

CHAPTER 3

INNOVATION, TECHNOLOGY, AND LEGAL ISSUES IN NURSING

INNOVATION AND HEALTHCARE TECHNOLOGY

Leading in the 21st century requires innovation and adaptation to the environment. Innovation may involve a simple change or a radical redesign of the system, but using something different seems to be the answer (Warner & Burton, 2009). To prepare competent practitioners versed in the practice environment today, innovation is necessary in nursing practice and nursing education.

Innovation is defined as creativity that is characterized by a new device, idea or method according to the Merriam-Webster Dictionary Online (n.d.). Innovation is that essential component of nursing practice that permits response and adaptation to the many variables presented in the practice environment. Innovation and creativity support dynamic nursing practice; creativity is enhanced with intrinsic motivation, a nurturing environment, an ability to function independently, and a willingness to take risks (Fasnacht, 2003).

A leader can enhance creativity by building an environment of trust and interpersonal relationships, along with promoting willingness to listen and a spirit of cooperation. Leveraging diversity in the workplace enhances innovation development, new patterns of thinking and decision making through the lens of multiple perspectives. In addition, according to Longo (2013), key strategies to enhancing creativity include providing time for educational offerings, providing time for creative work, and encouraging calculated risk-taking and acceptance of personal responsibility. The leader creates a culture that values, encourages and recognizes that innovation and new ideas benefit nursing practice across the continuum of care and the organization in adapting to changes in healthcare delivery.

The effect of the environment on the healthcare delivery landscape forces leaders to note that today's healthcare environment is quality-driven and risk-averse. The ultimate focus is on client care, which creates a pressure-cooker environment that can yield creative insights into the process of care and innovative solutions that evolve from concerns for clients and their care.

Healthcare delivery systems and organizations require leaders that can adjust, adapt, be innovative, and change to meet the new demands of the environment and marketplace. Effective

leaders recognize and explore options for improved ways to meet the growing demands and expectations of healthcare delivery while focusing on quality and outcomes. Operationalizing innovations requires that the effort takes place within a framework to evaluate the outcomes. This framework can be developed along the lines of a pilot study or small tests of change to promote opportunities to trial the innovation at a small level and be able to adjust or revise based on findings.

Risk-Taking and Changing the Healthcare Environment

Leaders as coaches can support risk-taking by welcoming calculated risks into the work environment and encouraging positive risk-taking. For employees, the benefits of taking risks is that it provides practice and participation in decision-making, increases confidence, increases a sense of control, decreases anxieties and fears, and can increase motivation.

Taking risk is engaging in behaviors that have potential to be harmful or dangerous, yet at the same time provide opportunity for some kind of outcome that can be perceived as positive (Tull, 2009). Risk in general can be defined as the “effect of uncertainty on objectives.” Uncertainty include events which may or may not happen, ambiguity, or a lack of information. It also includes both negative and positive effects on objectives (International Organization for Standardization, 2009).

As Mark Twain said, “Twenty years from now you will be more disappointed by the things you didn’t do than by the ones you did. So throw off the bowlines, sail away from the safe harbor, catch the trade winds in your sails. Explore. Dream. Discover.”

Technology as an Innovation That Affects Practice

Information technology as an integral part of life encompasses communication, documentation, and consumerism. Today the terms “information technology” and “informatics” are interchangeable. The primary goal of information technology is simply information management.

Continued developments in informatics support advances in clinical care, administration management, research, and education.

The goal of technology is to have the right information always available at the right time. Data management supports informed decision-making. Information systems provide leaders and managers with day-to-day information on client flow and acuity, resource use, staffing levels, and costs and budgetary balance. Healthcare information technology continues to advance as a result of national and nursing forces as well as client safety and cost containment goals.

National Forces

The national forces at work began with the creation of the President’s Information Technology Advisory Committee in 2005, which became the Office of Science and Technology in 2012. The timeline for electronic health records (EHRs) began with a call for their use in 2004. Federal legislation under President George W. Bush required that all medical health records be electronic by 2014, and provided initial subsidies to make this happen. This was the same timeline for establishment of the National Coordinator for Health Information Technology (NCHIT), a part of which was the creation of the 2008–2012 Strategic Plan with two goals addressing healthcare delivery: client-focused health care and population health (U.S. Department of Health and Human Services [DHHS], 2012). Today’s Strategic Plan continues this work with a direction toward improving

health, health care, and reduce costs through the use of information and technology through a process of collecting, using and sharing. (DHHS, 2015).

The goal of client-focused health care is to provide higher-quality, cost-effective care using electronic information exchange among healthcare providers, clients, and their designees. The strategic plan to reach this goal requires facilitating electronic exchange of health information while preserving privacy and security, increasing interoperability to facilitate exchange of information, promoting nationwide adoption of EHRs and personal health records, and establishing collaborative governance guiding health information technology infrastructure.

