CRITICAL CARE NURSES' KNOWLEDGE OF CONFIDENTIALITY LEGISLATION

By Angela B. Newman, RN, PhD, CNE, and Diane K. Kjervik, RN, JD

Background Health care legislation can be difficult to understand and apply in critical situations where patients may not be physically capable of autonomous control of confidential health information. Nurses are often the first to encounter confidential information about patients.

Objectives To explore critical care nurses' knowledge of federal and North Carolina state legislation regarding confidentiality.

Methods This descriptive, qualitative study included 12 critical care nurses who were asked to describe their knowledge of federal confidentiality legislation and specific knowledge of North Carolina's confidentiality legislation.

Results Critical care nurses were knowledgeable about federal confidentiality laws but demonstrated a need for further education about state-specific legislation.

Conclusion Nurses' application of confidentiality legislation demonstrates their knowledge of confidentiality legislation. To continue the trusting relationship that nurses have traditionally held with patients and patients' families, it is imperative for nurses to remain current about confidentiality legislation. Through education both before and after licensure, correct application of legislation can be achieved. Further research can aid in exploring the intersection between health care legislation and ethics. (*American Journal of Critical Care*. 2016;25: 222-227)

In critical care units, health care professionals face dilemmas involving the confidentiality of health information. Often, patients are incoherent or physically unstable and thus unable to make autonomous decisions about their confidential health information. Families, out of love and concern, have a need for information about their relatives. This need can become complicated for patients, patients' families, and health care workers because of confidentiality legislation.^{1,2} Professional codes of ethics^{3,4} help guide health care workers' values and practice related to confidentiality. Legislative standards guide practice and help to diminish mistrust and misunderstanding of health care workers by health care consumers. It is imperative to begin to understand critical care nurses' knowledge of the concept of confidentiality. The intersection of health care legislation and ethical principles is important to practice. Beginning to explore that intersection must start with understanding nurses' knowledge of the legislation. This research is focused on critical care nurses' knowledge of federal and North Carolina confidentiality legislation.

Protection of health information became a national incentive under the George H. W. Bush administration in the 1990s and continued through the Clinton administration. The Health Insurance Portability and Accountability Act (HIPAA) was enacted as PL104-191 in 1996 and recorded in the Code of Federal Regulations in 2000.⁵ After some modification, compliance was required by April 14, 2003. This legislation provides a legal minimum standard to protect the privacy and confidentiality of health care recipients.⁵

Individual state boards of nursing address the concept of patient confidentiality. According to the North Carolina State Board of Nursing,⁶ registered nurses are to "safeguard confidentiality." Protection of health information is addressed in the North Carolina Declaration of Patient Rights.⁷ North Carolina statutes regarding confidentiality are broad and do not explicitly define the maintenance of confidential patient information. Federal legislation preempts North Carolina state law in this instance; thus health care workers and covered entities must defer to federal law when in need of legislative guidance for protection of health information.⁸

Methods

A qualitative approach using open-ended questions was used to elicit critical care nurses'

knowledge of confidentiality legislation. Upon receiving approval from the University of North Carolina at Chapel Hill's Public Health and Nursing Institutional Review Board, informed consent was obtained. Participants were assigned pseudonyms to protect their confidentiality and are used in this write-up for clarity between participant data.

Participants were recruited from central regions of North Carolina by flyer, word of mouth, and snowball sampling. Interviews were conducted until saturation of data was achieved (n = 12). Twelve respondents had more than 2 years of critical care experience. Data were collected via face-to-face interviews using open-ended questions and a telephone interview 1 week later to allow the opportunity to add further information or clarify information already provided. Nurses were asked to describe their general knowledge of confidentiality legislation as well as legislation specific to North Carolina.

