Nursing Leadership and Management

1. Core Concepts and Definitions

Management vs. Leadership

The distinction between management and leadership is fundamental to nursing practice. While the two roles often overlap, they are defined by different orientations and sources of authority.

- **Management:** The process of utilizing available resources efficiently and effectively to achieve desired organizational goals. It involves "handling," "direction," and "control."
- **Leadership:** An interpersonal skill focused on influencing others toward goal achievement. It is characterized by moving forward, taking risks, and challenging the status quo.

Key Comparison Table

Feature	Managers	Leaders
Authority	Assigned position within a formal organization; delegated authority.	Often do not have delegated authority; power from influence.
Followers	Direct both willing and unwilling followers.	Direct willing followers.
Focus	Specific functions, duties, and responsibilities; resource utilization.	Interpersonal relationships, group process, and empowering others.
Goals	Organizational goals.	May have goals that do not reflect organizational goals.

Critical Observation: "Leaders can be managers, but not all managers are leaders."

Three-Fold Concepts of Management

Management is viewed through three lenses that define its role in a firm:

1. **Economic Source:** Determines a firm's productivity and profitability to a large extent.
2. **System of Authority:** Begins with top individuals determining the course of action for the rank and file.
3. **Class and Status System:** Managers are often viewed as an elite group defined by education and brainpower.

Managerial Skills and Roles

Effective management requires a balance of three primary skills, often referred to as Knowledge, Attitude, and Skills (KSA).

- **Conceptual (Knowledge):** The ability to see individual matters in relation to the "total picture" and develop creative responses to problems using relevant facts.
- **Human (Attitude):** Proficiency in dealing with people and the ability to get along with others.
- **Technical (Skills):** Proficiency in performing specific activities correctly and using the right techniques.

Managerial Roles (Mintzberg)

- **Interpersonal:** Acting as a symbol of the organization and a liaison between the organization and outside contacts.
- **Informational:** Monitoring and disseminating information; representing subordinates to superiors and vice versa.
- **Decisional:** Serving as a troubleshooter and conflict negotiator.

Levels of Management

Organizational hierarchy is typically divided into three tiers:

1. **Top Level:** Focuses on overall organizational direction.
2. **Middle Level:** Coordinates between top and first-line management.
3. **First Level:** Involved in the direct supervision of staff and day-to-day operations.

2. The Management Process

The management process is characterized by a series of functions often summarized by the acronym **POSDCORB**, introduced by Luther Gulick (1937), who advocated that management should be formally taught.

Core Functions (The Management Cycle)

- **Planning:** Setting the vision, mission, philosophy, goals, objectives, policies, procedures, and rules.
- **Organizing:** Establishing the organizational structure and determining the most appropriate type of patient care delivery.
- **Staffing:** Recruiting, interviewing, hiring, and orienting staff.
- **Directing:** Motivating, managing conflict, delegating, communicating, and facilitating collaboration.

- **Controlling:** Performance appraisals, fiscal accountability, quality control, and legal/ethical control.

3. Historical Evolution of Management Theories

The development of management thought has transitioned from a focus on tasks and efficiency to a focus on human behavior and organizational systems.

Scientific Management (Efficiency Focus)

- **Frederick Taylor:** Known for "Scientific Management Theory" and "Time and Motion Studies." He believed productivity increases if workers are taught the "one best way" to complete a task. His principles include:
    - Using science to design work for efficiency.
    - Scientific selection and training based on competence.
    - Using financial incentives (treating humans as "economic animals").
    - Distinguishing between worker performance and manager planning.
- **Frank and Lillian Gilbreth:** Emphasized job simplification, work standards, and motion studies.
- **Henry Gantt:** Developed the Gantt chart to relate work planned/completed to the time used.

Classic Organizational Theories (Structure Focus)

- **Henri Fayol:** The "Father of the Management Process School." He identified five functions (Planning, Organization, Command, Coordination, Control) and principles such as division of labor, scalar chain of authority, and *esprit de corps*.
- **Lyndall Urwick:** Expanded on Fayol's principles, highlighting:
    - **Span of Control:** The number of staff reporting to one manager.
    - **Unity of Command:** Each employee responds to only one supervisor.
- **Max Weber:** Advocated for **Bureaucracy** as the ideal organization. It features a well-defined hierarchy, division of work by specialization, and highly specified rules. Weber defined three bases of authority: Traditional, Charisma, and Rational-Legal (competence).