The goal of population health allows for access and use of electronic health information to support public health, biomedical research, quality improvement, and emergency preparedness. The strategic plan to reach this goal requires advancing privacy and security policies, principles, procedures, and protections for information access in population health. Reaching the goal of population health will also require enabling an exchange of health information to support population-oriented uses, promoting nationwide adoption of technologies to improve population and individual health, and establishing coordinated organizational processes supporting information use for population health.

The Federal Health Information Technology (IT) Strategic Plan for 2015–2020 focuses on the collect-share-use vision, a primary goal of information management in support of the mission to improve health and health care while reducing costs through the use of information and technology (DHHS, n.d.). The collect and share aspects continue the process of continued adoption of the health IT and improving on interoperability within a secure framework while the use aspect continues the work of the 2008–2012 Strategic Plan, strengthening healthcare delivery for individuals and communities while advancing research, scientific knowledge, and innovation (DHHS, n.d.).

The technology being adopted helps to build a culture of access and use for all stakeholders involved while respecting individual preferences for use and focusing on value. Health IT supports an environment of continuous learning and improvement and provides an avenue for innovation and competition, bringing all stakeholders together to individually and collectively continually work to strengthen healthcare delivery.

Nursing Forces

Nursing continues to help drive healthcare information technology along a timeline.

- ▶ 1993: National Center for Nursing Research; Became the National Institute of Nursing Research (NINR, n.d.)
 - ▷ Building clinical databases
 - ▷ Methods to evaluate nursing information systems
- ▶ 1997: National Agenda for Education & Practice
 - ▷ Educate nurses in core informatics content
- ▶ American Association of College of Nursing
 - ▷ Core competencies in healthcare technologies

Healthcare information technology contributes to evidence-based care through a standardization of terminologies and structure in documentation. In addition, the use of digital information, the

standards allowing for data exchange between heterogenous entities, the ability to capture data relevant to actual care provided, and competency among practitioners to use data will all contribute to evidence-based care (Bakken, 2001).

The Institute of Medicine (IOM) Reports (2001–2003) support the use of healthcare information technology to improve practices and promote client safety. Informatics is a core competency for all healthcare professionals and is seen as an important force in improving healthcare. Relevant areas the IOM focuses on are:

- ▶ National information infrastructure,
- ▶ Computerized clinical data,
- ▶ Clinical decision support,
- ▶ Use of the Internet, and
- ▶ Integration of evidence-based practice.

The American Nurses Association has also promoted the use of healthcare information technology, beginning with the 1994 *Standards of Practice for Nursing Informatics* and *Scope of Practice for Nursing Informatics* (ANA, 2014). In addition, the Committees for Nursing Practice Information Infrastructure and National Information and Data Set Evaluation Center are in place to support nursing practice with technology.

CLIENT SAFETY

Many client safety databases use aggregated data to identify safety issues. Examples include the vaccine adverse event reporting system through the Centers for Disease Control and Prevention (CDC), the U.S. Food & Drug Administration, and the National Nosocomial Infection Surveillance System through the CDC. Other processes that contribute to the culture of safety and support safe practice and quality client outcomes include using bar-coding systems for medication administration and computerized provider order entry systems.

The Agency for Healthcare Research and Quality (AHRQ) gathers data from its hospital survey on client safety culture into a Hospital Comparative Database Submission Information (AHRQ, 2015). The purpose is to help healthcare organizations identify strengths and opportunities for improvement in their client safety culture. In addition, this database tracks changes in the client safety culture over time to create a better picture of process and outcomes than would be provided by isolated reports.

Cost Containment

The Leapfrog Group was formed in response to the high costs of health care without the ability to assess quality or compare healthcare providers, and consisted of large American corporations. Their 2009 mission was to improve safety, quality, and affordability of health care. The group also works toward encouraging availability of information to consumers to facilitate informed healthcare decisions and using incentives and rewards to promote high-value health care. The Leapfrog Group collects voluntary data from healthcare organizations that they publish for consumer use on its website (Leapfrog Group 2015).

Increasing the Use of Healthcare Information Technology

Marketplace forces are driving increased use of healthcare information technology. Organizations are responding to the forces of competition, the need for economic survival in a competitive marketplace, the drive for professional accountability for the costs of diagnostic and therapeutic interventions and choices, and client outcomes and satisfaction.

Meaningful Use for Healthcare Information Technology

Generally stated goals for the increased use of healthcare information technology include improving quality, safety, and efficiency. Technology is being used to engage clients and families in the process of healthcare delivery. Improving care coordination across the continuum of care helps to improve the overall health of the public and population at large. Meaningful use for healthcare technology also helps to ensure privacy and security for personal health information. Meaningful use defines the core measures used and the requirements for reporting (Centers for Medicare and Medicaid Services, 2015).

