Overview

- In order to be safe practitioners, nurses must understand the legal aspects of the nursing profession.
- Understanding the laws governing nursing practice allows nurses to protect clients’ rights and to reduce the risk of nursing liability.
- Nurses are accountable for practicing nursing in accordance with the various sources of law affecting nursing practice. It is important that nurses know and comply with these laws. By practicing nursing within the confines of the law, nurses are able to:
  - Shield oneself from liability.
  - Advocate for clients’ rights.
  - Provide care that is within the nurse's scope of practice.
  - Discern the responsibilities of nursing in relationship to the responsibilities of other members of the health care team.
  - Provide safe, competent care that is consistent with standards of care.

Sources of Law

- Federal Regulations
  - Federal regulations have a great impact on nursing practice. Some of the Federal laws impacting nursing practice include:
    - The Health Insurance Portability and Accountability Act (HIPAA)
    - The Americans with Disabilities Act (ADA)
    - The Mental Health Parity Act (MHPA)
    - The Patient Self-Determination Act (PSDA)
• Criminal and Civil Laws
  ○ Criminal law is a subsection of public law and relates to the relationship of an individual with the government. A nurse who falsifies a record to cover up a serious mistake may be found guilty of breaking a criminal law.
  ○ Civil laws protect the individual rights of people. One type of civil law that relates to the provision of nursing care is tort law.

<table>
<thead>
<tr>
<th>UNINTENTIONAL TORTS</th>
<th>EXAMPLE</th>
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</thead>
<tbody>
<tr>
<td>Negligence</td>
<td>A nurse fails to implement safety measures for a client who has been identified as at risk for falls.</td>
</tr>
<tr>
<td>Malpractice (Professional negligence)</td>
<td>A nurse administers a large dose of medication due to a calculation error. The client has a cardiac arrest and dies.</td>
</tr>
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<thead>
<tr>
<th>QUASI-INTENTIONAL TORTS</th>
<th>EXAMPLE</th>
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<tbody>
<tr>
<td>Breach of confidentiality</td>
<td>A nurse releases the medical diagnosis of a client to a member of the press.</td>
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<tr>
<td>Defamation of character</td>
<td>A nurse tells a coworker that she believes the client has been unfaithful to her spouse.</td>
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<thead>
<tr>
<th>INTENTIONAL TORTS</th>
<th>EXAMPLE</th>
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<tbody>
<tr>
<td>Assault</td>
<td>The conduct of one person makes another person fearful and apprehensive (threatening to place a nasogastric tube in a client who is refusing to eat).</td>
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<tr>
<td>Battery</td>
<td>Intentional and wrongful physical contact with a person that involves an injury or offensive contact (restraining a client and administering an injection against her wishes).</td>
</tr>
<tr>
<td>False imprisonment</td>
<td>A person is confined or restrained against his will (using restraints on a competent client to prevent his leaving the health care facility).</td>
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</tbody>
</table>

• State Laws
  ○ The core of nursing practice is regulated by state law.
  ○ Each state has enacted statutes that define the parameters of nursing practice and gives the authority to regulate the practice of nursing to its state board of nursing.
  ○ In turn, the boards of nursing have the authority to adopt rules and regulations that further regulate nursing practice. Although the practice of nursing is similar among states, it is critical that nurses know the laws and rules governing nursing in the state in which they practice.
  ○ Boards of nursing have the authority to both issue and revoke a nursing license.
  ○ Boards also set standards for nursing programs and further delineate the scope of practice for registered nurses, licensed practical nurses, and advanced practice nurses.
LEGAL RESPONSIBILITIES

- Licensure
  - In general, nurses must hold a current license in every state where they practice. The states (about half of them) that have adopted the nurse licensure compact are exceptions. This model allows licensed nurses who reside in a compact state to practice in other compact states under a multi-state license. Within the compact, nurses must practice in accordance with the statues and rules of the state in which they provide care.

Professional Negligence

- Professional negligence is the failure of a person with professional training to act in a reasonable and prudent manner. The terms “reasonable and prudent” are generally used to describe a person who has the average judgment, intelligence, foresight, and skill that would be expected of a person with similar training and experience.

- Negligence issues that prompt most malpractice suits include failure to:
  - Follow either professional or facility-established standards of care.
  - Use equipment in a responsible and knowledgeable manner.
  - Communicate effectively and thoroughly with the client.
  - Document care that was provided.

