The Journal of
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Roles of the LNC

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The Journal of Legal Nurse Consulting

Purpose

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.

Manuscript Submission

The Journal accepts original articles, case studies, letters, and research. Query letters are welcomed but not required. Material must be original and never published before. A manuscript should be submitted with the understanding that it is not being sent to any other journal simultaneously. Manuscripts should be addressed to JLNC@aalnc.org.

Manuscript Review Process

Submissions are peer-reviewed by eminent professional LNCs with diverse professional backgrounds. Manuscript assistance can be provided upon request to the editor. Acceptance is based on the quality of the material and its importance to the audience.

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Features

Departments

The Role of the LNC: Ever Expanding, Ever Growing

In my role as Editor of the *JLNC*, I have the opportunity and honor to hear from LNCs all over the country. These individuals willingly share wonderful concepts and ideas. This month, Mary Larkin shared an expanded role she developed in her LNC practice: she provides consulting to correctional facilities in the area of review for quality of medical care delivery. Larkin wrote, "My role along with a panel of MDs and lawyers was to review medical records to look at whether the care being delivered under a contract provider was meeting the standard. Through our reviews, we were able to facilitate a new health care contract for prison health. I have also spoken with an advocacy program at one of our major medical centers. This program has in-house lawyers who help facilitate care for vulnerable populations through collaboration with medicine. Currently there is no LNC working with them, but it seems as though it could be a successful fit in programs such as this."

Larkin is just one of a number of professional peers who push the envelope of practice, through expanding the definition of the role of legal nurse consulting.

In this issue of the *JLNC*, we explore the growing role of the legal nurse consultant (LNC). One of the Feature articles demonstrates the art of critical thinking as a key component of the LNC's practice. It reminds us of our ability to participate as a valuable component of the litigation team. A second Feature highlights ethical decision-making with a case study on wrong site surgery, reminding us of our leadership role in clinical nursing practice. It underscores the responsibility that LNCs have in helping our peers understand moral and legal standards of care delivery. Focusing on the LNC in the acute care setting, a third Feature highlights a foundation for role expansion for LNCs into the growing field of risk management.

We continue this issue with some of your favorite Departments, the Q&A column and the Forensic Corner. We are also pleased to welcome an old favorite back to the core, Legalese. Many thanks go to the San Diego Chapter and their mentor Regina Noonan for reviving a strong contribution to *The Journal*.

Last but certainly not least, I leave you with this bit of information. As some of you may already know, the Supreme Court of Illinois has confirmed the role of nursing as a distinct and separate entity in the health care realm. With this decision, the importance of nursing as a component of health care delivery was brought to the forefront, and our position in the courtroom was solidified by restricting those who testify concerning standards of nursing care to nurses. This further enhances the professionalism of nursing practice and highlights the role of LNCs as expert witnesses. An author has promised a future manuscript for the *JLNC* that will expand on this landmark decision. Please join me in reading about and celebrating our diversity, our strength, and our growing role expansion as LNCs.

Lynda Kopishke

P.S. My personal thanks joins the Editorial Board's praise for each potential author who has contacted us regarding submission of manuscripts. We applaud your efforts, are ready to support you through mentorship, and await your personal celebration of success in getting published. Please keep those manuscripts rolling in! Those in search of topic ideas on which to consider writing can find an extensive list (generated by Editorial Board member Regina Noonan) on the AALNC Web site in the *JLNC* section. Happy summer and happy writing to all!

Attention Interested Reviewers!

Are you looking to get involved with *The Journal of Legal Nurse Consulting*? The Editorial Board is seeking readers interested in acting as content reviewers for specialized topics within the legal nurse consulting field. For more details and responsibilities, contact Journal Management at JLNC@aalnc.org or 877/402-2562.

Application of Critical Thinking Skills to the Role of the Legal Nurse Consultant?

Laurie C. Blondy, JD MSN RN

KEY WORDS
Critical Thinking, LNC Roles, Nursing Education

The understanding and application of critical thinking can help people to change attitudes and behaviors that can improve their own lives and the lives of others. Critical thinking is applicable to all areas of life, including one's personal, political, and work life. The importance of teaching critical thinking skills to students is well recognized in many curricula, including nursing. Nurses work in a variety of specialties, including legal nurse consulting. Critical thinking skills are essential in this newly recognized and growing field. These skills allow the legal nurse consultant to better serve clients and foster outcomes that ultimately serve both patients and the health care field.

Utilization of the process of critical thinking in nursing is well recognized as an essential component necessary for advancement of the profession and positive patient care outcomes. As the importance of critical thinking has come into focus, it has become a requirement in nursing education programs throughout the United States. Nurses are expected and encouraged to apply critical thinking skills to their work in all areas of specialty and expertise. Legal nurse consulting is no exception. As this segment of the nursing profession grows and gains recognition, the ability to think critically and demonstrate the components of this process in decision making serves to advance this role and validate the services that legal nurse consultants can provide.

There is a dearth of information published about the utilization of critical thinking skills by the legal nurse consultant, even though these skills comprise an essential component of almost every service that these consultants provide. It is the hope that this article will raise awareness and appreciation of the necessity of these skills in the legal nurse consulting role, as well as encourage consultants to hone their critical thinking skills so that they may better serve their clients while promoting the integrity and unique services this nursing specialty can provide.

Definitions of Critical Thinking

Brookfield (1987) defined critical thinking as the process of questioning one's assumptions and then being prepared to change one's behavior as a result of this questioning. He indicated that to think critically, a person often experienced a major event, albeit positive or negative, that triggered one to appraise or question assumptions and the usual way of doing things, thereby exploring alternative approaches and developing different perspectives. Integration of these new perspectives and approaches could then result in changed behavior and different outcomes (Brookfield, 1987).

Brookfield (1987) has identified four different components of critical thinking. First is to purposefully identify and challenge the assumptions that underlie our values, beliefs, and actions. This component also involves identification and challenge of the actions and beliefs of others, and leads to analysis of what we formerly took for granted. Another component is realizing that our assumptions, beliefs, and values have been shaped and molded over time by our culture and life experiences. Consciously thinking about our assumptions separately from our culture and experiences helps us to view our assumptions in a different light. By casting aside the usual way in which we perceive things, we can begin to experience greater understanding of the behaviors, opinions, and cultures of others. A third component involves the process of imagining and exploring alternatives. This step flows naturally from the previous two. Once we start to question our current beliefs and actions within our current environment, we can consider other possible ways of thinking and doing things. The final concept is that imagining and exploring alternatives leads to reflective skepticism. This component helps us to realize that there is more than one way to do things, and we begin to realize that things may not always be what they seem.

By comparison, Facione (1990) conducted a Delphi research project that developed a consensus statement defining critical thinking as being "…purposeful, self-regulatory judgment which results in interpretation, analysis, evaluation, conceptual, methodological, criteriological, or contextual considerations upon which that judgment is based…" Facione (1990) explained that the process of explanation and self-regulation involved critical thinkers' abilities to explain what they think and how they arrived at a particular judgment. This means that the critical thinker can apply the power of critical thinking to him- or herself, as well as others, to improve on his or her previous opinions and ideas.

The American Philosophical Association also developed a consensus definition of critical thinking through a Delphi project. This definition defined the ideal critical thinker as follows:

> …habitually inquisitive, well informed, trustful of reason, open minded, flexible, fair-minded in evaluation, honest in facing personal biases, prudent in making judgments, willing to reconsider, clear about issues, orderly in complex matters, diligent in seeking relevant information, reasonable in the selection of criteria, focused in inquiry, and persistent in seeking results as precise as the subject and the circumstances of the inquiry permit.

There are a multitude of critical thinking definitions found in both educational and nursing literature beyond those previously discussed. Difficulty in defining critical thinking compounds the problems of both teaching and evaluating critical thinking strategies. Upon review of definitions available, however, it becomes clear that there are similar concepts recognized as primary components of critical thinking. These definitions share general agreement that critical thinking involves purposeful, self-regulated thinking that is open to questioning how things are done, seeking out and incorporating new information and alternative ideas, and developing new solutions or approaches to problems. Lemire (2002) reviewed definitions of critical thinking from the literature and formed a common definition as the "acquisition of knowledge, reasoning and rational appraisal skills, analytic problem-solving behaviors, and reflective thinking."

Recognition of Critical Thinking Behaviors

Critical thinking is a self-regulated behavior. To become automatic, one must practice and consciously exercise the components of critical thinking (Brookfield, 1987). Doing so can help broaden perspectives, develop open-mindedness, increase analytical skills, and modify actions. People who have learned to think critically and incorporate it into their daily lives exhibit certain behaviors. In other words, there are specific, identifiable actions by which the process of critical thinking can be recognized. When people think critically, they realize that they are directly responsible for creating and recreating their environments (Brookfield, 1987). Critical thinkers understand that they are not powerless to change things, and that their future is not hopeless. They recognize their ability to help shape the future for themselves and those around them. Such people are keenly aware of the many multiple factors that influence their world and are adept at giving consideration to those factors when working to bring about change.

Critical thinking is a process rather than an outcome. We do not "arrive" at a place where all critical thinking has been accomplished and is no longer needed. Our lives are in constant flux, and the world around us is constantly changing. The ability to adapt and cope with such change is directly related to the ability to utilize the very concepts that comprise critical thinking (Bridges, 1980; Brookfield, 1987). Often, changes that are forced on people cause them to think critically and begin the process of exploring and thinking about other options that might be available to them. Critical thinking is thus emotive at times, as much as it is rational (Brookfield, 1987).

