Medical-Legal & Ethical Issues in Nursing

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Objectives

❖ Describe how current and future healthcare trends will impact legal and ethical issues in nursing, patient care technicians, social workers, and office personal.

❖ Describe “best practices” that protect your license and position, influence quality of care and reduce risk.

❖ Examine medical malpractice cases and the impact on the nurse and the various roles in the acute, long term care & outpatient setting.
Current and future healthcare trends

- Role of nurse continues to expand & is influenced by many aspects.
Trends
Best Practices
that protect your license, influence quality of care and reduce risk.

School:
Learn to **obtain** license

After school:
Learn to **maintain**/protect/keep license
Medications

✦ Giving meds on time – not when convenient for nurse (Heparin, Antibiotics, and etc.) Giving med and scanning med at a later time.

✦ Proper wasting of narcotics

✦ 5 rights

✦ No over riding system unless absolutely necessary.

✦ Don’t cover up if medication error occurs.
DNR

- Know your patients DNR status
- Legal order signed by the Doctor
- View original paperwork
Patient confidentiality

✦ Never leave paper chart/computer screen in a public place

✦ Discuss contents only with persons directly involved in patient’s care or those authorized by the patient. They should be listed by name. (Don’t assume partners have access to information)

✦ Ask for ID prior to providing information

✦ Do not discuss pt or pts info in public, places, elevators, cafeteria, or at parties.

✦ Don’t view patient’s information not in your care: family; friends; celebrities and etc.
Patient Falls & Restraints

Among senior citizens, falls represent the 5th leading cause of death, and the mortality rate from falls increases significantly with age.

Cases

- Failure to follow policy
- Failure to raise bedrails
Criteria for Incident Reports

- Should be completed for any usual, unexpected, or unanticipated occurrences, and for any event which has or may have an adverse patient outcome.

- Patient falls
- Medication error
- Loss of valuables, belongings
- Equipment malfunction
- Property damage
- Near misses
Incident reports

Be Objective

✧ Do not blame or admit liability
✧ What did you do?
✧ Do not include names/addresses of witnesses
✧ Document time/name of medical provider
✧ Do not file in chart
✧ Do not write “incident report made”
Proper handoff communication

- Required to properly “handoff” your patients to another qualified professional.

- Tool SBAR:
  - S=Situation: patient name, DOB, & medical provider
  - B=background: date of admission, diagnosis & current condition including test results
  - A=Assessment: summary of recent events/changes in condition or treatment and any anticipated changes in condition or treatment.
  - R=Recommendations: state your nursing recommendations with any new treatment in the plan of care by the medical provider.
Abandonment

- Termination of patient care without assuring the continuation of care at the same or higher level.
  - In various medical venues (office/clinic practice; walking off the job; leaving pt without transferring pt to another nurse; refusing overtime) (6)
Sexual Misconduct
Controlled Substances

- Self-prescribing controlled medication for one’s own use or for family members.
- Diversion
Social Media

- Facebook
- Twitter
- Texts
- E-mails

Info about & from patients
Telephone calls

Office scenario

✦ Date and time of call
✦ Advice you gave
✦ Who you spoke with and if other caregivers notified

Hospital scenario

Date and time of call
Provider name
Client’s chief complaint
Information you provided
Orders received/not received

✦ Nurses who disagree with a provider’s order should not carry out an obviously erroneous error.
Pitfalls for Staff
Red Flag Complaints
Documentation
Documentation

- Written evidence of interaction between and among health professionals, patients, and their families; the administration of procedures, treatments, and diagnostic tests; the patient’s response to them and education of the family support unit.

- Major purpose of medical record is to document the care given to the patient.

- Nurse Practice Act states the general duty is to “record pertinent information including the response to interventions”.

- Also a legal document. Courts have issued a warning to nurses & medical personnel that the availability of accurate medical records is NOT a technicality but IS a legal requirement.

- Chart is a persuasive witness because it’s a description of the facts at the time.

- Should be no unanswered questions to the patients chart that the plaintiff attorneys can use to construct their version of what happened.

