Legal Issues in Clinical Nursing Education

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Abstract

Nurse educators are concerned about legal implications of teaching students in clinical settings. Although literature is available about legal issues in working with students in the classroom, there is little recent information on clinical nursing faculty’s legal liability when working with students and ways to reduce the risk of becoming involved in a lawsuit. This article discusses the major issues in clinical settings that contribute to lawsuits against faculty and offers suggestions to reduce legal liability with students in clinical settings.

Nurse educators are concerned about the legal implications of teaching students in clinical settings, but there is little guidance in the literature for clinical nursing faculty seeking information on legal issues to consider when working with students or ways to reduce their risk of becoming involved in a lawsuit. Most literature available on this topic addresses classroom issues rather than clinical issues for nurse educators. This article outlines areas of risk in the clinical setting and offers suggestions for reducing the risks.

Areas of Risk: Standards and Precedents Influencing Legal Liability

Nurse educators who work with students in the clinical setting practice in 2 arenas: the education arena and clinical arena. Much has been written about legal issues in the academic arena, addressing topics such as admission, progression, and dismissal from programs.1 For faculty working with students in the clinical area, an academic issue to consider is assigning a failing grade in a clinical course, which in some cases may result in the student’s dismissal from the nursing program. Lawsuits filed against nursing programs and nursing faculty due to clinical failures have generally been found in favor of the programs and faculty if the institution followed standard administrative policy and procedures and the decision is viewed as fair, rather than arbitrary or discriminatory.2 An example of this is the case of Clements v County of Nassau.3 In this 1987 New York case, a student had been dismissed from the nursing program following 2 clinical failures. The student appealed the decision at the college, and the appeal was denied, so the student filed a lawsuit. The student argued that the faculty members’ personal animosity toward her was the reason for the failures rather than the student’s unsafe clinical practice, as alleged by the faculty and the college. The court found that the unsafe practice had been clearly documented by nursing faculty and that the student’s appeal had been resolved based on the institution’s procedural process and ruled against the student. Even in the clinical area, faculty must follow the academic procedural process and clearly document satisfactory and unsatisfactory student actions. However, in the clinical area, safety issues related to patients also pose the risk of legal liability, and much less is available in the literature to address these challenges for nurse educators.

The first place for nurse educators to start in consideration of legal risk in the clinical area is with the Nursing Practice Act. Nursing faculty must have a clear understanding of the legal definition of an RN in the state of their practice, the scope of practice for which the student is being prepared, and any legal definitions or requirements of nursing students or faculty in that state. The state’s Nursing Practice Act may be used in a court of law as a general guide for the standard of practice. An expert witness with similar qualifications as the defendant would also be used in legal cases filed against nurses, students, or faculty.

Clinical faculty sometimes say that nursing students “work under their (the faculty’s) license.” This is not necessarily true, depending on the state’s Nursing Practice Act. In North Carolina, for example, a student in the clinical setting is considered an “unlicensed provider.” In this capacity, the faculty may delegate tasks to the student, and the properly licensed RN faculty member is not legally responsible for errors made by the student as long as the student had been adequately prepared for the delegated task. The student is responsible for determining that he/she has the necessary skills and abilities to perform the delegated task.4

Using a grounded theory approach, Reid-Searl et al5 conducted audiotaped interviews with undergraduate nursing students to explore their experiences while dispensing medication in a clinical setting. Of the 28 students in the sample, 9 admitted to errors or near misses with medication errors. Findings indicated that inadequate supervision was a factor in all errors, and adequate supervision aided in avoidance of medication errors. In the interviews, the students reported feeling panicked and frightened to admit their mistakes, which is not conducive to learning. This article highlights the importance of adequate supervision of nursing students, although it does not address ways to protect nurse educators from legal issues, in this case, unsafe medication administration. One strategy for reducing medication errors might be to introduce a more transparent medication error reporting mechanism within the nursing program.6 Data from such a mechanism could be used to sensitize both faculty and students to error-prone medications, environments, or situations so that extra supervision could be given to students.

