Investigation of registered nurses Jurisprudence in Montana
by Nancy Jane Brown Smith

A thesis submitted in partial fulfillment of the requirements for the degree of MASTER OF NURSING
Montana State University

Abstract:
This has been a descriptive study to investigate active registered nurses knowledge of negligence and malpractice in clinical nursing situations.

The review of literature identified several areas (i.e., nurses' notes, medication therapy, patient safety, informed consent and respondeat superior doctrine) as common areas of litigations for professional nurses. Therefore, the questionnaire was composed of clinical nursing situations involving the above cited areas. The sample population was a geographical representation of active registered nurses of Montana.

The null hypothesis was retained showing no significant difference of mean scores among the diploma, the associate degree and the baccalaureate degree nurses in responding to the questionnaire. The areas of respondeat superior doctrine and consents had the lowest mean number of correct responses of the five areas included in the questionnaire.

Additional descriptive analysis of the sample was done regarding: educational background, continuing education, ANA member- ship, carrier of professional liability insurance, and the age of the respondents. Some of these areas demonstrate trends and the need for additional research on this subject.

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by

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A thesis submitted in partial fulfillment
of the requirements for the degree

of

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ABSTRACT

This has been a descriptive study to investigate active registered nurses' knowledge of negligence and malpractice in clinical nursing situations.

The review of literature identified several areas (i.e., nurses' notes, medication therapy, patient safety, informed consent and respondeat superior doctrine) as common areas of litigations for professional nurses. Therefore, the questionnaire was composed of clinical nursing situations involving the above cited areas. The sample population was a geographical representation of active registered nurses of Montana.

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Chapter 1

INTRODUCTION

Malpractice and professional negligence are becoming familiar terms in society. Americans are primarily linking malpractice with the medical profession. Being closely associated with the medical profession in health care delivery, nurses are also being implicated in malpractice issues.

Society is demanding competence in the health care delivery system. The witnessing of the medical profession's involvement with malpractice issues is alerting those in the nursing profession to know their nurse practice act and to develop criteria and standards of patient care to use as guidance for legal protection.

If a judge and/or jury are presented with a malpractice or negligence case involving the nurse they will refer to the established statute of nursing for that state. If there is some question as to the current status of the nurse practice act they will seek information in order to compare the particular nurse's act in question to that of a peer nurse. (i.e., Would another nurse of comparable skill presented the same circumstances have acted in a similar fashion?) Nurses need to be aware of the current laws and legislation affecting their practice. What is acceptable practice today may be obsolete in one, five, or ten years. The HEW commission on malpractice has published recommendations for the practice of nursing. In addition to the federal

government's guidelines, the consumer's expectations for quality health care is expressed in the Patient's Bill of Rights published by the American Hospital Association.

The profession of nursing is presently in the process of development. The new image of the nurse in expanded roles include having nurses assume decision making, problem finding as well as problem solving functions and the responsibility to be life long learners.[1]

This researcher has been concerned about nursing liability and malpractice since entering the profession as a registered nurse. Nursing colleagues have expressed lack of specific actions they practice to prevent liability in their practice of nursing. The data of this study was descriptive of the perceptions and knowledge of the Montana registered nurses regarding negligence and malpractice in the clinical setting.

STATEMENT OF THE PROBLEM

The problem of this study has been to identify and describe active registered nurses' responses to clinical nursing situations

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[1]Inez G. Hinsvork, "Implications for Action in the Expanded Role of the Nurse," The Nursing Clinics of North America, ed. Helen Creighton, IX (September, 1974), 411-423.

regarding professional negligence and malpractice.

This study has been primarily concerned with professional negligence and malpractice as it pertains to medication therapy, patient safety, records, consents and the respondeat superior doctrine.

NEED FOR THIS STUDY

Nurses in all fields of nursing practice are being included in malpractice and negligence litigations. One common bond of educational settings and employment settings of nurses is the concern for all nurse's actions to be that of a reasonably prudent nurse. The theoretical background and the application of judgement in the practice of nursing are complimentary. The data of this study provides insight for planners of curriculum, directors of in-service education and boards of continuing education.

GENERAL QUESTIONS TO BE ANSWERED

The general questions were:

1. Is there a difference among the respondents according to the basic educational preparation as to knowledge of legal issues and/or judgements in clinical nursing situations?

2. Are some areas of commonly cited litigations (i.e., medication therapy, patient safety, records, consents, and respondeat superior doctrine) better understood than others?

3. What is the educational background of the respondent?

4. Did the respondent participate in continuing education in the last year?

5. Did the respondent participate in any continuing educational programs concerning nursing legalities?

6. Did the respondent's educational setting include nursing legalities in the curriculum?

7. Is the respondent an ANA member?

8. Does the respondent maintain professional liability insurance?

NULL HYPOTHESIS

The purpose of this study was to carry out a descriptive investigation of registered nurses' knowledge of negligence and malpractice in clinical nursing situations.

The researcher used descriptive analysis of the findings related to questions two through eight.

In summarizing the first question, (i.e., Is there a difference among the respondents according to the basic educational preparation as to knowledge of legal issues in clinical nursing situations?) the researcher tested the following null hypothesis:

1. There would be no difference between the diploma graduate and the associate degree graduate.

2. There would be no difference between the diploma graduate and the baccalaureate degree graduate.

3. There would be no difference between the associate degree graduate and the baccalaureate degree graduate.

DELIMITATIONS

1. No cases were reviewed by the researcher due to inavailability of a law library.

2. Legal lessons were cited from an authority in nursing jurisprudence due to the researcher's limited vocabulary and knowledge of courts of law.

3. The population used in this study was limited to Montana due to time allotted as well as financial resources available to collect the data.

4. The population consisted of professional nurses maintaining a license to practice nursing.

DEFINITION OF TERMS

Active registered nurse--a professional nurse maintaining a license to practice nursing as defined by the State Board of Nursing of Montana.

CEU--(continued education unit) The American Nurses Association's standard of measuring educational instruction. One CEU equals

ten hours of organized, approved educational experience.

Informed Consent--information provided the patient to enable him/her to make knowledgeable decisions about his/her care.

Jurisprudence--"The philosophy of law, or the science which treats of the principles of positive law and legal relations."[2]

Liability insurance--"indemnity against liability."[3]

Legal lesson--Examples cited and knowledge given as guidelines and/or models.

Legal liability--"a liability which courts recognize and enforce between parties litigent."[4]

Malpractice--"Any professional misconduct, unreasonable lack of skill or fidelity in professional or fiduciary duties, evil practice, or illegal or immoral conduct."[5]

Negligence--"The omission to do something which a reasonable man, guided by those ordinary considerations which ordinarily regulate human affairs, would do, or the doing of something which a reasonable and prudent man would not do."[6]

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[2]Henry Campbell Black, Black's Law Dictionary (Minnesota: West Publishing, 1951), 992.

[3]Ibid., p. 1060.

[4]Ibid., p. 1040.

[5]Ibid., p. 1111.

[6]Ibid., p. 1184.

Nursing licensure--"Legal document that permits a person to offer the public skills and knowledge whose practice would otherwise be unlawful."[7]

Special care areas--Places of nurse-patient interaction that requires a skill which supercedes a nurse generalist, thus a nurse specialist.

SUMMARY

Malpractice and negligence are becoming familiar terms in society. The nursing profession is being included in negligence and malpractice issues.

This has been a descriptive investigation of registered nurses' knowledge of negligence and malpractice involved in clinical nursing situations.

Areas of investigation for this research have included:

1. basic educational preparation and continuing education of the respondents,
2. some areas commonly cited in litigations,
3. professional liability insurance.

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[7]Sidney H. Willig, The Nurse's Guide to the Law (New York: McGraw-Hill, 1970), p. 21.

Chapter 2

REVIEW OF LITERATURE

Society has high expectations for nursing. As professionals, we are to meet the standards of nursing care with clinical expertise and a theoretical body of knowledge. Nurses of the twentieth century are struggling to build a basis to support nursing practice. Some of the nursing issues today are:

1. Definition of the practice of nursing.
2. Examining various educational settings and licensure of the different levels of preparation.
3. Institutional vs. individual licensure.
4. Technical vs. professional nurses.
5. Certification programs.
6. Mandatory continuing education.

A study was done by Guard in Montana a decade ago to survey the licensed active duty nurses' beliefs regarding legal responsibilities in nursing. Her survey revealed that nurses lacked legal understanding of their professional activities.[8]

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[8]Carol Lee Guard, "A Survey of Licensed Active General Duty Nurses in Montana to Determine Their Beliefs Regarding Legal Responsibilities in Nursing" (unpublished Master's thesis, Montana State University, 1965).

It is the belief of this researcher that the theoretical framework of nursing practice should include legal concepts. This study investigated the registered nurses' perceptions and knowledge of negligence and malpractice in the clinical setting. Nurses must demonstrate specialized knowledge and skills in practicing the profession as well as accept the liability of providing health care services.

This review of literature reveals major areas of concern about legal issues for nurses. The areas are as follows:

1. The liability crisis of health care services.
2. Professional liability insurance for the professional nurse.
3. Malpractice and/or negligence concepts of litigations.
4. Educational preparation of professional nurses.
5. Five common areas of negligence for the nurse in the clinical setting.

PROFESSIONAL LIABILITY CRISIS

In the United States, until the 1960's, hospital diploma schools were in the majority. The student's learning experiences were classroom and clinical rotations throughout the hospital.

Educational preparation since the 1960's has moved to the collegiate setting. One disadvantage for the collegiate prepared nurse is less nurse-patient interaction.

Liability claims frequently emerge from the nurse-patient

relations. In administering nursing care the prudent nurse emphasizes "good public relations and good patient-nurse communications and rapport."[9] Some guidelines to avoid litigations in administering nursing services are: 1) never make guarantees, 2) never expect a patient to consent to a procedure unless he/she knows what is going to be done, 3) never be too busy to explain and 4) if a patient or relative offers complaints or information, follow-up and record the incident and findings.[10]

One purpose of this researcher has been to alert the practicing nurses, be they recent, less experienced graduates or the more experienced graduates, of the liability crisis involved in health care. Nurses must respond to the crisis and bridge the art and science of nursing thus delivering competent and safe health care scientifically, socially and legally.

The practicing nurses are the pathfinders in bringing the nurse's role and society's expectations of the role closer together.[11]

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[9]Helen Creighton, "The Malpractice Insurance Crisis," Supervisor Nurse, December, 1975, pp. 40-43.

[10]Helen K. Branson, "Malpractice: What Can the Nurse Say?" Nursing Care, 8:30-31, May, 1975.

[11]Irene Murchism, "Nursing Jurisprudence: The Need for a Conceptual Framework," Current Concepts in Clinical Nursing, ed. Edith H. Anderson and others (St. Louis: C.V. Mosby, 1973), pp. 323-325.

