Florida: Laws and Rules of Nursing (195)

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Contact hours: 2

Course price: $24

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Beginning on April 21, 2013, The Florida Board of Nursing is requiring that all licensees shall complete a two-hour course on the laws and rules that govern the practice of nursing in Florida for licensed practical nurses, registered nurses, clinical nurse specialists, and advanced registered nurse practitioners. Each course must include content on:

- Chapters 456 and 464 of the Florida Statutes and
- The rules in Title 64B9 of the Florida Administrative Code

This course meets that requirement.

Course Summary

Historical review of nurse practice acts and nursing boards. Comprehensive discussion of Chapters 456 and 464 of the Florida Statutes and Division 64B9 of the Florida Administrative Code. Description of the disciplinary process and the alternatives to discipline provided through the Florida Intervention Project for Nurses. Discussion of ethical decision making and the relationship of ethics and the law.

Conflict of Interest

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Commercial Support

No commercial support was received for this activity.

Criteria for Successful Completions

80% or higher on the post test, a completed evaluation form, and payment where required. No partial credit will be awarded.

Course Objectives

When you finish this course you will be able to:

1. Describe the history of nursing registration and nursing practice acts.
2. State the difference between boards of nursing and nursing professional organizations.
3. Distinguish between the general provisions of the Florida Statutes and the rules that cover practice for Florida nurses and nursing assistants.
4. Review the powers and duties spelled out in Division 64B9 of the Florida Administrative Code.
5. Summarize the grounds for discipline, due process procedures, and alternatives to discipline for nurses in the State of Florida.
6. Discuss the way in which medical ethics differs from the law.

The History of Nurse Practice Acts

Before 1900 no state had a nurse practice act and nurses were neither registered nor licensed. In fact, until the ratification of the Nineteenth Amendment to the U.S. Constitution in 1920, women were not allowed to vote. The vast majority of working nurses had no formal education and most worked in unregulated, crowded workplaces or as private nurses in homecare settings.

Although the first hospital in North America was established by the Spanish in St. Augustine in 1597 (Florida Memory, n.d.), by the 1800s medical training in Florida and throughout the United States was still largely through apprenticeships. Folk medicine, homeopathy, herbal medicine, and midwifery predominated. Midwives, mostly African American women, provided much of the medical care, particularly maternity care, in impoverished and isolated rural communities throughout the South (Florida Memory, n.d.).

The American Civil War (1861–1865) had a profound effect on the development of the nursing and medical professions and in many ways laid the foundation for modern nursing. Around the time of the Civil War there were only about 150 hospitals in the United States, and there were no formal schools of nursing, no nursing credentials, and no “trained” nurses (Egenes, 2009). In England, Florence Nightingale had only just succeeded in establishing the first professional nurse training school in the world at St. Thomas’ Hospital in London with the first class starting on July 9, 1860.

The hundreds of thousands of casualties during the U.S. Civil War created a need for caregivers and tens of thousands of women offered their services, mostly on a volunteer basis. In 1861, responding to the strong opposition to female volunteers, Dorothea Dix organized a march on Washington demanding that women be allowed to treat Union soldiers. She was quickly put in charge of nurses assigned to the U.S. Army.

Dix initially required nurses to be over 30 years of age, "plain looking" and without curls, and forbade them to wear anything except brown or black clothing without ornaments, jewelry, or hoops. The age requirement was soon dropped as the number of wounded soldiers began to overwhelm the medical system. It is estimated that 3,000 nurses served in the war (Egenes, 2009), although as many as 30,000 women worked as volunteers.

Nurse with Wounded Men after the Battle of Nashville, 1864

In the beginning, nurse volunteers were inexperienced, untrained, and disorganized. In 1867 Jane Currie Blaikie Hoge (*The Boys in Blue, or Heroes of the "Rank and File"*) stated:

> The system was an untried experiment, and was suspiciously watched and severely criticized. Unfortunate failures were magnified and widely circulated. The misguided zeal of some benevolent individuals thrust large numbers of women into hospitals, without organization or consultation with surgeons. As a consequence, they were summarily dismissed by the surgeons.

The situation changed quickly as the volunteer nurses gained experience and training. One such volunteer, Amanda Akins, was 35 when, in 1863, she left home to serve at the Armory Square Hospital in Washington, D.C. Just before her death in 1911 she published an account of her nursing experience during the Civil War (*The Lady Nurse of Ward E*):

> My Dear Sisters: You are no doubt anxiously looking for a "sign of life" from me, but I can tell you initiation into hospital life of such a novice is not lightly to be spoken of, and until my ideas ceased floundering and I could recognize my old self again, I could not trust myself with a pen (Smithsonian, 2011).

When the war ended, the sacrifices made by nurses and other female volunteers succeeded in changing public opinion about women working in healthcare. In 1868, just three years after the end of the Civil War, Samuel Gross, president of the American Medical Association, strongly endorsed the formation of training schools for nurses (Egenes, 2009).

Armory Square Nurses (c. 1863)

Amanda Akin and three of the nurses she worked with at Armory Square Hospital: (clockwise from top) Helen Griggs, S. Ellen Marsh, Nancy Maria Hill, and Akin. She included this image in her book *The Lady Nurse of Ward E*. Courtesy of National Library of Medicine.

Just five years later, in 1873, the first educational programs for nurses in the United States were established in New York, Massachusetts, and Connecticut. The teaching in the American schools were largely based on the Nightingale Method, although there were some differences, particularly in hospital oversight of the nursing students. This period—from 1873 to 1893—is considered by some to be a "pioneering period" of nursing education (Stewart, 1935). The new nursing schools were so popular and successful that soon every hospital wanted a school of nursing. Isabel Stewart, RN, wrote in 1935:

> The period from 1863 to 1893 was distinctly a pioneering period. The immediate problem was not to build a finished educational structure, but to clear the ground, to provide decent conditions for both patients and nurses, and to lay the foundation for an adequate nursing service.

Florida in the Late 1800s

In the late 1800s, Florida was still sparsely populated and regularly experienced outbreaks of yellow fever, cholera, typhoid fever, leprosy, scarlet fever, and smallpox, as well as hookworm infestations. Provisional boards of health, which had existed in Florida since 1821, did their best to address the recurring epidemics but lack of resources, poor communication, and the logistics of traveling the great distances between towns and counties highlighted the need for an organized, statewide board of health.

In 1888 Florida experienced a particularly severe epidemic of yellow fever, causing widespread panic. During the outbreak, 10,000 people (nearly one-third of the county's residents) fled Duval County, although many were turned away at their destinations. Among those who remained, there were more than 5,000 recorded cases of yellow fever and more than 400 deaths (Florida Memory, n.d.). Due to intense public outcry, and in an effort to better address these types of outbreaks, the Florida State Board of Health was established in 1889 by Florida Governor Francis Fleming.

Florida Refugees Unwelcome in New York

Refugees from areas with yellow fever were not allowed to leave the trains for fear of spreading the disease. From Frank Leslie's Illustrated (New York) Newspaper, 1888. Source: State Archives of Florida, Florida Memory.

The emergence of germ theory in the late 1800s was another event that had a profound effect on medicine. As medical doctors expanded their education and training, nurses also recognized the need for more comprehensive training. Thus began a period of significant increase in the number of nursing schools throughout the United States, and shortly thereafter the fight for nursing licensure (then referred to as "nursing registration"). As the nineteenth century drew to a close, nurses themselves, along with many women's organizations and their leaders, lobbied for nurse registration, the development of standards for nursing education, and establishment of nurse practice acts.

By 1900, between 400 and 800 nurse training schools were operating in the United States (Cortada, 2016) and both support for and opposition to the regulation of nursing practice was strong. Although a vocal proponent for improvements in education and working conditions, an aging Florence Nightingale famously opposed nurse registration. Nightingale stated in 1890,

> The tendency is now to make a formula of nursing, a sort of literary expression. Now, no living thing can less lend itself to a formula than nursing. It cannot be tested by public examinations, though it may be tested by current supervision (Goodnow, 1916).

Despite fierce opposition, the fight for nursing registration was on—led by members of the New York State Nurses Association, formed in 1901. The preliminary political work was spearheaded by a handful of women, most notably Isabel Hampton Robb, Sophia Palmer, Sylveen Nye, and members of the New York Federation of Women's Clubs, which a few years earlier had passed a resolution urging the formation in New York State of a Nursing Board of Examiners to be chosen by a state society of nurses.

Isabel Hampton Robb became the first president of the Society for Superintendents of Training Schools for Nurses, which was a forerunner of the National League for Nursing Education. She was also the first president of the Associated Alumnae Association, which eventually became the American Nurses Association—also serving as its first president.

Isabel Hampton Robb (1860–1910)

Robb is pictured here in 1891. Source: The Alan Mason Chesney Medical Archives of the Johns Hopkins Medical Institutions.

The First Registration and Practice Acts

In 1902 members of the newly formed New York Nurses Association met at the Rochester City Hospital to discuss the establishment of the nation's first nurse practice act. In attendance was an elderly and frail Susan B. Anthony, who urged the attendees to remember the influence and power of their work. Anthony predicted, in a speech to the group, "The day is coming when trained nurses will be required to possess a college education before being admitted to training" (Willis et al., 2013).

Just one year later, in 1903, North Carolina passed the first "permissive" registration law for nurses. Permissive licensure allowed nurses who met certain standards (such as graduating from a nursing school and passing a comprehensive exam) to work as a nurse but did not allow the use of the title "registered nurse."

