

Professional Responsibilities

Professional responsibilities are the obligations that nurses have to their clients. To meet their professional responsibilities, nurses must be knowledgeable in the following areas: client rights, advocacy, informed consent, advance directives, confidentiality and information security, information technology, legal practice, disruptive behavior, and ethical practice.

Client rights

- Client 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 client rights in health care settings in the Patient Care Partnership (www.aha.org).
 - Residents in nursing facilities that participate in Medicare programs similarly retain resident rights under statutes that govern the operation of these facilities.
- Nurses are accountable for protecting the rights of clients. Situations that require particular attention include informed consent, refusal of treatment, advance directives, confidentiality, and information security.

NURSING ROLE IN CLIENT RIGHTS

- Nurses must ensure that clients understand their rights. Nurses also must protect clients' rights during nursing care. 
- Regardless of the client's age, nursing needs, or the setting in which care is provided, the basic tenants are the same. Each client has the right to the following.
 - Be informed about all aspects of care and take an active role 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.

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 prescription for discharge 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 prescription for discharge, the nurse notifies the provider and discusses with the client the potential risks associated with 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 should be informed of the following.
 - Possible complications that could occur without treatment
 - Possibility of permanent physical or mental impairment or disability
 - Possibility of other complications that could lead to death
- 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.

Advocacy

Advocacy refers to nurses' role in supporting clients by ensuring that they are properly informed, that their rights are respected, and that they are receiving the proper level of care.

- Advocacy is one of the most important roles of the nurse, especially when clients are unable to speak or act for themselves.
- As an advocate, the nurse ensures that the client has the information he needs to make decisions about health care.
- Nurses must act as advocates even when they disagree with clients' decisions.
- The complex health care system puts clients in a vulnerable position. Nurses are clients' voice when the system is not acting in their best interest.
- The nursing profession also has a responsibility to support and advocate for legislation that promotes public policies that protect clients as consumers and create a safe environment for their care.

NURSING ROLE IN ADVOCACY

- As advocates, nurses must ensure that clients are informed of their rights and have adequate information on which to base health care decisions.
- Nurses must be careful to assist clients with making health care decisions and not direct or control their decisions.
- Nurses mediate on the client's behalf when the actions of others are not in the client's best interest or changes need to be made in the plan of care.
- Situations in which nurses might need to advocate for clients or assist them to advocate for themselves include the following.
 - End-of-life decisions
 - Access to health care
 - Protection of client privacy
 - Informed consent
 - Substandard practice
- Nurses are accountable for their actions even if they are carrying out a provider's prescription. It is the nurse's responsibility to question a prescription if it could harm a client (incorrect medication dosage, potential adverse interaction with another prescribed medication, contraindication due to an allergy or medical history). **Qs**

ESSENTIAL COMPONENTS OF ADVOCACY

SKILLS

- Risk-taking
- Vision
- Self-confidence
- Articulate communication
- Assertiveness

VALUES

- Caring
- Autonomy
- Respect
- Empowerment

Informed consent

- 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 with and understands the following.
 - Reason the treatment or procedure is needed
 - How the treatment or procedure will benefit the client
 - 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
 - Risk involved if the client chooses no treatment
- 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.
- The nurse should seek the assistance of an interpreter if the client does not speak and understand the language used by the provider. **Qecc**

INFORMED CONSENT GUIDELINES

Consent is required for all care given in a health care facility. For most aspects of nursing care, implied consent is adequate. The client provides implied consent when she complies with the instructions provided by the nurse. For example, the nurse is preparing to administer a TB skin test, and the client holds out her arm for the nurse.

- For an invasive procedure or surgery, the client is required to provide written consent.
- State laws regulate who is able to give informed consent. Laws vary regarding age limitations and emergencies. Nurses are responsible for knowing the laws in the state of practice.
- The nurse must verify that consent is informed and witness the client sign the consent form.

Signing an informed consent form

- The form for informed consent must be signed by a competent adult.
 - Emancipated minors (minors who are independent from their parents, such as a married minor) can provide informed consent for themselves.
- 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. The person must be able to fully communicate in return with the health care professional.
- When the person giving the informed consent is unable to communicate due to a language barrier or hearing impairment, a trained medical interpreter must be provided. Many health care agencies contract with professional interpreters who have additional skills in medical terminology to assist with providing information.

Individuals authorized to grant consent for another person

- Parent of a minor
- Legal guardian
- Court-specified representative
- Client's health care surrogate (individual who has the client's durable power of attorney for health care/health care proxy)
- Spouse or closest available relative (state laws vary)

INFORMED CONSENT RESPONSIBILITIES

PROVIDER: Obtains informed consent. To do so, the provider must give the client the following

- Complete description of the treatment/procedure
- Description of the professionals who will be performing and participating in the treatment
- Description of the potential harm, pain, and/or discomfort that might occur
- Options for other treatments
- The right to refuse treatment
- Risk involved if the client chooses no treatment

CLIENT: Gives informed consent. To give informed consent, the client must do the following.

- Give it voluntarily (no coercion involved).
- Be competent and of legal age or be an emancipated minor. (If the client is unable to provide consent, an authorized person must give consent).
- Receive sufficient information to make a decision based on an informed understanding of what is expected.