Brookfield (1993) defines four types of questions, or perspectives that indicate a person is thinking critically – epistemological, experiential, communicative, and political. The questions that must be asked in each of these categories are as follows: Epistemological questions examine the extent to which information is founded in empirical research, the cultural influences present in information being presented, as well as the intellectual framework surrounding the applicability of information to day to day life. Experiential questions identify what information seems to be missing or left out that is needed to make informed decisions, the ethical implications of solutions or information presented, and the application of information or solutions presented to the situation at hand. Communicative questions examine whose voices are heard when information is presented or gathered, how informed is the source of information to the real life situation being addressed, and how practical is the information to real life. The political perspective of critical thinking asks whether solutions or information presented is a product of teamwork or an individual opinion, the degree of democracy involved in the solution or information proposed, and whose interests are being served by the information or solution being presented.

Critical thinking can be beneficial to all areas of a person's life, whether it be personal, professional, or political. Utilizing critical thinking skills in personal relationships helps us to seek that which we want versus what we were taught we should want. It helps us to understand the people with whom we share our lives. Critical thinking helps us understand the cultural melting pot in which we live. Politically, critical thinking helps us to question the views presented to us and evaluate whose voice is being heard (Brookfield, 1993). Critical thinking in one's work life can help a person reach, grow, and develop professionally. Critical thinkers in the workplace recognize the need for continual learning and questioning, as well as openness to information. They constantly look for ways to improve existing practice and are motivated by the possibility of future influence on policy and hopes of promotion (Lowy, Lelleher, and Finestone, 1986 as cited in Brookfield, 1987). The discipline of nursing is no exception to this.

Critical Thinking Skills in Nursing Education

During the past few decades, nursing has evolved from an occupation of physician helpers who were task-oriented to a profession of highly educated professionals who are expected to be capable of making independent judgments and decisions directly influencing patient care (Martin, 2002). This progression has been accompanied by a demand for greater responsibility and decision making skills, such as those that comprise critical thinking. Most nurses work in

hospital settings. These organizations are highly complex, involving not only patients and their families, but also health care providers from many disciplines comprising an interdisciplinary team (Cody, 2003). These disciplines include but are not limited to medicine, respiratory therapy, physical therapy, occupational therapy, speech therapy, pharmacy, laboratory, imaging (such as X-Ray, CT, & MRI), social services, and home health care. Nurses evaluate data from all of these sources at various times, along with patient data to determine if what is being done for the patient is effective, and whether an alternative approach might result in better patient outcomes. Good critical thinking skills result in increased accuracy and competence of clinical judgments and nursing diagnoses (Daly, 1988; Lunney, 2003).

As the demand on nurses to work both independently and interdependently has increased, the need for critical thinking skills has been well recognized. Critical thinking in the nursing profession is necessary in order for nurses to develop true autonomy (Girot, 2000). Nursing literature describes critical thinking skills as encompassing a cognitive process that requires a higher order of thinking and decision making ability (Jones and Brown, 1991 as cited in Girot, 2000). This ability allows nurses to become proficient at gathering and analyzing data, problem solving, logical reasoning and developing conclusions (Bandman and Bandman, 1995 as cited in Girot, 2000). As nurses become more proficient in their exercise of critical thinking skills, they become more competent in identification of discrepancies between the goals of nursing and the organization for which they work and what actually is occurring in nursing practice that affects patient outcomes (Seymour, Kinn, and Sutherland, 2003).

The requirement that nurses think critically has resulted in implementation of strategies to teach critical thinking skills in nursing education curriculums (Martin, 2002). The National League for Nursing Accrediting Commission (NLNAC) and the Commission on Collegiate Nursing Education (CCNE) now mandate that nursing education programs incorporate significant content and activities committed to the development of critical thinking skills in students within their curriculums (AACN, 1998; NLN, 2003). Studies indicate that nurses learn critical thinking skills through both academic study and clinical experience (Girot, 2000; Martin, 2002).

Teaching critical thinking skills in nursing education is no easy task. There is criticism in literature that the term "critical thinking" in many cases is no more than a buzzword and that textbooks and educational programs often fail miserably in their ability to teach these skills (Cody, 2003). According to Thayer-Bacon (2000), critical thinking must be viewed as being relational and constructive in its nature (as cited in Cody, 2003). This means that nurses must be taught the importance of a constant dialogue and exchange of ideas with others, self-reflection of information gathered in relation to one's own beliefs, values and life's experiences, and the mutual development of a reality that is functional between and among the people involved (Cody, 2003). This description helps envision ways in which nurses can be taught critical thinking skills. Instead of studying case scenarios presented with options that suggest one correct answer, nursing students should be provided with information that allows the development of numerous possible outcomes based on nursing frameworks and nursing theory (Cody, 2003).

Girot (2000) has emphasized the importance of teaching critical thinking skills in graduate nursing programs. Nurses in graduate academic programs exhibited significantly better decision making skills than non-academic nurses in practice using the Jenkins' Clinical Decision-Making in Nursing Scale (Girot, 2000). This study suggests that advanced academic study was a more significant factor in a nurse's clinical decision making ability than experience in the work force. Martin (2002) conducted a study that indicated undergraduate and non-licensed nurses who had completed an undergraduate nursing program had poorer ability to make accurate patient nursing diagnoses than did licensed nurses in the workforce. These studies together indicate that advanced academic study *and* work experience foster development of critical thinking skills. As nurses continue to advance their practice in all areas of patient care, they also become more independent and valued as part of the health care team. Nurses must continue to expand their educational and professional work experiences in order to cultivate their critical thinking skills.

Critical Thinking in Legal Nurse Consulting

The process of legal nurse consulting is both relational and constructive in nature, similar to decision making in the clinical setting. The primary difference is twofold: clinical nurses work prospectively with a patient and family, along with the health care team, to influence patient outcomes in a positive manner. The legal nurse consultant works from a medical chart retrospectively to determine if patient outcomes could or should have been different, based on the care that was (or was not) provided. A legal nurse consultant's co-workers includes the patient and family, the client (who is usually an attorney), and the medical experts.

There is no shortage of information regarding the importance of critical thinking skills in nursing education and the clinical setting; however, there is very little published on the importance of critical thinking skills specifically for the legal nurse consultant (LNC). The cognitive components of the legal nurse consultant's role correlate very closely with the process of critical thinking. When examining the services an LNC performs against Brookfield's (1993) discussion of the four types of questions asked that provide evidence of the process of critical thinking, it becomes very clear that critical thinking is both necessary and invaluable when providing legal nurse consulting services.

From an epistemological perspective, it is important to evaluate if treatments and interventions employed were up-to-date and practical, in light of the patient's condition and needs. If the treating hospital or clinic did not have appropriate equipment, did they transfer the patient appropriately so that the needed treatment could be obtained? Was the patient's cultural background considered when evaluating treatment measures? For example, if someone is a Jehovah's Witness and blood products were not given per the patient's choice, and this contributed to the patient's demise, this would not equal negligence or malpractice. From an experiential perspective, were optional treatments that might have benefited the patient weighed against the practicality of implementing such treatments? Were there omissions in the care that was provided? Were all appropriate tests done to gather the information needed to make informed decisions? Were the treatment decisions ethical? From a communicative perspective, were the patient and family needs properly heard and addressed? Did the patient understand the choices presented, in a language he could understand, when he made so-called "informed decisions" about his health care? From a political perspective, were the patient's best interests served? Were decisions made with the input from an interdisciplinary team, or were they made solely by the primary treating doctor? This brief discussion easily demonstrates the applicability and essential need for critical thinking skills by the LNC. Like any other subspecialty of nursing, use of critical thinking skills by the LNC are developed and honed through education and experience.

Education, credentials, and experience are all important to the development of a successful career in legal nurse consulting (Dougherty, 2002). Years of clinical expertise in a variety of areas, coupled with a background in nursing education, helps prepare a nurse for the role of LNC. An educational background in basic nursing theory provides frameworks that help the LNC approach various medical situations and work through them examining a myriad of possible outcomes. This correlates with the critical thinking approach described by Cody (2003) of having nursing students work through nursing scenarios with the realization that there is not one best answer to a problem, and that their own experiences will play a part in the clinical judgments they make. Courses and certificate programs are now available to teach nurses how to be LNCs, and how to package their educational and clinical expertise and skills into services an LNC can provide (Milazzo, 2002). Programs vary from one-day seminars to courses that run several days or weeks. Certification as an LNC is also available to signify basic competencies in this profession.

Clinical work experience provides knowledge useful to the LNC when reviewing medical injuries and procedures as described in client records. Work experience also helps the nurse gain confidence in working with various members of the healthcare team (Milazzo, 2002). Nurses working clinically as part of an interdisciplinary team must learn when and how to implement their critical thinking skills (Cody, 2003). The LNC must know not only how to think critically, but how to tactfully apply these skills when working within a diverse group of highly educated people. Gaining these skills in the clinical setting will help the nurse to successfully apply them while working in the LNC role.

The role of the LNC is widely varied and highly complex. The skills of critical thinking are both necessary and expected in order to perform in this role successfully. It is crucial that LNCs both understand and utilize critical thinking skills in their jobs to foster further development of this emerging nursing specialty. Doing so will add prestige and respect to this valuable and unique profession. Nurses are encouraged to reflect upon and appreciate their critical thinking skills, and improve these skills in ways that will benefit both patients and the nursing profession.

