chapter 3

Legal and Ethical Aspects of Nursing

evolve

http://evolve.elsevier.com/deWit/fundamental

Objectives

Upon completing this chapter, you should be able to:

Theory

1. Explain the legal requirements for the practice of nursing and how they relate to a student nurse.
2. Identify the consequences of violating the nurse practice act.
3. Examine the issue of professional accountability, professional discipline, and continuing education for licensed nurses.
4. Compare and contrast the terms *negligence* and *malpractice.*
5. Discuss what you can do to protect yourself from lawsuits or the damages of lawsuits.
6. Differentiate a code of ethics from laws or regulations governing nursing, and compare the similarities of the codes of ethics from the NFLPN, NAPNES, and ANA.
7. Describe the NAPNES standards of practice.

Clinical Practice

1. Reflect on how laws relating to discrimination, workplace safety, child abuse, and sexual harassment affect your nursing practice.
2. Discuss the National Patient Safety Goals and identify where these can be found.
3. Interpret rights that a patient has in a hospital, nursing home, community setting, or psychiatric facility.
4. Describe three elements of informed consent.
5. Explain advance directives and the advantage of having them written out.

Key Terms

accountability (ă-kŏwn-tă-BĬ-lĭ-tē, p. 30)
advance directive (p. 36)
assault (ă-SĂLT, p. 37)
assignment (p. 31)
battery (p. 37)
competent (p. 36)
confidential (cŏn-fĭ-DĚN-shŭl, p. 33)
consent (p. 35)
defamation (dĕ-fă-MĀ-shŭn, p. 37)
delegation (p. 31)
discrimination (p. 32)
do-not-resuscitate (DNR) orders (rē-SŬ-sĭ-tāt, p. 36)
ethical codes, ethical principles, ethics committee (p. 29)
ethics (p. 40)
euthanasia (yū-thă-NĀ-zhē-ă, p. 43)
false imprisonment (p. 38)
health care agent (p. 36)
incident report (p. 40)
invasion of privacy (p. 38)
laws (p. 29)
liability (lī-ă-BĬL-ĭ-tē, p. 36)
libel (LĪ-bŭl, p. 37)
living will (p. 36)
malpractice (măl-PRĂK-tĭs, p. 37)
negligence (p. 37)
nondisclosure agreement (p. 38)
nurse licensure compacts (p. 30)
nurse practice act (p. 30)
Occupational Safety and Health (OSH) Act (ŏ-kū-PĀ-shŭn-ŭl, p. 31)
Occupational Safety and Health Administration (OSHA) (p. 31)
patient advocate (ĂD-vō-kăt, p. 37)
privilege (PRĬ-vĭ-lĕj, p. 29)
protective devices (p. 39)
prudent (p. 37)
Quality and Safety Education for Nurses (QSEN) project (p. 33)
reciprocity (rĕ-cĭ-PRŎ-cĭ-tē, p. 30)
release (p. 36)
sentinel event (p. 33)
sexual harassment (hă-RĂS-mĭnt, p. 32)
slander (p. 37)
standards of care (p. 31)
statutes (p. 30)
tort (p. 30)
whistle-blowing (p. 43)

Chapter #2 work sheet

Online Resources

- *Hans Selye's General Adaptation Syndrome,* www.essenceofstressrelief.com/general-adaptation-syndrome.html
- *Culture Clues (cultural information),* http://depts.washington.edu/pfes/CultureClues.htm
- *Maslow's Hierarchy of Needs,* www.businessballs.com/maslow.htm

Review Questions for the NCLEX® Examination

*Choose the **best** answer(s) for each question.*

1. Which statement *best* describes health? Health is:
   1. a relative state of being.
   2. the total state of physical and psychological well-being.
   3. the state of functioning well physically, mentally, and socially.
   4. being free of sickness or infirmity.

2. Taking on the sick role occurs when a patient:
   1. recognizes that vague aches and pains are present.
   2. states that she might be getting a cold.
   3. refuses to see a physician even though her cough is constant.
   4. buys and takes a couple of aspirin.

3. It is important that the nurse understand that certain cultural traits should be assessed in patients. Patients of Asian, African, and Hispanic descent should be assessed for:
   1. stomach cancer.
   2. retinopathy.
   3. sickle cell anemia.
   4. lactose intolerance.

4. Considering the patient's physical problems, as well as the psychological, sociological, and spiritual needs, results in _____ nursing care.

5. It is important to assess a patient's *actual* cultural beliefs because:
   1. a patient may not adhere to the usual health beliefs of her culture.
   2. cultural beliefs play a major role in how the patient perceives herself.
   3. the family's beliefs are inherent in the patient.
   4. cultural diversity is present in all parts of the United States.

6. When setting priorities of patient needs according to Maslow's hierarchy, you should: *(Select all that apply.)*
   1. only consider physiologic needs.
   2. consider airway status first.
   3. consider safety a high priority.
   4. place self-esteem needs before security needs.
   5. place activity needs before belonging needs.
   6. consider elimination needs before rest and comfort needs.

7. A patient had major surgery and says she's worried about what is happening at home, is worried about not being there to coach the soccer team tomorrow, is feeling pain, and wants to see her husband. Which action would you take *first?*
   1. Tell her not to worry about things at home.
   2. Allow her to call the children at home.
   3. Administer pain medication.
   4. Check to see who might be able to coach the soccer team.
   5. Put in a call to her husband so she can obtain information and have him arrange for someone to coach the soccer team.

8. Which is the *best* description of homeostasis?
   1. It is the tendency of the body to constantly adjust to changing conditions.
   2. It occurs when the equilibrium of the body is disturbed.
   3. It is the biologic reaction that takes place in response to a stressor.
   4. It is a static condition of the body during health.

9. The effects of stress on a person partially depend on:
   1. the presence of prior illness.
   2. the time of day it occurs.
   3. the surrounding environment.
   4. the perception of the stressor.

10. Common sympathetic reactions to a stressor that occurs suddenly include: *(Select all that apply.)*
    1. constriction of the pupils in the eyes.
    2. increase in saliva and tear production.
    3. a "weak in the knees" feeling.
    4. pounding of the heart with rapid pulse.
    5. dilation of the pupils.
    6. increased blood pressure.

Critical Thinking Activities

Discuss the following questions with your classmates.

1. Share some of your family's values and beliefs that contribute to your own definition of health.
2. What does illness mean to you?
3. What are your most effective coping techniques? How can you increase your ability to effectively cope with stress?
4. How would you go about helping a patient mobilize personal coping mechanisms?

An understanding of legal and ethical codes is essential for nurses to practice safely and to protect the rights of patients and co-workers. Nurses work in situations that give them **privilege** (permission to do what is usually not permitted in other circumstances) in respect to a patient's body and emotions. Laws define the boundaries of that privilege and make clear the nurse's rights and responsibilities. **Ethical codes** (actions and beliefs approved of by a particular group of people) are different from laws; they are important because not all situations are covered by a law, and there may not be one *right* action. In these situations, **ethical principles** (rules of right and wrong from an ethical point of view) are applied, often by an **ethics committee** (a committee formed to consider ethical problems).

SOURCE OF LAW

Laws are rules of conduct that are established by our government (Box 3-1 lists specialized vocabulary). In the United States, law comes from three sources: the Constitution and Bill of Rights, laws made by elected officials, and regulations made by agencies created by elected officials. Constitutional laws, both federal and state, provide for basic rights and create the legislative bodies (senate and assembly) that write laws governing our lives.

Judicial law results when a law or court decision is challenged in the courts and the judge affirms or reverses the decision. This is called "establishing a precedent," since in the future other judges will base their decisions on the preceding, or earlier, decision. Our federal Supreme Court is the highest court to which an appeal of a court decision can be brought. One well-known health care issue that has been ruled on by the Supreme Court was *Roe v. Wade* (1972), which established a woman's right to obtain an elective abortion. More recently, state courts are hearing cases challenging laws that deal with abortion, euthanasia, and assisted suicide.

Administrative law comes from agencies created by the legislature. In health care, agencies such as the Department of Health and Human Services or the Office of Professional Licensing oversee nursing and the other health care professions. These agencies write

Box 3-1 Legal Terms and Definitions

Advance directive: Written statement expressing the patient's wishes regarding future consent for or refusal of treatment if the patient is incapable of participating in decision making.

Appeal: Challenge to a court decision; a higher court will judge whether the original decision is affirmed or reversed.

Civil rights, civil law: Personal or individual conditions (e.g., life, liberty, privacy) guaranteed by the Constitution, Bill of Rights, and federal or regulatory law.

Competent: Mentally and emotionally able to understand and act (make choices). Able to appreciate consequences of actions.

