Care CEU's
Continuing Education for Nursing Home Administrators

Protecting Yourself from Malpractice Claims

Introduction

Medical malpractice claims and lawsuits have become a very real part of health care. Thus, health care professionals should understand how to protect themselves against medical malpractice claims. This course will provide insight into how health care professionals may protect themselves against medical malpractice claims and related litigation.

Section 1: Medical Malpractice

Medical malpractice may refer to the failure of a health care professional to follow the accepted standards of practice of his or her profession, resulting in harm to a patient.[1] Unfortunately, facing claims of medical malpractice and related lawsuits are very real possibilities for health care professionals in today's health care climate. Thus, health care professionals should understand how to protect themselves against medical malpractice claims and litigation. It has been argued, that one of the best ways for health care professionals to protect themselves against medical malpractice claims is to possess insight into the reasons why medical malpractice claims and related lawsuits may be brought against them. With that said, this section of the course will review some of the more common reasons why medical malpractice claims and lawsuits are brought against health care professionals.

Failing to Adhere to the Ethic Principles of Health Care

Health care professionals often face medical malpractice claims and lawsuits because they simply fail to adhere to the major ethic principles of health care, which include: patient autonomy, beneficence, nonmaleficence, and justice.[2] Therefore, health care professionals should be familiar with each of the aforementioned ethic principles of health care. Specific information regarding each of the four major ethic principles of health care may be found below. Health care professionals should note that a medical malpractice claim or lawsuit may arise against them due to a violation of one or all of the aforementioned ethic principles.

Patient autonomy - Patient autonomy refers to a patient's right to make decisions regarding his or her own personal health care (i.e., a patient's right to determine the course of his or her health care without outside influence).[2] Essentially, patient autonomy grants patients the sole right to make decisions regarding their health, health care, and personal well-being. Health care professionals must respect patient autonomy when caring for patients. Violations of patient autonomy may occur if a health care professional makes health care-related decisions for a patient, influences

a patient's health care-related decision, bullies a patient into making a health care-related decision, withholds health-care related information from a patient in order to steer a patient into making a specific decision, provides a patient with biased health care information and/or education, fails to provide vital health-related information to a patient, and/or simply does not give a patient an opportunity to make his or her own decision regarding the administration of health care (e.g., carries out a health care procedure without consent form a patient). Health care professionals may uphold patient autonomy by allowing patients to remain independent when making decisions about their health care. Health care professionals should note that they are allowed to provided patients with unbiased information and education to help them make a decision regarding their own health care - however, a health care professional must not make the final health care-related decision for a patient. Health care professionals should also note that there may be health care situations where patient autonomy concepts may not necessarily apply, such as emergency situations where life-saving interventions are required.

Beneficence - Beneficence, as it relates to health care, may refer to the act of doing what is best for the patient; acting in a manner that promotes patients' health.[2] Health care professionals must adhere to the principle of beneficence when caring for patients. Examples of potential violations of beneficence may include the following: a health care professional does not act in the best interest of a patient, a health care professional puts his or her own interest before a patient's best interest, a health care professional does not consider the risks and benefits of a health care intervention before it is administered to a patient, a health care professional does not consider a patient's pain, physical, and/or mental suffering when administering health care, a health care professional does not consider a patient's risk of disability, diminished health, and/or death when administering health care, and a health care professional does not promote a patient's health (e.g., a health care professional encourages a patient to follow a therapeutic regimen that will, ultimately, jeopardize his or her health, overall well-being, and quality of life). Health care professionals may uphold the ethic principle of beneficence by simply doing what is best for a patient's health. Health care professionals may also uphold the ethic principle of beneficence by continuing their education and staying up to date on relevant health care topics, so they may be best equipped to safely and effectively serve patient needs, and ultimately, do what is best for a patient. Health care professionals should note that individual patients may have specific needs or requirements. Health care professionals should consider individual patient needs and requirements when attempting to uphold the ethic principle of beneficence.

Nonmaleficence - Nonmaleficence, as it relates to health care, refers to inflicting no harm; do no harm; inflicting the least amount of harm as possible to achieve a

beneficial outcome.[2] In essence, the ethic principle of nonmaleficence dictates that health care professionals should do no harm to patients. With that in mind, many have argued that the ethic principle of nonmaleficence is the most important principle of health care. Many individuals have also argued that without nonmaleficence, there could be no health care system as it is know today. Thus, it is paramount that health care professionals adhere to the ethic principle of nonmaleficence. Examples of potential violations of nonmaleficence may include the following: a health care professional intestinally harms a patient, a health care professional gives a patient a medication knowing it will only harm the patient, a health care professional choose health care interventions for a patient that will harm the patient, a health care professional does not follow safety precautions while administering care to a patient, and a health care professional does not follow organizational polices and producers, which have been put in place to safeguard patients' health. Health care professionals may uphold the ethic principle of nonmaleficence by adhering to organizational polices and producers as well as safety precautions. Health care professionals may also uphold the ethic principle of nonmaleficence by simply acting in a manner that does not intentionally harm a patient. Health care professionals should note the following: although beneficence and nonmaleficence are related, they are two separate and distinct ethic principles of health care.

Justice - Justice, as it relates to health care, refers to the fair and legal allocation of health care resources to patients.[2] Essentially, the ethic principle of justice stipulates that patients in similar situations should have access to the same health care or the same level of health care. The following example highlights the previous concept. Two patients are admitted into a hospital. One patient is a 67-year-old male. The other patient is a 68-year-old female. Both patients have the same health insurance coverage and are both suffering from pneumonia (i.e., both patients are similar and in a similar situation). Therefore, they must receive the same level of health care. One patient cannot be neglected for any reason while the other patient receives extra attention or health care. Resources cannot be diverted from one patient and distributed to the other. The patients must receive an equal, unbiased allocation of health care resources. Health care professionals must administer health care in an objective, fair manner. A specific patient cannot be favored or receive different health care resources at the expense of the other patient. Both patients in the above example should receive of the same level of health care. Failure to provide similar patients in similar situations with the same level of health care may be viewed as a violation of justice, as it relates to health care.

Health care professionals can uphold justice by administering health care in an unbiased manner. Once a patient is admitted into a health care setting, health care professionals should treat patients equally and fairly. Health care should be

administered to patients based on need. Race, gender and/or socioeconomic status should not dictate how health care is administered to patients. Patients' personalities and/or personal backgrounds should also not dictate the administration of health care. In addition, personal relationships between health care professionals and patients should not affect the delivery of health care. A patient should not receive a higher level of health care due to a personal relationship with an individual health care professional; nor should health care be withheld based on a personal relationship. Justice, as it relates to health care, dictates the impartial allocation of available health care resources to patients in need. Similar patients in similar situations have the same right to available health care resources. A fair-minded approach to the administration of health care can ensure the aforementioned concepts are obtained.

Failing to Adhere to a Related Scope of Practice

Another major reason why health care professionals face medical malpractice claims and lawsuits is because they fail to adhere to their related scope of practice. The term scope of practice may refer to a description of services qualified health care professionals are deemed competent to perform and permitted to undertake under the terms of their professional license.[3] In other words, a scope of practice is a legal guide that highlights a health care professional's responsibilities and limitations. It is essential that health care professionals adhere to their related scope of practice. Health care professionals should note that specific scopes of practice may vary by state. A health care professional should be familiar with his or her particular state of licensure's relevant scope of practice. An example of a scope of practice may be found in Figure 1.

FIGURE 1: AN EXAMPLE SCOPE OF PRACTICE FOR RNs and LPNs[3]

Registered Nurses

Scope of RN practice is as follows: providing to individuals and groups nursing care requiring specialized knowledge, judgment, and skill derived from the principles of biological, physical, behavioral, social, and nursing sciences. Such nursing care includes:

1. Identifying patterns of human responses to actual or potential health problems amenable to a nursing regimen.
2. Executing a nursing regimen through the selection, performance, management, and evaluation of nursing actions.

3. Assessing health status for the purpose of providing nursing care.
4. Providing health counseling and health teaching.
5. Administering medications, treatments, and executing regimens authorized by an individual who is authorized to practice in this state and is acting within the course of the individual's professional practice.
6. Teaching, administering, supervising, delegating, and evaluating nursing practice.

RNs have independent licensed authority to engage in all aspects of practice. The RN must have an order from an individual who is authorized to practice in this state and is acting within the course of the individual's professional practice for administration of medication or treatments or for the regimen that is to be executed.

The RN determines the data to be collected to "assess the patient's health status for the purpose of providing nursing care. Assessing health status is further defined as "the collection of data through nursing assessment techniques, which may include interviews, observation, and physical evaluations for the purpose of providing nursing care."

Based on the "health status assessment" RNs determine the nursing care needs of the patient and the resulting nursing regimen that will be executed. Nursing regimen "may include preventative, restorative, and health-promotion activities." The definition of patient is "the recipient of nursing care, which may include an individual, a group, or a community." Therefore, the nursing regimen determined by RNs is not limited to individual patients, but may be established for specific populations or defined groups.

RN Role/Nursing Process

The following examples of RN practice are in the Nurse Practice Act and administrative rules.

The RN:

- Collects patient health data from patient, patient family, and LPN or other health care providers.
- Analyzes data to determine nursing regimen.
- Establishes, accepts, or modifies a nursing diagnosis or problem.
- Implements and communicates the plan of nursing care.

- Evaluates and documents the patient's response to the nursing care.
- Reassesses and revises the nursing plan of care as appropriate.

Licensed Practical Nurses

The scope of LPN practice is defined as "providing to individuals and groups nursing care requiring the application of basic knowledge of the biological, physical, behavioral, social, and nursing sciences at the direction of a registered nurse or any of the following who is authorized to practice in this state: a physician, physician assistant, dentist, podiatrist, optometrist, or chiropractor. Such nursing care includes:

1. Observation, patient teaching, and care in a diversity of health care settings.
2. Contributions to the planning, implementation, and evaluation of nursing.
3. Administration of medications and treatments authorized by an individual who is authorized to practice in this state and is acting within the course of the individual's professional practice, with excepts related to the administration of intravenous therapy. Medications may be administered by a licensed practical nurse upon proof of completion of a course in medication administration approved by the board of nursing.
4. Administration to an adult of intravenous therapy authorized by an individual who is authorized to practice in this state and is acting within the course of the individual's professional practice, on the condition that the licensed practical nurse is authorized to perform intravenous therapy and performs intravenous therapy only in accordance with those sections.
5. Delegation of nursing tasks as directed by a registered nurse.
6. Teaching nursing tasks to licensed practical nurses and individuals to whom the licensed practical nurse is authorized to delegate nursing tasks as directed by a registered nurse.

