

THE LNC NEWSLETTER

PRESENTED BY:

Medical-Legal Interface

Preparing Clients for Independent Medical Exams

Maggie Driscoll BSN RN CCRN CLNC

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As a legal nurse consultant, I am frequently contracted by attorneys to attend and observe Independent Medical Exams (IME) with their injured clients. Most commonly these exams are requested as a second opinion in Worker's Compensation cases or to evaluate injuries after medical negligence has been alleged.

By the time the IME has been requested months and sometimes years may have passed since the initial injury. Clients are often considerably anxious by this time. The thought of undergoing an exam that will potentially influence the outcome of their case adds to their escalating anxiety level. Attorneys and their staff can considerably reduce a client's anxiety and increase the likelihood of a favorable outcome for the case by preparing the client in advance for the examination and sending a medically-trained observer to attend the exam itself.

The following *general guidelines* can be related to clients prior to the exam in hopes of making the best impression on the adverse physician/examiner:

1. **Be honest** but do not attempt to gain sympathy by exaggerating your symptoms. There are both

physical and mental exams designed to detect faking. The examiner will have no problem reporting the apparent exaggeration of complaints in the results of the examination.

2. **Be cooperative and non-hostile, but do not forget the purpose of the exam.** If the examining physician asks what other doctors have told you about your condition, refer them to the medical records.
3. **Avoid giving details** about how the injury/accident occurred. Keep answers simple and in general terms.
4. **Listen carefully** to all the questions asked and be sure that you understand what it being asked before answering.
5. **Explain how the injuries have affected your life.** Be sure to tell the examining physician how the injuries have limited your ability to perform everyday tasks, enjoy hobbies and recreational activities.
6. **The exam begins as soon as you enter the parking lot.** The physician and his staff are asked to observe you from the time you walk in the door.

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LNCs Are Becoming More Utilized By The Legal Profession

Robert Morrison, RN BSN

Although there are no hard figures available, the Legal Nurse Consulting profession has grown significantly over the past 10 years. Attorneys and law firms have discovered the advantages of having a readily available source of medical and healthcare knowledge in their everyday practice. Just as attorneys need to have outside expertise in such areas as information technology, economics, science and engineering (to name but a few), they also benefit from outside sources of medical information and familiarity with the functions of the healthcare industry.

Nurses have served as legal consultants for many years, though not always recognized as such. Hospitals have always relied on nurses for such activities as utilization review, quality assurance and performance improvement, accreditation and licensure, and oversight of clinical practice departments and functions. Insurance companies also tap into this expertise for case management, liability review, and coverage issues.

LNCs may serve the legal profession as either in-house consultants, part-time independent consultants, or registered consulting firms. Their primary functions have been gathering and summarizing of medical records, obtaining missing or incomplete records, and building timelines and chronologies. As attorneys have gained an appreciation of the abilities and knowledge of LNCs, they have expanded their activities to include review for strengths and weaknesses and analysis,

identification of substandard care or treatment errors, research, education, case management of personal injury clients, and expert testimony, and many others. This allows the attorney to evaluate their decision whether or not to accept a new case before committing extensive time and expense.

As illustrated in this newsletter every month, nurses have dealt with a wide variety of clinical illnesses and problems throughout their careers. Physicians and medical administrators have always relied on this experience to help ensure the best possible outcome for patients. No patient exists in a vacuum. Any given situation involves the physician (often more than one), rehab and therapy, respiratory support, and dietary maintenance, and others specific to the situation. Multiple diagnostic data must be gathered, and changes to the data must be monitored. The activities of multiple providers must be coordinated to prevent overwhelming the patient. The effects of the patient's diagnosis on their family and personal financial situation must also be considered. All of these diverse factors affect the outcome. In addition, the nurse is doing all these things for several patients at any one time.