In addition to a registration law for nurses, North Carolina became the first state to pass a nurse practice act. Its nurse practice act, signed into law by the governor on March 2, 1903, read in part:

> At meetings it shall be their duty to examine all applicants for license as registered nurse, of good moral character, in the elements of anatomy and physiology, in medical, surgical, obstetrical and practical nursing, invalid cookery and household hygiene, and if on such examination they be found competent to grant each applicant a license authorizing her or him to register, as hereinafter provided, and to use the title "Registered Nurse" signified by the letters R.N. The said Board of Examiners may in its discretion, issue license without examination to such applicants as shall furnish evidence of competency entirely satisfactory to them. Each applicant before receiving license, shall pay a fee of $5.00, which shall be used for defraying the expenses of the Board (North Carolina Nursing History, 2013).

New York, New Jersey, and Virginia succeeded in passing nurse registration laws by the end of 1903, and by 1921, 48 states, the District of Columbia, and the Territory of Hawaii had enacted laws that regulated the practice of professional nursing (Egenes, n.d.). Florida signed its first nurse practice act into law on June 7, 1913.

Mandatory licensure for nurses became law in 1935, but due to World War II was not enforced until 1947. The terms *Registered Nurse* and *Licensed Practice Nurse* (vocational) are now legally protected titles in all states.

The First Nurses Association in Florida

With nursing registration and nurse practice acts becoming law in several states, nurses saw the need for professional organizations to represent their needs. In 1911 the Associated Alumnae Association—formed in 1896 to improve nursing education, establish a code of ethics, and promote the interests of nursing—renamed itself the American Nurses Association. The establishment of a national nursing association, along with the movement to develop registration laws and the adoption of practice acts, had a profound impact on nurses in Florida.

In Jacksonville, Florida, students from two training schools—De Soto Sanitarium and St Luke's Hospital—began to discuss the need for a professional association of nurses in Florida. Between 1909 and 1913, nurses and teachers from these schools formed what came to be known as the Florida Nurses Association. The goals of the new association were to promote unity among nurses, to keep abreast of progress, and to unite for greater control of nursing (educational, legal, practice) (FNA, n.d.).

Over the next decades, as nursing education improved and nurses began to practice in a variety of settings, nursing developed into a true profession. State nurses associations, as well as other professional nursing associations, developed professional regulations and standards of professional practice, promoted quality nursing, and engaged in legislative advocacy, collective bargaining, and public protection.

Recently celebrating its one hundredth anniversary, the Florida Nurses Association (FNA) has grown from a small group of dedicated nurses into a successful statewide organization. Its mission is to promote and advance professional nursing in Florida. It does so by influencing legislation, promoting education, and advocating for improved quality and availability of healthcare services in Florida. FNA is a nongovernmental organization and membership is voluntary.

Although there are dozens of professional organizations representing the interests of nurses in Florida, the Florida Nurses Association is the only nursing organization representing all Florida nurses regardless of specialty or practice area.

Florida Rules and Laws

As a result of the work of many early nurse advocates, nursing has become a respected profession, governed by state practice acts and nurtured by professional associations. Yet many nursing professionals know less than they should about the rules and laws that govern their profession. Certainly, as nurses take on more responsibilities within the healthcare system, it is imperative that they know where to find information about their practice act and their scope of practice. They also must know what to do if a complaint is filed against them, what is involved when a nurse is disciplined, and what is considered incompetent or unethical practice.

In fiscal year 2014–2015, the Florida Board of Nursing adjudicated 95 disciplinary cases involving CNAs and 227 cases involving LPN/RN/ARNPs. In some cases, the Secretary of the Department of Health took emergency action to suspend or restrict the license of someone who posed "an immediate threat to the health, safety, and welfare of the people of Florida." Others voluntarily relinquished their licenses, and the remainder received a variety of penalties, including probation (4 CNAs, 11 LPN/RN/ARNPs), suspension (23 CNAs, 81 LPN/RN/ARNPs), and revocation (28 CNAs, 15 LPN/RN/ARNPs) (FBON, 2015).

What follows is a discussion of the laws and rules that govern nursing in Florida, including general laws and rules that regulate professions and occupations, information about the Florida Nurse Practice Act, and an outline of the powers and duties of the board of nursing. These laws and rules are contained in the Florida Statutes and the Florida Administrative Code, all of which are available for viewing online.

The Florida Statutes

The Florida Statutes are a permanent collection of state laws organized by subject area into a code made up of titles, chapters, parts, and sections. The Florida Statutes are updated annually by laws that create, amend, transfer, or repeal statutory material.

General laws and rules that regulate professions and occupations in the state of Florida are contained in Title XXXII, Chapter 456 of the Florida Statutes.

Rules related to nursing in particular (including the nurse practice act), rules related to safe work practices, and rules that protect patients from unprofessional and unsafe nursing practice are contained in Title XXXII, Chapter 464 of the Florida Statutes. Chapter 464 has two parts: the Florida Nurse Practice Act and rules governing certified nursing assistants.

The Florida Administrative Code (FAC) is the official compilation of administrative rules and regulations promulgated by state regulatory agencies. State agencies receive rulemaking authority in the statutes that create them, and rules are filed with the Department of State, which oversees the publishing of the FAC and updates it weekly. Rules made by the Florida Board of Nursing to fulfill its legislative mandate as to organization, structure, and responsibility are contained in Chapters 64B9-1 to 64B9-17 of the FAC. (The Board of Nursing is part of the Department of Health, which is Department 64, and the Board of Nursing is Division 64B9). The complete text of FAC chapters applicable to the BON may be accessed here.

Florida Statutes and Florida Administrative Code	
Title XXXII, Florida Statutes	▪ Chapter 456 Health Professions and Occupations General Provisions ▪ Chapter 464 Nursing ▪ Part I: The Florida Nurse Practice Act ▪ Part II: Certified Nursing Assistants
Florida Administrative Code	▪ Chapter 64B9 Rules of the Florida Board of Nursing

Chapters 456 and 464, Florida Statutes

The Florida Statutes are organized into 58 Titles, each with a number of Chapters. Title XXXII, Regulation of Professions and Occupations, contains 39 chapters. **Chapter 456** describes general provisions relating to health occupations and professions.

A second chapter specifically related to nursing and certified nursing assistants—**Chapter 464**—contains regulations related to the practice of nursing in the state of Florida and is divided into two parts:

- Part I: Nurse Practice Act
- Part II: Certified Nursing Assistants

456: Health Professions and Occupations

In the United States, the states have the primary responsibility for regulating the health professions. State governments have a particular interest in regulating professions when there is a potential to harm the public's health, safety, or welfare if the profession is practiced by unqualified professionals (CLEAR, 2006). Regulations are broadly consistent from state to state.

In Florida, these regulations for health professions and occupations are found in Title XXXII of the Florida Statutes. Title XXXII contains laws that regulate professions and occupations in the State of Florida, ranging from attorneys-at-law to private investigate services. Chapter 456, in 86 parts, outlines the provisions related to professional practice for all health occupations and professions in Florida (Florida Legislature, 2016).

You can access Chapter 456 in its entirety here.

464: Nursing

Chapter 464, part I, contains Florida's Nurse Practice Act. The laws contained in it provide safe parameters within which to work, as well as provisions intended to protect patients from unprofessional and unsafe nursing practice. Florida nurses and certified nursing assistants covered by this chapter are responsible for understanding the laws and rules that govern and define their scope of practice.

Since their humble beginnings in the early 1900s, nurse practice acts have been revised, updated, and modernized. Gone are rules related to moral character, marriage restrictions, pregnancy, and age limits. Added are updated definitions of professional nursing, educational requirements, and regulations for certified nursing assistants, licensed practical nurses, registered nurses, advanced registered nurse practitioners, and clinical nurse specialists.

Computerized licensure databases have been developed, as have rules related to continuing nursing education, chemical dependency, delegation, and criminal background checks, among other additions. Because nursing scope of practice and responsibilities vary from state to state, nurses in the United States are responsible for knowing the regulatory requirements for nursing and the nurse practice act in every state in which they are practicing (NCSBN, 2016).

Part I: The Florida Nurse Practice Act

Each state and territory of the United States, including Florida, has a law called the Nurse Practice Act (NPA) that is enforced by the state's nursing board. Nurses are required to understand and comply with the laws and related rules of their own NPA in order to maintain their licenses (NCSBN, 2016a). All of the more than 300,000 registered and licensed practical nurses in Florida are governed by and work under the Florida Nurse Practice Act (NPA).

The NPA establishes rules and laws for the practice of nursing in Florida. It describes and establishes the minimal acceptable standards for safe and effective nursing practice by RNs, LPNs, certified nurse-midwives, certified nurse practitioners, certified registered nurse anesthetists, and clinical nurse specialists in any setting.

In general, nurse practice acts describe:

- Authority, power and composition of a board of nursing
- Education program standards
- Standards and scope of nursing practice
- Types of titles and licenses
- Requirements for licensure
- Grounds for disciplinary action, other violations and possible remedies (NCSBN, 2016a).

The *sole* legislative purpose in enacting this part is to ensure that every nurse practicing in Florida meets the minimum requirements for safe practice. It is the legislative intent that nurses who fall below minimum competency or who otherwise present a danger to the public shall be prohibited from practicing in Florida.

Part I of Chapter 464 (Nurse Practice Act) is contained within 25 sections:

- 464.001 Short title.
- 464.002 Purpose.

- 464.003 Definitions.
- 464.004 Board of Nursing; membership; appointment; terms.
- 464.005 Board headquarters.
- 464.006 Rulemaking authority.
- 464.008 Licensure by examination.
- 464.009 Licensure by endorsement.
- 464.0095 Nurse Licensure Compact.
- 464.0096 Nurse Licensure Compact; public records and meetings exemptions.
- 464.0115 Certification of clinical nurse specialists.
- 464.012 Certification of advanced registered nurse practitioners; fees; controlled substance prescribing.
- 464.013 Renewal of license or certificate.
- 464.014 Inactive status.
- 464.015 Titles and abbreviations; restrictions; penalty.
- 464.016 Violations and penalties.
- 464.017 Sexual misconduct in the practice of nursing.
- 464.018 Disciplinary actions.
- 464.019 Approval of nursing education programs.
- 464.0195 Florida Center for Nursing; goals.
- 464.0196 Florida Center for Nursing; board of directors.
- 464.0205 Retired volunteer nurse certificate.
- 464.022 Exceptions.
- 464.027 Registered nurse first assistant.