LPNs have a "dependent" practice, which means the LPN is authorized to practice only when the practice is directed by a registered nurse or any of the following who is authorized to practice in this state: a physician, physician assistant, dentist, podiatrist, optometrist or chiropractor. The "direction" required for LPN practice is further defined as "communicating a plan of care to a licensed practical nurse." A physician, physician assistant, dentist, podiatrist, optometrist or chiropractor, or the RN may provide LPNs verbal or written direction of the plan that each of these health care providers have established for the patient. LPNs are authorized to execute the

plan in accordance with the standards of LPN practice in accordance with rules. When the RN communicates the plan of care to the LPN, it may be verbally, in the form of an established nursing plan of care, or both. Further explains that the direction provided by RNs to LPNs about nursing practice is not meant to imply the RN is supervising the LPN in the employment context. The LPN is accountable to identify the RN or other authorized health care provider who is directing the LPN's practice. Otherwise, the LPN may be engaging in practice beyond the LPN authorized scope.

LPN Practice Prohibitions

The following are specific LPN practice prohibitions contained in the NPA and rules:

- Engaging in nursing practice without RN or authorized health care provider direction.
- Administering IV push medications (IV medications other than Heparin or Saline to flush an intermittent infusion device).
- Teaching the "practice of nursing."
- Supervising and evaluating "nursing practice."
- Assessing health status for purposes of providing nursing care.

The LPN contributes to all steps of the nursing process by communicating with the RN or the directing authorized health care provider concerning the patient's status and needs. When a RN is directing LPN practice, it is the RN who establishes the nursing regimen and communicates the nursing practice needs of the patient.

LPN Role/Nursing Process

The following are examples of LPN practice in the NPA and administrative rules. The LPN:

- Collects and documents objective and subjective data and observations about the patient.
- Contributes observations and health information to the nursing assessment and reports all data to the RN or authorized directing health care provider.
- Implements the current plan of nursing care at the direction of the RN, or the medication or treatment authorized by the directing physician, physician assistant, dentist, podiatrist, optometrist or chiropractor.

- Documents the patient's response to the nursing plan of care or the medication or treatment.
- Contributes to the revision of the nursing plan of care.
- Contributes to the evaluation of the patient's response to the plan of care through documentation and verbal communication with other members of the health care team.

LPN IV Therapy

This chapter defines terms, IV therapy procedures IV therapy certified LPNs may perform, and IV therapy procedures that LPNs are prohibited from performing. It also establishes the minimum curriculum requirements for LPNs to obtain their IV therapy certification.

Supervision of Nursing Practice

The supervision of nursing practice is specified within the definition of RN practice, noting that RNs teach, administer, supervise, delegate, and evaluate nursing practice. The LPN is authorized to delegate nursing practice when directed to do so by a RN, to teach a nursing task, and to make observations and provide patient teaching. Regarding the RN supervision of nursing practice, it is the "practice" of nursing that the RN supervises and evaluates, rather than a person's employment performance.

The supervision of nursing practice may include a determination by the RN that a particular nursing intervention is no longer appropriate for a patient and that the nursing regimen should be changed in response to the patient's needs. The RN may base this change on information communicated by the LPN and the RN may further direct the LPN to implement the revised nursing regimen, or the RN may implement the revision him/herself. The supervising RN must be continuously available through some form of telecommunication with the supervised nurse. Although the supervising RN is not required to be on-site on a routine basis to supervise the LPN in all of the nursing practice activities performed by the LPN, the supervising RN is required to take all action necessary, including but not limited to conducting periodic on-site visits, in order to insure the supervised nurse is practicing in accordance with acceptable and prevailing standards of safe nursing care. There are circumstances when onsite supervision by a RN is explicitly required by nursing law and rule. For example, on-site supervision is required in certain environments in which a qualified LPN performs IV therapy.

Supervision of employee performance and other employment requirements are established by the employer and may encompass responsibilities beyond the licensed practice of nursing.

Implementing Health Care Provider Orders

Both the RN and the LPN administer medications and treatments authorized by an authorized prescriber/health care provider, such as a physician or an advanced practice registered nurse. The RN is also authorized to execute a regimen authorized by an authorized health care provider. When administering medications and treatments, or when a RN is executing an authorized regimen, the licensed nurse must practice within their statutorily defined scope. An authorized health care provider's order does not expand the licensed nurse's scope. For example, an order from a physician does not authorize a LPN to intravenously administer a dose of Lasix. Similarly, an order does not authorize an RN to engage in activities that constitute advanced practice registered nursing or the practice of medicine or surgery.

Implementing the Nursing Process

Both the RN and LPN implement the nursing process in the provision of nursing care in accordance with rules. The scope of LPN practice does not include assessing health status for purposes of providing nursing care that is included in the RN scope. Although it is the RN who reviews and assimilates the patient's health status data and information into the nursing assessment for purposes of providing nursing care, the LPN is authorized to contribute to this process by obtaining responses to health questions posed to the patient, performing physical examinations, recognizing changes in patient status or complications that occur and communicating information collected to the RN or to the authorized health care provider who is directing the LPN's practice.

Delegation

The rules in this chapter provide general information about the delegation of nursing tasks; specific prohibitions regarding delegation of nursing tasks; criteria and standards for a licensed nurse delegating to an unlicensed person; minimum curriculum requirements for teaching a nursing task; and supervision of the performance of a nursing task performed by an unlicensed person.

Standards of Practice

Along with scopes of practice, health care professionals should also adhere to relevant standards of practice; failure to do so may lead to medical malpractice claims and lawsuits. The term standards of practice may refer to the authoritative statements of duties that all health care professionals, regardless of role, population or specialty are expected to perform competently.[4]

Professional organizations, like the American Nurses Association (ANA), have developed specific standards of practice for health care professionals. Standards of practice were established by the ANA and other professional organizations to provide a means for the consistent administration of health care across the various health care settings found in the current landscape of health care.

It is highly recommended that all health care professionals follow the standards of practice set for by their related professional organization in every aspect of health care administration to ensure they are in accordance with the necessary requirements for safe and effective health care.

Informed Consent

Health care professionals may face medical malpractice claims and lawsuits if they fail to obtain informed consent from a patient. Informed consent may refer to the process by which a health care professional obtains permission, from a patient, to conduct a health care intervention on a patient.[5]

Informed consent must be obtained, from a patient, before a health care intervention is conducted.

The major elements of informed consent include the following: the nature of the health care intervention should be explained to the patient, the risks and benefits of the health care intervention as well as the health care intervention itself should be explained to the patient, reasonable alternatives should be provided to the patient, the risks and benefits of the reasonable alternatives should be explained to the patient, and finally, the patient must be able to understand the previous elements.[5]

Informed consent is required for many aspects of health care including: treatment, dissemination of patient information, discussion of relevant laws, specific procedures, surgery, blood transfusions, and anesthesia.[5]

Obtaining informed consent should include: describing the proposed intervention, emphasizing the patient's role in decision-making, discussing alternatives to the proposed intervention, discussing the risks of the proposed intervention, and eliciting

the patient's preference (usually by signature).[5] Discussion of all risks is absolutely paramount to informed consent in this context; most consent includes general risks, risks specific to the procedure, risks of no treatment and alternatives to treatment; additionally, many consent forms express that there are no guarantees that the proposed procedure will provide a cure to the problem being addressed.[5]

The required standard for informed consent is determined by the state.[5]

Children (typically under 17) do not have the ability to provide informed consent; in such cases, parents must give permission for treatments or interventions.[5]

Informed consent is mandatory for all clinical trials involving human beings.[5]

Informed consent exceptions include the following: the patient is incapacitated, life-threatening emergencies with inadequate time to obtain consent, and voluntary waived consent.[5] Health care professionals should note the following: if the patient's ability to make decisions is questioned or unclear, an evaluation by a psychiatrist to determine competency may be requested.[5] Health care professionals should also note the following: a situation may arise in which a patient cannot make decisions independently but has not designated a decision maker; in the previous instance, the hierarchy of decision makers, which is determined by each state's laws, must be sought to determine the next legal surrogate decision maker; if this is unsuccessful, a legal guardian may need to be appointed by the court.[5]

Power of Attorney

Health care professionals may face medical malpractice claims and lawsuits if they fail to acknowledge a power of attorney. Power of attorney may refer to any written, legally binding authorization and/or authority that grants powers to an individual, which allows said individual, to act on another individual's behalf.[6]

A health care power of attorney grants, in writing, a particular agent the power to make health care decisions on another individual's behalf; the decision is usually in tandem with a durable power of attorney, which is essentially a proviso of the health care power of attorney that safeguards the power of attorney if a person loses the functional capacity to make their own decisions; a durable power of attorney for health care decisions may also be referred to as a health care proxy.[6]

A health care power of attorney and a living will are not the same (i.e., a living will is different from a health care power of attorney).[6] A living will may refer to a written statement by an individual in question, whereby specific wishes are stated and made known; a living will does not designate a particular agent to have decision-making

power in certain circumstances.[6] A living will may be used by a designated health care power of attorney individual to help guide his or her decision-making.[6]

Multiple people can be selected to have decision-making powers under a health care power of attorney; a "backup" agent may also be designated by a health care power of attorney.[6]

The process of determining capacity (i.e., a functional, clinical assessment) is one of the most vital functions of a health care professional when seeking to enact a power of attorney for health care decision-making.[6]

When determining patient capacity, health care professionals should be sure to include the following elements in their assessments: communication (i.e., can a patient express their wishes, and understand the rationale behind their wishes), understanding (i.e., is a patient able to recall conversations about treatment options and recognize causal relationships within the treatment plan), appreciation (i.e., is a patient able to appreciate the consequences of the illness, treatment options, or the decision to forego treatment, and how the outcome will affect him or her directly), and rationalization (i.e., is a patient able to process the risks and benefits of treatment options and come to a conclusion that coincides with their best interests and goals).[6]

Health care professionals should note that a patient's capacity may not be static and can change from absent to present as a patient progresses through the health care process.[6]

Medical Errors

Health care professionals and health care organizations may face medical malpractice claims and lawsuits if they fail to take the necessary steps to prevent medical errors. The term medical error may refer to a preventable adverse effect of care that may or may not be evident or causes harm to a patient.[7]

Medical errors are one of the leading causes of death in the United States.

Examples of medical errors include the following: a patient is administered the wrong medication, a patient is administered the wrong dose of medication, a patient receives an incorrect health care intervention, a delay in diagnosis occurs, an incorrect diagnosis is made, delays in treatment occur, hospital acquired infections, inadequate follow-up after a patient receives treatment, and a patient receives surgery on the wrong site.