During the current medical liability crisis nurses are being named as principles more frequently, as patients and their lawyers become more cognizant of the nurse's role as a participant in the health care delivery team.[12]

PROFESSIONAL LIABILITY INSURANCE

Professional liability insurance is a form of security a nurse can provide for herself. One author of nursing jurisprudence comments on professional liability insurance this way.

> Ethically speaking, professional nurses should be prepared to indemnify patients who are victims of accidents sparked by nursing service.[13]

The nurse delivering health care in an institutional setting (i.e., hospital) frequently has a false sense of security. The myth creating this security is that the employer's liability insurance covers them. The employee has no protection by the employer's policy unless it has an employee malpractice endorsement. Hospitals do have liability insurance, however, less than 10 percent of them provide coverage for the individual employee.[14]

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[12]Lorne C. Rozovsky, "A Nurse is Sued," Dimensions in Health Science, 52:8-9, May, 1975.

[13]Regan, loc. cit.

[14]Charles A. James, Jr., "Is Your Negligence Showing?" AORN Journal, 17:116, 118, 120, May, 1973.

Each nurse is responsible for her own acts. Insurance companies' lawyers are not hesitant to subrogate the nurse responsible for the act and recover any loss that the insurance company encountered.

The HEW Commission of Medical Malpractice report states that "57.2 percent of all claims arises from surgical procedures."[15] The scrub and/or circulating nurse in the operating room is responsible for the sponge count. Commonly cited cases in which rewards are in favor of the plaintiff involve sponges and/or instruments left in the surgical wound. The sponge count is becoming an area of nurse negligence. Mr. Regan refers to the surgical sponge count in the case of Chappetta v. Ciavella. The case resulted from a sponge remaining in the wound during an abdominal hysterectomy and causing an obstruction. The court awarded damages to the plaintiff. The nurses were not cited by the plaintiff as co-defendants in this case even though a breach of responsibility to the patient did occur. The legal lesson to be learned is as follows:

> The key lesson to be learned from this case is the joint liability of the operating surgeon and surgical nurses for things such as a laparotomy count. There was nothing in this case which indicated that the nurses were free from liability. It is assumed that if individual nurses are charged with a specific responsibility such as that of counting laparotomy sponges before

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[15] Appendix: Report of the Secretary's Commission on Medical Malpractice, Dept. HEW, Pub. # os 73-89 (Washington, D.C.: U.S. Government Printing Office), January 16, 1963, p. 10.

> and after surgery, and if a mistake is made in the process of such accountability, negligence may be inferred from that fact.[16]

In essence legal liability involves the characteristic of responsibility which courts recognize between people.[17]

The HEW Commission on Medical Malpractice has offered several recommendations to alleviate the malpractice crisis. They suggest the utilization of more professional nurses giving direct patient care, having more educational preparation in the hospital setting, thus increasing patient care activities, and constant improvement of interpersonal relations and continuing education of health care personnel.[18]

This researcher encourages nurses to take action in alleviating the malpractice crisis. The above recommendations by the HEW Commission on Medical Malpractice are guidelines for nurses in providing quality health care for the consumer.

NEGLIGENCE VS. MALPRACTICE

Negligence and malpractice are not synonymous. Malpractice involves a professional misconduct, unreasonable lack of skill or

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[16]William Regan, "Surgical Sponges: Surgeon-Nurse Joint Duties," The Regan Report of Nursing Law, 16:1, June, 1975.

[17]Henry Campbell Black, ed., Black's Law Dictionary (St. Paul, Minnesota: West Publishing Company, 1951).

[18]Appendix: Report of the Secretary's Commission on Medical Malpractice, loc. cit.

fidelity in professional duties, evil practice or illegal or immoral conduct.[19] Malpractice involves the professional person. Licensing of professionals provides the public with assurance that the professional has at least a minimum level of competency at the time of licensure. Therefore in a malpractice litigation the person holds a license for professional practice. In most cases it is a licensed professional who is accused of malpractice.[20]

Negligence can involve either a professional or nonprofessional and many times is the precursor to malpractice. Negligence is

> the omission to do something which a reasonable man, guided by those ordinary, considerations which ordinarily regulate human affairs would do, or the doing of something which a reasonable and prudent man would not do.[21]

Negligence in nursing can be defined as conduct which falls below a "standard of care established by law for the protection of others against unreasonable risk of harm."[22] In essence, the definition asks, how does the nurse or action in question compare to what a reasonably prudent nurse would do given similar circumstances?

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[19]Black, op. cit., p. 1111.

[20]Sidney H. Willig, The Nurse's Guide to the Law (New York: McGraw-Hill Book Co., 1970), p. 105.

[21]Black, op. cit., p. 1184.

[22]Irene Murchison, "Foreseeability of Harm--A Legal Rationale for Decision Making," Current Concepts in Clinical Nursing, ed., J.A. Murchison and T.S. Nichols, Vol. IV (New York: MacMillan Co., 1970), Chapter #36.

The nursing supervisor may not be negligent in a specific action of an employee however she could be negligent in her delegation. If she assigns a nurse to a particular setting and the nurse is not capable of functioning in that setting her delegation could be negligent. In this instance, as in other nursing situations, delegation and standards of care are two ingredients of negligence and/or malpractice. The elements of negligence can be defined as follows:

1. Defendent owed a duty to the plaintiff.

2. The defendent breached that duty.

3. The breach of that duty was the proximate cause of the plaintiff's injury.[23] In negligence, injury, is an essential element and the injury must be proven. Even if the nurse carelessly performs a function, as long as the patient isn't hurt there can be no finding of negligence.

To date, negligence has primarily been cited in litigation in court cases. Ruth Gauge, a nurse and lawyer, summarizes negligence as follows:

> All members of the professional health team offer to the public those services which require highly specialized skills. The public relies upon their education, experience and clinical

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[23]Charles W. Quimby, Jr., "You Can Be Sued," Vol. 17, No. 3, AORN Journal, (March, 1973), 107-111.

expertise. The law, in turn, as a general legal principle, demands definable standards of care in performing those professional services.[24]

EDUCATIONAL PREPARATION OF NURSES

Nurse educators are asking if law should be one component of the interdisciplinary base of nursing science.[25]

Nurse practitioners are asking for knowledge about legal sources of authority to guide the determination of boundaries of practice in the delivery of health services.[26]

This is a period of rapidly changing health care. Nurses are expanding the role of nursing practice. Bergerson and Duffey indicate that the conceptual framework of nursing practice must include legal aspects.[27]

The nursing profession is searching for the why of its practice. One contribution in formulating the basis of the nursing practice can be knowledge of the law in the guidance of nursing practice and

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[24]Ruth L. Gauge, "OR Nurses Face Potential Libailities," AORN Journal, XX (October, 1974), p. 660.

[25]Irene Murchison, "Nursing Jurisprudence: The Need for a Conceptual Framework," Current Concepts in Clinical Nursing, Vol. IV, ed. Edith Anderson, et. al. (St. Louis: C.V. Mosby, 1973), pp. 323-325.

[26]Ibid.

[27]Betty S. Bergersen and Margery Duffy, "An Excursion into the Law of Nursing Practice," Current Concepts in Clinical Nursing, Vol. IV, ed. Edith Anderson, et. al. (St. Louis: C.V. Mosby, 1973), pp. 321-322.

improving the quality of patient care. There is a lag in including legal knowledge in the preparation of nurses.[28]

Law can be constructive in supporting nursing decisions, however, planners of continuing education, associate degree, baccalaureate degree and higher educational programs haven't paid sufficient attention to the study of law and its application to nursing.[29]

Students have a choice of three educational settings in which to prepare for state board examinations enabling them to become registered nurses. All three of the educational programs increased in numbers in the 1960's. However, since then, the growth rate of the nursing programs has declined. National League of Nursing says there has been no change in the total number of registered nurse programs in the last three years, but rather a redistribution of numbers of the various educational settings. Diploma programs are continuing to decline in numbers. The baccalaureate programs continue to increase in numbers, however, this growth is not sufficient to overcome the decline in diploma schools and the reduced expansion of associate degree programs. For the academic year of 1975 there were 618 associate degree programs, 428 diploma programs and 329 baccalaureate degree

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[28]Irene Murchison, op. cit., pp. 323-325.

[29]Bergerson and Duffy, op. cit.

programs to prepare the beginning practitioner in nursing throughout the United States.[30]

Are there differences between the graduates of the three educational preparations? The position paper in 1965 by the Committee on Education of the American Nurses Association stated there were technical nurses and professional nurses. Later, nurses were labeled as 'care' nurses and 'cure' nurses. The 'care' nurses (the baccalaureate degree nurses) were concerned about the psychosocial skills and the 'cure' nurses (the associate degree nurses) were concerned about physiology and pathology.[31]

In the 1970's Hover directed her study to differences in degree graduates and diploma graduates in terms of 1) patient preferences, 2) satisfaction with and opinions about co-workers, supervisors and nursing, and 3) educational and career goals. She concluded there were differences.[32]

Are nurses alike in their perceptions and knowledge of the law of nursing practice? This was a concern of this researcher investigating

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[30]Walter L. Johnson, "Educational Preparation for Nursing--1975," Nursing Outlook, XXIV (September, 1976), pp. 568-573.

[31]Bonnie Bullough and Colleen Sparks, "Baccalaureate vs. Associate Degree Nurses: The Care-Cure Dichotomy," Nursing Outlook, XXIII (November, 1975), pp. 688-692.

[32]Julie Hover, "Diploma vs. Degree Nurses: Are They Alike?" Nursing Outlook, XXIII (November, 1975), pp. 684-687.

the knowledge of negligence and malpractice in clinical nursing situations of the nurses in Montana.

NURSES' NOTES

Nurses' notes are part of the medical record and are legally authentic. Nurses have a tendency to give the nurses' notes low priority, however, the recording of the nursing care is essential.

> The patient has a right to a chart that tells what was wrong with him initially; what was done for him; what, if anything, went wrong; and what was done to correct it."[33]

The record is equally important for the nurse. She must make objective notations. The nurse records the patient's comments, her assessment, and the nurse-patient interaction. These recordings are entered in the chart at regular intervals (i.e., every two to four hours or more frequently depending upon the assessment of the patient). In six months or six years as memory fades the record will document the day's proceeding with validity.

The legal use of the medical record is as follows:

1. settle accident and personal injury claims,

2. show the series of events leading to an injury and the conduct of the doctor and nurse,

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[33]Alice H. Keer, "Nurses Notes: That's Where the Goodies Are!" Nursing 75, V (February, 1975), 37.