Human Relations Movement (People Focus)

- **Mary Parker Follet:** Developed concepts of participatory management. She argued that managers should have "authority *with*, rather than *over* employees" and conceptualized the "Law of the Situation."
- **Elton Mayo (Hawthorne Studies):** Discovered the "Hawthorne Effect," where productivity increases when workers feel management is paying special attention to them, regardless of physical working conditions.
- **Jacob Moreno:** Developed "Sociometry," a system of pairings based on how people are attracted to, repulsed by, or indifferent to one another.

Behavioral Theories (Motivation Focus)

- **Abraham Maslow:** Described the Hierarchy of Needs, where basic needs must be satisfied in a sequence before higher-level motivators emerge.
- **Douglas McGregor:** Correlated managerial attitudes with employee satisfaction through two models:
    - **Theory X:** Assumption that employees are lazy, dislike work, and must be coerced.
    - **Theory Y:** Assumption that employees enjoy work, are self-motivated, and seek responsibility.
- **Frederick Herzberg:** Proposed the Two-Factor Theory, distinguishing between **Motivating Factors** (Satisfiers) and **Hygiene Factors** (Dissatisfiers).
- **William G. Ouchi:** Developed **Theory Z**, which emphasizes consensus decision-making, job security, holistic concern for workers, and lifetime employment.
- **Blake and Mouton's Managerial Grid:** Identified two dimensions: concern for people and concern for production.
    - **(1,1) Impoverished:** Low task, low relationship.
    - **(1,9) Country Club:** Low task, high relationship.
    - **(9,1) Authority-Compliance:** High task, low relationship.
    - **(9,9) Team Management:** High task, high relationship.

4. Contemporary Management Approaches

Modern management recognizes that organizations are complex and influenced by their environments.

- **Systems Theory:**
    - **Closed Systems:** Do not interact with their environment.
    - **Open Systems:** Interact with and are influenced by their environment.
- **Contingency Approach:** States there is "no one best way" to manage. Management must vary based on situational characteristics (contingencies), including the external environment and internal strengths/weaknesses.

5. Leadership Theories and Styles

Leadership theory has evolved from innate traits to situational adaptability and vision-building.

Trait and Behavioral Theories

- **Great Man Theory:** The belief that some people are born to lead and others are born to be led.
- **Charismatic Theory:** Leadership based on an inspirational quality that arouses loyalty and enthusiasm.
- **Behavioral Styles (Lewin, White, & Lippitt):**
    - **Authoritarian:** Strong control, downward communication, and punitive criticism.
    - **Democratic:** Less control, participative decision-making, and constructive criticism. Emphasis is on "we."
    - **Laissez-faire:** Permissive, little direction, and decision-making dispersed throughout the group.

Situational and Contingency Leadership

- **Fred Fiedler (1960):** Argued that no single leadership style is ideal for every situation.
- **Hersey and Blanchard:** Proposed that the best style depends on the **maturity level** of followers.

Style	Task/Relationship Orientation	Best When…
Directing	High Task, Low Relationship	Subordinates have low motivation and ability.
Coaching	High Task, High Relationship	Subordinates have motivation but low ability.
Supporting	Low Task, High Relationship	Subordinates have ability but low motivation.
Delegating	Low Task, Low Relationship	Subordinates are high in both ability and motivation.

Interactional Leadership

- **Transactional Leader:** Focuses on tasks, getting the work done, and maintaining the status quo.
- **Transformational Leader:** Focuses on vision, empowerment, and raising both leaders and followers to higher levels of motivation and morality.

6. Types and Sources of Power

Power is the ability to impose one's will to influence behavior in others. In nursing management, power stems from seven primary sources:

1. **Reward Power:** Ability to grant rewards for compliance.
2. **Coercive Power:** Based on fear of punishment for non-conformity.
3. **Legitimate Power:** Authority derived from an official position or title; creates an obligation for staff to accept influence.
4. **Referent Power:** Influence based on the followers' admiration for the leader or a desire to be like them.
5. **Expert Power:** Gained through knowledge, skills, information, experience, and competence.
6. **Information Power:** Derived from access to and the sharing of critical knowledge.
7. **Connection Power:** Derived from coalitions and interpersonal links to influential people inside or outside the organization.

Patient Care Delivery Systems and Organizational Structure

1. Patient Classification Systems (PCS) and Acuity Levels

A **Patient Classification System (PCS)** is an objective method for grouping patients based on the acuity of their illness and the complexity of nursing activities required. These systems serve as workload management tools to determine the proper number and skill mix of staff needed.

