

The Journal of
**Legal Nurse
Consulting**

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LEGAL NURSE CONSULTANTS**

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The purpose of The Journal is to promote legal nurse consulting within the medical-legal community; to provide both novice and experienced legal nurse consultants (LNCs) with a quality professional publication; and to teach and inform LNCs about clinical practice, current legal issues, and professional development.

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LEGAL NURSE CONSULTING

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Feature Articles

Traumatic Brain Injury: Improving the Patient's Outcome Demands Timely and Accurate Diagnosis 3

Cindy L. Iavagnilio, RN, MSN, CRNA

Traumatic brain injury (TBI) is a major public health concern contributing to a substantial number of deaths and cases of permanent disability annually in the United States. Most TBIs are the result of blunt trauma that occurs with accidents involving transportation vehicles, falls, firearms, assaults, and sport activities. Research has advanced considerably in the last decade leading to the development of clinical practice guidelines, tools, and related documents. Using the evidence and relevant practice guidelines for case analysis, this article presents a case history that clearly demonstrates how failure to follow evidence-based guidelines can significantly affect a patient's outcome.

Assisting the Drug Addicted Nurse: Information for the Legal Nurse Consultant..... 11

Marilyn McHugh, MSN, JD, Karen Papastrat, MSN, and Kathleen C. Ashton, PhD, APRN, BC

This article provides a scenario involving a nurse who has been confronted by his employer for diverting controlled substances. The scenario is a compilation of the authors' collective experiences spanning more than 25 years. This article explores the civil and criminal law issues that potentially arise from the diversion of controlled substances in the workplace, as well as the detection and treatment of substance abuse among nurses, and the recovery process and programs available.

Plastic Surgery: Plastic Surgeon and Cosmetic Dermatologist: Complications and Liability

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Nancy LaGasse, RN, MS, CDMS, CCM, CLCP, LHRM, ARM, MSCC, QRP

The purpose of this article is to familiarize the legal nurse consultant with the evolution of cosmetic plastic surgery performed by the plastic surgeon and dermatologist. Information has been included regarding the differences and similarities in the physicians' education, training and practices, practice complications, and prevention and associated regulations, risks, and liability.

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Building Better Workplaces Using Confident Voices: *The Nurses' Guide to Improving Communication and Creating Positive Workplaces*

Kathleen Ashton, PhD, ARPN, BC

The Importance of the Knowledge Base



Dear Colleagues,

This *Journal* issue is chocked full of excellent information that all readers will enjoy. Pertinent clinical information is presented on several topics accompanied by information important to legal nurse consulting.

In this issue of the *Journal*, Cindy Iavagnilio provides an excellent discussion of traumatic brain injury. She first presents important epidemiologic data that describes the characterization of TBI. A case study is presented and analyzed in detail within a framework describing important guidelines. This is followed by an examination of standards of care that are relevant to practice and the impact related to deviation from the standard of care. What is vitally important and keenly emphasized throughout the article is the necessity of early recognition of the severity and progression of TBI. The LNC will find this information critically helpful when developing a case investigation.

Using a case scenario approach, important information is presented by Marilyn McHugh, Karen Papastrat, and Kathleen Ashton on drug addiction and nursing. Knowing state board of nursing regulations is essential in supporting efforts to help nurses who find themselves addicted get treatment. The authors describe the importance of emphasizing support and recovery rather than punitive approaches to deal with the issue.

Nancy LaGasse discusses an important topic of plastic surgery. She describes differences between the plastic surgeon and cosmetic dermatologist and the types of complications that can occur. Levels of surgery are presented along with common causes of litigation relative to plastic surgery. It is important that patients be well informed when entertaining plastic surgery.

In the *Journal* special departments, Kara DiCecco provides a wealth of information on Post-traumatic Stress Disorder. Diagnostic indicators are discussed as well as treatment approaches including education, pharmacotherapy, and psychotherapy. Several references and resources are provided for the practitioner to access to learn more about the management of this disorder.

Holly Hillman and Eileen Watson describe the impact of electronic medical records in the Professional Practice, Trends, and Issues Department. Advantages and limitations are presented along with a discussion of what the LNC needs to be aware of in case review. In Questions and Answers, Judy Bulau examines negligence and error in judgment and describes the difference in these concepts. Liability is discussed as it relates to these elements, even though this continues to be a source of some debate.

Lastly, the book review is presented by Kathleen Ashton on *Building Better Workforces Using Confident Voices*. This is an important reading for all practitioners. The book discusses positive work environments and how these types of environments can support employees. This is contrasted to work environments that can create barriers to being productive and a contributing workforce member. This discussion will be beneficial for all of us.

I hope each of you has had a great summer and had some time to relax and enjoy the things you like to do.

Bonnie Rogers
Editor-in-Chief, *The Journal of Legal Nurse Consulting*

Traumatic Brain Injury: Improving the Patient's Outcome Demands Timely and Accurate Diagnosis

By Cindy L. Iavagnilio, RN, MSN, CRNA

KEY WORDS

Traumatic brain injury, clinical practice guidelines, malpractice/negligence

Traumatic brain injury (TBI) is a major public health concern contributing to a substantial number of deaths and cases of permanent disability annually in the United States. TBI is caused by a bump, blow, or jolt to the head that temporarily or permanently disrupts the normal functioning of the brain. Most TBIs are the result of blunt trauma that occurs with accidents involving transportation vehicles, falls, firearms, assaults, and sport activities. Learning to recognize the signs and symptoms of a serious or neurologically deteriorating head injury and implementing appropriate care can make the difference in saving a patient's life. Research has advanced considerably in the last decade focusing on the acute treatment and management of a TBI patient. This research has led to the development of clinical practice guidelines, tools, and related documents. Evidence suggests the routine use of these practice guidelines could result in a significant reduction in the number of deaths, disabilities, and cost to society. Using the evidence and relevant practice guidelines for case analysis, this article presents a case history that clearly demonstrates how failure to follow evidence-based guidelines can significantly affect a patient's outcome.

Introduction

Traumatic brain injury (TBI) is a life-threatening emergency that requires early and continuous assessment to prevent mortality and morbidity. Early detection and treatment is essential and can significantly affect patient outcomes or make the difference in saving someone's life. Practice guidelines developed for the initial management of TBI's have dramatically improved patient outcomes and will be introduced in this article.

Stiver & Manley (2008) define TBI as a physical injury of brain tissue that temporarily or permanently impairs brain function. Loss of consciousness may or may not occur. The National Institute of Neurological Disorders and Stroke (NINDS, 2011) defines TBI as damage or injury to the brain acquired by sudden trauma resulting in an open (penetrating) or a closed head injury. Penetrating injuries occur when an object pierces the skull and enters brain tissue. A closed injury occurs when the head suddenly and violently hits an object but the object does not necessarily break through the skull (NINDS, 2011). Closed head injuries may involve skull fractures but if present, suggests involvement of a significant force (Lettieri, 2006). The presence of a skull fracture with impairment of consciousness significantly increases the likelihood of intracranial pathology (Tolias & Sgouros, 2008).

The Brain Injury Association of America (BIAA, 2011), the voice for brain injury, asserts that a TBI should not be thought of as an event or outcome, but the beginning of a life-long disease process. It affects multiple organ systems and is both disease causative and disease accelerative (Masel, 2009). In 2011, BIAA officially adopted the following definition:

TBI is defined as an alteration in brain function, or other evidence of brain pathology, caused by an external force. Traumatic brain injury is an insult to the brain that may produce a diminished or altered state of consciousness, which results in an impairment of cognitive abilities or physical functioning. It can also result in the disturbance of behavioral or emotional functioning. These impairments may be either temporary or permanent and cause partial or total functional disability or psychosocial maladjustment (BIAA FAQ).

TBI Statistics

According to the Centers for Disease Control and Prevention (CDC, 2010), TBI's have contributed to a substantial number of deaths and cases of permanent disability. The statistics are staggering, but crucial in demonstrating the significance of this nationwide public health problem. The CDC estimates about 1.7 million cases of TBI occur in the U.S. every year. Of these cases, 275,000 are severe enough to require hospitalization, 52,000 cases result in death, and almost twice that number suffer permanent neurological deficits. An estimated 5.3 million people in the U.S. are presently disabled due to the multitude of ongoing and developing medical conditions related to a TBI (Zaloshnja, Miller, Langlois, & Selassie, 2005).

Falls are the leading cause of TBI in adults over 75 years of age and account for the majority of the TBI-related hospitalizations (NINDS, 2011). For adults under the age of 75 however, more than 50% are a result of crashes involving cars, motorcycles, bicycles, and are the leading cause of TBI-related deaths, with the highest age group being 20-24 years (LeMone, Burke, & Gerene, 2011). Violence (e.g., firearms, assaults, child abuse) and sport activities are additional causes

(Olson, 2010). An estimated \$60 billion is spent annually on brain injury treatment and rehabilitation (Bay, 2011). The major cost not coming from the initial injury but from the damage that evolves over the next hours to days that goes unnoticed in the healthcare setting.

Treatment of TBI

Effective treatment and management of the TBI patient requires an understanding of the pathophysiology of the mechanisms of injury that occur with trauma to brain tissue. At the time of impact, the primary injury to the brain has occurred and is irreversible. This primary injury sets in motion a surge of cellular events (secondary injury) that can worsen neurological injury and patient outcome (Littlejohns & Bader, 2001). Secondary injury is the progression or response of the brain to the initial injury such as edema, bleeding, or increased intracranial pressure (IICP) which in turn affects perfusion and oxygenation of brain cells (LeMone, Burke, & Gerene, 2011). Additional causes of intracranial insults include hemorrhage, ischemia, hypoxia, and infection (Rangel-Castilla, Gasco, Hanbali, & Salinas, 2009).

Optimal treatment of patients with TBI begins with the 911 call. The prehospital care and management is crucial in maximizing the possibility of a favorable patient outcome (Tang & Lobel, 2009). If treatment is delayed until the patient reaches the emergency room, the damage from the primary injury has occurred and the processes of secondary injury have been set in motion (Stiver & Manley, 2008). Significant neurological damage can occur between the time of injury and CT scanning. The goals of the emergency response team are to stabilize the airway, control any bleeding, treat damage caused by the primary injury, prevent or minimize secondary injury, while facilitating rapid transport to an appropriate facility capable of providing neurocritical care. Full immobilization of the cervical spine should be maintained until appropriate examination can be completed (Minardi & Crocco, 2009).

Upon arrival to the hospital a rapid, focused neurologic evaluation is part of the initial assessment which includes components of the Glasgow Coma Scale (GCS), and pupillary light reaction (Minardi & Crocco, 2009). The GCS, the mainstay for rapid neurologic assessment, was developed to assess patients with head trauma and provides an objective measure of the severity of unresponsiveness and brain injury. The scale is a standardized, 15-point test that assigns points based on responses to stimuli (eye opening, best verbal response, and best motor response). A score of 14-15 indicates mild injury, a score of 9-13 indicates moderate injury, and a score of 8 or less indicates severe injury (Pangilinan, Kelly, & Joseph, 2008; Stiver & Manley, 2008).

Initial and repeated assessment is essential for early detection of often subtle neurological changes (Patterson, Bloom, Coyle, Mouradjian, & Wilensky, 2005). Neurologic findings, mental status (as measured with the GCS and pupillary reaction), blood pressure (BP), pulse, and temperature should be recorded frequently for several

hours because any deterioration demands prompt attention (Pangilinan, Kelly, & Joseph, 2008).

Patient Outcomes

The outcomes of TBI patients can vary depending on the mechanism of injury, location of injury, and the extent of the brain affected (LeMone, Burke, & Gerene, 2011). While education and prevention may be the only way to avoid the initial injury to the brain, early detection, and aggressive treatment aimed at minimization of any secondary insults have proven to be a critical factor in affecting patient outcomes (Minardi & Crocco, 2009). A failure to diagnose in a timely manner can result in a condition being allowed to escalate causing a reduction in the treatment options for a patient.

