The Essential Legal Handbook for Nurses: Best Practices for Nursing Staff puts practical legal know-how into your hands whether you are a new or experienced nurse. It’s a proactive tool that provides crucial, commonsense steps to take to protect yourself and your employer against avoidable legal liability.

From social media practices to safety requirements, The Essential Legal Handbook for Nurses provides you with the rules of the road!

DINAH BROTHERS, RN, JD

Author of The Nurse Manager’s Legal Companion

Team-Building Handbook: Accountability Strategies for Nurses

Team-Building Handbook: Improving Nurse-to-Nurse Relationships

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THE ESSENTIAL LEGAL HANDBOOK FOR NURSES
BEST PRACTICES FOR NURSING STAFF

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About the Author

**Dinah Brothers, RN, JD**, is a nurse attorney based in Texas. Brothers is a solo practitioner specializing in civil litigation. In her practice, she defends healthcare professionals in civil and administrative proceedings.

Prior to becoming an attorney, Brothers worked as a nurse for 10 years. Her nursing experience includes psychiatric nursing, nursing management, and nursing education.
Staff nurses are pivotal in the day-to-day operation of every healthcare facility. Simply put, without staff nurses, the organization would be forced to cease operations. Healthcare facilities are in the business of providing patient care, and it is the staff nurse who ensures that care is provided using the most effective, efficient, and correct means possible. Never underestimate your significance in patient care or in the day-to-day operation of your hospital.

Being a staff nurse is very stressful. You encounter patients who are most likely experiencing some of the most stressful and fearful times of their lives. In these situations, your job is to be calm, competent, and comforting to your patients and their families. There will also be times in your career as a staff nurse when you feel like you’re navigating a legal minefield. It’s true—you face numerous legal challenges as a staff nurse. However, with some preparation and knowledge, you’ll be able to reduce your legal risks and enjoy a more rewarding career.
Protect Your Patients, Your Hospital, and Your License

This handbook shines a light on the common legal risks you face in your role as a nurse. We’ll discuss the law and legal standards for staff nurses, your requirement to report potential wrongdoing, and the different types of policies and procedures (written, unwritten, etc.). We’ll suggest some risk reduction behaviors you can use, and share specific legal scenarios and examples to show you what can go wrong (and right) in a number of circumstances, including bullying and whistleblowing.

By the time you finish this handbook, you’ll have an understanding of the legal risks related to nursing practice and a collection of practical skills for minimizing the chance that you’ll actually have to face them.

Let’s get started.
Chapter One

Adhering to Professional Standards of Care

Nurses are expected to be competent to provide patient care and to deliver that care within the scope of their defined practice. When you fail to provide competent care in your specialty or you practice outside the scope of practice, you may be found liable for violating professional nursing standards—and be held legally accountable.

The Standard of Care in Nursing Practice

When the quality of a nurse’s professional practice is at issue, one of the first questions asked is whether the nurse practiced within the standard of care. The standard of care is a set of minimal competencies a nurse must possess and practice to provide acceptable care. For the purposes of this handbook, we’ll refer to the “reasonably prudent nurse” benchmark to define the standard of care, which looks at actions this way:

Is the performance of the act within the accepted “standard of care” which would be provided in similar circumstances by reasonable and prudent nurses who have similar training and experience? (Texas Bureau of Nursing, n.d.)
Scenario: Standard of care

To understand the legal requirements of the standard of care, let’s look at a sequence of events that seem to challenge the standard of care provided.

Mr. Reilly was admitted to the intensive care unit of a general acute care hospital following an overdose suicide attempt. The unit’s intent was to stabilize Mr. Reilly while arrangements were made to transfer him to a psychiatric facility. While in intensive care, however, Mr. Reilly became more paranoid and delusional.

The nursing staff discussed the steps that should be taken to calm the patient and decided against the use of restraints, fearing that they would increase Mr. Reilly’s agitation. Instead, in an attempt to calm the patient, a nurse remained at Mr. Reilly’s bedside. Mr. Reilly got out of bed, knocked down the nurse, fought past two other nurses, and ran off the intensive care unit. Once off the unit, Mr. Reilly knocked out a third-story window and jumped, fracturing his arm and sustaining other minor injuries.

Think about this

1. Did the nurses practice within their established standards of care?
2. Do you believe that the nurses were liable for the patient’s injuries?
3. Why or why not?
In fact, in this actual case the intensive care nurses weren’t found liable for Mr. Reilly’s injuries. The intensive care nurses realized that the patient was a threat to himself and acted reasonably under the circumstances. The nursing actions they took were fully consistent with basic professional standards of practice for medical-surgical nurses in an acute care facility.

