Ernstmeyer & Christman

OPEN RN

NURSING MANAGEMENT & PROFESSIONAL CONCEPTS

SECOND EDITION

Expert-authored, peer reviewed.

WisTech open

Nursing Management and Professional Concepts 2e

Nursing Management and Professional Concepts 2e

ERNSTMEYER & CHRISTMAN - OPEN RESOURCES FOR NURSING (OPEN RN)

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This is the second edition of the *Nursing Management & Professional Concepts* nursing OER textbook that was developed specifically for prelicensure nursing students preparing to graduate and take the NCLEX-RN to obtain their nursing license. Content is based on the Wisconsin Technical College System (WTCS) statewide nursing curriculum for the Nursing Management & Professional Concepts course (543-114), the 2023 NCLEX-RN Test Plan,[1] and the Wisconsin Nurse Practice Act.[2] Here is a summary of updates made to the second edition.

This book introduces concepts related to nursing leadership and management, prioritization strategies, delegation and supervision, legal implications of nursing practice, ethical nursing practice, collaboration within the interprofessional team, health care economics, quality and evidence-based practice, advocacy, preparation for the RN role, and the avoidance of burnout with self-care. Several free, online, interactive learning activities are included in each chapter, including NCLEX Next Generation-style case studies that encourage students to develop clinical judgment while applying content to client-care situations. Additionally, the Appendix includes a "suite of patients" with suggested prompts for classroom discussion to assist students in applying concepts from the book to real client-care situations.

The following video provides a quick overview of how to navigate the online version.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://wtcs.pressbooks.pub/nursingmpc/?p=4#oembed-1

1. NCSBN. (n.d.). *Test plans.* https://www.nclex.com/test-plans.page
2. Wisconsin State Legislature. (2024). *Chapter 6: Standards of practice for registered nurses and licensed practical nurses*. Board of Nursing. https://docs.legis.wisconsin.gov/statutes/statutes/441

Preface

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- Wagner, J. (2018). *Leadership and Influencing Change in Nursing*. University of Regina Press. https://pressbooks.pub/leadershipandinfluencingchangeinnursing/
- World Health Organization. (2024). *Medication without harm: Policy brief*. WHO. https://www.who.int/publications/i/item/9789240062764
- Lowey, S. E. (2015). *Nursing care at the end of life*. Open Library. https://ecampusontario.pressbooks.pub/nursingcare/
- Steinmetz, J. (2019). *Politics, Power, and Purpose: An Orientation to Political Science*. FHSU Digital Press. https://fhsu.pressbooks.pub/orientationpolisci/
- Lapum, J., St-Amant, O., Hughes, M., Tan, A., Bogdan, A., Dimaranan, F., Frantzke, R., & Savicevic, N. (2019). *The scholarship of writing in nursing education: 1st Canadian edition*. Toronto LibreTexts. (2024). Anatomy and physiology (boundless). LibreTexts: Medicine. https://med.libretexts.org/Bookshelves/Anatomy_and_Physiology/Anatomy_and_Physiology_(Boundless)
- StatPearls [Internet]. (2025). StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK430685/

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Standards and Conceptual Approach

The Open RN *Nursing Management and Professional Concepts, 2e* textbook is based on several external standards and uses a conceptual approach.

External Standards

American Nurses Association (ANA)

The ANA establishes Standards for Professional Nursing Practice a Nursing Code of Ethics.[1,2]

- https://www.nursingworld.org/ana/about-ana/standards/

The National Council Licensure Examination for Registered Nurses: NCLEX-RN Test Plans

The NCLEX-RN test plans are updated every three years to reflect fair, comprehensive, current, and entry-level nursing competency.

- https://www.ncsbn.org/nclex.htm

The National League of Nursing (NLN): Competencies for Graduates of Nursing Programs

NLN competencies guide nursing curricula to position graduates in a dynamic health care arena with practice that is informed by a body of

1. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.
2. American Nurses Association. (2015). *Code of ethics for nurses with interpretive statements*. American Nurses Association. https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/

knowledge and ensures that all members of the public receive safe, quality care.

- https://www.nln.org/education/nursing-education-competencies/competencies-for-graduates-of-nursing-programs

American Association of Colleges of Nursing (AACN): The Essentials: Competencies for Professional Nursing Education

A framework for preparing individuals as members of the discipline of nursing, reflecting expectations across
the trajectory of nursing education and applied experience.

- https://www.aacnnursing.org/Portals/42/AcademicNursing/pdf/Essentials-2021.pdf

Quality and Safety Education for Nurses (QSEN) Institute: Pre-licensure Competencies

Quality and safety competencies include knowledge, skills, and attitudes to be developed in nursing prelicensure programs. QSEN competencies include client-centered care, teamwork and collaboration, evidence-based practice, quality improvement, safety, and informatics.

- https://qsen.org/competencies/

Wisconsin State Legislature, Administrative Code Chapter N6

The Wisconsin Administrative Code governs the Registered Nursing and Practical Nursing professions in Wisconsin.

- https://docs.legis.wisconsin.gov/code/admin_code/n/6

Healthy People 2030

Healthy People 2030 envisions a society in which all people can achieve their

full potential for health and well-being across the life span. Healthy People provides objectives based on national data and includes social determinants of health.

- https://health.gov/healthypeople

Conceptual Approach

The Open RN *Nursing Management and Professional Concepts* textbook incorporates the following concepts:

- **Holism.** Florence Nightingale taught nurses to focus on the principles of holism, including wellness and the interrelationship of human beings and their environment. This textbook encourages holistic nursing care by addressing the impact of social determinants of health (SDOH) and health care reimbursement models on client health.
- **Evidence-Based Practice (EBP).** Evidence-based practices are referenced by footnotes throughout the textbook. To promote the development of digital literacy, hyperlinks are provided to credible, free online resources that supplement content. The Open RN textbooks will be updated as new EBP is established and after the release of updated NCLEX Test Plans every three years.
- **Clinical Judgment.** Associated unfolding case studies are written to reflect the NCSBN Clinical Judgment Measurement Model used on the NCLEX-RN. Formative assessments encourage students to recognize cues, analyze cues, prioritize hypotheses, generate solutions, take action, and evaluate outcomes.[3]
- **Cultural Competency.** Nurses have an ethical obligation to practice with cultural humility and provide culturally responsive care to the clients and

3. Dickison, P., Haerling, K. A., & Lasater, K. (2019). Integrating the national council of state boards of nursing clinical judgment model into nursing educational frameworks. *Journal of Nursing Education*. *58*(2), 72-78. https://doi.org/10.3928/01484834-20190122-03

communities they serve based on the ANA Code of Ethics[4] and the ANA Scope and Standards of Practice.[5]

- **Safe, Quality, Client-Centered Care.** Content reflects the priorities of safe, quality, client-centered care.
- **Clear and Inclusive Language.** Clear language is used based on preferences expressed by prelicensure nursing students to enhance understanding of complex concepts.[6] "They" is used as a singular pronoun to refer to a person whose gender is unknown or irrelevant to the context of the usage, as endorsed by APA style. It is inclusive of all people and helps writers avoid making assumptions about gender.[7]
- **Open Source Images and Fair Use.** Images are included to promote visual learning. Students and faculty can reuse open source images by following the terms of their associated Creative Commons licensing. Some images are included based on Fair Use as described in the "Code of Best Practices in Fair Use for Open Educational Resources" presented at the OpenEd 2020 conference. Refer to the footnotes of images for source and licensing information throughout the text.

4. American Nurses Association. (2015). *Code of ethics for nurses with interpretive statements*. American Nurses Association. https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/

5. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

6. Verkuyl, M., Lapum, J., St-Amant, O., Bregstein, J., & Hughes, M. (2020). Healthcare students' use of an e-textbook open educational resource on vital sign measurement: A qualitative study. *Open Learning: The Journal of Open, Distance and e-Learning*. https://doi.org/10.1080/02680513.2020.1835623

7. American Psychological Association. (2021). *Singular "They."* https://apastyle.apa.org/style-grammar-guidelines/grammar/singular-they

- **Open Pedagogy.** Students are encouraged to contribute to the Open RN project in meaningful ways by reviewing content for clarity and assisting in the creation of open source images.[8]

Supplementary Material Provided

Several supplementary resources are provided with this textbook.

- Supplementary, free videos promote student understanding of concepts and procedures.
- Online, interactive, and written learning activities provide formative feedback. and promote the development of clinical judgment as students apply content to realistic client scenarios.
- Free NCLEX Next Generation-style case studies are provided in each chapter
- Free downloadable textbook versions are available for offline use.

8. Wagstaff, S. (2023). Open Pedagogy Notebook. https://openpedagogy.org/

PART I

CHAPTER 1 - OVERVIEW OF MANAGEMENT AND PROFESSIONAL ISSUES

1.1 Overview

This textbook discusses professional and management concepts related to the role of a registered nurse (RN) as defined by the American Nurses Association (ANA). The ANA publishes two resources that set standards and guide professional nursing practice in the United States: The *Code of Ethics for Nurses With Interpretive Statements* and *Nursing: Scope and Standards of Practice*. The *Code of Ethics for Nurses With Interpretive Statements* establishes an ethical framework for nursing practice across all roles, levels, and settings and is discussed in greater detail in the "Ethical Practice" chapter of this book. The *Nursing: Scope and Standards of Practice* resource defines the "who, what, where, when, why, and how of nursing" and sets the standards for practice that all registered nurses are expected to perform competently.[1]

The ANA defines the "who" of nursing practice as the nurses who have been educated, titled, and maintain active licensure to practice nursing. The "what" of nursing is the recently revised ANA definition of nursing: "**Nursing** integrates the art and science of caring and focuses on the protection, promotion, and optimization of health and human functioning; prevention of illness and injury; facilitation of healing; and alleviation of suffering through compassionate presence. Nursing is the diagnosis and treatment of human responses and advocacy in the care of individuals, families, groups, communities, and populations in recognition of the connection of all humanity."[2] Simply put, nurses treat human responses to health problems and life processes and advocate for the care of others.

Nursing practice occurs "when" there is a need for nursing knowledge,

1. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.
2. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

wisdom, caring, leadership, practice, or education, anytime, anywhere. Nursing practice occurs in any environment "where" there is a health care consumer in need of care, information, or advocacy. The "why" of nursing practice is described as nursing's response to the changing needs of society to achieve positive health care consumer outcomes in keeping with nursing's social contract and obligation to society. The "how" of nursing practice is defined as the ways, means, methods, and manners that nurses use to practice professionally.[3] The "how" of nursing, also referred to as a nurse's "scope and standards of practice," is further defined by each state's Nurse Practice Act; agency policies, procedures, and protocols; and federal regulations and ANA's Standards of Practice.

STATE BOARDS OF NURSING AND NURSE PRACTICE ACTS

RNs must legally follow regulations set by the Nurse Practice Act by the state in which they are caring for clients with their nursing license. The **Board of Nursing** is the state-specific licensing and regulatory body that sets standards for safe nursing care and issues nursing licenses to qualified candidates based on the Nurse Practice Act. The **Nurse Practice Act** is enacted by that state's legislature and defines the scope of nursing practice and establishes regulations for nursing practice within that state. If nurses do not follow the standards and scope of practice set forth by the Nurse Practice Act, they may be disciplined by the Board of Nursing in the form of reprimand, probation, suspension, or revocation of their nursing license. Investigations and discipline actions are reportable among states participating in the Nurse Licensure Compact (that allows nurses to practice

3. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

across state lines) or when a nurse applies for licensure in a different state. The scope and standards of practice set forth in the Nurse Practice Act can also be used as evidence if a nurse is sued for malpractice.

- Find your state's Nurse Practice Act on the National Council of State Board of Nursing (NCSBN) website.

- Read more about malpractice and protecting your nursing license in the "Legal Implications" chapter of this book.

- Read Wisconsin's Nurse Practice Act, Standards of Practice for Registered Nurses and Licensed Practical Nurses (Chapter N6) PDF, and Rules of Conduct (Chapter N7) PDF.

AGENCY POLICIES, PROCEDURES, AND PROTOCOLS

In addition to practicing according to the Nurse Practice Act in the state they are employed, nurses must also practice according to agency policies, procedures, and protocols.

A **policy** is an expected course of action set by an agency. For example,

hospitals set a policy requiring a thorough skin assessment to be completed when a client is admitted and then reassessed and documented daily.

Agencies also establish their own set of procedures. A **procedure** is the method or defined steps for completing a task. For example, each agency has specific procedural steps for inserting a urinary catheter.

A **protocol** is a detailed, written plan for performing a regimen of therapy. For example, agencies typically establish a hypoglycemia protocol that nurses can independently and quickly implement when a client's blood sugar falls below a specific number without first calling a provider. A hypoglycemia protocol typically includes actions such as providing orange juice and rechecking the blood sugar and then reporting the incident to the provider.

Agency-specific policies, procedures, and protocols supersede the information taught in nursing school, and nurses can be held legally liable if they don't follow them. It is vital for nurses to review and follow current agency-specific procedures, policies, and protocols while also practicing according to that state's nursing scope of practice. Malpractice cases have occurred when a nurse was asked by their employer to do something outside their legal scope of practice, impacting their nursing license. It is up to you to protect your nursing license and follow the Nurse Practice Act when providing client care. If you have a concern about an agency's policy, procedure, or protocol, follow the agency's chain of command to report your concern.

FEDERAL REGULATIONS

Nursing practice is impacted by regulations enacted by federal agencies. Two examples of federal agencies setting standards of care are The Joint Commission and the Centers for Medicare and Medicaid Services.

The Joint Commission accredits and certifies over 20,000 health care

organizations in the United States. The Joint Commission's standards help health care organizations measure, assess, and improve performance on functions that are essential to providing safe, high-quality care. The standards are updated regularly to reflect the rapid advances in health care and address topics such as client rights and education, infection control, medication management, and prevention of medical errors. The annual National Patient Safety Goals are also set by The Joint Commission after reviewing emerging client safety issues.[4]

The Centers for Medicare & Medicaid Services (CMS) is an example of another federal agency that establishes regulations affecting nursing care. CMS is a part of the U.S. Department of Health and Human Services (HHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid. The CMS establishes and enforces regulations to protect client safety in hospitals that receive Medicare and Medicaid funding. For example, one CMS regulation often referred to as "checking the rights of medication administration" requires nurses to confirm specific information several times before medication is administered to a client.[5]

STANDARDS OF PRACTICE

The ANA defines **Standards of Professional Nursing Practice** as "authoritative statements of the actions and behaviors that all registered

4. The Joint Commission. (2025). *National Patient Safety Goals*. https://www.jointcommission.org/standards/national-patient-safety-goals/
5. Centers for Medicare & Medicaid Services. (2024). *Quality initiatives-general information*. U.S. Department of Health and Human Services. https://www.cms.gov/medicare/quality/initiatives

nurses, regardless of role, population, specialty, and setting, are expected to perform competently."[6] These standards are classified into two categories: Standards of Practice and Standards of Professional Performance.

The **ANA's Standards of Practice** describe a competent level of nursing practice as demonstrated by the critical thinking model known as the **nursing process**. The nursing process includes the components of assessment, diagnosis, outcomes identification, planning, implementation, and evaluation and forms the foundation of the nurse's decision-making, practice, and provision of care.[7]

> Read more information about the nursing process in the "Nursing Process" chapter of Open RN *Nursing Fundamentals, 2e*.[8]

The **ANA's Standards of Professional Performance** "describe a competent level of behavior in the professional role, including activities related to ethics, advocacy, respectful and equitable practice, communication, collaboration, leadership, education, scholarly inquiry, quality of practice, professional practice evaluation, resource stewardship, and environmental health. All registered nurses are expected to engage in professional role activities,

6. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.
7. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.
8. Ernstmeyer, K., & Christman, E. (Eds.). (2024). *Nursing fundamentals 2E*. Open RN | WisTech Open. https://wtcs.pressbooks.pub/nursingfundamentals/

including leadership, reflective of their education, position, and role."[9] This book discusses content related to these professional practice standards. Each professional practice standard is defined in the following subsections with information provided to related content in this book and the Open RN *Nursing Fundamentals, 2e* textbook.[10]

ETHICS

The ANA's *Ethics* standard states, "The registered nurse integrates ethics in all aspects of practice."[11]

> Read about ethical nursing practice in the "Ethical Practice" chapter of this book.

9. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.
10. Ernstmeyer, K., & Christman, E. (Eds.). (2024). *Nursing fundamentals 2E*. Open RN | WisTech Open. https://wtcs.pressbooks.pub/nursingfundamentals/
11. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

ADVOCACY

The ANA's *Advocacy* standard states, "The registered nurse demonstrates advocacy in all roles and settings."[12]

> Read about nurse advocacy in the "Advocacy" chapter of this book.

RESPECTFUL AND EQUITABLE PRACTICE

The ANA's *Respectful and Equitable Practice* standard states, "The registered nurse practices with cultural humility and inclusiveness."

> Read about cultural humility and culturally responsive care in the "Diverse Patients" chapter in Open RN *Nursing Fundamentals, 2e*.[13]

12. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

13. Ernstmeyer, K., & Christman, E. (Eds.). (2024). Nursing fundamentals 2E. Open RN | WisTech Open. https://wtcs.pressbooks.pub/nursingfundamentals/

COMMUNICATION

The ANA's *Communication* standard states, "The registered nurse communicates effectively in all areas of professional practice."[14]

- Read about communicating with clients and team members in the "Communication" chapter in Open RN *Nursing Fundamentals, 2e*.[15]

- Read about interprofessional communication strategies that promote client safety in the "Collaboration Within the Interprofessional Team" chapter of this book.

14. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

15. Ernstmeyer, K., & Christman, E. (Eds.). (2024). *Nursing fundamentals 2E*. Open RN | WisTech Open. https://wtcs.pressbooks.pub/nursingfundamentals/

COLLABORATION

The ANA's *Collaboration* standard states, "The registered nurse collaborates with the health care consumer and other key stakeholders."[16]

> Read about strategies to enhance the performance of the interprofessional team and manage conflict in the "Collaboration Within the Interprofessional Team" chapter of this book.

LEADERSHIP

The ANA's *Leadership* standard states, "The registered nurse leads within the profession and practice setting."[17]

> Read about leadership, management, and implementing change in the "Leadership and Management" chapter of this book.

16. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

17. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

- Read about assigning, delegating, and supervising client care in the "Delegation and Supervision" chapter of this book.

- Read about tools for prioritizing client care and managing resources for the nursing team in the "Prioritization" chapter of this book.

EDUCATION

The ANA's *Education* standard states, "The registered nurse seeks knowledge and competence that reflects current nursing practice and promotes futuristic thinking."[18]

- Read about professional development and specialty certification in the "Preparation for the RN Role" chapter of this book.

18. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

SCHOLARLY INQUIRY

The ANA's *Scholarly Inquiry* standard states, "The registered nurse integrates scholarship, evidence, and research findings into practice."[19]

> Read about integrating evidence-based practice into one's nursing practice in the "Quality and Evidence-Based Practice" chapter of this book.

QUALITY OF PRACTICE

The ANA's *Quality of Practice* standard states, "The nurse contributes to quality nursing practice."[20]

> Read about improving quality care and participating in quality improvement initiatives in the "Quality and Evidence-Based Practice" chapter of this book.

19. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

20. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

PROFESSIONAL PRACTICE EVALUATION

The ANA's *Professional Practice Evaluation* standard states, "The registered nurse evaluates one's own and others' nursing practice."[21]

- Read about nursing practice within the legal framework of health care, negligence, malpractice, and protecting your nursing license in the "Legal Implications" chapter of this book.

- Read about reviewing the interprofessional team's performance, providing constructive feedback, and advocating for client safety with assertive statements in the "Collaboration Within the Interprofessional Team" chapter of this book.

RESOURCE STEWARDSHIP

The ANA's *Resource Stewardship* standard states, "The registered nurse utilizes appropriate resources to plan, provide, and sustain evidence-based

21. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

nursing services that are safe, effective, financially responsible, and used judiciously."[22]

> Read more about health care funding, reimbursement models, budgets and staffing, and resource stewardship in the "Health Care Economics" chapter of this book.

ENVIRONMENTAL HEALTH

The ANA's *Environmental Health* standard states, "The registered nurse practices in a manner that advances environmental safety and health."[23]

> Read about promoting workplace safety for nurses in the "Safety" chapter in Open RN *Nursing Fundamentals, 2e*.[24]

22. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

23. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

24. Ernstmeyer, K., & Christman, E. (Eds.). (2024). *Nursing fundamentals 2E*. Open RN | WisTech Open. https://wtcs.pressbooks.pub/nursingfundamentals/

- Read about fostering a professional environment that does not tolerate abusive behaviors in the "Collaboration Within the Interprofessional Team" chapter of this book.

- Read about addressing the impacts of social determinants of health in the "Advocacy" chapter of this book.

PART II

CHAPTER 2 - PRIORITIZATION

2.1 Prioritization Introduction

Learning Objectives

- Prioritize nursing care based on client acuity
- Use principles of time management to organize work
- Analyze effectiveness of time management strategies
- Incorporate clinical judgment to prioritize nursing care
- Apply a framework for prioritization

"So much to do, so little time." This is a common mantra of today's practicing nurse in various health care settings. Whether practicing in acute inpatient care, long-term care, clinics, home care, or other agencies, nurses may feel there is "not enough of them to go around."

The health care system faces a significant challenge in balancing the ever-expanding task of meeting client care needs with scarce nursing resources that has even worsened as a result of the COVID-19 pandemic. Many health care organizations have seen exacerbation in nurse turnover post-pandemic as nurses struggle with increasing stress, burnout, and feeling of uncertainty within the profession.[1] A recent nursing survey done by the American Nurses Foundation found that 60% of nurses reported extremely stressful, violent,

1. Kurtzman, E.T., Ghazal, L.V., Girouard,S., Ma, C., Martin, B., McGee, B.T., Pogue, C.A., Riman, K.A., Root, M.C., Schlak, A.E., Smith, J.M., Stolldorf, D.P., Townley, J.N., Turi, E., Germack, H.L. (2022). Nursing workforce challenges in the postpandemic world. *Journal of Nursing Regulation, 13*(2),49-60. https://doi.org/10.1016/S2155-8256(22)00061-8

and traumatic events as a result of the COVID-19 pandemic.[2] Additionally, a staggering 89% of nurses reported that their organizations experience significant staffing shortages.[3]

With a limited supply of registered nurses, nurse managers are often challenged to implement creative staffing practices such as sending staff to units where they do not normally work (i.e., floating), implementing mandatory staffing and/or overtime, utilizing travel nurses, or using other practices to meet client care demands.[4] Staffing strategies can result in nurses experiencing increased client assignments and workloads, extended shifts, or temporary suspension of paid time off. Nurses may receive a barrage of calls and text messages offering "extra shifts" and bonus pay, and although the extra pay may be welcomed, they often eventually feel burnt out trying to meet the ever-expanding demands of the client-care environment.

A novice nurse who is still learning how to navigate the complex health care

2. Kurtzman, E.T., Ghazal, L.V., Girouard,S., Ma, C., Martin, B., McGee, B.T., Pogue, C.A., Riman, K.A., Root, M.C., Schlak, A.E., Smith, J.M., Stolldorf, D.P., Townley, J.N., Turi, E., Germack, H.L. (2022). Nursing workforce challenges in the postpandemic world. *Journal of Nursing Regulation, 13*(2),49-60. https://doi.org/10.1016/S2155-8256(22)00061-8

3. Kurtzman, E.T., Ghazal, L.V., Girouard,S., Ma, C., Martin, B., McGee, B.T., Pogue, C.A., Riman, K.A., Root, M.C., Schlak, A.E., Smith, J.M., Stolldorf, D.P., Townley, J.N., Turi, E., Germack, H.L. (2022). Nursing workforce challenges in the postpandemic world. *Journal of Nursing Regulation, 13*(2),49-60. https://doi.org/10.1016/S2155-8256(22)00061-8

4. Rochefort, C. M., Abrahamowicz, M., Biron, A., Bourgault, P., Gaboury, I., Haggerty, J., & McCusker, J. (2021). Nurse staffing practices and adverse events in acute care hospitals: The research protocol of a multisite patient-level longitudinal study. *Journal of Advanced Nursing, 77*(3), 1567-1577. https://doi.org/10.1111/jan.14710

environment and provide optimal client care may feel overwhelmed by these conditions. Novice nurses frequently report increased levels of stress and disillusionment as they transition to the reality of the nursing role.[5] How can we address this professional dilemma and enhance the novice nurse's successful role transition to practice? The novice nurse must enter the profession with purposeful tools and strategies to help prioritize tasks and manage time so they can confidently address client care needs, balance role demands, and manage day-to-day nursing activities.

Let's take a closer look at the foundational concepts related to prioritization and time management in the nursing profession.

5. Hoeve, Y. T., Brouwer, J., Roodbol, P. F., & Kunnen, S. (2018). The importance of contextual, relational and cognitive factors for novice nurses' emotional state and affective commitment to the profession. A multilevel study. *Journal of Advanced Nursing, 74*(9), 2082-2093. https://doi.org/10.1111/jan.13709

Prioritization

As new nurses begin their career, they look forward to caring for others, promoting health, and saving lives. However, when entering the health care environment, they often discover there are numerous and competing demands for their time and attention. Client care is often interrupted by call lights, rounding physicians, and phone calls from the laboratory department or other interprofessional team members. Even individuals who are strategic and energized in their planning can feel frustrated as their task lists and planned client-care activities build into a long collection of "to dos."

Without utilization of appropriate prioritization strategies, nurses can experience **time scarcity**, a feeling of racing against a clock that is continually working against them. Functioning under the burden of time scarcity can cause feelings of frustration, inadequacy, and eventually burnout. Time scarcity can also impact client safety, resulting in adverse events and increased mortality.[1] Additionally, missed or rushed nursing activities can negatively impact client satisfaction scores that ultimately affect an institution's reimbursement levels.

It is vital for nurses to plan client care and implement their task lists while ensuring that critical interventions are safely implemented first. Identifying priority client problems and implementing priority interventions are skills that require ongoing cultivation as one gains experience in the practice environment.[2] To develop these skills, students must develop an

1. Cho, S., Lee, J., You, S. J., Song, K. J., & Hong, K. J. (2020). Nurse staffing, nurses prioritization, missed care, quality of nursing care, and nurse outcomes. *International Journal of Nursing Practice, 26*(1), e12803. https://doi.org/10.1111/ijn.12803

2. Jessee, M. A. (2019). Teaching prioritization: "Who, what, & why?" *Journal of*

understanding of organizing frameworks and prioritization processes for delineating care needs. These frameworks provide structure and guidance for meeting the multiple and ever-changing demands in the complex health care environment.

Let's consider a clinical scenario in the following box to better understand the implications of prioritization and outcomes.

Scenario A

Imagine you are beginning your shift on a busy medical-surgical unit. You receive a handoff report on four medical-surgical clients from the night shift nurse:

- Client A is a 34-year-old client post-op Day 1 from a total knee replacement who had an uneventful night. It is anticipated that she will be discharged today and needs health teaching for self-care at home.
- Client B is a 67-year-old male admitted with weakness, confusion, and a suspected urinary tract infection. He has been restless and attempting to get out of bed throughout the night. He has a bed alarm in place.
- Client C is a 49-year-old male, post-op Day 1 for a total hip replacement. He has been frequently using his patient-controlled analgesia (PCA) pump and last rated his pain as a "6."
- Client D is a 73-year-old male admitted for pneumonia. He has been hospitalized for three days and receiving intravenous (IV) antibiotics. His next dose is due in an hour.

Nursing Education, 58(5), 302-305. https://doi.org/10.3928/01484834-20190422-10

His oxygen requirements have decreased from 4 L/minute of oxygen by nasal cannula to 2 L/minute by nasal cannula.

Based on the handoff report you received, you ask the nursing assistant to check on Client B while you do an initial assessment on Client D. As you are assessing Client D's oxygenation status, you receive a phone call from the laboratory department relating a critical lab value on Client C, indicating his hemoglobin is low. The provider calls and orders a STAT blood transfusion for Client C. Client A rings the call light and states she and her husband have questions about her discharge and are ready to go home. The nursing assistant finds you and reports that Client B got out of bed and experienced a fall during the handoff reports.

It is common for nurses to manage multiple and ever-changing tasks and activities like this scenario, illustrating the importance of self-organization and priority setting. This chapter will further discuss the tools nurses can use for prioritization.

2.3 Tools for Prioritizing

Prioritization of care for multiple clients while also performing daily nursing tasks can feel overwhelming in today's fast-paced health care system. Because of the rapid and ever-changing conditions of clients and the structure of one's workday, nurses must use organizational frameworks to prioritize actions and interventions. These frameworks can help ease anxiety, enhance personal organization and confidence, and ensure client safety.

Acuity

Acuity and intensity are foundational concepts for prioritizing nursing care and interventions. **Acuity** refers to the level of client care that is required based on the severity of a client's illness or condition. For example, acuity may include characteristics such as unstable vital signs, oxygenation therapy, high-risk IV medications, multiple drainage devices, or uncontrolled pain. A "high-acuity" client requires several nursing interventions and frequent nursing assessments.

Intensity addresses the time needed to complete nursing care and interventions such as providing assistance with activities of daily living (ADLs), performing wound care, or administering several medication passes. For example, a "high-intensity" client generally requires frequent or long periods of psychosocial, educational, or hygiene care from nursing staff members. High-intensity clients may also have increased needs for safety monitoring, familial support, or other needs.[1]

Many health care organizations structure their staffing assignments based on

1. Oregon Health Authority. (2024). *Hospital nurse staffing interpretive guidance on staffing for acuity & intensity*. Public Health Division, Center for Health Protection. https://www.oregon.gov/oha/ph/providerpartnerresources/healthcareprovidersfacilities/healthcarehealthcareregulationqualityimprovement/pages/nursestaffing.aspx

acuity and intensity ratings to help provide equity in staff assignments. Acuity helps to ensure that nursing care is strategically divided among nursing staff. An equitable assignment of clients benefits both the nurse and client by helping to ensure that client care needs do not overwhelm individual staff and safe care is provided.

Organizations use a variety of systems when determining client acuity with rating scales based on nursing care delivery, client stability, and care needs. See an example of a client acuity tool published in the *American Nurse* in Table 2.3.[2] In this example, ratings range from 1 to 4, with a rating of 1 indicating a relatively stable client requiring minimal individualized nursing care and intervention. A rating of 2 reflects a client with a moderate risk who may require more frequent intervention or assessment. A rating of 3 is attributed to a complex client who requires frequent intervention and assessment. This client might also be a new admission or someone who is confused and requires more direct observation. A rating of 4 reflects a high-risk client. For example, this individual may be experiencing frequent changes in vital signs, may require complex interventions such as the administration of blood transfusions, or may be experiencing significant uncontrolled pain. An individual with a rating of 4 requires more direct nursing care and intervention than a client with a rating of 1 or 2.[3]

Table 2.3. Example of a Client Acuity Tool[4]

2. Ingram, A., & Powell, J. (2018). Patient acuity tool on a medical surgical unit. *American Nurse*. https://www.myamericannurse.com/patient-acuity-medical-surgical-unit/

3. Kidd, M., Grove, K., Kaiser, M., Swoboda, B., & Taylor, A. (2014). A new patient-acuity tool promotes equitable nurse-patient assignments. *American Nurse Today, 9*(3), 1-4. https://www.myamericannurse.com/a-new-patient-acuity-tool-promotes-equitable-nurse-patient-assignments/

4. Ingram, A., & Powell, J. (2018). Patient acuity tool on a medical surgical unit.

American Nurse. https://www.myamericannurse.com/patient-acuity-medical-surgical-unit/

	1: Stable Client	2: Moderate-Risk Client	3: Complex Client	4: High-Risk Client
Assessment	• Q8h VS • A & O X 4	• Q4h VS • CIWA < 8	• Q2h VS • Delirium • CIWA > 8	• Unstable VS
Respiratory	• Stable on RA	• O2 < 2L NC	• O2 > 2L NC	• O2 via mask
Cardiac	• VS	• Temp < 98.7 F • Pacemaker/ AICD • HR > 130	• Change in BP • Temp > 100.3 F	• Unstable rhythm • Afib
Medications	• PO/IVPB	• TPN, heparin infusion, blood glucose, PICC for blood draws	• CBI • 1 unit blood transfusion • Fluid bolus	• > 1 unit blood transfusion • Chemotherapy
Drainage Devices	• < 2 JP, hemovac, neph tube	• Chest to water seal • NG tube	• Chest tube to suction • Drain measured Q2 hrs	• Drain measured Q1 hr • CT > 100 mL/2 hrs

Pain Management	• Pain well-managed with PO or IV meds Q4 hrs	• PCA, nerve block • Nausea/ Vomiting	• Q2h pain management	• Uncontrolled pain with multiple pain devices
Admit/ Transfer/ Discharge	• Stable transfer, routine discharge	• Discharge to outside facility	• New admission, discharge to hospice	• Complicated post-op
ADLs and Isolation	• Independent	• Assist with ADLs • Two-person assist out of bed • Isolation	• Turns Q2h • Bedrest • Respiratory isolation	• Paraplegic • Total care
Client Score	**Most = 1**	**Two or > = 2**	**Any = 3**	**Any = 4**

Read more about using a client acuity tool on a medical-surgical unit.

Rating scales may vary among institutions, but the principles of the rating system remain the same. Organizations include various client care elements when constructing their staffing plans for each unit. Read more information about staffing models and acuity in the following box.

Staffing Models and Acuity

Organizations that base staffing on acuity systems attempt to evenly staff client assignments according to their acuity ratings. This means that when comparing client assignments across nurses on a unit, similar acuity team scores should be seen with the goal of achieving equitable and safe division of workload across the nursing team. For example, one nurse should not have a total acuity score of 6 for their client assignments while another nurse has a score of 15. If this situation occurred, the variation in scoring reflects a discrepancy in workload balance and would likely be perceived by nursing peers as unfair. Using **acuity-rating staffing models** is helpful to reflect the individualized nursing care required by different clients.

Alternatively, nurse staffing models may be determined by staffing ratio. **Ratio-based staffing models** are more straightforward in nature, where each nurse is assigned care for a set number of clients during their shift. Ratio-based staffing models may be useful for administrators creating budget requests based on the number of staff required for client care, but can lead to an inequitable division of work across the nursing team when client acuity is not considered. Increasingly complex clients require more time and interventions than others, so a blend of both ratio and acuity-based staffing is helpful when determining staffing assignments.[5]

5. Welton, J. M. (2017). Measuring patient acuity. *JONA: The Journal of Nursing Administration, 47*(10), 471. https://doi.org/10.1097/nna.0000000000000516

As a practicing nurse, you will be oriented to the elements of acuity ratings within your health care organization, but it is also important to understand how you can use these acuity ratings for your own prioritization and task delineation. Let's consider the Scenario B in the following box to better understand how acuity ratings can be useful for prioritizing nursing care.

Scenario B

You report to work at 6 a.m. for your nursing shift on a busy medical-surgical unit. Prior to receiving the handoff report from your night shift nursing colleagues, you review the unit staffing grid and see that you have been assigned to four clients to start your day. The clients have the following acuity ratings:

Client A: 45-year-old client with paraplegia admitted for an infected sacral wound, with an acuity rating of 4.

Client B: 87-year-old client with pneumonia with a low-grade fever of 99.7 F and receiving oxygen at 2 L/minute via nasal cannula, with an acuity rating of 2.

Client C: 63-year-old client who is postoperative Day 1 from a right total hip replacement and is receiving pain management via a PCA pump, with an acuity rating of 2.

Client D: 83-year-old client admitted with a UTI who is finishing an IV antibiotic cycle and will be discharged home today, with an acuity rating of 1.

Based on the acuity rating system, your client assignment load receives an overall acuity score of 9. Consider how you might use their acuity ratings to help you prioritize your care. Based on what is known about the clients related to their acuity rating, whom might you identify as your care priority? Although this can feel like a challenging question to answer because of the many unknown elements in the situation using acuity numbers alone,

> Client A with an acuity rating of 4 would be identified as the care priority requiring assessment early in your shift.

Although acuity can a useful tool for determining care priorities, it is important to recognize the limitations of this tool and consider how other client needs impact prioritization.

Maslow's Hierarchy of Needs

When thinking back to your first nursing or psychology course, you may recall a historical theory of human motivation based on various levels of human needs called Maslow's Hierarchy of Needs. **Maslow's Hierarchy of Needs** reflects foundational human needs with progressive steps moving towards higher levels of achievement. This hierarchy of needs is traditionally represented as a pyramid with the base of the pyramid serving as essential needs that must be addressed before one can progress to another area of need.[6] See Figure 2.1[7] for an illustration of Maslow's Hierarchy of Needs.

6. Maslow, A. H. (1943). A theory of human motivation. *Psychological Review*, *50*(4), 370–396. https://doi.org/10.1037/h0054346

7. "Maslow's_hierarchy_of_needs.svg" by J. Finkelstein is licensed under CC BY-SA 3.0

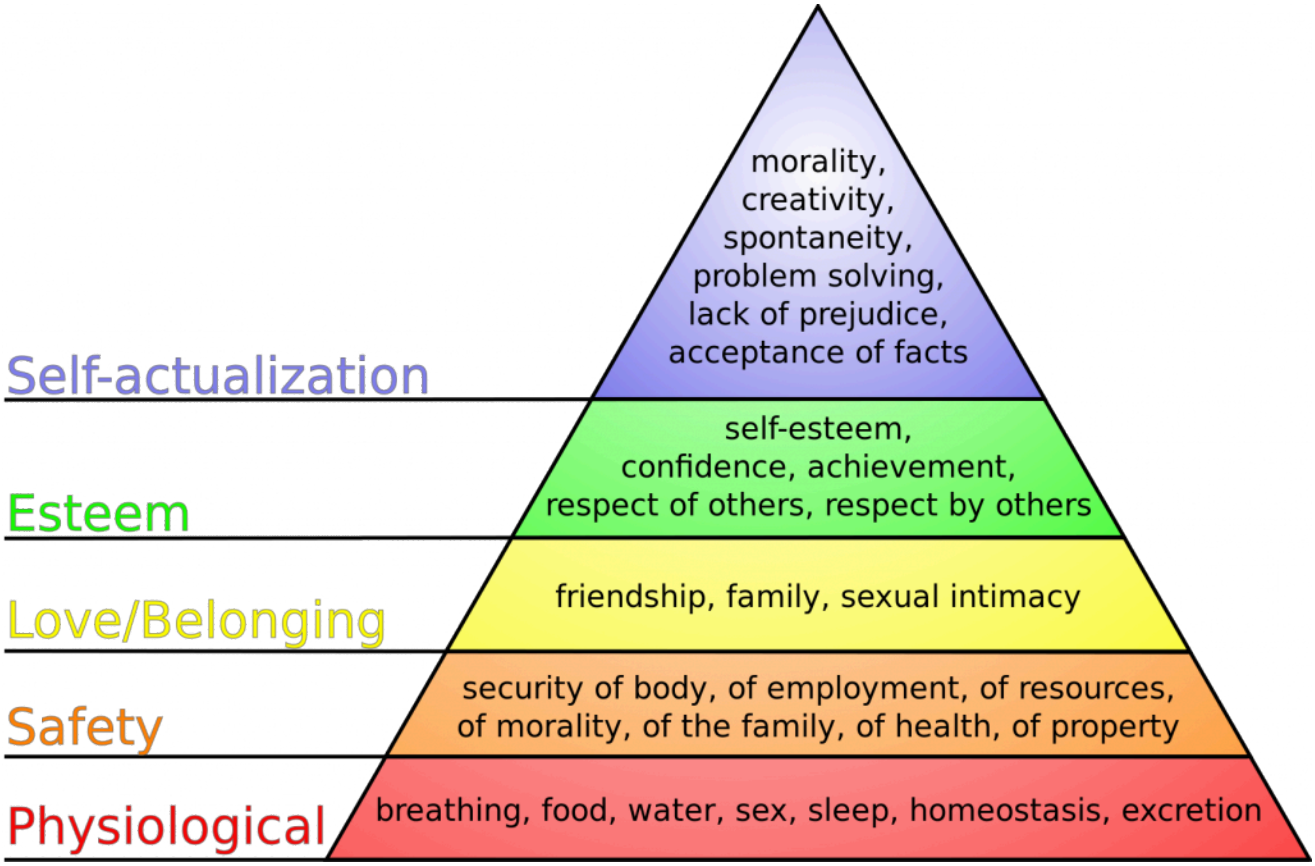

Figure 2.1 Maslow's Hierarchy of Needs

Maslow's Hierarchy of Needs places physiological needs as the foundational base of the pyramid.[8] Physiological needs include oxygen, food, water, sex, sleep, homeostasis, and excretion. The second level of Maslow's hierarchy reflects safety needs. Safety needs include elements that keep individuals safe from harm. Examples of safety needs in health care include fall precautions. The third level of Maslow's hierarchy reflects emotional needs such as love and a sense of belonging. These needs are often reflected in an individual's relationships with family members and friends. The top two levels of Maslow's hierarchy include esteem and self-actualization. An example of addressing these needs in a health care setting is helping an individual build self-confidence in performing blood glucose checks that leads to improved self-management of their diabetes.

8. Stoyanov, S. (2017). *An analysis of Abraham Maslow's A Theory of Human Motivation* (1st ed.). Routledge. https://doi.org/10.4324/9781912282517

So how does Maslow's theory impact prioritization? To better understand the application of Maslow's theory to prioritization, consider Scenario C in the following box.

Scenario C

You are an emergency response nurse working at a local shelter in a community that has suffered a devastating hurricane. Many individuals have relocated to the shelter for safety in the aftermath of the hurricane. Much of the community is still without electricity and clean water, and many homes have been destroyed. You approach a young woman who has a laceration on her scalp that is bleeding through her gauze dressing. The woman is weeping as she describes the loss of her home stating, "I have lost everything! I just don't know what I am going to do now. It has been a day since I have had water or anything to drink. I don't know where my sister is, and I can't reach any of my family to find out if they are okay!"

Despite this relatively brief interaction, this woman has shared with you a variety of needs. She has demonstrated a need for food, water, shelter, homeostasis, and family. As the nurse caring for her, it might be challenging to think about where to begin her care. These thoughts could be racing through your mind:

Should I begin to make phone calls to try and find her family? Maybe then she would be able to calm down.

Should I get her on the list for the homeless shelter so she wouldn't have to worry about where she will sleep tonight?

She hasn't eaten in a while; I should probably find her something to eat.

All these needs are important and should be addressed at some point, but Maslow's hierarchy provides guidance on what needs

must be addressed first. Use the foundational level of Maslow's pyramid of physiological needs as the top priority for care. The woman is bleeding heavily from a head wound and has had limited fluid intake. As the nurse caring for this client, it is important to immediately intervene to stop the bleeding and restore fluid volume. Stabilizing the client by addressing her physiological needs is required before undertaking additional measures such as contacting her family. Imagine if instead you made phone calls to find the client's family and didn't address the bleeding or dehydration – you might return to a severely hypovolemic client who has deteriorated and may be near death. In this example, prioritizing emotional needs above physiological needs can lead to significant harm to the client.

Although this is a relatively straightforward example, the principles behind the application of Maslow's hierarchy are essential. Addressing physiological needs before progressing toward additional need categories concentrates efforts on the most vital elements to enhance client well-being. Maslow's hierarchy provides the nurse with a helpful framework for identifying and prioritizing critical client care needs.

ABCs

Airway, breathing, and circulation, otherwise known by the mnemonic "ABCs," are another foundational element to assist the nurse in prioritization. Like Maslow's hierarchy, using the ABCs to guide decision-making concentrates on the most critical needs for preserving human life. If a client does not have a patent airway, is unable to breathe, or has inadequate circulation, very little of what else we do matters. The client's **ABCs** are reflected in Maslow's foundational level of physiological needs and direct critical nursing actions and timely interventions. Let's consider Scenario D in the following box

regarding prioritization using the ABCs and the physiological base of Maslow's hierarchy.

Scenario D

You are a nurse on a busy cardiac floor charting your morning assessments on a computer at the nurses' station. Down the hall from where you are charting, two of your assigned clients are resting comfortably in Room 504 and Room 506. Suddenly, both call lights ring from the rooms, and you answer them via the intercom at the nurses' station.

Room 504 has an 87-year-old male who has been admitted with heart failure, weakness, and confusion. He has a bed alarm for safety and has been ringing his call bell for assistance appropriately throughout the shift. He requires assistance to get out of bed to use the bathroom. He received his morning medications, which included a diuretic about 30 minutes previously, and now reports significant urge to void and needs assistance to the bathroom.