Standardized Levels of Care and Acuity

Level of Care	Patient Condition	Nursing Needs	Approx. Nurse-to-Patient Ratio
Level 1: Self-care / Minimal Care	Recovering, stable, awaiting elective surgery, or minor conditions.	Minimal therapy; occasional observation; mostly independent in hygiene and activities.	1 nurse : 6–8 patients
Level 2: Moderate Care	Moderately ill or recovering from serious surgery/illness.	Requires supervision and assistance with ambulation and hygiene; regular monitoring (e.g., VS every 4 hours).	1 nurse : 4–5 patients
Level 3: Intensive Care	Seriously ill; unstable but not yet life-threatening.	Complete care throughout the shift; continuous monitoring; nurse initiates and performs most activities.	1 nurse : 1–2 patients
Level 4: Critical Care	Acutely ill; unstable; life-and-death situations (e.g., cardiac arrest, septic shock).	Highest dependency; continuous observation; frequent adjustment of therapy; advanced life support.	1 nurse : 1 patient

Marquis and Huston Four Levels of Nursing Care Intensity (2017)

This framework categorizes nursing care intensity across eight specific areas of care:

Area of Care	Category 1 (Minimal)	Category 2 (Moderate)	Category 3 (Intensive)	Category 4 (Critical)
Eating	Feeds self.	Needs help with tray/encouragement.	Unable to feed self; can chew/swallow.	Difficulty swallowing; cannot feed self.
Grooming	Self-sufficient.	Needs help with bath/hair/oral care.	Unable to do much for self.	Completely dependent.
Excretion	Uses bathroom alone.	Needs help getting up/using urinal.	In bed; needs bedpan/urinal placed.	Completely dependent.
Comfort	Self-sufficient.	Needs help adjusting position/bed.	Cannot turn without help.	Completely dependent.
General Health	Good; diagnostic or simple procedures (e.g., biopsy).	Mild symptoms; mild emotional reaction.	Acute symptoms; severe emotional reaction to illness.	Critically ill; severe emotional reaction.
Treatments	Simple; supervised ambulation; VS once per shift.	Foley care; I&O; VS every 4 hours.	Medicated IVs; tube feeding; VS more than every 4 hours.	Elaborate procedures requiring 2 nurses; VS > every 2 hours.
Medications	Simple; routine; no pre/post evaluation needed.	PRN meds; meds needing pre/post evaluation.	High amount of meds; refractory diabetes control.	Extensive meds; IVs with close observation/regulation.
Teaching	Routine follow-up teaching.	Initial teaching (e.g., new diabetics, ostomies).	Teaching apprehensive or mildly resistive patients.	Supporting patients with severe emotional reactions.

2. Traditional Modalities of Nursing Care Delivery

Nursing care delivery models determine how nurses are deployed to meet patient needs.

Case Method (Total Patient Care)

- **Definition:** One nurse assumes total responsibility for meeting all the needs of assigned patients during their time on duty.
- **Key Features:** Holistic approach; direct nurse-patient relationship; patients are often assigned as "cases."
- **Pros:** High patient satisfaction, high accountability, continuity of care during the shift.
- **Cons:** Expensive; may be an inefficient use of skilled RNs for tasks that could be delegated.

Functional Nursing

- **Definition:** Personnel are assigned to specific tasks (e.g., one person gives meds, another does treatments) rather than specific patients.
- **Key Features:** Task-focused; efficient during staff shortages.
- **Pros:** Clear roles; tasks are completed quickly; cost-effective.
- **Cons:** Fragmented care; patient needs may be overlooked; low job satisfaction due to repetitive tasks.

Team Nursing

- **Definition:** A professional nurse (Team Leader) coordinates a group of ancillary personnel (LPNs, NAs) to provide care for a group of patients.
- **Key Features:** Collaborative; the Team Leader determines patient needs and plans individual care.
- **Pros:** Efficient use of skill mix; promotes teamwork.
- **Cons:** Requires strong leadership skills; risk of fragmented care if communication is poor.

Modular Nursing

- **Definition:** A variation of team nursing using "mini-teams" (often an RN and an assistant, called "care pairs").
- **Key Features:** Assignments are based on the geographic location of patients (districts or modules).
- **Pros:** Localized care saves time; more continuity than traditional team nursing.
- **Cons:** Dependent on staffing levels; requires high-level communication.

