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Functional Capacity Evaluations in Personal Injury Claims

Robert Morrison, RN BSN

After several years managing work-related disability claims, I have been struck by the many parallels between them and the medical aspects of personal injury. It only seems natural when you look at the overall situation. After all, many times the only difference between a Work Comp case and PI is whether the claimant was at work when the injury occurred. The injuries, and thus the assessments of their effects, may be identical. In this sense, my Worker's Comp experiences have been very helpful to me in assisting attorneys with PI claims.

First and foremost is to move the injured person forward through the treatment and rehab process to ensure maximal recovery from the injury. Once you reach this point the attorney assisting the PI claimant needs to quantify the damages that resulted from the injury. This article focuses on assessing the medical/functional aspects of this calculation. Two traditional tools of the work comp case manager that have helped our PI clients are the Functional Capacity Evaluation and the Loss of Earning Capacity evaluation. We'll leave the LOE for future articles and discuss the Functional Capacity Evaluation (FCE).

The FCE is an objective and comprehensive measurement of a person's abilities. The goal is to give specific, quantitative statements about their functional abilities and limitations. For the Work Comp provider, this test is often matched against the specific functional demands of the injured person's occupation in order to determine their ability to return to their previous job or environment. The treating physician may also use the FCE to assist in calculating permanent impairment ratings and activity limitations. It is also used by case managers, attorneys, and employers to assist in the legal settlement of the claim. For the PI attorney, this last purpose of the FCE is also useful in their practice. In measuring cont on p. 2

Guidelines for Assessment and the Triage of Obstetrical Patients

Jan Aken RN IBCLC LNC

It is the task of every "prudent" labor nurse to be familiar with the correct course of action when evaluating obstetrical patients.

A legal nurse consultant reviewing an obstetrical case would use the same guiding principles when evaluating the labor nurses' actions in medical malpractice cases for the attorney client..

Watch the *Legal Nurse Consultants Newsletters* for articles over the next two months as I am going to list some guidelines put forth by the Association of Women's Health, Obstetrics and Neonatal Nurses, AWHONN.

Guidelines for the Evaluation of Preterm Labor

A. Maternal Physical Status
   1. Change in vaginal discharge
   2. Backache
   3. Symptoms of urinary tract infection
   4. Precipitating Events
      a. Serious illness or death in the family
      b. Acts of God
         i. Earthquakes
         ii. Storms
   5. Symptoms of dehydration

B. Fetal Status
   1. If gestational age is <24 weeks gestation auscultate fetal heart rate.
   2. If gestational age is >24 weeks gestation obtain 20 minute fetal monitor strip to evaluate baseline rate and periodic patterns as described in the *Guidelines for Fetal Heart Rate Monitoring.*
   3. Assess fetal presentation.

C. Labor Status
   1. Review prenatal history for information regarding previous cervical exams and prescribed measures for preterm labor.
   2. Palpate abdomen for tenderness, uterine resting tone, and uterine contractions.
   3. Obtain monitor strip for uterine contraction assessment.

D. Patient/Family Teaching
   1. Signs and symptoms of preterm labor
   2. Precipitating events
   3. Interventions
   4. Fetal movement awareness
   5. Follow up appointment with care provider

Functional Capacity Evaluations in Personal Injury Claims

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the person's specific abilities and limitations, the FCE also gives information on the loss of function as a result of the injury.

There are two basic approaches to the FCE: psycho-physical protocols, such as the Key or Blankenship methods; and the kinesio-physical approach, such as the Isernhagen Work Systems test. The psycho-physical methods are more subjective, and determine level of function mainly through the reports and statements of the patient. The patient sets his or her own limits during this evaluation and determines when the evaluation is terminated. This method will also describe the patient as valid, invalid, or malingering. Due to the subjective method of testing, this type of FCE is more vulnerable to judgments and prejudices from the parties involved.