Room 506 has a 47-year-old woman who was hospitalized with new onset atrial fibrillation with rapid ventricular response. The client underwent a cardioversion procedure yesterday that resulted in successful conversion of her heart back into normal sinus rhythm. She is reporting via the intercom that her "heart feels like it is doing that fluttering thing again" and she is having chest pain with breathlessness.

Based upon these two client scenarios, it might be difficult to determine whom you should see first. Both clients are demonstrating needs in the foundational physiological level of Maslow's hierarchy and require assistance. To prioritize between these clients' physiological needs, the nurse can apply the

principles of the ABCs to determine intervention. The client in Room 506 reports both breathing and circulation issues, warning indicators that action is needed immediately. Although the client in Room 504 also has an urgent physiological elimination need, it does not overtake the critical one experienced by the client in Room 506. The nurse should immediately assess the client in Room 506 while also calling for assistance from a team member to assist the client in Room 504.

CURE

Prioritizing what should be done and when it can be done can be a challenging task when several clients all have physiological needs. Recently, there has been professional acknowledgement of the cognitive challenge for novice nurses in differentiating physiological needs. To expand on the principles of prioritizing using the ABCs, the CURE hierarchy has been introduced to help novice nurses better understand how to manage competing client needs. The CURE hierarchy uses the acronym "CURE" to guide prioritization based on identifying the differences among Critical needs, Urgent needs, Routine needs, and Extras.[9]

"Critical" client needs require immediate action. Examples of critical needs align with the ABCs and Maslow's physiological needs, such as symptoms of respiratory distress, chest pain, and airway compromise. No matter the complexity of their shift, nurses can be assured that addressing clients' critical needs is the correct prioritization of their time and energies.

After critical client care needs have been addressed, nurses can then address

9. Kohtz, C., Gowda, C., & Guede, P. (2017). Cognitive stacking: Strategies for the busy RN. *Nursing, 47*(1), 18-20. https://doi.org/10.1097/01.nurse.0000510758.31326.92

"urgent" needs. Urgent needs are characterized as needs that cause client discomfort or place the client at a significant safety risk.[10]

The third part of the CURE hierarchy reflects "routine" client needs. Routine client needs can also be characterized as "typical daily nursing care" because the majority of a standard nursing shift is spent addressing routine client needs. Examples of routine daily nursing care include actions such as administering medication and performing physical assessments.[11] Although a nurse's typical shift in a hospital setting includes these routine client needs, they do not supersede critical or urgent client needs.

The final component of the CURE hierarchy is known as "extras." Extras refer to activities performed in the care setting to facilitate client comfort but are not essential.[12] Examples of extra activities include providing a massage for comfort or washing a client's hair. If a nurse has sufficient time to perform extra activities, they contribute to a client's feeling of satisfaction regarding their care, but these activities are not essential to achieve client outcomes.

Let's apply the CURE mnemonic to client care in the following box.

10. Kohtz, C., Gowda, C., & Guede, P. (2017). Cognitive stacking: Strategies for the busy RN. *Nursing, 47*(1), 18-20. https://doi.org/10.1097/01.nurse.0000510758.31326.92

11. Kohtz, C., Gowda, C., & Guede, P. (2017). Cognitive stacking: Strategies for the busy RN. *Nursing, 47*(1), 18-20. https://doi.org/10.1097/01.nurse.0000510758.31326.92

12. Kohtz, C., Gowda, C., & Guede, P. (2017). Cognitive stacking: Strategies for the busy RN. *Nursing, 47*(1), 18-20. https://doi.org/10.1097/01.nurse.0000510758.31326.92

If we return to Scenario D regarding clients in Room 504 and 506, we can see the client in Room 504 is having urgent needs. He is experiencing a physiological need to urgently use the restroom and may also have safety concerns if he does not receive assistance and attempts to get up on his own because of weakness. He is on a bed alarm, which reflects safety considerations related to his potential to get out of bed without assistance. Despite these urgent indicators, the client in Room 506 is experiencing a critical need and takes priority. Recall that critical needs require immediate nursing action to prevent client deterioration. The client in Room 506 with a rapid, fluttering heartbeat and shortness of breath has a critical need because without prompt assessment and intervention, their condition could rapidly decline and become fatal.

Data Cues

In addition to using the identified frameworks and tools to assist with priority setting, nurses must also look at their clients' data cues to help them identify care priorities. **Data cues** are pieces of significant clinical information that direct the nurse toward a potential clinical concern or a change in condition. For example, have the client's vital signs worsened over the last few hours? Is there a new laboratory result that is concerning? Data cues are used in conjunction with prioritization frameworks to help the nurse holistically understand the client's current status and where nursing interventions should be directed. Common categories of data clues include acute versus chronic conditions, actual versus potential problems, unexpected versus expected conditions, information obtained from the review of a client's chart, and diagnostic information.

Acute Versus Chronic Conditions

A common data cue that nurses use to prioritize care is considering if a condition or symptom is acute or chronic. **Acute conditions** have a sudden and severe onset. These conditions occur due to a sudden illness or injury, and the body often has a significant response as it attempts to adapt. **Chronic conditions** have a slow onset and may gradually worsen over time. The difference between an acute versus a chronic condition relates to the body's adaptation response. Individuals with chronic conditions often experience less symptom exacerbation because their body has had time to adjust to the illness or injury. Let's consider an example of two clients admitted to the medical-surgical unit complaining of pain in Scenario E in the following box.

Scenario E

As part of your client assignment on a medical-surgical unit, you are caring for two clients who both ring the call light and report pain at the start of the shift. Client A was recently admitted with acute appendicitis, and Client B was admitted for observation due to weakness. Not knowing any additional details about the clients' conditions or current symptoms, which client would receive priority in your assessment? Based on using the data cue of acute versus chronic conditions, Client A with a diagnosis of acute appendicitis would receive top priority for assessment over a client with chronic pain due to osteoarthritis. Clients experiencing acute pain require immediate nursing assessment and intervention because it can indicate a change in condition. Acute pain also elicits physiological effects related to the stress response, such as elevated heart rate, blood pressure, and respiratory rate, and should be addressed quickly.

Actual Versus Potential Problems

Nursing diagnoses and the nursing care plan have significant roles in directing prioritization when interpreting assessment data cues. **Actual problems** refer to a clinical problem that is actively occurring with the client. A **risk problem** indicates the client may potentially experience a problem but they do not have current signs or symptoms of the problem actively occurring.

Consider an example of prioritizing actual and potential problems in Scenario F in the following box.

Scenario F

A 74-year-old woman with a previous history of chronic obstructive pulmonary disease (COPD) is admitted to the hospital for pneumonia. She has generalized weakness, a weak cough, and crackles in the bases of her lungs. She is receiving IV antibiotics, fluids, and oxygen therapy. The client can sit at the side of the bed and ambulate with the assistance of staff, although she requires significant encouragement to ambulate.

Nursing diagnoses are established for this client as part of the care planning process. One nursing diagnosis for this client is *Ineffective Airway Clearance*. This nursing diagnosis is an actual problem because the client is currently exhibiting signs of poor airway clearance with an ineffective cough and crackles in the lungs. Nursing interventions related to this diagnosis include coughing and deep breathing, administering nebulizer treatment, and evaluating the effectiveness of oxygen therapy. The client also has the nursing diagnosis *Risk for Skin Breakdown* based on her weakness and lack of motivation to ambulate. Nursing interventions related to this diagnosis include

repositioning every two hours and assisting with ambulation twice daily.

The established nursing diagnoses provide cues for prioritizing care. For example, if the nurse enters the client's room and discovers the client is experiencing increased shortness of breath, nursing interventions to improve the client's respiratory status receive top priority before attempting to get the client to ambulate.

Although there may be times when risk problems may supersede actual problems, looking to the "actual" nursing problems can provide clues to assist with prioritization.

Unexpected Versus Expected Conditions

In a similar manner to using acute versus chronic conditions as a cue for prioritization, it is also important to consider if a client's signs and symptoms are "expected" or "unexpected" based on their overall condition. **Unexpected conditions** are findings that are not likely to occur in the normal progression of an illness, disease, or injury. **Expected conditions** are findings that are likely to occur or are anticipated in the course of an illness, disease, or injury. Unexpected findings often require immediate action by the nurse.

Let's apply this tool to the two clients previously discussed in Scenario E. As you recall, both Client A (with acute appendicitis) and Client B (with weakness and diagnosed with osteoarthritis) are reporting pain. Acute pain typically receives priority over chronic pain. But what if both clients are also reporting nausea and have an elevated temperature? Although these symptoms must be addressed in both clients, they are "expected" symptoms with acute appendicitis (and typically addressed in the treatment plan) but are "unexpected" for the client with osteoarthritis. Critical thinking alerts you to

the unexpected nature of these symptoms in Client B, so they receive priority for assessment and nursing interventions.

Handoff Report/Chart Review

Additional data cues that are helpful in guiding prioritization come from information obtained during a handoff nursing report and review of the client chart. These data cues can be used to establish a client's baseline status and prioritize new clinical concerns based on abnormal assessment findings. Let's consider Scenario G in the following box based on cues from a handoff report and how it might be used to help prioritize nursing care.

Scenario G

Imagine you are receiving the following handoff report from the night shift nurse for a client admitted to the medical-surgical unit with pneumonia:

> *At the beginning of my shift, the client was on room air with an oxygen saturation of 93%. She had slight crackles in both bases of her posterior lungs. At 0530, the client rang the call light to go to the bathroom. As I escorted her to the bathroom, she appeared slightly short of breath. Upon returning the client to bed, I rechecked her vital signs and found her oxygen saturation at 88% on room air and respiratory rate of 20. I listened to her lung sounds and noticed more persistent crackles and coarseness than at bedtime. I placed the client on 2 L/minute of oxygen via nasal cannula. Within five minutes, her oxygen saturation increased to 92%, and she reported increased ease in respiration.*

Based on the handoff report, the night shift nurse provided

substantial clinical evidence that the client may be experiencing a change in condition. Although these changes could be attributed to lack of lung expansion that occurred while the client was sleeping, there is enough information to indicate to the oncoming nurse that follow-up assessment and interventions should be prioritized for this client because of potentially worsening respiratory status. In this manner, identifying data cues from a handoff report can assist with prioritization.

Now imagine the night shift nurse had not reported this information during the handoff report. Is there another method for identifying potential changes in client condition? Many nurses develop a habit of reviewing their clients' charts at the start of every shift to identify trends and "baselines" in client condition. For example, a chart review reveals a client's heart rate on admission was 105 beats per minute. If the client continues to have a heart rate in the low 100s, the nurse is not likely to be concerned if today's vital signs reveal a heart rate in the low 100s. Conversely, if a client's heart rate on admission was in the 60s and has remained in the 60s throughout their hospitalization, but it is now in the 100s, this finding is an important cue requiring prioritized assessment and intervention.

Diagnostic Information

Diagnostic results are also important when prioritizing care. In fact, the National Patient Safety Goals from The Joint Commission include prompt reporting of important test results. New abnormal laboratory results are typically flagged in a client's chart or are reported directly by phone to the nurse by the laboratory as they become available. Newly reported abnormal results, such as elevated blood levels or changes on a chest X-ray, may

indicate a client's change in condition and require additional interventions. For example, consider Scenario H in which you are the nurse providing care for five medical-surgical clients.

Scenario H

You completed morning assessments on your assigned five clients. Client A previously underwent a total right knee replacement and will be discharged home today. You are about to enter Client A's room to begin discharge teaching when you receive a phone call from the laboratory department, reporting a critical hemoglobin of 6.9 gm/dL on Client B. Rather than enter Client A's room to perform discharge teaching, you immediately reprioritize your care. You call the primary provider to report Client B's critical hemoglobin level and determine if additional intervention, such as a blood transfusion, is required.

Prioritization Principles & Staffing Considerations[13]

With the complexity of different staffing variables in health care settings, it can be challenging to identify a method and solution that will offer a resolution to every challenge. The American Nurses Association has identified five critical principles that should be considered for nurse staffing. These principles are as follows:

13. American Nurses Association. (2024). *Principles for nurse staffing. ANA*. https://www.nursingworld.org/practice-policy/nurse-staffing/staffing-principles/

1. **Health Care Consumer:** Nurse staffing decisions are influenced by the specific number and needs of the health care consumer. The health care consumer includes not only the client, but also families, groups, and populations served. Staffing guidelines must always consider the client safety indicators and clinical and operational outcomes that are specific to a practice setting. What is appropriate for the consumer in one setting, may be quite different in another. Additionally, it is important to ensure that there is resource allocation for care coordination and health education in each setting.
2. **Interprofessional Teams:** As organizations identify what constitutes appropriate staffing in various settings, they must also consider the appropriate credentials and qualifications of the nursing staff within a specific setting. This involves utilizing an interprofessional care team that allows each individual to practice to the full extent of their educational, training, and scope of practice as defined by their state Nurse Practice Act, and licensure. Staffing plans must include an appropriate skill mix and acknowledge the impact of more experienced nurses to help serve in mentoring and precepting roles.
3. **Workplace culture:** Staffing considerations must also account for the importance of balance between costs associated with best practice and the optimization of care outcomes. Health care leaders and organizations must strive to ensure a balance between quality, safety, and health care cost. Organizations are responsible for creating work environments, which develop policies allowing for nurses to practice to the full extent of their licensure in accordance with their documented competence. Leaders

must foster a culture of trust, collaboration, and respect among all members of the health care team, which will create environments that engage and retain health care staff.

4. **Practice environment:** Staffing structures must be founded in a culture of safety where appropriate staffing is integral to achieve client safety and quality goals. An optimal practice environment encourages nurses to report unsafe conditions or poor staffing that may impact safe care. Organizations should ensure that nurses have autonomy in reporting any concerns and may do so without threat of retaliation. The ANA has also taken the position to state that mandatory overtime is an unacceptable solution to achieve appropriate staffing. Organizations must ensure that they have clear policies delineating length of shifts, meal breaks, and rest period to help ensure safety in client care.
5. **Evaluation:** Staffing plans should be consistently evaluated and changed based upon evidence and client outcomes. Environmental factors and issues such as work-related illness, injury, and turnover are important elements of determining the success of need for modification within a staffing plan.[14]

14. American Nurses Association. (2024). *Principles for nurse staffing. ANA*. https://www.nursingworld.org/practice-policy/nurse-staffing/staffing-principles/

2.4 Critical Thinking and Clinical Reasoning

Prioritization of client care should be grounded in critical thinking rather than just a checklist of items to be done. **Critical thinking** is a broad term used in nursing that includes "reasoning about clinical issues such as teamwork, collaboration, and streamlining workflow."[1] Certainly, there are many actions that nurses must complete during their shift, but nursing requires adaptation and flexibility to meet emerging client needs. It can be challenging for a novice nurse to change their mindset regarding their established "plan" for the day, but the sooner a nurse recognizes prioritization is dictated by their clients' needs, the less frustration the nurse might experience. Prioritization strategies include collection of information and utilization of clinical reasoning to determine the best course of action. **Clinical reasoning** is defined as, "A complex cognitive process that uses formal and informal thinking strategies to gather and analyze client information, evaluate the significance of this information, and weigh alternative actions."[2] Clinical reasoning is fostered within nurses when they are challenged to integrate data in various contexts. The clinical reasoning cycle begins when nurses first consider a client situation and progress to collecting cues and information. As nurses process the information, they begin to identify problems and establish realistic goals. They then take appropriate actions and evaluate outcomes. Finally, they reflect upon the process and the learning that has occurred. The reflection piece is critical for solidifying or changing future actions and developing knowledge.

1. Klenke-Borgmann, L., Cantrell, M. A., & Mariani, B. (2020). Nurse educator's guide to clinical judgment: A review of conceptualization, measurement, and development. *Nursing Education Perspectives, 41*(4), 215-221. https://doi.org/10.1097/01.nep.0000000000000669
2. Klenke-Borgmann, L., Cantrell, M. A., & Mariani, B. (2020). Nurse educator's guide to clinical judgment: A review of conceptualization, measurement, and development. *Nursing Education Perspectives, 41*(4), 215-221. https://doi.org/10.1097/01.nep.0000000000000669

When nurses use critical thinking and clinical reasoning skills, they set forth on a purposeful course of intervention to best meet client-care needs. Rather than focusing on one's own priorities, nurses utilizing critical thinking and reasoning skills recognize their actions must be responsive to their clients. For example, a nurse using critical thinking skills understands that scheduled morning medications for their clients may be late if one of the clients on their care team suddenly develops chest pain. Many actions may be added or removed from planned activities throughout the shift based on what is occurring holistically on the client-care team.

Additionally, in today's complex health care environment, it is important for the novice nurse to recognize the realities of the current health care environment. Clients have become increasingly complex in their health care needs, and organizations are often challenged to meet these care needs with limited staffing resources. It can become easy to slip into the mindset of disenchantment with the nursing profession when first assuming the reality of client-care assignments as a novice nurse. The workload of a nurse in practice often looks and feels quite different than that experienced as a nursing student. As a nursing student, there may have been time for lengthy conversations with clients and their family members, ample time to chart, and opportunities to offer personal cares, such as a massage or hair wash. Unfortunately, in the time-constrained realities of today's health care environment, novice nurses should recognize that even though these "extra" tasks are not always possible, they can still provide quality, safe client care using the "CURE" prioritization framework. Rather than feeling frustrated about "extras" that cannot be accomplished in time-constrained environments, it is vital to use prioritization strategies to ensure appropriate actions are taken to complete what must be done. With increased clinical experience, a novice nurse typically becomes more comfortable with prioritizing and reprioritizing care.

2.5 Time Management

Time management is not an unfamiliar concept to nursing students because many students are balancing time demands related to work, family, and school obligations. To determine where time should be allocated, prioritization processes emerge. Although the prioritization frameworks of nursing may be different than those used as a student, the concept of prioritization remains the same. Despite the context, prioritization is essentially using a structure to organize tasks to ensure the most critical tasks are completed first and then identify what to move onto next. To truly maximize time management, in addition to prioritization, individuals should be organized, strive for accuracy, minimize waste, mobilize resources, and delegate when appropriate.

Time management is one of the greatest challenges that nurses face in their busy workday. As novice nurses develop their practice, it is important to identify organizational strategies to ensure priority tasks are completed and time is optimized. Each nurse develops a personal process for organizing information and structuring the timing of their assessments, documentation, medication administration, interventions, and client education. However, one must always remember that this process and structure must be flexible because in a moment's time, a client's condition can change, requiring a reprioritization of care. An organizational tool is important to guide a nurse's daily task progression. Organizational tools may be developed individually by the nurse or may be recommended by the organization. Tools can be rudimentary in nature, such as a simple time column format outlining care activities planned throughout the shift, or more complex and integrated within an organization's electronic medical record. No matter the format, an organizational tool is helpful to provide structure and guide progression toward task achievement.

See examples of organizational tools that can be helpful for structuring nursing task progression. These tools can be modified to align with individual nursing preference, shift, unit needs, etc.

- Organizational Tool Sample 1

- Organizational Tool Sample 2
- Organizational Tool Sample 3
- Organizational Tool Sample 4

In addition to using an organizational tool, novice nurses should utilize other time management strategies to optimize their time. For example, assessments can start during bedside handoff report, such as what fluids and medications are running and what will need to be replaced soon. Take a moment after handoff reports to prioritize which clients you will see first during your shift. Other strategies such as grouping tasks, gathering appropriate equipment prior to initiating nursing procedures, and gathering assessment information while performing tasks are helpful in minimizing redundancy and increasing efficiency. For example, observe an experienced nurse providing care and note the efficient processes they use. They may conduct an assessment, bring in morning medications, flush an IV line, collect a morning blood glucose level, and provide health teaching about medications all during one client encounter. Efficiency becomes especially important if the client has transmission-based precautions and the time spent donning and doffing PPE are considered. The realities of the time-constrained health care environments often necessitate clustering tasks to ensure that all client-care tasks are completed. Furthermore, nurses who do not manage their time effectively may inadvertently place their clients at risk as a result of delayed care.[1] Effective time management benefits both the client and the nursing staff.

Time estimation is an additional helpful strategy to facilitate time

1. Nayak, S. G. (2018). Time management in nursing–hour of need. *International Journal of Caring Sciences, 11*(3), 1997-2000. http://www.internationaljournalofcaringsciences.org/docs/72_nayak_special_11_3_2.pdf

management. **Time estimation** involves the review of planned tasks for the day and allocating time estimated to complete the task. Time estimation is especially helpful for novice nurses as they begin to structure and prioritize their shift based on the list of tasks that are required.[2] For example, estimating the time it will take to perform an assessment and administer morning medications to one client allows the nurse to better plan when to complete the dressing change on another client. Without using time estimation, the nurse may attempt to group all care tasks with the morning assessments and not leave themselves enough time to administer morning medications within the desired administration time window. Additionally, working in a time-constrained environment without using time estimation strategies increases the likelihood of performing tasks "in a rush" and subsequently increasing the potential for error.

Who's On My Team?

One of the most critical strategies to enhance time management is to mobilize the resources of the nursing team. The nursing care team includes advanced practice registered nurses (APRN), registered nurses (RN), licensed practical/vocational nurses (LPN/VN), and unlicensed assistive personnel (UAP). UAP include, but are not limited to, certified nursing assistants or aides (CNA), patient-care technicians (PCT), certified medical assistants (CMA), certified medication aides, and home health aides.[3] Each care environment may have a blend of staff, and it is important to understand the legalities associated with the scope and role of each member and what can be safely and appropriately delegated to other members of the team. For example,

2. Nayak, S. G. (2018). Time management in nursing–hour of need. *International Journal of Caring Sciences, 11*(3), 1997-2000. http://www.internationaljournalofcaringsciences.org/docs/72_nayak_special_11_3_2.pdf

3. American Nurses Association and NCSBN. (2019). *National guidelines for nursing delegation*. https://www.ncsbn.org/NGND-PosPaper_06.pdf

assistive personnel may be able to assist with ambulating a client in the hallway, but they would not be able to help administer morning medications. Dividing tasks appropriately among nursing team members can help ensure that the required tasks are completed and individual energies are best allocated to meet client needs.

> The nursing care team and requirements around the process of delegation are explored in detail in the "Delegation and Supervision" chapter.

2.6 Spotlight Application

Sam is a novice nurse who is reporting to work for his 0600 shift on the medical telemetry/progressive care floor. He is waiting to receive handoff report from the night shift nurse for his assigned clients. The information that he has received thus far regarding his client assignment includes the following:

- **Room 501:** 64-year-old client admitted last night with heart failure exacerbation. Client received furosemide 80mg IV push at 2000 with 1600 mL urine output. He is receiving oxygen via nasal cannula at 2L/minute. According to the night shift aide, he has been resting comfortably overnight.
- **Room 507:** 74-year-old client admitted yesterday for possible cardioversion due to new onset of atrial fibrillation with rapid ventricular response and is scheduled for transesophageal echocardiogram and possible cardioversion at 1000.
- **Room 512:** 82-year-old client who is scheduled for coronary artery bypass graft (CABG) surgery today at 0700 and is receiving an insulin infusion.
- **Room 536:** 72-year-old client who had a negative heart catheterization yesterday but experienced a groin bleed; plans for discharge this morning.

Based on the limited information Sam has thus far, he begins to prioritize his activities for the morning. With what is known thus far regarding his client assignment, whom might Sam plan to see first and why? What principles of prioritization might be applied?

Although Sam would benefit from hearing a full report on his clients and reviewing the clients' charts, he can already begin to engage in strategies for prioritization. Based on the information that has been shared thus far, Sam determines that none of the clients assigned to him are experiencing critical or urgent needs. All the clients' basic physiological needs are being met, but many have actual clinical concerns. Based on the time constraint with scheduled surgery and the insulin infusion for the client in Room 512, this

client should take priority in Sam's assessments. It is important for Sam to ensure that this client's pre-op checklist is complete, and he is stable with the infusion prior to transferring him for surgery. Although Sam may later receive information that alters this priority setting, based on the information he has thus far, he has utilized prioritization principles to make an informed decision.

Learning Activities

(Answers to "Learning Activities" can be found in the "Answer Key" at the end of the book. Answers to interactive activities are provided as immediate feedback.)

1. The nurse is conducting an assessment on a 70-year-old male client who was admitted with atrial fibrillation. The client has a history of hypertension and Stage 2 chronic kidney disease. The nurse begins the head-to-toe assessment and notes the client is having difficulty breathing and is complaining about chest discomfort. The client states, "It feels as if my heart is going to pound out of my chest and I feel dizzy." The nurse begins the head-to-toe assessment and documents the findings. Client assessment findings are presented in the table below. Select the assessment findings requiring immediate follow-up by the nurse.

Vital Signs

Temperature	98.9 °F (37.2°C)
Heart Rate	182 beats/min
Respirations	36 breaths/min
Blood Pressure	152/90 mm Hg
Oxygen Saturation	88% on room air
Capillary Refill Time	>3
Pain	9/10 chest discomfort

Physical Assessment Findings	
Glasgow Coma Scale Score	14
Level of Consciousness	Alert
Heart Sounds	Irregularly regular
Lung Sounds	Clear bilaterally anterior/posterior
Pulses-Radial	Rapid/bounding
Pulses-Pedal	Weak
Bowel Sounds	Present and active x 4
Edema	Trace bilateral lower extremities
Skin	Cool, clammy

2. The following nursing actions may or may not be required at this time based on the assessment findings. Indicate whether the actions are "Indicated" (i.e., appropriate or necessary), "Contraindicated" (i.e., could be harmful), or "Nonessential" (i.e., makes no difference or are not necessary).

Nursing Action	Indicated	Contraindicated	Nonessential
Apply oxygen at 2 liters per nasal cannula.			
Call imaging for a STAT lung CT.			
Perform the National Institutes of Health (NIH) Stroke Scale Neurologic Exam.			
Obtain a comprehensive metabolic panel (CMP).			
Obtain a STAT EKG.			
Raise the head-of-bed to less than 10 degrees.			
Establish patent IV access.			
Administer potassium 20 mEq IV push STAT.			

3. The CURE hierarchy has been introduced to help novice nurses better understand how to manage competing client needs. The CURE hierarchy uses the acronym "CURE" to help guide prioritization based on identifying the differences among **C**ritical needs, **U**rgent needs, **R**outine needs, and **E**xtras.

You are the nurse caring for the clients in the following table. For each client, indicate if this is a "critical," "urgent," "routine," or "extra" need.

	Critical	Urgent	Routine	Extra
Client exhibits new left-sided facial droop				
Client reports 9/10 acute pain and requests PRN pain medication				
Client with BP 120/80 and regular heart rate of 68 has scheduled dose of oral amlodipine				
Client with insomnia requests a back rub before bedtime				
Client has a scheduled dressing change for a pressure ulcer on their coccyx				
Client is exhibiting new shortness of breath and altered mental status				
Client with fall risk precautions ringing call light for assistance to the restroom for a bowel movement				

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingmpc/?p=105#h5p-34

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingmpc/?p=105#h5p-3

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingmpc/?p=105#h5p-6

Test your knowledge using this NCLEX Next Generation-style Case Study. You may reset and resubmit your answers to this question an unlimited number of times.[1]

1. "Chapter 2, Assignment 1" by Travis Christman for OpenRN is licensed under CC BY-NC 4.0

II Glossary

ABCs: Airway, breathing, and circulation.

Actual problems: Nursing problems currently occurring with the client.

Acuity: The level of client care that is required based on the severity of a client's illness or condition.

Acuity-rating staffing models: A staffing model used to make client assignments that reflects the individualized nursing care required for different types of clients.

Acute conditions: Conditions having a sudden onset.

Chronic conditions: Conditions that have a slow onset and may gradually worsen over time.

Clinical reasoning: "A complex cognitive process that uses formal and informal thinking strategies to gather and analyze client information, evaluate the significance of this information, and weigh alternative actions."[1]

Critical thinking: A broad term used in nursing that includes "reasoning about clinical issues such as teamwork, collaboration, and streamlining workflow."[2]

1. Klenke-Borgmann, L., Cantrell, M. A., & Mariani, B. (2020). Nurse educator's guide to clinical judgment: A review of conceptualization, measurement, and development. *Nursing Education Perspectives, 41(*4), 215-221. https://doi.org/10.1097/01.nep.0000000000000669
2. Klenke-Borgmann, L., Cantrell, M. A., & Mariani, B. (2020). Nurse educator's guide to clinical judgment: A review of conceptualization, measurement, and development. *Nursing Education Perspectives, 41(*4), 215-221. https://doi.org/10.1097/01.nep.0000000000000669

CURE hierarchy: A strategy for prioritization based on identifying “critical” needs, “urgent” needs, “routine” needs, and “extras.”

Data cues: Pieces of significant clinical information that direct the nurse toward a potential clinical concern or a change in condition.

Expected conditions: Conditions that are likely to occur or anticipated in the course of an illness, disease, or injury.

Maslow’s Hierarchy of Needs: Prioritization strategies often reflect the foundational elements of physiological needs and safety and progress toward higher levels.

Ratio-based staffing models: A staffing model used to make client assignments in terms of one nurse caring for a set number of clients.

Risk problem: A nursing problem that reflects that a client may experience a problem but does not currently have signs reflecting the problem is actively occurring.

Time estimation: A prioritization strategy, including the review of planned tasks and allocation of time believed to be required to complete each task.

Time scarcity: A feeling of racing against a clock that is continually working against you.

Unexpected conditions: Conditions that are not likely to occur in the normal progression of an illness, disease, or injury.

PART III

CHAPTER 3 - DELEGATION AND SUPERVISION

3.1 Delegation & Supervision Introduction

Learning Objectives

- Explain principles of delegation
- Evaluate the criteria used for delegation
- Apply effective communication techniques when delegating care
- Determine specific barriers to delegation
- Evaluate team members' performance based on delegation and supervision principles
- Incorporate principles of supervision and evaluation in the delegation process
- Identify scope of practice of the RN, LPN/VN, and unlicensed assistive personnel roles
- Identify tasks that can and cannot be delegated to members of the nursing team

As health care technology continues to advance, clients require increasingly complex nursing care, and as staffing becomes more challenging, health care agencies respond with an evolving variety of nursing and assistive personnel roles and responsibilities to meet these demands. As an RN, you are on the front lines caring for ill or injured clients and their families, advocating for clients' rights, creating nursing care plans, educating clients on how to self-manage their health, and providing leadership throughout the complex health care system. Delivering safe, effective, quality client care requires the RN to coordinate care by the nursing team as tasks are assigned, delegated, and supervised. **Nursing team members** include advanced practice

registered nurses (APRN), registered nurses (RN), licensed practical/vocational nurses (LPN/VN), and unlicensed assistive personnel (UAP).[1]

Unlicensed assistive personnel (UAP) are any assistive personnel trained to function in a supportive role, regardless of title, to whom a nursing responsibility may be delegated. This includes, but is not limited to, certified nursing assistants or aides (CNAs), patient-care technicians (PCTs), certified medical assistants (CMAs), certified medication aides, and home health aides.[2] Making assignments, delegating tasks, and supervising delegatees are essential components of the RN role and can also provide the RN more time to focus on the complex needs of clients. For example, an RN may delegate to UAP the attainment of vital signs for clients who are stable, thus providing the nurse more time to closely monitor the effectiveness of interventions in maintaining complex clients' hemodynamics, thermoregulation, and oxygenation. Collaboration among the nursing care team members allows for the delivery of optimal care as various skill sets are implemented to care for the client.

Properly assigning and delegating tasks to nursing team members can promote efficient client care. However, inappropriate assignments or delegation can compromise client safety and produce unsatisfactory client outcomes that may result in legal issues. How does the RN know what tasks can be assigned or delegated to nursing team members and assistive personnel? What steps should the RN follow when determining if care can be delegated? After assignments and delegations are established, what is the role and responsibility of the RN in supervising client care? This chapter will explore and define the fundamental concepts involved in assigning,

1. American Nurses Association and NCSBN. (2019). *National guidelines for nursing delegation*. https://www.ncsbn.org/public-files/NGND-PosPaper_06.pdf
2. American Nurses Association and NCSBN. (2019). *National guidelines for nursing delegation*. https://www.ncsbn.org/NGND-PosPaper_06.pdf

delegating, and supervising client care according to the most recent joint national delegation guidelines published by the National Council of State Boards of Nursing (NCSBN) and the American Nurses Association (ANA).[3]

3. American Nurses Association and NCSBN. (2019). *National guidelines for nursing delegation*. https://www.ncsbn.org/NGND-PosPaper_06.pdf

3.2 Communication

Effective communication is a vital component of proper assignment, delegation, and supervision. It is also one of the Standards of Professional Performance established by the American Nurses Association (ANA).[1] Research has identified that new graduate nurses are more susceptible to stress and isolation within their job roles due to poor communication and teamwork within the interdisciplinary team.[2] Strong communication skills foster a supportive work environment and colleagial relationships that benefit both clients and nursing staff.

Consider the fundamentals of good communication practices. Effective communication requires each interaction to include a sender of the message, a clear and concise message, and a receiver who can decode and interpret that message. The receiver also provides a feedback message back to the sender in response to the received message. See Figure 3.1[3] for an image of effective communication between a sender and receiver. This feedback message is referred to as **closed-loop communication** in health care settings. Closed-loop communication enables the person giving the instructions to hear what they said reflected back and to confirm that their message was received correctly. It also allows the person receiving the instructions to verify

1. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

2. Leonard, J.C., Whiteman, K., Stephens, K., Henry, C., Swanson-Bieaman, B. (2022). Improving communication and collaboration skills in graduate nurses: An evidence-based approach. *The Online Journal of Issues in Nursing, 27*(2), 3. https://www.doi.org/10.3912/OJIN.Vol27No02Man03

3. "Osgood-Schramm-model-of-communication.jpg" by Jordan Smith at eCampus Ontario is licensed under CC BY 4.0. Access for free at https://ecampusontario.pressbooks.pub/communicationatwork/chapter/1-3-the-communication-process/

and confirm the actions to be taken. If closed-loop communication is not used, the receiver may nod or say "OK," and the sender may assume the message has been effectively transmitted, but this may not be the case and can lead to errors and client harm.

An example of closed-loop communication can be found in the following exchange:

- **RN:** "Jane, can you get a set of vitals on Mr. Smith and let me know if the results are outside of normal range?"
- **Jane, CNA:** "OK, I'll get a set of vitals on Mr. Smith and let you know if they are out of range."

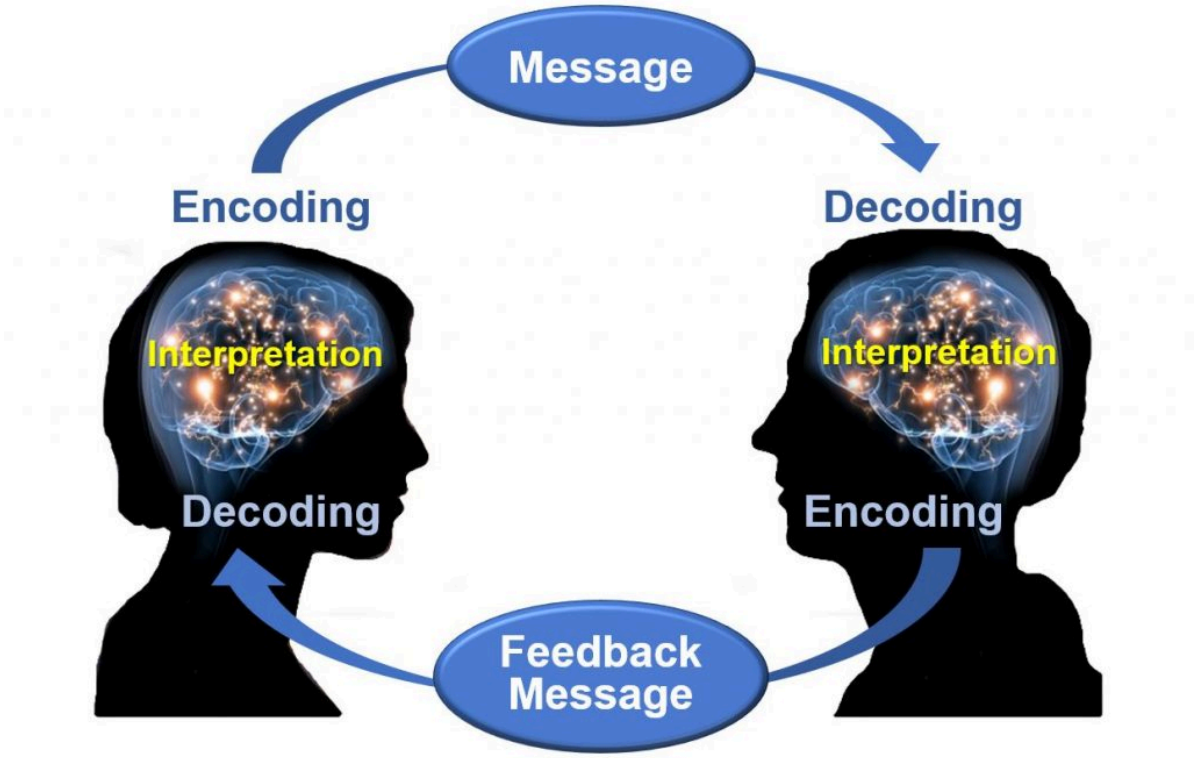

Figure 3.1 Effective Communication Between Sender and Receiver

Closed-loop communication is vital for communication among health care team members to avoid misunderstandings that can cause unsafe client care. According to the *HIPAA Journal*, poor communication leads to a "reduction in

the quality of care, poor client outcomes, wastage of resources, and high health care costs."[4] Parameters for reporting results and the results that should be expected are often left unsaid rather than spelled out in sufficient detail. It is imperative for the RN to provide clear, complete, concise instructions when delegating. A lack of clarity can lead to misunderstanding, unfinished tasks, incomplete care, and/or medical errors.[5]

Effective communication is at the core of proper assignment, delegation, and supervision. With effective communication at the beginning of every shift, each nursing team member should have a clear plan for their shift, what to do and why, and what and when to report to the RN or team leader. Communication should continue throughout the shift as tasks are accomplished and clients' needs change. Effective communication improves client outcomes and satisfaction scores, as well as improving team morale by enhancing the collaborative relationships of the health care team.

The RN is accountable for clear, concise, correct, and complete communication when making assignments and delegating, both initially and throughout the shift. These communication characteristics can be remembered by using the mnemonic the "4 Cs":

- **Clear:** Information is understood by the listener. Asking the listener to restate the instructions and the plan can be helpful to determine whether the communication is clear.
- **Concise:** Sufficient information should be provided to accurately perform the task, but excessive or irrelevant information should be avoided

4. Alder, S. (2025). *Effects of poor communication in healthcare. HIPPAA Journal.* https://www.hipaajournal.com/effects-of-poor-communication-in-healthcare/

5. Alder, S. (2025). *Effects of poor communication in healthcare. HIPPAA Journal.* https://www.hipaajournal.com/effects-of-poor-communication-in-healthcare/

because it can confuse the listener and waste precious time.

- **Correct:** Correct communication is not vague or confusing. Accurate information is also aligned with agency policy and the team member's scope of practice as defined by their state's Nurse Practice Act and other state regulations.
- **Complete:** Complete instructions leave no room for doubt. Always ask if further information or clarification is needed, especially regarding tasks that are infrequently performed or include unique instructions.[6]

The use of closed-loop communication is the best method to achieve clear, concise, correct, and complete information exchanged among team members. Closed-loop communication allows team members the opportunity to verify and validate the exchange of information. By repeating back information, members confirm the exchange has occurred, understanding is clear, and expectations are heard.

Closed-loop communication should also be used when the RN is receiving a verbal order from a provider. For example, when the resuscitation team leader gives a verbal order of "Epinephrine 1 mg/mL IV push now," the RN confirms correct understanding of the order by repeating back, "I will prepare Epinephrine 1 mg/mL to be given IV push now." After the provider confirms the verbal order and the task is completed, the nurse confirms completion of the task by stating, "Epinephrine 1 mg/mL IV push was administered."

In addition to using closed-loop communication, a common format used by health care team members to exchange client information is ISBARR, a mnemonic for the components of **I**ntroduction, **S**ituation, **B**ackground, **A**ssessment, **R**equest/Recommendations, and **R**epeat Back.

6. LaCharity, L. A., Kumagai, C. K., & Bartz, B. (2019). *Prioritization, delegation and assignment* (4th ed.). Mosby, p. 6.

ISBARR and other communication strategies are discussed in more detail in the "Interprofessional Communication" section of the "Collaboration Within the Interprofessional Team" chapter.

3.3 Assignment

Nursing team members working in inpatient or long-term care settings receive client assignments at the start of their shift. **Assignment** refers to routine care, activities, and procedures that are within the legal scope of practice of registered nurses (RN), licensed practical/vocational nurses (LPN/VN), or unlicensed assistive personnel (UAP).[1] Scope of practice for RNs and LPNs is described in each state's Nurse Practice Act. Care tasks for UAP vary by state; regulations are typically listed on sites for the state's Board of Nursing, Department of Health, Department of Aging, Department of Health Professions, Department of Commerce, or Office of Long-Term Care.[2]

See Table 3.3a for common tasks performed by members of the nursing team based on their scope of practice. These tasks are within the traditional role and training the team member has acquired through a basic educational program. They are also within the expectations of the health care agency during a shift of work. Agency policy can be more restrictive than federal or state regulations, but it cannot be less restrictive.

Client assignments are typically made by the charge nurse (or nurse supervisor) from the previous shift. A charge nurse is an RN who provides leadership on a client-care unit within a health care facility during their shift. Charge nurses perform many of the tasks that general nurses do, but also have some supervisory duties such as making assignments, delegating tasks,

1. American Nurses Association and NCSBN. (2019). *National guidelines for nursing delegation*. https://www.ncsbn.org/public-files/NGND-PosPaper_06.pdf

2. McMullen, T. L., Resnick, B., Chin-Hansen, J., Geiger-Brown, J. M., Miller, N., & Rubenstein, R. (2015). Certified nurse aide scope of practice: State-by-state differences in allowable delegated activities. *Journal of the American Medical Directors Association, 16*(1), 20–24. https://doi.org/10.1016/j.jamda.2014.07.003

preparing schedules, monitoring admissions and discharges, and serving as a staff member resource.[3]

Table 3.3a. Nursing Team Members' Scope of Practice and Common Tasks[4]

3. RegisteredNursing.org. (2025). *What is a charge nurse?* https://www.registerednursing.org/specialty/charge-nurse/

4. RegisteredNursing.org. (2024). *Assignment, delegation and supervision: NCLEX-RN*. https://www.registerednursing.org/nclex/assignment-delegation-supervision/

Nursing Team Member	Scope of Practice	Common Tasks
RN	• Create and implement individualized nursing care plans and revise as needed • Review prescribed medications for safety concerns, administer medications, and titrate medications based on protocols or standing orders • Plan and provide client education • Admit and discharge clients • Make referrals, such as to a caseworker, dietician, or chaplain, according to agency policy. (Many referrals to interprofessional team members require a provider order.) • Delegate appropriate tasks to LPN/VNs and UAPs	• Assess clients • Initiate administration of blood products to a client • Administer high-risk medications, including heparin and chemotherapeutic agents • Establish intravenous (IV) access • Initiate IV fluids and IV medications • Administer IV push medications • Titrate medications per provider order • Perform any tasks that may be performed by a LPN/VN or UAP

LPN/VN	• Assist the RN by performing routine, basic nursing care with predictable outcomes • Assist the RN with collecting data and monitoring client findings on stable clients • Implement interventions outlined in the nursing care plan, as appropriate • Reinforce client education as outlined in the nursing care plan • Delegate tasks to UAP	• Provide basic nursing care • Assist with the collection of client assessment data • Assist the RN with the development and revision of a nursing care plan • Reinforce teaching provided by an RN • Administer medications that are not high-risk • Administer enteral feeding • Perform routine dressing changes • Perform tracheostomy care on stable clients • Perform suctioning on stable or routine clients • Insert a urinary catheter • Perform any of the tasks that UAPs are permitted to perform Tasks That Potentially Can Be Delegated According to the Five Rights of Delegation: • Monitor the administration of blood products after they have been initiated by an RN and report findings to the RN • Assist with the administration of IV fluids and medications after they have been initiated by an RN and under the supervision of an RN; cannot hang the first dose or change medications

UAP	• Assist clients with activities of daily living (ADLs), including:
	  ◦ Eating
	  ◦ Bathing
	  ◦ Toileting
	  ◦ Ambulating
	• Perform routine data collection that does not require clinical assessment or critical thinking, such as:
	  ◦ Measuring vital signs, weight, and height
	  ◦ Measuring intake and output (e.g., food and drink, urine, bowel movements)
		• Assist stable clients with eating (although clients with dysphagia or at an aspiration risk require qualified health care members with specific training in this area)
		• Assist with personal hygiene, grooming, bathing, positioning, transfers, range-of-motion exercises, toileting, and making beds
		• Obtain vital signs on stable clients
		• Transport clients
		• Collect and transport routine urine specimens
		• Restock supplies
		• Report to the RN if a change in client's status is observed. Example, "Client is now complaining of pain at 9/10 when repositioned. Last time client was repositioned, no pain was reported."

