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RISK MANAGEMENT AND LEGAL ISSUES

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LEARNING OBJECTIVES AND ACTIVITIES

- Describe laws impacting health care.
- Differentiate among the elements of a risk management program.
- Identify the risks professional nurses face regarding malpractice and other torts.
- Outline a plan for professional nurses to use to reduce the risks of legal actions.



CONCEPTS

Torts, civil and criminal law, negligence, malpractice, defamation, slander and libel, assault and battery, false imprisonment, standard of care, respondeat superior.

Q U O T E

The only real mistake is the one from which we learn nothing.

—John Powell



NURSE MANAGER BEHAVIORS

Ensures compliance with the regulatory agency standards and policies of the organization; participates in the review of clinical policies and procedures; supports a nonpunitive reporting environment and rewards staff for reporting unsafe practices; ensures that unit staff is clinically competent and trained; identifies areas of risk/liability; encourages/requires prompt reporting of potential liability by unit staff at all levels; envisions and takes action to correct identified areas of potential liability; ensures that unit staff is educated on risk management and compliance issues.



NURSE EXECUTIVE BEHAVIORS

Articulates patient care standards as published within professional literature; understands, articulates, and ensures compliance with the regulatory agency standards and policies of the organization; ensures that organization clinical policies and procedures are reviewed and updated in accordance with evidence-based practice; possesses knowledge of and dedication to patient safety; designs safe clinical systems, processes, policies, and procedure; supports a nonpunitive reporting environment and a reward system for reporting unsafe practices; ensures staff is clinically competent and trained on their role in patient safety; identifies areas of risk/liability; ensures staff is educated on risk management and compliance issues; develops systems that encourage/require prompt reporting of potential liability by staff at all levels; envisions and takes action to correct identified areas of potential liability.

Introduction

One could easily say that health care today is “risky business.” In 1999 a seminal report was released from the Institute of Medicine indicating that medical errors contribute to the deaths of 44,000 to 98,000 hospitalized patients each year. It further indicated that more patients die each year from adverse events associated with health care than expire from automobile accidents (43,458), and that deaths resulting from medical errors surpass the number of deaths related to breast cancer, the eighth leading cause of death in the United States.¹ The report shook the public and healthcare community and generated a call for action. The Institute of Medicine report suggested that 90% of errors result from failures in the system and are not the blame of individuals.² Therefore a massive campaign was launched to increase patient safety through the transformation of complex systems within healthcare organizations. Despite enormous efforts by both private and governmental organizations to transform work environments and to improve patient safety, mistakes continue and the number of legal claims against healthcare providers continues to soar.³ Inevitably, rendering patient care in imperfect work environments with broken systems and by humans (who are fallible) affords multiple opportunities for mishaps and misunderstandings. Given the complexities of health care today, managing risk poses major challenges for those in positions who lead. It is essential that nurse managers and executives

possess a basic understanding of the law pertaining to health care and that every effort be made to institute safeguards for the protection of the public, employees, and organization.

“Rendering patient care in imperfect work environments with broken systems and by humans (who are fallible) affords multiple opportunities for mishaps and misunderstandings.”

LAW IMPACTING HEALTH CARE

There are two distinct divisions of the law within the United States: criminal (public) and civil (private). In health care, both criminal and civil law apply, with the preponderance of litigation being civil in nature.

Civil Law

Civil law pertains to a wrongdoing between individuals or between an individual and the state, excluding criminal acts. In a civil case, defendants are found liable as opposed to guilty and are directed to pay monetary compensation for economic (financial loss) and or noneconomic damages (pain and suffering). Tort law, which addresses transgressions of one individual on the legal rights of another, is the foundation of civil law. There are two types of tort: unintentional and intentional.

Unintentional Torts

An unintentional tort or negligence may occur as a result of carelessness or accident and focuses on injury or harm. Unintentional torts are the basis of malpractice suits.

Negligence Negligence is a part of tort or personal injury law and is defined as “a failure to use that degree of care that any reasonable and prudent person would use under the same or similar circumstances.”⁴ If a professional, such as a physician or nurse, is negligent while acting in his or her professional capacity, the term is coined medical negligence or malpractice. To recover damages when negligence is alleged, the burden of proof lies with the plaintiff to demonstrate each of the following four elements:

1. A legal duty to provide reasonable care
2. A breach of duty (an act or a failure to act)
3. Injury to another
4. Breach of duty must be the proximate (immediately related) cause of the injury

“Being named in a lawsuit does not mean that wrongdoing has occurred, and injury does not necessarily indicate that someone was at fault.”

Generally speaking, anyone or any agency is susceptible to a suit for negligence for just about any act or omission. The essence of a negligence claim is that one’s conduct fell below the expected care and the failure resulted in injury. Being named in a lawsuit does not mean that wrongdoing has occurred, and injury does not necessarily indicate that someone was at fault.

Medical Malpractice Medical malpractice is “negligence on the part of a professional only while he or she is acting in the course of professional duties.”⁵ Malpractice contends that

1. One’s conduct did not meet the expected professional standards or fell below the “standard of care,” *and*
2. The failure caused harm to a patient.

Malpractice cases begin with an incident of alleged negligence and alleged injury. The injured party (plaintiff) retains an attorney and files a lawsuit against another (defendant). The plaintiff could be the patient, the patient's family, or a legal guardian. Depending on the allegations, there may be multiple defendants in the same lawsuit, including one or more hospitals, physicians, nurses, or others.

Medical malpractice is a serious concern for the healthcare industry. The Agency for Healthcare Research and Quality defines medical errors as “mistakes made in the process of care that result in or have the potential to do harm to patients.”⁶ Numerous reports indicate that medical errors are commonplace. Following a review of 30,000 medical records of patients discharged from 51 New York hospitals, a research team at Harvard University found that 3.7% of those hospitalized suffered adverse events, with 27.6% of the adverse events attributed to negligent care.⁷ These findings are similar to other studies across the nation. Despite the high frequency of medical errors, only 1 of every 7.6 patients injured as a result of negligence file lawsuits, and even a smaller number receive compensation for injuries.⁸ Furthermore, most individuals who file a malpractice suit have suffered a genuine injury or loss; thus a common belief that most lawsuits are fraudulent is unfounded.⁹

Malpractice lawsuits continue to escalate. The following cases represent a small sampling of medical malpractice events. In *Monk v. Doctor's Hospital*, the facility and physician were found negligent when a Bovie plate was inappropriately applied during surgery, resulting in a patient burn.¹⁰ In an Alabama case, two nurses testified that they did not know a decubitus ulcer could be life threatening and a third nurse claimed ignorance in the need to call the doctor for symptoms of an infection. After their testimonies, the nursing facility employing these nurses was found negligent in providing training and supervision. The suit led to a judgment of 2 million dollars in damages for the plaintiff.¹¹ In *Lloyd Noland Hospital v. Durham*, the court ruled against the hospital when staff failed to administer a standing order of preoperative antibiotics to a patient.¹² Regrettably, the stories go on and on.

