patient not to change the setting; keep on skin for a maximum of 15 minutes, if possible, use a timer.

For conditions related to neurological impairment, decreased levels of consciousness or peripheral neuropathies (that cause numbness and tingling) it is essential to remain with the patient during the entire treatment, since these patients are unable to give accurate subjective data.

Frequently check the exposed sites for skin breakdown and changes in circulation. For those patients who are able to differentiate between extremes in temperature it is best to remain with them during the initial five minutes of the treatment. The rationale for this is because it usually takes at least two to three minutes for the warming effects of the therapy to become apparent. Any complaints of discomfort can then be attended to promptly. If you choose to leave the patient for any reason during the treatment, be certain that the patient has access to the call light. Assessments should minimally be performed every fifteen minutes.

Falls

This category of injury is in first place with regard to malpractice cases. It is important to assess the patient to determine high risk of falls. This information must be communicated to all staff. Nursing interventions must be instituted to: (1) teach the patient, if not impaired, to call for assistance when getting out of bed or chair; (2) use 1/2 side rails at head of bed at ALL times (full side rails usually require a

physicians order); and (3) use bed or chair alarms for patients who are impaired due to medications and/or dementia. The best advice is prevention and communication to staff and family.

The incidence of patient falls can also decline dramatically if nurses take the necessary precautions. Some of the patients at high risk for falls include the elderly, weak, debilitated, confused, postoperative, obese, sedated, semiconscious, and those with a history of syncope, vertigo or visual disturbances. During the initial admission assessment these patients should be identified. Always communicate your observations by proper documentation and the patient's care plan, as well as orally during shift reports. This will alert others unfamiliar with the patient, especially floating or agency nurses, to ensure the use of appropriate safety measures.

Eliminate potential hazards by ensuring that the side rail orders are always in place, the room is adequately lighted, the bed is locked and in the lowest position, the call bell is within reach, and the common walkways (such as to the bathroom) are free of obstacles. Some healthcare agencies are using color-coded non-slip socks to alert staff (orange = fall risk).

Most agencies use a computer-driven assessment scale that gives a numerical score for patients that are a high risk for falls. It is also important to assess other factors not always on the scale, such as a diagnosis of osteoporosis, deconditioning of the patient, medications that affect judgment or reduce reflexes, history of falls and/or fractures, and advancing age. Other necessary nursing measures include continuous monitoring and orientation assessments.

Also, don't forget to tell all patients what is expected of them—to call for assistance and to allow for a reasonable response time. Patients should understand that not every request can be tended to immediately. Most patients are unaware of the priorities nurses must make. They are oblivious to your concerns of poor

Common Causes Of Nursing Negligence

Unintentional Torts: Medication Errors, Burns, Falls, Failure to Observe/Report, Failure to Ensure Safe Equipment/Environment

Intentional Torts: Assault and Battery, Defamation of Character, Invasion of Privacy, False Imprisonment

staffing, high number of acutely ill patients, or multiple admissions. Some patients' feel their call light is supposed to be answered seconds after their fingers release the button. With this reasoning even a wait of a few minutes will cause impatience, frustration and attempts to get out of bed unassisted. If patients are aware in advance of their responsibilities then their expectations won't be as great, therefore they won't be disappointed when having to wait. Nurses, in turn, must make a reasonable effort to attend to their patient's needs promptly.

Safe Equipment/Environment

As part of their duties to safeguard patients, nurses are expected to not only know how to properly operate equipment but to ensure the safe usage of it as well. If a nurse is aware of faulty equipment she has a duty to refuse to utilize it, as well as taking the proper steps to correct the problem. Thus, before inserting a Foley catheter it is common practice to test the balloon to ascertain that it's functional and free of defects. If it's found to be defective replace it with one that is functioning properly.

If you fail to make this check and insert a faulty catheter and harm comes to the patient (pressure from an over-inflated balloon resulting in necrosis of the urethra) you will be liable for the sustained injury. A nurse's actions will always be compared to those of another reasonably prudent nurse and how they differ from the standards of care. Rightfully, then, if other nurses would have first tested the balloon, your failure to do so would constitute negligence.

All patients are entitled to a safe environment. As a nurse you are responsible for ensuring patient safety. Therefore, any broken glass, spills, cords, or faulty electrical wiring must be identified as potential hazards, and corrective measures must be instituted. It is necessary to communicate your findings with all concerned; the patient, visitors, housekeeping or maintenance departments and colleagues. Effective communication includes promoting awareness that the environment is unsafe, the reason it is unsafe, and your intentions to resolve the problem.

For instance, upon discovering that a light will not illuminate in the bathroom, it is not enough to only locate a replacement bulb. You must inform the patient of your discovery and ask him to refrain from using the bathroom until the light bulb is replaced. One can reasonably foresee that

he may possibly need the use of the toilet and, unaware of the unsafe environment, fall in the dark. Offering a urinal, notifying the maintenance department and posting a sign on the bathroom door are all appropriate safety measures that can be instituted.

Failure to Observe/Report

Other areas of nursing liabilities are the failure to properly observe and promptly report changes in patients' conditions to the physician, leading either to misdiagnoses and/or patient injury. The following example clearly illustrates the undesirable outcome of this type of omission.

Your patient is admitted with a pulmonary embolus and is subsequently placed on a heparin drip. A laboratory technician, unaware of the anticoagulant therapy, draws the standard blood tests ordered, but fails to apply the lengthy pressure necessary to control the bleeding. The patient begins to complain of pain at the antecubital region.

In assessing the site you note the formation of a small hematoma. Over the next several hours the patient continues to complain of pain. Noting his complaints, you decide to wait until the results of the blood values are available before notifying the physician. Upon receiving the values you discover that the partial prothrombin time is four times the normal level. Finally, you notify the physician of the lab results and the patient's complaints. An efficient action, you rationalize, because you are communicating the necessary information to the physician in one call, as opposed to having had to telephone him twice.

By this time the site is oozing continuously and the patient is complaining of numbness in the affected extremity. A large hematoma has developed, encompassing the entire joint. Despite aggressive treatment, the patient ultimately suffers nerve damage. You are then alleged to be guilty of failing to observe and report, failing to communicate vital information to the physician and other disciplines (laboratory technician), failing to recognize the signs of hemorrhaging, and failing to take the proper nursing interventions. Your breach of duty has concluded with patient suffering and a permanent disability. Your reputation and license are in jeopardy.

Any significant change in a patient's condition should be immediately communicated to the physician. If that physician fails to take proper action after receiving

the vital information notify your supervisor. Then document the conversations, times, and any witnesses in order to protect yourself. When it comes to patient safety, communication between the various healthcare disciplines must not only be conveyed, but also understood, documented, acknowledged and promptly acted upon.

Intentional Torts

Assault and Battery

Perhaps the most well known intentional tort is assault and battery. **Assault** is the threat of an immediate infliction of an injury with the present ability to commit battery. **Battery** is the actual unprivileged touching of another person. For example, you are dealing with an uncooperative geriatric patient. Frustrated, you tell him/her you are going to restrain him if he doesn't cooperate. This is an example of an assault. If you do actually apply the restraints as a punitive measure you have committed battery. Punitive damages may be awarded for any claims involving intentional torts.

With an assault, the threat of inflicting harm must be believable, thereby creating reasonable apprehension. In a situation where a robber holds a knife to a victim's throat, threatening to kill her if she doesn't give him all of her money, the threat of injury is very real and credible.

Conversely, if a mother tells her child that she is going to "break both of his legs" if he does not remain seated while riding on a bus, the child understands that his mother is only speaking in anger and has no intention of actually carrying out the threat.

An assault creates a mental disturbance that promotes an instantaneous feeling of apprehension that a battery is going to be committed. Threats to commit future wrongdoings do not constitute an assault because they fail to instill the immediate apprehension element. Examples of mental disturbances are fear, humiliation, or intimidation. Nurses may be guilty of assault by threatening to force feed anorexic patients or threatening to restrain or sedate uncooperative patients.

Battery is not categorized as an intentional tort based on the intent of harm. Rather, from a legal viewpoint, it is a civil wrong because the touching was unconsented and unpermitted. Most instances involving battery deal with phy-

sicians and uninformed consent, where a non-emergency operation or procedure is performed without the patient's full knowledge or consent. A claim of battery is applicable in a situation where a surgeon obtains consent for a breast biopsy and, discovering the tumor is malignant, performs a mastectomy at that time. Consent to perform a specific procedure is limited to that particular procedure. Any further actions on behalf of the practitioner, even if made in good faith, hold him/her liable for battery. General cases of nursing battery concern forcing a patient to eat, ambulate, or submit to an injection or treatment against his/her will.

False Imprisonment

As you already know, nurses have the ongoing responsibility of ensuring patient safety. One of the ways a nurse may need to safeguard a patient is by the use of restraints. Physical restraints may be applied with or without a physician's order, providing they are warranted. *The only time restraints are legally permissible is when they are applied for protective purposes.* If you restrain a patient because you believe him to be dangerous, either to him or others, you are acting within your legal bonds. However, if you are applying restraints for the sake of convenience (there isn't enough staff for proper monitoring) or as punishment (for being uncooperative) then you are guilty of false imprisonment, or the intentional, unlawful, unconsented restriction of movement and freedom.

Legally, a nurse can restrain a patient before obtaining a physician's order, if the lack of restraint would result in the endangerment of any person. This would be evident if a patient suddenly became belligerent and physically abusive. When finding yourself in this situation proceed with the application of the restraints. Then promptly notify the physician of the patient's condition to obtain a valid restraint order.

When alleging that a nurse falsely imprisoned a patient, that person must show that the nurse intended to confine him. He need not prove that the nurse intended to cause harm or injury. Punitive damages are recoverable. The confinement must always be against the patient's will. It is unlikely that a psychiatric patient who voluntarily commits himself to an institution will later be able to prove false imprisonment, as voluntary agreements for restraint are based upon consent.

Physical restraints are warranted in, but not limited to, the following conditions: history of *drug/alcohol abuse, combativeness, agitation, confusion, hallucinations, falls, aggression, or physically abusive behavior*. Physical restraints do not alleviate the responsibility of monitoring a patient; they actually augment it. The patient's mental, respiratory, integumentary, and circulatory statuses require frequent assessment. The affected extremities need to be checked every **two hours** for adequate pulses, color, motion, and sensation. The restraints themselves must be ideally released for at least **five minutes** every **two hours**, minimally once every eight hours.

Do not tie a restraint to a movable side rail where injury can result from use of the apparatus. Instead, tie them to the stationary bed or chair frame, well out of the patient's reach. Use only those knots that can be untied quickly in case of an emergency, not those so complicated they require several minutes to release. Before tying, flex the joint 1–2" to allow for limited movement. The goal is to protect the patient from injury, not to completely restrict all movement.

When using a waist or vest Posey restraint you should allow a space large enough to comfortably fit your hand in between the material and the patient. Again, frequent respiratory and integumentary assessments are necessary. Always check for adequate breathing excursion and chest expansion, areas of friction and skin breakdown, and, if the patient is alert, subjective complaints of pain. These important assessments should be performed **every two to four hours**. It is imperative to make on-going assessments as to the need for continuous restraints. Discontinue them as soon as the threat of harm is over. Otherwise, you may be liable for false imprisonment because, although once a necessity, the restraining devices are no longer justified. Document why the restraints are needed, the times of initiation and discontinuance, patient behavior, the type of restraint applied, the frequency of pertinent body system assessments, and any nursing interventions (range of motion exercises, frequency of releases, attempts to orient, etc.) which have been implemented. Your institutional *policy and procedure* (P&P) manual should contain clear and concise guidelines for the use and application of restraining devices.

Finally, note that restraint doesn't exclusively refer to physical retention by use of equipment; it may take the form of intimidation to achieve compliance. It is unlawful to refuse to discharge a patient due to lack of payment for services rendered, detain a patient wishing to sign out against medical advice (AMA), or unnecessarily detaining patients in a healthcare institution because of their medical condition (psychiatric patients not posing a threat to themselves or others).

When dealing with AMA patients it must be remembered that usually they are dissatisfied with their treatment and care. They feel more is "owed to them", and that their hospitalization lacks the proper attention, choice of treatment or information. Their method of coping with this stressful situation is to leave the premises. It is usually the nurse who first discovers the discontentment and intention to leave. The nurse's duty lies in attempting to discuss the situation, risks, consequences and alternatives with the patient.