3. show failure to utilize information,

4. show failure to transmit information to other departments, and

5. show failure to write clear medical orders.[34]

Problem oriented medical records (POMR) are a legal form of charting. Helen Creighton reports the problem oriented medical records enables the nurse to fulfill her responsibility in charting.[35]

The lawyers use of nurses' notes is distinctive and the reasons for this are as follows:

1. Nurses' notes give evidence as to whether the doctor's orders were carried out and the results.

2. Nurses' notes frequently are the only notes to contain time and dates.

3. Nurses' notes contain detailed information about the patient.[36]

The record has many uses other than legally, however the concern of this researcher is to arouse the nurse's legal conscience. The value of the record relies on nurses to provide continuing quality,

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[34]Murchison, op. cit., pp. 46-48.

[35]Helen Creighton, "Legality of POMR," Supervisor Nurse, (March, 1975), pp. 57-58.

[36]Kerr, op. cit., pp. 34-41.

objectivity, pertinency and accuracy. (See Appendix A: page 62, "Charting: Meaningful and Accurate Nurses Notes")

MEDICATIONS

Medication therapy is a time consuming activity for nurses and the professional is always wanting to delegate this function to the practical nurse or pharmacy personnel. Granted the physical administration of a medication may be a technical skill, but the interpretation of the medication interaction is a professional concern. When it takes a pharmaceutical chemist years to prepare and patent the drug for administration, a physician to prescribe a medication and a pharmacist to dispense it, how can such an important component of the patient's welfare become a menial task.

It is a common fact in institutional settings that a frequent incident report to be filled out and sent to the doctor and the respective institutional committee involves a medication error. The Department of Health, Education and Welfare Commission on Medical Malpractice recommends that clinical pharmacology be taught to all medical and nursing students throughout their life, including basic educational preparation, post graduate level and continuing educational

curricula.[37]

Many of the middle size hospitals and most of the small hospitals today struggle with the legal implications for a nurse to dispense a medication, an action which is against the Pharmacy Act. Drug dispensing involves the following:

> 1. issuance of one or more doses of a medication in containers other than the original...
> 2. the issuance of medication in its original container with a pharmacy-prepared label...
> 3. the container carries a pharmacy prepared label when the container is intended for nursing station use in a hospital or nursing home.[38]

A nurse is allowed to take a dose of a drug from the pharmacy to the nurses' station for a particular patient or she can take a properly prepackaged and labeled container to the nurses' station. The dispensing and administration of medications is being facilitated today by the pharmaceutical companies packaging individualized medications which are labeled as to dosage and name of the medication.

The trend in intravenous therapy is for the pharmacist to premix the intravenous solution and send it to the floor to be stored and/or refrigerated until the patient needs it. Some of the reasons for this

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[37]Department of Health, Education, and Welfare, Appendix: Report of the Secretary's Commission on Medical Malpractice, (Pub. No. os 73-88: Washington, D.C., Government Printing Office, January 16, 1963), p. 60.

[38]Helen Creighton, Law Every Nurse Should Know, 3rd ed., (Philadelphia: W.B. Saunders, 1975), p. 285.

trend are described in the Thur, Miller and Latiolias study cited in the American Journal of Hospital Pharmacy. They found sources of errors as follows:

1. Medication cards--14% contained a transcription error.
2. Ninety-nine percent of the nurses observed failed to cleanse the area of preparation.
3. When vials of water were used to prepare the mixtures eighty-four percent of the nurses observed failed to cleanse the vial top.
4. Other sources of errors were incorrect drug or solution and drug incompatability.[39]

The Thur, Miller and Latiolias study does not imply all intravenous therapy will include the same above cited errors, however, these errors are an area of concern. As a precaution and to decrease errors the institutions of health care should have an established and known policy and procedure for intravenous administration.

What about medications brought to the hospital by the patient? The author speaking to this issue stated that the main difficulty arises in identification of the medication. If the bottle contains the pharmacy and perscription number as well as the patient's name then the nurse is able to call the pharmacist for verification of the label.[40] This call for identification should be noted in the nurses' notes.

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[39]Michael P. Thur, William A. Miller and Clifton J. Latiolais, "Medication Errors in a Nurse-Controlled Parental Admixture Program," American Journal of Hospital Pharmacy, 29:298-304, April, 1972.

[40]Creighton, op. cit., p. 252.

However, the patient may substitute another medication into that bottle because that bottle was a better size with which to travel, or he may have put two medications into the same bottle. Again, the problem is in identification of the medication. The nurse is responsible for her actions. Identifying the patient's medication is an area of concern and most institutions should have a policy and procedures to see that the policy is in operation.

Lastly, the writer will address the injection form of medication administration. Every nurse (registered nurse or practical nurse) must have an educational course to prepare for drug administration. A nurse is liable for a faulty injection. She can never be too careful in giving and recording the injectable medications.

Some guidelines to give quality injections are:

1. Don't inject into infected areas or spinal cord, or nerves.
2. Carefully prepare the medication and site of injection.
3. Check for allergies, asthma, hay fever, and sensativities the patient may have.
4. Explain it may hurt a little.
5. Have a professional approach.[41]

Another responsibility in medication administration for the nurse is: the responsibility for all nurses to check with the physician

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[41]Lipman G. Feld, "Nurses Liability for Faulty Injections," Nursing Care, Vol. 7 (April, 1974), p. 25.

who prescribed the medication if there is any doubt about the medication, the dosage of the medication to be given and/or the time schedule for the medication to be given. "The law requires that the nurse check the drug order with the prescribing physician when faced with a question or doubt or apparent error in the order...."[42]

This researcher has identified areas of medication therapy which are common to nurse's role in institutional settings. These areas are: 1) guidelines to give quality injections, 2) identification of medication which the patient brings to the health care institution, 3) sources of contamination in preparing intravenous solutions and 4) the law requires the nurse to question the physician which ordered the medication if any doubt arises about the order.

PATIENT SAFETY

"Nurses have a duty to protect the patient from any known danger."[43]

The concept of foreseeability of harm is especially applicable to patient safety. The nurse in the general wards is confronted with the issues of side rails, heating pads, sitz baths, enemas, assisting

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[42]William A. Regan, "Legal Lesson of the Month," The Regan Report on Nursing Law, Vol. 12, No. 9 (February, 1972), p. 2.

[43]Creighton, op. cit., p. 123.

with patient ambulation and many others. Frequently she delegates these functions to other health care providers, however, she may be implicated under the doctrine of respondeat superior. (Briefly, the respondeat superior doctrine means 'let the master answer'.)

What about hospital infections? Who causes them? Who can prevent them? With increasing frequency court cases are finding the nurse responsible for infection occurring by cross contamination. A reasonably prudent nurse knows she must always wash her hands between caring for different patients.

The surgical nurse must be cautious in dressing changes. Of paramount importance is confining all dressings and discarding them by sanitary procedures. Equally important is hand washing techniques and gloving between dressing changes. The following case illustrates cross contamination of patients in a semi-private room.

> A patient did recover in excess of $67,000 damages for injuries resulting from a staphylococcus infection contracted in a hospital, and his wife recovered consequential damages when there was evidence that the hospital nursing staff touched the patient's roommate, who had a boil discharging pus, and then touched the plaintiff without observing the sterile technique prescribed by the hospital in cases in which infection is suspected. When a culture of the roommate's drainage showed it to have been caused by Staphylococcus aureus, he was removed to an isolation room. However, the staphylococcus infection penetrated the hip joint of the patient, who was undergoing hip surgery as a result of an automobile accident; this necessitated a second operation, in which the patient's hip was fused in a nearly immobile position. The lack of sterile technique in caring for these two patients, the possibility that mass transfer of germs could have occurred and the time between the discharge of pus from the roommate's boil

and the subsequent drainage from the patient's hip were enough to spell out the cause of the plaintiff's infection.[44]

One duty of a nurse is to provide a safe environment for the patient. Some factors confronting the nurse in providing patient safety are:

1. To protect people in a foreign environment.

2. People may be receiving medications such as sedatives, hypnotics, tranqualizers, etc. which may alter sensory perception.

3. Assessment of the level of consciousness of an emergency room patient. Not knowing the person's usual behavior it is sometimes difficult to initially evaluate that person's deviations from usual behavior.

This researcher will discuss one (there are many) safety measures, bed rails. Bed rails are not socially accepted. The patient (or family) becomes defensive when the bed rails are raised. The hospital policy will specify for the nurse to institute bed rails in various circumstances. However, the nurse must evaluate the patient and utilize her best judgement in providing patient safety. When a patient falls or sustains an injury in some fashion the patient suffers the consequences as well as all those involved in providing care.

According to Creighton, "nurses have a duty to protect the

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[44]Ibid., p. 135.

patient from any known danger."[45] In this discussion of patient safety, this researcher has attempted to illustrate the necessity of patient safety. (See Appendix C: page 65, "Side Rails: Who Makes the Restraint Decision.")

INFORMED CONSENT

The federal government through the medical malpractice commission has authorized and published some health care issues which affect the nursing profession. One issue involves the "patient's rights." The commission encourages clearer understanding between the physician and the patient and says that the patient has an inherent human right to know what will happen or might happen to his body.[46]

Another issue is the nurse's role in informed consent which encompasses the realities in which a consent to treatment and/or consent to surgery may be obtained. Some of the realities are:

1. The patient's emotional and physical and mental status.

2. The patient's inadequate knowledge to enable him to understand and/or ask questions.

3. And patients tend to feel themselves to be underlings and

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[45] Creighton, op. cit., p. 123.

[46] Medical Malpractice: Report of the Secretary's Commission on Medical Malpractice, Dept. HEW, (Washington, D.C.: No. os 73-88), January 16, 1973, p. 75.

are reluctant to question the doctor's rationale.[47]

What are the limitations and expectations of informed consent? The American Hospital Association issues two statements on 'what should the patient know'.

1. The patient should obtain complete current information about his health and/or illness in terms he can reasonably understand.

2. The patient should obtain necessary information enabling him to give informed consent prior to institutions of treatment.[48]

Schrader elaborates in the statement by the American Hospital Association by emphasizing that the doctor and the nurse are complimentary in the role of informed consent.[49] Therefore, the patient's need (i.e., information about his health/illness) to participate in decisions of his future health care is the goal of informed consent.

Opportunities for the professional nurse in informed consent are:

1. Emphasis be placed on an ongoing process where the patient can obtain information of specific interest for his (patient's) concern such as contact with peer patients.

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[47]William T. Carpenter, "The Nurse's Role in Informed Consent," Nursing Times, Vol. 71 (July 3, 1975), 1049-1051.

[48]Elinor S. Schrader, "Informed Consent, The Nurse's Responsibility," AORN Journal, XVIII (October, 1973), 667-668.

[49]Ibid.