Health care professionals should understand how to prevent medical errors from occurring.

Communication

Communication may not be one of the first reasons that comes to mind when considering why health care professionals face medical malpractice lawsuits, however communication, and more specifically a lack of communication, among health care professionals may lead to litigation. Communication may refer to the adequate transmission of information or messages between two or more individuals, while miscommunication may refer to the inadequate transmission of information or messages between two or more individuals.[8,9] Health care professionals should work to avoid miscommunication whenever possible.

Examples, of how issues with communication may lead to medical malpractice claims and lawsuits include the following: a health care professional fails to communicate all relevant patient information to another health care professional (e.g., a health care professional fails to communicate a patient's known allergies), a health care professional fails to communicate vital patient test results, a health care professional fails to communicate vital patient assessment results, and a health care professional fails to communicate vital information to a patient.

Health Care Documentation

Along the same lines as communication, issues with health care documentation may also lead to medical malpractice claims and lawsuits. Health care documentation may refer to a digital or an analog record detailing the administration of health care to patients.[10]

Health care professionals should note that the following concept often applies to medical malpractice claims and lawsuits: if it was not documented, then it was not done (i.e., if a health care professional does not effectively document health care or the administration of health care to a patient, when applicable, then it did not occur in the eyes of those typically involved in medical malpractice claims and lawsuits).

Health care professionals should be sure to effectively document health care. In order for health care documentation to be considered effective, it must function as a viable form of communication, as well as a means to establish a detailed record of health care administration.

Health care professionals should note the following: health care professionals may have a legal responsibility to complete effective health care documentation when administering health care to patients. Federal and individual state laws may apply to

health care documentation. Thus, health care professionals must be aware of the existing laws regarding health care documentation, especially when it comes to specific state laws. Every state possesses the potential to have different laws relating to health care; therefore, every state may have distinct laws when it relates to health care documentation. Furthermore, each state may have explicit laws outlining the requirements of health care documentation for each particular type of health care professional, such as nurses. For example, the state of California has specific requirements for nurses when it comes to health care documentation. An example of California's health care documentation laws can be observed in Figure 2. It is highly recommended that health care professionals consult their respective individual state laws to understand what their regulatory responsibilities are when completing health care documentation.

FIGURE 2: CALIFORNIA CODE OF REGULATIONS TITLE 22; SECTION 70215[11]

70215. (a) (1) A registered nurse shall directly provide: ongoing patient assessments as defined in the Business and Professions Code, Section 2725(d). Such assessments shall be performed, and the findings documented in the patient's medical record, for each shift and upon receipt of the patient when he/she is transferred to another patient care area.

Inadequate Patient Assessments and Monitoring

Medical malpractice claims and lawsuits may arise due to the failure of a health care professional to adequately assess and monitor patients.

Patient assessment may refer to the process of gathering information and relevant details related to a patient and a patient's health.[12]

Patient assessments may include the following elements: a patient history (i.e., an evaluation of the patient's current illness/injury, relevant past history, allergies and reactions, medications, immunization status, and family and social history), an evaluation of the patient's general appearance (i.e., an evaluation of the patients' overall physical, emotional, and behavioral state), vital signs (e.g., blood pressure

and heart rate), height/weight measurements, airway evaluation, skin color evaluations, hydration and nutrition evaluations, output, physical risk evaluations, neurological evaluations, sensory function evaluations, pain evaluations, as well as cardiovascular, gastrointestinal, renal, and hepatic evaluations.

Health care professionals should be aware of the specific patient assessment elements required for each patient.

Health care professionals should note that a patient assessment may occur when a patient presents to a health care facility, when a patient is admitted into a health care facility, and at any other point in a patient's health care treatment deemed necessary.

Patient monitoring may refer to the process of observing patients as well as patient disease states, conditions, illness, and/or medical parameters.[12] For some patients, patient monitoring may be essential to their health care, especially if a patient is admitted to an intensive care unit of a hospital or is on specific medications that may require routine analysis (e.g., warfarin).

Patient monitoring may involve the following: vital sign monitoring, blood glucose monitoring, cardiac monitoring, renal monitoring, hepatic monitoring, respiratory monitoring, neurological monitoring, body temperature monitoring, and medication monitoring.

Health care professionals should be aware of the specific monitoring needs of each patient.

Health care professionals should note that inadequate patient assessments and monitoring may lead to increases patient morbidity and mortality rates.

Health care professionals should also note that communication and effective health care documentation play an important role in patient assessments and monitoring. Information gathered by patient assessment and/or patient monitoring should be adequately communicated and documented.

Violations of the Health Insurance Portability and Accountability Act of 1996

Violations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) may lead to lawsuits against health care professionals. HIPAA may refer to the specific federal regulations or laws which provide provisions for safeguarding medical information.[13, 14]

HIPAA was enacted by the 104th United States Congress and signed into action by President Clinton in 1996. Since that time, HIPAA has undergone a variety of different modifications and updates to help increase its scope and effectiveness in protecting health-related information. Health care professionals should be very familiar with current HIPAA regulations. To help increase HIPAA awareness among health care professionals, relevant HIPAA details are highlighted below. The information found below was derived from materials provided by the federal government of the United States.[13,14]

- One of the major goals of HIPAA is to assure that individuals' health information is adequately protected while allowing the flow of health information needed to provide and promote high quality health care. Another major goal of HIPAA is to protect the public's health and well being.

- HIPAA regulations safeguard protected health information (PHI). PHI may refer to any information about health status, provision of health care, or payment for health care that is created or collected by a covered entity; individually identifiable health information. In essence, HIPAA regulations protect all individually identifiable health information held or transmitted by a covered entity or its business associate(s), in any form or media, whether electronic, paper, or oral.

- Health care professionals should note that individually identifiable health information is information, including demographic data, that relates to the following: an individual's past, present or future physical or mental health or condition, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to the individual, and that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual (i.e., individually identifiable health information is information that may be used to identify an individual and their relationship to the health care system). Health care professionals should also note that examples of individually identifiable health information include patients': names, birth dates, home addresses, and Social Security Numbers.

- HIPAA regulations stipulate the following: a covered entity may not use or disclose protected health information, except as HIPAA regulations permit or require; or as the individual who is the subject of the information (or the individual's personal representative) authorizes in writing. Fundamentally, HIPAA regulations determine how PHI may be used and/or disclosed to protect individuals' privacy.

- HIPAA regulations indicate the following: informal permission, regarding the use of PHI, may be obtained by asking an individual outright, or by circumstances that clearly give an individual the opportunity to agree, acquiesce, or object; when an individual is incapacitated (e.g., in an emergency situation) or not available, covered entities generally may make such uses and disclosures, if in the exercise of their professional judgment, the use or disclosure is determined to be in the best interest of an individual.
- Health care professionals should note the following: a central aspect of related HIPAA regulations is the principle of "minimum necessary" use and disclosure. A covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of PHI needed to accomplish the intended purpose of the use, disclosure, or request. Essentially, the minimum necessary rule can help prevent the disclosure of any unnecessary PHI. Health care professionals should always keep the minimum necessary rule in mind when disclosing PHI.
- HIPAA regulations also safeguard electronic PHI.
- Health care professionals should note the following: HIPAA regulations typically apply to health plans, health care clearinghouses, and to any health care provider who transmits health information in electronic form.
- Related HIPAA regulations allow covered entities to disclose the immunization records of students or prospective students to a school if state law requires the school to have proof of immunization and the covered entity obtains and documents the agreement of the parent or guardian.
- Related HIPAA regulations generally prohibit the sale of PHI, defined as remuneration (financial or otherwise) in exchange for PHI, without individual authorization.
- HIPAA regulations do allow health care professionals to share health-related information with a patient's potential loved ones in emergency or crisis situations.
- HIPAA regulations indicate that health care professionals do have a broad ability to share health-related information with patients' family members during certain crisis situations without violating HIPAA privacy regulations.
- HIPAA regulations indicate the following: a health care professional must give a patient the opportunity to agree or object to sharing health information with family, friends, and others involved in the individual's care or payment for care; a health care professional is not permitted to share health information

about patients who currently have the capacity to make their own health care decisions, and object to sharing the information, unless there is a serious and imminent threat of harm to health.

- Health care professionals should note the following: a patient's decision-making incapacity may be temporary and situational, and does not have to rise to the level where another decision maker has been or will be appointed by law; if a patient regains the capacity to make health care-related decisions, a health care professional must offer a patient the opportunity to agree or object before any additional sharing of health information occurs.
- Health care professionals should note the following: generally, state laws that are contrary to HIPAA regulations are preempted by the federal requirements, which means that the federal requirements will apply.

Section 1: Summary

Medical malpractice may refer to the failure of a health care professional to follow the accepted standards of practice of his or her profession, resulting in harm to a patient.[1] Unfortunately, medical malpractice claims and lawsuits have become a very real part of health care. Thus, health care professionals should understand why medical malpractice claims and lawsuits may arise, so they may work to prevent them and, ultimately, protect themselves.

Section 1: Key Concepts

Health care professionals may face medical malpractice claims and lawsuits for a variety of different reasons including the following: failing to adhere to the ethic principles of health care, failing to adhere to a related scope of practice, failing to adhere to a relevant standards of practice, issues related to informed consent, issues related to power of attorney, medical errors, issues with communication, ineffective health care documentation, inadequate patient assessments and monitoring, and violations of HIPAA.

Health care professionals should understand why medical malpractice claims and lawsuits may arise so they may work to prevent them.

Section 1: Key Terms

Medical malpractice - the failure of a health care professional to follow the accepted standards of practice of his or her profession, resulting in harm to a patient[1]

Patient autonomy - a patient's right to make decisions regarding his or her own personal health care; a patient's right to determine the course of his or her health care without outside influence[2]

Beneficence(as it relates to health care) - the act of doing what is best for the patient; acting in a manner that promotes patients' health[2]

Nonmaleficence (as it relates to health care) - inflicting no harm; do no harm; inflicting the least amount of harm as possible to achieve a beneficial outcome[2]

Justice (as it relates to health care) - the fair and legal allocation of health care resources to patients[2]

Scope of practice - a description of services qualified health care professionals are deemed competent to perform and permitted to undertake under the terms of their professional license[3]

Standards of practice - the authoritative statements of duties that all health care professionals, regardless of role, population or specialty are expected to perform competently[4]

Informed consent - the process by which a health care professional obtains permission, from a patient, to conduct a health care intervention on a patient[5]

Power of attorney - any written, legally binding authorization and/or authority that grants powers to an individual, which allows said individual, to act on another individual's behalf[6]

Living will - a written statement by an individual in question, whereby specific wishes are stated and made known (a living will does not designate a particular agent to have decision-making power in certain circumstances)[6]

Medical error - a preventable adverse effect of care that may or may not be evident or causes harm to a patient[7]

Communication - the adequate transmission of information or messages between two or more individuals[8,9]

Miscommunication - the inadequate transmission of information or messages between two or more individuals[8,9]

Health care documentation - a digital or an analog record detailing the administration of health care to patients[10]

Patient assessment - the process of gathering information and relevant details related to a patient and a patient's health[12]

Patient monitoring - the process of observing patients as well as patient disease states, conditions, illness, and/or medical parameters[12]

Health Insurance Portability and Accountability Act of 1996 (HIPAA) - may refer to the specific federal regulations or laws which provide provisions for safeguarding medical information[13,14]

Protected health information (PHI) - any information about health status, provision of health care, or payment for health care that is created or collected by a covered entity; individually identifiable health information[13,14]

Section 1: Personal Reflection Question

Why do medical malpractice claims arise in health care settings?

