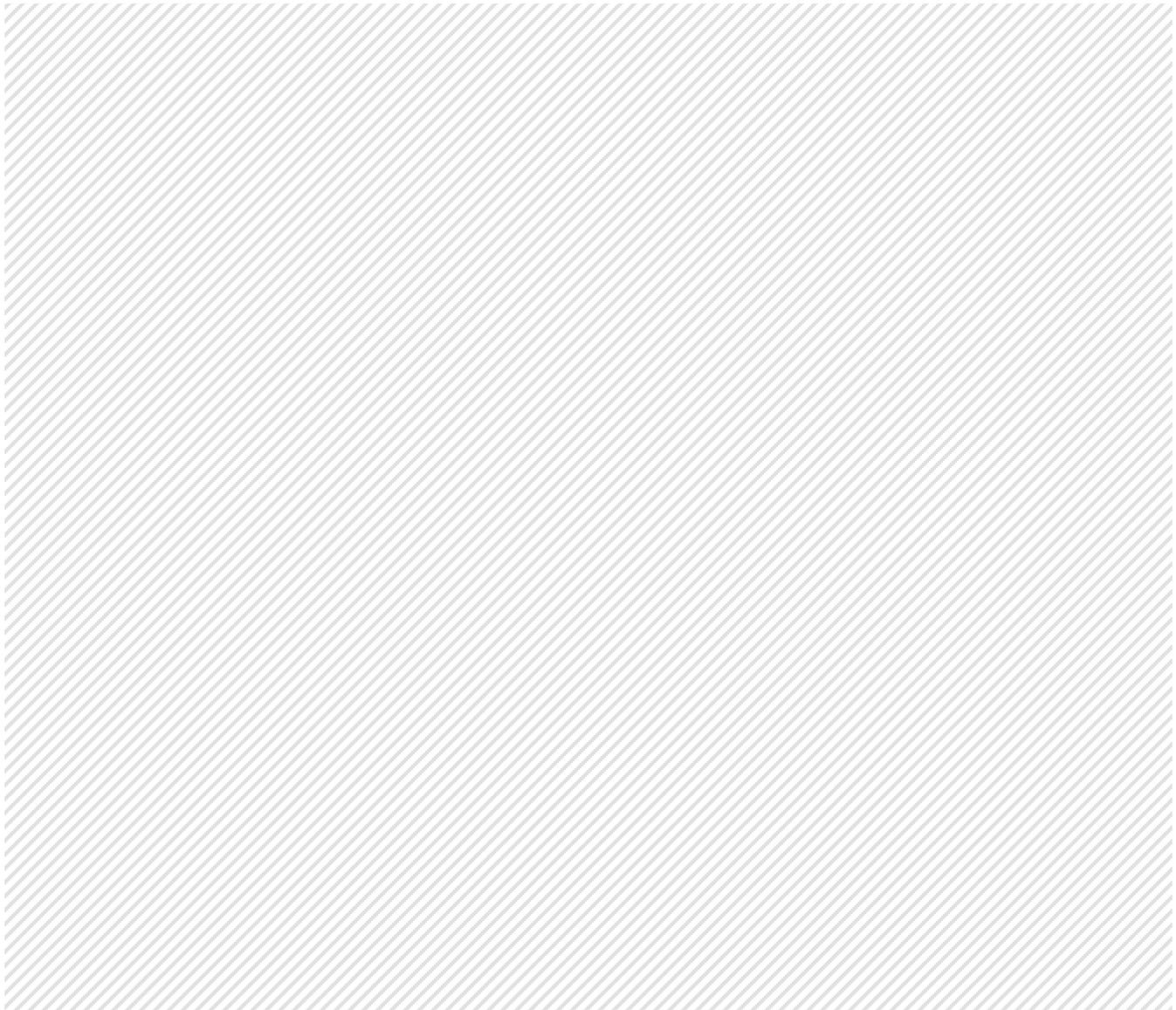


Legal Issues in Healthcare

Core Competency In-service

December 2018



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Introduction

Healthcare professionals constantly navigate their way through a maze of ethical and legal rules and regulations that govern the profession. The healthcare profession is one of the most legally scrutinized professions and has some of the strongest ethical guidelines. Healthcare requires this type of oversight, not only because the very lives of people are at stake, but also because of the vulnerability of many of the people being cared for within the industry.

Sources Used to Interpret the Law

Standards of Care

Standards of care are the level, or quality, of care considered appropriate by a profession, based on the skills and learning commonly possessed by all members of a profession. Standards of care are the minimal requirements that define an acceptable level of care. All hospital professionals must abide by these regulations to help ensure quality care is given to all patients, and that no unnecessary harm comes to any patient. Failure to meet these requirements is called neglect.