NURSE

- Witnesses informed consent. The nurse is responsible for the following. **Qs**
 - Ensuring that the provider gave the client the necessary information
 - Ensuring that the client understood the information and is competent to give informed consent
 - Having the client sign the informed consent document
 - Notifying the provider if the client has more questions or does not understand any of the information provided. (The provider is then responsible for giving clarification.)
- The nurse documents the following.
 - Reinforcement of information originally given by the provider
 - That questions the client had were forwarded to the provider
 - Use of an interpreter

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 PSDA requires that all clients admitted to a health care facility be asked if they have advance directives.
 - A client who does not have advance directives must be given written information that outlines her rights related to health care decisions and how to formulate advance directives. **Qpcc**
 - A health care representative should be available to help with this process.

COMPONENTS OF ADVANCE DIRECTIVES

Two components of an advance directive are the living will and the durable power of attorney for health care.

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. Types of treatments that are often addressed in a living will are those that have the capacity to prolong life. Examples of treatments that are addressed are cardiopulmonary resuscitation, mechanical ventilation, and feeding by artificial means.
- Living wills are legal in all states. However, state statutes and individual health care facility policies can vary. Nurses need to be familiar with their state statute and facility policies.
- Most state laws include provisions that health care providers who follow the health care directive in a living will are protected from liability.

Durable power of attorney for health care

A durable power of attorney for health care/health care proxy is a legal document that designates a health care surrogate, who is an individual authorized to make health care decisions for a client who is unable.

- The person who serves in the role of health care surrogate to make decisions for the client should be very familiar with the client's wishes.
- Living wills can be difficult to interpret, especially in the face of unexpected circumstances. A durable power of attorney for health care, as an adjunct to a living will, can be a more effective way of ensuring that the client's decisions about health care are honored.

Provider's prescriptions

- Unless a do not resuscitate (DNR) or allow natural death (AND) prescription is written, the nurse should initiate CPR when a client has no pulse or respirations. The written prescription 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.
- Additional prescriptions by the provider are based on the client's individual needs and decisions and provide for comfort measures. The client's decision is respected in regard to the use of antibiotics, initiation of diagnostic tests, and provision of nutrition by artificial means.

NURSING ROLE IN ADVANCE DIRECTIVES

- Providing written information regarding advance directives
- Documenting the client's advance directives status
- Ensuring that advance directives are current and reflective of the client's current decisions
- Recognizing that the client's choice takes priority when there is a conflict between the client and family, or between the client and the provider
- Informing all members of the health care team of the client's advance directives **Qpcc**

3.1 Advance directives



Advance Directive Living Will/Power of Attorney for Health Care

On this _____ day of _____, I, _____, being of sound mind, willfull designate the following individual, _____, as my agent to make all health care related decisions for me.

If, for any reason, should I revoke my agent's authority of if my agent is not willing, able, or available to make health care decisions for me, I designate as my first alternate, _____

MY AGENT shall have the authority to make health care decisions that will become effective if and when my primary physician determines that I am unable, either physically and/or mentally, to make my own decisions regarding my health care.

MY AGENT shall have the authority to make health care decisions in what he/she determines is my best interest and carry out any instructions that I mark as my own will to be done.

MY AGENT shall be in accordance with my following choice:

☐ Choice NOT to Prolong Life

I do not want to be resuscitated in the event I (1) have an incurable and irreversible condition that will result in my death within a short period of time, (2) become unconscious and have little or no chance of regaining consciousness, or (3) the risks of treatment would outweigh the expected benefits.

☐ Choice To Prolong Life

I want my life to be prolonged as long as possible within the scope and limits of accepted health care standards.

MY AGENT shall direct that treatment for alleviation of pain or discomfort should be provided at all times even if it directly affects the demise of my health or hastens my death.

MY AGENT shall donate my organs as specified below.

☐ I give all organs, tissues, or parts

☐ I give the following organs, tissues, or parts ONLY: _____

☐ My gift is for the following purposes (Place a mark in the box next to the desired purpose(s) for donation:

☐ Transplant

☐ Therapy

☐ Research

☐ Education

MY AGENT shall, upon my death, make health care decisions regarding authorization of any autopsy, making anatomical gifts, and the disposition of my remains.

This Power of Attorney will not be effective unless it is signed by me, my designated agent, my alternative agent and my primary physician.

Signature: _____

Date: _____

Signature: _____

Date: _____

Signature: _____

Date: _____

Physician Signature: _____

Date: _____

Confidentiality and information security

Clients have the right to privacy and confidentiality in relation to their health care information and medical recommendations.