Controlled substance: Specific drugs with a potential for abuse, such as narcotics, tranquilizers, stimulants, and sedatives. Laws regulate how these are prescribed, dispensed, and stored.

Crime: Violation of public law.

Damages: The monetary award to an injured plaintiff when the defendant is found responsible for the injury.

Defendant: Person accused of violation of public law (crime) or civil law (tort).

Emancipated minor: Person under 18 years of age who is legally considered an adult, usually because of marriage, parenthood, or enlistment in the armed services.

Felony: A serious crime that may result in a prison term of more than 1 year.

Health care agent: Person designated by the patient to make health care decisions when the patient is incapacitated (not able to make those decisions). Usually part of an advance directive.

Liability: Responsibility to pay or compensate for a loss or injury resulting from one's negligence.

Litigation: Lawsuit; legal process to prove facts of a dispute.

Malpractice: When a professional causes harm by failing to meet the standard of care; failure to do what a reasonable and prudent person in a similar situation would do.

Malpractice insurance: Policy that protects a nurse from the expense of defending herself from lawsuit; will pay the amount awarded up to policy limits if a nurse is found guilty of malpractice.

Medical power of attorney: Legal assignment of ability to make health care decisions for another person. Similar to a health care agent.

Misdemeanor: Less serious crime than felony; may result in fines, imprisonment of 1 year or less, or both.

Negligence: Departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a similarly trained and experienced professional.

Plaintiff: Person who believes he or she has been injured by the actions of another and seeks to prove it in a court of law.

Power of attorney: Legal action to allow a person to conduct business matters for another.

Precedent: A judicial decision that is used as a guide in interpreting the law and deciding cases afterward.

Privileged relationship: One that requires confidentiality; trust that information gained in the relationship will not be made public.

Statute: Legal term for a law.

Tort: Violation of a civil law, a wrong against an individual.

regulations or rules that control the profession and its practice. Administrative law governs schools of nursing; licensure; hospitals, nursing homes, and home health agencies; and health care insurance such as Medicare, Medicaid, or private insurance company policies.

CIVIL AND CRIMINAL LAW

Statutes (laws) may be either civil or criminal. Civil law deals with potential wrongdoing of a person against another person. Civil law guarantees individual rights, and a **tort** is a violation of civil law. You may be guilty of a tort if you harm a patient, for example, by administering the wrong dose of medication. A lawsuit may result, and, if the **defendant** is found guilty, a monetary award may be given to the **plaintiff.**

Criminal law deals with potential wrongdoing of a person against society. A **crime** is a wrong against society, and imprisonment and/or fines may result if one is convicted of a crime. Criminal action charges in nursing could result if a nurse was involved in drug diversion, patient abuse, intentional death, or mercy killing. Serious crimes are called **felonies** and are punished with prison terms of a year of more, or even the death penalty; less serious crimes are **misdemeanors** and may result in prison terms of less than a year, monetary fines, or both.

LAWS RELATED TO NURSING PRACTICE AND LICENSURE

NURSE PRACTICE ACT

State licensure is required to practice nursing in the United States, and each state writes its own laws and regulations regarding licensure, in what is called a **nurse practice act.** These laws define the scope of nursing practice and provide for the regulation of the profession by a state board of nursing.

SCOPE OF PRACTICE

The scope of practice includes the definition of nursing for the registered professional nurse (RN) and the licensed practical or vocational nurse (LPN or LVN) and may include definitions for advanced practice nurses such as nurse practitioners or nurse anesthetists. Nurse practice acts regulate the degree of dependence or independence of a licensed nurse working with or under other nurses, physicians, and health care providers. For example, an LPN/LVN practices under the direction of an RN, physician, or dentist. Nurses must follow the lawful order of a physician unless it is harmful to the patient, and must have a physician order to perform certain functions, such as administering prescription drugs or placing a patient in a protective device.

LICENSURE

Eligibility for licensure is determined by each state's board of nursing, usually involving completion of an approved educational program. The National Council of State Boards of Nursing, which develops the National Council Licensure Examination (NCLEX®), has a representative from each of the state boards of nursing who has input on the examination. A passing score on this test is accepted by the states for initial licensure when all other state requirements for eligibility are met. A current trend regarding licensure involves the creation of **nurse licensure compacts,** whereby certain participating states allow nurses to be licensed in one state and practice in any state belonging to the compact. If a nurse lives in a noncompact state, she can apply for **reciprocity** (recognition of one state's nursing license by another state).

Student Nurses

Student nurses are held to the same standards as a licensed nurse. This means that although a student nurse may not perform a task as quickly or as smoothly as the licensed nurse, the student is expected to achieve the same outcome without harm to the patient. The student is legally responsible for her own actions or inaction, and many schools require the student to carry **malpractice insurance.** The instructor who supervises a student is responsible for proper instruction and adequate supervision and evaluation of a student. Instructors are responsible for assigning students to patients of an appropriate level of complexity so that they do not jeopardize patient safety. A student's responsibility is to consult with the instructor when she is unsure in a situation, or when a patient's condition is changing rapidly. **Student nurses need to know the nurse practice act and its definition of nursing in the state where they are practicing, and they must not exceed the scope of practice. It is not legal to do something beyond the scope of nursing practice just because you were told to do so.** Hospitals or health care agencies may impose limitations on student practice, but they may not add duties or responsibilities beyond the scope of practice in that state.

PROFESSIONAL ACCOUNTABILITY

Accountability is taking responsibility for one's actions. Professional accountability is a nurse's responsibility to meet the patient's health care needs in a safe and caring way. To do so, students must prepare themselves in the classroom with **theory**—the textbook description of patient needs and nursing interventions—and then apply that information in the clinical setting. Accountability means asking for assistance when unsure, performing nursing tasks in a safe manner, reporting and documenting assessments and interventions, and evaluating the care given and the patient's response. Accountability also includes a commitment to continuing education to stay current and knowledgeable.

Delegation

Delegation is the assignment of duties to another person. Some states differentiate between delegation (only to another licensed person) and **assignment,** which can be done to an unlicensed person, such as a nursing assistant. An LPN may supervise nursing assistants, technicians, or other LPNs. The nurse is responsible for ensuring patient safety and observing patient rights. It is the delegating nurse's duty to supervise and evaluate the care a licensed or unlicensed person provides.

Assignment Considerations

Nurse's Responsibilities

When a licensed nurse gives an assignment to another person, the nurse is responsible for ensuring that the person has the skills and abilities to safely perform the assignment, and that an unlicensed person is not performing acts restricted to nursing under the law.

Standards of Care

Legally, you are responsible for your actions under the nurse practice act and according to the **standards of care** approved by the profession. These standards are defined in nursing procedure books, institutional policies, procedures or protocols, and nursing journals. On a national level, standards of care have been identified and published for clinical practice and specialty areas by professional nursing organizations. These standards provide a way of judging the quality and effectiveness of patient care and in legal cases determine whether a nurse acted correctly (see Box 1-1). Standards of care are continually being revised as treatments and techniques are updated and improved with nursing research. What is the standard today may not be the standard next year; it is crucial to keep current with continuing education.

PROFESSIONAL DISCIPLINE

State boards of nursing are also responsible for discipline within the profession. When a licensed nurse is charged with a violation of the nurse practice act, there will be an investigation and hearing to determine whether the charges are true. The most common charges brought against nurses include substance abuse, incompetence (doing something that can or did harm a patient), and negligence. **It is considered negligence not to report another professional's misconduct.** When a nurse is found guilty of professional misconduct, the penalties may result in a temporary suspension or loss of licensure.

CONTINUING EDUCATION

Many states have adopted laws that require evidence of continuing education after a nurse has passed the licensing examination. Once licensed, you are expected to function safely in any nursing situation. Therefore it is necessary to continue your education about changes in health care practice, pharmacology, and technology. You may stay current by attending educational programs provided by your employer or professional organizations, reading nursing journals, taking college courses, or attending Internet webinars.

LAWS AND GUIDELINES AFFECTING NURSING PRACTICE

When a licensed nurse accepts employment with an agency or individual, the nurse is bound to work within the laws and regulations governing nursing in that state. There are also federal laws that regulate safety and health in the workplace and forbid discrimination and sexual harassment. Although *not law,* the "Patient Care Partnership: Understanding Expectations, Rights, and Responsibilities" provides ethical guidelines for nursing practice (Box 3-2).

OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION (OSHA)

The **Occupational Safety and Health (OSH) Act** was passed in 1970 to improve the work environment in areas that affect workers' health or safety. It includes regulations for handling infectious or toxic materials, radiation safeguards, and the use of electrical equipment. With the passage of the OSH Act, Congress created the **Occupational Safety and Health Administration (OSHA),** whose mission is to keep working conditions

Box 3-2 Patient Care Partnership: Overview*

When you need hospital care, your health care professionals at our hospital are committed to working with you and your family to meet your health care needs. Our goal is for you and your family to have the same care and attention we would want for our families and ourselves.