You can access Part I of Chapter 464 (Nurse Practice Act) in its entirety here.

Part II: Certified Nursing Assistants

Part II of Chapter 464 establishes training and certification requirements for certified nursing assistants in Florida. The certification of nursing assistants is the responsibility of the Florida Board of Nursing, which establishes minimum qualification and training requirements for certification. Under this part, the nursing board also establishes rules for the denial, suspension, or revocation of certification and decides disciplinary and corrective actions.

Chapter 464.201 of the Florida Statutes describes the role of a nursing assistant:

> "Certified nursing assistant" means a person who meets the qualifications specified in this part and who is certified by the board as a certified nursing assistant.
>
> "Practice of a certified nursing assistant" means providing care and assisting persons with tasks relating to the activities of daily living. Such tasks are those associated with personal care, maintaining mobility, nutrition and hydration, toileting and elimination, assistive devices, safety and cleanliness, data gathering, reporting abnormal signs and symptoms, postmortem care, patient socialization and reality orientation, end-of-life care, cardiopulmonary resuscitation and emergency care, residents' or patients' rights, documentation of nursing-assistant services, and other tasks that a certified nurse assistant may perform after training beyond that required for initial certification and upon validation of competence in that skill by a registered nurse.

The regulations related to practice as a certified nursing assistant in Florida are contained within nine sections:

- 464.201 Definitions.
- 464.202 Duties and powers of the board.
- 464.203 Certified nursing assistants; certification requirement.
- 464.204 Denial, suspension, or revocation of certification; disciplinary actions.
- 464.205 Availability of disciplinary records and proceedings.
- 464.206 Exemption from liability.
- 464.207 Penalties.
- 464.208 Background screening information; rulemaking authority.

You can access Part II of Chapter 464 (Certified Nursing Assistants) in its entirety here.

Recent Florida Legislation, Nurse Practice Act

During every session of the Florida Legislature there is potential for legislation to be passed that affects the nursing profession. The Florida Board of Nursing website provides current information about legislative changes (potential and finalized), how they will affect licensed nurses, and provides links to additional information.

A number of important changes were made in 2016. In March, for example, legislation was passed that put the Nurse Licensure Compact in place with the stipulation that it will take effect on December 31, 2018 or when 26 other states have joined the compact, whichever comes first. Chapters 464.0095 and 464.0096 (listed above) were added as a result of that legislation.

Also in 2016, the legislation establishing the Council on Certified Nursing Assistants was repealed, so chapter 464.2085 was deleted from statute and related changes were made. Other recent legislation has addressed continuing education requirements, licensing requirements, and practice issues affecting certain ARNPs.

It is critical for licensed nurses to keep themselves up to date on the laws and regulations that affect their licensure and professional practice. It has been noted in multiple situations affecting nurses that ignorance of the law will not protect them from its consequences. The Nurse Licensure Compact is a particularly good example of the importance of staying informed.

The **Nurse Licensure Compact (NLC)** "allows nurses to have one multistate license, with the ability to practice in both their home state and other compact states." Currently 25 states have joined the compact. The NLC has benefits for nurses, employers, and the profession and helps to address the increasingly mobile workforce in healthcare. At the same time, a nurse is required by the compact to follow the nurse practice act and all other laws in place in the state where they are working, regardless of the laws in their home state (NCSBN, 2016d). Additional information about the NLC is available here.

Levels of Nursing Practice in Florida

In Florida, each level of nursing practice has a specific designation that is legally protected. The designations are described in Florida Statutes Chapter 464.003 (Definitions). They include:

- Registered Nurse (RN)
- Licensed Practical Nurse (LPN)
- Clinical Nurse Specialist (CNS)
- Advanced Registered Nurse Practitioner (ARNP) (this definition specifically includes the following designations)
  - Certified Registered Nurse Anesthetist (CRNA)
  - Certified Nurse Midwife (CNM or nurse midwife)
  - Nurse Practitioners

Chapter 464.015 (Titles and abbreviations; restrictions; penalty) addresses all the specific titles and abbreviations and when they can be used, including the designations Graduate Nurse (GN) and Graduate Practical Nurse (GPN), which are not included in section 464.003 (Definitions). The Florida Board of Nursing provides additional guidance on these two designations here.

In addition to the levels of nursing practice described above, section 464.027 addresses the intent to "encourage the use of registered nurse first assistants who meet the qualifications of this section as 'assistants at surgery' by physicians and hospitals to provide quality, cost-effective surgical intervention to health care recipients" in Florida. A **registered nurse first assistant** is any person who is licensed as a registered nurse, certified in perioperative nursing, and holds a certificate from, and has successfully completed, a recognized program.

Registered Nurse

"Registered nurse" means any person licensed in the State of Florida to practice professional nursing. Section 464.003 of the Florida Statutes reads in part, "practice of professional nursing" means the performance of those acts requiring substantial specialized knowledge, judgment, and nursing skill based upon applied principles of psychological, biological, physical, and social sciences which shall include, but not be limited to:

- The observation, assessment, nursing diagnosis, planning, intervention, and evaluation of care; health teaching and counseling of the ill, injured, or infirm; and the promotion of wellness, maintenance of health, and prevention of illness of others.
- The administration of medications and treatments as prescribed or authorized by a duly licensed practitioner authorized by the laws of this state to prescribe such medications and treatments.
- The supervision and teaching of other personnel in the theory and performance of any of the acts described in this subsection.

A professional nurse is responsible and accountable for making decisions that are based upon the individual's educational preparation and experience in nursing.

Advanced or Specialized Nursing Practice

Chapter 464.003 of the Florida Statutes reads in part, "advanced or specialized nursing practice" means, in addition to the practice of professional nursing, the performance of advanced-level nursing acts approved by the board which, by virtue of post basic specialized education, training, and experience, are appropriately performed by an advanced registered nurse practitioner. Within the context of advanced or specialized nursing practice, the advanced registered nurse practitioner may perform acts of nursing diagnosis and nursing treatment of alterations of the health status.

The **advanced registered nurse practitioner** may also perform acts of medical diagnosis and treatment, prescription, and operation as authorized within the framework of an established supervisory protocol. "Advanced registered nurse practitioner" means any person licensed in this state to practice professional nursing and certified in advanced or specialized nursing practice, including certified registered nurse anesthetists, certified nurse midwives, and nurse practitioners.

A **clinical nurse specialist** is any person licensed in this state to practice professional nursing and certified in clinical nurse specialist practice. "Clinical nurse specialist practice" means the delivery and management of advanced practice nursing care to individuals or groups, including the ability to:

- Assess the health status of individuals and families using methods appropriate to the population and area of practice.
- Diagnose human responses to actual or potential health problems.
- Plan for health promotion, disease prevention, and therapeutic intervention in collaboration with the patient or client.
- Implement therapeutic interventions based on the nurse specialist's area of expertise and within the scope of advanced nursing practice, including, but not limited to, direct nursing care, counseling, teaching, and collaboration with other licensed health care providers.
- Coordinate health care as necessary and appropriate and evaluate with the patient or client the effectiveness of care.

Licensed Practical Nurse

A **licensed practical nurse** (as defined in Chapter 464.003 of the Florida Statutes) is any person licensed in the State of Florida to practice practical nursing. "Practice of practical nursing" means the performance of selected acts, including the administration of treatments and medications, in the care of the ill, injured, or infirm; the promotion of wellness, maintenance of health, and prevention of illness of others *under the direction of a registered nurse, a licensed physician, a licensed osteopathic physician, a licensed podiatric physician, or a licensed dentist*; and the teaching of general principles of health and wellness to the public and to students *other than nursing students.* A practical nurse is responsible and accountable for making decisions that are based upon the individual's educational preparation and experience in nursing.

The parts of the Florida Statutes relating to levels of nursing practice (464.015) can be read here. The section related to the definition of levels of nursing (464.003) can be read here.

Scope and Standards of Practice

The job responsibilities of healthcare providers are defined by their **scope of practice**. A scope of practice (a standard) defines the procedures and actions that are permitted by law for licensed individuals of certain professions. It restricts the practice of a licensed professional to what the law permits for specific education, experience, and demonstrated competency. Scopes of practice are defined in each state's nurse practice act and certain assumptions can be made about a profession's scope of practice:

- Public protection should have top priority in scope of practice decisions, rather than professional self-interest.
- Changes in scope of practice are inherent in our current healthcare system.
- Collaboration between healthcare providers should be the professional norm.
- Overlap among professions is necessary.
- Practice acts should require licensees to demonstrate that they have the requisite training and competence to provide a service (NCSBN, 2012).

In Florida, the scope of practice for registered nurses and licensed practical nurses is defined in Chapter 464, Part I of the Florida Statutes—the Nurse Practice Act. This section provides definitions for nursing diagnosis, nursing treatment, practice of practical and professional nursing, and other definitions describing the scope of practice for nursing professionals.

Registered nurses are expected to use their education and judgment to ensure patient safety by reviewing and clarifying orders (in some instances, they can refuse to implement an order). RNs have specific and well-defined responsibilities that are distinct from those of an LPN or a CNA.

A registered nurse is expected to apply the nursing process in the practice of nursing. The steps of the nursing process are cyclical in nature so that the nurse's actions are directed by the client's changing status throughout the process. The nursing process involves the use of critical thinking and clinical judgment for each client under the registered nurse's care. The nursing process includes:

- Standards of assessment
- Analysis and reporting
- Planning
- Implementation
- Evaluation

The nurse may collaborate with the client, family, significant others, and other members of the healthcare team in applying the steps of the nursing process.

