Test Bank for Essentials of Nursing Law and Ethics 3rd Westrick

Essentials of Nursing Law and Ethics, Third Edition
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Test Bank Questions for Instructors

Part I: The Law and Nursing Practice

Chapter 1: The Legal Environment:

1. For which reason are nurses sometimes named as defendants in malpractice claims?

   A) Naming more individuals increases the likelihood of full recovery.
   B) Nurses have better malpractice insurance than other professions.
   C) The scope of practice for nurses has expanded recently.
   D) Nurses are suing their employers more often.

Answer: A. Hospitals or healthcare organizations that employ nurses and other professionals, such as physicians, are often named as defendants alongside their employees in lawsuits. It has become more common for plaintiffs to include multiple defendants, including nurses, to increase their chances of winning the case and receiving more damages. While nurses may carry malpractice insurance (B), this isn't the reason for the rise in legal claims. The scope of practice for nurses hasn't changed significantly (C). If a nurse were to sue their employer, the nurse would be the plaintiff, and the employer would be the defendant (D).

2. Legal processes follow a particular order after a claim of professional malpractice is made by a plaintiff against a defendant nurse. Place the following steps in order of occurrence:

   A) The defendant files an answer to the allegations.
   B) The defendant is served by summons with notice of the lawsuit.
   C) Discovery takes place, including depositions of the parties of the lawsuit or witnesses.
   D) Evidence in the case is presented to the judge or jury if the case goes to trial.
   E) An appeal can be filed by the losing party.
   F) A verdict or judgment is rendered.
   G) The lawsuit, including allegations against the defendant, is filed in court.

Answer: Order – G, B, A, C, D, F, E (Question uses alternate format of NCLEX style question)

Chapter 2: Regulation of Nursing Practice

1. Nurse Practice Acts (NPAs) are specific to each state and require:

   A) all professional nurses to have a baccalaureate degree.
   B) mandatory licensure for anyone practicing as an RN.

C) RNs to validate continuing education credits as a requirement for re-licensure each year.
D) the state to develop a list of tasks that nurses can and cannot perform.

Answer: B. Mandatory licensure for RNs is required by each state to avoid having unlicensed and unqualified individuals performing nursing tasks for compensation. This protects both the safety of the public and the integrity of the profession. Answers B and C are incorrect since baccalaureate degrees and continuing education credits are not required by all NPAs, although some states' NPAs do. Answer D is incorrect since a specific list of tasks for nurses is not developed, as it would quickly be outdated. Rather, a broad category of functions and areas of practice is defined.

2. Licensure of registered nurses (RNs) is a means to:

A) ensure that RNs meet standards for education in the scope of practice for RNs.
B) restrict the practice of other healthcare practitioners, such as social workers.
C) require states to join in multistate licensure pacts with other neighboring states.
D) allow nurses to practice only in an area for which they are credentialed.

Answer: A. Licensure protects the public by ensuring that those with the RN designation have met certain educational standards reflective of the scope of practice for RNs. Answer B is incorrect since Nurse Practice Acts are not designed to restrict other practitioners, such as social workers. Answer C is incorrect since the licensure system for RNs does not require participation in multistate licensure pacts, although it may be voluntary. Answer D is incorrect because credentialing is a voluntary process not required as a part of licensure, but it usually designates that a nurse is qualified in a specialty area through advanced training and/or experience. Nursing organizations typically offer and monitor credentialing processes.

Chapter 3: Nurses in Legal Actions

1. A nursing supervisor witnesses a nurse intentionally kick a bedside table toward a verbally abusive patient, knocking the patient to the floor. The patient had bruising but no major injuries. The nursing supervisor should:

A) verbally reprimand the nurse for mishandling the situation.
B) report the incident to the state board of nursing or to risk management for external state or federal agency reporting if required.
C) enroll the nurse in a remediation program.
D) refer the nurse and patient to social work.