In many industries mistakes do not produce grave consequences, leaving organizations with more latitude to view errors as learning opportunities. However, in a business where one delivers quite personal and commonly invasive care to human beings, mistakes can have devastating and irreversible effects for those served. Healthcare leaders are in a difficult position of attempting to balance the multitude of good that occurs from the care and services provided to the majority with the potentially serious consequences of negligent incidents. The challenge to keep a “stiff upper lip” is tough when the reports of medical errors tarnish the reputation of the industry. Press releases and personal experiences continue to shake the confidence of healthcare consumers. In a recent national survey, findings revealed that 55% of participants were dissatisfied with the care they received and 34% reported that either they or a family member experienced a medical error.¹³ These type of findings describe why today the public is more skeptical and leery of healthcare services and providers.

“The latest reports on malpractice claims indicate that the incidence of nurses personally named in lawsuits is greater today than ever before.”

The latest reports on malpractice claims indicate that the incidence of nurses personally named in lawsuits is greater now than ever before. According to the National Practitioner Data Bank, malpractice payments for nurses increased from 253 in 1998 to 5,567 in 2005.¹⁴ These numbers do not reflect the incidence of nurses involved in lawsuits covered under the doctrine of corporate liability, which holds organizations responsible for the practice of all those within their walls.

In a review of more than 350 cases between 1995 and 2001, Croke identified six key areas for nursing negligence¹⁵ summarized as the failure to

1. Follow standards of care
2. Use equipment in a responsible manner

TABLE 15-1

NATIONAL PRACTITIONER DATA BANK, 2005 ANNUAL REPORT

Number of Medical Malpractice Payment Reports by Malpractice Reason—Nurses (Registered Nurses, Nurse Anesthetists, Nurse Midwives, Nurse Practitioners, and Advanced Practice Nurses/Clinical Nurse Specialists) National Practitioner Data Bank (September 1, 1990–December 31, 2005)

Malpractice Reason	RN (Professional) Nurse	Nurse Anesthetist	Nurse Midwife	Nurse Practitioner	Advanced Practice Nurse/Clinical Nurse Specialist*	Total
Anesthesia related	128	915	1	8	1	1,053
Behavioral health related**	3	1	0	1	0	5
Diagnosis related	229	17	39	219	1	505
Equipment or product related	55	6	0	4	0	65
IV or blood products related	161	14	0	2	0	177
Medication related	555	29	3	62	1	650
Monitoring related	695	17	15	24	0	751
Obstetrics related	376	7	413	28	0	824
Surgery related	361	63	9	12	1	446
Treatment related	677	33	35	119	5	869
Miscellaneous	204	5	1	12	0	222
All reasons	3,444	1,107	516	491	9	5,567

Note: This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded. Medical malpractice payment reports that are missing data necessary to determine the malpractice reason (8 reports for RNs) are excluded.

*Reporting using the “Advanced Nurse Practitioner” category began on March 5, 2002. The “Advanced Nurse Practitioner” category was changed to “Clinical Nurse Specialist” on September 9, 2002. Prior to March 5, 2002, these nurses were included in the “RN (Professional Nurse)” category.

**The “Behavioral Health” category was added on January 31, 2004. Reports involving behavioral health issues filed before January 31, 2004 used other reporting categories. Cumulative data in this category includes only reports filed after January 31, 2004.

3. Communicate
4. Document
5. Assess and monitor
6. Act as a patient advocate

Patient falls and medication errors continue to be leading incidents for nursing malpractice lawsuits. Identifying and implementing practices to improve patient safety is a priority in healthcare settings.

Standard of Care The American Nurses Association describes a standard as an “authoritative statement defined and promoted by the profession by which the quality of practice, service or education can

TABLE 15-2

NATIONAL PRACTITIONER DATA BANK, 2005 ANNUAL REPORT

Mean and Median Medical Malpractice Payment Amounts by Malpractice Reason, 2005 and Cumulative through 2005—
Nurses (Registered Nurses, Nurse Anesthetists, Nurse Midwives, Nurse Practitioners, and Advanced Practice
Nurses/Clinical Nurse Specialists)
National Practitioner Data Bank (September 1, 1990–December 31, 2005)

Malpractice reason	2005 Only			Cumulative through 2005				
	Number of Payments	Mean Payment	Median Payment	Number of Payments	Actual		Inflation-Adjusted	
					Mean Payment	Median Payment	Mean Payment	Median Payment
Anesthesia related	68	\$368,594	\$110,938	1,053	\$261,779	\$100,000	\$309,042	\$123,867
Behavioral health related**	3	\$236,667	\$60,000	6	\$126,851	\$37,500	\$127,062	\$37,810
Diagnosis related	80	\$263,207	\$100,000	504	\$290,458	\$125,000	\$335,067	\$140,494
Equipment or product related	6	\$64,002	\$61,695	65	\$155,682	\$40,000	\$193,125	\$43,667
IV or blood products related	6	\$102,500	\$67,500	177	\$222,399	\$75,000	\$264,523	\$79,332
Medication related	62	\$406,830	\$87,500	650	\$267,366	\$62,500	\$306,440	\$70,087
Monitoring related	97	\$267,559	\$100,000	751	\$297,705	\$95,000	\$345,137	\$107,040
Obstetrics related	90	\$675,032	\$288,750	824	\$533,086	\$249,832	\$598,187	\$264,483
Surgery related	52	\$124,505	\$60,000	446	\$148,716	\$50,000	\$173,544	\$55,471
Treatment related	99	\$192,159	\$75,000	869	\$168,650	\$50,000	\$191,070	\$61,934
Miscellaneous	23	\$95,952	\$47,500	222	\$237,216	\$40,000	\$268,997	\$49,547
All reasons	586	\$319,905	\$100,000	5,567	\$282,821	\$90,000	\$324,929	\$102,482

Note: This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded. Medical malpractice payment reports that are missing data necessary to determine the malpractice reason (8 reports cumulatively) are excluded.

**The “Behavioral Health” category was added on January 31, 2004. Reports involving behavioral health issues filed before January 31, 2004 used other reporting categories. Cumulative data in this category includes only reports filed after January 31, 2004.

be evaluated.”¹⁶ Nursing standards of care identify the skill level and knowledge of the professional and the expected level of care given a similar setting and under similar circumstances.¹⁷ The standard of care or “customary practice” is the benchmark for measuring malpractice. The standard of care is commonly referenced in legal and nursing literature; however, if you ask most nurses to define the standard, the request tends to elicit a blank stare, at least momentarily. This is because the standard of care is not always easy to articulate. It is based on the circumstances surrounding the adverse event and the expected care of the “average” practitioner. If that were not complicated enough, add the uniqueness of individual patient needs and one can see why many times even experts have varying opinions about the standard. References such as standards and positions published by professional organizations, nurse practice acts, nursing texts, and other sources may be considered authoritative or “black lettered” reference materials and may be used to help clarify the standard. However, in a profession that holistically cares for the human elements of individuals, including the psychological, social, and physical

components, these publications alone may not adequately define the standard of care. Furthermore, many traditional practices in nursing viewed as standard care have yet to undergo the rigor of scientific study and thus are not based on evidence. It is generally the culmination of many sources coupled with practice norms that establishes the standard.

