## Ethical/Legal Dilemmas

### Scope and Standards of Practice

#### Situation

A young woman is admitted to the intensive care unit (ICU) after having several episodes of nonsustained VT credited to a history of viral cardiomyopathy. While she is being stabilized, she codes (pulseless VT) and needs intubation. A nurse anesthetist tries to intubate her 3 times unsuccessfully. There is an unforeseen delay in the arrival of the anesthesiologist. P.F., an ICU nurse who is a paramedic certified in advanced trauma life support (ATLS) and advanced cardiovascular life support (ACLS), tries to intubate the patient and does so successfully. The next day the nursing supervisor questions P.F. about intubating the patient since this is not within the scope of practice for an ICU nurse.

#### Ethical/Legal Points for Consideration

- The RN *Scope of Practice,* including rules and regulations that guide practice, are defined by individual state boards of nursing and can vary from state to state.
- Individual agencies have policies and procedures that describe the scope of practice for nurses. These can be more restrictive than those of the state.
- P.F. has had training, education, and certification beyond the usual nursing role.
- The life-threatening situation is an extenuating circumstance.
- Negligence may have been a factor if P.F., who is a nurse with training and experience, had not acted.

#### Discussion Questions

1. What would you have done in this situation?
2. How would you respond to the nursing supervisor?
3. What are the legal ramifications for P.F. in this situation?
4. What are the ethical issues in this situation?

The Joint Commission

# 2024 Hospital National Patient Safety Goals

**(Easy-To-Read)**

| | |
|---|---|
| **Identify patients correctly** | |
| NPSG.01.01.01 | Use at least two ways to identify patients. For example, use the patient's name *and* date of birth. This is done to make sure that each patient gets the correct medicine and treatment. |
| **Improve staff communication** | |
| NPSG.02.03.01 | Get important test results to the right staff person on time. |
| **Use medicines safely** | |
| NPSG.03.04.01 | Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up. |
| NPSG.03.05.01 | Take extra care with patients who take medicines to thin their blood. |
| NPSG.03.06.01 | Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Give the patient written information about the medicines they need to take. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor. |
| **Use alarms safely** | |
| NPSG.06.01.01 | Make improvements to ensure that alarms on medical equipment are heard and responded to on time. |
| **Prevent infection** | |
| NPSG.07.01.01 | Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. |
| **Identify patient safety risks** | |
| NPSG.15.01.01 | Reduce the risk for suicide. |
| **Improve health care equity** | |
| NPSG.16.01.01 | Improving health care equity is a quality and patient safety priority. For example, health care disparities in the patient population are identified and a written plan describes ways to improve health care equity. |
| **Prevent mistakes in surgery** | |
| UP.01.01.01 | Make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body. |
| UP.01.02.01 | Mark the correct place on the patient's body where the surgery is to be done. |
| UP.01.03.01 | Pause before the surgery to make sure that a mistake is not being made. |

**TABLE 1.5 5 Rights of Delegation**

| The 5 Rights of Delegation | | |
|---|---|---|
| The registered nurse uses critical thinking and professional judgment to be sure that the delegation or assignment is:<br>1. The right task<br>2. Under the right circumstances<br>3. To the right person<br>4. With the right directions and communication<br>5. Under the right supervision and evaluation | | |
| **Rights of Delegation** | Description | Questions to Ask |
| **Right Task** | One that can be delegated for a specific patient | Is it appropriate to delegate based on legal and agency factors?<br>Has the person been trained and evaluated in performing the task?<br>Is the person able and willing to do this specific task? |
| **Right Circumstances** | Appropriate patient setting, available resources, and considering relevant factors, including patient stability | What are the patient's needs right now?<br>Is staffing such that the circumstances support delegation strategies? |
| **Right Person** | Right person is delegating the right task to the right person to be performed on the right person | Is the prospective delegatee a willing and able employee?<br>Are the patient needs a "fit" with the delegatee? |
| **Right Directions and Communication** | Clear, concise description of task, including its objective, limits, and expectations | Have you given clear communication about the task? With directions, limits, and expected outcomes?<br>Does the delegatee know what and when to report? Does the delegatee understand what needs to be done? |
| **Right Supervision and Evaluation** | Appropriate monitoring, evaluation, intervention, and feedback | Do you know how and when you will interact about patient care with the delegatee?<br>How often do you need to directly observe?<br>Will you be able to give feedback to the staff member if needed? |

Source: National Guidelines for Nursing Delegation. Retrieved from www.ncsbn.org/1625.htm.

