

0 • Exam Map

COURSE FACTS

A1 · 40%

EXAM · 60%

Optional multiple choice quiz · 0% · formative

"The exam will be open-book (any materials you rely on must be hard copy)" (Assessment 2 Exam Details, LWS101 Semester 2 2026)

Exam: in-person invigilated; **two compulsory questions**; answer both with the framework; **all topics** examinable. Put rules beside the fact that activates them; do not merely list law or code provisions.

1 • Answer Spine

C2 · EVERY QUESTION

1 ID issue	2 TEST rules	3 ACT option	4 DO steps	5 REV review
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FACT → RULE → APPLY → END → NEXT

Framework pipeline. The unit's numbered headings replace an essay introduction and conclusion.

HEADING	WHAT EARNS SPACE
1	Precise question; every affected person.
2.1	Define + apply four principles; name the clash.
2.2	ICN number → relevant words → fact link.
2.3	Act/case/rule → elements → application → legal conclusion.
3	NMBA provision; compare options; decide and justify.
4-5	Concrete action, documentation, escalation, review.

EXAM MOVE → Give Evaluate the most space. A correct quotation earns little until tied to a scenario fact.

1b • Four Principles, Applied

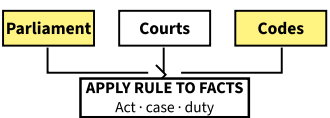
2.1 · NAME THE CLASH

PRINCIPLE	QUESTION ON THESE FACTS	LIKELY TENSION
Autonomy	What does this capable, informed person choose?	Beneficence when refusal may harm.
Beneficence	Which option promotes the person's welfare?	Autonomy; scarce resources.
Nonmaleficence	Which avoidable harm does each option create?	Benefit may require some risk.
Justice	Is treatment and resource allocation fair?	Individual benefit versus equitable access.

Three moves: define and cite → identify the engaging fact → explain what it directs. Acknowledge the competing principle, then resolve the clash in Step 3.

2 • Rule → Forum

C1 · LAW HEADING



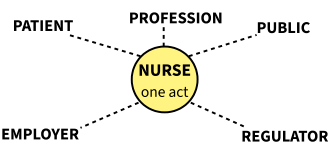
Where a ward rule comes from. Name whether it is statute, common law or a professional code.

TRACK	PURPOSE / TRIGGER
Criminal	State prosecutes an offence; punishment.
Civil	Person harmed claims compensation; requires actionable harm.
Disciplinary	Regulator protects public; registration may be restricted.
Coronial	Coroner investigates how and why a death occurred.

Precedent: lower courts follow higher courts in the same hierarchy; all Australian courts follow the High Court. One incident can open several tracks because each has a different purpose.

3 • Professional Accountability

C3 · NMBA / ICN



Five audiences. A single lapse may create patient, employment and regulatory consequences at once.

TRIGGER	AUTHORITY / ACTION
Registration duties	NMBA 1.1; National Law ss 129–131, 141; check threshold.
Unsafe colleague	NMBA 7.1; document facts → manager → consider Ahpra.
Advocacy / danger	ICN 2.7, 2.10; speak up through the right channel.
Boundary / money	NMBA 4.1, 4.5; power imbalance; avoid sexual/financial involvement.

Mandatory ≠ voluntary notification. Identify health, competence, conduct or addiction; state why the known or reasonably suspected concern may affect safe practice; then choose the route.

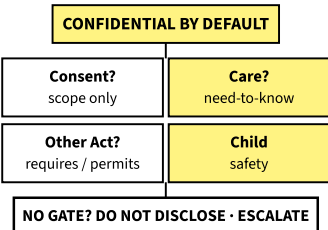
Speaking-up sequence: preserve immediate safety → record exactly what was seen/heard and when → raise it inside the team/with the manager → use the regulator route if the legal threshold is met. ICN 2.7 treats advocacy and open dialogue as professional work; ICN 2.10 requires action where a co-worker or practice endangers health.

BOUNDARY TRAP → A former patient does not erase the power imbalance. NMBA 4.1 covers current/former patients; NMBA 4.5 prohibits financial involvement with a person in care.

4 • Confidentiality Gates

C4 · HNB ACT S 142

Confidentiality protects information shared in care; **privacy** limits access to records and private information. In Queensland public health services, *Hospital and Health Boards Act 2011* § 142 makes non-disclosure the starting rule.



Four lawful exits. Test each gate; share only what the authority covers.

SCENARIO	RULE + APPLICATION
Treating team	Care/treatment gate; relevant, timely information only (NMBA 3.3).
Police request	No consent, treatment purpose or shown legal authority → decline, refer, record.
Unnamed image	Still prohibited without written informed consent: NMBA 3.5; ICN 1.5 covers all media.
Patient access	Employer generally owns record; patient may access under policy.