- Nurses who disclose client information to an unauthorized person can be liable for invasion of privacy, defamation, or slander.
- The security and privacy rules of the Health Insurance Portability and Accountability Act (HIPAA) were enacted to protect the confidentiality of health care information and to give the client the right to control the release of information. Specific rights provided by the legislation include the following:
 - The rights of clients to obtain a copy of their medical record and to submit requests to amend erroneous or incomplete information
 - A requirement for health care and insurance providers to provide written information about how medical information is used and how it is shared with other entities (permission must be obtained before information is shared)
 - The rights of clients to privacy and confidentiality

NURSING ROLE IN CONFIDENTIALITY

It is essential for nurses to be aware of the rights of clients in regard to privacy and confidentiality. Facility policies and procedures are established in order to ensure compliance with HIPAA regulations. It is essential that nurses know and adhere to the policies and procedures. HIPAA regulations also provide for penalties in the event of noncompliance with the regulations. **Qs**

PRIVACY RULE

The Privacy Rule of HIPAA requires that nurses protect all written and verbal communication about clients.

COMPONENTS OF THE PRIVACY RULE

- Only health care team members directly responsible for the client's care are allowed access to the client's records. Nurses may not share information with other clients or staff not involved in the care of the client.
- Clients have a right to read and obtain a copy of their medical record, and agency policy should be followed when the client requests to read or have a copy of the record.
- No part of the client record can be copied except for authorized exchange of documents between health care institutions. For example:
 - Transfer from a hospital to an extended care facility
 - Exchange of documents between a general practitioner and a specialist during a consult

- Client medical records must be kept in a secure area to prevent inappropriate access to the information. Using public display boards to list client names and diagnoses is restricted.
- Electronic records should be password-protected, and care must be taken to prevent public viewing of the information. Health care workers should use only their own passwords to access information.
- Client information may not be disclosed to unauthorized individuals, including family members who request it and individuals who call on the phone.
 - Many hospitals use a code system in which information is only disclosed to individuals who can provide the code.
 - Nurses should ask any individual inquiring about a client's status for the code and disclose information only when an individual can give the code.
- Communication about a client should only take place in a private setting where it cannot be overheard by unauthorized individuals. The practice of "walking rounds," where other clients and visitors can hear what is being said, is no longer sanctioned. Taped rounds also are discouraged because nurses should not receive information about clients for whom they are not responsible. Change-of-shift reports can be done at the bedside as long as the client does not have a roommate and no unsolicited visitors are present. **Qecc**

INFORMATION SECURITY

- Health information systems (HIS) are used to manage administrative functions and clinical functions. The clinical portion of the system is often referred to as the clinical information systems (CIS). The CIS may be used to coordinate essential aspects of client care. **Ql**
- In order to comply with HIPAA regulations, each health care facility has specific policies and procedures designed to monitor staff adherence, technical protocols, computer privacy, and data safety.

INFORMATION SECURITY PROTOCOLS

- Log off from the computer before leaving the workstation to ensure that others cannot view protected health information (PHI) on the monitor.
- Never share a user ID or password with anyone.
- Never leave a client's chart or other printed or written PHI where others can access it.
- Shred any printed or written client information used for reporting or client care after it is no longer needed.

USE OF SOCIAL MEDIA

- The use of social media by members of the nursing profession is common practice. The benefits to using social media are numerous. It provides a mechanism for nurses to access current information about health care and enhances communication among nurses, colleagues, and clients and families. It also provides an opportunity for nurses to express concerns and seek support from others. But nurses must be cautious about the risk of intentional or inadvertent breaches of confidentiality via social media.
- The right to privacy is a fundamental component of client care. Invasion of privacy as it relates to health care is the release of client health information to others without the client's consent. Confidentiality is the duty of the nurse to protect a client's private information.
- The inappropriate use of social media can result in a breach of client confidentiality. Depending on the circumstances, the consequences can include termination of employment by the employer, discipline by the board of nursing, charges of defamation or invasion of privacy, and in the most serious of circumstances, federal charges for violation of HIPAA.

PROTECTING YOURSELF AND OTHERS

- Become familiar with facility policies about the use of social media, and adhere to them.
- Avoid disclosing any client health information online. Be sure no one can overhear conversations about a client when speaking on the telephone.
- Do not take or share photos or videos of a client.
- Remember to maintain professional boundaries when interacting with clients online.
- Never post a belittling or offensive remark about a client, employer, or coworker.
- Report any violations of facility social media policies to the nurse manager.

Information technology

- Informatics is the use of computers to systematically resolve issues in nursing. The use of technology in healthcare is increasing and most forms of communication are in electronic format. **Q**
- Examples of how a nurse can use the electronic format while providing client care include laptops for documentation and the use of an automated medication dispensing system to dispense medications.
- Databases on diseases and medications are available for the nurse to review. These databases can also be used as a teaching tool when nurses are educating clients.
- The nurse can review medications, diseases, procedures, and treatments using an electronic format.
- Computers can be beneficial for use with clients who have visual impairments.
- The Internet is a valuable tool for clients to review current medications and or health questions. This is especially true for clients who have chronic illnesses.
- Nurses should instruct clients to only review valid and credible websites by verifying the author, institution, credentials, and how current the article is. A disclaimer will be presented if information is not medical advice.
- Clients can access their electronic health record (EHR) which is part of e-health. E-health enables the client to make appointments online, review laboratory results, refill an electronic prescription, and review billing information. The goal of e-health is improved health care outcomes due to 24 hr access by the client and provider to the client's health care information.