For the attorney, all of these tasks consume a considerable amount of time. This is time that is needed to be negotiating with opposing counsel, preparing for deposition or trial, maintaining court schedules and meeting with other clients. Just gathering and understanding all of the available

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The Use of Restraints

Jeannine Lurie RN, BSN, CLNC

Restraint refers to any physical, chemical, or environmental means of restricting, limiting, and/or inhibiting an individual's freedom of movement. Restraining patients is a complex issue with legal, safety and psychological implications. The application of restraints is an emergency measure indicated in exceptional cases when all other measures are not effective in achieving therapeutic goals. Physical restraints should never be used as a substitute for good nursing care, for punishment, or as a convenience to the staff.

An individual's right to respect, dignity, and autonomy may be violated when restraints are used in the provision of nursing care. Nurses, who routinely use restraints in the delivery of nursing care, should be knowledgeable of the numerous ethical, moral, and legal dilemmas associated with this practice. The literature identifies that in many clinical situations; alternatives to the use of restraints exist and should be explored.

Where restraints are used, the patient must be provided with sufficient information on which to independently make a decision regarding their use. In situations where a patient is not competent to make this decision, the family should be consulted. The process used to obtain informed consent should be documented on the progress notes. If a patient alleges that informed consent has not been given for the use of restraints, the potential exists for a suit of negligence, assault and battery, and/or false imprisonment against those involved in their application.

What are restraints?

By definition, "A restraint is the use of any method of restricting a person's freedom of movement, physical activity, or normal access to his or her body without the patient's permission".

As barbaric as it may sound, restraints are sometimes the last resource the health care professional has to protect a patient from harming him/herself or others. The order is usually given when other less restrictive measures have failed. The rights and dignity of the patient must be the main concern when making this decision. The patient's family and the patient must be given concise explanation of the procedure and the consequences of refusal. At the same time, they have the right to refuse. If their wishes are not followed, the action is

considered to be assault.

What is not a Restraint?

- Devices used for security, detention or public safety reasons on patients in forensic custody and are not involved in the provision of health care. HCFA
- A voluntary mechanical support used to achieve proper body position, balance, or alignment so as to allow greater freedom of mobility than would be possible without mechanical support.
- A positioning or securing device used to maintain the position, limit mobility or temporarily immobilize during medical, dental, diagnostic, or surgical procedures.

When to Use a Restraint?

- In an emergency when other less restrictive measures have been tried, in order to prevent a patient from physically harming him/herself or others.
- For acute medical/post-surgical conditions, to promote healing when there is non-violent or non aggressive behavior, such as immobilizing a leg after a femoral cut down.
- Restraint orders can never be standing or PRN. Restraint protocols are no longer acceptable.

What determines the use of restraints?

The health care professional is responsible for assessing the patient's behavior and determining the reason for the use of restraints. Alternative measures to using restraints should be a careful consideration of the nurse. After the decision is made that some restraint is necessary, it must be determined what type of restraint should be applied. It is the nurses' responsibility to select the most appropriate and least restrictive type of restraint

The physician must be immediately informed, and he will determine the type of treatment that will be given. An RN may initiate the use of restraints, but a written or verbal order from a physician involved in the case must be written within **one** hour. The physician's responsibility is then, to personally evaluate that patient within that hour.

What is the Physician's responsibility for restraints?

- The physician must see and evaluate

evaluate the patient within one hour after initiation of restraints.

- The treating physician must be notified as soon as possible if the treating physician did not order the restraints.
- If the physician initiating the order is not the attending physician, he/she has to be notified as soon as possible.
- The treating physician must be contacted immediately if leather restraints or 3 - 4 point restraints are required.
- The initial order is time limited:
 - Adults - Patients 18 years or older need to be personally evaluated by an MD every 8 hours, and every 4 hours for 17 years or younger.
- If the restraints are discontinued prior to the time limit, a new order must be obtained to re-apply restraints.
- The order must include:
 - Clinical justification for restraints
 - Type of restraint
 - Criteria for release of the restraints
 - Date, time, and maximum time for restraints

Patients who's behavior:

- Represents physical or psychological risk to the patient or to others
- Is hostile and destructive towards self and others
- Interferes with medical/surgical healing: Such situations include:
 1. Airway management for patients on life-support
 2. Pulling tubes (feeding tubes, endotracheal tube, urinary catheter, etc.)
 3. Fall risk
 4. Confused and disoriented patients unable to follow instructions
 5. Pulling invasive devices (IV lines, central lines, arterial lines)

Again, there must always be a physician's order. Each health care facility has it's own form, but all the requirements follow a specific path, as per the Joint Commission on the Accreditation of Healthcare Organization. It should be stressed that the order CANNOT be written as a PRN (as needed) order.

Who is responsible to assess the patient as per Restraint Assessment Form for:

It is the RN's responsibility to:

- Signs of injury to the site of placement
- Nutrition and hydration
- Circulation and Range of Motion in extremities
- Vital signs

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LNCs Are Becoming More Utilized By The Legal Profession

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information is a daunting task. It may also require considerable effort to overcome barriers from insurance companies, medical administrators, and physicians' offices when trying to obtain information, get clarification, or simply schedule evaluations or interviews.

That is where LNCs are becoming more important. The time spent performing these tasks can be considerably less when done by a professional that is used to dealing with all of these entities and complications. Nurses are, by nature as well as training, accustomed to the roles of educator, counselor, advocate and facilitator. We are used to dealing with multiple sources of management and administration, which may or may not have competing interests. A patient-focused approach helps the attorney provide a better legal outcome for their client.

When looking for the best LNC, the attorney needs first to decide what the specific needs are. Attorneys who work only with cancer-related malpractice or toxic tort claims may prefer a nurse with a solid background in oncology, for example. A Worker's Compensation specialist would be best served by a nurse with experience in occupational health and case management.

There is no way to predict all of the different all of the different healthcare specialties that future cases will involve. For that reason, it doesn't work well to "type" LNCs according to clinical background or current practice area, or limit your choices to specific clinical experience. Important things for the attorney to look for would be the LNCs ability to organize information and time, provide appropriate counsel and education, pay attention to detail, and have the ability to harness the healthcare knowledge and experience needed for the specific case.

Although Legal Nurse Consultants have been practicing for 20 years or more, they are becoming more visible and influential. Ongoing web searches of court decisions, case reviews, and legal journals show more references to LNCs and their involvement in litigation over the past few years. They have also become recognized by legal support professionals such as Legal Assistants. An article in the Legal Assistant Today, published in September 2003, illustrates how this profession is becoming an integral part of the legal team. For the busy attorney, pulled in many directions at once by multiple clients with multiple needs, they provide the knowledge and ability that is needed to attend to all the needs of a legal case.

Preparing Clients for Independent Medical Exams

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7. **Do not pay** for any expenses related to the examination.
8. **Contact the attorney immediately** or signal the observer at any time you feel uncomfortable with the exam or if the examiner attempts to examine areas unrelated to the injury or wants to perform x-rays or other testing not already pre-approved by your attorney.

Be sure to provide your client the details of the exam: the purpose and scope of the exam, the type of testing (if any) that will be performed, the location and name of the examiner performing the exam and the general length of time the process is expected to take. Additionally, if you send an observer, explain to the client the observer's role in the course of the examination. Advise the client not to enter the examination without the observer being present unless otherwise agreed.

Adequately preparing clients for Independent Medical Exams can lessen the client's anxiety level, increase the likelihood of an accurate portrayal of their sustained injuries and positively influence the outcome of their case.

Ten Questions and Answers Related to the Cervix

Jan Aken RN IBCLC

1. What is a fingertip dilatation?

The cervical dilatation is measured in centimeters. A fingertip dilatation is 1 centimeter. The tip of the finger fits into the os (opening) of the cervix.

2. What is a rim?

It is when the cervix is dilated greater than 9 centimeter and there is a rim of cervix remaining around the presenting part.

