

## **Parish Nursing: Practical Advice for Limiting Liability Concerns**

An 1800's American Naval Officer named David Porter once said "litigation is the basic legal right that guarantees every corporation its decade in court." However humorous this statement may be, it is a painful reality to anyone who has ever been sued. Win, lose, or draw, most defendants will agree that the experience of being sued was long and miserable at best, and personally and financially devastating at worst. For a professional who takes pride in her work, being accused of negligence or malpractice can permanently sour her attitude towards her chosen profession. For an organization that sponsors the accused, such allegations can create serious harm to the organization's reputation, programs, and fundraising ability. The sad fact is many claims of negligence or malpractice made against health care professionals are without merit. With proper legal representation the accused should find redemption in the court of law, but the scars created during the process are often permanent. Avoiding the process altogether should be the goal of all health care professionals.

For nurses, accusations of negligence and malpractice are becoming more and more commonplace. The unfortunate reality is that most nursing procedures are created by attorneys and claims adjusters in response to lawsuits. For the nurse who strictly follows the written procedures in his or her job, accusations of negligence or malpractice should not get serious consideration. But having an understanding of the history and basis for the procedures he or she follows is an even better way to avoid becoming known as "Defendant." This article will examine the basis for lawsuits against nurses – with a particular emphasis on parish nurses – and will illustrate the ways in which these nurses, and their respective employers, can avoid being sued for malpractice or negligence.

### **Negligence, Malpractice & Standards of Care**

The best way to think about the topic of risk management or liability management in the context of a particular setting is to try to see through the eyes of a plaintiff's attorney who would be examining your performance with the goal of discrediting you. Whether a case will rise above an accusation, an incident report, or an internal investigation to a lawsuit depends on whether the plaintiff's attorney sees any merit to his client's claim. Stated another way, whenever the actions or inactions of a health care professional can be blamed for the patient's injury, the plaintiff will have a case. The question, as we all know, is whether an attorney can force the health care professional, her employer, or her insurance carrier to compensate the plaintiff for his or her losses. The plaintiff's attorney will look to the "elements" of the cause of action and see how many fit in her client's situation. In the medical setting, the two most common causes of action are actions for negligence and malpractice. The elements of both are as follows:

1. Duty owed to the patient;
2. Breach of that duty;
3. Foreseeability;
4. Causation;
5. Injury; and
6. Damages

The most important element, or the one that frames the rest of the case, is the duty owed to the patient. This duty varies, depending on whether the case is one of negligence or malpractice. To prove that a defendant was negligent, the plaintiff will look to the “reasonable person” standard of care to determine the duty owed. In other words, did the defendant’s conduct lack in due care? Was he careless to the extent that you could say he deviated from the standard of care a reasonable person would use in the particular circumstance? Or alternatively, did he do something a reasonable person would not do? This is distinct from the standard of malpractice, which relies on a professional standard of care. The malpractice standard looks to both the particular profession’s standard of care and the professional status of the caregiver (i.e. a doctor, nurse, accountant, or attorney). In actions against health-care providers, the courts have summarized the elements of malpractice to say that a case of malpractice is established by showing:

1. The standard of care recognized by the medical community as applicable to the particular defendant;
2. That the defendant departed from that standard; and
3. That the defendant's departure was a direct cause of the plaintiff's injuries.<sup>1</sup>

In a trial setting, these elements would be established by the plaintiff’s attorney through the testimony of an expert witness. The expert would testify as to what the nurse should have done in her position and then demonstrate her failure to act accordingly. The question of duty owed to the patient has two distinct parts. It must first be shown that a duty was indeed owed to the patient. Then the question of the “scope of the duty” comes to play, that is, the “standard of care.” Although the first question is usually fairly easily established in the traditional hospital or clinic setting, it can be less clear in the case of a parish nurse. In the hospital setting, the nurse-employer relationship and the hospital-patient contract easily establish the applicability of the malpractice standard. Once the patient has checked into the hospital, he or she can rely on the fact that the medical professionals working for the hospital are governed by their professional standards of care.

In the case of a parish nurse, the patient may not be checked into a hospital or clinic, or the nurse may not be an employee of the hospital or clinic. However, although there is no clear guidance as to when the duty arises in a parish nurse’s job, it should be presumed to have arisen whenever the nurse is attending to someone who is presenting health care needs. In the Texas case Lunsford v. Board of Nurse Examiners, 648 S.W.2d 391, 395 (Tex.Civ.App. 1983), the court held that “[a] license to provide medical services is a covenant to serve the people of the State of Texas with professional skill and power and a contract to always act in a professional and honorable manner.” In that case, the nurse argued that because the patient was never formally admitted to the hospital, no formal physician-patient relationship had been established, and therefore no duty had arisen. The court held instead that the duty arose as soon as the patient presented at the hospital’s admitting desk and was met by a health care professional.

