NURSE PRACTICE REGULATIONS AND TORTS

Nurse Practice Regulations

Nurse Practice Acts (NPAs) are laws enacted by individual states that define the legal scope of nursing practice, guidelines, and grounds for disciplinary action.

Remember: The nurse must practice only within the legal scope of practice.

Remember: If an action is outside the scope of nursing, **DON'T** perform it just because another person tells you to.

The nurse should:

1. **Recognize the limitation**
2. **Stop/Clarify questionable actions with HCPs**
3. **Consult the appropriate supervisor**
4. **Follow applicable law and facility policy**

TORTS

A tort is a wrongful act or omission that causes harm and creates civil liability

NEGLIGENCE vs MALPRACTICE

Negligence

Failure to act as a reasonably prudent person would under similar circumstances.
Example: A nurse fails to implement fall precautions on an agitated client, and the client falls.

Malpractice

Professional negligence by a healthcare professional

Four elements of Nursing Malpractice- All four elements must be established for a malpractice claim

DUTY → Nurse had a duty to the patient
BREACH → Nurse failed to achieve the expected standard
CAUSATION → Breach caused the injury
HARM → Client experienced actual injury/damage

Example:
A nurse failed to assess the client's glucose level before administering insulin. The client develops severe hypoglycemia and is injured.

Duty: The nurse was responsible for monitoring the client
Breach: The nurse failed to appropriately assess/monitor the client
Causation: Failure contributed to deterioration of the client
Harm: Client experienced injury

INTENTIONAL TORTS

These involve an intentional act, rather than simply careless behavior

TORT	MEANING	EXAMPLE
ASSAULT "I threatened you."	Threat that causes fear of imminent harmful/offensive act	"If you don't eat your meal, I'll force you."
BATTERY "I touched you."	intentional harmful physical contact without consent	Giving IM medication after client refused
FALSE IMPRISONMENT "I trapped you."	Unlawful restraining of client's freedom of movement	Putting client on seclusion without an order or clinical justification

REDUCING LIABILITY

The safest nurse is a nurse who consistently follows the standards of care.

The nurse should:

1. **Assess: Perform appropriate assessments, identify changes in the client's condition, reassess client after interventions.**
2. **Communicate: Always report significant changes, clarify unclear or unsafe orders to HCPs, and use appropriate chain of command when needed.**
3. **Take action: Provide care within the scope of practice, follow professional standards and facility policies, and implement appropriate interventions**
4. **Document: Accurately and promptly document assessments, nursing interventions, client responses, and important communication.**

DOCUMENTATION—The legal record

"What has not been written, has not been done."

Remember: The nurse should document what was assessed, observed, what interventions were performed, the client's response, who was notified, the provider's response or orders, and any follow-up actions done.

Avoid: The nurse should avoid altering records, falsifying documentation, documenting care that was not performed, presenting opinions as facts, or blaming other healthcare workers in the client's medical record

INCIDENT REPORTS

An incident report is used to document an unexpected event or unusual occurrence, like: Falls, Medication Errors, Equipment injuries, Client Injuries, Treatment related incidents

Priority: assess client > treat > notify HCP > document > incident report

Remember: Do NOT write in the client's medical record that you have accomplished/completed an incident report. The incident report is a separate risk-management document.

CLIENT CONFIDENTIALITY AND MANDATORY REPORTING

CONFIDENTIALITY is protecting the client's private health information.

The nurse should only access or share information when there is authorization, or it is a legal requirement.

Remember:

- **Never access a client's chart out of curiosity.**
- **Never discuss clients with family or friends, and never in public areas**
- **Never post identifiable client information on social media (room number, diagnosis, chart, etc.)**
- **HIPAA requires appropriate protection of protected health information and generally limits unnecessary use or disclosure**

When can confidential information be disclosed?

Disclosure may be required or permitted for situations such as:

- **Continuity of care**
- **Legal requirements**
- **Public health reporting**
- **Abuse/Neglect reporting**

Family members DO NOT automatically have the right to receive information simply because they are family.

MANDATORY REPORTING

the nurse is legally required to report certain conditions or situations to the appropriate authority. This includes:

- **Suspected child abuse**
- **Suspected vulnerable adult/elder abuse**
- **Certain communicable diseases**
- **certain injuries, crimes**
- **Threats to safety**

Remember: The nurse does not need to prove abuse before reporting suspected abuse when the law requires reporting.

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INFORMED CONSENT

Informed consent means the client voluntarily agrees to a procedure after receiving enough information to make an informed decision.

> Remember: Informed consent applies only to clients who have decision-making capacity and have been fully informed by the provider. Provider explains the procedure, risks, benefits, and alternatives.

Valid consent should be:

Voluntary: The decision is made without force or coercion

Informed: The client receives enough education/information

Capacity: The client has appropriate decision-making capacity, or an authorized decision-maker gives consent when necessary

> Remember: If the client does not understand your language, provide a professional interpreter. Do not use members of the family as translators.

Information typically includes:

B-enefits
E-xpected outcomes
A-lternatives
R-isks
P-rocedure

Nurse's role in informed consent:
Verify consent, assess understanding, witness the signature when required, and advocate for the client.

> Remember: If the client tells you they signed the form but did not really understand what the provider is going to do, you should STOP and notify the provider. Do not explain the procedure in place of the provider.

If the client lacks capacity to consent, the healthcare power of attorney (if available), legal guardian, or next of kin — or a parent/guardian for a minor — can give consent.

The client has the right to refuse or revoke consent any time.

EMERGENCY CONSENT

Emergency treatments do not require the client's consent. Rather, the client's consent is implied.

Example: An unconscious client from a motor vehicle crash who needs an immediate craniotomy for intracranial hemorrhage may be operated on without signed consent.

RIGHT TO REFUSE

A competent adult has the right to withdraw consent, accept or refuse treatment even when the nurse or provider disagrees.

What will you do in case client refuses care?

Assess understanding> Provide appropriate information> Notify provider> Document> Respect decision

ADVANCE DIRECTIVES AND CODE STATUS

Advance directives

An advance directive communicates the client's healthcare wishes in case the client becomes unable to make or communicate decisions on their own.

Living will

The client's wishes regarding specific medical treatments, particularly future or end of life care

Durable power of attorney

Designates another person to make healthcare decisions if the client becomes unable to do so.

> Remember: Clients can change decisions regarding treatment any time.

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CODE STATUS

Code status tells the healthcare team what should happen regarding resuscitation if cardiopulmonary arrest occurs

Full code

The client wants resuscitation efforts if cardiac or respiratory arrest occurs. This includes CPR, defibrillation, advanced airway management, etc.

Do Not Resuscitate (DNR)

A DNR means that CPR/ resuscitative efforts should not be initiated if the client's heart or breathing stops

> **Remember: DNR specifically addresses resuscitation. It does not automatically mean "provide no care."**

Do Not Intubate (DNI):

If a client develops respiratory failure, do not insert an endotracheal tube or place them on invasive mechanical ventilation.

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