An example of a client assignment is when an RN assigns an LPN/VN to care for a client with stable heart failure. The LPN/VN collects assessment data, monitors intake/output throughout the shift, and administers routine oral medication. The LPN/VN documents this information and reports information back to the RN. This is considered the LPN/VN's "assignment" because the skills are taught within an LPN educational program and are consistent with the state's Nurse Practice Act for LPN/VN scope of practice. They are also included in the unit's job description for an LPN/VN. The RN may also assign some care for this client to UAP. These tasks may include assistance with personal hygiene, toileting, and ambulation. The UAP documents these tasks as they are completed and reports information back to the RN or LPN/VN. These tasks are considered the UAP's assignment because they are taught within a nursing aide's educational program, are consistent with the UAP's scope of practice for that state, and are included in the job description for the nursing aide's role in this unit. The RN continues to be accountable for the

care provided to this client despite the assignments made to other nursing team members.

Special consideration is required for UAP with additional training. With increased staffing needs, skills such as administering medications, inserting Foley catheters, or performing injections are included in specialized training programs for UAP. Due to the impact these skills can have on the outcome and safety of the client, the National Council of State Board of Nursing (NCSBN) recommends these activities be considered delegated tasks by the RN or nurse leader. By delegating these advanced skills when appropriate, the nurse validates competency, provides supervision, and maintains accountability for client outcomes. Read more about delegation in the "Delegation" section of this chapter.

When making assignments to other nursing team members, it is essential for the RN to keep in mind specific tasks that cannot be delegated to other nursing team members based on federal and/or state regulations. These tasks include, but are not limited to, those tasks described in Table 3.3b.

Table 3.3b. Examples of Tasks Outside the Scope of Practice of Nursing Assistive Personnel

Nursing Team Member	Tasks That Cannot Be Delegated
LPN/VN	• Cannot create nursing care plans, analyze client assessment data, establish nursing diagnoses or expected outcomes, or evaluate the effectiveness of a nursing care plan. (However, LPN/VNs can collect data and contribute to the development and revision of a client's nursing care plan in collaboration with the RN.) • Cannot administer high-risk medications (such as heparin and chemotherapeutic medications). • Cannot titrate medications. (**Titrate** refers to adjusting the dosage of medication until the desired effects are achieved.) • Cannot independently provide client education. (However, they can implement client education that has been planned by the RN.) • Cannot perform admission assessments or initial postoperative assessments. • Cannot discharge clients.
Unlicensed Assistive Personnel (UAP)	• Cannot complete tasks requiring clinical judgement and/or professional knowledge. For example, a nursing assessment of a client's skin cannot be delegated to UAP. However, UAP are encouraged to report concerns about skin breakdown and other potential signs and symptoms to a licensed nurse. • Cannot delegate tasks. • Cannot provide client education but can reinforce education previously provided. For example, UAP can encourage a client to keep their nasal cannula in place while eating. • Cannot complete tasks that require clinical expertise unless advanced training has been received and written agency policy allows, such as: ◦ Administering medications and injections ◦ Inserting Foley catheters ◦ Administering tube feedings ◦ Performing wound care or dressing changes[5]

As always, refer to each state's Nurse Practice Act and other state regulations for specific details about nursing team members' scope of practice when providing care in that state.

- Find and review Nurse Practice Acts by state at https://www.ncsbn.org/policy/npa.page.

- Read more about the Wisconsin's Nurse Practice Act and the standards and scope of practice for RNs and LPNs at Wisconsin's Legislative Code Chapter N6.

- Read more about scope of practice, skills, and practices of nurse aides in Wisconsin at DHS 129.07 Standards for Nurse Aide Training Programs.

5. State of Wisconsin Department of Health Services. (2018). *Medication administration by unlicensed assistive personnel (UAP): Guidelines for registered nurses delegating medication administration to unlicensed assistive personnel.* https://www.dhs.wisconsin.gov/publications/p01908.pdf

3.4 Delegation

There has been significant national debate over the difference between assignment and delegation over the past few decades. In 2019 the National Council of State Boards of Nursing (NCSBN) and the American Nurses Association (ANA) published updated joint National Guidelines on Nursing Delegation (NGND).[1] These guidelines apply to all levels of nursing licensure (advanced practice registered nurses [APRN], registered nurses [RN], and licensed practical/vocational nurses [LPN/VN]) when delegating when there is no specific guidance provided by the state's Nurse Practice Act (NPA).[2] It is important to note that states have different laws and rules/regulations regarding delegation, so it is the responsibility of all licensed nurses to know what is permitted in their jurisdiction.

The NGND defines a **delegatee** as an RN, LPN/VN, or UAP who is delegated a nursing responsibility by either an APRN, RN, or LPN/VN, is competent to perform the task, and verbally accepts the responsibility.[3] **Delegation** is allowing a delegatee to perform a specific nursing activity, skill, or procedure that is beyond the delegatee's traditional role and not routinely performed, but the individual has obtained additional training and validated their competence to perform the delegated responsibility.[4] However, the licensed

1. American Nurses Association and NCSBN. (2019). *National guidelines for nursing delegation*. https://www.ncsbn.org/public-files/NGND-PosPaper_06.pdf
2. American Nurses Association and NCSBN. (2019). *National guidelines for nursing delegation*. https://www.ncsbn.org/public-files/NGND-PosPaper_06.pdf
3. American Nurses Association and NCSBN. (2019). *National guidelines for nursing delegation*. https://www.ncsbn.org/public-files/NGND-PosPaper_06.pdf
4. American Nurses Association and NCSBN. (2019). *National guidelines for*

nurse still maintains accountability for overall client care. **Delegated responsibility** is a nursing activity, skill, or procedure that is transferred from a licensed nurse to a delegatee.[5] **Accountability** is defined as being answerable to oneself and others for one's own choices, decisions, and actions as measured against a standard. Therefore, if a nurse does not feel it is appropriate to delegate a certain responsibility to a delegatee, the delegating nurse should perform the activity themselves.[6]

Delegation is summarized in the NGND as the following[7]:

- A delegatee is allowed to perform a specific nursing activity, skill, or procedure that is outside the traditional role and basic responsibilities of the delegatee's current job.
- The delegatee has obtained the additional education and training and validated competence to perform the care/delegated responsibility. The context and processes associated with competency validation will be different for each activity, skill, or procedure being delegated. Competency validation should be specific to the knowledge and skill needed to safely perform the delegated responsibility, as well as to the

nursing delegation. https://www.ncsbn.org/public-files/NGND-PosPaper_06.pdf

5. American Nurses Association and NCSBN. (2019). *National guidelines for nursing delegation*. https://www.ncsbn.org/public-files/NGND-PosPaper_06.pdf
6. American Nurses Association and NCSBN. (2019). *National guidelines for nursing delegation*. https://www.ncsbn.org/public-files/NGND-PosPaper_06.pdf
7. American Nurses Association and NCSBN. (2019). *National guidelines for nursing delegation*. https://www.ncsbn.org/public-files/NGND-PosPaper_06.pdf

level of the practitioner (e.g., RN, LPN/VN, UAP) to whom the activity, skill, or procedure has been delegated. The licensed nurse who delegates the "responsibility" maintains overall accountability for the client, but the delegatee bears the responsibility for completing the delegated activity, skill, or procedure.

- The licensed nurse cannot delegate nursing clinical judgment or any activity that will involve nursing clinical judgment or critical decision-making to UAP.
- Nursing responsibilities are delegated by a licensed nurse who has the authority to delegate and the delegated responsibility is within the delegator's scope of practice.

An example of delegation is medication administration that is delegated by a licensed nurse to UAP with additional training in some agencies, according to agency policy. This task is outside the traditional role of UAP, but the delegatee has received additional training for this delegated responsibility and has completed competency validation in completing this task accurately.

An example illustrating the difference between assignment and delegation is assisting clients with eating. Feeding clients is typically part of the routine role of UAP. However, if a client has recently experienced a stroke (i.e., cerebrovascular accident) or is otherwise experiencing swallowing difficulties (e.g., dysphagia), this task cannot be assigned to UAP because it is not considered routine care. Instead, the RN should perform this task themselves or delegate it to a UAP who has received additional training on feeding assistance.

The delegation process is multifaceted. See Figure 3.2[8] for an illustration of the intersecting responsibilities of the employer/nurse leader, licensed nurse, and delegatee with two-way communication that protects the safety of the public. "Delegation begins at the administrative/nurse leader level of the

8. "Delegation.png" by Meredith Pomietlo for Chippewa Valley Technical College is licensed under CC BY 4.0

organization and includes determining nursing responsibilities that can be delegated, to whom, and under what circumstances; developing delegation policies and procedures; periodically evaluating delegation processes; and promoting a positive culture/work environment. The licensed nurse is responsible for determining client needs and when to delegate, ensuring availability to the delegatee, evaluating outcomes, and maintaining accountability for delegated responsibility. Finally, the delegatee must accept activities based on their competency level, maintain competence for delegated responsibility, and maintain accountability for delegated activity."[9]

9. American Nurses Association and NCSBN. (2019). *National guidelines for nursing delegation*. https://www.ncsbn.org/public-files/NGND-PosPaper_06.pdf

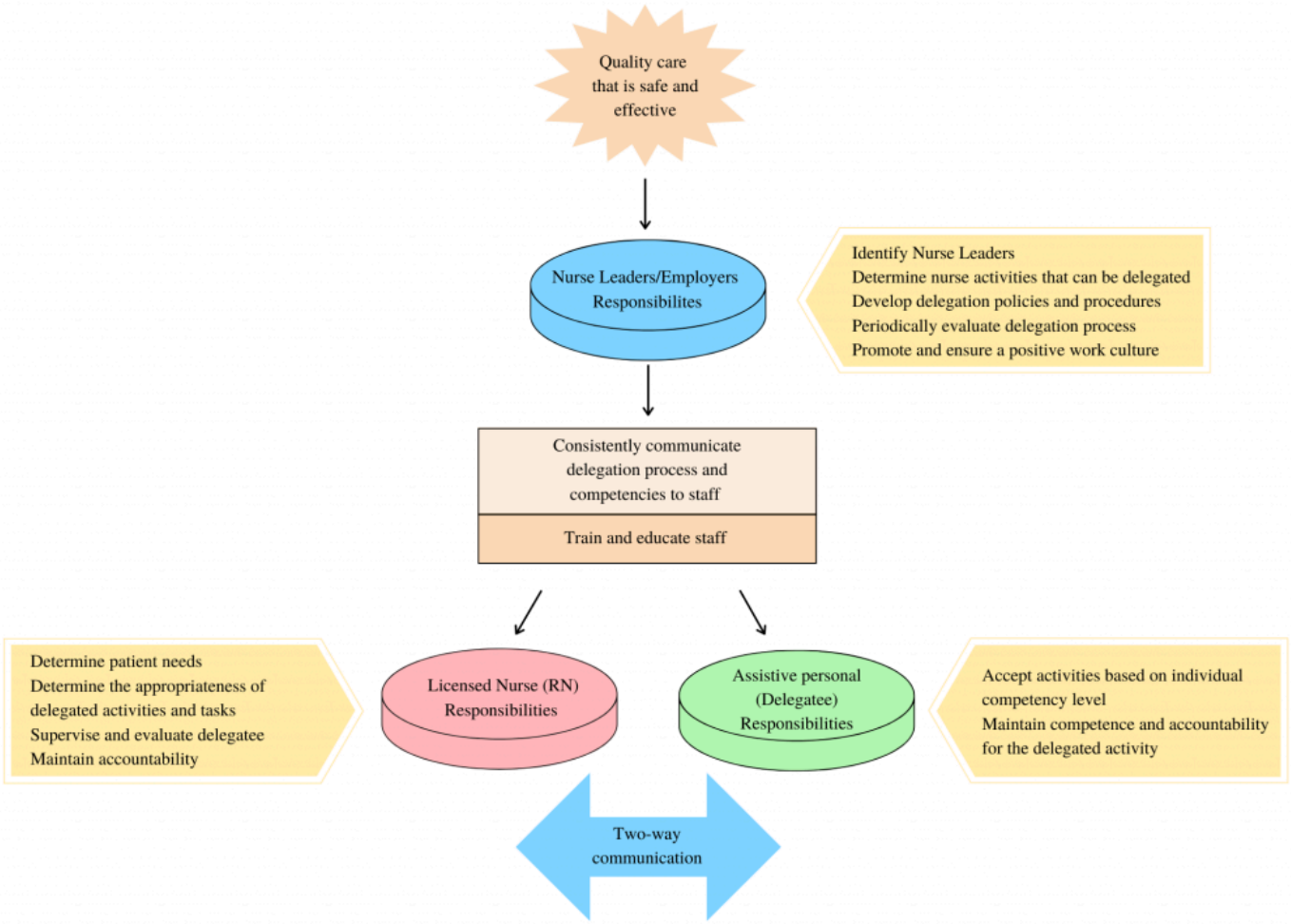

Figure 3.2 Multifaceted Delegation Process

Five Rights of Delegation

How does the RN determine what tasks can be delegated, when, and to whom? According to the National Council of State Boards of Nursing (NCSBN), RNs should use the five rights of delegation to ensure proper and

appropriate delegation: right task, right circumstance, right person, right directions and communication, and right supervision and evaluation[10]:

- **Right task:** The activity falls within the delegatee's job description or is included as part of the established policies and procedures of the nursing practice setting. The facility needs to ensure the policies and procedures describe the expectations and limits of the activity and provide any necessary competency training.

- **Right circumstance:** The health condition of the client must be stable. If the client's condition changes, the delegatee must communicate this to the licensed nurse, and the licensed nurse must reassess the situation and the appropriateness of the delegation.[11]

- **Right person:** The licensed nurse, along with the employer and the delegatee, is responsible for ensuring that the delegatee possesses the appropriate skills and knowledge to perform the activity.[12]

- **Right directions and communication:** Each delegation situation should be specific to the client, the nurse, and the delegatee. The licensed nurse is expected to communicate specific instructions for the delegated activity to the delegatee; the delegatee, as part of two-way

10. American Nurses Association and NCSBN. (2019). *National guidelines for nursing delegation*. https://www.ncsbn.org/public-files/NGND-PosPaper_06.pdf

11. American Nurses Association and NCSBN. (2019). *National guidelines for nursing delegation*. https://www.ncsbn.org/public-files/NGND-PosPaper_06.pdf

12. American Nurses Association and NCSBN. (2019). *National guidelines for nursing delegation*. https://www.ncsbn.org/public-files/NGND-PosPaper_06.pdf

communication, should ask any clarifying questions. This communication includes any data that need to be collected, the method for collecting the data, the time frame for reporting the results to the licensed nurse, and additional information pertinent to the situation. The delegatee must understand the terms of the delegation and must agree to accept the delegated activity. The licensed nurse should ensure the delegatee understands they cannot make any decisions or modifications in carrying out the activity without first consulting the licensed nurse.[13]

- **Right supervision and evaluation:** The licensed nurse is responsible for monitoring the delegated activity, following up with the delegatee at the completion of the activity, and evaluating client outcomes. The delegatee is responsible for communicating client information to the licensed nurse during the delegation situation. The licensed nurse should be ready and available to intervene as necessary. The licensed nurse should ensure appropriate documentation of the activity is completed.[14]

Simply stated, the licensed nurse determines the right person is assigned the right tasks for the right clients under the right circumstances. When determining what aspects of care can be delegated, the licensed nurse uses clinical judgment while considering the client's current clinical condition, as well as the abilities of the health care team member. The RN must also consider if the circumstances are appropriate for delegation. For example, although obtaining routine vital signs on stable clients may be appropriate to delegate to assistive personnel, obtaining vital signs on an unstable client is not appropriate to delegate.

13. American Nurses Association and NCSBN. (2019). *National guidelines for nursing delegation*. https://www.ncsbn.org/public-files/NGND-PosPaper_06.pdf

14. American Nurses Association and NCSBN. (2019). *National guidelines for nursing delegation*. https://www.ncsbn.org/public-files/NGND-PosPaper_06.pdf

After the decision has been made to delegate, the nurse assigning the tasks must communicate appropriately with the delegatee and provide the right directions and supervision. Communication is key to successful delegation. Clear, concise, and closed-loop communication is essential to ensure successful completion of the delegated task in a safe manner. During the final step of delegation, also referred to as **supervision**, the nurse verifies and evaluates that the task was performed correctly, appropriately, safely, and competently. Read more about supervision in the following section on "Supervision." See Table 3.4 for additional questions to consider for each "right" of delegation.

Table 3.4. Rights of Delegation[15]

15. NCSBN. (n.d.). *Delegation*. https://www.ncsbn.org/1625.htm

Rights of Delegation	Description	Questions to Consider When Delegating
Right Task	A task that can be transferred to a member of the nursing team for a specific client.	• Is this task legally appropriate to delegate to this team member according to the state's Nurse Practice Act and written agency policy and procedures? • Has the team member been trained and demonstrated competency in performing this task? • Does the team member feel comfortable and willing to perform the task?
Right Circumstances	The client is stable.	• Is there enough staffing to support delegation in this circumstance? • What is the client's current status? • What are the client's current needs?
Right Person	The person delegating the task has the appropriate scope of practice to do so. The task is also appropriate for this delegatee's skills and knowledge.	• Is the delegatee suitable to meet the client's needs? • Is the delegatee willing to accept the delegated task? • Has the delegatee demonstrated competence to perform the task?

Right Directions and Communication	The task or activity is clearly defined and described.	• Have clear communication and instructions been given regarding the task? • Did the instructions include data that need to be collected, the method for collecting the data, the time frame for reporting the results to the licensed nurse, and additional information pertinent to the situation? • Does the delegatee understand what needs to be done? • Is the delegatee aware of what should be reported and when it needs to be reported? • Has the delegatee accepted the delegated task? • Has the time frame to complete the task been defined? • Does the delegatee understand they cannot make any decisions or modifications in carrying out the activity without first consulting the licensed nurse? • Was closed-loop communication used?

Right Supervision and Evaluation	The RN appropriately monitors the delegated activity, evaluates client outcomes, and follows up with the delegatee at the completion of the activity.	• When and how will the RN connect with the delegatee to discuss the completion of the activity and communication of client information? • How often should the RN directly or indirectly observe the team member's performance? • When will the RN evaluate client outcomes? • When will the RN provide feedback to the team member? • Has documentation of the activity been completed?

Keep in mind that any nursing intervention that requires specific nursing knowledge, clinical judgment, or use of the nursing process can only be delegated to another RN. Examples of these types of tasks include initial preoperative or admission assessments, client teaching, and creation and evaluation of a nursing care plan. See Figure 3.3[16] for an algorithm based on the 2019 National Guidelines for Nursing Delegation that can be used when deciding if a nursing task can be delegated.[17]

16. "Delegation Decision Tree.png" by Meredith Pomietlo for Chippewa Valley Technical College is licensed under CC BY 4.0

17. American Nurses Association and NCSBN. (2019). *National guidelines for nursing delegation*. https://www.ncsbn.org/public-files/NGND-PosPaper_06.pdf

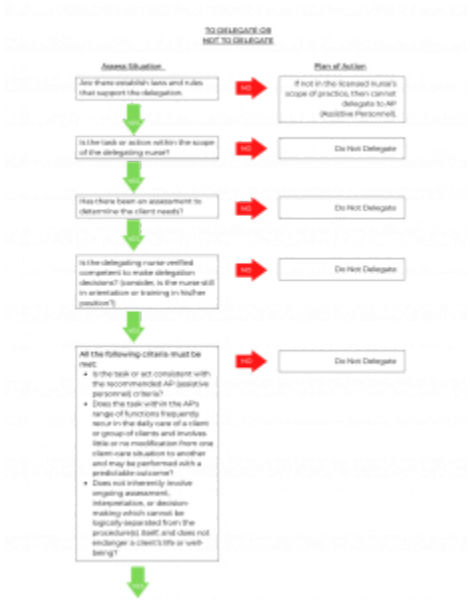

Figure 3.3 Delegation Algorithm

Responsibilities of the Licensed Nurse

The licensed nurse has several responsibilities as part of the delegation process. According to the NGND, any decision to delegate a nursing responsibility must be based on the needs of the client or population, the stability and predictability of the client's condition, the documented training and competence of the delegatee, and the ability of the licensed nurse to supervise the delegated responsibility and its outcome with consideration to the available staff mix and client acuity. Additionally, the licensed nurse must consider the state Nurse Practice Act regarding delegation and the employer's policies and procedures prior to making a final decision to delegate. Licensed nurses must be aware that delegation is at the nurse's discretion, with consideration of the particular situation. The licensed nurse maintains accountability for the client, while the delegatee is responsible for the delegated activity, skill, or procedure. If, under the circumstances, a nurse does not feel it is appropriate to delegate a certain responsibility to a delegatee, the delegating nurse should perform the activity.[18]

18. American Nurses Association and NCSBN. (2019). *National guidelines for*

1. The licensed nurse must determine when and what to delegate based on the practice setting, the client's needs and condition, the state's/ jurisdiction's provisions for delegation, and the employer's policies and procedures regarding delegating a specific responsibility. The licensed nurse must determine the needs of the client and whether those needs are matched by the knowledge, skills, and abilities of the delegatee and can be performed safely by the delegatee. The licensed nurse cannot delegate any activity that requires clinical reasoning, nursing judgment, or critical decision-making. The licensed nurse must ultimately make the final decision whether an activity is appropriate to delegate to the delegatee based on the "Five Rights of Delegation."

- **Rationale:** The licensed nurse, who is present at the point of care, is in the best position to assess the needs of the client and what can or cannot be delegated in specific situations.[19]

2. The licensed nurse must communicate with the delegatee who will be assisting in providing client care. This should include reviewing the delegatee's assignment and discussing delegated responsibilities, including information on the client's condition/stability, any specific information pertaining to a certain client (e.g., no blood draws in the right arm), and any specific information about the client's condition that should be communicated back to the licensed nurse by the delegatee.

- **Rationale:** Communication must be a two-way process involving both the licensed nurse delegating the activity and the delegatee being delegated the responsibility. Evidence shows that the better the communication

nursing delegation. https://www.ncsbn.org/public-files/NGND-PosPaper_06.pdf

19. American Nurses Association and NCSBN. (2019). *National guidelines for nursing delegation*. https://www.ncsbn.org/public-files/NGND-PosPaper_06.pdf

between the nurse and the delegatee, the more optimal the outcome. The licensed nurse must provide information about the client and care requirements. This includes any specific issues related to any delegated responsibilities. These instructions should include any unique client requirements. The licensed nurse must instruct the delegatee to regularly communicate the status of the client.[20]

3. The licensed nurse must be available to the delegatee for guidance and questions, including assisting with the delegated responsibility, if necessary, or performing it themselves if the client's condition or other circumstances warrant doing so.

- **Rationale:** Delegation calls for nursing judgment throughout the process. The final decision to delegate rests in the hands of the licensed nurse as they have overall accountability for the client.[21]

4. The licensed nurse must follow up with the delegatee and the client after the delegated responsibility has been completed.

- **Rationale:** The licensed nurse who delegates the "responsibility" maintains overall accountability for the client, while the delegatee is responsible for the delegated activity, skill, or procedure.[22]

20. American Nurses Association and NCSBN. (2019). *National guidelines for nursing delegation*. https://www.ncsbn.org/public-files/NGND-PosPaper_06.pdf

21. American Nurses Association and NCSBN. (2019). *National guidelines for nursing delegation*. https://www.ncsbn.org/public-files/NGND-PosPaper_06.pdf

22. American Nurses Association and NCSBN. (2019). *National guidelines for nursing delegation*. https://www.ncsbn.org/public-files/NGND-PosPaper_06.pdf

5. The licensed nurse must provide feedback information about the delegation process and any issues regarding delegatee competence level to the nurse leader. Licensed nurses in the facility need to communicate to the nurse leader responsible for delegation any issues arising related to delegation and any individual whom they identify as not being competent in a specific responsibility or unable to use good judgment and decision-making.

- **Rationale:** This will allow the nurse leader responsible for delegation to develop a plan to address the situation.[23]

The decision of whether or not to delegate or assign is based on the RN's judgment concerning the condition of the client, the competence of the nursing team member, and the degree of supervision that will be required of the RN if a task is delegated.[24]

Responsibilities of the Delegatee

Everyone is responsible for the well-being of clients. While the nurse is ultimately accountable for the overall care provided to a client, the delegatee shares the responsibility for the client and is fully responsible for the

23. American Nurses Association and NCSBN. (2019). *National guidelines for nursing delegation*. https://www.ncsbn.org/public-files/NGND-PosPaper_06.pdf

24. American Nurses Association and NCSBN. (2019). *National guidelines for nursing delegation*. https://www.ncsbn.org/public-files/NGND-PosPaper_06.pdf

delegated activity, skill, or procedure.[25] The delegatee has the following responsibilities:

1. The delegatee must accept only the delegated responsibilities that they are appropriately trained and educated to perform and feel comfortable doing given the specific circumstances in the health care setting and client's condition. The delegatee should confirm acceptance of the responsibility to carry out the delegated activity. If the delegatee does not believe they have the appropriate competency to complete the delegated responsibility, then the delegatee should not accept the delegated responsibility. This includes informing the nursing leadership if they do not feel they have received adequate training to perform the delegated responsibility, do not perform the procedure frequently enough to do it safely, or their knowledge and skills need updating.

- **Rationale:** The delegatee shares the responsibility to keep clients safe, and this includes only performing activities, skills, or procedures in which they are competent and comfortable doing.[26]

2. The delegatee must maintain competency for the delegated responsibility.

- **Rationale:** Competency is an ongoing process. Even if properly taught, the delegatee may become less competent if they do not frequently perform the procedure. Given that the delegatee shares the responsibility for the client, the delegatee also has a responsibility to maintain

25. American Nurses Association and NCSBN. (2019). *National guidelines for nursing delegation*. https://www.ncsbn.org/public-files/NGND-PosPaper_06.pdf

26. American Nurses Association and NCSBN. (2019). *National guidelines for nursing delegation*. https://www.ncsbn.org/public-files/NGND-PosPaper_06.pdf

competency.[27]

3. The delegatee must communicate with the licensed nurse in charge of the client. This includes any questions related to the delegated responsibility and follow-up on any unusual incidents that may have occurred while the delegatee was performing the delegated responsibility, any concerns about a client's condition, and any other information important to the client's care.

- **Rationale:** The delegatee is a partner in providing client care. They are interacting with the client/family and caring for the client. This information and two-way communication are important for successful delegation and optimal outcomes for the client.[28]

4. Once the delegatee verifies acceptance of the delegated responsibility, the delegatee is accountable for carrying out the delegated responsibility correctly and completing timely and accurate documentation per facility policy.

- **Rationale:** The delegatee cannot delegate to another individual. If the delegatee is unable to complete the responsibility or feels as though they need assistance, the delegatee should inform the licensed nurse immediately so the licensed nurse can assess the situation and provide support. Only the licensed nurse can determine if it is appropriate to delegate the activity to another individual. If at any time the licensed nurse determines they need to perform the delegated responsibility, the delegatee must relinquish responsibility upon request of the licensed

27. American Nurses Association and NCSBN. (2019). *National guidelines for nursing delegation*. https://www.ncsbn.org/public-files/NGND-PosPaper_06.pdf

28. American Nurses Association and NCSBN. (2019). *National guidelines for nursing delegation*. https://www.ncsbn.org/public-files/NGND-PosPaper_06.pdf

nurse.[29]

Responsibilities of the Employer/Nurse Leader

The employer and nurse leaders also have responsibilities related to safe delegation of client care:

1. The employer must identify a nurse leader responsible for oversight of delegated responsibilities for the facility. If there is only one licensed nurse within the practice setting, that licensed nurse must be responsible for oversight of delegated responsibilities for the facility.

- **Rationale:** The nurse leader has the ability to assess the needs of the facility, understand the type of knowledge and skill needed to perform a specific nursing responsibility, and be accountable for maintaining a safe environment for clients. They are also aware of the knowledge, skill level, and limitations of the licensed nurses and UAP. Additionally, the nurse leader is positioned to develop appropriate staffing models that take into consideration the need for delegation. Therefore, the decision to delegate begins with a thorough assessment by a nurse leader designated by the institution to oversee the process.[30]

2. The designated nurse leader responsible for delegation, ideally with a committee (consisting of other nurse leaders) formed for the purposes of addressing delegation, must determine which nursing responsibilities may be delegated, to whom, and under what circumstances. The nurse leader

29. American Nurses Association and NCSBN. (2019). *National guidelines for nursing delegation*. https://www.ncsbn.org/public-files/NGND-PosPaper_06.pdf

30. American Nurses Association and NCSBN. (2019). *National guidelines for nursing delegation*. https://www.ncsbn.org/public-files/NGND-PosPaper_06.pdf

must be aware of the state Nurse Practice Act and the laws/rules and regulations that affect the delegation process and ensure all institutional policies are in accordance with the law.

- **Rationale:** A systematic approach to the delegation process fosters communication and consistency of the process throughout the facility.[31]

3. Policies and procedures for delegation must be developed. The employer/nurse leader must outline specific responsibilities that can be delegated and to whom these responsibilities can be delegated. The policies and procedures should also indicate what may not be delegated. The employer must periodically review the policies and procedures for delegation to ensure they remain consistent with current nursing practice trends and that they are consistent with the state Nurse Practice Act. (Institution/employer policies can be more restrictive, but not less restrictive.)

- **Rationale:** Policies and procedures standardize the appropriate method of care and ensure safe practices. Having a policy and procedure specific to delegation and delegated responsibilities eliminates questions from licensed nurses and UAP about what can be delegated and how they should be performed.[32]

4. The employer/nurse leader must communicate information about delegation to the licensed nurses and UAP and educate them about what responsibilities can be delegated. This information should include the

31. American Nurses Association and NCSBN. (2019). *National guidelines for nursing delegation*. https://www.ncsbn.org/public-files/NGND-PosPaper_06.pdf

32. American Nurses Association and NCSBN. (2019). *National guidelines for nursing delegation*. https://www.ncsbn.org/public-files/NGND-PosPaper_06.pdf

competencies of delegatees who can safely perform a specific nursing responsibility.

- **Rationale:** Licensed nurses must be aware of the competence level of staff and expectations for delegation (as described within the policies and procedures) to make informed decisions on whether or not delegation is appropriate for the given situation. Licensed nurses maintain accountability for the client. However, the delegatee has responsibility for the delegated activity, skill, or procedure.

In summary, delegation is the transfer of the nurse's responsibility for a task while retaining professional accountability for the client's overall outcome. The decision to delegate is based on the nurse's judgment, the act of delegation must be clearly defined by the nurse, and the outcomes of delegation are an extension of the nurse's guidance and supervision. Delegation, when rooted in mutual respect and trust, is a key component to an effective health care team.

Delegation is an integral skill in the nursing profession to help manage the complexities of the dynamic and ever-changing health care environment. Delegation in nursing has been found to increase employee empowerment, decrease burnout, increase role commitment, and improve job satisfaction.[33] Cultivating delegation skills helps nurses better manage the complexities of their client care role, ensuring that their clients are safely cared for and outcomes are optimized. Delegation skills, like other nursing skills, require purposeful development and do not necessarily come easily when first transitioning into the nursing role. It is important that the new graduate nurse does not mistake delegation for pompous or arrogant behavior. Delegation requires mutual respect between the delegator and delegatee. Delegation is not seen as a sign or weakness and does not reflect one's desire

33. American Nurses Association. (2023). *Delegation in nursing: How to build a stronger team*. https://www.nursingworld.org/content-hub/resources/nursing-leadership/delegation-in-nursing/

to shirk their work responsibilities. Instead, delegation reflects strong leadership and organizational skills in which the nurse leader demonstrates that they understand how to leverage their team's strengths in order to achieve optimal care outcomes.

To help avoid any perception of arrogance in the delegation of an activity, it is important that the new graduate nurse approaches the task of delegation with humility. Clarity in the communication of the delegated responsibility is critical, and the rationale behind the delegation should be communicated to the delegatee. Within the task of delegation, the delegator should express appreciation for the delegatee and their contributions in the collaborative health care environment. Additionally, it is important to understand that no specific nurse delegated task is outside of the "nurse" role. For example, ambulating a client does not need to delegated to an unlicensed assistive personnel simply because that individual is able to perform that task. Rather, nurses must be willing to perform delegated tasks themselves when necessary. This reflects a team-oriented mindset and helps to reinforce among the care team that all roles are critical to optimizing client care. For new graduate nurses who first transition into a specific health care setting, having the opportunity to shadow individuals in various work roles helps to foster a team mindset. Asking questions of various team members regarding their work role can help a new graduate nurse demonstrate respect and value for other roles.

Examples of helpful questions may include the following:

- "What is the biggest challenge in your typical workday?"
- "What do you most enjoy about your job?"
- "How is it best to communicate with you when the unit is busy?"
- "What do you think people misunderstand most about your role?"

It is important to ensure that the team understands that care is optimized when they function as one collective unit and not in siloed roles. Each team member must feel valued and competent in their role. By understanding and practicing strategic delegation, new graduate nurses can overcome any

misconceptions of arrogance and contribute positively to the healthcare team.

Review the example below to consider variation in approach to task delegation.

Scenario A: Nurse June, a newly graduated nurse, is working in a busy hospital unit. She needs an unlicensed assistive personnel (UAP), Alex, to take vital signs of a client. Nurse June approaches Alex in the hallway and says in an abrupt tone, "Alex, I need you to take Mr. Smith's vital signs right now. I'm too busy to do it myself, and besides, that's what you're here for. Just get it done quickly."

Analysis: June's tone and words suggest she sees Alex's role as less important and purely as a means to offload her tasks. June does not explain the urgency or importance of the task. June doesn't acknowledge Alex's effort or capability, making the request seem like a command rather than a collaborative effort.

Scenario B: Nurse June, a newly graduated nurse, is working in a busy hospital unit. She needs an unlicensed assistive personnel (UAP), Alex, to take vital signs of a client. Nurse June approaches Alex and says, "Hi Alex, could you please help me by taking Mr. Smith's vital signs? I'm handling a few urgent matters right now, and it would really help to have your support. I know you're great at this, and your thoroughness really makes a difference in our client care. Thank you so much!"

Analysis: June speaks to Alex with courtesy and acknowledges the value of his role. June clearly explains why she needs Alex's help and the importance of the task. June acknowledges Alex's competence and expresses gratitude, fostering feelings of value and respect.

3.5 Supervision

The licensed nurse has the responsibility to supervise, monitor, and evaluate the nursing team members who have received delegated tasks, activities, or procedures. As previously noted, the act of supervision requires the nurse to assess the staff member's ability, competency, and experience prior to delegating. After the nurse has made the decision to delegate, supervision continues in terms of coaching, supporting, assisting, and educating as needed throughout the task to assure appropriate care is provided.

The nurse is accountable for client care delegated to other team members. Communication and supervision should be ongoing processes throughout the shift within the nursing care team. The nurse must ensure quality of care, appropriateness, timeliness, and completeness through direct and indirect supervision. For example, an RN may directly observe the UAP reposition a client or assist them to the bathroom to assure both client and staff safety are maintained. An RN may also indirectly evaluate an LPN's administration of medication by reviewing documentation in the client's medical record for timeliness and accuracy. Through direct and indirect supervision of delegation, quality client care and compliance with standards of practice and facility policies can be assured.

Supervision also includes providing constructive feedback to the nursing team member. **Constructive feedback** is supportive and identifies solutions to areas needing improvement. It is provided with positive intentions to address specific issues or concerns as the person learns and grows in their role. Constructive feedback includes several key points:

- Was the task, activity, care, or procedure performed correctly?
- Were the expected outcomes involving delegation for that client achieved?
- Did the team member utilize effective and timely communication?
- What were the challenges of the activity and what aspects went well?
- Were there any problems or specific concerns that occurred and how were they managed?

After these questions have been addressed, the RN creates a plan for future delegation with the nursing team member. This plan typically includes the following:

- Recognizing difficulty of the nursing team member in initiating or completing the delegated activities.
- Observing the client's responses to actions performed by the nursing team member.
- Following up in a timely manner on any problems, incidents, or concerns that arose.
- Creating a plan for providing additional training and monitoring outcomes of future delegated tasks, activities, or procedures.
- Consulting with appropriate nursing administrators per agency policy if the client's safety was compromised.

Please review the following example regarding constructive feedback and task supervision

Nurse Sarah, an experienced RN, delegated a task to Peter, an unlicensed assistive personnel (UAP), to take the vital signs of a post-operative client, Mrs. Johnson, and report any abnormalities immediately.

Sarah: "Hi Peter, I wanted to discuss the task you completed earlier with Mrs. Johnson's vital signs. Thank you for your help with that. Let's review how it went."

Was the task, activity, care, or procedure performed correctly?

Sarah: "First, I noticed you recorded the vital signs accurately. Good job on that. However, there was a delay in reporting Mrs. Johnson's elevated blood pressure to me. Can you walk me through what happened?"

Peter: "I took her vital signs, and her blood pressure was high. I was going to inform you, but I got called to assist with another client immediately after."

Were the expected outcomes involving delegation for that client achieved?

Sarah: "Ultimately, we did address the elevated blood pressure, but the delay could have impacted her care. It's crucial to report such abnormalities immediately."

Did the team member utilize effective and timely communication?

Sarah: "While you communicated the vital signs correctly, the timing was off. In future, if you can't find me immediately, please inform any available nurse or use the intercom system."

What were the challenges of the activity and what aspects went well?

Peter: "The challenge was managing multiple tasks at once. I did feel confident in taking and recording the vital signs accurately, though."

Sarah: "It sounds like you're balancing a lot of responsibilities well, but prioritizing urgent communications is key. You handled the technical part perfectly."

Were there any problems or specific concerns that occurred and how were they managed?

Sarah: "The main concern was the delay in reporting the elevated blood pressure. Fortunately, there were no serious consequences, but it's a potential risk we need to manage better. Let's create a plan to support you moving forward."

Recognizing difficulty of the nursing team member in initiating or completing the delegated activities:

> **Sarah:** "I recognize that you were busy with multiple tasks. It's important to prioritize client safety over other duties."

Observing the client's responses to actions performed by the nursing team member:

> **Sarah:** "I will check on Mrs. Johnson's response to ensure there are no ongoing issues, and I'll keep exploring how we can improve this process."

Following up in a timely manner on any problems, incidents, or concerns that arose:

> **Sarah:** "I'll follow up with you soon to see how you're managing your other tasks, and we can address any challenges you're facing."

Creating a plan for providing additional training and monitoring outcomes of future delegated tasks, activities, or procedures:

> **Sarah:** "We'll arrange some additional training on prioritizing tasks and urgent communication. Let's monitor the outcomes of your delegated tasks over the next few weeks to ensure you're supported."

Consulting with appropriate nursing administrators per agency policy if the client's safety was compromised:

> **Sarah:** "Fortunately, Mrs. Johnson is fine, but if there were any safety concerns, we'd need to report it according to our policy. Keep this in mind for the future."

> **Sarah:** "Peter, you're doing a great job with your responsibilities, and with a bit more focus on

communication priorities, I'm confident you'll excel even more. Let's touch base again in a week to see how things are going. Feel free to come to me with any questions or concerns in the meantime."

Peter: "Thank you, Sarah. I appreciate the feedback and will work on prioritizing urgent communications."

Sarah: "Great. Keep up the good work, and let's keep improving together."

3.6 Spotlight Application

You are an RN and are reporting to work on a 16-bed medical/renal unit in a county hospital for the 0700 – 1500 shift today. The client population is primarily socioeconomically disadvantaged. Staff for the shift includes four RNs, one LPN/VN, and two UAP.

You are a new RN graduate on the unit, and your orientation was completed two weeks ago. The LPN/VN has been working on the unit for ten years. Both UAP have been on the unit for six months and are certified nursing assistants after completing basic nurse aide training. You, as one of four RNs on the unit, have been assigned four clients. You share the LPN with the other RNs, and there is one UAP for every two RNs.

The charge nurse has assigned you the following four clients. Scheduled morning medications are due at 0800 and all four require some assistance with their ADLs.

- **Client A:** An obese 52-year-old male with hypertension and diabetes requiring insulin therapy. He has been depressed since recently being diagnosed with end-stage renal disease requiring hemodialysis. He needs his morning medications and assistance getting dressed for transport to hemodialysis in 30 minutes.
- **Client B:** A 83-year-old female client with acute pyelonephritis admitted two days ago. She has a PICC line in place and is receiving IV vancomycin every 12 hours. The next dose is due at 0830 after a trough level is drawn.
- **Client C:** A 78-year-old male recently diagnosed with bladder cancer. He has bright red urine today but reports it is painless. He has surgery scheduled at 0900 and the pre-op checklist has not yet been completed.
- **Client D:** A malnourished 80-year-old male client admitted with dehydration and imbalanced electrolyte levels. He is being discharged home today and requires health teaching.

Reflective Questions

1. At the start of the shift, you determine which tasks, cares, activities, and/or procedures you will delegate to the LPN and UAP. What factors must you consider prior to delegation?
2. What tasks will you delegate to the LPN/VN?
3. What tasks will you delegate to the UAP?

Learning Activities

(Answers to "Learning Activities" can be found in the "Answer Key" at the end of the book. Answers to interactive activities are provided as immediate feedback.)

1. Review the following case studies regarding nurse liability associated with inappropriate delegation:

- Nurse Case Study: Wrongful delegation of patient care to unlicensed assistive personnel
- Nurse Video Case Study: Failure to assess and monitor

Reflective Questions: What delegation errors occurred in each of these scenarios and what were the repercussions of these errors for the nurses involved?

2. The RN is delegating tasks to the LPN/VN and UAP on a medical-surgical unit. Using the columns as reference, indicate where delegation errors occurred using the 5 Rs of delegation.

	Right Person	Right Task	Right Circumstance	Right Direction and Communication	Right Supervision and Evaluation
Directs the UAP to assess the pain level of a client who is post-op Day 3 after a hip replacement and report back the finding.					
Directs the LPN to give 1 mg IV push morphine to a client who is 2-hours post total left knee replacement and ensure documentation.					
Assigns the UAP to collect blood pressures on all clients on the unit by 0800. Assumes the UAP will report back any abnormal blood pressures.					
Directs a new UAP to ambulate a client who is post-op Day 2 from a shoulder replacement who needs the assistance of one person and an adaptive walker. The UAP voices concerns about never having used an adaptive walker before. The RN directs the UAP to get another UAP to help.					

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingmpc/?p=143#h5p-36

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingmpc/?p=143#h5p-5

Test your knowledge using this NCLEX Next Generation-style Case Study. You may reset and resubmit your answers to this question an unlimited number of times.[1]

1. "Chapter 3, Assignment 1" by Travis Christman for OpenRN is licensed under CC BY-NC 4.0

III Glossary

Accountability: Being answerable to oneself and others for one's own choices, decisions, and actions as measured against a standard.

Assignment: Routine care, activities, and procedures that are within the authorized scope of practice of the RN, LPN/VN, or routine functions of the assistive personnel.

Closed-loop communication: A process that enables the person giving the instructions to hear what they said reflected back and to confirm that their message was, in fact, received correctly.

Constructive feedback: Supportive feedback that offers solutions to areas of weakness.

Delegated responsibility: A nursing activity, skill, or procedure that is transferred from a license nurse to a delegatee.

Delegatee: An RN, LPN/VN, or AP who is delegated a nursing responsibility by either an APRN, RN, or LPN/VN who is competent to perform the task and verbally accepts the responsibility.

Delegation: Allowing a delegatee to perform a specific nursing activity, skill, or procedure that is beyond the delegatee's traditional role but in which they have received additional training.

Delegator: An APRN, RN, or LPN/VN who requests a specially trained delegatee to perform a specific nursing activity, skill, or procedure that is beyond the delegatee's traditional role.

Five rights of delegation: Right task, right circumstance, right person, right directions and communication, and right supervision and evaluation.

Nursing team members: Advanced practice registered nurses (APRN), registered nurses (RN), licensed practical/vocational nurses (LPN/VN), and assistive personnel (AP).

Scope of practice: Procedures, actions, and processes that a health care practitioner is permitted to undertake in keeping with the terms of their professional license.

Supervision: Appropriate monitoring of the delegated activity, evaluation of patient outcomes, and follow-up with the delegatee at the completion of the activity.

