Welcome and Introduction to Medical Law, Ethics, and Delegation for Nurses

Introduction and Part 1: Medical Law

Welcome to the online course Medical Law, Ethics, and Delegation for Nurses. The purpose of this course is to familiarize you with some of laws, legal implications, ethics, ethical dilemmas, and delegation as they may affect your practice. Completion of this course does not make you lawyers or philosophers but it should alleviate some of the fears through knowledge.

Basic comprehension of the laws that affect nursing and medicine will assist you in avoiding being sued or charged with a crime. Investigating ethical issues prior to actually encountering them in practice will permit self-reflection. This activity will allow you to make better and more principled decisions when the real situations occur. Delegation is becoming more and more a factor in nursing practice due to many and varied influences. The role of the delegator must be clearly understood in order to both maintain patient care standards and to avoid legal and ethical complications.

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Part 1: *Law and terminology*.

How law affects nursing practice.

Nurses are not immune when it comes to lawsuits or the law in general. If you ever become involved in a lawsuit you will find the experience extremely stressful and unpleasant even if you are just called on to testify. If you ever "break the law" you will not find that being a nurse justifies your actions.

So what is law?

Law can be defined in several ways. It is a set of principles or rules set out by government. It is a collection of regulations that pertain to certain activities or circumstances such as medical, juvenile, or international law. Laws are collections of regulations that members of society must follow.

There are several terms you may encounter if you read about the law. **Common law** is supposedly based on common sense. It varies widely from state to state. Common law marriage is the term you are probably most familiar with. If a couple live as husband and wife a set number of years they are considered "married" in the eyes of the law.

Civil law contains the things we are most concerned with. Lawsuits are **torts** and would be examples of civil law having to do with damages or compensation between those involved. This is an example of **tort law**. Imprisonment as a punishment is usually not a factor.

Criminal law involves an action that is considered detrimental to society. Misdemeanors are generally judged to be more minor crimes and may be punished with a fine of less than $1,000 dollars and/or imprisonment of less than a year. A felony is a more serious act and may carry with it a fine of over $1,000 dollars, imprisonment over one year, or even death.

Let's look at some other terms that you should be familiar with.

Assault is defined as a deliberate threat. This can be verbal or physical. The person to whom this action is directed must feel that they are in danger of being hurt or otherwise attacked by the individual making the threat. This action can be criminal or a tort.

Example: The nurse says to the patient "If you don't keep still I will tie you in bed." The nurse did not touch the patient. Only words were exchanged. The patient understands that if they do not behave they will be tied to the bed.

Battery is the intentional unconsented physical interaction between people. This action can be criminal or tort.

Example: A lab technician needs to draw blood on a competent but frail patient. The patient says "I do not want my blood drawn…go away." The lab technician finds someone to hold down the patients arm and draws the sample.

The lab technician has committed assault (the threat to draw blood when the patient did not want it done) and battery (that actual action of drawing blood on the patient). The person who helped hold down the arm may also be involved.

So assault is the threat and battery is the action. They are usually seen together as it would be hard to have battery without assault.

Slander is a verbal statement. The statement is false and hurtful. The statement usually damages the other person's reputation.

Example: A fellow staff member calls the nurse a whore.

The statement is hurtful to the nurse to whom it is directed and is false. This very well could be considered slander.

Libel occurs when the "words" are in print or picture.

Example: A staff member writes a letter to you saying you are a whore.

The statement is hurtful, false, and in a printed media.

Just one note here. There is **Libel** and **Liable** do not confuse them. Liable is defined as responsible. So you could be liable for libel if you wanted.

Neglect is defined as failure to act as a "reasonable person" would in a similar circumstance. It usually involves not doing something as well as it should have been done.

Example: A parent could be guilty of neglect for not providing a coat for a child in the winter.

Most parents would have children adequately dressed for cold weather.

Nurse can be charged with neglect if they fail to provide a certain level of care.

Example: The nurse does not check the code cart as assigned. When the cart is needed some equipment is not present.

If the nurse had checked the code cart the lack of equipment would have been discovered prior to needing it.

Malpractice is sometimes called "professional negligence". Only professionals can be sued for malpractice but anyone can be charged with neglect. Professionals include doctors, lawyers, nurses, and respiratory therapists to only name a few. Malpractice can occur if you perform something outside your scope of practice. Malpractice can occur if you perform a task in an extremely hazardous manner. Can you think of an example involving a well-known entertainer?

Example: The RN could be charged with malpractice if he/she prescribed medication.