Expert Nurse Witness Because of the complexity of circumstances framing most alleged medical malpractice events, frequently an expert witness is called on to help the jurors interpret the applicable standard of care. Expert witnesses serve as agents in the legal process and are selected based on their experience in the specialty field and knowledge of the subject in question. Experts are asked to review the facts of the matter and to provide an opinion as to whether the care rendered by the defendant(s) met the ordinary or customary standard of practice. The expert is asked to testify regarding whether the care provided to the patient met the minimal requirement mandated by law, not the optimal level of care. Nurses are commonly asked to serve as expert witnesses by both defense or plaintiff attorneys. A nursing expert may be retained by an attorney to serve as a consultant or to give sworn testimony and generally receives payment for performing one or more of the following functions:

- Review records, charts, and depositions of other witnesses and give an opinion based on expert knowledge of standards related to the nursing care rendered to the patient at the center of the suit. Details of records and depositions are reviewed thoroughly to ensure understanding of the facts.
- Write a report of the review findings, sometimes referred to as a “downside review.” When the expert is anticipated to testify, written critiques of the findings are discouraged because these may not be protected and thus admissible as evidence in the case.
- Perform a literature review for relevant information pertaining to the facts of the case.
- Testify under oath in deposition and at trial. In the event of testimony, the retaining attorney works closely with the expert in preparation for the deposition or trial. Giving sworn testimony can be stressful for the expert as the opposing attorney attempts to confuse the witness and diminish the expert’s credibility. A nurse serving as an expert should take the responsibility of the role seriously and abide by an ethical code of conduct. Experts should rely on formal educational knowledge and experience to form opinions and should never adopt the opinion of others.

Nurses are qualified as an expert nurse based on formal education, licensure as a registered nurse, and experience. Nurses may become certified as legal nurse consultants through several accrediting organizations; however, certification is not a requirement to serve as an expert witness. Whether certified or not, preferred experts have published in peer-reviewed journals, possess the ability to speak convincingly and in language that a jury can understand, maintain good eye contact, have a record of accepting cases from both plaintiffs and defendants, and participate in professional organizations. The following case study describes a situation in which the testimony of an expert witness influenced the defense of the nursing care provided to an elderly patient.

Case Study

A Nurse Expert Witness Testified to the Nursing Standard An elderly, blind, female patient in a hospital in Alabama fell and broke her hip. The family sued the hospital for negligence. The patient’s chart indicated that the nursing personnel had planned her care with the patient and arranged the furniture in her room, including the position of her bed, so she could safely go to her chair and to the bathroom. It was the decision of the nursing personnel to leave the side rail at the foot of the bed nearest the bathroom down. The nursing personnel had documented that the patient was

instructed to call for assistance, if needed. The patient complied with instructions and for several days safely ambulated to the bathroom without incident.

The plaintiff's lawyer argued that all four side rails should have been up on the bed and that the patient should have been instructed to call nursing personnel before getting up for any reason. The expert testified that nurses make ongoing judgments about the safety and well-being of patients and in this case assessed the patient to be safe to ambulate to the bathroom alone. Furthermore, the documentation and testimony of nurses indicated that the patient had been compliant with instructions and repeatedly demonstrated the ability to safely ambulate. Based on the expert's testimony, the jury ruled in favor of the hospital.

Medical Malpractice Tort Reform Few issues in health care ignite as much emotion as the debates over medical malpractice. Over the last 30 years, states throughout the nation have experienced varying degrees of malpractice crisis. State legislators have intervened by enacting a number of laws known as tort reform to address issues such as the unavailability of insurance, rising premiums, and enormous pay outs. Since the mid-1970s the crises have calmed and resurged on numerous occasions. Once again, however, the frequency of claims and the size of pay outs are increasing. The latest tort crisis is characterized by both decreasing availability of medical malpractice insurance and rising premiums. Factors contributing to the crisis of today include increased public awareness of errors in health care, decreased confidence and trust among patients, advances in technology and increases in the intensity of medical services, higher expectations of the public, and less willingness of plaintiff lawyers to accept settlement offers.¹⁸

Patient Safety and the Tort System Is the quest for patient safety and the current tort system compatible? Although evidence indicates that most errors are attributed to system error rather than the provider of care, society continues to punish practitioners for errors. The medical liability system appears to be in direct conflict with efforts of regulatory agencies, employers, and professional organizations attempting to change punitive cultures into cultures that discuss and analyze errors and redesign systems.¹⁹ Although plaintiff lawyers argue that the threat of litigation improves patient safety, the “punitive, individualistic, adversarial approach of tort law is antithetical to the non-punitive, systems-oriented, and cooperative strategies promoted by leaders of the patient-safety movement.”²⁰ Physicians are hesitant to disclose medical errors or to participate in activities to improve patient safety for fear of legal action.²¹ Obviously, the tort system as we know it today is in need of restructuring to decrease reluctance of physicians and other healthcare professionals and organizations to fully disclose errors and to participate in patient safety initiatives without fear of retaliation.

“Although plaintiff lawyers argue that the threat of litigation improves patient safety, the ‘punitive, individualistic, adversarial approach of tort law is antithetical to the non-punitive, systems-oriented, and cooperative strategies promoted by leaders of the patient-safety movement.’”²²

Intentional Torts

An intentional tort is a conscious decision to commit or omit an act and to either intend the result or to possess reasonable knowledge of the foreseeable consequences. Intentional torts that nurses may face include defamation, false imprisonment, and assault and battery, among others. Intentional torts possess all three of the following elements:²³

1. An act that infringes on the rights of another with foreseeable consequences by the defendant
2. The individual carrying out the act or omission must deliberately intend the consequences
3. The consequences must be directly caused by the intended act or omission

Defamation Defamation is the issuance of a false statement about another person, which causes that individual to suffer harm. Libel involves the making of defamatory statements in a printed form, such as a magazine or newspaper. Slander, on the other hand, involves defamatory statements by oral representation. An example of slander is a malicious statement by a nurse that falsely accuses a patient or another individual of having an infectious disease or to be of immoral character. A person who defames the character of another and causes a loss of professional reputation must be able to prove the truth of

“A person who defames the character of another and causes a loss of professional reputation must be able to prove the truth of the accusation. Truth is the absolute defense of an action in slander and libel.”

the accusation. Truth is the absolute defense of an action in slander and libel. Claims of defamation are rare in health care.

False Imprisonment False imprisonment is the unlawful restraint of someone that affects the person’s freedom of movement. False imprisonment could be alleged due to confinement by a locked door, physical restraint, chemical restraint, or even

by the threat that force may be used. Recovery from a lawsuit based on false imprisonment includes damages for physical and psychological harm.

Years ago, it was common to see elderly people positioned in wheelchairs by vests or belt restraints to keep them from moving around independently. Today, it is possible that the application of restraints, unless used for medical reasons and in compliance with federal law or The Joint Commission (TJC) standards, may be interpreted as false imprisonment.²³ Strict guidelines exist in inpatient settings that define the appropriate use of restraints and seclusion along with required monitoring of those confined. Nurses should carefully adhere to these policies.

False imprisonment may also be alleged if an individual is prevented from leaving a facility by using restraint or coercion. There are legitimate reasons for detaining individuals that are legally justified. These include patients who are mentally incompetent or impaired and patients who are a threat to themselves or to others. In the event that there is question about the safety and well-being of a patient who desires to leave a facility against advice or when concern exists for another’s welfare, legal advice should be sought immediately.²⁴

Assault and Battery Assault is an intentional threat to inflict injury upon a person by another who has the ability to cause harm and thus puts the person in fear of an immediate danger. Battery is the intentional touching of or application of force to another person, in a harmful or offensive manner, and

“A nurse who carries out any nursing intervention without the patient’s consent, even if the intervention is beneficial, is potentially guilty of professional misconduct. The nurse may be disciplined by the state board of nursing and could be sued by the patient or face an allegation of assault and battery.”

without consent. The most commonly alleged act of battery against nurses is the treatment without consent.

