Chapter 03: Legal Issues

MULTIPLE CHOICE

1. Considering that a state uses the M'Naghten Rule when an individual is on trial for a crime, what would be most important to document for a nurse caring for a patient who will soon be tried on murder charges?
   a. The patient's participation in treatment planning
   b. The patient's comments about commission of the crime
   c. Examples of behaviors that support psychiatric diagnoses
   d. The patient's perceptions of the need for hospitalization and treatment

   ANS: B
   The M'Naghten Rule states that to be held legally accountable for his or her actions, a person with mental illness must be able to understand the nature and implications of the crime. Although each of the options refers to data that should be documented, the patient's comments about the crime would be of most importance to the trial.

   DIF: Cognitive level: Applying REF: p. 21
   TOP: Nursing process: Implementation MSC: NCLEX: Psychosocial Integrity

2. A patient tells the nurse, "You better take good care of me or I'll sue you using the precedent established in *Wyatt v. Stickney*." The nurse can interpret this as:
   a. intellectualization.
   b. concern about rights to adequate treatment.
   c. a warning about being coerced into treatment.
   d. a request for immediate discharge from the facility.

   ANS: B
   Wyatt v. Stickney was a case in which the court ruled that patients had the right to adequate treatment while hospitalized. Intellectualizing is a defense mechanism. Right to refuse treatment and commitment issues were not the focus of *Wyatt v. Stickney*.

   DIF: Cognitive level: Understanding REF: p. 21 TOP: Nursing process: Planning
   MSC: NCLEX: Safe, Effective Care Environment

3. A patient shouts, "I'm holding you responsible for mistreatment based on *Rogers v. Orkin*." The nurse can conclude that the patient is objecting to:
   a. loss of privileges to leave the unit.
   b. inability to make phone calls.
   c. taking medication.
   d. hospitalization.

   ANS: C
   Rogers v. Orkin was a case in which the court ruled that nonviolent patients could not be forced to take medication. It did not have implications related to hospitalization or application of patient privileges.

   DIF: Cognitive level: Understanding REF: p. 21
   TOP: Nursing process: Assessment MSC: NCLEX: Safe, Effective Care Environment

4. To help preserve patients' rights to freedom from restraint and seclusion, the most important interventions that the nurse can use are based on which principle?
   a. Therapeutic management
   b. Reality-based communication
   c. Confidentiality of documentation
   d. Effective use of ancillary personnel

   ANS: A
   Attention to the nurse–patient relationship, the therapeutic milieu, and principles of pharmacologic management can reduce the need for restrictive measures. The other options are important aspects of care but do not relate directly to the use of restraint and seclusion.

   DIF: Cognitive level: Understanding REF: p. 28
   TOP: Nursing process: Implementation MSC: NCLEX: Safe, Effective Care Environment

5. A nurse finds a psychiatric advance directive in the medical record of a patient experiencing psychosis. The directive was executed during a period in which the patient was stable and competent. The nurse should:
   a. ensure that the directives are respected in treatment planning.
   b. review the directive with the patient to ensure that it is current.
   c. consider the directive only if there is a cardiac or respiratory arrest.
   d. realize that such directives address only the use of psychotropic medication.

   ANS: A
   Advance directives for psychiatric care might be given by competent patients. They are considered binding and should be considered in planning treatment. Advance directives address several issues including psychotropic medication. Review is not required. A psychiatric advance directive relates specifically to mental health services, not cardiac or respiratory problems.

   DIF: Cognitive level: Applying REF: p. 30
   TOP: Nursing process: Implementation MSC: NCLEX: Safe, Effective Care Environment

6. A patient constantly interferes with activities on an inpatient unit. The nurse, speaking in a loud voice, tells the patient, "If you don't go to your room immediately, I will give you medication that will make you sleep." The nurse's behavior demonstrates:
   a. assault.
   b. battery.
   c. negligence.
   d. false imprisonment.

   ANS: A
   Assault is defined as an act that creates a reasonable apprehension of harmful or offensive contact to another without consent of the other. The nurse has threatened the patient. Battery is unwanted touching. Negligence is failure to do what is reasonably prudent under the circumstances. False imprisonment is not evident.