2. Nurses should be encouraged and respected in patient education which includes providing information for the patient to give his informed consent.[50]

Nurses have competence, skills and knowledge to be leaders in patient education. However, assuming leadership in roles traditionally restricted to the medical profession may bring some defensive behaviors by the physicians.[51]

To date the person liable for failing to provide informed consent is the physician. However, the nurse may be involved by witnessing permission requests. The patient is entitled to receive adequate information in consenting to a course of treatment. Failure to provide this information may be an instance of negligence or not informed consent.[52]

In discussing informed consent, it has been the purpose of this researcher to elaborate on the role of the patient and the nurse in informed consent. Informed consent, supplying adequate information for the patient so that he may participate in his health care and consent prior to the institution of care is an area of legal concern

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[50] Carpenter, op. cit.

[51] Ibid.

[52] Helen Creighton, "Informed Consent," Supervisor Nurse (January, 1975), pp. 9, 48, 49.

for the professional nurse according to Schrader, Carpenter, and Creighton. (See Appendix D: page 66, "Nurses and Informed Consent: Surgical Permits.")

RESPONDEAT SUPERIOR DOCTRINE

The doctrine of respondeat superior has a cumulative effect. Respondeat superior (let the master answer) speaks to the following issues:

1. negligence by the nurses' acts or omissions,
2. standards of care in determining if the act was wrongful,
3. the controlling agent (the employment) of nurse at the time the act occurred and
4. the properties of delegation.[53]

It is becoming increasingly important for each individual to be responsible for his/her own acts. He must possess a body of knowledge and/or clinical supervision and training sufficient to demonstrate his skills. The respondeat superior doctrine is enforced because the employing agency is also responsible for the employee's actions and the plaintiff will usually cite the agency in addition to the defendant to increase his chance of receiving his claim payment.

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[53] Nursing and the Law (2nd ed.) ed. The Health Law Center and Charles J. Streiff, esq. (Maryland: Aspen Systems Corp., 1975), p. 64.

The doctrine of respondeat superior applies when "the employer has the right to control the physical conduct of the employee's performance of duties".[54] Therefore, usually an independent contractor is not under this law. Another instance in which the respondeat superior doctrine would not be applicable is if the wrongful act was not within the job description (or contract) of the employee and employer.

The respondeat superior does not absolve the person who did the wrongful act. The injured sues the individual employee directly or the employer may seek indemnification to compensate for his loss.

The supervisor is included in the doctrine of respondeat superior in fulfilling her supervisory duties. The supervisor is not necessarily liable in thewrong doing of one she supervises but rather in assigning, delegating or instructing him. The agency is the employer not the supervisor and the supervisor is also an employee of the agency.[55]

Helen Creighton speaks of the three in one liability and emphasizes the standard of care requires sufficient nursing service personnel to meet apparent physical needs of the patients. When nurse

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[54]Ibid., p. 63.

[55]Ibid., p. 11.

shortage is a factor the agency is particularly vunerable.[56]

> As far as the patient is concerned, anyone who provides him with nursing care can be held to have the proficiency of a nurse in executing that function. This is true whether . . . a student, a trainee, or any other member of the nursing team.[57]

In essence the doctrine of respondeat superior means "a form of vicarious liability wherein an employer is held liable for the wrongful acts of an employee even though the employer's conduct is without fault."[58]

It is impossible to list all or even the majority of examples which would constitute the respondeat superior doctrine. The following cites a few of the more commonly occurring illustrations of enforcement of respondeat superior:

1. applying an overheated hot water bottle,
2. giving an enema of too hot a temperature,
3. injecting an incorrect medication,
4. continuing to inject a medication after noticing ill effect,
5. injury occurring to the patient if the nurse deviates from the physician's orders.[59]

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[56]Helen Creighton, Law Every Nurse Should Know, op. cit., p. 64.

[57]Willig, op. cit., p. 55.

[58]Nursing and the Law, op. cit., p. 63.

[59]Ibid., pp. 64-65.

The respondeat superior doctrine (let the master answer) is also referred to as the three-in-one liability. The liable three are: the one performing the act, the one supervising the person performing the act and the employer of both (the one responsible for the act and the supervisor). The person which performed the action is ultimately responsible for his own action. The supervisor is responsible in the supervision of the personnel. The employer is also responsible for the employees' acts. It has been this researcher's concern for each nurse (irregardless of her role) to be accountable.

SUMMARY

Nurses are being implicated in malpractice issues. The nurse is accountable for her actions. To date, negligence has primarily been cited in litigation in court cases.

Nurses are prepared in three educational settings (i.e., associate degree, diploma, and baccaluareate degree) to write the state board examinations and become licensed professional nurses. Nursing education can be strengthened by the inclusion of law in the conceptual framework of nursing practice.

Five areas which are commonly cited in litigations and applicable to the various fields of nursing are: records (nurses' notes), medication therapy, patient safety, informed consent and the respondeat superior doctrine.

Chapter 3

METHODS AND PROCEDURES

This investigation has been a descriptive approach in investigating the registered nurses' perceptions and knowledge of nursing jurisprudence. The respondents were licensed registered nurses presently employed in health care institutions and public health agencies.

POPULATION DESCRIPTION

The population consisted of registered nurses currently maintaining an active license in the state of Montana. The population was sampled by the following:

1. Geographical representation of the active registered nurses in Montana.

2. The records of the State Board of Nursing of Montana indicated the ten counties visited by the researcher had at least one hundred active registered nurses registered.

The employing agencies which participated included representation from the following areas: 1) community health, 2) gerontological nursing, 3) maternal-gynecologic nursing, 4) medical-surgical nursing, 5) pediatric nursing, and 6) psychiatric-mental health.

The nursing roles represented in the sample included the following: 1) administration, 2) supervision, 3) faculty, 4) head nurse, and 5) staff nurse.

The Board of Nursing at Helena reported the total number of registered nurses for 1976 for the state of Montana as 4456. These statistics are subdivided into counties. This study covered ten of the fifty-six counties. These ten counties comprised a population of approximately 3043 nurses.

The listing of community-public health agencies was obtained from the public health faculty at Montana State University. The Hospital Association division of the Environmental Health Services supplied the listing of institutional employing agencies for the counties. Of the thirty agencies contacted nineteen participated in the study. Following is a list of the ten counties and the number of active registered nurses which were represented in the study sample:

1. Cascade (552)
2. Custer (144)
3. Deer Lodge (135)
4. Flathead (208)
5. Gallatin (238)
6. Hill (125)
7. Lewis (216)
8. Missoula (446)
9. Silver Bow (304)
10. Yellowstone (675)

Data were collected through geographical representation and

population concentration areas. The total sample size was 336.

SAMPLING PROCEDURE

The problem was approached in the following manner.

1. Public health agencies and institutional health care agencies were contacted by letter asking for their cooperation and participation in the study.

2. All cooperating agencies were also contacted by telephone to establish a mutually convenient time for the researcher's visit.

3. The researcher visited all cooperating agencies in the ten representative counties throughout the state.

4. A questionnaire regarding professional negligence and malpractice was administered to each respondent. (Questionnaire: Appendix H, page 73.)

5. The data were collected June, 1976.

6. The researcher sampled 336 of the total 4456 licensed active registered nurses in Montana.

DEFINITION OF INVESTIGATIONAL CATEGORIES

It has been the purpose of this study to determine practicing nurses' perceptions and knowledge of nursing jurisprudence. The factual data gathered to describe the perceptions did not require a legal vocabulary to read or interpret. The areas commonly occurring

in negligence and malpractice issues and cited in this study were:

1. Patient safety. Any time a nurse is assigned patient care she/he assumes the responsibility of foreseeable safety.

2. Medication therapy. The medications are prescribed by the physician, dispensed by the pharmacy and administered by nurses. The nurse is responsible for knowing the mode of action, average dosage, route, adverse effects, side effects and antidote for each medication administered to the patient.

3. Nurses' notes. Nurses' notes are part of the medical record and are legally authentic.

4. Informed consent. The Patient's Bill of Rights published in 1969 explicitly states that the patient must receive adequate information about his care to determine the course he feels is right for him.

5. Respondeat superior doctrine. This extends the three-in-one liability: giver of negligent care, supervisor of care given and employer.

The data was analyzed to answer the proposed questions and to fulfill the need of this study.

Education levels of respondents were as follows:

1. The diploma graduate attends a three year educational period, usually under the auspices of a hospital and may or may not attend a local college for some courses.

2. The associate degree graduate has two years of study, usually affiliated with a junior college and a hospital health care facility for the student's clinical experience.

3. The baccalaureate graduate attends a four year program at a college with a school of nursing and a community hospital and community health agency serves as the student's clinical experience.

The variables not controlled were:

1. years of employment,
2. part-time, full-time and occasional status,
3. background in legal implications and
4. self-education.

The tool was applicable to the nurse generalist or the nurse specialist.

METHOD OF COLLECTING DATA

The questionnaire was composed of three parts. The first ten responses consisted of the respondent background data such as:

1. Various educational settings in which the nurse could have obtained knowledge regarding legal aspects of nursing practice.
2. Formal educational preparation.
3. Carrier of personal professional liability insurance.

With this background data about the respondent this researcher was able to answer the questions of the study such as: differences of knowledge

about legal liabilities in nursing, carrier of professional liability insurance, and other sources (i.e., ANA membership, CEU programs) where learning could have occurred about legal liabilities in nursing.

The remaining two parts of the questionnaire included clinical nursing situations and true-false questions about commonly occurring areas in litigation cases, (medication therapy, records, consents, patient safety and respondeat superior doctrine). These parts of the questionnaire enabled this researcher to describe the nurses' knowledge as it pertained to these five areas.

The nursing situations were obtained from a programmed text, The Nurse's Liability for Malpractice, written by Eli P. Bernzweig, a lawyer of New York state. Mr. Bernzweig was on the HEW Commission of Medical Malpractice for three years and is currently a member of the New York Bar Association.

The factual statements were obtained from a workbook, Nursing Faces the Law, which accompanies a set of cassette tapes written by Grace Barbee of the California Bar Association. Ms. Barbee is active in educational programs throughout the United States on nursing and the law.

The questionnaire had content validity due to the fact the situations were written by lawyers familiar with medical and nursing law.

Test reliability was accounted for in that the questionnaire

was not a memory device but emphasized principles of health care delivery by a prudent nurse.

One of the most cited arguments against mailed questionnaires is the percentage of return. For this reason as well as the financial loss for the researcher created by the non-respondent, this researcher visited the respondents through their employing agency and personally administered the questionnaire.

The questionnaire was administered to the present twelve graduate students of Montana State University as a pilot test.

The pilot test provided the following information.