- Documentation reflects: character, competency, and the care delivered by the nurse.
Documentation Do’s’s

- Nursing procedures (procedure name; when performed; who performed; how performed; client tolerated; adverse reactions)
- Phone calls
- Health care team visits
- Don’t wait to chart
- Client refusals
- Client’s subjective data
- Medication omission
- Late entry
- Not applicable
Required to document

- Sudden decline in patient’s condition, actions, outcome
- Patient injuries/medication errors
- Equipment failure/incorrect use
- Failure of provider to respond
- The “red flag” patient or family
- Client/family education/instructions
Documentation Don’ts

- Complaints
- Opinions
- Altering the record
- Chart ahead
- Staffing problems
- Staff conflicts
- Leave empty lines/spaces
- Make reference to incident reports
The following can lead to state licensing board suspending or revoking nurse license:

- Failure to document entries in patient record
- Falsification of patient record
- Making incorrect entries

Each health care provider is responsible for the ABC’s of recording: Accuracy, brief, complete
The old adage, “If it wasn’t charted it wasn’t done….,” is clarified in CBE (*charting by exception*) as “If interventions, expected outcomes, and patient responses weren't charted using symbols to reflect predefined norms-and variances weren't charted in detail-then it wasn’t done.”

CBE is a shorthand of documenting normal findings, based on clearly defined normal, standards of practice, and predetermined criteria for assessments and interventions. Significant findings or exceptions to the predefined norms are documented in detail.

Computerized charting: Protect password security & don’t forget to log off
Common Charting mistakes

- Failing to record pertinent health or drug info
- Failing to record nursing actions
- Failing to record that medications have been given
- Recording on the wrong chart
- Failing to document a discontinued medication
- Failing to record drug reactions or changes in the patient’s condition
- Transcribing orders improperly
- Writing illegible or incomplete records
Effective Documentation

- **Wrong:** Communication with patient’s family began today to specify the manner in which his condition is progressing and suggest a probable consequence of that progression.

- **Correct:** I contacted Mr. Schneider’s wife at 1332 hours. I explained that his cardiac status was worsening and that he was being prepared for a cardiac cath procedure scheduled for 1430.
Late entries

- Add late entries at first available space and as soon as possible if electronic.
- Document date and time the event occurred.
- Clearly identify the entry as a late one.

Better late than never, but never late is better :(
Red Flags

- Adding information
- Dating the entry
  - Dates/times conflict
  - Inaccurate information
  - Destroying records
Documentation

- Cases usually come to court a long time after the events occurred.

- Nurses and other personnel usually have little or no recollection of the events surrounding the case and must rely on their documentation for what occurred.

- Do you feel like your documentation would support you in a court of law?
Implications

Accidental Deaths in the U.S.

An estimated 1,000,000 people are injured each year as a result of medical errors occurring as a result of hospital treatment each year. 120,000 die from those injuries. These frightening statistics were obtained from a study led by Lucian Leape of the Harvard School of Public Health. For comparison, other causes of accidental death are presented.

![Bar chart showing accidental deaths in the U.S.](chart1.png)

Injuries Associated With Medical Negligence Claims

- 15% Major Physical Injury
- 39% Significant Physical Injury
- 26% Death
- 17% Minor Physical / Emotional Injury / Breach of Consent
- 3% No Adverse Injury

![Pie chart showing injuries associated with medical negligence](chart2.png)
2015 Statistics
Malpractice occurs when improper, injurious, or faulty treatment of a client that results in illness or injury.

Why Claims are Filed

- Upset with the System
- Devastating Injuries
- Unreasonable Expectations
- Unexpected Results
Extent of Suits

Medical Malpractice Claims
Sued the most
Legal Role of the Nurse

- Provider of service
  - Ensure that client receives competent, safe, & holistic care
  - Render care by “standards of reasonable, prudent person”
  - Supervise/evaluate that which has been delegated
  - Documentation of care
  - Maintain clinical competency
Legal Negligence in Nursing

- Failure to use equipment in a responsible manner
- Failure to assess and monitor and failure to communicate
- Failure to document
- Failure to act as a patient advocate
- Performing nursing procedures incorrectly
- Failing to take appropriate precautions
Responsible & Accountable

✦ You are responsible and accountable for your actions based on:

✦ Your clinical training
✦ Your title
✦ Scope of practice
✦ Standard of care guidelines
✦ Policies and procedures of your health care facility
Ways to Avoid Malpractice

- Know your own strengths and weaknesses
- Evaluate your assignment
- Delegate carefully
- Exercise caution when assisting procedures
- Document the use of restraints
- Take steps to prevent falls
- Comply with laws about advance directives
- Follow hospital policies and procedures
- Keep policies and procedures up to date
- Provide a safe environment
ELEMENTS OF NEGLIGENCE

- Deviation from the standard of care that results in harm to the patient
- 4 elements of negligence
  - Duty to act (Nurse – Patient relationship)
  - Breach of duty (SOC not followed - reasonably prudent nurse)
  - Damage (Physical & Psychological) No damage no case!
  - Causal connection (reasonably close connection between nurses conduct & injury)

All 4 must be proven
State Boards of Nursing

- NYSBON was created to “assist the Board of Regents and other departments on matters of professional licensing, disciplinary process and practice of the professions.”