The sections below explain some of the basics about how you can expect to be treated during your hospital stay.

WHAT TO EXPECT DURING YOUR HOSPITAL STAY

- High-quality hospital care
- A clean and safe environment
- Involvement in your care
  - Discussing your medical condition and information about medically appropriate treatment choices.
  - Discussing your treatment plan.
  - Getting information from you.
  - Understanding your health care goals and values.
  - Understanding who should make decisions when you cannot.
- Protection of your privacy
- Help preparing you and your family for when you leave the hospital
- Help with your bill and filing insurance claims

Modified from American Hospital Association. (2003). *Patient Care Partnership: Understanding Expectations, Rights, and Responsibilities.* Chicago: Author.
*Full document is available on Evolve.

safe for all workers. Health care agencies, as a result of OSHA requirements, provide mandatory orientation and continuing education regarding a wide range of topics, from isolation procedures and blood-borne pathogen exposure, to fire or bomb threats and lifting and evacuation procedures.

Safe storage and handling of toxic chemicals and drugs are important parts of the OSH Act. Each facility is required to keep a record of hazardous substances, including bleach, disinfectants, and other chemicals. The facility must store them properly in designated areas and maintain material safety data sheets (MSDSs), which outline the hazard the substance can pose. Employees must be updated on these workplace hazards and know the location of the MSDS collection.

CHILD ABUSE PREVENTION AND TREATMENT ACT (CAPTA)

The Child Abuse Prevention and Treatment Act (CAPTA) is a federal law. It was enacted in 1974 and most recently amended and reauthorized in 2010 by the CAPTA Reauthorization Act of 2010. This law defines child abuse and neglect as **"Any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse, or exploitation, or an act or failure to act which presents an imminent risk of serious harm."** A child is a person under the age of 18 unless state law specifies a younger age. Many children who are victims of abuse are too young to speak for themselves. **CAPTA states that licensed health care personnel are required to report child abuse.** Each facility usually has guidelines on how to report child abuse.

Clinical Cues

In cases of child abuse the account of the injury or accident given by the caregiver is often inconsistent with the physical signs and symptoms. A student should bring any suspicions of child abuse to the attention of the instructor.

DISCRIMINATION

Discrimination is making a decision or treating people based on a class or group to which they belong, such as race, religion, or sex. In 1964 federal legislation made it illegal for employers to **discriminate** (to hire, promote, or fire employees) on the basis of race, color, religion, sex, or national origin. The law has been amended to prohibit discrimination related to a person's disabilities, age, pregnancy, childbirth, and related medical conditions. Discrimination laws protect people with human immunodeficiency virus (HIV) infection or acquired immunodeficiency syndrome (AIDS) and those recovering from drug or alcohol addiction. It is not legal for employers to ask questions on an employment application that would indicate race, other protected categories, or health status. Laws also require employers to make reasonable accommodations for people with a disability.

SEXUAL HARASSMENT

Sexual harassment is defined by the Equal Employment Opportunity Commission (EEOC) as "unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature." Sexual harassment is illegal when used as a condition of employment or promotion or when it interferes with job performance. Sexual harassment prohibition has been further applied in schools and in the clinical setting. Student nurses and their instructors need to recognize what sexual harassment is; to refrain from conversation or actions that create a hostile, intimidating, or offensive atmosphere; and to report actions that are sexually harassing in the classroom or clinical setting. In our society, in which sexual comments and activities are commonplace on television and in movies, we must be aware of the right time and place for sexually suggestive or explicit words or touch. It is appropriate to state, "I am offended by your language (conversation, inappropriate touch)." If the sexually explicit or harassing behavior continues, report it to your supervisor.

GOOD SAMARITAN LAWS

Good Samaritan laws protect a health care professional from liability if she stops to provide aid in an emergency. In most states there is no legal requirement for a nurse to help in an emergency, but if a nurse does provide care, liability is limited unless there is evidence of gross negligence or intentional misconduct. These laws do not apply to employed emergency response workers.

PATIENT'S RIGHTS

In 1972, with revision in 1992, the American Hospital Association (AHA) developed the "Patient's Bill of Rights," a list of rights the patient could expect and responsibilities that the hospital must uphold. In 2003 this document was revised to "The Patient Care Partnership: Understanding Expectations, Rights, and Responsibilities" (see Box 3-2). This document is available in eight languages at www.aha.org. Although this is an ethical, not a legal, document, state legislators have written laws that prohibit certain actions or guarantee particular rights. Since the first patient bill of rights, which was hospital oriented, many others have been published, particularly for residents of nursing homes and those in psychiatric units. These documents emphasize that patients continue to have rights even if they are helpless and sick. They seek to preserve the patient's dignity, privacy, freedom of movement, and information needs.

Under some legally specified conditions, certain rights may be temporarily suspended, such as in an

emergency when the patient is unconscious or unable to communicate. Other conditions include the patient who is in danger of injury and cannot protect himself from harm, or when it is necessary to protect the public from harm. However, patients with psychiatric disorders in most states cannot be held against their will for more than 3 days, unless they are a distinct danger to self or others or are gravely disabled (unable to provide for basic needs). As long as someone is deemed to be harmless, the current principle is to protect the individual's right to be different, to disagree with the majority, to live one's own life, and to seek one's own solutions to private difficulties.

NATIONAL PATIENT SAFETY GOALS

The Joint Commission has developed goals to promote specific improvements in patient safety. The goals attempt to provide evidence- and expert-based solutions to areas that have caused problems with patient safety. The Joint Commission's National Patient Safety Goals are updated every year and are available on its website (www.jointcommission.org). All nurses should review these goals annually.

A **sentinel event** is an unexpected patient care event that results in death or serious injury (or risk of) to the patient. The Joint Commission tracks and reports sentinel events to improve hospital safety. One of the National Patient Safety Goals is to improve the effectiveness of communication among caregivers, since communication is The Joint Commission's most frequently cited cause of a sentinel event.

Safety Alert

Communication and Safety

Safe and effective patient care depends on complete communication between caregivers. **"Handoff" communication** describes times when information is passed from one caregiver to another, such as a change-of-shift report, patient transfer to another unit or facility, or contact with the physician.

One form of communication, termed the *SBAR method of communication*, is a strategy that reduces the likelihood of critical patient details being lost. SBAR is an acronym that stands for *S*ituation, *B*ackground, *A*ssessment, and *R*ecommendation. SBAR is useful when communicating with physicians, since nurses and physicians are taught different ways to communicate patient information. Nurses are taught to communicate in narrative form and to include every possible detail, whereas physicians are taught to communicate using brief "bullet" points. This SBAR format encourages caregivers to communicate in a way that is concise, yet complete. The American Association of Colleges of Nursing (AACN) and the **Quality and Safety Education for Nurses (QSEN) project** advocate adding the letter *I* at the beginning of the acronym (*I*ntroduction of yourself and your patient, including your role and unit) and the letter *R* at the end of the acronym (for *R*eadback, to encourage verification) when communicating with people over the telephone or from different departments. The resulting acronym is ISBAR-R.

Communication

Example of ISBAR-R Communication

Introduction: Hello, I'm Donna, the day shift nurse. Are you ready for the shift report on Mrs. Smith in room S21?

Situation: You are communicating the 3:00 P.M. change-of-shift report for a 65-year-old patient who was admitted 3 days ago with pneumonia.

Background: Mrs. Smith is a 65-year-old patient who was admitted 3 days ago with pneumonia and shortness of breath. She has completed 3 days of antibiotic therapy, nebulizer treatments every 4 hours, and continuous supplemental oxygen therapy.

Assessment: Mrs. Smith has clear lung sounds, and her pulse oximeter reads 98% on 2 L of oxygen. Vital signs: T 98.8°, P 86, R 22, BP 128/72. She ambulated twice this shift down the length of the hall and denies shortness of breath. She has an occasional cough, productive of yellow sputum.

Recommendation: Monitor pulse oximeter readings with vital signs once a shift; administer antibiotics and nebulizer treatments on time, ambulate one more time this evening; consider administering PRN cough medicine at bedtime.

Readback: Ask receiving nurse if there are any questions and to read back notes for clarification.

Key: *BP*, Blood pressure; *P*, pulse; *PRN*, as needed; *R*, respirations; *T*, temperature.