Diagnostic Errors and the Duty of Medical Professionals

Every doctor, nurse, dentist, and even hospital is bound by a legal duty to perform their jobs according to an accepted "standard of care" which most healthcare professionals do at every turn. However, if a healthcare provider's deviation from the accepted standards of practice leads to an injury or complications to the patient, he or she can be held liable for medical negligence or medical malpractice (Michon, 2011b). If a doctor or other medical provider fails to diagnose a medical condition, illness, or injury that should have been detected based on the patient's symptoms, the provider can be held liable for medical negligence. With that being said, a mistake in diagnosis by itself does not imply negligence because even the most skillful physicians can, and do, make diagnostic errors even when exercising reasonable care (Michon, 2011a).

Delayed or late diagnosis is one of the more common diagnostic errors and was found to be the most frequently cited allegations (43%) in emergency department (ED) medical malpractice claims (Bisaillon, 1997). If a doctor eventually makes the correct diagnosis after a significant delay, to determine negligence it is necessary to look at the "differential diagnosis" method used in making treatment determinations (Michon, 2011a). Differential diagnosis is a systematic method used by doctors to identify a disease or condition in a patient. The physician tests the strength of each diagnosis by making further medical observations, investigating symptoms and medical history, ordering tests, or referring the patient to specialists. If the doctor included the correct diagnosis on the differential diagnosis list, but failed to perform appropriate tests or investigate the viability of the diagnosis, resulting in injury to the patient, the physician can be found negligent (Michon, 2011b).

The following case history illustrates this very act or omission which resulted in permanent injury to the plaintiff. It includes the case analysis and medical malpractice allegations filed on behalf of the plaintiff against the treating physician, nursing staff, and hospital.

Case History

Prehospital Management

John Smith, a 32 year old male was struck by a car while riding his motorcycle and was transferred to a nearby small community hospital. The ambulance transfer form reported Mr. Smith was asking repetitive questions, had no memory of the accident, but appeared to become more lucid enroute to the hospital. He displayed good range of motion (ROM) and strength, and was assigned a GCS score of 14/15.

Mr. Smith arrived at the ED at 1:16 p.m. The triage assessment documented complaints of pain in the back of his head, left hip, left arm, and left knee. He was alert and responded to questions appropriately. Dr. West assessed Mr. Smith upon arrival to the ED and described him as alert. His assessment of cranial nerves, sensation, and motor assessments were normal, and the pupils equal, round, and reactive to light. Diagnoses following examination, x-rays, and CT scan included a basilar skull fracture, a non-displaced odontoid fracture, and multiple contusions and abrasions.

Following a neurosurgical consult with Dr. Roberts, arrangements were made for the transfer of Mr. Smith by ambulance to the Area Regional Trauma Center (2:56 p.m.). The administrations of Dilaudid 1mg IV (via saline lock) at 2:40 p.m. and Phenergan 12.5 mg IV at 3:45 p.m. were documented. The patient transfer summary form listed the patient's condition as "stable" and a copy of the x-rays, laboratory reports, and ED record accompanied the patient. Time of departure to the trauma center was 3:50 p.m.

Hospital Management

In Dr. Roberts' initial history and physical examination, it was reported the only history available was that Mr. Smith was hit by a car while on a motorcycle, had an apparent episode of lost consciousness, but was able to talk to the physicians and nurses in the ED. Dr. Roberts further reported, "Patient is very lethargic but does arouse to his name when called several times loudly. He will answer yes or no to questions, but is still somewhat slow in his responses, and rapidly falls sleep. He localizes pain and is able to grasp the suction device with an attempted emesis." Dr. Roberts notes a contusion over the nose and soft tissue swelling in the left parietal and occipital areas; pupils are 2 mm and sluggishly reactive; patient moves all four extremities well.

Dr. Roberts reviewed the CT scan and x-rays that accompanied Mr. Smith, but disagreed with Dr. West's diagnosis of an odontoid and basilar skull fracture. His opinion was the odontoid fracture was a congenital cleft and he was unable to identify a basilar skull fracture "as there was a significant amount of rotation of the patient." Dr. Roberts instead diagnosed Mr. Smith with a concussive head injury, multiple abrasions and contusions, and a possible basilar skull fracture. He admitted the patient for observation to a medical-surgical floor with orders for vital signs every four hours, nothing by mouth, foley catheter as needed, bed

rest, head of bed at 30°, Philadelphia collar, IV @ 75cc/hr, Dilaudid as needed for pain, and Reglan as needed for nausea.

In-Hospital Observation

Mr. Smith was admitted to the medical-surgical unit at 6:00 p.m. where he remained until around 1:00 a.m. The following details document care he received.

- **6:00 p.m.** Nurse James documented that Mr. Smith was admitted to the unit and recorded "Pt. sleeping, heavily medicated as reported by hospital and ambulance so patient will not arouse enough to do neurological checks." GCS was 9/15, pupils were equal, 2mm, and sluggish. Mobility was described as "fatigued and weak," behavior "sedated," and respiratory status "WNL" (within normal limits). No vital signs were charted.
- **8:00 p.m.** Nurse James documented "patient has moderate movement and strength when agitated from sternal rub otherwise weak in movement and strength." The GCS remained at 9/15, pupils equal, 3mm, and sluggish, "unresponsive" behavior, and "incontinent." BP was 122/62, heart rate 60, respirations 20, oxygenation saturation 96% on room air, and temperature 97.3°F. This is the first assessment of vital signs recorded on the medical record.
- **10:00 p.m.** Two hours later, the BP remained at 122/62, heart rate 60, respirations 20, with an increase in temperature to 101.6°F. There was no GCS documented.
- **10:20 p.m.** The patient's record reveal telephone orders were obtained per Dr. Roberts for an immediate portable chest x-ray, continuous pulse oximeter, oxygen at 2 liters per nasal cannula, Rocephin 1gram now and every day, and Tylenol grains 10 rectally every 4 hours as needed. The radiology report stated decreased oxygen saturation as reason for the procedure. No documentation regarding this telephone conversation or explanation for new orders was found in the medical record.
- **11:30 p.m.** Nurse James documented "patient weaker with movement and strength of extremities even with localized pain." GCS remained 9/15, but a noted change in pupil assessment of "unequal (left 4mm/right 3mm) and non-reactive". The respirations were described as "labored with use of accessory muscles." Dr. Roberts was notified of change in condition.
- **12:45 a.m.** Dr. Roberts returned to the hospital to talk to Mr. Smith's family and wrote orders for his transfer to the intensive care unit (ICU) which included, vital signs and neurological checks every hour, nasal trumpet/oral airway, Mannitol, Decadron, and a "Head CT without contrast in AM (morning) for "head injury." No documentation in the physician's progress note was made explaining the orders for the immediate chest x-ray, oxygen, Rocephin, or Mr. Smith's transfer to the ICU.
- **1:00 a.m.** The next documented assessment is noted on the 24-hour critical care flow sheet. GCS 8/15, pupils remained unequal (left 4mm/right 3mm), BP of 140/63, pulse of 88, respirations 32, and temperature of 100.9

F. Mr. Smith had an emesis at 2:00 a.m. after which his oxygen saturations began to decline (to 94%) on 2 liters of O₂. A nasal trumpet was inserted but oxygen saturations remained at 94%; he continued “using accessory muscles” to breath with respiratory rates as high as 36. At 4:00 a.m., pupillary assessment changed to unequal (left 5mm/right 3mm). The GCS remained at 8/15 and he continued to show signs of respiratory distress. He was medicated twice during the night for “vomiting” and once “for restlessness.” By 8:15 a.m., Mr. Smith’s cardiac rhythm displayed premature ventricular contractions (PVC’s), he was not following commands, and had questionable decerbrate posturing.

- **9:00 a.m.** Mr. Smith was sent for his scheduled CT scan where a “left sided posterior temporoparietal lobe epidural hematoma (8 cm in length) causing significant midline shift and edema” was discovered. Dr. Roberts was immediately notified of the results.
- **10:30 a.m.** Mr. Smith was taken to the operating room for evacuation of the epidural hematoma.

Discussion

Role of the LNC

The research on the effectiveness of implementing clinical practice guidelines for TBI patients continues to mount. The implementation of evidence-based guidelines for the acute treatment and management of TBI patients in trauma centers has demonstrated improved outcomes and suggests a potential for massive savings of healthcare costs (Tang & Lobel, 2009; Littlejohns & Bader, 2001; Minardi & Crocco, 2009). Guidelines can also serve as a valuable guide for the LNC when establishing the standards of care for treatment of patients with a TBI. The National Guideline Clearinghouse (NGC), an initiative of the Agency for Healthcare Research and Quality (AHRQ), provides evidence-based clinical practice guidelines and recommendations for “best practice in the diagnosis, acute management, and rehabilitation of children, young people, and adults after traumatic brain injury.” The guidelines set forth in *Traumatic Brain Injury: Diagnosis, Acute Management and Rehabilitation* (NGC, 2006) were used as a resource during review and analysis of this case involving a delayed diagnosis of a deteriorating traumatic brain injury. A summary of these guidelines is shown in Table 1: Pre-Hospital Assessment, Acute Management, and Referral for Patients with Traumatic Brain Injury; Table 2: Acute Phase of Traumatic Brain Injury Care; and Table 3: Hospital Care for the Patient with Traumatic Brain Injury.

Case Analysis

Pre-Hospital Assessment – Acute

According to the NGC guidelines for initial assessment and treatment (Table 1), Mr. Smith was appropriately assessed, monitored, and transported to the closest ED for stabilization

by paramedics trained in the Advanced Trauma Life Support. Assessment and care was well documented.

Emergency Department Assessment

Upon arrival to the ED, the triage nurse and Dr. West immediately evaluated Mr. Smith. At that time, he was alert, and his neurological exam was essentially normal. The primary investigation for TBI patients is CT imaging of the head as determined by the presence of risk factors (Table 2). Mr. Smith’s high-risk mechanism of injury, loss of consciousness, and GCS score less than 15 warranted a more thorough neurological evaluation with CT scanning. Meeting several criteria indicating the need for hospital admission, Dr. West appropriately consulted and arranged for the transfer of Mr. Smith’s care to a hospital with a neurosurgical unit.

In-Hospital Observation of People with Traumatic Brain Injury

The NGC guidelines for in-hospital care appear to provide reasonable and appropriate suggestions for the observation, assessment, management, and treatment necessary to provide safe care (Table 3). They describe standards of care that would apply to any patient with a TBI. Unfortunately, Dr. Roberts failed to order adequate type or frequency of neurological assessments. In addition, he failed to recognize the urgent need for reappraisal of Mr. Smith’s condition. As the care Mr. Smith appeared to receive deteriorated, so did his neurological status. As in Mr. Smith’s case, the evidence supports the vigilant assessment and early detection and treatment of any neurological deterioration can significantly affect patient outcomes. The failure to diagnose and treat in a timely manner the secondary injuries that were occurring, resulted in avoidable permanent impairments.

Dr. Roberts failed to perform an adequate initial assessment of Mr. Smith. It is imperative to determine a patient’s initial neurological status to provide a baseline against which to measure any changes that occur in order to effectively manage the patient. Dr. Roberts’ disagreement with the interpretations of the initial CT scan and x-rays would seem to have warranted validation or a repeat scan and x-ray to provide better visualization. Additionally, the assessment data of significant lethargy, slow responses, inability to obtain any history from the patient, and the attempted emesis, suggest a neurological deterioration from the previous neurological status reported in the ED warranting further investigation. Mr. Smith’s GCS had significantly dropped from the initial GCS of 14/15 documented by the paramedics. Furthermore, Dr. Roberts failed to document explanations for the obvious diminished neurological status.

Dr. Roberts failed to order adequate assessments for Mr. Smith. The reported minimum documented neurological observations as noted in the NGC guidelines (Table 1) should be: GCS, pupil size and reactivity, limb movement assessments, and vital signs performed and recorded every 15 minutes or more until the person has achieved a GCS score of 15/15 on two consecutive occasions.

Table 1: Pre-Hospital Assessment, Acute Management, and Referral to Hospital for Patients with Traumatic Brain Injury

PRE-HOSPITAL ASSESSMENT – ACUTE
<ul style="list-style-type: none"> A person with a suspected TBI should initially be assessed and managed according to the principles and standard practice as embodied in the Advanced Trauma Life Support.
<ul style="list-style-type: none"> Individuals should be transported directly to a trauma center or to the closest facility for stabilization depending on severity of injuries.
<ul style="list-style-type: none"> GCS, any loss of, or alteration in, consciousness, post-traumatic amnesia, and neurological signs should be assessed and recorded.
<ul style="list-style-type: none"> It is expected that all acute hospitals accepting people who have sustained a suspected TBI should have the resources to expeditiously assess and intervene to optimize outcome.

