

# [Essay on individual negligence in nursing](https://assignbuster.com/essay-on-individual-negligence-in-nursing/)

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The expectations of health care providers include possessing knowledge of legal issues related to the profession. They have to be aware of any potential legal claims against them in the course of undertaking their professional duties and responsibilities (Guido, 2010). In some instances, filing of such legal claims is dome without their knowledge of liability, especially when the patients believe that certain responsibilities were not carried out efficiently. Most of the cases filed against nurses involve negligence, malpractice and, gross negligence (Guido, 2010). However, problems arise from the inability of nurses to differentiate between negligence, gross negligence, and malpractice. It is, therefore, fundamental for the nurses to differentiate between negligence, gross negligence, and malpractice while maintaining the importance of documentation, especially in relation to patients’ information.

## Negligence

The definition of negligence in health care practice is the act of carrying out an activity, especially toward a patient without care (Guido, 2010). In other words, it is an activity done in a way that a person with a prudent mind will not. Nurses just like any other practitioners are liable for negligence. Similarly, activities done by non-medical persons are liable to negligence in instances that they do not involve care. There have been several cases of nurse negligence.

A charge of negligence applies when a nurse fails to carry out ordinary care for the patient, resulting in injury (Judson-Harrison, 2010). If proved that the nurse failed to perform the required duties in a responsible way, different from the way a responsible nurse would have performed; prosecution to the nurse is likely. The nurses may be affected by liabilities if proved beyond doubt that there was a failure in carrying out the required obligation in a proper manner and carelessness was paramount. For instance, delaying a patient’, the nurse may be liable for negligence because of carelessness resulting to the patient sustaining injuries.

## Malpractice

Malpractice in nursing is the professional negligence whereby the nurse fails to carry out his or her duty efficiently as dictated by the profession and the professional standards (Guido, 2010). An individual liable for malpractice must be a professional who failed to follow the professions standards and requirements in carrying his or her professional responsibilities. The difference between negligence and malpractice occur when considering the professional obligations. In negligence, a nurse is not obligated by the professional requirement while in malpractice; professional obligations standards ties down a nurse (Stubenrauch, 2007).

Nurses are liable to malpractice when they fail to apply their professional skills, experiences and abilities in carrying out their obligations toward the patients. By disregarding of established professional standards, criminal intent, neglect, malice and failure to foresee negative consequences that a nursing profession should foresee, in turn compounding malpractice (Guido, 2010). A nurse may also be liable for malpractice if he or she is in contract with the patient to carry out his or her professional mandates as dictated by the profession’s standards (Judson-Harrison, 2010). It is noted that nurses are in contract when they obtain professional license that enable them to practice.

## Gross Negligence

Gross negligence in its terms is very different from both negligence and malpractice. In nursing, gross negligence refers to the intentional and voluntary cause of harm to patients. Many factors can lead to gross negligence. For example, by crime and mostly involve assaults, battery, false imprisonment, and intentional infliction of emotional distress. Gross negligence becomes different from both negligence and malpractice in that the plaintiff (the injured patient) does not need to prove the element of malpractice and negligence (Guido, 2010). It follows the rule of Res ipsa loquitor—“ the thing speaks for itself,” that does not require proof that the injury occurred because of gross negligence; rather it can be noticed plainly.

## The Scenario

In relation to the scenario whereby a patient’s wrong leg was amputated, it brings into the fold negligence, malpractice, and gross negligence in which the medical staff in the hospital failed to carry out duties as required. Carelessness in failing to document the leg, which was to be amputated, is evidence of negligence. Malpractice is evident when the medical team failed to apply their professional abilities in determining the leg to be amputated. Gross negligence is evident as the injury caused by the medical team is enormous that it speaks for itself. However, it would be difficult to determine if the action of the medical team in amputating the wrong leg was intentional as one cannot judge based on lack of clear evidence.   
On this stand, the statement is false because the wrong amputation was not caused by the shortage of nurses. It is illogical that the decision to amputate the leg was in anyway related to the shortage of nurses. The news was misleading because it lacked documentation. Documentation of the medical procedure would show exactly what was put on record as the intended treatment and also what was done. Health care providers should document the procedures, medication, and treatment, so that another nurse coming on duty can know the treatments earlier offered to the patient. Documentation also becomes vital to nurses, especially during handoffs when a patient is being transferred from one unit to another or from one health care provider to another (Prideaux, 2011). Therefore, proper documentation would have prevented the wrong amputation of the leg.

The wrong amputation of the patient’s leg occurred from lack of proper documentation. The person responsible for documenting the patient’s treatment plan did not enter the right information regarding the leg to be amputated. This calls into question their method of recording facts and the accuracy of documentation. Documentation refers to written or electronically produced information in relation to a patient, which clearly describe the services issued to the patient. Documentation becomes vital in showing the records of a patient and helping in showing the accurate accounts of what occurred and when it occurred.

Documentation is fundamental in ensuring that health care providers communicate efficiently in relation to the patient’s condition and assessment. Documentation of a patient’s history enables nurses to carry out consistent care for the patient. For instance, documentation of the patient’s right leg to be amputated would ensure that the surgical team did not amputate the wrong leg. Similarly, documentation of a patient’s condition is effective for nurses in ensuring that he or she analyzes the information from a critical point of view. In relation to the wrong amputation, the nurses could have used the patient’s information in critically analyzing the leg to be amputated before the procedure took place. Last, documentation is vital in demonstrating that nurses carried out the duties in line with the nursing knowledge, skills and, judgment as dictated by the professional standards (Prideaux, 2011). It also makes it easy when the patient reports for follow- up check-ups. The records, when accurately done, speak for themselves and, the patient will be able to get the right medication in line with his or her course of treatment.   
If in a situation whereby the wrong leg of a patient is amputated, I would practice my professional obligation by filing an incident report outlining that a medical error had occurred. Knowing that the incident reports filed with the agencies are exempted from a legal proceeding, I would ensure that the report is void of opinions of the causes of the medical error. This would keep the report objective and would also avoid bias when presented before a judging panel, or used as evidence.

Nurses’ actions while in practice may make them liable to law suits. Negligence through carelessness as well as professional incompetence may lead to law suits against nurses. Similarly, carrying out intentional negligence mostly referred to as gross negligence can make the nurses liable to far-reaching repercussions. It, therefore, becomes the duty of the nurses to ensure that they carry out their responsibility with the utmost care and in accordance with the required professional standards to avoid legal suits. Additionally, nurses are under obligation to document patients’ information, which is vital in avoiding medical errors. However, when medical errors occur, the ethical principle requires nurses to file an incident report.

## References

Guido, W. G. (2010). Legal and ethical issues in nursing (5thed.). Upper Saddle River, NJ: Prentice Hall.   
Judson−Harrison. (2010). Law and Ethics for Medical Careers (5thed.). New York, NY: Pearson Health Science. (n. d.). The neighborhood. Retrieved April 22, 2012. NUR/478 – Health Law and Ethics.

https://portal. phoenix. edu/classroom/coursematerials/hcs\_478/20120403/in/McGrawHill.   
Prideaux, A. (2011). Issues in nursing documentation and record-keeping practice. The British Journal of Nursing, vol 20(22); 1450-1454.   
Stubenrauch, J. (2007). Malpractice vs. Negligence. American Journal of Nursing, Vol 107(7); 63-64.