Negligence essay

Thankfully hospitals are becoming more safety conscious and are instituting new safety standards that draw attention to individual habits and system processes that contribute to errors (Day, 2010). This paper will explain the legal terms negligence, gross negligence, and malpractice in an effort to distinguish the difference between them while applying negligence and malpractice to the newspaper article entitled “ Amputation mishap, negligence cited. The article indicates not only the importance of good communication, but highlights how essential thorough documentation in the patient’s medical record can limit the liability or the health care provider. After reading this paper, I hope the readers will be more informed of the meanings of negligence, gross negligence, and malpractice and the measures to take that can avoid legal trouble for the health care provider. Negligence has been defined as a failure to exercise care that a reasonably prudent individual would exercise in a similar situation.

In other words, if one fails to use reasonable care and it results in damage or injury to another person. Gross negligence has been defined as negligence that is marked by total disregard for the rights of others and total indifference to the consequences off particular act. Malpractice refers to improper or negligent practice and a failure to exercise a degree Of professional skill by one who is providing a service (such as a physician) and results in injury, loss, or damage (negligence, gross negligence, malpractice, 2012). In a court of law all must be proven by what is known as clear and convincing evidence. What is meant by clear and convincing evidence is “ the measure of the degree of proof that will produce in the mid of the Trier of

fact a firm belief or conviction as to the truth of the allegations sought to be established” (Thornton, 2006, p. 4).

The article “ Amputation mishap, negligence cited” was about a patient who entered a hospital to have a scheduled amputation of his because of circulation issues caused by diabetes. The article goes on to describe how shocked this gentleman was to wake up and find the wrong leg was amputated. Although the article did not go in to detail as to specifics of the case and the steps that were taken from here on out to prevent such mistakes, it did allude to the fact that the hospital has been experiencing many problems that would affect workflow and lead to errors and patient safety events. I agree with the newspaper article statement that cites this incident as negligence. Referring to the definition of negligence being that failure to exercise care that one would administer to another individual in a similar situation, the operating team for this patient did not render the appropriate level of care to this patient that they may have to another patient that very same day. There appears to be a lack of attention to detail relative to the consent, as it should have listed which leg was to be amputated, the act of a universal time-out just prior to the operation taking place, marking of either the affected or unaffected extremity depending on hospital policy and protocol, and surgeon responsibility to ensure the right site (Baseman & Headpiece, 2012). In my opinion this incident is not the fault of one member of the surgical team, but the entire team working together to prevent this serious safety event. In 2003 the Joint Commission on Health Care Accreditation developed national patient safety goals around wrong-site surgeries, calling them sentinel events, those unexpected

occurrences that may result in death or serious physical or psychological harm.

They recommended the creation and use of a preoperative verification checklist, implement a process to mark the surgical site and involve the patient in that marking process (Pyre, 2002). This universal protocol process has been revised as recently as 2010 in an effort to address patient safety issues and allow facilities to be flexible in their applications of the process within their own work environments/facilities (“ Universal Protocol, “). The wrong site event mentioned in the article does not elude to the fact that a universal protocol process was used, however if hey were a joint commission accredited facility, they must have a universal protocol process. Therefore, agree with the article’s assessment that this event was negligence because if universal protocol and teamwork were followed as strictly as it should be, this event would not have occurred. Documentation is a key entity in providing safe care as well as exhibiting proof that a process was followed, like the universal protocol and time out process prior to procedures. However, in the simulation it is possible that there was documentation of a time out in this case but perhaps it would have men incorrect or falsified based on the outcome. Another element of documentation that would have been beneficial in this case would have been that of marking the affected limb by the staff and the patient as another measure to prevent the wrong site event. If were one of the members of the health care team on this case my documentation would reflect thoroughness, attention to detail, questioning attitude, and being a wingman.

If all members of the team were committed to ensuring this patient’s safety, there would be a checklist in the patient’s chart that indicates we had performed that crucial time out procedure prior to the first cut. I would also make sure a note was entered in the chart stating which site was marked for appropriateness according to my hospital policy. There would also be documentation indicating the patient was involved in the verification of which leg was to be amputated. As a nurse, if I were involved in this situation or a similar situation, my practice would be guided by primarily one ethical principle, beneficence. Use this principle because the intent is to do no harm and the patient’s welfare should be the caregivers primary concern.

In this simulation, the health care team did not appear to have the patient’s welfare s their primary concern or proper protocol would have been followed and the wrong site mishap would have been avoided. Another ethical principle that any health care worker should operate under is malefaction because you should not intentionally inflict harm upon another individual. Do not believe this event was done intentionally or maliciously, however, so I do believe all health care workers on this team used this principle.