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Nurses, Negligence, and Malpractice



An analysis based on more than 250 cases against nurses.

More and more nurses are being named defendants in malpractice lawsuits, according to the National Practitioner Data Bank (NPDB). From 1998 to 2001, for instance, the number of malpractice payments made by nurses increased from 253 to 413 (see Figure 1, page 55). The trend shows no signs of stopping,¹⁻³ despite efforts by nursing educators to inform nurses and student nurses of their legal and professional responsibilities and limitations. A charge of negligence against a nurse can arise from almost any action or failure to act that results in patient injury—most often, an unintentional failure to adhere to a standard of clinical practice—and may lead to a malpractice lawsuit.

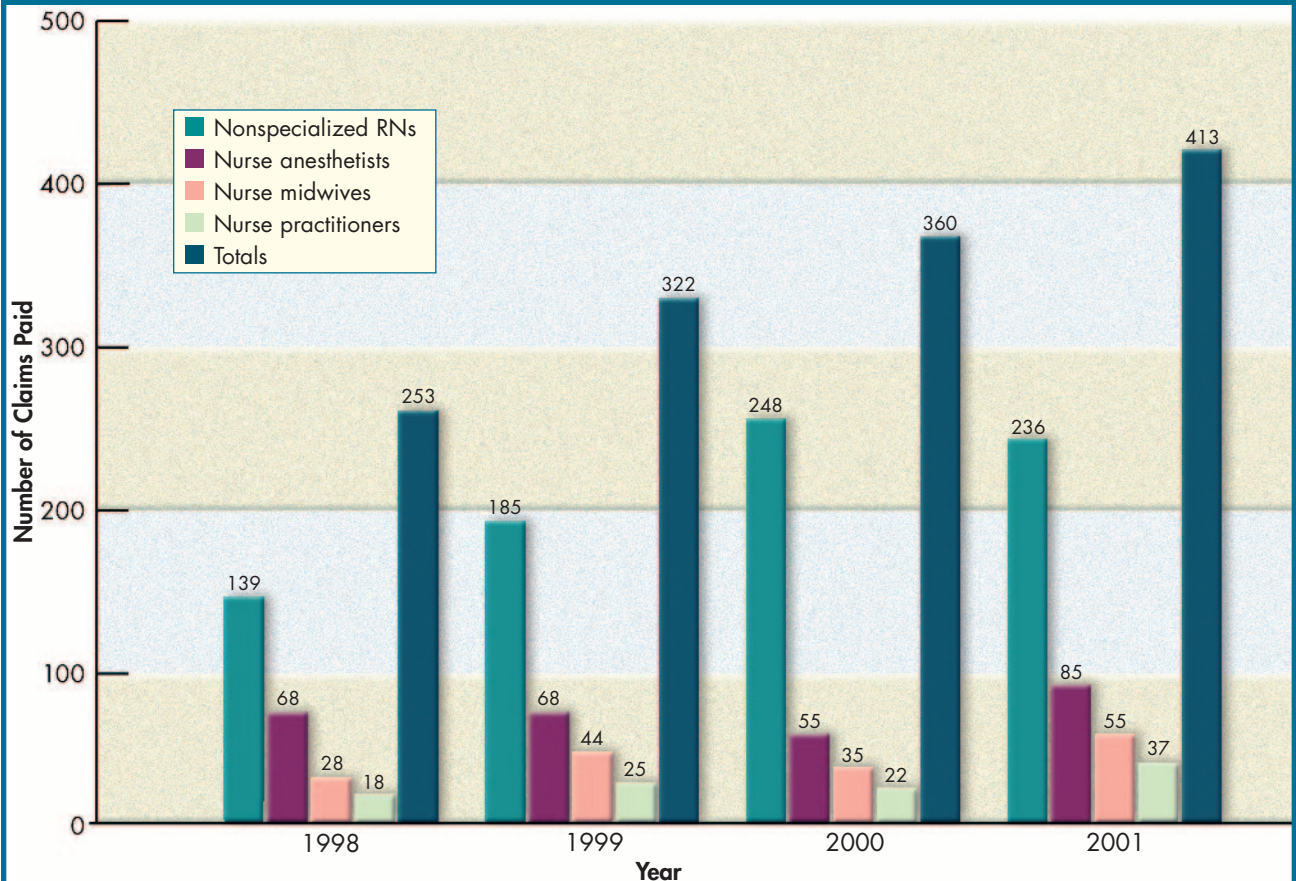
This article analyzes cases decided between 1995 and 2001 and identifies the actions and issues that prompted charges of negligence that led to malpractice lawsuits against nurses, as well as the areas of nursing practice named most frequently in the complaints. (This article does not address criminal cases arising from intentional acts, such as assault, battery, or false imprisonment, for which nurses have been arrested and sometimes prosecuted.)