The data were analyzed by using content analysis, then coded using keywords from the language of the participants, paraphrased, and placed into emerging categories. Common to naturalistic qualitative research, reliability and validity were replaced by values of credibility, transferability, dependability, and confirmability.⁹ Prolonged engagement with the data optimized the credibility of the findings. A clear and concise audit trail enhanced dependability and confirmability. Thick, rich description of the data and the use of quotes from participants in the write-up confirmed that the findings reflected the data and enhanced the transferability of the findings.⁹

Often critical care patients are unable to participate in decisions about their confidentiality.

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Results

All of the participants noted that health information was protected. Lilly commented that "all patient information is protected from anyone that's not directly involved in that patient's care." Evelyn's description of confidentiality law was more specific. She stated,

Again, we are responsible not to divulge patient information to anyone that is not authorized by the patient. Again, in practice, sometimes the patient cannot authorize anybody and we have to go to the next of kin, to the best we can find.

Half of the participants further specified that confidentiality legislation limited sharing information with anyone who was not directly involved in the patient's care. Janelle commented, "That means that we're not sharing information about that patient with other people that don't need to know that information if they're not involved in helping that person get well."

When asked to identify confidentiality legislation, all of the nurses referred to HIPAA. Hannah responded, "Well, you know, HIPAA—that's probably the biggest one. HIPAA—don't say anything, don't talk." Charlotte further clarified that HIPAA applied to physicians' offices and insurance companies, sharing of information over the telephone and,

In general, patients have to give permission for someone else to get information about their medical condition or their position. I know that physician's offices can't, they have, every visit you make, you sign saying that they can give information to insurance companies. It impacts whenever they are calling with lab results back to you. They have to have permission whether they can leave a message on your answering machines.

Hannah indicated specific knowledge of HIPAA in her discussion of incidental breach when visitors walk past nurses during shift report. She stated, "It's a breach. It's a breach but I guess an understandable breach in that you were doing what you were supposed to do appropriately; however, the information

still got out." All of the participants indicated knowledge that there were individual and institutional penalties related to breach of confidentiality.

Half of the participants demonstrated familiarity with the concept of *in loco parentis*,

Latin for "in the place of a parent"¹⁰ in their discussions of sharing information about patients unable to make autonomous decisions. Hannah and Charlotte discussed the role of a health care power of attorney (HCPOA). Charlotte commented,

Oh yes, it makes it much easier in my case, in my view. Because then this person, who is now not able to speak for themselves, at some point gave this some thought and said "if I am not able to speak for myself, if I'm not, it's okay for, I want this person to be a spokesperson for me."

Hannah noted that HCPOA supersedes next of kin but in the absence of a HCPOA, information could be shared with next of kin: "It would be either a spouse or the eldest child that is of age and you go to the mother, father, parent and then you just continue to the next of kin unless they have a power of attorney." Evelyn similarly stated, "that is, at least North Carolina if not beyond. It talks about next of kin as far as child and spouse first, then child and parent and then going down the list." Federal legislation requires persons acting as personal representatives or *in loco parentis* be treated as the individual.¹¹

In North Carolina, minors who become pregnant and certain others may petition for emancipation. According to the North Carolina general statutes, pregnancy does not automatically ensure emancipation unless the minor is legally married.¹² Lilly commented on her experience,

Sometimes we get teenagers, but generally if they've had a baby, they are responsible for themselves. Sometimes their mother might try to take over and I probably would feel that way too as a mother; this is a minor I'm responsible for and I deserve to have that information or say in what's going on.

When asked how she handled those situations, Lilly replied, "Usually, I contact the supervisor or someone who knows specifically how that relationship works in terms of when the patient is kind of emancipated from their parents." No other participants reported caring for minors or others under legal guardianship.

Participants did identify information that is and is not confidential. All of the participants said that they could share "general" information. All included the patient's condition as part of general information. Beth described general information as: "the patient is stable, we are monitoring the patient." Donna said, "They're resting comfortably. They are getting better. They are holding their own; very general comments." Charlotte stated that she "would not give them much of anything." She commented, "A lot of nurses will just say, 'I'm sorry we can't give out any information, you will have to touch base with the family.'" Less common responses about what information could be shared included assessment and laboratory data, nutrition, fluid status, disease processes, and the plan of care.

