I. Introduction to Leadership and Management

A. Manager vs. Leader

Feature	Leader	Manager
Origin of Power	Obtained through influence and personal relationships	Assigned position with legitimate delegated authority
Core Focus	Group process, empowering others, purpose, creating change	Control, structure, procedures, decision analysis, results
Timeframe	Future-oriented ("Do the right things")	Present-oriented ("Do things right")
Followers/Subordinates	Directs willing followers	Directs willing and unwilling subordinates
Role Scope	Broader variety of informal and formal roles	Specific duties and organizational accountability

B. Management Theories

1. Early Management & Scientific Management Theory (1900–1930)

- **Frederick W. Taylor ("Father of Scientific Management")**: Advocated replacing "rule-of-thumb" work methods with scientific analysis. Postulated that workers could be taught "one best way" to complete a task. Viewed humans as "economic animals" motivated primarily by money. Utilized **time and motion studies** to design work tasks and paid workers differential rates.
- **Frank and Lillian Gilbreth**: Lillian is known as "The First Lady of Management". Used motion picture films to analyze physical movements and streamline tasks. Emphasized job simplification, fatigue reduction, and categorized hand movements into 17 motion units called **"Therbligs"**.
- **Henry Gantt**: Disciple of Taylor who advocated for humanitarian management and created the **Gantt Chart** for production scheduling.

2. Classical Organizational Theories

- **Henri Fayol (1925) ("Father of the Management Process School")**: Formulated the 5 management functions (*Planning, Organizing, Command, Coordination, Control*) and **14 Principles of Management** (Division of work, Authority, Discipline, Unity of command, Unity of direction, Subordination of individual interest, Remuneration, Centralization, Scalar chain/line of authority, Order, Equity, Stability of tenure, Initiative, Esprit de corps).
- **Luther Gulick (1937)**: Expanded Fayol's functions into the 7 management activities (**POSDCORB**): Planning, Organizing, Staffing, Directing, Coordinating, Reporting, Budgeting.

- **Max Weber ("Father of Organizational Theory / Management")**: Developed the organizational chart and concept of **bureaucracy**. Identified 3 bases of authority: *Traditional*, *Charismatic*, and *Rational-legal*.
- **Lyndall Urwick**: Combined the work of Taylor and Fayol; popularized the concepts of **span of control** and **unity of command**.

3. Human Relations Management (1930–1970)

- **Mary Parker Follett (1926)**: Early pioneer of participative management; advocated for "authority with" workers rather than "authority over" them.
- **Elton Mayo & Harvard Associates (Hawthorne Studies)**: Discovered the **Hawthorne Effect**—workers increase productivity when given special attention or when they realize they are being observed, regardless of physical working conditions.
- **Jacob Moreno**: Developed **Sociometry**, a technique to analyze interpersonal affinities, repulsions, and group dynamics.

4. Behavioral Science Movement

- **Abraham Maslow**: Formulated the *Hierarchy of Needs* (Physiological, Safety/Security, Love/Belonging, Self-Esteem, Self-Actualization), asserting that higher-level motivators only emerge once lower-level basic needs are satisfied.
- **Frederick Herzberg**: Proposed the **Two-Factor Motivational Theory**:
    - *Hygiene Factors (Dissatisfiers)*: Salary, working conditions, company policy, status, job security (prevent dissatisfaction but do not motivate).
    - *Motivators (Satisfiers)*: Achievement, recognition, responsibility, advancement, work itself.
- **Douglas McGregor (1960)**: Formulated **Theory X and Theory Y**:
    - *Theory X*: Managers view employees as inherently lazy, lacking ambition, and needing constant direction and control.
    - *Theory Y*: Managers view employees as self-motivated, creative, and eager to assume responsibility.
- **William Ouchi**: Developed **Theory Z**, blending Japanese consensus decision-making and lifelong employment practices with American individual responsibility.
- **William Blake (Managerial Grid)**: Classified managerial leadership based on concern for production vs. concern for people:
    - *Impoverished (1,1)*: Low production, low people concern.
    - *Country Club (1,9)*: Low production, high people concern.
    - *Authority-Obedience / Produce or Perish (9,1)*: High production, low people concern.
    - *Middle-of-the-Road (5,5)*: Medium production, medium people concern.
    - *Team Manager (9,9)*: High production, high people concern.