1. Fifteen to twenty-five minutes were required to complete the questionnaire.

2. The class members did not express difficulty in reading and/or interpreting the questions.

3. The following table summarizes the class scores.

Table 1

Pilot Test Results

Subject Content of Question	Number of Responses	$\bar{x}$ Number Correct
Medication Therapy	7	6.00
Patient Safety	3	3.00
Records	3	2.83
Consents	3	2.00
Respondeat Superior Doctrine	10	7.41
Totals	26	21.24

METHOD OF ORGANIZING DATA

The method used to organize data obtained was charts. Frequencies and percents have been reported to describe the population.

The analysis of data was done by using the one way analysis of variance statistical test of difference. Level of significance was alpha .05. If a significant difference among the means had been found the Scheffe' multiple comparison test would have been utilized to test the differences between the pairs of means.

PRECAUTIONS TAKEN FOR ACCURACY

Descriptive data from the questionnaire were scored by hand and totals computed by a desk calculator. The data were double checked for accuracy. The analysis of variance for the stated hypothesis was done by the computer center at Montana State University.

SUMMARY

This has been a descriptive approach in investigating the registered nurses' knowledge of legal implications in nursing practice.

The population has been a geographical representation of active registered nurses in Montana. The data was collected in June, 1976.

The questionnaire included three parts. The first ten responses of the questionnaire asked for the respondents' background which could include learning situations for acquiring knowledge about liabilities in nursing. The second and third parts of the questionnaire were clinical situations and true-false questions pertaining to common areas of nursing practice which have occurred in court litigation cases.

The questionnaire was composed by this researcher utilizing questions written by two lawyers familiar with legal issues concerning nursing.

Chapter 4

ANALYSIS OF DATA

STATISTICAL HYPOTHESIS

The data collected in this research study will be discussed in relation to general questions to be answered that were stated in the first chapter of this paper.

1. Is there a difference among the respondents according to the basic educational preparation as to knowledge of legal issues and/or judgements in clinical nursing situations?

A one-way analysis of variance design was used to test the null hypothesis of no difference among the three means (i.e., associate degree graduate, diploma graduate, baccalaureate degree graduate) regarding their perceptions and knowledge of professional negligence and malpractice. The hypothesis was tested at alpha .05. The .05 level was chosen as a compromise between the probability of making either a type I or type II error. The following table illustrates the overall stated null hypothesis that no differences existed among the three groups: the diploma graduates, the associate degree graduates and the baccalaureate degree graduates in responding to the questionnaire involving nursing legalities.

Table 2

Null Hypothesis

Basic Educational Preparation	N	Mean
Diploma	196	20.84
Associate Degree	48	21.02
Baccalaureate Degree	92	21.27
Totals	336	20.98

Least-squares analysis of variance F = 1.55 df = 2.333

Critical value of F, alpha .05 = 3.03

GENERAL QUESTIONS ANSWERED

2. Are some areas of commonly cited litigations (i.e., medication therapy, patient safety, records, consents and respondeat superior doctrine) better understood than others?

For specific illustration of the questionnaire according to the above identified subject areas refer to Appendix I, page 81.

The following table shows the number of responses given in each category, the basic educational preparation of the respondent, the percent of incorrect responses and the mean number of correct responses.

All respondents of the questionnaire demonstrated more

Table 3

Categorization of Questionnaire

Subject Content of Questions	Number of Responses	N	Educational Preparation	% of Incorrect Responses	$\bar{x}$ Number Correct
Medication Therapy	7	196	Diploma	14	6.02
		48	A.D.	12	6.18
		92	Bacc.	13	6.07
Patient Safety	3	196	Diploma	10	2.70
		48	A.D.	7	2.79
		92	Bacc.	7	2.78
Records	3	196	Diploma	3	2.90
		48	A.D.	3	2.91
		92	Bacc.	3	2.91
Consents	3	196	Diploma	46	1.62
		48	A.D.	38	1.86
		92	Bacc.	42	1.75
Respondeat Superior Doctrine	10	196	Diploma	23	7.66
		48	A.D.	28	7.27
		92	Bacc.	22	7.79
Totals	26	336			

difficulty in the areas of consents and respondeat superior doctrine. However, the respondents of the three educational settings exhibited similar mean scores in each subject area.

The concept of consent to treatment involves several areas:

1. legal requirement of doctors and nurses to obtain the patient's consent (consent to treatment, consent to touch),

2. the right of the patient to decide the extent of treatment for himself, and

3. common law does not require written consent.

The law does require the consent be informed and voluntary. The written consent is merely proof of a consent obtained. Doctors and nurses have a false sense of security that written consent insures legality.

The Patient's Bill of Rights is one official document which has educated that consent to health care be voluntary and informed.

The area of the doctrine of respondeat superior was troublesome for all graduates. Several points to remember in this law are:

1. the wrongdoer cannot avoid liability for his own acts even if someone shares that liability, and

2. a supervisor may be liable if negligent in supervising others but not for the negligent acts of those she supervises.

The prudent nurse is responsible to the patient in foreseeing any reasonable safety precautions necessary. In so doing the nurse

will take into consideration the age, mental stability, medication influence and general condition. This is a common area for negligence claims. The sample population indicated an awareness of patient's safety.

One fundamental responsibility of all nurses is to keep accurate notes (records) of the patient's condition. The sample population recognized an understanding of the important concepts presented in this questionnaire.

3. What is the educational background of the respondent?

Total Number Respondents 336

Diploma	196	(11 percent have further education in academic settings)
Associate Degree	48	(10 percent have further education in academic settings)
Baccalaureate Degree	92	(5 percent have further education in academic settings)

This question was included so that this researcher could describe the sample's educational background.

4. Did the respondent participate in continuing education last year? YES

Diploma	68 percent
A.D.	52 percent
Bacc.	60 percent

5. Did the respondent participate in any continuing education programs concerning nursing legalities? YES

Diploma	46 percent
A.D.	23 percent
Bacc.	29 percent

Questions four and five concern continuing education. Continuing education programs offer opportunities for nurses to update professional knowledge and/or issues affecting nursing practice. The fifth questions shows some of the nurses participated in a continuing education program involving nursing legalities.

6. Did the respondent's educational setting include nursing legalities in the curriculum? YES

Diploma	51 percent
A.D.	73 percent
Bacc.	73 percent

The basic educational preparation of nurses is moving toward the associate degree and the baccalaureate settings. Question six shows seventy-three percent of the graduates of the associate degree and baccalaureate degree programs had educational instruction involving nursing legalities.

7. Is the respondent an ANA member? YES

Diploma	50 percent
A.D.	25 percent
Bacc.	54 percent

An ANA member through some state associations has an opportunity to subscribe to a professional liability insurance policy. Therefore,

one possible way of receiving information of liability insurance would be through the state nurses association.

8. Does the respondent maintain professional liability insurance? YES

Diploma	53 percent
A.D.	46 percent
Bacc.	72 percent

Maintaining professional liability insurance is a controversial issue at this time in history. Due to the increase in malpractice cases the medical professional is counter pointing the issue by dropping malpractice insurance. Can the individual afford to pay the premium? Can the individual afford not to pay the premium? Individuals must answer this question for his/her need.

As a further description of the sample population the following table illustrates an estimate of the age of the respondents in the three groups. The following table is only an estimate because five respondents did not give their year of birth. The age given in the table was calculated as follows: 1976 minus year of birth equals age.

Table 4

Age of Sample

	Mean Age	Standard Deviation	Range
Diploma	42.26 yrs.	20.91	22 - 65 yrs.
A.D.	27.60 yrs.	6.41	20 - 46 yrs.
Bacc.	31.18 yrs.	9.78	22 - 60 yrs.

A descriptive analysis was done utilizing the educational preparation, age groupings and three controversial issues which the respondents were asked to express themselves. The three controversial issues were continuing education units, American Nurses Association membership and subscribing to professional liability insurance.

Some of the descriptive data illustrated in Table 5 is as follows:

1. The 51-65 year age group was not represented in the associate degree respondents.

2. CEU. More respondents had participated in continuing education units in the last year than had not participated, in all age groupings of the three educational preparation programs.

3. CEU. The 36-50 year age groupings were the most favorable age group to participate in continuing education for the diploma and the associate degree respondents.

4. CEU. The 51-65 year age group of the baccalaureate degree nurses tend to favor continuing education however that was also the smallest group sampled of baccalaureate degree nurses.

5. ANA. There were more negative responses to ANA membership in the 21-35 year grouping in the diploma and the associate degree respondents. This tended to equalize in the 36-50 year groupings in the respective educational preparation.

6. ANA. The baccalaureate prepared respondents were somewhat

Table 5

Controversial Issues

Educational Preparation		CEU's			ANA Membership			Liability Insurance			Total
		Yes	No	*	Yes	No	*	Yes	No	*	
Diploma	AGE										
	21-35	36	20	1	17	40	0	25	32	0	
	36-50	67	21	1	50	38	1	49	40	0	
	51-65	29	18	0	31	16	0	31	16	0	
	**										3
	Totals	132	59	2	98	94	1	105	88	0	193
Associate Degree	21-35	20	19	0	7	32	0	19	20	0	
	36-50	6	2	0	5	3	0	4	4	0	
	51-65	-	-	-	-	-	-	-	-	-	
	**										1
	Totals	26	21	0	12	35	0	23	24	0	47
Bacc. Degree	21-35	39	26	2	34	33	0	49	18	0	
	36-50	13	5	0	11	7	0	14	4	0	
	51-65	4	1	1	5	1	0	4	2	0	
	**										1
	Totals	56	32	3	50	41	0	67	24	0	91
											336

* = no response given
** = no age given by respondent

more positive toward ANA membership for all age groupings.

7. Liability Insurance. The associate degree nurses were almost equally divided in responding to the questionnaire regarding professional liability insurance.

8. Liability Insurance. The age grouping of 36 - 50 year diploma nurses, which includes the mean age of that group, shows a balancing effect of those who do and do not purchase professional liability insurance.

9. Liability Insurance. The baccalaureate degree nurses exhibit preference toward professional liability insurance.

SUMMARY

The data were gathered and analyzed by the writer with the assistance of the Montana State University Computer Center. The null hypothesis was retained, showing no significant difference among groups in the legal liability questionnaire administered to the respondents.

Additional sample descriptions given in tables are as follows:

1. percent of incorrect responses of each group in answering the questionnaire's categories (medications, patient safety, records, consents, and respondeat superior doctrine),

2. mean number of correct responses of each subject category in the questionnaire according to basic educational preparation of the respondent,

3. educational background,

4, continuing education,

5. ANA membership,

6. carrier of professional liability insurance,

7. an estimate of the sample population's age, and

8. positive and negative responses to continuing education, ANA membership and liability insurance according to age groupings of the basic educational preparation of the respondents.

Chapter 5

SUMMARY, CONCLUSIONS, RECOMMENDATIONS

SUMMARY

Nurses are being implicated in malpractice issues. The HEW Commission initiated an investigation of negligence and malpractice of health care. The commission recommends more professional nurses giving direct patient care, more education in the institutional setting and more proficiency in interpersonal relations and communications to decrease legal suits.