Source: National Guideline Clearinghouse (NGC). (2006). Guideline summary: *Traumatic brain injury: Diagnosis, acute management and rehabilitation: evidence-based best practice guideline summary*. In: National Guideline Clearinghouse (NGC). Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); Retrieved from: <http://www.guideline.gov/content.aspx?id=10281&search=traumatic+brain+injury>

Table 2: Acute Phase of Traumatic Brain Injury Care

EMERGENCY DEPARTMENT ASSESSMENT
<ul style="list-style-type: none"> Assessment should focus on the identification of actual or potential hypotension and/or hypoxia, clinically significant brain injuries and appropriate referral for imaging. Anyone presenting to an Emergency Department with impaired consciousness (GCS score of less than 15) should be assessed immediately by a triage nurse and assessed within 10 minutes by a health care practitioner with experience in the assessment of such people. Imaging (for those meeting selection criteria) should be done early, in preference to admission and observation for neurological deterioration.
PRIMARY INVESTIGATION FOR PEOPLE WITH A SUSPECTED TRAUMATIC BRAIN INJURY
<p>The primary investigation of choice for the detection of clinically significant acute complications of traumatic brain injury is CT imaging of the head. CT scans should be immediately requested with any one of the following risk factors:</p> <ul style="list-style-type: none"> Any deterioration in condition A GCS score of 13 or 14 two hours after the injury A suspected open or depressed skull fracture Focal neurological deficit More than one episode of vomiting High-risk mechanism of injury (a pedestrian struck by a motor vehicle, an occupant ejected from a motor vehicle, or a fall from a height of greater than one meter or five stairs) <p>All CT scans of the head should be reviewed by a clinician who has been deemed competent to review such images.</p>
TRANSFER FROM SECONDARY TO TERTIARY CARE SETTINGS
<p>There should be designated consultants in both the referring hospital and the tertiary care facility (generally a neurosurgical unit) with responsibility for the transfer and receipt of patient's with suspected traumatic brain injury.</p>

Source: National Guideline Clearinghouse (NGC). (2006). Guideline summary: *Traumatic brain injury: Diagnosis, acute management and rehabilitation: evidence-based best practice guideline summary*. In: National Guideline Clearinghouse (NGC). Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); Retrieved from: <http://www.guideline.gov/content.aspx?id=10281&search=traumatic+brain+injury>

Table 3: Hospital Care for the Patient with Traumatic Brain Injury

INDICATIONS FOR HOSPITAL ADMISSION
<ul style="list-style-type: none"> A deteriorating GCS score Clinically significant abnormalities on imaging A GCS score of less than 15 after imaging Focal or abnormal neurological signs Skull fracture A major force of injury Continuing signs of concern to the clinician (e.g., vomiting, severe headaches, amnesia)
IN-HOSPITAL OBSERVATION OF PATIENTS WITH TRAUMATIC BRAIN INJURY
Observation: General
<ul style="list-style-type: none"> In-hospital observation, including all ED observation of a person with TBI should be conducted only by health care practitioners competent in the assessment of TBI.
Type and Frequency of Observation
<p>Minimum documented neurological observations should be:</p> <ul style="list-style-type: none"> GCS Pupil size and reactivity Limb movements Respiratory rate Heart rate Blood pressure Temperature <p>Observations should be performed and recorded every 15 minutes, or more frequently in some cases, until the person has achieved a GCS score of 15 on two consecutive occasions. For people with an initial GCS score of 15, or who have returned to a GCS of 15 on two consecutive observations, the minimum frequency of observations following the initial assessment should be:</p> <ul style="list-style-type: none"> Half hourly for the first two hours, then Hourly for four hours, then Every two hours thereafter
NEED FOR REASSESSMENT/OTHER ACTION
<p>An urgent reappraisal should be done by the supervising doctor if any of the following signs of neurological deterioration occur:</p> <ul style="list-style-type: none"> Development of agitation or abnormal behavior A sustained (i.e., ≥30 minutes) drop of one point in the GCS score Any drop of more than two points in the GCS score Development of severe/increasing headache or persisting vomiting New or evolving neurological symptoms or signs <p>An immediate CT scan should be considered if any of the above signs of neurological deterioration occur</p>

Source: National Guideline Clearinghouse (NGC). (2006). Guideline summary: *Traumatic brain injury: Diagnosis, acute management and rehabilitation: evidence-based best practice guideline summary*. In: National Guideline Clearinghouse (NGC). Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); Retrieved from: <http://www.guideline.gov/content.aspx?id=10281&search=traumatic+brain+injury>

Dr. Roberts neglected to arrange for appropriate investigation and intervention. It is evident by the orders written that Dr. Roberts was treating Mr. Smith for increased intracranial pressure and an obtunded respiratory status but neglected to arrange for appropriate investigation to explain these symptoms. According to Lettieri (2006), the “textbook” presentation of an epidural hematoma is a brief loss of consciousness followed by a “lucid interval” then progressive neurological deterioration, sometimes into coma. If an epidural hematoma is left untreated, it will lead to decerebrate rigidity, increased blood pressure, respiratory distress, and death. In this case, the documentation reports the continued deterioration in the patient’s neurological status and undoubtedly warrants investigation for explanation. The clinical guidelines repeatedly recommend reappraisal by the physician if there is any evidence of clinical worsening. Mr. Smith was exhibiting several of the signs of neurological deterioration requiring an urgent reappraisal and immediate CT scan.

Departure from Nursing Standards of Care (SOC)

The American Nurses Association (ANA) standards of practice can provide a guideline for the LNC when reviewing a case involving nursing negligence. These standards are voluntary standards, developed and implemented by the nursing profession (ANA, 2004). All nurses are responsible for adhering to the standards of care for their area of practice and the nursing responsibilities detailed in the policies, procedures, and job description provided by the hospital or healthcare agency where they practice. A standard of care, what a reasonably prudent person would or would not have done under similar circumstances, can determine if a breach of duty has occurred. The four elements that must be established for proof of negligence are duty, breach of duty, causation, and damages (Taylor, Lillis, Lemone, & Lynn, 2008).

Specialty nursing associations have also developed standards of practice specific to their area of practice. The American Association of Critical-Care Nurses (AACN) scope and standards of practice for acute and critical care nursing practice provides guidelines useful for the review of the care of Mr. Smith (Bell, 2008), as shown here.

Standard I: Assessment

The nurse caring for acute and critically ill patients collects relevant patient health data. The priority of data collection activities is driven by the patient’s immediate condition and/or anticipated needs. Appropriate assessment techniques and instruments are used. Data collection is systematic, ongoing, and documented in a retrievable form.

Departures from standard:

- Failure to perform a complete admission assessment
- Significant omissions in recorded database
- Failure to note and execute the need for more frequent nursing assessments

Standard of Care V: Implementation

The nurse caring for acute and critically ill patients implements interventions identified in the plan of care. Interventions are delivered in a manner that minimizes complications and life-threatening situations and documented in a retrievable manner.

Departures from standard:

- Failure to communicate including failure to notify the physician in a timely manner when the patient’s condition warrants medical intervention
- Failure to document the patient’s progress and response to treatment, pertinent nursing assessment information and information on telephone conversations with the physician including time, content of communication, and actions taken

Standard of Care VI: Evaluation

The nurse caring for acute and critically ill patients evaluates the patient’s progress toward attaining expected outcomes. Evaluation is systematic, ongoing, and criterion-based. Evaluation occurs within an appropriate time frame after interventions are initiated, and the patient’s responses to interventions are documented.

Departures from standard:

- Failure to recognize and to report significant changes in the patient’s condition
- Failure to adequately assess and monitor the patient’s ongoing progress, and interpret the patient’s signs and symptoms or recognize significant changes in a patient’s condition and communicate them promptly to the appropriate healthcare provide.

Nurse James recorded the “patient sleeping heavily medicated as reported by hospital and ambulance so patient will not arouse enough to do neuro checks.” There was no evidence of initial assessment of vital signs in the medical record. The first documented set of vital signs was not until 8:00 p.m. According to the medical records, vital signs had not been assessed since the patient arrived in the ED at 1:25 p.m. The minimum standard of care is to assess vital signs upon admission to the hospital and/or medical unit to provide baseline data, which directs the proper care of a patient. A “heavily medicated patient” as reported would warrant a more thorough assessment and is not an acceptable reason to forgo neurological or vital sign assessments.

The minimum acceptable documented neurological observations are GCS, pupil size and reactivity, limb movements, respiratory rate, heart rate, blood pressure, temperature, and oxygen saturation. Nursing staff should carry out a neurological assessment upon arrival to the unit and compare it with that obtained in the ED. Any discrepancy between assessments, suggesting deterioration or other concerns about the patient’s condition should be discussed immediately with the relevant medical staff. Although Nurse James finally notified Dr. Roberts of Mr. Smith’s condition, the care documented in the medical record clearly fell below the acceptable standard. A nurse involved in the care of a

head injured patient should be competent in neurological and vital sign assessments and be concerned about the risk of deterioration in neurological status. "Unable to arouse to perform neuro checks" is unacceptable. The nurses failed to recognize Mr. Smith's signs and symptoms of deterioration, failed to keep him under close observation, and failed to promptly report his condition to the physician. This nursing care fails to meet the standard of care for assessment of a patient with serious head injuries.

Allegations of Negligence

The failure to accurately, proficiently, and timely assess, and treat Mr. Smith's serious head injury has left him with permanent physical and cognitive impairments. He suffers from permanent brain damage, retrograde amnesia, is blind in one eye with impaired vision in the other eye, and has also undergone sinus surgery and still suffers from loss of smell. The following allegations of malpractice were filed against Dr. Roberts, the nurses involved in Mr. Smith's care, and the hospital. The plaintiff alleged the failure to provide the standard of care in the assessment, documentation, and treatment resulting in permanent brain damage and disability. The delay in diagnosis of his deteriorating status resulted in his permanent impairment. The case went to a medical review panel that determined Dr. Roberts and the staff nurses (hospital) were negligent. The claim was settled out of court for the full amount of damages allowed in the state.

Conclusion

Traumatic brain injury (TBI) is a complex disease, with a variety of precipitating causes that affect the location and severity of injury and influence the course of recovery. The outcomes of TBI patients can vary depending on the area and the extent of the brain affected. Prevention and education may possibly be the only way to influence the patient outcome of the primary injury sustained with a TBI. However, if preventing or minimizing secondary injury to the brain can improve patient outcomes it may be the first step in decreasing the incidences of morbidity and mortality associated with TBI. There lies the significance of assuring a timely and accurate diagnosis of a TBI. A failure to diagnose in a timely manner can result in a condition being allowed to escalate causing a reduction in the treatment options for a patient, and ultimately permanent impairments.

Evidence-based guidelines such as those provided by the NGC can be a valuable resource in the management of clinical conditions. Health care professionals need to be aware of these scientific resources that can help guide practice to achieve successful patient outcomes.

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Assisting the Drug Addicted Nurse: Information for the Legal Nurse Consultant

By Marilyn McHugh, MSN, JD, Karen Papastrat, MSN, and Kathleen C. Ashton, PhD, APRN, BC

KEY WORDS

Impaired nurse, drug diversion, addiction recovery, legal advice

This article provides a scenario involving a nurse who has been confronted by his employer for diverting controlled substances. The scenario is a compilation of the authors' collective experiences spanning more than 25 years. This article explores the civil and criminal law issues that potentially arise from the diversion of controlled substances in the workplace, as well as the detection and treatment of substance abuse among nurses, and the recovery process and programs available.

Nurse J., a highly experienced registered nurse, arrives at the law office for a scheduled appointment regarding his current employment and licensure issues with the State Board of Nursing. Nurse J. is employed as a medical-surgical nurse in a large, inner city hospital. Lately, Nurse J. has experienced extreme financial pressure due to increasing medical costs associated with the care of his special needs child. Nurse J. has recently worked considerable overtime that has aggravated the chronic arthritic pain in his lower back. Time constraints have prevented him from going to the gym or physical therapy that had been very helpful in ameliorating his back pain in the past.