The National Patient Safety Goals and requirements apply to nearly 15,000 hospitals and health care organizations accredited by The Joint Commission. There are specific goals for numerous types of patient care areas, such as ambulatory care, assisted living, behavioral health, home care, long-term care, hospitals (Box 3-3), and others. The QSEN project is a movement funded by the Robert Wood Johnson Foundation (RWJF) to educate future nurses in developing the knowledge, skills, and attitudes needed to improve the quality and safety of our future health care systems.

LEGAL DOCUMENTS

THE CHART OR MEDICAL RECORD

When a person enters the health care system to visit a physician, clinic, hospital, or emergency department or to receive home health care, a record is begun (or continued) that documents that person's health status or problem and the care given. The record is a legal document that includes records of all assessments, tests, and care provided. The chart, or medical record, is **confidential** (kept private), meaning that only people directly associated with the care of that patient have legal access to the information in the chart. **The chart is the property of the hospital, agency, or**

Box 3-3 2012 Hospital National Patient Safety Goals

Goal: Identify patients correctly.
- Use at least two ways to identify patients.
- Make sure the correct patient receives the correct blood when they receive a transfusion.

Goal: Improve staff communication.
- Get important test results to the right staff person on time.

Goal: Use medicines safely.
- Before a procedure, label medicines that are not labeled.
- Take extra care with patients who take medications to thin their blood.
- Record and pass along correct information about a patient's medicines.

Goal: Prevent infection.
- Use hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization.
- Use proven guidelines to prevent infections that are difficult to treat.
- Use proven guidelines to prevent infection of the blood from central lines.
- Use proven guidelines to prevent infection after surgery.
- Use proven guidelines to prevent infections of the urinary tract that are caused by catheters.

Goal: Identify patient safety risks.
- Find out which patients are most likely to try to commit suicide.

Goal: Prevent mistakes in surgery.
- Make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body.
- Mark the correct place on the patient's body where the surgery is to be done.
- Pause before the surgery to make sure that a mistake is not being made.

Modified from The Joint Commission. (2012). *Hospital National Patient Safety Goals*. Retrieved from www.jointcommission.org/assets/1/6/2012_NPSG_HAP.pdf.

physician—not the patient. However, the patient does have the right of access to the chart, and the patient may authorize his caregivers to provide copies of information in the chart to other agencies—for example, if a patient transfers from one physician or health care facility to another. Health care researchers and insurance companies may also gain access to chart information with the patient's permission.

Student nurses must protect their patients' confidentiality. Charts may not be copied. Reports or notes on patients used for school purposes (case studies, nursing care plans, task lists) should not identify the patient by name. Case discussion should indicate "a 67-year-old man" rather than "Mr. Joe Morales."

As a legal document, the chart is used to determine the truth of what happened—what was done or not done—to a patient during a period of time. Therefore its contents always need to be accurate, pertinent, and timely. Erasures or changes to a patient's chart may suggest dishonesty. Charting should focus on the patient and the nursing care provided. The chart may be introduced as evidence in a court case. Charting guidelines are discussed in Chapter 7.

Box 3-4 Rights Provided by HIPAA (Health Insurance Portability and Accountability Act)

HIPAA covers six patient rights and provider responsibilities:

Consent: Written consents must contain a clause that says the patient agrees to allow the provider to use and disclose his information for treatment, payment, and health care operations. A notice must be attached to the consent form.

Notice: The provider's obligations are outlined regarding the privacy of the patient's health care information. It includes the six patient rights and responsibilities of the provider. It details how the patient information will be protected and a process for filing a complaint if the patient believes privacy rights have been violated.

Access: The patient has the right to inspect and copy his medical record.

Amendment: A patient has the right to amend his record for the purpose of accuracy.

Accounting for disclosures: Providers are held accountable for how patients' medical information is handled. Tracking of any disclosures of information not related to treatment, payment, or health care operations, or that were not authorized by the patient, must occur.

Restriction of disclosure: The patient can request that the provider restrict the use and disclosure of his information. The provider does not, however, have to grant the request.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required the creation of regulations regarding patient privacy and electronic medical records. Failure to comply with these rules may lead to civil penalties. Intentional violation of the regulations can lead to sizable fines and jail time. Box 3-4 presents the six patient rights covered in these regulations.

A considerable amount of information about patients is shared among health care professionals each day. HIPAA privacy rules took effect in 2003. These rules protect the way patient information is conveyed and stored, and to whom information may be revealed. These rules state that disclosing medical information to family members, close personal friends, or other individuals identified by the patient *is* permitted if *the patient does not object*. It is important to make certain you have the patient's consent to relay information about his health care to family members. It is also important to know and follow the hospital's privacy policies.

The HIPAA rules also give patients the right to the information in their medical records and the

Box 3-5 Types of Consents

Admission agreement: Commonly obtained at the time of admission to a hospital, this form spells out the hospital's or facility's responsibility to the patient. The hospital agrees to provide room, meals, basic nursing care, and medical care prescribed by the physician. The patient consents to diagnostic services, such as radiographs, medication administration, and nursing treatments. The patient acknowledges responsibility to pay for the services. Consent to bill insurance companies and provide medical information about the patient to receive payment is usually part of the admission agreement.

Operative consent: All surgical or invasive procedures, such as repair of a hernia or removal of the appendix, **biopsies** (taking a piece of tissue to examine), and many diagnostic tests that are **invasive** (involve an incision or cutting of the patient's body, or the introduction of an instrument into a body cavity), require an operative consent. It may be called a surgical consent or permission for surgery or anesthesia. **The physician, surgeon, or anesthesiologist who performs the procedure is responsible for explaining the procedure, its risks and benefits, and possible alternative options.**

Consent to receive blood: A consent to receive a blood transfusion would indicate that the patient was informed of the benefits and risks of transfusion, as is done for surgical or invasive procedures. Some patients hold religious beliefs that would prohibit transfusions, even in life-threatening situations.

Research consent: Clinical research is carried out only with the patient's informed consent about the possible risks, consequences, and benefits of the research. A patient always has the right to refuse to participate in a research study, and no patient may be given a research drug or treatment without his informed consent.

Consent to release information: A specific consent to release confidential patient information to other agencies or people is required before the information may be released. An exception is that information may be shared between consulting or referring physicians without a specific consent.

Other consents: Special consents are required to perform an autopsy, donate organs after death, or be photographed, and for the disposal of body parts during surgery.

right to amend an erroneous record. Privacy and confidentiality of patient information have always been part of the ethical code of nurses, physicians, and health care facilities; the new rules have simply increased awareness of the need for confidentiality and imposed new guidelines. Charts and flow sheets must be secured and not left where they may be viewed by others. Public displays of patient information (e.g., on a white board in the nurse's station) are not acceptable. Nurses must be careful with printouts, such as the Kardex sheet or care plan, and shred them when the shift is over. Patients must sign a specific release form if they want information to be sent to another agency, physician, or insurance company.

Legal & Ethical Considerations

Protecting Patient Privacy

- Keep interactions with patients as private as possible. If your patient is not in a private room, lower your voice to keep others from hearing what is said.
- Remember that any discussions about patients in clinical postconference are for educational purposes only and not for gossip. These discussions should never contain identifying information, and the cases should not be discussed outside the clinical conference or classroom setting.
- Do not leave patient information on display. If you use a clipboard, place a cover sheet to shield patient data.
- Before providing any information about your patient to anyone not directly involved in the patient's care (such as patient's family), check for authorization to release health-related information.
- Never photocopy the patient's medical record for any purpose.
- Never write about your clinical day on your social networking site. Even without providing identifying patient information, you may unintentionally compromise patient confidentiality and may be punished and/or fined!
- Remove all identifying information from personal notes or assignments. Maintain such notes in a secure and confidential manner, even if they contain no identifying patient information. They must not be left unattended at school, at home, in your car, or on your computer. Shred or destroy all such documents once the purpose has been fulfilled (e.g., once your assignment has been graded).

CONSENTS AND RELEASES

A **consent** is permission given by the patient or his legal representative. Consents or **releases** are legal documents that record the patient's permission to perform a treatment or surgery or to give information to insurance companies or other health care providers (Box 3-5).

Informed consent indicates the patient's participation in the decision-making process. The person signing must have knowledge of what the consent allows and be able to make a knowledgeable decision. Informed consent for surgery or treatment must include three elements. The patient must be told, in terms he can understand, (a) the risks and benefits of the proposed treatment, (b) the possible consequences of not having the procedure done, and (c) the name of the health care professional who will perform the procedure. This information is usually provided by the professional performing the procedure. **If the patient**

has any questions, they should be satisfactorily answered before the patient signs the consent. It is important to determine that proper consent has been obtained, both *legally* and *ethically*. Failure to obtain a valid informed consent may lead to charges of assault and battery or invasion of privacy (explained later in this chapter).