Nurses' litigations are usually on negligence counts. Five areas which are commonly cited in litigations and applicable to the various fields of nursing are: records (nurses' notes), medication therapy, patient safety, informed consent and the respondeat superior doctrine.

This investigation has descriptively analyzed the clinical registered nurses' perceptions and knowledge of the above cited areas. The data collected has been presented in reference to the nurses' basic preparation enabling him/her to write the state board examination.

The null hypothesis was retained, showing no significant difference of mean scores among the diploma, the associate degree and the baccalaureate graduate in responding to a questionnaire regarding professional negligence and malpractice.

Additional sample descriptions given in tables include the following:

1. percent of incorrect responses of each group in answering the categories in the questionnaire as to medications, patient safety, records, consents, and respondeat superior doctrine,

2. mean number of correct responses of each subject category in the questionnaire according to basic educational preparation of the respondent,

3. educational background,

4. continuing education,

5. ANA membership,

6. subscriber of professional liability insurance,

7. the respondent's age,

8. positive and negative responses to continuing education, ANA membership and liability insurance according to age groupings of the basic educational preparation of the respondents.

Nurses need to keep current by constant study. Nursing is being recognized by society as a profession and society expects quality health care.

CONCLUSIONS

This research project has led the writer to three primary conclusions. The conclusions are as follows:

1. The review of literature identified the professional nurse's responsibility for practicing in a competent manner according to professional standards as well as to society's standards.

Society's voice was channeled through the HEW Commission's investigation as to suggested guidelines for the professional nurse and through the Patient's Bill of Rights published in 1969.

The health care consumer has a right to participate in his care. When the consumer is dissatisfied with the care he receives, litigations may follow.

The nurse is accountable for his/her actions and the supervision of others. Nurses' litigations are usually on negligent counts.

2. The null hypothesis was retained showing no difference among the means of the diploma, the associate degree and the baccalaureate degree nurse on a questionnaire regarding negligence and malpractice. However, all respondents of the questionnaire demonstrated more difficulty in the areas of consents and respondeat superior doctrine.

3. The sample was descriptively analyzed according to three age groups of each educational program as the respondents indicated a

positive or negative response to three controversial issues; continuing education, ANA membership and personal professional liability insurance. Although not statistically analyzed several trends were indicated such as:

a. Continuing education was positive among all respondents.

b. The highest membership of ANA for the associate degree and diploma respondents was between the 36-50 year age group. The baccalaureate respondents tended to be members rather than non-members in all the age groups.

c. Liability insurance. Those respondents who indicated that liability insurance was a personal responsibility were found in the 36-50 year age group of the diploma nurses and all age groups of the baccalaureate degree nurses. The associate degree graduates were equally divided in all age groups.

The conclusions of this researcher are that the respondents exhibit similar overall knowledge on the questionnaire regarding negligence and malpractice. However, the areas of consents and respondeat superior doctrine presented greater weaknesses than did patient safety, medication therapy, and records among all respondents.

RECOMMENDATIONS

The review of literature reveals many well versed authors providing the professional nurse with knowledge and guidelines. Yet, research in the area of nursing jurisprudence is very limited.

This researcher suggests the following approaches of investigating the breadth and depth of nurses' knowledge of negligence and malpractice.

1. Investigating one area of nursing practice (i.e., consents) to determine the clinical nurses' knowledge and/or application of principles in that area in delivering patient care.

2. Studying a select population of nurses (i.e., medical nurses, surgical nurses, critical care nurses, obstetrical nurses, etc.) to determine knowledge and/or application of legally competent nursing practice unique to their particular speciality.

3. Utilizing a chart audit to identify the legal competence of the written recordings.

4. Providing more opportunity to attend workshops and conferences in continuing education (CEU) in this state with experts presenting the legal aspects of nursing.

5. Encouraging nurses to belong to their national, state, and district nurses association (ANA) to bring about certification, continuing education and up-dating their knowledge in professional,

legal and ethical standards of care given to patients.

6. The inclusion of legal knowledge in the basic educational preparation (i.e., diploma, associate degree, baccalaureate programs) of nurses.

7. A replication of the study in the future to determine changes which might have occurred due to the recommendations of this study.

APPENDICES

APPENDIX A

CHARTING: MEANINGFUL AND ACCURATE NURSES' NOTES

The case in point: Glenn v. Kerlin-Citation: 305 So. 2n 611 (LA)

FACTS OF THE CASE: This lawsuit was brought by John Wesley Glenn, a surgical patient, against physicians and a hospital, charging inadequate post-operative care. It was alleged that the negligence of the doctors and the hospital allowed the development of decubitus ulcers ultimately resulting in the amputation of the patient's right leg. At the time of the hospitalization giving rise to this lawsuit, the patient was 53 years of age and had been a paraplegic since 1964. On June 10, 1970, the patient was admitted to Willis-Knighton Hospital for a cystectomy and a bilateral cutaneous ureterostomy. Post-surgical complication resulted in a second surgical procedure on June 25, 1971 to correct a gangerous condition of the distal end of the left ureter. ... The plaintiff's condition improved sufficiently after this operation to allow his discharge from the hospital on July 8th. Among other things, the plaintiff alleges that he received negligent nursing care. He alleges that he developed decubitus ulcers prior to leaving the hospital and that he was permitted to leave in this condition and that his discharge from the hospital under those circumstances was negligent. The principal thrust of the plaintiff's argument is that the Trial Judge erred in accepting the nursing staff's testimony at face value when the hospital nursing chart or daily log on the patient did not contain the corresponding entries to corroborate this testimony. ... They testified that in the process of changing linen or cleansing the patient, he was repositioned to his side from his back and that such minor procedure would probably not be recorded. The Trial Court entered a Judgement in favor of the doctor-defendants and in favor of the hospital as employer of the nurses. ...

LEGAL LESSON: The importance of the patient's charts and particularly of the nurses' notes on such charts cannot be overstated in relation to a case such as this one. Unfortunately, the amount of space available for the nurses to enter notations regarding the continuing care and observations of this patient raised some questions as to the possible conflict between the testimony given verbally during trial by these

nurses and the absence of corresponding notations in the medical record in this regard, the case points up the necessity for every nurse being as accurate and explicit as possible in entering notations regarding patient care. In this case, the Courts were inclined to accept the verbal testimony of the nurses and the rationale that many of the routine functions carried out by nurses need not be charted. Another Judge under similar circumstances might exclude testimony which was contrary to or inconsistent with charted observations by nurses. Unfortunately, patients' charts in many hospitals contain precious little space for the entry of legally adequate nurses' notes. The modern trend towards abbreviated nurses' notes seems practical and reasonable until a lawsuit such as this one hinges on the completeness and clarity of such important professional nursing observations.

William A. Regan, "Charting: Meaningful and Accurate Nurses' Notes," The Regan Report on Nursing Law, Vol. 15, No. 10, (March, 1975), p. 2.

APPENDIX B

DRUG ERROR: $1.5 MILLION JUDGEMENT

The case in point: Talcott v. Holl Florida: 224 So. 2d 420

CASE: A hospital nurse, carrying out a drug order written by the defendant physician, apparently administered an overdose of drugs resulting in severe brain damage and permanent neurological disability to the plaintiff, a 35-year-old mother of three minor children. It was alleged at trial that the brain damage and resulting extensive permanent mental and physical impairment was proximately caused by the administration of drugs in excessive strength and amount contrary to proper and accepted medical practice. The plaintiff's principal medical witness testified that the patient would need constant nursing attention. Asked about the patient's physical future and life expectancy, the expert answered that there would be no effect on the patient's longevity if she were given adequate and proper nursing and medical care. On the strength of this testimony, the trial court rendered judgement in the amount of $1.5 million and the District Court of Appeals sustained the verdict.

LEGAL LESSON: The case demonstrates the fact that there is literally no limit to the amount of money which might be recovered in personal injury litigation of this type. The Appellate Court here was asked to reduce the judgement against the defendant doctor on the theory that it was completely out of proportion with the injuries and damages sustained by the patient. The court refused to set aside the verdict since there was no evidence introduced to substantiate the alleged disproportion of the money judgement in relation to the injuries sustained and the need for continuing medical and nursing attention for the rest of the patient's life. Nurses who are satisfied with an absolute minimum amount of professional liability insurance would be well advised to reflect upon the implications of a hefty jury verdict against them.

William A. Regan, "Legal Lesson of the Month," The Regan Report on Nursing Law, Vol. 12, No. 9 (February, 1972), p. 2.

APPENDIX C

SIDE RAILS: WHO MAKES THE RESTRAINT DECISION

Case in point: McGuire v. Overton Memorial Hospital Et Al.
Citation: 514 S.W. 2d 79 (tex)

FACTS OF THE CASE: Lonnie McGuire brought this suit against Overton Memorial Hospital and Dr. Jules Leven for injuries received when he fell trying to get out of bed while a patient in the hospital. He was admitted to the hospital on November 19, 1970 with a diagnosis of possible acute appendicitis. Dr. Leven was his treating physician. Surgery was performed. On December 4, the plaintiff, while attempting to get out of bed, fell and sustained a fracture of the right hip. ... The doctor also testified that the plaintiff's recovery following the appendectomy was routine, uneventful and normal, and that he saw no necessity for bed rails fourteen days after his surgery. ...

COURT'S OPINION: ...On the question of bed rails and the Court said: "The record does not make clear whether the placing of the bed rails on the bed was an administrative duty on the part of the nurses or employees of the hospital or whether the bed rails should have been installed only on the orders of the doctor. To constitute negligence there must be a violation of a duty owed to the person making a claim on the grounds of negligence. ...

NURSING LESSON: There was a great deal of confusion regarding the relative responsibility of the attending physician and/or the nursing service in the hospital for installing bed rails to protect this debilitated and somewhat disoriented patient. Generally speaking, the applying of restraints is the nature of a treatment process and should be initiated by a medical order. ...When a situation arises wherin the exigencies of time or other considerations prevent contact with any physician, the reasonable and prudent nurse will use the degree of restraint and such methods of restraining a patient as appear to be required by the patient's apparent physical condition.

William A. Regan, "Legal Lesson of the Month," The Regan Report on Nursing Law, Vol. 15, No. 7 (December, 1974), p. 2.