DEFINING AND TRACKING MALPRACTICE

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) defines *negligence* as a “failure to use such care as a reasonably prudent and careful person would use under similar circumstances.”

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Figure 1. Malpractice Payments by Nursing Category, 1998–2001



Note: Annual subtotals for 1990–1997 are unavailable.

Source: The National Practitioner Data Bank. [Web site.] 2003. www.npdb-hipdb.com/annualrpt.html.

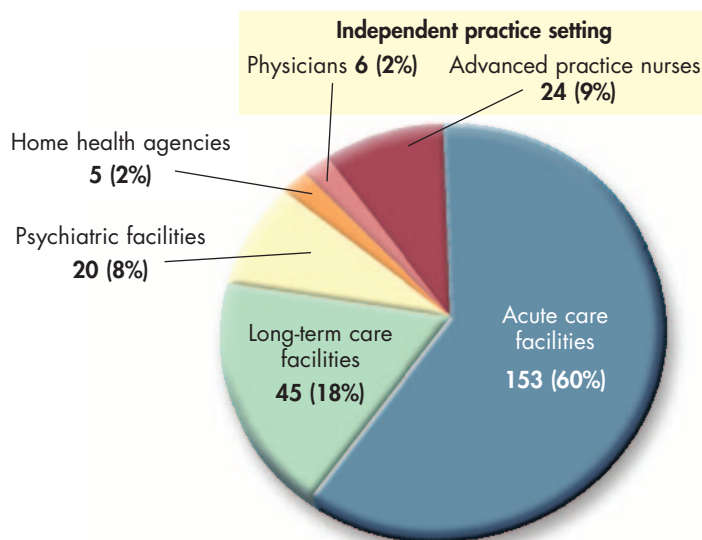
JCAHO defines *malpractice* as “improper or unethical conduct or unreasonable lack of skill by a holder of a professional or official position; often applied to physicians, dentists, lawyers, and public officers to denote negligent or unskillful performance of duties when professional skills are obligatory. Malpractice is a cause of action for which damages are allowed.”⁴ Malpractice is defined variously under state nurse practice acts, institutional policies, and federal guidelines such as JCAHO standards, all of which may be taken into consideration in court.

Several factors have contributed to the increase in the number of malpractice cases against nurses.

- **Delegation.** As a result of cost-containment efforts in hospitals and HMOs, nurses are delegating more of their tasks to unlicensed assistive personnel. Delegation of some of these tasks may be considered negligence according to a given facility's standards of care or a state's nurse practice act.

- **Early discharge.** Patients are being discharged from hospitals at earlier stages of recovery and with conditions requiring more acute and intensive nursing care.⁵ Nurses may be sued for not providing care or not making referrals appropriate to the patient's condition.
- **The nursing shortage and hospital downsizing** have contributed to greater workloads for nurses, increasing the likelihood of error.
- **Advances in technology** require nurses to have knowledge of a variety of technologies' capabilities, limitations, and safety features.
- **Increased autonomy and responsibility of hospital nurses** in the exercise of advanced nursing skills have also brought about greater risk of error and liability.
- **Better-informed consumers** are more likely to be aware of malpractice issues and to recognize insufficient or inappropriate care.

Figure 2. Incidence of Nursing Negligence Allegations by Setting, 1995–2001



Note: Total number of complaints = 253; percentages are rounded to the nearest 1%, resulting in a total of 99%.

- **Expanded legal definitions of liability** have held all professionals to higher standards of accountability.¹ For example, because of the expanded scope of practice of advanced practice nurses, courts have held them to a medical standard of care.²

In 1990 the NPDB began collecting information about health care practitioners who, as the result of judgments in malpractice suits, have entered into settlements, had disciplinary action taken against them that resulted in licenses being revoked or privileges to practice being limited, or had to pay monetary awards (or whose employers or insurance carriers have had to pay monetary awards).¹ (Established in 1986 and regulated by the Bureau of Health Professions, the Health Resources and Services Administration, and the U.S. Department of Health and Human Services, the NPDB assists eligible agencies such as state licensing boards, hospitals, and HMOs in checking the qualifications of practitioners whom the agencies wish to hire or to whom they wish to grant licenses, membership, or clinical privileges.⁶)

The NPDB classifies RNs into four categories: nonspecialized RNs, nurse anesthetists, nurse midwives, and nurse practitioners. According to the data bank, RNs have been responsible for 3,615 malpractice payments over the history of the NPDB (only

those cases reported to the NPDB between September 1, 1990, and December 31, 2001, are included). Nonspecialized RNs made the most malpractice payments (2,311 or 63.9%), followed by nurse anesthetists (820 or 22.7%), and nurse midwives (296 or 8.2%). Nurse practitioners made the fewest malpractice payments (188 or 5.2%). (For numbers pertaining to 198 through 2001, see Figure 1. Annual reports of the NPDB are available online at www.npdb-hipdb.com.)