To be valid, a consent must be signed by the person or the legal agent for that person. Consents must be freely signed without threat or pressure and must be witnessed by another adult. **Consent can be withdrawn at any time before the procedure or treatment is started.** When a person is older than 18 years and **competent,** he must sign the consent for treatment. A competent person is one who is legally fit (mentally and emotionally). A person is considered incompetent if he is unconscious, under the influence of mind-altering drugs (including narcotics used as "premedication" for the procedure), or declared legally incompetent. In these situations a next of kin, appointed guardian, or one who holds a durable power of attorney (discussed later) has legal authority to give consent. Minors (younger than 18 years) may not give legal consent; their parents or guardians have this right. If a child's parents are divorced, the custodial parent is the legal representative. Stepparents usually cannot give consent unless they have legally adopted the child. **An emancipated minor, or one who has established independence by moving away from parents or through service in the armed forces, marriage, or pregnancy, is considered legally capable of signing a consent form.**

Implied consent is assumed when, during a life-threatening emergency, consent cannot be obtained from the patient or family. Consent may be obtained by telephone if it is witnessed by two people who hear the consent of the family member.

A **release** is a legal form used to excuse one party from **liability** (responsibility). A commonly used release is a **leave against medical advice** (discussed later in the chapter). The term *release* may also refer to forms used to authorize an agency to send confidential health care information to another agency, school, or insurance company.

WITNESSING WILLS OR OTHER LEGAL DOCUMENTS

Occasionally, nurses may be asked to witness a will or other legal document. Although it is not illegal, most hospitals and health care agencies have policies against this. Wills or legal documents may be contested, and the nurse who witnessed the document can be called to court to testify regarding the patient's health, mental condition, or relationship to visitors. To avoid this conflict, hospitals often provide business office personnel or a notary public to witness the signature. To witness the signing of a legal document, you need not know the content of the document. Legally, it is necessary only that the witness confirms that the signature or mark is made under no influence (drug or otherwise) and that the person knows what he is signing.

ADVANCE DIRECTIVES

An **advance directive,** sometimes called a **"living will,"** is a consent that has been constructed before the need for it arises. It spells out a patient's wishes regarding surgery and diagnostic and therapeutic treatments. Clear direction for making decisions is then present if the patient suffers an accident or illness that renders him unresponsive or incompetent. This has become important because health care technology allows the prolonging and maintaining of life with sophisticated treatments that may cause conflict among family members or between the health care professionals and the family as to how the patient would want to live (or die) in this situation. When a person puts in writing his wishes regarding life support and the use of medical technology, both the medical community and the family have clear direction. A **durable power of attorney** is a document that gives legal power *to* a **health care agent** (surrogate decision maker), who is a person chosen by the patient to follow the patient's advance directives and make medical decisions on his behalf.

All 50 states recognize advance directives, but each state regulates advance directives differently, and an advance directive from one state may not be recognized in another, depending on the differences in their laws. Advance directives do not expire; it is a good idea for the patient to review his advance directive periodically to be certain it still reflects his wishes. Historically, emergency medical technicians (EMTs) have not been able to honor advance directives. Therefore, if a patient had an advance directive limiting the types of care he wanted and a loved one called 911, the EMTs had to perform any and all procedures to stabilize the patient and bring him to the hospital. More recently, however, many states have enacted laws to allow EMTs to honor DNR orders and/or advance directives, provided documentation is available at the scene.

Do-not-resuscitate (DNR) orders are written by a physician when the patient has indicated a desire to be allowed to die if he stops breathing or his heart stops. In this situation, no cardiac compressions or assisted breathing (cardiopulmonary resuscitation [CPR]) would be started. **It is very important for nursing personnel to know who is to be resuscitated and who is NOT.** A nurse who attempts to resuscitate a patient who has a physician's DNR order would be acting without the patient's consent and committing battery.

It is also illegal to call for or participate in a "slow code." In a slow code, there is no DNR order but staff do not respond quickly to a patient who has stopped

breathing or whose heart has stopped, so that the CPR will not be effective.

VIOLATIONS OF LAW

A nurse needs to know about a number of civil laws in order to practice safely and within the legal system. A nurse needs to know not only the law in regard to her own practice but also how to act as a **patient advocate,** one who speaks for and protects the rights of the patient.

NEGLIGENCE AND MALPRACTICE

Negligence is failing to meet the standard of care; failing to do something a reasonable and **prudent** (sensible and careful) person would do, or doing something a reasonable and prudent person would *not* do.

Malpractice is negligence by a professional person. The person does not act according to professional standards of care as a reasonable and prudent professional would. **In nursing malpractice, a reasonable and prudent person is a similarly educated, licensed, and experienced nurse.** An example of nursing malpractice would be if a nurse did not check the patient's vital signs and condition after surgery, there was hemorrhage, and the patient went into shock and died.

To prove malpractice, four elements must be present: duty, a breach of duty, causation, and injury (Box 3-6). If even one of these four elements was not present, the nurse was not guilty of malpractice. For example, if a nurse made a clinical error that did not result in harm to the patient, the event would not be considered to be malpractice; however, it would be a deviation from the standard of care, and as such could be grounds for discipline by the employer, the licensing board, or both.

Box 3-6 Elements of Malpractice

Duty: The obligation to use due care (e.g., a nurse has a duty to monitor the condition of the patient for whom she is caring).

Breach of duty: Failure to use due care (e.g., a nurse fails to check the vital signs or condition of the patient after surgery; or a nurse begins CPR on a patient who has a DNR order).

Causation: The nurse's action or inaction causes injury or harm to the patient. There must be a direct link between the breach of duty and the injury. The nurse's failure to check the patient's condition could lead to an undetected loss of blood that causes the patient's death.

Injury or damages: The actual harm or disorder that results from the negligence. Injury or damages may be physical, emotional, or financial. Pain and suffering, loss of ability to continue in a job, physical or emotional disability, extended hospitalization, or death would all be considered injury or damage in a negligence action.

COMMON LEGAL ISSUES

Nurses have access to private information and personal contact that is permitted by their professional caregiver role. With that right to information and touch come legal responsibilities to respect the patient's privacy, to protect the patient's safety, and to ensure the patient's right to make decisions. When legal boundaries are violated, and injury occurs, nurses may be subject to **litigation** (a lawsuit).

Assault and Battery

Assault is the threat to harm another, or even to threaten to touch another without that person's permission. The person being threatened must believe that the nurse has the ability to carry out the threat. **Battery** is the actual physical contact that has been refused or that is carried out against the person's will. An example of assault would be the nurse who says, "If you don't let me give you this injection, two other nurses will hold you down so I can give it to you." Battery would occur when a patient is held down to receive an injection he has refused. It would also include the rough physical handling of an excited, confused, or psychotic patient in ways that would be described as angry, violent, or negligent.

Adults who are alert and oriented have the right to refuse medications, baths, treatments, dressing changes, irrigations, insertion of a catheter, and diagnostic tests as well as surgery. Even if the test or procedure is necessary for the patient's well-being or comfort, the patient has the legal right to refuse. **It is the nurse's responsibility to explain why a particular drug or treatment is important. However, if the patient still refuses, the nurse should obtain a release from liability because the treatment is not done or the drug is not taken.** Performing a procedure without the proper consent is battery (except in emergency situations when the patient is unable to give consent).

Elder Care Points

Although an elderly person may be forgetful and require supervision of activities of daily living, he still has rights of privacy and self-determination (the right to consent to or refuse treatments). Nurses need to document carefully any explanations given and the patient's ability to understand the benefits, risks, and consequences of decisions.

Defamation

Defamation is when one person makes remarks about another person that are untrue, and the remarks damage that other person's reputation. There are two forms of defamation: **slander** (oral) and **libel** (written). Two nurses may be overheard talking about a physician in a way that holds the physician up to ridicule or contempt. If another person decides never to use that physician because of the derogatory comments, the

physician's reputation is damaged and the nurses may be guilty of slander. An example of libel is a letter or newspaper article quotation stating that a person is incompetent or dishonest. The loss of respect for and trust of the person may result in damage to his reputation and loss of business. A person sued for slander or libel may be found innocent if the statements made were true or were said or written with no intent to harm the person, but for a justified purpose.

Invasion of Privacy

Invasion of privacy occurs when there has been a violation of the confidential and privileged nature of a professional relationship. When patients entrust themselves to our care, it is with the expectation of confidentiality—that what is told to the health care professional and what is learned about the patient's health and personal history are private information to which no one else should have access.

