**Medical Malpractice Awareness**

Student Name

Institution Affiliation

Course

Instructor

Date

**Purpose of Paper, the topic chosen, applicable federal and/or state laws**

**Introduction and topic justification**

This paper aims at highlighting the issue of medical malpractice and the deep implications it has on the health sphere. Medical malpractice is essential as it impacts the lives of patients and also deals with the integrity and responsibility of the health sector. Such a choice is made because it is actual and relevant to enhancing patients’ safety as well as creating a culture of accountability within the sphere of healthcare. In its broadest sense, medical malpractice can be simply described as negligence on the part of a healthcare provider that causes injury to the patient. This deviation most of the time results in legal and ethical issues that affect the quality of services that are offered in health facilities (Liang et al., 2023). Overall, it is critical to address this problem to eliminate risks, promote compliance with the standards, and respect the trust patients have for their healers.

**Laws and policies**

Medical malpractice pertains to the civil liability arising out of the delivery of health care services, while federal and state laws are critical in the governance of this vice. At the federal level there is the Emergency Medical Treatment and Labor Act (EMTALA), which requires stabilization of any patient that presents at a hospital’s emergency department regardless of their ability to pay to prevent acts of malpractice relating to patient abandonment or negligence. Most states have enacted laws, policies, and codes, including California’s MICRA, that regulate and prescribe limits on noneconomic damages and establish a framework within which the claims for medical malpractice may be pursued. For example, MICRA limits noneconomic damages to $250,000 and prescribes only a one-year time bar for legal actions. Also, the formal policies of many healthcare organizations are focused on the enhancement of the quality of services and the legal requirement of reporting (Dickinson, 2024). These policies work hand in hand with federal and state statutes, enhancing proper ethical standards across the countries and minimizing the prevalence of cases of malpractice.

**The specifically targeted employee group and specific health services setting**

**Employee role**

With regard to risks in the clinical setting that can lead to medical negligence, the head nurse emerges as a critical figure in the present analysis. The head nurse controls clinical activities and is directly responsible for the nursing staff, as well as enforcing care quality, ensuring patient safety, and overall organizational responsibilities. Consequently, head nurses play a critical role in initiating practices that reduce legal and medical mistakes and enhance legal and ethical compliance. They also educate their staff on the need to document their services appropriately to gain consent from the service users and the need to practice in accordance with best practices. Liang et al. (2023) observed that poor leadership in these areas results in malpractice claims, showing the head nurse’s position in preventing such risks. The head nurses interact between the management of a hospital and the clinical staff to ensure that the policies of the institution support and complement patients’ care by addressing logistical issues that may cause or lead to malpractice, the participant said.

**Health services setting**

The Emergency Department (ED) is selected as a healthcare setting because of its significantly high-risk interference, where most find themselves making decisions and attending to patients in an unstable and rather stern environment. There are a number of unique challenges faced in the ED, such as overcrowding, time pressures, and challenging patient populations, all of which put patients at greater risk of a medical error. As highlighted by the interviewee, the head nurses in this setting are central in supervising flow, incidents, and protocol management that include EMTALA directives. For instance, inadequate triage of a client in the ED leads to the conclusion of poor client outcomes, practitioners’ malpractice, and fulfillment of malpractice claims (Dickinson, 2024). By adhering to set organizational guidelines, being a role model, and setting proper expectations and accountability, the head nurse minimizes the likelihood of errors in this fast-paced setting.

**Discussion of Three Critical Aspects of Employees’ Responsibilities**

**a) Discussion of Employee-Specific Critical Responsibility 1**

***Consequences for Failing in Documentation Standards***

One of the primary responsibilities of a head nurse is to document and maintain records of patient care. Consequences of failing to meet this responsibility are legal action, endangerment of the lives of patients, and sometimes revocation of an individual’s license. Inadequate documentation also hampers proper defense in cases of malpractice, as it becomes challenging to prove that proper care was offered to the patient (Liang et al., 2023). Such a failure was unlikely to leave any patient safe from harm from one provider to another due to care coordination challenges that exist as part of increased malpractice dangers.