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<sup>1</sup> McDonough v. Allina Health Systems, 685 N.W.2d 688, 697 (Minn. App. 2004), citing Fabio v. Bellomo, 504 N.W.2d 758 (Minn. 1993).

The Lunsford case seems to illustrate that a plaintiff's attorney can show that a duty of care exists in most cases. Accordingly, the conservative position would be to say that parish nurses, by virtue of their licenses, owe a duty of care to anyone who comes before them under any circumstance with medical needs. So the next, and more difficult question, is what is the scope of the duty owed? Again, from the perspective of the plaintiff's lawyer, the question will be whether the nurse acted in a manner that a reasonable, prudent nurse with similar education would in like circumstances. The basis for examining this question has been held by most courts to be the national "Standards of Care" as defined by the industry. In the case of nurses the American Nurses Association (ANA) has developed *Nursing: Scope and Standards of Practice (2004)* which apply to all registered nurses regardless of practice, and *Faith Community Nursing: Scope and Standards of Practice (2005)*<sup>2</sup> which apply specifically to parish nurses. The standards for parish nurses were developed through a collaborative project between the ANA and Health Ministries Association, Inc. (HMA).<sup>3</sup> The results of the project were posted on the HMA website for six weeks and more than 200 comments were considered. The final draft of the standards is as follows:

1. **Assessment** – The faith community nurse collects comprehensive data pertinent to the patient's wholistic health or the situation.
2. **Diagnosis** – The faith community nurse analyzes the wholistic assessment data to determine the diagnosis or issues.
3. **Outcomes Identification** – The faith community nurse identifies expected outcomes for a plan individualized to the patient or the situation.
4. **Planning** – The faith community nurse develops a plan that prescribes strategies and alternatives to attain expected outcomes for individuals, groups, or the faith community as a whole.
5. **Implementation** – The faith community nurse implements the specified plan.
  - a. **Coordination of Care** – The faith community nurse coordinates care delivery.
  - b. **Health Teaching and Health Promotion** – The faith community nurse employs strategies to promote wholistic health, wellness, and a safe environment.
  - c. **Consultation** – The faith community nurse provides consultation to facilitate understanding and influence the specified plan of care, enhance the ability of others, and effect change.
  - d. **Prescriptive Authority and Treatment** – (*Optional for appropriately prepared APRN*) The advanced practice registered nurse, faith community nurse uses prescriptive authority, procedures, referrals, treatments, and therapies in accordance with state and federal laws and regulations.
6. **Evaluation** – The faith community nurse evaluates progress toward attainment of outcomes.

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<sup>2</sup> This publication is available for purchase from the ANA at the following website:  
<http://nursingworld.org/books/anpsearchdetail.cfm?PubNum=05SSF&thedesc=faith%20community&DisNum=10&StartRow=1>

<sup>3</sup>See, <http://www.healthministries.info/index.html>

These standards reflect the current state of parish nursing from a national perspective, the professional and ethical standards applicable, and the legal scope of the “duty of care” applicable to parish nurses. Each of the standards above is further defined by the ANA to include a number of “measurement criteria” that help apply the standards to real life situations. All parish nurses and their employers/sponsors should thoroughly review these measurement criteria to be certain they are incorporated into the parish nursing program. These standards will be cited by any court reviewing the performance of a parish nurse. This is not to say that parish nurses can never be wrong, just that their errors in judgment should be reasonable under the circumstances. What the court looks to is the level of care given, and whether that care was in line with the prevailing standards.

The ANA also promulgated *Standards for Professional Performance for Faith Community Nursing (2005)*<sup>4</sup> to help further define a competent level of behavior of a parish nurse. These additional standards are as follows:

1. **Quality of Practice** – The faith community nurse systematically enhances the quality and effectiveness of faith community nursing practice.
2. **Education** – The faith community nurse attains knowledge and competency that reflects current nursing practice.
3. **Professional Practice Evaluation** – The faith community nurse evaluates ones own nursing practice in relation to professional practice standards and guidelines, relevant statutes, rules, and regulations.
4. **Collegiality** – The faith community nurse interacts with and contributes to the professional development of peers and colleagues.
5. **Collaboration** – The faith community nurse collaborates with the patient, spiritual leaders, members of the faith community, and others in the conduct of this specialized nursing practice.
6. **Ethics** – The faith community nurse integrates ethical provisions in all areas of practice.
7. **Research** – The faith community nurse integrates research findings into practice.
8. **Resource Utilization** – The faith community nurse considers factors related to safety, effectiveness, cost, and impact on practice in the planning and delivery of nursing services.
9. **Leadership** – The faith community nurse provides leadership in the professional practice setting and the profession.