- Ensure public safety from dishonest and incompetent practitioners
- Ensure that you practice within your scope of practices, SOC guidelines, and other state statues.
- Ensure that you are not impaired physically or mentally from drugs and alcohol while practicing.
- Ensure that nursing schools provide you with adequate education and clinical skills needed to provide quality care.
Nursing Charges

Most common charges brought against nurses include:

- Substance abuse
- Incompetence
- Negligence

State board of nursing is responsible for discipline within the profession. The Board participates in licensure, disciplinary, restoration, and moral character proceedings.

All members of the State Board and the committee for professional assistance must be dedicated to the public protection, quality professional preparation, and conduct.
THREE CATEGORIES OF IMPAIRMENT

**PROFESSIONAL**
- Deficit in Medical Knowledge, Expertise or Judgment

**BEHAVIORAL**
- Includes unprofessional, unethical, or criminal conduct

**MEDICAL**
- Conditions which *permanently* impede or preclude a provider from safely practicing medicine
Professional Misconduct

- Violating any guidelines set forth by your state nursing board places you at risk of being charged with professional misconduct.
  - Obtaining license fraudulently
  - Practicing while impaired by ETOH, drugs, physical or mental disability.
  - Habitual drunk or dependent on narcotics and other drugs with similar affects
  - Refusing to provide professional service to a person based on race, creed, color, or national origin
  - Practicing beyond authorized scope, with gross incompetence, with gross negligence on a particular occasion or negligence or incompetence on more than one occasion.
Maintaining License & a Valid Registration Certificate

 PREFIX PROFESSIONAL LICENSE IS “VALID FOR LIFE UNLESS REVOKED OR SURRENDERED FOR PROFESSIONAL MISCONDUCT.”

 PREFIX IT’S YOUR OBLIGATION & RESPONSIBILITY TO BE MINDFUL OF THE FOLLOWING WHEN IT COMES TO MAINTAINING YOUR REGISTRATION:

 PREFIX EXPIRATION DATE. IF EXPIRED DO NOT PRACTICE UNTIL RENEWED.
 PREFIX REPORT NAME OR ADDRESS CHANGE TO LICENSING AGENCY FOR FUTURE RENEWALS.
 PREFIX ANSWER ALL QUESTIONS PERTAINING TO BOTH CRIMINAL CONVICTIONS & TERMINATIONS OF EMPLOYMENT TRUTHFULLY.
 PREFIX PRACTICE WITHIN YOUR SCOPE OF PRACTICE AND STANDARD OF CARE GUIDELINES.
Code of Ethics

- Code of ethics defines the moral principles that govern how you practice nursing and is the foundation on which nursing is built.

- Legal definition: “the minimum standards of appropriate conduct within legal and regulatory parameters involving the duty owed to your patient and other members of your profession.”

- Submitting work vouchers for home care visits not made
- Breach of confidentiality
- Fraud
- Refusing to provide care for patient of specific cultural origin
Grounds for Suspension & Revocation of License

- Incompetent nursing practice
- Professional misconduct
- Conviction of a crime (Homicide; theft; manslaughter; illegible possession of controlled substance; sexual assault; arson; DUI)

Violations may include

- Procurement of a license by fraud
- Unprofessional, dishonorable, immoral, or illegal conduct
- Performance of specific actions prohibited by statute
- Malpractice

Hearings: Moral Character; Disciplinary; Restoration

Actions taken are based upon the severity of the violation. (reprimand or warning; probation; suspension of license; revocation of license)
Be Competent in Your Practice

- You are always held accountable for their own behavior.
- Refusal to perform procedure for which they have not been prepared.
- Be reminded that the Nurse Practice Act changes ever so often; it is the responsibility of all nurses to be current with the laws that govern their scope of practice.

- “Ignorance of the law is no excuse.”
Impaired

- Referred to PAP (professional assistance panel) if no harm to patient
- Surrender license while receiving treatment
- Participate in PAP program (SPAN)
- If successfully complete the NYS PAP program disciplinary charges will not be brought up against you from the bureau of controlled substance or State Education Dept.
Cases
Conclusion

🔹 Embrace and participate in current and future trends.

🔹 Maintain “best practices” that protect your license, influence quality of care and reduce risk.

🔹 Make the most of every day & have a grateful heart.