***Statutory requirements for documentation***

Evidence documentation procedures are also state and federal legal requirements. For instance, the Health Insurance Portability and Accountability Act of HIPAA specifies the documentation standards to ensure the provision of patients’ information security during the course of the care provision and hence care coordination. Moreover, the state nursing boards set regulations that make nurses responsible for keeping and producing highly comprehensive and accurate records (Susila, 2021). These statutes also stress that the documentation has to show all the care processes, such as informed consent, medication administration, and interactions with the patient.

***Real-Life Case: Failure in Documentation***

A landmark case, *Thomas v. Davis Hospital,* shows the effects of poor documentation. In this case, the hospital ended up on the wrong side of the law after records that doubted adequate post-operation care were provided since they were incomplete and could not reveal the extent of harm the patient had been subjected to (Dickinson, 2024). This case shows that if documentation is not properly conducted, then institutions are likely to engage in expensive litigation and suffer loss of reputation.

**b) Discussion of Employee-Specific Critical Responsibility 2**

***Consequences for Failing in Patient Safety Protocols***

The head nurse is also responsible for ensuring that the staff complies with the various patient safety measures. Failure to do so may lead to violations such as misunderstandings, mistakes, new infections, or other undesirable outcomes for a patient. Lack of adherence to infection control measures in emergency care results in HAIs in the emergency department. (Mensah et al., 2024). These consequences pose risks of patients losing their lives besides bearing a financial loss for the organization.

***Statutory Requirements for Patient Safety***

The Federal Patient Safety and Quality Improvement Act (PSQIA) ensures proper compliance in implementing safety measures to reduce healthcare risks. Likewise, state laws have mandated that staff receive constant training and that these workplaces are subject to periodic compliance checks, which they have to pass (Susila, 2021). These procedures are supposed to be monitored by head nurses, who also ensure that safety measures like proper instrument sterilization and hand washing are put into practice.

***Real-Life Case: Patient Safety Neglect***

In *Smith v. County General Hospital*, a patient developed sepsis due to failure to adhere to the patient’s infection prevention measures with wound care, among other reasons. In this study, the head nurse was partly to blame for not cracking the whip on the various staff members regarding safety measures (Liang et al., 2023). This case shows to what extent a lack of oversight in patient safety has dire consequences and may lead to legal proceedings against the healthcare facility.

**c) Discussion of employee-specific critical responsibility 3**

***Consequences for Falling Short in Staff Supervision***

Supervising the nursing staff is essential to avert mistakes and enhance the quality of care. Failures in supervision typically result in medication errors, misunderstandings, or procedural errors that commonly cause claims against healthcare professionals. Many of these have negative implications for the institution's leadership and bring an additional risk of liability.

**Statutory requirements for supervision**

Across the states, nursing boards require head nurses to ensure the competence and adherence of their teams. The regulations, which include standard operating procedures, usually call for performance assessments at least once a year and corrective actions any time there is non-compliance (Dickinson, 2024). For example, current federal recommendations of the Centers for Medicare & Medicaid Services (CMS) stress the importance of staff and supervision in attaining the desired outcome for patient care.

***Real-Life Case: Supervision Lapses***

In the case of *Jones v. Metropolitan Medical Center*, a head nurse screwed up and failed to properly supervise a new nurse, which led to a serious medication mistake that injured the patient. The hospital was victorious in the malpractice claim, with the court stating that assertive supervision measures are to be implemented to avoid a reoccurrence (Mensah et al., 2024). This case provides an understanding of how much head nurses contribute to team accountability for errors and their resolution.

**Conclusion**

Head nurses play a significant role in ensuring the quality of healthcare service delivery in that they are tasked with vital functions, including documentation, patient safety, and staff supervision duties. Inability to perform these responsibilities results in adverse consequences like patient harm, litigation, and negative hospital image, among others. Documentation prevents and unmasks errors and is legal for the hospital in legal affairs, while the Patient Safety Mechanisms safeguard patients from risks that could be eliminated. This way, good supervision covers the mistakes that the nursing team could make and ensures that the right procedures are followed. When they are not properly performed, then the quality of care that the patient receives is compromised, and public confidence in health care is eroded. This underlines the significant role of leadership and supervision in avoiding medical negligence and focusing on the identification of high-quality medical practice.

For more information about this issue, refer to the sources in the references section.

**References**

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