The Isernhagen system, developed by Susan J. Isernhagen in the early 1980's, is a two-day standardized test that assesses 29 work related functional activities. The functional level is determined by objective measurement of musculoskeletal ability. The evaluation is controlled by the examiner rather than the patient, and the patient is also given instruction in proper body mechanics as the test progresses, both in contrast to the Key or Blankenship methods. Levels of cooperation and consistency of effort are described more objectively by Isernhagen, thus avoiding labels such as "malingerer" which only serve to create animosity between the parties involved. The two-day format allows the examiner to re-test specific areas in order to increase confidence in the FCE's accuracy. It is also a way to see how the patient recovers from a day of heavy physical activity.

An examiner using either method will need to address the issue of symptom magnification if they feel that this is affecting the results. This is where the more objective measurements of Isernhagen may be preferable to the subjective statements of Key or Blankenship. After all, there are at least two people involved in this test- the examiner and the patient. The personal opinions and beliefs of each will affect their perceptions of the other. While it may not be possible for the examiner to "block out" all of their personal feelings, their judgments will be more accurate if they are describing objective measurements rather than subjective opinions. Even so, the examiner may have reason to believe the patient is magnifying their symptoms. This isn't always because the patient is intentionally trying to inflate their legal claim. A patient who is afraid of re-injuring the affected body part will be understandably hesitant to "give it their all," as one opposing attorney said to me. Whatever the cause, such labeling only serves to distract everyone away from the real issue- determining the injured person's functional ability secondary to the injury.

When properly used, the FCE can accurately measure a person's functional abilities. This quantitative measurement, combined with available knowledge of the person's abilities prior to the accident, can then be used to measure the functional loss suffered by the person as a result of the injury. This is one component of the attorney's statement of financial loss when trying to calculate the settlement needs of the client. While it has historically been seen as a Worker's Compensation tool, it has a place in the field of personal injury law as well.

(Grateful acknowledgment is given to Doug Page, PT for his insight and assistance on this article.)

Falls in the Nursing Home

Jeannine Lurie RN, BSN, CLNC

Fall Prevalence

"Accidents" are the fifth leading cause of death in the elderly, with falls the most frequently reported type of "accident". (Rubenstein, Josephson, and Robbins, 1994). Falls and fractures are a major cause of disability and death in the elderly. Two of a nursing home's biggest responsibilities are to maintain mobility and prevent falls. Most falls in nursing homes are "unwitnessed". Also, most nursing home residents are unable to recall the circumstances of the fall, and thus, these events are simply categorized as "found on the floor". Between 30% and 60% of nursing home residents fall each year. Among those with Alzheimer's disease or other dementing illnesses, the annual incidence of falls is twice the rate of older persons without dementia. (Capezuti and Talerico, in press; Rubin, Morris, and Mandel, 1987; Nevitt, Cummings, and Hudes, 1991).This includes falls while transferring residents. Approximately 10 to 20% of nursing home falls result in serious injuries; 2 to 6% result in fractures.

*Note: It has been estimated that with the aging of "baby boomers" there will be a 25.8% increase in injurious falls between 1995-2020 resulting in more than 17 million injurious falls by 2020 (Englander, Hodson and Terregrossa 1996).

Consequences of falls

Despite the high incidence of falls, most falls do not result in physical injury. Fall-related injuries include:

- Fractures
- Dislocated joints
- Subdural hematoma
- Laceration requiring sutures
- Soft tissue injuries requiring medical treatment
- Bruises
- Abrasions
- Certain sprains
- Other soft tissue injuries

An overall higher rate of both falls and fall-related injuries occurs among nursing home residents (Baker and Harvey, 1985), especially among those with dementia (Buchner and Larson, 1987). Approximately 11 % (range 1 – 36 %) of falls in nursing homes result in injury; hip fractures account for 1 to 6 % of the fall related injuries of nursing home residents. More than 90% of hip fractures result from falls, with the greater majority occurring in those over the age of seventy; Fractures other than those of the hip or pelvis account for about 2 – 3 % of fall related injuries while serious soft tissue injuries requiring medical intervention and causing impaired functional status represent approximately 10 % of falls. (Tinetti, 1987). Cont on p 4

Reducing Communication Errors in Healthcare

Maggie Driscoll RN, BSN, CCRN, CLNC

In a continued effort to improve safety for residents and patients in health care organizations, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) identified and approved its first set of 6 National Patient Safety Goals (NPSG) in July of 2002. Specific recommendations are associated with each of the identified goals. These goals and associated recommendations were derived from information gathered by the *Sentinel Event Alert Advisory Group* as evidence- or consensus-based, cost-effective and practical. In July of 2004 one new goal was added to the original set of six that focuses on reducing the risk of health care-acquired infections.