For the past month, as a way of self-medicating his back pain, Nurse J. has been diverting and self-administering Dilaudid, a controlled substance prescribed for his assigned patients. Diversion is the redirecting of drugs from legitimate use into illicit channels (Hrobak, 2003). The hospital attorney told Nurse J. that diverting a controlled substance is a theft offense and felony offense that violates both Federal and State Controlled Substances Acts, punishable by fines and imprisonment in accordance with the Comprehensive Drug Abuse Prevention and Control Act of 1970. A few days ago, Nurse J. was summoned to meet with the nurse manager, director of human resources, and a pharmacist where he was confronted with the following information. The medical-surgical unit's Pyxis records revealed that Nurse J. consistently signed out more narcotics than any other staff member on that unit. Unit Pyxis records showed that Nurse J. frequently signed out larger doses of medication than were prescribed, even when the precise dose ordered was available. Nurse J.'s documentation of administration of narcotics frequently lacked chronological sequence and there was excessive reporting that narcotic containers had been broken. In multiple instances, Nurse J. failed to follow the hospital's controlled substance policy and did not obtain a co-signature on any documented breakage.

Nurse J. states that the hospital attorney informed the local prosecutor about his drug diversions. The hospital attorney gave Nurse J. some general information regarding the multiple mandatory and non-mandatory legal actions that could be taken by the hospital regarding his diversion

of narcotics. Mandatory actions include reporting the drug diversions to the local prosecutor and to the State Board of Nursing. There are variations in reporting requirements among the states so in each instance the State Board of Nursing should be contacted to determine that state's requirements. The hospital is mandated to report drug diversions to the local criminal authorities. The prosecutor's office then has discretion regarding the institution of criminal charges against the offender. In cases where the individual admits drug addiction combined with evidence that the diversion was for self-use rather than profit, usually a non-criminal disposition is the result, provided that the individual attends any required rehabilitation program. Non-mandatory legal actions might also arise mostly from the area of employment law.

The hospital reported Nurse J.'s diversion of controlled substances to the State Board of Nursing and placed him on a medical leave of absence. Nurse J. contacted a private attorney and presented a letter from the State Board of Nursing that required Nurse J.'s written response to the allegation that he diverted controlled substances from the hospital. Nurse J. is seeking legal advice from the private attorney regarding his potential criminal liability and his potential termination from employment at the hospital. He requests assistance from the attorney in writing his response to the State Board of Nursing. As a legal nurse consultant (LNC), you are present with the attorney during this initial client interview to assist in gathering facts regarding the specifics of the drug diversions.

Support and Recommendations

The attorney's recommendations should reflect knowledge regarding the disease of addiction, treatment of impairment, potential licensure penalties, availability of an Impaired Professional Nurse Program, Peer Assistance Program, or Alternative Disciplinary Program along with possible employment protections afforded by the Americans with Disabilities Act (ADA). All of these programs are non-punitive and confidential and seek to identify, assist, and monitor nurses with substance abuse problems. Peer Assistance Programs are usually associated with State Nurses

Associations and services are provided by registered nurses. Impaired Professional Programs may target not only nurses but also physician assistants, emergency medical technicians, and other health professionals with addiction problems who may receive services from other health professionals. For example, Texas, Massachusetts, Tennessee, New Jersey, and Oklahoma have Peer Assistance Programs, while New York and West Virginia advertise Impaired Professional Programs.

The individual identified as an impaired nurse will require assistance that addresses both legal and treatment strategies. The ADA is a civil rights law that guarantees equal employment opportunities to individuals with disabilities. Certain conditions constitute protected physical impairments, including the impairments of drug addiction and alcoholism. A drug addiction is considered a disability under the ADA if it creates a substantial limitation to one or more major life activities. Safety is a permissible consideration. Employers must be able to demonstrate that the person excluded because of a history of drug addiction or drug treatment poses a significant risk of harm to the health or safety of the individual or others that cannot be eliminated or reduced by reasonable accommodations. However, the ADA does not extend protection to current users of illegal drugs. Actions taken by employers are not subject to penalties for violation of the ADA if based upon the employee's current illegal drug use. However, those addicted to drugs, but who are no longer using drugs illegally and are receiving treatment for drug addiction or who have been rehabilitated successfully are protected from discrimination by the ADA (ADA, 1990). Upon entering a drug treatment program, Nurse J. will qualify for the employment protections under the ADA and be able to maintain his employment until a time that his employer demonstrates that he continues to pose a significant risk of harm to patients that cannot be reduced or eliminated by reasonable accommodations.

Most often drug treatment is supported, rather than prosecution demanded, where the individual's criminal activity is the result of the demand for substances due to their own active addiction. Consequently, the most effective way for Nurse J. to avoid prosecution for the drug diversions is to admit his addiction to the local prosecutor and to enter into a drug treatment program.

A review of the policies of the State Boards of Nursing reveals that a majority have mandatory reporting laws that require a hospital, health care facility, peer, or colleague to report addicted or impaired co-workers who are not receiving treatment. Failure to report an impaired co-worker can result in disciplinary action against the nurse or the institution by most State Boards of Nursing determined on a case-by-case basis (See individual state boards' websites for further details). Nurses and health care institutions that report impaired health professionals are immune from civil and criminal liability as long as the reporting is done in good faith (American Nurses Association [ANA], 2010).

A nurse with an active drug addiction jeopardizes patient safety. According to Flood (2003), impaired nursing practice

can be defined as the inability to perform the essential functions of practice with reasonable skill or safety because of chemical dependency on drugs or alcohol, or mental illness. The number one reason named by State Boards of Nursing for disciplinary actions against nurses is diverting controlled substances for personal use (Sullivan and Decker, 2001). According to Maher-Brisen (2007), over 40 State Boards of Nursing have alternatives to disciplinary actions, including peer assistance programs, and recovery monitoring programs. Health care professionals who participate in professional monitoring programs have a high rate of long-term recovery and there is more success with recovery when it is linked to a person's employment and licensure (Trossman, 2003). Professional monitoring programs provide the addicted professional with both treatment and monitoring. In general, upon requesting to participate in such programs, the impaired professional signs a consent agreement that has the power to suspend or revoke the professional license if non-compliance with the monitoring program contract occurs. Examples of failures to comply with the monitoring contract include such violations as failure to pass random drug screenings, failure to attend and document 12 step meetings, or failure to participate in prior agreed-upon counseling (National Council of State Boards of Nursing, 2006).

Many times nurses fail to ask for help for their drug addiction until they are confronted with evidence of their drug diversion. Despite recognition that addiction is a disease, there is still a stigma associated with the disease of addiction. Co-workers are reluctant to report an impaired colleague because of the widespread belief among nurses that reporting an impaired co-worker will automatically result in the impaired person's loss of a nursing license rather than treatment for the addiction. Reluctance to report an impaired nurse occurs especially if that impaired nurse is a long-time friend and the belief exists that no patient harm has ever resulted from this friend's impairment. While patient safety concerns are the main reason for reporting an impaired colleague, there is no doubt that this action might save the life of the addicted nurse (Holloran, 2009).

In almost all states, the nurse with an addiction problem is given the opportunity for treatment and continued monitoring of nursing practice, provided the nurse remains in compliance with the requirements of the monitoring program. Although some nurses can hide their addiction for a long period of time, the disease of addiction is progressive and the signs and symptoms that something is very wrong will eventually become apparent to nurse co-workers. Some of the behavioral changes noted in these addicted nurses include pinpoint pupils, runny nose, deteriorating work habits, frequent bathroom breaks, preference for night shifts, and assigned patients complaining of no pain relief (Hrobak, 2003).

Nurses who have legal problems and licensure issues due to their addiction are often burdened by the negative societal stigma associated with this disease. Health professionals tend to be extremely harsh towards their peers suffering

from an addiction because it undermines the public trust and reflects poorly on the profession of nursing (Hrobak, 2003). According to Dunn (2005), stressors in the workplace such as increased workload, mandatory overtime, floating to unfamiliar units, fatigue, and stress may fuel a nurse's drug addiction.

The ANA reports that 10% of the approximately three million active registered nurses (RN) in the United States have a drug or alcohol addiction (Copp, 2009). This means that 1 out of every 10 active RNs has a drug or alcohol addiction; so, it is very likely that the practicing nurse will encounter another nurse with the disease of addiction. This is similar to reported findings about the general United States population with 9.4% reporting being addicted to either drugs or alcohol (Substance Abuse and Mental Health Services Administration, 2009).

Some hospitals and employers still take a punitive approach towards the treatment of nurses who have diverted drugs for personal use. The ANA (2001) encourages the rehabilitation of impaired nurses so they can return to work where they can practice safely through the abstinence from any mood-altering chemicals. Presently, the nursing profession is increasing the number of diversionary and alternative disciplinary programs that are available for the impaired

nurse, reflecting a commitment to rehabilitation rather than an emphasis on disciplinary actions against nurses.

The goals of the legal team for Nurse J. will include recommendations for him to complete an inpatient drug program and successfully complete a professional health monitoring program such as those described previously. Any evidence or documentation Nurse J. submitted to the State Board of Nursing should first be reviewed and approved by the client's attorney to make sure that it contains no incriminating statements. Additional advice by the attorney to Nurse J. would include:

1. Decline to speak to any investigators unless his attorney is present.
2. Gather positive witness statements supporting a positive perception of Nurse J.
3. Obtain a list of favorable character and professional witnesses.
4. Decline discussing the drug diversions with co-workers.
5. Enter into an in-patient drug treatment program and follow-up program.
6. Maintain documentation of steps taken towards recovery.
7. Write down facts that support the drug diversion was for personal use.

The LNC plays a critical role in protecting the public by encouraging the impaired nurse to obtain drug treatment and



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to return to the safe practice of nursing. The goal is to assist the impaired nurse to complete recommended treatment in order to maintain his or her professional license through adopting a lifestyle that includes complete abstinence from mood-altering substances. In addition to the LNC's role in protecting the public, the LNC can serve as an understanding colleague who can direct the impaired nurse to the appropriate resources for assistance, monitoring, and eventual recovery and return to the practice of nursing.

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Plastic Surgery: Plastic Surgeon and Cosmetic Dermatologist: Complications and Liability

Issues for the Legal Nurse Consultant

By Nancy LaGasse RN, MS, CDMS, CCM, CLCP, LHRM, ARM, MSCC, QRP

KEY WORDS

Plastic surgeon, dermatologist, ambulatory surgery center

The purpose of this article is to familiarize the legal nurse consultant (LNC) with the evolution of cosmetic plastic surgery performed by the plastic surgeon and dermatologist. Information has been included regarding the differences and similarities in the physicians' education, training and practices, practice complications, and prevention and associated regulations, risks, and liability.

The Evolution of Cosmetic Plastic Surgery

In years past, plastic surgeons concentrated mainly in the area of reconstructive surgery, which included correction of trauma-related injuries, congenital birth defects, burns, and skin cancers. As a result of the advances in technology and surgical techniques, plastic surgeons began to add more cosmetic procedures to their practices. As the number of cosmetic surgical procedures increased, so did the number of lawsuits filed (N. Smith, personal communication, July 14, 2009). Dermatologists concentrated in the area of diseases of the skin, hair and nails, but also expanded their practices to include cosmetic surgeries. Although their areas of practice vary, the types of lawsuits can be identical with single awards being in excess of a million dollars.

Cosmetic surgeries modify or improve the appearance of a physical feature, irregularity, or defect (American Heritage Medical Dictionary, 2007). There is little question of insurance coverage for reconstructive surgeries, which includes the diagnosis and treatment of skin cancers; however, cosmetic surgeries are not generally covered for reimbursement under insurance plans. There are a few exceptions, which include correction of an impairment that can also be cosmetic in nature. Examples include blepharoplasty (upper eyelids) if a visual field examination demonstrates an impairment to vision, or rhinoplasty (nose) if the impairment to the nasal structure is affecting the patient's respiratory function (Centers for Medicare & Medicaid, 2010). With the passage of time and visible results, more individuals have chosen to pay for cosmetic surgery.