5. Contemporary Management Approaches

- **Systems Theory**: Views an organization as a set of interdependent components.
    - *Closed System*: Does not interact with or adapt to its external environment.
    - *Open System*: Interacts dynamically with internal and external environments.
- **Contingency Approach**: Rejects "universal" management rules; asserts that there is **no single best way to manage**. Management style must adapt to internal strengths/weaknesses, external environment, task structures, and workforce characteristics.
- **Summer's Management Factors**:
    - *Knowledge Factors*: Logical ideas, principles, and concepts.
    - *Attitude Factors*: Beliefs, values, and emotional orientations.
    - *Ability Factors*: Art, judgment, clinical wisdom, and executive skills.

6. Levels of Management

- **Top-Level Managers**: Focus on total organizational direction, overall strategy, mission/vision statements, major policy formulation, and resource allocation (e.g., Chief Nursing Officer, Director of Nursing).
- **Middle-Level Managers**: Coordinate departmental activities, integrate day-to-day operations with higher policies, and establish specific operational objectives (e.g., Nursing Supervisors, Department Heads).
- **First-Level Managers**: Directly oversee non-managerial staff and daily service delivery; serve as direct links between staff and upper administration (e.g., Head Nurses, Charge Nurses, Unit Managers).

7. Essential Managerial Skills (Robert Katz)

- **Technical Skill**: Specialized knowledge, methods, and proficiency in performing specific clinical/procedural tasks.
- **Human Skill**: Ability to work effectively with people, resolve conflicts, and foster teamwork.
- **Conceptual Skill**: Ability to view the organization as a whole, analyze complex situations, and identify long-term strategic relationships.

8. Managerial Roles (Mintzberg)

- **Interpersonal Roles**: Figurehead/Symbol, Leader (hiring, training, motivating), Liaison (networking across units).
- **Informational Roles**: Monitor (seeking data), Disseminator (transmitting information), Spokesperson (representing the unit).
- **Decisional Roles**: Entrepreneur/Innovator, Disturbance Handler/Troubleshooter, Resource Allocator, Negotiator.

C. Leadership Theories

1. Early & Classical Leadership Theories

- **Great Man Theory (1900–1940)**: Asserts that leaders are born, not made (Aristotelian philosophy). Great leaders emerge naturally when situational crises arise.
- **Trait Theory**: Asserts that effective leaders possess inherent (or learned) personality traits such as decisiveness, energy, self-confidence, intelligence, and technical competence.
- **Charismatic Theory**: Focuses on leaders who possess extraordinary personal magnetism that inspires devotion and high performance.
- **Situational Theory**: Asserts that leadership performance varies depending on situational factors such as task structure, physical environment, organizational culture, and follower maturity.
- **Fiedler's Contingency Theory (1960s)**: Matches leadership style to situational favorableness based on 3 dimensions:
    - *Leader-Member Relations*: Level of trust and confidence followers have in the leader (evaluated via Group Atmosphere Scale).
    - *Task Structure*: Extent to which tasks are defined, clear, and standardized.
    - *Position Power*: Degree of formal authority to reward or discipline subordinates.
- **Path-Goal Theory**: Asserts that leaders motivate followers by clarifying goals, removing obstacles along the path to goal achievement, and providing meaningful rewards.
- **Situational Leadership Theory (Hersey & Blanchard)**: Matches leadership style to the **maturity/readiness level** (ability and willingness) of subordinates:
    - *Directing (S1)*: High Task, Low Relationship (for low ability, low willingness/motivation).
    - *Coaching (S2)*: High Task, High Relationship (for low ability, high willingness/motivation).
    - *Supporting (S3)*: Low Task, High Relationship (for high ability, low willingness/motivation).
    - *Delegating (S4)*: Low Task, Low Relationship (for high ability, high willingness/motivation).
- **Transactional Leadership**: Based on an exchange relationship; focuses on day-to-day operations, routine task completion, and maintaining status quo via contingent rewards or corrective discipline.

