CHAPTER II

REVIEW OF LITERATURE

Review of literature is a written summary of the state of existing knowledge on research problem. Research reviews the literature to develop research idea, to determine knowledge on a topic of interest to get a context for a study and justify the need for a study.

Review of literature is a key step in research process. It is essential for the researcher to analyse the existing knowledge before going into a new research study. For the present study, the researcher has reviewed extensively various journals, reports, unpublished thesis, texts, Medline, internet, helinet to obtain information pertaining to knowledge, attitude, practices of staff nurses’ towards selected legal responsibilities in Nursing Profession.

According to DAVIS. A.J (1987), an exploratory pilot study on “Nursing and medical students attitudes towards nursing disclosure of information to patients” was conducted with a convenience sample of 28 senior nursing and 28 senior medical students at a major health science centre in California. The students of the both groups were given five cases related to disclosure of information and questions were formulated. The results showed that nursing students have higher legal knowledge scores and positive attitudes towards providing information about the condition to the patients. This study also showed that nursing students have more confidence about independent thinking of patient on treatment and decisions than the medical students.

According to HARJINDER KAUR (1993), a professional nurse should possess special skills in caring the patients with the background of medico legal origin in Nehru hospital Chandigarh. Here nurse must apply her knowledge and skills which are relevant to the working situation. A nurse is expected to be punctual in carrying out all her duties. Every procedure that involves nursing activities also involves legal responsibilities, which can prove to be significant in medico legal cases. The nurse can protect self from legal charges by promptly following right views and through right speech, right action, right habits, right efforts and right mindedness.
According to GLAD STONE G (1995), another study explored the factors underlying the occurrence and reporting of drug errors in district general hospital by nurses in Exeter, England. The sample of 102 nurses, and 17 nurse managers were included in the study and a separate interview was conducted to the nurses who made drug administration errors. The findings of the study highlighted that lack of knowledge is the commonest factor to make the nurse commit drug administration errors, which made them to face legal consequences3.

According to ALLEN D. (1998), a study conducted on attitude of nurses on record keeping in routine nursing practice in the wards. The study was undertaken on a surgical ward and medical ward in a single district general hospital in United Kingdom. Data were generated by using established method of ethnographic research. The field work lasted for ten months, where researcher observed and participated in the working environments of nurses, doctors, health care assistants, auxiliaries and clinical managers and 57 tape recorded semi structured interviews carried out with ward nurses, doctors, auxiliaries and clinical managers. The findings of the study shown that nurses used nursing record in two important ways, first as a management tool, second to protect from consumerism and legal responsibilities. The study findings also revealed that nurses were having contradictory attitude towards the nursing records4.

According to MANIAS E. STREET A. (2000), an ethnographic case study approach was used to study the legitimation of nurses’ knowledge through policies and protocols in clinical practice in a 16- bed, critical care unit in a public teaching hospital in Melbourne, Australia. The data were collected through professional journaling, participant observation and individual and focus group interviews. The results of the study showed that the permanent nursing staff and medical consultants were having higher knowledge on policy and protocol documentation than temporary staff in critical care unit. The study findings also showed that policy and protocols acts as main source of knowledge of staff nurses and also nurses used this knowledge in communication and decision making with the doctors legally5.

According to SPITZER A. GOLANDAR H (2001), the level of knowledge concerning health care reforms and law of national insurance were explored among registered nurses Tel Avil, Israel. A comparison was made between the levels of
knowledge difference in relation to employment setting i.e. hospital, community, and educational settings. The study sample included registered nurses of hospitals, curative and preventive care and nursing schools of Israel. The stratified random sampling method was used. The results showed that low-to moderate level of knowledge related to health care insurance law. The greater level of knowledge was demonstrated by nurses with more years of experience, managerial position. The study findings also revealed that nurses’ with managerial groups were having significantly higher knowledge scores than the staff nurses. Nurses who were employed in curative settings demonstrated highest level of knowledge relating to Israel’s Health Law6.