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A Bioethical Scenario: The Surgical Process Involving Wrong Site Surgery

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KEY WORDS
Ethical Dilemma, LNC Roles, Wrong Site Surgery

Legal nurse consultants (LNCs) who practice in the clinical setting are frequently asked to assist their peers with ethical dilemmas. Understanding a decision making model and working through a case scenario helps sharpen the LNC's skills in the area of bioethical concerns. This article proposes a clinical scenario ripped from the pages of the daily news and walks the LNC and clinical nurse through a process for moral decision making. It also provides some basis in law for ethical decision making guidance.

The Scenario

"Susan," an operating room (OR) nurse, has worked in the operating room at "County Hospital" for the past 10 years. She is beginning a course of study to be a legal nurse consultant (LNC). Over the years, she has witnessed many changes in the OR, including advances in equipment, enhances in surgical procedures, different physicians coming and going, and an abundance of new policies and procedures. The latest wave of policies and procedures has involved the efforts of the Joint Commission on Accreditation of Hospital Organization's (JCAHO) movement to eliminate wrong site surgeries.

County Hospital has made attempts to follow the new guidelines in order to reduce the chance of an incidence in their facility. Widespread education has taken place during the last 3 months with all nurses, surgeons, and anesthesiologists. The procedures accepted to reduce the chances of wrong site surgery include marking of the surgical site in the pre-surgical suite, a pre-surgical assessment, and a checklist that is to be signed by the OR nurse, surgeon, and anesthesiologist in coordination with a "time-out" to occur before the actual incision. The first month of implementation resulted in a great deal of confusion regarding the procedure including resistance by the staff related to a change in their "normal" practices. The second month seemed to go much smoother, with everyone on board in order to make the necessary changes. The third month produced a great deal of compliance with the new procedures.

Approximately 5 months after the initiation of the new procedures, Susan noticed a decrease in compliance with the process while running her OR rooms. Although she has upheld her duty to the patient in doing her pre-surgical assessment and making sure the patient is marked, Susan has experienced increased difficulty in getting the rest of her teammates to cooperate in the consistency of following the correct procedures. She has noticed that the surgeons have become consistently late to the OR suite, arriving after the first anesthesia medications are pushed, that the anesthesia personnel have not been doing their part in asking the patient what surgery is to be performed, as well as no consistency during proposed "time-out" before incision.

Susan has repeatedly taken her concerns to management, without resolution. When confronting either the anesthesiologist or the surgeon, she is dismissed as worrying too much and overreacting to the situation. Several surgeons have become nasty with her, declaring that they are busy and will arrive to the OR suite when they get there. Susan is bothered by this new laissez-fair attitude toward the new initiatives designed to prevent patient harm and injury. Another co-worker has also recently approached Susan in regard to her overbearing paranoia about the new initiatives because "County Hospital has never had an incident with wrong site surgery." Feeling as though her concerns are invalid and of no concern to anyone, Susan contemplates dropping her high standards and work ethic in order to be more like everyone else. She contemplated approaching her Risk Management Department but decided against it, fearing that she would be viewed as an "informant" against her department.

What should Susan do? Should she risk her own standards and ethics toward her patients in order to be more accommodating to a smoother running room, her co-workers, and the surgeons? What information can Susan use in order to back up her concerns? How should she make her decision regarding approaching Risk Management?

Background Information

In recent years, there has been a sweeping movement by several organizations to wrap their arms around a growing and alarming problem. The purpose of such revision is to increase awareness of the possibility of wrong site surgery and to provide better patient outcomes both pre- and post-op. Patient safety is a priority for all hospital and ambulatory surgery centers. Patients put a great deal of trust in their surgeons, the nursing staff, and the hospital of their choice. When patients enter the health care system, they expect their surgery to be performed according to the pre-surgical discussion. They do not expect to awaken after their surgery to find that the wrong procedure was performed on their

body. This nightmare could have detrimental outcomes, such as surgery on the wrong limb or removal of an incorrect organ. It is everyone's duty and responsibility to provide the best possible care to the patients entering the system for a surgical procedure.

The above dilemma presents many facets of ethics to the nurse in her duty to the patient. The weight of giving in to peer pressure must not outweigh the duty to the patient of ensuring the safest possible surgery. Some may say wrong site surgery is a mistake, in which even surgeons and nurses are human. Others may say that this is a situation that should never happen in a health care facility allowing 0% error.

Landmark cases of surgeries being performed on the wrong patient or the wrong site have forced the nation to deal with the issues involving wrong site surgery. JCAHO made it a recent and future mission to see that the number of wrong site surgeries is greatly decreased, as well as an initiative put in place in order to change the process. As of July 18, 2003, JCAHO again included wrong site surgery on their list of 2004 National Patient Safety Goals (NPSG) including recommendations to implement the goals (Facts about the 2004 National Patient Safety Goals, n.d.). This is not a new goal: JCAHO recognized this initiative as a priority in their 2003 NPSG (Mooney, 2003).

The inclusion of wrong site surgery in the NPSG arose from the reporting of sentinel events reviewed by the Sentinel Event Alert Advisory Group. The most recent report issued by the Joint Commission on June 29, 2004, showed that, since January 1995, a total of 2,552 sentinel events have occurred in various settings. Out of the total 2,552 events, 310 (or 11.8%) wrong site surgeries were performed resulting in a ranking of the third most common sentinel event. In the December 17, 2003, report, the incidence of wrong site surgeries in general hospitals was reported as the second most common sentinel event and ranked the most common sentinel event in free-standing ambulatory care centers (Sentinel event statistics, n.d.).

This information has led to the scrutiny of the process leading to the actual surgery and a new initiative backed by several organizations. On May 9, 2003, JCAHO held a Wrong Site Surgery Summit in order to face this problem head-on and develop universal protocols in assisting to prevent wrong site surgery (www.ama-assn.org, n.d.). JCAHO worked in collaboration with the following supporting organizations: American Medical Association, American Hospital Association, American College of Physicians, American College of Surgeons, American Dental Association, and the American Association of Orthopedic Surgeons, as well as leaders from 20 other organizations. Progress made at this summit led to the establishment of a universal protocol for preventing wrong site, wrong procedure, and wrong person surgery, including guidelines for a process for facilities to follow (Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery, n.d.).

Application of Critical Thinking Skills

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In addition, the Association of Operating Room Nurses (AORN), along with the American Academy of Orthopedic Surgeons (AAOS), identified contributing factors to performing wrong site surgery, risk-reduction strategies in order to eliminate wrong site surgery, and drafted a position statement from AORN concerning their stance toward eliminating wrong site surgery (www.aorn.org, n.d.). It is also worth mentioning that wrong site surgery does not necessarily mean surgery performed on the wrong site, but is an all-encompassing broad term to include surgery on the wrong side, wrong patient, and the wrong procedure (Croteau, 2003).

Statistics reviewed by Croteau (2003) included the following information of reported wrong site surgeries: 59% were performed on the wrong side, 12% were performed on the wrong patient, 10% were the wrong procedure, and 19% were performed on the wrong site. It is assumed that, understanding the background information on wrong site surgery, one can identify numerous ethical dilemmas surrounding this issue.

Ethical Perspectives

There are two schools of thought regarding the ethical perspectives involved in the topic of this paper. One is a general ethical perspective, involving the greater concept of ethics in patient care. The second involves Susan, the nurse in the introductory ethical dilemma, which presents a first-person perspective illuminating how one deals with the ramifications of universal protocols regarding the prevention of wrong site surgery.

Broad ethical perspectives may include the patient's trust in the hospital staff, the facility, their surgeon and the medical system in general. A breech in the concept of veracity involving the surgeon and staff may enter into the picture if, indeed, a wrong site surgery was performed on a patient. How each individual deals with the unexpected result will determine the patient's long-term outcome. Questions arise: How will the patient be told? What corrective actions will be taken by the surgeon in order to rectify the damage to the patient?

Autonomy of the patient is lost after an incident like this has occurred. Most patients may feel completely powerless concerning their new situation. Justice for each patient is affected, as each victim of a wrong site surgery did not receive the same treatment in that given operative day. Finally, fidelity was breeched due to the lack of commitment the surgeon had to the patient to perform the correct surgery on the correct person. Another ethical dilemma that can be raised is where the responsibility lies to complete the correct surgery on the correct patient. Is it ultimately the surgeon, or the peri-operative nurse, or the team approach (if one exists) who makes sure the process is correct and is followed? Or perhaps some of the responsibility lies with the patient in order to make sure correct interactive communications are held with their surgeon and surgical team?

One frequently cited study, published by the *Journal of Bone and Joint Surgery* (Meinberg & Stern, 2003), surveyed 1,560 members of the American Society for Surgery of the Hand (ASSH) in regard to wrong site surgery. Survey questions were comprised of three sections: information about the surgeon's specialty, practice, and operative load; details regarding any episodes of performed wrong site surgery; and assessment regarding the influence of the "Sign Your Site" campaign and safeguards instituted by the AAOS. The results of 1,050 (67%) surgeons who responded to the survey showed that 173 (16%) of the surgeons had experienced a near miss with operating on the wrong side and realized it before incision, and 217 (21%) reported that they actually performed wrong site surgery at least once during their career. Instances of one incident (193 or 18%), two incidents (23 or 2%), and three incidents (1 or 0.1%) of performed wrong site surgery were also reported.