Section 2: Recommendations to Help Prevent Medical Malpractice Litigation

It has been well established that medical malpractice claims and lawsuits have become a very real part of health care. Thus, health care professionals should understand how to protect themselves against medical malpractice claims and litigation. It has been argued that one of the best ways health care professional may protect themselves against medical malpractice claims and lawsuits is to understand why they may arise in the first place. That being said, health care professionals may also protect themselves against medical malpractice claims and lawsuits by following recommendations that were developed to help health care professionals prevent medical malpractice litigation. Fortunately, for health care professionals, recommendations have been developed to help them prevent medical malpractice claims and lawsuits. This section of the course will review such recommendations.

Recommendations to Help Prevent Medical Malpractice Claims and Lawsuits

Health care professionals should be aware of the necessary elements of a malpractice suit - in order to prove malpractice against a health care professional the following elements should be present: a health care professional has a duty to a patient, a health care professional breached said duty to a patient, a patient injury

occurred, and a causal relationship exists between breach of health care duty and patient injury (e.g., a health care professional deviates from his or her deemed appropriate duties, which in turn causes an injury to a patient).[1] Health care professionals should note the following: understanding the elements of a medical malpractice suit may provide a context for the following recommendations.

Health care professionals should uphold the ethic principles of health care - health care professionals should ensure that they uphold the four major ethic principles of health care, which include: patient autonomy, beneficence, nonmaleficence, and justice.[2] Working within the ethic parameters of health care can help health care professionals prevent medical malpractice claims and lawsuits, as well as ensure the safe and effective administration of health care to patients.

Health care professionals should adhere to their related scopes of practice - as previously mentioned, a scope of practice is a legal guide that highlights a health care professional's responsibilities and limitations. It is essential that health care professionals adhere to their related scopes of practice. Health care professionals should note that specific scopes of practice may vary by state. A health care professional should be familiar with his or her particular state of licensure's scope of practice.

Health care professionals should adhere to relevant standards of practice - it is highly recommended that all health care professionals follow the standards of practice set forth by their professional organization in every aspect of health care administration to ensure they are in accordance with the necessary requirements for safe and effective health care. A failure to do so may lead to medical malpractice claims.

Health care professionals should determine a patient's capacity when administering health care - it is important for health care professionals to assess a patient's capacity when administering health care. Patients should possess the capacity to understand what is happening to them, and should be able to make their own individual decisions regarding their personal health care.

Health care professionals should obtain informed consent from a patient, when applicable - informed consent is an essential aspect of health care. Thus, health care professionals should obtain informed consent from a patient before a health care intervention is conducted. Typically, the process of obtaining informed consent requires a signature from a patient. Health care professionals should note the following informed consent exceptions: the patient is incapacitated, life-threatening emergencies with inadequate time to obtain consent, and voluntary waived consent.[5]

Health care professionals should acknowledge a power of attorney - a health care power of attorney grants, in writing, a particular agent the power to make healthcare decisions on another individual's behalf.[6] If a health care professional is presented with a power of attorney form and is not sure how to proceed, he or she should consult with a manager and/or a health care administrator.

Health care professionals should work to prevent medical errors from occurring - in an ideal health care climate, medical errors would not occur - however, the simple truth of the matter is that they do. Thus, health care professionals should work to prevent medical errors from occurring. One method health care professionals may use to prevent medical errors from occurring is to follow the Joint Commission's medical error prevention recommendations. Specific information regarding the Joint Commission's medical error prevention recommendations may be found below. The information found below was derived from materials provided by the Joint Commission.[7]

The Joint Commission's Medical Error Prevention Recommendations:

- Use at least two patient identifiers when providing care, treatment, or services.
- Use at least two patient identifiers when administering medications, blood, or blood components; when collecting blood samples and other specimens for clinical testing; and when providing treatments or procedures. The patient's room number or physical location is not used as an identifier.
- Label containers used for blood and other specimens in the presence of the patient.
- Establish communication tools among staff (for example, visually alerting staff with signage noting newborns with similar names).
- Develop written procedures for managing the critical results of tests and diagnostic procedures.
- Implement the procedures for managing the critical results of tests and diagnostic procedures.
- Evaluate the timeliness of reporting the critical results of tests and diagnostic procedures.
- Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings.

- In perioperative and other procedural settings both on and off the sterile field, label medications and solutions that are not immediately administered. This applies even if there is only one medication being used (note: an immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to a patient, and administers to that patient without any break in the process).
- In perioperative and other procedural settings both on and off the sterile field, labeling occurs when any medication or solution is transferred from the original packaging to another container.
- Verify all medication or solution labels both verbally and visually. Verification is done by two individuals qualified to participate in the procedure whenever the person preparing the medication or solution is not the person who will be administering it.
- Label each medication or solution as soon as it is prepared, unless it is immediately administered. (note: an immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to a patient, and administers to that patient without any break in the process).
- Immediately discard any medication or solution found unlabeled.
- Remove all labeled containers on the sterile field and discard their contents at the conclusion of the procedure (note: this does not apply to multiuse vials that are handled according to infection control practices).
- All medications and solutions both on and off the sterile field and their labels are reviewed by entering and exiting staff responsible for the management of medications.
- Use only oral unit-dose anticoagulant therapy products, prefilled syringes, or premixed infusion bags when these types of products are available (note: for pediatric patients, prefilled syringe products should be used only if specifically designed for children).
- Use approved protocols for the initiation and maintenance of anticoagulant therapy.
- Before starting a patient on warfarin, assess the patient's baseline coagulation status; for all patients receiving warfarin therapy, use a current International Normalized Ratio (INR) to adjust this therapy. The baseline status and current INR are documented in the medical record (note: the patient's baseline

coagulation status can be assessed in a number of ways, including through a laboratory test or by identifying risk factors such as age, weight, bleeding tendency, and genetic factors).

- Use authoritative resources to manage potential food and drug interactions for patients receiving warfarin.
- When heparin is administered intravenously and continuously, use programmable pumps in order to provide consistent and accurate dosing.
- Provide education regarding anticoagulant therapy to prescribers, staff, patients, and families.
- Obtain information on the medications the patient is currently taking when he or she is admitted to a hospital or is seen in an outpatient setting.
- Compare the medication information the patient brought to the hospital with the medications ordered for the patient by the hospital in order to identify and resolve discrepancies (note: discrepancies include omissions, duplications, contraindications, unclear information, and changes).
- Provide the patient (or family as needed) with written information on the medications the patient should be taking when he or she is discharged from the hospital or at the end of an outpatient encounter (for example, name, dose, route, frequency, purpose); when the only additional medications prescribed are for a short duration, the medication information the hospital provides may include only those medications.
- Explain the importance of managing medication information to the patient when he or she is discharged from the hospital or at the end of an outpatient encounter.
- Improve the safety of clinical alarm systems.
- Educate staff and licensed independent practitioners who are involved in managing central lines about central line-associated bloodstream infections and the importance of prevention. Education occurs upon hire or granting of initial privileges and periodically thereafter as determined by the organization.
- Prior to insertion of a central venous catheter, educate patients and, as needed, their families about central line-associated bloodstream infection prevention.

- Use a catheter checklist and a standardized protocol for central venous catheter insertion.
- Use a standardized supply cart or kit that contains all necessary components for the insertion of central venous catheters.
- Educate staff and licensed independent practitioners involved in surgical procedures about surgical site infections and the importance of prevention. Education occurs upon hire, annually thereafter, and when involvement in surgical procedures is added to an individual's job responsibilities.
- Educate patients, and their families as needed, who are undergoing a surgical procedure about surgical site infection prevention.
- Implement policies and practices aimed at reducing the risk of surgical site infections. These policies and practices meet regulatory requirements and are aligned with evidence-based guidelines (for example, the CDC and/or professional organization guidelines).
- Educate staff and licensed independent practitioners involved in the use of indwelling urinary catheters about catheter-associated urinary tract infections (CAUTI) and the importance of infection prevention. Education occurs upon hire or granting of initial privileges and when involvement in indwelling catheter care is added to an individual's job responsibilities. Ongoing education and competence assessment occur at intervals established by the organization.
- Conduct a preprocedure verification process.
- Implement a preprocedure process to verify the correct procedure, for the correct patient, at the correct site (note: the patient is involved in the verification process when possible).
- Mark a procedure site before surgery.
- Identify those procedures that require marking of the incision or insertion site. At a minimum, sites are marked when there is more than one possible location for the procedure and when performing the procedure in a different location would negatively affect quality or safety (note: for spinal procedures, in addition to preoperative skin marking of the general spinal region, special intraoperative imaging techniques may be used for locating and marking the exact vertebral level).