Requirements for Healthcare Information Technology

Today's requirements for effective healthcare technology include ability to track and quantify the costs of care, the process of care, and the outcomes of care. Information technology that can document the timeliness of care being delivered in a fast, efficient, and consistent manner is also needed.

Investing in Nursing Informatics

Best practices include promoting the use of health information technology systems that improve documentation and reduce time spent in documentation. The best practice systems also provide client data for quality improvement and research.

Supporting Practice

Three major domains of data in healthcare information technology support the delivery of care for the client, the provider, and administrative (Huber, 2014). Client care is supported through the client's medical record, including the evaluation process, the gathering of all clinical data, documentation of client outcomes, and achieved care outcomes. In addition, it is necessary to gauge client satisfaction and to assess and document the costs and access to care.

Healthcare information technology supports practice and the provider through personnel records and links to client records and national databases. General information that can be gathered includes professional data, caregiver outcomes, job enrichment opportunities, and job or work satisfaction. Information technology also provides an opportunity to gather information on physician satisfaction, job stress, and intent to leave. Health IT can also provide decision-maker variables and support for general care delivery through access to standards and databases.

Nurse leaders rely on administrative databases for management issues and resource oversight as well as quality performance benchmarking activities. Efficient practice is supported through access to databases containing real-time information in areas such as workforce capacity, costs, productivity, turnover, and income. A global view of the organization includes databases that contain overall systems outcomes and supports a culture of safety.

The Role of Nursing Informatics

Nursing informatics as a practice specialty is having a major impact on the way care is planned and delivered in the current healthcare environment. Nursing informatics refers to that component of informatics designed for and relevant to nurses and includes information management, knowledge from sciences other than nursing, and the importance of informatics within all areas of nursing practice

The Specialty of Nursing Informatics

In a technologic world where information turns over rapidly, nursing informatics provides and facilitates nursing education in informatics and technology, allowing nurses to analyze, design, and implement information and communication systems. In addition, nursing informatics specialists, commonly referred to as informaticists, conduct and participate in effectiveness research to advance nursing epistemology.

Leadership Competencies in Healthcare Information Technology

Nurse leaders need a working knowledge of healthcare information management and technology, with a foundation in basic software skills (spreadsheets, word processing, email, social media, Internet use, and database management). Correctly used, technology supports financial management, process improvement, and quality improvement. Additionally, healthcare information technology supports general business intelligence and benchmarking for assessment and comparison of performance, while clinical information systems support the care delivery process. Information management using technology displays business intelligence in navigating, understanding, and using all sources of data to manage the complexity of a healthcare delivery system or organization.

Today's Health Care and Information Technology

Documentation is an integral part of providing healthcare services today. Looking at the need for documentation for client care and regulatory and accrediting bodies, a function of technology is to provide modification rather than redundancy of information and uniform rather than individualized care processes. Technology supports parallel rather than serial processing of clients through a transparency of technology. Technology and computers work their magic behind the scenes, where the user should perceive only the results and not the process unless so desired.

Technology and Documentation

Healthcare information technology provides for standardized language and terminology that improves quality outcomes and decreases medical errors. Documentation pathways link assessments, interventions, and outcomes for all users to provide the right information at the right time. Technology provides links to literature and nursing research to promote an evidence-based practice environment. Technology is changing the paradigm of documentation and promoting culture shifts, with increasing use of the electronic health record.

The American Nurses Association and Documentation Standardization Efforts

The American Nurses Association (ANA) has been actively involved in promoting standard documentation for healthcare records and nursing practice, beginning with the USA Nursing Minimum Data Sets (NMDS). The NMDS supports nursing care and client demographics in nursing education, health information system designs, and clinical research. For leaders, the ANA has developed the Nursing Management Minimum Data Set (NMMDS), which provides data on the

environment, nursing care, and financial resources and is used to obtain information to manage the environment and provide comparable data for benchmarking.

Management Information Systems

Management information systems (MISs), essential to the business of health care, represent an almost staggering investment of resources to ensure that the systems needed to conduct business, document clinical care, capture trends, and meet the demands of regulatory bodies and purchasers are in place. The rapidity with which technology is changing means not only an initial investment but also ongoing capital and operational expenditures.

Organizations related to healthcare MISs have come into existence in recent years, as have careers in this area. Medical records administrators and clinical librarians are but two of the careers that have changed dramatically with the advent of MIS. Indeed, these job titles themselves are nearly obsolete. It is not uncommon to see a chief information officer (CIO) integrated into the executive level of the organizational chart of healthcare organizations.