2. Behavioral Leadership Styles (Kurt Lewin)

- **Authoritarian (Autocratic)**: Maintains tight control over the group, dictates decisions top-down, uses positional power, and uses punitive criticism. High task output, but low creativity and autonomy.
- **Democratic**: Promotes collaborative decision-making, emphasizes "we" over "I", encourages constructive feedback, and fosters autonomy and growth. Fosters high group morale, though decision-making takes more time.
- **Laissez-Faire (Permissive/Passive)**: Offers minimal or no direction, provides complete freedom to the group, and avoids control or intervention. Effective only with highly mature, self-directed, expert teams; otherwise leads to apathy and disorganization.

3. Contemporary Leadership Frameworks

- **Transformational Leadership**: Inspires followers to achieve extraordinary outcomes by transforming their values, encouraging intellectual stimulation, building vision, and fostering individual development.
- **Servant Leadership**: Prioritizes serving others (staff, patients, community) above personal ambition; builds trust through empathy, active listening, and collective empowerment.
- **Authentic Leadership**: Leaders lead by staying true to their personal values, displaying internal consistency, and acting with moral integrity.
- **Thought Leadership**: Recognized by peers for pioneering innovative ideas and influencing organizational or industry practice.

D. Power

- **Reward Power**: Ability to grant favors, promotions, pay raises, or desirable assignments for compliance.
- **Coercive Power**: Based on fear of punishment, formal reprimands, demotion, or termination.
- **Legitimate Power**: Position-based authority conferred by organizational hierarchy.
- **Referent Power**: Derived from personal charisma, respect, and followers' desire to identify with the leader.
- **Expert Power**: Gained through specialized knowledge, technical competence, and clinical expertise.
- **Information Power**: Derived from access to, control over, and distribution of valuable information.
- **Connection Power**: Derived from networking and formal/informal relationships with influential people inside or outside the organization.

II. Patient Health Care Delivery System

A. Patient Classification System (PCS)

A Patient Classification System (PCS) categorizes patients based on acuity of illness and nursing care requirements to determine appropriate staffing levels.

Acuity Levels and Nursing Care Hours (NCH)

PCS Acuity Level	Description	NCH Needed per Patient per Day
Level 1	Self-Care / Minimal Care	**1.50 hours**

Level 2	Moderate / Intermediate Care	**3.00 hours**
Level 3	Total / Intensive Care	**4.50 hours**
Level 4	Highly Specialized / Critical Care	**6.00 to 7.00+ hours**

PCS Categories Across Nursing Care Domains

Care Domain	Category 1 (Minimal)	Category 2 (Moderate)	Category 3 (Total)	Category 4 (Critical)
Eating	Feeds self / minimal help	Needs help preparing tray	Cannot feed self; chews/swallows	Cannot feed self; difficulty swallowing
Grooming	Self-sufficient	Needs some help with bath/hygiene	Unable to do much for self	Completely dependent
Excretion	Bathroom independently	Needs help to bathroom/urinal	In bed; bedpan/urinal required	Completely dependent
Comfort	Self-sufficient	Needs help adjusting position/tubes	Cannot turn without help	Completely dependent
General Health	Good; diagnostic/minor procedures	Mild symptoms; mild incontinence	Acute symptoms; severe emotional reaction	Critically ill; unstable
Treatments	Simple; VS once/shift	Foley care, I&O, VS q4h	Medicated IVs, suctioning, VS < q4h	Complex/2-nurse procedure, VS < q2h

Medications	Simple routine; <=1/shift	Diabetic, cardiac, anticoagulants, PRN >1/shift	High Category 2; refractory diabetes monitoring	Extensive; IV titration, frequent observation
Teaching	Routine follow-up	Initial ostomy/diabetic teaching	Intensive teaching; disoriented/confused	Teaching resistive/severely upset patient