Answer: B. Nursing supervisors will be responsible under any state licensing or federal reporting laws for their own inaction if they do not make a mandatory report of patient

harm (regardless of seriousness) caused by an intentional act by licensed staff. Answer A is not correct since the supervisor should follow the Human Resources policy on employee reprimand. A referral to social work (D) may be indicated for the patient but is not the appropriate response for an employee. A remediation program is meant for nurses who have acted incompetently and have an opportunity to improve. This incident is not an example of incompetence that would be corrected by remediation (C).

2. Which of the following is *not* a right to due process under administrative licensing board procedures?

   A) Right to be informed
   B) Right to be heard
   C) Right to state your side of the facts without repercussion
   D) Right to be treated fairly in the process

Answer: C. The right to state your side of the facts without repercussion is not part of the process. In fact, anything said by the nurse will be used by the board to support the allegations. The nurse should always seek advice from an attorney before speaking to an investigator.

Chapter 4: Standards of Care

1. A nurse–midwife is sued for failure to timely resuscitate a neonate in the neonatal intensive care unit. Regarding the applicable standards of care, which of the following is true?

   A) The scope of practice for nurse–midwives is the same in every state.
   B) The hospital's resuscitation policy may expand the scope of practice for the midwife.
   C) A pediatric nurse practitioner may be consulted to explain the neonatal resuscitation standards to the jury.
   D) The nurse–midwife's response should be compared to similar responses by emergency room physicians.

Answer: C. A pediatric nurse practitioner shares responsibility of neonatal resuscitation, and most states allow each specialty to act as expert on the shared procedure. Answer A is incorrect because scope of practice varies according to each state statute. Answer B is incorrect because policies may not expand the scope of practice set by a Nurse Practice Act, and answer D is incorrect because standards of care should be compared within the same specialty only. The response of a nurse–midwife is not comparable to the response by an emergency room physician because they have different practice settings and licenses.

2. When determining whether an activity falls within the scope of nursing practice, the nurse should consider which of the following? (Check all that apply.)

   A) ___ Is the activity consistent with sound nursing practice?
   B) ___ Is there a standard for this activity from professional organizations?
   C) ___ Does the activity provide a good patient outcome?
   D) ___ Is the nurse prepared to accept accountability?
   E) ___ Does the nurse have the competency for this activity?

Answer: A, B, D, and E. All are correct except "Does the activity provide a good patient outcome?" This is not part of determining the scope of nursing practice criteria.

Chapter 5: Defenses to Negligence or Malpractice

1. Which among the following is a reasonable defense to a malpractice action by a plaintiff-patient against a nurse?

   A) The patient was not aware of the risks listed in the signed consent form.
   B) Too much time has passed; the statute of limitations now bars the claim.
   C) The nurse was not familiar with the procedure that was implemented for the patient.
   D) Complications are an inherent part of medical care.

Answer: B. Claims can be time barred by being claimed after the period of time that is required by the statute of limitations, generally two to three years in malpractice actions, with certain exceptions. The fact that the nurse is not familiar with a procedure or intervention is not a defense to the alleged negligence or malpractice claim (C). The nurse must refuse to implement the intervention if not competent to perform the action. Patients can assume the risk of certain interventions by being informed but then cannot claim that they did not know of the risk (A). While there are risks with medical care, the patient does not assume the risk if the damage was negligent (D).

2. Immunity from liability for claims of negligence would *not* be applied for a nurse who:

   A) performs acts that are outside of the nurse's scope of practice if working under short-staffing conditions.
   B) works as a governmental employee and the Federal Tort Claims Act (FTCA) is used to substitute the government as the defendant.
   C) renders services as a volunteer under the state's "Good Samaritan Act."
   D) renders freely offered reasonable care to victims at the site of an emergency.

Answer: A. When a nurse undertakes acts that are not within the scope of practice, there is no defense to a negligence or malpractice claim that there is a short-staffing situation. Immunities can be provided as a federal employee (B), or while acting within the boundaries of the state "Good Samaritan Act" (C) as long as the assistance is not grossly negligent or reckless.