Invasion of privacy occurs when unauthorized persons learn of the patient's history, condition, or treatment from the professional caregiver. It might include the nurse's giving information over the telephone to a caller who asks about the patient's condition. It occurs when health care workers are overheard carelessly discussing their patients in the elevator or cafeteria. It occurs when a next-door neighbor asks about another neighbor who is in the hospital and the nurse tells him about the patient's condition. It occurs when a nurse, out of curiosity, reads the chart of a public figure who has been admitted to her unit, but to whom the nurse is not assigned or responsible. Releasing information to a newspaper, another health care agency, an insurance company, or a person without the patient's valid consent is invasion of privacy. However, **nurses are required by law in most states to report information regarding child or elder abuse, sexual abuse, or violent acts that may be crimes (e.g., stab or gunshot wounds).** When such reporting is done in good faith, the nurse cannot be held liable for invasion of privacy. Be knowledgeable of the required reporting procedures for abuse or crime where you work.

Invasion of privacy extends to leaving the curtains or door open while a treatment or procedure is being done, or to leaving patients in a position that might cause them loss of dignity or embarrassment. Exposing the patient's body more than necessary, or leaving a confused and agitated patient in a hallway where he might behave in ways that would be embarrassing if he were in his normal state, are also examples of invasion of privacy. Interviewing a patient or family member in a room with only a curtain between the patients, or where conversation can be overheard, allows confidential information to be heard by unauthorized persons. **The reasonable and prudent nurse does for the patient what the patient cannot do for himself: covers the patient's body, protects him from public exposure, and preserves his dignity.**

A growing area of concern regarding privacy has to do with computerized data banks and the Internet. Many health care agencies are computerizing their records, and nurses (and other personnel) can enter and retrieve information about patients in that facility. Always safeguard patient privacy when entering or using data in a computer network. HIPAA, discussed earlier, sets rules governing transmission of patient data (electronic, telephone, fax), including the requirement that the sending facility must have reasonable safeguards in place to ensure the data are sent to the intended place and are treated in a confidential manner. Some hospitals require employees and individual nursing students to sign a **nondisclosure agreement** (NDA), also known as a confidentiality agreement, when they are hired or begin a clinical rotation, which gives the hospital legal recourse if they can prove the person broke confidentiality. A national data bank is envisioned in the future that could allow health care practitioners to access a patient's medical record wherever that patient sought care—from California to New York, from a clinic to a major medical center, from a private practice physician to a pharmacist at the local drugstore. But the need for safeguards to prevent unauthorized access, as well as the reluctance of many people to have confidential health information so readily accessible, may prevent this from becoming a reality soon.

False Imprisonment

Just as a patient has the right to refuse medications or tests or treatments, a patient has the right to leave a hospital or health care facility or to move about in it. Preventing a person from leaving, or restricting his movements in the facility, is **false imprisonment.** When a person wants to leave the hospital against the advice of the physician, a release to leave "against medical advice" (AMA) is used. The patient, by signing the form, releases the hospital and staff of responsibility for any consequences that occur as a result of the patient's leaving. It is also important to follow your facility's policies regarding a competent adult who wishes to leave AMA. The policy may include finding out why the patient wishes to leave, informing the physician, informing the patient of the risks of refusing treatments, and carefully documenting all aspects of the situation.

People who have psychiatric disorders may be admitted to a psychiatric unit on a voluntary or involuntary basis. A person who is admitted voluntarily agrees to the admission, can refuse or accept any treatment, and can leave the facility as a regular discharge. If the physician believes the patient should not be discharged, the patient can sign an AMA release.

An involuntary admission is made against the patient's wishes to protect him from self-harm or from

harming others. There is a limit to the time (usually 72 hours) a person can be detained without consent. During that time, if the patient does not agree to a voluntary admission and health care personnel remain convinced that the person is a threat to self or others, two psychiatrists can petition a judge to issue a court order for the patient to be held in the psychiatric facility for a specific period.

Protective Devices. The inappropriate use of devices that limit a person's mobility is a nursing action that can result in charges of false imprisonment. **Protective devices** may be mechanical, such as locks, rails, belts, or garments that prevent a person from getting out of a room, bed, or chair, or they may be chemical: drugs such as sedatives or tranquilizers that sedate the patient so that he is unable to move about. **A physician order is necessary for any protective device, mechanical or chemical.** Creative nurses and health care facilities have developed ways of allowing for mobility while protecting the confused or agitated person from danger. Nurses must be alert to the abuse of protective devices when other less restrictive techniques may be effective. A reasonable and prudent nurse will carefully assess a patient's potential for falls or other harm and document the need for and proper application of physician-ordered protective devices to ensure the patient's safety. Consult with your supervisor about using protective devices in an emergency situation when no physician order is available. Document the need to protect the patient from harm, and secure a physician order as soon as possible to protect yourself from liability for charges of false imprisonment or malpractice.

Elder Care Points

Careful assessment of an elderly patient's mental status, medications, potential for orthostatic hypotension, balance, and mobility can identify the patient with a risk for falls and injury. Specific nursing interventions can then be identified and used to protect the patient from injury.

DECREASING LEGAL RISK

Nursing Competence

Although nurses cannot prevent a lawsuit from being filed, several actions can reduce the likelihood of a suit (Box 3-7). **First and most important is competent and well-documented nursing care.** Nursing **competence** is defined as possessing the suitable skill, knowledge, and experience necessary to provide adequate nursing care. Establishing rapport and effective communication skills can create a relationship in which patient anger or misunderstanding can be resolved rather than grow to lawsuit proportions. Competence in nursing also includes following the proper policies and procedures and upholding the standards of care. Sometimes

Box 3-7 Guidelines to Reduce Legal Risk

1. Maintain competence.
   - Learn skills thoroughly.
   - Know your state's nurse practice act.
   - Know and follow your employer's institutional policies.
   - Develop the ability to evaluate your knowledge and performance; identify areas in which you are weak and work to improve these.
   - Attend continuing education programs and keep abreast of changes in health care.
   - Keep records of workshops or seminars you attend.
   - Identify experienced nurses whose competence you respect, and seek their assistance when you are unfamiliar with equipment or a technique.
2. Document fully. There is an expression in nursing: "If you didn't chart it, it didn't get done."
   - Accurate, factual, and timely charting of the nursing assessment, plan, interventions, and evaluation is essential to prove that nursing care that meets standards of care was carried out.
   - Anecdotal records are a tool for nurses to use in assisting their memory. Anecdotal records are the nurse's recollection or notes of an incident written as close to the time of the incident as possible, and kept by the nurse in a secure place. Relying on memory is a poor way to prove what a nurse did or did not do. Lawsuits often take years from the date of occurrence of an event to the filing and notice of a lawsuit.
3. Establish rapport.
   - Develop rapport, and treat each patient with respect: identify yourself, smile, listen attentively, address patients by their preferred name.
   - Be careful of damaging the relationship between the patient and his physician or other staff by engaging in critical or negative conversation with the patient.
   - Listen to patient complaints and communicate professionally to attempt to resolve problems.
4. Communicate effectively.
   - Therapeutic communication techniques can allow the patient to express feelings without the nurse agreeing or supporting charges of incompetence or negligence.
   - Notify your supervisor of any situation in which a patient or family members are dissatisfied with the nursing care received or with another health care professional.
   - Follow the procedure for communication with the risk management team.
5. Take care of yourself.
   - Be at your best for every clinical day.
   - Follow the principles of proper nutrition and regular exercise; obtain adequate, restful sleep.
   - Recognize that fatigue is a significant factor in making clinical errors: refrain from working hours in excess of what you can safely do, even though the money may be tempting.

in nursing you may observe another nurse "bending the rules" in an unsafe way to save time; as a novice in the field, you may feel peer pressure to follow "the way things are done on this unit." Rule bending might appear to be the only solution on a unit that is chronically understaffed, but it only provides a temporary solution. What is more likely needed is a permanent change in the situation that will make rule bending unnecessary. If hospital rules are out-of-date or unrealistic, it is important to get involved (e.g., on the hospital's policy committee) to change these rules, rather than work around them.

Sometimes a patient believes he has suffered an injury or loss. Documentation is the key element in proving that nursing actions used were appropriate, thus protecting the nurse from liability.

Potential lawsuits may be avoided by early identification of dissatisfied patients. Many facilities have risk management teams composed of people specially trained to deal with situations that may put the facility at risk for a lawsuit. Part of a comprehensive risk management program would include in-service programs to promote safety, preventive maintenance for equipment and the physical plant, and counseling and interventions in situations that pose potential for lawsuits.

? Think Critically

How would you respond to a patient who complains to you that the nurse on the night shift ignored his call for assistance for 45 minutes, and that the nurse said that the unit was short staffed and the patient should not bother them unless it was absolutely necessary?