Faculty who work at state-supported institutions may believe they cannot be sued because of the Doctrine of Sovereign Immunity. This doctrine protects state and local governments from being sued unless the governments have waived this immunity granted to them.7 This doctrine has been adopted by some states and is based on the English concept that “the king could do no wrong” so could not be liable for damage to subjects. Although it may apply to elected officials, it often does not protect all state employees. The 1980 court case James v Jane8 changed the concept of sovereign immunity. The defendants were full-time faculty members of the University of Virginia Medical School, with responsibility for teaching, research, and patient care. The defendant physicians attempted to use the Doctrine of Sovereign Immunity when sued by patients because they were employees of the University of Virginia Hospital. The court decided that the physicians were not acting as agents of the state in this case and that the patients had the same rights to care as if they had been treated in a private hospital, so the Doctrine of Sovereign Immunity did not prevent these physicians from being sued. Furthermore, the court stated that immunity is more clearly applied to government employees such as elected officials and judges, rather than to other categories of state employees.9

In a court of law, legal actions against nurse educators fall under tort law, which is civil law that deals with wrongs committed by 1 person against another person.10 The most common tort law claim against nurses is negligence toward a patient11 or failure to do what a reasonable nurse would do, which results in damage or injury. Three elements must exist for the charge of tort to be made against a nursing educator regarding the performance of a student toward a patient: (1) a duty or obligation by the accused student when under the supervision of the instructor, (2) a violation or breach of the duty: the nurse educator fails to meet the standard of care achieved by his/her peers in the same situation, and (3) actual causation/damages: there must be harm suffered as a result of the breach in the nurse educator’s performance of duty. Not only may a patient sue a student; the patient may also sue the nurse educator, educator’s school of nursing, and hospital.1 Generally, negligence is said to have occurred if the defendant did not perform acts that a reasonable person would do under the same circumstances.12

The standards of care for nurses, as well as the state’s Nursing Practice Act, provide benchmarks or comparisons of actions or behaviors that a competent professional would do in the same situation. To address what a competent professional would do, typically an expert witness is used in court. The expert witness is another professional with the same license as the accused and usually with experience in the same specialty. He/she gives an “expert” opinion on what would have been the correct behavior in the situation. Nurse educators must be familiar with their specialty’s standards of care. An example of a specialty standard of care would be those of the Association of Women’s Health, Obstetric and Neonatal Nurses; this organization determines the standard of excellence in the care of pregnant women and newborns. Educators should instruct students in the expected standards of each field in order to protect clients, effectively teach students, and avoid legal liability.

Secondary liability or vicarious liability, known as the doctrine of Respondeat Superior,13 occurs when 1 person or entity, such as an employer, is liable for the negligent actions of another, such as an employee. If the court holds a hospital legally responsible for the actions of a physician or nurse employed by the hospital or holds a nurse educator responsible for the actions of a student, this is secondary liability. The standards of practice are used as a benchmark to determine liability of health care employees, nurse educators, or students in medical malpractice suits. A nurse educator may be found liable for the actions of a student if the student was injured in the clinical area, if the student injured someone else when not adequately supervised, or if the accident was foreseeable.

The case of Mastrangelo v West Side Union High School,14 while not occurring in the clinical area, is a good example of faculty member liability due to breaching duty to a student in a way that causes injury. West Side Union High School is the Respondeat Superior as the employer of the teacher. A high school chemistry student was injured severely in a laboratory accident. The chemistry teacher was found negligent for not warning the student of the potential danger of the gun powder the student was using and for lack of adequate supervision. This was the first case in which a teacher was held liable for the actions of his student.12 Negligence in the supervision of adult students is illustrated in the case of Brigham Young University v Lillywhite.15 In this case, an 18-year-old chemistry student sued the professor for an injury received in a laboratory explosion; the courts found the professor guilty for failure to supervise the experiment, and the appeals court agreed.16

In a third case, LaVoie v State,17 a college sophomore chemistry student sat a bottle of ether next to a Bunsen burner, the ether ignited, and the student was burned. The student sued the university because she was not told (foreseeability) by the instructor to keep the ether away from the flame, nor did the printed instructions for that laboratory experiment contain a warning to keep ether away from a flame. The jury awarded the student $45,000, and the appellate court upheld the award.18 Although these cases did not occur in a clinical nursing area, they are examples of the educator’s responsibilities to warn students about risks of which the students are not aware because of their novice status. Nurse educators must be certain that their curriculum includes instructions to reduce the risk of harm to students as well as patients. As educators, we will never be able to include every possible risk; however, being aware of safety issues and diligent in supervision of students will reduce our risks for a lawsuit due to student injury.

Goudreau and Chasens12 mention another case, Gross v Family Services Agency Inc and Nova Southeastern University.19 In this case, a 23-year-old graduate student in the psychology program was sexually assaulted while at a mandatory clinical site visit. The university was aware (foreseeability) of the dangerous location of the Family Service Agency and did not warn the student of the known risk of danger; therefore, the university was found liable for failure to maintain student safety. This case illustrates the need for nurse educators to be aware of student safety issues at clinical sites, including community clinical sites, and of their potential liability if a student is harmed when not adequately forewarned of potential risk.