   DIF: Cognitive level: Understanding REF: p. 24
   TOP: Nursing process: Implementation MSC: NCLEX: Safe, Effective Care Environment

7. A patient tells the nurse, "When I get out, I'm going to get even with a lot of people." With respect to the nurse's duty to warn, the nurse should:

a. take no action on a general threat.
b. notify local law enforcement officials.
c. warn close relatives and significant other.
d. document and discuss the threat with the clinical team.

ANS: D
The Tarasoff ruling specifies that a specific threat to a readily identifiable person or persons must be made. In this situation, the threat is nonspecific. The prudent action is to document and discuss with the clinical team to determine the need for providing a warning to third parties.

DIF: Cognitive level: Applying REF: pp. 23-24
TOP: Nursing process: Implementation MSC: NCLEX: Safe, Effective Care Environment

8. A gravely disabled psychiatric patient has a guardian. What is the essential implication for nursing care?
a. The patient can override the guardian's judgment at any time.
b. Guardianship is a legal matter that does not affect clinical care.
c. The guardian's rights apply only to a patient's financial interests.
d. The guardian participates in treatment planning on behalf of the patient.

ANS: D
Guardians make decisions on behalf of the patient and represent the patient in treatment planning meetings. Guardianship affects clinical care, as previously mentioned. The guardian has the right to refuse treatment for the patient. The patient cannot override the guardian's judgment, because the patient is considered incompetent.

DIF: Cognitive level: Understanding REF: p. 26
TOP: Nursing process: Implementation MSC: NCLEX: Safe, Effective Care Environment

9. A patient tells the nurse, "I still have suicidal thoughts, but don't tell anyone because I am supposed to be discharged today." Select the nurse's best course of action.
a. Have the patient sign a "no suicide" contract.
b. Respect the patient's request related to confidentiality.
c. Inform the health care provider and other team members.
d. Search the patient's belongings for potentially hazardous items.

ANS: C
Patient right to confidentiality never includes keeping important clinical information secret, especially information related to patient safety. Patients should be informed that all relevant information will be shared with the health care team. None of the other options sufficiently address the safety issue presented by a patient who expresses suicidal thoughts.

DIF: Cognitive level: Applying REF: pp. 29-30
TOP: Nursing process: Implementation MSC: NCLEX: Safe, Effective Care Environment

10. Which situation is an example of a tort?
a. The primary nurse does not complete the plan of care for a patient within 24 hours of the patient's admission.
b. An advanced-practice nurse recommends that a patient who is dangerous to self and others be voluntarily hospitalized.
c. A patient's admission status is changed from involuntary to voluntary after the

patient's hallucinations subside.

d. A nurse gives a PRN dose of an antipsychotic drug to a patient to prevent violent acting out because the unit is short staffed.

ANS: D

A tort is a civil wrong against a person that violates his or her rights. Giving unnecessary medication for the convenience of staff controls behavior in a manner similar to secluding a patient; thus false imprisonment is a possible charge. The other options do not exemplify torts.

DIF: Cognitive level: Understanding REF: pp. 22, 24 TOP: Nursing process: Evaluation
MSC: NCLEX: Safe, Effective Care Environment

11. A crisis team led by a psychiatric nurse is called to a home because a patient with a history of paranoid schizophrenia is standing on the lawn shouting, "People are poisoning my water." The nurse should advise the police officer to institute procedures for:
    a. emergency care.
    b. long-term commitment.
    c. a probable-cause hearing.
    d. short-term observation and treatment.

    ANS: A

    Individuals who are deemed to be dangerous to self, dangerous to others, or gravely disabled can be detained involuntarily for evaluation and emergency treatment for a specified period of time (often for 72 hours). Long-term commitment might be unnecessary. A probable-cause hearing is needed only for short-term observation and treatment.

    DIF: Cognitive level: Applying REF: p. 25
    TOP: Nursing process: Implementation MSC: NCLEX: Safe, Effective Care Environment

12. Which individual would be the most likely candidate to have a guardian appointed?
    a. A patient with panic attacks
    b. A bipolar patient who refuses medication
    c. A patient with frequent admissions for drug abuse
    d. A gravely disabled patient with paranoid schizophrenia

    ANS: D

    Guardians or conservators are appointed by the courts to manage the affairs of mentally ill individuals found to be incompetent and unable to manage their own affairs appropriately. A gravely disabled patient with schizophrenia would be in need of a conservator or guardian, whereas the other individuals would more likely be judged competent.