Incident or Occurrence Reports

If an occurrence is out of the ordinary, an **incident** (occurrence) **report** is often used to document what happened, the facts about the incident, and who was involved or witnessed it. The incident report is a tool used by the risk management department (see Chapter 10). This report is useful for several reasons. It allows the facility to note dangerous patterns—for example, if several visitors or staff have tripped and fallen in the same location, or if a change in the appearance of a medication might have been a factor in several recent similar medication errors. The incident report also serves as an immediate recall of an occurrence that may result in injury or damages and future lawsuit. Some examples of when an incident report might be written include when a medication error is made, a patient falls out of bed, or a visitor faints in the hall (Figure 3-1). **Incident reports are generally not filed as part of the patient's chart; no reference to the incident report is made in the patient's chart,** although the medically relevant details about the incident, if they relate to patient care, should be included in the progress notes. Incident reports should be timely, factual, and concise and should not contain unnecessary details, such as explanations about why the event might have occurred.

Liability Insurance

Liability insurance does not provide protection from being sued. It can, however, protect the nurse's livelihood and assets should the nurse get sued. If a nurse is sued, liability insurance pays for the expenses of a lawyer to defend the nurse and pays any award won by the plaintiff up to the limits of the policy. It may also pay for attorney costs and related costs if the nurse is subjected to review by the state board of nursing. Having liability insurance does not increase your chances of being sued, and most authors agree that it is unwise to rely on the employer's liability insurance policy because there may be situations in which the institution's interests are at odds with your legal interests. Nursing liability insurance is relatively inexpensive and is available through nursing organizations and private insurance companies.

ETHICS IN NURSING

Ethics or **ethical principles** are rules of conduct that have been agreed to by a particular group. They are based on the consensus (agreement) of the group that these rules are morally right or proper for that group. Professional groups such as physicians, nurses, and lawyers have developed codes of ethics that guide the professional to act in ways approved by the group. Ethics are different from laws: they are voluntary. There are no prescribed legal penalties for violating a code of ethics, although in many instances it may result in disciplinary action by a licensing or regulating agency. In some cases, ethics and the law overlap—for example, in dealing with issues of confidentiality. But in many cases, ethics deal with ideals or situations in which there is no right or wrong solution to a problem and about which thoughtful, caring people may hold opposing views. Debate continues about life-and-death issues such as abortion, life support, and euthanasia.

Ethics are closely linked with **values,** the worth or importance of an action or belief to an individual. An ethical **dilemma** (problem or conflict) may result when people hold differing values. Codes of ethics attempt to provide a framework for making professional decisions.

? Think Critically

How would you react to a patient who refuses surgery that might prolong and perhaps enhance his life? What values do you hold regarding quality of life, right to die, and self-determination? Is there a difference if the patient is 23 years old or 87 years old?

BASSETT HEALTHCARE COMPUTER LOG # _____

INCIDENT/VARIANCE REPORT

#1001 4/88 rev. 8/94; 4/98; 6/98; 7/98; 8/98;11/98;9/03;11/03;1/04;10/04 (f:\riskmgt\.doc)

Instructions: Complete form immediately after an incident occurs. Send original to PI/RM within 24 hours of incident and keep copy for department use.

INCIDENT DATE: _____ TIME: _____

IDENTIFICATION: ☐ PATIENT ☐ VISITOR ☐ VOLUNTEER ☐ OTHER ☐ EMPLOYEE; DEPT _____

LAST NAME: _____ FIRST NAME: _____

CHART #: _____ AGE: _____ SEX: ☐ MALE ☐ FEMALE

Incident Location

☐ Inpatient Services Unit/Room: _____
☐ MIBH ☐ O'Connor ☐ Cobleskill Regional Hospital
☐ Tri Town Regional Hospital ☐ Little Falls Hospital
☐ Emergency Services
☐ Health Center: _____
☐ Food Services
☐ Laboratory: Section: _____
☐ Operative Services; Unit: _____
☐ Other
☐ Outpatient Services
Clinic: _____
☐ Outside Property
List: _____
☐ Pharmacy
☐ Radiology
☐ Rehabilitative Services

Category:

☐ Fall (Inpatient Units–STOP. Use fall analysis tool #6647)
☐ Fracture/Dislocation
☐ Burn
☐ Chemical Burn
☐ Contusion/Laceration
☐ Back/Muscle Strain
☐ Blood/Body Fluid Exposure (describe event thoroughly below)
☐ Blood ☐ Other body fluid _____
☐ Clean needle ☐ Contaminated needle
Source patient chart #: _____
☐ Patient Care Equipment
Equipment type/tag #: _____
☐ Equipment not available
☐ Electrical problem/shock
☐ Mechanical problem
☐ Security Variance
☐ Hospital property loss
☐ Personal property loss
☐ Suspected crime/assault
☐ Medical Gas
☐ Wrong source
☐ O_2 not connected
☐ Wrong O_2 % / flow
☐ Other: _____
☐ Patient left AMA without signing AMA form
☐ Medication and IV variance - STOP
Use medication variance report (#2308) and medication variance evaluation worksheet (#5610) to report
☐ Transport _____
☐ Procedural Variance
☐ Laboratory specimen/testing error
☐ Unlabeled specimen
☐ Mislabeled specimen
☐ Other
☐ Other _____

Brief Description:

_____
_____
_____
_____
_____

Seen by provider?

☐ No ☐ Yes Date: _____
Outcome: _____
_____

Investigation Outcome / Corrective Action (Must Complete) _____

_____
_____
_____
_____
_____

Copy sent and referred to _____ **for investigation and response.**
(Attention receiving department: Send response to PI/RM)

SIGNATURE AND TITLE OF PERSON COMPLETING THIS FORM DATE SIGNATURE OF MANAGER/SUPERVISOR DATE

FIGURE 3-1 Sample incident report.

Box 3-8 NAPNES Code of Ethics

The Licensed Practical/Vocational Nurse Shall:

1. Consider as a basic obligation the conservation of life and the prevention of disease.
2. Promote and protect the physical, mental, emotional, and spiritual health of the patient and his family.
3. Fulfill all duties faithfully and efficiently.
4. Function within established legal guidelines.
5. Accept personal responsibility (for his/her acts) and seek to merit the respect and confidence of all members of the health team.
6. Hold in confidence all matters coming to his/her knowledge, in the practice of his/her profession, and in no way and at no time violate this confidence.
7. Give conscientious service and charge just remuneration.
8. Learn and respect the religious and cultural beliefs of his/her patient and of all people.
9. Meet his/her obligation to the patient by keeping abreast of current trends in health care through reading and continuing education.
10. As a citizen of the United States of America, uphold the laws of the land and seek to promote legislation that will meet the health needs of its people.

From National Association for Practical Nurse Education and Service. (2004). *Standards of Practice for Licensed Practical/Vocational Nurses.* Retrieved from www.napnes.org/standards.pdf.

CODES OF ETHICS

The International Council of Nurses (ICN), the American Nurses Association (ANA), the National Association for Practical Nurse Education and Service (NAPNES), and the National Federation of Licensed Practical Nurses (NFLPN) have developed codes of ethics for nurses (Box 3-8). Although the codes are worded differently, they have many commonalities. They all indicate the following:

- A respect for human dignity and the individual, and provision of nursing care that is not affected by race, religion, lifestyle, or culture
- A commitment to continuing education, to maintaining competence, and to contributing to improved practice
- The confidential nature of the nurse-patient relationship, outlining behaviors that bring credit to the profession and protect the public

In addition, NAPNES has set standards for nursing practice since 1941 (Box 3-9). The standards represent the foundation for the provision of safe and competent nursing practice. Competence implies knowledge, understanding, and skills that transcend specific tasks and is guided by a commitment to ethical/legal principles. Box 3-10 presents the NFLPN Code for Licensed Practical/Vocational Nurses.

ETHICS COMMITTEES

Many health care facilities have ethics committees that are composed of people from various departments such as nursing, medicine, surgery, psychiatry, pharmacy, legal, economics, spiritual, and social work. Together they develop policies, address issues in their facility, and come to a better understanding of ethical dilemmas from different viewpoints.

Box 3-9 NAPNES Standards of Practice for Licensed Practical/Vocational Nurses

The LPN/LVN student on program completion will display the following standards and competencies:

- **Professional behaviors:** Demonstrate accountability and professionalism according to legal and ethical standards.
- **Communication:** Effectively communicate with patients, significant others, and health care team members.
- **Assessment:** Collect holistic assessment data, communicate that data to health care providers, and evaluate patient responses to interventions.
- **Caring:** Demonstrate a caring and empathic approach to patient care.
- **Planning and interventions:** Collaborate with the health care team to utilize assessment data to plan, revise, implement, and evaluate patient care.
- **Managing:** Under supervision, implement patient care and assign care to unlicensed assistive personnel.