In this instance we are talking about a registered nurse with no advanced education. An advanced practice nurse or nurse practitioner may prescribe medications with the proper training and certifications.

Abuse is usually associated with harm being inflicted on another individual. Abuse can be physical, psychological, financial or sexual. The object of the abuse may be a child, elder or other adult. The object of the abuse is usually dependent on the abuser. The abused are usually vulnerable.

Unfortunately, abuse is something we have to become extremely familiar with. One of the primary jobs of the nurse is to act as the patient advocate. We must take action when the patient will not or cannot.

Nurses are bound by law to report suspected cases of child abuse. The agency may vary state to state and county by county. It is very important that you discover which agency you should report to. In some counties you must call the Division of Youth and Family Services (DYFS pronounced dyfus) while in others you may contact the county prosecutor's office.

Failure to contact the proper authorities could result in being involved in a lawsuit or worse should anything happen to the child at a later time. Nurses and other professionals have not violated patient confidentiality or other privacy rules as long as they have reported the incident in "good faith". This means all you really need is a strong suspicion. You do not need positive proof and you are not slandering/libeling the parent or caretaker.

Let's now look at patient confidentiality and how that affects nursing practice.

HIPAA (pronounced hippa) is the Health Insurance Portability and Accountability Act of 1996. Part of this law deals with medical insurance. While that may be important for some

member of the health team nurses are more concerned with other aspects of this law. One of the major areas that HIPAA covers is patient confidentiality.

Basically HIPAA states that if you are caring for or supervising a patient you need to and should have access to their health care records. If you are not directly involved with patient care you cannot access that information.

Example: A movie star has a car accident and is brought to your hospital. If you are the nurse caring for that patient you may look at anything in the chart. If you are not caring for that patient you may not look at the chart even if you are just curious. If it is discovered that you have accessed information improperly you could be charged with HIPAA violation and may lose your job.

A word of warning here. Electronic health care records (EHR) will be replacing written documentation in the near future. When you sign on to a computer to "look" at a chart that action can be traced back to you by your password or ID. Be careful not to violate HIPAA regulations.

HIPAA also is concerned with the health care record and who can be sent a copy of them.

Example: Your doctor wants to send a copy of your chart to the insurance company. Your doctor should obtain written permission from you.

Consent is another topic that nurses deal with every day. Consent occurs when the patient gives permission for a procedure to occur. There are two types of consent. They are informed and implied consent.

Informed Consent: Informed consent occurs when the procedure is explained to the patient prior to that procedure occurring. The patient gives permission to the health care provider to continue.

Example: The nurse needs to obtain a blood pressure reading. He/she asks the patient if the blood pressure can be obtained. The nurse need not go into detail as to how the process will occur unless the patient asks. If the patient says it's OK, then go ahead. In this case the consent is verbal only.

Sometimes informed consent is more involved.

Physicians must obtain written informed consents for procedures such as surgery, invasive tests, and blood transfusions. The physician must explain what will happen and discuss the benefits and risks. Written consents are signed by the patient or caretaker and the physician. The nurse will sign as witness to the signature of the patient or care taker only.

IMPORTANT: It is the responsibility of the nurse to make sure the consent is on the chart. It is not the responsibility of the nurse to obtain the consent. That is the job of the physician.

Implied Consent: This can get a little confusing. The basic example occurs in the case of a medical emergency when the patient cannot respond.

Example: You walk into a patient room and find them unresponsive and not breathing. You call for help and proceed with CPR. The patient cannot give you permission and consent is inferred.

Example: You take a patient's radial pulse. You should ask permission to touch the patient but you are usually not liable for battery by touching the patient in order to obtain a pulse unless the patient has told you not to touch them at all.

Remember that patients can refuse any treatment or any procedure at any time even though that refusal may cause them harm.

Example: A patient is a Jehovah's Witness and medically would benefit from a blood transfusion. The physician must discuss the procedure with the patient and review the benefits and risks. The patient may refuse the transfusion even though they may die without it.

There can be some problems when it comes to when such decisions can be made. This usually has to do with competency.

Competency: The patient must be mentally capable of making medical choices. The patient must not be severely mentally challenged or under the influence of drugs or alcohol.

Import note: You will find that pain is the 5th vital sign and nurses work to make the patient as comfortable as possible. Pain medications are frequently given by nurses. A problem occurs when the patient has been given narcotics prior to signing a consent form. While the physician must obtain a consent the patient is now under the influence of narcotics and may not be considered "competent" to make health care decisions.

Abandonment: Abandonment occurs when the nurse or physician walks away from the patient after having taken responsibility for caring for that individual.