Acts of commission or omission that plaintiffs commonly alleged 20 years ago continue to be alleged causes of nursing negligence.^{1,3} According to the NPDB's annual reports, from 1990 through 2001 the majority of payments in malpractice suits resulted from the following nursing negligence issues: among nonspecialized RNs, problems relating to monitoring, treatment, medication, obstetrics, and surgery; among nurse anesthetists, problems relating to anesthesia; among nurse midwives, problems relating to obstetrics; and among nurse practitioners, problems relating to diagnosis and treatment.

A 1997 study identified the following nursing negligence issues as the bases of settlements or verdicts in favor of plaintiffs: failure to communicate adequate information to the physician; inadequate patient assessment, nursing interventions, or nursing care; medication errors; inadequate infection control; and unsafe or improper use of equipment.⁷ (Similar negligence issues were identified in studies by Campazzi [1980],⁸ Smith [1989],⁹ Mayberry and Croke [1996],³ and Smith-Pittman [1998].¹⁰)

It's important to note that a payment or claim made in a malpractice action shouldn't be construed as a presumption of the provider's guilt. As a fact sheet from the NPDB states, "settlement of a medical malpractice claim may occur for reasons that do not necessarily reflect negatively on the professional competence or conduct"⁶ of the provider. For example, a nurse's insurance policy might allow the insurance carrier to settle without the policyholder's consent.²

CASE SUMMARY REVIEW

I have reviewed more than 350 trial, appellate, and supreme court case summaries, which were drawn from legal research sources such as the NPDB; regional reports and digests; the LexisNexis database; the Internet portals FindLaw and MedLaw; secondary sources such as nursing malpractice insurance information; and professional newsletters, journals, and books, including *Medical Malpractice Law & Strategy*, *Legal Eagle Eye Newsletter for the*

Nursing Profession, Journal of Legal Nurse Consulting, Journal of Nursing Law, Legal and Ethical Issues in Nursing, Nurse's Legal Handbook, and Nursing Practice and the Law. Only cases that met all of the following criteria were included in the analysis: a nurse was engaged in the practice of nursing as defined by his or her state's nurse practice act; a nurse was a defendant in a civil lawsuit as the result of an unintentional action (no criminal cases were considered); and a trial was held between 1995 and 2001.

Two hundred fifty-three case summaries were included in the analysis. The summaries provided information on the nurses' areas of practice, the types of negligence involved, and the case outcomes (settlements or jury verdicts). Monetary awards were paid either directly by independent practitioners or by employers on behalf of employees according to the doctrine of *respondeat superior* (Latin for "let the master answer," this principle holds that an employer is responsible for actions performed by an employee in the course of employment).²

As shown in Figure 2 (page 56), the greatest frequency of reported cases of negligence occurred in acute care hospitals (60%). The rest occurred in long-term care facilities (nursing homes and rehabilitation and transitional care units) (18%); psychiatric facilities (8%); home health agencies (2%); and independent practice care settings of physicians (2%); and advanced practice nurses, which include nurse practitioners, nurse midwives, and nurse anesthetists (9%).

The great difference in proportion between acute care facilities and long-term care facilities may be explained by the larger number of specialty practice areas in acute care and by the condition of patients in the specialty practice areas—in EDs; operating and recovery rooms; and obstetrical, intensive care, coronary care, and medical-surgical units, patients are sicker, may require immediate interventions, and may have rapidly changing conditions.¹⁰

NEGLIGENCE ISSUES

In my case review, I identified six major categories of negligence issues that prompted malpractice lawsuits. Documentation describing the negligent behavior often used terms such as *failure to*, *lack of*, *incomplete*, *ineffective*, and *improper*. The categories of negligence are: failure to follow standards of care, failure to use equipment in a responsible manner, failure to communicate, failure to document, failure to assess and monitor, and failure to act as a patient advocate (see *Six Major Categories of Negligence That Result in Malpractice Lawsuits*,

Six Major Categories of Negligence That Result in Malpractice Lawsuits

Failure to follow standards of care, including failure to

- perform a complete admission assessment or design a plan of care.
- adhere to standardized protocols or institutional policies and procedures (for example, using an improper injection site).
- follow a physician's verbal or written orders.