Ten participants said that they could not share any information that was considered socially

When asked to identify confidentiality legislation, all of the nurses referred to HIPAA.

stigmatic. Disease processes considered socially stigmatic included diagnoses of HIV infection, AIDS, cancer, substance abuse, or sexually transmitted diseases. Gail recalled this story:

We had a case just last week where we were sure the family didn't know that the patient had HIV. So we had to be careful. I don't think it came across that we were being mean, I think we handled that well. So in that case, even though the person is their contact person by law, you can't tell them everything.

Hannah indicated that she perceived socially stigmatic information as more protected than other health information. Similarly, Lilly stated, "I think the HIV, I would probably be a little more protective of because that has to do with personal choices the patient's made or possibly made." Charlotte disagreed: "Everything is supposed to be kept confidential. You think of it as need[ing] to be more confidential. It's actually in practice; everything is as confidential as that."

Federal legislation requires that protected health information be released when the health and benefit of the public or private citizens is affected. Contrary to the legislation, Gail stated, "I don't think it works that way. I think I would be legally compelled to not say anything." Kristen specified that "suicide and abuse" required reporting. Janelle's statement conveyed knowledge of HIPAA¹³:

If it is affecting the health of another person, TB [tuberculosis], things that the other person needs to look to see if they are contracting a disease too, it's regulated; TB and communicable diseases that can be passed on. The health department requires that.

Laboratory and other test results as well as the medical record were also considered confidential. Information considered least confidential was assessments, physicians' names, skin care, and treatments. Hannah specified that confidential information included, "If they have family issues, diagnosis, medication, what's happening with them at that time, skin care, anything having to do with the patient."

Nurses' Knowledge of North Carolina State Legislation

Knowledge of North Carolina law varied among participants. "I don't know" was the most common response (n = 8) when nurses were asked if North Carolina had state-specific confidentiality legislation. Frances was unsure about specific legislation but noted that North Carolina law was affected by other regulations. "I'm sure they do with HIPAA and the NC Board of Nursing." Evelyn shared more detailed knowledge, noting that at times federal legislation supersedes state legislation: "I figure

HIPAA covers. Between HIPAA and [hospital] practice it pretty much took care of what I needed to know." Evelyn believed that North Carolina had also established common-law marriage legislation. She said: "I think it's 7 years . . . they call it common-law wife or common-law spouse and I think its 7 years." North Carolina does not recognize common-law marriages; therefore, long-term partners or significant others are not legal next of kin.

According to North Carolina general statute regarding privilege,¹⁴ communication between patients and nurses is considered privileged and indicates that no disclosure of patient-nurse communication should occur except under the direction of a superior or district court judge for purposes of justice. None of these nurses verbalized knowledge of privileged communication legislation. Anne commented, "It's not, I don't think it is . . . and yet there are some things that we have to be able to ask them to take care of them. There again, there is that level of trust that is established." When specifically asked, Irene indicated the most accurate perception. She stated, "You know I've never thought, I think it depends on what they say. With some, there are a lot of private things they disclose to us, but yes, I think as their caregiver, that is privileged." None of the nurses acknowledged duty-to-warn legislation, the Declaration of Patient Rights⁷ or the Patient's Bill of Rights.¹⁵

This study begins to fill gaps in the literature in regard to what nurses do and do not know about state legislation. The nurses were unable to specify whether or not North Carolina had specific confidentiality legislation, but they correctly assumed that HIPAA preempted state legislation when HIPAA was more stringent.⁸ Nurses did not discuss the Patient's Bill of Rights or the requirement by the North Carolina general statute¹⁵ that requires that the Patient's Bill of Rights be publically displayed in all facilities. Irene indicated that she considered nurse-patient communication privileged but she did not say that it was a legal obligation as specified in the North Carolina general statute regulating nurse privilege.¹⁴ These regulations are important to the protection of patient rights and the protection of communication with patients. It is imperative for nurse leaders to recognize the importance of this legislation and to communicate these rights and privileges to nurses in direct care settings.