Plastic Surgeon and Dermatologist

According to the American College of Surgeons (2011), plastic surgeons have more than six years of surgical training and experience with a minimum of three years in the areas of reconstructive and cosmetic surgery following completion of their medical degree. They are qualified to perform procedures on all areas of the body and most have inpatient hospital privileges, in addition to operating in outpatient ambulatory surgery centers. They are board certified by the

American Board of Plastic Surgery and by the Royal College of Physicians and Surgeons of Canada. Plastic surgeons do not provide treatment for skin diseases and disorders.

A dermatologist receives three additional years of training in dermatology following the medical degree, and most often has a general practice for treatment of skin diseases. They can perform cosmetic procedures if they have had training in that specific treatment area. Many dermatologists complete training in Mohs surgery, microscopically controlled surgery for treatment of common skin cancers, and become affiliated with the American Academy of Dermatology, the American College of Mohs surgery (ACMS), and the Dermatology Association of America (ACMS, personal communication, June 9, 2010).

Questions are often raised regarding the differences in the types of cosmetic procedures performed by the plastic surgeon and the dermatologist. According to the American Society of Plastic Surgeons (2010), the American Association of Dermatologists (2010), and the American Academy of Dermatology (2008) both of these specialties can inject dermal fillers, prescribe skin enhancement products, perform dermabrasions and chemical peels, liposuction, hair removal, skin cancer screenings, laser skin rejuvenation procedures, and non-invasive skin tightening by infrared laser, pulsed infrared light, or radiofrequency. Some providers specialize in hair restoration and transplant with scalp surgery. The more complex surgeries requiring sedation must be performed in either a hospital or ambulatory surgery center, which in some states determines who can perform the surgery.

Regulation of Surgery

According to the United States Department of Health and Human Services (2011), each state has its own form of medical oversight. For example, in Florida, ambulatory surgery centers are regulated by the Agency for Health Care Administration (AHCA, 2009) with the guidance of the Ambulatory Surgery Center Association (Ambulatory Surgery Center Association, 2010). In Louisiana, these centers are regulated by the Louisiana Department of Health & Hospitals, and in

Michigan, they are regulated by the Michigan Department of Licensing and Regulatory Affairs (2011).

Plastic surgeons generally practice surgery in both hospitals and outpatient ambulatory surgical centers. In most states, the hospital and the physician have a written agreement listing those surgeries approved by the hospital (Venice Regional Medical Center, 2010), as well as a written transfer agreement for patients who develop complications (N. Gahhos, personal communication, June 9, 2010). In some states, dermatologists do not have hospital surgical privileges, but have privileges to visit patients for evaluation and treatment of skin disorders. In New Jersey and New York, dermatologists can also perform cosmetic surgeries if they have had appropriate training and initial supervision by another physician/or physicians (F. Rothman, personal communication, May, 2011).

Levels of Surgery

There are three generally accepted levels of surgery, which may vary from state to state. Table 1 provides an example of the levels of surgery (Florida's Department of Health, Division of Medical Quality Assurance , 2011) for quick reference and to familiarize the reader with the requirements of each level of surgical intervention. The levels of surgery are important in determining the appropriate selection of location, type of procedure, level of sedation, equipment and support staff required for the assurance of the patient's safety. Most level one surgeries are considered minor procedures, such as excision of skin lesions performed by the surgeon under topical or local anesthesia in either the office or an ambulatory surgery center. Level two surgeries involve the use of pre-operative medication and sedation for altering the level of consciousness, thus making intra and post-operative monitoring necessary. Procedures can include breast biopsies and liposuction. Level three surgeries require the administration of general or regional anesthesia and include more complex surgeries with a dedicated person, such as an anesthesiologist to administer the anesthesia.

Ambulatory Surgery Centers

The emergence of the ambulatory surgery center has altered the practice of reconstructive plastic and cosmetic surgery by creating an opportunity for physicians to own their facilities and operate independently. In addition, more patients have become willing to undergo surgery as an outpatient in a facility, rather than consider hospital admission.

Surgeries that do not require hospital admission and whose patient stay is not expected to exceed 24 hours are performed in ambulatory surgery centers. The patient arrives on the day of the procedure, which is performed in an operating room followed by recovery under the care of the nursing staff. According to the Ambulatory Surgery Center Association, the first ambulatory surgery center in the United States opened in 1970 and there are now approximately 5,000 centers performing an estimated 20 million surgeries

each year. State licensure is required in 43 of those states, which specifies the criteria for licensure. Medicare first approved reimbursement for surgery in ambulatory surgery centers in 1982, approving 200 surgical procedures, which has grown to over 2,500 procedures. Ambulatory surgery centers are considered to be the most strictly regulated type of ambulatory medical facility. The surgical center can choose to pursue accreditation by the Accreditation Association for Ambulatory Health Care (AAAHC), The Joint Commission, and the American Association for Accreditation for Ambulatory Surgery Facilities (AAAASF).

In some states, such as Florida, the surgeon must establish a risk management program to include the identification, investigation, and analysis of the frequency and causes of adverse incidents to his/her patients (P. Lohrengel, personal communication, June 22, 2010). The owner/responsible party (surgeon) must also identify trends or patterns of incidents and develop appropriate measures for correction. A risk manager is not required in all states, but all states require that risk management activities be in place. According to the Ambulatory Surgery Center Association (2011), it is unknown how many centers are linked to plastic surgeons or dermatologists nationally. Both states and Medicare survey ambulatory surgery center's are regularly audited to verify that the standards are being met. Each state's oversight agency has similar requirements within the standard of practices adopted by the Ambulatory Surgery Center Association.

The Physician's Role in Prevention of Complications

In order to avoid complications, it is important to maintain written policies and procedures, which are updated annually. Educational staff meetings addressing a variety of topics related to safety, equipment, medical trends, and treatment provide consistency and help to improve standards of practice. It is mandatory to be compliant with all federal, state, and local statutes, rules, and regulations that apply to the facility (N. Smith, personal communication, July 14, 2009) and assure that billing codes related to each patient, the type of reconstructive surgery, and/or cosmetic procedures are applied correctly. An example of a billing error is to bill Medicare for removal of more than two skin cancers during the same surgery (N. Gahhos, personal communication, June 9, 2010). The practice of auditing files at random on a regular basis will help to assure compliance.

Documentation of the patient's medical record needs to include a complete medical history, emergency contact, physical examination, photos, measurements, biopsy reports, signed consent, and recovery room and operative reports. One of the important areas of documentation in plastic/cosmetic surgery is the patient's understanding of the planned procedure, pre-operative and post-operative instructions, projected outcomes, potential complications, and the projected change in physical appearance. If the patient is non-compliant with written instructions, he/she

increases the risk of infection and scarring. A documented call to or follow-up visit within 24 hours after surgery is also included in the record. Case entries should not be altered following initial entry. If a change is needed, the reason should be recorded separately and documented as to the reason and signed. Deleted or replaced policies, procedures, and forms should be maintained for a period of four years (N. Smith, personal communication, July 14, 2009). A review of all insurance policies on an annual basis including workers

compensation and liability is important to maintaining adequate coverage. All new employees must have a documented period of orientation, which includes a review of policies and procedures, risk management principles and practices to include "how to report an incident". Patient's medical records in accordance with HIPPA regulations must have limited access. In order to prevent lawsuits, a physician should become more aware of the causes of medical malpractice and how to avoid them.

Table 1

LEVEL I SURGERY
1. Minor procedures such as excision of skin lesions, moles, warts, cysts, lipomas, repair of lacerations or surgery limited to skin and subcutaneous tissue performed under topical or local anesthesia not involving drug-induced alteration of consciousness other than minimal pre-operative tranquilization of the patient.
2. Liposuction with removal of less than 4,000cc supernatant fat.
3. Incision and drainage of superficial abscesses, skin biopsies.
4. Pre-operative medications not required.
5. Chances of complications requiring hospitalization remote.
Standards for Level I Surgery
1. Surgeon must have continuing medical education to include: proper dosages of medication, management of toxicity or hypersensitivity to regional anesthetic drugs. Basic Life Support certification recommended.
2. Equipment and supplies required include oxygen, positive pressure ventilation device, epinephrine, corticoids, antihistamines and atropine if anesthesia is used.
3. No assistance of other personnel required.
LEVEL II SURGERY
1. Peri-operative medication and sedation used altering level of consciousness, thus making intra and post-operative monitoring necessary. Procedures include, but are not limited to, breast biopsies and liposuction.
2. The level of sedation the patient receives allows him/her to tolerate unpleasant procedures while maintaining adequate cardiopulmonary function and ability to respond purposefully to verbal commands and/or tactile stimulation.
Standards for Level II Surgery
1. A written transfer agreement required with staff privileges at a hospital to perform the same procedure in the hospital or be able to document satisfactory training such as Board certification, Board eligibility, or to establish a comparable background, training and experience.
2. Assistance is required during the procedure by another physician or physician assistant or RN/ LPN.
3. One assistant must be currently certified in Basic Life Support and the surgeon certified in Advanced Cardiac Life Support.
4. Equipment and supplies required include a crash cart at the location where anesthesia is administered, fully stocked with current resuscitative medications; required monitors for blood pressure/EKG/ oxygen saturation, emergency intubation equipment, defibrillator, adequate operating room lighting, an emergency power source to run equipment for a minimum of two hours, appropriate sterilization equipment, IV solution, and IV equipment.
5. Post-operatively, patient monitored by a physician, physician assistant, or RN/LPN in recovery room until patient is recovered from anesthesia. These individuals must be certified in Advanced Life support

LEVEL III SURGERY
1. Surgery which involves use of general anesthesia or major conduction anesthesia (nerve block injection) and pre-operative sedation.
2. General anesthesia includes loss of consciousness and vital reflexes by the patient with probable requirement of external support of pulmonary or cardiac functions
3. Only patients classified under the American Society of Anesthesiologist's risk classification criteria Class I or II are appropriate candidates for Level III office surgery.
4. All Level III surgeries on patients classified as ASA III (American Society of Anesthesiologists Classification/ system used to stratify the severity of patients' underlying disease and potential for suffering) and higher can only be performed in the hospital or ambulatory surgery center.
5. For patients over age 40, the surgeon must obtain an EKG and complete workup prior to surgery. If the patient has a complicated medical history, he/she must be referred for independent medical clearance to an appropriate medical consultant. The referral may be waived by an anesthesiologist's evaluation.
Standards for Level III Surgery
1. The surgeon must have staff privileges at a hospital to perform the same procedure in hospital, as in an ambulatory surgery center or be able to document satisfactory training such as Board certification or Board eligibility or establish comparable background, training and experience and knowledge of general anesthesia
2. An RN, physician assistant, or operating room technician must assist with surgery.
3. Assistance required during procedure by anesthesiologist, certified RN anesthetist /physician assistant who must administer general or regional anesthesia; no other duties during surgery.
4. One assistant currently certified in Basic Life Support and surgeon certified in Advanced Cardiac Life Support.
5. Emergency procedures related to anesthesia complications written, reviewed, and posted.
6. Equipment required includes dantrolene, monitored post-anesthesia recovery comparable to free standing ASC; monitors: blood pressure/ EKG/pulse oximeter, tidal CO2, temperature, precordial or esophageal stethoscope; emergency intubation equipment, defibrillator, table capable of trendelenburg and positions necessary to facilitate surgical procedure, IV solution, and equipment.
7. Post-operatively, patient monitored by physician, physician assistant or RN / LPN in recovery room until patient recovered from anesthesia; all monitoring staff must be certified in advanced life support.

Source: Florida Department of Health (2011). *Division of Medical Quality Assurance: floridashealth.com*. Retrieved from http://doh.state.fl.us/mqa/medical/osr_faq.html

The Reality of Litigation Risk

There are a variety of complications that can occur during and following cosmetic surgery. Some of the most common complications are infections, rupture of breast implants, inability to close eyes following blepharoplasty, and dissatisfaction with the outcome of surgery (N. Gahhos, June 9, 2010).

According to the American College of Mohs Surgery (2010), the roots of a skin cancer may extend beyond the visible portion of the tumor and if not removed, the cancer can reoccur. The visible portion of the tumor is surgically removed followed by removal of a layer of skin, and examined microscopically. If cancer cells are found, another layer of skin is removed. The removal process stops when there is no longer any evidence of cancer remaining in the surgical site.