Primary Nursing (Professional Practice Model)

- **Definition:** One RN (Primary Nurse) is accountable for the 24-hour planning of a patient's care from admission to discharge.
- **Key Features:** Relationship-based; associate nurses provide care based on the primary nurse's plan when the primary nurse is off duty.
- **Pros:** Consistent care; high accountability; strong nurse-patient relationships.
- **Cons:** Costly; requires a high ratio of skilled RNs; heavy responsibility for the primary nurse.

Case Management

- **Definition:** A collaborative process of assessment and advocacy to meet individual health needs through available resources.
- **Key Features:** Focuses on cost-effectiveness and quality outcomes across the system; involves discharge planning and community resource access.
- **Pros:** Prevents readmission; manages resources efficiently; holistic across the care continuum.
- **Cons:** Requires highly experienced RNs; time-consuming and resource-dependent.

3. Contemporary Nursing Models

Modern models focus on empowering clinicians and centering care on the patient and family.

Model	Core Concept	Key Features
Professional Practice (Magnet)	Framework emphasizing autonomy and control over practice.	Core feature of Magnet hospitals; high RN-to-patient ratios; higher satisfaction and safety.
Differentiated Nursing Practice	Roles are defined by educational level (ADN, BSN, APN) and expertise.	ADN: Bedside care; BSN: Collaboration/facilitation; APN: System-wide care across settings.
Clinical Nurse Leader (CNL)	Master's-prepared generalist who leads care at the bedside.	Not an administrative role; focuses on quality improvement and outcome-based practice.
Synergy Model	Patient needs drive nurse competencies.	Synergy occurs when patient characteristics (e.g., stability, complexity) match nurse competencies (e.g., clinical judgment).
Transforming Care at the Bedside (TCAB)	Unit-based innovation to improve safety and teamwork.	5 Pillars: Transformational leadership, safe/reliable care, vitality/teamwork, patient-centered care, value-added processes.
Patient- and Family-Centered Care (PFCC)	Collaborative partnership between providers and families.	Principles: Respect, information sharing, participation, and collaboration across all settings.

4. Principles of Organizing and Organizational Structure

Organizing is the process of establishing formal authority, setting up groupings/roles, and determining staffing patterns and job descriptions.

Organizational Components

- **Authority:** The formal power to act or command.
- **Responsibility:** The obligation to perform assigned tasks.
- **Accountability:** The requirement to answer for the outcomes of one's actions.

Formal vs. Informal Structure

1. **Formal Organizational Structure:** Defined by clear managerial authority, responsibility, and accountability. Roles, functions, rank, and hierarchy are explicitly outlined.
2. **Informal Organizational Structure:** Centered on camaraderie and social relationships. It can produce direct responses from individuals and is useful when formal structures become ineffective.

The Organizational Chart

An organizational chart is a line drawing depicting formal relationships. It shows:

- Lines of authority and communication.
- Areas of responsibility.
- To whom each person is accountable.
- Channels of the organization.

Exam Review Notes

- **Five-Step Nursing Process:** Assessment \rightarrow Diagnosis \rightarrow Planning \rightarrow Implementation \rightarrow Evaluation.
- **PCS Utility:** Remember that PCS is primarily used for **staffing** and **workload management**.
- **Team Nursing vs. Modular Nursing:** Team nursing uses larger groups; Modular nursing uses "care pairs" (RN + assistant) and is strictly **geographically** organized.
- **CNL Role Distinction:** A Clinical Nurse Leader is a **provider and coordinator**, not a manager or administrator.
- **Differentiated Practice:** Know the educational distinctions—ADN focuses on technical bedside care, BSN handles coordination from admission to discharge, and APN handles system-wide care.
- **Magnet Hospitals:** These typically prioritize the **Professional Nursing Practice Model**, high RN ratios, and evidence-based practice.

Evidence-Based Practices

1. National Nursing Care Competency Standards (NNCCS) in the Philippines

The NNCCS serves as the foundational framework for nursing practice, education, and regulation in the Philippines. It ensures that nurses possess the necessary skills to provide safe and quality care.

Historical Development

- **2001:** Development began through the initiative of the **Professional Regulation Commission - Board of Nursing (PRC-BON)**. A National Task Force for Core Competency Standards Development was created.
- **2005:** The project was completed following extensive workshops and consultations among nursing practice, education, and community health representatives.
- **2012:** The standards were revised under the leadership of PRC Chair **T.R. Manzala**. These revised standards emphasized specific roles for the "Beginning Nurse."