<table>
<thead>
<tr>
<th>THE FIVE ELEMENTS NECESSARY TO PROVE NEGLIGENCE</th>
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<tbody>
<tr>
<td>ELEMENT OF LIABILITY</td>
</tr>
<tr>
<td>-----------------------</td>
</tr>
<tr>
<td>1. Duty to provide care as defined by a standard</td>
</tr>
<tr>
<td>2. Breach of duty by failure to meet standard</td>
</tr>
<tr>
<td>3. Foreseeability of harm</td>
</tr>
<tr>
<td>4. Breach of duty has potential to cause harm (combines elements 2 and 3)</td>
</tr>
<tr>
<td>5. Harm occurs</td>
</tr>
</tbody>
</table>
LEGAL RESPONSIBILITIES

• Nurses can avoid being liable for negligence by:
  - Following standards of care.
  - Giving competent care.
  - Communicating with other health team members.
  - Developing a caring rapport with clients.
  - Fully documenting assessments, interventions, and evaluations.

CLIENT RIGHTS

Overview

• Nurses are accountable for protecting the rights of clients. Specific situations that provide nurses with the opportunity to protect clients’ rights are informed consent, refusal or treatment, advance directives, confidentiality, and information security.
  - Clients’ rights are the legal guarantees that clients have with regard to their health care.
  - Clients using the services of a health care institution retain their rights as individuals and citizens of the United States.
  - The American Hospital Association (AHA) identifies patients’ rights in health care settings and is contained in “The Patient Care Partnership.” For more information regarding this document, visit the organization’s Web site (http://www.aha.org).
  - Further protection of rights are ensured for residents in nursing facilities that participate in Medicare programs from “Resident Rights” statutes that govern their operation.

Nursing Role in Client Rights

• Nurses must ensure that clients understand their rights, and nurses must also protect the rights of clients for whom they are providing care.

• Regardless of the age of the client, the client’s nursing needs or the setting in which care is provided, the basic tenets are the same. The client has the right to:
  - Be informed about the aspects of care in order to be active in the decision-making process.
  - Accept, refuse, or request modification to the plan of care.
  - Receive care that is delivered by competent individuals who treat the client with respect.
Overview

- Informed consent is a legal process by which a client has given written permission for a procedure or treatment to be performed. Consent is considered to be informed when the client has been provided and understands:
  - The reason the treatment or procedure is needed
  - How the treatment or procedure will benefit the client
  - The risks involved if the client chooses to receive the treatment or procedure
  - Other options to treat the problem, including the option of not treating the problem
- The nurse’s role in the informed consent process is to witness the client’s signature on the informed consent form and to ensure that informed consent has been appropriately obtained.

Informed Consent Guidelines

- Consent is required for all care that is given to the client in a health care facility. For most aspects of nursing care, “implied consent” is adequate. The client provides implied consent when the client adheres to the instructions provided by the nurse. For example, the nurse is preparing to administer a TB skin test and the client holds out his arm for the nurse.
- For an invasive procedure or surgery, the client is required to provide written consent.
- State laws prescribe who is able to give informed consent. Laws will vary regarding age limitations and emergencies. The nurse is responsible for knowing the laws in the state of practice.
- The form for informed consent must be signed by a competent adult. The person who signs the form must be capable of understanding the information provided by the health care professional who will be providing the service, such as a surgical procedure, and the person must be able to fully communicate with the health care professional. When the person giving the informed consent is unable to communicate due to a language barrier or due to a hearing impairment, a trained medical interpreter must be provided. Many health care facilities contract with professional interpreters who have additional skills in medical terminology to assist with providing information.
- Individuals who are authorized to grant consent for another person include:
  - Parent of a minor
  - Legal guardian
  - Court-specified representative
o An individual who has durable power of attorney authority for health care
o Emancipated minors (minors who are independent from their parents, such as a married minor) provide informed consent for themselves.

- The nurse must verify that consent is “informed” and may witness the client sign the consent form.

<table>
<thead>
<tr>
<th>RESPONSIBILITIES FOR INFORMED CONSENT</th>
<th>THE PROVIDER</th>
<th>THE CLIENT</th>
<th>THE NURSE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>THE PROVIDER</strong></td>
<td>A complete description of the treatment/procedure</td>
<td>o Give it voluntarily (no coercion involved).</td>
<td>o Ensure that the provider gave the client the necessary information.</td>
</tr>
<tr>
<td>o A description of the professionals who will be performing and participating in the treatment</td>
<td>o Be competent and of legal age or be an emancipated minor. When the client is unable to provide consent, another authorized person must give consent.</td>
<td>o Ensure that the client understood the information and is competent to give informed consent.</td>
<td></td>
</tr>
<tr>
<td>o A description of the potential harm, pain, and/or discomfort that might occur</td>
<td>o Receive enough information to make a decision based on an understanding of what is expected.</td>
<td>o Have the client sign the informed consent document.</td>
<td></td>
</tr>
<tr>
<td>o Options for other treatments</td>
<td>o The right to refuse treatment</td>
<td>o Notify the provider if the client has more questions or appears not to understand any of the information provided. The provider is then responsible for giving clarification.</td>
<td></td>
</tr>
<tr>
<td>o The nurse also documents any addition reinforcement of teaching. The nurse is responsible for recording the use of an interpreter in the client’s medical record.</td>
<td>o Document questions the client has and that the provider was notified. The nurse also documents any addition reinforcement of teaching. The nurse is responsible for recording the use of an interpreter in the client’s medical record.</td>
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</tbody>
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| THE NURSE | o Wtinesses informed consent. | o Have the client sign the informed consent document. | o Ensure that the provider gave the client the necessary information. |
| o This means the nurse must: | o Notify the provider if the client has more questions or appears not to understand any of the information provided. The provider is then responsible for giving clarification. | o Document questions the client has and that the provider was notified. The nurse also documents any addition reinforcement of teaching. The nurse is responsible for recording the use of an interpreter in the client’s medical record. |
Refusal of Treatment