The acronyms *WAN* (wide-area network) and *LAN* (local-area network) are common terms to the majority of administrators and clinicians alike. Now an entire vocabulary of technology terms sits alongside the medical lexicon.

Local-area network refers to several personal computers linked together through a "server." The concept is somewhat akin to an office that has several phone lines, each connected to the other although able to be used independently.

Wide-area networks are made up of LANs, and the system can be enlarged exponentially. Connections are effected by specialized networking software and are transparent to the user.

Nursing has its own association, the American Nursing Informatics Association, whose members are involved with or interested in the field of nursing informatics. The ANA describes nursing informatics as a scientific discipline that is broader in scope of practice than nursing and incorporates other disciplines, such as computer science and information science.

Electronic data transfer fosters the integration of care across the continuum. However, the promise of the fully functional computerized medical record is yet to be realized. As those who practice in the field of informatics have learned, the complexity of health care is such that the anticipated migration from paper to "bits and bytes" has yet to occur on a large scale.

Nonetheless, the *electronic health record* will eventually become a near-universal reality. An understanding of semantics related to the computerization of medical and health records is useful. The *automated medical record (AMR)* is considered a "first-level" product that brings together information from other sources. The AMR is delivered electronically to an end-user for her or his use in caring for the client. However, the end-user cannot immediately enter data (respond to) what she or he has received (i.e., the AMR is not interactive).

The next level is termed the *computerized medical record system*, in which paper-based products now become available electronically through scanning. The *electronic medical record* is the third-level product; it provides capability for electronic data entry, electronic signature, data integrity, and audit tools. The *electronic client record* is the fourth-level product; it brings together information about the client from more than one organization, thus supporting the argument for a universally agreed-on "e-language" and code. Finally, the *electronic health record* is the fifth-level product, including information about the person's well-being from multiple sources, not only about her or his medical problems (Carter, 2008).

The Internet

The World Wide Web represents a phenomenon without parallel. The instantaneous availability of information and the ability to connect with the person next door or colleagues half a world away does indeed make planet Earth seem a bit smaller.

The Internet is changing the way medicine—and by extension, nursing—is practiced. Clients are engaged in self-care as never before. They approach their providers with the latest articles about illness, medications, treatments, and research in hand. Expectations have changed; relationships have been altered. While the concepts of *client as partner* or *client as leader of her or his health team* are not yet universally embraced, they are clearly on the horizon.

Telehealth

Telehealth is no longer in the realm of science fiction. The Office of the National Coordinator of Healthcare Technology now exists as a division within the Health Resources and Services Administration, itself a division of the U.S. Department of Health and Human Services (<https://www.healthit.gov/>).

In telehealth, nurses use laptops and small video cameras to videotape the client in her or his residence in real time. The recording can be transmitted immediately to other healthcare providers so that assessment and needed intervention can occur in the moment. The transmission is not constrained by time or distance; thus, clients in remote locations can enjoy the same level of consultation as those who live adjacent to medical centers. Radiologists read digitized images from a location far removed from the diagnostic imaging department. Laboratory data are transmitted via secure servers from location to location.

Telehealth provides to real-time access to healthcare services. The client and provider interact at the same time with the ability to store and forward communication to additional healthcare providers, if necessary. Telehealth facilitates electronic capture of diagnostics for specialist interpretation.

An extension of telehealth is *telehomecare*. Recognizing the need to provide access to services to clients in need, telehomecare is the ability to monitor and deliver care at home through a variety of services. Examples of telehomecare services include portable monitoring devices, automatic pill dispensers and reminders, and biometric garments.

Other examples of technology supporting the care environment include e-intensive care units for remote monitoring of critical care clients and teletrauma that is used in rural hospitals for second opinions and advice from trauma care experts. The goal in using the technology is to enhance client care and provide access to healthcare services in rural areas of the country.

Telenursing

A new and developing specialty is *telenursing*. Telenursing is used in various settings, including colleges, hospitals, and healthcare insurers' client outreach programs. The practice of telenursing creates more collaborative and autonomous roles for nurses and also contributes to cost-containment efforts.

Challenges to telehealth and telenursing

As new and emerging forms of care delivery develop, issues and challenges arise. Reimbursement and medicolegal issues, along with technical issues, are common challenges. As technology facilitates new forms of practice and outreach, opportunities are created for research to determine the outcomes and effectiveness of new care delivery systems.

Few barriers exist in the virtual world save for the electronic security “firewalls” purposely incorporated into information systems. Many organizations take advantage of the firewall concept to create intranet systems that allow communication only within defined boundaries.

As with any seemingly wondrous invention, the Internet also brings with it a cautionary tale. The accuracy and source of information must be carefully scrutinized. It is incumbent on healthcare professionals to assist clients and families in distinguishing information that is of high quality from that which is questionable or even harmful. Vigilance also is called for with regard to “hackers” who break into systems, sometimes with the intent to harm, at other times simply for the thrill of proving they can “scale the wall.”