Sometimes a patient will respond favorably to your suggestions. At other times he/she will remain adamant. If he/she refuses your help and you are unable to talk him/her out of leaving, notify the physician and significant others. Explain the discharge procedures, **have him/her sign an AMA release form**, provide routine discharge care, and document thoroughly any conversations and the sequence of events leading up to the actual time of departure. Above all, *do not attempt to restrain or detain him/her*, as this will only contribute to his anger. It may also result in charges of false imprisonment.

Defamation of Character

Not only touching, but also communications to a third party of false information, is a **tort**. The term "defamation of character" means an injury to another's character or reputation by false and malicious statements. These derogatory statements must be intentional and publicized or spoken in the presence of a third party. **Slander is oral defamation. Libel is written defamation.** Defamation does not apply to deceased persons. Imputed references to crimes, female promiscuity, or loathsome diseases constitute defamation. Usually, all other defamatory statements are punishable only if the plaintiff is able to prove that he suffered economic damages as a direct result of the defamation, if malice

can be proven and/or if it is proved that the communication was made without probable cause. Punitive damages may be recovered.

Telling your sister that she is “selfish, fat and arrogant” in the privacy of one’s own home does not constitute legal grounds for defamation of character. However, cajoling with a group of nurses in the hospital corridor that a certain orderly is homosexual and probably is infected with the AIDS virus has different implications and constitutes malicious behavior. Especially if patients with whom the orderly has direct contact overhear that conversation and refuse his services.

The best advice would be not to attack anyone’s credibility in public, even if the intention is innocent or in jest. Use prudence with both verbal and written communications. When charting in the medical record avoid libelous phrases by confining your documentation to the facts; “strong scent of alcohol on breath, bilateral pinpoint pupils @ 2mm., visible needle marks, hallucinating, bradypnea”, instead of “exhibits classic symptoms of IV drug and alcohol abuse”.

Invasion of Privacy

Invasion of privacy is the wrongful intrusion into another’s private affairs. Communications which invade another’s privacy must be public while the subject of these communications must be private. Giving information to the local news station about a celebrity’s condition, discussing a patient’s treatment, prognosis, or behavior in a public elevator or cafeteria, or allowing a police photographer to take pictures of an abused child without parental consent are all applicable illustrations. Even failure to properly cover a patient during transport or failing to close the patient’s door or pull the bedside curtains during a procedure theoretically constitute a tort.

When responding to telephone inquiries about a patient’s condition, the information offered should be brief and confined to the most basic facts. Confidentiality must be preserved at all times. Technically, the patient’s consent should be initially obtained before disclosing any information, even if it is only shared with family members. Nurses are legally able to release a patient’s name, age, address, and condition (good, fair, poor, critical) without prior consent. An exception to the confidentiality rule deals with state and federal mandatory disclosure rules; namely

the duty to report child/elderly abuse, communicable diseases, etc. In these instances immunity from legal recourse is afforded by laws protecting the providers of certain mandated information.

The patient wronged is able to sue for damages for breach of confidentiality against unauthorized persons disclosing medical information about him. The defendant may escape liability if she is able to prove she acted innocently or was under the belief that the patient had given prior consent. Both professionally and ethically you have a responsibility to protect your patient’s privacy. The only healthcare providers entitled to patient information are those directly involved in the patient’s treatment, care or diagnosis.

Important Confidentiality Considerations for Health Care Professionals:

2012 HIPAA (American Health Insurance Portability and Accountability Act)

HIPAA is a set of rules to be followed by doctors, hospitals, and all health care providers. It helps to ensure that all patient medical records, medical billing, and patient accounts meet consistent standards with regard to documentation, handling, and privacy. Any healthcare provider that electronically stores, processes, or transmits medical records, medical claims, or remittances or certifications must comply with all HIPAA regulations. (*For more information see course #840 Legal Issues in Nursing*).

Criminal Activity

In contrast to civil law, applicable to the affairs of private citizens, criminal law applies when behavior is detrimental to the society as a whole. The penalty is not exclusively monetary damages. Instead, it is much more severe, in an attempt to deter wrongful behavior and punish the offender. Usually the imposition of fines, incarceration, and/or rehabilitation are used to deprive offenders of their freedom, thus ensuring the safety of the public. Conviction of a crime requires a criminal act, criminal intent and causation.

Crimes are categorized into three distinct levels depending on their severity:

1. **Infraction** is the *least serious* criminal offense. Penalties imposed consist only of fines. A traffic violation (speeding ticket) is an example of an infraction. Some jurisdictions do not recognize infractions as a component

of criminal law.

2. **Misdemeanor** is the second type of criminal offense. A *fine, probation* and/or *incarceration* serve as penalties. Jail terms usually consist of less than one year in a local prison. An example of a misdemeanor is failure to report child or elder abuse.

3. **Felony** is the most serious crime. Punishments are comprised of incarcerations in addition to fines and/or rehabilitation. Jail terms are usually served for more than one year in a state prison. Examples of felonies are murder, fraud, embezzlement, manslaughter, rape, arson, and theft.

Nurses need to be aware of applicable misdemeanors and felonies which may jeopardize their practices. Misdemeanors include violations of NPA, unlawfully practicing pharmacy or medicine without a license (except in an emergency) or alteration of medical records for concealment purposes. Specific instances of felonies include possession of illegal hypodermic syringes or drugs, participating in the cessation of life-support systems, by not, or slowly resuscitating terminally ill patients without a “no-code” order, and the administration of unusually high doses of narcotic analgesics to the terminally ill.

Somewhat confusing, there is one instance when negligence may also be considered a crime; if it is found to be **gross negligence**. *This crime is applicable to malicious, reckless conduct which results from failing to exercise even the slightest degree of care during one’s duties.* Gross negligence might be relevant to a case where an OR team fails to correctly identify two surgical candidates. One patient is scheduled to have a thyroidectomy, the other a colostomy. The mistaken identity is not discovered until after the opposing operations are in the process of being performed. Punitive damages are frequently assessed for cases of gross negligence.

Qualified Privilege

Clearly, any scrupulous nurse will make a conscious effort to avoid engaging in unprofessional or unethical practices. But what should you do when a colleague is involved in criminal or otherwise unsafe activity? The fundamental rule which must be considered is that the patient’s welfare

is paramount in any situation. Your responsibilities always belong to the patient first, and to your colleagues second.

Qualified privilege gives immunity from libel when making a true statement about a colleague that might otherwise be construed as defamatory. Reports of professional misconduct made in good faith and without malicious intent are acceptable. Those invalid are accusations made in revenge, spite, or ill will. Nurses must use prudence and judgment when documenting in the medical record, on incident reports or when acting as nurse recruiters to refrain from libelous statements.

Deciding whether or not to report a colleague can be a troubling experience. Nurses facing this dilemma should be aware that most of the 50 states have rules and regulations regarding the obligation to report violations by other licensees. This means that a nurse failing to report unsafe or unlawful practices will be subject to disciplinary conduct. Nurses should also recognize that they are not only protecting themselves, but also their colleague as well. By addressing the issue and bringing it to the attention of the proper authorities they will be providing an invaluable service to the public.

After filing a report there is a chance that the initiating source will be discovered, as anonymity is unlikely to be maintained during the ensuing lengthy investigational period. This is almost certain to create an atmosphere of negative repercussions — unpleasantness, discord, and bad rapport — among colleagues. Expect repercussions from the administration, as well as retaliation from the offended party in an attempt to discredit your character, competence and performance.

Although it will be difficult to jeopardize personal relationships, nurses must remember that they will be upholding their professional, moral, legal, and ethical obligations to safeguard their patients. Initial feelings of anger and hostility should gradually succumb to those of appreciation and admiration. Remember in reporting such practices you will not be initiating an incident; you will be preventing one.

Any communications pertinent to professional misconduct must be made in an accurate, factual and discreet

manner. Information on how to proceed with a reporting should be found in the institutional P&P manual. When describing the incident limit your statements to the facts as you recall them. Avoid conclusions and interpretations about the individual's character. Refrain from reporting any colleague in the absence of witnessed events. Accusations originating from second-hand knowledge or rumors could be rendered as defamatory. Avoid discussing the incident by maintaining confidentiality at all times; another's reputation, license, and career may be at stake.

Specific Doctrines of Negligence

Res Ipsa Loquitur

In every case of negligence the initial burden of proof is the responsibility of the plaintiff. He must prove that a particular duty was owed, that duty was breached, because of the breach damages (injuries) were suffered, and it was a particular defendant's negligent conduct that caused the injury. If evidence for any one of the four elements cannot be presented the case will be dismissed.

Reasonably, then, if the plaintiff could not prove that the sustained injuries were related to a particular action by a particular defendant, then he would be unable to collect compensation for his injuries. But how could a patient reasonably prove that a particular defendant was negligent if he did not see that person actually cause the injury? The answer is he could not. For the blatant existence of negligence does it seem fair that a plaintiff cannot receive compensation because he fails to directly prove each element of negligence? Certainly not.

In order to ensure fairness to the plaintiff the concept of *res ipsa loquitur* (RIL) evolved. RIL is a Latin phrase which literally means, "the thing speaks for itself." It is a legal doctrine of negligence which states that negligence may be indirectly inferred from the fact that an accident occurred provided:

1. There is an injury
2. The instrument causing the injury must have been under the exclusive control of the defendant
3. The injury wouldn't normally occur without some negligence,

4. The plaintiff must not have contributed to the act.

A case example will clarify this concept. Suppose a patient is under the effects of anesthesia. During the operation a set of retractors is left in the abdominal cavity of the patient causing persistent pain, immobility, and digestive disorders. Because he was unconscious the patient cannot prove the exact cause of the injury; he does not know that retractors have been left inside his body. Furthermore, due to the numerous professionals involved in his care, it is impossible for him to identify exactly who was responsible for the injury. Given this reasoning, the patient would not be able to prove his case.

All four legal concepts of RIL will be applied to this case and demonstrate how the doctrine is primarily used in surgical cases such as this one. First, there is an injury: the presence of a foreign body in a place where none normally exists (in an abdominal cavity). Second, the act is under the exclusive control of the defendants (doctors and nurses), who were in charge of and assisted in the operation. Third, there would be no foreign object left in the body without negligence by someone. Finally, the plaintiff could not possibly have contributed to the injury while anesthetized and unconscious.

As you can see, this doctrine permits the finding of negligence based on circumstantial (reasonably inferred) evidence. *There is a distinct difference between direct and circumstantial evidence.* A general illustration might be the finding of mail in your mailbox. A witnessed delivery, of mail being placed into the mailbox, by the postal carrier is considered to be direct evidence. For an unwitnessed delivery, one could reasonably infer that the mail in the mailbox was placed there by the postal carrier, despite the fact that the action was unobserved.

By applying the doctrine of RIL the burden of proof shifts from the plaintiff to the defendant. RIL entitles the plaintiff to an explanation of the incident. For RIL to apply to a case there must be existence of negligence, but the plaintiff need not prove a specific negligent act nor whom he feels is responsible. Because the burden of proof now shifts to the defendant, it is the defendant who must prove the absence of negligent conduct. In many RIL cases expert testimony is not required because the relevance of the facts permits lay persons

to arrive at a reasonable conclusion without need for in-depth medical knowledge.

Respondeat Superior

A second major doctrine of negligence is called *respondeat superior* (RS), a Latin phrase meaning, “let the master respond”. This legal concept came into being during medieval times when wealthy masters owned penniless slaves. For commission of any wrongful acts the law required the violators to pay monetary damages. Acts of revenge, greed, or spite by the masters proved to be costly.

One clever master discovered that if he were to instruct the slaves to do wrongful acts for him, it would be the slaves who were required to pay damages instead of him. Similar conduct was soon followed by other masters. This arrangement proved to be profitable for the masters, but not for the recipients of the wrongdoings. Unsuccessfully attempting to collect money from paupers was very frustrating, if not impossible, for the persons owed compensation.