The study concluded that there were several preventive measures that surgeons and the OR team can take to reduce the instances of wrong site surgery. One ethical concern raised in reviewing the study was whether the surgeons answering the survey were truthful in their responses. Thus, the basis of this study involved the responsibility being accepted by the surgeons and other health care professionals.

On the flip side, another study published by the *Journal of Bone and Joint Surgery* (Digiovanni, Kang, & Manuel, 2003) investigated the patient's responsibility in ensuring that the surgeon and team perform their surgery on the correct site. Although this is a rough study with many variables and weaknesses, it is an attempt to include the patient in identifying the correct site rather than solely the surgeon and the OR team. The study was a blinded study, which involved 100 patients from one foot and ankle orthopedic practice. The sample group was a mix in age ranging from 13 – 48 years and included both male and female participants with varied backgrounds in work history, medical coverage, previous surgeries, disability, worker's compensation cases, and retirees. The premise was to give the 100 patients specific written and verbal instructions with specific points underlined, capitalized, and in boldfaced print to the patients before leaving the office and after their surgical consultation with their surgeon. The focus of the study was whether patients followed the instructions exactly, partially followed the instructions, or did not follow the instructions at all by marking a "NO" on the non-operative foot or ankle with an indelible black marker.

The basic results of the study showed that, of the 100 patients, 63 (63%) had marked the non-operative side before surgery. Of the 63 patients, 59 had followed the directions completely, 4 had marked something different than what the instructions had stated, and 37 had no mark of any kind regarding their surgery. The discussion of the study revolved around compliance versus non-compliance of the patient regarding pre-op instructions. The authors offered opinions of what surgeons could do to minimize the risk of wrong site

surgery. However, it is noted at the end of the discussion how the doctor-patient relationship has evolved over the years from complete responsibility of the surgeon to a shared responsibility with a proactive patient. The final statement of the journal article maintains, "Our data suggest that we must do a better job of educating our patients about their vital role in the proactive prevention of avoidable complications such as wrong-site surgery" (Digiovanni, Kang, & Manuel, 2003). One could view this journal study as having numerous ethical dilemmas in its own context. The above journal review spurs many ethical dilemmas regarding whose responsibility it is to prevent wrong site surgery.

Another facet of responsibility for this ethical dilemma is the hospital facility itself. What proactive role do they play in preventing patient harm with wrong site surgery? Since the reporting of sentinel events is purely voluntary by the health facilities, the information and statistics acquired rely solely on self-reporting (www.jcaho.org, n.d.). Croteau (2003) states, "It is estimated that only 10% of actual wrong site surgeries are reported due to the voluntary reporting system." Again, this itself is an ethical dilemma. How can organizations really grapple with the problem without knowing exactly what results and how many wrong site surgeries they are truly dealing with?

The second train of thought brought forth in this article is how to help Susan with her ethical dilemma in a real-world scenario of non-compliance regarding the actual process, the surgeons, and her teammates. Susan has several ethical dilemmas on her hands: she must struggle with providing the best care and upholding her promise as a nurse to her patients; she must deal with how to handle her teammates in an effectual way that will result in a positive outcome rather than resulting in flared tempers, making the process even more ineffective; and she needs to deal with her ineffective management team and whether or not to report her department to Risk Management.

Susan has also taken a step to identify elements in her own moral values, attitude, and commitment to her work ethic. Should she put her own values and work ethic on the back burner in order to give into pressures of her co-workers? Overall, are her concerns valid, or is she really just worrying too much about something that has never occurred at County Hospital? In order to assist Susan, this article proposes the usage of the "MORAL" model for ethical decision making (lecture notes, 2004): **M**assage the dilemma, **O**utline the options, **R**eview criteria and resolve, **A**ffirm position and act, and **L**ook back. Applying the MORAL model to Susan's dilemma will help clarify what she should do to solve her problem.

"Massage the dilemma." Collect the appropriate data that can correctly identify the core of the problem. Acknowledge that most problems have more than one component; identify the facts that play into the ethical dilemma and the decision; highlight variable factors that will influence both the problem and the decision; and recognize any laws, ethical codes, and government regulations that may influence the choices of the decision. Susan also must identify who is mostly responsible for making the decision and who has a stake in the decision. She must view the problem and decision from another's perspective and consider who is involved.

Susan has identified that the people involved are the patients, the OR staff, the surgeons, herself, and management. The major issue is a breakdown in the implemented JCAHO process in order to identify the correct surgical site and correct patient. The governing bodies are the JCAHO protocols and the hospital policy. She realizes that with the people mentioned above, that there are several cultural and political factors vested in this dilemma. Susan can empathize with the patient regarding trust in the surgeon and the nurses—she has had surgery herself and can identify with the frightening reality of surgery alone. Complete trust must be placed in every member of the team to perform the correct surgery. Susan has a great deal of trouble putting herself in her teammates' shoes because she does not quite understand why they are not worried about following the protocols. She understands that the surgeons have a busy schedule; however, she cannot understand their lack of desire for the best possible patient outcome. After all, they are surgeons, and that is what they do: they should have a commitment to the best possible outcomes. Susan can also understand that management is between a rock and a hard place but does not quite understand why they will not listen to her pleas for help regarding a process not being followed.

"Outline the options." There are many options for Susan. She brainstorms and comes up with at least four options. First, she could ignore the problem and hope that no adverse event occurs. Second, she could gather information regarding the incidence of wrong site surgery and facts, and take this to her manager in a one-on-one meeting to express her concern again. Third, Susan could suggest forming a committee to oversee the protocols and institute a quality improvement study to monitor the adherence to the process. Fourth, she could report her department to Risk Management.

"Review criteria and resolve." In this step, Susan weighs her four options and decides the best and worse case scenarios for each option. She evaluates the options on the basis of beneficence, autonomy, and justice. She uses a positive and negative column format in order for her to "see" her options clearly.

"Affirm position and act." The next step is to affirm her position and act on her decision. In order to help make her decision, Susan waits a couple days in order to think about her options. In addition, she seeks input from a friend who works in an OR in the next city to get her opinion on the matter. This helps Susan greatly and solidifies her decision (final decision is revealed at the end of this article).

"Look back." After Susan decides on the appropriate option, she re-evaluates herself and the outcome. Indeed,

Susan is content with the decision she made and hopes for the best possible outcome in this ethical dilemma. She feels as though everyone involved will benefit from the option and believes that it will create the best possible outcome for her patients entering her facility for surgery.

During this process, Susan was able to clearly delineate her moral obligation to her patients and her own moral standards of care and work ethic versus her duty to her teammates. In the end, Susan decided that when she took the oath to be a nurse, she indeed had a moral obligation to her patients to provide the best possible care without unnecessary harm. Susan also believes that she is a good person and that her own moral standards and work ethic are indeed valid in her mind. She feels that if it goes unrecognized by others, then perhaps it is just a matter of individuality and cultural beliefs. Susan is relieved to know that she is fine with that thought, as long as she knows she is doing the best possible work she can for her patients. Susan eventually recognizes the importance of discovering what she has to offer to her patients and a respect for herself in order to make a positive impact both morally and ethically within the workplace. She has rewarded herself by becoming part of the changing process.

This scenario is, in fact, not uncommon. There are many instances in the work place that in themselves create ethical dilemmas due to work place and personality differences. The ANA Code of Ethics states, "Virtues and excellences are an important feature of the professionalization of the nurse, but they can be thwarted by the work environment" (Hook and White, n.d.). In essence, the Code encourages nurses to be part of the organizational change, thus improving both patient outcomes and the work environment. The Code suggests that the principle of respect for others must first start within oneself (nursingworld.org, n.d.).

Court Cases

There are numerous court cases that uphold the fact that wrong site surgery is problematic. In *Elizabeth Ebaugh v. R. Rabkin, M.D., et al. [Civ. 28464, California Court of Appeal]*, the plaintiff sued for compensatory and punitive damages in relation to a wrong person surgery (web2.westlaw.com, n.d.). The plaintiff was scheduled on the morning of February 6, 1967, for a breast biopsy. The same morning, another patient was admitted for gallbladder surgery by a Dr. Scuggs. Each patient was transported from the pre-op ward to the OR suite at approximately the same time, 7:35 a.m. and 7:40 a.m. respectively. Unfortunately, there was a mix up in the accompanying charts. The plaintiff arrived to the OR suite only to be operated on by Dr. Scruggs for gallbladder surgery. At the same time, the defendant Dr. Rabkin received the second patient and proceeded to perform a breast biopsy on a patient he thought was Ebaugh. Both surgeons realized the mistake and stopped the surgeries immediately. After the mistaken surgery, Dr. Rabkin performed the breast biopsy on Ebaugh. The plaintiff proceeded with suit against Dr. Rabkin (with Kaiser Foundation), Dr. Scruggs (with Permanente Medical), and the Kaiser Foundation Hospitals and Permanente Medical Group. The jury returned with a verdict in favor of the plaintiff awarding both compensatory and punitive damages. The compensatory damages were awarded in the sum of $7,500; however, the punitive damages were contended by both defendant parties. The punitive damages appeal was dismissed for both surgeons but rendered moot for the Kaiser Foundation Hospitals and the Permanente Medical Group.