Goal 2 of the NPSG concentrates on improving the effectiveness of communication among caregivers through two specific recommendations: standardization of abbreviations, acronyms, and symbols throughout the organization and to provide a process for taking verbal or telephone orders or critical test results that require a verification "read-back" of the complete order or test result by the person receiving the order or test result.

Abbreviations to Avoid

JCAHO has identified a minimum list of dangerous abbreviations that can no longer be used in all accredited facilities. In addition to this list of banned abbreviations, each organization must add at least another three "do not use" abbreviations, acronyms, or symbols of its own choosing to their list by April 1, 2004.

The requirement to avoid the banned list applies to all clinical documentation including all types of orders, progress notes, consultation reports, and operative reports. It is expected in 2005 that JCAHO will include all forms of documentation such as preprinted forms and software that contain the prohibited items in the ban.

JCAHO Banned Abbreviations

Abbreviation	Potential problem	Preferred term
U (for unit)	Mistaken as zero, four or cc.	Write "unit"
IU (for international unit)	Mistaken as IV (intravenous) or 10 (ten).	Write "international unit"
Q.D., Q.O.D. (Latin abbreviation for once daily and every other day)	Mistaken for each other. The period after the Q can be mistaken for an "I" and the "O" can be mistaken for "I".	Write "daily" and "every other day
Trailing zero (X.0 mg) [*Note: Prohibited only for medication-related notations*]; Lack of leading zero (.X mg)	Decimal point is missed.	Never write a zero by itself after a decimal point (X mg), and always use a zero before a decimal point (0.X mg)
MS MSO_4 $MgSO_4$	Confused for one another. Can mean morphine sulfate or magnesium sulfate.	Write "morphine sulfate" or "magnesium sulfate"

Because patient safety is the main priority, JCAHO has identified an exemption to this requirement: “If, in the judgment of the people providing care to the patient (e.g., the registered nurse and pharmacist), the order is clear and complete and the delay to obtain confirmation from the prescriber prior to execution of the order would place the patient at greater risk, then the order should be carried out and the confirmation obtained as soon as possible thereafter.”

Although JCAHO does not require an “approved abbreviation” list, healthcare organizations may still maintain both an approved list and a banned list of abbreviations, acronyms and symbols. If the issues in your case surround a communication error, both lists may need to be requested during discovery.

Reading back verbal and phone orders

All caregivers, including physicians, are now required to write down and then read back all verbal and telephone orders (not just medication orders, but all orders) in addition to all verbally reported critical test results. Critical test results are not limited to laboratory results and should include radiology exams, electrocardiograms, and other diagnostic testing. It is up to each facility to identify and define “critical test” results. If the facility fails to identify what it considers as “critical tests”, JCAHO will consider all verbal and telephone results to be critical during surveys.

In emergency situations it may not feasible to write down and read back orders before administering medications and life-saving interventions. In these cases, it is considered acceptable to perform a “repeat-back” of the orders.

Documentation

It is up to each facility how the read-backs will be documented and tracked for compliance. Many organizations are using the abbreviations “TORB” (telephone order read back) and “VORB” (verbal order read back) on their orders and in progress notes.

A read back order may look like one of the following:

- T.O. Dr. Hurt/ read back/N. Nurse RN
- TORB Dr. Nice/S. Smith RN

JCAHO requirements greatly influence healthcare organizational policy that in part, cont on p 4

Falls in the Nursing Home

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Cost

Treatment and associated care due to fall-related injuries account for a disproportionately high use and expenditure of health care resources in the elderly. The average cost for a fall-related hospitalization in Washington State in 1989 was $6776, excluding professional fees and post hospital rehabilitation services. One can well imagine that the cost in today's dollars is considerable higher. For a woman 85 years of age and older (the average nursing home resident), almost half of hospitalization for trauma were fall- related. The estimated cost per fall injury in 1994 for those 65 years of age was $7,399, totaling over 20 million dollars nationally. (Alexander, Rivara, and Wolf, 1992). Despite the assumed safety of nursing home environment, falls remain an important clinical problem and present a complicated clinical challenge for nursing home staff.