Practice Acts and Standards

Practice acts and standards are created by each state and define healthcare professions' legal scope of practice. These rules and regulations help protect patients from harm by governing health professionals' education standards, licensing requirements, professional duties, professional rights, and disciplinary actions for disobedience. State boards, of every health profession, publish acceptable standards in practice acts relevant to each individual discipline. These rules and regulations have the force of law because they are met or violated based on evidence presented.

Professional Position Statements

Professional position statements explain, or justify, why a decision was made, or action was done. Professional organizations publish their own position statement to the body of their standards of care.

Policies and Procedures

This is a standard set forth by an individual institution as the minimal acceptable practice. In court cases, institutional policies and procedures are presented and evaluated to determine if a clinical defendant has met the standard of care set forth by the institution.

Negligence vs Malpractice

Negligence

Negligence is a general term that means failing to act as a reasonable prudent person would act. Negligence is when a healthcare professional deviates from the set standards of care in which any reasonable person would use.

Malpractice

Malpractice is a form of negligence when a medical professional, purposefully or accidentally, mistreats a patient. The wrong or injudicious treatment must result in injury, unnecessary suffering, or death to the patient. Malpractice can stem from ignorance, carelessness, lack of proper professional skill, the disregard of established rules, neglect, or a malicious/criminal intent. These purposeful or accidental acts can potentially impact the health, safety, and finances of a patient. When this happens, a liability exists which can result in a lawsuit being filed against the healthcare professional whether they acted in good faith or not.

Healthcare Laws

Health Insurance Portability and Accountability Act (HIPAA): Privacy Rule

All healthcare professionals across the healthcare industry are required by law to protect the privacy of their patients. The HIPAA Privacy Rule is a federal regulation that requires healthcare professionals to take all reasonable measures to make sure that patient information is only viewed by those with proper authority on a need to know basis. Patients also have the right to obtain a copy of their medical chart to have in their possession if they so choose.

Fraud and Abuse Laws

Fraud is defined as purposefully submitting misinterpreted medical claims for monetary gains. Abuse is, purposefully or accidentally, billing for unnecessary medical services. To help prevent fraud and abuse healthcare professionals must be vigilant in reporting fraudulent claims and abuse to the appropriate federal authorities. Providers, as well as consumers, must be committed to providing appropriate documentation in order to address abuse issues, and take a moral and ethical stand against fraud in the healthcare environment. The federal government has set laws to help reduce fraud and abuse.

- **False Claims Act:** Prevents knowingly submitting claims that are not true.
- **Anti-Kickback Statutes:** Prevents rewards in exchange for referrals.

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- **Physicians Self-Referral Law (Stark Law):** Prevents physicians from referring patients to any company they, or their family members, are invested in.
 - **Criminal Healthcare Fraud Statute:** Protects against submitting claims that were not medically necessary.

Consent

In order for treatment to be legal the patient, and or legal guardian, must give their informed consent. Failure to obtain basic informed consent exposes the healthcare professional to a claim of medical battery. Getting informed consent is more than simply getting the patient to sign a consent form. Educating the patient so they can make an informed decision, either to accept or reject the proposed treatment, gives meaning to patient autonomy and ensures the bodily integrity of every patient.

Documentation

Proper documentation can protect healthcare professionals, just as lax documentation can weaken a defense during a lawsuit. What happened, when did it happen, and why did it happen, are fundamental questions that must be answered in every potential claim. Sloppy documentation can hamper a healthcare professional's ability to defend their answers to these questions. Proper documentation is a healthcare professional's best defense in any legal issue. **Documentation must be precise and true. Improper or false documentation could lead to a lawsuit.**

Incident, Occurrence, Event Report

An incidence report also called an occurrence or event report is a tool used to document near misses, potential legal issue, or patient harm. Occurrence reports should be a nonjudgmental way for healthcare professionals to report facts about a problem and its consequences. Completing an incident report is not admitting to negligence. These tools are simply records of every event that isn't a part of routine medical care.

The incident report should include:

- A detailed description of how the incident happened.
- Where and at what time the incident happened.
- Who was present to witness the event?
- How the patient was cared for after the event.
- Who was notified?
- Patient's symptoms and activity before the event occurred.
- Post event vital signs.
- Were any injuries sustained during the event?
- Were any environmental hazards involved in the event?
- Corrective actions taken to prevent this from occurring again.

Just Culture

To promote effective reporting and achieve quality care, facilities need to adopt what's referred to as a "just culture." The just culture recognizes that it's rare for any single nurse to be the cause of an incident; instead, multiple system factors often combine to create the circumstances. The just culture eliminates punitive action against the person filing out the incident report and encourages looking beyond the incident to determine other factors. These factors may include orientation and training, staffing ratios, and other issues influencing patient safety.

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