    DIF: Cognitive level: Analyzing REF: p. 26
    TOP: Nursing process: Assessment MSC: NCLEX: Safe, Effective Care Environment

13. An involuntarily admitted inpatient with paranoid schizophrenia repeatedly calls the local mayor. The patient verbally abuses the person who answers the phone as well as the mayor. Select the most appropriate initial nursing intervention.
    a. Allow the patient to continue to use the phone.
    b. Include the patient in a social skills building group.
    c. Suspend the patient's phone privileges temporarily, and document the reason.
    d. Ask the patient advocate to review the limits of the patient's rights with the patient.

ANS: C
The nurse should document that the patient's calls violated the rights of others, thus providing a basis for temporary suspension of the right to make phone calls to the mayor's office. Allowing continued calls violates the rights of others. It might require several days for the advocate to meet with the patient.

DIF: Cognitive level: Analyzing REF: pp. 29-30
TOP: Nursing process: Implementation MSC: NCLEX: Safe, Effective Care Environment

14. A nurse in a community mental health center receives a call asking for information about a patient. Under which condition can the nurse release information to the caller?
    a. The caller is related to the patient.
    b. The psychiatrist approves the request.
    c. The caller is a mental health professional.
    d. The patient has given written consent for release of information.

ANS: D
Patient information is privileged. Information cannot be released without consent signed by the patient. None of the other conditions is sufficient.

DIF: Cognitive level: Applying REF: p. 27
TOP: Nursing process: Implementation MSC: NCLEX: Safe, Effective Care Environment

15. A patient backs into a corner of the room and shouts at the nurse, "Stay away from me." Select the best initial nursing intervention in this situation.
    a. Obtain an order for seclusion.
    b. Administer a PRN antipsychotic drug.
    c. Call for assistance to physically restrain the patient.
    d. Talk to the patient in a calm, nonthreatening manner.

ANS: D
Verbal intervention provides the least restrictive alternative in this situation. Verbal intervention might halt escalation and prevent the need for medication or the use of restraint or seclusion. Seclusion, restraint, and medication usage are all more restrictive than verbal intervention.

DIF: Cognitive level: Analyzing REF: p. 28
TOP: Nursing process: Implementation MSC: NCLEX: Safe, Effective Care Environment

16. A patient was restrained after assaulting a staff member. Which nursing measure has priority?
    a. Monitor the patient every 30 minutes.
    b. Maintain constant supervision of the patient.
    c. Administer a sedating medication after applying the restraints.
    d. Distract the patient at frequent intervals while restraints are in use.

ANS: B
Restrained patients must be constantly observed, with documentation of physical safety and comfort interventions occurring at 15-minute intervals. Medication may be administered, but this is not the priority action. Distraction is not an effective technique to use when a patient is in restraints, because minimal stimulation is preferred.

DIF: Cognitive level: Analyzing REF: p. 28

TOP: Nursing process: Implementation MSC: NCLEX: Safe, Effective Care Environment

17. Which patient should be considered for involuntary commitment for psychiatric treatment?
    a. A patient who is noncompliant with the treatment regimen
    b. A patient who sold and distributed illegal drugs
    c. A patient who threatens to harm self and others
    d. A patient who fraudulently filed for bankruptcy

    ANS: C
    Involuntary commitment protects patients who are dangerous to themselves or others and cannot care for their own basic needs. Involuntary commitment also protects other individuals in society. The behaviors described in the other options are not sufficient to require involuntary hospitalization.

    DIF: Cognitive level: Understanding REF: p. 24
    TOP: Nursing process: Assessment MSC: NCLEX: Safe, Effective Care Environment

18. A patient who is admitted involuntarily with bipolar disorder, manic phase, refuses a prescribed dose of lithium. The nurse assembles a show of force and intimidates the patient into taking the medication. As an outcome of this action, the patient:
    a. will experience lessened mania.
    b. can bring civil suit for assault and battery.
    c. can sue the hospital for false imprisonment.
    d. has no recourse, because the medication is in the interest of the patient's welfare.