Although these additional standards are not considered part of the national requirements, it is highly advisable to incorporate them into each parish nursing program.

### **“Building Blocks” of Liability Protection**

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<sup>4</sup> American Nurses Association (2005) *Faith Community Nursing: Scope and Standards of Practice*. Silver Spring, MD: Author.

Liability protection can be thought of as a wall of security, and to the extent that your wall is made of a good number of bricks, your chances of avoiding a lawsuit are enhanced. Court cases have, over time, specifically defined the “bricks” that will help strengthen your case and avoid lawsuits. Most nurses are probably aware of these types of things, but may not know the importance of some of these more mundane parts of their jobs. Coupled with the national *Standards of Practice*, the lessons learned from court decisions can help parish nurses and their sponsors develop sound practices that would further limit liability concerns.

If a plaintiff’s lawyer starts to analyze a parish nurse’s performance and finds that the nurse strictly followed procedures, documented his or her actions well, and regularly consulted with a physician, the lawyer will start to lose interest in bringing suit. This is because these are some of the pieces of defense evidence that they will have to anticipate and overcome in trial. Even if a parish nursing program has not incorporated the ANA *Standards* into their practice, they can still successfully defend against a lawsuit if their procedures are determined to be reasonably similar to the national standards. Following are some of the procedural protections learned from court cases that parish nurses should, at a bare minimum, incorporate into their practice.

1. Treat patients and their families with respect and honesty. Communicating in a truthful, open, and professional manner may well prevent a negligence cause of action.
2. Using your nursing knowledge to make appropriate nursing diagnosis and to implement necessary nursing interventions. You have an affirmative duty not only to make correct nursing diagnosis, but to take actions required to implement your diagnosis.
3. Remember that the first line of duty is to the patient. If the physician is hesitant to order necessary therapy or to respond to a change in the patient condition, call your supervisor or another physician. Question orders if they are (a) ambiguous or unclear, (b) questioned or refused by the patient, (c) telephone orders, or (d) inappropriate, such as when a major change occurs in the patient’s status and the orders remain unchanged. For telephone orders, reread the orders to the physician and clarify them prior to hanging up the phone.
4. Remain current and up-to-date in your skills and education. Take advantage of continuing education programs and in-service programs on a regular basis. Read your professional journals. Refuse to perform skills and procedures if you are unfamiliar with them, have never performed them before, or lack the necessary materials and equipment to perform them safely.
5. Base your nursing care on the nursing process model. Using all five steps of the model prevents the inadvertent overlooking of a vital part(s) of required nursing care for a given patient.
6. Document completely every step of the nursing care plan and the patient’s responses to interventions. Express yourself clearly and completely.

Chart all entries as soon as possible while the facts and observations are clear in your mind.

7. Respects the patients's right to education about his or her illness, and ensure that the patient and family are taught about disease entity, therapy, and possible complications prior to discharge. Chart any discharge instruction in the medical record.
8. Delegate patient care wisely, and know the scope of practice for yourself and those whom you supervise. Never accept or allow others to accept more responsibility than they can handle or than they are allowed to accept by law.
9. Know and adhere to your hospital policies and procedures. Help to update those that are outdated, and ensure that the personnel you supervise are also aware of hospital policies and procedures. All personnel should reread the manual periodically.
10. Keep your malpractice liability insurance policy current, and know the limits of coverage.<sup>5</sup>

## **Conclusion**

Ambrose Bierce once defined a lawsuit as “[a] machine which you go into as a pig and come out as a sausage.” As mentioned above, even defendants who ultimately prevail most often feel tarnished by the experience. A parish nursing program that has spent some time on the front end developing standards and procedures that are based in the national standards will be much better off in the long run. An ongoing commitment to education, strong peer networks, a good malpractice insurance policy, and a clear method of seeking consultations and referring patients will also serve the program well.

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<sup>5</sup> Wacker Guido, G. (2001) *Legal and Ethical Issues in Nursing (3<sup>rd</sup> Edition)*. Upper Saddle River, N.J. Prentice Hall.

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