The 3 Roles of the Beginning Nurse (2012 Revision)

The revised standards categorize the competencies of an entry-level nurse into three distinct professional roles:

1. **Client Care:** Focuses on direct patient intervention and health needs.
2. **Management and Leadership:** Focuses on resource management and professional coordination.
3. **Research:** Focuses on utilizing evidence to improve clinical practice.

The 11 Core Competencies of Nursing

The NNCCS identifies eleven essential areas of competence required for professional nursing practice:

1. Safe and quality nursing care
2. Communication
3. Collaboration and teamwork
4. Health education
5. Legal responsibility
6. Ethico-moral responsibility
7. Personal and professional development
8. Quality improvement
9. Research
10. Management of resources and environment
11. Record management

Significance in the Nursing Profession

The NNCCS is critical for the following areas:

- **CHED Curriculum:** Used by the Commission on Higher Education to guide the Basic Nursing Education Program.
- **NLE Board Exams:** Serves as the competency-based test framework for development of course syllabi and test questions for "entry-level" practice.
- **Professional Settings:** Establishes standards for nursing practice and evaluation tools across various clinical and community settings in the Philippines.

The 10 Development Phases of the NNCCS

The standards were developed and implemented through a structured ten-phase process:

Phase	Description
Phase 1	Work Setting scenario

Phase 2	Validation studies of roles and responsibilities / Benchmarking
Phase 3	Integrative review of outputs from validation strategies
Phase 4	Core competency consensual validation
Phase 5	Conduct of public hearing
Phase 6	Promulgation of the revised and modified core competency standards
Phase 7	Printing of the revised and modified standards
Phase 8	Training in the implementation of the revised standards
Phase 9	Implementation of the revised standards
Phase 10	Evaluation of the effectiveness of the revised standards

2. Patient Care Safety Standards & Key Elements

Patient safety is defined as an aspect of quality that involves avoiding preventable harm while making appropriate, effective care available to those who need it.

Core Aims of Safety

- To prevent harm to patients, their families, and friends.
- To protect healthcare professionals, contract workers, and volunteers within the healthcare environment.

Key Elements of Patient Safety

Leadership and Political Commitment

- Essential at the health facility level to make safety an integral component of care.
- Leadership must address strategic priorities for institutional development, infrastructure, and stakeholder engagement.

Institutional Development

To institutionalize safety, facilities must consider:

- **Resources:** Financial and human resource allocation.
- **Infrastructure:** Effective facility and equipment management.
- **Accountability:** Strengthening management responsibility, authority, and competency.
- **Standards:** Formulating clear expectations for health providers and providing necessary training.
- **Patient Voice:** Utilizing feedback systems and satisfaction surveys.

Proactive Reporting and Feedback

- **Reporting System:** The National Patient Safety Committee is tasked with developing a proactive reporting and learning system. Leadership must encourage the reporting of events without fear of blame.
- **Benchmarking:** Establishing mechanisms to communicate leadership responses to reports, demonstrating a commitment to continuous improvement.

Risk Management and Disclosure

- **Prevention:** Utilizing risk assessment, health technology assessment, and safety assessment codes.
- **Disclosure:** While individual case confidentiality is maintained, the results of investigations and annual summary reports must be made available to the public to ensure transparency regarding serious events.

3. Nursing Actions & Professional Development

Nurses are responsible for implementing interventions that minimize harm and maximize the quality of health outcomes.

Core Nursing Objectives

- Implement safe, quality interventions to address client health needs.
- Institute appropriate corrective actions to prevent harm.
- Provide evidence-based care using a participatory approach that considers theorists, research, and client preferences.
- Adhere to professional standards to provide high-quality care.

Strategies for Staff and Patient Safety

- **Clinical Judgment:** Continuous training and supervision are imperative to improve the decision-making and clinical judgments of healthcare staff.
- **Professional Behavior:** Instilling standard norms of behavior, such as courtesy, is essential to the safety culture.

- **Environmental Control:** Managing the environment and resources is a core competency (Competency 10) to ensure the clinical area remains safe for both staff and patients.

4. Professional Standards and Performance

The standards of nursing practice provide a framework for quality care and professional behavior.