Registered nurses may choose to receive specialized education and training that allows them to practice as a clinical specialist, nurse anesthetist, nurse midwife, or nurse practitioner. These specialties have scopes of practice that differ from that of a registered nurse.

Chapter 64B9: Rules of the Florida Board of Nursing

The Florida Board of Nursing (BON) is both a regulatory board and a state government agency. Its organization, structure, and responsibilities are contained within Chapter 64B9 of the Florida Administrative Code. The BON consists of 13 members whose chief responsibility is to implement and enforce state laws related to nursing licensure, practices, education, and Florida nursing schools. The Florida Board of Nursing is a member of the National Council of State Boards of Nursing.

The overall mission of a nursing board is "to actively safeguard the health of the public through effective regulation of nursing care." Nursing boards are legally responsible for enforcing their state's nurse practice act. They are responsible for establishing standards for safe nursing care and issuing licenses to practice nursing. They monitor compliance with state laws and are empowered to take action against licensees who have exhibited unsafe nursing practice. Nursing boards oversee education requirements and rules for licensure and define the scope of nursing practice in their state (NCSBN, 2013a).

In general, nursing boards are responsible for:

- Protecting the public
- Ensuring the competence of all practitioners regulated by the board
- Ensuring due process and ethical decision making
- Sharing accountability
- Engaging in strategic collaboration
- Developing evidence-based regulations
- Responding to the marketplace and healthcare environment
- Understanding the globalization of nursing (NCSBN, 2012)

The Florida Department of Health's Division of Medical Quality Assurance serves as the principle administrative support unit for the Florida BON. The BON has a full-time staff based in Tallahassee and its regulatory functions are funded in full by fees paid by its licensees. Board members are appointed by the governor and subject to confirmation by the senate. Members of the board can serve two four-year terms. Despite the expiration of a term, board members can continue to serve until they have been either replaced or reappointed (FBON, 2013).

The thirteen members of the Florida BON must be residents of Florida. Seven of the board members must be RNs who have been engaged in the practice of professional nursing for at least four years (one must be an advanced registered nurse practitioner, one a nurse executive, and one a nurse educator from an approved program). The board also contains three LPNs who have been engaged in the practice of practical nursing for at least four years and three consumer members who have never been connected with the practice of nursing.

Powers and Duties

The powers and duties of the Florida Board of Nursing are defined in Chapters 64B9-1 through 64B9-17 of the Florida Administrative Code. The sixteen chapters encompass 101 rules outlining the responsibilities of the Florida Board of Nursing.

- 64B9-1 Organization
- 64B9-2 Nursing Programs
- 64B9-3 Requirements for Licensure
- 64B9-4 Administrative Policies Pertaining to Certification of Advanced Registered Nurse Practitioners
- 64B9-5 Continuing Education Requirements
- 64B9-6 Inactive Status and Reactivation of Inactive License
- 64B9-7 Fees
- 64B9-8 Hearings, Proceedings, Conferences, Discipline
- 64B9-9 Impaired Nurse Program
- 64B9-11 Maintenance of Medical Records
- 64B9-12 Administration of Intravenous Therapy by Licensed Practical Nurses
- 64B9-13 Home Hemodialysis Treatments
- 64B9-14 Delegation to Unlicensed Assistive Personnel
- 64B9-15 Certified Nursing Assistants
- 64B9-16 LPN Supervision in Nursing Home Facilities
- 64B9-17 Role of the Registered Nurse in Conscious Sedation

Chapter 64B9 can be viewed in its entirety here.

License Verification: MQA and NurSys

The Medical Quality Assurance Services (MQA) within the Florida Department of Health maintains a license lookup page where a nurse's license can be verified. You can access the MQA license verification website here.

Florida also participates in a national system called NurSys that is overseen by the National Council of State Boards of Nursing and provides:

- Publicly available discipline and license status updates of an employer's nurse(s) from the board of nursing.
- An online license look-up system that allows verification of a nurse's licensure status.

- License verification to another state or territory for nurses who need to verify their current license to a board of nursing to obtain a new license in the other state/territory.

National Council of State Boards of Nursing

Nursing boards are part of a national organization called the National Council of State Boards of Nursing (NCSBN). Established in 1978, the NCSBN provides a collective voice for nursing regulation, including the development of "a psychometrically sound and legally defensible nurse licensure examination consistent with current nursing practice" (NCSBN, 2013b).

The NCSBN got its start within the American Nurses Association, but split off as an independent entity because ANA recognized that a regulatory organization needed to be separate from the professional organization. The primary mission of NCSBN is to protect the public by ensuring that licensed nurses provide safe and competent nursing care.

In the United States and its territories, sixty boards make up the membership of the NCSBN. In addition, sixteen associate members, including nursing organizations from Canada, Bermuda, Ireland, New Zealand, and Singapore, are NCSBN members.

Federations of Regulatory Boards exist to foster exchanges of information about regulatory best practice. Typically these are financed through membership dues from member boards, though a number also provide a national examination that is required for initial state licensure as a demonstration of basic competence (CLEAR, 2006).

The Disciplinary Process

> Basically, the nurse may be disciplined for any violation of the Nurse Practice Act, for any violation of Chapter 456, Florida Statutes, for violation of any Rule of the Board of Nursing (Chapter 64B9, F.A.C.), for violation of any law applicable to nurses or nursing, or for violation of any final order of the Board of Nursing or Department of Health. The most ambiguous of these tends to be actions of the nurse which fail to meet "minimal standards of acceptable and prevailing nursing practice" (sometimes called "falling below the standard of nursing practice" or "substandard performance"), as stated in Section 464.018, Florida Statutes.
>
> George F. Indest III
> *Nursing Law Manual*, 2008

Each state has a method for investigating and disciplining its nurses. The Florida State legislature grants the Florida Board of Nursing the authority to hear and decide cases against nurses who have been accused of violating their state practice act. Laws related to the various ground for discipline include:

- Chapter 456, Florida Statutes (applies to all licensed health professionals)
- Chapter 464, Florida Statutes (Florida Nurse Practice Act)
- Chapter 64B9, Florida Administrative Code (Rules adopted by the Board of Nursing)

The Florida Nurse Practice Act describes disciplinary actions that can be levied against a licensed nurse in Florida. It outlines specific acts that constitute grounds for denial of a license or disciplinary action. A wide variety of criminal acts such as bribery, fraudulent practices, indecent exposure, assault, battery, child abuse, and domestic violence, among other transgressions, can be grounds for denial of license or other disciplinary action by the board.

Legal Representation

Most nurses work from a place of service and goodwill. They think if they just explain what they have done the issue will be resolved. This is a risky assumption. Any nurse formally charged with a violation of practice should seek legal representation before making any statement to *anyone* in defense of self.

Denial of a License or Disciplinary Action

According to section 464.018 of the Florida Statutes, the following acts constitute grounds for denial of a license or disciplinary action:

- Procuring, attempting to procure, or renewing a license to practice nursing by bribery, by knowing misrepresentations, or through an error of the department or the board.
- Having a license to practice nursing revoked, suspended, or otherwise acted against, including the denial of licensure, by the licensing authority of another state, territory, or country.
- Being convicted or found guilty of, or entering a plea of nolo contendere to, regardless of adjudication, a crime in any jurisdiction which directly relates to the practice of nursing or to the ability to practice nursing.

In addition, being found guilty, regardless of adjudication, of any of the following offenses:

- A forcible felony

- A violation relating to:
  - theft, robbery, and related crimes
  - fraudulent practices
  - lewdness and indecent exposure
  - assault, battery, and culpable negligence
  - child abuse, abandonment, and neglect

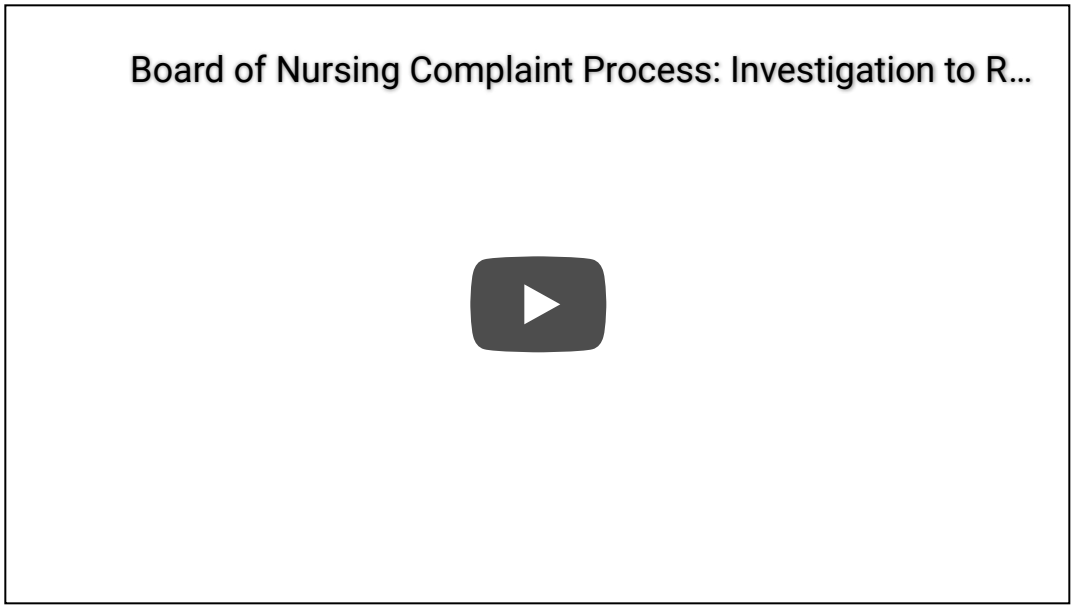
Other actions that can result in a disciplinary action include:

- Having been found guilty of domestic violence.
- Making or filing a false report or record.
- False, misleading, or deceptive advertising.
- Unprofessional conduct.
- Engaging or attempting to engage in the possession, sale, or distribution of controlled substances.
- Being unable to practice nursing with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, or chemicals or any other type of material or as a result of any mental or physical condition.
- Failing to report to the department any person who the licensee knows is in violation of this part or of the rules of the department or the board.
- Knowingly violating any provision of this part.
- Failing to report to the department any licensee who the nurse knows has violated the grounds for disciplinary action set out in the law.
- Failing to meet minimal standards of acceptable and prevailing nursing practice, including engaging in acts for which the licensee is not qualified by training or experience.