    ANS: B
    A nurse who forces a patient to accept treatment or take medication in a nonemergency situation against the patient's wishes can be found liable for assault (threatening) and battery (nonconsenting touching) in civil court, even if the nurse had the best interest of the patient in mind. Diminished symptoms of mania are not likely to be related to a single dose of lithium. The scenario does not describe the conditions of false imprisonment. Actions taken in the best interest of the patient that violate the patient's rights are cause for civil action.

    DIF: Cognitive level: Applying REF: p. 24 TOP: Nursing process: Evaluation
    MSC: NCLEX: Safe, Effective Care Environment

19. To reduce the risk of a lawsuit based on false imprisonment, mental health nurses must give the highest priority to which intervention?
    a. Educating patients about unit protocols
    b. Providing adequate treatment during hospitalization
    c. Selecting the least restrictive treatment environment that will be effective
    d. Ensuring that patients have probable-cause hearings within 24 hours of admission

    ANS: C
    Treating a patient in the least restrictive environment that will be effective lessens the threat of the patient bringing civil suit for false imprisonment. In the least restrictive environment the disruption to patient rights is minimized. Providing information about unit rules and providing adequate treatments are of less immediate importance than ensuring the least restrictive alternative. Probable-cause hearings are necessary only in certain cases.

    DIF: Cognitive level: Analyzing REF: p. 24 TOP: Nursing process: Planning
    MSC: NCLEX: Safe, Effective Care Environment

20. How many violations of Medicare and Medicaid guidelines are evident in this documentation?

Patient assaulted nurse in hall at 1730. Staff provided verbal intervention, but patient continued to strike out. Patient placed in seclusion at 1745. Observation instituted at hourly intervals. Order received from physician at 1930. Patient sleeping soundly at 2100. Patient released from seclusion at 2230 and returned to own room.

a. Two
b. Three
c. Four
d. Five

ANS: D
Constant observation of a secluded individual is necessary, with attention given at frequent intervals for safety and comfort interventions. No mention is made of providing fluids or bathroom privileges. Seclusion requires a written order posted within 1 hour. Seclusion must be terminated when patient behavior permits. If the patient is calm enough to sleep, the need for seclusion should be reevaluated. The patient should be debriefed after the seclusion.

DIF: Cognitive level: Analyzing REF: p. 28 TOP: Nursing process: Evaluation
MSC: NCLEX: Safe, Effective Care Environment

21. A nurse at the mental health center prepares to administer a scheduled injection of haloperidol decanoate (Haldol depot injection) to a patient diagnosed with schizophrenia. As the nurse swabs the site, the patient shouts, "Stop, stop. I don't want to take that medicine anymore. I hate the side effects." Select the nurse's first action.

a. Stop the medication administration procedure and say to the patient, "Tell me more about the side effects you've been having."
b. Proceed with the injection but explain to the patient that there are medications that may help reduce the unpleasant side effects.
c. Say to the patient, "Since I've already drawn the medication in the syringe, I'm required to give it, but let's talk to the doctor about delaying next month's dose."
d. Notify other staff to report to the room for a show of force, and proceed with the injection, using restraint if necessary.

ANS: A
The nurse, as an advocate and educator, should seek more information about the patient's decision and should not force the medication. Patients with mental illness retain their civil rights unless there is clear, cogent, and convincing evidence of dangerousness. The patient in this situation presents no evidence of dangerousness. It is not reasonable to promise a reduction in side effects without first discussing them, nor is it appropriate to pressure the patient into taking the medication. The medication cannot be given without the patient's informed consent.

DIF: Cognitive level: Analyzing REF: p. 29
TOP: Nursing process: Implementation MSC: NCLEX: Safe, Effective Care Environment

22. An example of a breach of a patient's right to privacy occurred when a nurse:

a. released information to the patient's employer without consent.
b. documented the patient's daily behaviors during hospitalization.
c. discussed the patient's history with other staff during care planning.

d. asked a family to share information about a patient's behavior prior to admission.

ANS: A
Release of information without patient authorization violates the patient's right to privacy. The other options are acceptable nursing practices.