B. Modalities of Care

- **Case Method / Total Patient Care Nursing**: Oldest delivery model. The RN takes complete responsibility for all care of an assigned patient during their shift. High autonomy and unfragmented care, but requires a highly skilled workforce and can be costly.
- **Functional Nursing**: Task-oriented model arising from WWII nurse shortages. Staff are assigned specific tasks (e.g., medication nurse, vital signs nurse, bath nurse) rather than specific patients. Highly efficient for routine tasks, but results in fragmented patient care and low job satisfaction.
- **Team Nursing**: An RN serves as a team leader overseeing a group of diverse health personnel (LPNs, nursing assistants) caring for a group of patients. Requires democratic leadership and structured team conferences; teams should not exceed 5 members.
- **Modular Nursing**: A variation of team nursing using mini-teams (usually 2–3 members, including at least one RN) assigned to a geographically designated group of patient rooms ("district").
- **Primary Nursing (Relationship-Based Nursing)**: The primary RN maintains **24-hour accountability** for establishing and directing the patient's plan of care from admission to discharge. Associate RNs execute the plan when the primary nurse is off duty.
- **Case Management**: A collaborative process of assessing, planning, coordinating, and evaluating options to meet health needs cost-effectively. Uses **Critical Pathways** and **Care MAPs** (Multidisciplinary Action Plans) to monitor expected patient trajectories and track **variances** (deviations from standard pathways).

C. Contemporary Models of Delivering Care

- **Professional Nursing Practice Model**: Promotes RN autonomy and professional control over practice; heavily utilized in Magnet-designated hospitals.
- **Differentiated Nursing Practice Model**: Differentiates clinical role expectations based on education, experience, and competence:
    - *Associate Degree*: Technical direct bedside care.
    - *Baccalaureate (BSN)*: Broad care coordination from admission to discharge.
    - *Advanced Practice (APN)*: Comprehensive clinical leadership across care systems.
- **Clinical Nurse Leader (CNL) Model**: Master's-prepared advanced generalist who designs, coordinates, and evaluates care outcomes at the microsystem level (non-administrative clinical leader).
- **Synergy Model (AACN)**: Asserts that patient care outcomes are optimized when nurse competencies are matched directly to patient/family characteristics (e.g., matching resiliency, vulnerability, stability with nurse clinical judgment and advocacy).
- **Transforming Care at the Bedside (TCAB)**: Empowers bedside nurses to redesign care processes around 5 themes: *Transformational Leadership, Safe/Reliable Care, Vitality/Teamwork, Patient-Centered Care, and Value-Added Care Processes*.
- **Patient- and Family-Centered Care Model**: Direct collaboration with patients and families in care planning, placing ultimate decision-making control in the patient's hands.

Formal vs. Informal Organizational Structure

- **Formal Structure**: Formally defined managerial authority, official job descriptions, clear rank, explicit accountability, and official chain of command.
- **Informal Structure**: Social network filling procedural gaps through camaraderie, interpersonal relationships, and informal communication channels (**the Grapevine**).
- **Bureaucracy (Max Weber)**: Clear division of labor, explicit hierarchy, impersonal professional relationships, clear rules governing positions, and selection/promotion based strictly on technical competence.

III. Evidence-Based Practice in Nursing Management

A. National Nursing Core Competency Standards (NNCCS)

Initiated by the PRC Board of Nursing (PRC-BON) in 2001 and revised in 2012.

3 Roles of the Beginning Nurse

1. **Client Care Role**: Utilizes the nursing process, adheres to legal/ethical standards, maintains documentation, and collaborates with the interdisciplinary team.
2. **Management and Leadership Role**: Applies management skills to deliver care safely, demonstrates organizational accountability, leads support staff, and manages facility referrals/linkages.
3. **Research Role**: Engages in health research under experienced supervision, conducts written research critiques, and applies research findings to clinical quality improvement.