Technology as an Innovation

Innovation is nursing practice that permits response and adaptation to the many variables presented in the practice environment. Healthcare information technology is at the foundation of effective current practice, promoting effective management of resources for nurse leaders who are highly dependent on up-to-date and efficient use of information that requires integration of client, staff, and economic variables.

Nursing is the largest and most labor-intensive component of hospital costs, using on average 50% of operating budgets. Nurses are also the most constant presence at point of care. Technology has been shown to promote client safety, quality efforts, access to care, and cost containment. Nurse leaders are in a key position to be actively involved in all healthcare information technology activities to evaluate products and systems, lobby for the purchase of products and systems, and use all technology available to support care delivery in today’s healthcare organizations.

Consumers and Electronic Health Records

As information technology changes nursing practice and health care, consumers will have to become a part of this paradigm shift in delivery practices. Technology sets the stage for consumers to begin taking more responsibility for their health care. Provider–client relationships are changing as consumers become more informed, seek information on the Internet, and begin to maintain personal health records.

The personal health record gives clients the ability to communicate with their authorized providers at their own convenience and to maintain and manage their own personal health information. Three main formats currently exist: software applications for computer or flash drive, web-based services to store information remotely, and hybrids. The benefit of the personal health record is its ability to promote collaborative care and facilitate personal management of disease treatment. There are challenges to the personal health record that generally involve the issues of data security, data standards, and data presentation. There are also concerns related to costs, provider reluctance, and maintaining unique client identifiers.

As with all new technologies, the challenges to personal health records are ones that will continue to be addressed as user numbers increase. Personal health records as a technology will support the continuum of care by providing the right information at the right time.

Healthcare information technology in general reaches beyond the walls of healthcare organizations and intensive care environments across the continuum of care to palliative care. Technology requires ongoing training on medical devices and ultimately managing medical technology in a client-safe way.

LEGAL ISSUES IN PROFESSIONAL PRACTICE AND INSTITUTIONAL LIABILITIES

Law That Affects Organizations and Practice

Two areas of the law that most involve healthcare leaders and managers are employment law and malpractice. The major employment laws include the Family Medical Leave Act (FMLA), Civil Rights Act of 1964, the Age Discrimination in Employment Act of 1967, and Occupational Health and Safety Act (OHSA). The general liabilities related to these laws include a violation of the FMLA, discrimination, retaliation, wrongful termination, wage and hour violations, and violations of OSHA. Strategies to decrease employment law liabilities include documentation of all issues and employee encounters; reporting up the chain of command; unilaterally enforcing policies, procedures, and laws; and consulting legal council. Laws and regulatory issues are covered in depth in Chapter 6.

Malpractice issues for nurse leaders include personal negligence in clinical practice; liability for delegation and supervision; and staffing issues such as adequate numbers of staff with increased client acuity and limited resources, floating staff from one unit to another, and the use of temporary or agency personnel to augment staffing (Guido, 2010). Nurse leaders are charged with a duty to orient, educate, and evaluate; failure to attend to these issues can result in malpractice claims. Nurse leaders also are charged with strict product liability for the actions of staff. Lastly, negligent hiring may be an area of malpractice if staff is hired without the appropriate license and credential verification.

Corporations have a duty and responsibility to their clients and staff (Guido, 2010). The duties implied include maintaining a safe facility and safe equipment; providing competent, qualified, trained, and licensed persons to provide care; providing proper orientation and supervision of the staff; and maintaining appropriate policies, procedures, and bylaws. Additional responsibilities and liabilities include *respondeat superior* (vicarious liability), ostensible authority, corporate negligence, Emergency Medical Treatment and Active Labor Act (EMTALA) claims, and mandatory reporting at the federal and state level for issues of neglect, child abuse, and elder abuse (Guido, 2010).

Tort Law and Medical Malpractice

A *tort* is a civil wrong other than breach of contract that allows the injured person to seek damages. Damages (compensation) are paid to the injured by the person or organization that caused the harm. Tort law is civil law and protects others from unreasonable and foreseeable risks of harm.

Types of torts include both negligence and professional negligence. *Negligence* is conduct falling below legal standards that protect members of society from harm. Professional negligence is conduct of professionals that falls below a professional standard of due care. Torts include assault and battery, libel and slander, and wanton and willful conduct.

Professional negligence varies in definition from state to state. Professional negligence is generally described as a failure to apply a professional standard of care. Medical malpractice is professional negligence; a nurse's conduct is compared to what a reasonable nurse would do in the same situation or circumstance.

