Legal and ethical issues in elderly care

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This essay is to examine the case study scenario of Mrs. Davis a resident at the Sunnyside day respite care center. We will be looking at the legal and ethical issues and the implications of these issues in this case study that could impact the RN, EEN and family members of Mrs. Davis as well as the care facility.

CONSENT – there are three types of consent, implied consent (non verbal), verbal consent and written consent.

All healthcare workers must gain consent from the patient before touching a patient and or any procedures and treatment can take place.(Forrester & Griffiths, 2010).

In the case of Mrs. Davis it is clear that she did not give consent in any way to be restrained.

There is no mention in the case study that there is a restraint authorization from a medical doctor or any family members.

RESTRAINTS – The use of restraints can apply to some patients in certain circumstances.

The department of Health and Ageing 2005 identified a high level of restraint usage in Australian nursing homes. Due to the high level of restraint usage it is now regulated in all healthcare facilities.

All healthcare facilities require a doctor’s order for restraints the doctor must assess the patient as to what type of restraint is to be used. (Crisp & Taylor, 2013pp 285- 286).

If a patient is restrained unlawfully and with out consent there could be a claim of false imprisonment. . (Forrester & Griffiths, 2010).

In the case of Mrs. Davis there was no consent given and no evidence in the case study of any restraint authorization.

ASSAULT and BATTERY – If a patient makes a claim of false imprisonment this claim could also lead to assault and battery.

Battery is the unlawful touching of a patient that has not given consent as in the case study of Mrs. Davis no consent was given. . (Forrester & Griffiths, 2010).

DUTY OF CARE – duty of care in tort law is a legal obligation imposed on a person-requiring adherence to a standard of reasonable care whilst performing tasks that could cause harm to others. (Forrester & Griffiths, 2010).

It is apparent in this case study the RN and aged care facility failed to give duty of care to Mrs. Davis as a result of being restrained Mrs. Davis sustained physical harm to her person.

NEGLIGENCE – negligence is a civil action that can be taken by a patient or patient’s family against healthcare workers and facilities if a patient is injured while in their care.

(Forrester & Griffiths, 2010).

Mrs. Davis was injured whilst in a healthcare facility sustaining a head injury whilst being restrained unlawfully.

VICARIOUS LIABILITY – Is a form of secondary liability that is common law in which a secondary party in which a senior healthcare worker can be held accountable for directing a junior healthcare worker to perform a duty that has caused harm to a patient.

The healthcare facility can also be held accountable for all employees' actions. (Forrester & Griffiths, 2010).

SCOPE OF PRACTICE – is defined as a nursing practice that nurses are educated, competent, and authorized to practice to meet the healthcare needs of patients within a facility where nursing care is provided and must abide by relevant policies and protocols of the healthcare facility. (The Australian Nursing Federation, 2005).

ADVOCACY – is fundamentally the nurse's role to advocate for patients they care for. Advocacy is to protect the patient from potential harm from other healthcare workers and can also be to protect the patient from family members. It is the nurse's duty of care to report any potential harm to there patient. It is the nurse's duty to advocate for patient safety and patient rights. . (Forrester & Griffiths, 2010).

DOCUMENTATION – is an essential part of patient care from admission to discharge, although patient records are not legal documents they can be used in court under the rules of evidence. With effective documentation

there is several factors to consider the information should be clear, accurate, concise and objective, contemporaneous reporting any changes to the condition of the patient must be documented immediately or very shortly afterwards. All documentation must have a date and time of entry, the writing must be legible the nurse should only document what is seen and heard and assessed by her/him, the patients name DOB and numerical number must be on all documentation.

Documentation should never be written in advance it must be written in ink and must be signed by the writer with designation. . (Forrester & Griffiths, 2010).

In the case of Mrs. Davis clear concise objective data should be recorded and an incident form should also be recorded by both the RN and EEN, the DON and family of Mrs. Davis should be informed of events.

OPEN DISCLOSURE – is defined as a open discussion of incidents that has resulted in harm to a patient whilst in the care of an healthcare facility with family, carers and other support persons of the patient.(Australian Commission on Safety and Quality Health Care. (2013).

CORONER – the coroner in Australia usually is a magistrate who has a legal background. The coroners court forms part of the Australian court hierarchy, the role of the coroner is identifying the deceased and to hold a public hearing into reportable deaths the function of the coroner when required investigates a death that occurs in certain circumstances. . (Forrester & Griffiths, 2010).

In relation to Mrs. Davis her death would be considered a reportable death, as it was accidental, unexpected and sudden whilst in the care of a healthcare facility.

PART 2

THE DECIDE MODEL

D – DEFINE THE PROBLEM

The problem is the RN that involved Mrs. Davis getting hurt and subsequently dieing restrained Mrs. Davis without consent.

The second problem being that the RN has asked the EEN to lie about the preceding events.

E – ETHICAL

The RN and EEN have a duty of care to Mrs. Davis the ethical issue is there was a failure of duty of care and two the RN wants the EEN to lie about the events this is a breach of the code of ethics and professional code of conduct.

C – CONSIDER THE OPTIONS.

Lying about the events preceding the incident would be a serious breach of care. In regards to the case study there could have been other options open to the RN in Mrs. Davis care rather then restraining her against her will" FALSE IMPRISONMENT" with no restraint order in place from her GP and family.

I – INVESTIGATE OUTCOMES.

The outcome of events which resulted in the death of the patient while in the care of a healthcare facility, both the RN and EEN as well as the employer of both parties are accountable for the actions and events that led to the devastating event to occur.

D – DECIDE ON ACTION.

After reviewing all of the information in the case study the only action that can be taken by the EEN is that she has an ethical and professional responsibility to report all of the facts as accurately as possible that occurred as she was under the direction of the RN.

E – EVALUATE RESULTS

The coroner will evaluate all the events that led to the patient dying he will evaluate the legal and ethical issues in the case study he will draw on all the facts to come to a conclusion and accountability of the nursing home the RN and EEN which may led to criminal charges in this case.

In conclusion this case study illuminates the ethical and legal issues faced by healthcare professionals in healthcare facilities weather it is a hospital or a nursing home when adverse events happen. A nurse or care giver should always practice within their scope of practice and adhere to codes of practice of which they are employed.

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