APPENDIX D

NURSES AND INFORMED CONSENT: SURGICAL PERMITS

Bailey v. Belinfante--A Case in Point

AS A PROFESSIONAL NURSE, YOU SHOULD BE CONCERNED WHEN THE ONLY CONSENT A PATIENT HAS SIGNED PRIOR TO SURGERY IS A VAGUE AND MEANINGLESS PERMIT AUTHORIZING THE PHYSICIAN "TO PERFORM SURGERY". You should also be deeply concerned professionally when permission for surgery is extracted from a patient after the patient has had pre-op medication. How do you react when attempting to get a consent form signed, you become aware for the first time that the patient hasn't the slightest idea what's ahead in surgery? You should withdraw tactfully from the patient's bedside and refer the matter through proper nursing-administrative channels back to the surgeon for correction. All of these problems were present to a degree in a recently reported Georgia lawsuit captioned: Bailey v. Belinfante (218 S.E. 2d 289).

FRANKLIN E. BAILEY HAD SERIOUS DENTAL PROBLEMS. HE WAS ADVISED BY THE DEFENDANT ORAL SURGEON THAT ELEVEN TEETH SHOULD BE EXTRACTED. The patient signed a form containing the following language: "I agree for Dr. Lweis S. Belinfants to perform whatever surgery or treatment he feels is required and use whatever anesthesia, local or general he feels is best for my case." Two weeks later he was hospitalized and signed a "Consent to Operation" form which contained the following language: "I authorize the performance upon Franklin Bailey of the following operation, teeth extraction, to be performed under the direction of Dr. Belinfante. I consent to the performance of any operations and procedures in addition to or different from those now contemplated, which the above-named doctor or his associates or assistants, may consider necessary or advisable in the course of the operation". Before the operation, Dr. Belinfante reviewed the patient's records and decided that all of the teeth (27) should be removed. The doctor testifies that he told the patient just prior to surgery that all the teeth should be removed and the patient replied, "You're the doctor". The patient had been administered pre-operative medication at the time of this alleged conversation. The patient later testified to no recollection of having seen

the doctor prior to surgery. After recovering from the dental surgery, the patient brought this lawsuit alleging Battery and Negligence. ...

HOW DOES ALL THIS AFFECT YOU AS A PROFESSIONAL NURSE. IT IS NOT UNUSUAL FOR THE PROFESSIONAL NURSE IN A PHYSICIAN'S OFFICE, IN A HOSPITAL ADMITTING DEPARTMENT, OR IN A PATIENT CARE UNIT TO BE CHARGED WITH THE RESPONSIBILITY FOR OBTAINING THE PATIENT'S SIGNATURE ON A SURGICAL CONSENT FORM. In order to avoid any later involvement in litigation or the leveling of a charge that the nurse conspired with one or several physicians to shield the true facts concerning a surgical procedure from a patient, it is important that the nurse obtaining such a consent form assures herself that the patient is: (1) conscious and aware of what is being signed, (2) informed regarding the nature and purpose as well as regarding the calculated risks of the proposed surgery, and (3) ready and willing to execute the consent for surgery voluntarily and without duress. When any one or all of these factors are absent, it is legally imperative for the nurse to defer the signing of the consent form until she has communicated the problem through appropriate channels to the surgeon with a view toward obtaining an INFORMED consent.

William A. Regan, "Nurses and Informed Consent: Surgical Permits," The Regan Report on Nursing Law, Vol. 16, No. 8 (January, 1976), p. 1.

APPENDIX E

LETTER TO AGENCIES

Date

Inside Address

Dear

I am writing this letter to request your cooperation and that of the registered nurses to participate in a descriptive study designed to identify professional nurse's knowledge of laws affecting nursing practice. The study uses a questionnaire which elicits the nurse's knowledge of negligence and malpractice in nursing situations such as: charting, medication therapy, patient safety and communications. The questionnaire applies to the general field of nursing whether in the hospital or out, in specialized services or general. I am eager to receive responses from nurses in various nursing roles including staff nurses, clinicians, supervisors, faculty members, administrators and others.

I am a graduate student in the School of Nursing at Montana State University working under the sponsorship of Professor Phyllis Hillard, Chairperson of my thesis committee.

Selected employing agencies in ten counties throughout Montana are being contacted. I will visit each agency which indicates an interest in participating between June 21, 1976 and July 20, 1976 and will personally administer the questionnaire to the nurses. The questionnaire requires approximately twenty minutes to complete. The responses will be confidential with no institution name or code number attached to the individual questionnaire.

I am enclosing a stamped, self-addressed envelope for your convenience in responding. I will contact you to establish a mutually convenient time for me to visit your institution for the administration of the questionnaires.

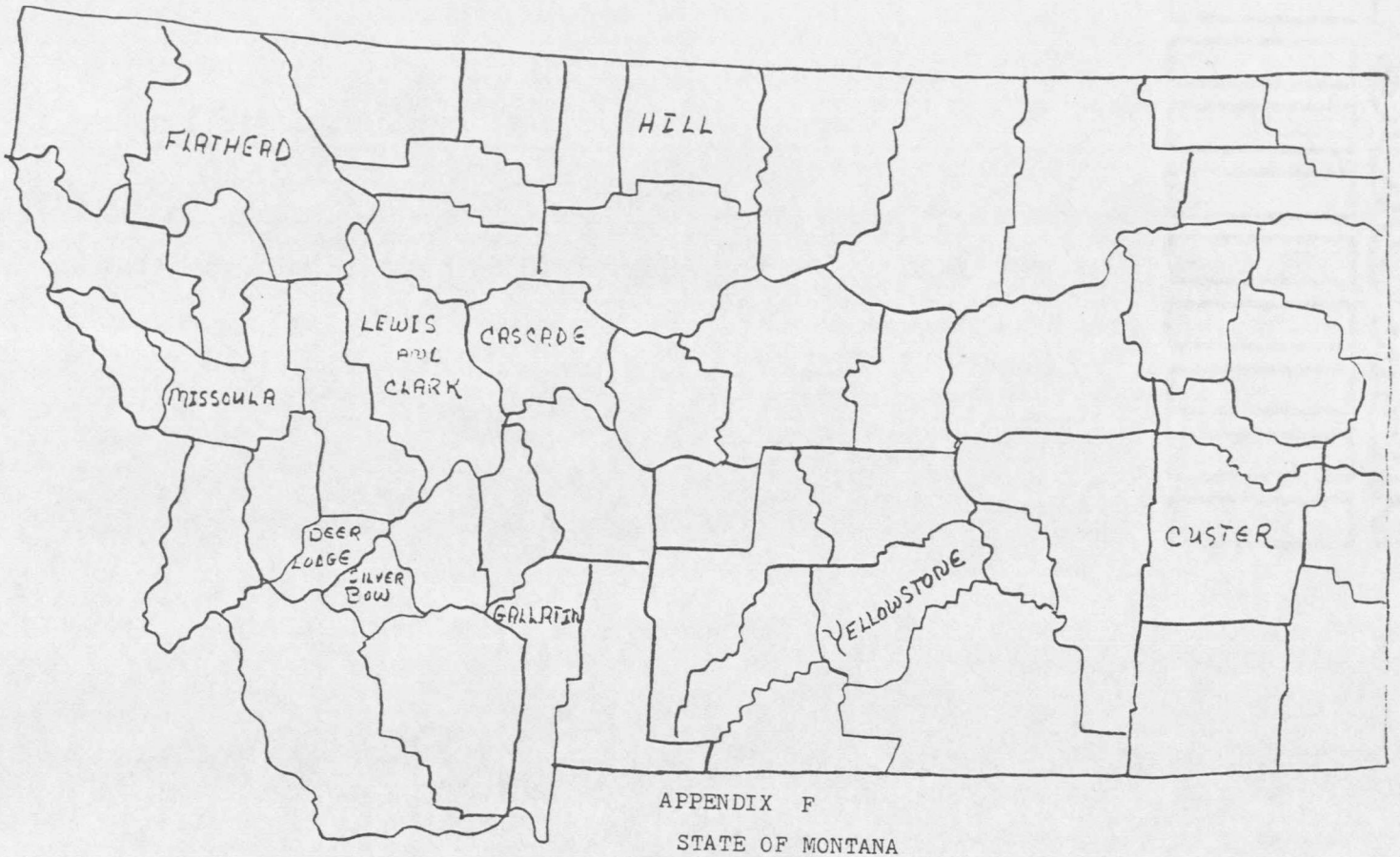
I will be happy to share the results of the study with you upon its completion if you wish to receive an abstract of the completed study.

Respectfully yours,

Nancy Jane Smith
Graduate Student
Apt. 1-C 106 G. Chamb.
Bozeman, MT 59715

Approved:

Anna M. Shannon, R.N., D.N.S.
Director School of Nursing



APPENDIX F

STATE OF MONTANA

Geographical sample taken from identified counties.

McGraw-Hill Book Company

1221 Avenue of the Americas
New York, New York 10020
Telephone 212/997-1221

March 12, 1976

Mrs. N. Jane Smith
Apt. 1-G
106 Grant Chamberlain Drive
Bozeman, Montana 59715

Dear Mrs. Smith:

We have now had an opportunity to consider your request of March 5, signed by Anna M. Shannon and yourself, addressed to Mr. Bernzweig and the instrument you enclosed in which you used selected nursing situations from THE NURSE'S LIABILITY FOR MALPRACTICE for research purposes as outlined.

I am pleased to tell you that McGraw-Hill has no objection and is willing to have you borrow the situations from our book as you have done in the 6 page instrument you sent with your request. This permission does not imply commercial publication or general distribution of the material outside the limited use for which it has been requested.

In addition to citing the author and title as the source of the situations you should also include the copyright date and owner of the book and the fact that it is used with permission of the publisher, McGraw-Hill Book Company.

Sincerely,

M:m

Marjorie Mitchell
Manager, Copyrights & Permissions

c.c: Anna M. Shannon

The following ten questions are taken from the workbook Nursing Faces the Law, written by Grace Barbee. They are true-false questions. Please circle the CORRECT response.

true false 1. Since a nurse is always liable for his or her own negligence that produces injury, the nurse does not have to be concerned about anyone else becoming legally involved.

true false 2. To assign a registered nurse (or lesser prepared person) to speciality care unit would be negligent delegation if the nurse so assigned lacked the required special preparation and skills.

true false 3. A nurse does not have to check out what a parent who is in the hospital says to her about the condition of his child who is a patient.

true false 4. A nurse could be held negligent in handing the physician a drug which the nurse knew would endanger the patient, even if the nurse thought the physician had ordered it.

true false 5. A physician must denote the route of adminstration of a drug.

true false 6. The nurse's notes do not have to show the route of administration used.

true false 7. If a nurse is in doubt about a medication order, she can clear it with any physician available.

true false 8. An informed consent may be written or oral; they both are legal.

true false 9. A patient's records, including nurses' notes, meet many needs; they can make or break a malpractice defense.

true false 10. Records--if inaccurate, inadequate or incomplete--have been accepted in courts as proving negligence in malpractice suits.