The terms *negligence* and *malpractice* are sometimes confused with one another or assumed to be synonymous. This is not the case. *Negligence* is

- ▶ The failure to do what a reasonably careful and prudent person would do under the same or like circumstances (*omission*) or
- ▶ The doing of something that a reasonably careful and prudent person would not do under the same or like circumstances (*commission*).

Briefly, negligence is the failure to exercise reasonable or ordinary care.

Malpractice goes beyond negligence. Four elements must be present for malpractice to occur:

1. *Duty*: How would a reasonable and prudent provider behave under the same circumstances?
2. *Breach of duty*: Did the provider breach the standard of care in this particular situation?
3. *Causation*: Was the unreasonable, careless, or inappropriate behavior on the part of the provider the proximate cause of the injury or insult?
4. *Injury*: Did injury to the client occur?

If any one of these elements cannot be proved “beyond a reasonable doubt,” then a malpractice claim may be dismissed.

Professional negligence claims against nurses are based almost exclusively on personal injury and have resulted from various types of negligent conduct. Current negligence claims have involved product liability and, most recently, complementary and alternative healthcare options suggested by nurses to clients for personal use.

Defenses against allegations of professional negligence include untimely filing of the case (filing after the statute of limitations runs out) and an assumption of risk whereby the plaintiff knew “it” was dangerous, had facts about the danger, and chose to take on the danger. Another defense is immunity from suit such as described in the common “Good Samaritan” laws that offer legal protection to people who act reasonably when assisting strangers they believe are sick or injured. Overall, the best strategies for prevention of malpractice include striving for continued best practices, and being professional, pleasant, and people-oriented.

A charge of negligence can arise from any action or failure to act that results in client injury. Most often this occurs from an unintentional failure to adhere to a standard of clinical practice. The best defense is a good offense. Knowing the factors contributing to the increase in the number of malpractice cases against nurses helps to build a good defense, and in today’s health care, the greatest number of cases are reported in acute care healthcare organizations, followed by long-term-care facilities (nursing homes, rehabilitation facilities, transitional care units).

Insurance

Two types of liability are of concern to those in the health professions: (1) personal liability and (2) corporate liability. *Personal liability* holds that people are responsible for their own actions. *Vicarious liability* is an extension of personal liability and holds that certain parties may not be negligent themselves, but their negligence is assumed because of association with the negligent person. *Corporate liability* holds that an organization is responsible for its conduct.

Healthcare organizations are, by the nature of their business, heavily insured to protect against liability and, by extension, their employees also are insured. The doctrine of *respondeat superior*

(let the master speak) allows the courts to hold employers responsible for the actions of the organization's employees when the employees are performing services for the organization. This concept sometimes gives nurses and other healthcare professionals a false sense of security in that they assume they cannot be sued individually in the case of actual or perceived wrongdoing. Indeed, clients may sue both the institution and the individual practitioner. Thus, nurses are advised to carry their own personal liability insurance.

Documentation

The need for precise, accurate documentation has been reinforced repeatedly in the field of nursing. "If it's not documented, it's not done" is an oft-repeated mantra within the profession. New challenges lie ahead as computerized documentation systems become more widespread without benefit of standardized rules, processes, and technical languages. Although such guidelines will come in time through various regulatory bodies, the initial products are being activated at the institutional level. At present, electronic documentation systems are no more consistent than their paper-and-pen counterparts (Smith, Smith, Krugman, & Oman, 2005)

The Medical Record

Documentation takes place in the form of a client's medical record. The medical record serves as a complete and accurate record of client's condition. The record also serves as a basis for evaluating healthcare operations resources by providing research data and helping to determine reimbursement by third-party payors.

The medical record is a legal document admissible in a court of law and provides a summary of a client's hospital stay with treatments and outcomes noted. The record itself is generally owned by the hospital, but the client owns the information it contains. The record is confidential and should not be discussed with anyone not in direct care of the client without the client's permission.

In general, the medical record should be documented accurately and in a timely fashion and should contain the elements of assessments, plan of care, medical interventions, and evaluations of the treatments. The record can assist with a malpractice defense if completed appropriately, or can hinder a malpractice defense if documented poorly. Defense attorneys value accurate, clear, and concise documentation and consider the medical record to be the best defense in a malpractice suit.

Legal Impact of Medical Errors

The Institute of Medicine reports that medical error is a leading cause of death in the United States (IOM, 1999). As currently reported, more people die from medical errors than from breast cancer, HIV, or motor vehicle crashes. The *Archives of Internal Medicine* reports that medication errors occur nearly 1 out of every 5 doses (Barker, Flynn, Pepper, Bates, & Mikeal, 2002). Factors in the healthcare environment, including cognitive lapses (e.g., lack of attention, interruptions, "slips"), a tendency to generalize, confirmation bias, and overconfidence, all contribute to medical errors.

