The expanded role of acute care nurses: The issue of liability

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Abstract

For a variety of reasons the activities performed by health care professionals are ever increasing, however the legislative process regulating these specialised workers is not keeping up with the practice realities. While competency statements and credentialling mechanisms are developing, they are not uniformly in place for specialists. Therefore activities completed by these practitioners may be legally controversial. This study documents a variety of tasks completed independently by nurses employed in three acute care hospitals that legally require medical orders and then examines the legal implications of this role extension. Credentialling is one mechanism by which nurses and other health care professionals can ensure they possess the levels of knowledge and skill required to perform the advanced activities required of them and consequently avoid negative legal repercussions.

Introduction

Nationally and internationally, the last decade has seen unprecedented transformations in health care organisations (Greenwood & Lachman 1996). Technological developments, economic rationalisation, and changing societal needs are seen to fuel these changes and appear almost rhetorical. Whatever the rationale, professions within these organisations are required to adapt and work within these new structures. It is well acknowledged that the tasks health care professionals are required to perform are both complex and uncertain (Southon & Braithwaite 1998). Importantly, to ensure patients receive the care they require, many health care professionals must function beyond their legal scope of practice on a regular basis. While this workplace reality may result in better patient care, it leaves these practitioners in a precarious legal position. This article examines how one group of health care professionals, acute care nurses, have modified their practices to remain viable in today's health care environment. After documenting

the actual activities that hospital nurses perform independently, this article examines the advanced practice issues from a legal perspective. Without legislative changes, advance practitioners are leaving themselves open to litigation.

Whilst all States and Territories have registration acts which dictate nursing practice, the reality is that the role of many nurses, including those in critical care, is expanding. Increasing medical specialisation, which ultimately results in delegation of work, has been seen as one rationale for the transfer of medical duties to other health care professionals (Hughes 1958; Larson 1977; Salvage 1985). In nursing, this delegation has recently been termed 'role expansion' (Wright 1995), 'upskilling' (Harvey 1995) and, more negatively, 'passing the task' (Willis 1994). Regardless of the labels used, nurses and other health care professionals must recognise that there are legal implications to whatever activities they undertake.

As with other professions, nursing practice is dictated by law, however, workplace realities are often at odds with legislation. Following the trend in other Australian occupational groups, the Australian Nursing Council has minimum competencies that must be met for nurses to become registered. Advanced competencies have been generated for specialist nurses (Confederation of Australian Critical Care Nurses 1996; Australian Nursing Federation 1997), however, until recently there has been no legal recognition of these competencies. In August 1998 the New South Wales Government announced that, after accreditation, nurse practitioners would legally be able to practise in an expanded role in rural and remote areas (McLean 1998). However this development does not apply to the majority of nurses working in acute care, which leaves them with credentialling as a natural alternative. The benefits of credentialling have been seen to include objective and measurable evidence of expertise; increased motivation for nurses to maintain and update knowledge and skills; and increased job satisfaction as nurses are recognised for their advanced knowledge and skills (Bailey 1996). More importantly, credentialling demonstrates public accountability and assists organisations in upholding their duty of care to patients (Robertson & Chiarella 1995; Bailey 1996).

In 1991 the New South Wales Department of Health published guidelines for the extended practice of health professionals. These guidelines stated that:

> *Any extension of practice … is a matter for an employer and/or the individual professional to determine, and limited only by statutory requirements. Both the individual and the employer need to satisfy themselves that the procedures as performed do not constitute a risk to the patient (p 1).*

These guidelines suggest that the accountability for expanded practice is shared between the individual and the employer.

When nurses perform these expanded role activities, they must consider the legal ramifications of their actions. Both the existence of a duty of care and a breach of that duty causing damage to the patient are the basis for the liability of any health professional in a negligence action. While it is necessary that the plaintiff, or in this case

patient, establishes all of the elements of the action, the pivotal point is this breach of duty. First, the court must establish the standard of care required by the nurse, then determine whether the nurse's actions or omissions met this standard. When nurses undertake practices for which they have no educational preparation, and which are not condoned by the employer or professional registering authority, it is likely that the court will conclude that there has been a breach of standard. However, there is no guarantee that because nurses follow the practices of the professional organisation, the court will not find them liable. Court decisions have consistently demonstrated that the level of skill and knowledge of the particular professional will determine the standard of expected care (Forrester & Chaboyer 1998). Not only do competency standards and credentialling provide an objective indicator of the expected level of practice, they also allow the court to gain some understanding of what a nurse of a particular level should have considered as a reasonable and foreseeable risk.