Prevention of Falls

The current Standard of Care: The minimum standard of care to which nursing homes are required to conform is set forth in the Nursing Home Reform Act (NHRA). Contained within the Omnibus Budget Reconciliation Act 1987 (OBRA '87, 42 CFR § 1395i and 1396, et seq.), this law provides the benchmark against which conduct is judged. Federal regulations also provide for a nursing home "Bill of Rights", 42 CFR § 483.10. The Bill of Rights, when read in conjunction with the NHRA, is the starting point for establishing the standard of care. Standards are "benchmarks of clinical performance and practice by … an average qualified practioner exercising a reasonable degree of care and skill… taking into account advances in the profession" (Holzer, 1990, p.70). The standard of care used to evaluate a case, therefore, must be based on the governmental regulations and clinical/professional standards in effect at the time of the fall (s). Governmental regulations are based on Federal Law governing Medicare and Medicaid state licensing statues (Cohen and Kruschitz, 1997). (*Note, in California it is Title 22, Social Security). The focus of the Omnibus Budget Reconciliation Act of 1987 (OBRA ' 87 or Nursing Home Reform Act), is to improve care aimed at promoting a resident's highest practicable level of physical, mental, and social functioning (Sheriden, White, and Fairchild, 1993). Basically, what this means is that Federal and state guidelines mandate that each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care. The facilities plan of care should be revised if the resident's clinical condition demonstrates decline in condition.

Fall Risk Assessment – Evaluation tools

The assessment of fall risk is the responsibility of medical, nursing, and rehabilitation staff of the nursing home. Every resident is to be evaluated with the MDS, the RAP triggers, and when indicated, the RAP guidelines (all required by Federal regulations). Additionally, the facility (or chain) may have its own fall risk assessment tool and a specific policy and procedure describing its use. Although falls may be isolated events, most residents who have fallen should have a thorough evaluation. This is especially important for those with a history of recurrent falls. Although there are numerous published fall risk assessment tools, there is no "one" tool that is considered "standard" in the nursing home industry.

Nursing home records are far more detailed than other health care records because the service is provided over a long period of time. The records are replete with information necessary to fulfill regulatory requirements. Many nursing home negligence cases are cases occurring over a long period of time versus a sudden, untoward event. Unlike medical malpractice or other types of negligence cases, a nursing home case more likely than not is seated in the cumulative aspect of long-term care. A neglected person who requires care over a long period of time physically and or mentally deteriorates slowly, but surely. Even when there is a single event or catalyst, such as a fall or burn, upon closer inspection, these events usually stem from long-term neglect of known risk factors. (Note, a typical defense to a nursing home action is that the resident's physical or mental problems, not the conduct of the nursing home, caused the resident's deterioration or injury).

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reflects the standards of care across the continuum. Updating your knowledge of JCAHO requirements will assist you in determining the standards of care applicable to your cases.

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1. A list of dangerous abbreviations published by the Institute for Safe Medication Practices (ISMP) is available online at website: http://www.ismp.org/
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EPIGLOTTITIS

Gail Hendrickson RN, CEN, LNC

Epiglottitis is a potentially life threatening bacterial infection of the epiglottis *(the soft tissue in the throat that covers the airway opening to the lungs*.) It causes swelling of the epiglottis that can result in an airway obstruction. *Haemophilus influenzae* type B is the organism that causes this. If the infection goes untreated, the airway may close completely resulting in inability to breathe and death. Luckily the incidence of epiglottitis has significantly declined since the *H. influenzae* type B conjugate vaccine became available in the late 1980's. Children between the ages of 2 and 5 years are most frequently affected, although it is reported in young adults and the elderly.

