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