APPENDIX H

QUESTIONNAIRE

Questionnaire respondent:

Thank-you for cooperating in this study of professional negligence and malpractice in the clinical setting. This is a descriptive study of the professional nurses of Montana regarding nursing jurisprudence.

Please do NOT put your name on the instrument. All responses are anonymous.

I am a graduate student at Montana State University working under the sponsorship of Mrs. Phyllis Hillard, chairperson of my thesis committee.

N. Jane Smith, R.N.

Basic Educational Program (circle one)

1. Diploma
2. Associate Degree
3. Baccalaureate or Higher Degree

Year basic educational program was completed. _____

Highest Level of Educationa Completed. (circle one)

1. Diploma
2. Associate Degree
3. Baccalaureate in Nursing
4. Baccalaureate in other field
5. Masters in Nursing
6. Masters in other field
7. Doctorate (eg. Ph.D., Ed.D.)

Year highest level of education was completed. _____

Did you participate in any educational programs in the last year excluding your employing agency (i.e. CEU's)

_____yes
_____no

Have you attended any educational programs concerning nursing legalities? (i.e. negligence, malpractice)

_____yes
_____no

Did your educational program(s) include nursing legalities in the curriculum?

_____yes
_____no

Are you a member of ANA?

_____yes
_____no

Do you have professional liability insurance?

_____yes
_____no

What is your year of birth? _____

The following clinical nursing situations were obtained from Eli P. Bernzweig's programmed text entitled, The Nurse's Liability for Malpractice, published by McGraw-Hill Book Company in 1975. These situations exhibit areas of common concern for most practicing professional nurses. Permission to utilize the following eleven situations has been granted by the publisher.

Please respond to the following clinical situations by placing an X by the answer. There is only ONE correct response.

SITUATION #1
In his haste, a physician writes an incomplete and partially illegible medication order. Nurse N. in an effort to be efficient and in order not to bother the physician with questions, decides which drug was intended, the dosage form, and the route of administration of the drug. Her judgment proves wrong, and the patient suffers serious harm.

On what basis could Nurse N. be held liable for failing to have excercised reasonable care?

_____for failing to question the physician concerning his incomplete and partially illegible medication order.
_____for showing more concern for the doctor than the patient.
_____for prescribing a drug without proper authority.

SITUATION #2
Why is the registered nurse held to a higher standard of care than the practical nurse with respect to reporting the patient's reactions and symptoms?

_____because the registered nurse is more directly involved in patient care
_____because the registered nurse has been trained to evaluate and interpret reactions and symptoms and to make judgments thereon concerning essential action necessary
_____because practical nurses are not expected to concern themselves with reactions and symptoms of their patients.

SITUATION #3
Patient P. goes to Doctor D's office for treatment of a dislocated thumb, and Doctor D. asks his office nurse, Nurse N. to secure Novocain for local anesthesia. Nurse N. orders a medical technician (also employed by Doctor D.) to get the drug, but the latter, by mistake hands her a bottle labeled Adrenalin. Nurse N. does not check the label and prepares the hypodermic for Dr. D. Thirty minutes after he receives the injection, Patient P. dies from a systemic reaction to the Adrenalin.

What conduct on the part of Nurse N. would legally constitute unreasonable care in this case?

_____requesting a technician to get the drug
_____failing to check the label on the drug
_____preparing the hypodermic before showing the drug to the doctor.

Would Dr. D. have a right to assume that the hypodermic handed to him by Nurse N. contained the proper drug in the proper dosage?

_____yes
_____no

Who could be held liable to P.'s estate in this case?

_____only Nurse N.
_____only Dr. D.
_____only the technician
_____both Nurse N. and Dr. D.
_____Nurse N., Dr. D. and the technician

SITUATION #4
Under what circumstances will a nurse be held legally responsible for seeing that no harm comes to her patient?

_____only when she is engaged to care for him as a private-duty nurse
_____only when she has been specifically directed to protect him against harm
_____whenever she is assigned to caring for the patient

SITUATION #5
A nurse's responsibility to safegard and protect her patient from harm is one which

_____requires either a written or verbal order from a physician or nurse-supervisor
_____she must excercise independently of any special medical order or supervisory directive
_____she must excercise only when employed by a hospital, nursing home, or other health care institution.

SITUATION #6

P, a 76-year-old female hospitalized for treatment of congestive heart failure, was known to lapse into a semicomatose state from time to time. When lucid, she constantly complained of being cold and asked for hot water bottles around her legs. No specific doctor's orders were given for these complaints, but Nurse N. was given general instructions by supervisory Nurse S. to "keep the patient warm".

Nurse N. irritated by P's constant complaints, placed several excessively hot water bottles around P's legs while P. was semicomatose, disregarding the patient's immediate objection to the intensity of the heat. Upon checking the patient an hour later, it was noted that she had sustained serious burns on her legs, requiring extensive remedial measures. P. later sued Nurse N, Nurse S, her treatment physician, and the hospital for the injuries sustained.

What was the legal duty owed by Nurse N. with respect to the safety of Patient P?

_____the duty to respond to all requests for nursing care made by P.
_____the duty to safeguard and protect P. from any known or reasonably foreseeable harm.
_____the duty to remain in the room with P. at all times.

Supervisory Nurse S. gave Nurse N. specific instructions to keep Patient P. warm. If a jury was to decide that Nurse N. was negligent in fulfilling her legal responsibilities to P, what likely effect would this have on Nurse S's liability?

_____No liability would result since the instructions in question were well within the capabilities of a trained nurse.
_____Nurse S. would be held liable for failing to check on P's condition personally.
_____Nurse S. would be held liable for giving only general instructions to Nurse N. about keeping Patient P. warm.

Assuming Nurse N's negligence in this case, who else would probably be held liable for her conduct?

_____the doctor and the hospital
_____the hospital
_____no one else

SITUATION #7

Recording and reporting the patient's physical signs and general emotional behavior is the responsibility of

_____all nurses
_____registered nurses only
_____practical nurses only

SITUATION #8

A patient's consent to treatment is said to be informed when

_____he consents to the procedure in writing
_____his physician has spoken to him about the proposed treatment
_____he fully understands the nature of the treatment

The doctrine of informed consent recognizes the fundamental right of--

_____the doctor
_____the patient
_____to decide what course of treatment to undertake

SITUATION #9

Supervisory Nurse S. and general-duty Nurse N. are employed by Hospital H. In the course of treating a patient, S. (negligently) directs N. to give the patient the wrong medication, and in the process of administering the drug, N. (belligerently) injuries the patient.

Who can be held liable to the patient for the resulting harm?

_____only Nurse S.
_____only Nurse N.
_____only Hospital H.
_____both nurses, but not the hospital
_____all three parties

SITUATION #10
Nurse N. employed by a large midwestern hospital, commits an act of malpractice in the course of her duties which results in serious injury to Patient P.

Under these facts, which of the following statements would be true?

_____ P. can sue either Nurse N. or her employer for N.'s negligent conduct, but not both.

_____ If P. is successful in a suit against N.'s employer and the latter pays the judgment rendered in the case, N. can be held liable to her employer for the judgment paid.

_____ If P. is successful in a suit against Nurse N. and N. pays the judgment, she is legally entitled to recover from her employer the amount thus paid.

SITUATION #11
What is the general rule regarding the legal liability of a supervisory nurse?

_____ The supervisory nurse cannot be held liable for any acts of negligence on the part of registered nurses she supervises, only for acts of negligence on the part of practical nurses or nurse's aides whom she supervises.

_____ The supervisory nurse is not automatically liable for all acts of negligence on the part of those whom she supervises, but she may be liable where she is negligent in supervising others.

_____ The supervisory nurse is not automatically liable for all acts of negligence on the part of someone whom she supervises since each nurse is liable for her own negligent conduct.

Permission to utilize the following ten true-false questions has been granted by Mrs. Grace C. Barbee, author of the workbook, Nursing Faces the Law, in which the questions are published. Please CIRCLE the correct response.

true false 1. Since a nurse is always liable for his or her own negligence that produces injury, the nurse does not have to be concerned about anyone else becoming legally involved.

true false 2. To assign a registered nurse (or lesser prepared person) to a speciality care unit would be negligent delegation if the nurse so assigned lacked the required special preparation and skills and this was known or should have been known to the person making the assignment.

true false 3. A nurse does not have to check out what a parent who is in the hospital says to her about the condition of his child who is a patient.

true false 4. A nurse could be held negligent in handing the physician a drug for direct administration which the nurse knew would endanger the patient, even if the nurse thought the physician had ordered it.

true false 5. A physician must denote the route of administration of a drug.

true false 6. The nurse's notes do not have to show the route of administration used.

true false 7. If a nurse is in doubt about a medication order, she can clear it with any physician available.

true false 8. An informed consent may be written or oral; they both are legal.

true false 9. A patient's records, including nurses' notes, meet many needs; they can make or break a malpractice defense.

true false 10. Records--if inaccurate, inadequate, or incomplete-have been accepted in courts as proving negligence in malpractice suits.

APPENDIX I

CATEGORIZATION OF QUESTIONNAIRE

The questionnaire responses illustrate the identified categories (i.e., medication therapy, patient safety, records, consents, and respondeat superior doctrine) as follows:

Medication therapy--Situation #1. On what basis could nurse N. be held liable for failing to have exercised reasonable care? Situation #2. What conduct on the part of Nurse N. would legally constitute unreasonable care in this case? Would Dr. D. have a right to assume that the hypodermic handed to him by Nurse N. contained the proper dosage? True-False #4, #5, #6, and #7.

Patient Safety--Situation #4. Under what circumstances will a nurse be held legally responsible for seeing that no harm comes to her patient? Situation #5. A nurse's responsibility to safeguard and protect her patient from harm is one which... . Situation #6. What was the legal duty owed by Nurse N. with respect to the safety of Patient P?

Records (nurses' notes)--Situation #7. Recording and reporting the patient's physical signs and general emotional behavior is the responsibility of ... . True-False #9, #10.

Consents--Situation #8. A patient's consent to treatment is said to be informed when ... . The doctrine of informed consent

recognizes the fundamental right of .... . True-False: #8.

Respondeat Superior Doctrine--Situation #3. Why is a registered nurse held to a higher standard of care than the practical nurse with respect to reporting the patient's reactions and symptoms? Situation #2. Who could be held liable to P.'s estate in this case? Situation #6. Supervisory Nurse S. gave Nurse N. specific instructions to keep Patient P. warm. If a jury was to decide that Nurse N. was negligent in fulfilling her legal responsibilities to P, what likely effect would this have on Nurse S's liability? Assuming Nurse N's negligence in this case, who else would probably be held liable for her conduct? Situation #9. Who can be held liable to the patient for the resulting harm? Situation #10. Under these facts, which of the following statements would be true? Situation #11. What is the general rule regarding the legal liability of a supervisory nurse? True-False: #1, #2, #3.

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