- Identify patients that may be at risk for suicide - the suicide of a patient while in a staffed, round-the-clock care setting is a frequently reported type of sentinel event (sentinel event may refer to an unanticipated event in a health care setting that results in death or serious physical or psychological injury to a patient(s), not related to the natural course of the patient's illness); identification of individuals at risk for suicide while under the care of or following discharge from a health care organization is an important step in protecting these at-risk individuals.[7] To help prevent any litigation that may arise from a suicide-related issue, health care professionals and health care organizations should adhere to the following recommendations: identify patients at risk for suicide, conduct a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide, address the patient's immediate safety needs and most appropriate setting for treatment, and, finally, when a patient at risk for suicide leaves the care of the hospital, provide suicide prevention information (such as a crisis hotline) to the patient and his or her family.[7]
- Practice effective hand hygiene - according to the Centers for Disease Control and Prevention (CDC), each year, millions of people acquire an infection while receiving care, treatment, and services in a health care organization.[15] Consequently, health care-associated infections are a patient safety issue affecting all types of health care organizations. One of the most important ways to address health care-associated infections is by practicing effective hand hygiene. Hand hygiene may refer to the process of cleaning hands in order to prevent contamination and/or infections.[15] Hand hygiene is most effective when dirt, soil, microorganisms and other contaminates are removed from the hands. To carry out effective hand hygiene, health care professionals should follow recommended steps when using soap and water or an alcohol-based formulation. The recommended steps for hand hygiene with soap and water as well as an alcohol-based formulation may be found below. The information found below was derived from materials provided by the CDC.[15] Health care professionals should note that the duration of the entire hand washing procedure with soap and water should last between 40 - 60 seconds.[15] Health care professionals should also note the duration of the entire hand hygiene procedure with an alcohol-based formulation should last between 20 - 30 seconds.[15]

Hand Hygiene Procedure with Soap and Water

1. The health care professional should wet his or her hands with water.

2. The health care professional should apply enough soap to cover all hand surfaces.
3. The health care professional should rub his or her hands palm to palm.
4. The health care professional should rub the right palm over the left dorsum with interlaced fingers and vice versa.
5. The health care professional should rub his or her hands palm to palm with fingers interlaced.
6. The health care professional should rub the backs of fingers to opposing palms with fingers interlocked.
7. The health care professional should engage in rotational rubbing of the left thumb clasped in the right palm and vice versa.
8. The health care professional should engage in rotational rubbing, backwards and forwards with clasped fingers of the right hand in the left palm and vice versa.
9. The health care professional should then rinse his or her hands with water.
10. The health care professional should then dry his or her hands thoroughly with a single use towel.
11. Finally, the health care professional should use a towel to turn off the faucet.

Hand Hygiene Procedure with an Alcohol-Based Formulation

1. The health care professional should first apply a palmful of alcohol-based product in a cupped hand, making sure to cover all surfaces.
2. The health care professional should then rub his or her hands palm to palm.
3. The health care professional should rub the right palm over the left dorsum with interlaced fingers and vice versa.
4. The health care professional should rub his or her hands palm to palm with fingers interlaced.

5. The health care professional should rub the backs of his or her fingers to opposing palms with fingers interlocked.
6. The health care professional should engage in the rotational rubbing of the left thumb clasped in the right palm and vice versa.
7. The health care professional should engage in rotational rubbing, backwards and forwards with clasped fingers of the right hand in the left palm and vice versa.
8. Finally, health care professionals should note that their hands are safe once they are dry.

- Apply fall precautions to all patients - falls can be very dangerous to patient care and possess the potential to dramatically impact patients' health and overall well-being. Additionally, patient falls may lead to incidents which potentially could cause medical malpractice claims and lawsuits. Therefore, it is essential that health care professionals apply fall precautions to all patients, independent of age, diagnosis, or treatment. In other words, fall precautions constitute the basics of patient safety and should be applied in all health care facilities to all patients. Specific fall precautions may be found below. The information found below was derived from materials provided by the CDC.[15]

Fall Precautions

- Familiarize the patient with the environment
- Have the patient demonstrate call light use
- Maintain call light within reach
- Keep the patient's personal possessions within patient safe reach
- Have sturdy handrails in patient bathrooms, room, and hallway
- Place the hospital bed in low position when a patient is resting in bed; raise bed to a comfortable height when the patient is transferring out of bed
- Keep hospital bed brakes locked
- Keep wheelchair wheel locks in a locked position when stationary
- Keep nonslip, comfortable, well-fitting footwear on the patient
- Use night lights or supplemental lighting

- Keep floor surfaces clean and dry
- Clean up all spills promptly
- Keep patient care areas uncluttered
- Follow safe patient handling practices

Health care professionals should identify patients that have special needs and/or requirements - some patients such as older adult patients (the term older adult may refer to individuals 65 years or older) or patients suffering from anxiety, depression, or attention-deficit/hyperactivity disorder (ADHD) may have special needs and/or requirements.[15] Health care professionals should work to identify such patients to ensure they meet the needs and requirements of each individual patient. Failure to do so may lead to medical malpractice claims/lawsuits.

Health care professionals should identify patients that require antithrombosis stockings - to build on the previous recommendation, health care professionals should be sure to identify patients that require antithrombosis stockings. An antithrombosis stocking may refer to a any health care stocking that may be used to put pressure on the legs in order to improve upon circulation and thus reduce the chance of a blood clot.[15] Antithrombosis stockings may be essential to the health care of some patients, thus, health care professionals should ensure that patients that require antithrombosis stocking, have antithrombosis stockings. Failure to do so may lead to medical malpractice claims/lawsuits.

Health care professionals should make sure patients are adequately hydrated - adequate hydration may be an essential aspect of patient care. Thus, health care professionals should ensure patients are adequately hydrated. Health care professionals should note the following sings of dehydration: very dry skin, rapid heartbeat, rapid breathing, confusion, and dark urine output.

Health care professionals should make sure patients receive adequate nutrition - it is important patients are well nourished when receiving health care. Thus, health care professionals should ensure patients receive adequate nutrition. Health care professionals should note the following symptoms of malnutrition: fatigue, dizziness, and weight loss.

Health care professionals should address patient emergencies in a timely manner - failure to address patient emergencies in a timely manner may be viewed as a breach of health care duty.[1] Thus, health care professionals should address emergencies in a timely manner to prevent potential medical malpractice claims/ lawsuits.

Health care professionals should be sure they understand how to use vital health care equipment - the term health care equipment may refer to any equipment used for the purposes of health care (i.e., equipment used for the purposes of health care diagnosis, treatment, and/or therapy).[15] Health care professionals should ensure they are adequately trained on how to use any such health care equipment necessary for patient care. If a health care professional is not sure how to effectively use any piece of health care equipment they should seek training and education pertaining to the health care equipment in question. Health care professionals should also ensure health care equipment is adequately sterilized, when applicable.

Health care professionals should foster effective communication - effective communication occurs when information and messages are adequately transmitted, received and understood.[8] To foster effective communication health care professionals should work to achieve an open communication climate or culture within health care organizations. An open communication climate is characterized by communication that requires unrestricted, honest and mutual interaction for people to understand each other better, in order to promote tolerance, minimize conflicts, and promote safe and effective health care.[8] An open communication climate is essential to achieve a healthy work environment and it can therefore be regarded as health-promoting due to its potential ability to strengthen the conditions for health care professionals to exert a positive influence and become involved in the adequate care of pateints.[8]

Health care professionals should work to avoid miscommunication when transmitting relevant patient information to other health care professionals, patients, and patients' families - when miscommunication occurs between individuals, intended meaning may be lost. Miscommunication can be problematic in health care environments because it may lead to issues which, in turn, could cause medical malpractice claims and lawsuits against health care professionals. Thus, health care professionals should work to prevent miscommunication whenever possible. Health care professionals may prevent miscommunication by: removing physical barriers when communicating with other individuals, maintaining eye contact, remaining professional, allowing for a free flow of information between individuals, engaging in active listening, clarifying points of confusion, asking questions, maintaining emotional stability, allowing others to speak, and by limiting interruptions and distractions.[9]

Complete effective health care documentation - health care professionals should recall the following concept when considering health care documentation and medical malpractice claims and lawsuits: if it was not documented, then it was not done. That being said, health care professionals should be sure to complete effective health care

documentation when applicable. In order for health care documentation to be considered effective, it must function as a viable form of communication, as well as a means to establish a detailed record of health care administration. There are many different forms of health care documentation - however, if health care professionals include the following specific characteristics in their documentation, they can ensure their documentation will be effective.

The first characteristics of effective documentation are objectivity and accuracy. Health care documentation should include objective information free of subjective judgment, bias or opinion. Health care documentation should also be accurate - meaning it should include information which can be measured or verified by another individual.

Additional characteristics of effective health care documentation include clarity and completeness. Clarity, as it relates to health care documentation, may refer to a quality which enables multiple health care professionals to obtain meaning from recorded data and/or information relating to health care. Completeness, as it relates to health care documentation, may refer to a state where all of the necessary components and/or parts are present. Only when **c**larity and completeness are achieved can health care documentation be considered effective.

Finally, the information found within health care documentation should be readily accessible and available to all those who require it. Thus, health care professionals must include accurate times and dates of health care administration when completing their health care documentation to further its effectiveness.

Complete adequate patient assessments - a patient assessment may occur when a patient presents to a health care facility, when a patient is admitted into a health care facility, and at any other point in a patient's health care treatment deemed necessary. Failure to complete adequate patient assessments and/or failure to effectively communicate and document the relevant patient information obtained from a patient assessment may lead to medical malpractice claims/lawsuits.

Adequately monitor patients - for some patients, patient monitoring may be essential to their health care, especially if a patient is admitted to an intensive care unit of a hospital or is on specific medications that may require routine analysis (e.g., warfarin). Failure to complete adequate patient monitoring and/or failure to effectively communicate and document the relevant patient information obtained from patient monitoring may lead to medical malpractice claims/lawsuits.

Health care professionals should adhere to health care organizations' policies and procedures - typically, health care organizations' policies and procedures are

designed to safeguard patient safety and health care. They also may be designed to help health care professionals avoid circumstances that may lead to medical malpractice claims and lawsuits. Thus, health care professionals should be familiar with their specific health care organization's policies and procedures. Failure to follow health care organization's policies and procedures may lead to medical malpractice claims/lawsuits.

Health care professionals should report potential patient safety issues that may warrant investigation to appropriate individuals associated with their health care organizations - reporting potential patient safety issues (e.g., faulty health care equipment) that may exist within their associated health care facility may help health care professionals, their peers, and their associated health care organizations avoid incidents that may lead to medical malpractice claims. With that said, in order for health care professional reporting to be effective, health care organizations must have internal channels for such reporting. Health care professionals should be familiar with their associated health care organization's methods for patient safety reporting. If no such channels exist, health care professionals should consider approaching representatives of their health care organization that may be able to help develop such channels.

Health care professionals should make attempts to continue their health care education and remain up to date on relevant health care topics - health care information is always being updated. Thus, health care professionals should pursue opportunities to further their education. Remaining up to date on relevant health care topics can help health care professionals in their daily practice and can further their understanding of how to provide safe and effective health care to patients in need.

Health care professionals should adhere to HIPAA regulations and other relevant laws - violations of HIPAA regulations and other relevant health care-related laws may lead to lawsuits against health care professionals. Thus, health care professionals must follow HIPAA regulations and other relevant health care-related laws when practicing health care. Health care professionals should note that each state may have different, relevant health care-related laws. Health care professionals should be familiar with their states of licensure-related laws.