Records: state what is documented, by whom and when. ICN 2.12 makes nurses accountable for data integrity. Related privacy statutes named in the unit: *Information Privacy Act 2009* and *Right to Information Act 2009*.

DISCLOSURE PARAGRAPH BUILDER

DEFAULT
§ 142 protects the information – identify the requested information and proposed recipient.

GATE
Consent? care/treatment need? another Act requires or permits? child protection?

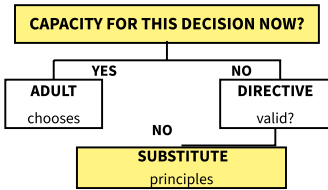
SCOPE + RESULT
Explain why the fact does/does not fit; if authorised, disclose only the necessary scope; otherwise decline and escalate.

INFORMATION PRACTICE	WHY IT MATTERS
Corridor conversation	Shared-space disclosure can breach confidentiality even without a written record.
Late/amended note	Keep the record accurate and professional; never disguise when an entry was made.
Curiosity access	Treatment relationship is not permission to browse unrelated information.

5 • Adult Consent Route

C5 · SS 11B–11C

Treatment needs consent or another legal basis; otherwise it risks **assault**. Presume capacity; test it for **this decision, at this time**. A diagnosis or age does not itself remove capacity. A capable adult may refuse any treatment.



Decision route. Capacity first, then directive, then authorised substitute.

VALID CONSENT TEST	ASK
Voluntary	Free choice; no coercion; may change mind.
Informed	Understands benefits, risks, nature and alternatives?
Capacity	Can decide and communicate for this matter now?
Time/language	Questions, interpreter and real opportunity to decide?

Authorities: NMBA 2.3; ICN 1.3. For impaired capacity, *Guardianship and Administration Act 2000* (Qld) **ss 11B–11C**: support the adult first; consider views/wishes, condition/prognosis, alternatives/risks, delay, dignity and autonomy; choose the least restrictive option.

Signature ≠ consent. A form records a valid decision; it cannot cure lack of understanding.

SUBSTITUTE DECISION CHECKLIST

ORDER	QUESTION
1 Support	What information, interpreter, time or assistance could let the adult decide?
2 Wishes	What present views and previously expressed preferences are known?
3 Clinical	Condition/prognosis; benefits, burdens, risks and alternatives; can care wait?
4 Rights	Which option best preserves dignity, autonomy and participation with least restriction?

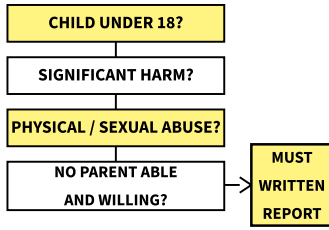
Refusal: do not convert disagreement into incapacity. If capable, the adult may reject recommended or life-saving treatment. Confirm understanding, address reversible communication barriers, respect the choice and record it.

Fluctuation: repeat the assessment at the relevant time and for the relevant decision. A person may make some decisions and not others.

6 • Child: Decide or Protect?

C6 · CHILD PROTECTION ACT

Consent: parents usually decide in the child's best interests. An older child may consent alone if sufficiently mature and intelligent for the specific treatment. State age, maturity and understanding before choosing the route.



Reportable suspicion chain. All limbs support the mandatory route under s 13E.

ROUTE	THRESHOLD / SECTION
Mandatory	Registered nurse + reportable suspicion in employment → written report; § 13E(1) .
Non-mandatory	Anyone may report reasonable suspicion child may need protection; § 13A .
Suspicion	Clinical signs, disclosure, injuries, symptoms, behaviour; weigh § 13C matters.
Protection	Honest/reasonable report: liability protection § 197A ; notifier identity limited § 186 .

Do: stay calm; use age-suited open questions; listen; document exact words and clinical basis; follow the written route. **Do not:** promise secrecy, interrogate, prove abuse or identify the offender. Investigation belongs to Child Safety and police.

REASONABLE SUSPICION: BUILD, DO NOT GUESS

Use **observation/disclosure → inference → statutory limb**. Location, developmental inconsistency, repeated injuries or a disclosure may combine into a well-founded concern. Section 13C permits attention to evident or likely physical or psychological effects.

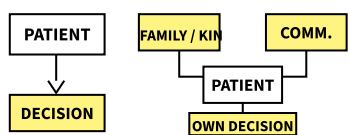
Keep branches separate: age/maturity govern consent; best interests limits parental authority; protection is added only if its own threshold is met. In the report, distinguish what was observed from what was said.