Legal practice

In order to be safe practitioners, nurses must understand the legal aspects of the nursing profession. **Qs**

- Understanding the laws governing nursing practice allows nurses to protect client rights and 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 do the following.
 - Provide safe, competent care
 - Advocate for clients' rights
 - Provide care that is within the nurse's scope of practice
 - Discern the responsibilities of nursing in relation to the responsibilities of other members of the health care team
 - Provide care that is consistent with established standards of care.
 - Shield oneself from liability

SOURCES OF LAW

Federal regulations

Federal regulations have a great impact on nursing practice. Some of the federal laws affecting nursing practice include the following.

- HIPAA
- Americans with Disabilities Act (ADA)
- Mental Health Parity Act (MHPA)
- Patient Self-Determination Act
- Uniform Anatomical Gift Act
- National Organ Transplant Act

Criminal and civil laws

Criminal law is a subsection of public law and relates to the relationship of an individual with the government. Violations of criminal law can be categorized as either a **felony** (a serious crime, such as homicide) or **misdemeanor** (a less serious crime, such as petty theft). A nurse who falsifies a record to cover up a serious mistake can 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. Torts can be classified as unintentional, quasi-intentional, or intentional.

Unintentional torts

- **Negligence:** Practice or misconduct that does not meet expected standards of care and places the client at risk for injury (a nurse fails to implement safety measures for a client who has been identified as at risk for falls).
- **Malpractice:** Professional negligence (a nurse administers a large dose of medication due to a calculation error. The client has a cardiac arrest and dies).

Quasi-intentional torts

- **Invasion of privacy:** Intrusion into a client's private affairs or a breach of confidentiality (a nurse releases the medical diagnosis of a client to a member of the press).
- **Defamation:** False communication or communication with careless disregard for the truth with the intent to injure an individual's reputation.
 - **Libel:** Defamation with the written word or photographs (a nurse documents in a client's health record that a provider is incompetent).
 - **Slander:** Defamation with the spoken word (a nurse tells a coworker that she believes a client has been unfaithful to the spouse).

Intentional torts

- **Assault:** 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).
- **Battery:** Intentional and wrongful physical contact with a person that involves an injury or offensive contact (restraining a client and administering an injection against his wishes).
- **False imprisonment:** A person is confined or restrained against his will (using restraints on a competent client to prevent his leaving the health care facility).

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 give the authority to regulate the practice of nursing to its state board of nursing.
 - 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.
 - The laws and rules governing nursing practice in a specific state can be accessed at the state board's Web site.
 - Boards of nursing have the authority to both issue and revoke a nursing license. Boards may revoke or suspend a nurse's license for a number of offenses, including practicing without a valid license, substance use disorders, conviction of a felony, professional negligence, and providing care beyond the scope of practice. Nurses should review the practice act in their states.
 - Boards also set standards for nursing programs and further delineate the scope of practice for registered nurses, licensed practical nurses, and advanced practice nurses.

Good Samaritan laws

- Good Samaritan laws, which vary from state to state, protect nurses who provide emergency assistance outside of the employment location. The nurse must provide a standard of care that is reasonable and prudent.
- State laws vary as to when an individual may begin practicing nursing. Some states allow graduates of nursing programs to practice under a limited license, whereas some states require licensure by passing the NCLEX® before working.

Licensure

- Until the year 2000, nurses were required to hold a current license in every state in which they practiced. This became problematic with the increase in the electronic practice of nursing. For example, a nurse in one state interprets the reading of a cardiac monitor and provides intervention for a client who is physically located in another state. Additionally, many nurses cross state lines to provide direct care. For example, a nurse who is located near a state border makes home visits on both sides of the state line.
- To address these issues, the mutual recognition model of nurse licensure (the Nurse Licensure Compact [NLC]) has been adopted by many states. This model allows nurses who reside in a NLC state to practice in another NLC state. Nurses must practice in accordance with the statutes and rules of the state in which the care is provided. State boards may prohibit a nurse from practicing under the NLC if the license of the nurse has been restricted by a board of nursing.
- Nurses who do not reside in a NLC state must practice under the state-based practice model. In other words, if a nurse resides in a non-NLC state, the nurse must maintain a current license in every state in which she practices. Some states now require background checks with licensure renewal. It is illegal to practice nursing with an expired license.

MALPRACTICE
(PROFESSIONAL NEGLIGENCE)

- Malpractice 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, foresight, intelligence, and skill that would be expected of a person with similar training and experience. (3.2)
- Professional negligence issues that prompt most malpractice suits include failure to do the following.
 - 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
- Nurses can avoid being liable for negligence by doing the following.
 - 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

3.2 Elements necessary to prove negligence

EXAMPLE: CLIENT WHO IS A FALL RISK	
1. <i>Duty to provide care as defined by a standard</i> Care that should be given or what a reasonably prudent nurse would do	The nurse should complete a fall risk assessment for all clients upon admission, per facility protocol.
2. <i>Breach of duty by failure to meet standard</i> Failure to give the standard of care that should have been given	The nurse does not perform a fall risk assessment during admission.
3. <i>Foreseeability of harm</i> Knowledge that failing to give the proper standard of care can cause harm to the client	The nurse should know that failure to take fall-risk precautions can endanger a client at risk for falls.
4. <i>Breach of duty has potential to cause harm (combines elements 2 and 3)</i> Failure to meet the standard had potential to cause harm: relationship must be provable	If a fall risk assessment is not performed, the client's risk for falls is not determined and the proper precautions are not put in place.
5. <i>Harm occurs</i> Occurrence of actual harm to the client	The client falls out of bed and breaks his hip.