Chapter 6: Prevention of Malpractice

1. The nurse assists a transport company with positioning a patient with a hip fracture connected to traction on a stretcher prior to discharge. The nurse receives a lawsuit notice 6 months later claiming permanent injury to the fractured hip due to negligent transport methods at discharge. Which of the following is true regarding the legal issues based on this scenario?

   A) The nurse's defense will be that the orders for traction and transport were placed by the provider.
   B) The nurse's defense will be that they were not aware of how to set up traction for an ambulance ride.
   C) The claim of negligence against the nurse is based on the duty to act to prevent foreseeable harm to the patient by the transport method.
   D) The claim of negligence against the nurse is based on inappropriate delegation of patient positioning to an outside transport company.

Answer: C. The nurse has an independent duty to act on the known standard of care (knowledge as to the correct positioning of the fractured hip) if an act known to the nurse can cause harm to the patient. Therefore, the nurse should have recognized that the traction was not applied correctly and could cause harm prior to leaving the hospital.

2. A surgical nurse performed a postoperative sponge count and notified the circulating nurse that it was correct. The surgical nurse received a lawsuit notice months later that a sponge was retained after surgery. Which healthcare provider would be held responsible for this error?

   A) The surgical nurse
   B) The surgeon
   C) Surgical technicians
   D) The circulating nurse

Answer: A. While surgeons were once considered to be responsible for all negligent acts that occur during surgery, surgical nurses now have their own independent liability for incorrect sponge and needle counts.

Chapter 7: Nurses as Witnesses

1. A nurse who is testifying as an expert witness during a deposition involving allegations of negligence by another nurse typically can testify about:

   A) the standard of care of other nursing specialties.
   B) hypothetical questions involving facts similar to issues in the lawsuit.
   C) the standard of care required by physicians in the situation in question.
   D) the defendant's credentials.

Answer: B. Hypothetical questions are often asked to clarify the testimony. The nurse expert is only qualified to testify about the standard of care for those whom they are familiar with through training, education, or experience, and this would not include physicians (C) or other specialties (A). Expert witness nurses typically testify about their own credentials to establish credibility and to qualify as an expert who can give an opinion in the case, but they do not testify about the defendant's credentials.

2. If a family member requests that the primary nurse sign an important document as a witness to their patient's signature, the nurse should:

   A) sign the document.
   B) ask another appropriate person to sign as a witness.
   C) sign it only if no one else is available.
   D) consult with a lawyer.

Answer: B. Nurses should not sign these documents as a witness since doing so attests to the fact that the patient had the capacity to sign and understand the document. The nurse may be called to testify at a later proceeding if these issues are raised, so it is best to avoid this possible conflict. Additionally, many employers have policies against signing such documents, so these should be checked. The family is asking the nurse to be a witness and not agree to anything on the document, so consulting a lawyer should not be necessary.

Chapter 8: Professional Liability Insurance

1. Reasons that it is prudent for a nurse to have an individual professional liability insurance policy include: (Check all that apply to receive credit for this question.)

A) ___ Coverage is typically provided for defense of actions by the state board of nursing.
B) ___ The nurse's individual policy will not be considered as a primary policy if other policies cover any judgment or settlement.
C) ___ The nurse's interest in any litigation may be adverse to the employer's interest.
D) ___ The insurance company will provide an attorney who will defend the nurse.
E) ___ Volunteer activities while functioning as an RN are usually covered.
F) ___ Protection for excess judgments beyond your individual policy limits.

Answer: A, C, D, and E. Answer B is not true because the policy may be considered primary or secondary, depending on the facts of the case and how the court interprets each contract of insurance that is involved. Answer F is not true because the policy is a contract and will only cover to the extent of any limits of the policy; excess judgments may be recovered from the policies of other parties or from the nurse's individual assets. (alternate format NCLEX style question)

2. Exclusions that are typically part of an individual professional liability insurance policy for an RN include:

A) punitive damages awarded to the plaintiff.
B) actions that are within the scope of practice for the RN.
C) claims that arise based on an unintentional mistake by the nurse.
D) any action by the nurse that could have been prevented.