In a second example, the surgeon was purely negligent in three separate wrong site surgeries. His medical license was revoked in the state of New York. The Supreme Court upheld in the matter of *Mitchell L. Kaphan, Petitioner, v. Barbara De Buono, as Commissioner of Health of New York State, et al., Respondents [January 27, 2000]* that there was substantial evidence that the surgeon was negligent, grossly negligent, and incompetent with respect to three wrong site surgeries and also upheld that the revocation of the surgeon's license was not an excessive discipline (web2.westlaw.com, n.d.). In April 1987, the surgeon operated on a patient who came from the emergency room with a right hip fracture; Kaphan operated on her left hip. Upon realizing his mistake, he then operated and fixed the right hip. Again, in February 1992, the surgeon was to perform arthroscopic knee surgery on a patient's left knee; he operated on the right knee after the nursing staff mistakenly prepped the wrong knee for surgery. Upon realizing the mistake, he continued to operate on the wrong knee, stating that there was damage to that knee as well that needed correcting. Finally, in December 1995, Kaphan made yet another surgical error. This also involved an injury to the right hip; however, after reviewing the x-rays and speaking with the patient's son, the surgeon decided himself that the fracture was not on the right but was on the left and the x-rays must have been mislabeled. Instead of getting another x-ray to confirm the correct hip, he operated on the left hip that did not have a fracture. The court upheld their ruling of revoking his medical license.

Conclusion

The ethical dilemma, two journal studies, and two court cases cited in this article exemplify the ethical dilemmas that arise from both actual and potential wrong site surgical scenarios. This is a greater problem than one may have anticipated upon researching this topic. This topic is multifaceted in not only processes and people, but moral and ethical issues as well. Indeed, there are numerous questions regarding wrong site surgery. Who is ultimately responsible for intervening or preventing a wrong site surgery? What consequences occur if wrong site surgery is performed on the wrong site, person, or side? What ethical dilemmas develop when an OR team is not on the same page with prevention and utilization of protocols? Moreover, in the end, who really suffers the most? The surgeon for making the mistake, the OR team for not intervening and preventing the mistake, the hospital for not forcing everyone to comply with the universal protocol, the managers for not evaluating a process that is so vital to the surgical process, the patient who suffers if a wrong

site surgery is performed on their body, or the general public who suffers mistrust after a mistake of this great proportion becomes publicized?

So what did Susan do about the lack of compliance in County Hospital? She gathered as much information as she could regarding wrong site surgery in order to back up her opinion on a process gone awry. Over a 3-week period, she documented the offending surgeons of the newly instituted process as well as non-compliant team members and anesthesia personnel. She made an appointment to meet with her direct manager and asked that the OR director be there as well. (The OR director could not attend.) When Susan met with her OR manager, she presented her information along with the documented sheet of offenders. She expressed that she had a hard time deciding how to confront this issue. She told her OR manager that she values her job at County Hospital and would like to see the best OR operation in place. She also expressed the reasons she went to nursing school and how her work ethic drives her decision making ability while at work. The OR manager was very receptive to Susan, and they came up with a plan. Susan had stated that she wondered how everyone else felt about the process thus far and maybe they should conduct a survey of the general OR staff. The manager agreed.

After that, Susan and the OR manager planned to create a wrong site surgery task force for continual review of the newly instituted protocols. This review process included a documentation sheet with tardiness of surgeons, patients who come from pre-hospital suites unmarked, OR teammates who do not implement a "time-out" before incision, and the anesthesia personnel who do not confirm the procedure with the patient before pushing medications. Armed with this new task force idea, they decided to ask for volunteers for the committee. They decided that, in the beginning, the task force committee should meet once every 2 weeks until they establish their set goals. After the introductory period, they will meet on a monthly basis. Goals for the task force include process improvement, an increased rate of compliance with the new protocols, and disciplining of the OR members who do not comply (including surgeons). The manager was so pleased with Susan's concern that she made her chairperson of the task force committee and recognized her efforts in her employee file. In retrospect after the meeting, Susan is happy and relieved that her moral and ethical values paid off in the end. She hopes that her efforts will prevent wrong site surgeries in the future at County Hospital.

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** **"Effective July 1, 2004, compliance with the Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery will be required of all Joint Commission accredited organizations, to the extent that these requirements are relevant to the services provided by the organization." (Frequently Asked Questions, n.d.). The Universal Protocol can be found on JCAHO's web site at www.jcaho.org.**

The Role of the Legal Nurse Consultant in Risk Management

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KEY WORDS
LNC Roles, Management Consulting, Risk Management

The role of the legal nurse consultant (LNC) in the risk management department encompasses the knowledge of both the legal arena and the nursing process, along with a strong clinical background. Risk management is based on four principles that are very much like the four steps of the nursing process: identification of risk, planning, implementation, and evaluation. LNCs can either work as risk management LNC consultants or as risk management employees within the facility. When working as a risk management employee, the work may include participation in many different areas such as work on committees to maintaining standards and accreditation, monitoring reports and trends, or as a component of the defense of the facility working with the attorney. The LNC risk management consultant's role focuses on high-risk issues and staff education. This article will explore the varied roles of LNCs in risk management.

Mendez (2003) states, "Ultimately the goal is to protect patients, their visitors, and the staff from harm." The principles of risk management and the nursing process are similar in that both include assessment, planning, changes or interventions, and then re-evaluation to see if there was an effective outcome (Mendez, 2003). Risk management has three main areas: risk identification and loss prevention; loss reduction; and risk financing (Yale-New Haven Hospital).

The assessment phase can include many different types and areas of data collection for risk management. The LNC could be responsible for reviewing internal event reports, following up with patient or family complaints, attending quality improvement meetings, reviewing patient satisfaction reports, reviewing compliance documents from accreditation bodies, and receiving letters of intent from possible complaints or lawsuits. Many times, it will be the LNC's responsibility to interview staff after an incident to try and help them prepare themselves for a more formal meeting with the hospital's risk manager. The facility-based risk management LNC will also generally be present at any depositions given or taken concerning a case involving that facility.

If an LNC is a risk management consultant, the duties can vary slightly from those of a facility-based risk management LNC. Health care facilities often hire LNCs to come in and do a risk assessment of either problem areas or high-volume areas. Typically, the risk management consultants do interviews, chart review, and walk-throughs of the areas. In this role, the LNC would most likely not have access to confidential employee and litigation-based information.

Creating the Risk Management Plan

A very important part of the risk management department involves the creation of a risk management plan. The basis for this plan is risk identification, with the outcome of the plan geared toward loss reduction or prevention. The LNC provides assistance in formulating the risk management plan, as well as helping to get the plan implemented.

The LNC's role in helping develop the risk management plan could be tracking, trending, and analyzing data from event reports. Once problem areas of risk are identified, the LNC can then author and implement the plan. An additional role that the LNC may undertake is to assist with setting up education sessions, to help both decrease risk and control loss to the facility. Once the potential areas of loss are identified, the administration can begin to plan for and control risk financing.

Gathering Data

In a study done by Clarke, Rockett, Sloane, and Aiken (2002), the importance of data gathering and trending was used to highlight the incidence and causative factors for accidental needle sticks of nurses. Researchers studied data tracked by risk management and various other departments in the facility to determine to what extent staffing ratios, poor equipment, or nursing experience had on an increased number of needle sticks. As a result of the data collected, a specific plan of safety changes was implemented for the health of everyone involved. Most hospitals now use needle-less systems, as well as needles that cannot be recapped. This change was the direct result of the trending and tracking of data.

After the risk management plan has been implemented the LNC's job is not finished. Continuing education for all departments concerning the proposed changes needs to be completed and maintained. Additionally the monitoring of outcomes and continually reviewing the plan for updates becomes crucial to a successful risk management plan. Transitioning to this aspect of the risk management role is much less stressful for the LNC given the experience nurses have with the nursing process.

Reducing Litigation

One of the major roles that the LNC plays in the risk management department is to act as a liaison between patients, their families, and the facility. It is estimated that only 20% of all medical malpractice cases involved negligence (Wu, 1999). It is thought that more than half of all the malpractice cases filed in the United States could have been avoided if there had been disclosure of a medical error or an apology given to the patient or their family at the time of the event. Most patients aren't looking for free money; they just want someone to talk to them and tell them what happened.

The risk management LNC who meets with the patient and answers questions in a non-defensive manner may help reduce the incidence of litigation for the facility. Adherence to the facility's policy for communication with patients is critical. Many times, if a meeting can be arranged and the patient or family's concerns addressed, no law suit will follow. The LNC's background as a nurse helps when speaking with patients and their families. Nurses are experienced patient educators and can use assessment skills to determine the level of education required for each individual.

Assisting the Attorney

Another area within risk management, in which the LNC participates, is helping to prepare for deposition and trial. The LNC will review the medical records for the attorney and then meet with the attorney to explain the contents and help formulate questions for the deposition. The attorney may also have the LNC go though any outside medical records that will impact the case. An LNC who has a variety of clinical experiences is well-qualified to assist the attorney. The LNC can educate the attorney and participate in all phases of the court case.

The LNC who wants to become a risk manager needs to become very well aware of state regulations and standards. The ability to research on the Internet, as well as an introductory course in legal research and writing, would benefit the LNC in practice.

In conclusion, the risk management principles used by LNCs in risk management positions are similar to those required in the nursing process. This provides an area of comfort for LNCs. The LNC brings the clinical experience to the table, which is especially well-suited for working in this arena. An experienced LNC becomes an integral part of the risk management team, combining nursing experience with knowledge of the legal system.

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Q: What Information Should Be Considered During a Retroactive Review of Attendant Care?