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 following.
 - The nurse practice act of each state
 - These acts govern nursing practice, and 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: These are developed by professional organizations such as the American Nurses Association, National Association of Practical Nurse Education and Services, Inc., and specialty organizations such as the American Association of Critical Care Nurses, Wound, Ostomy and Continence Nurses Society; and Oncology Nurses Society.
 - Accrediting bodies (e.g., The Joint Commission)
 - Originally mandated quality assurance programs, which have evolved into quality improvement
 - Sentinel event reporting: "An unexpected occurrence involving death or serious or psychological injury, or the risk thereof"
 - Failure Mode and Effects Analysis: Examines all potential failures in a design, including event sequencing risks, vulnerabilities, and improvement areas
 - National Patient Safety Goals: Augments core measures and promotes patient safety through patient identification, effective staff communication, safe medication use, infection prevention, safety risk identification, and preventing wrong-site surgery
- Health care facility policies and procedures
 - Policies and procedures, maintained in the facility's policy and procedure manual, establish the standard of practice for 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 who practice according to institutional policy are legally protected if that standard of care still results in an injury. For example, if a client files a complaint with the board of nursing or seeks legal counsel, the nurse who has followed the facility's policies will not usually be charged with misconduct.
 - It is very important that nurses are familiar with their institution's policies and procedures and provide client care in accordance with these policies. For example:
 - ◻ Assess and document findings postoperatively according to institutional policy.
 - ◻ Change IV tubing and flush saline locks according to institutional policy.
- Standards of care guide, define, and direct the level of care that should be given by practicing nurses. They also 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. **Qs**
- A nurse who suspects a coworker of using alcohol or other substances while working has a duty to report the coworker to appropriate management personnel as specified by institutional policy. At the time of the infraction, the report should be made to the immediate supervisor, such as the charge nurse, to ensure client safety.
- Health care facility policies should provide guidelines for handling employees who have a substance use disorder. Many facilities provide peer assistance programs that facilitate the health care provider's entry into a treatment program.
- Each state board of nursing has laws and regulations that govern the disposition of nurses who have been reported secondary to substance use. Depending on the individual case, the boards have the option to require the nurse to enter a treatment program, during which time the nurse's license can be retained, suspended, or revoked. If a nurse is allowed to maintain licensure, there usually are work restrictions put in place, such as working in noncritical care areas and being restricted from administering controlled medications.
- Health care providers who are found guilty of misappropriation of controlled substances also can be charged with a criminal offense consistent with the infraction.
- Behaviors can be difficult to detect if the impaired nurse is experienced at masking the substance use disorder.

BEHAVIORS CONSISTENT WITH A SUBSTANCE USE DISORDER

- Smell of alcohol on breath or frequent use of strong mouthwash or mints
- Impaired coordination, sleepiness, shakiness, and/or slurred speech
- Bloodshot eyes
- Mood swings and memory loss
- Neglect of personal appearance
- Excessive use of sick leave, tardiness, or absences after a weekend off, holiday, or payday
- Frequent requests to leave the unit for short periods of time or to leave the shift early
- Frequently "forgetting" to have another nurse witness wasting of a controlled substance
- Frequent involvement in incidences where a client assigned to the nurse reports not receiving pain medication or adequate pain relief (impaired nurse provides questionable explanations)
- Documenting administration of pain medication to a client who did not receive it or documenting a higher dosage than has been given by other nurses
- Preferring to work the night shift where supervision is less or on units where controlled substances are more frequently given

MANDATORY REPORTING

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

ABUSE

- All 51 jurisdictions (50 states and the District of Columbia) have statutes requiring report of suspicion of child abuse. The statutes set out which occupations are mandatory reporters. In many states, nurses are mandatory reporters.
- A number of states also mandate that health care providers, including nurses, report suspected abuse of vulnerable persons, such as older or dependent adults.
- Nurses are mandated to report any suspicion of abuse following facility policy.

COMMUNICABLE DISEASES

- Nurses are also mandated to report to the proper agency (local health department, state health department) when a client is diagnosed with a communicable disease. **Qs**
- 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, 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 do the following.
 - 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.
 - Educate the community on prevention and treatment of these diseases.

ORGAN DONATION

- Organ and tissue donation is regulated by federal and state laws. Health care facilities have policies and procedures to guide health care workers involved with organ donation.
- Donations may be stipulated in a will or designated on an official card.
- Federal law requires health care facilities to provide access to trained specialists who make the request to clients and/or family members and provide information regarding consent, organ and tissues that can be donated, and how burial or cremation will be affected by donation.
- Nurses are responsible for answering questions regarding the donation process and for providing emotional support to family members.