The section on disciplinary actions against licensed nurses can be read here.

The following video, produced by the National Council of State Boards of Nursing describes the complaint process, from investigation to resolution.

Video—Nursing Complaint Process (9:59)



Source: NCSBN Disciplinary Resources Committee, 2010.
https://www.ncsbn.org/426.htm
https://www.youtube.com/watch?v=fzEwtCxaTmI&feature=youtu.be

Denial, suspension, or revocation of certification can be taken by the board against a certified nursing assistant as well for any violation of Chapter 456 or any of the rules adopted by the nursing board. The regulations related to disciplinary actions against a certified nursing assistant are described in Chapter 464, Part II (464.204) of the Florida Statutes.

The section on disciplinary actions against certified nursing assistants can be read here.

An Alternative to Discipline

Licensed nurses may be subject to a complaint if their behavior or practice is affected by the use of drugs, alcohol, or other chemicals or by a physical or mental condition or if they are in violation of nursing or nursing-related laws or rules (NCSBN, 2013a). The American Nurses Association estimates that in the United States 6% to 8% of nurses are impaired by drugs or alcohol while at work; yet, only about one-third of one percent of all actively licensed nurses are sanctioned each year for their conduct (NCSBN, 2011).

The Florida Intervention Project for Nurses (IPN)—is a statewide program established in 1983 as an alternative to discipline. It was the first diversion program for nurses in the United States. IPN is not part of the board of nursing and a nurse can complete the IPN program without ever having notified the board. In fact, about 80% of complaints to the IPN program come from individuals and employers, while only about 20% are referred by the board of nursing (Personal communication, 2013).

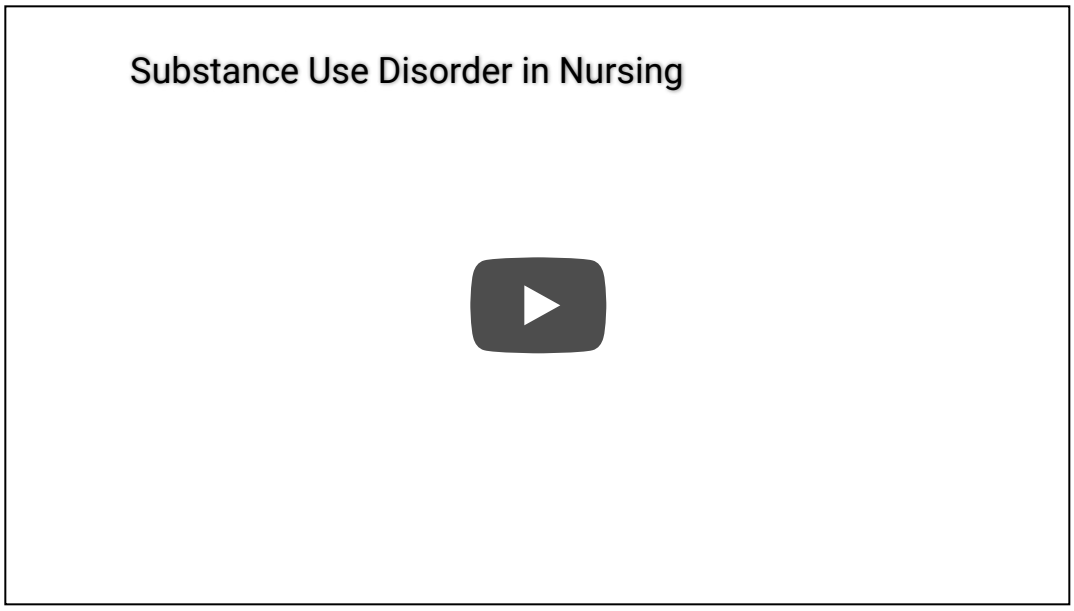
The goal of the IPN program is to ensure public health and safety by providing close monitoring of nurses who are unsafe to practice due to impairment as a result of misuse or abuse of alcohol or drugs, or both, or due to a mental or physical condition that could affect the licensee's ability to practice with skill and safety (IPN, 2013).

A nurse entering the IPN program goes through an organized process involving intake, intervention, evaluation, treatment, and monitoring. If the licensee refuses to participate or fails to progress, a report is made to the Department of Health, which begins a process involving an investigation that can lead to disciplinary action (Smith, 2013).

Educating employers about the IPN diversion program is a primary goal of the IPN program. According to Vicki Fitzpatrick, clinical director and nurse support group liaison at IPN, many employers see substance abuse as a "moral failing" rather than a progressive brain disease that can be effectively treated. IPN works to dispel this perception. The ultimate goal is recovery from substance abuse and retention of the nurse in the profession.

Florida's mandatory reporting law requires licensed nurses to report anyone who engages in acts that constitute grounds for denial of a license. However, if you suspect a colleague of engaging in an activity that constitutes grounds for denial of license and that colleague is actively participating in a board-approved program for the treatment of a physical or mental condition, you are only required to report the person to an impaired professional's consultant (Smith, 2013).

Video—Substance Use Disorder in Nursing (12:35)



Source: NCSBN, 2013.
https://www.ncsbn.org/333.htm
https://www.youtube.com/watch?v=p8Rhs5h6QIc&feature=youtu.be

Ethical and Legal Practice

Ethics is a branch of philosophy that deals with right and wrong. It is a system of principles and rules of conduct recognized and accepted by a specific group or culture. **Bioethics** covers a broad set of possible topics such as ethical standards and moral problems created by the practice of medicine, ethical issues in neuroscience, protection of research participants, privacy issues raised by genome sequencing, and research with children.

Clinical ethics is a discipline or methodology for considering the ethical implications of medical technologies, policies, and treatments, with special attention to determining what ought to be done (or not done) in the delivery of healthcare (Brock & Mastroianni, 2013).

Law is the set of enforced rules under which a society is governed. Laws can be created either through legislation, which is called statutory law, or by opinions written by judges in court cases, which is called case law (Center for Bioethics, n.d.).

The law establishes the rules that define a person's rights and obligations. Law also sets out penalties for those who violate these rules. Laws are changed frequently to reflect societal needs. In every society laws often have a strong moral standard (Porter, 2001). Two of the most common types of potential legal actions against healthcare providers for injuries resulting from healthcare involve lack of informed consent and violation of the standard of care (Brock & Mastroianni, 2013).

Nursing Code of Ethics

Ethical practice guidelines have been around since the early days of nursing. An ethical pledge for nurses—a modified version of the Hippocratic Oath called the Nightingale Pledge—was developed by Lystra Gretter in 1893. The first code of ethics for nurses was suggested by the American Nurses Association in 1926 and adopted in 1950 (Lyons, 2011).

For generations, nurses have taken seriously their Code of Ethics and their role as those who "promotes, advocates for, and strives to protect the health, safety and rights of the patient." The American Nurses Association maintains the current code of ethics for the nursing profession, called *A Code of Ethics for Nurses with Interpretive Statements*. Last modified in 2001, it contains nine provisions, which detail "the ethical obligations and duties of every individual who enters the nursing profession (ANA, 2001). The code is currently under revision, with the revised code of ethics expected in late 2014.

Codes of ethics are broadly written and are not meant to serve as a blueprint for ethical decision making. They are intended to provide a reminder of standards of conduct: that the nurse has a duty to keep confidentiality, maintain competence, and safeguard patients from unethical practice (Lyons, 2011).

The Language of Bioethics

The language of biomedical ethics is applied across all practice settings, and four basic principles are commonly accepted by bioethicists. These principles include (1) autonomy, (2) beneficence, (3) nonmaleficence, and (4) justice. In health fields, veracity and fidelity are also spoken of as ethical principles but they are not part of the foundational ethical principles identified by bioethicists.

The Principle of Autonomy: Personal Freedom

Autonomy is an American value. We espouse great respect for individual rights and equate freedom with autonomy. Our system of law supports autonomy and, as a corollary, upholds the right of individuals to make decisions about their own healthcare.

Respect for autonomy requires that patients be told the truth about their condition and informed about the risk and benefits of treatment. Under the law, they are permitted to refuse treatment even if the best and most reliable information indicates that treatment would be beneficial, unless their action may have a negative impact on the well-being of another individual. These conflicts can set the stage for ethical dilemmas.

The concept of autonomy has evolved from paternalistic physicians who held ethical decision-making authority, to patients empowered to participate in making decisions about their own care, to patients heavily armed with Internet resources who seek to prevail in *any* decision making. This transition of authority has been slower to evolve in the geriatric population but, as the baby boomers age they are asserting this evolving standard of independence. Autonomy, however, does not negate responsibility. Healthcare at its foundation is a partnership between the provider and the recipient of care. Each owes the other responsibility and respect.

The Principle of Beneficence: Kindness

Beneficence is the act of being kind. The beneficent practitioner provides care that is in the best interest of the patient. The actions of the healthcare provider are designed to bring about a positive good. Beneficence always raises the question of subjective and objective determinations of benefit versus harm. A beneficent decision can only be objective if the same decision were made regardless of who was making it.

Traditionally the ethical decision making process and the ultimate decision were the purview of the physician. This is no longer the case; the patient and other healthcare providers, according to their specific expertise, are central to the decision-making process (Valente, 2000).