In the case of *Roberson v. Provident House*, a nurse inserted a catheter following a physician’s as needed (PRN) Foley order.²⁵ The patient did not want to be catheterized and protested. The nurse was found to have committed assault and battery. Nurses must obtain permission from the patient before touching the patient. The consent procedure does not have to be formal and may be implied such as when the patient holds his arm out for the start of an intravenous line. Litigation regarding the

requirement for informed consent has focused around the physician’s failure to explain the risks, benefits, and alternatives to the procedure. However, hospitals and nurses may be held liable for lack of informed consent if they know or should have known there was not adequate disclosure or adequate consent.

How would you like to be in this circumstance? An older slightly confused patient is admitted to a medical-surgical unit for severe anemia of unknown etiology. The elderly man’s appearance is unkempt. He has a scraggly beard consisting of long matted hair. A conscientious nurse, with good inten-

tion, decides to place the patient in the shower and thoroughly “scrub” the patient. After the bath, she trims his beard. When his son arrives, the son is irate about the beard being trimmed. The patient begins crying and accuses the nurse of restraining his hands while she cut his beard. He claims that despite his protests she continued to cut his beard. As innocent as the nurse may have been in this situation, claims of battery occurred. Fortunately, in this case, a letter of apology soothed this patient and son’s ruffled feathers.

Criminal Law

Criminal law applies to an intentional wrongdoing against society as well as to an individual victim. A criminal offense is prosecuted by the state in which it occurs or by the U.S. Department of Justice. Crimes are defined as either misdemeanors or felonies. A misdemeanor is less serious than a felony, and guilt is generally punishable by fines or imprisonment for less than a year.²⁶ A felony such as rape or murder is punishable by confinement in a penitentiary for longer than 1 year.²⁷ Although less common than civil claims, healthcare providers have been accused of criminal negligence. Criminal negligence is an action that is considered to be “a reckless disregard for the safety of others.”²⁸

One of the earliest and most famous cases of criminal negligence by a nurse is the Somera case, reported in *The International Review* (July 1, 1930, pp. 325–334). Lorenza Somera, as the head nurse, was directed by the operating surgeon to prepare 10% cocaine with adrenaline for administration to a patient for a tonsillectomy. Ms. Somera repeated and verified the order. A few moments after the injection was given, the patient showed symptoms of convulsions and died. The operating surgeon meant to say 10% procaine. Only Ms. Somera was found guilty of manslaughter due to negligence. The negligence consisted of following an order that the nurse should have known by reason of her training and experience was incorrect. Although the physician was negligent, the cause of death was the nurse’s negligence.²⁹ According to the American Nurses Association’s *Code of Ethics for Nurses with Interpretive Statements*, “Nurses are accountable for judgments made and actions taken in the course of nursing practice, irrespective of healthcare organizations’ policies or providers’ directives.”³⁰

In 1997, when a patient bled to death, a court in New Jersey charged five nurses with endangering the welfare of a patient. During the same year, in Colorado, three nurses were indicted for criminal negligence in the death of a newborn after an overdose of 10 times the prescribed amount of penicillin. In 2004, criminal charges were filed against an emergency room nurse who failed to report suspected child abuse for a 2-year-old boy. The child subsequently died at the hands of his stepfather. In Wisconsin, a nurse was charged with a felony after mistakenly administering an epidural anesthetic intravenously instead of the prescribed order of penicillin. The Wisconsin nurse failed to read the medication label carefully and neglected to follow the established bar code policy. These cases have raised serious concerns for nurses and other healthcare providers who are today exposed to both civil and criminal litigation for errors or misjudgments.

“Although less common than civil claims, healthcare providers have been accused of criminal negligence. Criminal negligence is an action that is considered to be ‘a reckless disregard for the safety of others.’”

“Nurses are accountable for judgments made and actions taken in the course of nursing practice, irrespective of healthcare organizations’ policies or providers’ directives.”

CORPORATE LIABILITY

Healthcare corporations are incorporated by the state and designated as either for-profit or not-for-profit. Not-for-profit organizations are exempt from federal taxes and, in most cases, state taxes. They also qualify for donations and charitable deductions.³¹

Board of Directors/Chief Operating Officers

Every institution is governed by a board of directors that has responsibility for the operation and viability of the institution. With the authority awarded a governing board, the board and its personal members have specific legal responsibilities and liabilities. The board and its members are accountable for the overall management of the institution. A chief operating officer is appointed by the board to carry out daily operations. The board reviews financial reports, approves strategic plans, and monitors internal operations. Furthermore, the governing body has the ultimate authority and responsibility to select medical staff.³²

High ethical conduct is required of board members. Generally, strict rules of conduct are imposed on members to avoid conflicts of interest and self-gain. The members of the board are responsible for operating the organization in compliance with state, federal, and local laws. A case demonstrating how those in governing positions can face penalties when laws are not adhered to is that of *People v. Casa Blanca Convalescent Homes*. In this case the court found multiple violations of statutory regulations, including deficient staffing and inadequate care of residents. The operator of the facility was fined a significant amount for failure to comply with regulations.³³ Other instances of violations of the law have led to criminal prosecution.

Corporate Negligence

For years, hospitals and medical centers remained immune from liability for medical acts. With the erosion of charitable and governmental immunity, however, hospital risk for exposure increased. Under a doctrine of corporate law, hospitals are legally responsible for the safety and security of patients, employees, and visitors. The doctrine creates a duty of the hospital itself, directly to the patient. Thus hospitals cannot abdicate the responsibility to a third party. With a duty specific to the patient, hospitals are responsible to monitor the personnel involved in the processes within the organization, assess the overall operation of the facility, and make a conscious effort to identify potential risks. Corporate law in most states includes the following four duties:

1. The duty to use reasonable care in maintaining safe and adequate facilities and equipment
2. The duty to formulate adequate policies to ensure quality care for patients
3. The duty to oversee all persons who practice within its walls
4. The duty to select and retain competent physicians and staff

Respondeat Superior

The legal doctrine, *respondeat superior*, holds the employer responsible for torts committed by employees while on the job.³⁴ *Darling v. Charleston Community Hospital*, a landmark case, opened the door to corporate negligence liability of hospitals.³⁵ The case involved a young college football player who, after an injury, lost his leg after traction and cast application. Despite obvious signs of circulatory impairment and numerous attempts by the patient and family to seek assistance from staff, no remedial steps were taken. Although the patient was seen daily by a staff doctor, the court found the hospital negligent for not ensuring that the nurses reported important findings to physicians and notified supervisory personnel in the event that the doctor failed to act.³⁶

As with physicians, hospitals are facing ever-increasing medical malpractice claims. The cost of hospital malpractice liability premiums are on the rise and can have a significant impact on operating funds. According to the Institute of Medicine, 54% of healthcare workers are nurses; therefore nurses have heightened opportunity for claims.³⁷ As indicated by the American Organization of Nurse Executives, an important skill for nurse managers is human resource leadership. Determining and provid-

ing for educational needs, assessing competency, appropriate evaluation, and having “crucial conversations” are key to enhancing patient safety and minimizing organizational liability.