One of the complications that can occur is unclear evidence of the epidermal margin. This can result from vigorous scrubbing, poorly controlled curettage, poor tissue health, and technician's and surgeon's error. Misreading of the pathology slide can result in a missed or inaccurate diagnosis. Artifacts including compression, freezing, cautery, tissue folds, crush artifacts from forceps, and poor staining can give a false impression regarding the surgical margin being clear. Heavily inflamed tissue or tumors along a nerve can make it difficult to visualize the tumor. Areas that are not flat surfaces are difficult to excise and process, such as the ear and eye resulting in reoccurrence of the lesion and/or disfigurement (Mohs surgery, 2011). In addition, recurrent skin cancer with multiple areas can be found within scar tissue and problematic to remove. Some physicians may have received poor or inadequate training compared to other physicians resulting in an increase in complications including failure to remove all of the lesions with reoccurrence (Mohs surgery, 2011).

Most Common Causes of Litigation

One of the most prevalent types of law suits filed against the plastic surgeon and dermatologist is the failure to timely diagnose and treat melanoma resulting in metastasis and/or reduced life expectancy and death and awards in excess of one million dollars. Examples of information reported to AHCA (2009) are shown in Table 2 and often results in litigation.

Examples of Cited Litigation

A verdict search revealed that there are several cases cited for wrongful death from medical malpractice and the failure to diagnose and/or properly excise the lesion. In case one, a mole was removed from a patient's back, which the pathologist read as moderate atypia requiring complete removal. The surgeon reexcised the mole and the second pathology report stated that additional excision was required, which was not performed. One year later, the plaintiff returned concerned about the same mole. Another excision and pathology report revealed malignant melanoma. The verdict was in excess of one million dollars. The plaintiff received interferon

Table 2

CITED CAUSES OF LITIGATION
1. Surgery on the wrong patient.
2. Surgery on the wrong site or the wrong procedure performed can result in failure to provide appropriate treatment of the lesion and/or disfigurement and dissatisfaction by the patient requiring the need for a second surgery.
3. Failure to biopsy the lesion before and after surgery can result in metastasis of the lesion.
4. Failure to inform and obtain a written informed consent for the procedure.
5. Misdiagnosis of a lesion and/or skin disease can result in failed treatment and metastasis.
6. Time on the table during surgery exceeds the standards of practice and places the patient at risk for complications, such as medical instability, infection and/or poor healing with disfigurement.
7. Failure to remove the entire lesion and/or skin cancer can result in reoccurrence.
8. Failure to timely diagnose and provide treatment of melanoma, resulting in progression of the disease, leading to a terminal prognosis.
9. HIPPA violations (Reading of records /Providing of information/ documentation to others).
10. Damage to a nerve during surgery resulting in paralysis / continuing limited motion.
11. Failure to diagnose breast cancer prior to placement of breast implants places the patient at risk for metastasis.
12. Fraudulent billing and coding can result in the physician losing his ability to practice medicine.
13. Leaving of a sponge or instrument in the patient can result in infection and pain requiring an additional surgery for removal.
14. Failure to provide timely, appropriate post-operative follow-up with an understandable explanation to patient can result in infection, unresolved hematoma, pain and disfigurement.
15. Required surgical repair of damage or injuries places the patient at risk for further complications.
16. Substandard medical /surgical nursing care can result in medical instability, disfigurement, infection, and pain and suffering for the patient.
17. Failure to provide the appropriate documentation, credentialing, and patient selection exposes the surgeon to risk of losing his ability to practice.
18. Failure to provide a safe environment increases the risk of complications for the patient and places the staff at ongoing risk of injury.
19. Disfigurement of a patient can cause the patient to have additional surgeries to correct the disfigurement and/or the disfigurement may not be correctable resulting in psychological damage to the patient.

Source: Agency for Health Care Administration.(2009), *Florida Center for Health Information And Policy Analysis*. Tallahassee, FL.

treatment and died four years following treatment from metastasis (Verdict Search, 2010).

An 18 year old underwent excision of a mole on her left leg with a full-thickness graft. Seven months later, a biopsy of a lump on her thigh revealed metastatic melanoma. The slides from the initial procedure performed were reviewed by a different pathologist and revealed that the slides had been misread. The diagnosis was invasive malignant melanoma. The plaintiff had received three years of treatment and her

prognosis was poor. A pre-trial settlement resulted in an undisclosed award reported to be in the range of \$500,000-\$1,000,000 (Verdict Search, 2010).

In August of 2002, a woman had a mole excised by her physician, which was to be sent to the pathologist. A year later, the mole returned and the woman requested her records be forwarded to another physician. It was found that the specimen had never been sent to pathology. She was diagnosed with malignant melanoma. The jury returned a \$3.25 million judgment against the facility (Sparrow, 2009).

Important Guidelines for the LNC

The LNC needs to be thorough in the review of each case and the legal requirements of the state in which the incident occurred. It is important to always be aware of HIPAA guidelines, while gathering information. When the case includes licensed professionals, a good place to begin is with the regulatory and credentialing bodies. Verification of the status of the physician's and/or nurses license, credentials, and insurance establishes the credibility of the professional. Further investigation should include a history of prior lawsuits, the outcomes and awards, and standards of practice related to each professional named in the lawsuit. It is important to obtain information regarding each lawsuit, the specific charges, and whether or not there have been recurrent charges. Examples more commonly related to cosmetic and reconstructive surgeries are failure to follow standards of practice, misdiagnosis, disfigurement, infections, retained instruments and sponges, damage to a nerve, failure to remove the entire lesion resulting in metastasis, and related pain and suffering. Additionally, whether there was an admission or denial of guilt by the cosmetic surgeon is of importance.

There are several criteria involved in the selection of experts including current active area of practice, prior testimony, experience, reputation, and knowledge concerning standards of practice and/or regulations within the state of occurrence. It is helpful for the LNC to identify cases with similar incidents and their outcomes.

Summary

The majority of plaintiffs enter into a lawsuit with the goal of being awarded financial compensation and/or emotional resolution, but the physician has the ultimate goal of avoiding or defending litigation which can result in loss of reputation and earnings, in addition to experiencing prolonged stress. The uninformed patient can be at risk for complications and has a right to expect the performance of best practices on his/her behalf. The patient can be the unknowing victim of a surgery performed in an office or ambulatory surgery center that should have been performed in a hospital, a surgeon who did not have the appropriate training and experience for the surgical procedure, and/or staff lacking in the appropriate training. The surgeon may have made an improper diagnosis and/or the lesion may not have been totally removed resulting in metastasis, particularly in the misdiagnosis of melanoma

resulting in a poor prognosis ending in death. There are many additional risks associated with surgery and the patient should be made aware of the potential risks, in order to make an informed decision. As the number of cosmetic surgeries increase, it is projected that the number of lawsuits filed and the oversight of these surgeries will also be increased.

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Post-traumatic Stress Disorder (PTSD)

By Kara DiCecco, MSN, RN, LNCC

Arguably, no other anxiety disorder has so many potential triggers leading to its development as post-traumatic stress disorder (PTSD). The traumatic events that can precipitate the onset of PTSD are varied, numerous, and the manifestations of the disorder are highly individualized. PTSD can develop in response to natural disasters (APA, n.d.) or as a psychological reaction to receiving devastating news (Murphy et. al, 1999). Frequently the disorder evolves following a victim's violent assault although in some cases the onset of PTSD may not be immediate, following instead, months after the devastating event. Literature sources estimate that 40% of adults and 8-25% of children develop PTSD following motor vehicle accidents (Jones-Alexander, J., Blanchard, E. B. & Hickling, E. J., 2005). The following is a brief overview of PTSD and not meant to replace medical or legal advice.

Pathophysiology

Classified by the American Psychiatric Association (APA) among the anxiety disorders, PTSD may develop following a traumatic event involving either actual or perceived threat of death or injury (DSM-IV TR, p. 463). Classic presentation of those experiencing PTSD is a replaying of the traumatic event over and over. The memories may manifest as terrifying dreams, a sensation of reliving the trauma (flashbacks), or emotional upheaval triggered by event-related dates (<http://www.psychiatryonline.com/content.aspx?aID=3357>).

Diagnostic Criteria

The American Psychiatric Association (2004) Practice Guideline for PTSD (DSM-IV TR 309.81) may be found at http://www.psychiatryonline.com/pracGuide/pracGuideTopic_11.aspx

Diagnostic Features of PTSD (in part)

This summary is not meant to be the complete diagnostic criteria for PTSD. For additional explanation and criteria see core features of PTSD at <http://www.psychiatryonline.com/content.aspx?aID=52640>

1. The person has been exposed to a traumatic event.
 - Actual or perceived threat of death or serious injury, or a threat to the physical integrity of self or others
 - The person's response involves intense fear, helplessness, or horror
2. The traumatic event is persistently reexperienced.
 - Intrusive distressing recollections of the event
 - Recurrent dreams of the event
 - Feeling as if the traumatic event were recurring (this may include hallucinations, illusions, dissociative flashbacks)
 - Intense psychological distress and/or physiological activity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event (for example, anniversary dates of the event)
3. Persistent avoidance of stimuli associated with the trauma occurs and generalized numbing of feelings.

- Avoidance behaviors of associated emotions or physical locality of the traumatic event
 - Amnesic affect related to the traumatic event
 - Markedly diminished interest or participation in significant activities
 - Feeling of detachment
 - Flattened affect to stimuli
 - Sense of a restricted future or shortened life span
4. Persistent symptoms of increased arousal occurs.
 - Insomnia or early wakening
 - Emotional lability
 - Difficulty concentrating
 - Hypervigilance
 - Exaggerated startle response

Author's note: Although the final publication of the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5) will not be available until 2013, the DSM-5 development site and proposed changes are currently available at <http://www.dsm5.org/Pages/Default.aspx>

Treatment Triad

The three arms of treatment for PTSD are education, medication, and therapy (Lange, Lange & Calbatica, 2000).

Patient Education

Begins as close to the traumatic event as possible. Early treatment has been associated with favorable recovery. The patient is instructed regarding the symptoms of acute stress disorder/acute PTSD and the need for immediate intervention.

Pharmacotherapy

Several medications are used to treat PTSD. In reality, a combination of medications may be prescribed to treat the symptoms. This list is not exhaustive.

1. Selective Serotonin Reuptake Inhibitors (SSRIs) work selectively on serotonin in controlling aggression,

impulsiveness, and anxiety. Common SSRIs are Paxil (paroxetine), Zoloft (sertraline), Prozac (fluoxetine), Celexa (citalopram), Lexapro (escitalopram), and Luvox (fluvoxamine).

2. Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs) work on both serotonin and norepinephrine. Norepinephrine affects alertness and arousal. Common SNRIs are Cymbalta (duloxetine), Remeron (mirtazapine), and Effexor (venlafaxine).
3. Tricyclic antidepressants (TCAs) may be used in patients not responding to SSRIs or SNRIs. Common tricyclics include nortriptyline (Pamelor), amitriptyline (Elavil), imipramine (Tofranil), and desipramine (Norpramin).
4. Buspar (buspirone) is an anti-anxiety agent used to treat PTSD.
5. Benzodiazepines are a classification of anti-anxiety drugs that work quickly but can cause dependency. For that reason, they are not the primary choice for treatment of PTSD. Common benzodiazepines are Restoril (temazepam), Serax (oxazepam), Ativan (lorazepam), Halcion (triazolam), Librium (chlordiazepoxide), Tranxene (clorazepate), Xanax (alprazolam), Klonopin (clonazepam), Dalmane (flurazepam), and Valium (diazepam).
6. Beta-blockers are showing promise in the treatment of PTSD by blocking memory formation. In controlled settings the patient may be asked to recall the event and then immediately administered Inderal (propranolol).
7. Monoamine Oxidase Inhibitors (MAOIs), mood stabilizers, anti-convulsants may also be prescribed as augmentation therapy (Madison Institute of Medicine, 2011).