TRAP → "Should report" is incomplete. Name mandatory or non-mandatory, the threshold, section and fact supporting suspicion.

§ 11 PARENT → Mother, father or person exercising parental responsibility; for an Aboriginal or Torres Strait Islander child, also a person regarded as a parent by tradition or custom.

7 • Culturally Safe Consent

C7 · NMBA PRINCIPLE 3



Widen the process, not the owner. Family/community may shape how the patient decides.

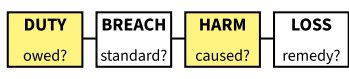
CODE	EXAM APPLICATION
NMBA 3.1	Value family, community and shared decision-making.
NMBA 3.2	Avoid bias, discrimination and racism; person/family judge safety.
NMBA 3.3	Meet language/cultural needs; interpreter; confirm understanding.

Silence or a nod is not informed agreement. Ask, listen, allow time, offer an interpreter or Aboriginal and Torres Strait Islander health worker, invite chosen family, then confirm understanding in the patient's own words.

Application: patient first; then chosen family/kin, community, interpreter and health worker. Pause signing; ask whom to involve; explain; confirm understanding; adapt and record. Collective input supports, not displaces, the patient's consent.

8 • Negligence Chain

C8 · CIVIL COMPENSATION



ONE BROKEN LINK → NO NEGLIGENCE CLAIM

Link by link. An error without injury may be reportable, but it does not complete negligence.

Duty	Patient relationship or sufficient proximity.
Breach	What reasonable nurse would do → contrast actual conduct.
Causation	Trace the injury to the breach, not merely to the episode.
After event	NMBA 2.4: protect, report, open disclosure, explain/apologise, support, document, review system.

Following policy is evidence of reasonable care, not an automatic defence. A skipped policy step often supports breach; explain and document any departure.

Beyond existing patients: emergency care, a second opinion or another sufficiently close relationship may create duty. No harm means no completed negligence claim, but a near miss may still require reporting, scrutiny and system change.

SERVICE-LEVEL STEP → After the legal conclusion, name what the service should change to prevent recurrence; Principle 2.4 also requires non-punitive incident management and support.

9 · Fast Answer Method

EXAM EXECUTION

READ

issues

PLAN

heads

WRITE

apply

CHECK

next

TWO EQUAL BLOCKS

move on; return after Q2

Timing without invented minutes. Divide the available writing period equally; preserve a check inside each block.

LAW MINI-LOOP INSIDE 2.3

Issue precisely → Law with case/Act/section and elements → Apply each element to a named fact → Conclude provisionally.

READ	WRITE IN MARGIN
Decision-maker?	capacity → directive → authorised substitute
Information?	confidential default → exact exception
Harm?	civil chain + report/open disclosure
Child?	age/maturity + best interests + report threshold
Restriction?	legal authority + capacity + least restrictive

Application sentence: "Because *[fact]* satisfies/fails *[element]*, *[rule]* points to *[result]*." Give a separate ethical and legal conclusion when they differ.

10 · Drill 1 – Fluctuating Capacity

WE5 · ADULT REFUSAL

Facts: Mr Farah, 79, discusses care clearly by day. At 2 am he is agitated and disoriented, removes his feeding tube and refuses reinsertion.

DAY

clear

→

2 AM

confused

REASSESS THIS DECISION AT THIS TIME

Capacity is not global. A lucid daytime decision does not answer capacity at 2 am, or vice versa.

1. **Issue:** Is the 2 am refusal capable and binding; if not, who decides?
2. **Law:** presume capacity; assess this decision now. Capable refusal governs. If capacity is absent, check a valid applicable directive, then lawful substitute under the Queensland principles.
3. **Apply:** disorientation and agitation justify assessment, not automatic incapacity. Seek urgent clinical cause, communicate simply and support decision-making.
4. **Action:** do not treat a diagnosis/age as incapacity; escalate, document behaviour and assessment, follow the lawful decision route.

Conclusion: the facts do not yet establish a binding refusal or authorise forced treatment. Capacity must be assessed first.

11 · Drill 2 – Police at the Ward

WE4 · S 142

Facts: police ask whether a named patient was admitted and what injuries he has. They show no warrant or written request.

REQUEST

police ask

AUTHORITY?

consent/care Act/child

NONE

withhold

DECLINE · REFER · RECORD · RECHECK

Request ≠ authority. Do not confirm admission unless a disclosure gate is established.