Failure to use equipment in a responsible manner, including failure to

- follow the manufacturer's recommendations for operating equipment.
- check equipment for safety prior to use.
- place equipment properly during treatment.
- learn how equipment functions.

Failure to communicate, including failure to

- notify a physician in a timely manner when conditions warrant it.
- listen to a patient's complaints and act on them.
- communicate effectively with a patient (for example, inadequate or ineffective communication of discharge instructions).
- seek higher medical authorization for a treatment.

Failure to document, including failure to note in the patient's medical record

- a patient's progress and response to treatment.
- a patient's injuries.
- pertinent nursing assessment information (for example, drug allergies).
- a physician's medical orders.
- information on telephone conversations with physicians, including time, content of communication between nurse and physician, and actions taken.

Failure to assess and monitor, including failure to

- complete a shift assessment.
- implement a plan of care.
- observe a patient's ongoing progress.
- interpret a patient's signs and symptoms.

Failure to act as a patient advocate, including failure to

- question discharge orders when a patient's condition warrants it.
- question incomplete or illegible medical orders.
- provide a safe environment.

page 57). (These categories are not mutually exclusive; in one of the cases discussed below, two kinds of negligence are involved.)

The following are summaries of five randomly selected malpractice cases in which nurses were named as defendants. They illustrate the range of actions that result in breaches of the standards of care.

Failure to follow standards of care. Standards such as hospital policies have evolved to protect consumers from substandard care. In defining acceptable levels of care—the ordinary and reasonable care required to ensure that no unnecessary harm comes to patients²—standards of care provide criteria for determining whether a nurse has breached duty in the care owed to the patient. Standards of care are derived from sources such as state boards of nursing, professional nursing associations (for example, the ANA and the National League for Nursing), hospital policies and procedures, and the guidelines of federal organizations (for example, JCAHO and the Centers for Medicare and Medicaid Services).

In *Hall v. Arthur* (1998), the United States Court of Appeals for the Eighth Circuit upheld a trial court's decision, which held a hospital liable because of a nurse's breach of a standard of care in an anterior cervical discectomy and fusion (ACF).¹¹ In the trial, the plaintiff's argument focused on the use of Orthoblock, a ceramic substance used to replace bone in maxillofacial surgery, which was implanted in the patient's spine. (The usual procedure in such surgery would be to obtain bone from a bone bank or harvest it from the patient's hip.) After four months of back difficulties, the patient, Mr. Hall, required a second ACF to remove the Orthoblock and have his own bone implanted.

Hospital policy required that any "unusual requests" for use of a product undergo review by department managers to assess the product's appropriateness.² The nurse failed to seek such a review and ordered the Orthoblock for use in the patient's ACF. The package insert for the product, presented as evidence at trial, indicated that Orthoblock was specifically contraindicated for use in spinal procedures. The plaintiff's attorney argued that the nurse's failure to follow hospital policy contributed to Mr. Hall's injury.

On appeal, the hospital did not dispute the jury's finding of negligence, but asserted that the plaintiff produced insufficient evidence from which a juror (or "reasonable fact finder") or judge could conclude that the nurse's negligence contributed to Mr. Hall's injury. The appellate court disagreed, stating:

"[W]hile we cannot say with certainty that Mr. Hall would not have been injured if the nurse had not been negligent, we believe that the jury could reasonably conclude that her negligence played a significant part in allowing Mr. Hall to be injured by the use of Orthoblock for his ACF surgery. All that one has to assume here is that the hospital would not have allowed the surgery to take place, and we do not regard this assumption as requiring a leap of faith."¹¹

Failure to use equipment in a responsible manner. Nurses must know the safety features, capabilities, and limitations of any equipment they use, as well as its hazards. Nurses must follow the manufacturers' usage recommendations and refrain from modifying the equipment. The Safe Medical Devices Act of 1990 requires that all medical device-related adverse incidents that result in death or serious illness or injury be reported to the manufacturer and the Food and Drug Administration within 10 working days.²

In *Chin v. St. Barnabas Medical Center* (1988), the Superior Court of New Jersey, Appellate Division, reversed a trial court's judgment against a physician alone and said that other hospital personnel should also be held liable.¹² The case involved the death of a 45-year-old woman, Ms. Chin, from a massive air embolism during a diagnostic hysteroscopy. The woman's estate had brought a medical malpractice suit against all the providers who had possibly played a role in the events leading to her death: the physician who performed the procedure, three operating room nurses (one scrub nurse and two circulating nurses), the hospital, and the manufacturer of the hysteroscope, an optical device with a pump used in examining the uterus. During the procedure, fluid is pumped continuously into the uterus to enhance the view of its interior. The device requires the connection of four tubes: an irrigation tube through which fluid flows into the uterus, a suction tube that draws fluid out of the uterus, a tube that connects a source of compressed nitrogen to the pump, and an exhaust tube. Because one of the tubes was connected to the hysteroscope incorrectly, nitrogen was pumped into the patient's uterus, causing a fatal air embolism in the coronary arteries.