Psychotherapy

1. Counseling may be employed, such as play therapy for children.
2. Cognitive Therapy involves recognition of feelings and their associated emotions, replacing negative thoughts with positive self-talk.
3. Exposure (habituation) is based on the premise repeated exposure may lead to desensitization. Under controlled circumstances the person may be asked to return to a place of avoidance related to the trauma. For example, slowly returning to driving following a traumatic motor vehicle accident.
4. Anxiety management entails a variety of skills such as relaxation techniques, controlled breathing exercises, thought-stopping, and more.
5. Other treatments may include hypnotherapy, biofeedback, and eye movement desensitization movement (EMDR) although the latter has had controversial success (Madison Institute of Medicine, 2011).

Legal Considerations

- Clients may experience related or concurrent anxiety, depression, alcohol and/or drug abuse, panic attacks, and insomnia (Post-traumatic Stress Disorder, 2011).
- Testing for PTSD is subjective as it relies on the patient's report of symptoms and psychological evaluation and results are subject to the test administrator's interpretation.
- A study supporting the premise that immediate onset PTSD with early intervention is more likely to respond favorably to treatment (Berkowitz, Stover & Marans, 2011).
- The diagnosis of PTSD (309.81), is made by meeting the criteria specified in the Diagnostic and Statistical Manual of Mental Disorders, Text Revision (DSM-IV TR), published by the American Psychiatric Association.
- Because children do not have the ability to verbalize extensively, they may communicate what they are experiencing by engaging in repetitive play involving the events, or repeated nightmares where they are unable to identify the content. They may demonstrate disorganized behavior and thought as well as agitation (<http://www.behavenet.com>)
- The classification of medications used to treat PTSD have various side effects, some serious. To learn more, research the medications at <http://www.rxlist.com>
- All APA practice guidelines are now published (free without subscription) on PsychiatryOnline.com at <http://www.psychiatryonline.com/pracGuide/pracGuideHome.aspx>.

A Look at Case Law and Resources

An informal search of online case law was conducted using the GOOGLE search engine and keywords (in quotes) "posttraumatic stress disorder", "PTSD", "case law", "case study", and "disability" in alternating string searches. A review of the information retrieved provided both formal and informal sources. A sampling of the *preliminary results* via internet retrieval is provided here.

Mottram v. Fairfax County Fire and Rescue

Worker's compensation claim for paramedic sustaining PTSD in the course of employment.

<http://caselaw.findlaw.com/va-court-of-appeals/1174846.html>

Williams v. Funk

Case heard on appeal to determine if jury was correct in awarding economic damages, but no non-economic damages. Following motor vehicle accident, diagnosis of PTSD was controverted, which was exception to application of law (in Oregon) awarding non-economic damages.

<http://www.publications.ojd.state.or.us/A136778.htm>

Review of research study conducted by the faculty of the University of California, San Francisco (UCSF) at the San Francisco Veterans Administration Medical Center (SFVAMC) on Risk of Accelerated Aging Seen in PTSD Patients with Childhood Trauma.

<http://www.ucsf.edu/news/2011/04/9776/risk-accelerated-aging-seen-ptsd-patients-childhood-trauma>

Practice Guideline for Patients with Acute Stress Disorder and Post-Traumatic Stress Disorder (2004) available at <http://www.pbhcare.org/Guidelines/Guidelines/Blurb/Tree/Adult%20Mental%20Health/Acute%20Stress%20And%20PTSD/PTSD%20Algorithm.pdf>

MedlinePlus

Interactive tutorials for PTSD

<http://www.nlm.nih.gov/medlineplus/tutorials/ptsd/htm/index.htm>

Case study and overview from Johns Hopkins Geriatric Education Center Consortium

<http://www.hopkinsmedicine.org/gec/studies/ptsd.html>

Website of Jonathan Ginsberg, Esq. providing case studies of PTSD and their relation to Social Security Disability Benefits

<http://www.ptsd-disability.com/case-studies/>

Home page of the International Society for Traumatic Stress Studies (ISTSS)

<http://www.istss.org/Home.htm>

Journal of Traumatic Stress (JTS)

<http://www.istss.org/JournalofTraumaticStress/3630.htm>

Educational article about critical incident debriefing; one form of treatment for preventing PTSD

http://www.psybersquare.com/anxiety/post_critical.html

A Gift from Within

Website promotes it is an international nonprofit organization for survivors of trauma and victimization. Numerous resources for PTSD sufferers and their caregivers/families.

<http://www.giftfromwithin.org/>

ABA Journal/Military Law

Article focusing on attorney Gordon Erspamer and pro bono commitment to veteran's benefits.

http://www.abajournal.com/news/article/meet_gordon_erspamer_vas_worst_nightmare_in_ptsd_benefits_case/

Potential Experts

- Psychiatrists
- Psychologists
- Primary Physicians/Internists
- Psychopharmacologists
- Pediatricians (based on age related symptoms)
- Gerontologists (based on age related symptoms)
- Licensed Therapists/Counselors

National Center for Crisis Management in collaboration with the American Academy of Experts in Traumatic Stress provide a searchable directory of experts accessible at <http://www.nc-cm.org/caregiversearch.htm>

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References and Resources

Post-traumatic Stress Disorder

By Kara DiCecco, MSN, RN, LNCC

Due to the expansive list of traumatic events that can precipitate the onset of Post-traumatic Stress Disorder (PTSD), the violent nature of many of these events, and the evolving understanding of this disorder, the broad approach to coverage of resources in this section is intentional. The resources here are meant to provide the reader with a starting point for learning more. This list is not exhaustive and this is not an endorsement of any commercial sites. As with any online resource, the reader must independently confirm its authority and credibility.

GLOSSARY OF TERMS

Office of Victims of Crime (Office of Justice Programs, U.S. Department of Justice)
Crime Victimization Glossary, frequently encountered terminology and related legal terms.
<http://www.ojp.usdoj.gov/ovc/library/glossary.html>

Glossary of Cyberbullying Terminology
From the Cyberbullying Research Center
http://www.cyberbullying.us/cyberbullying_glossary.pdf

The Center for Victims of Violence and Crime
List of legal terms related to criminal and juvenile justice systems.
<http://www.cvvv.org/CrimeVictimsAssistance/glossary.php>

OVERVIEW OF PTSD

National Library of Medicine, National Institute of Health: Medline Plus
Comprehensive topic coverage on PTSD. Provides the latest news, alternate therapies, and research links.
<http://www.nlm.nih.gov/medlineplus/posttraumaticstressdisorder.html>

National Institute of Mental Health
Links to videos, clinical trials, and children-focused publications all related to PTSD.
<http://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml>

American Family Physician
Primary Care Treatment of Post Traumatic Stress Disorder
Excellent article (2000, September 1) on the treatment of PTSD from the primary care physician perspective.
<http://www.aafp.org/afp/20000901/1035.html>

Post Traumatic Stress Reactions Following Motor Vehicle Accidents
Good synopsis of factors unique to MVA as precursor to the development of PTSD (1999, August).
<http://www.aafp.org/afp/990800ap/524.html>

JAMA Patient Page: PTSD
Informative, downloadable resource for clients. For providers, see more in the August 1, 2007 JAMA-themed issue on violence and human rights.
<http://jama.ama-assn.org/content/298/5/588.full.pdf>

OVERVIEW OF PTSD (CONTINUED)

National Alliance on Mental Illness (NAMI)
PTSD information page.
http://www.nami.org/Template.cfm?Section=Posttraumatic_Stress_Disorder

American Psychiatric Association (APA)
Topic specific page for information from the APA on PTSD.
<http://www.psych.org/search.aspx?SearchPhrase=posttraumatic+stress+disorder>

United States Department of Veterans Affairs: National Center for PTSD
Primary source for information related to VA-related claims. This site provides PDF of new regulations, effective July 13, 2010, for PTSD claims. Provides searchable database on topics such as women and war, where to get help, information for families, classification of trauma, and returning from war. Excellent site to explore.
<http://www.ptsd.va.gov/public/pages/help-for-veterans-with-ptsd.asp>

Click on "Providers & Researchers" button on home page for research on specific groups such as children, women, ethnic, elderly.
http://www.ptsd.va.gov/ptsd_search.asp?QT=&RPP=20&SECT=2&go.x=18&go.y=6

PILOTS Database (accessible from the left hand menu in the National Center for PTSD link above)
"The PILOTS" bibliographic database, covering the Published International Literature On Traumatic Stress, is produced at the headquarters of the National Center for Post-Traumatic Stress Disorder in White River Junction, Vermont. The PILOTS database is sponsored by the U.S. Department of Veterans Affairs. Its goal is to include citations to all literature on post-traumatic stress disorder (PTSD) and other mental-health sequelae of traumatic events, without disciplinary, linguistic, or geographical limitations, and to offer both current and retrospective coverage." (ProQuest, 2009).

The Veterans Health Research Institute
Website promotes itself as the "leading nonprofit research institute in the United States devoted to advancing Veterans health research." Areas of research: psychological health / post-traumatic stress, traumatic brain injury, Gulf War illness, heart disease, cancer, Alzheimer's and Parkinson's disease, chronic kidney and liver disease, readjustment and reintegration into society. Partners with the San Francisco VA Medical Center and UC San Francisco.
<http://www.ncire.org/>

OVERVIEW OF PTSD (CONTINUED)
<p>PTSD Coach (free mobile app) created by the VA's National Center for PTSD and the Department of Defense National Center for Telehealth and Technology. Free mobile app for PTSD resources. http://www.ptsd.va.gov/public/pages/PTSDcoach.asp</p>
<p>VA PTSD Services Locator Interactive map showing VA centers that have specific treatment for PTSD. http://www2.va.gov/directory/guide/ptsd_fish.asp</p>
SUPPORT
<p>The National Center for Victims of Crime Resource centers on dating violence, stalking, DNA. Sites also offers topic specific materials and victim assistance. http://www.ncvc.org/ncvc/Main.aspx</p>
<p>Office of Victims of Crime (Office of Justice Programs, U.S. Department of Justice) Handouts/Materials Links to a variety of downloadable handouts on nursing home abuse, international crime, missing and exploited children, terrorism and more. http://ovc.ncjrs.gov/HelpVictim.aspx Crime Topics Topic specific information on various crimes, such as stalking, campus crime, hate crimes, human trafficking; over 22 crime related topics. http://ovc.ncjrs.gov/topic.aspx?topicid=2</p>
<p>Medical University of South Carolina, National Crime Victims Research and Treatment Center List of web-based organizations providing services for victims of various crimes such as sexual assault, elder abuse, PTSD, domestic violence, and more. http://academicdepartments.musc.edu/ncvc/resources_public/links_public.htm</p>
<p>Real Warriors Initiative of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) in part to promote facilitating recovery and reintegration for military personnel and their families. http://www.realwarriors.net/</p>
<p>Substance Abuse and Mental Health Services Administration (SAMHSA) In the Wake of Trauma, PDF format resources and tips for college students following trauma. http://www.samhsa.gov/mentalhealth/afterdisaster.pdf Resource of PTSD related web sites. http://store.samhsa.gov/websites/facet/Issues-Conditions-Disorders/term/Posttraumatic-Stress-Disorder</p>

SUPPORT (CONTINUED)
<p>Mothers Against Drunk Driving (MADD) Resources for victims of drunk drivers. http://www.madd.org/victim-services/</p>
<p>The Dart Center for Journalism and Trauma "A project of the Columbia University Graduate School of Journalism, is dedicated to informed, innovative and ethical news reporting on violence, conflict and tragedy." Excellent resources that provide a critical thinking perspective of the impact on media coverage of violence and trauma. http://dartcenter.org/overview</p>
<p>Gateway to Posttraumatic Stress Disorder Information A web portal for one stop access to a variety of resources on PTSD provided by the Dart Foundation (the western-based Dart Center located at the University of Washington in Seattle). http://www.ptsdinfo.org/</p>
<p>David Baldwin's Trauma Information Pages Personal website of David Baldwin, PhD, licensed psychologist. Extensive list of trauma-related resources. http://www.trauma-pages.com/links.php</p>
<p>Bullying OnLine Website originally developed by Tim Field, a well-respected British, anti-bullying activist, whose vision was a world free of bullying. After his death in 2006 a foundation was set up to continue his vision (http://timfieldfoundation.org/) and is now a project of the Quakers and Business (http://qandb.org/). An extensive list of articles, resources, political action updates and more. While Tim Field's original focus was on workplace bullying based on his personal experience as a victim of workplace bullying, his mission spread to eliminate all forms of bullying. http://www.bullyonline.org/index.htm http://www.bullyonline.org/stress/ptsd.htm</p>

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Electronic Medical Records: Help or Hindrance?

