

Urden: Priorities in Critical Care Nursing, 6th Edition

Chapter 02: Ethical and Legal Issues

Test Bank

MULTIPLE CHOICE

1. The difference between morals and ethics is that ethics:
- is more concerned with the “why” of behavior.
 - distinguishes the good or right in conduct.
 - is broader in scope.
 - concentrates on the right or wrong of behavior.

ANS: A

Ethics is derived from an evaluation of an action, based on a set of standards; morals are codes of conduct, determining right or wrong actions. Morals are concerned with the “shoulds,” “should nots,” “oughts,” and “ought nots” of actions and behaviors. Ethics and morals are both broad in scope. Ethics is concerned with the “why” of the action rather than with whether the action is right or wrong.

DIF: Cognitive Level: Comprehension REF: 8

OBJ: Nursing Process: Assessment TOP: Ethics

MSC: NCLEX: Safe and Effective Care Environment: Management of Care

2. A patient’s wife has been informed by the physician that her spouse has a permanent C2-3 spinal injury, resulting in permanent quadriplegia. The wife states that she does not want the physician or nursing staff to tell the patient about his injury. The patient is awake, alert, and oriented when he asks his nurse to tell him what has happened. The nurse has conflicting emotions about how to handle the situation and is experiencing:
- powerlessness.
 - moral distress.
 - moral doubt.
 - frustration.

ANS: B

The nurse has been placed in a situation initially causing moral distress and is struggling with determining the ethically appropriate action to take. Powerlessness can be a symptom of moral distress. Moral doubt can be a symptom of moral distress. Frustration can be a symptom of moral distress.

DIF: Cognitive Level: Analysis REF: 8

OBJ: Nursing Process: Analysis

TOP: Ethics MSC: NCLEX: Safe and Effective Care Environment: Management of Care

3. The critical care nurse can best enhance the principle of autonomy by:
- allowing the patient to do as much for himself or herself as possible.
 - assisting with only those tasks that cannot be done by the patient.
 - providing the patient with all information and facts.
 - guiding the patient toward the best choices for care.

ANS: C

Autonomy can be viewed as the freedom to make decisions about one's own body without the coercion or interference of others. Patients and families must have all the information about a certain situation to make an autonomous decision that is best for them. Allowing the patient to do as much for himself/herself as possible is the concept of self-care. Assisting with only those tasks that cannot be done by the patient is the concept of self-care. Guiding the patient toward the best choice for care can be viewed as interfering with the patient's freedom to make a decision and, thus, interfering with the patient's autonomy.

DIF: Cognitive Level: Synthesis REF: 9
OBJ: Nursing Process: Planning
TOP: Ethics MSC: NCLEX: Safe and Effective Care Environment: Management of Care

4. Which of the following ethical principles is most important when soliciting informed consent from a patient?
- Nonmaleficence
 - Fidelity
 - Beneficence
 - Veracity

ANS: D

Veracity is important when soliciting informed consent because the patient needs to be aware of all potential risks and benefits to be derived from specific treatments or their alternatives. Nonmaleficence is concerned with doing no harm to the patient. Fidelity is concerned with faithfulness and promise-keeping to the patient. Beneficence is concerned with doing good and preventing harm to the patient.

DIF: Cognitive Level: Comprehension REF: 9
OBJ: Nursing Process: Evaluation
TOP: Ethics MSC: NCLEX: Safe and Effective Care Environment: Management of Care

5. Fidelity includes faithfulness and promise-keeping to patients and incorporates the added concepts of:
- confidentiality and privacy.
 - truth and reflection.
 - autonomy and paternalism.

d. beneficence and nonmaleficence.

ANS: A

Confidentiality is a right involving the sharing of patient information with only those involved in the patient's care. Privacy includes confidentiality but goes further to include the right to privacy of person and personal space, such as ensuring that a patient is adequately covered during a procedure. Truth and reflection are not part of the ethical principle of fidelity. Autonomy is a separate ethical principle from fidelity, and paternalism is related to the concept of beneficence. Beneficence and nonmaleficence are separate ethical concepts that relate to doing no harm to the patient.