According to SPITZER. A (2002), an exploratory study was conducted to assess the Swiss nurses’ knowledge related to health care reforms on the national level in Haifa, Israel. With the sample comprised of 74 nurses working in different settings such as in the community, in hospitals and in schools of nursing. The research questionnaires consisted of 40 items to examine the nurses’ knowledge regarding the basic principles of federal health insurance law, what is the level of nurses’ knowledge concerning the principles of health care reforms and are there knowledge differences relating to employment setting and level of education. Data were collected through questionnaires which were administered to the participants at their work place. The data generated from the results concluded that nurses’ from all the settings have moderate to high level of knowledge on all three study scales. The knowledge level of nurse managers was found to be higher than the knowledge level of staff nurses. The study findings also revealed that nurses with RN degree were having higher level of knowledge than nurses with academic degree7.

According to BJORVELL C. WREDLING R (2003), another study was conducted to describe the registered nurses’ perceptions of and attitudes towards the effect of a 2 year comprehensive intervention using VIPS (it is an acronym formed from the Swedish words for well-being, integrity, prevention and security) model for nursing documentation in Stockholm Sweden. Twenty registered nurses were selected out of 34 nurses from three wards of the hospital and attended intervention for two years. Data were collected through focus group discussions. The study findings showed that the registered nurses have stated increasing awareness in patient care
needs which were clearly defined and nursing interventions were specific to the problems identified. The registered nurses also expressed that there was change in oral shift reports to written records and it was more appropriate for documentation and increased safety of both patients and the nurse. The most interesting finding in the group discussions was that nurses made statements that structured way of documentation of nursing care provided made them to critically think more about the working situation with the patients. It was also found that nurses had good level of knowledge on implementation of nursing documentation in clinical practice after interventional programme.

According to BJORVELL.C. (2003), a comparative and descriptive survey was conducted to explore the registered nurses’ perceptions regarding nursing documentation and patient safety Sweden. A three day nursing documentation programme was given to 377 registered nurses after dividing into two groups. The data collected by administering questionnaire of 20 items on opinions about the consequences and pre requisites of nursing documentation in accordance with the VIPS model (VIPS is an acronym formed from the Swedish words for well-being, integrity, prevention and security) and nursing process. The findings of the study revealed that majority (77%) of the registered nurses believed that nursing documentation increases patient safety. The findings also revealed that most influential barriers to nursing documentation were; lack of time to develop nursing documentation, lack of time to document nursing care, organizational policies, lack of facilities to document, and lack of knowledge to document nursing care provided to the clients.

According to SHELDAN T. (2003), a Dutch nurse had been sentenced to life imprisonment after being found guilty of murdering four patients and attempting to murder three others in Hague Netherland. In all these cases the nurse administered lethal doses of drugs including potassium, chloral hydrate, and morphine. She was also charged with falsifying her school diploma to gain a place on nurse training course and misappropriating parts of medical records of a prison hospital where she worked.
According to **NICOLE DAVIS (2003)**, a prospective study was conducted among physicians and nurses with the aim to improve the process of informed consent in the critically ill, at medical intensive care unit of a tertiary hospital in Chicago. Preliminary data was collected from physicians and nurses by administering questionnaire containing 25 items. Later interventional programme on improving the process of informed consent was given for a period of two months and Data collected by administering the questionnaire. The results of the study found that there was an increase in number of informed consent obtained, the absolute difference of 37.4% from the preliminary findings \(^{11}\).

According to **HAGBAGBERY AM. (2004)**, a qualitative study was conducted to explore the factors facilitating and inhibiting effective decision making in nursing in Tehran, Iran. Data was collected from 38 staff nurses by using semi-structured interviews and participation observation methods. The results of the study revealed that the factors which facilitated staff nurses for effective clinical decision making were; good level of knowledge, skills and experience, support from the management, nursing education, and the factors which inhibited staff nurses from effective clinical decision making were; lack of self confidence, inappropriate methods of education, physician centred environment, lack of authority, unbalanced nurse-patient ratios, heavy work load, increased non-nursing duties, lack of support from organization, medical oriented educational system, lack of care facilities and poor salaries \(^{12}\).