Health care professionals should be familiar with good Samaritan laws - fortunately, there are laws in place which protect individuals attempting to help persons in need from legal action - such laws are referred to as good Samaritan laws. Specific information regarding good Samaritan laws, and how they relate to health care professionals, may be found below.

<u>Information Regarding Good Samaritan Laws</u>

- Good Samaritan laws have their basis on the concept that consensus agreement favors good "public policy" to limit liability for those who voluntarily perform care and rescue in emergency situations.[16]
- The general principle of most versions of the good Samaritan law provides for protection from claims of negligence for those who provide care without expectation of payment.[16]
- All 50 states and the District of Columbia have a good Samaritan law, in addition to Federal laws for specific circumstances (health care professionals should be familiar with their states of licensure-related laws).[16]
- Good Samaritan laws give liability protection against “ordinary negligence” (the term ordinary negligence may refer to the failure to act as a reasonably prudent person).[16]
- Good Samaritan laws do not, typically, protect against "gross negligence" or willful actions (the term gross negligence may refer to a conscious and voluntary disregard of the need to use reasonable care, which is likely to cause foreseeable grave injury or harm to persons, property, or both).[16]
- In order for good Samaritan laws to be applicable for health care professionals, certain conditions must apply. For example, there must exist no duty to treat (for the aforementioned reason, good Samaritan law protection does not typically apply to on-call health care professionals; any health care professional that has a pre-existing relationship with a patient cannot be considered a good Samaritan).[16] Another exclusion to almost all state statutes is that the health care professionals providing aid cannot receive compensation for their care (if one receives any remuneration for helping in rendering emergency care, he or she can no longer be considered a good Samaritan, and therefore, the protections no longer apply).[16]
- Health care professionals should note that due to the current opioid crisis in the U.S., at least, 40 states and the District of Columbia have enacted good Samaritan laws specific to opioid-related issues such as responding to opioid overdoses.[16]
- Health care professionals should note the following: most good Samaritan laws do not apply to medical professionals or career emergency responders during on-the-job conduct; however, some extend protection to professional rescuers when they are acting in a volunteer capacity.[16]

Health care professionals should understand how to make effective decisions to adequately resolve any challenges or conflicts that may arise when administering health care to patients in need - this final recommendation for health care professionals may be one of the most important, because all of the other previous recommendations may be dependent upon it. That being said, health care professionals do face many challenges and/or conflicts when administering health care to patients, which, if not adequately resolved may lead to medical malpractice claims and lawsuits. Thus, health care professionals should understand how to effectively make decisions to adequately resolve any challenge or conflict that may arise in order to foster safe and effective health care and to, ultimately, prevent medical malpractice claims/lawsuits. With the previous concept in mind, how can health care professionals make effective decisions to adequately resolve any challenges and/or conflicts that may arise? It has been argued that one of the best methods to resolve a challenge or conflict is to use a multistep decision-making model. A decision-making model, as it relates to this course, may refer to a step-by-step process which may be used to reach an informed decision or necessary course of action to resolve a challenge and/or conflict.[17] Health care professionals should note that there are many different types of decision-making models which may be used by health care professionals to resolve challenges and/or conflicts. However, the various types of decision-making models have core, fundamental steps in common which form the basis of most models. Therefore, it is essential that health care professionals understand the seven core, fundamental steps of decision-making models so they may use any such model to efficiently and effectively resolve any challenge and/or conflict that may arise when administering health care. Information regarding the seven core, fundamental steps of decision-making models may be found below.

<u>The Seven Fundamental Steps of Most Decision-Making Models</u>

Step 1: Gather information - gathering information is essential to any endeavor, especially when it comes to making a decision. After all, how can individuals make a decision if they do not know what they are making a decision about? In essence, information is the foundation on which a decision is built on or made. Thus, information relevant to a decision must be obtained before any other step is taken, especially when it comes to making a decision related to health care. Simply put, health care-related information is essential to health care decisions - so much so, it has often been argued, that without relevant health care information, effective health care decisions cannot be made. For example, a health care professional cannot make a safe and effective decision regarding a patient's medication if the health care professional does not have any information indicating what the patient's medications are or have been over a certain period of time. The same

principles which apply to the previous example can be applied to health care professionals and decision making. A health care professional cannot make a decision regarding a challenge/conflict if the health care professional does not have any information indicating what the challenge/conflict is, who it involves and any other related health care information. Thus, when a health care professional is presented with a challenge/dilemma the first thing he or she should do is gather relevant information (e.g., the who, what, where and why elements of a challenge/conflict).

Step 2: Clarify relevant points of interest to accurately identify the principle issue of the presented challenge/conflict - once a health care professional obtains information regarding a challenge/conflict, he or she should mentally sift through the information to identify the most relevant points of interest that can help the health care professional make a decision and/or resolve the challenge/conflict at hand. Furthermore, health care professionals should take time to reflect on the collected relevant information to ensure they are accurately identifying the principle issue presented by the challenge/conflict at hand.

Step 3: Identify and consider relevant standards, principles, and laws which apply to the challenge/conflict's principle issue or issues - in other words, once a health care professional understands what the principle issue behind a challenge/conflict is, then he or she should consider what laws and ethic principles apply to the particular issue of concern. For example, if a health care professional identifies confidentiality as the main issue behind a challenge/conflict, then the health care professional should review all of the state and federal laws which apply to confidentiality. Health care professionals should use state and federal laws in conjunction with different applicable ethic principles to guide their decision-making process when making health care decisions and/or resolving challenges/conflicts.

Step 4: Develop potential courses of action that may be used to make a decision and/or resolve a challenge/conflict - as it pertains to this course, a course of action may refer to the possible solution(s) or method(s) which may be used to resolve a challenge and/or conflict. When faced with a challenge/ conflict, it is always a good idea to conceive or develop many different potential solutions or methods to obtain resolution to the challenge/conflict at hand. One can never be quite sure as to what may occur to prevent a possible solution from taking action. Having multiple potential solutions at hand can provide health care professionals with several options to have at their disposal in case events do not proceed as planned and the health care professional has

to change his or her course of action. Additionally, generating multiple courses of action can help provide health care professionals with perspective on the challenge/conflict. Contemplating events and pondering possible solutions may allow the health care professional to view a challenge/conflict from a different perspective, which in turn may shed new light on the challenge/ conflict and open up additional potential options for resolution. Often when presented with a challenge, it is typically better to have more options for resolution, than few or no options. Thus, by developing several potential courses of action regarding a challenge/conflict, health care professionals can provide themselves with multiple options to efficiently and effectively resolve the challenge/conflict at hand.

Step 5: Identify and consider the pros and cons of each potential course of action - when a decision is reached regarding a patient and a related challenge/conflict, it possesses the potential to affect many other individuals connected to the patient. In other words, health care professionals' decisions may not only impact their lives and patients' lives but also the individuals around them. Therefore, it is important for health care professionals to understand the weight of their decisions. Identifying the pros and cons or risks and benefits of each potential course of action can help health care professionals understand how their decisions or courses of action will affect the people around them, including the patients.

Health care professionals may identify the possible pros and cons of potential courses of action regarding a dilemma by using several different methods. One such method involves simply writing out each course of action and then creating a list of possible pros and cons for each course of action. The aforementioned method of examining the possible pros and cons of potential courses of action can help health care professionals visualize the risks and benefits of each potential course of action. By generating a pros-cons list, a health care professional may be able to clearly see which course of action has the most pros and which courses of action have the most cons, allowing the health care professional to eliminate the courses of action with the most cons and select the course of action with the most pros. When creating the pros-cons list for each possible course of action, health care professionals should ask themselves several questions to help them create each list. Examples of the types of questions health care professionals should ask themselves include the following:

- How will this course of action affect the patient?

- How will this course of action affect the patient's treatment?
- How will this course of action affect the patient's overall health?
- How will this course of action affect my colleagues?
- Is this course of action in line with state and federal laws?
- Is this course of action in line with applicable codes of ethics?
- Will this course of action resolve the challenge/conflict or intensify the challenge/conflict?
- What steps may have to be taken to fulfill this course of action?

By asking the previous types of questions for each potential course of action, it may help health care professionals identify possible pros and cons that were not previously considered.

Step 6: Make a decision - Step 6 is arguably the most important step in this process. At this point in the decision-making process, a health care professional should have a clear choice of action to reach resolution (i.e., the previous five steps should have provided a health care professional with the optimal course of action required for his or her challenge/conflict). If, at this point in the process, health care professionals do not have a clear choice for a course of action to resolve the pressing challenge/conflict, then health care professionals should repeat the previous five steps until one emerges. Once a clear course of action presents itself, health care professionals should document the selected course of action, as well as the steps taken to obtain it, if applicable. When the appropriate documentation is complete, all that remains is for the health care professional to set the selected course of action in motion and resolve the challenge/conflict at hand.

Step 7: Reflection and redirection, if necessary - reflection, as it pertains to decision-making, may refer to a process of thought and/or consideration. Anytime a major decision is made, it is best to reflect on the chosen decision to ensure it is the best possible decision available to achieve desired outcomes. Reflection on decisions can come in many forms such as: deep thought, journaling and/or discussions with colleagues. Whatever form of reflection health care professionals choose to take, they should ask themselves certain questions to facilitate the reflection process and to achieve a clear perspective on the chosen course of action's ability to resolve the challenge

and/or conflict at hand. The types of questions health care professionals should ask themselves during the reflection process may include:

- Is the selected course of action the best possible method to resolve the challenge/conflict?
- Will the selected course of action achieve desired results and/or outcomes?
- Will the selected course of action benefit the parties involved?
- Is the selected course of action objective in nature?
- How is the selected course of action impacting the situation and the individuals involved now that it has been set in motion?
- Is the selected course of action improving the situation regarding the challenge/conflict?
- How is the selected course of action improving the situation regarding the challenge/conflict?

If any of the aforementioned types of questions cannot be answered, or if the health care professional determines that the chosen course of action may not be the best possible solution to achieve desired outcomes after all, then the health care professional may have to act and redirect the course of action if deemed necessary.

Redirection, as it pertains to decision-making, can refer to the process of assessing, altering, adjusting and/or changing the course of action selected to resolve a challenge/conflict. Redirection may be necessary when resolving a challenge/conflict for several different reasons. For example, perhaps the chosen course of action proves to be harmful to the individuals involved in the challenge/conflict as opposed to beneficial, or perhaps the selected course of action requires altering, adjustments or subtle modifications because new information regarding the challenge/conflict has surfaced, or perhaps the selected course of action needs to be completely changed or replaced because it is no longer legally feasible. Whatever the case may be, if a health care professional determines, upon reflection, that a selected course of action is not working as desired or requires adjustments for any other appropriate reason, he or she should not hesitate in redirecting the selected course of action to ensure optimal outcomes are achieved. If redirection is necessary,

health care professionals may have to document why it was required, what adjustments were made and/or how a new course of action was selected.