- The Patient Self-Determination Act (PSDA) stipulates that on admission to a health care facility, all clients must be informed of their right to accept or refuse care. Competent adults have the right to refuse treatment, including the right to leave a health care facility without a discharge order from the provider.

- If the client refuses a treatment or procedure, the client is asked to sign a document indicating that he understands the risk involved with refusing the treatment or procedure and that he has chosen to refuse it.

- When a client decides to leave the facility without a discharge order, the nurse notifies the provider and discusses with the client the risks faced by leaving the facility prior to discharge.

- The nurse carefully documents the information that was provided to the client and that notification of the provider occurred.

- The client is asked to sign an “Against Medical Advice” form.

- If the client refuses to sign the form, this is also documented by the nurse.

Standards of Care (Practice)

- Nurses base practice on established standards of care or legal guidelines for care. These standards of care can be found in:
  - The nurse practice act of each state. Its legal guidelines for practice are established and enforced through a state board of nursing or other government agency.
  - Nurse practice acts vary from state to state, making it obligatory for the nurse to be informed about her state’s nurse practice act as it defines the legal parameters of practice.
  - Published standards of nursing practice developed by professional organizations and specialty groups, including the American Nurses Association (ANA), the American Association of Critical Care Nurses (AACN), and the American Association of Occupational Health Nurses (AAOHN).
Health care facility policies and procedures maintained in the facility’s policy and procedure manual.

- Policies and procedures establish the standard of practice expected to be maintained by employees of that institution.
- These manuals provide detailed information about how the nurse should respond to or provide care in specific situations and while performing client care procedures.
- Nurses should be familiar with their facility’s policies and procedures and provide client care in accordance with these policies. For example:
  - Assess and document client findings postoperatively according to institutional policy.
  - Change IV tubing and flush saline locks according to institutional policy.

- Standards of care define and direct the level of care that should be given by practicing nurses, and they are used in malpractice lawsuits to determine if that level was maintained.
- Nurses should refuse to practice beyond the legal scope of practice and/or outside of their areas of competence regardless of reason (staffing shortage, lack of appropriate personnel).
- Nurses should use the formal chain of command to verbalize concerns related to assignment in light of current legal scope of practice, job description, and area of competence.

Impaired Coworkers

- Impaired health care providers pose a significant risk to client safety.
- A nurse who suspects a coworker of using alcohol or abusing drugs while working has a duty to report the coworker to appropriate management personnel as specified by institutional policy.
- Institutional policies should provide guidelines for handling employees with a chemical abuse issue, and many provide peer assistance programs that facilitate the health care provider’s entry into a treatment program.
- Each state has laws and regulations that govern the disposition of nurses who have been reported secondary to chemical abuse.
- Health care providers who are found guilty of misappropriation of controlled substances can also be charged with a criminal offense consistent with the infraction.

Advance Directives

- The purpose of advance directives is to communicate a client’s wishes regarding end-of-life care should the client become unable to do so.
- The Patient Self-Determination Act (PSDA) requires that all clients admitted to a health care facility be asked if they have advance directives.
Clients without advance directives must be given written information that outlines their rights related to health care decisions and how to formulate advance directives. A health care representative should be available to help with this process.

Types of Advance Directives

- **Living Will**
  - A living will is a legal document that expresses the client’s wishes regarding medical treatment in the event the client becomes incapacitated and is facing end-of-life issues.
  - Most state laws include provisions that health care providers who follow the health care directives in a living will are protected from liability.

- **Durable Power of Attorney for Health Care**
  - A durable power of attorney for health care is a document that designates a health care proxy, who is an individual authorized to make health care decisions for a client who is unable.

- **Provider’s Orders**
  - Unless a “do not resuscitate” (DNR) or “allow natural death” (AND) order is written, the nurse initiates cardiopulmonary resuscitation (CPR) when the client has no pulse or respirations. The written order for a DNR or AND must be placed in the client’s medical record. The provider consults the client and the family prior to administering a DNR or AND.