The Principle of Nonmaleficence: Do No Harm

Nonmaleficence means doing no harm. Providers must ask themselves whether their actions may harm the patient either by omission or commission. The guiding principle of primum non nocere, "first of all, do no harm," is based in the Hippocratic Oath. Actions or practices of a healthcare provider are "right" as long as they are in the interest of the patient and avoid negative consequences.

Florence Nightingale spoke of nonmaleficence more than 150 years ago when she reminded us that "the very first requirement in a hospital is that it should do the sick no harm"—and proceeded to set up systems and practices that are still being used today to enhance the quality and safety of patient care (Hughes, 2008).

Patients with terminal illnesses are often concerned that technology will maintain their life beyond their wishes; thus, healthcare providers are challenged to improve care during this end stage of life. Patients may even choose to hasten death if options are available (Phipps et al., 2003). The right of the individual to choose to "die with dignity" is the ultimate manifestation of autonomy, but it is difficult for healthcare providers to accept death when there may still be viable options.

Here we see the principle of nonmaleficence conflicting with the principle of autonomy as the healthcare providers desire to be beneficent or, at the least, cause no harm. The active choice to hasten death versus the seemingly passive choice of allowing death to occur requires that we provide patients with all the information necessary to make an informed choice about courses of action available to them.

A complicating factor in end-of-life decisions is patients' concern that, even if they make their wishes clear (eg, through an advance directive), their family members or surrogates will not be able to carry out their desires and permit death to occur (Phipps et al., 2003). Treating against the wishes of the patient can potentially result in mental anguish and subsequent harm.

The Principle of Justice: Equity and Fairness

Justice speaks to equity and fairness in treatment. Hippocrates related ethical principles to the individual relationship between the physician and the patient. Ethical theory today must extend beyond individuals to the institutional and societal realms (Gabard & Martin, 2003).

Justice may be seen as having two types: distributive and comparative. **Distributive justice** addresses the degree to which healthcare services are distributed equitably throughout society. Within the logic of distributive justice, we should treat similar cases similarly, but how can we determine if cases are indeed similar? Beauchamp and Childress (2001) identify six material principles that must be considered, while recognizing that there is little likelihood all six principles could be satisfied at the same time.

Principles of Justice

To each person:

- An equal share
- According to need
- According to effort
- According to contribution
- According to merit
- According to free market exchanges

Looking at the principles of justice as they relate to the delivery of care, it is apparent that they do conflict in many circumstances; for example, a real-life system that attempts to provide an equal share to each person is distributing resources that are not without limit. When good patient care demands more than the system has allocated, there may be a need for adjustments within the marketplace.

Comparative justice determines how healthcare is delivered at the individual level. It looks at disparate treatment of patients on the basis of age, disability, gender, race, ethnicity, and religion. Of particular interest currently are the disparities that occur because of age. In 1975 Singer related bias as a result of age to gender and race discrimination and referred to the practice as *ageism* (Gabard & Martin, 2003). In a society where equal access to healthcare does not exist, there is a continuing concern about the distribution of resources, particularly as the population ages and the demand for services increases.

The first wave of baby boomers is signing up for Medicare now, and the health spending projections for the next decade are significant (Keehan et al., 2008). Thorpe and Howard (2006) found that there has been an increase in medication use of 11.5% in the past decade just for the medical management of metabolic syndrome, an age-associated complex of diseases. McWilliams and colleagues (2007) found that Medicare beneficiaries who were previously uninsured, and who enrolled in Medicare at age 65, may have greater morbidity, requiring more intensive and costlier care, than they would have had they been previously insured. The cost to the system of low levels of care is extensive. Recognizing the number of uninsured Americans who will ultimately come into the Medicare program with potentially greater morbidity, it appears that the demands of justice in the healthcare system will continue to increase.

Equitable allocation of resources is an ever-increasing challenge as technology improves and lives are extended through natural and mechanical means. All of these factors place greater stress on an already inefficient and overburdened healthcare system and results in more difficult ethical decisions about workforce allocation and equitable distribution of financial resources.

The Principle of Veracity: Truthfulness

Veracity is not a foundational bioethical principle and is granted just a passing mention in most ethics texts. It is at its core an element of respect for persons (Gabard, 2003). Veracity is antithetical to the concept of medical paternalism, which assumes patients need to know only what their physicians choose to reveal. Obviously there has been a dramatic change in attitudes toward veracity because it forms the basis for the autonomy expected by patients today. *Informed consent*, for example, is the ability to exercise autonomy with knowledge.

Decisions about withholding information involve a conflict between veracity and deception. There are times when the legal system and professional ethics agree that deception is legitimate and legal. Therapeutic privilege is invoked when the healthcare team makes the decision to withhold information believed to be detrimental to the patient. Such privilege is by its nature subject to challenge.

The Principle of Fidelity: Loyalty

Fidelity is faithfulness, or loyalty. It speaks to the special relationship developed between patients and their healthcare provider. Each owes the other loyalty; although the greater burden is on the medical provider, increasingly the patient must assume some of the responsibility (Beauchamp & Childress, 2001). Fidelity often results in a dilemma, because a commitment made to a patient may not result in the best outcome for that patient. At the root of fidelity is the importance of keeping a promise, or being true to your word. Individuals see this differently. Some are able to justify the importance of the promise at almost any cost, and others are able to set aside the promise if an action could be detrimental to the patient.

The Relationship of Ethics and the Law

> The moral conscience is a precursor to the development of legal rules for social order.
>
> Brock & Mastroianni, 2013

Ethics has been described as beginning where the law ends. Both share the goal of creating and maintaining social good (Brock & Mastroianni, 2013). Ethics never stands alone, nor does the law. Some issues that have both ethical and legal components include:

- Access to medical care
- Informed consent
- Confidentiality and exceptions to confidentiality
- Mandatory reporting
- Mandatory drug testing
- Privileged communication with healthcare providers
- Advance directives
- Reproductive rights/abortion
- Physician-assisted suicide

The Carnegie Foundation describes the educational components needed for work as a professional as involving three essential areas: (1) intellectual training to learn the academic knowledge base and the capacity to think in ways important to the profession; (2) a skill-based apprenticeship of practice; and (3) an apprenticeship to the ethical standards, social roles, and responsibilities of the profession, through which the novice is introduced to the meaning of an integrated practice of all dimensions of the profession, grounded in the profession's fundamental purposes (Hughes, 2008).

The Affordable Care Act is an example of a set of laws developed with a number of ethical issues in mind. Due to preexisting conditions or simple unavailability, tens of millions of people have been unable to purchase health insurance at any cost. The law addresses this inequity by requiring most U.S. citizens and permanent residents to purchase health insurance (Lachman, 2012). The law also addresses insurances choices and costs, and puts into place certain rights and protections for consumers.

Recall the ethical concept of *distributive justice* discussed in the previous section, which addresses the degree to which healthcare services are distributed equitably throughout society. The Affordable Care Act was developed largely in response to this ethical concept, namely the situation in which many millions of people have no insurance and up to $100 billion of care is cost-shifted onto patients who are able to pay or who are on an existing insurance plan. This shift raised the average annual health insurance premium roughly $1,000 for every insured family (Lachman, 2012), which raises additional ethical issues of equity and fairness.

The Affordable Care Act also touches on the ethical principles of *beneficence* (kindness) and *nonmaleficence* (do no harm) by setting up affordable healthcare exchanges and plans. The exchanges are an integral part of the complicated issue that is created when healthcare is mandated. It is based on the concept that mandating health insurance without addressing affordability would cause significant harm to individuals and families who are struggling financially (Lachman, 2012).

Although ethics attempts to identify all available options to a given problem and consider the implications of each option, the law often places limits on those options. This intersection of the law and ethic often creates conflict and raises these important questions (Porter, 2001):

- Which bioethical choices, if any, should be limited by laws?
- Should laws make "immoral" activities illegal if there is no victim?
- How much weight should courts and legislators give to bioethical arguments when creating new laws?
- What is the proper balance between individual rights to treatment and the cost and efficacy of such treatment? (Porter, 2001)

Ethical Conflicts and Dilemmas

Ethical dilemmas arise when there are equally compelling reasons both for and against a particular course of action and a decision *must* be made. It is a dilemma because there is a conflict between the choices. Usually one action, though morally right, violates another ethical standard. A classic example is stealing to feed your family. Stealing is legally and ethically wrong, but if your family is starving it might be morally justified (Noel-Weiss et al., 2012).

Kidder calls this a "right vs. right" dilemma. When evaluating the alternatives, both courses of action have positive and negative elements. Right vs. right is an *ethical dilemma*, whereas right vs. wrong is identified as a *moral temptation* (Kidder, 1996).

Working through an ethical dilemma until a satisfactory conclusion is reached, making decisions that lead to good actions, and avoiding negative consequences and regret are the foundational principles of ethical practice (Noel-Weiss et al., 2012).

Sources of Ethical Conflict

Research suggests that ethical conflicts are on the rise in the nursing field, due both to the increasing complexity of care and to scientific and technological advances. Several studies that sought to analyze ethical conflicts that arise in critical care units noted that the ethical conflicts experienced by critical care nurses stem from three main sources:

1. Relationships with patients and their families
2. The provision of certain treatments
3. The characteristics of the setting in which the clinical team works (Falcó-Pegueroles et al., 2013)

In the first area, the decision-making process comes up against issues such as the difficulty of ensuring informed consent, a failure to respect confidentiality, and failure to protect the patient's interests. The second area involves the provision of certain treatments in which nurses experience conflict when asked to administer treatment they regarded as overly aggressive, when pain management seemed to be deficient, or when it became necessary to limit the use of life support procedures. In the third area—workplace dynamics—conflict arises when nurses were not fully involved in the decision-making process or if they feel the work environment made it difficult to consider questions of a bioethical nature (Falcó-Pegueroles et al., 2013).