According to the court, these intensive care nurses didn’t have, nor were they expected to have, specialized psychiatric nursing skills, and they wouldn’t be judged as though they possessed such competencies.

**THE BOTTOM LINE**

You’ll be held accountable within your specialty area and will be expected to practice within the standard of care in your specialty, but you won’t be expected to possess knowledge and skills outside your specific area of practice.

**Negligence vs. Professional Malpractice**

*Negligence* is defined as “conduct which falls below the standard established by law for the protection of others against unreasonable risk or harm.” (*Restatement [Second] of Torts §282 [1965].*)

*Professional malpractice* is negligence committed by a professional person.

A person may be found liable for professional malpractice when, *acting within their professional capacity*, they fail to exercise reasonable conduct. This means that if you fail to practice within the standard of care or if you practice outside the scope of your identified practice, you will expose yourself to accusations that you were negligent and (because the accusations are related to your nursing practice) you may be sued for professional malpractice.
You also need to know that negligence leading to a professional malpractice suit may occur if a person fails to act when a reasonably prudent person would have taken action in a similar situation. To be found liable for negligence, all five of the elements below must be established:

1. A duty of care owed by you to the individual
2. A breach of that duty
3. An actual causal connection between your conduct and the resulting harm
4. Proximate cause, meaning the potential for harm was foreseeable
5. Damages resulting from your conduct

(Restatement [Second] of Torts §282 [1965])

NOTE

To clarify the relationship between negligence and professional malpractice, negligence essentially becomes professional malpractice when the act is committed by a person in their professional capacity. If you don’t call housekeeping when you see a puddle of water on the floor, and someone then slips and gets injured, that act wouldn’t be professional malpractice, it would be negligence.

Scenario: Alarming negligence

The standard for establishing professional malpractice is essentially the same as the standard for establishing negligence. Let’s see how the five elements above apply to a real situation.

A 15-month-old child was admitted to the hospital after being successfully resuscitated when he stopped
breathing at home. The physician ordered the child to be placed on a pediatric apnea monitor.

Although the child was placed on the monitor, the nursing staff failed to activate the alarm. When the child stopped breathing, the alarm didn’t sound a warning, and the child died. The nurse who placed the child on the pediatric apnea monitor was found liable for professional malpractice for failing to turn on the alarm.

**Think about this**

To understand how professional malpractice was determined in this case, take a look at the following analysis.

1. Was there a **duty of care** owed by the defendant (the nurse) to the plaintiff (the patient)?
   
   *Yes. The professional duty of the nurse was activated when she assumed care of the pediatric patient.*

2. Was there a **breach** of that duty?

   *Yes. The nurse had a duty to provide competent nursing care to the patient. A competent pediatric nurse in similar circumstances would have activated the pediatric apnea monitor. The duty to provide competent nursing care was breached when the nurse failed to activate the pediatric apnea monitor.*

3. Was there an **actual causal connection** between the defendant’s conduct and the resulting harm?
Yes. There is a causal connection between the defendant’s failure to activate the pediatric apnea monitor and the plaintiff’s death. It could be successfully argued that, but for the nurse failing to activate the apnea monitor, the patient wouldn’t have died.

4. Were the defendant’s actions the proximate cause of the plaintiff’s injuries? Was it foreseeable that the plaintiff would sustain such injuries?

Yes. It was foreseeable that the failure to activate the pediatric apnea monitor (especially in a pediatric patient with previous apnea episodes) would cause the plaintiff to sustain such injuries. In this instance, the defendant’s actions were the proximate cause of the plaintiff’s injuries.

5. Was the plaintiff damaged from the defendant’s conduct?

Yes. The defendant’s conduct caused damage, and resulting death, to the plaintiff.

A nurse practicing within the standard of care would have activated the alarm for the pediatric patient. The nurse who failed to do so was determined to be liable for professional malpractice.

THE BOTTOM LINE

Nursing is defined by a set of specialized skills, knowledge, and abilities, and the law requires you to practice within these established professional standards. If you practice outside the
established professional standard of care, you invite a charge of liability for professional malpractice.

**Duty to Report**

As part of your professional role, you have a legal and ethical duty to report illegal acts and unsafe practices. Often the *legal duty* to report is established in the statutes of state nursing boards. The *ethical duty* to report occurs when you witness a practice with which you’re extremely uncomfortable; it “doesn’t feel right.” In these situations, you have an obligation to report based upon your personal moral compass.

**Scenario: Duty to report**

One night, while at work, you walk into the break room and witness a fellow staff nurse place a syringe full of clear liquid into her purse. When she sees you, she quickly places the purse in her locker, secures the locker, and leaves the break room.