Titrate: Making adjustments to medication dosage per an established protocol to obtain a desired therapeutic outcome.

Unlicensed Assistive Personnel (UAP): Any assistive personnel trained to function in a supportive role, regardless of title, to whom a nursing responsibility may be delegated. This includes, but is not limited to, certified nursing assistants or aides (CNAs), patient-care technicians (PCTs), certified medical assistants (CMAs), certified medication aides, and home health aides.[1]

1. American Nurses Association and NCSBN. (2019). *National guidelines for nursing delegation*. https://www.ncsbn.org/NGND-PosPaper_06.pdf

PART IV

CHAPTER 4 - LEADERSHIP AND MANAGEMENT

4.1 Leadership & Management Introduction

Learning Objectives

- Differentiate the role of leader and manager
- Examine the roles of team members
- Identify steps in the management process and activities that managers perform
- Describe the role of the RN as a leader and change agent
- Discuss effects of power, empowerment, and motivation in leading and managing a nursing team

As a nursing student preparing to graduate, you have spent countless hours on developing clinical skills, analyzing disease processes, creating care plans, and cultivating clinical judgment. In comparison, you have likely spent much less time on developing management and leadership skills. Yet, soon after beginning your first job as a registered nurse, you will become involved in numerous situations requiring nursing leadership and management skills. Some of these situations include the following:

- Prioritizing care for a group of assigned clients
- Collaborating with interprofessional team members regarding client care
- Participating in an interdisciplinary team conference
- Acting as a liaison when establishing community resources for a client being discharged home
- Serving on a unit committee
- Investigating and implementing a new evidence-based best practice
- Mentoring nursing students

Delivering safe, quality client care often requires registered nurses (RN) to

manage care provided by the nursing team. Making assignments, delegating tasks, and supervising nursing team members are essential managerial components of an entry-level staff RN role. As previously discussed, nursing team members include RNs, licensed practical/vocational nurses (LPN/VN), and unlicensed assistive personnel (UAP).[1]

> Read more about assigning, delegating, and supervising in the "Delegation and Supervision" chapter.

An RN is expected to demonstrate leadership and management skills in many facets of the role. Nurses manage care for high-acuity clients as they are admitted, transferred, and discharged; coordinate care among a variety of diverse health professionals; advocate for clients' needs; and manage limited resources with shrinking budgets.[2]

> Read more about collaborating and communicating with the interprofessional team; advocating for clients; and admitting, transferring, and discharging clients in the "Collaboration Within the Interprofessional Team" chapter.

An article published in the *Online Journal of Issues in Nursing* states, "With

1. American Nurses Association & NCSBN. (2019). *National guidelines for nursing delegation*. https://www.ncsbn.org/public-files/NGND-PosPaper_06.pdf
2. Cherry, B., & Jacob, S. R. (2017). Nursing leadership and management. In Cherry, B. & Jacob, S. (Eds.), *Contemporary nursing: Issues, trends, and management* (8th ed.). Elsevier, pp. 294-314.

the growing complexity of healthcare practice environments and pending nurse leader retirements, the development of future nurse leaders is increasingly important."[3] This chapter will explore leadership and management responsibilities of an RN. Leadership styles are introduced, and change theories are discussed as a means for implementing change in the health care system.

3. Dyess, S. M., Sherman, R. O., Pratt, B. A., & Chiang-Hanisko, L. (2016). Growing nurse leaders: Their perspectives on nursing leadership and today's practice environment. *OJIN: The Online Journal of Issues in Nursing, 21*(1). https://ojin.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-21-2016/No1-Jan-2016/Articles-Previous-Topics/Growing-Nurse-Leaders.html

Organizational Culture

The formal leaders of an organization provide a sense of direction and overall guidance for their employees by establishing organizational vision, mission, and values statements. An organization's **vision statement** defines why the organization exists, describes how the organization is unique from similar organizations, and specifies what the organization is striving to be. The **mission statement** describes how the organization will fulfill its vision and establishes a common course of action for future endeavors. See Figure 4.1[1] for an illustration of a mission statement. A **values statement** establishes the values of an organization that assist with the achievement of its vision and mission. A values statement also provides strategic guidelines for decision-making, both internally and externally, by members of the organization. A values statement may also be reflected as the organization's "**core values**," which are the foundational ideals that guide the organization's actions and decision-making processes. The vision, mission, and values statements are expressed in a concise and clear manner that is easily understood by members of the organization and the public.[2]

1. "Mission_statement.jpg" by RadioFan (talk) is licensed under CC BY-SA 3.0
2. Wagner, J. (2018). *Leadership and Influencing Change in Nursing*. University of Regina Press. https://leadershipandinfluencingchangeinnursing.pressbooks.com/chapter/chapter-5-providing-nursing-leadership-within-the-health-care-system/

Figure 4.1 Mission Statement

Organizational culture refers to the implicit values and beliefs that reflect the norms and traditions of an organization. An organization's vision, mission, and values statements are the foundation of organizational culture. Because individual organizations have their own vision, mission, and values statements, each organization has a different culture.[3] Organizational culture helps reflect the expected norms and behaviors that are inherent to an organization. Expected conduct is comprised of the unwritten rules and standards that reflect how employees should behave in different situations. The culture also informs the common communication styles that are inherent to an organization, including both formal and informal channels. The culture may also be manifested outwardly through various symbols and artifacts that embedded within the organization. These may include specific logos, objects, or other physical manifestations of elements that represent the organization's culture. Some organizations may also reflect their cultural values through activities or ceremonies held within the community.

As health care continues to evolve and new models of care are introduced, nursing managers must develop innovative approaches that address change while aligning with that organization's vision, mission, and values. Leaders embrace the organization's mission, identify how individuals' work

3. Wagner, J. (2018). Leadership and Influencing Change in Nursing. University of Regina Press. https://leadershipandinfluencingchangeinnursing.pressbooks.com/chapter/chapter-5-providing-nursing-leadership-within-the-health-care-system/

contributes to it, and ensure that outcomes advance the organization's mission and purpose. Leaders use vision, mission, and values statements for guidance when determining appropriate responses to critical events and unforeseen challenges that are common in a complex health care system. Successful organizations require employees to be committed to following these strategic guidelines during the course of their work activities. Employees who understand the relationship between their own work and the mission and purpose of the organization will contribute to a stronger health care system that excels in providing quality client care. The vision, mission, and values provide a common organization-wide frame of reference for decision-making for both leaders and staff.[4]

It is important for employees in health care organizations to have understanding of how their roles and responsibilities connect to the broader mission and vision of the organization. This alignment fosters a cohesive work environment where each staff member is motivated by a shared purpose, leading to more effective and high-quality client care. It is important that both the leader and employee have clarity in the underlying vision, mission, and values of an organization. This involves responsibility for both the leader and employee. Leaders must articulate the organization's vision, mission, and values clearly and consistently. This involves regular communication through meetings, written materials, etc. Employees share in the responsibility by being empowered to ask questions and seek clarification on how their daily tasks contribute to the organization's overarching goals.

Learning Activity

4. Wagner, J. (2018). *Leadership and Influencing Change in Nursing*. University of Regina Press. https://leadershipandinfluencingchangeinnursing.pressbooks.com/chapter/chapter-5-providing-nursing-leadership-within-the-health-care-system/

Investigate the mission, vision, and values of a potential employer, as you would do prior to an interview for a job position.

Reflective Questions

1. How well do the organization's vision and values align with your personal values regarding health care?
2. How well does the organization's mission align with your professional objective in your resume?

Followership

Followership is described as the upward influence of individuals on their leaders and their teams. The actions of followers have an important influence on staff performance and client outcomes. Being an effective follower requires individuals to contribute to the team not only by doing as they are told, but also by being aware and raising relevant concerns. Effective followers realize that they can initiate change and disagree or challenge their leaders if they feel their organization or unit is failing to promote wellness and deliver safe, value-driven, and compassionate care. Leaders who gain the trust and dedication of followers are more effective in their leadership role. Everybody has a voice and a responsibility to take ownership of the workplace culture, and good followership contributes to the establishment of high-functioning and safety-conscious teams.[5] Key elements of effective followership include proactive engagement, constructive communication, collaboration, advocacy, continuous improvement, and a supportive leadership environment.

5. Wagner, J. (2018). *Leadership and Influencing Change in Nursing*. University of Regina Press. https://leadershipandinfluencingchangeinnursing.pressbooks.com/chapter/chapter-5-providing-nursing-leadership-within-the-health-care-system/

In order to demonstrate proactive engagement, followers must also be initiators. Effective followers do not passively wait for instruction by rather take initiative to address issues, propose solutions, and contribute to ideas. They recognize the importance of their voice in engaging in problem-solving and understand that being an effective follower does not mean being passive in their role. Effective followers also employ a keen situational awareness where they maintain vigilant assessment of the environment and potential risks, ensuring that they act in the best interests of clients. They must be confident that they can raise concerns if they identify potential problems or unsafe practices. This reflects a culture where followers feels that their feedback is welcomed and valued. Effective followership also involves communication practices in which the message is clearly conveyed, measures to confirm the message are employed, and the confirmation is received. To be an effective follower, support of the team's goals must be a central tenet of one's work. Collaboration with others involves supporting colleagues and working together toward the common goal even when viewpoints may differ. Identifying strategies that create a respectful opportunity to debate and explore different opinions is important to effective followership. Additionally, followers must take accountability for their own actions while understanding how their role and performance impacts the function of the team, as well as client outcomes. Effective followers also practice ethical advocacy, ensuring that the needs of clients are prioritized and respected. This advocacy also involves the ability to courageously challenge any decisions or actions that may jeopardize care or organizational values. Finally, effective followers engage in continuous learning to enhance their skills and knowledge. They seek feedback and use the feedback to contribute to their own performance and also the growth of the team. Effective followership is further cultivated when leaders and followers come together with mutual respect, trust, and work with a purposeful drive toward shared goals that reflect the organization's mission.

Team members impact client safety by following teamwork guidelines for good followership. For example, strategies such as closed-loop communication are important tools to promote client safety.

> Read more about communication and teamwork strategies in the "Collaboration Within the Interprofessional Team" chapter.

Leadership and Management Characteristics

Leadership and management are terms often used interchangeably, but they are two different concepts with many overlapping characteristics. **Leadership** is the art of establishing direction and influencing and motivating others to achieve their maximum potential to accomplish tasks, objectives, or projects.[6,7] See Figure 4.2[8] for an illustration of team leadership. There is no universally accepted definition or theory of nursing leadership, but there is increasing clarity about how it differs from management.[9] **Management** refers to roles that focus on tasks such as planning, organizing, prioritizing,

6. Northouse, P. (2004). *Leadership: Theory and practice* (9th ed.). Sage Publications.

7. Specchia, M. L., Cozzolino, M. R., Carini, E., Di Pilla, A., Galletti, C., Ricciardi, W., & Damiani, G. (2021). Leadership styles and nurses' job satisfaction. Results of a systematic review. *International Journal of Environmental Research and Public Health, 18*(4), 1552. https://doi.org/10.3390/ijerph18041552

8. "3D_Team_Leadership_Arrow_Concept.jpg" by lumaxart is licensed under CC BY-SA 2.0

9. Scully, N. J. (2015). Leadership in nursing: The importance of recognising inherent values and attributes to secure a positive future for the profession. *Collegian, 22*(4), 439-444. https://doi.org/10.1016/j.colegn.2014.09.004

budgeting, staffing, coordinating, and reporting.[10] The overriding function of management has been described as providing order and consistency to organizations, whereas the primary function of leadership is to produce change and movement.[11] View a comparison of the characteristics of management and leadership in Table 4.2a.

Figure 4.2 Leadership

Table 4.2a. Management and Leadership Characteristics[12]

10. Hannaway, J. (1989). *Managers managing: The workings of an administrative system*. Oxford University Press, p. 39.

11. Northouse, P. (2004). *Leadership: Theory and practice* (9th ed.). Sage Publications.

12. Northouse, P. (2004). *Leadership: Theory and practice* (9th ed.). Sage Publications.

MANAGEMENT	LEADERSHIP
Planning, Organizing, and Prioritizing • Establish agenda • Set goals and time frames • Prioritize tasks • Establish policies and procedures	**Establishing Direction** • Create a shared vision • Identify issues requiring change • Set strategies • Implement evidence-based practices
Budgeting and Staffing • Allocate resources • Hire and terminate employees • Make assignments	**Influencing Others** • Listen to team members' concerns • Communicate effectively • Advocate for clients, family members, communities, and the nursing profession • Build effective teamwork
Coordinating and Problem-Solving • Generate solutions • Develop incentives • Take corrective actions • Participate in quality improvement initiatives	**Motivating** • Inspire, energize, and empower team members • Promote professional growth

Leader Vs. Manager Case Activity

Utilizing the information from the table above, review the following cases and identify whether the individual is serving as a leader or manager based upon the actions taken within the case scenario. Include supportive rationale for your decision regarding the role.

Case 1: Sima, the head nurse, reviews the upcoming schedule and allocates resources to ensure each shift is adequately staffed. She also makes assignments for the nursing staff based on their skills and client needs. Additionally, she is responsible for hiring new staff and, when necessary, terminating employees who do not meet performance standards.

Case 2: Juan, a senior nurse, is passionate about improving client care. He identifies an issue with the current handoff process between shifts and proposes a new strategy that incorporates evidence-based practices to enhance communication and reduce errors. He reaches out to his team at their monthly department meetings in order to develop a shared vision for this change and encourages them to partner with him on the new process.

Case 3: Maria, a unit supervisor, holds a meeting to set specific goals and time frames for the department's upcoming projects. She prioritizes tasks for the team and establishes policies and procedures to ensure these tasks are completed efficiently and within the given deadlines.

Case 4: Emily, the nurse director, is tasked with preparing the budget for the upcoming fiscal year. She allocates resources effectively to ensure all departments are adequately funded. Emily also manages the staffing needs, ensuring that the hiring and termination processes are handled efficiently.

Case 5: Rachel, an experienced nurse, takes the time to build effective teamwork within her unit. She advocates for her clients, their families, and the nursing profession as a whole. Rachel communicates openly and listens to her team's concerns, ensuring everyone feels valued and heard.

Not all nurses are managers, but all nurses are leaders because they

encourage individuals to achieve their goals. The American Nurses Association (ANA) established *Leadership* as a Standard of Professional Performance for all registered nurses. Standards of Professional Performance are "authoritative statements of action and behaviors that all registered nurses, regardless of role, population, specialty, and setting, are expected to perform competently."[13] See the competencies of the ANA *Leadership* standard in the following box and additional content in other chapters of this book.

Competencies of ANA's Leadership Standard of Professional Performance

- Promotes effective relationships to achieve quality outcomes and a culture of safety
- Leads decision-making groups
- Engages in creating an interprofessional environment that promotes respect, trust, and integrity
- Embraces practice innovations and role performance to achieve lifelong personal and professional goals
- Communicates to lead change, influence others, and resolve conflict
- Implements evidence-based practices for safe, quality health care and health care consumer satisfaction
- Demonstrates authority, ownership, accountability, and responsibility for appropriate delegation of nursing care
- Mentors colleagues and others to embrace their knowledge, skills, and abilities
- Participates in professional activities and organizations for

13. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

professional growth and influence
- Advocates for all aspects of human and environmental health in practice and policy

Read additional content related to leadership and management activities in corresponding chapters of this book:

- Read about the culture of safety in the "Legal Implications" chapter.
- Read about effective interprofessional teamwork and resolving conflict in the "Collaboration Within the Interprofessional Team" chapter.
- Read about quality improvement and implementing evidence-based practices in the "Quality and Evidence-Based Practice" chapter.
- Read more about delegation, supervision, and accountability in the "Delegation and Supervision" chapter.
- Read about professional organizations and advocating for clients, communities, and their environments in the "Advocacy" chapter.
- Read about budgets and staffing in the "Health Care Economics" chapter.
- Read about prioritization in the "Prioritization" chapter.

Leadership Theories and Styles

In the 1930s Kurt Lewin, the father of social psychology, originally identified three leadership styles: authoritarian, democratic, and laissez-faire.[14,15]

Authoritarian leadership means the leader has full power. Authoritarian leaders tell team members what to do and expect team members to execute their plans. When fast decisions must be made in emergency situations, such as when a client "codes," the authoritarian leader makes quick decisions and provides the group with direct instructions. However, there are disadvantages to authoritarian leadership. Authoritarian leaders are more likely to disregard creative ideas of other team members, causing resentment and stress.[16]

Democratic leadership balances decision-making responsibility between team members and the leader. Democratic leaders actively participate in discussions, but also make sure to listen to the views of others. For example, a nurse supervisor may hold a meeting regarding an increased incidence of client falls on the unit and ask team members to share their observations regarding causes and potential solutions. The democratic leadership style often leads to positive, inclusive, and collaborative work environments that

14. Carlin, D. (2019). Democratic, authoritarian, laissez-faire: What type of leader are you? *Forbes*. https://www.forbes.com/sites/davidcarlin/2019/10/18/democratic-authoritarian-laissez-faire-what-type-of-leader-are-you/?sh=618359422a6b

15. Lewin, K., Lippitt, R., & White, R. K. (1939). Patterns of aggressive behavior in experimentally created "social climates." *Journal of Social Psychology, 10*(2), 271-301. https://doi.org/10.1080/00224545.1939.9713366

16. Carlin, D. (2019). Democratic, authoritarian, laissez-faire: What type of leader are you? *Forbes*. https://www.forbes.com/sites/davidcarlin/2019/10/18/democratic-authoritarian-laissez-faire-what-type-of-leader-are-you/?sh=618359422a6b

encourage team members' creativity. Under this style, the leader still retains responsibility for the final decision.[17]

Laissez-faire is a French word that translates to English as, "leave alone." Laissez-faire leadership gives team members total freedom to perform as they please. Laissez-faire leaders do not participate in decision-making processes and rarely offer opinions. The laissez-faire leadership style can work well if team members are highly skilled and highly motivated to perform quality work. However, without the leader's input, conflict and a culture of blame may occur as team members disagree on roles, responsibilities, and policies. By not contributing to the decision-making process, the leader forfeits control of team performance.[18]

Over the decades, Lewin's original leadership styles have evolved into many styles of leadership in health care, such as passive-avoidant, transactional, transformational, servant, resonant, and authentic.[19,20] Many of these

17. Carlin, D. (2019). Democratic, authoritarian, laissez-faire: What type of leader are you? *Forbes*. https://www.forbes.com/sites/davidcarlin/2019/10/18/democratic-authoritarian-laissez-faire-what-type-of-leader-are-you/?sh=618359422a6b

18. Carlin, D. (2019). Democratic, authoritarian, laissez-faire: What type of leader are you? *Forbes*. https://www.forbes.com/sites/davidcarlin/2019/10/18/democratic-authoritarian-laissez-faire-what-type-of-leader-are-you/?sh=618359422a6b

19. Northouse, P. (2004). *Leadership: Theory and practice* (9th ed.). Sage Publications.

20. Specchia, M. L., Cozzolino, M. R., Carini, E., Di Pilla, A., Galletti, C., Ricciardi, W., & Damiani, G. (2021). Leadership styles and nurses' job satisfaction. Results of a systematic review. *International Journal of Environmental Research and Public Health, 18*(4), 1552. https://doi.org/10.3390/ijerph18041552

leadership styles have overlapping characteristics. See Figure 4.3[21] for a comparison of various leadership styles in terms of engagement.

Figure 4.3 Leadership Styles

Passive-avoidant leadership is similar to laissez-faire leadership and is characterized by a leader who avoids taking responsibility and confronting others. Employees perceive the lack of control over the environment resulting from the absence of clear directives. Organizations with this type of leader have high staff turnover and low retention of employees. These types of

21. "Full_Range_Leadership_model.jpg" by John Pons is licensed under Public Domain, CC0

leaders tend to react and take corrective action only after problems have become serious and often avoid making any decisions at all.[22]

Transactional leadership involves both the leader and the follower receiving something for their efforts; the leader gets the job done and the follower receives pay, recognition, rewards, or punishment based on how well they perform the tasks assigned to them.[23] Staff generally work independently with no focus on cooperation among employees or commitment to the organization.[24]

Transformational leadership involves leaders motivating followers to perform beyond expectations by creating a sense of ownership in reaching a shared vision.[25] It is characterized by a leader's charismatic influence over team members and includes effective communication, valued relationships, and consideration of team member input. Transformational leaders know how to convey a sense of loyalty through shared goals, resulting in increased productivity, improved morale, and increased employees' job satisfaction.[26]

22. Specchia, M. L., Cozzolino, M. R., Carini, E., Di Pilla, A., Galletti, C., Ricciardi, W., & Damiani, G. (2021). Leadership styles and nurses' job satisfaction. Results of a systematic review. *International Journal of Environmental Research and Public Health, 18*(4), 1552. https://doi.org/10.3390/ijerph18041552

23. Northouse, P. (2004). *Leadership: Theory and practice* (9th ed.). Sage Publications.

24. Specchia, M. L., Cozzolino, M. R., Carini, E., Di Pilla, A., Galletti, C., Ricciardi, W., & Damiani, G. (2021). Leadership styles and nurses' job satisfaction. Results of a systematic review. *International Journal of Environmental Research and Public Health, 18*(4), 1552. https://doi.org/10.3390/ijerph18041552

25. Northouse, P. (2004). *Leadership: Theory and practice* (9th ed.). Sage Publications.

26. Specchia, M. L., Cozzolino, M. R., Carini, E., Di Pilla, A., Galletti, C., Ricciardi, W., &

They often motivate others to do more than originally intended by inspiring them to look past individual self-interest and perform to promote team and organizational interests.[27]

Servant leadership focuses on the professional growth of employees while simultaneously promoting improved quality care through a combination of interprofessional teamwork and shared decision-making. Servant leaders assist team members to achieve their personal goals by listening with empathy and committing to individual growth and community-building. They share power, put the needs of others first, and help individuals optimize performance while forsaking their own personal advancement and rewards.[28]

> Visit the Greenleaf Center site to learn more about What is Servant Leadership?

Resonant leaders are in tune with the emotions of those around them, use empathy, and manage their own emotions effectively. Resonant leaders build strong, trusting relationships and create a climate of optimism that inspires

Damiani, G. (2021). Leadership styles and nurses' job satisfaction. Results of a systematic review. *International Journal of Environmental Research and Public Health, 18*(4), 1552. https://doi.org/10.3390/ijerph18041552

27. Specchia, M. L., Cozzolino, M. R., Carini, E., Di Pilla, A., Galletti, C., Ricciardi, W., & Damiani, G. (2021). Leadership styles and nurses' job satisfaction. Results of a systematic review. *International Journal of Environmental Research and Public Health, 18*(4), 1552. https://doi.org/10.3390/ijerph18041552

28. Specchia, M. L., Cozzolino, M. R., Carini, E., Di Pilla, A., Galletti, C., Ricciardi, W., & Damiani, G. (2021). Leadership styles and nurses' job satisfaction. Results of a systematic review. *International Journal of Environmental Research and Public Health, 18*(4), 1552. https://doi.org/10.3390/ijerph18041552

commitment even in the face of adversity. They create an environment where employees are highly engaged, making them willing and able to contribute with their full potential.[29]

Authentic leaders have an honest and direct approach with employees, demonstrating self-awareness, internalized moral perspective, and relationship transparency. They strive for trusting, symmetrical, and close leader–follower relationships; promote the open sharing of information; and consider others' viewpoints.[30]

Table 4.2b. Characteristics of Leadership Styles

Authoritarian	Democratic	Laissez-Faire or Passive-Avoidant
• Demonstrate centralized decision-making • Use power to control others • Motivate through fear or reward • Disregard needs of group members	• Demonstrate participatory decision-making • Display multidirectional communication • Build close, personal relationships • Encourage goal attainment	• Demonstrate passive, permissive, or absent decision-making

29. Specchia, M. L., Cozzolino, M. R., Carini, E., Di Pilla, A., Galletti, C., Ricciardi, W., & Damiani, G. (2021). Leadership styles and nurses' job satisfaction. Results of a systematic review. *International Journal of Environmental Research and Public Health, 18*(4), 1552. https://doi.org/10.3390/ijerph18041552

30. Specchia, M. L., Cozzolino, M. R., Carini, E., Di Pilla, A., Galletti, C., Ricciardi, W., & Damiani, G. (2021). Leadership styles and nurses' job satisfaction. Results of a systematic review. *International Journal of Environmental Research and Public Health, 18*(4), 1552. https://doi.org/10.3390/ijerph18041552

Transactional	Transformational	Servant
• Promote both parties receiving something for efforts • Motivate with external rewards • Reward good performance and penalize low performance • Do not focus on team cooperation or commitment to the organization	• Create ownership with shared, inspiring vision • Demonstrate effective communication • Value relationships • Consider individuals' needs and abilities	• Focus on growth and well-being of team members • Share in decision-making • Develop team members to their highest potential

Resonant Leaders	Authentic Leaders
• Build strong, trusting relationships • Tune into the emotions of those around them, use empathy, and manage their own emotions effectively • Create a climate of optimism	• Use an honest and direct approach • Develop close leader–follower relationships • Promote the open sharing of information • Consider others' viewpoints

Outcomes of Various Leadership Styles

Leadership styles affect team members, client outcomes, and the organization. A systematic review of the literature published in 2021 showed significant correlations between leadership styles and nurses' job satisfaction. Transformational leadership style had the greatest positive correlation with nurses' job satisfaction, followed by authentic, resonant, and servant leadership styles. Passive-avoidant and laissez-faire leadership styles showed a negative correlation with nurses' job satisfaction.[31] In this challenging health

31. Specchia, M. L., Cozzolino, M. R., Carini, E., Di Pilla, A., Galletti, C., Ricciardi, W., & Damiani, G. (2021). Leadership styles and nurses' job satisfaction. Results of a

care environment, managers and nurse leaders must promote technical and professional competencies of their staff, but they must also act to improve staff satisfaction and morale by using appropriate leadership styles with their team.[32]

Systems Theory

Systems theory is based on the concept that systems do not function in isolation but rather there is an interdependence that exists between their parts. Systems theory assumes that most individuals strive to do good work but are affected by diverse influences within the system. Efficient and functional systems account for these diverse influences and improve outcomes by studying patterns and behaviors across the system.[33]

Many health care agencies have adopted a culture of safety based on systems theory. A **culture of safety** is an organizational culture that embraces error reporting by employees with the goal of identifying systemic causes of problems that can be addressed to improve client safety. According to The Joint Commission, a culture of safety includes the following components[34]:

systematic review. *International Journal of Environmental Research and Public Health, 18*(4), 1552. https://doi.org/10.3390/ijerph18041552

32. Specchia, M. L., Cozzolino, M. R., Carini, E., Di Pilla, A., Galletti, C., Ricciardi, W., & Damiani, G. (2021). Leadership styles and nurses' job satisfaction. Results of a systematic review. *International Journal of Environmental Research and Public Health, 18*(4), 1552. https://doi.org/10.3390/ijerph18041552

33. Anderson, B. R. (2016). Improving health care by embracing systems theory. *The Journal of Thoracic and Cardiovascular Surgery, 152*(2), 593-594. https://www.jtcvs.org/article/S0022-5223(16)30001-0/pdf

34. The Joint Commission. (2017). The essential role of leadership in developing a safety culture. *Sentinel Event Alert*, Issue 57.

- **Just Culture:** A culture where people feel safe raising questions and concerns and report safety events in an environment that emphasizes a nonpunitive response to errors and near misses. Clear lines are drawn by managers between human error, at-risk, and reckless employee behaviors. See Figure 4.4[35] for an illustration of Just Culture.
- **Reporting Culture:** People realize errors are inevitable and are encouraged to speak up for client safety by reporting errors and near misses. For example, nurses complete an "incident report" according to agency policy when a medication error occurs, or a client falls. Error reporting helps the agency manage risk and reduce potential liability.
- **Learning Culture:** People regularly collect information and learn from errors and successes while openly sharing data and information and applying best evidence to improve work processes and client outcomes.

Just Culture

The American Nurses Association (ANA) officially endorses the Just Culture model. In 2019 the ANA published a position statement on Just Culture, stating, "Traditionally, healthcare's culture has held individuals accountable for all errors or mishaps that befall clients under their care. By contrast, a Just Culture recognizes that individual practitioners should not be held accountable for system failings over which they have no control. A Just Culture also recognizes many individual or 'active' errors represent predictable interactions between human operators and the systems in which they work. However, in contrast to a culture that touts 'no blame' as its governing principle, a Just Culture does not tolerate conscious disregard of clear risks to clients or gross misconduct (e.g., falsifying a record or performing professional duties while intoxicated)."

https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/sentinel-event/sea_57_safety_culture_leadership_0317pdf.pdf

35. "Just Culture Infographic.png" by Valeria Palarski 2020. Used with permission.

The Just Culture model categorizes human behavior into three causes of errors. Consequences of errors are based on whether the error is a simple human error or caused by at-risk or reckless behavior.

- **Simple human error:** A simple human error occurs when an individual inadvertently does something other than what should have been done. Most medical errors are the result of human error due to poor processes, programs, education, environmental issues, or situations. These errors are managed by correcting the cause, looking at the process, and fixing the deviation. For example, a nurse appropriately checks the rights of medication administration three times, but due to the similar appearance and names of two different medications stored next to each other in the medication dispensing system, administers the incorrect medication to a client. In this example, a root cause analysis reveals a system issue that must be modified to prevent future client errors (e.g., change the labelling and storage of look alike-sound alike medication).
- **At-risk behavior:** An error due to at-risk behavior occurs when a behavioral choice is made that increases risk where the risk is not recognized or is mistakenly believed to be justified. For example, a nurse scans a client's medication with a barcode scanner prior to administration, but an error message appears on the scanner. The nurse mistakenly interprets the error to be a technology problem and proceeds to administer the medication instead of stopping the process and further investigating the error message, resulting in the wrong dosage of a medication being administered to the client. In this case, ignoring the error message on the scanner can be considered "at-risk behavior" because the behavioral choice was considered justified by the nurse at the time.
- **Reckless behavior:** Reckless behavior is an error that occurs when an action is taken with conscious disregard for a substantial and unjustifiable risk.[36] For example, a nurse arrives at work intoxicated and

36. American Nursing Association. (2010). *Position statement: Just culture*.

administers the wrong medication to the wrong client. This error is considered due to reckless behavior because the decision to arrive intoxicated was made with conscious disregard for substantial risk.

These examples show three different causes of medication errors that would result in different consequences to the employee based on the Just Culture model. Under the Just Culture model, after root cause analysis is completed, system-wide changes are made to decrease factors that contributed to the error. Managers appropriately hold individuals accountable for errors if they were due to simple human error, at-risk behavior, or reckless behaviors.

If an individual commits a simple human error, managers console the individual and consider changes in training, procedures, and processes. In the "simple human error" above, system-wide changes would be made to change the label and location of the medication to prevent future errors from occurring with the same medication.

Individuals committing at-risk behavior are held accountable for their behavioral choice and often require coaching with incentives for less risky behaviors and situational awareness. In the "at-risk behavior" example above where the nurse ignored an error message on the barcode scanner, mandatory training on using a barcode scanner and responding to errors would be implemented, and the manager would track the employee's correct usage of the barcode scanner for several months following training.

If an individual demonstrates reckless behavior, remedial action and/or punitive action is taken.[37] In the "reckless behavior" example above, the

https://www.nursingworld.org/~4afe07/globalassets/practiceandpolicy/health-and-safety/just_culture.pdf

37. American Nursing Association. (2010). *Position statement: Just culture*. https://www.nursingworld.org/~4afe07/globalassets/practiceandpolicy/health-and-safety/just_culture.pdf

manager would report the nurse's behavior to the state's Board of Nursing with mandatory substance abuse counseling to maintain their nursing license. Employment may be terminated with consideration of patterns of behavior.

A Just Culture in which employees aren't afraid to report errors is a highly successful way to enhance client safety, increase staff and client satisfaction, and improve outcomes. Success is achieved through good communication, effective management of resources, and an openness to changing processes to ensure the safety of clients and employees. The infographic in Figure 4.4[38] illustrates the components of a culture of safety and Just Culture.

38. "Just Culture Infographic.png" by Valeria Palarski 2020. Used with permission.

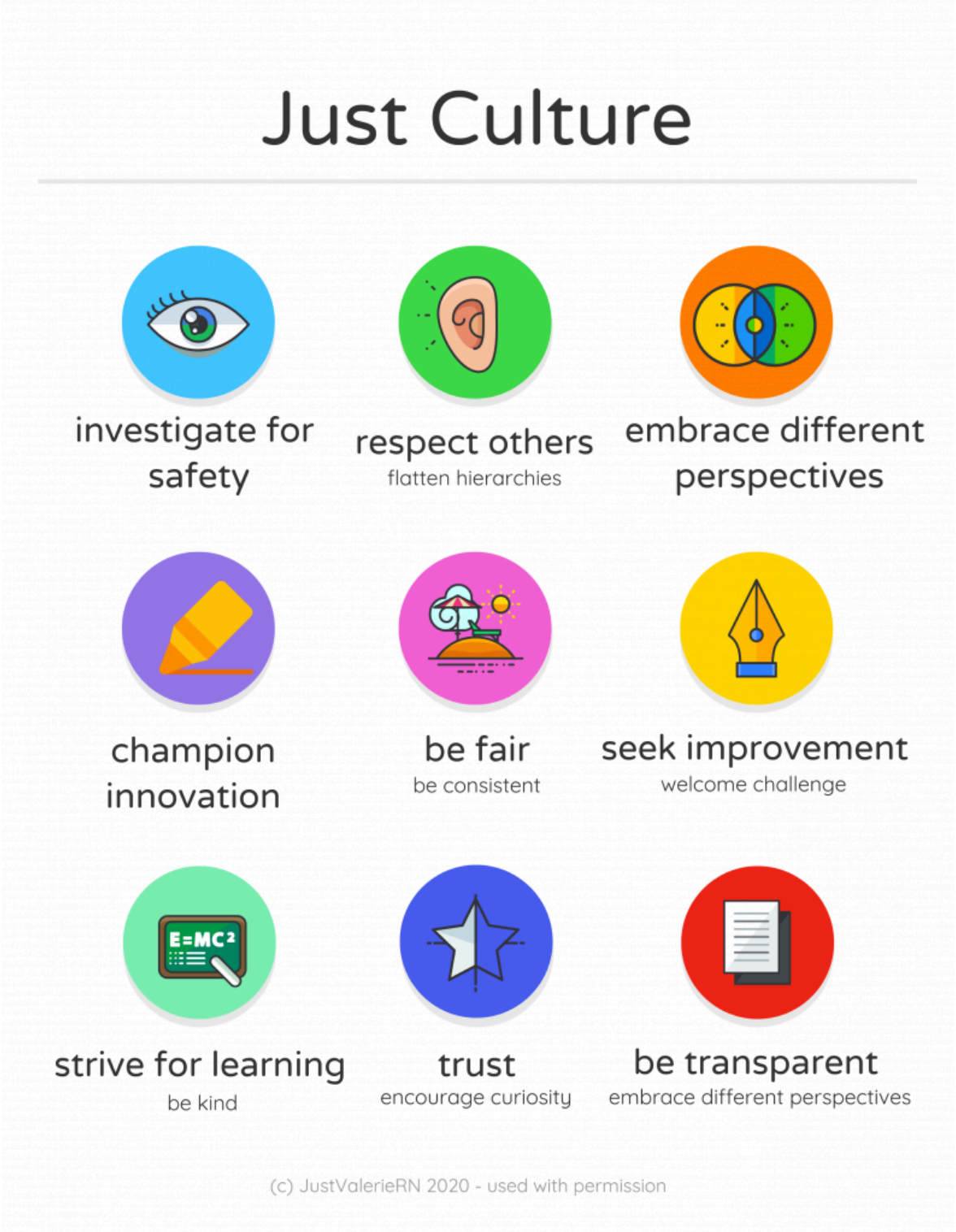

Figure 4.4 Just Culture. Used with permission.

The principles of culture of safety, including Just Culture, Reporting Culture, and Learning Culture are also being adopted in nursing education. It's understood that mistakes are part of learning and that a shared accountability model promotes individual- and system-level learning for

improved client safety. Under a shared accountability model, students are responsible for the following[39]:

- Being fully prepared for clinical experiences, including laboratory and simulation assignments
- Being rested and mentally ready for a challenging learning environment
- Accepting accountability for their part in contributing to a safe learning environment
- Behaving professionally
- Reporting their own errors and near mistakes
- Keeping up-to-date with current evidence-based practice
- Adhering to ethical and legal standards

Students know they will be held accountable for their actions but will not be blamed for system faults that lie beyond their control. They can trust that a fair process will be used to determine what went wrong if a client care error or near miss occurs. Student errors and near misses are addressed based on an investigation determining if it was simple human error, an at-risk behavior, or reckless behavior. For example, a simple human error by a student can be addressed with coaching and additional learning opportunities to remedy the knowledge deficit. However, if a student acts with recklessness (for example, repeatedly arrives to clinical unprepared despite previous faculty feedback or falsely documents an assessment or procedure), they are appropriately and fairly disciplined, which may include dismissal from the program.[40]

39. Barnsteiner, J., & Disch, J. (2017). Creating a fair and just culture in schools of nursing. *American Journal of Nursing, 117*(11), 42-48. https;//doi.org/10.1097/01.NAJ.0000526747.84173.97.

40. Barnsteiner, J., & Disch, J. (2017). Creating a fair and just culture in schools of nursing. *American Journal of Nursing, 117*(11), 42-48. https://doi.org/ 10.1097/01.NAJ.0000526747.84173.97.

See Table 4.2c describing classifications of errors using the Just Culture model.

Table 4.2c. Classification of Errors Using the Just Culture Model

Human Error	**At-Risk Behavior**	**Reckless Behavior**
The caregiver made an error while working appropriately and focusing on the client's best interests.	The caregiver made a potentially unsafe choice resulting from faulty or self-serving decision-making.	The caregiver knowingly violated a rule and/or made a dangerous or unsafe choice.
Investigation reveals system factors contributing to similar errors by others with similar knowledge and skills.	Investigation reveals the system supports risky action and the caregiver requires coaching.	Investigation reveals the caregiver is accountable and needs retraining.
Manage by fixing system errors in processes, procedures, training, design, or environment.	Manage by coaching the caregiver and fixing any system issues: • Remove incentives for at-risk behaviors • Create incentives for safe behaviors • Increase situational awareness	Manage by disciplining the caregiver. If the system supports reckless behavior, it requires fixing.
CONSOLE	COACH	PUNISH

Systems leadership refers to a set of skills used to catalyze, enable, and support the process of systems-level change that is encouraged by the Just Culture Model. Systems leadership is comprised of three interconnected elements:[41]

41. Dreier, L., Nabarro, D., & Nelson, J. (2019). *Systems leadership for sustainable development: Strategies for achieving system change*. CR Initiative at Harvard Kennedy School. https://www.hks.harvard.edu/sites/default/files/centers/mrcbg/files/Systems%20Leadership.pdf

- **The Individual:** The skills of collaborative leadership to enable learning, trust-building, and empowered action among stakeholders who share a common goal
- **The Community:** The tactics of coalition building and advocacy to develop alignment and mobilize action among stakeholders in the system, both within and between organizations
- **The System:** An understanding of the complex systems shaping the challenge to be addressed

Just Culture Cases

Review the following case descriptions. Identify the classification of error that has occurred and the recommended actions that should occur.

A chief nursing officer receives a daily report of organization incident reports and reviews the following incident:

Incident Description

Client Mr. Joe Doden, Room 13067, Medical-Surgical floor

On the afternoon of May 15, 2024, Nurse Sarah was responsible for administering Mr. Joe Doden's insulin dose. The insulin vials used by the hospital had recently been redesigned by the manufacturer, which led to changes in the labeling. The client was scheduled to receive ten units of regular insulin at 14:30. However, at 1450 the client turns on his call light, reports feeling unwell. He is shaky, confused, and sweating profusely. The client's glucose is checked, and he is found to be hypoglycemic. He is treated based upon the hypoglycemia protocol and recovers without further complication.

Case Investigation A

Action: Sarah RN who administered the insulin was following the protocol but mistakenly read the dosage due to a poorly designed label on the insulin vial. The nurse was focused on the clients best interests and followed all required steps.

Findings: The investigation revealed that the labeling on the insulin vials was confusing and had led to similar errors by other nurses in the past. The system's design flaw contributed significantly to the error.

Question A: How would you classify this error? What actions should be taken?

Case Investigation B

Action: Sarah RN, due to time pressure and a high client load, decided to skip the double-check protocol for administering the same insulin dose, believing it would save time without causing harm.

Findings: The investigation revealed that the hospital's workload and time pressures often led to shortcuts in following safety protocols.

Question B: How would you classify this error? What actions should be taken?

Case Investigation C

Action: Sarah RN, is familiar with the protocol and knowingly bypassed the double check system, dismissing its importance and administering a medication dose on her own.

Findings: The investigation found that the nurse had a history of disregarding safety protocols, showing a pattern of reckless behavior. This behavior was not supported by the hospital's policies or environment.

Question C: How would you classify this error? What actions should be taken?

4.3 Implementing Change

Change is constant in the health care environment. **Change** is defined as the process of altering or replacing existing knowledge, skills, attitudes, systems, policies, or procedures.[1] The outcomes of change must be consistent with an organization's mission, vision, and values. Although change is a dynamic process that requires alterations in behavior and can cause conflict and resistance, change can also stimulate positive behaviors and attitudes and improve organizational outcomes and employee performance. Change can result from identified problems or from the incorporation of new knowledge, technology, management, or leadership. Problems may be identified from many sources, such as quality improvement initiatives, employee performance evaluations, or accreditation survey results.[2]

Nurse managers must deal with the fears and concerns triggered by change. They should recognize that change may not be easy and may be met with enthusiasm by some and resistance by others. Leaders should identify individuals who will be enthusiastic about the change (referred to as "early adopters"), as well as those who will be resisters (referred to as "laggers"). Early adopters should be involved to build momentum, and the concerns of resisters should be considered to identify barriers. Data should be collected, analyzed, and communicated so the need for change (and its projected consequences) can be clearly articulated. Managers should articulate the reasons for change, the way(s) the change will affect employees, the way(s)

1. Ana, B. H., & Hendricks-Jackson, L. (2017). *Nursing professional development review and resource manual* (4th ed.). American Nurses Association, Nursing Knowledge Center. https://www.nursingworld.org/~49379b/globalassets/catalog/sample-chapters/npdsamplechapter.pdf
2. Ana, B. H., & Hendricks-Jackson, L. (2017). *Nursing professional development review and resource manual* (4th ed.). American Nurses Association, Nursing Knowledge Center. https://www.nursingworld.org/~49379b/globalassets/catalog/sample-chapters/npdsamplechapter.pdf

the change will benefit the organization, and the desired outcomes of the change process.[3] See Figure 4.5[4] for an illustration of communicating upcoming change.