Nurses' Knowledge of Federal Legislation

This study was the first to explore critical care nurses' knowledge of confidentiality legislation.

In North Carolina, communication between patients and nurses is privileged.

Critical care nurses are at the heart of patient confidentiality.

Based on the present findings, it can be hypothesized that the continuing education about confidentiality legislation provided to these nurses was effective. Findings indicated that nurses are generally knowledgeable about federal legislation (HIPAA) as the primary rule governing patient confidentiality. Participants clearly showed knowledge of HIPAA restrictions.¹⁶ Their descriptions of confidential patient information were similar to those presented in the literature.¹⁷

Although they did not specifically use the legal term *in loco parentis*, the nurses were able to describe this concept in regard to with whom they shared confidential information in the absence of the patient. Lilly in particular demonstrated knowledge of this concept in her discussion of emancipated minors. Her description indicated an in-depth understanding of the general rules of HIPAA.¹¹ Critical care nurses in this study also indicated that they released information on a “need to know” basis, indicating knowledge of HIPAA legislation that requires information to be released on a “minimally necessary” basis.¹¹ Although none of the nurses mentioned the American Nurses Association (ANA) Code of Ethics, their practice of releasing only minimally necessary

information is consistent with the ANA’s recommendation regarding the nurse’s role in patient confidentiality.^{4,11}

Although it is impossible to consider every possible situation and detail of patient information, the study provides a list of items that the nurses deemed confidential. These items should serve as a starting point for nurse leaders and policy makers when writing and revising confidentiality policy.

The nurses in this study conveyed familiarity with incidental breach legislation as outlined by HIPAA.¹¹ They indicated that shift reports and rounds were times that incidental breaches of information occurred. These findings are similar to those of other researchers,^{18,19} who noted that information is often overheard by patients’ families and visitors. The findings indicate that nursing leaders may need to evaluate current policies and establish a plan of action regarding the coordination of shift report and visitation policies while keeping patients’ families involved in the care of their loved ones.

Limitations

The sample used in this study was 12 critical care nurses from central North Carolina who were white, natural-born citizens. The experiences of nurses from other types of practice and geographic locations were not the focus of this study and therefore such information was not collected.

Demographic data such as marital status, age, and shift assignment were also not the focus of this study, and their impact on the findings was not explored.

Nurses were not asked about their previous education regarding confidentiality law or ethics. It is therefore unknown what level, type, and frequency of education about confidentiality legislation and ethical principles the nurses had. All of the participants’ education related to confidentiality legislation most likely came from institutional resources. Although not generalizable, the findings can be transferable as readers may connect or relate their own perceptions and experiences to the findings of this study.

Implications

Providing simulation and scenarios in a structured, safe environment would allow students to apply confidentiality regulations. Increased access to legislative regulations in clinical settings may also increase understanding and applicability. Replication of this study to explore a sample and setting outside of central North Carolina to explore the impact of location on nurses’ knowledge of confidentiality legislation and the impact that these factors have on their practice would be useful. Future research should focus on the decision-making process at the bedside, where decisions are made without much time to consider all of the legal nuances and ethical theories related to sharing or not sharing confidential health information.

Conclusion

Critical care nurses’ actions are at the heart of patient confidentiality. Nurses should be encouraged to share information with patients and patients’ family members within regulations of state-specific and federal legislation. Provision of prelicensure education and regular reinforcement of knowledge related to state and federal legislation is needed for all nurses. Knowledge about state and federal legislation and codes of ethics affects decisions regarding confidential health information. To continue the trusting relationship that nurses have traditionally held with patients and patients’ families, it is imperative for nurses to remain current about confidentiality legislation. This exploration of critical care nurses’ knowledge of confidentiality legislation provides insight into their understanding and application of legislation.

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FINANCIAL DISCLOSURES

None reported.

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