Credentialing Liability

Corporate responsibility extends beyond the hospital’s obligation to ensure sound management practices, safe operations, and appropriate behavior of employees and agents to liability for clinical competence and performance of all practitioners granted clinical privileges. As part of the credentialing process of any healthcare facility, organizations are responsible to appropriately investigate the qualifications and background of licensed independent practitioners applying to practice within the organization. Licensed independent practitioners are defined by the The Joint Commission (TJC) as “individuals permitted by law and by the organization to provide care and services without direction or supervision.”³⁸ The TJC requires verification of licensure and credentials, work experience, and quality of care and encourages institutions to be thorough and deliberate when granting privileges.³⁹ Hospitals are mandated by law to query the National Practitioner Data Bank before granting physician privileges to practice within the facility and to recheck the file of healthcare practitioners every 2 years thereafter. The National Practitioner Data Bank, a nationwide tracking system, was established by federal law in 1986 and formally inaugurated in 1990 to flag those who engage in unprofessional behavior and to restrict incompetent physicians and other healthcare practitioners from moving state to state without disclosure or discovery of previous medical malpractice payment and adverse action history.⁴⁰

A landmark case in which a surgeon operated on a hip, injuring the femoral artery and nerve and causing permanent damage and paralysis, was the first legal case where a hospital was held liable for negligent credentialing.⁴¹ A closer look at the physician revealed suspension from other hospitals and involvement in other cases of malpractice. The court held that hospitals have a duty to responsibly select medical staff.

Nurses who are victims of or who witness inappropriate behavior of a licensed independent practitioner are responsible to report such behavior. The same is true when a nurse observes competency issues. Nurse executives, as advocates for both the patient and staff, are expected to confront and address the matters utilizing processes defined within the organization to deal with behavioral or clinical performance matters.

OTHER AREAS OF LIABILITY FOR NURSES

Supervisor Liability

In 1994 the U.S. Supreme Court defined a nursing supervisor as a nurse who assigns, oversees, and provides direction to licensed or unlicensed personnel. This definition not only exposes nurses in formal supervisory positions to supervisory liability but expands the legal responsibility to staff nurses, particularly those who assume the responsibility of charge nurse. The “supervisor” may be found negligent if failing to assign or supervise appropriately. Furthermore, the corporation, under the doctrine of *respondeat superior*, is liable for the actions of both the nurse performing the assigned care and the nurse making the assignment.

Inadequate Staffing

Nursing facilities are responsible under federal law to provide adequate staffing.⁴² Adequate staffing includes a sufficient number of competent staff to reasonably ensure safe care. An important nurse executive competency identified by the American Organization of Nurse Executives is the appropriate allocation of nursing resources based on patient acuity. This can be a major challenge for nurse

administrators and other healthcare leaders of today, as organizations compete for dwindling numbers of healthcare providers.

Floating

Floating is common necessity in times of high acuity or short staffing. Floating has implications for both the nurse who is floating, the personnel reassigning the nurse, and the nurse delegating patient care to the floating nurse. The nurse who is being assigned to float has a professional duty to the organization and the patient to accept the assignment unless the nurse is lacking education and skill to perform the assigned duties. The nurse is obliged to provide for patients' safety. In extreme staffing circumstances, abandoning patients may potentially jeopardize patient care and safety. In these instances, "a nurse lacking in certain skills and experience is preferable to the patient lacking a nurse."⁴³ Thus fear or uncertainty is not a legitimate reason to refuse an assignment and used alone as a basis for refusing to float is considered unprofessional and may subject the nurse to the legal consequences of abandonment.

On the other hand, nurse managers and supervisors have a responsibility to appropriately staff the nursing units and when resources are limited must critically appraise the circumstances and carefully distribute personnel, striving to match the needs of the patients with the skills of the nurse. As indicated earlier, the supervisor, whether formally designated as such, or a staff nurse, who fails to assign and supervise appropriately, may be found negligent.

Following the Chain of Command

A nurse who fails to question an order of a physician when he or she believes that it is not in the best interest of the patient may be liable. Furthermore, nurses are responsible to contact a supervisor when a physician fails to take appropriate action or is unwilling to cooperate in a situation that threatens the well-being of a patient. Organizations should have a policy and procedure that clearly defines the chain of command. However, policy alone is not sufficient. Nurses need to be educated on their responsibility to notify an individual in authority to assist with unresolved or threatening situations. Commonly, by referring unusual or difficult situations to a higher level, action can be taken that can protect a patient's well-being. Therefore it is important to recognize that the nurse's duty to a patient extends beyond direct care and carries the responsibility of advocacy.

NURSES AND THE LITIGATION PROCESS

Nurses in an executive or manager role may be required to testify as a result of direct involvement in an alleged malpractice event, under the *respondeat superior* doctrine, or as the corporate representative. The designation of a corporate representative occurs following notice or subpoena of the organization to designate a person to testify on behalf of company policy. Staff nurses employed by the facility may be either personally named in a lawsuit or, more commonly, subjected to the litigation process as an agent of the facility. At any level, participation in the unfamiliar legal arena can be threatening and stressful. Figure 15-1 describes steps in the legal procedure. During the litigation process, communication between the attorney and client is considered privileged or protected by law and is inadmissible in court. However, if the client shares the discussion with others, the communication is no longer protected and may be entered as evidence in court. Unfortunately, the "code of silence" can magnify the anxiety of those involved in a lawsuit and can intensify feelings of shame, guilt, or isolation experienced by the defendants.⁴⁴ Education and emotional support of nurses going through the long and frightening litigation process is paramount.

FIGURE 15-1 STEPS IN A LEGAL PROCEDURE

1. A lawsuit begins when a complaint is filed by the plaintiff. Frequently, multiple parties are named in a lawsuit.
2. The insurance provider for the individual or entity is contacted and becomes involved in providing a legal team. When more than one party is named in the lawsuit, unfavorably for the defense, finger pointing between defendants may occur, especially if the parties are insured by different insurance carriers.
3. The discovery phase is the time whereby attorneys of opposing sides seek to identify the facts of the case in preparation for the legal battle. The discovery process can be quite lengthy as opposing attorneys exchange documents about the individuals, entities, policies, and medical records pertaining to the adverse event. Depositions of fact and expert witnesses on both sides are taken during the discovery phase.
4. As the case unfolds, commonly, there are attempts by the opposing attorneys to negotiate a settlement. It should be noted that settling a case does not confer guilt and may be the least risky and less costly resolution. The cost of the litigation process is high; thus settlement may be a reasonable compromise. However, some malpractice insurance providers may be reluctant to negotiate settlements for fear that bargaining encourages frivolous lawsuits.
5. If the parties cannot resolve the issue through settlement, a trial date is set by the court. Evidence and testimony is presented to a jury and a verdict is delivered.
6. Either side may appeal the decision of the court based on questions of law, not simple displeasure with the verdict. The cost associated with litigation must be weighed in the decision to appeal a verdict.

Source: Author.