TRANSCRIBING MEDICAL PRESCRIPTIONS

- Nurses might need to receive new prescriptions for client care or medications by verbal or telephone prescription.
- When transcribing a prescription into a paper or electronic chart, nurses must do the following.
 - Be sure to include all necessary elements of a prescription: date and time prescription was written; new client care prescription or medication including dosage, frequency, route of administration; and signature of nurse transcribing the prescription as well as the provider who verbally gave the prescription.
 - Follow institutional policy with regard to the time frame within which the provider must sign the prescription (usually within 24 hr).
 - Use strategies to prevent errors when taking a medical prescription that is given verbally or over the phone by the provider.
 - Repeat back the prescription given, making sure to include the medication name (spell if necessary), dosage, time, and route. **Qs**
 - Question any prescription that seems contraindicated due to a previous or concurrent prescription or client condition.

Disruptive behavior

- Nurses experience incivility, lateral violence, and bullying at an alarming rate. The perpetrator can be a provider or a nursing colleague. Consequences of disruptive behavior include poor communication, which can negatively affect client safety and productivity, resulting in absenteeism, decreased job satisfaction, and staff turnover. Some nurses may choose to leave the profession due to these counterproductive behaviors.
- If disruptive behavior is allowed to continue, it is likely to escalate. Over time, it can be viewed as acceptable in that unit or department's culture.

TYPES OF DISRUPTIVE BEHAVIOR

- **Incivility** is defined as an action that is rude, intimidating, and insulting. It includes teasing, joking, dirty looks, and uninvited touching.
- **Lateral violence** is also known as horizontal abuse or horizontal hostility. It occurs between individuals who are at the same level within the organization. For example, a more experienced staff nurse can be abusive to a newly licensed nurse. Common behaviors include verbal abuse, undermining activities, sabotage, gossip, withholding information, and ostracism.
- **Bullying** behavior is persistent and relentless and is aimed at an individual who has limited ability to defend himself or herself. Bullying occurs when the perpetrator is at a higher level than the victim (for example, a nurse manager to a staff nurse). It is abuse of power that makes the recipient feel threatened, disgraced, and vulnerable. For example, a nurse manager can demonstrate favoritism for another nurse by making unfair assignments or refusing a promotion.
- **Cyberbullying** is a type of disruptive behavior using the Internet or other electronic means.

INTERVENTIONS TO DETER DISRUPTIVE BEHAVIORS

- Create an environment of mutual respect among staff.
- Model appropriate behavior.
- Increase staff awareness about disruptive behavior.
- Make staff aware that offensive online remarks about employers and coworkers are a form of bullying and are prohibited even if the nurse is off-duty and it is posted off-site from the facility.
- Avoid making excuses for disruptive behavior.
- Support zero tolerance for disruptive behavior.
- Establish mechanisms for open communication between staff nurses and nurse managers.
- Adopt policies that limit the risk of retaliation when disruptive behavior is reported.

Ethical practice

- **Ethics** has several definitions, but the foundation of ethics is based on an expected behavior of a certain group in relation to what is considered right and wrong.
- **Morals** are the values and beliefs held by a person that guide behavior and decision-making.
- **Ethical theory** analyzes varying philosophies, systems, ideas, and principles used to make judgments about what is right and wrong, good and bad. Two common types of ethical theory are utilitarianism and deontology.
 - Utilitarianism (teleological theory): Decision-making based on what provides the greatest good for the greatest number of individuals
 - Deontological theory: Decision-making based on obligations, duty, and what one considers to be right or wrong
- Unusual or complex ethical issues might need to be dealt with by a facility's ethics committee.

ETHICAL PRINCIPLES are standards of what is right or wrong with regard to important social values and norms. Ethical principles pertaining to the treatment of clients include the following. **Qccc**

- **Autonomy:** The ability of the client to make personal decisions, even when those decisions might not be in the client's own best interest
- **Beneficence:** Care that is in the best interest of the client
- **Fidelity:** Keeping one's promise to the client about care that was offered
- **Justice:** Fair treatment in matters related to physical and psychosocial care and use of resources
- **Nonmaleficence:** The nurse's obligation to avoid causing harm to the client
- **Veracity:** The nurse's duty to tell the truth

3.3 The nurse's role in ethical decision-making

	EXAMPLES
<i>An agent for the client facing an ethical decision</i>	Caring for an adolescent client who is deciding whether to undergo an elective abortion even though her parents believe it is wrong Discussing options with parents who have to decide whether to consent to a blood transfusion for a child when their religion prohibits such treatment
<i>A decision-maker in regard to nursing practice</i>	Assigning staff nurses a higher client load than recommended because administration has cut the number of nurses per shift Witnessing a surgeon discuss only surgical options with a client without informing the client about more conservative measures available

ETHICAL DECISION-MAKING IN NURSING

Ethical dilemmas are problems for which more than one choice can be made, and the choice is influenced by the values and beliefs of the decision-makers. These are common in health care, and nurses must be prepared to apply ethical theory and decision-making.