Framework for Quality Care

- **Participatory Approach:** Care should be based on a variety of theorists and standards relevant to healing research and clinical practice.
- **Standard Compliance:** Following established nursing standards is the primary method for providing quality care and ensuring both client and staff safety.
- **Competency-Based Evaluation:** The NNCCS provides the tools necessary to evaluate nursing performance across various practice settings in the Philippines.

Ethico-Legal and Moral Considerations

1. Code of Ethics for Registered Nurses

The Code of Ethics, approved on July 14, 2004, through Board Resolution No. 220, defines the ethical obligations and duties of every registered nurse.

Philippine Code of Ethics (Articles I-VII)

Article	Focus	Key Principles and Guidelines
I: Preamble	Fundamental Rights	Health is a fundamental right. Responsibility includes promotion of health, prevention of illness, restoration of health, and assistance toward a peaceful death.
II: RNs and People	Respect and Privacy	Respect values, customs, and spiritual beliefs. Maintain strict confidentiality. Uphold the right to rational, unconstrained decisions.
III: RNs and Practice	Competence and Advocacy	Human life is inviolable. Quality and excellence are goals. Documentation is the hallmark of accountability. Nurses must act as patient advocates and respect the "Patients' Bill of Rights."
IV: RNs and Co-workers	Solidarity	Maintain solidarity with the healthcare team and collegial relationships. Maintain professional identity while collaborating.
V: RNs, Society, and Environment	Citizenship	Commit to life preservation and a healthy environment. Participate in community health needs and primary health care.
VI: RNs and the Profession	Integrity and Growth	Maintain loyalty to the profession. Membership in the Accredited Professional Organization (PNA) is required. Strive for equitable socio-economic conditions for nurses.
VII: Administrative Penalties	Enforcement	Violations can lead to revocation or suspension of the Certificate of Registration per Sec 23 (f), Art. IV of RA 9173.

License Status and Re-issuance

- **Suspension:** The nurse is temporarily prohibited from practicing until the case is resolved; the license is not confiscated.
- **Revocation:** The license is confiscated either temporarily or permanently.
- **Re-issuance:** A revoked certificate may be re-issued after 4 years from the date of revocation, provided the cause has been corrected and fees are paid.

ICN Code of Ethics for Nurses

First adopted in 1953 (latest revision 2012), the International Council of Nurses (ICN) Code includes four principal elements:

1. Nurses and people
2. Nurses and practice
3. Nurses and the profession
4. Nurses and co-workers

2. Scope of Nursing Practice & Legal Duties (RA 9173)

Article VI, Section 28 of RA 9173 (Philippine Nursing Act of 2002)

Nursing practice involves performing nursing services to individuals, families, and communities across the lifespan. Key duties include:

- Utilizing the nursing process (therapeutic use of self, health teachings, comfort measures).
- Executing health care techniques and procedures.
- **Medication Administration:** Administering written prescriptions for oral, topical, and parenteral medications.
- **Special Procedures:** Internal examinations during labor (if no bleeding) and suturing of perineal lacerations (requires special training).
- **Supervision:** Teaching and supervising nursing students and subordinates.

Legal Execution of Medical and Telephone Orders

- **Medical Orders:** Written orders are the standard. They must be clear, specific, and legible.
- **Telephone Orders:** Limited to extreme emergencies when no doctor is present.
    - **Nurse Protection Protocol:** Read back the order, write the physician's name "per" the nurse's own name, and note the time.
    - The physician must sign the order within 24 hours.

IV Therapy Requirements

While previously governed by various resolutions, current practice (RA 9173 and BON Res 38 S. 2016) dictates that special training is required for the administration of intravenous injections according to established protocols.

3. Contracts, Wills, and Property Disposition

Requisites and Kinds of Contracts

A contract is a "meeting of minds" where one party binds themselves to give something or render a service.

- **Requisites:** Consent, object (the subject matter), cause (time, price), and legal capacity (18+ years old, sound mind, literate, not under duress).
- **Types of Contracts:**
    - **Formal:** Required to be in writing (e.g., deeds of sale).
    - **Voidable:** Consent was obtained via coercion; valid until avoided.
    - **Void:** Null from the start; ceases to be enforceable.
    - **Quasi-Contract:** Resembles a contract in law (e.g., a private duty nurse finding a replacement if they must leave a contract).

Breach and Illegal Contracts

- **Breach of Contract:** Failure to perform an agreement without cause (e.g., abandonment of duty, loafing, or failure to use due care).
- **Illegal Contracts:** Obtained through fraud (deception), duress (coercion), or undue influence (e.g., using a relationship with an elderly patient to secure property).