Making the Right Decision

Situations that create ethical conflicts highlight the difficulty involved in making the right decision. Andrew Jameton identified three types of ethical conflicts that nurses may experience in the clinical setting that can cause distress (Falcó-Pegueroles et al., 2013):

1. Moral uncertainty
2. Moral dilemma
3. Moral distress

In a situation of *moral uncertainty* the professional is unsure whether or not an ethical problem exists, or recognizes that there is such a problem but is unclear about the ethical principles involved. A *moral dilemma* can arise when the professional must choose between two or more morally correct principles, each of which would lead to a distinct course of action (Falcó-Pegueroles et al., 2013).

Finally, *moral distress* is felt when the professional recognizes the ethical principles involved and knows the right thing to do but is constrained by something or somebody from acting accordingly. Judith Wilkinson has described an additional type of ethical conflict, which she calls *moral outrage*, a type of ethical conflict in which the professional experiences a sense of impotence in the face of an immoral action performed by others (Falcó-Pegueroles et al., 2013).

The Ethical Decision-Making Process

The primary function of a decision is to commit to some sort of action: a decision reduces to zero the uncertainty about what to do. *Primary uncertainty* is the uncertainty associated with "what to do."

To arrive at a decision, called *secondary uncertainty*, the decision maker must be motivated by some sort of pressure and must work to reduce uncertainty about the pros and cons of a selected course of action. Secondary uncertainty includes uncertainty about the situation, goals to be achieved, and available options or courses of action. Once secondary uncertainty has been reduced, commitment to a chosen option can occur. As soon as a commitment is made, a decision is made, and uncertainty falls to zero (Brecke & Garcia, 1998).

While exploring how to improve a person's decision-making skills, researchers have categorized decision makers as novice, advanced, competent, or expert:

Novice

- Able to solve simple decision-making problems
- Slow and unreliable in recognizing problems needing decisive action
- Unable to identify a decision window
- Rudimentary ability to discern between important and unimportant features of a situation

- Unable to identify options in a hierarchical manner

Advanced

- Proficient in using, finding, and defining decision-making concepts.
- Can invent their own way of doing things
- Recognizes the need to make a decision in a timely and reliable manner
- Able to solve moderately complex decision-making problems
- Only able to develop incomplete options

Competent

- Able to use principles and achieve competence in finding procedures and rules
- Capable of focusing on situation and context and can modify options to fit these features
- Recognizes decision problems
- Manages time well
- Develop well-ordered and complete options
- Can solve complex decision-making problems
- Fully competent in reducing uncertainty

Expert

- Decision-making is automatic, fast, and reliable
- Recognition and timing is no longer a problem
- Able to judge and apply context intuitively and instinctively
- Able to quickly identify the “first, best” option—satisfactory option simply “comes to mind”
- Very efficient at reducing uncertainty
- Able to see the situation, goal, and options based on minimal cues
- Able to probe available information for a perceived pattern (Brecke & Garcia, 1998)

Case

Tim is a 79-year-old man with moderate to severe Alzheimer's disease who was admitted from his home to a rural nursing home for long-term care. Tim is fit and slim, walks well with good balance, and is able to do his activities of daily living with some supervision. Tim is also a "wanderer," is hard of hearing, and is very confused about where he is. Three days after he was admitted Tim was found missing from his room when the nursing assistant brought dinner. On this particular cold, dark, and foggy evening there were three nursing assistants and one licensed vocational nurse on duty (acting as the charge nurse). In addition, there was one physical therapist working late to finish up on the day's paperwork. The facility had 51 residents, some of whom had moderate to severe dementia, plus eight acute rehab patients.

As soon as Tim was reported missing, a search was begun. Two of the nursing assistants refused to join the search outside because they were afraid of the dark. They also felt that they should not leave the rest of the residents alone. The charge nurse, PT, and one nursing assistant began searching while the two remaining nursing assistants rummaged through drawers for flashlights. Five flashlights were found but all had dead batteries and no fresh batteries were available. The charge nurse and the PT agreed not to call 911 or notify the facility administrator or the family. They felt confident that they would quickly find Tim and get him back to his room for dinner.

After a search of about 30 minutes Tim was found on his back in a shallow stream next to the horse pasture that abuts the nursing home. He had fallen, slid under a barbed wire fence down a 10-foot muddy slope and was stuck, unable to stand. He was in jeans and a T-shirt; the temperature outside was 38 degrees.

The charge nurse and the PT discussed whether to call 911 but decided against it. They used a doubled sheet to pull Tim up the slope and assisted him back to his room. He appeared to be unharmed. Tim's nursing assistant cleaned him up, found dry clothes, and encouraged him to eat his dinner. The charge nurse decided not to document all the details of Tim's outside adventure and the PT finished her paperwork and went home.

On Saturday morning, the PT, feeling uncomfortable about what had happened, called the state department of health and reported the incident. She felt certain that if nothing was done that this would happen again. On Monday morning, the LVN who had been in charge during Tim's escape called the PT into a supply closet and loudly dressed her down for calling the state. The PT wasn't sure what to say so she just listened and silently went back to work, ashamed that she had gotten the LVN in trouble. A representative from the state reviewed the incident but no action was taken against the facility.

Questions

1. Did the staff do the right thing when they found Tim missing from his room?
2. Should the managers of the nursing home have equipment, policies, and procedures in place for these types of emergencies?
3. Did the charge nurse and PT act in an ethical manner when they agreed not to call 911 when they found Tim missing from his room and then later in the horse pasture?
4. Is it ethical for a nursing home to admit Alzheimer's patients when they have neither the staff nor the security and safety features in place to ensure a patient's safety?
5. Was it ethical for the LVN to later "dress down" the PT for calling the state department of health?
6. Is the facility properly staffed to adequately care for the clientele they have accepted to this nursing home?
7. Does the inadequate staffing indicate neglect?
8. As mandated reporters, did the nurse and PT have a legal duty to report the incident?

Discussion

Tim's case is an example of a situation in which ethical and legal issues intersected. Although they did their best to find Tim and make sure he was okay, the nurse, PT, and nursing assistants cooperated to cover up a serious, even life-threatening incident. This is a serious ethical lapse, violating the principle of veracity (truthfulness) at the very least. They also violated the principle of nonmaleficence (do no harm) when they dragged Tim up out of the stream without checking for injuries.

From a legal standpoint, the nursing home is required to have an adequate number of qualified staff on duty at all times to meet the needs of its residents. They are legally and ethically at fault for inadequate staffing, lack of policies and procedures for handling residents with dementia, lack of staff training, failure to keep equipment in working order, and failure to make the necessary changes once the incident was reported.

Ethically, the facility still cannot comply with the ethical principle of nonmaleficence (do no harm) because after this incident they continued to admit residents with Alzheimer's disease but failed to address staffing, training, equipment, and safety issues related to residents suffering from dementia.

The state department of health visited the nursing home about a week later. They found no wrongdoing.

Bioethics, Global Inequality, and Social Justice

It is certainly undeniable that our current medical system is complex, with many options available for treatment of illness and disease. Unfortunately, many of these new techniques and medications are only available to certain segments of society and only in certain parts of the world, creating vast health disparities.

Although ethical issues related to global health disparities might be expected to feature prominently in bioethics discussions, mainstream bioethics is often marked by attention to bioethical issues largely affecting the world's more affluent countries. Steven Miles writes that the "soul of bioethics" has been rendered unhealthy partly by its tendency to engage more with issues of assisted reproduction and gene therapy than with the growing number of medically uninsured, with minority and migrant health, with the links between health and human rights, or with the political and economic barriers preventing developing countries from gaining greater access to essential medicines (Rennie & Mupenda, 2008).

Many effective health interventions have not been implemented in low-income countries and millions of deaths and disabilities occur due to conditions we already know how to prevent or treat. For example, several global initiatives have sought to increase access to AIDS treatment in low-income countries. But HIV-positive individuals in low-income countries may suffer from other health conditions for which there is no local or affordable treatment; their homes may be destroyed by natural disasters or civil strife; they may be children orphaned from their dead parents, or have to take care of such children; and they may have more regular access to antiretroviral treatment than they do to the food that helps them absorb it. Anecdotal reports of AIDS patients selling their drugs to buy other medications for their family members or for food indicate that there may be differences in perception about health-related needs and priorities on the part of global initiatives and local communities (Rennie & Mupenda, 2008).

Bioethics has tended to gravitate towards the agonizing dilemmas of patients, family members, and clinicians at an individual level. High-technology interventions in particular have a prominent profile in bioethics discussions. Bioethics also tends to align itself with whatever topics are currently considered scientifically fundable. The focus of bioethicists on novel technologies may be related to the potential market value of these technologies (Rennie & Mupenda, 2008), which has troubling ethical implications.

The question is whether it is desirable, or even ethically justified, for bioethics to continue to reflect a "90/10" gap in which 90% of discussions on bioethics in the literature and popular media revolve around issues affecting 10% of the world's population. Bioethical questions related to urban poverty, drug use, immigration, occupational hazards in the workplace, or environmental injustice make only rare appearances in peer-reviewed bioethics journals, course syllabi, and conferences. These areas of scholarship—tightly linked to issues of social justice—may fall below the radar of many bioethicists due to the social, class, and racial barriers between many practitioners of bioethics and the most affected communities (Rennie & Mupenda, 2008).

Bioethical challenges in the low-income countries have much in common with those in underserved or marginalized communities within more affluent nations, arising from historical inequities, limited access to healthcare, racial discrimination, and gender violence. For this reason, greater attention to ethical issues arising from biomedical research, clinical practice, and public health interventions "far away" might have a positive effect on bioethics "closer to home," potentially expanding the horizons of the field and enhancing its social relevance (Rennie & Mupenda, 2008).