RISK MANAGEMENT

Risk management in health care serves to provide a safe and effective environment for patients, visitors, and employees, thus averting or decreasing loss to the institution.⁴⁵ Identification, analysis, treatment, and evaluation of actual or potential hazards are the focus of risk management activities. Risk management has its beginnings in the transportation industry, particularly in investigations into aviation and traffic accidents. The primary reasons for these investigations were to determine patterns or causative factors in the accidents and then to eliminate, or at least control, as many factors as possible. Insurance carriers for institutions support risk management programs and commonly decrease the cost of premiums for providers who implement practices that reduce liability.⁴⁵

Risk Management Responsibilities

Most healthcare institutions today have used the services of a risk manager. Because of the diversity in the size and organization of institutions, job descriptions of the risk manager vary considerably. Figure 15-2 defines competencies of a risk manager. Important areas of responsibilities include loss prevention and reduction, claims management, financial risk, and risk regulatory and accreditation compliance.⁴⁶

Loss Prevention and Reduction

Loss prevention and reduction is the largest category of risk management and includes the following activities:

- Institution of a system to identify risk exposure such as incident or occurrence reporting, establishment of a communication system for referrals, and review of medical records, patient complaints,

FIGURE 15-2

RISK MANAGER COMPETENCIES

1. Keep an up-to-date manual, including policies, lines of authority, safety roles, disaster plans, safety training, procedures, incident and claims reporting, procedures and schedule, and description of retention/insurance program.
2. Update programs with changes in properties, operations, or activities.
3. Review plans for new construction, alterations, and equipment installation.
4. Review contracts to avoid unnecessary assumptions of liability and transfer to others where possible.
5. Keep up-to-date property appraisal.
6. Maintain records of insurance policy renewal dates.
7. Review and monitor all premiums and other billings and approve payments.
8. Negotiate insurance coverage, premiums, and services.
9. Prepare specifications for competitive bids on property and liability insurance.
10. Review and make recommendations for coverage, services, and costs.
11. Maintain records and verify compliance for independent physicians, vendors, contractors, and subcontractors.
12. Maintain records of losses, claims, and all risk management expenses.
13. Supervise claim-reporting procedures.
14. Assist in adjusting losses.
15. Cooperate with the director of safety and the risk management committee to minimize all future losses involving employees, patients, visitors, other third parties, property, and earnings.
16. Keep risk management skills updated.
17. Assess the system for causes of errors and adverse events. Fix the system.
18. Use focus groups to identify unreported errors and adverse events. Eliminate punitive organizational culture.
19. Prepare annual report covering status, changes, new problems and solutions, summary of existing insurance and retention aspects of the program, summary of losses, costs, major claims, and future goals and objectives.
20. Prepare an annual budget.

Source: Author.

and performance improvement data. Developing early warning systems is crucial to the investigation of events. Early notification of events provides an opportunity to conduct timely interviews of involved parties and to secure medical records and malfunctioning equipment associated with the event.

- Development of policies and procedures that address key risk management areas, including confidentiality, informed consent, products recalls, and sentinel events
- Collaboration with quality management, nursing, medical staff, and infection control to promote loss reduction strategies. The TJC recommends the integration of risk management and quality assurance initiatives as a more efficient and cost-effective method for promoting quality and safety. Performance improvement data can identify potential risk areas and form the basis for action plans to reduce adverse occurrences. Quality and risk prevention go hand and hand. A thor-

ough study of sentinel events using a root-cause analysis can provide valuable lessons for the organization. Aggregating and analyzing statistical data regarding quality and safety. These reports are presented to various committees and used by others, including the organization's board of directors, to determine the institution's risk for loss and to implement strategies to reduce exposure to liability.

- Coordination of education for staff on risk management issues
- Participation in the contract review process

Claims Management

All claims activities are generally handled by the risk management department. These functions include establishing files of potential or actual claims, coordinating claims activities, including negotiation of settlements, and serving as a liaison to administration as to the status of claims.⁴⁷ Claims management can be a time-consuming activity for a risk management department depending on the number and complexity of claims against an organization.

Financial Risk

A major concern of healthcare businesses is financial loss due to legal liability. Risk managers attempt to identify areas within the organization that may expose the institution to loss and estimate the potential and size of loss for exposure. When an adverse event occurs, effort is made to reduce the severity of loss through risk control strategies such as writing off hospital bills or personally meeting with the patient or family representative to resolve the grievance. The JCAHO mandates disclosure of sentinel events and other poor outcomes of care to patients and their families, when appropriate.⁴⁸ Unfortunately, many clinicians and institutions are reluctant to openly discuss bad outcomes for fear that discussion may be interpreted as an admission of guilt, even if not the case.⁴⁹ Furthermore, healthcare providers may incur legal obstacles with full disclosure.

In 2005, after the loss of a brother to a medical error, Doug Wojcieszak formed The Sorry Works! coalition. The coalition was formed based on this family's experience. The coalition advocates that in the event of medical error or negligence, the provider admits fault, provides the patient/family with an apology, explains plans to prevent the error from reoccurring, and offers fair compensation.⁵⁰ If medical error was not found to be the cause of the unexpected outcome, the coalition recommends that providers, accompanied by legal counsel, conduct a meeting with the patient/family and explain what happened and then apologize and offer empathy without acknowledging fault. Until safe systems are developed in health care that foster learning from mistakes while continuing to underscore individual accountability for wrongdoing, discomfort and debate about disclosure after an unexpected outcome will continue.

Compliance with Regulatory and Accreditation Agencies

Risk management includes the duty to comply with regulatory and accrediting bodies, such as the Occupational Safety and Health Administration, Emergency Medical Treatment and Active Labor Act, Health Insurance Portability and Accountability Act, and TJC, among many others. Additional regulatory activities may include mandatory reporting of deaths based on defined criteria to the coroner, compliance with safety codes, and requirements to report select incidents to state and federal agencies.⁵¹

Documentation

The medical record is an account of the patient's experience during a healthcare encounter. The primary purpose of the medical record is to accurately reflect in written form the medical and nursing care

that a patient receives. It is important that nurses strive to document as accurately and timely as possible. Contradictions, inconsistencies, and unexplained gaps in the medical records are difficult to defend during litigation. It is recommended that documentation take place as soon after the occurrence as possible and that a minute-by-minute recording is done during an emergency. When time is of the essence, which is quite common in a busy clinical setting, brief notes with times, interventions, and other relevant information should be written on a piece of paper and transferred to the medical records as soon as time permits.

The old adage “if it wasn’t documented, it wasn’t done” is a good guideline to use in practice, but there is no legal basis for the premise. Every nurse knows that it is impractical for nurses to chart all nursing functions and patient care activities. To do so would leave many duties undone, possibly including patient care. However, when malpractice is alleged, the medical record is the primary source of information for determining whether the standard of care was met. Furthermore, failure to document appropriate information may be interpreted as a violation of the standard. In a New York case, *Gerner v. Long Island Jewish Hillside Medical Center*, an infant suffered brain damage after developing jaundice. Several events occurred that delayed diagnosis and treatment of the jaundiced condition, including the fact that the nurses failed to note the color of the baby’s skin in the record until the third hospital day. Judgment was in favor of the plaintiff partially due to failure to document the patient’s condition.⁵²

Electronic documentation adds new dimensions of liability. Care must be taken to safeguard patient confidentiality and unauthorized access to information with computerized systems. Policies must be developed to protect computerized patient data and audits performed routinely to ensure that only those who have a “need to know” access records. Furthermore, nurses need to be fully educated to understand that when documenting electronically, the exact time that data are charted in the computer is captured automatically. Most nursing computerized documentation programs allow nurses to manually enter the time that an assessment or intervention occurs; however, when the time is different from the entry time, it may be difficult to explain the discrepancy in time. Therefore a procedure for late entries should be developed to guide staff on how to enter late entries. Finally, when implementing electronic documentation, it is essential that organizations minimize the need for duplicate documentation to prevent confusion; thus point-of-care documentation is preferable, whenever feasible.