Modified from National Association for Practical Nurse Education and Service. (2007). *Standards of Practice and Educational Competencies of Graduates of Practical/Vocational Nursing Programs.* Alexandria, VA: Author.

Box 3-10 NFLPN Code for Licensed Practical/Vocational Nurses

1. Know the scope of maximum utilization of the LP/VN as specified by the nurse practice act and function within this scope.
2. Safeguard the confidential information acquired from any source about the patient.
3. Provide health care to all patients regardless of race, creed, cultural background, disease, or lifestyle.
4. Uphold the highest standards in personal appearance, language, dress, and demeanor.
5. Stay informed about issues affecting the practice of nursing and delivery of health care and, where appropriate, participate in government and policy decisions.
6. Accept the responsibility for safe nursing by keeping oneself mentally and physically fit and educationally prepared to practice.
7. Accept responsibility for membership in NFLPN and participate in its efforts to maintain the established standards of nursing practice and employment policies which lead to quality patient care.

ETHICAL DILEMMAS

Many ethical dilemmas may face the nurse today. A current issue revolves around life-and-death decisions.

When a patient is diagnosed with a terminal illness, family members and even the health care team may often have conflicting opinions about seeking life-prolonging treatment versus refusing such treatment. Patients have the right to information about alternative as well as conventional treatment options, with their risks, consequences, and benefits. Nurses must honor the patient's right to choose or refuse any treatment or procedure, even if it would not be the nurse's choice.

Perhaps even more difficult is the choice to initiate or terminate life support or treatment. Questions of whether to allow a patient to stop artificial feedings, or not to treat an infection with antibiotics in a terminally ill person, often raise uncomfortable feelings in nurses. Respecting the patient's right to self-determination means respecting and supporting a patient's informed choice regarding treatment. Providing compassionate care at the end of life honors the person's decision to live his remaining time in the way he chooses.

Another ethical issue involves **assisted suicide,** which is aiding a person (providing the means) to end his life. The Supreme Court in June 1997 held that there was no constitutional right to physician-assisted suicide. Legally, at this time assisted suicide is a crime except in Oregon, Washington, and Montana, which have enacted assisted suicide laws. Assisted suicide is often confused with **euthanasia,** sometimes called mercy killing. Euthanasia is the act of ending another person's life, with or without the person's consent, to end actual or potential suffering. It is not legal in any state. Participation in assisted suicide is a violation of the ANA *Code for Nurses,* as well as the ethical tradition of "do no harm." The issue remains very controversial, with intelligent and caring people holding different values.

On a daily basis, nurses face personal ethical decisions involving honesty, **whistle-blowing** (reporting illegal or unethical actions), and provision of care. Our professional code of ethics dictates that we act as patient advocates and safeguard our patients from harm. Who will know if a nurse gives a wrong medication or fails to assess an unconscious patient? Should a nurse report suspected incompetence or impairment of a fellow nurse or physician? What care can be omitted in a short-staffed unit where all the needs are urgent? How does a nurse treat difficult patients—those who are abusive or who arouse feelings of anger or hatred, such as a person convicted of brutal crimes?

Nursing codes of ethics provide guidelines for behavior that promote excellence in patient care and the profession. They promote values such as dignity, honesty, integrity, and compassion.

On an institutional level, the ethics committee may be occupied with end-of-life issues such as withholding or withdrawing life sustaining treatments. On a state and national level, legislators choose where to spend money and write laws that affect health care. Those decisions are influenced by ethics and values, and nurses can have an impact by sharing their ethical concern for patients and speaking up for patients' rights.

Nurses can consciously consider what is right or wrong for them, in light of personal values. When a nurse feels confused or conflicted about the right course of action in a situation, talking with other nurses, the unit supervisor, or the ethics committee in the agency can assist the nurse in solving the problem from an ethical viewpoint.

Get Ready for the NCLEX® Examination!

Key Points

- Legislators, agencies, and courts create laws; codes of ethics are written by professional organizations. Laws are civil (private) or criminal (public). A civil wrong is a tort; a public wrong is a crime.
- Nursing is governed by state nurse practice acts, which define the scope of practice. State boards of nursing administer the law. Standards of care are developed by professional organizations. Students are held to the same standards and laws as the professional.
- Professional accountability means taking responsibility for one's own actions. Nurses may delegate patient care to unlicensed personnel, but they remain responsible for safe, effective patient care.
- Continuing education is an ethical responsibility to keep knowledge and skills current and safe. In many states it is a legal requirement for continuing licensure.
- OSHA monitors the workplace for the health and safety of its employees.
- CAPTA requires licensed nurses and other health care professionals to report child abuse.
- The "Patient Care Partnership" recognizes that patients do not lose their civil rights when they are hospitalized.
- Consent is necessary to perform invasive procedures, to divulge confidential information, or to conduct research. Consent must be legally obtained to show the patient's permission.
- Types of advance directives include living wills and a medical power of attorney. A living will allows a patient to express his wishes about medical treatment; a medical power of attorney gives legal power to a person to make decisions when the patient is unable.
- HIPAA regulations strictly guard the privacy of patient information. They require a specific signed consent for release of information.

Chapter 3 work sheet

- Negligence and malpractice are common torts in health care; assault, battery, defamation, invasion of privacy, or false imprisonment may result in malpractice torts.
- A successful lawsuit requires the following four elements to be proven: duty, breach of duty, causation, and injury.
- Competent nursing practice, careful documentation, development of a caring relationship with patients, and professional communication can reduce one's likelihood of being named in a lawsuit. Patient safety, medication or treatment errors, and failure to assess are frequent areas of lawsuits for nurses.
- Malpractice insurance protects nurses from financial damages in the event of a lawsuit and pays for legal assistance.
- Codes of ethics have been developed by nursing organizations and provide principles to guide behavior in situations in which there may be no "right" answer.
- Ethical dilemmas result when people hold differing views on issues. Ethics committees can provide an interdisciplinary approach to solving ethical dilemmas.

Additional Learning Resources

SG Go to your Study Guide for additional learning activities to help you master this chapter content.

Evolve Go to your Evolve website (http://evolve.elsevier.com/deWit/fundamental) for the following FREE learning resources:

- Animations
- Answer Guidelines for Think Critically boxes and Critical Thinking Questions and Activities
- Answers and Rationales for Review Questions for the NCLEX® Examination
- Glossary with pronunciations in English and Spanish
- Interactive Review Questions for the NCLEX® Examination and more!

Online Resources

- *Brent's Law*, www.nurse.com/AskTheExperts/BrentsLaw

Review Questions for the NCLEX® Examination

*Choose the **best** answer(s) for each of the following questions.*

1. You have just graduated your nursing program and wish to apply for licensure as a nurse. Which agency should you contact regarding your application?
   1. Your state's board of nursing
   2. The National Council of State Boards of Nursing
   3. The American Nurses Association
   4. The American Hospital Association

2. Which action(s) would be considered an invasion of a patient's privacy? *(Select all that apply.)*
   1. Discussing the comatose patient's condition with his father-in-law
   2. Discussing the outcome of a patient's test with another nurse from the unit while in an elevator with other people
   3. Relaying information about the patient's concerns to the nurse who will care for him on the next shift
   4. Relaying a complaint by the patient's wife to the charge nurse
   5. Posting an update on your personal website about a difficult clinical day, including information about the hospital and patient's diagnosis, but NOT stating the patient's name

3. Which action(s) would be classed as assault? *(Select all that apply.)*
   1. Telling the patient for the second time that you will bring the pain medication as soon as it is time for it
   2. Restraining the patient's feet because he is kicking the nurse when an injection is to be administered
   3. Threatening not to bring a meal tray if the patient won't behave
   4. Grasping the patient's upper arm snugly when administering a subcutaneous insulin injection
   5. Informing the patient that if he attempts to get out of bed one more time, he will be restrained

4. For a nurse to be found guilty of malpractice when a patient has been injured, it would have to be shown that she did not:
   1. take responsibility for a medication error.
   2. do what a reasonable and prudent nurse would have done in a similar patient care situation.
   3. remember to put up the side rails on the bed to prevent the patient from falling out of bed.
   4. keep the details of a patient's diagnosis and care private.

5. Your patient has experienced severe complications during surgery and remains on life support. Decisions about care can be more easily made if the patient has which documents in place?
   1. A power of attorney over financial affairs
   2. An advance directive
   3. A will
   4. No documentation—this allows the physician to do what is medically best for the patient

6. The visitor of one of your patients stops you in the hall and says, "I hope you will not try to revive my neighbor if her heart stops." The correct response is:
   1. "That decision is up to the physician."
   2. "We are all trained in CPR."
   3. "I understand your concern, but I can't discuss your neighbor's care with you."
   4. "There is a 'do-not-resuscitate' order on her chart."