Example: A nurse is working and becomes ill and wants to go home. The nurse is informed by fellow health care team member that he/she must inform the supervisor so that arrangements can be made to care for those patients he/she is assigned to. The nurse does not inform the supervisor and leaves the unit to go home. The nurse could be found to be guilty of abandonment.

Abandonment can occur in relation to "floating" to other units. Be very careful here. Nurses can be "floated" to other units or floors when the need arises. Ideally you will only be

floated to floors on which you feel comfortable and have the skills or experience to work on, but this is not always the case.

Example: A nurse who has only worked on a long term care floor would not be the ideal candidate to be floated to the open-heart surgical unit. The nurse's skills would probably not be adequate to work on such a floor.

If you are floated to another unit and take an assignment you are responsible for those patients. If there is any hesitancy on your part you must make both verbal and written notification to the supervisor. In that written statement include your qualifications and clear objections. Make a copy of this document and keep it for your own records. This shifts the responsibility to the supervisor. You may want the supervisor to sign the document.

You must remember that there are certain procedures that you cannot do without proper certifications or education.

Example: A RN is floated to the oncology unit. The RN may not administer chemotherapy medication without proper certification. The RN can render most care to the patient and give any medication except chemotherapy agents. The RN would not be abandoning the patients in his/her care in this instance. Regular floor staff could administer the drugs.

Example: The LPN is floated to a surgical floor on which he/she has never worked. The LPN notifies the supervisor in both verbal and written form of his/her concerns. The supervisor states that the LPN will be oriented to the unit. The LPN refuses orientation. Orientation is considered a learning experience. The LPN would not be completely responsible for patients during orientation. This could cause trouble if declined. If an employee refuses proper orientation to another unit this may be reason for dismissal.

Putting something in writing and keeping a copy for your records is an extremely important concept to understand. You will forget specific instances or time. If the situation is in writing you will better recall the occasion should the need ever occur.

Americans with Disabilities Act (ADA) of 1990: The ADA is concerned with making facilities and services available and accessible to all. It is something to be aware of. This act is also concerned with patients who have Acquired Immune Deficiency Syndrome (AIDS). We see the results of this act every day.

Some adaptions you might be familiar with are:

- Handicapped parking spaces
- Curb ramps
- Elevator buttons that can be reached from a wheelchair
- Brail writing on elevator buttons
- Telephone adaptors for the hard of hearing

The ADA requires that sign language interpreters are provided for those who require them. No one is saying that the nurse is responsible to provide all the physical modifications under this act but if a patient needs and requests a person who can perform sign language then a supervisor must carry out that demand.

In relation to AIDS or HIV positive patients the act states that care cannot be totally denied because of the diagnosis. In the case of a physician the patient must be referred to another doctor. If a nurse refused to take care of a patient in a similar setting the consequences could be the same.

Let's look at another related topic.

You just graduated from school and are looking for a job. You go to an interview. You are nervous but know that you can do the job. The interviewer will probably ask you questions. What kind of questions can they legally ask? What kind of questions can they not ask you?

Questions that should not be asked during an interview:

How old are you?

Age discrimination in the workplace is a fact even though it is illegal. The only time this question can be asked is if the applicant needs to be over or under a certain age to use machinery or attain a license. The question must then be changed to ask "Are you between the ages of 17 and 70?".

What religion are you?

This question is not legal. The interviewer may ask if you are able to work on Saturday or Sunday if working those days is normally part of the job expectations.

Do you have any health problems?

Again, this question is not appropriate. The exception here would be if handicap would interfere with your ability to perform the job.

Have you ever been arrested?

Illegal. Arrest is not conviction.

What is your height and weight?

Generally this is illegal unless the job is dependent upon that physical condition.

What questions are legal to ask?

Are you a citizen of the United States?

Do you belong to any organizations?

While it is legal to ask if you belong to any organizations it is illegal to ask which ones.

What is your address or where do you live?

Legal as well as how long you have lived there.

Most of the above questions are under federal regulation (Equal Employment Opportunity Commission (EEOC)). Federal law governs the whole country. State laws usually cannot override federal law. Local ordinances cannot supersede state or federal decisions.

What would you do if you felt you were discriminated against during an interview?

Hint: Initials followed by .gov usually allows you to contact federal agencies.

Documentation

"If you didn't chart it you didn't do it."

This is a statement you will hear over and over again. What nurses see and do is recorded in the patient chart. Proper documentation can save you and/or your facility in a law suit. Poor documentation will not have such a happy outcome.