Recently Bucknall and Thomas (1995–1996, 1996) examined clinical decision-making in a group of critical care nurses belonging to one branch of the Confederation of Australian Critical Care Nurses. Their results indicated that some critical care nurses were making decisions that were legally controversial. During a discussion of the findings, these researchers suggested that if the documented activities constitute common practice, then the appropriateness of relevant laws must be questioned. Other researchers have found that critical care nurses perform activities beyond their legal scope of practice (Last et al. 1992; Daffurn 1993). Given that the studies of both Bucknall and Thomas (1995–1996, 1996) and Daffurn (1993) were completed on select groups of critical care nurses, it is unknown whether these practices are pervasive within the acute care hospital environment. Building on Bucknall and Thomas's (1995–1996, 1996) work, this article describes a survey documenting the activities hospital nurses perform which are not covered under current nurses' registration Acts, and then considers the legal implications of these findings.

The study

The results reported here are part of a larger study of clinical nursing practice. All critical care nurses and a random sample of non-critical care nurses working in three large acute care hospitals were invited to participate. Nurses were excluded from this study if they did not work directly with patients (for example, nurse educators or administrators), if they worked in midwifery or psychiatry (because they were endorsed separately), or if they worked in paediatrics (because only one of the three hospitals accepted paediatric patients). A comparative survey design (Wood & Brink 1989) was chosen to document critical care nursing practices and to describe similarities between it and non-critical care nursing.

This article reports the results from the six-item Independent Actions Scale which was developed from a preliminary qualitative study of 17 critical care nurses and a literature review. These items detailed nursing activities that legally require a doctor's order to be

performed, however, the survey asked nurses how frequently they performed these tasks without medical orders. Demographic questions were also devised. A correlation matrix used to signify the construct validity of the scale (Nunnally & Bernstein 1994) found item-total correlations to range from 0.36 to 0.66. The Cronbach's alpha reliability of 0.77 demonstrated the internal consistency (Nunnally & Bernstein 1994) of the scale. The survey packets, including covering letter, survey and a reply-paid return envelope, were mailed to all potential subjects via each of the hospital's internal mail departments. Two weeks later a reminder note was sent to all potential subjects.

Results

There were a total of 555 completed returned surveys for a response rate of 56%. There was no difference in the response rate by type of nurse or by hospital. The nurses in this study ranged in age from 20 to 63 years, with the average age of nurses being 31 years for both groups. However, chi-square analysis revealed that a curvilinear relationship between age and specialty existed with younger and older nurses more frequently working in non-critical care areas. While the majority of both groups were female, males were more likely to work in critical care than in non-critical care units. Other demographic information is presented in Table 1.

Table 1: Demographic data

Characteristic	Critical care	Non-critical care
Responses	189 (57% of 333 sent)	366 (55% of 666 sent)
Female	82%	89%
Male	18%*	11%
Average years as a registered nurse	9.0	8.4
Bachelor's qualifications	53%	58%

* $p < 0.05$

A comparison of the average scale scores identified that critical care nurses performed independent actions more frequently than non-critical care nurses ($t = 16.6$, $df = 536$, $p < 0.001$). Table 2 gives more detail of the differences seen between the two groups of nurses for the items in the Independent Actions Scale. Critical care nurses administered narcotics and other medication to emergency admissions without medication orders, independently adjusted drug infusions, oxygen delivery and intravenous fluids, and inserted intravenous catheters more frequently than non-critical care nurses. Furthermore, critical care nurses performed these tasks on a regular basis.