The 11 Key Responsibility Areas / Core Competencies

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

Philippine Professional Nursing Practice Standards (PPNPS - PRC-BON Res. No. 22 s. 2017)

- **Domain A: Value-Based Nursing Practice** (Care of Clients, Ethical-Moral-Legal, Personal/Professional Values).
- **Domain B: Knowledge-Based Nursing Practice** (Research, Evidence-Based Practice, Continual Quality Improvement).
- **Domain C: Outcome-Oriented Professional Relationships** (Communication, Collaboration/Teamwork, Transcultural Care).
- **Domain D: Leadership and Governance** (Personal/Prof Development, Accountability, Positive Practice Environment, Social Responsibility, Resource Management).

B. Patient Care Safety Standards & Key Elements of Patient Safety

- **Safety Definition**: Prevention of healthcare-related harm, avoidance of preventable risk, adverse outcomes, or treatment-induced injuries.
- **Key Elements of Patient Safety**:
    1. *Leadership*: Political/institutional commitment to safety as a strategic priority.

2. *Institutional Development*: Standards enforcement, equipment maintenance, and patient feedback surveys.
3. *Reporting System*: Non-punitive, proactive learning system for near-misses and events.
4. *Feedback & Communication*: Continuous benchmarking and leadership responses to reported events.
5. *Risk Management*: Systematic risk assessments and technology safety audits.
6. *Disclosure*: Confidential reporting coupled with appropriate transparent public summaries.
7. *Professional Development*: Continuous training in decision-making and safety protocols.
8. *Patient-Centered Empowerment*: Partnering with consumers in all safety initiatives.

5 Ways to Improve Staff Safety

1. **Promote a Culture of Safety**: Align safety practices with workplace professionalism.
2. **Measure Safety Performance**: Use structured checklists, incident logs, and data analytics.
3. **Optimize Staff Scheduling**: Maintain safe staffing ratios to prevent burnout and fatigue-induced errors.
4. **Improve Patient Handling**: Implement modern mechanical lift devices and safe body mechanics protocols.
5. **Use Safer Medical Equipment**: Implement needleless IV systems, safety-engineered lancets/syringes, and closed drug transfer systems.

C. ANA Standards of Professional Nursing Practice

Standards of Practice (Nursing Process)

1. **Assessment**: Collects comprehensive health data.
2. **Diagnosis**: Analyzes assessment data.
3. **Outcomes Identification**: Identifies individualized expected outcomes.
4. **Planning**: Formulates strategies to achieve outcomes.
5. **Implementation**: Executes the plan.
    - *5a. Coordination of Care*
    - *5b. Health Teaching & Health Promotion*
    - *5c. Consultation (Advanced Practice)*
    - *5d. Prescriptive Authority & Treatment (APRN)*
6. **Evaluation**: Assesses progress toward outcomes.
7. **Ethics**: The registered nurse practices ethically.
8. **Education**: The registered nurse attains knowledge and competence that reflects current nursing practice.
9. **Evidence-Based Practice and Research**: The registered nurse integrates evidence and research findings into practice.
10. **Quality of Practice**: The registered nurse contributes to quality nursing practice.
11. **Communication**: The registered nurse communicates effectively in all areas of practice.
12. **Leadership**: The registered nurse demonstrates leadership in the professional practice setting and the profession.
13. **Collaboration**: The registered nurse collaborates with the healthcare consumer, family, and others in the conduct of nursing practice.
14. **Professional Practice Evaluation**: The registered nurse evaluates her or his own nursing practice in relation to professional practice standards and guidelines, relevant statutes, rules, and regulations.
15. **Resource Utilization**: The registered nurse utilizes appropriate resources to plan and provide nursing services that are safe, effective, and financially responsible.
16. **Environmental Health**: The registered nurse practices in an environmentally safe and healthy manner.