Chart documentation delivers several things.

- It provides professional obligation and accountability. In the case of nursing this is best represented by the nursing process.
- The chart provides communication between members of the health care team.
- Nurses read other nurses notes in order to gain information about the patient.

- ❖ Even physicians can use nurse's notes as a source.

The chart may be used by legal professionals to determine if standards of practice were adhered to.

Insurance companies may use chart documentation to assure compliance for reimbursement.

In class you have discussed the nursing process. You will recall that the nursing process is a series of steps that nurses use to achieve goals.

The steps of the nursing process are:

Assessment: This is usually based on information or data about the patient. It can be objective (BP, elevated temperature, unsteady gait) or subjective (complaints of pain or nausea).

Nursing Diagnosis: What is the risk for the patient? What could be improved?

Goals/Plan: Goals can be short term or long term. What is the desired outcome?

Intervention/Implementation: What actions will be done by the nurse in order to achieve those objectives?

Evaluation: Did it work? If not then reassess and start again.

Example: A patient's breathing is becoming more and more difficult. The nurse contacts the physician. Orders are received. The nurse documents calling the doctor and getting the orders. A treatment is given but the patient's condition does not improve. The nurse does not chart the poor response. The patient's condition gets worse.

What is wrong with this example?

The assessment was increasingly difficulty breathing. The nursing diagnosis could have been at risk for hypoxia. The goal was to ease the respiratory effort or improve respiratory function. The intervention was to contact the physician, obtain, and carry out medical orders. The evaluation to the intervention never occurred or was never charted. This is where the nurse failed in the nursing process. The assessment should have indicated the need for further actions. This did not happen.

The nurse could be accused of negligence for failing to follow the nursing process.

The patient must come first. The nurse does not drop everything in order to chart but complete and proper documentation is very important for nurses. Had proper evaluation occurred in the above scenario the patient might have had a better outcome.

Example: A patient is hospitalized for an orthoscopic procedure on her left knee. The nurse documents that patient teaching included ringing the call bell for assistance when the patient wants to go to the bathroom. During the evening the patient falls on the way to the bathroom. The nurse asks the patient why she did not ring for help. The patient stated she tried to ring the call bell but it was not working. The bell had not been working when the patient tried it earlier but the nurse was never informed. The family sues the nurse and facility for the fall.

In this case the nurse documented well. The assessment was unsteady gait due to procedure, the nursing diagnosis was risk for injury, the goal was to prevent injury and the intervention was to teach the patient about the call bell and to wait for assistance. You do not have to evaluate right away.

The patient stated the call bell did not work. The nurse stated she would replace the bell or called the maintenance department if the patient has told her the bell was not working.

The nurse should not face penalty in this case. Documentation was proper and complete.

For written charting the documentation must be legible and orderly. If you have ever tried to read notes (nurses or doctors) you know what we are talking about. If the chart is a form of communication among the health care team members then all members should be able to read it with ease. Spelling should be correct. Grammar should be proper but not usually in full sentences. Abbreviations should be minimal and authorized. Your facility will have a list of abbreviations that can and cannot be used. The chart's documentation should be timed and factual. Opinion should not be included.

Look at nurse's notes in the charts you review. How could you make them better? Has the nurse omitted something vital? Practice on your own.

Nursing documentation is changing. In the year 2015 all medical documentation should be computerized. This includes all entries by members of the health care team. The overall goals of the electronic healthcare record (EHR) are to prevent medical errors, increase communication, and improve patient care.

There are several programs available for use but they are all somewhat similar in nature. In general nurse will have "check sheets" for patient care. Common nursing actions will be options. Usually these forms will be presented by system (cardiac, respiratory, urinary). The nurse will complete each part of the electronic record. Some programs do not allow the nurse to proceed to the next system without finishing that page. Most programs will have sections where the nurse can write something that was not included on the check list. If the nurse must input additional data then the rules of written charting will again apply.

Like anything else there are pros and cons to the implementation of the EHR. First is the need for training. All members of the health care team must enter data. That includes doctors.

Education required time and commitment. Some programs are more “user friendly” than others. Staff input prior to selection is imperative. Ideally the program can be modified to meet the needs of each specialty. It would illogical to have a program designed for a long term facility used on an intensive care unit.

To review:

Knowing something about the law and how it affects nursing practice could help you avoid lawsuits or worse.

- You will be nurses, not lawyers but your actions must be kept within your practice act.
- Documentation is a crucial part of practice.
- It is better to avoid a lawsuit by proper and prudent nursing practice.