Protecting Yourself from Malpractice Claims

Introduction

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

Section 1: Medical Malpractice

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

Failing to Adhere to the Ethic Principles of Health Care

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

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

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

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

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

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

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

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

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

Failing to Adhere to a Related Scope of Practice

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

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

Registered Nurses

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

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

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

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

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

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

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RN Role/Nursing Process

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

The RN:

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

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

Licensed Practical Nurses

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

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

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

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

LPN Practice Prohibitions

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

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

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

LPN Role/Nursing Process

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

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

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

LPN IV Therapy

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

Supervision of Nursing Practice

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

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

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

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

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

Case Study Review

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

<u>Is it possible that medical malpractice occurred in the presented case study?</u>

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

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

<u>How could the potential for medical malpractice litigation been avoided?</u>

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

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

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

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

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

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

Conclusion

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

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