At trial, all parties accepted the theory that the exhaust hose was the source of the gas that killed Ms. Chin; who was at fault for attaching the hysteroscope incorrectly was disputed. Evidence presented at trial revealed that the two nurses assigned to the surgical procedure had neither hospital train-

ing nor experience in the hysteroscope's use. Evidence also showed that the supervising nurse who made the assignments was unaware of the nurses' lack of experience. No expert opinion on the standard of care was presented at trial.

At the end of the trial, the judge instructed jury members to use their "common knowledge" to decide if the nurses deviated from their duty in caring for Ms. Chin. (The common-knowledge standard applies when the facts of a case are such that a layperson's common knowledge and experience would enable a juror to conclude, without hearing expert testimony, that a duty of care has been breached.) The judge also informed the jury that because Ms. Chin was unconscious at the time of the procedure, she was blameless in her own death and at least one of the defendants clearly was at fault—shifting the entire burden of proof from the plaintiff to the defendants (that is, each defendant had to prove that he or she was not at fault).

The jury awarded the plaintiff \$2,000,000 in damages and found the defendants liable in the following proportions: the physician, 20%; the experienced circulating nurse, 25%; the inexperienced circulating nurse, 20%; and the hospital, 35%. The scrub nurse and the manufacturer were cleared of all liability.

Immediately after the verdict, the trial judge ruled in favor of the hospital's motion that questioned the validity of applying the common-knowledge standard in this case; the judge reapportioned liability solely to the physician. In granting the hospital's motion, the judge said the application of the common-knowledge standard had been an error. But in the physician's appeal, the appellate court reversed the trial court's decision and essentially restored the original jury verdict, saying that each defendant had not entirely established the lack of fault in Ms. Chin's death and that the trial court had not erred in applying the common-knowledge standard.

Failure to assess and monitor and failure to communicate. Changes in the health status of a patient can be gradual or sudden and nurses are usually the first to see the changes and take action. A nurse's accuracy in assessing and monitoring and her timely reporting of changes in health status to a physician can often mean the difference between life and death. Vital aspects of communication besides timeliness in reporting the change include persistence in notifying the physician of the change, and accuracy in communicating the nature and degree of the change.

What To Do If You Are Served with a Complaint

First: notify your insurance carrier.

A complaint is a legal pleading made by a plaintiff to initiate a lawsuit. It includes a formal statement of the charges and the alleged cause or causes of action against the defendant. This document may be the first indication a nurse has that she's being named as a defendant in a civil lawsuit. Once the complaint has been served, the nurse must notify her employer and liability insurance carrier. Usually the insurance carrier and the employer will assign attorneys to the case, but if the nurse doesn't have liability insurance, she should engage the services of an attorney. The nurse *must* also refrain from discussing the case with anyone but the assigned defense attorney.

When notifying her liability insurance carrier, the nurse should give a written description of the event, including the time, place, and circumstances surrounding the incident, as well as a list of the names and addresses of the injured party or parties and any witnesses. Once served, the nurse must forward all relevant documents to the insurance carrier within the specified time period set forth in the liability insurance policy. If the nurse does not notify the insurer within the specified time period, the insurer may deny coverage to the nurse.¹

REFERENCE

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In *Busta v. Columbus Hospital Corporation* (1996), the Montana Supreme Court affirmed the judgment and orders of the District Court of the Eighth Judicial District.¹³

While he was a postoperative patient at Columbus Hospital in Great Falls, Mr. Busta died from injuries sustained in a fall from his third-floor window; apparently he had tried to climb down on an improvised rope. At trial, the nurse assigned to care for Mr. Busta testified that during her last evening visit with him, he had experienced an episode of tachycardia and hypertension. He had also behaved atypically, desiring isolation and refusing all nursing care and his prescribed medication, known to have adverse effects, including confusion, anxiety, and psychosis. The nurse did not report the

symptoms and the change in behavior to the physician. She also testified that when she observed the patient at midnight, he appeared to be sleeping; she did not reassess his vital signs.