Reasoning that the master shouldn't be able to evade liability for the directed wrongful acts of his servants the doctrine of RS came into existence. First applicable to any wrongful actions, it's usage was eventually confined to negligent acts. Currently, RS holds employers responsible for the negligent acts of their employees, as long as these acts are performed within the scope of employment. Under this doctrine a hospital would be liable for the wrongful acts of a nurse who mistakenly uses formaldehyde to irrigate a wound instead of hydrogen peroxide. Conversely, a hospital would not be liable for the wrongful acts of a nurse who is caught selling the penicillin she stole from the institution; an act clearly not within the scope of her employment.

Supervisors are not held liable for the negligent acts of nurses, but they are liable for negligent supervision. For example, potential liability exists when assigning four new graduate nurses to work

in a coronary care unit in the absence of experienced staff and with minimal supervision and availability of the supervisor. In such a case the supervisor may be held liable for failure to make out assignments properly and/or give close supervision to those nurses requiring it.

Instructors of student nurses are responsible for all of the students' actions. It is the duty of the instructors to assign students to patients whose conditions fall within their capabilities. Students have the responsibility of knowing their limitations and informing their supervisors of these limitations, especially when placed in situations which could be detrimental to a patient's safety. Thus, a student nurse on the first day of clinical practice should decline an assignment that involves caring for a newborn who is ventilator dependent; even if she risks being in subordinate in doing so. If a staff nurse volunteers to supervise a student, and, under the staff nurse's supervision, the student performs negligently then it is the staff nurse, not the instructor, who is liable.

Not all nurses are afforded protection under the RS doctrine, only those considered to be employees are covered. An employee is someone who renders care exclusively under the control, supervision and direction of his employer. Examples of these types of nurses are full and part-time staff nurses and private duty nurses who are employed by either hospitals or private physicians.

Home care private duty nurses, occupational health nurses, nurse practitioners, nurse midwives, school nurses, and industrial nurses are all considered to be independent contractors. These types of professionals are not covered under RS. Independent contractors render care based on personal professional judgments according to the individual needs of the patient.

In other words, independent contractors do not require direct supervision or direction from others; they are solely responsible for all professional services rendered. In the

eyes of the law they are not considered to be employees. Thus, because no employee-employer relationship exists, RS is not applicable to these types of nurses.

Registry nurses are employed by the agencies for which they work, not the institutions in which they are practicing. If a registry nurse is negligent while working in a private home, it is the agency who is liable, as well as the nurse. If a registry nurse is working in a healthcare institution (nursing home or hospital) as a temporary staff member the liability may shift from the agency to the institution. Of course, the nurse is always personally liable for negligence regardless of the location of her work. Knowing this, it is advisable for all independent contracting nurses to carry their own malpractice insurance, keep their licenses current, maintain their skills, and to abide by the P&P of the institution in which they work.

Borrowed Servants

A special extension of the respondeat superior (RS) doctrine is the “borrowed servant” doctrine. It maintains that employers are liable for the negligent acts of their employees, when these employees are acting as a servant (under the special service) of another. These types of employees are called “borrowed servants” because they are temporarily under the control of another person.

Primarily this theory has been applied to surgeons and operating room teams. In the operating room, nurses act as “special or borrowed servants” to the surgeons. Should a nurse perform negligently the surgeon will be liable for the nurse's wrongful acts, as long as the surgeon is present and in control of the nurse at the time of the error. Under the doctrine of RS both the nurse and hospital will also be liable for sustained injuries. The “borrowed servant” doctrine permits the injured patient to recover damages from the hospital when the negligent acts are performed by independent contracting services within the hospital environment.

"Deciding whether or not to report a colleague can be a troubling experience. Health professionals facing this dilemma should be aware that most of the 50 states have rules and regulations regarding the obligation to report violations by other licensees. This means that failing to report unsafe or unlawful practices will be subject to disciplinary conduct."

Rule Of Personal Liability

Institutions are required to compensate an injured plaintiff, under the doctrine of RS, for the negligent acts of their employees. The idea of the institution assuming liability and paying the damages for your negligent actions may appear comforting. However, it is not safe to assume that an institution will always undertake all liabilities while the negligent nurse assumes little or no responsibility. There is a special doctrine, called the rule of personal liability, that holds every professional, individually responsible for his own tortuous conduct.

In fact, although the chances are remote, the hospital legally has the right to seek reimbursement from the negligent nurse for the damages incurred during the settlement. However, because rarely do a nurse's assets ever rival the amount awarded in a large settlement, the hospital is more likely to terminate a nurse's employment than to sue her.

In the final analysis both the employer and the employee will suffer, each in a distinct manner. While it's true that the hospital is responsible for the major financial burden, the emotional losses you endure may be just as costly. Future attempts in seeking reemployment, as well as a malpractice insurance carrier, will be increasingly difficult. Further, your self-esteem and reputation will be forever compromised. Maintaining competency and adhering to the standards of care are some of the best ways to avoid liabilities.

Defenses

In response to any claim of negligence a defendant-nurse may alleviate liability by proving she acted reasonably under the circumstances. In the majority of malpractice cases the burden of proof is the responsibility of the plaintiff, since he is the one initiating the lawsuit. The plaintiff must introduce sufficient evidence for each of the four elements of negligence. In response to a malpractice complaint, the defendant must provide answers to each of the allegations. Total responsibility on behalf of the defendant may be alleviated by using affirmative defenses when answering a complaint. These defenses, as discussed below, shift the burden of proof from the plaintiff to the defendant who, in turn,

must prove the absence of substandard care. When using an affirmative defense it is admitted that negligence was established, but the defendant argues that he should not be held fully liable because of the actions of the plaintiff.

Contributory Negligence

Applications of *contributory negligence* require the injured plaintiff to have contributed to his/her own injury, thus failing to protect himself/herself from foreseeable risks. Consequently, the plaintiff is unable to recover damages, despite negligent conduct on behalf the defendant, even if his negligence was minor compared to the negligence of the defendant. The effects of this plea are to bar the plaintiff's recovery of damages, if he is shown to be negligent in the slightest degree in contributing to the injury.

An application of this defense is exhibited in the following situation. A patient breaks his leg in a skateboarding accident and seeks medical attention. The emergency room physician unknowingly applies a cast that is too tight, but gives the plaintiff detailed instructions as to the care of the cast and his limitations; specifically not to bear weight on the affected extremity until his next appointment and to call the physician with any alterations in sensation.

Hours later the plaintiff decides that the cast is too constricting and very painful. Instead of heeding the physician's advice, he decides that ambulation is the only method in which to loosen the wet plaster and also alleviate the pain. While standing erect and attempting to ambulate he reinjures his leg. In the ensuing lawsuit the court finds both parties to be negligent; the defendant by 75%, and the plaintiff by 25%. Using the defense of contributory negligence the defendant would prevail in winning the lawsuit and owe the plaintiff nothing; as no partial recovery is allowable.

When this defense is used the courts acknowledge both parties to be at fault in contributing to an injury. However, the vast knowledge gap between healthcare providers and ordinary persons, coupled with the trauma of an illness and the intimidating healthcare environment, make it difficult for the courts to accept the notion that the patient knowingly and willfully contributed to his own injury. It seems unfair that a plaintiff should be deprived of all recovery if his negligence didn't significantly contribute to his own injury.

Because many courts have recognized this inequality, some jurisdictions no longer consider this to be an acceptable defense. They reason that the plaintiff was assumed to have exercised due care or conformed to the standard conduct of another reasonably prudent person.

Comparative Negligence

As an alternative to contributory negligence *comparative negligence* is used in many jurisdictions. *This defense is based upon fairness; the plaintiff may recover damages if his/her negligence does not exceed that of the defendant.* This is to say that if the jury finds the plaintiff to be negligent by 50% or less, then the plaintiff is able to collect damages which are proportional to his contributory negligence. Hence, the guilty plaintiff is allowed partial recovery, despite his role in the injury.

As an illustration, assume the total award for damages in a case is found to be \$10,000.00. The plaintiff is found to be 25% negligent, the defendant 75% negligent. A recovery for comparative negligence would be 75% of \$10,000.00 (.75 x 10,000) or \$7,500.00 by the plaintiff. Had the defendant been found to be 100% negligent, the damages collected would have been the entire \$10,000.00. However, had the plaintiff been found to be 51% negligent compared to the defendant's 49% negligence, no recovery would be allowed.

In cases involving multiple parties, liability is determined by each person's relative contribution to the injury and damages owed are proportionally determined by the percentage of negligence for each person found guilty. It is the combined percentage of negligence of all persons found guilty which is taken into consideration. The total sum of damages must equal 100% when dealing with two or more parties. As an example, if there were two defendants named in a suit, and the plaintiff was found to be 30% guilty, defendant #1 to be 25% guilty, and defendant #2 to be 45% guilty, the total negligence of the defendants (70%) will have exceeded that of the plaintiff (30%). Hence, the plaintiff would be awarded \$7,000.00 (70% or .7 x 10,000) of a possible \$10,000.00 judgment. Defendant #1 would be liable for 25% of \$10,000.00 (.25 x 10,000) or \$2,500.00; defendant #2 would be liable for 45% of \$10,000.00 (.45 x 10,000) or \$4,500.00. Comparative negligence can always be distinguished from contributory negligence by remembering the concept of fairness to the plaintiff.

Statute of Limitations

The time period in which a malpractice suit must be filed is specified in the law called the *statute of limitations*. Each state enacts its own statute, which specifies the effective time frame, usually between 1–4 years, for the initiation of a lawsuit. This ruling protects healthcare providers, as well as ensuring that an adequate amount of evidence exists in order for the courts to justly decide lawsuits. If your state has a two-year statute and a patient decides to file a complaint for a negligent act occurring twenty-five years ago, by using this defense you may be able to nullify any further proceedings. The restriction on the amount of time a patient has to initiate a complaint is important; with each passing year memories fade, evidence may be destroyed or misplaced, witnesses relocate or die; all making the truth more difficult to be determined.

Many jurisdictions require that the medical records be saved for at least three years—the time most statutes are in effect. Medical records have been proven to provide the best source of evidence during litigation proceedings. Those healthcare providers who deal with minors are required to retain their records for longer periods of time. The laws in some states permit minors to file lawsuits alleging negligence after they have reached a certain age; usually eighteen years old, reasoning that before this time they lack the legal capacity to sue.

Usually the limitations period is initiated when the injury occurred, although there are certain conditions where lawsuits may still be valid despite overextending the preset period. In these cases the time frame counts not from when the injury initially occurred, but from the time the injury was discovered, or reasonably should have been discovered. This rule, called the **discovery rule**, is primarily reserved for cases involving sterilization or foreign objects left inside bodily cavities. With these cases, the effects of negligence and harm are not always immediately apparent. Frequently they are discovered after the limitation period has elapsed. **Recognizing that it is more difficult to find these types of errors, the courts may choose to extend the limitation period; in some cases up to ten years.**

Other claims pursued after the limitations period has expired may be for proof of fraud (healthcare practitioner concealing an injury) or in termination of treatment rulings (an injury results from a series of treatments

occurring over a period of time, as opposed to an injury occurring from a single incident. The statute of limitations begins on the date of the final treatment).

Forms of Consent

The doctrine of consent is derived from battery law. *Battery is the act of unauthorized, unconsented touching.* In order to alleviate claims of battery, before any invasive, risky, or experimental procedure, operation, or test may take place, a patient must first give his permission to be touched (treated). Once this permission has been granted, healthcare providers are authorized to provide care. A competent adult possesses the legal right to revoke his consent at any time before a procedure takes place. There are two types of informed consent that are valid, **Express Consent** and **Implied Consent**

Informed Consent

In order for informed consent (also known as Expressed Consent) to be valid, three criteria must be met:

1. Competency
2. The offering of sufficient information/comprehension
3. The element of a voluntary decision

Legally, all competent adults have the right to determine what shall be done to their own bodies. Competent adults possess the capacity to make responsible decisions and to understand the nature and risks of the proposed procedure. Incompetent persons lack the capacity to make reasonable decisions or choices concerning their welfare.

All adults are presumed competent unless incompetency has been declared by law. Consent by a competent person is always valid; consent by an incompetent person is always invalid. Examples of physically and mentally incompetent persons would be infants, children, insane, comatose, severely mentally handicapped, substance abusers and persons under the influence of drugs or alcohol.

Although both written and oral forms of consent are acceptable, written consent is preferable in that it prevents future denial of the existence of consent.