Concluding Remarks

What is the purpose of a course on nursing rules and laws? The requirement very likely comes from a desire on the part of the Florida Board of Nursing and other leaders in the nursing profession to protect patients from unsafe practices and to prevent nursing professionals from engaging in practices that affect patient safety and endanger a nurse's livelihood.

Nurses from earlier generations fought hard to promote the profession of nursing. They oversaw the development of practice acts, codes of ethics, and other laws that regulate nursing. They established professional organizations that fought for improved education, working conditions, and pay for nurses throughout the world.

In Florida, as in other states, nurse practice acts ensure the health and safety of the people by establishing guidelines for nurses who practice in the state. All licensees is responsible for understanding the rules and laws that govern their profession. The rules and laws that govern the practice of nursing are contained in the Florida Statutes and the Florida Administrative Code. These laws and rules detail nurses' scope of practice, their responsibilities as healthcare providers, what they can and cannot do as nurses, and what happens if they break the law or violate the tenets of the state's practice act.

You are responsible for practicing not only according to rules and laws but also in an ethical manner. Understanding the difference between ethics and the law is an important part of nursing practice. Your ability to practice in an ethical manner and your comprehension of the laws and rules of your profession will allow you practice safely while protecting your patients and your license.

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Quiz (FL Laws and Rules 195)

Use the answer sheet following the test to record your answers.

1. The nation’s first nurse practice act was signed into law:

    a. In California in 1850.
    b. In North Carolina in 1903.
    c. In Ohio in 1915.
    d. In Puerto Rico in 1897.

2. Florida signed its first nurse practice act into law:

    a. Immediately following the Civil War.
    b. In the early 1950s, following World War II.
    c. In 1935, when licensure for nurses became mandatory,
    d. In 1913, just prior to World War I.

3. The mission of the Florida Nurses Association is to:

    a. Represent the interests of advanced practice nurses in Florida.
    b. Enforce the rules and laws that must be followed by all Florida nurses.
    c. Promote and advance professional nursing in Florida.
    d. Protect Florida nurses from the influence of unions.

4. The Florida Statutes are:

    a. A permanent collection of state laws updated annually.
    b. Rules through which Florida governs the practice of nursing.
    c. Laws amended every five years as needed by the State of Florida.
    d. Professional guidelines applying to all healthcare workers.

5. The Florida Administrative Code is:

    a. A set of guidelines for nursing practice.
    b. A permanent collection of state laws updated annually.
    c. Laws amended every five years as needed by the State of Florida.
    d. An official compilation of administrative rules updated weekly.

6. The Florida Nurse Practice Act is located in the:

a. Florida Statutes.

b. Florida Administrative Code.

c. Code of ethics for Florida nurses.

d. Bylaws of the Florida Senate.

7. In general, nurse practice acts in the United States describe:

a. Who can and cannot apply to nursing school.

b. Staff ratios—how many patients can be assigned to each nurse for treatment in a given day.

c. The role and behavior of lobbyists.

d. Scope of practice and qualifications for licensure.

8. A professional nurse at any level is always responsible and accountable for making decisions that are within the scope of the individual's educational preparation and experience in nursing.:

a. True

b. False

9. Scope of practice standards:

a. Provide suggestions for which procedures and actions are allowed.

b. Define the procedures and actions permitted by law for licensees in certain professions.

c. Establish ethical standards for each level of nursing practice.

d. Are suggestions not intended to limit the procedures a nurse can perform.

10. A registered nurse is expected to:

a. Use critical thinking and clinical judgment but defer to superiors.

b. Apply the nursing process only when time permits.

c. Apply the nursing process consistently in every practice situation.

d. Work autonomously despite disagreement of colleagues.

11. The Florida Board of Nursing was established:

a. To encourage nurses to advance in their careers.

b. As a resource for nurses throughout the state.

c. To oversee and regulate nursing care under Florida law.

d. To protect nurses whose licenses are involved in legal disputes.

12. The difference between boards of nursing and professional nursing associations is:

a. The professional associations advise the boards and can override their decisions.

b. The board of nursing is a public regulatory board, while the associations are private and voluntary.

c. Professional associations carry more weight because of their larger memberships.

d. The board of nursing can disband a professional association if it so desires.

13. The Florida Intervention Project for Nurses (IPN) is:

a. A program tailored to nurses that treats alcohol abuse exclusively.

b. Designed to monitor the behavior of practicing nurses statewide.

c. A diversion program for nurses that bypasses a referral to the board of nursing.

d. An arm of the board of nursing designed to identify and treat impaired nurses.

14. An evolving standard of autonomy supports patients but must be balanced with:

a. Demonstrated skills in ethical decision making.

b. A willingness to partner responsibly with their provider.

c. Effective use of the Internet to gather facts about their care.

d. Absence of mental or emotional issues.

15. Beneficence means:

a. Being kind.

b. Doing little harm.

c. Ensuring services for all.

d. Encouraging independence.

16. Nonmaleficence means:

a. First of all, assess your patient.

b. Not being malicious.

c. Doing no harm.

d. Avoiding malpractice.

17. Veracity means:

a. Paternalism, based on the need for hierarchical decision making.

b. Therapeutic privilege founded on a practitioner's right to privacy.

c. Legitimacy and the concept of moral relativism.

d. Truthfulness founded on a respect for persons.

18. In ethics, "right vs. right" is an ethical dilemma. What is "right vs. wrong"?:

a. A moral temptation.

b. An ethical morass.

c. An easy choice.

d. A stark divide.

19. Ethical conflicts are on the rise in the nursing field due to:

a. Society in general is exhibiting a decline in ethical standards.

b. Increasing complexity of care and advances in technology.

c. Patients are more aggressive and demanding due to the Internet.

d. Nursing education fails to address potential ethical conflicts that may arise.

20. The primary function of a decision is to commit to some sort of action. To arrive at an ethical decision, you must:

a. Weigh the ethical principles involved no matter how long it takes.

b. Assess the situation, goals to be achieved, and options for action, then commit.

c. Explore your uncertainties to look for possible hidden motivations.

d. Look over the situation and then make your move. It's better to act than to wait.

21. A criticism leveled at bioethicists is:

a. They are ivory tower people with their heads in the clouds.

b. They are dependent on government research grants and thus constrained.

c. They talk and talk but never really give society valuable guidance.

d. They focus on issues of the affluent and less on the poor.

Answer Sheet

FL: Laws and Rules of Nursing (195)

Name (Please print your name): _____

Date: _____

Passing score is 80%

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____
21. _____

Course Evaluation (FL Laws and Rules 195)

Please use this scale for your course evaluation. Items with asterisks * are required.

- 5 = Strongly agree
- 4 = Agree
- 3 = Neutral
- 2 = Disagree
- 1 = Strongly disagree

* Upon completion of the course, I was able to:

a. Describe the history of nursing registration and nursing practice acts.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

b. State the difference between boards of nursing and nursing professional organizations.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

c. Distinguish between the general provisions of the Florida Statutes and the rules that cover practice for Florida nurses and nursing assistants.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

d. Review the powers and duties spelled out in Division 64B9 of the Florida Administrative Code.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

e. Summarize the grounds for discipline, due process procedures, and alternatives to discipline for nurses in the State of Florida.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

f. Discuss the way in which medical ethics differs from the law.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

* The author(s) are knowledgeable about the subject matter.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

* The author(s) cited evidence that supported the material presented.

5 4 3 2 1

* This course contained no discriminatory or prejudicial language.

Yes No

* The course was free of commercial bias and product promotion.

Yes No

* As a result of what you have learned, do you intend to make any changes in your practice?

Yes No

If you answered Yes above, what changes do you intend to make? If you answered No, please explain why.

* Do you intend to return to ATrain for your ongoing CE needs?

- Yes, within the next 30 days.
- Yes, during my next renewal cycle.
- Maybe, not sure.
- No, I only needed this one course.

* Would you recommend ATrain Education to a friend, co-worker, or colleague?

- Yes, definitely.
- Possibly.
- No, not at this time.

* What is your overall satsfaction with this learning activity?

5 4 3 2 1

* Navigating the ATrain Education website was:

- Easy.
- Somewhat easy.
- Not at all easy.

* How long did it take you to complete this course, posttest, and course evaluation?

- 60 minutes (or more) per contact hour
- 50-59 minutes per contact hour
- 40-49 minutes per contact hour
- 30-39 minutes per contact hour
- Less than 30 minutes per contact hour

I heard about ATrain Education from:

- Government or Department of Health website.
- State board or professional association.
- Searching the Internet.
- A friend.
- An advertisement.
- I am a returning customer.
- My employer.
- Other
- Social Media (FB, Twitter, LinkedIn, etc)

Please let us know your age group to help us meet your professional needs.

- 18 to 30
- 31 to 45
- 46+

I completed this course on:

- ○ My own or a friend's computer.
- ○ A computer at work.
- ○ A library computer.
- ○ A tablet.
- ○ A cellphone.
- ○ A paper copy of the course.

Please enter your comments or suggestions here: _____

_____

_____

_____

Registration Form (FL Laws and Rules 195)

Please print and answer all of the following questions (* required).

* Name: _____

* Email: _____

* Address: _____

* City: _____ * State: _____ * Zip: _____

* Country: _____

* Phone: _____

* Professional Credentials/Designations:

_____

* License Number and State: _____

* Please email my certificate:

◯ Yes ◯ No

(If you request an email certificate we will not send a copy of the certificate by US Mail.)

Payment Options

You may pay by credit card or by check.
Fill out this section only if you are **paying by credit card.**
2 contact hours: $24

Credit card information

* Name: _____

Address (if different from above): _____

* City: _____ * State: _____ * Zip: _____

* Card type:

◯ Visa ◯ Master Card ◯ American Express ◯ Discover

* Card number: _____

* CVS#: _____

* Expiration date: _____