Mr. Busta's surgeon testified that, because of the mind-altering adverse effects of the patient's medication, he would have reassessed his patient if he had been notified of the changing signs and symptoms. Expert testimony opined that the nurse was negligent in failing to adequately monitor Mr. Busta on the evening and night before he died, and in failing to report the constellation of signs and symptoms to the surgeon; and that the hospital was negligent in failing to maintain a safe environment (evidence presented at trial showed that the hospital had not acted on a JCAHO directive to restrict the opening of windows in patients' rooms).

The jury found that the negligence of Columbus Hospital combined with the patient's contributory negligence caused the patient's injuries and death; the jury apportioned 70% of the liability to the hospital and 30% to Mr. Busta. The jury found that Mr. Busta and his estate were damaged in the amount of \$5,000 and his heirs, \$800,000. Based on the jury's apportioned liability, the district court entered a judgment in favor of Mr. Busta's estate in the amount of \$3,500 and in favor of his heirs, of \$560,000.

Failure to document. Documentation—the purpose of which is primarily to communicate patient information among providers—must accurately reflect the nursing process, showing evidence of nursing assessment and diagnosis, planning for nursing intervention, implementation and evaluation of planned interventions, and patient response.^{14, 15}

The Court of Appeals of Louisiana, Fourth Circuit, affirmed the trial court's verdict in *Pellerin v. Humedacenters*, a case concerning a failure to document nursing procedures.¹⁶ The plaintiff had alleged that an ED nurse administered an injection of meperidine (Demerol) and hydroxyzine pamoate (Vistaril) in a substandard manner, causing a lump at the injection site and continuous pain, which was later diagnosed by a neurologist as cutaneous gluteal neuropathy. How the injury actually occurred could not be proven at trial. Medical experts gave conflicting testimony regarding the cause of the patient's nerve injury (either the hydroxyzine pamoate or the needle could have caused it). Nurse experts opined that the failure to document the site and mode of injection fell short of the standard of care. At trial, the defendant testified that her customary practice was giving an intramus-

cular injection and that this practice met the standard of care. The jury found in favor of the plaintiff and awarded more than \$90,000 in damages.

On appeal, the defendants (the hospital and the nurse) argued that evidence presented at trial demonstrated that the nurse's breach of the standard of care could not have caused the patient's injury. The appellate court disagreed, stating that the nurse experts' testimony—insufficient by itself to support the jury's decision—did support that decision when combined with the other evidence presented at trial.

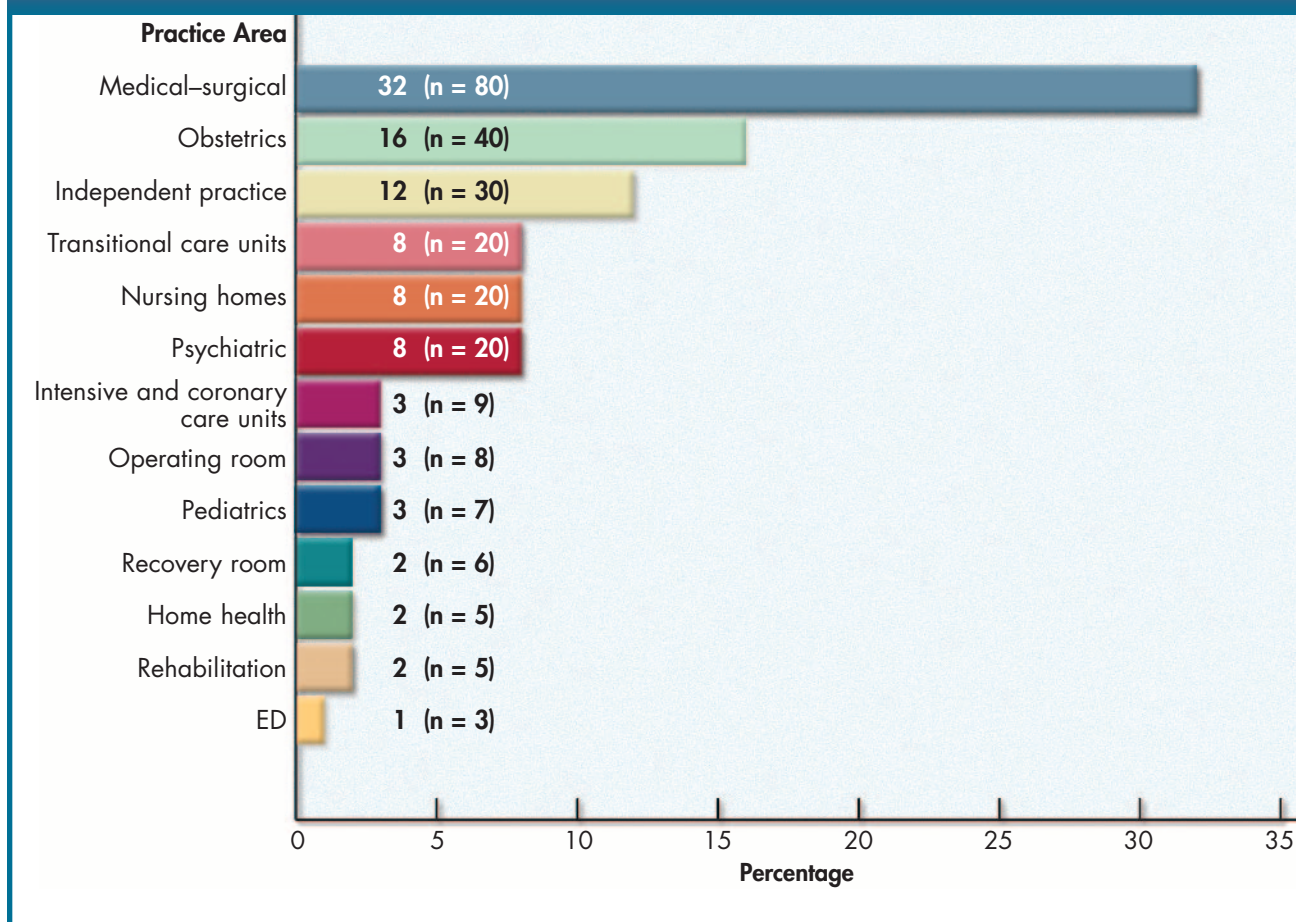
Failure to act as a patient advocate. Legal and ethical issues often become entwined in health care settings, and nurses must be knowledgeable in both.² The ANA's *Code of Ethics for Nurses with Interpretive Statements* provides nurses with a framework for ethical decision making and defines the role of the nurse as patient advocate.