Epiglottitis must be included in the differential diagnosis of any child who presents with rapid onset of high fever, respiratory distress and stridor *(high pitched, harsh sound heard during respiration.)* A child with epiglottitis usually appears anxious, exhausted, hoarse, and drooling because of the inability to swallow secretions. They may be in the tripod position *(sitting upright holding their neck slightly hyperextended.)* The finding on physical examination is a swollen cherry-red epiglottis. However, it is not recommended that a tongue blade be used to look in the back of the child's throat because it can lead to laryngospasm, and cardiopulmonary arrest. This should only be done if the physician is prepared to intubate *(put a breathing tube into the trachea)* the patient immediately and has the appropriate equipment and personnel to control the airway. This is usually done in the operating room. A lateral neck x-ray is commonly obtained to help confirm the presence of epiglottitis if the child is stable. It is very important to keep the child calm. This may mean having the child sit in his parents lap. Humidified oxygen should be applied, if tolerated. If the child will not tolerate it by facemask, it should be held near his face.

The most important aspect of care given to patients with epiglottitis is control of the airway. In most cases, the visualization of the epiglottis is done in the operating room. If the patient is so critical, the emergency physician may have to establish an airway urgently. Endotracheal intubation is the first choice, but if this is not successful, a needle cricothyroidotomy *(inserting a needle into the trachea)* is usually the next step to open an airway. It is a temporary measure, which must be followed by surgical cricothyroidotomy or tracheostomy *(surgical opening into the tracheal)*. Most often these patients are admitted to the intensive care unit for close monitoring and placed on intravenous antibiotics. A child may need to be transferred to another hospital if they are in a small community hospital since their ICU's are not usually set up to care for children. The most extreme complication of acute epiglottitis is airway obstruction. The failure to diagnose or treat epiglottitis leaves the doctor open to malpractice. The patient that is injured by the failure to diagnose will likely suffer dramatic injuries, such as brain damage or death. When such dramatic results occur due to the failure to perform a simple and inexpensive procedure such as intubation, the matter is wide open for a dramatic and effective argument to the jury.

I had a personal experience with epiglottitis many years ago. My brother in law had been to his primary care physician two times, complaining of a severe sore throat, and difficulty swallowing. He was sent home with an antibiotic. After the second visit, he drove himself to the emergency room, where he was immediately diagnosed with epiglottitis. By the time I got to the hospital he was in moderate respiratory distress, and taken to the operating room for airway maintenance. Luckily they were able to put in an endotracheal tube and he did fine after a 5-day stay in the intensive care unit. Needless to say, he changed his primary care physician after that.

What is a TBI?

Pattie Patterson, RN, LNCC, LCP

A TBI or traumatic brain injury is caused by external forces impacting the brain, which includes injuries with and without skull fractures, that disrupt normal brain functioning**.** Every 21 seconds, one person in the U.S. Sustains a Traumatic Brain Injury**.** Among the causes are MVAs, violence, sports and recreation and falls.

Types of TBI's include:

1. Focal Brain Injury: one localized area of brain damage
2. Diffuse Brain Injury: multiple areas of brain damage
3. Contrecoup Brain Injury: damage to the brain is in the opposite region from the insult (example: blow occurring to the frontal lobe with such a force that it shifts the brain backwards and damages the occipital lobe).

Consequences of the TBI can include; cognitive impairments such as:

- Short-term memory loss; long-term memory loss
- Slowed ability to process information
- Trouble concentrating or paying attention for periods of time
- Difficulty keeping up with a conversation; other communication difficulties such as word finding problems
- Spatial disorientation
- Organizational problems and impaired judgment
- Unable to do more than one thing at a time
- A lack of initiating activities, or once started, difficulty completing tasks without reminders

physical problems such as;

- Seizures of all types
- Muscle spasticity
- Double vision or low vision, even blindness
- Loss of smell or taste
- Speech impairments such as slow or slurred speech
- Headaches or migraines
- Fatigue, increased need for sleep
- Balance problems

or emotional disturbances such as:

- Increased anxiety
- Depression and mood swings
- Impulsive behavior
- More easily agitated
- Egocentric behaviors; difficulty seeing how behaviors can affect others.

(To be continued next month.)

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