The medical record is sacred ground and should never be altered after an entry is made. If it is found that a medical record has been modified, destroyed, or falsified in any fashion, the act may be construed as an attempt to conceal or manipulate facts and, under such instances, is considered a felony or criminal offense.⁵³ Moreover, manipulation of the record may be interpreted as malice in a medical negligence case and punitive damages may be awarded the plaintiff, even if the alteration of the record did not directly cause harm.⁵⁴ Figure 15-3 highlights a few tips for documentation.

Policies and Procedures

Policies and procedures are directives for the daily operations of an institution and are required for compliance with regulatory and accreditation agencies. Policy and procedure manuals are developed as a resource tool for employees to describe the general rules of conduct but are never intended to supersede the judgment of the employee. If a patient experiences an adverse outcome, the plaintiff’s attorney ordinarily petitions the institution’s policies and procedures to evaluate whether the practitioner’s conduct was in compliance with the established internal practices.

Policies and procedures are expected to be followed unless there is a reasonable explanation as to why a deviation should occur. Plaintiff attorneys frequently argue that internal policies and procedures form the basis for the standard of care. However, “a policy and procedure manual is not necessarily the definitive source for standards of care.”⁵⁵ Nevertheless, policies and procedures find their way into court rooms every day. For this reason, each version of a policy should be retained when revisions are

FIGURE 15-3

TIPS FOR DOCUMENTATION

- Never use the medical record as a forum to record complaints against another.
- Document instructions given to patients.
- Any corrections to the medical record should be done with a thin line drawn through the original entry, dated and initialed unless otherwise specified by hospital policy.
- Documented information should be factual and objective.
- Specific communication with physicians about the patient's condition should be recorded.
- Late entries should be recorded according to the facility's policy.

Source: Author.

made because often in lawsuits an organization is asked to produce the policy in effect at the time of the incident. Unfortunately, institutions may be remiss in ensuring that policies are updated timely and that the content reflects reasonable expectation rather than optimal practice. Organizations must be careful not to develop policies that specify conduct greater than recognized by authorities. This practice could result in the institution being held to a higher standard than the norm. Thus policies and procedures should be based on the best evidence and consistent with national standards.

This requires vigilance on the part of the organization to attend to details in the development, ongoing review, and revision of policies and procedures.⁵⁷ Finally, policies and procedures should be broad enough to allow for reasonable flexibility between departments and practitioners.

“The American Nurses Association defines evidence-based practice as “a process founded on the collection, interpretation, and integration of valid, important, and applicable patient-reported, clinician-observed, and research-derived evidence. The best available evidence, moderated by patient circumstances and preferences is applied to improve the quality of clinical judgments.”⁵⁶

Incident/Occurrence Reporting

An incident or occurrence report is an effective tool used to identify potential losses, opportunities, or potential claims. These reports are prepared for any unusual occurrence or near miss involving people or property, whether or not injury or damage occurs. Preferably, the report is generated at the time of the incident and by the individual(s) involved in the incident. However, if this is not possible, the incident report should be completed when it is first discovered.

Use of Incident Reports

Incident reports are used to collect and analyze future data for the purpose of determining risk-control strategies. Blake describes the use of a multiple causation model in incident report investigation. This theory suggests that causes, subcauses, and contributing factors weave together in particular sequences to cause incidents. An incident may have many concomitant causes; therefore seeking out as many causes as possible and rating them by their proximate or primary influence on the incident may be useful in reducing the chance of the incident recurring. Proximate causes are often referred to as parent and closest cause of the incident. Primary causes are procedural in nature, and such causes are discovered through back tracking from the proximate cause.⁵⁸

Preparation of Incident Reports

Incident reports are commonly discovered during the legal process. Discoverability of incident reports depends on “state Quality Assurance and peer review statutes or statutes creating an attorney-client or insurer-insured privilege.”⁵⁹

Contents of incident reports may be either helpful in explaining facts of a case or incriminating. Commonly, defending attorneys argue against discovery, asserting that occurrence reports are part of the quality assurance process and must be protected to afford organizations the opportunity to assess and improve care without fear of legal exposure. In *Columbia/HCA Healthcare Corp. v. Eighth Judicial District Court*, the court ruled that because incident reports are part of the hospital’s normal course of business, they remain open to discovery during the litigation process.⁶⁰ Incident reports should be objectively written, complete and factual. The incident report is corrected in the same manner as any other medical record and should not be altered or rewritten. It should contain no comments criticizing or blaming others. Figure 15-4 lists the dos and don’ts of incident reporting.

It may be institutional policy to send the incident report to the risk manager; however, if the event requires immediate attention, notification may need to be more prompt. The preparer can call the risk manager and nurse manager and give them verbal information on the need to investigate and evaluate events and to make needed corrections. To accomplish this, managers should establish a climate of trust that supports incident reporting by nurses. The TJC requires that incidents be reported.

FIGURE 15-4

DOS AND DON'TS OF INCIDENT REPORTING

Do

- Report any event involving patient mishap or serious expression of dissatisfaction with care.
- Report any event involving visitor mishap or property.
- Be complete.
- Follow established policy and procedure.
- Be prompt.
- Act to reduce fear in the nursing staff.
- Correct in the same manner as any medical record.
- Include names and identities of witnesses; record their statements on separate pages.
- Report equipment malfunctions, including control numbers. Remove equipment from service for testing.
- Keep the report confidential.
- Report to nurse manager.
- Confer with risk manager.
- Work to provide nursing care to meet established standards.
- Attend all staff development programs.
- Confirm all telephone orders in writing.

Don't

- Place blame on anyone.
- Place report on the patient’s chart.
- Make entry about an incident report on the patient’s chart.
- Alter or rewrite.
- Report hearsay or opinion.
- Be afraid to consult, ask questions, or complete incident reports. They can be part of your best defense and protection.
- Prescribe in the physician’s domain.
- Be cold and impersonal to patients, families, or visitors.

Source: Author.

Risk Management and Nursing

Nursing leaders of today must challenge old practices and strive to build a culture of safety. Increasing demands for services and the rising cost of health care accompanied by diminishing reimbursement requires patients to move through the healthcare system quicker than ever before. The rapidity of patient turnover increases the chance of error and leaves potential gaps in communications. Further complicating the working conditions is the increase in patient acuity, high staff turnover, long work hours, increased interruptions and demands, and rapidly changing technology.⁶¹ Moving from a culture of blame to one of safety begins with identifying the reason for errors rather than focusing on the individual making the error.⁶² As the largest group of healthcare providers and those in closest contact to patients, nurses are in key positions to identify errors and to initiate measures to protect those they serve. However, studies indicate errors to be significantly underreported by nurses.⁶³ Improving systems that encourage reporting and ensure anonymity is necessary to identify and address safety issues. Safe working environments are built on open communication, properly prepared employees who are competent in performing required duties, adequate resources, and an infrastructure that allows staff to perform work successfully.⁶⁴ Lessons from other industries must be incorporated into health care. The aviation industry has created a culture of safety by closely monitoring the hours worked by pilots, re-designing systems, and promoting teamwork and communication to prevent errors.