Factors Affecting the Practice Environment and Liability

Nurse leaders are faced with challenges in the healthcare environment due to financial constraints and constriction of the environment. Greater productivity and efficiency challenge access to healthcare services while the public demands equitable access and funded healthcare services. In addition, healthcare reimbursement has changed based on government policy. Leaders are responsible for developing a culture of safety within the workplace that supports employee engagement and employee/patient safety, often through the use of current technologies.

The litigious environment of health care is affected by the fact that the public and citizens know their rights relating to health care. They are more knowledgeable about health matters and are aware of government intervention and policies regarding client involvement in care. Clients have the right to participate in decision-making matters relating to their health and no longer accept the old paternalistic paradigm of healthcare delivery.

Another factor to consider in the review of legal issues is as simple as the aging population. People are living longer and, as a result, the number of older Americans with multiple health care needs and requiring complex care are increasing. The last factor contributing to a complex legal environment for the delivery of health care is a shift in the practice setting from hospitals to primary care clinics, directed by government and reimbursement factors, and the continual practice of transferring clients between acute and chronic care settings, and then back home as care needs change.

Nurse Leaders at the Forefront of Culture Change

Changing the culture paradigm is a responsibility of a nurse leader in today's healthcare environment. A strategy for changing the culture includes facilitating a move to assess events beyond blame, because errors do and will always occur. Other responsibilities relating to events include the duty to:

- ▶ Prevent events and errors when possible,
- ▶ Report events,
- ▶ Remedy injuries related to events, and
- ▶ Promote a culture of safety.

Other strategies to change the culture include promoting identification of safety issues as opportunities for performance improvement, ensuring a nonpunitive environment for event reporting, reinforcing communication within the healthcare team and with clients and families, and encouraging clients to participate in their care.

Nurses must recognize that today's healthcare environment contributes to the rise in malpractice claims against nurses. Increased autonomy and responsibility of nurses bring about greater risk of error and liability. Effective risk-control strategies begin with the personal responsibilities of maintaining competencies and nursing skills through continuing education efforts; ensuring accurate, objective, and thorough documentation in all records; and examining personal professional practice to understand the challenges and risks.

Keeping current of the most common personal and organizational allegations is a good place to begin, because nurses leaders can identify their own vulnerabilities in the practice environment and take appropriate action to protect their practice and license.

REFERENCES

- Agency for Healthcare Research and Quality. (2015). *Introduction to the AHRQ quality indicators for hospitals & health systems* [transcript]. Retrieved from http://www.qualityindicators.ahrq.gov/Downloads/Resources/Webinars/2015/Introduction_to_AHRQ_Quality_Indicators_Transcript.pdf
- American Nurses Association. (2006). *Scope and standards of nursing informatics practice*. Silver Spring, MD: Nursebooks.org
- American Nurses Association. (2009). *Nursing administration: Scope and standards of practice*. Silver Spring, MD: Nursesbooks.org.
- American Nurses Association. (2014). *Nursing informatics: Scope and standards of practice*. Silver Spring, MD: Nursebooks.org
- Bakken, S. (2001). An informatics infrastructure is essential for evidence-based practice. *Journal of the American Medical Informatics Association*, 8(3), 199–201.
- Barker, K. N., Flynn, E. A., Pepper, G. A., Bates, D. W., & Mikeal, R. L. (2002). Medication errors observed in 36 health care facilities. *Archives of Internal Medicine*, 162(16):1897–1903
- Benner, P. (2001). *From novice to expert: Excellence and power in clinical nursing practice*. (commemorative ed.). Menlo Park, CA: Addison-Wesley.
- Brandi, J. (2003). *Nine ways to engage staff and please the customer*. Retrieved from http://www.customerfocusconsult.com/articles/articles_template.asp?ID=47
- Bobinski, M. A., Hall, M. A., & Orentlicher, D. (2007). *Health care law and ethics* (7th ed.). New York: Wolters Kluwer/Aspen.
- Carter, J. H. (2008). *Electronic health records: A guide for clinicians and administrators* (2nd ed.). Philadelphia: American College of Physicians.
- Centers for Medicare and Medicaid Services. (2015). Health IT incentive program: Meaningful use. Retrieved from <https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/EHRIncentivePrograms/>
- Ditkoff, M. (2011). 50 awesome quotes on risk taking. Idea champions: The heart of innovation. Retrieved from http://www.ideachampions.com/weblogs/archives/2011/03/security_is_mos.shtml
- Fashnacht, P. H. (2003). Creativity: A refinement of the concept for nursing practice. *Journal of Advanced Nursing*, 41(2), 195–202.
- Guido, G.W. (2010). *Legal and ethical issues in nursing* (5th ed.) Upper Saddle River, NJ: Pearson Education.
- Huber, D. (2014). *Leadership and nursing care management* (5th ed.). Philadelphia: Saunders/Elsevier.
- Institute of Medicine (IOM). (1999). *To err is human: Building a safer health care system*. Washington, DC: National Academies Press.
- Institute of Medicine (IOM). (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: National Academy Press.
- Institute of Medicine (IOM). (2003). *Health professions education: A bridge to quality*. Washington, DC.: The National Academies Press. Retrieved from <http://www.nationalacademies.org/hmd/Reports/2003/Health-Professions-Education-A-Bridge-to-Quality.aspx>