1. **Issue:** may confidential admission and injury information be disclosed?
2. **Rule:** *Hospital and Health Boards Act 2011* s 142; start with non-disclosure. Test consent, care/treatment, another Act, child protection.
3. **Apply:** none is shown. Police status alone is not a gate on these facts.
4. **Conclude/action:** politely decline; refer to nurse unit manager; record the request. If legal authority later appears, release only what it covers.

TRAP → *Never write "police need the information". Identify the precise legal permission or keep the information confidential.*

12 · Digital Disclosure + Records

C4 · FAST DISTINCTIONS

WEAK ANSWER	CORRECT MOVE
"No name, so safe."	NMBA 3.5 prohibits information/images without written informed consent, even unnamed.
"Private chat."	ICN 1.5: confidentiality in all media.
"Delete it."	Deletion does not undo disclosure; report, contain, document and escalate.
"Record belongs to patient."	Usually employer-owned; patient may have access rights.
"Privacy = confidentiality."	Related, distinct duties; name the one the facts engage.

Implementation line: preserve an accurate professional entry describing what occurred and action taken; maintain data integrity (ICN 2.12).

12b · Unsafe Colleague Drill

C3 · NMBA 1.1/7.1

Facts: a colleague puts a drug vial in her bag.

MOVE	ANSWER
Concern	State observed conduct; do not diagnose beyond facts.
Rule	NMBA 1.1 notification duties; 7.1 unsafe-colleague action.
First	Record what/when/where; protect patients; account for drug.
Next	Manager promptly; assess Ahpra threshold.

Mandatory only if its legal threshold is met; otherwise consider the voluntary route.

13 · Drill 3 – Suspicious Burn

COURSE WORKED EXAMPLE

Facts: a three-year-old has an iron-shaped burn on the back and older healing marks. A parent's explanation does not fit.

BURN SHAPE

odd site

OLD MARKS

past pattern

POOR FIT

story

REASONABLE SUSPICION

threshold, not proof

Build the suspicion. Link observed signs and inconsistent explanation; do not investigate.

1. **Status:** registered nurse = mandatory reporter under *Child Protection Act 1999* s 13E(1).
2. **Threshold:** facts support reasonable suspicion of significant harm from physical abuse.
3. **Protective-parent limb:** if the parent may be involved, there may be no parent both able and willing to protect.
4. **Result:** written report stating the basis. Honest and reasonable reporting is protected by s 197A; identity protection is in s 186.

Do not prove abuse. Record the child's words and clinical observations; use open, age-suited questions; never promise secrecy.

14 · Child Consent Branch

C6 · MATURITY/BEST INTERESTS

FACT PATTERN	ROUTE
Older child understands specific treatment	Assess mature-minor capacity; may consent alone; document understanding.
Young child	Parent decides, limited by child's best interests.
Parent refusal risks lasting harm	Advocate; escalate; consider whether protection threshold is met.
Concern short of mandatory test	Consider non-mandatory s 13A report; explain missing limb.

Parent (s 11): mother, father or person exercising parental responsibility, not a temporary stand-in; for an Aboriginal or Torres Strait Islander child, includes a parent under tradition or custom.

14b · Consent at a Distance

WE7 · CULTURAL SAFETY

Facts: after a video explanation of surgery, a Torres Strait Islander man silently nods and is asked to sign.

HEADING	HIGH-VALUE APPLICATION
Issue	A nod does not show informed understanding.
3.3	Meet language needs; interpreter; confirm understanding.
3.1	Offer chosen family/community involvement and time.

15 · Drill 4 – Missed Handover

WE8 · NEGLIGENCE

Facts: a nurse omits a known penicillin allergy from handover. The next shift administers penicillin; the patient has a severe reaction.

DUTY

patient

BREACH

omission

CAUSE

dose given

HARM

reaction

ALL LINKS → CLAIM

plus NMBA 2.4 response

Carry the facts to the end. The omission enabled administration, which produced the reaction.

1. **Duty:** existing patient; nurse and hospital owe care.
2. **Breach:** reasonable nurse hands over a known allergy; omission falls below that standard.
3. **Causation/harm:** the drug the omission allowed caused the severe reaction.
4. **Conclusion:** all negligence elements are arguable; damages compensate.

Then practise, not just liability: NMBA 2.4 — protect the patient immediately; report; use open disclosure and non-punitive incident management; appropriate team member explains and apologises; support the person; document; review the system.

16 · Same Event, Four Doors

C1/C3 · CONSEQUENCES

IF THE PATIENT...	ANALYSE
is harmed	Civil negligence: duty + breach + harm caused.
is not harmed	No completed negligence claim; workplace/disciplinary reporting may remain.
dies unexpectedly	Add coronial inquiry; criminal possibility depends on facts.
faces ongoing risk	Immediate protection and escalation; regulator's public-protection role.