Figure 4.5 Identifying Upcoming Change

Change Theories

There are several change theories that nurse leaders may adopt when implementing change. Two traditional change theories are known as Lewin's Unfreeze-Change-Refreeze Model and Lippitt's Seven-Step Change Theory.[5]

3. Ana, B. H., & Hendricks-Jackson, L. (2017). *Nursing professional development review and resource manual* (4th ed.). American Nurses Association, Nursing Knowledge Center. https://www.nursingworld.org/~49379b/globalassets/catalog/sample-chapters/npdsamplechapter.pdf

4. "Change-1080×675.jpg" by Amman Wahab Nizamani is licensed under CC BY-SA 4.0

5. Ana, B. H., & Hendricks-Jackson, L. (2017). *Nursing professional development review and resource manual* (4th ed.). American Nurses Association, Nursing Knowledge Center. https://www.nursingworld.org/~49379b/globalassets/catalog/sample-chapters/npdsamplechapter.pdf

Lewin's Change Model

Kurt Lewin, the father of social psychology, introduced the classic three-step model of change known as Unfreeze-Change-Refreeze Model that requires prior learning to be rejected and replaced. Lewin's model has three major concepts: driving forces, restraining forces, and equilibrium. Driving forces are those that push in a direction and cause change to occur. They facilitate change because they push the person in a desired direction. They cause a shift in the equilibrium towards change. Restraining forces are those forces that counter the driving forces. They hinder change because they push the person in the opposite direction. They cause a shift in the equilibrium that opposes change. Equilibrium is a state of being where driving forces equal restraining forces, and no change occurs. It can be raised or lowered by changes that occur between the driving and restraining forces.[6,7]

- **Step 1: Unfreeze the status quo.** Unfreezing is the process of altering behavior to agitate the equilibrium of the current state. This step is necessary if resistance is to be overcome and conformity achieved. Unfreezing can be achieved by increasing the driving forces that direct behavior away from the existing situation or status quo while decreasing the restraining forces that negatively affect the movement from the existing equilibrium. Nurse leaders can initiate activities that can assist in the unfreezing step, such as motivating participants by preparing them for change, building trust and recognition for the need to change, and encouraging active participation in recognizing problems and brainstorming solutions within a group.[8]

6. Ana, B. H., & Hendricks-Jackson, L. (2017). *Nursing professional development review and resource manual* (4th ed.). American Nurses Association, Nursing Knowledge Center. https://www.nursingworld.org/~49379b/globalassets/catalog/sample-chapters/npdsamplechapter.pdf

7. Nursing Theory. (2023). *Lewin's change theory.* https://nursing-theory.org/theories-and-models/lewin-change-theory.php

- **Step 2: Change.** Change is the process of moving to a new equilibrium. Nurse leaders can implement actions that assist in movement to a new equilibrium by persuading employees to agree that the status quo is not beneficial to them; encouraging them to view the problem from a fresh perspective; working together to search for new, relevant information; and connecting the views of the group to well-respected, powerful leaders who also support the change.[9]
- **Step 3: Refreeze.** Refreezing refers to attaining equilibrium with the newly desired behaviors. This step must take place after the change has been implemented for it to be sustained over time. If this step does not occur, it is very likely the change will be short-lived and employees will revert to the old equilibrium. Refreezing integrates new values into community values and traditions. Nursing leaders can reinforce new patterns of behavior and institutionalize them by adopting new policies and procedures.[10]

Example Using Lewin's Change Theory

A new nurse working in a rural medical-surgical unit identifies

8. Kritsonis, A. (2005). Comparison of change theories. *International Journal of Scholarly Academic Intellectual Diversity, 8*(1). https://globalioc.com/wp-content/uploads/2018/09/Kritsonis-Alicia-Comparison-of-Change-Theories.pdf
9. Kritsonis, A. (2005). Comparison of change theories. *International Journal of Scholarly Academic Intellectual Diversity, 8*(1). https://globalioc.com/wp-content/uploads/2018/09/Kritsonis-Alicia-Comparison-of-Change-Theories.pdf
10. Kritsonis, A. (2005). Comparison of change theories. *International Journal of Scholarly Academic Intellectual Diversity, 8*(1). https://globalioc.com/wp-content/uploads/2018/09/Kritsonis-Alicia-Comparison-of-Change-Theories.pdf

that bedside handoff reports are not currently being used during shift reports.

Step 1: Unfreeze: The new nurse recognizes a change is needed for improved client safety and discusses the concern with the nurse manager. Current evidence-based practice is shared regarding bedside handoff reports between shifts for client safety.[11] The nurse manager initiates activities such as scheduling unit meetings to discuss evidence-based practice and the need to incorporate bedside handoff reports.

Step 2: Change: The nurse manager gains support from the director of nursing to implement organizational change and plans staff education about bedside report checklists and the manner in which they are performed.

Step 3: Refreeze: The nurse manager adopts bedside handoff reports in a new unit policy and monitors staff for effectiveness.

Lippitt's Seven-Step Change Theory

Lippitt's Seven-Step Change Theory expands on Lewin's change theory by focusing on the role of the change agent. A **change agent** is anyone who has the skill and power to stimulate, facilitate, and coordinate the change effort. Change agents can be internal, such as nurse managers or employees appointed to oversee the change process, or external, such as an outside consulting firm. External change agents are not bound by organizational

11. Agency for Healthcare Research and Quality. (2010). *Bedside shift report checklist*. https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/engagingfamilies/strategy3/Strat3_Tool_2_Nurse_Chklst_508.pdf

culture, politics, or traditions, so they bring a different perspective to the situation and challenge the status quo. However, this can also be a disadvantage because external change agents lack an understanding of the agency's history, operating procedures, and personnel.[12] The seven-step model includes the following steps[13]:

- **Step 1: Diagnose the problem.** Examine possible consequences, determine who will be affected by the change, identify essential management personnel who will be responsible for fixing the problem, collect data from those who will be affected by the change, and ensure those affected by the change will be committed to its success.
- **Step 2: Evaluate motivation and capability for change.** Identify financial and human resources capacity and organizational structure.
- **Step 3: Assess the change agent's motivation and resources, experience, stamina, and dedication.**
- **Step 4: Select progressive change objectives.** Define the change process and develop action plans and accompanying strategies.
- **Step 5: Explain the role of the change agent to all employees and ensure the expectations are clear.**
- **Step 6: Maintain change.** Facilitate feedback, enhance communication, and coordinate the effects of change.
- **Step 7: Gradually terminate the helping relationship of the change**

12. Lunenburg, F. C. (2010). Managing change: The role of the change agent. *International Journal of Management, Business, and Administration, 13*(1). https://naaee.org/sites/default/files/lunenburg_fred_c._managing_change_the_role_of_change_agent_ijmba_v13_n1_2010.pdf

13. Ana, B. H., & Hendricks-Jackson, L. (2017). *Nursing professional development review and resource manual* (4th ed.). American Nurses Association, Nursing Knowledge Center. https://www.nursingworld.org/~49379b/globalassets/catalog/sample-chapters/npdsamplechapter.pdf

agent.

Example Using Lippitt's Seven-Step Change Theory

Refer to the previous example of using Lewin's change theory on a medical-surgical unit to implement bedside handoff reporting. The nurse manager expands on the Unfreeze-Change-Refreeze Model by implementing additional steps based on Lippitt's Seven-Step Change Theory:

- The nurse manager collects data from team members affected by the changes and ensures their commitment to success.
- Early adopters are identified as change agents on the unit who are committed to improving client safety by implementing evidence-based practices such as bedside handoff reporting.
- Action plans (including staff education and mentoring), timelines, and expectations are clearly communicated to team members as progressive change objectives. Early adopters are trained as "super-users" to provide staff education and mentor other nurses in using bedside handoff checklists across all shifts.
- The nurse manager facilitates feedback and encourages two-way communication about challenges as change is implemented on the unit. Positive reinforcement is provided as team members effectively incorporate change.
- Bedside handoff reporting is implemented as a unit policy, and all team members are held accountable for performing accurate bedside handoff reporting.

Read more about additional change theories in the Current Theories of Change Management pdf.

Change Management

Change management is the process of making changes in a deliberate, planned, and systematic manner.[14] It is important for nurse leaders and nurse managers to remember a few key points about change management[15]:

- Employees will react differently to change, no matter how important or advantageous the change is purported to be. Recognizing this variability is crucial for effectively managing the transition process.
- Basic needs will influence reaction to change, such as the need to be part of the change process, the need to be able to express oneself openly and honestly, and the need to feel that one has some control over the impact of change. Ensuring these needs are met can significantly reduce resistance.
- Change often results in a feeling of loss due to changes in established routines. Employees may react with shock, anger, and resistance, but ideally will eventually accept and adopt change. Acknowledging these feelings and providing support can facilitate smoother transitions.

14. Ana, B. H., & Hendricks-Jackson, L. (2017). *Nursing professional development review and resource manual* (4th ed.). American Nurses Association, Nursing Knowledge Center. https://www.nursingworld.org/~49379b/globalassets/catalog/sample-chapters/npdsamplechapter.pdf

15. Ana, B. H., & Hendricks-Jackson, L. (2017). *Nursing professional development review and resource manual* (4th ed.). American Nurses Association, Nursing Knowledge Center. https://www.nursingworld.org/~49379b/globalassets/catalog/sample-chapters/npdsamplechapter.pdf

- Change must be managed realistically, without false hopes and expectations, yet with enthusiasm for the future. Employees should be provided information honestly and allowed to ask questions and express concerns. This transparency builds trust and helps in aligning everyone towards common goals.

Strategies for Effective Change Management

- **Engage Stakeholders Early:** Involve key stakeholders in the planning stages of the change process. Their input can provide valuable insights and help in identifying potential challenges early on.
- **Communicate Clearly and Frequently:** Clear and frequent communication is essential. Use multiple channels to disseminate information and ensure that the message is consistent and comprehensible to all staff members.
- **Provide Training and Resources:** Equip employees with the necessary skills and resources to adapt to the change. This might include training sessions, informational materials, or access to support personnel.
- **Build a Supportive Culture:** Create an environment where change is viewed positively. Encourage collaboration and create opportunities for employees to share their experiences and strategies for adapting to change.
- **Monitor and Adjust:** Continuously monitor the progress of the change initiative and be prepared to make adjustments as needed. Solicit feedback from employees and be responsive to their concerns.

There are multiple strategies that can employed to overcome resistance to change. First, it is important to understand the underlying reasons for resistance. Resistance is commonly aligned to feelings of fear, lack of trust in

leadership, or logistical concerns regarding workload, seniority, etc. To implement change effectively, a leader should empower staff by making sure they feel that their voice is respected and valued. When individuals feel valued and hear, they are more likely to support change, even if they do not personally agree with all elements associated with the change. Leaders also must understand that change is stressful for individuals. Depending on the significance of change, a leader may take actions to ensure that employee assistance programs, support groups, or additional counseling services or resources are available. These additional resources can be beneficial for individuals as they work through the emotions associated with the proposed change. Additionally, the benefits for any change should be clearly described. It is important to highlight how the proposed change will help improve work processes and client care quality. It is also helpful to acknowledge and demonstrate appreciation for early adopters of the change. This can provide motivation and encouragement for others to follow suit and fosters a positive attitude toward future changes.

4.4 Spotlight Application

Jamie has recently completed his orientation to the emergency department at a busy Level 1 trauma center. The environment is fast-paced, and there are typically a multitude of clients who require care. Jamie appreciates his colleagues and the collaboration that is reflected among members of the health care team, especially in times of stress. Jamie is providing care for an 8-year-old client who has broken her arm when there is a call that there are three Level 1 trauma clients approximately five minutes from the ER. The trauma surgeon reports to the ER, and multiple members of the trauma team report to the ER intake bays. If you were Jamie, what leadership style would you hope the trauma surgeon uses with the team?

In a stressful clinical care situation, where rapid action and direction are needed, an autocratic leadership style is most effective. There is no time for debating different approaches to care in a situation where immediate intervention may be required. Concise commands, direction, and responsive action from the team are needed to ensure that client care interventions are delivered quickly to enhance chance of survival and recovery.

Learning Activities

(Answers to "Learning Activities" can be found in the "Answer Key" at the end of the book. Answers to interactive activities are provided as immediate feedback.)

Sample Scenario

An 89-year-old female resident with Alzheimer's disease has been living at the nursing home for many years. The family decides they no longer want aggressive measures taken and request to the RN on duty that the resident's code status be changed to Do Not Resuscitate (DNR). The evening shift RN documents a progress note that the family (and designated health care agent) requested that the resident's status be made DNR. Due to numerous other responsibilities and needs during the evening shift, the RN does not notify the attending physician or relay the information during shift change or on the 24-hour report. The day shift RN does not read the night shift's notes because of several immediate urgent situations. The family, who had been keeping vigil at the resident's bedside throughout the night, leaves to go home to shower and eat. Upon return the next morning, they find the room full of staff and discover the staff performed CPR after their loved one coded. The resident was successfully resuscitated but now lies in a vegetative state. The family is unhappy and is considering legal action. They approach you, the current nurse assigned to the resident's care, and state, "We followed your procedures to make

sure this would not happen! Why was this not managed as we discussed?"[1]

Reflective Questions

1. As the current nurse providing client care, explain how you would therapeutically address this family's concerns and use one or more leadership styles.
2. As the charge nurse, explain how you would address the staff involved using one or more leadership styles.
3. Explain how change theory can be implemented to ensure this type of situation does not recur.

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingmpc/?p=1005#h5p-23

An interactive H5P element has been excluded from this version of the text. You can view it

1. Agency for Healthcare Research and Quality. (2023). *TeamSTEPPS long term care specialty scenarios.* https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/education/curriculum-tools/teamstepps/longtermcare/scenarios/scenarios.pdf

online here:
https://wtcs.pressbooks.pub/nursingmpc/?p=1005#h5p-24

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingmpc/?p=1005#h5p-25

Test your knowledge using this NCLEX Next Generation-style Case Study. You may reset and resubmit your answers to this question an unlimited number of times.[2]

2. "Chapter 4, Assignment 1" by Travis Christman for OpenRN is licensed under CC BY-NC 4.0

IV Glossary

Change: The process of altering or replacing existing knowledge, skills, attitudes, systems, policies, or procedures.[1]

Change agent: Anyone who has the skill and power to stimulate, facilitate, and coordinate the change effort.

Change management: Process of making changes in a deliberate, planned, and systematic manner.

Core values: The foundational ideals that guide the organization's actions and decision-making processes.

Culture of safety: Organizational culture that embraces error reporting by employees with the goal of identifying systemic causes of problems that can be addressed to improve client safety. Just Culture is a component of a culture of safety.

Followership: The upward influence of individuals on their leaders and their teams.

Just Culture: A culture where people feel safe raising questions and concerns and report safety events in an environment that emphasizes a nonpunitive response to errors and near misses. Clear lines are drawn between human error, at-risk, and reckless employee behaviors.

Leadership: The art of establishing direction and influencing and motivating

1. Ana, B. H., & Hendricks-Jackson, L. (2017). *Nursing professional development review and resource manual* (4th ed.). American Nurses Association, Nursing Knowledge Center. https://www.nursingworld.org/~49379b/globalassets/catalog/sample-chapters/npdsamplechapter.pdf

others to achieve their maximum potential to accomplish tasks, objectives, or projects.[2,3]

Management: Roles that focus on tasks such as planning, organizing, prioritizing, budgeting, staffing, coordinating, and reporting.[4]

Mission statement: An organization's statement that describes how the organization will fulfill its vision and establishes a common course of action for future endeavors.

Organizational culture: The implicit values and beliefs that reflect the norms and traditions of an organization. An organization's vision, mission, and values statements are the foundation of organizational culture.

Systems leadership: A set of skills used to catalyze, enable, and support the process of systems-level change that focuses on the individual, the community, and the system.

Systems theory: The concept that systems do not function in isolation but rather there is an interdependence that exists between their parts. Systems theory assumes that most individuals strive to do good work, but are affected by diverse influences within the system.

Values statement: The organization's established values that support its

2. Northouse, P. (2004). *Leadership: Theory and practice* (9th ed.). Sage Publications.

3. Specchia, M. L., Cozzolino, M. R., Carini, E., Di Pilla, A., Galletti, C., Ricciardi, W., & Damiani, G. (2021). Leadership styles and nurses' job satisfaction. Results of a systematic review. *International Journal of Environmental Research and Public Health, 18*(4), 1552. https://doi.org/10.3390/ijerph18041552

4. Hannaway, J. (1989). *Managers managing: The workings of an administrative system*. Oxford University Press, p. 39.

vision and mission and provide strategic guidelines for decision-making, both internally and externally, by members of the organization.

Vision statement: An organization's statement that defines why the organization exists, describes how the organization is unique and different from similar organizations, and specifies what the organization is striving to be.

PART V

CHAPTER 5 - LEGAL IMPLICATIONS

5.1 Legal Implications Introduction

Learning Objectives

- Examine competent practice within the legal framework of health care
- Analyze legal dilemmas of nursing practice utilizing professional and industry standards
- Examine how negligence and malpractice apply to nursing practice
- Practice within the legal framework of the Nurse Practice Act
- Examine the role of the nurse when observing illegal and/or unsafe practices

Nurses are responsible for being aware of the laws and regulations affecting their nursing care in the state(s) in which they are practicing. If allegations are made regarding a nurse's professional conduct or provision of client care, the excuse "I did not know" does not hold up in a court of law or with a state's Board of Nursing. This chapter will provide foundational legal knowledge for nursing practice in complex health care environments.

Understanding the Legal System

There are several types of laws and regulations that affect nursing practice. **Laws** are rules and regulations created by a society and enforced by courts and professional licensure boards. Nurses are responsible for being aware of public and private laws that affect client care, as well as legal actions that can result when these laws are broken.

Laws are generally classified as public or private law. **Public law** regulates relations of individuals with the government or institutions, whereas **private law** governs the relationships between private parties.

Public Law

There are several types of public law, including constitutional, statutory, administrative, and criminal law.

- **Constitutional law** refers to the rights, privileges, and responsibilities established by the U.S. Constitution.[1] The right to privacy is an example of a client right based on constitutional law.
- **Statutory law** refers to written laws enacted by the federal or state legislature. For example, the Nurse Practice Act in each state is an example of statutory law enacted by that state's legislature. The Health Insurance Portability and Accountability Act (HIPAA) is an example of a federal statutory law. HIPAA required the creation of national standards to protect sensitive client health information from being disclosed without the client's consent or knowledge.
- **Administrative law** is law created by government agencies that have been granted the authority to establish rules and regulations to protect

1. Legal Information Institute. (n.d.) Cornell Law School. https://www.law.cornell.edu

the public.[2] An example of federal administrative law is the regulations set by the Occupational Safety and Health Administration (OSHA). OSHA was established by Congress to ensure safe and healthy working conditions for employees by setting and enforcing federal standards. An example of administrative law at the state level is the State Board of Nursing (SBON). The SBON is a group of individuals in each state, established by that state's legislature, to develop, review, and enforce the Nurse Practice Act. The SBON also issues nursing licenses to qualified candidates, investigates reports of nursing misconduct, and implements consequences for nurses who have violated the Nurse Practice Act.

- **Criminal law** is a system of laws concerned with punishment of individuals who commit crimes.[3] A **crime** is a behavior defined by Congress or state legislature as deserving of punishment. Crimes are classified as felonies, misdemeanors, and infractions. Conviction for a crime requires evidence to show the defendant is guilty "beyond a reasonable doubt." This means the prosecution must convince a jury there is no reasonable explanation other than guilty that can come from the evidence presented at trial. In the United States, an individual is considered innocent until proven guilty. See Figure 5.1[4] for an illustration of a trial with a jury.

2. Legal Information Institute. (n.d.) Cornell Law School. https://www.law.cornell.edu

3. Legal Information Institute. (n.d.) Cornell Law School. https://www.law.cornell.edu

4. "Courtroom Trial with Judge, Jury – Vector Image" designed by WannaPik is licensed under CC0

Figure 5.1 Trial by Jury

Serious crimes that can result in imprisonment for longer than one year are called **felonies**. Felony convictions can also result in the loss of voting rights, the ability to own or use guns, and the loss of one's nursing license. An example of a felony committed by some nurses is drug diversion of controlled substances.

Misdemeanors are less serious crimes resulting in penalties of fines and/or imprisonment for less than one year. For example, in Wisconsin, misdemeanors are categorized as Class A, B, or C based on their sentencing. Class A misdemeanors are sentenced to a fine not to exceed $10,000 or imprisonment not to exceed nine months, or both. Class B misdemeanors are sentenced to a fine not to exceed $1,000 or imprisonment not to exceed 90 days, or both. Class C misdemeanors are sentenced to a fine not to exceed $500 or imprisonment not to exceed 30 days, or both.[5] Examples of misdemeanors include battery, possession of controlled substances, petty theft, disorderly conduct, and driving under the influence (DUI) charges.

5. Wisconsin State Legislature. (2021). 939.51 *Classification of misdemeanors*. https://docs.legis.wisconsin.gov/statutes/statutes/939/iv/51

Although considered less serious crimes, misdemeanors can impact an individual's ability to obtain or maintain a nursing license.

Nurses who are found guilty of misdemeanors or felonies, regardless if the violation is related to the practice of nursing, must typically report these violations to their state's Board of Nursing.

Infractions are minor offenses, such as speeding tickets, that result in fines but not jail time. Infractions do not generally impact nursing licensure unless there is a significant quantity of them over a short period of time.

Sample Case

An LPN working for a hospice agency was accused of stealing a client's pain medications and substituting them with anti-seizure medication. The family asserted the actions of the LPN prolonged the client's suffering. The LPN served time in prison for diverting the client's medications.[6]

Private Law

Private law, also referred to as **civil law**, focuses on the rights, responsibilities, and legal relationships between private citizens. Civil law typically involves compensation to the injured party. Unlike criminal law that requires a jury to determine a defendant is guilty beyond reasonable doubt, civil law only

6. Nurses Service Organization (NSO) and CNA Financial Corporation. (2020). *Nurse professional liability exposure claim report: 4th edition: Minimizing risk, achieving excellence*. https://www.nso.com/Learning/Artifacts/Claim-Reports/Minimizing-Risk-Achieving-Excellence

requires a certainty of guilt of greater than 50 percent.[7] See Figure 5.2[8] illustrating balancing the evidence to determine the certainty of guilt. Any nurse can be impacted by civil law based on actions occurring in daily nursing practice.

Figure 5.2 Balancing the Evidence to Determine Guilt

Civil law includes contract law and tort law. **Contracts** are binding written, verbal, or implied agreements. A **tort** is an act of commission or omission that gives rise to injury or harm to another and amounts to a civil wrong for which courts impose liability. In the context of torts, "injury" describes the invasion of any legal right, whereas "harm" describes a loss or detriment that an individual suffers.[9]

Two categories of torts affect nursing practice: intentional torts, such as intentionally hitting a person, and unintentional torts (also referred to as negligent torts), such as making an error by failing to follow agency policy.

7. Legal Information Institute. (n.d.) Cornell Law School. https://www.law.cornell.edu
8. "Balance Scales (Ethics)" by The Open University (OU) is licensed under CC BY-NC-ND 2.0
9. Legal Information Institute. (n.d.). Cornell Law School. https://www.law.cornell.edu

INTENTIONAL TORTS

Intentional torts are wrongs that the defendant knew (or should have known) would be caused by their actions. Examples of intentional torts include assault, battery, false imprisonment, slander, libel, and breach of privacy or client confidentiality.

UNINTENTIONAL TORTS

Unintentional torts occur when the defendant's actions or inactions were unreasonably unsafe. Unintentional torts can result from acts of **commission** (i.e., doing something a reasonable nurse would not have done) or **omission** (i.e., failing to do something a reasonable nurse would do).[10]

Negligence and malpractice are examples of unintentional torts. Tort law exists to compensate clients injured by negligent practice, provide corrective judgement, and deter negligence with visible consequences of action or inaction.[11,12] Examples of common torts affecting nursing practice are discussed in further detail in the following subsections. See Table 5.2 for a comparison of public and private law.

Table 5.2 Comparison of Public and Private Law

10. Brous, E. (2019). The elements of a nursing malpractice case, Part 2: Breach. *American Journal of Nursing, 119*(9), 42–46. https://doi.org/10.1097/01.NAJ.0000580256.10914.2e

11. Legal Information Institute. (n.d.). Cornell Law School. https://www.law.cornell.edu

12. Mello, M. M., Frakes, M. D., Blumenkranz, E., & Studdert, D. M. (2020). Malpractice liability and health care quality: A review. *JAMA, 323*(4), 352–366. https://doi.org/10.1001/jama.2019.21411

Type of Law	Subtypes of Law and Examples
Public Law	• Statutory law (Nurse Practice Act and HIPAA) • Constitutional law (Right to Privacy) • Administrative law (State Board of Nursing and OSHA) • Criminal law (felonies and misdemeanors)

Private Law (Civil Law)	• Contract law
	  ◦ Written
	  ◦ Verbal
	  ◦ Implied
	• Tort law
	  ◦ Assault
	  ◦ Battery
	  ◦ Confidentiality
	  ◦ Consent
	  ◦ False imprisonment
	  ◦ Fraud
	  ◦ Negligence
	  ◦ Malpractice

Examples of Intentional and Unintentional Torts

ASSAULT AND BATTERY

Assault and battery are intentional torts. **Assault** is defined as intentionally putting another person in reasonable apprehension of an imminent harmful or offensive contact.[13] **Battery** is defined as intentional causation of harmful or

13. Legal Information Institute. (n.d.). Cornell Law School. https://www.law.cornell.edu

offensive contact with another person without that person's consent.[14] Physical harm does not need to occur to be charged with assault or battery. Battery convictions are often misdemeanors but can be felonies if serious bodily harm occurs. To avoid the risk of being charged with assault or battery, nurses must obtain consent from clients to provide hands-on care.

FALSE IMPRISONMENT

False imprisonment is an intentional tort. False imprisonment is defined as an act of restraining another person and causing that person to be confined in a bounded area.[15] In nursing practice, restraints can be physical, chemical, or verbal. Nurses must strictly follow agency policies related to the use of restraints. Physical restraints typically require a provider order and documentation according to strict guidelines within specific time frames. See Figure 5.3[16] for an image of a simulated client in full physical medical restraints.

Chemical restraints include administering medications such as benzodiazepines and require clear documentation supporting their use. Verbal threats to keep an individual in an inpatient environment can also qualify as false imprisonment and should be avoided.

14. Legal Information Institute. (n.d.). Cornell Law School. https://www.law.cornell.edu

15. Legal Information Institute. (n.d.). Cornell Law School. https://www.law.cornell.edu

16. "PinelRestaint.jpg" by James Heilman, MD is licensed under CC BY-SA 4.0

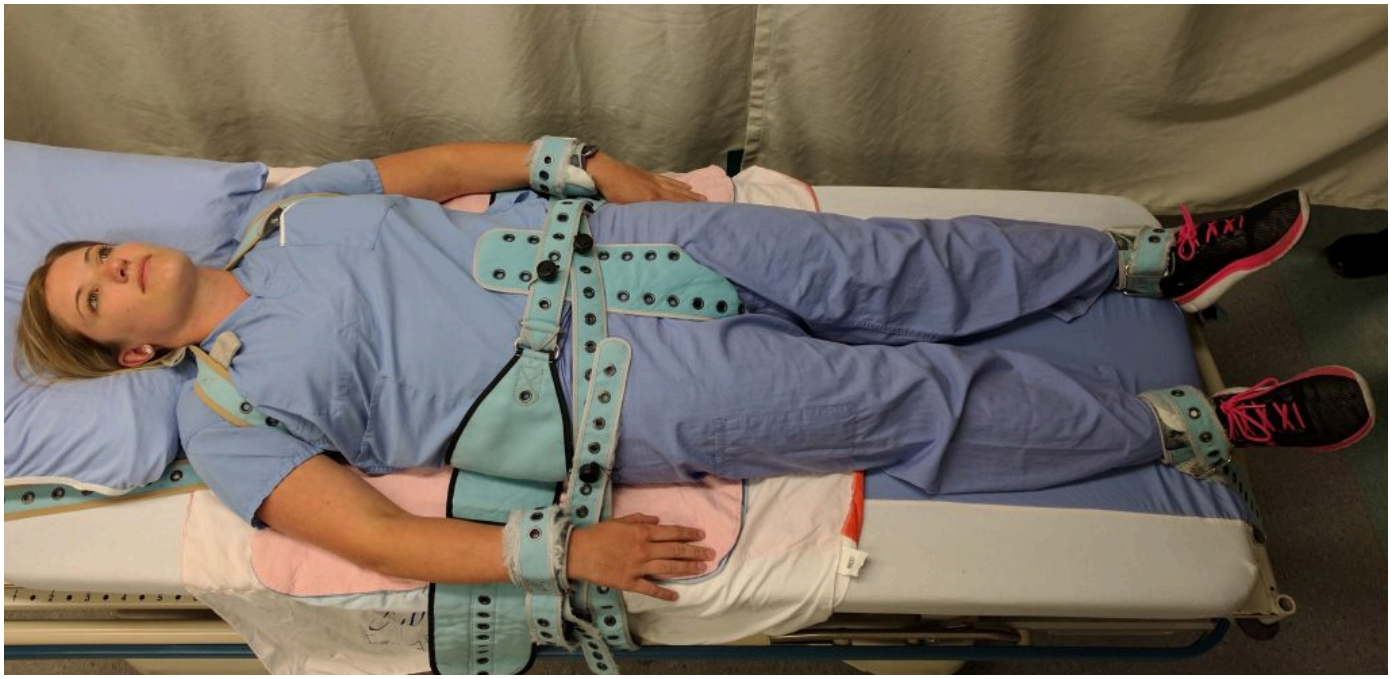

Figure 5.3 Full Physical Medical Restraints

BREACH OF PRIVACY AND CONFIDENTIALITY

Breaching privacy and confidentiality are intentional torts. **Confidentiality** is the right of an individual to have personal, identifiable medical information, referred to as protected health information (PHI), kept private. Protected Health Information (PHI) is defined as individually identifiable health information, including demographic data, that relates to the individual's past, present, or future physical or mental health or condition[17]; the provision of health care to the individual; and the past, present, or future payment for the provision of health care to the individual.

This right is protected by federal regulations called the Health Insurance Portability and Accountability Act (HIPAA). HIPAA was enacted in 1996 and was prompted by the need to ensure privacy and protection of personal health records and data in an environment of electronic medical records and third-party insurance payers. There are two main sections of HIPAA law: the

17. U.S. Department of Health & Human Services. (2022). *Summary of the HIPAA Privacy Rule.* https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html

Privacy Rule and the Security Rule. The Privacy Rule addresses the use and disclosure of individuals' health information. The Security Rule sets national standards for protecting the confidentiality, integrity, and availability of electronically protected health information. HIPAA regulations extend beyond medical records and apply to client information shared with others. Therefore, all types of client information should be shared only with health care team members who are actively providing care to them.[18,19]

HIPAA violations may result in fines from $100 for an individual violation to $1.5 million for organizational violations. Criminal penalties, including jail time of up to ten years, may be imposed for violations involving the use of PHI for personal gain or malicious intent. Nursing students are also required to adhere to HIPAA guidelines from the moment they enter the clinical setting or risk being disciplined or expelled by their nursing program.

Sample Case

An RN accessed a client's medical records, as well as the records of the newborn son, although she was not assigned to their care because she believed the newborn was her biological grandchild. Although the chart was accessed for less than five seconds, it was unauthorized. The nurse was publicly reprimanded by the state's Board of Nursing, and her multistate

18. Ernstmeyer, K., & Christman, E. (Eds.). (2024). *Nursing fundamentals 2E*. Open RN | WisTech Open. https://wtcs.pressbooks.pub/nursingfundamentals/

19. U.S. Department of Health & Human Services. (2022). *Summary of the HIPAA Privacy Rule.* https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html

licensure privileges were revoked. Expenses to defend the nurse exceeded $2,800.[20]

Read more about the HIPAA Privacy Rule.

SLANDER AND LIBEL

Slander and libel are intentional torts. **Defamation of character** occurs when an individual makes negative, malicious, and false remarks about another person to damage their reputation. **Slander** is spoken defamation and **libel** is written defamation. Nurses must take care to communicate and document facts regarding client care without defamation in their oral and written communications with clients and coworkers.

FRAUD

Fraud is an intentional tort occurring when an individual is deceived for personal gain. An example of fraud is financial exploitation perpetrated by

20. Nurses Service Organization (NSO) and CNA Financial Corporation. (2020). Nurse professional liability exposure claim report: 4th edition: Minimizing risk, achieving excellence. https://www.nso.com/Learning/Artifacts/Claim-Reports/Minimizing-Risk-Achieving-Excellence

individuals who are in positions of trust.[21,22] A nurse may be charged with fraud for documenting interventions not performed or altering documentation to cover up an error. Fraud can result in civil and criminal charges and also suspension or revocation of a nurse's license.

NEGLIGENCE AND MALPRACTICE

Negligence and malpractice are types of unintentional torts. **Negligence** is the failure to exercise the ordinary care a reasonable person would use in similar circumstances. Wisconsin civil jury instruction states, "A person is not using ordinary care and is negligent, if the person, without intending to do harm, does something (or fails to do something) that a reasonable person would recognize as creating an unreasonable risk of injury or damage to a person or property."[23] **Malpractice** is a specific term used for negligence committed by a professional with a license. See Figure 5.4[24] for an illustration related to malpractice.

21. DeLiema, M. (2018). Elder fraud and financial exploitation: Application of routine activity theory. *The Gerontologist, 58*(4), 706–718. https://doi.org/10.1093/geront/gnw258

22. DeLiema, M., Deevy, M., Lusardi, A., & Mitchell, O. S. (2020). Financial fraud among older Americans: Evidence and implications. *The Journals of Gerontology. Series B, Psychological Sciences and Social Sciences, 75*(4), 861–868. https://doi.org/10.1093/geronb/gby151

23. Wis. JI—Civil 1005. (2016). https://wilawlibrary.gov/jury/civil/instruction.php?n=1005

24. "malpractice.jpg" by Nick Youngson hosted by Pix4free is licensed under CC BY-SA 3.0

Figure 5.4 Malpractice

ELEMENTS OF NURSING MALPRACTICE

Nurses and nursing students don't often get sued for malpractice, but when they do, it is important to understand the elements required to prove malpractice. All the following elements must be established in a court of law to prove malpractice[25]:

- **Duty:** A nurse-client relationship exists.
- **Breach:** The standard of care was not met and harm was a foreseeable consequence of the action or inaction.
- **Cause:** Injury was caused by the nurse's breach.
- **Harm:** Injury resulted in damages.

Parties bringing a lawsuit must be able to demonstrate their interests were harmed, providing a reason to stand before the court. The person bringing the lawsuit is called the **plaintiff**. The parties named in the lawsuit are called **defendants**. Most malpractice lawsuits name physicians or hospitals,

25. Brous, E. (2019). The elements of a nursing malpractice case, Part 1: Duty. *American Journal of Nursing, 119*(7), 64–67. https://doi.org/10.1097/01.NAJ.0000569476.17357.f5

although nurses can be individually named. Employers can be held liable for the actions of their employees.[26]

Malpractice lawsuits are concerned with the legal obligations nurses have to their clients to adhere to current standards of practice. These legal obligations are referred to as the **duty of reasonable care**. Nurses are required to adhere to standards of practice when providing care to clients they have been assigned. This includes following organizational policies and procedures, maintaining clinical competency, and confining their activities to the authorized scope of practice as defined by their state's Nurse Practice Act. Nurses also have a legal duty to be physically, mentally, and morally fit for practice. When nurses do not meet these professional obligations, they are said to have breached their duties to clients.[27]

Duty

In the work environment, a duty is created when the nurse accepts responsibility for a client and establishes a nurse-client relationship. This generally occurs during inpatient care upon acceptance of a handoff report from another nurse. Outside the work environment, a nurse-client relationship is created when the nurse volunteers services. Some states have statutes requiring notification of authorities (also referred to as mandatory reporting) or summoning assistance.[28]

26. Brous, E. (2019). The elements of a nursing malpractice case, Part 1: Duty. *American Journal of Nursing, 119*(7), 64–67. https://doi.org/10.1097/01.NAJ.0000569476.17357.f5

27. Brous, E. (2019). The elements of a nursing malpractice case, Part 1: Duty. *American Journal of Nursing, 119*(7), 64–67. https://doi.org/10.1097/01.NAJ.0000569476.17357.f5

28. Brous, E. (2019). The elements of a nursing malpractice case, Part 1: Duty.

GOOD SAMARITAN LAW

The **Good Samaritan Law** provides protections against negligence claims to individuals who render aid to people experiencing medical emergencies outside of clinical environments. All 50 states in the United States have a version of a Good Samaritan Law. See Figure 5.5[29] for historical artwork depicting a Good Samaritan. Differences exist in state laws regarding protection of bystanders who provide aid. For example, in Wisconsin, the law states, "Any person who renders emergency care at the scene of any emergency or accident in good faith is immune from civil liability for the person's acts or omissions in rendering such emergency care."[30] There are a few states that require some emergency bystander action, so nurses should review the law in states they are visiting. It is also important to keep in mind that although anyone can file a lawsuit against someone who provides bystander aid, the Good Samaritan laws typically negate any penalty to the person rendering aid.

Although the majority of Good Samaritan laws are at the state level, the federal Aviation Medical Assistance Act (AMAA) provides liability protection for aid given on aircraft. The most common in-flight medical emergencies involve syncope, as well as gastrointestinal, respiratory, and cardiac events.[31]

American Journal of Nursing, 119(7), 64–67. https://doi.org/10.1097/01.NAJ.0000569476.17357.f5

29. "The_good_samaritan_helping_a_stranger_who_has_been_ignored_b_Wellcome_V0015249.jpg" by S. Smith after C. L. Eastlake is licensed under CC BY 4.0

30. Otis, A. (2017). Civil immunity under Wisconsin's Good Samaritan Law [Memo]. Wisconsin Legislative Council. https://docs.legis.wisconsin.gov/misc/lc/information_memos/2017/im_2017_03

31. West, B. & Varacallo, M. A. (2022). *Good Samaritan Laws*. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK542176/

Note that consent for care by an unconscious person is implied, but consent must be obtained from alert individuals.

5.5 Good Samaritan

MANDATORY REPORTING

Nurses are legally responsible for reporting certain crimes. Mandatory reporting requirements vary based on the state of practice, but there are some commonalities. For example, nurses are mandated to report suspected abuse of children, the elderly, and the disabled (if they have been deemed as incompetent by a court of law or as incapacitated by qualified health care providers).

Nurses are also mandated to report gunshot wounds, dog bites, some communicable diseases, and unsafe or illegal practices of other health care team members. Reporting responsibility often begins at the organizational

level. The nurse may also need to identify the appropriate local, state, or federal authorities to submit the report and pursue it to its resolution.

Sample Statute Regarding Duty to Assist

A Minnesota statute states that a person at the scene of an emergency who knows that another person is exposed to or has suffered grave physical harm shall, to the extent that the person can do so without danger or peril to self or others, give reasonable assistance to the exposed person. Reasonable assistance may include obtaining or attempting to obtain aid from law enforcement or medical personnel. A person who violates this is guilty of a petty misdemeanor.[32]

IMPLICATIONS FOR NURSES

Duty can be established in many ways. Nurses have a duty of reasonable care for a client they have been assigned. They may also have a duty in other circumstances. Therefore, nurses should understand the following[33]:

- Recognize that a nurse-client relationship is established upon acceptance of responsibility for a client, whether after a handoff report in the workplace or during volunteered services.

32. Brous, E. (2019). The elements of a nursing malpractice case, Part 1: Duty. *American Journal of Nursing, 119*(7), 64–67. https://doi.org/10.1097/01.NAJ.0000569476.17357.f5

33. Brous, E. (2019). The elements of a nursing malpractice case, Part 1: Duty. *American Journal of Nursing, 119*(7), 64–67. https://doi.org/10.1097/01.NAJ.0000569476.17357.f5

- Assume that on-call or supervisory responsibilities create a duty to clients, even in the absence of an expressed nurse-client relationship.
- Know if there is a duty to rescue statute in their state, and if so, what it demands.

Breach of Duty

The second element of malpractice is breach of duty. After a plaintiff has established the first element in a malpractice suit, that the nurse owed a duty to the plaintiff, the plaintiff must then demonstrate that the nurse breached that duty by failing to comply with the duty of reasonable care.[34]

To demonstrate that a nurse breached their duty to a client the plaintiff must prove the nurse departed from acceptable standards of practice. The plaintiff must establish how a reasonably prudent nurse in the same or similar circumstances would act and then show that the defendant nurse departed from that standard of practice. The plaintiff must claim the nurse did something a reasonably prudent nurse would not have done (an act of commission) or failed to do something a reasonable nurse would have done (an act of omission).[35]

Experts are needed during court hearings to explain things outside the knowledge of non-nurse jurors. In reaching their opinions, experts review many materials, including the state's Nurse Practice Act and organizational policies, to determine whether the nurse adhered to them. To qualify as a nurse expert, the person testifying must have relevant experience, education,

34. Brous, E. (2019). The elements of a nursing malpractice case, Part 2: Breach. *American Journal of Nursing, 119*(9), 42–46. https://doi.org/10.1097/01.NAJ.0000580256.10914.2e

35. Brous, E. (2019). The elements of a nursing malpractice case, Part 2: Breach. *American Journal of Nursing, 119*(9), 42–46. https://doi.org/10.1097/01.NAJ.0000580256.10914.2e

skill, and knowledge. They typically have advanced degrees, are published in nursing literature, have spoken at professional conferences, and belong to professional organizations. Medical malpractice trials take place primarily in state courts, so experts are deemed qualified based on state requirements.

Sample Case Regarding Breach of Duty[36]

Mary Jones was an 87-year-old woman who presented to the hospital with dizziness, nausea, intermittent slurred speech, an unsteady gait, and a history of four falls at home that day. Significant medical history included heart disease and multiple medications. The admitting nurse assessed her as being at risk for falls and placed her on universal fall precautions. The fall precautions included keeping the bed in the lowest position, instructing her on the use of the call light and ensuring the call light was within her reach, providing a bedside commode, and placing her in a room close to the nurses' station where she could be observed. However, the nurse did not use a formal scoring system for fall risk assessment that was set forth in a nursing procedures textbook. Additionally, bed alarms had not been working at this agency for a year.

Five days later, a nurse responded to a sound coming from Mrs. Jones's room and found her lying on the bathroom floor. She was conscious and able to move all extremities but complained of left knee and elbow pain. The physician was notified, and Mrs. Jones

36. Mello, M. M., Frakes, M. D., Blumenkranz, E., & Studdert, D. M. (2020). Malpractice liability and health care quality: A review. *JAMA, 323*(4), 352–366. https://doi.org/10.1001/jama.2019.21411

was sent for X-rays and a CT scan. When Mrs. Jones returned to her room, the nurse observed she was diaphoretic and deteriorating. The nurse took Mrs. Jones to the emergency department, where she lost consciousness. She was evaluated by a neurosurgeon, intubated, and airlifted to a different hospital for a higher level of care. She never regained consciousness and died the next day from intracranial bleeding that was aggravated by anticoagulant therapy.

Mrs. Jones's estate brought a lawsuit alleging nursing malpractice. The estate's nursing expert stated the universal fall precautions had been inadequate for a high-risk client and additional measures should have been instituted. The expert testified that not only had the admitting nurse not adhered to the formal scoring system for fall risk assessment in the nursing procedures textbook, but also the standard of care required nurses to use bed alarms, institute 15-minute rounds, or place a sitter in the room.

A defense expert used The Joint Commission's National Patient Safety Goals to define the standard of care and testified it was her opinion the nurse had met that standard. The organizational policy did not require bed alarms as part of its fall prevention plan. Although the nurses did not use the formal scoring system in a textbook to assess the client's risk, they clearly identified her as being at risk for falling; assessed her frequently; maintained her bed in the lowest position; kept the wheels of her bed locked and her side rails up; and kept the call light within her reach. They instructed her on the use of the call light and placed her in a room where she could be readily observed.

The court entered the judgment for the defendant hospital, noting that "under the circumstances, it is a close call on whether the hospital, by not having functioning bed alarms and

staff not checking on Mary more frequently, breached the standard of care."[37] In this case, the plaintiff's expert had not demonstrated the standard of care was breached.

IMPLICATIONS FOR NURSES

Nurses defending themselves against allegations of professional malpractice must demonstrate their actions conformed with accepted standards of practice. They must convince a jury they acted as a reasonably prudent nurse would have in the same or similar circumstances. Nurses should always follow these practices[38]:

- Adhere to organizational policies and procedures. Work-arounds can create liability. The standard of practice is to adhere to agency policy. Failing to do so creates an assumption of departure from standards.
- Document in a manner that permits accurate reconstruction of client assessments and the sequence of events, especially when notifying providers regarding clinical concerns.
- Maintain competence through continuing education, participation in professional conferences, membership in professional organizations, and subscriptions to professional journals.
- When using an interpreter, ensure that properly trained interpreters are used and document the name of the interpreter. The use of family,

37. Brous, E. (2019). The elements of a nursing malpractice case, Part 2: Breach. *American Journal of Nursing, 119*(9), 42–46. https://doi.org/10.1097/01.NAJ.0000580256.10914.2e

38. Brous, E. (2019). The elements of a nursing malpractice case, Part 2: Breach. *American Journal of Nursing, 119*(9), 42–46. https://doi.org/10.1097/01.NAJ.0000580256.10914.2e

friends, or other untrained interpreters is unsafe practice and is not consistent with acceptable standards of practice.
- Maintain professional boundaries. Personal relationships with clients or their families can be red flags for juries and can be viewed as evidence of departure from professional standards.