IV. Ethico-Legal and Moral Considerations in Nursing

A. Code of Ethics for Registered Nurses

Promulgated via **BON Resolution No. 20, Series of 2004** pursuant to **RA 9173**:

- **Article I: Preamble**: Health is a fundamental right. The primary duty of the nurse is to preserve life, promote health, prevent illness, alleviate suffering, and assist toward a peaceful death when restoration is not possible.
- **Article II: Registered Nurses and People**: Respect customer values, customs, spiritual beliefs, individual autonomy, and personal information (confidentiality).
- **Article III: Registered Nurses and Practice**: Human life is inviolable. RNs must maintain clinical competence, accurate documentation, and decline gifts or commissions that exploit patients.
- **Article IV: Registered Nurses and Co-Workers**: Maintain collegial solidarity and safeguard the reputation of healthcare colleagues.
- **Article V: Registered Nurses, Society, and Environment**: Participate in community health initiatives and primary health care.
- **Article VI: Registered Nurses and the Profession**: Maintain loyalty to the profession and belong to the accredited professional organization (**PNA**).
- **Article VII: Administrative Penalties**: License **Suspension** (temporary practice restriction; license retained) or **Revocation** (confiscation of certificate of registration). Re-issuance of revoked certificates may occur after **4 years** upon proper application and correction of causes.

ICN Code of Ethics (4 Core Elements)

1. Nurses and People -primary professional responsibility is to people requiring nursing care
2. Nurses and Practice -carries personal responsibility and accountability for nursing practice
3. Nurses and the Profession -determining and implementing acceptable standards of clinical nursing practice, management,research and education.
4. Nurses and Co-workers-sustains a collaborative and respectful relationship with co- workers in nursing and other fields.p

B. Philippine Nursing Act of 2002 (RA 9173)

Section 28: Scope of Nursing Practice

Defined as initiating and performing nursing care to individuals, families, and communities across the lifespan.

- *Key Directives*: Administration of written medical prescriptions (oral, topical, parenteral); performing internal examinations during labor (in the absence of prenatal bleeding) and delivery; **suturing of perineal lacerations** (requires special accredited training).

Telephone Orders Guidelines

- Must be strictly limited to **extreme emergency situations** where no doctor is physically present.
- *Mandatory Steps*:
    1. Nurse reads back the complete order to the physician.
    2. Nurse transcribes the order, noting the ordering doctor's name, time, and date.
    3. The ordering physician must countersign the order within **24 hours**.

C. Contracts in Nursing

A **Contract** is a meeting of minds between two persons whereby one binds himself with respect to the other to give something or render service.

Kinds of Contracts

- **Formal Contract**: Required by law to be in writing (e.g., deeds, employment agreements).

- **Informal Contract**: Arises from oral agreements or written correspondence where strict formal writing is not legally mandated.
- **Express Contract**: Terms are explicitly stated in words or writing.
- **Implied Contract**: Inferred from actions/conduct of parties (e.g., *Facio ut des* — "I do that you may give").
- **Voidable Contract**: Valid until annulled; consent was vitiated by mistake, coercion, fraud, or undue influence.
- **Void / Inexistent Contract**: Null from the beginning; object/cause is contrary to law, morals, or public order.
- **Unenforceable Contract**: Valid in law but cannot be enforced in court due to lack of proof or non-compliance with the Statute of Frauds.
- **Executory vs. Executed**: Executory = obligations yet to be performed; Executed = obligations fulfilled.

Essential Requisites of a Contract

1. **Consent** of the contracting parties.
2. **Object** (subject matter that is lawful and within the commerce of man).
3. **Cause/Consideration** (the legal obligation established).
4. **Legal Capacity** (parties must be of age, sound mind, and free from coercion).

Breach of Contract

Failure to perform a contractual duty without legal excuse. Includes: abandonment of duty, going off-duty without endorsement, substitution of performance, or failure to use due care.

D. Wills and Gifts

A **Will** is a legal declaration of a person's disposition of property to take effect after death (*testamentary document*).

