**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**

The goal of this paper is to expose the subject of medical malpractice and the deep effect it has on healthcare systems. Medical malpractice acts as an essential topic since they touch patients’s lives while also putting into contention the workings and integrity of healthcare organizations. The decision to focus on this publication’s topic is topical because it relates to dramatically reducing adverse patient outcomes and to promoting the culture of safe behavior among healthcare providers. In its primary sense, medical malpractice is any negligence committed by a healthcare professional that causes the patient an injury. This divergence usually creates legal and ethical issues that determine the quality of care delivered in healthcare facilities (Liang et al., 2023). Overcoming this problem remains crucial for managing risks and improving compliance with standards, which formalizes the trust patients have in medical practitioners.

**Laws and policies**

A significant contingent of rules governing medical malpractice and professional responsibility is contained in federal and state laws. On the federal level, the Emergency Medical Treatment and Labor Act (EMTALA) delivers specific requirements for emergency treatment irrespective of a patient’s capability to pay in order to decrease malpractice concerning patient abandonment or negligence. Statutes limiting noneconomic damages and providing laws regulating malpractice suits are state-specific and include the MICRA passed in California. For instance, MICRA sets noneconomic damages’ ceiling at $250,000 and a one-year rule of limitation on filing a claim. Also, general policies of the healthcare organization devote much attention to quality improvement measures and reporting systems to correspond with these legislations (Dickinson, 2024). They help add to federal and state laws and regulate standards of ethical conduct, thus preventing cases of malpractice.

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

**Employee role**

In this case, the roles of different staff personnel are going to be a focus in trying to avoid the risks of the medical malpractice. The head nurse bears administration and supervision of the clinical services; the staff nurse reports to this head nurse, besides monitoring the compliance of the provided care to regulated guidelines; this makes this position critical in nursing service responsibility and client protection. Head nursing professionals are part of the management team that enforces processes and procedures that decrease risks of error and adherence to the rule of law as well as These entail orientation of the members of staff and reinforcement on compliance with evidence-based practices, more especially on documentation and consent. In their study, Liang et al. (2023) noted that in such areas, there is little supervision, and this leads to claims of malpractice, a role that the head nurse caters to. More so, from the participant’s interview, head nurses are middle management between the hospital administration and other nurses, hence the balancing by ensuring that implemented and intended policies are compatible with the hospital’s patient care standards as well as managing operational concerns that could result in malpractice.

**Health services setting**

The healthcare setting is the Emergency Department (ED) for its high risk that includes quick decision-making and immediate treatment for patients under immense pressure. The ED poses specific risk factors for harm, such as overcrowding, limited time, and challenging patient populations, thereby raising the risk for adverse events. The interviewee opined that in this setting, head nurses are particularly involved in patient flow and critical incidents and how and whether the providers conform to the laws, regulations, or EMTALA guidelines. For instance, if a patient is triaged ineffectively in the ED, it causes delays in treatment, nasty consequences, and most likely, they will be subjected to a malpractice lawsuit (Dickinson 2024). This brings the probability of malpractice in this demanding setting to a standstill through responsive communication, setting, and enforcement of adherence to laid-down rules and policies, besides encouraging accountability on the head nurse.

**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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