According to **BARNABAS& SEEMA (2004)**, a descriptive survey study was conducted the knowledge of legal responsibilities in patient care among 91 nursing graduates was assessed in Ludhiana Punjab. The data were collected through structured questionnaire. The study findings showed that B.Sc. nursing graduates had better knowledge of legal responsibilities in patient care than G.N.M. Nursing Staff. The study also found that nursing graduates needed a well conceived education programme on certain areas of legal responsibilities \(^{13}\).

According to **KIRCHHOFF T.K. (2004)**, Documentation is very essential in legal standpoint and to categorise and standardise the care provided to the patients. An exploratory study to assess the documentation on withdrawal of life support in adult patients in the intensive care unit was assessed by using charts of fifty adult patients who died in the intensive care unit at a large hospital after initiation of withdrawal of life support. Data collected by developing a form after reviewing the
ventilator withdrawal documentation. The results showed that one fourth of the charts had no record of date and time of withdrawal of life support. Only 2 charts had date but no time. Only 11 charts had documentation about presence of physician with patient’s families while withdrawal of life support. Only 3 charts had documentation signifying that physician’s explanation to the family members related to withdrawal process. None of the charts had documentation of nurses’ presence with patients’ family members after withdrawal of life support. The interesting part of the study findings revealed that, the number of charts with documentation on the participation of nurses was greater than the number with documentation on the participation of physicians. This clearly indicates that nurses are practicing legal responsibilities in patient care14.

According to BETTY.P.KUNJUMON (2005), by using descriptive survey, a study was conducted to assess the knowledge in protecting the patient rights among 80 staff nurses in Kerala. The results showed that half of the staff nurses had high level knowledge scores in protecting patient rights15.

According to SUHONEN R. (2005), information plays a vital role in health care industry in Forsa, Finland. A descriptive survey was conducted among 928 patients with the aim to explore the informational needs of the patients and information they received from the nurses. The findings of the study concluded that patients did not receive adequate information from the staff nurses. The findings also revealed that nurses were not assessing patients’ informational needs to solve the problems identified16.

According to FARHAN J (2005), Medical records play a vital role in health information system in the hospitals and acts as a basic source of communication and exchange of information between health workers in Riyadh, Saudi Arabia. Hence accurate documentation of medical records is very important. A pilot study was conducted about documentation and coding of medical records in a tertiary care centre. The coding is given after selecting patients’ charts from medical records department. The study findings showed that with regard to the degree of documentation, coding accuracy and the quality of medical records audited, only 61.78% met the bench mark for good quality medical record. This indicated that the health care workers should improve and practice high quality documentation in their daily practice17.
According to KUNJOMON PB. (2006), a descriptive survey was conducted among 80 staff nurses to explore the factors which inhibit them in protecting the patients’ rights in Private Hospital in Kerala. The results of the study revealed that the factors which inhibit the staff nurses in protecting patients’ rights were shortage of time, lack of knowledge, lack of experience, lack of role models, restriction by the hospital policies, lack of autonomy and independence, and increased work load.

According to LIANA L. (2006), a research study explored the conflicts and ethical dilemmas experienced by 12 nurses working in surgical centres of macro-regional hospitals by conducting interviews in Grande, Brazil. The findings of the study revealed that due to lack of infrastructure the nurses were facing conflicts and dilemma in daily practice, which in turn lead to failure in meeting the demands and to follow the deontology code.

According to NEGARANDEH R (2006), one of the primary roles of a competent nurse is patient advocacy. A study explored the barriers and facilitators influencing the role of advocacy among Iranian nurses in Iran. The data were collected through an extensive grounded theory with the sample consisted of 24 nurses working in a large university hospital by using semi-structured interviews. The result of the study findings indicated that barriers of advocacy were powerlessness, lack of law and code of ethics, lack of support for nurses, domination of doctors, lack of time, limited communication with patients, risk of advocacy, and lack of motivation. The facilitatory factors were effective nurse patient relationship, recognising and paying attention to patients’ needs and conditions, nurses’ responsibility and accountability, physician as a colleague and knowledge and skills.