Patricia Covalle, RN CCM, Greater Detroit Chapter, American Association of Legal Nurse Consultants

A: Attendant care claims are as complex as they are numerous. Being highly individualized, no two claims are the same, even with identical injuries. Fortunately, the unique background of a legal nurse consultant allows for an informative review that is specific to each situation. Here is a systematic approach for the determination of appropriate levels of attendant care and where to find accurate, reliable rates to use in your calculations.

It is vital to fully understand what attendant care is. The term "attendant" can be found in documents that date back as early as the 15th century. Today, an attendant it is one who provides a service for another, a helper, or assistant. This assistance can be in the form of supervision, hands-on assistance with personal care, stand-by assistance during ambulation, skilled nursing services, and so on. When these services are not provided by a home care agency, family members and friends often provide the help.

Activities of daily living (ADLs) are all those activities in the non-occupational environment arising from daily living needs. Basic ADLs include mobility, personal hygiene, dressing, toileting, sleeping, and eating. The advanced or instrumental ADLs encompass those skills required for community living. Chores such as housework and yard work are often categorized separately from ADLs. You may wish to check with the laws in your state for further clarification regarding this.

Rehabilitative medicine has grown by leaps and bounds in recent years. In an effort to provide the best services possible, many facilities adopted an approach known as "outcome orientated rehabilitation." Patients are evaluated on admission and then at various intervals during their stay using one of many functional assessment tools available. The following are three more commonly used tools:

- Functional Independence Measure (FIM): This system was developed in 1984, designed to be an easy-to-understand, standardized assessment tool that any clinician can use to evaluate how well patients function. The 18 measures of the FIM focus on essential motor and cognitive skills that we all use every day in activities such as eating, dressing, communicating, and problem-solving, and evaluates how independently a patient performs each skill.
- Rehabilitation Institute of Chicago's Functional Assessment Scale (RIC-FAS): In 1981, RIC began measuring and analyzing rehab outcomes. Their goal was to develop an assessment instrument that would provide a common language across all disciplines, while taking into account the needs of complex physical rehab outcomes of a diverse mix of patients. It incorporates the FIM measures and goes on to evaluate 71 other areas such as health maintenance, caregiver requirements, coping, behavioral considerations, and community integration skills. This scale allows for five main levels of required attendant care supervision, which are then further subdivided.
- Barthel ADL Index: This is the most widely used ADL index and is considered by many to be the best standard measure available today. It is known for its simplicity and only takes a few minutes to administer.

Before You Begin

Organizing the records is the first order of business. This time is well spent, as it will allow you to follow the records in chronological order and gain a better sense of the issues. I prefer records to be in order by date, from earliest to most recent. Duplicate records are removed, and dates are separated by year and put into chronological order. The file should read like a book telling a story from beginning to end. If you have records that predate the event in question, place them in the appropriate order. Hopefully, these records will contain information that is pertinent to the pre-injury level of functioning.

As you already know, retroactive record review can encompass years of medical information. Your task is neither quick nor easy. You must be diligent and make all attempts to work the file from beginning to end with a minimal amount of interruptions. The larger the file, the more difficult it is to keep specific facts straight, especially with the frequent interruptions that sometimes occur during any given day. An organized approach will improve your efficiency and can save you valuable time.

Getting Started

Begin at the beginning. I have found that creating a timeline of the pertinent information allows me to "see" correlations more clearly. Timelines can be set up in many

different ways. You can document pertinent information by date on a word processing program or lay out the entire timeline on a large tri-fold board. This second method allows you a big-picture view all at one time. If appropriate, mount your timeline on the board; it can then be used as a visual aide while discussing the case with an attorney or in trial to clarify and illustrate how you came to your conclusions as an expert witness.

Focus your attention on the objective information that may be located within the reports from all of the members of the treatment team. Physical, occupational, and speech therapies can provide valuable recommendations regarding compensatory strategies to improve both physical and cognitive functioning. You will need to be familiar with the treatment goals set in each of these areas. Durable medical equipment and modifications to the home environment can greatly improve one's independence with ADLs. If these have not previously been explored, you may want to include this with your recommendations. As you read through the records, note the documented progress and/or lack thereof. Consider the norms for recovery: is the progress in line with the norms? If not, can a reason for the variance be identified? As you review the office notes from the treating physicians, consider that there should be similarities in their objective findings (range of motion, strength, etc.) when compared to therapy notes from the same time period.

Many factors can affect progress of reaching the pre-injury level of functioning. Obviously, complications associated with prolonged immobility, infection, and poor healing can lead to additional procedures. It is not unusual for the number of attendant care hours to increase and decrease. The hours should change to reflect current needs and should therefore be reevaluated whenever the condition changes. Attendant care needs, whether provided through a local home care agency or by family and friends, typically do not apply during inpatient hospitalizations. Although family members may remain at the bedside for support, the hospital staff is responsible for delivering care during that time.

Brain injuries can result in multiple cognitive and behavioral issues. An individual may be ambulatory and essentially normal with regards to their functional mobility, while at the same time displaying alterations in the following:

- Comprehension;
- Verbal and/or non-verbal expression;
- Pragmatics;
- Problem-solving;
- Memory; or
- Behavioral Control.

Although they might be functionally independent from basic ADLs from a physical standpoint, strategies such as cuing may be necessary to initiate activities such as bathing and grooming.

A status of "modified independent" can be achieved when the brain-injured client is able to consistently utilize compensatory strategies in their home and community (planners, lists, medication dispenser with alarm, etc.).

Determination of attendant care needs for an injured child presents a special challenge. You will need to clarify the premorbid level of assistance and supervision. Very young children who are uninjured require the 24-hour supervision of an adult to provide for their needs. As children grow, they gradually become independent with their basic ADLs. Older teens may have a regular job and hold a valid drivers license. Although they live at home with their parents, they can be fully independent with all basic and advanced ADLs. The question that must be asked is: How are the needs different since the incident?

Let's say a young child sustains a traumatic brain injury. If they fail to obtain independence with basic and advanced/instrumental ADLs when compared to non-injured children of the same age, it would not be unreasonable for their attendant care needs to increase proportionally. You will need to be familiar with patterns of normal growth and development, and may wish to include this in your report.

When writing the report, it is sometimes helpful to include a summary of the injuries to educate the reader. Your unique background might allow you to recognize correlations between the injury and the disability that would otherwise go unnoticed. Include only the information that is pertinent to your determination of the attendant care need.

Don't be afraid to point out any inconsistencies you observe within the medical records. The purpose of your evaluation is to present the evidence as it is and draw a reasonable conclusion. Your professional opinion regarding recommendations for attendant care should be backed up with sound facts and written objectively.

Calculating the Numbers

The National Association for Home Care (NAHC) developed a handbook for the purpose of providing home care agencies with a uniform method for calculating the costs of delivering an hour of direct care. They define a "Direct Service Hour" as "an hour of time that the home care aide spends in actually serving the client (either in or outside of the home) in accordance with the prescribed plan of care (often referred to as "direct service")."

You will need to determine whether family members provided skilled or non-skilled services. One approach involves calculating a daily per diem rate that includes multiple levels of service reimbursement. For example:

- 1 hour per day for time providing skilled services (e.g. changing a complex dressing each morning or administering IV antibiotics at home).

- 15 hours per day for non-skilled services including assistance with basic and advanced/instrumental ADLs. Seven of those hours would be calculated at a base day shift rate, with an afternoon differential included in the remaining 8 hours.

- 8 hours of reimbursement at the HHA I (companion) level of service during the midnight shift. Again, the appropriate differential would need to be included.

Once you have determined the appropriate number of attendant care hours required during the various phases of recovery, you will need to offer a reasonable hourly wage on which to base reimbursement. It is important to offer comparison rates that are local to the geographic area in which services were provided. The best source I have found for this information is the HomeCare Salary & Benefits Report. Published annually by the Hospital & Healthcare Compensation Service and in cooperation with the National Association for Home Care & Hospice, it provides detailed salary, hourly, and per-visit data on 72 job titles in the home care industry. Visit their Web site at www.hhcsinc.com for more information.

Don't forget to include pay differentials for work performed on off shifts and weekends. This is a widely accepted practice within the home care industry and should be considered when reimbursing family members for their time. PDA organizers and online calendars allow you to quickly "click" backward in time to calculate the number of weekend vs. weekdays care was provided.

Home Health Aide Services	
Home Care Aide I (HCA I)	Assists with environmental services such as housekeeping and homemaking services in order to preserve safe, sanitary home and enhance family life. The HCA I does NOT provide personal care. May also be called a chore worker, homemaker or companion.
Home Care Aide II (HCA II)	Provides non-medically directed personal care. May also be called personal care attendant.
Home Care Aide III (HCA III)	Provides personal care services under a medically supervised plan of care. Meets federal and/or state training and licensure requirements. May also be called home health aide.

Large files can span 20 years or more. On those cases, it is necessary to research the historical pay rates. Your county library should maintain a number of newspapers on microfilm. Check the classified sections for the advertised rates of pay. You may also want to refer to the annual cost-of-living adjustments (COLA), which can be found on the Social Security Administration's web site at www.socialsecurity.gov.

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Elements of Nursing Malpractice

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Negligence and malpractice are used synonymously in literature. You may see the term "negligent malpractice," with the negligence being the predominant theory of the medical malpractice (American College of Legal Medicine, 1995; King, 1986). Some nursing literature proposes that there is a difference in the terms with "malpractice more restricted, a specialized kind of negligence, defined as a violation of professional duty or a failure to meet a standard of care or failure to use the skills and knowledge of other professionals in similar circumstances" (Nurse's Legal Handbook, p. 204). For the purpose of this article, "nursing negligence" will be used to describe actions (or non-actions) that breech standards of care, causing damages and nursing malpractice action.