DIF: Cognitive Level: Comprehension REF: 10

OBJ: Nursing Process: Assessment TOP: Ethics

MSC: NCLEX: Safe and Effective Care Environment: Management of Care

6. The Code of Ethics for Nurses provides a framework for the nurse in ethical decision making. This code:

- a. is usurped by state or federal laws.
- b. allows the nurse to focus on the good of society rather than the uniqueness of the patient.
- c. was recently adopted by the National League of Nursing.
- d. describes the nurse's role in advocating for patient rights and safety.

ANS: D

The Code of Ethics for Nursing describes the professional role of the nurse in advocating for and protecting patients' rights to health and safe care. The Code of Ethics for Nurses is a source of ethical guidance and is not bound by state and federal laws. The Code of Ethics for Nurses focuses on the nurse's responsibility to the patient and to society. The Code of Ethics for Nurses was developed by the American Nurses Association in 2002.

DIF: Cognitive Level: Knowledge REF: Fig. 2-2

OBJ: Nursing Process: Analysis

TOP: Ethics MSC: NCLEX: Safe and Effective Care Environment: Management of Patients

7. Ethical decisions are best made by:

- a. following the guidelines of a framework or model.
- b. having the patient discuss alternatives with the physician or nurse.
- c. prioritizing the greatest good for the greatest number of persons.
- d. careful consideration by the ethics committee once all diagnostic data are reviewed.

ANS: A

To facilitate the ethical decision-making process, a model or framework must be used so that all involved will consistently and clearly examine the multiple ethical issues that arise in critical care. Having the patient discuss alternatives with a health care provider is only one part of making an ethical decision when a decision-making framework is used. Ethical decisions are best made with the individual patient in mind. Ethical decisions are generally best made by the patient and family, not the ethics committee.

DIF: Cognitive Level: Comprehension REF: 12
OBJ: Nursing Process: Implementation TOP: Ethics
MSC: NCLEX: Safe and Effective Care Environment: Management of Care

8. The first step of the ethical decision-making process is:
- consulting with an authority.
 - identifying the health problem.
 - delineating the ethical problem from other types of problems.
 - identifying the patient as the primary decision maker.

ANS: B

Step one involves identifying the major aspects of the patient's medical and health problems.

The ethical decision-making process does not necessarily involve consulting with an authority. Step two involves delineating the ethical problem from other types of problems. Step four involves identifying the patient as the primary decision maker.

DIF: Cognitive Level: Knowledge REF: 12
OBJ: Nursing Process: Implementation TOP: Ethics
MSC: NCLEX: Safe and Effective Care Environment: Management of Care

9. Values clarification can assist the patient to clarify his or her own values to facilitate effective decision making. Which of the following nursing activities is incorporated into this intervention?
- Avoiding the use of open-ended questions.
 - Using multiple sessions to cross-examine the patient to ensure he or she is clear about personal values.
 - Using appropriate questions to assist the patient in reflecting on the situation and what is personally important.
 - Encouraging members of the health care team to relate how they would make the decision.

ANS: C

Appropriate questions should be used to assist the patient in reflecting on the situation and what is personally important. Open-ended questions facilitate values clarification and should be used. Values clarification can occur through a group meeting or through personal introspection and should not involve cross-examining the patient. Members of the health care team should not be encouraged to relate how they would make the decision as this may further confuse the patient and may inhibit effective decision making. This may occur if the patient seeks the information as part of his or her own process of values clarification.

DIF: Cognitive Level: Application REF: 12
OBJ: Nursing Process: Implementation TOP: Ethics
MSC: NCLEX: Safe and Effective Care Environment: Management of Care

10. Which of the following is NOT a criterion for defining an ethical dilemma?
- An awareness of different options
 - An issue in which only one viable option exists
 - The choice of one option compromises the option not chosen
 - An issue that has different options

ANS: B

One of the criteria for an ethical dilemma to exist is that two or more viable options exist. An issue in which only one viable option exists does not constitute an ethical dilemma. The criteria for identifying an ethical dilemma are threefold: (1) an awareness of the different options, (2) an issue that has different options, and (3) the choice of one option over another, compromising the option not chosen.

DIF: Cognitive Level: Knowledge REF: 11
OBJ: Nursing Process: Assessment TOP: Ethics
MSC: NCLEX: Safe and Effective Care Environment: Management of Care

11. The legal standard of care for a nurse's actions is defined as:
- minimal competency under the Nurse Practice Act.
 - the ability to distinguish what is right or wrong for the patient.
 - the demonstration of satisfactory knowledge of policies and procedures.
 - providing reasonable, prudent care comparable to that of like practitioners.