Cause

The third element of malpractice is cause. After the plaintiff has established the nurse owed a duty to a client and then breached that duty, they must then demonstrate that damages or harm were caused by that breach. Plaintiffs cannot prevail by only demonstrating the nurse departed from acceptable standards of practice but must also prove that such departures were the cause of any injuries.[39] Additionally, nurses are held accountable for foreseeability, meaning a nurse of ordinary skill, care, and diligence could anticipate the risk of harm of departing from standards of practice in similar circumstances.[40]

Plaintiffs must be able to link the defendant's acts or omissions to the harm for which they are seeking compensation. This requires expert testimony from a physician because it requires a medical diagnosis. Unlike in criminal cases, in which the standard of proof is that elements of prosecution must be proven "beyond reasonable doubt," the elements of a malpractice lawsuit must be proven by a "preponderance of evidence." Expert testimony is

39. Brous, E. (2019). The elements of a nursing malpractice case, Part 3A: Causation: A plaintiff must prove not only that a provider departed from acceptable standards of practice–but that this departure caused an injury. *American Journal of Nursing, 119*(11), 54–59. https://doi.org/10.1097/01.naj.0000605380.52689.af

40. Brous, E. (2020). The elements of a nursing malpractice case, Part 3B: Causation. *American Journal of Nursing, 12*0(1), 63–66. https://doi.org/10.1097/01.naj.0000652128.66135.55

required to demonstrate “medical certainty” that the nurse’s breach was the cause of an actual injury.

Sample Cases Regarding Causation

Case 1

Janusz Osiecki was admitted to a subacute nursing facility to recover from Guillain-Barre syndrome. The standard of nursing care for this client included respiratory assessments and tracheostomy care. One morning, three weeks into his stay, he was found unresponsive, without pulse or respirations. His wife brought a wrongful death lawsuit, and expert witnesses testified the nurses breached the standard of care in not performing respiratory and tracheostomy assessments every two hours. Their rationale was that the purpose of the assessments was to detect and report pulmonary congestion, and if the nurses had done so in a timely manner, Mr. Osiecki could have received medical care that would have saved his life. A jury awarded the widow $577,005 for wrongful death and $250,000 for harm to family relationships.[41]

Case 2

A client identified as “C” was locked in a seclusion room after presenting to a hospital with psychosis and continuing bizarre

41. Brous, E. (2019). The elements of a nursing malpractice case, Part 3A: Causation: A plaintiff must prove not only that a provider departed from acceptable standards of practice–but that this departure caused an injury. *American Journal of Nursing, 119*(11), 54–59. https://doi.org/10.1097/01.naj.0000605380.52689.af

behavior, hallucinations, irrationality, lack of contact with reality, and agitation. She was in the seclusion room undergoing treatment for over a week when she suffered a grand mal seizure. A psychiatrist ordered antipsychotic medication. The medication order was not noted by nursing staff until the next day, at which point it was discovered the medication was unavailable at the pharmacy. The psychiatrist was not made aware the medication was unavailable, and the client went without the prescribed medication for three days. The nurses also did not notify the psychiatrist during those three days that C was becoming increasingly more agitated and hallucinating. On the fourth day, C attempted to leave the unit and told staff she was hearing voices instructing her to harm herself. She was returned to seclusion and remained there without being assessed or treated. Four hours later, she was found unconscious with her head wedged between the side rail and the mattress. She suffered brain damage that left her in a permanent semicomatose state.

C's estate brought a lawsuit alleging it was negligent to leave C in a steel bed in a seclusion room without constant observation. The jury awarded $3.6 million. The hospital appealed, but the appellate court upheld the jury verdict and explained that particular injuries do not need to be foreseen, only the general harm that can occur. The court stated, "It is not extraordinary that a psychotic client who is delusional...might wedge herself between a mattress and side rail in an attempt to hurt herself."[42]

42. Brous, E. (2020). The elements of a nursing malpractice case, Part 3B: Causation. *American Journal of Nursing, 12*0(1), 63–66. https://doi.org/10.1097/01.naj.0000652128.66135.55

IMPLICATIONS FOR NURSES

Nurses can reduce their liability by adhering to professional standards and documenting their observations and communications. Nurses should always follow these standards[43]:

- Follow the chain of command when there are concerns about unclear or potentially unsafe orders. Pursue concerns to resolution, documenting precisely who is notified and at what times.
- Document observations to justify clinical decisions. Variance charting (i.e., only charting things that vary from the norm) does not provide sufficient evidence of compliance with the standards of care.
- Adhere to organizational policies and procedures with an understanding that a failure to do so creates foreseeable harm to clients.

Harm

The fourth element of malpractice is harm. In a civil lawsuit, after a plaintiff has established the nurse owed a duty to the client and breached that duty and injury was caused by the nurse's breach, they must prove the injury resulted in damages. They request repayment for what they have lost.[44]

There are several types of injuries for which clients or their representatives seek compensation. Injuries can be physical, emotional, financial, professional, marital, or any combination of these. Physical injuries include loss of function, disfigurement, physical or mental impairment, exacerbation of prior medical problems, the need for additional medical care, and death.

43. Brous, E. (2020). The elements of a nursing malpractice case, Part 3B: Causation. *American Journal of Nursing, 120*(1), 63–66. https://doi.org/10.1097/01.naj.0000652128.66135.55

44. Brous, E. (2020). The elements of a nursing malpractice case, Part 4: Harm. *American Journal of Nursing, 120*(3), 61–64. https://doi.org/10.1097/01.naj.0000656360.21284.50

Economic injuries can include lost wages, additional medical expenses, rehabilitation, durable medical expenses, the need for architectural changes to one's home, the loss of earning capacity, the need to hire people to do things the plaintiff can no longer do, and the loss of financial support. Emotional injuries can include psychological damage, emotional distress, or other forms of mental suffering.[45]

Determining the specific amount a plaintiff needs can require expert witness testimony from a person known as a life care planner who is trained in analyzing and evaluating medical costs, as well as the subjective determination of a jury. Damages fall into several categories, including compensatory (economic) damages, noneconomic damages, and punitive damages.[46] See Figure 5.6[47] for an illustration of damages.

Figure 5.6 Damages

45. Brous, E. (2020). The elements of a nursing malpractice case, Part 4: Harm. *American Journal of Nursing, 120*(3), 61–64. https://doi.org/10.1097/01.naj.0000656360.21284.50

46. Brous, E. (2020). The elements of a nursing malpractice case, Part 4: Harm. *American Journal of Nursing, 120*(3), 61–64. https://doi.org/10.1097/01.naj.0000656360.21284.50

47. "damages.jpg" by Nick Youngson hosted by Pix4free is licensed under CC BY-SA 3.0

Economic damages (also referred to as actual damages) can be quantified. They are intended to restore the plaintiff to the position they were in before being injured. Compensatory damages are objectively calculated to provide the plaintiff with the amount of money necessary to replace what was lost.[48]

Noneconomic damages are subjective and can include things such as emotional distress, pain and suffering, loss of enjoyment of life, reputation damage, loss of companionship, or loss of parental guidance. They are more difficult to quantify than economic damages.[49]

Punitive damages are awards not related to the actual injury but are intended to punish the defendant(s) and deter others from engaging in similar conduct. In professional malpractice cases, punitive damages are difficult for plaintiffs to obtain because they must be related to outrageous conduct, such as gross negligence, recklessness, willful actions, or fraud.[50]

48. Brous, E. (2020). The elements of a nursing malpractice case, Part 4: Harm. *American Journal of Nursing, 120*(3), 61–64. https://doi.org/10.1097/01.naj.0000656360.21284.50

49. Brous, E. (2020). The elements of a nursing malpractice case, Part 4: Harm. *American Journal of Nursing, 120*(3), 61–64. https://doi.org/10.1097/01.naj.0000656360.21284.50

50. Brous, E. (2020). The elements of a nursing malpractice case, Part 4: Harm. *American Journal of Nursing, 120*(3), 61–64. https://doi.org/10.1097/01.naj.0000656360.21284.50

Sample Case Related to Damages[51]

Betty Shiflett fell out of bed in the recovery room after undergoing knee surgery. Three days later, she reported a clicking sound and pain in her knee to one of the nurses. Although the nurse documented these symptoms, she did not convey the information to the physician. A physical therapist reported these symptoms to the physician a week later. The physician then identified a previously undiagnosed nondisplaced left tibial fracture that was now avulsed. Two additional surgeries were unsuccessful, and Betty remained disabled, confined to a wheelchair, and in chronic pain.

Betty and her husband filed a lawsuit alleging negligence for the fall and the nurse's failure to report the symptoms to the physician. They also asserted a claim for a loss of consortium, meaning the spouse or family had also been harmed. The harm suffered is a loss of companionship, conjugal relations, support and services, or marital quality. The jury awarded total damages of $2,391,620 with the following breakdown:

- $791,620 for future medical expenses
- $800,000 for past noneconomic damages
- $500,000 for future noneconomic damages
- $300,000 for loss of consortium with spouse

51. Brous, E. (2020). The elements of a nursing malpractice case, Part 4: Harm. *American Journal of Nursing, 120*(3), 61–64. https://doi.org/10.1097/01.naj.0000656360.21284.50

Implications for Nurses

Nurses can reduce their liability exposure by following these principles[52]:

- Practicing according to current standards of practice.
- Maintaining professional liability insurance to provide coverage for events and licensure defense.
- Avoiding work-arounds or deviations from organizational policies and procedures.
- Maintaining clinical competency, including awareness of standard-of-practice changes.
- Engaging the chain of command with client concerns and pursuing concerns to resolution.
- Documenting in a manner that permits accurate reconstruction of client assessments, notification of others, and the sequence of events.

52. Brous, E. (2020). The elements of a nursing malpractice case, Part 4: Harm. *American Journal of Nursing, 120*(3), 61–64. https://doi.org/10.1097/01.naj.0000656360.21284.50

5.3 Professional Liability and Your Nursing License

As discussed in the previous sections, professional liability occurs when a civil lawsuit compensates clients who allege they have suffered injury or damage as a result of professional negligence. Many nurses elect to purchase malpractice insurance to protect themselves from professional liability, especially if working in specialty areas that experience a high number of claims, such as in obstetrics or post-anesthesia care units (PACUs). The Nursing Service Organization (NSO) works in association with the American Nurses Association to provide malpractice insurance for nurses interested in purchasing it.

> Read more about malpractice insurance available for nurses at https://www.nso.com/.

The civil justice system cannot make rulings regarding your nursing license. It is the responsibility of the State Board of Nursing to suspend or revoke an individual's nursing license based on a disciplinary process.

The State Board of Nursing (SBON) governs nursing practice according to that state's Nurse Practice Act. The purpose of the SBON is to protect the public through licensure, education, legislation, and discipline. A nursing license is a contract between the state and licensee in which the licensee agrees to provide nursing care according to that state's Nurse Practice Act. Deviation from the Nurse Practice Act is a breach of contract that can lead to limited or revoked licensure. The SBON can suspend or revoke an individual's nursing license to protect the public from unsafe nursing practice. Nursing scope of practice and standards of nursing care are defined in the Nurse Practice Act that is enacted by the state legislature and enforced by the SBON. Nurses must practice according to the Nurse Practice Act of the state in which they are providing client care.

A nurse may be named in a board licensing complaint, also called an

allegation. Allegations can be directly related to a nurse's clinical responsibilities, or they can be nonclinical (such as substance abuse, unprofessional behavior, or billing fraud). A complaint can be filed against a nurse by anyone, such as a client, a client's family member, a colleague, or an employer. It can be filed anonymously. After a complaint is filed, the SBON follows a disciplinary process that includes investigation, proceedings, board actions, and enforcement. The process can take months or years to resolve, and it can be costly to hire legal representation.[1]

During the investigation process, investigators use various methods to determine the facts, such as interviewing parties who were present, reviewing documentation and records, performing drug screens (if impairment is alleged), and compiling pertinent facts related to the events and circumstances surrounding the complaint. Nurses being investigated may receive a letter, email, or phone call from the SBON, or they may be required to appear at a certain date and time for an interview with an investigator. It is recommended that nurses consult with an attorney before responding to the SBON within the deadline provided. Nurses should be cooperative but should be aware that whatever is shared will be provided to a prosecuting attorney and/or the SBON.[2]

After completion of the investigation, the prosecuting attorney will determine how to proceed. A conference may be scheduled where the nurse will be interviewed by a member of the SBON and possibly the prosecuting attorney.

1. Nurses Service Organization (NSO) and CNA Financial Corporation. (2020). *Nurse professional liability exposure claim report: 4th edition: Minimizing risk, achieving excellence*. https://www.nso.com/Learning/Artifacts/Claim-Reports/Minimizing-Risk-Achieving-Excellence
2. Nurses Service Organization (NSO) and CNA Financial Corporation. (2020). *Nurse professional liability exposure claim report: 4th edition: Minimizing risk, achieving excellence*. https://www.nso.com/Learning/Artifacts/Claim-Reports/Minimizing-Risk-Achieving-Excellence

It is recommended for the nurse to have an attorney present during proceedings. The nurse has the opportunity to present evidence supporting their case. A resolution may be offered after the conference that ends the matter.[3]

However, if the SBON believes there is significant evidence, a formal hearing is held where a disciplinary action is proposed. This formal hearing is similar to a civil trial. The hearing panel may include some or all of the SBON members. A court reporter records the entire proceeding and a transcript is created. Witnesses may be called to testify and the nurse undergoes cross-examination. When both sides have presented their cases, the hearing is concluded. The outcome of the formal hearing is a ruling by the administrative law judge and the SBON. The nurse may face disciplinary action such as a reprimand, limitation, suspension, or revocation of their license. Nondisciplinary actions, such as a warning or a remedial education order, may be set. See a description of possible disciplinary actions enforced by the Wisconsin State Board of Nursing in Table 5.3a.

Table 5.3a. Potential Disciplinary and Nondisciplinary Actions of the Wisconsin State Board of Nursing[4]

3. Nurses Service Organization (NSO) and CNA Financial Corporation. (2020). *Nurse professional liability exposure claim report: 4th edition: Minimizing risk, achieving excellence*. https://www.nso.com/Learning/Artifacts/Claim-Reports/Minimizing-Risk-Achieving-Excellence

4. Wisconsin Department of Safety and Professional Services. (2021). *Board of nursing newsletter.* https://content.govdelivery.com/accounts/WIDSPS/bulletins/2d71e3d

Disciplinary Options	**Reprimand:** The licensee receives a public warning for a violation. **Limitation of License:** The licensee has conditions or requirements imposed upon their license, their scope of practice, or both. **Suspension:** The license is completely and absolutely withdrawn and withheld for a period of time, including all rights, privileges, and authority previously conferred by the credential. **Revocation:** The license is completely and absolutely terminated, as well as all rights, privileges, and authority previously conferred by the credential.
Nondisciplinary Options	**Administrative Warning:** A warning is issued if the violation is of a minor nature or a first occurrence, and the warning will adequately protect the public. The issuance of an administrative warning is public information; however, the reason for issuance is not. **Remedial Education Order:** A remedial education order is issued when there is reason to believe that the deficiency can be corrected with remedial education, while sufficiently protecting the public.

- Find and review your state's Nurse Practice Act at https://www.ncsbn.org/policy/npa.page.
- Read more about Wisconsin's Board of Nursing and Administrative Code.

Liability considerations does not only apply when working in your professional nursing role, but also within your student nurse role. As you work as a student nurse, there are other role considerations which may impact the decision regarding professional liability. Please see Table 5.3b for a comparison of different types of liability.

5.3b. Types of Liability

Type of Liability	Definition	Example
Supervisory Liability[5]	When a clinical supervisor or preceptor is held responsible for the actions of the student nurse or for failing to properly supervise them.	A clinical supervisor fails to provide proper guidance during a procedure, resulting in the student nurse administering the wrong medication to a client. The supervisor could be held liable for inadequate supervision.
Institutional Liability[6]	When the health care institution (e.g., hospital, clinic) is held responsible for the actions of its employees or for failing to implement adequate policies and procedures to prevent harm.	A hospital does not provide proper orientation or training programs for student nurses, leading to a student nurse making a critical error. The hospital could be held liable for not ensuring adequate training.
Student Liability[7]	When the student nurse is held responsible for their own actions that cause harm to clients or violate protocols.	A student nurse neglects to follow infection control protocols, resulting in a client's condition worsening. The student nurse could be held liable for their negligence.

5. Dyer, A. M. & Griffin, S. (2024). Just culture, liability concerns, and ensuring a safe working environment. AOCN, Association of periOperative Registered Nurses. https://www.aorn.org/article/just-culture#:~:text=This%20is%20called%20vicarious%20liability,the%20nurse's%20scope%20of%20practice

6. Oliva, A., Caputo, M., Grassi, S., Vetrugno, G., Marazza, M., Ponzanelli, G., Cauda, R., Scambia, G., Forti, G., Bellantone, R., & Pascali, V. (2020). Liability of health care professionals and institutions during COVID-19 pandemic in Italy: Symposium proceedings and position Statement. *Journal of Patient Safety 16*(4), e299-e302. https://doi.org/10.1097/PTS.0000000000000793

7. Nurses Service Organization (NSO) and CNA Financial Corporation. (2020). Nurse professional liability exposure claim report: 4th edition: Minimizing risk, achieving excellence. https://www.nso.com/Learning/Artifacts/Claim-Reports/Minimizing-Risk-Achieving-Excellence

5.4 Frequent Allegations and SBON Investigations

The Nurses Service Organization (NSO) reported the three most common allegations resulting in state board investigations in 2020 were related to the categories of professional conduct, scope of practice, and documentation errors or omissions.[1]

Professional Conduct

Common allegations related to professional conduct included drug diversion and substance abuse, professional misconduct, reciprocal actions, and wastage errors.

DRUG DIVERSION AND SUBSTANCE ABUSE

The most common allegations related to professional conduct for both RNs and LPN/VNs in 2020 were related to drug diversion and/or substance abuse. Examples include diverting medications for oneself or others and apparent intoxication from alcohol or drugs while on duty.

The National Council of State Boards of Nursing (NCSBN) created a brochure titled *Substance Abuse Disorder in Nursing* to address this common issue.[2] Many states have programs in place to assist nurses with substance abuse, such as Wisconsin Nursing Association's Nurses Caring for Nurses (Peer

1. Nurses Service Organization (NSO) and CNA Financial Corporation. (2020). Nurse professional liability exposure claim report: 4th edition: Minimizing risk, achieving excellence. https://www.nso.com/Learning/Artifacts/Claim-Reports/Minimizing-Risk-Achieving-Excellencehttps://www.nso.com/Learning/Artifacts/Claim-Reports/Minimizing-Risk-Achieving-Excellence

2. National Council State Board of Nursing. *Substance abuse disorder in nursing* [Brochure]. https://www.ncsbn.org/nursing-regulation/practice/substance-use-disorder.page

Assistance) program or New York State Nursing Association's Statewide Peer Assistance for Nurses (SPAN) program.[3,4]

PROFESSIONAL MISCONDUCT

Professional misconduct as defined by state regulations was the second most common allegation related to professional conduct. This category includes unprofessional conduct towards coworkers and clients, as well as allegations of falling asleep.

Sample Case

A home health RN was assigned to monitor an 11-month-old child from 1900 to 0700. The child was intubated and required constant monitoring to ensure the tubing remained secure while she was in her crib. However, the child's father found the RN sleeping and the child's tubing unsecured. The child did not suffer harm due to the incident, but the SBON publicly reprimanded the RN, and the costs to defend the nurse exceeded $2,400.[5]

3. Wisconsin Nurses Association. (n.d.). *Nurses caring for nurses (peer assistance).* https://www.wisconsinnurses.org/about-wna/affiliates/nurses-caring-for-nurses-peer-assistance/

4. Statewide Peer Assistance For Nurses. https://www.statewidepeerassistance.org/

5. Nurses Service Organization (NSO) and CNA Financial Corporation. (2020). Nurse professional liability exposure claim report: 4th edition: Minimizing risk, achieving excellence. https://www.nso.com/Learning/Artifacts/Claim-Reports/Minimizing-Risk-Achieving-Excellence

RECIPROCAL ACTIONS

The third most common professional conduct allegation was reciprocal actions. Many cases involved nurses who were trying to contend with clients who were violent or aggressive and either retaliated against the client or responded to the client ‘s aggression in an inappropriate or unprofessional manner.

Sample Case

A client in an inpatient behavioral health unit became agitated, pulled a phone out of the wall, and threw it. The nurse entered the room and following a brief interaction, an altercation between the client and the nurse ensued. The nurse received a public reprimand and disciplinary actions from the SBON.[6]

WASTAGE ERRORS

Wastage errors were the fourth most common allegation. Wastage errors occurred when nurses neglected to perform accurate medication counts or did not appropriately document proper disposal of opioids and other drugs with a high potential for abuse.

6. Nurses Service Organization (NSO) and CNA Financial Corporation. (2020). Nurse professional liability exposure claim report: 4th edition: Minimizing risk, achieving excellence. https://www.nso.com/Learning/Artifacts/Claim-Reports/Minimizing-Risk-Achieving-Excellence

Sample Case

An RN left two 15 milligram tablets of a benzodiazepine called Temazepam unattended in an area accessible to clients. The medication went missing and was apparently taken by a client. The nurse falsely documented the Temazepam as wastage, knowing the medication was actually missing. The SBON issued a $200 fine, and expenses to defend the nurse exceeded $7,200.[7]

Scope of Practice

Common allegations related to scope of practice include failure to maintain a minimum standard of practice and providing services beyond one's scope of practice.

FAILURE TO MAINTAIN MINIMUM STANDARD OF NURSING PRACTICE

The most common allegations related to scope of practice include failure to maintain a minimum standard of nursing practice. These cases include a breach of minimum professional standards, incompetence, and negligence.

7. Nurses Service Organization (NSO) and CNA Financial Corporation. (2020). Nurse professional liability exposure claim report: 4th edition: Minimizing risk, achieving excellence. https://www.nso.com/Learning/Artifacts/Claim-Reports/Minimizing-Risk-Achieving-Excellence

Sample Case

A nurse working in home health failed to complete required client assessments and omitted pertinent client information in the health care record. This omission could have caused a disruption in the continuity of treatment resulting in client harm. The SBON determined the nurse failed to exercise the degree of learning, skill, care, and experience ordinarily possessed and exercised by a competent RN. The SBON placed the nurse on probation for three years, and the expenses associated with defending the nurse exceeded $5,400.[8]

Sample Case

An RN failed to follow agency policy and procedures by neglecting to properly verify identification of two clients and omitting the review of relevant laboratory results. As a result of bypassing standard safety procedures, the RN gave an extra unit of blood to one client that was intended for the other client, thereby depriving that client the extra unit of blood required based on her lab results. The SBON placed the nurse on probation for three years. However, the nurse did not comply with the terms of her probation by failing to report to the SBON when she applied for licensure in two other states. The nurse also failed to obtain approval prior to commencing employment. The nurse was ultimately ordered to surrender her license.[9]

8. Nurses Service Organization (NSO) and CNA Financial Corporation. (2020). Nurse professional liability exposure claim report: 4th edition: Minimizing risk, achieving excellence. https://www.nso.com/Learning/Artifacts/Claim-Reports/Minimizing-Risk-Achieving-Excellence

9. Nurses Service Organization (NSO) and CNA Financial Corporation. (2020). Nurse professional liability exposure claim report: 4th edition: Minimizing risk, achieving excellence. https://www.nso.com/Learning/Artifacts/Claim-Reports/Minimizing-Risk-Achieving-Excellence

Sample Case

A student nurse was instructed to discontinue an intravenous (IV) antibiotic for a client with a central venous catheter. When the student discontinued the IV, she unknowingly loosened the catheter connection from the lumen luer connector. The loosened line would likely have been discovered when the line was flushed per agency policy, but the student testified she did not know she was supposed to flush the catheter line or clamp it after the medication was discontinued. Shortly thereafter, the client became unresponsive, and a code was called. The disconnection was not discovered until the client was transferred to the intensive care unit three hours later. The client experienced an air embolism and died. A malpractice claim was awarded.[10]

PROVISION OF SERVICES BEYOND SCOPE OF PRACTICE

The second most common allegation related to scope of practice is provision of services beyond one's scope of practice. This category typically involves nurses making changes to clients' prescribed treatments or administering medication that had not been prescribed.

Sample Case

An RN in the ICU was caring for a client with extreme nausea. The nurse made several unsuccessful attempts to reach the provider for an order for Ondansetron. The nurse called the pharmacy and relayed her concern for the client's nausea and her inability to reach the provider. The nurse informed the

10. Nurses Service Organization (NSO) and CNA Financial Corporation. (2020). Nurse professional liability exposure claim report: 4th edition: Minimizing risk, achieving excellence. https://www.nso.com/Learning/Artifacts/Claim-Reports/Minimizing-Risk-Achieving-Excellence

pharmacist that she believed the situation was urgent, and she would contact the provider for an order. The pharmacy dispensed Ondansetron and the nurse administered the medication. Although the client did not suffer adverse effects from the medication, no order was ever received for the medication. Upon finding the RN violated the Nurse Practice Act by practicing beyond the scope of practice for an RN, the SBON publicly reprimanded the nurse and ordered her to pay a fine of $600. Expenses associated with defending the nurse exceeded $6,100.[11]

Documentation

Over half of the allegations in 2020 regarding documentation were related to fraudulent or falsified client care or billing records. The health care record is a legal document. It should never be altered, deleted, or falsified. Maintaining accurate and timely documentation is a primary professional responsibility of nurses.

Sample Case

In a case involving a nursing student, the preceptor instructed the student to monitor the client's vital signs every 15 minutes for one hour and then every 30 minutes for two hours and then every hour for four hours. The student allegedly documented vital signs every 15 minutes for one hour but did not record any vital signs thereafter. When confronted by her preceptor about the incomplete record, the student stated that she "forgot to do them." Approximately 30 minutes later, the preceptor discovered the missing vital signs were documented in the client's record. The preceptor asked the student about the entries, and the student replied that she "made them up." The student later contended that she meant she charted the vital signs accurately but made up the times the vital signs were taken to match the preceptor's instructions. The SBON considered the student was still learning but viewed documentation as a basic

11. Nurses Service Organization (NSO) and CNA Financial Corporation. (2020). Nurse professional liability exposure claim report: 4th edition: Minimizing risk, achieving excellence. https://www.nso.com/Learning/Artifacts/Claim-Reports/Minimizing-Risk-Achieving-Excellence

nursing skill. Because the student's conduct involved dishonesty, they imposed a penalty of a one-year suspension followed by one year of probation. The expenses associated with defending the student nurse exceeded $6,900.[12]

Professional Misconduct Case Study Scenario

Sarah is a registered nurse working in a busy hospital emergency department. One evening, she is assigned to care for Mr. Thompson, a 68-year-old man who was admitted with severe chest pain. The emergency department is understaffed, and Sarah is handling multiple clients at once.

During her shift, Sarah receives a call from her supervisor asking her to assist in another critical case. In her hurry to attend to the other client, Sarah administers Mr. Thompson's medication without double-checking the doctor's orders. Unfortunately, she administers the wrong dosage of a medication, causing Mr. Thompson's condition to worsen significantly.

Upon realizing her mistake, Sarah panics and decides not to report the error to avoid potential disciplinary action. She adjusts Mr. Thompson's medical record to conceal the mistake. Later, Mr. Thompson's condition deteriorates further, requiring intensive care. An investigation reveals the medication error and the altered medical records.

12. Nurses Service Organization (NSO) and CNA Financial Corporation. (2020). Nurse professional liability exposure claim report: 4th edition: Minimizing risk, achieving excellence. https://www.nso.com/Learning/Artifacts/Claim-Reports/Minimizing-Risk-Achieving-Excellence

1. Identify the ethical and legal issues present in this case.
2. How does Sarah's behavior constitute professional misconduct?
3. What are the potential consequences for Sarah, both professionally and legally?
4. How might the lack of adequate staffing and supervision have contributed to this incident?
5. What policies should the hospital have in place to prevent such errors and ensure proper reporting?
6. How did Sarah's actions affect Mr. Thompson's safety and overall outcome?
7. What impact might this incident have on the trust between health care professionals and clients?

5.5 Protecting Your Nursing License

You have worked hard to obtain a nursing license and it will be your livelihood. See Figure 5.7[1] for an illustration of a nursing license. Protecting your nursing license is vital.

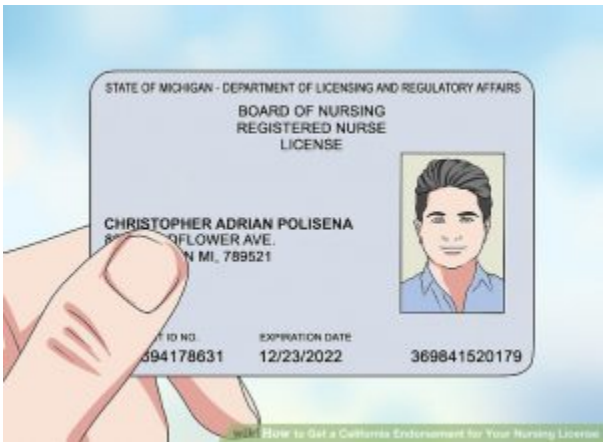

Figure 5.7 Nursing License

Actions to Protect Your License

There are several actions that nurses can take to protect their nursing license, avoid liability, and promote client safety. See Table 5.5 for a summary of recommendations.

Table 5.5 Risk Management Recommendations to Protect Your Nursing License

1. "aid9688616-v4-728px-Get-a-California-Endorsement-for-Your-Nursing-License-Step-11.jpg" by unknown is licensed under CC BY-NC-SA 3.0

Legal Issues	Recommendations to Protect Your License
Practicing outside one's scope of practice	• Practice within the requirements of your state's Nurse Practice Act, in compliance with organizational policies and procedures, and within the national standard of care. • Maintain basic clinical and specialty competencies by proactively obtaining the professional information, education, and training needed to remain current regarding nursing techniques, clinical practice, biologics, and equipment.[2] • Only accept client care assignments you are trained and competent to perform. Ask for additional training as needed. • Recognize one's limitations and ask for assistance when needed. • If necessary, utilize the chain of command or the risk management or legal departments regarding concerns about client care or practice issues and pursue concerns to resolution.[3]
Failure to assess & monitor	• Ensure that you are following appropriate guidelines for routine assessments and following up appropriately if client condition warrants additional monitoring. • Ensure the client condition aligns to skills and monitoring capabilities of unit/staff. • Escalate changes in client condition via appropriate channels.

2. Nurses Service Organization (NSO) and CNA Financial Corporation. (2020). Nurse professional liability exposure claim report: 4th edition: Minimizing risk, achieving excellence. https://www.nso.com/Learning/Artifacts/Claim-Reports/Minimizing-Risk-Achieving-Excellence

3. Nurses Service Organization (NSO) and CNA Financial Corporation. (2020). Nurse professional liability exposure claim report: 4th edition: Minimizing risk, achieving excellence. https://www.nso.com/Learning/Artifacts/Claim-Reports/Minimizing-Risk-Achieving-Excellence

Documentation	• Document client care assessments, observations, communications, and actions in an objective, timely, accurate, complete, and appropriate manner. • Document in a manner that permits accurate reconstruction of client assessments, notification of others, and the sequence of events. • Document as close to the time of care provision as possible. (In court, if it is not documented, it is considered not done.) • Provide an accurate documentation of a change in client condition, care provided, providers notified, and orders received. • Document specific times of interventions provided during emergency situations. • When notifying a provider about a client, document the name of the provider notified, the time of the notification, and the provider's response. Follow through with any nursing actions taken and the client's response. • Never alter, delete, or falsify information. • If there is information that should have been charted but was not, document "late entry," noting the time the charting occurred and the specific time the assessment or intervention actually took place.[4] • When describing a client problem, include the nursing actions taken and the client's response.[5] • Use medical terminology. • Avoid abbreviations. • Review notes from other health care team members to ensure coordination of efforts is occurring.[6] • Maintain your own personal files that can be helpful with respect to your character, such as letters of recommendation, performance evaluations, and continuing education certificates.[7]

4. Brous, E. (2019). The elements of a nursing malpractice case, Part 1: Duty. *American Journal of Nursing, 119*(7), 64–67. https://doi.org/10.1097/01.NAJ.0000569476.17357.f5

5. Brous, E. (2019). The elements of a nursing malpractice case, Part 1: Duty. *American Journal of Nursing, 119*(7), 64–67. https://doi.org/10.1097/01.NAJ.0000569476.17357.f5

6. Brous, E. (2019). The elements of a nursing malpractice case, Part 1: Duty. *American Journal of Nursing, 119*(7), 64–67. https://doi.org/10.1097/01.NAJ.0000569476.17357.f5

7. Nurses Service Organization (NSO) and CNA Financial Corporation. (2020). Nurse professional liability exposure claim report: 4th edition: Minimizing risk, achieving excellence. https://www.nso.com/Learning/Artifacts/Claim-Reports/Minimizing-Risk-Achieving-Excellence

Medication errors	• Avoid workarounds. (For example, if an error message is received when scanning a medication with a barcode scanner during med pass, don't assume it is a technology error and "workaround" it by just documenting the medication in the MAR. Instead, investigate error messages because they could be indicating a medication error, not a technology error.) • Always check the "rights of medication administration" three times, even when using barcode scanners and other equipment. (Review information about checking medication rights in the "Administration of Enteral Medications" chapter in Open RN *Nursing Skills, 2e*.) • Be aware of look alike/sound alike medications. • Double-check dosage calculations, especially for pediatric clients. • Follow agency policies and procedures related to medication administration and documentation. • Clarify prescriptions with prescribing providers if they are unclear or you have concerns. For example, if acetaminophen is prescribed for fever and the client is experiencing pain, clarify the indications in the order before administering it for pain. • Avoid distractions while preparing and administering medications. (Read more information about preventing medication errors in the "Legal/Ethical" chapter in Open RN *Nursing Pharmacology, 2e*.) • Maintain a chain of possession when administering medications. Never administer a medication for which you have not personally done the medication checks. • Never leave medication unattended. • If a medication error occurs, follow agency policy regarding notification and submitting an incident report.

Substance abuse and drug diversion	• Waste controlled substances and document wasting according to agency policy. • Perform accurate counting and documentation of controlled substances per agency policy. • Seek assistance if you are experiencing challenges with substance use. Report impaired professionals regarding suspected substance abuse. (Read more about drug diversion and support for nurses with substance use disorder in the "Legal/Ethical" chapter in Open RN *Nursing Pharmacology, 2e*.) • Report convictions such as drug possession, driving under the influence (DUI), or operating under the influence (OWI) to your State Board of Nursing as required.
Acts that may result in potential or actual client harm	• Participate in accurate and thorough handoff reports according to agency policy. (Read more about handoff reports in the "Communication" chapter of Open RN *Nursing Fundamentals, 2e*.) • Communicate with other members of the health care team using ISBARR format. (Read more about ISBARR format in the "Communication" chapter of Open RN *Nursing Fundamentals, 2e*.) • Follow the nursing care plan. Assess appropriateness of interventions according to the client's current condition before implementing them. • Conduct thorough nursing assessments, especially for skin breakdown or pressure injuries. (Read more about assessing skin breakdown and pressure injuries in the "Integumentary" chapter of Open RN *Nursing Fundamentals, 2e*.) • Advocate for quality client care and speak up regarding concerns about client safety. • Educate clients and encourage them to actively participate in their care and make informed decisions. • Follow National Patient Safety Goals. Implement fall prevention interventions according to agency policy. Report unsafe equipment. (Read more about promoting client safety in the "Safety" chapter in Open RN *Nursing Fundamentals, 2e*.) • Document and report unsafe staffing or other workplace safety concerns per agency policy, state policy, or OSHA.

Safe-guarding client possessions & valuables	• Encourage client valuables to be sent home. • Document all client possessions upon admission to inpatient facilities and obtain client or family signature or acknowledgement. • Lock up client valuables per agency policy. • Follow agency policy regarding receipt of gifts from clients or family.
Adherence to mandatory reporting responsibilities	• Report suspected abuse of children, elders, and other vulnerable populations. (Read more about mandatory reporting under the "Duty" subsection of the "Understanding the Legal System" section of this chapter.) • Report gunshot wounds, dog bites, and communicable disease per agency and state policy.

Culture of Safety

It can be frightening to think about entering the nursing profession after becoming aware of potential legal actions and risks to your nursing license, especially when realizing even an unintentional error could result in disciplinary or legal action. When seeking employment, it is helpful for nurses to ask questions during the interview process regarding organizational commitment to a culture of safety to reduce errors and enhance client safety.

Many health care agencies have adopted a **culture of safety** that embraces error reporting by employees with the goal of identifying root causes of problems so they may be addressed to improve client safety. One component of a culture of safety is "Just Culture." Just Culture is culture where people feel safe raising questions and concerns and report safety events in an environment that emphasizes a nonpunitive response to errors and near

misses. Clear lines are drawn between human error, at-risk, and reckless behaviors.[8]

The American Nurses Association (ANA) officially endorses the Just Culture model. In 2019 the ANA published a position statement on Just Culture. They stated that while our traditional health care culture held individuals accountable for all errors and accidents that happened to clients under their care, the Just Culture model recognizes that individual practitioners should not be held accountable for system failings over which they have no control. The Just Culture model also recognizes that many errors represent predictable interactions between human operators and the systems in which they work. However, the Just Culture model does not tolerate conscious disregard of clear risks to clients or gross misconduct (e.g., falsifying a record or performing professional duties while intoxicated).[9]

The Just Culture model categorizes human behavior into three categories of errors: simple human error, at-risk behavior, or reckless behavior. Consequences of errors are based on these categories.[10] When seeking employment, it is helpful for nurses to determine how an agency implements a culture of safety because of its potential impact on one's professional liability and licensure.

8. The Joint Commission. (2017). The essential role of leadership in developing a safety culture. *Sentinel event alert, Issue 57*. https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/sentinel-event/sea_57_safety_culture_leadership_0317pdf.pdf

9. American Nursing Association. (2010). *Position statement: Just culture*. https://www.nursingworld.org/~4afe07/globalassets/practiceandpolicy/health-and-safety/just_culture.pdf

10. American Nursing Association. (2010). *Position statement: Just culture*. https://www.nursingworld.org/~4afe07/globalassets/practiceandpolicy/health-and-safety/just_culture.pdf

- Read more about the Just Culture model in the "Basic Concepts" section of the "Leadership and Management" chapter.

5.6 Other Legal Issues

In addition to being aware of the legal and regulatory frameworks in which one practices nursing, it is also important for nurses to understand the legal concepts of informed consent and advance directives.

Informed Consent

Informed consent is the fundamental right of a client to accept or reject health care. Nurses have a legal responsibility to provide verbal and/or written information and obtain verbal or written consent for performing nursing care such as bathing, medication administration, and urinary or intravenous catheter insertion. While physicians have the responsibility to provide information and obtain informed consent related to medical procedures, nurses are typically required to verify the presence of a valid, signed informed consent before the procedure is performed. Additionally, if nurses do not believe the client has adequate understanding of a procedure, its risks, benefits, or alternatives to treatment, they should request the provider return to clarify unclear information with the client. Nurses must remain within their scope of practice related to informed consent beyond nursing acts.

Two legal concepts related to informed consent are competence and capacity. **Competence** is a legal term defined as the ability of an individual to participate in legal proceedings. A judge decides if an individual is "competent" or "incompetent." In contrast, **capacity** is "a functional determination that an individual is or is not capable of making a medical decision within a given situation."[1] It is outside the scope of practice for nurses to formally assess capacity, but nurses may initiate the evaluation of client capacity and contribute assessment information. States typically require two health care providers to identify an individual as "incapacitated" and unable

1. Darby, R. R., & Dickerson, B. C. (2017). Dementia, decision making, and capacity. *Harvard Review of Psychiatry, 25*(6), 270–278. https://doi.org/10.1097/HRP.0000000000000163

to make their own health care decisions. Capacity may be a temporary or permanent state.

The following box outlines situations where the nurse may question a client's decision-making capacity.

Triggers for Questioning Capacity and Decision-Making[2]
• Inability to voice a decision • Blanket acceptance or refusal of care • Absence of questions about the treatment being offered or provided • Excessive or inconsistent reasons for refusing care • New inability to perform activities of daily living • Hyperactivity, disruptive behavior, or agitation • Labile emotions or affect • Hallucinations • Intoxication

If an individual has an advance directive in place, their designated power of attorney for health care may step in and make medical decisions when the client is deemed incapacitated. In the absence of advance directives, the legal system may take over and appoint a guardian to make medical decisions for an individual. The guardian is often a family member or friend but may be completely unrelated to the incapacitated individual. Nurses are instrumental in encouraging a client to complete an advance directive while they have capacity to do so.

Advance Directives

The Patient Self-Determination Act (PSDA) is a federal law passed by Congress in 1990 following highly publicized cases involving the withdrawal of

2. American Nursing Association. (2010). *Position statement: Just culture*. https://www.nursingworld.org/~4afe07/globalassets/practiceandpolicy/health-and-safety/just_culture.pdf

life-supporting care for incompetent individuals. (Read more about the Karen Quinlan, Nancy Cruzan, and Terri Shaivo cases in the boxes at the end of this section.) The PSDA requires health care institutions, such as hospitals and long-term care facilities, to offer adults written information that advises them "to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate, at the individual's option, advance directives."[3] **Advance directives** are defined as written instructions, such as a living will or durable power of attorney for health care, recognized under state law, relating to the provision of health care when the individual is incapacitated. The PSDA allows clients to record their preferences about do-not-resuscitate (DNR) orders and withdrawing life-sustaining treatment. In the absence of a client's advance directives, the court may assert an "unqualified interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual."[4] For this reason, nurses must educate and support the communities they serve regarding the creation of advanced directives.

Advanced directives vary by state. For example, some states allow lay witness signatures whereas some require a notary signature. Some states place restrictions on family members, doctors, or nurses serving as witnesses. It is important for individuals creating advance directives to follow instructions for state-specific documents to ensure they are legally binding and honored.

Advance directives do not require an attorney to complete. In many organizations, social workers or chaplains assist individuals to complete

3. Centers for Medicare & Medicaid Services, Department of Health and Human Services. (2012). *Part 489-Provider agreements and supplier approval, Subpart A-General provisions*. https://www.govinfo.gov/content/pkg/CFR-2012-title42-vol5/pdf/CFR-2012-title42-vol5-chapIV.pdf

4. Nurses Service Organization and CNA Financial. (2020, June). *Nurse professional liability exposure claim report* (4th ed.). https://www.nso.com/Learning/Artifacts/Claim-Reports/Minimizing-Risk-Achieving-Excellence

advance directives following referral from physicians or nurses. Clients should review and update their documents every 10-15 years, as well as with changes in relationship status or if new medical conditions are diagnosed.

Although advanced directive documents vary by state, they generally fall into two categories, referred to as a living will or durable power of attorney for healthcare.

LIVING WILL

A **living will** is a type of advance directive in which an individual identifies what treatments they would like to receive or refuse if they become incapacitated and unable to make decisions. In most states, a living will only goes into effect if an individual meets specific medical criteria.[5] The living will often includes instructions regarding life-sustaining measures, such as cardiopulmonary resuscitation (CPR), mechanical ventilation, and tube feeding.

DURABLE POWER OF ATTORNEY FOR HEALTHCARE

It is impossible for an individual to document their preferences in a living will for every conceivable medical scenario that may occur. For this reason, it is essential for individuals to complete a durable power of attorney for healthcare. A **durable power of attorney for healthcare (DPOAHC)** is a person chosen to speak on one's behalf if one becomes incapacitated. Typically, a primary health care power of attorney (POA) is identified with an alternative individual designated if the primary POA is unable or unwilling to do so. The health care POA is expected to make health care decisions for an

5. AARP. (2020). *Advance directive forms.* https://www.aarp.org/caregiving/financial-legal/free-printable-advance-directives/#more-advancedirectives

individual they believe the person would make for themselves, based on wishes expressed in a living will or during previous conversations.[6]

It is essential for nurses to encourage clients to complete advance directives and have conversations with their designated POA about health care preferences, especially related to possible traumatic or end-of-life events that could require medical treatment decisions. Nurses can also dispel common misconceptions, such as these documents give the health care POA power to manage an individual's finances. (A financial POA performs different functions than a health care POA and should be discussed with an attorney.)

After the advance directives are completed and included in the client's medical record, the nurse has the responsibility to ensure they are appropriately incorporated into their care if they should become incapacitated.

- View state-specific advance directives at the American Association of Retired Persons website.

Sample Case: Karen Ann Quinlan[7]

6. AARP. (2020). *Advance directive forms*. https://www.aarp.org/caregiving/financial-legal/free-printable-advance-directives/#more-advancedirectives

7. Arthur J. Morris Law Library. (n.d.). *Karen Ann Quinlan and the right to*

Karen Ann Quinlan is an important figure in the United States' history of defining life and death, a client's privacy, and the state's interest in preserving life and preventing murder. In April 1975, Karen Quinlan was 21 years old and became unresponsive after ingesting a combination of valium and alcohol while celebrating a friend's birthday. She experienced respiratory failure, and although resuscitation efforts were successful, she suffered irreversible brain damage. She remained in a persistent vegetative state and became ventilator dependent. Her parents requested her physicians discontinue the ventilator because they believed it constituted extraordinary means to prolong her life. Her physicians denied their request out of concern of possible homicide charges based on New Jersey's law. The Quinlans filed the first "right to die" lawsuit in September of 1975 but were denied by the New Jersey Superior Court in November. In March of 1976, the New Jersey Supreme Court determined the parent's right to determine Karen's medical treatment exceeded that of the state. Karen was discontinued from the ventilator six weeks later. When taken off the ventilator, Karen shocked many by continuing to breathe on her own. She lived in a coma for nine more years and succumbed to pneumonia on June 11, 1985.