The obtaining of informed consent is primarily the responsibility of the physicians, for they are the ones who will be

performing the actual procedures. The physicians are responsible for disclosing all relevant information to the patient concerning the purpose, nature, risks, alternative treatments, and probability of success of the proposed procedure to the patient. Reasonable disclosure informs the patient of the most common recognized risks. The law does not require informing the patient of all remote risks. While a cerebral vascular accident (CVA) is a common risk of a carotid endarterectomy, it is a remote risk of a cholecystectomy. While it is necessary for a surgeon, seeking consent for the first procedure, to inform the patient of the possibility of a CVA, it is not required to be revealed as a risk for the second procedure.

A nurse's responsibility does not include disclosing relevant information about the procedure. *Her/his role is to assess the patient's knowledge level, concerns, fears or misconceptions, and to share this information with the physician.* An effective method of determining a patient's knowledge level is to ask him to reiterate, in his own words, his interpretation of the upcoming procedure. If it is discovered that a patient is unaware of any aspect of the procedure (i.e. the side effects or purpose), it is the nurse's duty to notify the physician, prior to the procedure taking place. Be sure that neither you, nor the patient, signs the consent form. Even if the patient has already given his signature, do not proceed with the preparations (enema, preoperative medications) until the physician has been notified.

The nurse's role may also be to act as a witness. The significance of witnessing is that it informs others that a disinterested third party person observed the patient signing the form, and that the patient appeared to be aware of what he was signing. Witnessing does not imply that the nurse who co-signs the consent form was present for the disclosure discussion between the physician and the patient. When adding your signature to the consent form use your full name and title. Double check the form for the inclusions of the date, time, and name of the procedure. Attach the document to the medical record, as it is required to accompany the patient to the procedure.

The final criteria is that the consent must be given voluntarily. Consent discovered to have been given under undue influ-

ence, coercion, duress, or manipulation is considered invalid. Legal implications (battery charges) exist for those persons found to have willfully participated in performing the procedure and/or in obtaining consent, while having prior knowledge of the mental incapacity of the patient.

Implied Consent

Implied consent is applicable to both medical and nursing procedures. In emergency life-threatening situations, consent for medical treatment is always implied (suggested or understood) by law for persons of all ages and competencies. The law presumes that had the person been in a non-emergent situation, he/she would have readily agreed to the necessary treatment. A person suffering from a respiratory arrest, whether it be a child, a person with Down's syndrome, or an unconscious adult, is able to undergo emergency medical treatment, despite the absence of informed consent.

Common nursing procedures are considered to be implied contracts, requiring only verbal consent. In signing an authorization to be treated form, prior to being admitted to an institution, patients give their permission for nurses to perform necessary, invasive nursing procedures. It is sufficient, as well as proper nursing practice, for the nurse to explain the purpose and procedure of a treatment before performing it. Nurses need not explain the probability of success, risks, or feasible alternatives. Examples of routine invasive nursing procedures include catheterizations, enemas, and intravenous (IV) therapy.

During the initiation of IV therapy, a nurse needs only to inform the patient of the intention to introduce a catheter into a vein for the restoration of fluid and electrolyte balance. The nurse need not give an in-depth explanation of the remote possibilities of air emboli, infiltration, or infection. Should the patient choose to refuse any treatment, his/her wishes must be respected; treatments may not be forced, despite being part of routine nursing care.

Minors/Mentally Incompetent Persons

Usually, consent and signatures from minors and the mentally incompetent are always invalid. There are only two instances where minors may legally give consent to medical care. Exemption is

granted for those persons under the age of eighteen years old whom the courts deem have the legal right and capacity to consent to treatment.

The first group, called emancipated minors, are those persons who are no longer under the care, custody, or control of their parents. Examples would be those married, divorced, widowed, in the armed forces, mothers and mothers-to-be, those financially independent, self-supporting, and living apart from their parents. In some jurisdictions mothers and fathers under the age of eighteen years old may legally give consent for medical treatment for their children.

The second group is comprised of those seeking medical treatment for substance abuse, rehabilitation programs, serious communicable diseases, birth control pills, contraceptives, and abortions. The right to privacy is the protection offered by the courts for not obtaining permission from the parents. The responsibility of payment in these cases belongs to the minors, not the parents.

Consent for the mentally handicapped and minors may be legally given by a third party, usually the parents, significant others, legal guardians, or the courts. If a guardian does not exist then the court will appoint one. Neither parents nor guardians have the right to deny a minor or mentally incompetent person emergency life-threatening treatment. For nonemergency treatment parental or guardian consent must be obtained before a treatment is initiated. Oral consent, such as over the telephone, is permissible and requires the date, time, name of the consent giver, and at least one other witness. In some jurisdictions, when the parents are separated or divorced, consent is primarily granted by the parent who has custody of the minor.

Refusal of Treatment

Any competent adult has the legal right to refuse necessary medical treatment. All persons have the legal right to control their own bodies and decide which direction their course of treatment will take. Wrongfully rendered treatment, no matter how it may be justified by the healthcare provider, without the proper consent of a competent person, is the intentional tort of assault and battery. Although it may be a conflict of interests, healthcare providers must support and respect their patient's wishes.

Should a competent patient refuse medical treatment the proper course of action is to explain the risks of refusal, in addition to exploring the patient's motives. Why is this person capable of making reasonable decisions seemingly making an unreasonable one? Is he aware of any alternatives? Of the consequences of his decision? A nurse's duty is to assist the patient in understanding the basis of the proposed regime and why healthcare providers feel it is necessary. Should these measures prove unsuccessful and the patient remains adamant about the refusal then notify your supervisor and the physician. Document thoroughly all conversations to the best of your knowledge in the medical record. Check the P&P manual for direction on how to handle this situation. The policy may require the signing of a refusal of treatment form or documentation from other witnesses. If applicable notify the family and/or significant others. Examples of persons exercising their rights to refuse treatment are Jehovah's Witnesses, right-to-die and death with dignity believers, certain religious sects, and those wishing to discontinue life support systems.

Legal Risks While Off Duty

Nurse practice act define nursing responsibilities for services rendered while on duty for compensation (payment). Few acts set guidelines for off duty nursing practice, or the uncompensated volunteering of nursing services. Similarly, many liability insurance policies do not cover actions that fall outside the scope of employment. Legally, nurses volunteering to render care may be held liable for any negligently performed acts or omissions of acts. Fortunately, the incidence of liability claims for off duty practice is relatively low.

Keep in mind the rule of personal liability, which holds each nurse responsible for her own actions, when confronted with a situation requiring professional services. If you feel that you simply lack the expertise or skill required to be beneficial to another's welfare, then refrain from offering assistance. The law cannot compel professionals to offer services for which they are not compensated. Each nurse is her own best critic; she alone is well aware of her capabilities and limitations. Follow your conscience and morals; they are valuable inherent guides.

"In order for informed consent to be valid, three criteria must be met: competency, the offering of sufficient information/comprehension, and the element of a voluntary decision."

Good Samaritan Acts

Before the passage of statutes protecting the caregiver, professionals were hesitant to render emergency treatment for fear of being sued for negligence and/or battery. Hence, many healthcare providers were reluctant to offer their skills in critical situations. Recognizing this to be true, most jurisdictions offer the affordance of legal protection by permitting non-physicians to render emergency medical care. Currently almost all fifty states have adopted "Good Samaritan Acts." The purpose is to encourage prompt treatment of injured persons at the scene of an accident, emergency, or disaster. These statutes waive liability for practicing medicine without a license and for damages that are the result of ordinary negligence in performing emergency treatment. Immunity is not granted for gross negligence, reckless misconduct, if compensation has been accepted or for emergency services rendered in an emergency room or other healthcare institutional setting.

Three choices confront a nurse upon discovering an accident; to stop and offer assistance, fail to stop, but call for help as soon as possible, or to do neither. Because the offering of assistance in emergency situations is strictly voluntary and personal, legal obligations do not exist. The law cannot compel any person to render healthcare in the absence of payment for services, regardless of ethical or moral obligations. Trepidation of liability will persuade some nurses to opt for the latter choice. Those nurses unsure of their capabilities, but nevertheless motivated by their morals, would probably choose the second option. Those nurses choosing the first option will be offered protection under the law, only if they use due care, act in good faith and do not leave the victim in worse condition than he was found to be in prior to their arrival.

A motor vehicle accident has just occurred. The victim involved is injured, but alert and oriented. It is noted that he is bleeding profusely from a wide laceration on the neck. The caregiver, in saving the victim's life, applies a bandage made out of material from an old dirty blanket

(the only available means of dressing the wound). Under the *Good Samaritan Act* the caregiver would not be liable if the wound later became infected. Conversely, the caregiver who uses the same blanket, but wraps the tourniquet too tightly around the victim's neck, leaving him anoxic and comatose, probably will not escape civil liability. No person will be afforded protection under a *Good Samaritan Act* for gross misconduct.

If the claim of negligence were to be alleged against a nurse, the courts would take into consideration the nature of the first aid rendered, the urgency of the situation, and the nurse's qualifications to perform that particular treatment. Nurses would not be held to the same standards of care expected of them during a nonemergency situation in a controlled environment (i.e. hospital setting). A nurse is only expected to exercise the same prudence and skill as another nurse would have used in a similar situation. Again, these rules apply only to care rendered in areas outside places of professional employment and only for those services offered voluntarily and without compensation.

Nursing responsibilities end upon the arrival of rescue services or other persons of superior medical qualifications, when the victim is no longer in need of emergency care or when the victim is pronounced dead (legally nurses may not pronounce death). In some states, premature departure from an accident scene is considered a tort, more commonly known as abandonment of patient. Be certain you know whether or not your state has adopted a *Good Samaritan Act*, before finding yourself in a compromising emergency situation.

Offering Medical Advice

Often the primary reaction to the discovery of your profession inevitably leads to the pursuit of medical advice. Unless the poser has intentions of paying you for your information, you are volunteering your expertise. If an injury arises from this free advice you may be held liable for any harm incurred. Lay persons value professional opinions; they take healthcare advice seri-

ously. This is just one of the ways in which ordinary citizens are constantly striving to become more knowledgeable about their health. If someone asks a nurse's professional opinion, she can be assumed that the poser has every intention of adhering to what is said.

Casually, your eighty-year-old neighbor tells you that her arthritis has exacerbated over the past week and that her rubbing ointments are no longer helpful. She wonders if it would be all right for her to take aspirin to ease the pain. In agreement, you tell her that aspirin is one of the drugs of choice for arthritis pain. Unknowingly to you she has a long-standing history of gastric ulcers. Also unknown to you, she cannot read the medicine label and decides to take two tablets every few hours, in accordance with the time schedule she uses for her ointment applications. Days later you notice an ambulance at her home. She is actively hemorrhaging and later diagnosed with an acute upper gastrointestinal bleed. Test results prove that the excessive aspirin intake was the cause of the bleeding.

Don't take an unnecessary risk such as this one; most NPA do not define voluntary services. This means a potentially increased liability problem for nurses. Try to avoid offering casual advice, no matter how trifle it may seem at the time. If you choose to offer medical advice minimize your legal risks by giving only that information that lies within the scope of your NPA, education and experience. Also include a clause such as "These are my recommendations, but call your doctor for his approval before instituting them."

It is advantageous to admit ignorance rather than to guess. Refrain from speculating about an illness. Never suggest changes in currently prescribed treatments or doctor's orders. Abstain from recommending or criticizing a particular practitioner, institution or treatment regime. Avoid offering impromptu advice by considering all possible options before making a judgment. Researching the subject and making referrals to other persons and resources, the appropriate literature,

Some States that Require Reporting Of Illegal Or Unethical Practices: Arizona, Florida, Idaho, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Montana, Nebraska, New Mexico, N. Carolina, Tennessee, Texas, Utah, Vermont, Wisconsin, Wyoming

and/or support groups are safe approaches to dealing with the situation.

Documentation

One of the most basic skills a nurse possesses is the ability to effectively communicate. A medical record is a tool used for effective communication, continuity and evaluation of patient care. By accurately charting assessments, plans, implementations, and evaluations of patients, nurses are actually reflecting the facts of their judgments and utilization of the nursing process. This information serves as proof of quality care rendered.