- International Organization for Standardization. (2012). ISO 31000:2009 Risk management: Principles and guidelines. *ISO store: Standards catalogue*. Retrieved from http://www.iso.org/iso/catalogue_detail.htm?csnumber=43170
- Ironside, P., & Valiga, T. M. (2007). How innovative are we? What is the nature of our innovation? *Nursing Education Perspectives, 28*(1), 51–53.
- Keehan, S., Sisko, A., Truffer, C., Smith, S., Cowan, C., Poisal, J., ... National Health Expenditure Accounts Projections Team. (2008, February 26). Health spending projections through 2017: The baby-boom generation is coming to Medicare. *Health Affairs*, W145–W155. Retrieved from <http://content.healthaffairs.org/cgi/content/abstract/27/2/w145>
- Leadershipnow.com. (2012). Quotes on *risk-taking*. Retrieved from <http://www.leadershipnow.com/risktakingquotes.html>
- Leapfrog Group (2015). *About Leapfrog: Mission statement*. Retrieved from http://www.leapfrog-group.org/about_leapfrog
- Longo, A. (2013). Change, complexity, and creativity. In L. Roussel (Ed.), *Management and leadership for nurse administrators* (6th ed., pp. 122–159). Burlington, MA: Jones & Bartlett Learning.
- Medicare.gov. (n.d.). *Help fight Medicare fraud*. Retrieved from <https://www.medicare.gov/forms-help-and-resources/report-fraud-and-abuse/fraud-and-abuse.html>
- Merriam-Webster Dictionary Online. (n.d.) Innovation. <http://www.merriam-webster.com/dictionary/innovation>
- National Institutes of Health, Center for Information Technology. (n.d.). *Strategic plan 2008–2012*. Retrieved from <http://cit.nih.gov/NR/rdonlyres/54A93894-A76C-4742-A559-421738E78557/0/CITStrategicPlan2008Final.pdf>
- National Institute of Nursing Research. (n.d.). Important Events in the National Institute of Nursing Research History. Retrieved from https://www.ninr.nih.gov/aboutninr/history#.VwGmPXo_vOM
- Porter-O'Grady, T., & Malloch, K. (Eds). (2009). *Innovation leadership: Creating the landscape of healthcare*. Sudbury, MA: Jones & Bartlett
- Reising, D. L., & Allen, P. A. (2007, February). Protecting yourself from malpractice claims. *American Nurse Today, 2*(2), 39–44. Retrieved from <http://www.americannursetoday.com/protecting-yourself-from-malpractice-claims/>
- Seton Healthcare Network. (2016). *Nursing at Seton*. Retrieved from http://www.seton.net/employment/nursing/nursing_at_seton/
- Sewell, J., & Thede, L. (2013). *Informatics and nursing: Opportunities and challenges* (4th ed.). Philadelphia: Wolters-Kluwer/Lippincott, Williams & Wilkins.
- Smith, K., Smith, V., Krugman, M., & Oman, K. (2005). Evaluating the impact of computerized clinical documentation. *CIN: Computers, Informatics, Nursing, 23*(3), 132–138.
- Tull, M. (2009). Managing impulsive behaviors: Impulsive behaviors can be associated with PTSD. *About.com: Health: Post traumatic stress (PTSD)*. Retrieved from <http://ptsd.about.com/od/selfhelp/qt/impulsecope.htm>
- U. S. Department of Health and Human Services. (2012). *Update on the adoption of health information technology and related efforts to facilitate the electronic use and exchange of health*

information: A report to Congress. Retrieved from <https://www.healthit.gov/sites/default/files/pdf/january-2012-update-on-hit-adoption-report-to-congress.pdf>

U.S. Department of Health and Human Services, Office of the National Coordinator for Health Information Technology. (n.d.) *Federal health IT strategic plan 2015–2020*. Retrieved from <http://www.healthit.gov/sites/default/files/federal-healthIT-strategic-plan-2014.pdf>

Warner, J. R., & Burton, D. A. (2009). The policy and politics of emerging academic-service partnerships. *Journal of Professional Nursing, 25*(6), 329–334.