Answer: A. Punitive damages are usually not covered by malpractice policies since they are usually awarded to punish the wrongdoer and serve as an example for deterrence for these actions by others. Thus, they are awarded on the basis of particularly egregious behavior. Actions that are within the scope of the RN's practice and are unintended mistakes (negligence) that are often preventable are what the liability policy covers against.

Chapter 9: Accepting or Refusing an Assignment/Patient Abandonment

1. A new graduate nurse has been informed by the nursing supervisor that he will need to work on another patient care unit where he has not worked before for this shift. The new graduate nurse should first:

A) inform the supervisor that he is not prepared to accept an assignment off his regular unit.
B) ask his coworkers if someone else will float to the other unit.
C) accept the assignment.

D) inquire about the patient population and skills needed on the other unit.

Answer: D. Nurses should first consider whether they have the knowledge and skill to care for the patients. The nurse needs this information before either refusing (A), accepting (C), or finding another nurse to take the assignment (B). The ANA Code of Ethics and Position Statements support the nurse's refusal to care for patients when the nurse is not competent to do so.

2. Which outcome may be expected if a nurse refuses an assignment due to short staffing?

   A) The employer will be required to find additional staff to help.
   B) The nurse could be subject to a claim of patient abandonment.
   C) The court will uphold the nurse's choice to do so.
   D) The nurse cannot be found negligent if done in good faith.

Answer: B. Patient abandonment is a consideration if there are no other caregivers. The nurse cannot simply walk off and leave patients unattended by professional caregivers. The employer may not be able to provide additional staff despite the nurse's refusal (A). The court will examine whether all internal processes were followed, whether there is a union contract in place (although not required), and the facts and circumstances of the case before determining if a claim is upheld (C). If a nurse refuses a patient assignment and a later charge of negligence or professional malpractice is brought, the impact of the refusal will be considered (D).

Chapter 10: Delegation to Unlicensed Assistive Personnel

1. Which factors are correctly stated in an RN's decision to delegate a task to unlicensed assistive personnel (UAP) to avoid RN liability for any adverse outcomes? (Check all that apply to receive credit for this question.)

   A) ___ The competency of the UAP as documented in the job description
   B) ___ If the task is delegable
   C) ___ The number of RNs working on the unit
   D) ___ If the nurse can provide guidance and supervision to the UAP
   E) ___ The patient's needs and which level of staff is needed to meet those needs
   F) ___ UAP states he is not familiar with the task that is to be delegated
   G) ___ Whether the family says they can perform the task

Answer: A, B, D, E, F. Answer C is incorrect since the nurse must consider the needs of the patient and whether a task is delegable, not whether there is anyone else to do the

task. It is no excuse to delegate just because the unit is short-staffed, since doing so may compromise patient safety. Answer G is incorrect because a nurse cannot delegate a task to the family, since they are not staff and the nurse has no authority over them or their actions. (alternate format NCLEX question)

Part II: Liability in Patient Care

Chapter 11: Patients' Rights and Responsibilities

1. Which of the following are included in the Patients' Bill of Rights? (Check all that apply to receive credit.)

   A) ___ The hospital must clearly post the bill of rights.
   B) ___ Patients have the right to confidential communications.
   C) ___ States may allow patients to bring a private cause of action for deprivation of rights.
   D) ___ Recipients of mental health services have specific rights to privacy of this information.
   E) ___ Patients must be free of restraint and seclusion unless specifically consented to.

Answer: A, B, C, and D. All statements are checked except the last statement (E) regarding restraints, which, due to the emergent nature of the intervention, do not require consent when applied to preserve the safety of the patient or others. The Patients' Bill of Rights states patients are free of restraint use for coercion.

2. A nurse is caring for a patient who wishes to refuse a treatment that the physician has recommended. The patient has expressed understanding of the risks and consequences of refusal. What is the nurse's primary responsibility in this situation according to the Patients' Bill of Rights?