DIF: Cognitive level: Understanding REF: p. 27
TOP: Nursing process: Implementation MSC: NCLEX: Safe, Effective Care Environment

23. An adolescent is hospitalized after a violent physical outburst and tells the nurse, "I'm going to kill my parents, but you can't tell them." Select the nurse's initial response.
a. "You're right. Federal law requires me to keep information private."
b. "Those kinds of threats will make your hospitalization longer."
c. "You really should share this thought with your psychiatrist."
d. "I am required to talk to the treatment team about your threats."

ANS: D
Breach of nurse–patient confidentiality does not pose a legal dilemma for nurses in these circumstances, because a team approach to delivery of psychiatric care presumes communication of patient information to other staff members to develop treatment plans and outcome criteria. The patient should know that the team may have to warn the patient's parents of the risk for harm.

DIF: Cognitive level: Analyzing REF: pp. 21-23
TOP: Nursing process: Implementation MSC: NCLEX: Safe, Effective Care Environment

24. A patient's insurance will not pay for continuing hospitalization at a private facility, so the family considers transferring the patient to a public psychiatric hospital. They express concern that the patient will "never get any treatment." Select the nurse's most helpful reply.
a. "Under the law, treatment must be provided. Hospitalization without treatment violates patients' rights."
b. "That's a justifiable concern, because the right to treatment extends only to provision of food, shelter, and safety."
c. "Much will depend on other patients, because the right to treatment for a psychotic patient takes precedence over the right to treatment of a patient who is stable."
d. "All patients in public hospitals have the right to choose both a primary therapist and a primary nurse."

ANS: A
The right to medical and psychiatric treatment was conferred on all patients hospitalized in public mental hospitals under federal law. The remaining statements do not accurately describe that right.

DIF: Cognitive level: Applying REF: pp. 22, 30-31
TOP: Nursing process: Implementation MSC: NCLEX: Safe, Effective Care Environment

25. A patient diagnosed with paranoid schizophrenia believes that evil spirits are being stirred by a local minister and verbally threatens to bomb a local church. The psychiatrist notifies the minister. What is the basis for this action?
a. Information cannot be released without proper authorization.
b. There is a duty to warn and protect.
c. No action can violate the patient's confidentiality.

d. Charges of malpractice must be avoided.

ANS: B
It is the health care professional's duty to warn or notify an intended victim after a threat of harm has been made. Informing a potential victim of a threat is a legal responsibility of the health care professional. It is not considered a violation of confidentiality or an example of malpractice.

DIF: Cognitive level: Understanding REF: pp. 21-23
TOP: Nursing process: Implementation MSC: NCLEX: Safe, Effective Care Environment

MULTIPLE RESPONSE

1. Which interventions apply to the care plan of a patient being secluded? Select all that apply.
   a. Seclusion instituted when verbal intervention ineffective in stopping threatening behavior
   b. Written medical order obtained within 2 hours
   c. Patient debriefed when seclusion discontinued
   d. Patient offered bathroom privileges hourly
   e. Fluids offered every 4 hours

   ANS: A, C, D
   The correct interventions meet Medicare and Medicaid guidelines for the psychiatric setting. Other guidelines exist and should also be observed so that care can be evaluated as safe and effective. Fluids should be offered more often than every 4 hours, and a medical order must be secured within 1 hour.

   DIF: Cognitive level: Applying REF: p. 28 TOP: Nursing process: Planning
   MSC: NCLEX: Safe, Effective Care Environment

2. A patient diagnosed with bipolar disorder is admitted involuntarily during a manic phase. Lithium 300 mg PO t.i.d. is prescribed. The patient refuses the morning dose. What are the nurse's best actions? Select all that apply.
   a. Get the prescription changed to an elixir, and administer it in juice.
   b. Assemble adequate help to force the patient to take the medication.
   c. Educate the patient about the importance of lithium in stabilizing the mood.
   d. Allow the patient to refuse the medication, and document the patient's comments.
   e. Inform the patient that unit privileges are contingent on taking prescribed medications.

   ANS: C, D
   Patients have the right to refuse consent to treatment, including medication administration. The courts have ruled that neither voluntary nor involuntary patients can be forced to take psychotropic medication. Hiding the medication in food or fluids is not ethical. Assembling a show of force implies that forcible administration will occur. Making privileges contingent on medication ingestion is coercion.

   DIF: Cognitive level: Analyzing REF: p. 29
   TOP: Nursing process: Implementation MSC: NCLEX: Safe, Effective Care Environment