Sample Case: Nancy Beth Cruzan[8]

Nancy Cruzan is another important figure in the history of US "right to die" legal cases. At the age of 25, Nancy Cruzan was in a car accident on January 11, 1983. She never regained consciousness. After three years in a rehabilitation hospital, her parents began an eight-year battle in the courts to remove Nancy's feeding tube. Nancy's case was the first "right to die" case heard by the United States Supreme Court. Beyond allowing for the discontinuation of Nancy's feeding tube, the U.S. Supreme Court ruled that all adults have the right to the following:1) Choose or refuse any medical or surgical intervention, including artificial nutrition and hydration.
2) Make advance directives and name a surrogate to make decisions on their behalf.

die. https://archives.law.virginia.edu/dengrove/writeup/karen-ann-quinlan-and-right-die

8. Taub, S. (2001). Art of medicine "Departed, Jan 11, 1983; At Peace, Dec 26, 1990." *Virtual Mentor, American Medical Association Journal of Ethics, 3*(7), 231-233. https://journalofethics.ama-assn.org/sites/journalofethics.ama-assn.org/files/2021-05/artm1-0107.pdf

3) Surrogates can decide on treatment options even when all concerned are aware that such measures will hasten death, as long as causing death is not their intent. Nancy died nine days after removal of her feeding tube in December 1990. As a result of the Cruzan decision, the Patient Self-Determination Act (PSDA) was passed and took effect December 1, 1991. The act requires facilities to inform clients about their right to refuse treatment and to ask if they would like to prepare an advance directive.

Sample Case: Terri Schaivo[9]

The Terri Schaivo case is a key case in history of advance directives in the United States because of its focus on the importance of having written advance directives to prevent family animosity, pain, and suffering. In 1990 Terri Schaivo was 26 years old. In her Florida home, she experienced a cardiac arrest thought to be a function of a low potassium level resulting from an eating disorder. She experienced severe anoxic brain injury and entered a persistent vegetative state. A PEG tube was inserted to provide medications, nutrition, and hydration. After three years, her husband refused further life-sustaining measures on her behalf, based on a statement Terri had once made, stating, "I don't want to be kept alive on a machine." He expressed interest in obtaining a DNR order, withholding antibiotics for a urinary tract infection, and ultimately requested removal of the PEG tube. However, Terri's parents never accepted the diagnosis of

9. Weijer, C. (2005). A death in the family: Reflections on the Terri Schiavo case. *Canadian Medical Association Journal = journal de l'Association medicale canadienne, 172*(9), 1197–1198. https://doi.org/10.1503/cmaj.050348

persistent vegetative state and vigorously opposed their son-in-law's decision and requests. Seven years of litigation generated 30 legal opinions, all supporting Michael Schiavo's right to make a decision on his wife's behalf. Terri died on March 31, 2005, following removal of her feeding tube.

5.7 Spotlight Application

Sara is a new graduate nurse orienting on the medical floor at a large teaching hospital. She has been working on the floor for two weeks and notices that many of the nurses provide shift handoff reports to one another outside of the client rooms. Sara asks her preceptor why the nurses stand and report client care information in the hallway. Her preceptor responds that this is the standard way staff can meet the agency guidelines for beside handoff reporting without "disturbing" clients while they are resting. Sara has concerns about this action on many levels. What legal repercussions might this "hallway reporting" have?

Sara is smart to identify that discussing client care information in a hallway outside of client rooms may jeopardize client HIPAA protections and confidentiality. Sensitive client information should never be discussed freely where others may overhear care information and details. Additionally, the act of bedside handoff reporting is meant to provide an inclusive environment for clients to participate with care staff in the report and information exchange. Discussing report details outside of the client room does not actively include the client in the bedside reporting procedure.

Learning Activities

(Answers to "Learning Activities" can be found in the "Answer Key" at the end of the book. Answers to interactive activities are provided as immediate feedback.)

1. In 2006 Nurse Julie Thao was charged with felony criminal negligence in the death of a 16-year-old laboring mother when she mistakenly hung a bag of epidural medication instead of intravenous penicillin. Although the baby was successfully delivered via cesarean section, the client died following aggressive resuscitation attempts as a result of circulatory collapse. Nurse Thao was fired from her job of 16 years. Her felony charge was amended to two misdemeanor counts, and her state's Board of Nursing suspended her license, imposed practice limitations upon return, mandated completion of an education program, and imposed a $2,500 fine. Beyond these sanctions, she stated at her sentencing hearing, "The anguish and remorse are a life sentence that will serve for all time."

View the Chasing Zero Documentary on YouTube[1]

1. TMIT1. (2012, August 3). *Chasing zero: Winning the war on healthcare harm* [Video]. YouTube. All rights reserved. https://youtu.be/MtSbgUuXdaw

Discuss factors that contributed to Nurse Julie Thao's medication error. What reflections on your own nursing practice can be made after viewing this video clip? What actions might have been taken to avoid this error? Do you believe other members of the health care team were culpable in their actions?

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingmpc/?p=262#h5p-7

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingmpc/?p=262#h5p-8

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingmpc/?p=262#h5p-9

- Test your knowledge using this NCLEX Next Generation-style Case Study. You may reset and resubmit your answers to this question an unlimited number of times.[2]

2. "Chapter 5, Assignment 1" by Travis Christman for OpenRN is licensed under CC BY-NC 4.0

V Glossary

Administrative law: Law made by government agencies that have been granted the authority to pass rules and regulations. For example, each state's Board of Nursing is an example of administrative law.

Advance directives: Written instruction, such as a living will or durable power of attorney for health care, recognized under state law, relating to the provision of health care when the individual is incapacitated.

Assault: Intentionally putting another person in reasonable apprehension of an imminent harmful or offensive contact.[1]

Battery: Intentional causation of harmful or offensive contact with another's person without that person's consent.[2]

Capacity: A functional determination that an individual is or is not capable of making a medical decision within a given situation.

Civil law: Law focusing on the rights, responsibilities, and legal relationships between private citizens.

Commission: Doing something a reasonable nurse would not have done.[3]

Competence: In a legal sense, the ability of an individual to participate in legal

1. Legal Information Institute. (n.d.). Cornell Law School. https://www.law.cornell.edu
2. Legal Information Institute. (n.d.). Cornell Law School. https://www.law.cornell.edu
3. Brous, E. (2019). The elements of a nursing malpractice case, Part 2: Breach. *American Journal of Nursing, 119*(9), 42–46. https://doi.org/10.1097/01.NAJ.0000580256.10914.2e

proceedings. A judge decides if an individual is “competent” or “incompetent.”

Confidentiality: The right of an individual to have personal, identifiable medical information kept private.

Constitutional law: The rights, privileges, and responsibilities established by the U.S. Constitution. For example, the right to privacy is a right established by the constitution.

Contracts: Binding written, verbal, or implied agreements.

Crime: A type of behavior defined by Congress or state legislature as deserving of punishment.

Criminal law: A system of laws concerned with punishment of individuals who commit crimes.

Culture of safety: Culture that embraces error reporting by employees with the goal of identifying root causes of problems so they may be addressed to improve client safety.

Defamation of character: An act of making negative, malicious, and false remarks about another person to damage their reputation. Slander is spoken defamation and libel is written defamation.

Defendants: The parties named in a lawsuit.

Durable power of attorney for healthcare (DPOAHC): Person chosen to speak on one’s behalf if one becomes incapacitated.

Duty of reasonable care: Legal obligations nurses have to their clients to adhere to current standards of practice.

Ethics: A system of moral principles that a society uses to identify right from wrong.

False imprisonment: An act of restraining another person causing that

person to be confined in a bounded area. Restraints can be physical, verbal, or chemical.

Felonies: Serious crimes that cause the perpetrator to be imprisoned for greater than one year.

Fraud: An act of deceiving an individual for personal gain.

Good Samaritan Law: State law providing protections against negligence claims to individuals who render aid to people experiencing medical emergencies outside of clinical environments.

Informed consent: The fundamental right of a client to accept or reject health care.

Infractions: Minor offenses, such as speeding tickets, that result in fines but not jail time.

Institutional liability: When the healthcare institution (e.g., hospital, clinic) is held responsible for the actions of its employees or for failing to implement adequate policies and procedures to prevent harm.

Intentional tort: An act of commission with the intent of harming or causing damage to another person. Examples of intentional torts include assault, battery, false imprisonment, slander, libel, and breach of privacy or client confidentiality.

Laws: Rules and regulations created by society and enforced by courts, statutes, and/or professional licensure boards.

Libel: Written defamation.

Living will: A type of advance directive in which an individual identifies what treatments they would like to receive or refuse if they become incapacitated and unable to make decisions.

Malpractice: A specific term used for negligence committed by a professional with a license.

Misdemeanors: Less serious crimes resulting in fines and/or imprisonment for less than one year.

Negligence: The failure to exercise the ordinary care a reasonable person would use in similar circumstances. Wisconsin civil jury instruction states, "A person is not using ordinary care and is negligent, if the person, without intending to do harm, does something (or fails to do something) that a reasonable person would recognize as creating an unreasonable risk of injury or damage to a person or property."[4]

Omission: Not doing something a reasonable nurse would have done.[5]

Plaintiff: The person bringing the lawsuit.

Private law: Laws that govern the relationships between private entities.

Protected Health Information (PHI): Individually identifiable health information and includes demographic data related to the individual's past, present, or future physical or mental health or condition; the provision of health care to the individual; and the past, present, or future payment for the provision of health care to the individual.

Public law: Law regulating relations of individuals with the government or institutions.

Slander: Spoken defamation.

Statutory law: Written laws enacted by the federal or state legislature. For

4. Wis. JI—Civil 1005. (2016). https://wilawlibrary.gov/jury/civil/instruction.php?n=1005

5. Brous, E. (2019). The elements of a nursing malpractice case, Part 2: Breach. *American Journal of Nursing, 119*(9), 42–46. https://doi.org/10.1097/01.NAJ.0000580256.10914.2e

example, the Nurse Practice Act in each state is an example of statutory law that is enacted by the state government.

Student liability: When the student nurse is held responsible for their own actions that cause harm to clients or violate protocols.

Supervisory liability: When a clinical supervisor or preceptor is held responsible for the actions of the student nurse or for failing to properly supervise them.

Tort: An act of commission or omission that causes injury or harm to another person for which the courts impose liability. In the context of torts, "injury" describes the invasion of any legal right, whereas "harm" describes a loss or detriment the individual suffers. Torts are classified as intentional or unintentional.

Unintentional tort: Acts of omission (not doing something a person has a responsibility to do) or inadvertently doing something causing unintended accidents leading to injury, property damage, or financial loss. Examples of unintentional torts impacting nurses include negligence and malpractice.

PART VI

CHAPTER 6 - ETHICAL PRACTICE

6.1 Ethical Practice Introduction

Learning Objectives

- Compare theories of ethical decision making
- Examine resources to resolve ethical dilemmas
- Examine competent practice within the ethical framework of health care
- Apply the ANA Code of Ethics to diverse situations in health care
- Analyze the impact of cultural diversity in ethical decision making
- Explain advocacy as part of the nursing role when responding to ethical dilemmas

The nursing profession is guided by a code of ethics. As you practice nursing, how will you determine “right” from “wrong” actions? What is the difference between morality, values, and ethical principles? What additional considerations impact your ethical decision-making? What are ethical dilemmas and how should nurses participate in resolving them? This chapter answers these questions by reviewing concepts related to ethical nursing practice and describing how nurses can resolve ethical dilemmas. By the end of this chapter, you will be able to describe how to make ethical decisions using the Code of Ethics established by the American Nurses Association.

6.2 Basic Ethical Concepts

The American Nurses Association (ANA) defines **morality** as "personal values, character, or conduct of individuals or groups within communities and societies," whereas **ethics** is the formal study of morality from a wide range of perspectives.[1] Ethical behavior is considered to be such an important aspect of nursing the ANA has designated *Ethics* as the first Standard of Professional Performance. The ANA Standards of Professional Performance are "authoritative statements of the actions and behaviors that all registered nurses, regardless of role, population, specialty, and setting, are expected to perform competently." See the following box for the competencies associated with the ANA *Ethics* Standard of Professional Performance[2]:

Competencies of ANA's Ethics Standard of Professional Performance[3]

- Uses the *Code of Ethics for Nurses With Interpretive Statements* as a moral foundation to guide nursing practice and decision-making.
- Demonstrates that every person is worthy of nursing care

1. American Nurses Association. (2015). *Code of ethics for nurses with interpretive statements*. American Nurses Association. https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/coe-view-only/

2. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

3. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

through the provision of respectful, person-centered, compassionate care, regardless of personal history or characteristics (Beneficence).
- Advocates for health care consumer perspectives, preferences, and rights to informed decision-making and self-determination (Respect for autonomy).
- Demonstrates a primary commitment to the recipients of nursing and health care services in all settings and situations (Fidelity).
- Maintains therapeutic relationships and professional boundaries.
- Safeguards sensitive information within ethical, legal, and regulatory parameters (Nonmaleficence).
- Identifies ethics resources within the practice setting to assist and collaborate in addressing ethical issues.
- Integrates principles of social justice in all aspects of nursing practice (Justice).
- Refines ethical competence through continued professional education and personal self-development activities.
- Depicts one's professional nursing identity through demonstrated values and ethics, knowledge, leadership, and professional comportment.
- Engages in self-care and self-reflection practices to support and preserve personal health, well-being, and integrity.
- Contributes to the establishment and maintenance of an ethical environment that is conducive to safe, quality health care.
- Collaborates with other health professionals and the public to protect human rights, promote health diplomacy, enhance cultural sensitivity and congruence, and reduce

health disparities.
- Represents the nursing perspective in clinic, institutional, community, or professional association ethics discussions.

Reflective Questions

1. What *Ethics* competencies have you already demonstrated during your nursing education?
2. What *Ethics* competencies are you most interested in mastering?
3. What questions do you have about the ANA's *Ethics* competencies?

The ANA's *Code of Ethics for Nurses With Interpretive Statements* is an ethical standard that guides nursing practice and ethical decision-making.[4] This section will review several basic ethical concepts related to the ANA's *Ethics* Standard of Professional Performance, such as values, morals, ethical theories, ethical principles, and the ANA *Code of Ethics for Nurses*.

Values

Values are individual beliefs that motivate people to act one way or another and serve as guides for behavior considered "right" and "wrong." People tend to adopt the values with which they were raised and believe those values are "right" because they are the values of their culture. Some personal values are considered sacred and moral imperatives based on an individual's religious

4. American Nurses Association. (2015). *Code of ethics for nurses with interpretive statements*. American Nurses Association. https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/coe-view-only/

beliefs.[5] See Figure 6.1[6] for an image depicting choosing right from wrong actions.

Figure 6.1 Values

In addition to personal values, organizations also establish values. The American Nurses Association (ANA) Professional Nursing Model states that nursing is based on values such as caring, compassion, presence, trustworthiness, diversity, acceptance, and accountability. These values emerge from nursing practice beliefs, such as the importance of relationships, service, respect, willingness to bear witness, self-determination, and the pursuit of health.[7] As a result of these traditional values and beliefs by nurses, Americans have ranked nursing as the most ethical and honest profession in Gallup polls since 1999, with the exception of 2001, when firefighters earned the honor after the attacks on September 11.[8]

5. Ethics Unwrapped – McCombs School of Business. (n.d.). *Ethics defined (a glossary).* University of Texas at Austin. https://ethicsunwrapped.utexas.edu/glossary

6. "ethics-2991600_1920" by Tumisu is licensed under CC0 1.0

7. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

8. Walker, A. (2025). Nurses ranked most trusted profession for 23rd years in a

The National League of Nursing (NLN) has also established four core values for nursing education: caring, integrity, diversity, and excellence[9]:

- **Caring:** Promoting health, healing, and hope in response to the human condition.
- **Integrity:** Respecting the dignity and moral wholeness of every person without conditions or limitations.
- **Diversity:** Affirming the uniqueness of and differences among persons, ideas, values, and ethnicities.
- **Excellence:** Cocreating and implementing transformative strategies with daring ingenuity.

View the McCombs School of Business Values video on YouTube.[10]

Morals

Morals are the prevailing standards of behavior of a society that enable people to live cooperatively in groups. "Moral" refers to what societies sanction as right and acceptable. Most people tend to act morally and follow societal guidelines, and most laws are based on the morals of a society. Morality often

row. Nurse.org. https://nurse.org/articles/nursing-ranked-most-honest-profession

9. National League for Nursing. *Core values*. https://www.nln.org/about/about/core-values

10. McCombs School of Business. (2018, December 18). *Values | Ethics defined* [Video]. YouTube. All rights reserved. https://youtu.be/SCjYaatMJuY

requires that people sacrifice their own short-term interests for the benefit of society. People or entities that are indifferent to right and wrong are considered "amoral," while those who do evil acts are considered "immoral."[11]

Ethical Theories

There are two major types of ethical theories that guide values and moral behavior referred to as deontology and consequentialism.

Deontology is an ethical theory based on rules that distinguish right from wrong. See Figure 6.2[12] for a word cloud illustration of deontology. Deontology is based on the word *deon* that refers to "duty." It is associated with philosopher Immanuel Kant. Kant believed that ethical actions follow universal moral laws, such as, "Don't lie. Don't steal. Don't cheat."[13] Deontology is simple to apply because it just requires people to follow the rules and do

11. Ethics Unwrapped – McCombs School of Business. (n.d.). *Ethics defined (a glossary)*. University of Texas at Austin. https://ethicsunwrapped.utexas.edu/glossary

12. "ethics-947572_1920" by rdaconnect at Pixabay.com is licensed under CC0 1.0

13. Ethics Unwrapped – McCombs School of Business. (n.d.). *Ethics defined (a glossary)*. University of Texas at Austin. https://ethicsunwrapped.utexas.edu/glossary

their duty. It doesn't require weighing the costs and benefits of a situation, thus avoiding subjectivity and uncertainty.[14,15,16]

The nurse-client relationship is deontological in nature because it is based on the ethical principles of beneficence and maleficence that drive clinicians to "do good" and "avoid harm."[17] Ethical principles will be discussed further in this chapter.

14. Alexander, L., & Moore, M. (2024). Deontological ethics. *Stanford Encyclopedia of Psychology*. https://plato.stanford.edu/entries/ethics-deontological/

15. Ethics Unwrapped – McCombs School of Business. (n.d.). *Ethics defined (a glossary).* University of Texas at Austin. https://ethicsunwrapped.utexas.edu/glossary

16. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

17. Mandal, J., Ponnambath, D. K., & Parija, S. C. (2016). Utilitarian and deontological ethics in medicine. *Tropical Parasitology, 6*(1), 5–7. https://pubmed.ncbi.nlm.nih.gov/26998430/

Figure 6.2 Deontology

View the McCombs School of Business Deontology video on YouTube.[18]

Consequentialism is an ethical theory used to determine whether or not an action is right by the consequences of the action. See Figure 6.3[19] for an illustration of weighing the consequences of an action in consequentialism. For example, most people agree that lying is wrong, but if telling a lie would help save a person's life, consequentialism says it's the right thing to do. One

18. McCombs School of Business. (2018, December 18). *Deontology | Ethics defined* [Video]. YouTube. All rights reserved. https://youtu.be/wWZi-8Wji7M

19. "balance-6097898_1280" by mohamed_hassan is licensed under CC0 1.0

type of consequentialism is utilitarianism. **Utilitarianism** determines whether or not actions are right based on their consequences with the standard being achieving the greatest good for the greatest number of people.[20,21,22] For this reason, utilitarianism tends to be society-centered. When applying utilitarian ethics to health care resources, money, time, and clinician energy are considered finite resources that should be appropriately allocated to achieve the best health care for society.[23]

Image 6.3 Consequentialism

20. Alexander, L., & Moore, M. (2024). Deontological ethics. *Stanford Encyclopedia of Psychology*. https://plato.stanford.edu/entries/ethics-deontological/

21. Ethics Unwrapped – McCombs School of Business. (n.d.). *Ethics defined (a glossary).* University of Texas at Austin. https://ethicsunwrapped.utexas.edu/glossary

22. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

23. Mandal, J., Ponnambath, D. K., & Parija, S. C. (2016). Utilitarian and deontological ethics in medicine. *Tropical Parasitology, 6*(1), 5–7. https://doi.org/10.4103/2229-5070.175024

Utilitarianism can be complicated when accounting for values such as justice and individual rights. For example, assume a hospital has four clients whose lives depend upon receiving four organ transplant surgeries for a heart, lung, kidney, and liver. If a healthy person without health insurance or family support experiences a life-threatening accident and is considered brain dead but is kept alive on life-sustaining equipment in the ICU, the utilitarian framework might suggest the organs be harvested to save four lives at the expense of one life.[24] This action could arguably produce the greatest good for the greatest number of people, but the deontological approach could argue this action would be unethical because it does not follow the rule of "do no harm."

Watch McCombs School of Business Consequentialism video on YouTube.[25]

Read more about Decision making on organ donation: The dilemmas of relatives of potential brain dead donors.

Interestingly, deontological and utilitarian approaches to ethical issues may result in the same outcome, but the rationale for the outcome or decision is

24. Ethics Unwrapped – McCombs School of Business. (n.d.). *Ethics defined (a glossary)*. University of Texas at Austin. https://ethicsunwrapped.utexas.edu/glossary

25. McCombs School of Business. (2018, December 18). *Consequentialism | Ethics defined* [Video]. YouTube. All rights reserved. https://youtu.be/51DZteag74A

different because it is focused on duty (deontologic) versus consequences (utilitarian).

Societies and cultures have unique ethical frameworks that may be based upon either deontological or consequentialist ethical theory. Culturally derived deontological rules may apply to ethical issues in health care. For example, a traditional Chinese philosophy based on Confucianism results in a culturally acceptable practice of family members (rather than the client) receiving information from health care providers about life-threatening medical conditions and making treatment decisions. As a result, cancer diagnoses and end-of-life treatment options may not be disclosed to the client in an effort to alleviate the suffering that may arise from knowledge of their diagnosis. In this manner, a client's family and the health care provider may ethically prioritize a client's psychological well-being over their autonomy and self-determination.[26] However, in the United States, this ethical decision may conflict with HIPAA Privacy Rules and the ethical principle of client autonomy. As a result, a nurse providing client care in this type of situation may experience an ethical dilemma. Ethical dilemmas are further discussed in the "Ethical Dilemmas" section of this chapter.

See Table 6.2 comparing common ethical issues in health care viewed through the lens of deontological and consequential ethical frameworks.

Table 6.2. Ethical Issues Through the Lens of Deontological or Consequential Ethical Frameworks

26. Wang, H., Zhao, F., Wang, X., & Chen, X. (2018). To tell or not: The Chinese doctors' dilemma on disclosure of a cancer diagnosis to the patient. *Iranian Journal of Public Health, 47*(11), 1773–1774. https://www.ncbi.nlm.nih.gov/pubmed/30581799

Ethical Issue	Deontological View	Consequential View
Abortion	Abortion is unacceptable based on the rule of preserving life.	Abortion may be acceptable in cases of an unwanted pregnancy, rape, incest, or risk to the mother.
Bombing an area with known civilians	Killing civilians is not acceptable due to the loss of innocent lives.	The loss of innocent lives may be acceptable if the bombing stops a war that could result in significantly more deaths than the civilian casualties.
Stealing	Taking something that is not yours is wrong.	Taking something to redistribute resources to others in need may be acceptable.
Killing	It is never acceptable to take another human being's life.	It may be acceptable to take another human life in self-defense or to prevent additional harm they could cause others.
Euthanasia/ physician-assisted suicide	It is never acceptable to assist another human to end their life prematurely.	End-of-life care can be expensive and emotionally upsetting for family members. If a competent, capable adult wishes to end their life, medically supported options should be available.
Vaccines	Vaccination is a personal choice based on religious practices or other beliefs.	Recommended vaccines should be mandatory for everyone (without a medical contraindication) because of its greater good for all of society.

Ethical Principles and Obligations

Ethical principles are used to define nurses' moral duties and aid in ethical analysis and decision-making.[27] Although there are many ethical principles that guide nursing practice, foundational ethical principles include autonomy (self-determination), beneficence (do good), nonmaleficence (do no harm), justice (fairness), fidelity (keep promises), and veracity (tell the truth).

27. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

Autonomy

The ethical principle of **autonomy** recognizes each individual's right to self-determination and decision-making based on their unique values, beliefs, and preferences. See Figure 6.4[28] for an illustration of autonomy. The American Nurses Association (ANA) defines autonomy as the "capacity to determine one's own actions through independent choice, including demonstration of competence."[29] The nurse's primary ethical obligation is client autonomy.[30] Based on autonomy, clients have the right to refuse nursing care and medical treatment. An example of autonomy in health care is advance directives. Advance directives allow clients to specify health care decisions if they become incapacitated and unable to do so.

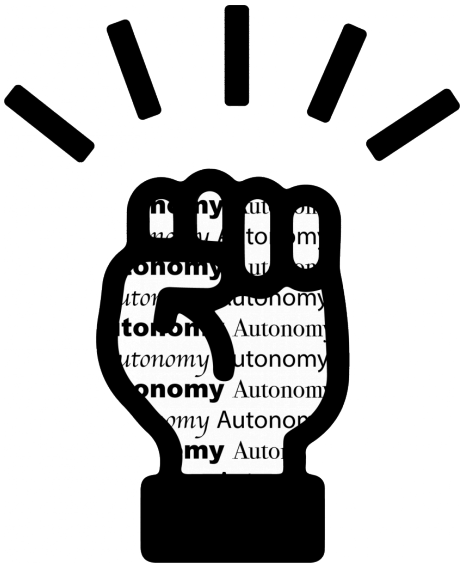

Figure 6.4 Autonomy and Self-Determination

28. "Autonomy and Self-Determination.png" by Meredith Pomietlo for Chippewa Valley Technical College is licensed under CC BY 4.0

29. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

30. American Nurses Association. (2015). *Code of ethics for nurses with interpretive statements*. American Nurses Association. https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/coe-view-only/

> Read more about advance directives and determining capacity and competency in the "Legal Implications" chapter.

NURSES AS ADVOCATES: SUPPORTING AUTONOMY

Nurses have a responsibility to act in the interest of those under their care, referred to as advocacy. The American Nurses Association (ANA) defines advocacy as "the act or process of pleading for, supporting, or recommending a cause or course of action. Advocacy may be for persons (whether an individual, group, population, or society) or for an issue, such as potable water or global health."[31] See Figure 6.5[32] for an illustration of advocacy.

Figure 6.5 Advocacy

Advocacy includes providing education regarding client rights, supporting autonomy and self-determination, and advocating for client preferences to health care team members and family members. Nurses do not make decisions for clients, but instead support them in making their own informed

31. American Nurses Association. (2015). *Code of ethics for nurses with interpretive statements*. American Nurses Association. https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/coe-view-only/

32. "Advocacy" by Meredith Pomietlo for Chippewa Valley Technical College is licensed under CC BY 4.0

choices. At the core of making informed decisions is knowledge. Nurses serve an integral role in client education. Clarifying unclear information, translating medical terminology, and making referrals to other health care team members (within their scope of practice) ensures that clients have the information needed to make treatment decisions aligned with their personal values.

At times, nurses may find themselves in a position of supporting a client's decision they do not agree with and would not make for themselves or for the people they love. However, self-determination is a human right that honors the dignity and well-being of individuals. The nursing profession, rooted in caring relationships, demands that nurses have nonjudgmental attitudes and reflect "unconditional positive regard" for every client. Nurses must suspend personal judgement and beliefs when advocating for their clients' preferences and decision-making.[33]

Beneficence

Beneficence is defined by the ANA as "the bioethical principle of benefiting others by preventing harm, removing harmful conditions, or affirmatively acting to benefit another or others, often going beyond what is required by law."[34] See Figure 6.6[35] for an illustration of beneficence. Put simply,

33. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

34. American Nurses Association. (2015). *Code of ethics for nurses with interpretive statements*. American Nurses Association. https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/coe-view-only/

35. "Air_Force_special_operations_medical_team_saves_lives,_helps_shape_future_of_Afghan_medicine_111010-F-QW942-082.jpg" by Senior Airman Tyler Placie is in the Public Domain

beneficence is acting for the good and welfare of others, guided by compassion. An example of beneficence in daily nursing care is when a nurse sits with a dying client and holds their hand to provide presence.

Figure 6.6 Beneficence

Nursing advocacy extends beyond direct client care to advocating for beneficence in communities. Vulnerable populations such as children, older adults, cultural minorities, and the homeless often benefit from nurse advocacy in promoting health equity. **Cultural humility** is a humble and respectful attitude towards individuals of other cultures and an approach to learning about other cultures as a lifelong goal and process.[36] Nurses, the largest segment of the health care community, have a powerful voice when addressing community beneficence issues, such as health disparities and

36. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

social determinants of health, and can serve as the conduit for advocating for change.

Nonmaleficence

Nonmaleficence is defined by the ANA as "the bioethical principle that specifies a duty to do no harm and balances avoidable harm with benefits of good achieved."[37] An example of doing no harm in nursing practice is reflected by nurses checking medication rights three times before administering medications. In this manner, medication errors can be avoided, and the duty to do no harm is met. Another example of nonmaleficence is when a nurse assists a client with a serious, life-threatening condition to participate in decision-making regarding their treatment plan. By balancing the potential harm with potential benefits of various treatment options, while also considering quality of life and comfort, the client can effectively make decisions based on their values and preferences.

Justice

Justice is defined by the ANA as "a moral obligation to act on the basis of equality and equity and a standard linked to fairness for all in society."[38] The principle of justice requires health care to be provided in a fair and equitable way. Nurses provide quality care for all individuals with the same level of fairness despite many characteristics, such as the individual's financial status, culture, religion, gender, or sexual orientation. Nurses have a social contract to

37. American Nurses Association. (2015). *Code of ethics for nurses with interpretive statements*. American Nurses Association. https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/coe-view-only/

38. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

"provide compassionate care that addresses the individual's needs for protection, advocacy, empowerment, optimization of health, prevention of illness and injury, alleviation of suffering, comfort, and well-being."[39] An example of a nurse using the principle of justice in daily nursing practice is effective prioritization based on client needs.

> Read more about prioritization models in the "Prioritization" chapter.

Other Ethical Principles

Additional ethical principles commonly applied to health care include **fidelity** (keeping promises) and **veracity** (telling the truth). An example of fidelity in daily nursing practice is when a nurse tells a client, "I will be back in an hour to check on your pain level." This promise is kept. An example of veracity in nursing practice is when a nurse honestly explains potentially uncomfortable side effects of prescribed medications. Determining how truthfulness will benefit the client and support their autonomy is dependent on a nurse's clinical judgment, self-reflection, knowledge of the client and their cultural beliefs, and other factors.[40]

A principle historically associated with health care is paternalism. **Paternalism** is defined as the interference by the state or an individual with another person, defended by the claim that the person interfered with will be better

39. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

40. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

off or protected from harm.[41] Paternalism is the basis for legislation related to drug enforcement and compulsory wearing of seatbelts.

In health care, paternalism has been used as rationale for performing treatment based on what the provider believes is in the client's best interest. In some situations, paternalism may be appropriate for individuals who are unable to comprehend information in a way that supports their informed decision-making, but it must be used cautiously to ensure vulnerable individuals are not misused and their autonomy is not violated.

Nurses may find themselves acting paternalistically when performing nursing care to ensure client health and safety. For example, repositioning clients to prevent skin breakdown is a preventative intervention commonly declined by clients when they prefer a specific position for comfort. In this situation, the nurse should explain the benefits of the preventative intervention and the risks if the intervention is not completed. If the client continues to decline the intervention despite receiving this information, the nurse should document the education provided and the client's decision to decline the intervention. The process of reeducating the client and reminding them of the importance of the preventative intervention should be continued at regular intervals and documented.

Care-Based Ethics

Nurses use a client-centered, care-based ethical approach to client care that focuses on the specific circumstances of each situation. This approach aligns with nursing concepts such as caring, holism, and a nurse-client relationship rooted in dignity and respect through virtues such as kindness and

41. Dworkin, G. (2020, September 9). Paternalism. *Stanford Encyclopedia of Philosophy*. https://plato.stanford.edu/entries/paternalism/

compassion.[42,43] This care-based approach to ethics uses a holistic, individualized analysis of situations rather than the prescriptive application of ethical principles to define ethical nursing practice. This care-based approach asserts that ethical issues cannot be handled deductively by applying concrete and prefabricated rules, but instead require social processes that respect the multidimensionality of problems.[44] Frameworks for resolving ethical situations are discussed in the "Ethical Dilemmas" section of this chapter.

Nursing Code of Ethics

Many professions and institutions have their own set of ethical principles, referred to as a **code of ethics**, designed to govern decision-making and assist individuals to distinguish right from wrong. The American Nurses Association (ANA) provides a framework for ethical nursing care and guides nurses during decision-making in its formal document titled *Code of Ethics for Nurses With Interpretive Statements (Nursing Code of Ethics)*. The *Nursing Code of Ethics* serves the following purposes[45]:

42. Fry, S. T. (1989). The role of caring in a theory of nursing ethics. *Hypatia, 4*(2), 87-103. https://doi.org/10.1111/j.1527-2001.1989.tb00575.x

43. Taylor, C. (1993). Nursing ethics: The role of caring. *Awhonn's Clinical Issues in Perinatal and Women's Health Nursing, 4*(4), 552-560. https://pubmed.ncbi.nlm.nih.gov/8220369/

44. Schuchter, P., & Heller, A. (2018). The care dialog: The "ethics of care" approach and its importance for clinical ethics consultation. *Medicine, Health Care, and Philosophy, 21*(1), 51–62. https://doi.org/10.1007/s11019-017-9784-z

45. American Nurses Association. (2015). *Code of ethics for nurses with interpretive statements*. American Nurses Association. https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/coe-view-only/

- It is a succinct statement of the ethical values, obligations, duties, and professional ideals of nurses individually and collectively.
- It is the profession's nonnegotiable ethical standard.
- It is an expression of nursing's own understanding of its commitment to society.

The preface of the ANA's *Nursing Code of Ethics* states, "Individuals who become nurses are expected to adhere to the ideals and moral norms of the profession and also to embrace them as a part of what it means to be a nurse. The ethical tradition of nursing is self-reflective, enduring, and distinctive. A code of ethics makes explicit the primary goals, values, and obligations of the profession."[46]

The *Nursing Code of Ethics* contains nine provisions. Each provision contains several clarifying or "interpretive" statements. Read a summary of the nine provisions in the following box.

Nine Provisions of the ANA *Nursing Code of Ethics*

- **Provision 1:** The nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person.
- **Provision 2:** The nurse's primary commitment is to the client, whether an individual, family, group, community, or population.
- **Provision 3:** The nurse promotes, advocates for, and

46. American Nurses Association. (2015). *Code of ethics for nurses with interpretive statements*. American Nurses Association. https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/coe-view-only/

protects the rights, health, and safety of the client.

- **Provision 4:** The nurse has authority, accountability, and responsibility for nursing practice; makes decisions; and takes action consistent with the obligation to promote health and to provide optimal care.
- **Provision 5:** The nurse owes the same duties to self as to others, including the responsibility to promote health and safety, preserve wholeness of character and integrity, maintain competence, and continue personal and professional growth.
- **Provision 6:** The nurse, through individual and collective effort, establishes, maintains, and improves the ethical environment of the work setting and conditions of employment that are conducive to safe, quality health care.
- **Provision 7:** The nurse, in all roles and settings, advances the profession through research and scholarly inquiry, professional standards development, and the generation of both nursing and health policy.
- **Provision 8**: The nurse collaborates with other health professionals and the public to protect human rights, promote health diplomacy, and reduce health disparities.
- **Provision 9:** The profession of nursing, collectively through its professional organizations, must articulate nursing values, maintain the integrity of the profession, and integrate principles of social justice into nursing and health policy.

- Read the free, online full version of the *ANA's Code of Ethics for Nurses With Interpretive Statements.*

In addition to the *Nursing Code of Ethics*, the ANA established the Center for Ethics and Human Rights to help nurses navigate ethical conflicts and life-and-death decisions common to everyday nursing practice.

- Read more about the ANA Center for Ethics and Human Rights.

Specialty Organization Code of Ethics

Many specialty nursing organizations have additional codes of ethics to guide nurses practicing in settings such as the emergency department, home care, or hospice care. These documents are unique to the specialty discipline but mirror the statements from the ANA's *Nursing Code of Ethics*. View examples of ethical statements of specialty nursing organizations using the information in the following box.

Sample Ethical Statements of Selected Specialty Nursing Organizations

- American College of Nurse-Midwives
- National Association of Neonatal Nurses

6.3 Ethical Dilemmas

Nurses frequently find themselves involved in conflicts during client care related to opposing values and ethical principles. These conflicts are referred to as ethical dilemmas. An **ethical dilemma** results from conflict of competing values and requires a decision to be made from equally desirable or undesirable options.

An ethical dilemma can involve conflicting client's values, nurse values, health care provider's values, organizational values, and societal values associated with unique facts of a specific situation. For this reason, it can be challenging to arrive at a clearly superior solution for all stakeholders involved in an ethical dilemma. Nurses may also encounter moral dilemmas where the right course of action is known but the nurse is limited by forces outside their control. See Table 6.3a for an example of ethical dilemmas a nurse may experience in their nursing practice.

Table 6.3a. Examples of Ethical Issues Involving Nurses

Workplace	Organizational Processes	Client Care

• High client acuity
• Inadequate staffing
• Overuse of agency staff
• Improper use of assistive personnel
• Practicing beyond one's scope of practice
• Floating to other units without appropriate orientation
• Horizontal violence/workplace bullying
• Impaired coworkers
• Violation of client privacy on social media
	• Paperwork and administrative task requirements
	• Substituting outpatient for inpatient care
	• Spending limits on care based on reimbursement codes for medical conditions
	• Discharging clients too soon and expecting family members to provide care
		• Reproduction Issues
		  ◦ Abortion
		  ◦ Birth control methods
		  ◦ Sterilization
		  ◦ Alternative conception
		• End-of-Life Issues
		  ◦ Physician-assisted suicide
		  ◦ Withdrawal of food/fluids
		  ◦ Withdrawal of life support
		  ◦ DNR/DNI
		  ◦ Full code despite a persistent vegetative state
		• Genetics
		  ◦ Screening
		  ◦ Stem cell research
		  ◦ Cloning
		• Organ transplantation
		• Client refusal of medications or treatments

Read more about Ethics Topics and Articles on the ANA website.

According to the American Nurses Association (ANA), a nurse's ethical competence depends on several factors[1]:

- Continuous appraisal of personal and professional values and how they may impact interpretation of an issue and decision-making
- An awareness of ethical obligations as mandated in the *Code of Ethics for Nurses With Interpretive Statements*[2]
- Knowledge of ethical principles and their application to ethical decision-making
- Motivation and skills to implement an ethical decision

Nurses and nursing students must have **moral courage** to address the conflicts involved in ethical dilemmas with "the willingness to speak out and do what is right in the face of forces that would lead us to act in some other way."[3] See Figure 6.7[4] for an illustration of nurses' moral courage.

1. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

2. American Nurses Association. (2015). *Code of ethics for nurses with interpretive statements*. American Nurses Association. https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/coe-view-only/

3. American Nurses Association (ANA). (2025). *Ethics topics and articles.* https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/ethics-topics-and-articles/

4. "Moral courage.png" by Meredith Pomietlo for Chippewa Valley Technical College is licensed under CC BY 4.0

Figure 6.12 Moral Courage

Nurse leaders and organizations can support moral courage by creating environments where nurses feel safe and supported to speak up.[5] Nurses may experience **moral conflict** when they are uncertain about what values or principles should be applied to an ethical issue that arises during client care. Moral conflict can progress to **moral distress** when the nurse identifies the correct ethical action but feels constrained by competing values of an organization or other individuals. Nurses may also feel **moral outrage** when witnessing immoral acts or practices they feel powerless to change. For this reason, it is essential for nurses and nursing students to be aware of frameworks for solving ethical dilemmas that consider ethical theories, ethical principles, personal values, societal values, and professionally sanctioned guidelines such as the ANA *Nursing Code of Ethics*.

Moral injury felt by nurses and other health care workers in response to the COVID-19 pandemic has gained recent public attention. **Moral injury** refers to the distressing psychological, behavioral, social, and sometimes spiritual aftermath of exposure to events that contradict deeply held moral beliefs and expectations.[6] Health care workers may not have the time or resources to

5. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

6. Norman, S. & Maguen, S. (2024). *Moral injury.* PTSD: National Center for PTSD,

process their feelings of moral injury caused by the pandemic, which can result in burnout. Organizations can assist employees in processing these feelings of moral injury with expanded employee assistance programs or other structured support programs.[7]

> Read more about self-care strategies to address feelings of burnout in the "Burnout and Self-Care" chapter.

Frameworks for Solving Ethical Dilemmas

Systematically working through an ethical dilemma is key to identifying a solution. Many frameworks exist for solving an ethical dilemma, including the nursing process, four-quadrant approach, the MORAL model, and the organization-focused PLUS Ethical Decision-Making model.[8] When nurses use a structured, systematic approach to resolving ethical dilemmas with appropriate data collection, identification and analysis of options, and inclusion of stakeholders, they have met their legal, ethical, and moral responsibilities, even if the outcome is less than ideal.

U.S. Department of Veterans Affairs. https://www.ptsd.va.gov/professional/treat/cooccurring/moral_injury.asp

7. Dean, W., Jacobs, B., & Manfredi, R. A. (2020). Moral injury: The invisible epidemic in COVID health care workers. *Annals of Emergency Medicine, 76*(4), 385–386. https://doi.org/10.1016/j.annemergmed.2020.05.023

8. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

Nursing Process Model

The nursing process is a structured problem-solving approach that nurses may apply in ethical decision-making to guide data collection and analysis. See Table 6.3b for suggestions on how to use the nursing process model during an ethical dilemma.[9]

Table 6.3b. Using the Nursing Process in Ethical Situations[10]

9. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

10. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

Nursing Process Stage	Considerations
Assessment/Data Collection	• What is the issue? • Who is involved? • What are the facts (health status, pain, treatment)? • What are the stakeholder (client, family, health care team, community) concerns? • What ethics resources exist (such as an organization's ethics committee)?
Assessment/Analysis	• Analyze the facts and stakeholder values using ethical principles, ethical theories, the ANA *Nursing Code of Ethics*, or another ethical framework model. • Document the ethics resources consulted.
Diagnosis	• Determine the care context and issues, including areas of agreement and conflict. • Consider the entire context, including the client, family, health care team, and institutional circumstances.
Outcome Identification	• Establish a goal based on client autonomy.
Planning	• Identify a range of options, realizing there may only be "best available" options when possibilities are limited.
Implementation	• Ensure the option chosen is right, suitable, and appropriate. Be aware that not all options are appropriate in all contexts. • Implement the plan in collaboration with the client, family, and other stakeholders.

Evaluation	• Evaluate what happened and what can be learned after every ethical dilemma.

Four-Quadrant Approach

The four-quadrant approach integrates ethical principles (e.g., beneficence, nonmaleficence, autonomy, and justice) in conjunction with health care indications, individual and family preferences, quality of life, and contextual features.[11] See Table 6.3c for sample questions used during the four-quadrant approach.

Table 6.3c. Four-Quadrant Approach[12]

11. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

12. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

Health Care Indications **(Beneficence and Nonmaleficence)** • What is the diagnosis/prognosis? • What are the goals of treatment/care? • What is the likelihood of success of treatment? • Will the proposed treatment plan benefit the client and avoid harm?	**Individual and Family Preferences** **(Respect for Autonomy)** • What are the client's preferences? • Does the client understand their condition? • Has the client provided informed consent, and do they understand the risks and benefits of the proposed treatment? • Is the client competent and capacitated to make decisions? If not, are there advance directives in place?
Quality of Life **(Beneficence, Nonmaleficence, and Respect for Autonomy)** • What is the probability of the client's return to normal life with or without treatment? • Would the person experience any physical, mental, or social deficits even if the treatment succeeds? • Do the health care providers have any biases that might prejudice their evaluation of the client's quality of life? • Has forgoing treatment been discussed? • Are there plans for comfort and/or palliative care?	**Contextual Features** **(Justice and Fairness)** • Are there family or provider issues, such as implicit bias, that might influence treatment decisions? • Are there religious, financial, social, racial, or legal issues that might affect treatment decisions? • Are there issues related to allocation of resources that might affect treatment?