- **Key Terminology**: *Testator* (makes will); *Testate* (dies with valid will); *Intestate* (dies without will); *Probate* (judicial process proving a will); *Administrator* (court-appointed estate manager).
- **Holographic Will**: Must be **entirely written, dated, and signed by the hand of the testator**.
- **Nuncupative / Oral Will**: Spoken deathbed declaration made before required witnesses during final illness.
- **Requisites of a Valid Will**: Testator must be at least **18 years old** and of **sound mind**; executed without duress/fraud; signed in the presence of at least **3 credible witnesses** who sign in the presence of the testator and each other; notarized.
- **Gifts (Donation Causa Mortis)**: Personal property transferred in anticipation of approaching death.

E. Consent

- **Informed Consent**: Voluntary authorization by a competent patient for a medical/surgical procedure based on full explanation of diagnosis, procedure details, risks, alternatives, expected benefits, and consequences of refusal.
- **Who Consents**:
    - *Competent Adult*: Consents for self.
    - *Minors / Mentally Incompetent*: Parent or legal guardian must sign (except emancipated minors or married minors).
    - *Emergencies*: Immediate life-saving action requires **no consent** under the implied consent rule.
    - *Sterilization*: Requires consent from **both spouses**.
- **Student Charting**: Clinical instructors countersigning student nurses' charting attest to personal verification and accuracy; signing without verification creates joint legal liability.

F. Professional Negligence and Malpractice

Key Definitions

- **Negligence**: Commission of an act that a reasonably prudent nurse would not do, or omission of an act that a prudent nurse would do in similar circumstances, resulting in injury.
- **Malpractice**: Professional negligence or unskillful care committed in the course of professional performance, or stepping beyond one's scope of authority.

4 Essential Elements of Professional Negligence

1. **Duty**: Existence of a nurse-patient relationship establishing standard of care.
2. **Breach of Duty**: Failure to meet standard of care (commission or omission).
3. **Foreseeability / Proximate Cause**: Direct link between nurse's breach and resulting injury.
4. **Injury / Harm**: Actual physical, financial, or emotional damage to the plaintiff.

Legal Doctrines in Negligence

- **Res Ipsa Loquitur ("The thing speaks for itself")**: The harm could not have occurred without negligence, and the agency was under defendant's exclusive control (e.g., surgical sponge left in abdomen, foreign body after surgery, wrong-site injection nerve injury).
- **Force Majeure**: Unforeseen or inevitable events (e.g., floods, earthquakes, natural disasters) relieve nurses from negligence liability if unable to render standard service.
- **Respondeat Superior ("Let the master answer")**: Holds employers (hospitals) vicariously liable for negligent acts committed by employees within the scope of their employment.

G. Crimes and Intentional Torts Affecting Nursing

- **Assault**: Threat or attempt to inflict bodily harm creating reasonable apprehension of immediate danger (e.g., threatening a patient with an injection if they don't comply).
- **Battery**: Intentional, non-consensual physical contact or touching without legal justification (e.g., administering treatment after explicit competent refusal).
- **False Imprisonment**: Unlawful restraint or detention of a patient against their will using physical force, threats, or unauthorized physical/chemical restraints.
- **Defamation**: Harm to reputation through false statements (*Slander* = spoken; *Libel* = written/published).
- **Invasion of Privacy**: Unauthorized disclosure of confidential patient record data or exposing a patient's body publicly.

H. Legal Procedure and Trial

- **Key Parties**: *Plaintiff* (complainant bringing legal action); *Defendant* (party accused of harm).
- **Statutes of Limitation**: Strict statutory timeframe to file lawsuits (Negligence = 2–3 years; Felonies = 2–6 years; Murder = no time limit).
- **Court Process**:
    - *Pleading*: Initial complaint filed; determination of probable cause.
    - *Pre-Trial*: Conference between judge and lawyers to clarify issues or attempt settlement.
    - *Trial*: Evidence and witness testimonies presented to determine liability.
- **Subpoena Types**:
    - *Subpoena ad testificandum*: Order commanding a person to appear and testify in court.
    - *Subpoena duces tecum*: Order commanding a witness to bring specific documents, medical records, or physical evidence.
- **Witness Types**: Fact witness (testifies strictly on direct observation); Expert witness (qualified by special training/experience to give opinion on standard of care).
- **Execution of Judgment**: Court enforcement of financial damages or penalties; failure to comply constitutes **Contempt of Court**.