According to O'Keefe in *Nursing Malpractice and the Law*, "Patient rights are the hallmark for advocacy of nursing care. Nurses are compelled to strive for excellent care of patients and the inclusion of their rights in today's health care system."¹⁷ It's important to note that, as patient advocates, nurses may be required to care for patients whose health care decisions conflict with the nurse's ethical beliefs.

In *Koeniquer v. Eckrich* (1988), the Supreme Court of South Dakota reversed and remanded for trial an order of summary judgment in favor of Dakota Midland Hospital by the Circuit Court of the Fifth Judicial Circuit.¹⁸ The case involved the death of a patient, Winnifred Scoblic, as a result of sepsis, which was alleged to have developed when she was discharged with a fever some 11 days after urinary tract surgery. The plaintiff, Ms. Koeniquer, representing her mother's estate, initiated a medical malpractice suit against two physicians and Dakota Midland Hospital, alleging deviation from the appropriate standards of care for a patient in post-operative urology.

Ms. Scoblic's surgery was performed on January 5, 1983. Her temperature fluctuated during her post-operative hospital stay and was recorded as 100.2°F on January 16 at 8:15 AM, after the treating physician had completed rounds. The patient was discharged at 10:45 AM on the same day. She was readmitted to the hospital on January 19 with a diagnosis of sepsis. On January 21, she was transferred to the University of Minnesota Hospital and on March 6 died of multiple organ failure. The plaintiff's expert witness opined that the nurses failed to adequately monitor Ms. Scoblic's changing

Figure 3. Distribution of Malpractice Cases by Practice Area (N = 253)



condition and provide acceptable postoperative care: although they claimed they had reported the patient's elevated temperature and the condition of the incision and drainage from it to the physician on the day of discharge but had failed to document such a report; the expert also opined that allowing Ms. Scoblic to be discharged with an elevated temperature and failing to provide Ms. Scoblic with discharge instructions about monitoring her temperature were examples of failing to act as patient advocate.

Although the hospital argued that the decision to discharge was a medical one, the hospital's director of nursing stated in her deposition that sometimes it is the nurse's responsibility to question the physician's order, especially when there has been a significant change in the patient's condition. The director also confirmed the expert's assertions that the nurse has a responsibility to independently evaluate the

patient's condition, to bring her concerns to the physician, and to appeal to other authorities if the nurse believes the physician's decision is wrong.

The court accepted the hospital's argument that it's a physician's decision to discharge a patient and, therefore, that the hospital was an inappropriate respondent to the suit. The state supreme court, however, ruled there was expert testimony in the record showing that hospital nurses had a duty to attempt to delay Ms. Scoblic's discharge, because of her changing symptoms that day, yet there was no evidence in the record that any nurse questioned or disagreed with the physician's decision to discharge her. The court held that nurses have a duty to question a physician's order if they think it is in the patient's best interest to do so and to delay discharge if they believe discharge deviates from acceptable standards of care.¹⁹ In this case, the nurse neglected her role as advocate.