MORAL Model

The MORAL model is a nurse-generated, decision-making model originating from research on nursing-specific moral dilemmas involving client autonomy,

quality of life, distributing resources, and maintaining professional standards. The model provides guidance for nurses to systematically analyze and address real-life ethical dilemmas. The steps in the process may be remembered by using the mnemonic MORAL. See Table 6.3d for a description of each step of the MORAL model.[13,14]

Table 6.3d. MORAL Model

M: Massage the dilemma	Collect data by identifying the interests and perceptions of those involved, defining the dilemma, and describing conflicts. Establish a goal.
O: Outline options	Generate several effective alternatives to reach the goal.
R: Review criteria and resolve	Identify moral criteria and select the course of action.
A: Affirm position and act	Implement action based on knowledge from the previous steps (M-O-R).
L: Look back	Evaluate each step and the decision made.

PLUS Ethical Decision-Making Model

The PLUS Ethical Decision-Making model was created by the Ethics and Compliance Initiative to help organizations empower employees to make ethical decisions in the workplace. This model uses four filters throughout the ethical decision-making process, referred to by the mnemonic PLUS:

- **P:** Policies, procedures, and guidelines of an organization
- **L:** Laws and regulations
- **U:** Universal values and principles of an organization

13. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

14. Crisham, P. (1985). Moral: How can I do what is right? *Nursing Management, 16*(3), 44. https://journals.lww.com/nursingmanagement/citation/1985/03000/moral__how_can_i_do_what_s_right_.6.aspx

- **S:** Self-identification of what is good, right, fair, and equitable[15]

The seven steps of the PLUS Ethical Decision-Making model are as follows[16]:

- Define the problem using PLUS filters
- Seek relevant assistance, guidance, and support
- Identify available alternatives
- Evaluate the alternatives using PLUS to identify their impact
- Make the decision
- Implement the decision
- Evaluate the decision using PLUS filters

15. Ethics & Compliance Initiative. (2021). *The PLUS Ethical Decision Making Model*. https://www.ethics.org/resources/free-toolkit/decision-making-model/

16. Ethics & Compliance Initiative. (2021). *The PLUS Ethical Decision Making Model*. https://www.ethics.org/resources/free-toolkit/decision-making-model/

6.4 Ethics Committees

In addition to using established frameworks to resolve ethical dilemmas, nurses can also consult their organization's ethics committee for ethical guidance in the workplace. **Ethics committees** are typically composed of interdisciplinary team members such as physicians, nurses, allied health professionals, administrators, social workers, and clergy to problem-solve ethical dilemmas. See Figure 6.8[1] for an illustration of an ethics committee. Hospital ethics committees were created in response to legal controversies regarding the refusal of life-sustaining treatment, such as the Karen Quinlan case.[2]

Figure 6.8 Ethics Committee

> Read more about the Karen Quinlan case and controversies surrounding life-sustaining treatment in the "Legal Implications" chapter.

1. "Ethics Committee.png" by Meredith Pomietlo for Chippewa Valley Technical College is licensed under CC BY 4.0
2. Annas, G., & Grodin, M. (2016). Hospital ethics committees, consultants, and courts. *AMA Journal of Ethics, 18*(5), 554-559. https://journalofethics.ama-assn.org/article/hospital-ethics-committees-consultants-and-courts/2016-05

After the passage of the Patient Self-Determination Act in 1991, all health care institutions receiving Medicare or Medicaid funding are required to form ethics committees. The Joint Commission (TJC) also requires organizations to have a formalized mechanism of dealing with ethical issues. Nurses should be aware of the process for requesting guidance and support from ethics committees at their workplace for ethical issues affecting clients or staff.[3]

Institutional Review Boards and Ethical Research

Other types of ethics committees have been formed to address the ethics of medical research on clients. Historically, there are examples of medical research causing harm to clients. For example, an infamous research study called the "Tuskegee Study" raised concern regarding ethical issues in research such as informed consent, paternalism, maleficence, truth-telling, and justice.

In 1932 the Tuskegee Study began a 40-year study looking at the long-term progression of syphilis. Over 600 Black men were told they were receiving free medical care, but researchers only treated men diagnosed with syphilis with aspirin, even after it was discovered that penicillin was a highly effective treatment for the disease. The institute allowed the study to go on, even when men developed long-stage neurological symptoms of the disease and some wives and children became infected with syphilis. In 1972 these consequences of the Tuskegee Study were leaked to the media and public outrage caused the study to shut down.[4]

3. Aulisio, M. (2016). Why did hospital ethics committees emerge in the US? *AMA Journal of Ethics, 18*(5), 546-553. https://journalofethics.ama-assn.org/article/why-did-hospital-ethics-committees-emerge-us/2016-05

4. Centers for Disease Control and Prevention. (2021). The Untreated Syphilis

Potential harm to clients participating in research studies like the Tuskegee Study was rationalized based on the utilitarian view that potential harm to individuals was outweighed by the benefit of new scientific knowledge resulting in greater good for society. As a result of public outrage over ethical concerns related to medical research, Congress recognized that an independent mechanism was needed to protect research subjects. In 1974 regulations were established requiring research with human subjects to undergo review by an **institutional review board (IRB)** to ensure it meets ethical criteria. An IRB is group that has been formally designated to review and monitor biomedical research involving human subjects.[5] The IRB review ensures the following criteria are met when research is performed:

- The benefits of the research study outweigh the potential risks.
- Individuals' participation in the research is voluntary.
- Informed consent is obtained from research participants who have the ability to decline participation.
- Participants are aware of the potential risks of participating in the research.[6]

Study at Tuskegee Timeline. https://www.cdc.gov/tuskegee/about/timeline.html?CDC_AAref_Val=https://www.cdc.gov/tuskegee/timeline.htm

5. U.S. Food & Drug Administration. (2019). *Institutional review boards (IRBs) and protection of human subjects in clinical trials.* U.S. Department of Health & Human Services. https://www.fda.gov/about-fda/center-drug-evaluation-and-research-cder/institutional-review-boards-irbs-and-protection-human-subjects-clinical-trials

6. Annas, G., & Grodin, M. (2016). Hospital ethics committees, consultants, and courts. *AMA Journal of Ethics, 18*(5), 554-559. https://journalofethics.ama-assn.org/article/hospital-ethics-committees-consultants-and-courts/2016-05

View a YouTube video discussing Henrietta Lacks, the Tuskegee Experiment, ethics and research.[7]

7. CrashCourse. (2018, April 18). *Henrietta Lacks, the Tuskegee experiment, and ethical data collection: Crash course statistics #1* [Video]. YouTube. All rights reserved. https://youtu.be/CzNANZnoiRs

6.5 Ethics and the Nursing Student

Nursing students may encounter ethical dilemmas when in clinical practice settings. Read more about research regarding ethical dilemmas experienced by students as described in the box.

Nursing Students and Ethical Dilemmas[1]

An integrative literature review performed by Albert, Younas, and Sana in 2020 identified ethical dilemmas encountered by nursing students in clinical practice settings. Three themes were identified:

1. Applying learned ethical values vs. accepting unethical practice

Students observed unethical practices of nurses and physicians, such as breach of client privacy, confidentiality, respect, rights, duty to provide information, and physical and psychological mistreatment, that opposed the ethical values learned in nursing school. Students experienced ethical conflict due to their sense of powerlessness, low status as students, dependence on staff nurses for learning experiences, and fear of offending health care providers.

2. Desiring to provide ethical care but lacking autonomous decision-making

Students reported a lack of moral courage in questioning unethical practices. The hierarchy of health care environments

1. Albert, J. S., Younas, A., & Sana, S. (2020). Nursing students' ethical dilemmas regarding patient care: An integrative review. *Nurse Education Today, 88*, 104389. https://doi.org/10.1016/j.nedt.2020.104389

left students feeling disregarded, humiliated, and intimidated by professional nurses and managers. Students also reported a sense of loss of identity in feeling forced to conform their personal identity to that of the clinical environment.

3. Whistleblowing vs. silence regarding client care and neglect

Students observed nurses performing unethical nursing practices, such as ignoring client needs, disregarding pain, being verbally abusive, talking inappropriately about clients, and not providing a safe or competent level of care. Most students reported remaining silent regarding these observations due to a lack of confidence, feeling it was not their place to report, or the fear of negative consequences. Organizational power dynamics influenced student confidence in reporting unethical practices to faculty or nurse managers.

The researchers concluded that nursing students feel moral distress when experiencing these kinds of conflicts:

- Providing ethical care as learned in their program of study or accepting unethical practices
- Staying silent about client care neglect or confronting it and reporting it
- Providing quality, ethical care or adapting to organizational culture due to lack of autonomous decision-making

These ethical conflicts can be detrimental to students' professional learning and mental health. Researchers recommended that nurse educators should develop educational

programs to support students as they develop ethical competence and moral courage to confront ethical dilemmas.[2]

Read more about ethics education in nursing in the *ANA's Online Journal of Issues in Nursing* article.

COVID-19 and the Nursing Profession

The COVID-19 pandemic has highlighted the importance of nurses' foundational knowledge of ethical principles and the *Nursing Code of Ethics*. Scarce resources in an overwhelmed health care system resulted in ethical dilemmas and moral injury for nurses involved in balancing conflicting values, rights, and ethical principles. Many nurses were forced to weigh their duty to clients and society against their duty to themselves and their families. Challenging ethical issues occurred related to the ethical principle of justice, such as fair distribution of limited ICU beds and ventilators, and ethical dilemmas related to end-of-life issues such as withdrawing or withholding life-prolonging treatment became common.[3]

Regardless of their practice setting or personal contact with clients affected by COVID-19, nurses have been forced to reflect on the essence of ethical professional nursing practice through the lens of personal values and morals.

2. Albert, J. S., Younas, A., & Sana, S. (2020). Nursing students' ethical dilemmas regarding patient care: An integrative review. *Nurse Education Today, 88,* 104389. https://doi.org/10.1016/j.nedt.2020.104389

3. McKenna, H. (2020). Covid-19: Ethical issues for nurses. *International Journal of Nursing Studies, 110*, 103673. https://doi.org/10.1016/j.ijnurstu.2020.103673

Nursing students must be knowledgeable about ethical theories, ethical principles, and strategies for resolving ethical dilemmas as they enter the nursing profession that will continue to experience long-term consequences as a result of COVID-19.[4]

4. McKenna, H. (2020). Covid-19: Ethical issues for nurses. *International Journal of Nursing Studies, 110*, 103673. https://doi.org/10.1016/j.ijnurstu.2020.103673

6.6 Spotlight Application

A True Story of a New Nurse's Introduction to Ethical Dilemmas

A new nurse graduate meets Mary, a 70-year-old woman who was living alone at home with Amyotrophic Lateral Sclerosis (ALS or also referred to as "Lou Gehrig's disease"). Mary's husband died many years ago and they did not have children. She had a small support system, including relatives who lived out of state and friends with whom she had lost touch since her diagnosis. Mary was fiercely independent and maintained her nutrition and hydration through a gastrostomy tube to avoid aspiration.

As Mary's disease progressed, the new nurse discussed several safety issues related to Mary living alone. As the new nurse shared several alternative options related to skilled nursing care with Mary, Mary shared her own plan. Mary said her plan included a combination of opioids, benzodiazepines, and a plastic bag to suffocate herself and be found by a nurse during a scheduled visit. In addition to safety issues and possible suicide ideation, the new nurse recognized she was in the midst of an ethical dilemma in terms of the treatment plan, her values and what she felt was best for Mary, and Mary's preferences.

Applying the MORAL Ethical Decision-Making Model to Mary's Case

Massage the Dilemma	**Data:** Mary lives alone and does not want to go to a nursing home. She lacks social support. She has a progressive and incurable disease that affects her ability to swallow, talk, walk, and eventually breathe. She has made statements to staff indicating she prefers to die rather than leave her home to receive total care in a long-term care setting. **Ethical Conflicts:** According to the deontological theory, suicide is always wrong. According to the consequentialism ethical theory, an action's morality depends on the consequences of that action. Mary has a progressive, incurable illness that requires total care that will force her to leave the home. She wishes to stay in her home until she dies. **Ethical Goals:** To honor Mary's dignity and respect her autonomy in making treatment decisions. For Mary to experience a "good" death as she defines it, and neither hasten nor prolong her dying process through illegal or amoral interventions.
Outline the Options	• Allow Mary to implement her plan for suicide. • Admit Mary to the hospital due to suicidal ideation with a clearly expressed plan and means to implement her plan. • Talk Mary into being admitted to a nursing home. • Call distant family members or friends to see if they could care for Mary. • Remove all available means that Mary could use to end her life prematurely (including medications for symptom management that could be used to end her life, resulting in untreated pain). • Discontinue tube feeding and limit hydration to only that necessary for medication to provide comfort and symptom management. • Facilitate Mary's ideas regarding physician-assisted suicide. Although illegal in Mary's state of residence, Mary discussed travelling to a state where it was legal.
Review Criteria and Resolve	Mary was assessed to be rational and capable of decision-making by a psychiatrist. Mary defined a "good" death as one occurring in her home and not in a hospital or long-term care setting. Mary did not want her life to be prolonged through the use of technology such as a ventilator. **Resolution:** Mary elected to discontinue tube feeding and limit hydration to only that necessary for medication to provide comfort care and symptom management.

Affirm Position and Act	Although some health care members did not personally believe in discontinuing food and fluids through the g-tube based on their interpretation of the deontological ethical theory, Mary's decision was acceptable both legally and ethically, based on the consequentialism ethical theory that the decision best supported Mary's goals and respected her autonomy. Daily visits were scheduled with hospice staff, including the nurse, nursing assistant, social worker, chaplain, and volunteers. Hired caregivers supplemented visits and in the last couple of days were scheduled around the clock. Mary died comfortably in her bed seven days after implementation of the agreed-upon plan.
Look Back	The health care team evaluated what happened during Mary's situation and what could be learned from this ethical dilemma and applied to future client-care scenarios.

Learning Activities

(Answers to "Learning Activities" can be found in the "Answer Key" at the end of the book. Answers to interactive activities are provided as immediate feedback.)

Ethical Application & Reflection Activity

Case A

Filmmaker Lulu Wang first shared a story about her grandmother on *This American Life* podcast and later turned it into the 2019 movie *The Farewell* starring Awkwafina. Both share the challenges of a Chinese-born but U.S.-raised woman returning to China and a family who has chosen to not disclose that the grandmother has been given a Stage IV lung cancer diagnosis and three months to live. Listen to the podcast and then answer the following questions:

- 585: In Defense of Ignorance Act One: What You Don't Know

1. Reflect on the similarities and differences of your family culture with that of the Billi family. Consider things such as what family gatherings, formal and informal, look like and spoken and unspoken rules related to communication and behavior.

2. The idea of “good” lies and “bad” lies is introduced in the podcast. Nai Nai’s family supports the decision to not tell her about her Stage IV lung cancer, stage a wedding as the excuse to visit and say their goodbyes, and even alter a medical report as good lies necessary to support her mental health, well-being, and happiness. Is the family applying deontological or utilitarian ethics to the situation? Defend your response.

3. Define the following ethical principles and identify examples from this story:

- Autonomy
- Beneficence
- Nonmaleficence
- Paternalism

4. Imagine this story is happening in the United States rather than China and you are the nurse admitting Nai Nai to an inpatient oncology unit. Using the ethical problem-solving model of your choice, identify and support your solution to the ethical dilemma posed when her family requests that Nai Nai not be told that she has cancer.

Ethical Application & Reflection Activity

Case B

You are caring for a 32-year-old client who has been in a persistent vegetative state for many years. There is an

outdated advanced directive that is confusing on the issue of food and fluids, though clear about not wanting to be on a ventilator if she were in a coma. Her husband wants the feeding tube removed but is unable to say that it would have been the client's wish. He says that it is his decision for her. Her two adult siblings and parents reject this as a possibility because they say that "human life is sacred" and that the daughter believed this. They say their daughter is alive and should receive nursing care, including feeding. The health care team does not know what to do ethically and fear being sued by either the husband, siblings, or the parents. What do you need to know about this clinical situation? What are the values and obligations at stake in this case? What values or obligations should be affirmed and why? How might that be done?

1. Define the problem.

2. List what facts/information you have.

3. What are the stakeholders' positions?

- Client:
- Spouse:
- Family:
- Health Care Team:
- Facility:
- Community:

4. How might the stakeholders' values differ?

5. What are your values in this situation?

6. Do your values conflict with those of the client? Describe.

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingmpc/?p=422#h5p-10

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingmpc/?p=422#h5p-26

Test your knowledge using this NCLEX Next Generation-style Case Study. You may reset

- and resubmit your answers to this question an unlimited number of times.[1]

1. “Chapter 6, Assignment 1” by Travis Christman for OpenRN is licensed under CC BY-NC 4.0

VI Glossary

Advocacy: The act or process of pleading for, supporting, or recommending a cause or course of action. Advocacy may be for persons (whether an individual, group, population, or society) or for an issue, such as potable water or global health.[1]

Autonomy: The capacity to determine one's own actions through independent choice, including demonstration of competence.[2]

Beneficence: The bioethical principle of benefiting others by preventing harm, removing harmful conditions, or affirmatively acting to benefit another or others, often going beyond what is required by law.[3]

Code of ethics: A set of ethical principles established by a profession that is designed to govern decision-making and assist individuals to distinguish right from wrong.

Consequentialism: An ethical theory used to determine whether or not an action is right by the consequences of the action. For example, most people agree that lying is wrong, but if telling a lie would help save a person's life, consequentialism says it's the right thing to do.

1. American Nurses Association. (2015). *Code of ethics for nurses with interpretive statements*. American Nurses Association. https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/coe-view-only/

2. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association

3. American Nurses Association. (2015). *Code of ethics for nurses with interpretive statements*. American Nurses Association. https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/coe-view-only/

Cultural humility: A humble and respectful attitude towards individuals of other cultures and an approach to learning about other cultures as a lifelong goal and process.

Deontology: An ethical theory based on rules that distinguish right from wrong.

Ethical dilemma: Conflict resulting from competing values that requires a decision to be made from equally desirable or undesirable options.

Ethical principles: Principles used to define nurses' moral duties and aid in ethical analysis and decision-making.[4] Foundational ethical principles include autonomy (self-determination), beneficence (do good), nonmaleficence (do no harm), justice (fairness), and veracity (tell the truth).

Ethics: The formal study of morality from a wide range of perspectives.[5]

Ethics committee: A formal committee established by a health care organization to problem-solve ethical dilemmas.

Fidelity: An ethical principle meaning keeping promises.

Institutional Review Board (IRB): A group that has been formally designated to review and monitor biomedical research involving human subjects.

4. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association

5. American Nurses Association. (2015). *Code of ethics for nurses with interpretive statements*. American Nurses Association. https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/coe-view-only/

Justice: A moral obligation to act on the basis of equality and equity and a standard linked to fairness for all in society.[6]

Moral conflict: Feelings occurring when an individual is uncertain about what values or principles should be applied to an ethical issue.[7]

Moral courage: The willingness of an individual to speak out and do what is right in the face of forces that would lead us to act in some other way.[8]

Moral distress: Feelings occurring when correct ethical action is identified but the individual feels constrained by competing values of an organization or other individuals.[9]

Moral injury: The distressing psychological, behavioral, social, and sometimes spiritual aftermath of exposure to events that contradict deeply held moral beliefs and expectations.

Morality: Personal values, character, or conduct of individuals or groups within communities and societies.[10]

6. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.
7. American Nurses Association (ANA). *Ethics topics and articles.* https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/ethics-topics-and-articles/
8. American Nurses Association (ANA). *Ethics topics and articles.* https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/ethics-topics-and-articles/
9. American Nurses Association (ANA). *Ethics topics and articles.* https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/ethics-topics-and-articles/
10. American Nurses Association. (2015). *Code of ethics for nurses with*

Moral outrage: Feelings occurring when an individual witnesses immoral acts or practices they feel powerless to change.[11]

Morals: The prevailing standards of behavior of a society that enable people to live cooperatively in groups.[12]

Nonmaleficence: The bioethical principle that specifies a duty to do no harm and balances avoidable harm with benefits of good achieved.[13]

Paternalism: The interference by the state or an individual with another person, defended by the claim that the person interfered with will be better off or protected from harm.[14]

Utilitarianism: A type of consequentialism that determines whether or not actions are right based on their consequences, with the standard being achieving the greatest good for the greatest number of people.

interpretive statements. American Nurses Association. https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/coe-view-only/

11. American Nurses Association (ANA). *Ethics topics and articles*. https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/ethics-topics-and-articles/

12. Ethics Unwrapped – McCombs School of Business. (n.d.). *Ethics defined (a glossary)*. University of Texas at Austin. https://ethicsunwrapped.utexas.edu/glossary

13. American Nurses Association. (2015). *Code of ethics for nurses with interpretive statements*. American Nurses Association. https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/coe-view-only/

14. Dworkin, G. (2020). Paternalism. *Stanford Encyclopedia of Philosophy*. https://plato.stanford.edu/entries/paternalism/

Values: Individual beliefs that motivate people to act one way or another and serve as a guide for behavior.[15]

Veracity: An ethical principle meaning telling the truth.

15. Ethics Unwrapped – McCombs School of Business. (n.d.). *Ethics defined (a glossary).* University of Texas at Austin. https://ethicsunwrapped.utexas.edu/glossary

PART VII

CHAPTER 7 - COLLABORATION WITHIN THE INTERPROFESSIONAL TEAM

7.1 Collaboration Within the Interprofessional Team Introduction

Learning Objectives

- Describe how nurses collaborate with the healthcare team to coordinate appropriate healthcare services for clients
- Describe collegial and professional practice within the healthcare team
- Identify members of the team and describe their contributions to optimize client outcomes
- Explore community resources to maximize a client's functional abilities
- Describe procedures used to safely admit, transfer, and/or discharge clients

All health care students must prepare to deliberately work together in clinical practice with a common goal of building a safer, more effective, client-centered health care system. The World Health Organization (WHO) defines **interprofessional collaborative practice** as multiple health workers from different professional backgrounds working together with clients, families, caregivers, and communities to deliver the highest quality of care.[1]

Effective teamwork and communication have been proven to reduce medical

1. World Health Organization. (2010). *Framework for action on interprofessional education & collaborative practice*. https://www.who.int/publications/i/item/framework-for-action-on-interprofessional-education-collaborative-practice

errors, promote a safety culture, and improve client outcomes.[2] The importance of effective interprofessional collaboration has become even more important as nurses advocate to reduce health disparities related to social determinants of health (SDOH). In these efforts, nurses work with people from a variety of professions, such as physicians, social workers, educators, policy makers, attorneys, faith leaders, government employees, community advocates, and community members. Nursing students must be prepared to effectively collaborate interprofessionally after graduation.[3]

The Interprofessional Education Collaborative (IPEC) has identified four core competencies for effective interprofessional collaborative practice. This chapter will review content related to these four core competencies and provide examples of how they relate to nursing.

2. AHRQ. (2015). *TeamSTEPPS: National implementation research/evidence base*. https://www.ahrq.gov/teamstepps/evidence-base/safety-culture-improvement.html
3. National Academies of Sciences, Engineering, and Medicine. (2021). *The future of nursing 2020-2030: Charting a path to achieve health equity*. The National Academies Press. https://doi.org/10.17226/25982

7.2 IPEC Core Competencies

The Interprofessional Education Collaborative (IPEC) established standard core competencies for effective interprofessional collaborative practice. The competencies guide the education of future health professionals with the necessary knowledge, skills, values, and attitudes to collaboratively work together in providing client care. See Table 7.2 for a description of the four IPEC core competencies.[1] Each of these competencies will be further discussed in the following sections of this chapter.

Table 7.2. IPEC Core Competencies[2]

1. Interprofessional Education Collaborative. (2023). *IPEC core competencies*. https://www.ipecollaborative.org/ipec-core-competencies
2. Interprofessional Education Collaborative. (2023). *IPEC core competencies*. https://www.ipecollaborative.org/ipec-core-competencies

Competency 1: Values/Ethics for Interprofessional Practice Work with individuals of other professions to maintain a climate of mutual respect and shared values.
Competency 2: Roles/Responsibilities Use the knowledge of one's own role and those of other professions to appropriately assess and address the health care needs of clients and to promote and advance the health of populations.
Competency 3: Interprofessional Communication Communicate with clients, families, communities, and professionals in health and other fields in a responsive and responsible manner that supports a team approach to the promotion and maintenance of health and the prevention and treatment of disease.
Competency 4: Teams and Teamwork Apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan, deliver, and evaluate client/population-centered care and population health programs and policies that are safe, timely, efficient, effective, and equitable.

7.3 Values and Ethics for Interprofessional Practice

The first IPEC competency is related to values and ethics and states, "Work with individuals of other professions to maintain a climate of mutual respect and shared values."[1] See the box below for the components related to this competency. Notice how these interprofessional competencies are very similar to the Standards of Professional Performance established by the American Nurses Association related to *Ethics, Advocacy, Respectful and Equitable Practice, Communication*, and *Collaboration*.[2]

Components of IPEC's Values/Ethics for Interprofessional Practice Competency[3]

- Place interests of clients and populations at the center of interprofessional health care delivery and population health programs and policies, with the goal of promoting health and health equity across the life span.
- Respect the dignity and privacy of clients while maintaining confidentiality in the delivery of team-based care.
- Embrace the cultural diversity and individual differences

1. Interprofessional Education Collaborative. (2023). *IPEC core competencies*. https://www.ipecollaborative.org/ipec-core-competencies
2. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.
3. Interprofessional Education Collaborative. (2023). *IPEC core competencies*. https://www.ipecollaborative.org/ipec-core-competencies

that characterize clients, populations, and the health team.

- Respect the unique cultures, values, roles/responsibilities, and expertise of other health professions and the impact these factors can have on health outcomes.
- Work in cooperation with those who receive care, those who provide care, and others who contribute to or support the delivery of prevention and health services and programs.
- Develop a trusting relationship with clients, families, and other team members.
- Demonstrate high standards of ethical conduct and quality of care in contributions to team-based care.
- Manage ethical dilemmas specific to interprofessional client/population-centered care situations.
- Act with honesty and integrity in relationships with clients, families, communities, and other team members.
- Maintain competence in one's own profession appropriate to scope of practice.

Nursing, medical, and other health professional programs typically educate students in "silos" with few opportunities to collaboratively work together in the classroom or in clinical settings. However, after being hired for their first job, these graduates are thrown into complex clinical situations and expected to function as part of the team. One of the first steps in learning how to function as part of an effective interprofessional team is to value each health care professional's contribution to quality, client-centered care. Mutual respect and trust are foundational to effective interprofessional working relationships for collaborative care delivery across the health professions.

Collaborative care also honors the diversity reflected in the individual expertise each profession brings to care delivery.[4]

Cultural diversity is a term used to describe cultural differences among clients, family members, and health care team members. While it is useful to be aware of specific traits of a culture, it is just as important to understand that each individual is unique, and there are always variations in beliefs among individuals within a culture. Nurses should, therefore, refrain from making assumptions about the values and beliefs of members of specific cultural groups.[5] Instead, a better approach is recognizing that culture is not a static, uniform characteristic but instead realizing there is diversity within every culture and in every person. The American Nurses Association (ANA) defines **cultural humility** as, "A humble and respectful attitude toward individuals of other cultures that pushes one to challenge their own cultural biases, realize they cannot possibly know everything about other cultures, and approach learning about other cultures as a lifelong goal and process."[6] It is imperative for nurses to integrate culturally responsive care into their nursing practice and interprofessional collaborative practice.

4. Interprofessional Education Collaborative. (2023). *Core competencies for interprofessional collaborative practice: Version 3.* Interprofessional Education Collaborative. IPEC Core Competencies for Interprofessional Collaborative Practice: Version 3

5. Interprofessional Education Collaborative. (2023). *Core competencies for interprofessional collaborative practice: Version 3.* Interprofessional Education Collaborative. https://www.ipecollaborative.org/assets/core-competencies/IPEC_Core_Competencies_Version_3_2023.pdf

6. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

> Read more about cultural diversity, cultural humility, and integrating culturally responsive care in the "Diverse Patients" chapter of Open RN *Nursing Fundamentals, 2e*.

Nurses value the expertise of interprofessional team members and integrate this expertise when providing client-centered care. Some examples of valuing and integrating the expertise of interprofessional team members include the following:

- A nurse is caring for a client admitted with chronic heart failure to a medical-surgical unit. During the shift the client's breathing becomes more labored and the client states, "My breathing feels worse today." The nurse ensures the client's head of bed is elevated, oxygen is applied according to the provider orders, and the appropriate scheduled and PRN medications are administered, but the client continues to complain of dyspnea. The nurse calls the respiratory therapist and requests a STAT consult. The respiratory therapist assesses the client and recommends implementation of BiPAP therapy. The provider is notified and an order for BiPAP is received. The client reports later in the shift the dyspnea is resolved with the BiPAP therapy.
- A nurse is working in the Emergency Department when an adolescent client arrives via ambulance experiencing a severe asthma attack. The paramedic provides a handoff report with the client's current vital signs, medications administered, and intravenous (IV) access established. The paramedic also provides information about the home environment, including information about vaping products and a cat in the adolescent's bedroom. The nurse thanks the paramedic for sharing these observations and plans to use information about the home environment to provide client education about asthma triggers and tobacco cessation after the client has been stabilized.
- A nurse is working in a long-term care environment with several

unlicensed assistive personnel (UAP) who work closely with the residents providing personal cares and have excellent knowledge regarding their baseline status. Today, after helping Mrs. Smith with her morning bath, one of the UAPs tells the nurse, "Mrs. Smith doesn't seem like herself today. She was very tired and kept falling asleep while I was talking to her, which is not her normal behavior." The nurse immediately assesses Mrs. Smith and confirms her somnolescence and confirms her vital signs are within her normal range. The nurse reviews Mrs. Smith's chart and notices that a new prescription for furosemide was started last month but no potassium supplements were ordered. The nurse notifies the provider of the client's change in status and receives an order for lab work including an electrolyte panel. The results indicate that Mrs. Smith's potassium level has dropped to an abnormal level, which is the likely cause of her fatigue and somnolescence. The provider is notified, and an order is received for a potassium supplement. The nurse thanks the AP for recognizing and reporting Mrs. Smith's change in status and successfully preventing a poor client outcome such as a life-threatening cardiac dysrhythmia.

Effective client-centered, interprofessional collaborative practice improves client outcomes. View supplementary material and reflective questions in the following box.[7]

View the "How does interprofessional collaboration impact care: The patient's perspective?" video on YouTube regarding clients' perspectives about the importance of interprofessional collaboration.

Read Ten Lessons in Collaboration. Although this is an older

7. Leadership and Influencing Change in Nursing by Joan Wagner is licensed under CC BY 4.0

publication, it provides ten lessons to consider in collaborative relationships and practice. The discussion reflects many components of collaboration that have been integral to nursing practice in interprofessional teamwork and leadership.

Reflective Questions

1. What is the difference between client-centered care and disease-centered care?
2. Why is it important for health professionals to collaborate?

7.4 Roles and Responsibililites of Health Care Professionals

The second IPEC competency relates to the roles and responsibilities of health care professionals and states, "Use the knowledge of one's own role and those of other professions to appropriately assess and address the health care needs of clients and to promote and advance the health of populations."[1]

See the following box for the components of this competency. It is important to understand the roles and responsibilities of the other health care team members; recognize one's limitations in skills, knowledge, and abilities; and ask for assistance when needed to provide quality, client-centered care.

Components of IPEC's Roles/Responsibilities Competency[2]

- Communicate one's roles and responsibilities clearly to clients, families, community members, and other professionals.
- Recognize one's limitations in skills, knowledge, and abilities.
- Engage with diverse professionals who complement one's own professional expertise, as well as associated resources, to develop strategies to meet specific health and health care needs of clients and populations.
- Explain the roles and responsibilities of other providers and

1. Interprofessional Education Collaborative. (2023). *IPEC core competencies*. https://www.ipecollaborative.org/ipec-core-competencies

2. Interprofessional Education Collaborative. (2023). *IPEC core competencies*. https://www.ipecollaborative.org/ipec-core-competencies

the manner in which the team works together to provide care, promote health, and prevent disease.
- Use the full scope of knowledge, skills, and abilities of professionals from health and other fields to provide care that is safe, timely, efficient, effective, and equitable.
- Communicate with team members to clarify each member's responsibility in executing components of a treatment plan or public health intervention.
- Forge interdependent relationships with other professions within and outside of the health system to improve care and advance learning.
- Engage in continuous professional and interprofessional development to enhance team performance and collaboration.
- Use unique and complementary abilities of all members of the team to optimize health and client care.
- Describe how professionals in health and other fields can collaborate and integrate clinical care and public health interventions to optimize population health.

Nurses communicate with several individuals during a typical shift. For example, during inpatient care, nurses may communicate with clients and their family members; pharmacists and pharmacy technicians; providers from different specialties; physical, speech, and occupational therapists; dietary aides; respiratory therapists; chaplains; social workers; case managers; nursing supervisors, charge nurses, and other staff nurses; assistive personnel; nursing students; nursing instructors; security guards; laboratory personnel; radiology and ultrasound technicians; and surgical team members. Providing holistic, quality, safe, and effective care means every team member taking care of clients must work collaboratively and understand the knowledge, skills, and scope of practice of the other team members. Table 7.4 provides examples of

the roles and responsibilities of common health care team members that nurses frequently work with when providing client care. To fully understand the roles and responsibilities of the multiple members of the complex health care delivery system, it is beneficial to spend time shadowing those within these roles.

Table 7.4. Roles and Responsibilities of Members of the Health Care Team

Member	Role/Responsibilities
Unlicensed Assistive Personnel (UAP) (e.g., certified nursing assistants [CNA], patient-care technicians [PCT], certified medical assistants [CMA], certified medication aides, and home health aides)	Work under the direct supervision of the RN. (Read more about Unlicensed Assistive Personnel (UAP) in the "Delegation and Supervision" chapter.)
Licensed Practical/ Vocational Nurses (LPN/VN)	Assist the RN by performing routine, basic nursing care with predictable outcomes. (Read more details in the "Delegation and Supervision" chapter.)
Registered Nurses (RN)	Use the nursing process to assess, diagnose, identify expected outcomes, plan and implement interventions, and evaluate care according to the Nurse Practice Act of the state they are employed.
Charge Nurses or Nursing Supervisors	Supervise members of the nursing team and overall client care on the unit (or organization) to ensure quality, safe care is delivered.
Directors of Nursing (DON), Chief Nursing Officer (CNO), or Vice President of Patient Services	Ensure federal and state regulations and standards are being followed and are accountable for all aspects of client care.
Clinical Nurse Specialist (CNS)	Practice in a variety of health care environments and participate in mentoring other nurses, case management, research, designing and conducting quality improvement programs, and serving as educators and consultants.

Nurse Practitioners (NP) or Advanced Practice Registered Nurses (APRN)	Work in a variety of settings and complete physical examinations, diagnose and treat common acute illness, manage chronic illness, order laboratory and diagnostic tests, prescribe medications and other therapies, provide health teaching and supportive counseling with an emphasis on prevention of illness and health maintenance, and refer clients to other health professionals and specialists as needed. NPs have advanced knowledge with a graduate degree and national certification.
Certified Registered Nurse Anesthetists (CRNA)	Administer anesthesia and related care before, during, and after surgical, therapeutic, diagnostic, and obstetrical procedures, as well as provide airway management during medical emergencies.
Certified Nurse Midwives (CNM)	Provide gynecological exams, family planning guidance, prenatal care, management of low-risk labor and delivery, and neonatal care.
Medical Doctors (MD)	Licensed providers who diagnose, treat, and direct medical care. There are many types of physician specialists such as surgeons, pulmonologists, neurologists, cardiologists, nephrologists, pediatricians, and ophthalmologists.
Physician Assistants (PA)	Work under the direct supervision of a medical doctor as licensed and certified professionals following protocols based on the state in which they practice.
Doctors of Osteopathy (DO)	Licensed providers similar to medical physicians but with different educational preparation and licensing exams. They provide care, prescribe, and can perform surgeries.
Dieticians	Assess, plan, implement, and evaluate interventions related to specific dietary needs of clients, including regular or therapeutic diets. Formulate diets for clients with dysphagia or other physical disorders and provide dietary education such as diabetes education.

Physical Therapists (PT)	Develop and implement a plan of care as a licensed professional for clients with dysfunctional physical abilities, including joints, strength, mobility, gait, balance, and coordination.
Occupational Therapists (OT)	Plan, provide, and evaluate care for clients with dysfunction affecting their independence and ability to complete activities of daily living (ADLs). Assist clients in using adaptive devices to reach optimal levels of functioning and provide home safety assessments.
Speech Therapists (ST)	Develop and initiate a plan of care for clients diagnosed with communication and swallowing disorders.
Respiratory Therapists (RT)	Specialize in treating clients with respiratory disorders or conditions in collaboration with providers. Provide treatments such as CPAP, BiPAP, respiratory treatments and medications like aerosol nebulizers, chest physiotherapy, and postural drainage. They also intubate clients, assist with bronchoscopies, manage mechanical ventilation, and perform pulmonary function tests.
Social Workers (SW)	Provide a liaison between the community and the health care setting to ensure continuity of care after discharge. Assist clients with establishing community resources, health insurance, and advance directives.
Psychologists and Psychiatrists	Provide mental health services to clients in both acute and long-term settings. As physician specialists, psychiatrists prescribe medications and perform other medical treatments for mental health disorders. Psychologists focus on counseling.
Nurse Case Managers or Discharge Planners	Ensure clients are provided with effective and efficient medical care and services, during inpatient care and post-discharge, while also managing the cost of these services.

The coordination and delivery of safe, quality client care demands reliable teamwork and collaboration across the organizational and community boundaries. Clients often have multiple visits across multiple providers working in different organizations. Communication failures between health care settings, departments, and team members is the leading cause of client harm.[3] The health care system is becoming increasingly complex requiring collaboration among diverse health care team members. For example, when a COPD exacerbation client is discharged from the acute care setting, their condition may necessitate home resources or care in order to optimize their recovery. This may require the coordination of home oxygen resources, a walker, or home visits in order to assess their transition and recovery. Nurses must understand that community resources are individualized to their regional area and advocating for client needs and resource gaps is an important part of their role.

The goal of good interprofessional collaboration is improved client outcomes, as well as increased job satisfaction of health care team professionals. Clients receiving care with poor teamwork are almost five times as likely to experience complications or death. Hospitals in which staff report higher levels of teamwork have lower rates of workplace injuries and illness, fewer incidents of workplace harassment and violence, and lower turnover.[4]

Valuing and understanding the roles of team members are important steps toward establishing good interprofessional teamwork. Another step is

3. Rosen, M. A., DiazGranados, D., Dietz, A. S., Benishek, L. E., Thompson, D., Pronovost, P. J., & Weaver, S. J. (2018). Teamwork in healthcare: Key discoveries enabling safer, high-quality care. *The American Psychologist, 73*(4), 433-450. https://doi.org/10.1037/amp0000298

4. Rosen, M. A., DiazGranados, D., Dietz, A. S., Benishek, L. E., Thompson, D., Pronovost, P. J., & Weaver, S. J. (2018). Teamwork in healthcare: Key discoveries enabling safer, high-quality care. *The American Psychologist, 73*(4), 433-450. https://doi.org/10.1037/amp0000298

learning how to effectively communicate with interprofessional team members.

Community Resource Care Coordination Case Scenario

Patient Background

Name: Mr. Gerald Hermso

Age: 72

Medical History: Chronic Heart Failure (CHF), Hypertension, Type 2 Diabetes, Hyperlipidemia

Recent Hospitalization: Mr. Hermso was admitted to the hospital due to a CHF exacerbation characterized by shortness of breath, fatigue, and fluid retention. After stabilization with diuretics, beta-blockers, and lifestyle adjustments, Mr. Hermso is ready for discharge.

Discharge Planning Goals:

1. Ensure Mr. Hermso's safe transition from hospital to home.
2. Minimize the risk of readmission.
3. Provide ongoing support for managing CHF at home.

Discharge Coordinator's Role:

The discharge coordinator plays a crucial role in organizing Mr. Hermso's transition from the hospital to his home. This includes identifying and coordinating community resources that can support his ongoing care.

- **Assessment of Needs:** The coordinator reviews Mr. Hermso's medical records and discharge plan, including prescribed medications, follow-up appointments, dietary restrictions, and physical activity recommendations. The

coordinator assesses Mr. Hermso's living situation. Does he live alone? Does he have any support systems such as family or friends who can assist him? Identify any potential barriers to Mr. Hermso managing his condition at home, such as mobility issues, medication management challenges, or limited access to transportation.

- **Collaboration with Nursing Staff:** The discharge coordinator collaborates with the nurse assigned to Mr. Hermso to ensure all his needs are met. The nurse provides insights into Mr. Hermso's physical and psychological readiness for discharge. Together, they develop a plan to address his needs post-discharge.
- **Community Resources Identification:** The discharge coordinator arranges for a home health nurse to visit Mr. Hermso several times a week to monitor his vital signs, administer medications, and provide education on CHF management. The coordinator sets up a service with a local pharmacy for medication delivery and synchronization, ensuring that Mr. Hermso receives his prescriptions on time. The nurse will teach Mr. Hermso how to use a pill organizer. A referral is made to a community dietitian who specializes in CHF to provide Mr. Hermso with personalized meal planning that aligns with his dietary restrictions. The coordinator arranges for Mr. Hermso to receive telehealth equipment, including a scale and blood pressure monitor, so that his weight and blood pressure can be monitored remotely. The nurse will educate Mr. Hermso on using this equipment. The coordinator refers Mr. Hermso to a local cardiac rehab program, where he can receive supervised exercise and education on heart health. If Mr. Hermso lacks transportation, the coordinator connects him with local

transportation services that can take him to follow-up appointments and rehab sessions. The coordinator links Mr. Hermso with a local CHF support group where he can connect with others who have similar experiences, providing emotional and social support.

Nurse's Role:

- **Patient Education:** The nurse provides detailed education on CHF management, including recognizing early signs of exacerbation, the importance of medication adherence, dietary restrictions (e.g., low-sodium diet), and the need for regular physical activity. The nurse teaches Mr. Hermso how to use his new telehealth equipment and ensures he understands how to log and report his readings.
- **Care Coordination:** The nurse ensures that all community resources are in place before discharge. This includes confirming home health services, medication delivery, and transportation arrangements. The nurse reviews the discharge plan with Mr. Hermso and his family (if applicable) to ensure they understand the follow-up schedule and how to access the resources provided.
- **Follow-up:** The nurse schedules a follow-up call within 48 hours of discharge to check on Mr. Hermso's progress, answer any questions, and address any emerging issues.

Outcome:

- **Immediate Post-Discharge:** Mr. Hermso transitions home with a solid support system in place. He has access to home health services, medication management, dietary support, and telehealth monitoring.
- **Long-term Monitoring:** Through consistent follow-up and

engagement with community resources, Mr. Hermso is better equipped to manage his CHF at home, reducing the likelihood of readmission and improving his overall quality of life.

7.5 Interprofessional Communication

The third IPEC competency focuses on interprofessional communication and states, "Communicate with clients, families, communities, and professionals in health and other fields in a responsive and responsible manner that supports a team approach to the promotion and maintenance of health and the prevention and treatment of disease."[1] See Figure 7.1[2] for an image of interprofessional communication supporting a team approach. This competency also aligns with The Joint Commission's National Patient Safety Goal for improving staff communication.[3] See the following box for the components associated with the Interprofessional Communication competency.

1. Interprofessional Education Collaborative. (2023). *IPEC core competencies*. https://www.ipecollaborative.org/ipec-core-competencies

2. "1322557028-huge.jpg" by LightField Studios is used under license from Shutterstock.com

3. The Joint Commission. *(2025). Hospital national patient safety goals*. https://www.jointcommission.org/standards/national-patient-safety-goals/hospital-national-patient-safety-goals/

Figure 7.1 Image from Nursing Fundamentals

Components of IPEC's Interprofessional Communication Competency[4]

- Choose effective communication tools and techniques, including information systems and communication technologies, to facilitate discussions and interactions that enhance team function.
- Communicate information with clients, families, community members, and health team members in a form that is understandable, avoiding discipline-specific terminology when possible.

4. Interprofessional Education Collaborative. *(2023). IPEC core competencies.* https://www.ipecollaborative.org/ipec-core-competencies