3. What is an anterior lip?

This is a greater dilatation than the rim. The only part of the cervix remaining is the top and this is called an anterior lip.

4. What is effacement of the cervix?

The normal length of the cervix is 2.5 to 3 in length. As the due date nears the cervix usually begins to soften and thin. Those of us who work in the obstetrical unit may be heard to say or will document the cervix is 50% effaced. That means that in cervix

measurement is one-half of the normal length or 1.25-1.5 centimeters in length. We will often say or make a note in the medical record the cervix is paper thin. That would mean the cervix is like the thickness of paper.

5. What is an unfavorable cervix?

This notation on the record may indicate the cervix is very firm and closed, meaning you would not be able to put the tip of your finger into the cervix. This notation is most often seen when some thought is given to inducing the patient. In this case it may be hard to get the patient into labor.

6. What is a vertex position?

Observing this on the labor flow sheet would indicate the head is down and in the normal position.

7. What is caput or molding?

If this is noted on the labor record, this indicates some swelling is noted on the tissues of the head.

8. What does station indicate?

This is the level of the presenting part above or below the ischial spines. An ischial spine is a pointed process on the posterior boarder of the hip. If the baby's skull is level with the ischial spines, the position is said to be at a zero station. If the head is above the station is minus 1 and up. If the head is below the ischial spines, the station is plus 1, plus 2, 3, until the baby is on the perineum. On the perineum would mean the baby is being delivered.

9. What is ballotable?

Ballotable indicates that the baby is not engaged in the pelvis. Meaning upon vaginal examination, the head can be pushed up and will float out of the pelvis. This position is usually a minus 3 or more

10. What is a compound presentation?

This is a presentation when 2 parts of the baby are presenting at the same time. When doing a vaginal examination one may feel the fetal hand on the top of the fetal head.

Minor Refusing Treatment in the Emergency Department

By Gail Hendrickson, RN, CEN

All competent adults are asked to sign consent for treatment form when they present to the emergency department. Minors accompanied by a parent are also asked to sign consent forms, however the parent is asked to sign the consent form.

A minor who presents to the emergency department without a parent presents challenges for care. Individual state laws define the chronological age of a minor. Typically a minor is defined as a person under the age of 18. In general, minors are not allowed to give medical consent. Therefore, they are not allowed to refuse emergency medical treatment.

A common problem that presents to emergency personnel is the minor who is involved in a motor vehicle accident. Many times, there is a careful of minors who are involved in an accident. The police arrive, and call for an ambulance. The ambulance personnel arrive, and find all the passengers out of the car. They all are under the age of 18. They all refuse transport to the hospital. If they were adults, the prehospital personnel have a written release allowing them to refuse care and transport to the hospital. However, a minor is not allowed to sign off and refuse care. Prehospital ambulance personnel are not trained to advise any patient that medical care is not required. Hopefully, all three are transported to the hospital for further evaluation. Attempts must be made to reach a parent to give consent for treatment for their child. Many times, the minor will not give the number for the parent, or tells the hospital personnel that their parents are not available.

A typical case where a minor refuses treatment might look like this:

A 16-year-old driver is involved in a roll over, and totals his car. He has 2 passengers, both minors in his car. They all get out of the car before the police arrive. The driver complains of abdominal pain, but refuses to go to the hospital. He has been drinking, and is afraid that they will find that out if he goes to the hospital. When the ambulance arrives, they realize that all 3 minors need to be transported to the hospital for further evaluation. From the mechanism of the accident, they know that there can be serious injuries to these 3

patients.

After much encouragement, they all agree to be transported. Upon arrival to the ER, the two passengers give the number for their parents, and verbal permission is obtained to treat them. However, the driver tells the nurse that his parents are away on a cruise, and unobtainable. An ER physician sees him and lab work is ordered. A CT scan is needed to rule out any internal injuries. The patient is informed of the need for these tests, and he agrees. All tests end up negative, and he is discharged with one of his friend's parents who agree to keep him at their house for the night to keep an eye on him.