ANS: D

The nurse is legally obligated to provide reasonable and prudent care comparable to that which would be provided by practitioners facing similar situations. While the Nurse Practice Act may provide the underpinnings of what a reasonable and prudent nurse would do, it is not the definition of the legal standard of care. The ability to distinguish what is right or wrong for the patient is critical in caring for a patient, but it is not the definition of the legal standard of care. Demonstration of satisfactory knowledge of policies and procedures is important in caring for patients safely, but it is not the definition of the legal standard of care.

DIF: Cognitive Level: Comprehension REF: 13
OBJ: Nursing Process: Implementation TOP: Legal
MSC: NCLEX: Safe and Effective Care Environment: Management of Care

12. Injury resulting from the failure to meet an ordinary duty or standard of care is termed:

- a. negligence.
- b. malpractice.
- c. assault.
- d. battery.

ANS: A

Injury resulting from the failure to meet an ordinary duty or standard of care is termed negligence. Malpractice is a type of professional liability, based on negligence, in which the defendant is held accountable for breach of a duty of care involving special knowledge and skill. In assault, the act is a behavior that places the plaintiff (person being wronged who later sues) in fear or apprehension of offensive physical contact. Battery is the unlawful or offensive touching of, or contact with, the plaintiff or something attached to the plaintiff.

DIF: Cognitive Level: Comprehension REF: 13
OBJ: Nursing Process: N/A
TOP: Legal MSC: NCLEX: Safe and Effective Care Environment: Management of Care

13. A nurse receives laboratory results of a critical magnesium level at 03:00 during their night shift. The patient has a full no-code, do-not-resuscitate order documented, and the nurse chooses not to call the attending physician because of the present code status.

In doing so, the nurse is showing:

- a. failure to take appropriate action.
- b. respect for the patient's wishes.
- c. failure to timely communicate patient findings.
- d. A and C

ANS: D

Nurses caring for acutely and critically ill patients must appropriately notify physicians of situations warranting treatment actions. The full no-code, do-not-resuscitate order does not exclude this patient from receiving treatment to correct the critical laboratory value.

Choosing not to call the physician does not show respect for the patient's wishes as the patient is still entitled to treatment.

DIF: Cognitive Level: Synthesis REF: Box 2-7
OBJ: Nursing Process: Implementation TOP: Legal
MSC: NCLEX: Safe and Effective Care Environment: Management of Care

14. Two nurses talking about a patient's condition in the cafeteria could lead to allegations of:

- a. slander.
- b. libel.
- c. invasion of privacy.
- d. defamation.

ANS: C

Talking in an unrestricted area, thus revealing confidential information without authorization, may support an allegation of a failure to preserve patient privacy.

Slander is oral defamation.

Libel is written defamation. Defamation is communication that injures a person's reputation or good name.

DIF: Cognitive Level: Analysis REF: 13

OBJ: Nursing Process: N/A

TOP: Legal MSC: NCLEX: Safe and Effective Care Environment: Management of Care

15. Malpractice is a specialized form of:

- a. injury.
- b. negligence.
- c. intentional torts.
- d. damages.

ANS: B

Malpractice is a specialized form of negligence in which the defendant is held accountable for breach of a duty of care involving special knowledge and skill.

Injury involves an actual loss or damage to the plaintiff and may be the result of malpractice. Damages refer to the actual injury or loss to the plaintiff and may be the result of malpractice. Intentional torts are intentional acts, and malpractice is an example of an unintentional tort or act.

DIF: Cognitive Level: Comprehension REF: 14

OBJ: Nursing Process: N/A

TOP: Legal MSC: NCLEX: Safe and Effective Care Environment: Management of Care

16. A nurse fails to recognize an intubated patient's need for nasotracheal suctioning. The endotracheal tube becomes clogged and the patient has a respiratory arrest.

Which of the following best describes the type of negligence the nurse may be liable for?

- a. Improper administration of treatments
- b. Inadequate communication
- c. Insufficient supervision of patients

d. Assault

ANS: A

Nurses have a duty to assess and analyze the care required by each patient they care for. Failure to do so puts the nurse at risk for negligence related improper administration of treatments.