Section 2: Summary

Health care professionals may protect themselves against medical malpractice claims and lawsuits by understanding why they may arise in the first place. Health care professionals may also help prevent medical malpractice claims and lawsuits by following recommendations that were developed to help them prevent medical malpractice litigation. Fortunately, for health care professionals, recommendations have been developed to help them prevent medical malpractice claims and lawsuits. Such recommendations include the following: health care professionals should be aware of the necessary elements of a malpractice suit, health care professionals should uphold the ethic principles of health care, health care professionals should adhere to their related scope of practice, health care professionals should adhere to relevant standards of practice, health care professionals should determine a patient's capacity when administering health care, health care professionals should obtain informed consent from a patient (when applicable), health care professionals should acknowledge a power of attorney, health care professionals should work to prevent medical errors from occurring, health care professionals should identify patients that may be at risk for suicide, practice effective hand hygiene, apply fall precautions to all patients, health care professionals should identify patients that have special needs and/or requirements, health care professionals should identify patients that require antithrombosis stockings, health care professionals should make sure patients are adequately hydrated, health care professionals should make sure patients receive adequate nutrition, health care professionals should address patient emergencies in a timely manner, health care professionals should be sure they understand how to use vital health care equipment, health care professionals should foster effective communication, health care professionals should work to avoid miscommunication when transmitting relevant patient information to other health care professionals, patients, and/or patients' families, health care professionals should complete effective health care documentation, complete adequate patient assessments, adequately monitor patients, health care professionals should adhere to health care organizations' policies and procedures, health care professionals should report potential patient safety issues that may warrant investigation to appropriate individuals associated with their health care organizations, health care professionals should make attempts to continue their health care education and remain up to date on relevant health care topics, health care professionals should adhere to HIPAA regulations and other relevant laws, health care professionals should be familiar with

good Samaritan laws, and health care professionals should understand how to make effective decisions to adequately resolve any challenge or conflict that may arise when administering health care to patients in need.

Finally, health care professionals should note the following: health care professionals should work in tandem with their health care organizations to promote patient safety and to prevent medical malpractice claims and lawsuits.

Section 2: Key Concepts

Health care professionals can help prevent medical malpractice claims and lawsuits by following related recommendations.

Section 2: Key Terms

Sentinel event - an unanticipated event in a health care setting that results in death or serious physical or psychological injury to a patient(s), not related to the natural course of the patient's illness[7]

Hand hygiene - the process of cleaning hands in order to prevent contamination and/or infections[15]

Older adult - may refer to individuals 65 years or older[15]

Antithrombosis stocking - any health care stocking that may be used to put pressure on the legs in order to improve upon circulation and thus reduce the chance of a blood clot[15]

Health care equipment - any equipment used for the purposes of health care; equipment used for the purposes of health care diagnosis, treatment, and/or therapy[15]

Clarity (as it relates to health care documentation) - a quality which enables multiple health care professionals to obtain meaning from recorded data and/or information relating to health care

Completeness (as it relates to health care documentation) - a state where all of the necessary components and/or parts are present

Good Samaritan laws - laws in place which protect individuals attempting to help persons in need from legal action[16]

Ordinary negligence - the failure to act as a reasonably prudent person[16]

Gross negligence - a conscious and voluntary disregard of the need to use reasonable care, which is likely to cause foreseeable grave injury or harm to persons, property, or both[16]

Decision-making model (as it relates to this course) - a step-by-step process which may be used to reach an informed decision or a necessary course of action to resolve a challenge and/or conflict[17]

Course of action (as it relates to decision-making) - the possible solution(s) or method(s) which may be used to resolve a challenge and/or conflict

Reflection (as it relates to decision-making) - a process of thought and/or consideration

Redirection (as it relates to decision-making) - the process of assessing, altering, adjusting and/or changing the course of action selected to resolve a challenge/ conflict

Section 2: Personal Reflection Question

How can health care professionals apply the above recommendations to patient care and the prevention of medical malpractice claims?

Case Study: Medical Malpractice

A medical malpractice-related case study is presented below to review the concepts found in this course. A case study review will follow the case study. The case study review includes the types of questions health care professionals should ask themselves when attempting to prevent medical malpractice. Additionally, reflection questions will be posed, within the case study review, to encourage further internal debate and consideration regarding the presented case study and medical malpractice prevention.

Case Study

A 20-year-old female patient presents to a health care facility with complaints of anxiety. Upon initial examination, the patient reports that she has an allergy to ibuprofen. The patient also reports that she has taken ibuprofen in the past and experienced hives as a result. A health care professional notes the patient's ibuprofen allergy but does not document it. The patient then goes on to explain that she has been feeling "very restless and anxious." She also explains that she cannot focus and has recently "quit school" because of her inability to focus. Upon further questioning

the patient reports that she has recently been diagnosed with attention-deficit/ hyperactivity disorder (ADHD), however has not been taking her medications. The patient also adds that her parents do not know about her current situation regarding school and her medication use. The health care professional does not ask the patient any further questions about her symptoms, medications, or why she has not been taking her medications.

After further examination, the patient is admitted into the health care facility. The patient is shown to her room. The health care professional responsible for escorting the patient to her room leaves the patient alone in her room, as the patient begins to get into her bed, without providing the patient with any further information. Several hours later, after becoming restless and anxious, the patient attempts to get out of bed to use the bathroom. Unfortunately, the patient falls when attempting to get out of bed. The patient sustains several injuries as a result of her fall and begins to experience pain. While the patient is being treated for her injuries she is administered ibuprofen. Shortly after the ibuprofen is administered the patient experiences hives as well as facial swelling. The patient's allergic reaction from the ibuprofen is treated, and the patient recovers without any further incident. However, due to the allergic reaction and the fall, the patient becomes very anxious after the ordeal. Soon the patient begins to act out and become aggressive. The patient also makes claims that she does not want to live anymore because "she just cannot take it." The patient's claims are noted, although no further assessment is completed regarding the patient's claims.

Eventually, the patient's attitude and demeanor begin to slightly improve. Additionally, the patient begins medication treatment for her ADHD. The patient responds well to her ADHD medication and soon the patient is discharged from the health care facility. The patient does not receive any discharge instructions regarding her medication use. Soon after discharge, the patient stops using her medications due to related confusion. After some time passes, the patient's parents become aware of their daughter's situation, as well as her experiences in the health care facility. The patient's parents are outraged and seek the consultation of a lawyer.

Case Study Review

What patient details may be relevant to possible medical malpractice litigation?

The following patient details may be relevant to possible medical malpractice litigation: the patient reports that she has an allergy to ibuprofen, the patient reports that she has taken ibuprofen in the past and experienced hives as a result, a health care professional notes the patient's ibuprofen allergy but does not document it, the patient reports that she has been feeling "very restless and anxious", the patient

reports that she cannot focus and has recently "quit school" because of her inability to focus, the patient reports that she has recently been diagnosed with ADHD, the patient reports that she has not been taking her medications, the health care professional does not ask the patient any further questions about her symptoms, medications, or why she has not been taking her medications, the health care professional responsible for escorting the patient to her room leaves the patient alone in her room, as the patient begins to get into her bed, without providing the patient with any further information, the patient falls when attempting to get out of bed, the patient sustains several injuries as a result of her fall and begins to experience pain, the patient is administered ibuprofen, shortly after the ibuprofen is administered the patient experience hives as well as facial swelling, the patient makes claims that she does not want to live anymore because "she just cannot take it," the patient's claims specific to not wanting to live are noted, although no further assessment is completed regarding the patient's claims, the patient does not receive any discharge instructions regarding her medication use upon discharge, and finally, soon after discharge the patient stops using her medications due to related confusion.

Are there any other patient details that may be relevant to possible medical malpractice litigation; if so, what are they?

How are each of the aforementioned patient details relevant to possible medical malpractice litigation?

Each of the previously highlighted patient details may be potentially relevant to possible medical malpractice litigation. The potential relevance of each patient detail may be found below.

The patient reports that she has an allergy to ibuprofen - the previous patient detail is relevant because it shows that the patient indentified that she is allergic to ibuprofen. The previous patient detail may also be relevant because it shows the patient informed a health care professional about her ibuprofen allergy, which is information that may prove relevant in a medical malpractice lawsuit.

The patient reports that she has taken ibuprofen in the past and experienced hives as a result - the previous patient detail is relevant because it shows that the patient's allergy is a true allergy. Often patients report that they have an allergy to a specific medication to a health care professional. However, the reported allergy may not represent a true allergy. At times, patients confuse medication side effects with a medication allergic reaction. Experiencing medication side effects does not mean the patient has an allergy to a medication. When a patient reports that he or she has a medication allergy, health care professionals should ask follow up questions to the patient to determine if the medication allergy is indeed a true allergy. An example of

the types of questions health care professionals should ask patients regarding their reported medication allergies include the following: what happened when you took the medication in the past; what was your reaction to the medication when you took it previously? Once a health care professional determines the true nature of a patient's reported medication allergy, he or she should be sure to effectively document the patient's allergies as well as any relevant, related information. Failure to do so may lead to incidents that may warrant the potential for medical malpractice litigation.

A health care professional notes the patient's ibuprofen allergy but does not document it - the previous patient-related detail may be extremely relevant to possible medical malpractice litigation because it may be used to prove a breach in health care professional duties. As previously mentioned, in order to prove malpractice against a health care professional the following elements should be present: a health care professional has a duty to a patient, a health care professional breached said duty to a patient, a patient injury occurred, and a causal relationship exists between breach of health care duty and patient injury (e.g., a health care professional deviates from his or her deemed appropriate duties, which in turn causes an injury to a patient).[1] Often health care documentation is viewed upon as a health care professional duty. Thus, failure to complete effective health care documentation may prove to be a breach in health care professional duty and, ultimately, an essential element of medical malpractice litigating. That being said, health care professionals should note the following: in order for health care documentation to be considered effective, it must function as a viable form of communication, as well as a means to establish a detailed record of health care administration. Health care professionals should also note that effective health care documentation includes the following characteristics: objectivity, accuracy, clarity and completeness, as well as accurate times and dates of health care administration.

The aforementioned patient detail may also be relevant because it may be evidence of an inadequate patient assessment. Health care professionals should note that medical malpractice litigation may arise due to the failure of a health care professional to adequately assess patients and document relevant assessment patient details.