A month later, the hospital receives a call from the patient's mother refusing to pay the bill. She states that they were never called, and never gave permission to treat their son. They were not on a cruise as their son had stated. They do not have medical insurance, and refuse to pay the \$3,000 bill for emergency treatment.

The parents decide to pursue a lawsuit. They say that since they never gave permission for their son to be treated, the doctor had no valid consent to perform the tests, and procedures, thus constituting battery. The plaintiff case is that the physician took advantage of their son by ordering expensive tests, which he didn't understand well enough to refuse. They may say that since all the tests turned out negative, they were not needed.

The defense for this case would be that the ER doctor suspected serious internal injuries and delay of treatment might have lead to serious complications. Careful documentation is needed to confirm this. The doctor documented clearly his findings, and concern for internal bleeding. He also documented that this patients parents were unavailable, and that he had spent time explaining the need for the tests to the patient, and he agreed.

Another angle on this scenario would be if the minor refused to be taken to the hospital for evaluation. 24 hours later, he is found dead, due to a slow bleed from a ruptured spleen. This sure would lead to a much different medical malpractice case.

Glasgow Coma Scale: What is it and What Does it Mean?

Pattie Patterson RN, LNCC

The Glasgow Coma Scale is a widely used scoring system for qualifying the level of consciousness in a person who has had a traumatic brain injury. This is based on motor response, verbal performance and eye opening to appropriate stimuli. It was designed and should be used to assess the depth and duration of the coma and impaired consciousness. This scale helps to gauge the impact of a wide variety of conditions such as acute brain damage due to traumatic and/or vascular injuries or infections, metabolic disorders such as hepatic or renal failure, hypoglycemia and diabetic ketoacidosis to name a few.

The score range is from 3 to 15, with 3 having no response in all areas and 15 being a normal person with no deficits. (See below) However, there are limitations to its use, as other factors may alter the patient's level of consciousness, verbal response and eye opening. Such factors are shock, drug use, alcohol intoxication; metabolic disturbances may alter the person's level of consciousness and alter the GSC independently of the brain injury. Also, a patient with a spinal cord injury will make the motor scale invalid, and a severe orbital trauma may make eye opening impossible to assess. Also, if the patient is intubated, they cannot talk. This is why it is preferred to record the findings as E-4, V-intubated, M-6, as opposed to 10, which would suggest a moderate brain injury, which, in fact is more than likely is not the case. In spite of these limitations, it is quite useful and is the most widely used scoring system used today to assess patients with traumatic brain injury.

Generally, as long as these aforementioned factors are not in play, a total score of 13 or higher suggests a mild brain injury, 9 to 12 and a total score of 8 or less is indicative of severe brain injury. Furthermore, a score of 8 is the critical score, as anything over 8 means that the person is not in a coma.

Glasgow Coma Scoring

Eye opening

4=Spontaneous-opens eyes with blinking at baseline.

3=Open eyes to

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The Use of Restraints

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- Hygiene and elimination
- Physical/psychological status and comfort
- Need to continue/discontinue use

Types of restraints

1. Soft wrist restraints - Applied to the wrists mainly to prevent a confused or a patient on life support to pull the endotracheal tube, intravenous lines or any other devices essential in maintaining the integrity of that patient. These are tied to the bottom of the bed.
2. Mittens - Used as soft restraints on the confused elderly who picks on intravenous devices, dressings or likes to pinch and scratch the staff.
3. Posey Vest - Applied over the patients head and criss-crossed on chest, then tied under the bed or when sitting, at the back of a chair. This prevents the risk of falling, if the patient is confused.
4. 4-point leather restraints - Used on more aggressive and dangerous patients to protect patient and staff.
5. Chemical restraints - Used to restrain patients involuntarily to protect the patient and the staff from harm.