Wills and Property Disposition

- **Holographic Will:** Entirely written, dated, and signed by the testator's hand. Requires at least one witness who knows the handwriting for probate.
- **Oral Will:** Spoken during the last illness before at least two witnesses; must be put in writing within a specific timeframe.
- **Nurse's Responsibility:** Note the soundness of the patient's mind, freedom from influence, and ensure the testator is at least 18.
- **Gifts Causa Mortis:** Donations of personal property made in anticipation of approaching death.

4. Legal Procedures, Consent, and Torts

Legal Procedures

- **Statutes of Limitation:** Negligence/malpractice claims vary (2–3 years); criminal cases (2–6 years), except murder, which has no time limit.
- **Witness Summons:**
    - **Subpoena:** Directs a witness to appear and testify.
    - **Subpoena Duces Tecum:** Requires a witness to bring specific records or papers.
- **Hearsay Exception:** Dying declarations (ante-mortem statements) are admissible in court for crime victims.

Informed Consent

Consent is a free and rational act. The patient has the right to determine what is done to their body.

- **Essential Elements:** Diagnosis, explanation of procedures, risks/consequences, alternatives, benefits, and prognosis if refused.
- **Emergency Exception:** No consent is necessary if inaction would cause greater injury.
- **Refusal:** Mentally and legally competent patients may refuse treatment regardless of the danger to their life.

Intentional Torts

1. **Assault:** Imminent threat of harmful contact or verbal threat.
2. **Battery:** Intentional, unconsented touching (e.g., giving an injection despite refusal).
3. **False Imprisonment:** Unjustifiable detention (exception: communicable diseases to protect the public).
4. **Defamation:** Character assassination. **Slander** is oral; **Libel** is written. Requires a third person to hear or read it.

5. Professional Negligence, Malpractice, and Legal Doctrines

Elements of Professional Negligence

Negligence is the omission or commission of an act that a reasonably prudent person would or would not do.

1. Existence of a duty.
2. Failure to meet the standard of care.
3. Foreseeability of harm.
4. Injury to the plaintiff (proximate cause).

Legal Doctrines

- **Res Ipsa Loquitur:** "The thing speaks for itself." The injury could not have happened without negligence (e.g., forceps left in a patient).
- **Respondeat Superior:** "Let the master answer." Employers/supervisors are liable for the acts of subordinates.
- **Force Majeure:** Irresistible, unforeseen, or inevitable forces (e.g., floods, earthquakes). Nurses are generally not held negligent for service failures during these events.

Liability and Delegation

- **Nurse Trainees/Volunteers:** Accountable for their own practice; must exercise independent judgment.
- **Nursing Aides:** Nurses should not delegate professional functions to aides. Aides perform selected activities under direct supervision and are responsible for their own actions.
- **Nursing Students:** Must be supervised by clinical instructors. Assignments should match their level of training. Instructors who countersign charting without verification assume legal risk.

6. Crimes, Criminal Liability, and Circumstances

Parties and Intents

- **Parties: Principal** (mastermind/direct part), **Accomplice** (previous knowledge/cooperation), **Accessory** (profits or assists after the crime).
- **Felony:** Committed with **Deceit** (deliberate intent) or **Fault** (negligence/imprudence).
    - **Reckless Imprudence:** Voluntary act without malice, causing immediate damage.
    - **Simple Imprudence:** Lack of precaution where danger was not immediate.

Circumstances Affecting Liability

Circumstance	Impact on Liability	Examples/Conditions
Justifying	No criminal liability	Self-defense, fulfillment of duty.
Exempting	No criminal liability	Insanity, age <9, accident without fault, irresistible force.
Mitigating	Lessens liability	No intent for grave wrong, age <18 or >70, voluntary surrender.
Aggravating	Increases liability	Taking advantage of public position, abuse of confidence, acting during calamity.
Alternative	Can be either	Relationship, intoxication, or illiteracy (depending on the nature of the crime).

Measures to Avoid Criminal Liability

1. Maintain familiarity with Philippine nursing laws and job descriptions.
2. Upgrade skills and competence continuously.
3. Accept only responsibilities within the scope of employment.
4. Develop good interpersonal relationships with the health team.
5. Verify unclear or potentially erroneous orders.
6. Maintain accurate and adequate records.