DIF: Cognitive Level: Synthesis REF: 14

OBJ: Nursing Process: Assessment TOP: Legal

MSC: NCLEX: Safe and Effective Care Environment: Safety and Infection Control

17. Mr. B was receiving heparin by intravenous infusion. The nurse received an order to increase the heparin infusion rate and obtain a partial thromboplastin time in 1 hour. Blood for determination of the partial thromboplastin time was drawn correctly and revealed a critically elevated level. The nurse was busy with another patient and failed to follow the facility's policy of reporting the critical result to the physician within 30 minutes. Subsequently, Mr. B suffered a massive intracerebral bleed. Which of the following best describes the type of negligence for which the nurse is liable?

- a. Improper administration of medications
- b. Inadequate communication
- c. Insufficient supervision of patients
- d. Battery

ANS: B

Failure to communicate and document patient findings in a timely manner is a form of inadequate communication. Improper administration of medications relates to errors in drug identification, administration, and dosages. Insufficient supervision of patients relates to failure to properly monitor the patient and allowing harm to come to him or her. Battery is not a form of negligence. Battery is the unlawful or offensive touching of, or contact with, the plaintiff or something attached to the plaintiff.

DIF: Cognitive Level: Synthesis REF: 15

OBJ: Nursing Process: Assessment TOP: Legal

MSC: NCLEX: Safe and Effective Care Environment: Safety and Infection Control

18. The best action a critical care nurse can take to prevent allegations of malpractice is:

- a. carry malpractice insurance.
- b. clarify orders with the nursing supervisor.
- c. delegate care to nursing assistants.
- d. provide care according to standards of practice.

ANS: D

The best action a nurse can take to prevent allegations of malpractice is to provide care in accordance with current standards of practice and to act in a reasonable and prudent manner, as any other critical care nurse would act under similar circumstances. Carrying malpractice insurance will not prevent allegations of malpractice but may assist with handling the situation should it occur. Care should only be delegated to nursing assistants after careful analysis of the task, as inappropriate delegation of tasks can increase the nurse's risk of malpractice. Clarifying orders should always occur with the health care provider who wrote the orders and not the nursing supervisor.

DIF: Cognitive Level: Application REF: 15

OBJ: Nursing Process: Implementation TOP: Legal

MSC: NCLEX: Safe and Effective Care Environment: Management of Care

19. While participating in critical care rounds, the nurse is interrupted by the wife of a ventilated patient, who informs the nurse that her husband is having difficulty breathing. The patient is found disconnected from the ventilator and unresponsive when the nurse enters the room after rounds; the alarm mode on the ventilator had been turned off. This is an example of:

- a. assault.
- b. battery.
- c. abandonment.
- d. negligence.

ANS: D

This is an example of negligence. All four elements of negligence are present: duty and standard of care, breach of duty, causation, and injury. This is not an example of assault. In assault the act is a behavior that places the plaintiff (person being wronged who later sues) in fear or apprehension of offensive physical contact. Assault is an intentional act. This is not an example of battery. Battery is the unlawful or offensive touching of, or contact with, the plaintiff or something attached to the plaintiff. Abandonment is a type of negligence in which a duty to give care exists, is ignored, and results in harm to a patient. In this case, the nurse was not ignoring the patient (the nurse was participating in rounds); thus, it is not a case of abandonment.

DIF: Cognitive Level: Synthesis REF: 14

OBJ: Nursing Process: Implementation TOP: Legal

MSC: NCLEX: Safe and Effective Care Environment: Safety and Infection Control

20. After admission to the intensive care unit, a patient shares with the nurse a concern that her adult children will not be able to reach agreement on what to do if she is no longer able to make decisions for herself. The nurse informs the patient that it is possible to grant authority to one person to make decisions by procuring a:

- a. court-appointed guardian.
- b. do-not-resuscitate order.

- c. durable power of attorney for health care.
- d. living will.

ANS: C

This form of advance directive allows the individual to grant legal authority to another to make health care decisions if he or she is no longer competent. As the patient is competent to make a decision, a court-appointed guardian would be inappropriate as this time.

A do-not-resuscitate order is given when a patient does not wish to be resuscitated. A living will is a form of advance directive in which the patient specifies his or her wishes but does not grant authority to make decisions for the patient to another person.