- A problem is an ethical dilemma if:
 - It cannot be solved solely by a review of scientific data.
 - It involves a conflict between two moral imperatives.
 - The answer will have profound effect on the situation/client.
- Nurses have a responsibility to be advocates, and to identify and report ethical situations.
 - Doing so through the chain of command offers some protection against retribution.
 - Some state nurse associations offer protection for nurses who report substandard or unethical practice.
- Ethical decision-making is the process by which a decision is made about an ethical issue. Frequently, this requires a balance between science and morality. There are several steps in ethical decision-making:
 - Identify whether the issue is an ethical dilemma.
 - State the ethical dilemma, including all surrounding issues and individuals involved.
 - List and analyze all possible options for resolving the dilemma, and review implications of each option.
 - Select the option that is in concert with the ethical principle applicable to this situation, the decision maker's values and beliefs, and the profession's values set forth for client care. Justify why that one option was selected.
 - Apply this decision to the dilemma and evaluate the outcomes.
- The American Nurses Association Code of Ethics for Nurses (2001) and the International Council of Nurses' Code of Ethics for Nurses (2006) are commonly used by professional nurses. The Code of Ethics for Licensed Practical/Vocational Nurses issued by the National Association for Practical Nurse Education and Services also serves as a set of standards for Nursing Practice. Codes of ethics are available at the organizations' websites.
- The Uniform Determination of Death Act (UDDA) can be used to assist with end-of-life and organ donor issues.
 - The UDDA provides two formal definitions of death that were developed by the National Conference of Commissioners on Uniform State Laws. Death is determined by one of two criteria.
 - Irreversible cessation of circulatory and respiratory functions
 - Irreversible cessation of all functions of the entire brain, including the brain stem
 - A determination of death must be made in accordance with accepted medical standards.

PRACTICE Active Learning Scenario

A nurse is preparing to serve on a committee that will review the policy on disruptive behavior. Use the ATI Active Learning Template: Basic Concept to complete this item.

RELATED CONTENT: Describe another term used for lateral violence.

NURSING INTERVENTIONS: Describe at least four interventions to deter disruptive behavior.

Application Exercises

1. A nurse manager is observing the actions of a nurse she is supervising. Which of the following actions by the nurse requires the nurse manager to intervene? (Select all that apply.)
 - A. Reviewing the health care record of a client assigned to another nurse
 - B. Making a copy of a client's most current laboratory results for the provider during rounds
 - C. Providing information about a client's condition to hospital clergy
 - D. Discussing a client's condition over the phone with an individual who has provided the client's information code
 - E. Participating in walking rounds that involve the exchange of client-related information outside clients' rooms
2. A nurse is caring for a client who is scheduled for surgery. The client hands the nurse information about advance directives and states, "Here, I don't need this. I am too young to worry about life-sustaining measures and what I want done for me." Which of the following actions should the nurse take?
 - A. Return the papers to the admitting department with a note stating that the client does not wish to address the issue at this time.
 - B. Explain to the client that you never know what can happen during surgery and that he should fill the papers out just in case.
 - C. Contact a client representative to talk with the client and offer additional information about the purpose of advance directives.
 - D. Inform the client that surgery cannot be conducted unless he completes the advance directives forms.
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
4. A nurse is serving as a preceptor to a newly licensed nurse and is explaining the role of the nurse as advocate. Which of the following situations illustrates the advocacy role? (Select all that apply.)
 - A. Verifying that a client understands what is done during a cardiac catheterization
 - B. Discussing treatment options for a terminal diagnosis
 - C. Informing members of the health care team that a client has do-not-resuscitate status
 - D. Reporting that a health team member on the previous shift did not provide care as prescribed
 - E. Assisting a client to make a decision about his care based on the nurse's recommendations
5. A nurse manager is providing information to the nurses on the unit about ensuring client rights. Which of the following regulations outlines the rights of individuals in health care settings?
 - A. American Nurses Association Code of Ethics
 - B. HIPAA
 - C. Patient Self-Determination Act
 - D. Patient Care Partnership
6. A newly licensed nurse is preparing to insert an IV catheter in a client. Which of the following sources should the nurse use to review the procedure and the standard at which it should be performed?
 - A. Website
 - B. Institutional policy and procedure manual
 - C. More experienced nurse
 - D. State nurse practice act
7. A nurse is reviewing a client's health care record and discovers that the client's do-not-resuscitate (DNR) prescription has expired. The client's condition is not stable. Which of the following actions should the nurse take?
 - A. Assume that the client does not want to be resuscitated, and take no action if she experiences cardiac arrest.
 - B. Write a note on the front of the provider prescription sheet asking that the DNR be represcribed.
 - C. Anticipate that CPR will be instituted if the client goes into cardiopulmonary arrest.
 - D. Call the provider to determine whether the prescription should be immediately reinstated.
8. A nurse is caring for a toddler who is being treated in the emergency department following a head contusion from a fall. History reveals the toddler lives at home with only her mother. The provider's discharge instructions include waking the child every hour to assess for indications of a possible head injury. In which of the following situations should the nurse intervene and attempt to prevent discharge?
 - A. The mother states she does not have insurance or money for a follow-up visit.
 - B. The child states her head hurts and she wants to go home.
 - C. The nurse smells alcohol on the mother's breath.
 - D. The mother verbalizes fear about taking the child home and requests she be kept overnight.