Never collapse the doors. Civil compensates; criminal punishes; discipline protects the public; coronial process explains death. State who initiates each and its purpose.

TRAP → "Policy followed" is not conclusive. Measure conduct against reasonable care in the circumstances.

16b · Open Disclosure Script

NMBA 2.4 · IMPLEMENTATION

Protect	Address harm; stop repeat exposure.
Report	Identify route; accurate record.
Explain	Appropriate person gives honest account/apology.
Support	Respond; seek advice if unsure.
Learn	Review the system condition.

17 · End-of-Life Classifier

C9 · CATEGORY FIRST

PALLIATIVE

relieve pain

VAD

regulated

ASSIST

provide means

HOMICIDE

end life

LAWFUL CARE

MAY BE CRIMINAL

Classify before concluding. Do not assume a lawful process where the facts do not show one.

ACT	CLASSIFICATION / AUTHORITY
Prescribed pain relief for severe pain	Palliative care; purpose is symptom relief; NMBA 3.6.
Lawful regulated end-of-life process	Voluntary assisted dying; verify process rather than assume.
Leave lethal tablets at request	Providing means: assisted suicide; request alone does not make it lawful.
Actively end another's life	Homicide category; can be a criminal offence.

Conscientious objection: ICN 2.8 permits objection only while respectful, timely care continues. NMBA 4.4: tell person, employer and colleagues; ensure alternative care. Stay, assess pain/distress, escalate and document.

18 · Directive vs Family

WE10 · BLAND

CAPABLE

refuses

→

DIRECTIVE

records

→

INCAPABLE

it governs

CHECK VALIDITY + WHETHER IT APPLIES

Across time. A valid applicable directive carries the adult's own capable refusal forward.

Facts: incapable woman has a valid directive refusing CPR; husband demands resuscitation. **Result:** directive governs after validity/application are checked; husband does not override it. Listen and support; alert team; document and escalate conflict.

Airedale NHS Trust v Bland (1993): common law accepted that withholding or stopping life-sustaining treatment for a patient without capacity may be in that patient's best interests. Queensland's *Powers of Attorney Act 1998* and *Guardianship and Administration Act 2000* permit withdrawal in certain circumstances.

Stopping treatment ≠ stopping care. NMBA 3.6: relieve distress, respect cultural practice, support family and continue comfort care.

DECISION SOURCE	WHEN IT BITES
Capable adult	Own decision first.
Directive	After capacity loss if applicable.
Substitute / Tribunal	If no directive resolves it.
Common law	Bland: best interests.

19 · Liberty, Risk, Restraint

C11 · WEEKS 11-12

LIBERTY

choice/wishes

RISK

harm/safety

LEGAL AUTHORITY?

LIBERTY

choice/wishes

RISK

harm/safety

CHOOSE LEAST RESTRICTIVE LAWFUL OPTION

Three-question test. Authority? capacity? less restrictive alternative?

TEMPTING SHORTCUT	CORRECTION
Mental illness = incapacity	Capacity remains decision- and time-specific.
Dementia = no decisions	Presume capacity; support the adult before substitution.
Safety justifies restraint	NMBA 4.1 bars unauthorised restraint/unnecessary force; identify legal authority.
Attorney may do anything	Bound by principles, adult's interests, views and wishes.
Nurse decides what is safest	Compare lawful, less restrictive options; escalate proper decision.

Wandering resident: tying the person to bed would be unauthorised restraint and may be assault. Decline; try supervision/environmental changes; escalate; document behaviour and options tried.

Financial exploitation: speak privately, record what was seen/heard, escalate under policy and any aged-reporting obligation (NMBA 1.3); ICN 4.2 opposes exploitation.

20 · Rapid Code + Trap Finder

FINAL SCAN

TOPIC FACT	START HERE
Consent / language	NMBA 2.3 · ICN 1.3
Adverse event	NMBA 2.4
Culture / family / interpreter	NMBA 3.1 / 3.2 / 3.3
Confidentiality / image	NMBA 3.5 · ICN 1.5
End-of-life comfort	NMBA 3.6
Boundary / restraint / objection	NMBA 4.1 / 4.4 / 4.5
Unsafe colleague	NMBA 7.1 · ICN 2.10

FINAL CHECK — EVERY ANSWER

Issue and all parties? · ethical clash applied? · exact ICN provision? · law elements + facts? · exact NMBA provision? · options compared? · decision justified? · implementation names who/what/when? · outcome review?

LAST-LINE DISCIPLINE → A conclusion answers the issue. An implementation step says who acts next, what they do, when they do it and what gets documented.