DIF: Cognitive Level: Application REF: 17

OBJ: Nursing Process: Planning

TOP: Legal MSC: NCLEX: Safe and Effective Care Environment: Management of Care

21. In which of the following situations did the nurse disregard the patient's right to privacy?
- a. Informing the physician that the patient was verbalizing suicidal thoughts
 - b. Notifying the health department of a patient's positive tuberculosis diagnosis
 - c. Reporting possible dependent-adult abuse to the police
 - d. Warning a visitor to wear gloves when giving a back rub because the patient is HIV positive

ANS: D

Telling the visitor of the patient's HIV status violated the patient's right to privacy. The nurse could have ensured the visitor's safety by providing gloves and explaining universal precautions. Informing the physician about a patient's issue is not an invasion of privacy and failure to do so may result in harm to the patient. Informing the health department about a public health issue is not an invasion of the patient's privacy and is required under many public health laws. Reporting abuse to the police is required under state and federal law and is not considered a violation of the patient's right to privacy.

DIF: Cognitive Level: Analysis REF: 13

OBJ: Nursing Process: Implementation TOP: Legal

MSC: NCLEX: Safe and Effective Care Environment: Management of Care

22. Which of the following statements best describes the definition of battery?
- a. An intentional act that causes the patient to believe harm may be done
 - b. A statement that causes injury to the patient's reputation or standing in the community
 - c. Negligence or malpractice that results in harm to a spousal relationship
 - d. An intentional act that brings about harm or offensive contact with the patient

ANS: D

Battery is defined as an intentional act that brings about harm or offensive contact with the patient. An intentional act that causes the patient to believe harm may be done is assault. A statement that causes injury to the patient's reputation or standing in the community is known as defamation. Negligence or malpractice that results in harm to a spousal relationship is known as loss of consortium.

DIF: Cognitive Level: Comprehension REF: 13

OBJ: Nursing Process: N/A

TOP: Legal MSC: NCLEX: Safe and Effective Care Environment: Management of Care

23. Which of the following would be considered insufficient supervision of patients?

- a. Not documenting the patient's response to pain medication
- b. Leaving a confused patient alone in the bathroom
- c. Not recognizing a malfunctioning chest tube
- d. Leaving a sponge in the patient after surgery

ANS: B

Leaving a confused patient alone in the bathroom is an example of insufficient supervision of patients. This patient is at significant risk for falling and potentially harming himself or herself. Not documenting the patient's response to pain medication is an example of improper administration of medications. Not recognizing a malfunctioning chest tube is an example of improper administration of treatments. Leaving a sponge in the patient after surgery is an example of incorrect perioperative instrument and sponge counts.

DIF: Cognitive Level: Application REF: 15

OBJ: Nursing Process: Implementation TOP: Legal

MSC: NCLEX: Safe and Effective Care Environment: Safety and Infection Control

24. Which of the following defines the scope of practice for nursing?

- a. Hospital policies
- b. State Nurse Practice Acts
- c. State Board of Nursing
- d. State Department of Health

ANS: B

State Nurse Practice Acts establish entry requirements, definitions of practice, and criteria for discipline. These acts are established through state regulation. Hospital policies may further clarify the standards under which the nurse may practice within the hospital, but they do not define the scope of practice for nursing. The State Board of Nursing is usually responsible for ensuring adherence to the scope of nursing practice. The State Department of Health ensures adherence to state regulations regarding the provision of patient care within different health care organizations.

DIF: Cognitive Level: Knowledge REF: 14

OBJ: Nursing Process: N/A

TOP: Legal MSC: NCLEX: Safe and Effective Care Environment: Management of Care

25. A nurse providing care for a patient with a recent tracheostomy notes the presence of an ulceration/wound at the tracheostomy site. The nature of the ulceration/wound clearly indicates it has been present for at least several days. The nurse finds no documentation regarding the ulceration/wound since the insertion of the tracheostomy tube 12 days earlier. Each nurse providing care for the patient before this nurse has committed:

- a. negligence.
- b. improper postoperative treatment and wound care.
- c. a breach in standards of care.
- d. All of the above

ANS: D

Negligence is the failure to act as an ordinary prudent person would, which, in this case, resulted in a breach of a standard of care related to wound assessment and care. The type of negligence can be categorized as improper postoperative treatment and wound care.

DIF: Cognitive Level: Analysis REF: Box 2-7

OBJ: Nursing Process: Implementation TOP: Legal

MSC: NCLEX: Safe and Effective Care Environment: Safety and Infection Control