In order to have a nursing malpractice case, negligence needs to be established. "Negligence" is the failure of a nurse to act as a reasonably prudent person, under the same or similar circumstances, which causes or results in harm to the patient. The elements of negligence are (1) duty; (2) breach of duty; (3) causation; and (4) injury and damages. Without all four elements clearly established, there is not sufficient negligence to go to trial.

Duty is usually not an issue because the nurse, as an employee of the hospital, has agreed to the assignment. Breech of duty refers to a nurse who falls below the established standard of care found in the hospital's/unit's policies and procedures, authoritative nursing textbooks, BRN (Board of Registered Nursing), and nursing specialty association guidelines/standards. This is where a nurse expert would assess if the assigned bedside nurse followed the accepted standard of care. "Standard of care" can be defined as care that is in taught in nursing schools, with reference text books, and the hospitals policy and procedure manuals.

Causation is often referred to as the "but for" element: "But for the ……incident/negligence, the injury would not have happened." For example: (1) But for the wrong dose of Digoxin, the plaintiff would not have had symptomatic bradycardia; (2) But for the delay in notifying the physician of the decreased hemoglobin, the plaintiff would have received the transfusions in a timely manner.

Lastly, there must be an injury. If there is no injury, there is no established negligence. There has been no instance of damages.

Examples

Example 1: A patient goes to surgery for an exploratory laparatomy, and a sponge is inadvertently left in the abdomen. On a routine post-operative abdominal x-ray, while the patient is in the SICU, intubated (anesthesia was not reversed), the retained sponge is identified. The vital signs are stable, and the patient is emergently taken back to the operating room. The retained sponge is removed, and the patient has an uneventful recovery. Yes, there was a duty: certainly, leaving the sponge in his abdomen was below the established standard of care. Causation was also established: but for the retained sponge, the plaintiff would not have had to have a second surgery. But, were there any damages? No, there were no residual damages.

Example 2: A nurse inadvertently gives the wrong insulin dose. When the blood sugar is rechecked 2 hours later, the patient's blood sugar is less than 30. The nurse follows the standard of care for hypoglycemia. D50 is administered intravenously, and the intravenous solution is changed to D5 instead of .45 NS. The attending physician is notified, and the patient is monitored. The patient's blood sugar quickly returns to normal within 1 hour. In this instance, there are, once again, no residual damages. There is duty, a breach of duty (the drug error), and causation (the subsequent low blood sugar), but no damages.

The following are areas of nursing care that are at risk for malpractice:

- Safety issues—bed positioning, bed rails, and restraints.
- Medication errors—with one of the wrong six: wrong patient, dose, time, drug, route, and technique.
- Nursing assessment—is it adequate and timely.
- Competent knowledge regarding medical procedures—blood glucose monitoring, blood administration, and (in critical care settings) swan ganez catheter monitoring and care.
- Use of equipment—inexperience and inadequate orientation to equipment (pacemakers or infusion pumps).
- Communication—lack of communication or miscommunication, i.e. not notifying the physician in a timely manner of a change in patient status.
- Failing to follow established health system's policies and procedures:
  - fall injuries from improper use positioning of bed and not using side rails;
  - skin breakdowns from lack of preventing and monitoring decubitus ulcers;

- DVT [deep vein thrombosis] from not placing TED hose and PAS stockings resulting in pulmonary embolus; or
- aspiration from not following swallow guidelines and having suction equipment at the bedside.

• Inadequate documentation—failing to document observations and changes in the patient's condition, actions taken, and responses of medical professionals. The medical record provides legal proof of the quality of care given. It remains a legal standard that "if it isn't documented, it hasn't been done."

Case Studies

Documentation Negligence: A boy with a fractured leg has a cast applied and is placed in traction. The evening nurse records the condition of the boy's toes several times during her shift. The night nurse does not record the conditions of his toes until 6:00 a.m., when she notices they are cold and dusky. The physician is promptly notified, and the boy's leg required a partial amputation.

The child's family sues the hospital, claiming that the night nurse failed to observe the condition of the boy's toes in a timely fashion. In her defense, the nurse testifies that she had observed the toes periodically and that they were normal. The nurse did not chart her observations until after her shift was over. The jury concluded that failure to document implies failure to observe and, therefore, held the nurse liable for malpractice.

Nursing Negligence: A 6-year-old child is admitted to the emergency room and diagnosed with chicken pox. The nurse's notes indicate that he was febrile with a temperature of 104.8, tachycardic with a pulse of 183, and tachypneic with a respiratory rate of 60. The nurse is unable to palpate a blood pressure or obtain an arterial blood gas (ABG) test. The child is given Pediaprofen (pediatric Ibuprofen), and an intravenous line is started. 2 hours later, the child remains tachycardiac with a pulse of 196 and tachypneic with respirations at 64. He is placed on 4 liters of O2 and is transferred to the pediatric intensive care. His admitting diagnosis is: 1) varicella, 2) bronchial asthma, and 3) basilar pneumonia. There was no documentation of lung sounds, skin condition, or level of consciousness (LOC). The child was in the emergency room for 3 hours.

In the intensive care unit (ICU), the child's heart rate remains tachycardic. He has labored and shallow respirations, with an infiltrated intravenous line. He becomes extremely restless and confused, with dusky coloring in his lips and extremities. The physician, notified of the patient's

vital signs and skin color, orders a pediatric pulmonary consultation. The child is given a dose of Tylenol. The intravenous line is re-started. He receives a respiratory treatment. An hour after the child is transferred to the ICU, he starts seizing. He has fixed and dilated pupils. He receives Ativan for the seizures. Then, 15 minutes after the seizure, the child goes into cardiac arrest. A code is called and CPR is initiated. The child does not survive. The death was due to sepsis. In this case, there was a missed diagnosis of sepsis.

The standard for treating a diagnosis of sepsis, or suspected sepsis, is appropriate antibiotic therapy (an antibiotic was ordered, but was not the correct antibiotic), hydration (based on CVP and swan ganz readings), pulmonary support with oxygen treatment, and monitoring and vasoactive therapy for blood pressure support. Laboratory studies include blood cultures, chemistry panel, CBC, arterial blood gases, and chest x-rays. In this case, the chemistry panel and blood culture were drawn and revealed a low sodium and a CO2 of 18mmol/L [indicative of acidosis and/or hyperventilation]. The chest x-ray indicated early pneumonia. The CBC count indicated an elevated WBC count of 19.1 k/cmm and an elevated hematocrit of 44.0% (which indicated an infection with dehydration). The laboratory results were reported to the physician in the emergency room, who ordered intravenous fluid but at an inappropriate rate for this patient.

In this case, multiple nursing standards were breached. There was no nursing documentation regarding the change in his level of consciousness (i.e. periods of confusion), his lungs sounds, his skin color, and his peripheral pulses. There was failure to identify and treat life-threatening symptoms, such as the increase in pulse and respirations. There was failure to appropriately monitor a critically ill patient with lack of vital signs, nursing documentation, and notifying the physicians of deteriorating vital signs. There was failure to act and provide treatment for symptoms, i.e. high flow oxygen, intubation, and proper IV hydration. The standard of care was not met for this patient, in the emergency room or the pediatric intensive care unit, by both nursing and physician staff.

This case settled out of court. The element of duty was established when the emergency room and intensive care nurses accepted the assignment. The nurses fell below the standard of care and breached their duty by failing to properly document vital signs, treat the critical life threatening symptoms (tachycardia, and tachypneia), and notify the physician of change in patient status. The element of causation was established when the patient continued to deteriorate due to the lack of treatment for a sepsis, i.e. proper hydration for the height and weight of a pediatric patient (20cc per kilogram per hour), oxygen (higher concentration of oxygen with monitored oxygen saturations, documented respiratory rate and arterial blood gases), and pulmonary support (increase in bronchial inhalers and respiratory treatments). Injuries and damages were the child's death related to delay of treatment for sepsis. In the majority of medical mal-practice cases, all four elements of negligence must be met for the case to be filed or come to trial. There is one instance where the four elements of negligence do not have to be met.

"Res Ipsa Loquitur" is a Latin phrase that translates into "the thing speaks for itself." This is where the damage is so evident that the incident leaves no doubt as to malpractice. For example, a patient has an indwelling gastrostomy tube and a Groshong catheter. A night shift nurse inadvertently attaches the tube feeding to the Groshong catheter, and the patient suffers a cardiac arrest and expires. There is no doubt that the tube feeding in the patient's chest was the cause of his demise. Res Ipsa Loquitor is often the theory behind retained surgical instruments that cause damage to the patient many weeks, months, or years following the surgery.

These are a few important and dramatic instances where nurses were found justifiably liable for malpractice. All of the elements of malpractice were clearly established. As an LNC, use the elements of malpractice as your "mental" template. When you initially review the case, write on sticky notes and put into the margins: 1) duty; 2) breach of duty); 3) causation; and 4) injury and damages. Include these terms in your report to the attorney to support your conclusion confirming that there is a legitimate malpractice case. Using the elements of medical negligence as a beginning strategy for chart review, will enhance your ability to quickly and accurately review cases and provide you with guidelines to give directions and recommendations to the attorney.