Because memories fade, conversations are forgotten, and details are difficult, if not impossible to retain, the written information contained in the medical record is the best source of evidence in a lawsuit. The majority of lawsuits do not go to trial until years after the injurious event occurred. The recollection of specific clinical facts and procedures is required to establish the presence, or absence, of negligence. The contents of the medical record are always of greater significance to the outcome of a lawsuit than any oral testimonies given. Proper documentation provides the evidence necessary to determine whether or not a standard of care was met.

Possessing this knowledge, one can understand why incomplete documentation can easily lead to the finding of substandard care (negligence). The courts regularly conclude that if a particular assessment or procedure was not charted, then it was not performed. Thus, failure to document may be construed as careless conduct. This, in turn, may be interpreted as an indication of the services rendered; careless conduct by a careless nurse. The validity of this assumption is not relevant.

Documentation is one aspect over which nurses have exclusive control; every nurse is responsible for her own charting. You alone know of the quality care you provide; it is your responsibility to concisely document this care.

For a lawsuit coming to trial several years later it will be detrimental to your defense

if you do not have an accurate and honest recall. Personal recollection alone will not establish the facts as to whether the procedure in question was carried out in a reasonably prudent manner. Assumptions hold little weight; *"I always change a dressing on a surgical wound, therefore I must have done it on this one."* Statements like this, while offering little defense on your behalf, will more importantly destroy your credibility. If, by chance, you are able to accurately recall your actions, how can you prove the standard of care had been met? Without proper documentation it will be very difficult.

Assume a nurse is named as a defendant in a lawsuit alleging negligence for failing to protect the patient from harm. The plaintiff—patient fell out of bed, despite the application of a restraining device. The nurse claims that the patient contributed to his own injury by untying himself and consequently fell out of bed. Her nurse's notes reflect that a waist Posey restraint was applied, secondary to disorientation, and that she had observed the patient to have fallen during the shift. Important notations concerning the time of restraint application and the time of the injury have been omitted. The family is alleging that the patient fell before the restraint was applied. The absence of witnesses to the incident, coupled with the defendant—nurse's incomplete charting, won't present the facts sufficiently enough to prove that quality care indeed had been rendered.

In addition to reflecting your judgments, observations, and proof of care, your nurse's notes reflect the type of caregiver you are. Illegible penmanship, poor grammar, misspelled words, and the use of non-standard abbreviations are all symbols of unprofessionalism. In contrast, notations which are legible, well written, accurate and complete symbolize a thorough and thoughtful nurse. Nurse's notes bearing professional traits reflect upon the nurse's character. Conversely, "sloppy" notations may be construed as characteristics of a "sloppy" nurse.

What is documented is as important as how it is documented. Be certain to draw a straight line through any blank spaces to prevent future additions by other persons.

Refrain from writing in the margins or between lines. To correctly conclude a notation, sign your first initial, last name, and title on the right side of the page. All entries in the medical record must be written in indelible ink; documentation is meant to be permanent. Never document care provided by another person in your notes as your own. If you intend to co-sign another person's notes, read and verify the information written before placing your signature on the medical record. In the event of a lawsuit both persons will be liable. Document the performance of treatments and care after they are rendered, as opposed to in advance. Use only standard and approved abbreviations when documenting. The P&P manual should include institutionally acceptable abbreviations.

The inclusion of the following guidelines in every notation will ensure the documentation of a high standard of care.

- **Date and time.** Always date and time each entry in the medical record, whether it be for nurse's notes or transcriptions of doctor's orders. Timed, or hourly charting (7:45 A.M. Sent to x-ray via stretcher) is preferable to block charting (i.e. 7–3 P.M., or 3–7 P.M., 7–11 P.M.) for accuracy. Specific times of events display evidence of attentiveness paid to the patient.

- **Completeness.** Courts routinely evaluate the completeness, consistency, and accuracy of documentation. Patient problems must be identified, acted upon, evaluated and followed through. If a nurse identified a problem of ankle edema which required diuretic therapy yesterday, it is imperative to document assessments on that problem during subsequent shifts. Vital information included when documenting, such as the exacerbation or resolution of the edema, any additional therapy necessary, not only medical intervention but nursing interventions instituted (the patient's legs were elevated and circulatory assessments performed every four hours) is evidence that a standard of

care has been met and continuity of care has been provided.

Common nursing errors involving incompleteness include omissions of pertinent data; specifically patient education and teaching, attempts to reach the doctor, safety precautions instituted, nursing actions in response to patient problems, the patient's condition and emotional/clinical responses to treatments and medications. Routine nursing functions, such as linen changing, need not be documented.

• **Objectivity.** Personal opinions are subjective data of what you conclude or assume, as opposed to the facts. Primarily objective data should be included in nurse's notes. Objective assessments negate ambiguities during interpretations of nurse's notes. If you wish to include subjective data for statements that a patient has said use quotation marks. A notation such as "patient is obnoxious" could mean he's physically or verbally abusive, always ringing the call bell, uncooperative, or purposefully incontinent. Describe your assessments by using specific terms. Take extra steps to avoid vagueness. The golden rule of charting is that one can never say too much; the more information given, the more legal protection afforded.

Nurses who chart almost the exact same data for all of their patients (slept well, IV infusing as ordered, linen changed) are in effect "cloning" their documentation. Personalize nurse's notes in the same manner in which you personalize your care. When nurses tend to chart similarly on all of their patients they fall into the habit of generalizing by the overuse of trite statements. "Had a quiet day." is too broad a statement and not an example of professional judgment and observation. What made you reach this conclusion? patient slept most of day? displayed a decreased activity level? Facts and assessments must always support your conclusions.

• **Addenda and late entries.** Supplemental information may be added to the medical record by the use of addenda and late entries. Each late entry should be added to the next available space, even if this new entry coincides with an entry from a later date. Do not attempt to include

supplements in previously written notations. It is imperative to include the current date and time, the date and time of the original entry, and a caption, such as "oversight in charting" to clarify why the late entry was made. Make corrections and additions as quickly as possible to reduce errors attributed to forgetfulness.

• **Corrections.** Corrections should be dealt with very carefully. Upon discovering an error the correct procedure is to draw a thin, straight line through the incorrect word or section, ascertaining that the original entry remains legible. Label it as such by writing the word "error" and your initials above the correction. As a human being you are likely to make errors. Identify them as such and you are documenting within your legal bounds. *It is never acceptable to obliterate, erase, or "white out" any part of a medical record.* This type of falsification may be interpreted by the courts as a deliberate attempt to conceal vital information, regardless of your genuine intentions. An innocent blunder could have serious legal repercussions.

When there lies the question of potential litigation proceedings, check with your supervisor and/or hospital attorney to determine if it is safe to make an alteration or addendum. Under no circumstances should you alter a medical record after a lawsuit has been initiated. If the opposing attorney already has a copy of these records, chances are he will discover the alterations and discredit your testimony. Consequently, you may then be charged with deception and attempting to hide information. *Falsification of a medical record for concealment purposes is a criminal offense.* The courts reason that you are aware of your negligence and are deliberately attempting to disguise your mistakes.

Avoid these common pitfalls of documenting by first understanding the difference between the correct way and the incorrect way to document. Secondly, take an objective look at some of your previous entries in the medical record. Finally, make a comparison between the contents of your entries and the contents of these guidelines to determine personal strengths and weaknesses. Improve your

documentation skills by implementing these guidelines into your entries.

Incident Reports

An incident report is a factual summary of any patient, employee or visitor injury, patient complaint, medication error, or any other unfavorable or unusual event. They are primarily used to alert the administration to the possibility of potential liability claims, to protect the patients and to detect, correct and establish trends of both new and recurrent problems. They are not intended to serve as a basis for employee disciplinary proceedings.

In order to help prevent similar problems from continually occurring these reports are compiled and evaluated, usually by risk managers, to discover trends, locality, and frequency of incidents. Once identified, problems may be simple or complex to rectify. For instance, over the period of one month, ten employees reportedly had fallen in the cafeteria during lunch hours due to slippery floors. After further investigation it was discovered that this was the same time of day when environmental services mopped a particular region of the building. In order to decrease the amount of future accidents the cleaning schedule would have to be rearranged so that the cafeteria and surrounding area floors remain dry during mealtimes.

A more difficult dilemma to solve would concern the low voltage problems in an older intensive care unit. When originally built the circuits were able to provide sufficient capacity for the electrical load. However today, with the use of electrical beds, cardiac monitors, ventilators, suction and infusion pumps, there are numerous incidents of equipment malfunction caused by circuit overload. The optimal solution may necessitate the rewiring of the entire unit or the construction of a new unit. The expense associated with this type of solution would certainly delay any immediate solutions.

Whatever the magnitude of the problem or how trivial the event may seem, *always* file an incident report for any unusual or unfavorable event. This holds true even if an injury did not result from the event. Rain leaking through a windowpane during a storm and a nurse stuck with a contaminated syringe are two events requiring the filing of an incident report.

Points To Remember For Proper Documentation

- Accuracy and Completeness, Neatness and Legibility
 - Use of Standard Abbreviations, Objectivity, Impeccable Penmanship
 - Avoidance of Assumptions/Conclusions/Opinions
 - Proper Technique for Making Corrections
 - Proper Technique for Adding Addenda
-

Although the first example has not resulted in an actual injury, it will give the administration a chance to institute changes in order to prevent future recurrences and potential injuries.

It is not sufficient to only file an incident report or only document the incident in the nurse's notes. The event must be *written in both* places. However, neither the incident report nor a notation that an incident report had been filed, are to be placed in the medical record, as this is not considered to be clinical information.

Ideally, the report forms should consist of checklists and short answer questions. Lengthy, narrative, and open-ended responses force the reporter to include subjective data. Report an incident utilizing the same documentation techniques required for nurse's notes; the use of clear, concise, accurate and factual (objective) information. Incomplete or poorly documented material might be construed as an attempt to conceal evidence. Exclude opinions, conclusions, and assumptions from a report; all could prove damaging to a defense. "Patient apparently fell" is a conclusion. "Patient found on bathroom floor" is a fact.

Refrain from suggesting who was responsible, how the incident could have been avoided, or admissions of negligence. Do not mention any actions that could have been taken to prevent recurrences, even if your incident report form includes a question requiring this information. Essentially this question seeks personal opinions and conclusions. Leave this section blank and alert the administration to this liability hazard in an attempt to have it permanently removed from the incident report. The patient's attorney may have access to the report and any mention of who was responsible, references to investigations or reports to insurance companies, or admissions of negligence will be detrimental to a defense. Correctly written reports will be of little value to an opposing attorney.

Information included on the incident report should be limited to objective data, the injured person's name, location of the incident, date and time, notification of the physician and supervisor, follow-up treatment and any names of persons witnessing the event. Omit personal information about a witness, such as an address, telephone number or social security number.

The medical record should provide similar information as to the brief, factual description of the event, date, time, location, patient assessment, notification of the physician and follow-up treatment (i.e. x-rays). Unlike the incident report, your nurse's notes should also include any immediate treatments rendered (ice application and elevation of extremity) and patient response.

Reports filed within a twenty-four hour period ensure accurate recollections of the event. Addenda are acceptable, but should not be added to the original report. Instead, place the date and time of the new or corrected information on a separate sheet of paper and attach it to the original report. Only the persons witnessing the incident should act as reporters. Never countersign, or sign your name to reports made out by others. Multiple witnesses to the same incident should make out individual reports.

Patient confidentiality will be breached if the event is discussed in the presence of third parties. Discuss the incident only with those involved in it's review. You may lower your risk of a lawsuit by maintaining professional human relations with the injured patient and answering his questions honestly. While it is acceptable to be apologetic, it is never acceptable to blame yourself or others in the presence of the patient or significant others.

Traits Of Common Parties in Malpractice Claims

The initial interaction between the patient and the nurse may invariably set the tone of the nurse-patient relationship. If either, or both, parties are antagonistic from the beginning, then the events that follow may cascade into a nurse's worst fear; being named as a defendant in a malpractice lawsuit. Psychological factors play an important role in a nurse-patient relationship. They also play a deciding factor in the patient's decision to sue. If a patient feels he's received substandard emotional treatment and happens to experience an unfavorable medical event he's more likely to sue than a patient who has experienced a similar situation, but received personal and individualized care from compassionate, friendly, caring nurses. Patients reason such agreeable professionals could not possibly be responsible for unfavorable outcomes.