V. Organizational Communication

A. Communication Models and Structure

- **Components**: *Sender* $\rightarrow$ *Encoding* $\rightarrow$ *Message* $\rightarrow$ *Channel/Medium* $\rightarrow$ *Receiver* $\rightarrow$ *Decoding* $\rightarrow$ *Feedback* (with potential *Noise/Interference*).
- **Directional Channels in Healthcare**:
    - *Downward Communication*: Superior to subordinate (e.g., policies, unit memos, task delegations).
    - *Upward Communication*: Subordinate to superior (e.g., incident reports, staff feedback, status updates).
    - *Horizontal/Lateral Communication*: Between staff at equal organizational levels (e.g., nurse-to-nurse shift handovers, interdisciplinary rounds).
    - *Diagonal Communication*: Between individuals across different hierarchy levels and departments (e.g., staff nurse communicating directly with pharmacy director).
    - *Informal (Grapevine)*: Unofficial social channel that spreads information quickly, though prone to rumor.

B. Peplau's Theory of Interpersonal Relations

Developed by **Hildegard Peplau** ("Mother of Psychiatric Nursing"):

4 Phases of the Nurse-Patient Relationship

1. **Orientation Phase**: Initial meeting; problem definition, trust building, boundaries established.
2. **Identification Phase**: Patient expresses feelings, identifies with the nurse, and develops a sense of belonging.
3. **Exploitation (Working) Phase**: Patient makes full use of services offered to achieve therapeutic goals.
4. **Resolution Phase**: Needs met; therapeutic relationship terminates, fostering patient independence.

6 Nursing Roles in Communication

- *Stranger*: Initial respectful contact.
- *Resource Person*: Provides accurate health information.
- *Teacher*: Imparts knowledge and health education.
- *Leader*: Facilitates care goals.
- *Surrogate*: Acts on patient's behalf or assumes assigned temporary role.
- *Counselor*: Helps patient integrate feelings surrounding illness.

C. Barriers to Communication

- **Environmental Barriers**: Noise, lack of privacy, high unit activity, interruptions.
- **Psychological/Emotional Barriers**: Anxiety, defensiveness, fear, emotional burnout.
- **Physiological/Physical Barriers**: Sensory deficits (hearing loss), impaired speech (aphasia), pain, fatigue.
- **Organizational Barriers**: Strict hierarchies, status differences between doctors and nurses, unclear delegation.
- **Cultural & Language Barriers**: Differences in dialects, non-verbal cues, or cultural health values.

D. Guidelines for Writing a Memorandum (Memo)

A **Memo** is an internal business document used to communicate policies, procedures, announcements, or directives within an organization.

- **Standard Header Format**:
    - **TO**: Target audience and title

    - **FROM**: Writer's name and designation
    - **DATE**: Current complete date
    - **SUBJECT**: Concise, specific description of purpose
- **Structural Guidelines**:
    - *Opening*: State the core objective immediately in the first paragraph.
    - *Body Paragraphs*: Provide clear, factual details organized with bullet points or bold subheadings.
    - *Action / Closing*: Specify required follow-up actions, deadlines, and contact information.
    - *Tone*: Direct, objective, professional, and clear.

E. Reports in Nursing

- **Shift Handover Report (End-of-Shift Report)**: Direct transfer of essential patient information between outgoing and incoming nursing shifts using standardized tools:
    - **ISBAR Format**: *Identification, Situation, Background, Assessment, Recommendation*.
- **Incident / Variance Reports**: Written record of any unexpected event, near-miss, or safety hazard occurring in a healthcare facility.
    - *Key Rules*:
        1. Completed immediately by the healthcare provider who witnessed or discovered the event.
        2. Factual, objective, and non-judgmental (avoid placing blame or drawing unsubstantiated conclusions).
        3. Used internally for quality assurance and system improvement.
        4. **Do NOT document in the patient's official medical chart that an incident report was completed.** Describe only the physical facts of the event and clinical care provided in the chart.