The patient reports that she has been feeling "very restless and anxious" - the previous patient detail is relevant because it provides insight into the patient's presentation to the health care facility and recently diagnosed ADHD. The previous patient detail is also relevant because it represents important patient information that should be effectively documented. That being said, there is no evidence present in the case study to determine if the health care professional documented the

aforementioned relevant patient detail. If the health care professional did not effectively document the previous patient detail, the lack of health care documentation may be used as further evidence to establish a breach in health care professional duty and/or used as evidence to support inadequate patient assessment.

The patient reports that she cannot focus and has recently "quit school" because of her inability to focus - the previous patient detail is relevant because it provides further insight into the patient's presentation to the health care facility and recently diagnosed ADHD.

The patient reports that she has recently been diagnosed with ADHD - the previous patient detail is relevant because it provides further insight into the patient's presentation to the health care facility. The previous patient detail is also relevant because it may be used to identify the patient as a potential patient that may have special needs and/or requirements. As previously mentioned, some patients such as older adult patients or patients suffering from anxiety, depression, or ADHD may have special needs and/or requirements. Health care professionals should work to identify such patients to ensure they meet the needs and requirements of each individual patient. Failure to do so may lead to medical malpractice litigation.

The patient reports that she has not been taking her medications - the previous patient detail is relevant because it provides additional insight into the patient's presentation to the health care facility. The previous detail is also relevant because it is an important piece of health care information that should be documented.

The health care professional does not ask the patient any further questions about her symptoms, medications, or why she has not been taking her medications - the previous patient detail is relevant because it may point to an inadequate patient assessment. When patients present to health care facilities, it is important for health care professionals to obtain as much information about the patient's presenting condition as possible. When patients talk about their presenting symptoms, medications, or lack of medication adherence it is important for health care professionals to ask follow up questions to ascertain additional, relevant information that may prove to be very useful in the patient's care. Examples of the types of questions health care professionals should ask patients include the following: are you experiencing any other symptoms, what medications are you currently taking, what are the doses of your current medications, do you take your medications as instructed, and why did you stop taking your medications, if applicable. Health care professionals should be sure to document any relevant patient information they receive when asking patients questions and/or follow-up questions.

The health care professional responsible for escorting the patient to her room leaves the patient alone in her room, as the patient begins to get into her bed, without providing the patient with any further information - the aforementioned patient detail is relevant because it points to the possibility that the health care professional did not apply fall precautions to the patient. As previously mentioned, it is essential that health care professionals apply fall precautions to all patients, independent of age, diagnosis, or treatment. Fall precautions constitute the basics of patient safety and should be applied in all health care facilities to all patients. Failure to do so may lead to medical malpractice litigation. Examples of fall precautions include the following: familiarize the patient with the environment, have the patient demonstrate call light use, maintain call light within reach, keep the patient's personal possessions within patient safe reach, have sturdy handrails in patient bathrooms, room, and hallway, place the hospital bed in low position when a patient is resting in bed; raise bed to a comfortable height when the patient is transferring out of bed, keep hospital bed brakes locked, keep wheelchair wheel locks in the locked position when stationary, keep nonslip, comfortable, well-fitting footwear on the patient, use night lights or supplemental lighting, keep floor surfaces clean and dry, clean up all spills promptly, keep patient care areas uncluttered, and follow safe patient handling practices.[15]

The patient falls when attempting to get out of bed - the previous patient detail is relevant because it may be used to support any medical malpractice claims that may arise.

The patient sustains several injuries as a result of her fall and begins to experience pain - the previous patient-related detail may be extremely relevant to possible medical malpractice litigation because it may be used to provide evidence of the following essential element of medical malpractice suits: a patient injury occurred.

The patient is administered ibuprofen - the previous patient detail may be relevant because the patient has a reported allergy to ibuprofen. The fact that the patient was administered ibuprofen, even after she reported it as an allergy, may be used to support any medical malpractice claims that may arise.

Shortly after the ibuprofen is administered, the patient experienced hives as well as facial swelling - the aforementioned patient detail is relevant because it may be used to show the patient had an allergic reaction to the ibuprofen, which in turn may be used to support any medical malpractice claims that may arise.

The patient makes claims that she does not want to live anymore because "she just cannot take it" - the previous patient detail may be relevant because it may

indicate that patient is at risk for suicide. Health care professionals should note the following: the suicide of a patient while in a staffed, round-the-clock care setting is a frequently reported type of sentinel event; identification of individuals at risk for suicide while under the care of or following discharge from a health care organization is an important step in protecting these at-risk individuals.[7] To help prevent any litigation that may arise from a suicide-related issue, health care professionals and health care organizations should adhere to the following recommendations: identify patients at risk for suicide, conduct a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide, address the patient's immediate safety needs and most appropriate setting for treatment, and, finally, when a patient at risk for suicide leaves the care of the hospital, provide suicide prevention information (such as a crisis hotline) to the patient and his or her family.[7]

The patient's claims specific to not wanting to live are noted, although no further assessment is completed regarding the patient's claims - this patient-related detail may be relevant because it may be used to show that the health care facility did not follow any of the aforementioned recommendations regarding patients at risk for suicide, which in turn may be used to support any medical malpractice claims that may arise.

The patient does not receive any discharge instructions regarding her medication use upon discharge - this patient-related detail may be relevant because it may be used to support any medical malpractice claims that may arise.

Soon after discharge, the patient stops using her medications due to related confusion - the previous patient detail may be relevant because it may be used to support any medical malpractice claims that may arise.

What other ways, if any, are the patient details relevant to possible medical malpractice litigation?

Is it possible that medical malpractice occurred in the presented case study?

Based on the highlighted information, it does appear it is possible medical malpractice occurred in the presented case study.

Are the necessary elements of a malpractice suit present in the case study (i.e., is there enough evidence to support medical malpractice litigation)?

How could the potential for medical malpractice litigation been avoided?

The potential for medical malpractice in the case study could have been avoided in a variety of ways including the following: adequate patient assessments were conducted, effective health care documentation was completed, fall precautions were applied to the patient, the patient was effectively identified as a potential suicide risk, and the patient was given adequate discharge instructions regarding her medications.

Are there any other ways the potential for medical malpractice litigation could have been avoided; if so, what are they?

How could have the patient's experience in the health care facility been different if the aforementioned essential elements of care were applied to the patient?

The patient's experience in the health care facility could have been very different if essential elements of care were applied to the patient. An example scenario of how the patient's experience in the health care facility could have been different if essential elements of care were applied to the patient is as follows: a 20-year-old female patient presents to the health care facility with complaints of anxiety; upon initial examination the patient reports that she has an allergy to ibuprofen and that she has taken ibuprofen in the past and experienced hives as a result; a health care professional notes the patient reported ibuprofen allergy and effectively documents it along with the patient's reported reaction from ibuprofen in an attempt to show the patient reported ibuprofen allergy is a true allergy; the patient then goes on to explain that she has been feeling "very restless and anxious;" the patient also explains that she cannot focus and has recently "quit school" because of her inability to focus; upon further questioning the patient reports that she has recently been diagnosed with attention-deficit/hyperactivity disorder (ADHD), however has not been taking her medications; a health care professional effectively documents the previous patient details and acknowledges the patient as a potential patient that may have special needs and/or requirements; the health care professional asks the patient follow-up questions about her presenting condition, past medical history, and medication use; the patient's answers to the health care professional's questions are effectively documented; the patient is admitted into the health care facility; the patient is shown to her room; the health care professional responsible for escorting the patient to her room applies fall precautions to the patient; as a result the patient becomes comfortable and familiar with her room; the patient does not experience a fall; the patient begins treatment for her diagnosed ADHD; after some time passes the patient makes a few comments that are perceived as an indication of possible suicidal thoughts; the patient's comments are noted and effectively documented; the patient receives effective monitoring and undergoes risk assessment to determine if the patient is indeed at risk for suicide; at the conclusion of the risk assessment, health

care professionals determine the patient is not a risk for suicide; eventually the patient is discharged from the health care facility; upon discharge the patient receives discharge counseling, which include medication education; the patient feels comfortable with her medications and continues them after discharge from the health care facility; the patient progresses with her recovery and treatment; the patient contacts her family; the patient and the patient's family are content with the recent health care treatment; medical malpractice litigation is not considered; the patient further progress with her treatment and her health, overall well-being, and quality of life improve.

Are there any other ways the patient's experience in the health care facility could been different if essential elements of care were applied to the patient; if so, what are they?

Conclusion

Medical malpractice may refer to the failure of a health care professional to follow the accepted standards of practice of his or her profession, resulting in harm to a patient.[1] Health care professionals may protect themselves against medical malpractice claims and lawsuits by understanding why they may arise in the first place. Health care professionals may also help prevent medical malpractice claims and lawsuits by following recommendations that were developed to help them prevent medical malpractice litigation. Finally, health care professionals should work in tandem with their health care organizations to promote patient safety and to prevent medical malpractice from occurring.

References

1. Bono et al. Medical Malpractice. StatPearls. January 19, 2019.

2. Bhanji SM (2013) Health Care Ethics. J Clinic Res Bioeth 4:142. doi:10.4172/2155-9627.1000142.

3. www.ohio.gov

4. The American Nurses Association. Nursing: Scope and Standards of Practice, 3rd Ed. ISBN-13: 978-1-55810-619-2. SAN: 851-3481. 07/2015.

5. Gossman et al. Informed Consent. StatPearls. July 10, 2019.

6. Desai et al. Power of Attorney. StatPearls. June 3, 2019.

7. www.jointcommission.org

8. Bergman et al. Exploring Communication Processes in Workplace Meetings: A Mixed Methods Study in a Swedish Health Care Organization. Work. 2016; 54(3): 533–541. Published online 2016 Jul 26. doi: 10.3233/WOR-162366.

9. Vertino et al. Effective Interpersonal Communication: A Practical Guide to Improve Your Life. Online J Issues Nurs. 2014 Sep 30;19(3):1.

10. Paans et al. Prevalence of Accurate Nursing Documentation in Patient Records._J Adv Nurs. 2010 Nov;66(11):2481-9. doi: 10.1111/j.1365-2648.2010.05433.x. Epub 2010 Aug 23.

11. "California Code of Regulations Title 22; Section70215," www.rn.ca.gov

12. Toney-Butler et al. Nursing Admission Assessment and Examination. StatPearls. July 30, 2019.

13. www.hhs.gov

14. www.congress.gov

15. www.cdc.gov

16. West. et al. Good Samaritan Laws. StatPearls. May 27, 2019.

17. Chen et al. An Exploration of the Correlates of Nurse Practitioners' Clinical Decision-Making Abilities. J Clin Nurs. 2016 Apr;25(7-8):1016-24. doi: 10.1111/jocn.13136. Epub 2016 Feb 16.

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