Chances are, patients will not remember the thoughtfulness incorporated into their care plan, who was responsible for starting their intravenous line, or how efficiently their test results were reported. Many may not even remember caregiver's names. The areas of patient concern are how edible the food is, how promptly the call light is answered, and how the treatment received meets their expectations. We all have experienced times when we let our professionalism override the humanistic aspect of nursing.

Attempts to establish priorities may place the demands for performing technical tasks much higher than the need for emotional support and personal attention. Most nurses will agree it is difficult to always maintain a positive attitude, a friendly smile, and an air of sympathy when the realities of short staffing, demanding patients, nurse burnout, and other job related stressors are continually present. There is no denying the truth of this matter. However, it is essential to *remember that the patient's welfare is paramount in*

any situation. Welfare is synonymous for health, happiness, and comfort. If you are not including provisions in your care for each of these three aspects, then you are only partially accomplishing your goal of maintaining the standards of care. Ethical and professional nursing standards address the physical and psychological well being of every patient.

Defendant–Nurse Profile

There are several major types of personality patterns that nurses may possess. They may be extremely warm and caring, but lack organization and skills. They may demonstrate superior organization and skills, but lack patience and sympathy, or they may display characteristics of both patterns. Technically, the first type of nurses may be incompetent. Emotionally, the second type of nurses may be incompetent. Most nurses strive to possess traits of the third category; not overly personable, but nevertheless proficient on the job.

Not surprisingly, it is the characteristics of the second category that tend to upset patients the most. If some patients are treated badly emotionally before a negligent act occurred, they are more likely to sue for malpractice. It may almost appear as if they are just waiting for some unfavorable event to occur, so that they may receive compensation as revenge for unpleasant emotional treatment.

The following traits reflect characteristics of a suit-prone nurse: coldness, aloofness, authoritativeness, and curtiness. The air of hostility and unfriendliness makes patients feel uncomfortable and inferior. Other staff members may relate to these feelings when these nurses exhibit exaggerated sensitivity towards criticism and evade responsibility for wrongdoings.

Typically, suit-prone nurses display insensitivity towards the patient's emotional needs. They are so preoccupied with attending to nursing duties that they leave little time for meaningful human interaction. The only time a patient sees the nurse is during care with technical skills (i.e. perform a catheterization). Patients are not exclusively concerned with how much education or experience a nurse possesses. *Instead patients seek the establishment of warm relationships, by sensitive, caring individuals who "do" things for them, instead of "to" them.* By encouraging patients to participate in their own care, nurses are creating a less

stressful environment that is conducive to learning. This also plays an important role in promoting strong physical and emotional well-being.

By paying special attention to the needs of each patient as an individual, nurses may project a more humanistic and less threatening approach to care giving. In other words, nurses do not function to exclusively provide routine technical skills and carry out physician's orders to an endless array of patients. *Rather, nurses aim to personalize and individualize their care in an attempt to assist patients with coping with a crisis.*

Any hospitalization is a traumatic experience. It is a time when the patient is truly in need of sympathy and understanding. Feelings of apathy towards participation in one's own care, and even resentment towards the nurse, may surface in a relationship comprised only of the utmost professionalism. Without realizing it, many nurses may be focusing on the task rather than the patient. Professionalism without personality makes a nurse susceptible to liability.

Identification of the personality traits in the profile of suit-prone nurses will enable nurses to recognize similarities in their actions or in those of their colleagues. With this information nurses can modify their, or another's, present behavior to decrease the risks of being sued. Recognizing one's behavior to be a potential legal hazard should instill the motivation necessary to initiate a personality change. Reduce liability risks by promoting strong nurse-patient relations by displaying a genuine interest in both the physical and psychological needs of the patient. Try placing the patient's interests before rules and regulations. Above all, do not lose sight of one of the classic qualities a nurse can possess — **to care for and about the patient.**

Plaintiff — Patient Profile

Nurses are not the only causes of poor nurse-patient relationships; many times the source of conflict originates from the patient. Despite avoiding the characteristics of a suit-prone nurse and genuinely paying the patient the special attention he deserves, nurses still may be unsuccessful in creating a cohesive rapport.

Nurses may find patients to be disagreeable or uncooperative at some

point during their hospitalization.

This does not mean that almost every patient possesses a lawsuit profile. A woman experiencing a difficult labor may display traits of hostility and uncooperativeness. After her delivery she is pleasant, cooperative and appreciative; all characteristics of her true personality. This type of patient is not categorized as a suit-prone patient.

Some patients, especially those who have a long history of independence or those who have never been acutely ill, have difficulty attempting to control their environment when placed in situations in which they are unable to do so. Much of their anger has no personal direction, but they see no other way to vent their frustrations than to complain at the people with whom they have the closest contact. Sometimes anger is directed toward the family, usually it is directed toward the nursing staff.

Patients exhibiting common traits of a malpractice plaintiff are those whose personalities reflect malcontent and adversity in every day activities. While shopping, on the job, or even at home, they display vengeful and vindictive behavior. They may seek revenge on a policeman for receiving a parking ticket. They may persistently insult the shopper ahead of them for making them wait in line to check out their groceries. Minor incidents are perceived as significant stress producers to these types of persons.

When hospitalized these feelings are augmented, which makes the threat of a lawsuit a potential reality. The inclination to be persistently hostile, uncooperative, demanding, dependent, difficult, and unreasonable differentiates them from all other patients. The endless complaints, absence of a smile, and derogatory remarks make it difficult to maintain a positive attitude, friendly tone, and sympathetic ear. However, this is exactly what nurses must do. Try to understand that this person is basically immature and his tendency to blame others for his own inadequacies is actually his unique way of coping. He is full of suppressed anxiety due, in part, to his lack of control over his environment and loss of privacy.

After unsuccessfully and repeatedly dealing with a patient who has unrealistic expectations, little confidence in your judgment and is always making negative remarks, nurses may find themselves becoming impatient, insensitive, and

apathetic towards the suit-prone patient. Refrain from reciprocating this behavior. If a minor incident does in fact occur coincidentally, the patient will take this opportunity to blow the event out of proportion; first in the healthcare institution, then in the courtroom. Whether or not the plaintiff succeeds depends on the incident. Remember, the patient must prove the existence of some injury or harm in order to collect damages. Rarely does the court render a verdict in favor of the plaintiff for purely emotional distress. Interestingly, it is unusual for a suit-prone patient to sue based solely on an unfavorable incident. Generally there must be the initial infliction of emotional distress to instill feelings of anger in an already insecure personality, before a negligent act actually takes place.

However, because a lawsuit brings embarrassment, loss of prestige, worry and possible financial woes, it is best to take all of the necessary precautions to avoid one; even if this means being empathetic and tolerant of your least favorite patient. In fact it is best to provide extra special attention, encouragement, and praise for cooperation for this type of patient. This may seem contradictory; being especially agreeable and attentive to someone who is persistently rude and obnoxious. By making allowances for emotional needs nurses will be protecting themselves against the threat of a malpractice lawsuit. *The key element to dealing with this type of patient is to first recognize the personality traits, and then to deal with the behavior effectively.*

Professional Liability Insurance

Policy Types

With the number of healthcare malpractice claims steadily rising, and the number of nurses choosing to specialize and/or become independent contractors, the need for purchasing professional liability insurance is evident. Instead of relying on your employer to cover you, as not all do, it is best to have individual insurance coverage. Under the rule of personal liability each person is accountable for his own actions. Individual coverage is invaluable for numerous situations such as volunteer work (off

duty activities), if the sum of the awarded settlement exceeds the upper limit allowable by the employer's coverage (the nurse will assume responsibility for the remainder of the damages), or if the employer files a countersuit against the defendant-nurse.

The decision to purchase a policy is a personal one. Understanding the purpose and benefits of a policy may persuade nurses without coverage to purchase a policy. An insurance policy is a contract between the insured and the insurer. A contract is a promise in exchange for a promise. Thus, if you agree (promise) to pay a premium, an insurance company will agree (promise) to assume the risks of your liability costs.

In deciding what type of plan to purchase there are several points of consideration. Nurses can opt for a group or individual plan. The two differ in that the group plan requires membership in an organization, while the individual plan waives this requirement. Most policies will cost under \$100.00 annually; a small price to pay considering the amount of protection each plan will afford. The majority of plans are tax deductible.

Basically, there are two distinct types of policies offered; occurrence and claims-made. *Occurrence policies provide coverage for all incidents that occur during the policy period, even if a suit is filed after the policy has lapsed.* This is the broadest coverage available because it ensures coverage anytime in the future, as long as the policy was in effect when the incident occurred. As an example, if a policy is effective during the period of July 2012–July 2013, and a patient files a claim in October 2014 for an incident which took place on April 14, 2013, liability will be assumed by the insurer, even if the nurse had since retired and no longer carried an insurance policy.

Claims-made policies cover damages for incidents filed while the policy is in effect. They do not cover incidents occurring after the policy expired. Suppose a nurse was covered during the entire decade of 2000–2009. She then intends to leave the nursing profession completely and decides not to renew the insurance policy as of January 2010. If a patient files a claim in March 2010, the insurer will not assume liability costs because the policy has expired. This would hold true even if the incident occurred in May of 2008, the time the policy was in

effect. Claims-made policies will not afford protection for claims yet to be alleged (future claims). If you already own a claims-made plan, and are considering changing it to an occurrence plan, you can be assured of continual coverage during the transfer by purchasing a “tail coverage policy” which most insurers offer specifically for this purpose. Contact your individual insurance company for details.

Policy Components

As with any contract, the terms of a professional liability insurance policy must be clearly stated and agreed upon. The insurer will issue a potential buyer a printed document. Buyers wishing to purchase the plan must sign the document and enclose a payment. Placing a signature on the document initiates an agreement to abide by the rules of the contract. The insurer, by accepting the premium, has agreed to provide legal council for lawsuits and to pay any damages incurred during a settlement. Failure of either party to adhere to the obligations of the agreement is a civil wrong called breach of contract. The majority of the policies offer coverage for one full year. Before the term expires the insured has the option of either renewing or cancelling the policy. Cancellations must be followed exactly as described in the policy in order to be rendered effective.

The policy will include both the insured and insurers names and addresses, the policy period and the policy limits. The type of policy (occurrence v. claims-made) will be stated. Most likely this information will be contained on the first page of the policy. The policy limits are usually written as two separate numbers which are divided by a slash mark (i.e. \$500,000.00/\$1,000,000.00). The first number is the amount the insurer will pay per occurrence or per claim. The second number is the aggregate, or total dollar amount allowable per period; in this case a maximum of \$1,000,000.00 per year. This means that in the unlikely event a nurse is involved in more than one lawsuit during the same policy period, the insurer would not be liable for damages exceeding \$1,000,000.00. The nurse would be expected to assume personal liability for any amount exceeding one million dollars.

Subsequent pages will provide detailed

Items To Include On An Incident Report

Name, Date, Time and Location, Objective Data Notification of Physician, Follow-up Treatment

explanations of the limits of liability. Read this information carefully. It will tell the nurse the scope of professional acts covered. All policies provide coverage for professional liability (on duty). Some policies entitle the insured to additional provisions for personal liability (off duty). Most policies include coverage for all acts of negligence, some for intentional torts, and very few, if any, for criminal activities or punitive damages. As a general rule, incidents occurring during a performance that falls within the scope of nursing practice will be covered by most insurers.

A policy should include a glossary of all key terms and their definitions. This will ensure that both the insurer and the insured have a similar understanding of the meaning of terms included in the contract. Wide variations in terminology and contents will exist between policies. Read a policy thoroughly before entering into any agreement. When shopping for an insurer, do not randomly choose a policy. Some policies may be more beneficial than others depending on your specialty. Request applications from several insurance companies. If you are having difficulty deciding which policy would be best for you, ask a peer in your specialty area or seek assistance from a local or national nursing organization. Make a point of finding out what kind, if any, insurance your employer provides for you. Knowing this may assist the nurse who is currently undecided as to which type of policy would be best for her.

All policies cover the cost of the insured's legal defense and judgments, and provide an attorney. All insurers are obliged to defend the insured for all claims made against the insured, regardless of the validity of the allegation. Because no insurer wants to lose a settlement, you can be assured that you will be represented by one of the best malpractice lawyers available. Merely paying a premium does not guarantee that the insurer will assume all liabilities. The insured may be denied liability coverage in certain situations; if the insured or his employer refuse to cooperate with the insurance company or their attorney, if the application is found to have been falsified, if the incident is excluded from the stated coverage, if the insured or his employer have failed to pay their premiums or for violations of the contract's rules.