Nursing Role in Advance Directives

- Nursing responsibilities regarding advance directives include:
  - Provide written information regarding advance directives.
  - Document the client’s advance directives status.
  - Ensure that the advance directives reflect the client’s current decisions.
  - Inform all members of the health care team of the client’s advance directives.

Mandatory Reporting

- In certain situations, health care providers have a legal obligation to report their findings in accordance with state law.

- Abuse
  - Nurses are mandated to report any suspicion of abuse (child or elder abuse, domestic violence) following facility policy.
• Communicable Diseases
  
  ○ Nurses are also mandated to report to the proper agency (local health department, state health department) when a client has been diagnosed with a communicable disease.
  
  ○ A complete list of reportable diseases and a description of the reporting system are available through the Centers for Disease Control and Prevention Web site (http://www.cdc.gov). Each state mandates which diseases must be reported in that state. There are more than 60 communicable diseases that must be reported to public health departments to allow officials to:

  ■ Ensure appropriate medical treatment of diseases (tuberculosis).
  ■ Monitor for common-source outbreaks (foodborne, hepatitis A).
  ■ Plan and evaluate control and prevention plans (immunizations for preventable diseases).
  ■ Identify outbreaks and epidemics.
  ■ Determine public health priorities based on trends.
1. A nurse reviewing a client’s chart discovers that the client’s do-not-resuscitate (DNR) order has expired. The client’s condition has not been stable today. Which of the following actions should the nurse take?
   A. Assume that the client still wishes to be a DNR client.
   B. Write a note on the front of the provider order sheet asking that the DNR be reordered.
   C. Notify the nurse manager that the DNR order has expired.
   D. Call the provider to get the order immediately reinstated.

2. Which of the following actions by a nurse can minimize her chances of being charged with negligence? (Select all that apply.)
   ______ Thoroughly explaining procedures prior to performing them
   ______ Approaching the client in a caring manner
   ______ Asking the client if she has any questions about her care
   ______ Providing care according to the plan of care
   ______ Documenting assessments in the client’s medical record
   ______ Carrying out the provider’s orders without question

3. A nurse witnesses an assistive personnel (AP) under her supervision reprimanding a client for not using the urinal properly. The AP threatens to put a diaper on the client if he does not use the urinal more carefully next time. Which of the following torts is the AP committing?
   A. Assault
   B. Battery
   C. False imprisonment
   D. Invasion of privacy
CHAPTER 4: LEGAL RESPONSIBILITIES

Application Exercises Answer Key

1. A nurse reviewing a client’s chart discovers that the client’s do-not-resuscitate (DNR) order has expired. The client’s condition has not been stable today. Which of the following actions should the nurse take?

   A. Assume that the client still wishes to be a DNR client.
   B. Write a note on the front of the provider order sheet asking that the DNR be reordered.
   C. Notify the nurse manager that the DNR order has expired.
   D. Call the provider to get the order immediately reinstated.

   D. Call the provider to get the order immediately reinstated.

   DNR orders must be reinstated by the provider on an institutionally specified basis. Without a current DNR order, the nurse must institute CPR if the client goes into cardiopulmonary arrest. Since the client has been unstable today, the nurse should call the provider to get a current order reinstated. The nurse cannot assume that the client’s wishes have not changed. Leaving a note on a medical record is unreliable, and there is no need to inform the charge nurse if the nurse contacts the provider immediately to confirm the client’s or family’s wishes and resolves the situation.

NCLEX® Connection: Management of Care: Client Rights

2. Which of the following actions by a nurse can minimize her chances of being charged with negligence? (Select all that apply.)

   - Thoroughly explaining procedures prior to performing them
   - Approaching the client in a caring manner
   - Asking the client if she has any questions about her care
   - Providing care according to the plan of care
   - Documenting assessments in the client’s medical record
   - Carrying out the provider’s orders without question

   All of these options except for the last option can help the client receive (and perceive that she is receiving) competent, caring, and thorough client care. If all of these criteria are met, the chances of negligence occurring are minimized. It is necessary to question a provider’s order if the nurse deems it could have adverse effects on the client or if it is contraindicated secondary to another condition or treatment. If the nurse carries out an order that goes against what a reasonable and prudent nurse should know, he could be held liable for implementing the order.

NCLEX® Connection: Management of Care: Legal Rights and Responsibilities
3. A nurse witnesses an assistive personnel (AP) under her supervision reprimanding a client for not using the urinal properly. The AP threatens to put a diaper on the client if he does not use the urinal more carefully next time. Which of the following torts is the AP committing?

A. Assault  
B. Battery  
C. False imprisonment  
D. Invasion of privacy

By threatening the client, the AP is committing assault. Her threats could make the client become fearful and apprehensive. Since the AP has only verbally threatened the client, battery has not occurred. False imprisonment and invasion of privacy have not been committed.

NCLEX® Connection: Management of Care: Legal Rights and Responsibilities