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Mitigation Specialist: A Natural Role for the LNC

Lynda Kopishke, MSN RN CLCP LNCC

Mitigation specialists provide the societal perspective for cases involving serious crimes. Encarta's dictionary defines the term mitigation as to "partly excuse a crime: to make an offense or crime less serious or more excusable; lessen something: to make something less harsh, severe, or violent" and a mitigation specialist as a "criminal defense researcher: a member of a criminal defense team who gathers detailed information about a defendant in order to persuade a jury not to impose the death penalty" (http://ca.encarta.msn.com/dictionary_1861678951/mitigation_specialist.html).

Background, Definitions

Mitigation is used at the time of sentencing to portray to a judge or jury the human side of a defendant who has committed a serious or capital crime, such as rape or murder. It can also be used to a lesser degree in a pre-sentence investigation, as ordered by the court, to determine the background of a defendant prior to imposition of punishment for a crime. "Although it makes no express demands on counsel, the [right to offer mitigating evidence] does nothing to fulfill its purpose unless it is understood to presuppose the defense lawyer will unearth, develop, present and insist on consideration of those 'compassionate or mitigating factors stemming from the diverse frailties of humankind'." (Bilionis & Rosen, Lawyers, Arbitrariness and the Eighth Amendment, 75 Tex. L. Rev. 1301, 1316-17 (1997) (citing Woodson v. North Carolina, 428 U.S. 280, 304 (1976) (opinion of Stewart, Powell, & Stevens, JJ.)

An up side of mitigation is that the judge or jury gets to see the defendant as a person rather than the perpetrator of the crime. An effective mitigation can assist the judge or jury in returning an appropriate sentence and punishment. In fact, *not* doing mitigation or doing a less-than-adequate job of presenting mitigating factors can have a negative affect on an attorney, as it can enable a successful appeal by the defendant who claims the attorney provided ineffective counsel. A successful appeal on these grounds generally means a new trial with a different court-appointed attorney. It also requires the victim or victim's family to remain involved with the court system and can prevent these individuals from resolving grief and moving on with their lives. For all of these reasons, an effective mitigation strategy is imperative for a successful outcome for all parties in the criminal case.

Traditionally, mitigation specialists have been professionals in either the social work or psychology fields. Mitigation historically has been a portrayal to the jury as the social background of a defendant who is charged with a capital murder or serious crime. Mitigation experts frequently rely on psychological reports, neuropsychological testing, school records, and interviews with family members or coworkers, all of which is used to present a picture of the defendant's background. In the past, this type of mitigation met the court's definition of an "adequate defense," preventing a successful appeal and the need for remand of the case for retrial. That, however, was the past; the stakes have now changed.

Mitigation and the LNC

With the swift development and increasing awareness of biotechnology and new emerging genetic research, there are many new areas to explore in medical mitigating factors. The skills of the legal nurse consultant (LNC) are a perfect match for nurses who wish to excel in this field of subspecialty.

Mitigation work for the LNC begins with an in-depth interview of the defendant. This requires the LNC to travel inside the walls of the correctional facility to meet the defendant face to face. Just as nurses must establish rapport with patients, a rapport must be established with defendants, many of whom have little faith or trust in the judicial system from prior experiences. Some defendants have long-standing drug or alcohol issues that have diminished their ability to remember dates or events for history taking. Some defendants would rather accept a death sentence than reveal their abusive family environments. The LNC must develop active listening skills to overcome the reluctance, cognitive impairments, or attitude that mitigation work presents. Multiple visits are often needed to gain the trust and information necessary to begin the mitigation process.

The LNC needs to first obtain a comprehensive history. Although other professionals have asked questions and gained histories, the nursing history is often much more comprehensive because of society's level of trust of nursing professionals. In the correctional facility, the medical unit is a place prisoners often seek out because of their trust of the nurse who provides health care services in a nonjudgmental manner. This trust can extend to a mitigation specialist who is a registered nurse and often helps break the ice in history acquisition. Nurses can ask opened-ended questions and, by nature of their education and training, are taught to listen and probe. In a recent example, when asked, "Have you ever been physically abused?", the defendant adamantly denied any physical abuse in his family setting. The nurse asked the follow-up question, "All children get in trouble for things growing up—how was punishment handled in your house?" The defendant stated his dad would hit him. The nurse probed deeper: "Did your dad hit you like a slap on the butt, or did he use a belt or something else?" The defendant, who had been making eye contact

and smiling back at the nurse interviewer, at that point dropped his smile and avoided eye contact. Using therapeutic silence, the nurse waited; eventually, the defendant looked up and said, "I don't know. I guess he used a belt or his hand or whatever was handy." The nurse tucked this tidbit away and continued with a health history, later coming back to ask about punishment for siblings, and following up with whether the defendant thought his punishments as a child were justified based on what he did to deserve the punishment.

Through interviews with family members and neighbors, and subsequent interviews with the defendant, a history emerged of domestic violence that included threats of death, weapons pointed at family members, a staged break-in where one parent destroyed family treasures, and a fire set by one parent for revenge against the other. The defendant had witnessed these events as a young child but refused to discuss them because he was protecting family secrets that the family did not discuss and pretended didn't happen. Through collaboration of the events with police records, hospital records, and family court records, a pattern of abuse, neglect, incredible fear, self-medication with drugs and alcohol, and a psychiatric diagnosis of posttraumatic stress disorder emerged as mitigating factors.

The LNC brings not only intense interviewing skills to the mitigation process, but also a thorough understanding of medical systems and medical record acquisitions. The LNC can assist the attorney in identifying sources for medical records and documents that support or provide mitigating information. Obtaining signed medical releases, tracking down records in archival storage systems, and looking for unique sources for records are skills the LNC is comfortable with from experiences in civil practices. Thinking outside the box, the LNC may contact the public health department to determine whether a particular neighborhood was ever tested for lead levels. Reviewing medical records, the LNC may note that the defendant's mother gave a history of premature birth, suggesting the possibility of medical complications for the defendant. Or in reviewing pediatric records, the LNC may note the absence of routine immunizations or the presence of many emergency department visits for injury, suggesting neglect or abuse. Screening growth and development charts for height and weight ratios may provide information related to nutritional status. An understanding of developmental stages and developmental tasks provide a foundation for explaining the underlying pro-social and anti-social behaviors in the defendant's childhood.

As our understanding of chronic medical conditions improves with scientific research into genetics, the LNC's ability to understand and communicate disease processes provides invaluable insight into chronic conditions. Attention Deficit Hyperactivity Disorder (ADHD), Fetal Alcohol Syndrome Disorder (FASD), conduct disorder (CD), and environmental damage (lead toxicity, volatile organic chemicals, etc) all play a role in impacting growth and development and thus are important mitigating factors.

The LNC who testifies as an expert brings experience in testimony to the attorney seeking a mitigation expert. In addition to developing trial themes for the penalty phase of the trial, the LNC can testify as a fact expert witness regarding findings in the interview process and medical records. Experienced nurses provide patient education in a variety of settings on a daily basis. Explaining complex medical conditions in laymen's terms is another level of comfort for the LNC in a mitigation specialist role.

So, how does an LNC increase their knowledge of the role of a mitigation specialist? The answer lies at the computer keyboard with an Internet interface. There is a wealth of mitigation material available on the Web, from books and articles on the topic to information on regional and national conferences. A list of resources is included at the completion of the Forensics Corner for further study and interest.

In conclusion, the LNC who desires to expand a civil practice can transfer skills gained in personal injury and medical malpractice cases—such as access, retrieval, and analysis of medical records, medical research, demonstrative displays, and expert testimony—to the challenging subspecialty field of mitigation specialist. In doing so, the LNC will find ethical challenges, the need for critical thinking and the ongoing need for self-evaluation and learning a refreshing addition to a growing list of established skills.

Resources

A federal government site with a good explanation and a helpful list of references for federal death penalty cases: www.uscourts.gov/dpenalty/4REPORT.htm

American Bar Association guidelines for Appointment of the defense attorney and mitigation specialist in capital cases: http://dpa.ky.gov/library/advocate/sept03/abaguidelines.htm

Illinois Court of Appeals: www.state.il.us/defender/d_7th.html

National Coalition to Abolish the Death Penalty: www.ncadp.org/board.html

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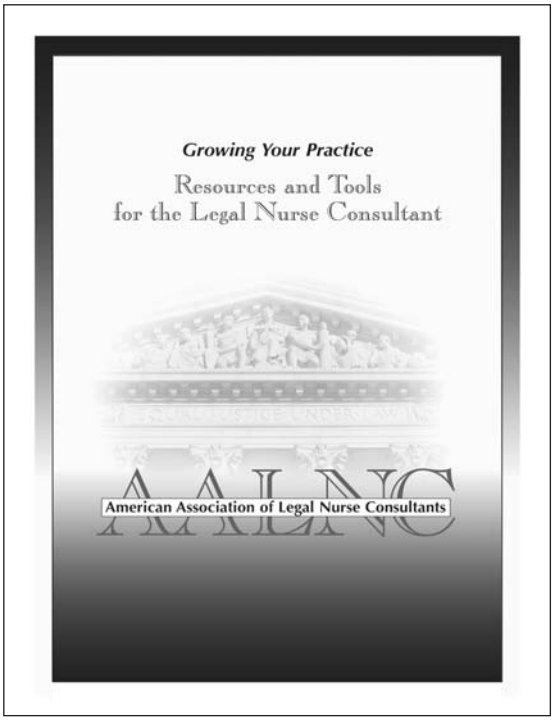

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