## Ethical/Legal Dilemmas

### Board of Nursing Disciplinary Action

#### Situation

The state board of nursing has received multiple complaints about J.R., an RN who works in a long-term care facility. J.R. has signed off on 3 controlled substances count sheets that have been determined to be inaccurate. During an investigation it was discovered that several members of the nursing staff knew about J.R.'s reported behavior, but they did not report their observations to the unit administrator because the administrator is J.R.'s aunt. After the investigation, the board of nursing subpoenas J.R. to a meeting to discuss charges in preparation for a disciplinary hearing.

#### Ethical/Legal Points for Consideration

Regulation of professional nursing practice is the right of each of the 50 states. Most have regulatory agencies charged with writing regulations and rules to implement the state nurse practice act. The regulations approved by these agencies carry the weight of law. Failure to behave accordingly places a nurse at risk for disciplinary action.

The RN who is charged with unprofessional behavior has been charged with an offense and is entitled to the same legal rights as any other person, including a fair and timely hearing, opportunity to confront the accusers, right to be represented by an attorney, and right to prepare a defense.

Possible disciplinary actions include temporary suspension of the nursing license, revocation of the nursing license, mandatory rehabilitation for substance use, and mandated supervision and evaluation of practice. Sometimes the disciplinary action includes fines and requires reeducation. The state board of nursing may report the action to the state attorney general if evidence suggests that a crime has been committed. The RN who is found guilty of unprofessional practice must report this action on all future applications for nursing positions.

All RNs should be familiar with their state's nurse practice act and regulations, and the composition and actions of the state board of nursing. Nurses should pay attention to the regulation that lists examples of actionable behavior and disciplinary actions sanctioned by the state.

RNs have a legal and ethical obligation to report suspected illegal behavior to their administrators and to continue reporting until the situation is resolved. By failing to report, the RN may be charged as an accessory to the act or aiding and abetting the behavior. This RN may be charged with unprofessional behavior and risks losing his or her nursing license. Shifting the obligation to someone else to report or failure to continue reporting each incident does not satisfy this duty.

#### Discussion Questions

1. How would you handle a situation in which retaliation for reporting unprofessional behavior may occur?
2. What would you do if the nurse suspected of illegal behavior is related to someone in the administrative hierarchy?

## Nursing Process

Nurses provide patient-centered care using an organizing framework called the *nursing process*. The **nursing process** is a problem-solving approach to the identification and treatment of patient problems that is the foundation of nursing practice. The nursing process framework provides a structure for delivering nursing care and the knowledge, judgments, and actions that nurses use to achieve best patient outcomes. Once started, the nursing process is continuous and cyclic.

The nursing process consists of 5 phases: assessment, diagnosis, planning, implementation, and evaluation (Fig. 1.3). There is a basic order to the nursing process, beginning with assessment. *Assessment* is the collection of subjective and objective patient information on which you will base your plan of care. *Diagnosing* is the act of analyzing the assessment data and making a judgment about the nature of the data. It includes your identifying nursing diagnoses or problems and collaborative problems. During *planning*, you use nursing diagnoses and problems to develop patient outcomes or goals and identify nursing interventions to accomplish the outcomes. *Implementation* is the activation of the plan with the use of nursing interventions. *Evaluation* is a continual activity. During evaluation you decide whether the patient outcomes have been met because of the nursing interventions. If the outcomes were not met, a review of the steps of the process is necessary to figure out why not. You may need to revise the assessment (data collection), nursing diagnoses, planning (determining patient outcomes), or implementation (nursing interventions).