Rules are clearly defined within the contract. Any violation of a rule could nullify a

contract. One of the most important rules to remember is to give the insurance company sufficient notice of real or potential claims. Any of the following should be promptly reported: any acts or omissions which result in patient injury, any talk of a lawsuit by the patient or significant others or the receipt of a summons. Without prior knowledge of a claim the insurer may refuse to accept liability. The policy will specify what actions to take for reporting a claim as well as the acceptable length of time required to complete them.

In the event that the incident in question is not covered by the insurer, the policy has lapsed, the nurse does not carry liability insurance or there is a conflict of interests between the defendant–nurse and the attorney assigned to the case, a nurse may have to select her own attorney. There are several ways to find a competent malpractice attorney. Acquaintances with any persons in the legal profession might be of assistance by making a personal referral. If this is not feasible, try to obtain a reference from an employer, a professional nursing organization, a colleague, or a friend. As a last resort, check in the yellow pages for a local listing in your area.

Be certain to interview the attorney chosen before accepting his representation. Some firms will not charge an initial consultation fee. *Questions to ask should concern the level of experience, credentials, specialization in this particular incident, terms of payment, and attorney accessibility.* During the consultation a harmonious relationship should be established. Chances of incompatibility are likely if a nurse does not feel comfortable with the attorney, the attorney is unable to communicate the legal jargon effectively or there is evidence of a personality conflict. Should a poor rapport develop it is best to continue searching for another attorney, as this relationship must endure for several months or years until the lawsuit is settled. Nurses may opt to be represented by a nurse attorney. In some instances the similarities in experience and practice between the two professionals may provide the insight and empathy the defendant–nurse is seeking.

Legal Process of a Lawsuit

Basic proceedings

The time frame for most malpractice cases to actually reach the courtroom averages about three years. During this period

a similar sequence of pre-trial and trial events is followed for every lawsuit. All cases originate by the patient discovering an injury and bringing it to the attention of an attorney. The patient outlines the negligent conduct leading to the injury and relays this information to an attorney. The case is then evaluated by the attorney to determine whether the evidence presented is sufficient to establish liability.

During this evaluation, photocopies of the medical record are made, the facts of the case are reviewed, and usually a physician is consulted to determine if there is reasonable cause for the suit. If the attorney feels the facts raise a legitimate question of liability he will agree to represent the patient. A suit is initiated when the patient files a complaint (formal charge) in the court. The patient now becomes the plaintiff. The individual being sued becomes the defendant.

The defendant is then notified of the lawsuit by being issued a summons and a copy of the complaint. In addition to notifying the defendant of action being taken against him, the summons demands that the defendant answer the plaintiff's allegations formally before the court. Immediately notify the insurance company upon receipt of a summons. The insurer will then make arrangements for representation by an attorney. Once consulted the attorney will give detailed instructions to the defendant on how he wishes to proceed with the litigation process.

The defendant has a certain length of time, usually *thirty days*, to answer a complaint. The time span varies according to the laws of each state. Failure to respond to a complaint may be construed as an admission of guilt. In the answer to the complaint the defendant must either admit, deny, state insufficient knowledge as to the truth, or assert the affirmative defenses to each paragraph of the alleged complaint. When asserting the affirmative defenses the answer will indicate which defenses are intended for use in the lawsuit. Definitions and examples of these defenses (i.e. contributory negligence, informed consent, etc.) have already been discussed.

About *two weeks* after the response to the complaint, the lawsuit is evaluated by a screening panel, sometimes referred to as a tribunal, to determine whether the allegations are frivolous or justified. The tribunal may be comprised of a judge, an attorney, and a representative of the pro-

fession of the defendant. If the decision of the tribunal is in favor of the defendant, the plaintiff must render a decision of his intentions. He has the option of either dropping, appealing, or proceeding with the lawsuit. Further proceedings will be aborted if the lawsuit is dropped. In order to continue with the lawsuit the plaintiff must file a bond, perhaps \$2,000.00, to cover legal defense costs in advance. If appealed, the case will go to a higher court of appeals. If the decision is favorable for the plaintiff, or the bond is filed, the lawsuit will be pursued.

At this time the attorneys for both parties will obtain facts relevant to their cases in a pre-trial phase called discovery. Information can be gathered using several methods; through independent review of medical and other relevant documents, medical research, physical or mental examinations, interrogatories, and depositions. Interrogations are questionnaires limited to only those persons named in the lawsuit. They request certain information, such as the specifics of the injury, damages, and names and addresses of all persons involved in the suit. They are answered under oath, in writing, and used as evidence during the trial.

Depositions are oral testimonies from parties named in the lawsuit and other third party witnesses. They are also answered under oath and used as evidence at the trial. Cross-examinations of opposing witnesses and questioning of expert witnesses are also performed during the depositions. Expert witnesses may be doctors, nurses, psychiatrists, or other experts in the healthcare field. Their knowledge and opinions enable the court to determine the standard of care applicable to the case, the duty owed, whether that duty was breached and the nature and extent of injuries sustained.

The discovery phase is an important one as it enables the attorneys to uncover new evidence, build their defense arguments, develop liability, refresh the memory of the witnesses, and also discredit witnesses. It may take several months before all of the discovery phase has been completed.

A trial date is then set. While waiting for the trial the attorneys will update the parties on any new developments in the case. There are usually settlement and/or negotiation talks before the trial, as both parties attempt to resolve the dispute out of court. Negotiations are made for obvi-

ous liability. In the event that a pre-trial settlement cannot be reached, the case will be resolved in court.

Immediately preceding the trial a jury is selected from a random group of citizens. A jury may be comprised of professionals and nonprofessionals, even of doctors and nurses. Prospective jurors will be asked questions concerning their beliefs and prejudices, relationship to the witnesses, and other similar queries by the court. Some jurors may then be asked to step down from the panel before the trial begins depending on their responses.

In a case involving a child's death which resulted from a defendant driving while intoxicated, a grieving juror who recently lost her only child under similar circumstances will probably be disqualified (asked to step down from the panel) if one, or both, of the attorneys feels she lacks objectivity.

Once the jury selection has been finalized the case begins. Opening statements, or the concise summaries of facts, are then given by both attorneys to introduce their client's case. The contents of these statements are not admissible as evidence. The plaintiff's attorney always presents his case first. Oral evidence, or testimony, is presented by the plaintiff, witnesses, and expert witnesses. Physical evidence (medical records, equipment, etc.) is also introduced. The defendant's attorney then cross-examines the plaintiff's witnesses. After all of the evidence is presented the plaintiff's case is closed.

This is followed by a similar sequence of the presentation of the defendant's case, oral and physical evidence, expert witness and witness testimony, and cross-examination of witnesses by the plaintiff's attorney. Finally the defendant closes his case. Closing arguments, or the summations of evidence from each side, are presented. The contents of these arguments are not admissible as evidence. The defendant's attorney is the first to present his closing speech. This enables the plaintiff's attorney to make the first and last impressions in the minds of the jury members. Each attorney summarizes the testimony, argues how the evidence presented favors his client's case, and requests that the jury find on behalf of his client.

The judge then instructs the jury members of the laws governing the case and how these laws are to be applied to the facts of the case. The jury members then privately review the facts, identify any liability and damages, and vote on a verdict. This stage of

the trial is called deliberation. When arriving at a decision jury members are instructed to make a decision based on "preponderance of the evidence" (excess of influence) for civil lawsuits, or "beyond a reasonable doubt" for criminal lawsuits. The verdict is then announced by a preselected jury member and a judgment is rendered by the judge. This judgment is not a finality; any lawsuit may be appealed to a higher court if mistakes in the interpretation or instruction of the law were found to have been made during the original trial.

Trial Considerations

It is estimated that approximately three quarters of all malpractice claims are settled out of court. Negligence is determined in part by the testimony of the witnesses. If discredited, a key witness may prove damaging to a defense. The outcome of any case depends upon the credibility, believability and convincing ability of the witnesses.

The following considerations will assist nurses acting as defendants or as third party witnesses. Undoubtedly feelings of anxiety, nervousness, and insecurity will surface during the trial. The courtroom itself may prove to be intimidating, especially for those unfamiliar with legal proceedings. To promote confidence and relaxation attend other trials to gain vicarious experience; if possible any trials pertinent to negligence. Observe the atmosphere, mode of questioning, attire, and pace of the trial. Public attendance at most trials is unrestricted.

The attorney will prepare a witness for giving testimony and the correct method of responding to questioning. Most importantly he will advise the witness not to elaborate or volunteer information. It is imperative to listen to and read carefully all questions, taking sufficient time for recall, before answering. Give responses only to those questions that fall within a nurse's field of knowledge. If a witness does not know the answer to a question or is unable to recall specific information, she should state insufficient knowledge. *Perjury, a crime punishable by imprisonment, is committed when intentionally lying while under oath.* Always maintain eye contact with those posing queries. Give direct, factual, and concise responses.

When giving testimony at the trial a witness can expect the opposing attorney to make any attempt to discredit her, especially if her testimony is known to be harmful to her opponent's case. The opposing attorney may try several tactics; using flattery to

Types Of Professional Liability Insurance

Occurrence

Provides extended coverage for future claims; even if the policy has lapsed.

Claims-Made

Provides coverage only for those claims being initiated during the policy period.

give a false sense of security, interrupting constantly, and attempting to confuse, intimidate, and badger the witness in order to make her appear unknowledgeable.

Despite the application of this undue stress it is imperative to maintain a professional appearance both physically and emotionally at all times. Possess an air of confidence, authority and intelligence. Witnesses should avoid losing their tempers; professional reputations are at stake. Remain as calm, confident and composed as possible. Ponder all questions before answering; refrain from offering impromptu responses which may be worded incorrectly because of haste. Avoid to use of superlatives (“always”, “never”) and vague expressions (“apparently”, “I thought”) when answering questions. Ask for repetitions of questions which are not understood. Responses must be thoughtful, clear and accurate in order to instill credibility in the minds of the jurors.

Throughout the pre-trial and trial stages the quality of a nurse’s documentation will become evident. Poor documentation will be a hindrance, proper documentation a help to the defense. *Remember, the medical record is the best source of evidence; more credible than any oral testimonies given.* By studying the contents of the medical record and keeping a file of personal papers a nurse will be better prepared when answering questions. Follow all advice given by the attorney carefully. Do not discuss the case with anyone except the attorney. Avoid seeking sympathy from colleagues, the patient, or the patient’s significant others. Any attempts to persuade the patient to drop the proceedings will be futile and may be interpreted as an admission of guilt.

Nurses as Expert Witnesses

In all court cases the jury consists of ordinary citizens. Because these laypersons are unfamiliar with the acceptable standards of professional care, professional practices and medical terminology, there arises the need for expert testimony. An expert witness is someone displaying an expert opinion

regarding a particular element of a case. These persons use their expertise, skill and knowledge to render an opinion, which defines the duty owed, and breach of duty applicable to the case.

Not every medical or nursing negligence case has a need for expert testimony. Only those cases where the jury is unable to reach a reasonable decision, due to lack of medical knowledge, is this testimony necessary. Usually these cases involve technical skills or knowledge. Technical skills would involve a detailed explanation on the correct way to care for an intubated patient on a ventilator. Technical knowledge is required to understand the signs and symptoms of congestive heart failure. Without expert opinion jury members would be unable to determine whether or not the defendant acted reasonably and whether or not the standard of care was met.

Lawsuits dealing with common knowledge, such as those involving ordinary negligence, may not need expert testimony. An example of ordinary negligence would involve failure of a nurse to remain with a pediatric patient who is on an examination table. While unattended the toddler falls and is injured. In this instance, jury members would not need professional opinions to determine negligence. The common knowledge, intuition and life experience they possess enable them to decide the reasonableness of the defendant’s actions.

Criteria for becoming an expert witness vary from state to state. The judge of each lawsuit is responsible for determining an if expert will qualify to testify in that particular case. Trial qualification will depend upon the responses the expert gives to questions asked regarding her skill, knowledge, expertise and education. In order to qualify as an expert, a nurse should possess a valid nursing license, be currently practicing and a display an in depth knowledge of the subject of the lawsuit. Membership to professional organizations and knowledge of professionally accepted standards of practice, codes for nursing practice and codes of

ethics will enhance an expert’s qualifications. Good communication skills, both verbal and written, are essential.