   A) Convince the patient to follow the physician's advice
   B) Document the refusal and notify the physician
   C) Notify the patient's family of their decision
   D) Determine if the refusal will likely lead to harm

Answer: B. Under the Patients' Bill of Rights, patients have the right to informed refusal of treatment. The nurse's role is to respect this decision, ensure proper documentation, and inform the physician without attempting to coerce or override the patient's autonomy.

Answer A is incorrect since it is not the nurse's role to persuade patients to act against their wishes. Answer C is incorrect since the nurse may be breaking confidentiality to share the decision with the family. Answer D is incorrect since it is not the nurse's duty to determine if a refusal will cause harm; it is the provider's role to explain the risks and benefits of treatment options.

Chapter 12: Confidential Communication

1. The nurse manager is working with a new employee nurse on the GYN unit and is orienting her to unit and agency policies regarding patient confidentiality. The nurse manager determines that the new nurse needs more instruction when she states:

   A) "I will make sure that I throw out my work papers related to my patient assignment in the confidential paper bin before I leave the unit to go home."
   B) "I will make sure that I don't discuss any of the patient's lab data reports with anyone but immediate family or spouse."
   C) "I know I cannot discuss any patient issues even with my husband."
   D) "I know I cannot load any patient information in any portable storage device, such as a flash drive."

Answer: B. The nurse cannot discuss lab data or other information, even with a patient's spouse or immediate family, without the patient's permission. Confidential medical information must be discussed only with the patient. Any papers that contain protected health information (PHI) must be used and discarded only in the workplace in proper receptacles.

2. A violation of patient confidentiality occurs when the nurse:

   A) gives information about the patient on the phone without verifying who is receiving the information.
   B) allows state inspectors enforcing regulations to view patient records to verify that proper documentation has been completed to meet standards.
   C) completes an interagency transfer note when a patient is discharged to a nursing home.
   D) gives testimony in a court case involving documentation that the nurse made in a confidential medical record.

Answer: A. The nurse should have a method to verify who is receiving information during a telephone conversation. Some hospitals use the last 4 digits of social security numbers, or the patient's hospital ID number to verify the caller. Confidential medical information may be disclosed in legal proceedings and may be used by official state regulators or in valid transfers to other caregivers or agencies on an as-needed basis.

3. Which practice by healthcare organizations can be used to effectively implement the privacy rules of the Heath Insurance Portability and Accountability Act (HIPAA)?

   A) Give patient information over the telephone if the caller identifies themselves
   B) Ask family members to relay medical information to patients to save time
   C) Notify patients that they can file any complaints about privacy and confidentiality to the risk management department
   D) Give nursing staff members access to all computerized information for admitted patients in the institution

Answer: C. A policy that informs patients of their right to file any complaints about confidentiality and privacy assures them that they have an avenue to voice their concerns and to have corrective action taken, if appropriate. Answer A is incorrect because staff should expect callers to use two identifiers or a unique code before any information is given over the telephone. Merely recognizing a voice is not enough. Answer B is incorrect because staff would be revealing confidential information to the family member, which is not permitted. Answer D is incorrect because information about patients should be accessed only on a "need to know" basis, and there would be no need to know information about patients unless they are under the nurse's direct care. Access is usually limited to the unit or units where the nurse regularly works.

Chapter 13: Competency and Guardianship

1. The hospital nurse is caring for an older, confused client who has a legal guardian. Which approach to implementing nursing care when a patient has a guardian is correct?

   A) The guardian must be consulted before any assessment and nursing care planning are completed.
   B) The nurse needs to make sure that the guardian's consent is obtained before any invasive procedures are implemented.
   C) The guardian must be present in order to participate in the patient's care in any way.
   D) The social worker should be consulted to handle all issues with the guardian.

Answer: B. Consent must be obtained from the guardian in any situation where it would normally be obtained from the patient. Answer A is incorrect since routine nursing care can be completed without the guardian's consent. Answer C is incorrect since guardians are not present during care; guardians are often contacted by telephone for their participation. Answer D is incorrect since the social worker would be consulted if there