By Holly Hillman, MSN, RN and Eileen Watson, EdD, MSN, RN, ANP

Computerization of patients' medical records, referred to as electronic medical records (EMRs) or electronic health records (EHRs), has been evolving for approximately 30 years, and the Institute of Medicine (IOM) has studied and reported on this concept for the past 15 years (Gartee, 2007). The position of the National Coordinator for Health Information Technology was created by an Executive Order signed in 2004 by President George Bush to facilitate the goal of implementing health information technology (HIT) nationwide (Gartee, 2007). However, a study in 2009 found that only 1.5% of hospitals were fully computerized, and subsequently \$19 billion from the Obama administration economic stimulus plan has been allocated for a wider adoption of EMRs by medical facilities (Freeman, 2009).

According to Gartee (2007), EMR systems enhance quality of care and patient safety in several ways by

- Affording multiple healthcare providers simultaneous access to up to date patient information and data
- Enhancing communication and connectivity among departments and care providers
- Reducing errors with computerized provider order entry (CPOE)
- Offering decision support such as medication interaction alerts and prompts or reminders to check lab results or enter patient data
- Providing patient education support
- Assisting with administrative processes and reporting
- Producing information required for reporting population health

Aside from the primary issues of maintaining privacy and security of protected health information (PHI) related to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, additional security issues include administrative policies, auditing and training, physical security of the system related to access control and back-up and disaster recovery procedures, and encryption and authentication technical security (Terry, 2001).

Malpractice liability carriers are now offering discounts or premium credits for physicians or medical groups using EMRs (Freeman, 2009). While long term research has yet to prove that EMR use will eliminate medical malpractice suits, a study at Harvard Medical School in 2008 revealed that a fewer number of physicians who used computer records paid malpractice claims versus those physicians who used paper records (Freeman). Additionally, the payments made

by the EMR users were considerably less than the paper record users (Freeman). However, the majority of the claims stemmed from misdiagnoses rather than technical errors such as incorrect medication orders; thus, it is likely that decision support features found in EMRs would not prevent such errors.

The obvious advantage in reviewing an EMR is the readability. There is no argument that reviewing clearly printed text from a hard copy is far superior than trying to decipher unfamiliar abbreviations and multiple handwritings which are often illegible and/or poorly photocopied from a paper chart. However, a hard copy from an EMR may not appear exactly as viewed on a computer screen (Freeman).

Whether a medical record is a paper chart or computerized, documentation should sufficiently communicate a complete representation of a patient's status. The adage "if it was not charted, it was not done" holds for both formats. Thorough, accurate charting will serve to describe the event in question, and conversely, incomplete charting can be detrimental in defending a case. Regardless of the format, elements of essential documentation include information to objectively and accurately describe a patient's course of care, from initial assessment, through all interventions and health teaching, to the final outcome (Guido, 2010).

EMR documentation is limited to using a specific format dependant on the type of software that is selected. When charting in an EMR a nurse can select assessments or interventions by clicking on items in a list. While this saves time it can limit thorough, descriptive documentation. Using a rote process of documentation could also lead to inadvertently checking off a category that was not appropriate to a particular patient. Although most products have the capability to include fields for keyboard input of free text, nurses may not have enough time to provide more detailed information to adequately describe a patient's status. Human error is also a risk if an incorrect keystroke is made when entering data.

For nursing alone there are 13 code set nomenclatures recognized by the American Nurses Association, with some designed for a particular clinical specialty, such as perioperative or home health care (Gartee, 2007). Additional code sets are designed for billing. For example, the Current Procedural Technology (CPT-4) and the International Classification of Diseases (ICD-9CM), and other code sets are used for research and analysis (Gartee). Cases involving

EMRs may need additional inquiry about the process of establishing the selection and approval of the contents for documentation categories to comply with evidence-based minimum standards of care.

Choosing phrases from a template may be just as limiting as charting by exception (CBE). CBE requires only documentation of abnormal or significant findings (Guido, 2010). Standards of care, practice or protocols and expected results specific to the facility and/or the patient population are presumed, and therefore, not necessary to include in the chart (Brooke, 2004; Geller, 2007; Guido, 2010; Michael, 2003). However, CBE was the policy used by the hospital in *Lama v. Borrás* (1994), in which the court ruled that sporadic charting by nurses delayed communication of early signs of infection (Guido, 2010).

Altered and missing records are equally problematic whether in paper or computer format. While healthcare professionals learn the preferred way to make corrections in paper charts, there have been cases where entries have been completely obliterated with ink or correction liquid. Worse yet, original pages are removed and rewritten documentation is inserted. Handwriting experts can determine alterations in records, such as different inks and changes in slant and pressure in the writing (Guido, 2010). Addendum to EMRs is easier to recognize, in that the person must log onto the system to access the EMR and entries are automatically date and time-stamped with proof of identify. Audit trails can also determine if there were attempts to change the record. Just as with a paper chart, a hard copy of an EMR can have missing pages that would be critical to the legal case. Information technology administrators may also have to be included in interrogatories or subpoenas to locate the missing records and determine data backup procedures.

Technology should improve our lives, but as technology continues to increase, so do the experts in the respective fields. With the expanded use of EMRs, besides physician and nurse experts for the healthcare issue, additional professionals called to testify may include the administrator of information technology (IT), computer forensics experts, and medical and nursing informatics experts.

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Liability for Negligence and Error in Judgment

By *Judith M. Bulau, MSN, RN*

Q: Are healthcare professionals liable for negligence and errors in judgment related to medical malpractice?

A: Yes and no. Healthcare professionals are liable for negligence but they may not be liable for errors in judgment depending on state law.

Understanding liability related to negligence and error in judgment is important in successfully defending allegations of medical malpractice. The liability of healthcare professionals depend on proving professional negligence. Turkewitz (2007) defines negligence as the failure to use reasonable care under the circumstances, doing something that a reasonably prudent doctor would not do under the circumstances, or failing to do something that a reasonable prudent doctor would do under the circumstances. It is a deviation or departure from accepted practice. According to the Encyclopedia of Nursing and Allied Health, negligence can be a wrongful act by a physician, nurse, or other medical (healthcare) professional in the administration of treatment – or at times, the omission of (medical) treatment to a patient. Negligence can result from a lack of knowledge or skill, or from failure to exercise reasonable judgment in the application of professional knowledge or skill. These situations are determined by comparing the action in question with what a similar practitioner would reasonably be expected to do in the same circumstances (Wojahn, 2011). This is defined similarly by Peterson and Kopische (2010).

According to Aiken & Warlich (2010) a plaintiff in a medical malpractice case must prove four elements of professional negligence: (1) a duty must be owed to the patient; (2) there is a breach of duty or standard of care by the professional; (3) proximate cause or causal connection must be evident between the breach of duty and the harm or damages that have occurred to the patient/plaintiff; and (4) damages or injuries must be suffered by the plaintiff. An example of professional negligence is failure to diagnose and treat cancer in time, resulting in loss of chance of survival and untimely death. Medical malpractice has not occurred if these elements do not prove negligence.

Aiken & Warlich describe an error in judgment as a legal defense that says a healthcare professional is not liable for negligence if the professional's: (1) care conformed to the current professional standards of care and was not a departure from accepted practice; (2) knowledge and skills are similar to those of an average member of the profession; and (3) professional judgment was used to choose between

alternative available treatments or courses of action, both of which would be within the standard of care. Healthcare professionals cannot be held liable for errors in judgment as long as their judgment is based on the standard of care. The plaintiff must prove that the error in judgment fell below the standard expected of a reasonable competent healthcare professional and that the error in judgment caused the plaintiff's injury. Defendants may be found liable for negligence if plaintiffs can prove these three factors and that the departure from accepted practice was a significant cause of injury to the patient.

The error in judgment defense and its impact on state law is described by Grabois (2010) who cites a 1891 Pennsylvania case that became law as established in the trial court's instructions to the jury for its deliberations in the case of *William v. Lebar*, 141 Pa. 149, 21 A 525 (1891). Based on the court's instructions related to error in judgment the jury found that the defendant was not negligent.

However, Grabois discusses changes in state law may be slowly eroding the legal protection that defendants have under the error in judgment defense. For example, in the case of *Pringle v. Rapaport*, Superior Ct. PA. docket 173WDA2007, August 31, 2009, 2009, Pa. Super. 171, the plaintiffs sued a physician for negligence because their newborn baby had sustained a brachial plexus injury with permanent right arm paralysis during the baby's birth. The trial court gave the following instructions to the jury to consider as to whether the defendant was not negligent: "...if a physician has used his best judgment and he has exercised reasonable care and he has the requisite knowledge or ability, even though complications resulted, the physician is not responsible. The rule requiring the physician to use best judgment does not make a physician liable for a mere error in judgment provided he does what he thinks best after careful judgment."

"Physicians who exercise the skill, knowledge and care customarily exercised in their profession is not liable for a mere mistake of judgment. Under the law, physicians are permitted a broad range of judgment of professional duties

and they are not liable for errors in judgment unless it is proven that an error of judgment was the result of negligence.”

Based on these instructions the jury found that the defendant was not negligent. The plaintiffs sought a new trial, which the trial court denied. The plaintiffs then appealed to Pennsylvania’s Superior Court who ruled that the error in judgment instructions were inherently confusing and should not be used in negligence cases. It granted a new trial to the plaintiffs. As a result, this ruling is now Pennsylvania law and it has effectively taken away the legal right of physicians to use the error in judgment defense in Pennsylvania. It may only be a matter of time for other states to strip away this defense.

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Building Better Workplaces Using Confident Voices: *The Nurses' Guide to Improving Communication and Creating Positive Workplaces*

By Beth Boynton and Bonnie Kerrick

Reviewed by Kathleen Ashton, PHD, ARPN, BC

Beth Boynton has teamed up with Bonnie Kerrick to remind us all of the basics of communication. Many of us believe we are communicating just fine, but the rates of errors and other communication-related incidents in today's healthcare environment tell a different story. The effect of poor communication is being recognized as a contributing factor in many adverse events in the hospital and other healthcare settings. In any field communication is usually pivotally important and the field of Legal Nurse Consulting is no exception.

The first 4 chapters of the book set the stage with theories, research, and actual stories concerning current conditions. The scope of the problem is delineated through examples of toxic workplaces and a look at workplace violence. Boynton contends that nurses who "eat their young", abusive physicians, and toxic workplaces are evidence of dysfunctional conflicts that permeate our healthcare culture. She takes us back to Maslow and that Hierarchy of Needs we all learned in our basic programs while interspersing quotes from well-known leaders and great thinkers. Included is a look at the types of organizational cultures and relationships. Some very foundational ideas such as how dress affects the culture of an organization are explored in detail.

Three foundational principles of communication are presented in Part II as a means of changing the status quo. These include respectful listening, being responsive by speaking up assertively, and effectiveness in creating a safe environment. Boynton's examples and discussion of these principles serve as a guide for effecting change. Every chapter includes discussion and reflection questions at the end, making the book quite useful in a variety of settings with all levels of professionals.

Part II is focused on change and presents some very real solutions to the problem of workplace dysfunction. One section discusses the benefits of using "I" statements and offers some practice exercises. Chapter 6 reviews the components of respectful listening and describes true curiosity as one of the important components. Chapter 7 is aimed at all levels of professionals but points especially to those in leadership positions and exhorts the leaders to look closely at the dynamics of communication. Boynton states

that, "Disrespectful behavior cannot be excused at any level". She then offers steps to create a better environment.

Part III is intended to move the reader from toxic to positive workplaces with an eye towards integration of the concepts discussed earlier into the context of real nursing experiences. Two very interesting stories are detailed in chapters 8 and 9 and when used with the discussion and reflection questions at the end of each chapter could serve as great scenarios for a leadership and management class setting. Chapter 10 gives the reader a glimpse of some real champions and provides guidance for those who truly wish to improve their skills.

As an example of the change sought throughout the book, the epilogue is titled, "Where Nurses Nurture Their Young". It is the author's challenge to all nurses to use good communication principles to combat the increased workplace violence and incivility seen in our profession and to start the change process using the guidance offered by this very informative book.

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