PRACTICE AREAS CITED IN COMPLAINTS

In my case review, I identified 13 specialty practice areas of nurses involved in malpractice cases. As indicated in Figure 3 (page 61), nurses employed in acute care facilities were named as defendants in such litigation more frequently (153 cases) than nurses employed elsewhere (100 cases). In acute care facilities, seven specialty practice areas were identified. Nurses employed on medical-surgical units had the highest percentage of involvement in litigation (32%), followed by nurses employed on obstetrics units (16%). (Similar findings were noted for medical-surgical units in studies by Campazzi⁸ and Mayberry and Croke.³)

The areas within acute care facilities in which nurses had the least involvement in litigation include coronary care and intensive care units, operating rooms, and pediatrics (each with 3% of all cases), followed by recovery rooms (2%) and EDs (1%). (Smith⁹ and Smith-Pittman¹⁰ identified EDs, obstetrics units, psychiatric units, and operating rooms as specialty practice areas associated with high frequencies of litigation.)

I identified six specialty practice areas outside acute care in the review. Advanced practice nurses employed in independent settings had the highest percentage of involvement in litigation (9%), followed by nurses on transitional care and psychiatric units and in nursing homes (each with 8%). The areas with least involvement in litigation included home health and rehabilitation units (each with 2%). (Campazzi,⁸ Smith,⁹ Mayberry and Croke,³ and Smith-Pittman¹⁰ found that nurses employed in areas outside acute care were named less frequently as defendants in malpractice litigation than nurses employed in acute care, but their studies do not reveal a consistent trend as to which specialty practice area accounts for the most malpractice litigation.)

REDUCING POTENTIAL LIABILITY

“Nursing judgment involves the analysis of facts and circumstances on a case-by-case basis. To prevent malpractice, it is essential that the nurse undertake this evaluation with regard to everything that he or she does in the clinical setting.”¹⁴ Increasingly, nurses are held accountable to the public for their professional judgment and the outcomes arising from that judgment.

Malpractice litigation is both professionally and emotionally devastating and can be financially disastrous. Each nurse can take steps to help reduce potential liability by using caution and common sense and by maintaining a heightened awareness of

his or her legal responsibilities. The following can help nurses reduce potential liability.

Maintain open, honest, respectful relationships and communication with patients and family members.

- Patients are less likely to sue if they feel that a nurse has been caring and professional.¹⁹
- Don't offer opinions when a patient asks what you think is wrong with him—you may be accused of making a medical diagnosis.
- Don't make a statement that a patient may interpret as an admission of fault or guilt.
- Don't criticize health care providers or their actions when you are with patients.
- Maintain confidentiality in the health care setting.

Maintain competence in your specialty area of practice.

- Attend relevant continuing education classes.
- Attend relevant hospital in-service programs.
- Expand your knowledge and technical skills.

Know legal principles and incorporate them into everyday practice.

- Keep up to date on your state's nurse practice act.
- Keep up to date on hospital policies and procedures.

Practice within the bounds of professional licensure.

- Perform only the nursing skills allowed within your scope of practice and that you are competent to perform.

Know your strengths and weaknesses. Don't accept a clinical assignment you don't feel competent to perform.

- Evaluate your assignment with your supervisor
- Accept only those duties you can perform competently
- Let an experienced nurse on the unit assume responsibilities for the specialized duties.
- Document all nursing care accurately.
- If care is not documented, courts assume it was not rendered.
- When documenting care on the patient's chart, use the FACT mnemonic: be **f**actual, **a**ccurate, **c**omplete, and **t**imely.²⁰ ▼



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CE²^{HOURS}

Continuing Education

GENERAL PURPOSE: To provide registered professional nurses with an overview of the issues surrounding professional negligence and malpractice.

LEARNING OBJECTIVES: After reading this article and taking the test on the next page, you will be able to

- describe trends related to negligence and malpractice in health care.
- list legal principles related to negligence and malpractice.
- outline recommendations aimed at reducing malpractice liability.

To earn continuing education (CE) credit, follow these instructions:

1. After reading this article, darken the appropriate boxes (numbers 1-17) on the answer card between pages 48 and 49 (or a photocopy). Each question has only one correct answer.

2. Complete the registration information (Box A) and help us evaluate this offering (Box C).*

3. Send the card with your registration fee to: Continuing Education Department, Lippincott Williams & Wilkins, 345 Hudson Street, New York, NY 10014.

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