The decision to utilize an expert in a lawsuit belongs to the attorney. Experts are used both in the pre-trial and trial stages of a lawsuit. If consulted, experts must decide whether or not they are able to render an opinion, based on the type of expertise the case requires. They must also consider other pertinent factors. Ideally, the expert should be unfamiliar with all involved parties, so that objectivity will be maintained. Experts must then determine their availability to fulfill the required deadlines, responsibilities and expectations. Consider personal, family and occupational obligations. Decide if they will permit keeping such a lengthy commitment. Most trials take years before actually entering the courtroom.

The acceptance commitment to a case establishes a contract between the expert and the attorney. The contract will outline the expert’s responsibilities and terms of compensation. An expert is entitled to a fee for services, whether or not the case goes to trial. Salaries are individualized according to experience and education. Avoid entering into any agreement where compensation is contingent upon the outcome of the case. Compensation should be allotted for court preparation, travel, depositions, consultations and court appearances. Method and terms of payment should also be included in the contract.

The attorney and expert work closely together during the case. The attorney will prepare the expert for participation in the legal process. The expert will develop an opinion and analysis of the case based on information obtained from the medical record and other related documents, and recognized nursing standards and codes.

The expert’s opinion must be formed independently, without bias and formally (in writing). Follow the same guidelines for serving as a witness during a trial as outlined in the previous “Trial considerations” section.

Important Ways To Avoid Legal Hazards

Several important ways of avoiding liabilities have been identified and stressed throughout this course. A summation of these points follow:

- **Become familiar with the NPA pertinent to your state.** Nurses finding it difficult to interpret the legal language may ask any attorney, risk manager, their employer, or anyone with legal knowledge for assistance. Only by knowing the scope of legal boundaries will nurses be able to practice within them safely. Awareness of acceptable standards of care is necessary to maintain a safe level of practice. Nurses must accept responsibility for their judgments and actions if they wish to be regarded as professionals.
- **Familiarize yourself with institutional policies and procedures (P&P) for both general and nursing departments.** All policies should reflect current standards, quality assurance, patient's rights and a defined scope of practice. Bring any outdated or unrevised policies to the attention of the appropriate committee. P&P consistently found to be outdated will jeopardize nursing practice. Nursing care is judged by current national standards, as opposed to by locality. Ascertain the location and availability of the nursing and general institutional P&P manuals.
- **Maintain a level of expertise and competency by keeping up to date on your practice** by participating in educational programs, whether or not your state mandates continuing education for relicensure. Educate yourself because you voluntarily desire to better your practice, not

because it is necessary to fulfill a requirement. Attending inservices and seminars, reading nursing journals, or independently studying, are all excellent ways of achieving on-going education, both on and off the job.

- **Possess at least a basic knowledge of the law and how it affects nursing practice.** Ignorance of the law is never an excuse for substandard performance. If it were, public welfare would be jeopardized. The sole purpose of laws is to protect public welfare. Because nurses will not always be able to manage every legal and ethical issue arising in everyday practice, they need readily available assistance. If your place of employment does not have a risk manager, legal consultant or ethics committee convince the administration of the need to hire or establish one. Urge your colleagues to support you in your efforts of this worthy cause.
- **Continually make conscious efforts to personalize patient care.** Individual needs should be reflected in the care rendered, nursing care plans and nurse's notes. Take time to establish a warm relationship with both the patient and significant others. Explaining all procedures and answering all questions are ways to achieve good rapport. Provide emotional support to all patients, not exclusively to those suffering during the acute phase of an illness. Treat all persons, colleagues, patients and family members with kindness and respect.
- **Keep your nursing license current and easily accessible.** Know your registration number. Notify the state BON immediately with any change of address. Ascertain you meet all of the necessary criteria for license renewal. Present a renewed license

to your employer upon receiving it. Practicing without a valid license is a misdemeanor. Be aware of state licensure and relicensure requirements.

- **Accurately document all nursing assessments, plans, implementations and evaluations.** Your notes should reflect all phases of the nursing process as well as your continual monitoring of the patient. Do not fear being verbose; a nurse can never chart too much information. Documentation is legal evidence of care rendered. The medical record states only what has been done; what hasn't been documented is assumed not to have been done. The more information documented, the more legal protection afforded.

- **Consider purchasing malpractice insurance regardless of the area of nursing being practiced.** Nurses may be skeptical about investing in a policy who do not work in a high risk area, who feel they always perform their duties carefully and safely or who feel it will make patients more likely to sue them. These are attempts to justify that there isn't a need for protection. Any nurse without insurance is assuming all liability risks personally. Judgments are then collected out of that nurse's assets. Despite all the advantageous reasons already given, the piece of mind a policy will provide you alone is worth the decision to invest. It is difficult to perform hundreds of skills in the absence of an incident, whether it be minor or major. No matter how safely nurses practice it should be anticipated that there lies the remote possibility that an incident may occur.

Finally, the law is not something nurses automatically associate with the practice of nursing. However, society is slowly changing the way nurses should think. Patients pay a high price for healthcare

Steps of a Lawsuit

Pretrial

Discovery of an Injury, Filing of a Complaint, Issuance of a Summons
Defendant Response, Review by Screening Panel, Discovery Phase
Pretrial Settlements/negotiations

Trial

Jury Selection, Opening Statements, Presentation of Plaintiff's Case
Presentation of Defendant's Case, Closing Arguments, Jury Deliberation, Case Verdict, Possible Appeal

and expect to receive the high standards of care for which they are paying. Neither experience, training, nor skill alone will ensure a truly safe practice. Only by raising the consciousness of the law will health professionals be able to improve their performance.

Awareness of potential liabilities force professionals to scrutinize and improve their individual practices. Comprehending the relationship between the law and nursing practice will enable nurses to deliver a high level of quality care. In doing this nurses will be safeguarding their patients, careers, and reputations. Today nurses must adapt to numerous ethical, practical and legal requirements. Only education will enable them to do so successfully. ♦

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Legal Terminology:

Arbitration - alternative dispute resolution (ADR) performed outside of legal processes and before the trial where participation is usually voluntary, and a third party who participates can be a private judge who implements a resolution. Arbitrations usually occur because parties to contracts agree that any future dispute concerning the agreement will be resolved by the arbitration ADR.

Advanced Directives - Advanced directives are written instructions regarding a patient's medical care and preferences. The patient's family, physician, and caregivers will consult the advanced directive if a patient is unable to make his own health care decision.

Allegation - A statement that a person expects to be able to prove.

Assault - An intentional act which is designed to make the victim fearful and which produces reasonable apprehension of harm.

Battery - The touching of one person by another without permission.

Certified Legal Nurse Consultant (CLNC) - A Registered Nurse who uses medical expertise in conjunction with specialized legal training and comprehensive exam toward certification which enables them to assist attorneys to research and develop medically related cases.

Common Law - The legal traditions of England and the United States where part of the law is developed by means of court decisions.

Confidentiality - see Privileged Communication.

Consent - A voluntary act by which one person agrees to allow someone else to do something. For medical liability purposes, consents should be in writing with an explanation of the procedures to be performed.

Decedent - A deceased person.

Deconditioning - the loss of muscle tone and endurance due to chronic disease, immobility, or loss of function. Brought on by inactivity or bed rest affects important body systems and results in reduced functional capacity. Elderly individuals are particularly vulnerable to becoming deconditioned.

Defamation - The injury of a person's reputation or character caused by the false statements of another made to a third person. (Libel & Slander - page 6)

Defendant - In a civil suit, the party against who suit is brought demanding that he or she pay the other party for legal relief.

Deposition - The questioning under oath of a witness, expert, or party by an attorney prior to the trial.

Discovery - The procedures for obtaining information from the parties involved in the lawsuit before the trial begins.

Forensic Document Examiner (FDE) - Legal professional specially trained to assess and scientifically/factually detect inaccuracies, inconsistencies, and potential tampering of a medical document.

Harm or Injury - Any wrong or damage done to another, either to the person, to rights or to property.

2012 HIPAA (American Health Insurance Portability and Accountability Act) - HIPAA is a set of rules to be followed by doctors, hospitals, and all health care providers. It helps ensure that all patient medical records, medical billing, and patient accounts meet consistent standards with regard to documentation, handling, and privacy. Any healthcare provider that electronically stores, processes, or transmits medical records, medical claims, or remittances or certifications must comply with all HIPAA regulations.

Interrogatories - A set or series of written questions directed to a party in a lawsuit requiring written responses.

Liability - An obligation one has incurred or might incur through any act or failure to act.

Living Will - Written legal document spells out the types of medical treatment and life-sustaining measures the patient requests, or refuses, such as mechanical breathing, tube feeding or nutritional sustenance, or resuscitation. In some states, living wills may be called health care declarations or health care directives.

Malpractice - Professional misconduct, improper discharge of professional duties, or failure to meet the standard of care of a professional, which resulted in harm to another.

Mediation - (ADR) Alternative dispute resolution outside the legal process completed before trial where there is a third party, a mediator, who facilitates the resolution process (and may even suggest

a resolution, known as a "mediator's proposal"), but does not require a resolution of the parties.

Medical or health care power of attorney (POA) - The medical POA is a legal document that designates an individual-referred to as a health care agent or proxy- to make decision in the event that a patient is unable to do so.

Negligence - Carelessness, failure to act as an ordinary prudent person, or action contrary to what a reasonable person would have done.

Negotiation - (ADR) Alternative dispute resolution outside of the legal process before trial where participation is voluntary and with no third party to facilitate the resolution process or impose a resolution.

Ombuds - third party selected by an institution - for example a university, hospital, corporation or government agency - to deal with complaints by employees or clients or related effected parties.

Physical and mental examination - Any party who's physical or mental status in question may be required to have an appropriate examination.

Plaintiff - The party to a civil suit who brings the suit seeking damages.

Prima Facie Case - Plaintiff must show a duty owed (standard of care implied by law) to him by the defendant.

Privileged Communication - Statement made to a physician, attorney, spouse or anyone in a position of trust. Due to the confidential nature of such information, the law protects it from being revealed, even in court. Term can occur in two distinct situations. (1) The communications between certain persons, such as physician and client, cannot be divulged without consent of the client. (2) In some situations the law provides an exemption from liability for disclosing information where there is a higher duty to speak, such as statutory reporting requirements.

Proximate - In immediate relation with something else. In negligence cases, the careless act must be the proximate cause of injury.

Request for admission - A written statement of facts or opinions regarding the case submitted to a party where that party must admit or deny the opinions/facts under oath.

Notes

Request for production - A request to another member in the lawsuit asking that party to produce certain documents or tangible items.

Res Ipsa Loquitur - "The thing speaks for itself." A doctrine of law applicable to cases where the defendant had exclusive control of the thing which caused the harm and where the harm ordinarily could not have occurred without negligent conduct.

Respondeat Superior - "Let the master answer." The employer is responsible for the legal consequences of the acts of the servant or employee while acting within the scope of employment. (Don't be fooled by this one, the hospital can then turn around and sue you for being sued)

Standard of Care - Those acts performed or omitted that an ordinary prudent person would have performed or omitted. It is a measure against which a defendant's conduct is compared.

Stare Decisis - "Let the decision stand." The legal principle indicating that courts should apply previous decisions to subsequent cases involving similar facts and questions.

Statute of Limitations - A statute defining the period within which legal action may be taken.

Subpoena - Requires the individual to appear at a designated time and place to give testimony.

Subpoena duces tecum - requires the legal party questioned (deposed) to supply

Subpoena duces tecum - requires the legal party questioned (deposed) to supply any and all documents related to the deposition. Essentially, any documents discoverable and not privileged that are used for deposition preparation should be turned over.

Suit - Court proceeding where one person seeks damages or other legal remedies from another.

Tort - A civil wrong. Torts may be intentional or unintentional.

Tort-feasor - One who commits a tort.

Tort of Intentional Spoliation - A civil wrong pertaining to when the defense intends to destroy or conceal evidence, or fails to preserve evidence (lost records).

Voir dire - "to speak the truth" is to test the legal qualifications and preliminary examinations of the potential jury panel members by counsel. It also may be implemented during preliminary examination to determine witness competency.