Here, you are faced with a legal and ethical dilemma that requires you to act. First, the nurse’s act is potentially illegal because she may be diverting medication from the unit. If so, you have a legal duty to report her actions. Most state nursing boards have enacted statutes or rules requiring a nurse to report when they have knowledge that another nurse has engaged in illegal behavior.

You also have an ethical duty to report the nurse. If the nurse in question is impaired and a patient is harmed due to the nurse’s impaired status, you’ll have difficulty coming to terms with the fact that you may have been able to intervene before the patient was injured.
Here, the situation is difficult because you don’t know what was contained in the syringe, but if you are in a hospital where controlled substances are maintained and the nurse in question has access to those controlled substances, you must report what you saw to your charge nurse and nurse manager. If you witness such an incident, it should be reported immediately to the charge nurse because if the nurse is impaired she needs to be removed from patient care immediately. Additionally, if you make the report to your charge nurse immediately, the evidence (the syringe containing the clear liquid) will still be in the nurse’s purse and she will not have had the opportunity to dispose of the evidence.

Make no doubt about it, you’re going to struggle, because you’ll have concerns about “getting the nurse in trouble.” Just remember, your legal duty is to protect the patients on your unit, and if you fail to report this, you may be placing those patients at risk of harm. If you fail to report this, you may also be opening yourself up to some liability if, at a later date, a patient is harmed by the nurse and it becomes known that you had noticed that the nurse was diverting medication yet failed to report.

When you go to the charge nurse to report what you saw, do it in a confidential setting and tell the charge nurse only what you witnessed. For example, “I went into the break room and saw Judy stick a syringe of clear liquid into her purse.”

Do not speculate as to what was contained in the syringe. Only report what you saw.

**Think about this**

Take a moment to review the steps you and your charge nurse should take when reporting an illegal or unsafe act you’ve witnessed.
1. First notify your immediate supervisor (in this example, the charge nurse) of the reportable incident. You and your charge nurse will also report the incident to the nurse manager. Complete any documentation, such as an incident report, that may be required by your facility.

2. Consistent with the hospital’s policies and procedures, your nurse manager will gather appropriate evidence and documentation to substantiate the claim.

3. Your nurse manager must then go to his or her supervisor and move up the chain of command with the documentation, always consistent with the facility’s policies and procedures.

4. Your nurse manager should keep you informed of the status of the complaint, so that you know it is being taken seriously. Please know that because of employee confidentiality, your nurse manager may not be able to go into great detail about what is being done to address your complaint, but you should still be made aware that your complaint is being addressed.

Patient Abandonment

Patient abandonment is a legal issue that may result once you have accepted the care of a patient. If you’ve accepted the care of a patient and you explicitly terminate the nurse-patient relationship without reasonable notice, even though the patient remains in need of care, you run the risk of liability for patient abandonment. When you accept the care of a patient, you have a legal
duty to provide care for that patient until the care of that patient is assumed by another nursing professional or you are relieved of that duty by your nursing supervisor.

If you abandon a patient, you will face legal liability issues. Additionally, you can expect discipline from your state board of nursing, including suspension or revocation of your professional nursing licenses depending upon the severity of the offense.

**Scenario: Patient abandonment**

Once you’ve accepted the care of a patient, you have a duty to fulfill the assignment or transfer the responsibility to another qualified person, as you’ll see in this scenario:

_Nurse Jensen was notified by her supervisor that one of the day-shift nurses would be required to work an extra shift due to a staff shortage. According to the hospital’s mandatory overtime policy, the nurse with the least seniority (Nurse Jensen) was required to stay. She agreed to stay, but left after an hour without informing anyone that she was leaving. Twenty-nine patients, three of them ventilator-dependent, were left without registered nurse supervision. Upon leaving the floor, Nurse Jensen informed staff she was going to see the supervisor and that they could page her if an emergency occurred._

This actual case was brought before the state board disciplinary panel. The panel found that the overtime policy was appropriate, that the nurse was aware of the policy, and that an emergency staffing situation existed on the day in question.
The state board disciplinary panel ruled that the nurse had abandoned the patients, and her license was suspended for one year.

**Think about this**

Consider the legal significance of a “nursing report” at shift change. When you give a nursing report to the oncoming nurse who will take over your patients, you are handing over the responsibility for those patients to the oncoming nursing staff, ensuring that there will be no patient abandonment allegations made against you. When you complete a report and the oncoming shift accepts patient responsibility, you have met your duty to your patients.
The Essential Legal Handbook for Nurses: Best Practices for Nursing Staff puts practical legal know-how into your hands whether you are a new or experienced nurse. It's a proactive tool that provides crucial, commonsense steps to take to protect yourself and your employer against avoidable legal liability.

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