Prevention and Alternatives to Restraints

The health care professional has a responsibility to consider alternatives to the use of restraints after assessing the patient. Family members and the patient need to be educated when the patient is found to have the need to be on restraints. Allowing the family to participate actively in their care decreases the patients' frustration allowing more cooperation from their part. It is always comforting to allow a family member to stay with the patient. This gives them a sense of security, especially when dealing with a strange and unfamiliar place. If a family member is not available, hospitals usually have a list of sitters who are paid to keep the patient accompanied.

Keeping a patient who is confused oriented to time, place, person and situation helps the patient keep track of what is going on in his environment. The closest to the nurse's station the patient can be, the easier it is to monitor the actions that can keep that patient safe.

Nursing Care and Documentation for the Restrained Patient

The RN/LVN (LPNs)'s are responsible to do vital signs and ongoing care of the restrained patient. Unlicensed personnel,

such as a nurses aide or a technical partner, can be delegated to do vital signs and activities of daily living (ADL's).

For behavioral restraints assessment and documentation every 15 minutes should include:

1. Signs of any injury associated with the application of restraints
2. Nutrition and hydration
3. Circulation in the extremities and range of motion
4. Vital signs
5. Hygiene and elimination
6. Physical and psychological status and comfort
7. Readiness for discontinuation of restraints

For Medical/Surgical reasons, assessment is done every 2 hours and includes:

1. Physical and emotional well being of the patient
2. Patient's rights, dignity and safety
3. Less restrictive methods
4. Change in behavior or clinical condition
5. Proper application, removal or reapplication of restraints
6. Assessment of site of restraints for adequate circulation, sensation or skin breakdown
7. Repositioning the patient
8. Offering assistance with toileting
9. Removing restraints and performing range of motion exercises
10. Education of family and patient pertaining the plan of care, need for restraints, continued reassessment of the situation and identifying how the family can participate in this process to limit or stop the use of restraints.

Each healthcare institution has an assessment form and checklist to document patient care to conform to the guidelines of the standards of care stipulated by the Joint Commission Accreditation on Healthcare Organization (JCAHO). This should be complimented with nurses notes when there have been changes in behavior or clinical status. All this documentation becomes a permanent part of the MEDICAL RECORD.

Glossary of Terms:

Restraint - The use of mechanical, chemical, environmental, or physical measures intended to limit the activity and/or control the behavior of an individual.

Physical/Mechanical Restraint - An appliance that restricts freedom of movement, for example, vest restraints, lap belts, pelvic restraints, mittens, geriatric chairs with locked trays. Also included is the use of bindings, stockinette, sheets, and other materials that may be used to prevent free movement.

Chemical Restraint: Medication given to restrict a patient's freedom or for emergency control of behavior and is **not** standard treatment for a patient's medical or psychiatric condition.

Behavioral Restraint: A physical device or chemical which restricts movement and is used to control aggressive or violent behavior.

Non-behavioral Restraint: A physical device or chemical which restricts movement and is used to control behavior which is not aggressive or violent.

Environmental - The use of environment, including seclusion or a time out room, to restrict freedom of movement or to allow for safe release of energy.

Glasgow Coma Scale: What is it and What Does it Mean?

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verbal stimuli.

2=Responds to pain only (not applied to face)

1=No response.

Verbal response

5=Oriented-normal conversation.

4=Confused conversation but is able to answer questions.

3=Inappropriate words.

2=Incomprehensible speech.

1=No response.

Motor response

6=Obeys commands for movement.

5=Purposeful movement to painful stimuli.

4=Withdraws in response to pain.

3=Flexion in response to pain (decorticate posturing)

2=Extension response in response to pain (decerebrate posturing)

1=No response.

**HAVE A SAFE AND
HAPPY FOURTH OF JULY!**

Medical-Legal Interface

Pattie Patterson RN, LNCC
Legal Nurse Consultant-Certified
Life Care Planner
6501 Galaxie Road
Richmond, Va. 23228

Phone: 804-262-2991

Fax: 804-266-5701

Email: leglnurs@bellatlantic.net

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case.”*