Table 2: Independent Actions Scale items

Activity performed weekly	Critical care (n = 188*) Number (%)	Non-critical care (n = 365*) Number (%)
Administer narcotics to emergency admissions without medication orders	**68 (36)	11 (2)
Administer other drugs to emergency admissions without medical orders	**75 (40)	25 (7)
Independently adjust a drug infusion to stabilise a patient	**143 (76)	51 (14)
Independently alter a patient's oxygen delivery to improve their condition	**152 (81)	178 (49)
Insert an intravenous cannula for emergency drugs or fluids	**47 (25)	84 (23)
Independently alter intravenous fluids depending on the patient's hydration status	39 (21)	58 (16)

* Numbers vary slightly due to missing values
** $p < 0.001$

Discussion

A large sample of both critical care and non-critical care nurses from three large acute care hospitals participated in this study. The two groups were similar in most demographic characteristics, however, there were more male nurses working in critical care than non-critical care areas. In relation to the Independent Actions Scale, critical care nurses were much more likely than non-critical care nurses to regularly perform procedures that require medical orders, independent of those orders. This finding supports the study of 230 critical care nurses undertaken by Bucknall and Thomas (1996), who found that half the nurses in the study independently carried out procedures on a daily basis which, by legislation, required a physician's order. In addition, this study found that non-critical care nurses performed these skills, albeit less frequently than did critical care nurses.

Endacott (1996) contends that one major factor that has influenced the role of the critical care nurse is the changing trends in the medical management of the critically ill. It appears that this argument should be extended to other acute care nurses, given that these practices permeated the roles of the majority of acute care hospital nurses in this study. A natural consequence of the fact that acute care nurses are in constant contact with their patients is that they are able to quickly respond to alterations in patients' conditions. This response is more likely related to a concern for patient outcomes than to role delineation and legal boundaries. However, the legal and professional repercussions for nurses who carry out procedures independent of medical orders, particularly in the context of specialty areas, remain unclear.

If a nurse performs some activity such as administering a narcotic without a doctor's order and the patient is compromised as a result of this administration, the court must first establish the duty of care owed to the patient by the nurse. Once this is established, breach of duty must next be determined. Importantly, without advanced practice guidelines or credentials, it is likely that in the event of an untoward incident, the undertaking of types of activities described in Table 2 may be seen to have breached the duty of care.

Historically, in negligence suits, professionals have been judged in relation to their particular skill and knowledge. It is self-evident that the possession of formal credentials is an objective and measurable evidence of expertise, which is open to public scrutiny and accountability. Employers too have a means by which to measure a particular nurse's competence in practice. If a nurse is found negligent, the employer in most circumstances assumes liability through the doctrine of vicarious liability. This does not remove the blame from the employee, but rather shifts the responsibility for the financial burden of paying compensation from the nurse to the employer. However, employers may escape this obligation if they are able to satisfy the court that the nurse was practising outside the course and scope of his or her employment. Importantly, how the court will respond to such cases is yet to be determined.

The move by professions and their specialty groups to introduce competency standards and credentialling is long overdue. Friedson (1994, p 100) states:

> *there are some kinds of expertise which are so valuable or potentially dangerous, or which are so complex and esoteric, that labor consumers are unable to choose competent practitioners without the aid of formal testimonials to competence and reliability.*

This statement suggests that credentialling will help to ensure that patients are provided with optimal care by persons who are acknowledged to possess high levels of knowledge and skills in their clinical specialty. There is also a need to systematically examine the scope of practice of all these professional groups. The data presented in this article indicate that nurses are making decisions regarding patient care and undertaking treatments and procedures that may leave them open to legal action. If, for economic or other resource reasons, advanced tasks have become a part of nursing practice, then it is time to consider the appropriateness of existing legislation and the parameters of the current scope of nursing. It would appear that the move to formalise standards and accredit advanced nursing practice is a step towards ensuring that nurses have adequate and definable levels of knowledge and skills upon which to make clinical decisions.

The case of acute care nursing is not unique. Parallels can be found with other health care professionals who are required to perform tasks beyond their scope of practice for the benefit of patient outcomes. Careful consideration should be given to the legal ramifications of these actions because the changing nature of health care delivery suggests an expansion rather than a retraction in the activities performed by health care professionals. Professional organisations are well advised to consider how their activities are helping to ensure that their members are prepared for these potential legal challenges.

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