A more recent, unresolved case, from July 2011, represents another possible aspect of nurse educator liability—curriculum development. A nurse anesthesia student at West Virginia’s Mountain State University sued the university for breach of contract, breach of good faith and fair dealing, fraud, negligence, negligent representation, and intentional infliction of emotional distress.20 One of the claims the student made is that she never received a syllabus in any class and never received graded course work. This case has not yet been decided; however, the nurse anesthesia program was no longer listed as accredited by the Council on Accreditation of Nurse Anesthesia Education Programs in December 2011,18 and Mountain State University closed effective January 1, 2013.22

Reducing the Risk: Practical Strategies to Decrease Nurse Educator Liability

There are many actions nurse educators and nursing program directors can take to reduce their risk for lawsuits and increase student and patient safety when teaching in the clinical area. Four areas are discussed here: faculty-student ratios, faculty and preceptor qualifications, building relationships with nursing staff on the unit, and teaching strategies for working with students.

Faculty-Student Ratios

Maximum allowed faculty-student ratios in the clinical area are often stated by Boards of Nursing; a common ratio in the United States for faculty-led clinical groups is 1:10, and that for prelicensure preceptor-led clinical experiences is 1:1.23 Although the literature mentions faculty-student ratios in clinical education as having a potential impact on error rates,24 and some nursing units limit the number of students allowed at 1 time to below the regulatory limit because of patient acuity and other factors,25 no studies could be located that empirically examined faculty-student ratios in relation to patient safety and learning effectiveness. Research is needed in this area.

A survey of faculty, staff nurses, and nursing unit directors in Georgia showed that most respondents believed the current Georgia Board of Nursing–prescribed faculty-student ratio of 1:10 was too high and preferred a ratio of 1:8. Fifty-eight percent of respondents considered the 1:10 ratio a safety issue.26 A study of student-made medication errors27 showed that student inexperience and distraction were the most common factors associated with the errors. This highlights the importance of close supervision of learners in the clinical area.

Nursing program administrators are often responsible for creating teaching assignments and deciding how many students a faculty member will supervise at 1 time. Small faculty-student ratios are more expensive for the nursing program and may be difficult to attain with faculty shortages. However, especially for beginning students and students on high-acuity units, this may be money well spent in terms of student learning, patient safety, and reduction in the risk for lawsuits.

Faculty and Preceptor Qualifications

It is important that both faculty and preceptors are adequately prepared to teach and supervise students.11 The nursing program must provide orientation to the teaching process and the expectations for students in the particular course, including for part-time faculty teaching in the clinical area.28 In addition, it is recommended that nursing faculty have professional liability insurance29 and that the university carry insurance on both the faculty and students.30

All faculty should have clear and concise information about the learning objectives of the clinical course and the competencies the students should come with and be expected to learn during the clinical rotation. Nurse educators should also be reminded of the legal implications of teaching students in the clinical area, including the state Nursing Practice Act. Faculty should be clinically competent for the patient population cared for in the unit where students will be learning, to be able to guide students according to the current standards of care. Nurse educators should arrange an orientation for themselves to both the health care agency and specific unit where the clinical rotation will be held. Special attention should be paid to policies and procedures for the clinical unit.

Building Relationships With Nursing Staff on Unit

Clinical instructors should have a good relationship with nursing staff in the clinical setting29 characterized by close communication with the staff nurses assigned to care for patients on the unit. Faculty should clearly communicate the students’ learning objectives for the day, including what aspects of patient care the students will carry out. Especially important to discuss is medication administration. Medication errors are common among both staff and students, and frequently errors occur because staff may not be clear about what medications students will give and which they will not. Students and faculty must also be aware of institution policies regarding high-alert medications, to make sure that system safeguards for these medications are also followed by students and faculty.31 If faculty have a good relationship with nursing staff on the unit, it is more likely that information about the students’ performance can be easily exchanged, and any unsafe actions by the student can be quickly noticed and corrected.

Strader29 pointed out that clinical instructors should be aware of the needs of each patient assigned to a nursing student and conduct daily interviews with each patient cared for by the student. Interviewing patients and families about their nursing care is also a good way to assess the student’s technical ability to provide care and the student’s ability to form therapeutic relationships with patients and families. Health care providers who have good relationships with patients and families are less likely to have legal actions brought against them.32 Postcare interviews with patients and families cared for by nursing students, followed by private, frank discussions with each student regarding recommendations or praise can also be helpful in modeling ways to evaluate patient response to nursing care.