According to HARIHARAN S. (2006), an exploratory study was conducted to assess the knowledge, attitude and practices among doctors and nurses in relation to health care ethics and law in Barbados, West India. More than half of the nurses and doctors had only little knowledge on law. About 34% of nurses and one-sister in charge did not know the ‘Nurses Code’. About 29% of physicians and 37% of nurses were unaware of the existence of an ethics committee at the institution. The major findings of the study showed that majority of the respondents are not having enough knowledge about law related to working place. There was significant difference in attitudes of doctors and nurses related to adherence to patient wishes, confidentiality, and consent for procedures.
According to CANTINI .F. (2007), a descriptive survey was conducted among 95 clinical trial nurses to explore their role in informed consent process and elicit information about the current practice in Quebec, Canada. Data was collected after administering questionnaire of 50 items. The study results revealed that the clinical trial nurses are having an important role in informed consent process and practicing to the greater extent22.

According to PREMAPAUL (2007), a quasi-experimental study was conducted to assess the nurses’ knowledge of their legal responsibilities towards patient care in Pune, Maharashtra. The data were collected on a sample of 50 staff nurses through structured knowledge questionnaire. The study results showed that nurses had low knowledge of their legal responsibilities towards patient care. The study also found that after administration of self instructional module on nurse’s’ legal responsibilities towards patient care, nurses had highly significant increase in their knowledge scores than the pre-test scores and 86% nurses believed that the information booklet was a good source of learning; and 98% believed that booklet should be made available to all the staff nurses23.

According to FURNISS K. (2007), a survey design was adopted with purpose to elicit nurses and their barriers to screening for intimate partner violence among 385 staff nurses in hospitals in Montclair, USA. The study results shown that lack of privacy, lack of time, need for resources and protocols, legal questions, personal belief issues, and language acted as barriers for nurses to screen for intimate partner violence24.

According to SHRMA.F (2007), a retrospective study was conducted to assess the standard of note keeping and documentation of notes in patient case records in Leighton hospital, Crewe, United Kingdom. Out of 96 patients’ case records, 5 randomly picked up case records were examined. The findings of the study revealed that appropriate documentation was used in 92.8% of cases. The results also explored that incomplete documentation and illegible hand writing in notes was a common practice by health team members25.

According to KIM J. (2007), an exploratory survey was conducted with 886 nurses at eight Korean teaching hospitals to describe nurses’ perception of frequency of error reporting and patient safety culture in their work environment in Korea. The
findings of the study revealed that the majority of the nurses are not practicing error reporting and safety issues in work place. The findings also high-lightened that there is no special consideration present in teaching hospitals with regard to patient safety culture and error reporting systems\textsuperscript{26}.

According to \textbf{LEPINE I. (2007)}, a descriptive survey conducted to assess the knowledge of health care personnel related with the informed consent in a teaching hospital in Barcelona, Spain. Revealed that half of the health care professionals were unaware of what an informed consent consists of, and its different sections, and law/ regulation that regulates it\textsuperscript{27}.

According to \textbf{KAZAOKA T. (2007)}, a simulation study was conducted to explore why nurses make medication errors with the purpose to investigate about the communication problems in the nursing systems Japan. Baseline data was collected from the sample of 100 third year nursing students and 163 registered staff nurses. The simulation scene has provided in the setting. The results revealed that there was lack of explanation between nurse leaders and nurses and no explanation between nurses. This indicates that nurses lack practice of legal responsibilities in patient care due to absence of clear and open ended communication\textsuperscript{28}.

According to \textbf{TANG F (2007)}, according to few studies conducted, errors in medication administration commonly takes place at the time of prescription and administration phases, and an extent between 65\% and 87\% of all medication errors are in these phases in Taiwan. Drug administration remains a traditional act of nurses in spite of extended and expanded roles of the nurse. About 40\% of medication errors occur at the time of medication administration and make nurse to undergo shame, guilt and fear of punishment. A study was conducted to assess nurses relating the contributing factors involved in medication errors by using a snowball sampling method, a semi-structured interview schedule was conducted with 72 staff nurses. The findings of the study revealed the factors contributing to medication errors were personal neglect in which the normal procedure of checking the five rights of drug administration was neglected, heavy work load was the high risk for drug errors, and new graduate staffs who were unfamiliar with the high-risk situations and limited work experiences\textsuperscript{29}. 