Figure 15-5 lists innovative initiatives recently used to improve patient safety, and Figure 15-6 lists strategies to reduce malpractice claims. There is still much work to be done to ensure delivery systems

FIGURE 15-5

PATIENT SAFETY INITIATIVES

- Development of rapid response teams (RRTs). As part of the Institute for Healthcare Improvement's campaign to save 5 million lives hospitals throughout the country have implemented RRTs to rescue medical-surgical patients from impending crisis. Studies have demonstrated a significant reduction in morbidity and mortality of hospitalized patients.⁶⁵
- Implementation of communication models for reporting such as SBAR (situation, background, assessment, and recommendation)
More than 60% of sentinel events reported to JCAHO identified communication as a root cause of the event.⁶⁶
- Improvement of medication delivery systems including the use of bar coding. The Institute of Medicine reported that adverse drug events are the most common reason for medical errors and cost hospitals more than \$20 billion per year.⁶⁷
- Implementation of processes to improve the work environment such as transforming care at the bedside (TCAB). As many as 35% to 40% of unexpected hospital deaths occur in hospital medical-surgical units. TCAB projects sponsored by the Robert Wood Johnson and Institute of Healthcare Improvements aim to dramatically improve care on medical-surgical units by redesigning workspace, enhancing efficiency and reducing waste.⁶⁸
- Development of teamwork. In the airline industry, "crew resource management" is a strategy to facilitate the team of flight attendants, pilots, and other crew.⁶⁹ Roles and responsibilities are clearly defined for numerous scenarios to ensure safety. This model is being used in some healthcare organizations such as obstetrical units where staffs "practice for emergencies."
- Development of clinical guidelines to promote standardization of care. A study of obstetrical patients indicated that when care failed to follow establish clinical guidelines, there was a sixfold increase in litigation cases.⁷⁰
- Development of high-performing microsystems. High-performing microsystems yield better outcomes and effective care at lower cost and produce a more satisfying work environment.⁷¹

Source: Author.

FIGURE 15-6

STRATEGIES TO REDUCE MALPRACTICE CLAIMS

1. Ignorance of the law is not an excuse for wrongdoing. If a law exists but a person does not know it, that person will not be excused for breaking it.
2. Every person is responsible for his or her own actions. The nurse must know the cause and effect of all actions or will be subject to suit for malpractice when harm occurs to a patient.
3. A nurse will not carry out an illegal order of a physician or any other healthcare provider. The nurse must know that the order is a legal one before carrying it out.
4. New nurse graduates must not be assigned to duties beyond their competence.
5. An employer hiring a nurse is required to exercise ordinary, prudent policies and procedures.
6. By the “respondeat superior” or “master–servant” rule, injury by an employee because of negligence makes both employee and employer equally responsible to an injured party. The injured party may sue both employer and employee. Both may not necessarily be found guilty.
7. Professional nurses should carry malpractice insurance. Even when an employer insures an employee, the licensed employee is usually not covered outside the place of employment.
8. Malpractice litigation can be reduced by documenting telephone advice to patients, improving communication and listening skills, and effectively obtaining patients’ informed consent.
9. Malpractice risks are increased when professional nurses supervise unlicensed employees.
10. Knowledge of state laws, such as mandatory reporting of abuse, is important for nurses.
11. Courts have interpreted ERISA (Employee Retirement Income Security Act) to limit physician autonomy and subordinate clinical decision making to cost-containment decisions made by managed care organizations.
12. Good provider–patient relationships contribute to preventing malpractice suits.
13. Iatrogenic injuries are a significant public health problem that must be addressed by professional nurses.
14. The costs of malpractice litigation can be reduced by managing risks rather than vindicating providers accused of malpractice. Successful risk management techniques include credentialing of professional staff, monitoring and tracking of complaints and incidents, and documenting in the patient’s medical record.
15. The medical malpractice field appeared in the United States around 1840 and has been sustained by changing pressures on medicine, adoption of uniform standards, the advent of medical malpractice liability insurance, contingency fees, citizen juries, and the nature of tort pleading.
16. Human errors in clinical nursing practice are common and underreported.
17. With increased credentialing of advanced practice nurses in health maintenance organizations, there will be increased liability for their employers and increased need for personal malpractice insurance.
18. The nursing profession appears to hold its licensees to safer standards than does the medical profession; therefore nurses are disciplined more often and more harshly than are physicians.
19. Personal involvement with patients places the professional nurse in jeopardy of legal action by the state board of nursing.
20. Many charting practices can help decrease the liability risks for nurses.

Source: Author.

that are safe and effective and require commitment of the mass. Leaders must be willing to give power to others and trust in the skill and wisdom of the whole. The legendary management consultant Peter Drucker once said, “The leaders who work most effectively, it seems to me, never say ‘I.’ And that is not because they have trained themselves not to say ‘I.’ They don’t think ‘I.’ They think ‘we’; they think ‘team.’ They understand their job is to make the team function. They accept responsibility and don’t sidestep it, but ‘we’ gets the credit. This is what creates trust, what enables you to get the job done.”

Evidence-Based Practice 15-1

Sivell et al. reported on the significance of assessing risk as it relates to genetic screening. Per the researchers, as an individual perceives genetic risk such may influence risk management decisions, underscoring the need to understand the ways in which risk is constructed and interpreted. The authors systematically reviewed the literature, doing a narrative synthesis of 59 studies presenting data on the ways in which individuals perceive, construct, and interpret their risk and the subsequent effects. Although most studies assessed perceived risk from a quantitative perspective, the combined evidence noted that individuals find risk difficult to accurately quantify, with a tendency to overestimate. According to the researchers, rather than being a stand-alone concept, risk is something lived and experienced, and the process of constructing risk is complex and influenced by many factors. Although evidence of the effects of perceived risk is limited and inconsistent, there is some evidence that notes high risk estimations may adversely affect health and lead to inappropriate uptake of medical surveillance and preventative measures by some individuals. A more focused approach to research is needed with greater exploration of the ways in which risk is constructed, along with the development of stronger theoretical models, to facilitate effective and patient-centered counseling strategies.⁷²

SUMMARY

There is an element of risk when practicing in the healthcare environment. Nurses and nurse leaders should be familiar with the potential liability associated with their chosen nursing role. Civil, criminal, and corporate laws apply to certain aspects of health care. Familiarity and compliance with laws is necessary to protect the nurse from liability. Medical malpractice claims continue to escalate as consumers of health care become more informed and expectations rise. Today, the public is less trusting of providers and less forgiving of mistakes. Good communication and rapport between providers and recipients of care accompanied by quality and safety measures are essential to decrease the incidence of malpractice claims. The litigation process is generally foreign territory for the nurses at any level of practice. Education and support is required to help the nurses through the lengthy and threatening experience of litigation. Risk management activities can identify potential risk for the organization and implement strategies to improve the safety and quality of care. Nurse leaders are responsible to ensure that risk management principles are practiced in the workplace.

APPLICATION EXERCISES

Exercise 15-1

Interview a risk manager. How do the risk manager's competencies compare with those outlined in Figure 15-2? What risk prevention strategies does the manager use? What has been the cost of losses caused by negligence during the past year?

Exercise 15-2

Examine the incident reporting program in a healthcare agency. What are the strengths? Weaknesses? How can it be improved?

Exercise 15-3

Interview a nurse executive. Using the patient safety initiatives outlined in Figure 15-5, review with the nurse executive patient safety concerns and strategies used in his or her healthcare organization.

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