Teaching Strategies for Working With Students

To limit legal liability for both the student and nurse educator, it is important to assess the students’ abilities and limitations and set benchmarks for students; students should not progress until the benchmarks are reached.11 The nurse educator should discuss with nursing staff the skills most often used on the particular clinical unit and use skills checklists to document progress and evaluation forms to document achievements/failures. This will provide legal documentation of education and student progress while also providing constant feedback to the staff and students. All skills and behaviors on which the students will be evaluated should be tied to the learning objectives for the course. Any concerns about the student’s performance should be discussed immediately with the student, and skills performed by students should be supervised in the clinical setting, even if the student has previously demonstrated proficiency in that particular skill in the laboratory setting.

Nurse educators should assess student preparation for the clinical experience. Conferences are a practical way to assess student preparedness for clinical. Preclinical and postclinical conferences give students and instructors an opportunity to discuss questions and difficult patient care assignments in a safe learning environment. Instructors should hold a preconference with students to ensure understanding of patient care and to determine the students’ preparedness; if unprepared, a student should not be assigned a patient29 until preparation can be accomplished.

Goudreau and Chasens12 recommend educators document student competence in basic nursing skills such as hand washing, lifting techniques, practicing needle safety, and using personal protective equipment to avoid injury or lawsuit. This documentation should be done prior to the student’s first clinical experience to protect students and patients from potential harm and to protect faculty from potential liability. The students should be given adequate practice in simulation laboratories, with guided supervision and instruction by qualified staff prior to entering the hospital or any other clinical setting.

To reduce faculty risk of legal liability, we must first have documented validation of every student’s skills. Faculty members in nursing programs are expected to provide a curriculum that will enable students to develop the knowledge, skills, and competencies needed to provide safe and effective care for patients, in an environment that is also safe for students. Goudreau and Chasens12 reference a case of a resident physician who was sued by a patient for malpractice (Swidryk v St. Michael’s Medical Center).33 The physician in turn sued his medical school supervising physician, claiming that he was not adequately prepared to care for patients in his residency. His claim was dismissed in the courts, however, which showed the students’ responsibility for learning the content taught in the curriculum.

Students should be instructed in the legal implications of nursing practice and should become thoroughly familiar with the state’s Nursing Practice Act as well as clinical site policies and procedures prior to entering the clinical area. Access to policy and procedures should be included in the orientation process and adherence to policies included in the final grade of the student. Instruction in legal liability should be included in the first required courses in any nursing program because this would aid students in understanding actual responsibilities to patients and their own risk of legal liability. Every nursing course should include examples of actual court cases filed against health care personnel. This would be a powerful tool for learning as it would allow students and faculty to learn from the mistakes of the health care professionals in the cases presented. It also would increase awareness of our litigious society and encourage adherence to the standards of nursing expected by the nursing program and the state Board of Nursing. Nurse attorneys, with their dual education and experience in both nursing practice and the law, could present seminars on common legal issues faced by nurses.34

Even prior to the clinical experience, there are teaching strategies used in the classroom and laboratory settings to increase patient safety and decrease legal liability in the clinical area. One of these is the use of simulation to educate and test nursing students. This can provide a safe environment where students can make errors and learn from them. Simulation can also be used to role-play legal issues in nursing; this type of instruction has been shown to help students learn to deal with practice issues in ways to decrease their risk of lawsuits as they prepare for independent practice.35

Role-playing scenarios between students can be used in the classroom or laboratory setting. Allowing students to take on roles as patients or as other nurses enables them to gain a better understanding of another’s perspective and can help with communication, delegation, and collaboration skills important in the clinical area. Classes on defensive documentation education can be offered to improve students’ ability to document proactively to protect themselves against potential lawsuits. Table, Supplemental Digital Content 1, http://links.lww.com/NE/A189, provides 2 case studies illustrating clinical situations with legal implications.

Conclusion

If nurse educators are aware of the legal implications and potential areas of legal liability in the clinical area, they can take steps to minimize risks to themselves, their students, and the patients cared for by the students. Nurses practice in a litigious environment, and nursing faculty are often unaware of the measures they should take to protect themselves and their students from legal liability. Planning clinical instruction with patient and student safety in mind can reduce these risks.

Acknowledgments

The authors acknowledge the assistance of Megan L. Stanley, JD, RN, LLM, CPHRM, in the review of this manuscript and the editorial assistance of Elizabeth Tornquist.

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