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According to **Kim KK. (2006)**, a survey design with cross sectional method was used to examine the knowledge and attitude of Korean nurses towards legal awareness and, legal liability South Korea. A sample of 288 registered nurses participated in the study. The results showed that 83.7% of nurses were having high levels of knowledge related to rights to health in Korean constitutional law and the declaration of the universal human rights 93.1%. The staff nurses had a more positive attitude towards duty and liability of related to legal responsibilities than nurse administrators\(^{30}\).

According to **ALFREDSDOTTIR H (2008)**, an action research project was conducted at university hospital in Iceland, to know nursing and patient safety in operating room. Data were collected in two stages\(^{33}\). Preliminary survey was conducted under the stage one with aim to explore operating room nurses’ goals, values, and characteristics of their work by administering open ended questionnaires to 60 operating room nurses. Data was analysed by critical incident technique. The findings revealed that the skilful, knowledgeable and providing safe environment as a main aim of operating room nurses. Based on these findings a qualitative survey involving semi-structured interviews and focus group interviews were conducted for 14 operating room nurses with the aim to find out facilitatory and inhibitory factors in practicing patient safety in operating room. The findings of the study shown that preventative measures in protecting patients, expertise in teams and nurses with long experience in operating rooms acts as facilitatory factors in practicing patient safety. Worries about demands for increased speed and productivity, the pressure to increase constant concentration and speed of work for prolonged time, lack of control over circumstances such as ignorance, lack of experience, distraction, imbalance staffing, which may be under or over staffing are factors which inhibit operating room nurses to practice patient safety in their work environment\(^{31}\).

According to **HAYES B. (2008)**, an exploratory survey was conducted to Medical errors are recognized as a significant issue in health care practice in Nepal. An ethical and professional guideline highlights the responsibility of health care team to disclose errors to patients. An exploratory survey was conducted among 127 health team members of a hospital to understand staff attitudes to medical errors and suggest how they could be handled. The findings of the study revealed the factors which
hinder the health team members to disclose errors to patients were; educational level of the patient, socio-legal climate, damage to the reputation of doctors and nurses. The factors which facilitated health team members to disclose errors to the patients were; clear hospital policy on dealing with errors, development of incident reporting forms, formulation of error investigation team, and providing adequate training in communicating about errors for the appropriate staff.

According to MOIRA ATTREE (2008), an exploratory survey was conducted in Manchester, United Kingdom. To explore patient’s safety in an English pre-registration nursing curriculum with the aims, to identify patient safety themes in the curriculum, explore where and how patient safety themes are thought, examine the assessment of patient safety in theory and practice and explore factors in the educational milieu that affect the development of students’ knowledge, attitude and behaviour in relation to patient safety. An organizational case study design and curriculum analysis was used to investigate patient safety. Focus group interviews to perceive patient safety with students from all three years of the programme and ten educators who teach on the programme, and to explore the curriculum content pertaining to patient safety. Open questions based on objectives were asked using semi-structured interview schedule. The findings showed that students gained most of the knowledge in patients’ safety through clinical practice and not from formal curriculum.

According to Friberg F. an exploratory study was conducted to search the details of patient teaching nursing documentation by analysis of patient records in a medical ward in Sweden. The data collected from the 35 patients’ records in which nurses’ documented for a period of 206 days. Terms and expressions used by nurses while documentation related to patient teaching activities were analysed. The results showed that eight patient records did not have details of ongoing documentation. Whereas the nurses documentation was not in the structured way and it was in scattered form in all the patient records. This indicates nursing documentation was inappropriate and shows lack of documentation.
According to **FENG X. BOHAY K. WEISS M. (2008)**, patient safety is an important issue in health care organizations in Sweden. With the aim to explore factors contributing to the patient safety culture and consequences, a concept analysis method was carried by using papers, books, and theses. The findings of the study high-lightened the factors which facilitate for patient safety viz. management commitment, open door policy, support from supervisors, confidentiality, feed back, and analysis of errors.

**Conclusion:** Like this, there are studies on Legal Responsibilities of Nursing Profession, mostly in other countries. Study is a maiden attempt by the researcher on Legal Responsibilities of Nursing Profession with adoration in India. The researcher could not review the latest studies on the subject under study as these were not.
REFERENCES (in the order of citation in Review of Literature)