Application Exercises Key

1. A. **CORRECT:** To maintain confidentiality, client information is disseminated on a need-to-know basis only. A nurse who is not assigned to care for a client should not access the client's information.
B. **CORRECT:** Paper copies of confidential information create a risk for breach of confidentiality.
C. **CORRECT:** Information about a client's condition is disseminated on a need-to-know basis. It is inappropriate to share this information with the hospital clergy.
D. The nurse can share information with an individual who has been provided the information code.
E. **CORRECT:** Sharing information in the hallway where it can be overheard by others can result in a breach of confidentiality.
NCLEX® Connection: Management of Care, Assignment, Delegation and Supervision
2. A. The nurse should advocate for the client by ensuring that the client understands the purpose of advance directives.
B. This response is nontherapeutic and can cause the client to be anxious about the surgery.
C. **CORRECT:** The nurse should advocate for the client by ensuring that the client understands the purpose of advance directives. Seeking the assistance of a client representative to provide information to the client is an appropriate action.
D. This statement is untrue and is a barrier to therapeutic communication.
NCLEX® Connection: Management of Care, Advance Directives/Self-Determine/Life Planning
3. A. **CORRECT:** Assault is conduct that makes a person fear he or she will be harmed.
B. Battery is physical contact without a person's consent.
C. False imprisonment is restraining a person against his or her will. It includes the use of physical or chemical restraints, and refusing to allow a client to leave a facility.
D. Invasion of privacy is the unauthorized release of a client's private information.
NCLEX® Connection: Management of Care, Concepts of Management
4. A. **CORRECT:** Ensuring that the client has given informed consent illustrates nurse advocacy.
B. Discussing treatment options is not within the scope of practice of the nurse.
C. **CORRECT:** Ensuring that the client's care is consistent with his DNR status illustrates nurse advocacy.
D. **CORRECT:** Ensuring that all clients receive proper care illustrates nurse advocacy.
E. Assisting a client to make decisions about his care based on nurse recommendations is inappropriate. The nurse should support the client in making his own decisions.
NCLEX® Connection: Management of Care, Client Rights
5. A. The American Nurses Association Code of Ethics provides nurses with a set of standards for nursing practice.
B. The Privacy Rule of HIPAA ensures client privacy and confidentiality.
C. The Patient Self-Determination Act is federal legislation that requires that all clients admitted to a health care facility be asked whether they have advance directives.
D. **CORRECT:** The Patient Care Partnership is a document that addresses clients' rights when receiving care.
NCLEX® Connection: Management of Care, Information Technology
6. A. A website might not provide information that is consistent with institutional policy.
B. **CORRECT:** The institutional policy and procedure manual will provide instructions on how to perform the procedure that is consistent with established standards. This is the resource the nurse should use.
C. A more experienced nurse on the unit might not perform the procedure according to the policy and procedure manual.
D. The nurse practice act identifies scope of practice and other aspects of the law, but it does not set standards for performance of a procedure.
NCLEX® Connection: Management of Care, Advance Directives/Self-Determine/Life Planning
7. A. Without a current DNR prescription, the nurse must initiate emergency resuscitation, which most likely is not consistent with the client's wishes.
B. Without a current DNR prescription, the nurse must initiate emergency resuscitation, which most likely is not consistent with the client's wishes. Writing a note on the prescription sheet likely will result in a delay in resolving the problem.
C. Without a current DNR prescription, the nurse must initiate emergency resuscitation, which most likely is not consistent with the client's wishes.
D. **CORRECT:** The nurse should immediately call the provider to determine whether the prescription should be reinstated. This is the action to take to be sure that the client's wishes are carried out.
NCLEX® Connection: Management of Care, Advocacy
8. A. Lack of insurance does not warrant a delay in discharge, but it can indicate the need for referral for social services to assist with client needs.
B. The toddler's report of pain is an expected finding.
C. **CORRECT:** It would be unsafe to discharge a toddler who requires hourly monitoring with a mother who might be chemically impaired.
D. Fear verbalized by the mother does not warrant denial in discharge. The nurse should allay the mother's fears by educating her about how to monitor the child and provide phone numbers for the mother to use.
NCLEX® Connection: Management of Care, Ethical Practice

PRACTICE Answer

Using ATI Active Learning Template: Basic Concept

RELATED CONTENT: Lateral violence is also known as horizontal abuse or horizontal hostility.

NURSING INTERVENTIONS

- Create an environment of mutual respect among staff.
- Model appropriate behavior.
- Increase staff awareness about disruptive behavior.
- Make staff aware that offensive online remarks about employers and coworkers are a form of bullying and is prohibited even if the nurse is off-duty and it is posted off-site of the facility.
- Avoid making excuses for disruptive behavior.
- Support zero tolerance for disruptive behavior.
- Establish mechanisms for open communication between staff nurses and nurse managers.
- Adopt policies that limit the risk of retaliation when disruptive behavior is reported.

NCLEX® Connection: Management of Care, Concepts of Management