

THE LNC NEWSLETTER

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Medical-Legal Interface

Gauging Responsibility in Worker's Compensation Claims

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When looking at a new medical record that is the center of a Worker's Compensation suit there are many things that the LNC needs to assist the attorney client to evaluate. As this writer entered the LNC profession following several years in Worker's Compensation management, we are able to analyze the case beyond the employee's medical record. It has been interesting to note that we have gone from a career in defense to a primarily plaintiff clientele.

By the time we become involved in such a case the parties are firmly entrenched. The employee feels they have been abandoned, or never properly

treated in the first place. It is common to hear that the employer has not ever been involved in the plaintiff's case, nor very involved in the overall care of their employee population. On the other hand, the employer feels that they did all they could do for this employee, gave them the treatment they needed, and now the employee is simply out to "get" them. Our job is to help sort it all out so our attorney client can take a good look at the pros and cons of the case.

On thing that we need to evaluate is the Log of Occupational Injuries and Illnesses. This is the one place that the employer must list
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Dental Malpractice

Sarah McLain RN, CLNC

The medical malpractice crisis continues to be greatly unresolved in the majority of states across the country that are unable to come to a compromise between the two disputing sides. Insurers consider New Jersey and Missouri as "crisis" states because of soaring malpractice premiums, but studies show malpractice claims and awards are not increasing in either state. Despite these figures, doctors and insurers continue to side with the Republican party to place caps on jury awards, which consumer groups, trial lawyers and a Democratic majority claim will continue to punish the most severely injured victims of malpractice while allowing negligence to continue unpunished.

Experts say dental malpractice is its own category and does not generally reflect what is going on in the larger health care market. This goes specifically for the high settlement amounts. The majority of insurance companies, in fact, only write policies for dental malpractice if they are writing policies for physicians.

Claims for malpractice are considered inherently smaller in dentistry than for medical

claims. Although the number of dental malpractice claims has remained fairly steady in frequency and outcome in the last decade, dentists have a duty to patients. A general practitioner, for example, must realize performing a procedure that is also performed by a specialist must be held to a level that is considered the same level of expertise as the specialist. Failing to refer a case early enough to a specialist can result in higher liability if the dentist is later involved in a dental malpractice claim.

A possible dental malpractice claim can involve a wide range of improper treatment services rendered, or the failure to appropriately detect or diagnose conditions. Dental malpractice cases have included injuries to the jaw, lip and tongue nerves, anesthesia related injuries and deaths, the failure to detect or diagnose oral cancer and other oral diseases and injuries related to dental surgeries and treatments. Like any other healthcare professional, a dentist is held to a certain standard of care when providing services to a patient. A breach of this duty might result in instances of dental malpractice or negligence.
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Gauging Responsibility in Worker's Compensation Claims

Robert Morrison, RN BSN

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all of their "recordable" injuries. There are several things to look for in this log: injury rate (particularly for this employee's type of injury); the total number of lost and restricted days each year; patters that may relate to days of the week, months, or seasons; frequency of similar injuries. This log can help identify weaknesses in the employer's injury prevention programs and perhaps support the plaintiff's claim that the employer's response to this type of injury is less than stellar.

Does the employer have an on-site occupational health team that includes both healthcare and safety professionals? This is an important point. When the occupational care team does not include an experienced nurse then the employer's ability to oversee treatment and evaluate the employee's needs is hindered. In these cases the plaintiff's attorney may have several items that they can present in court to illustrate insufficient care.

Now we progress to the medical record itself. First we look at the immediate response of the on-site team at the time of the injury. Who responded, what were their qualifications and experience, and what did they do? Was outside rescue or EMS activated if indicated? Where was the employee taken and what was done for them at that point? This review serves to identify insufficient responses by the employer. It may also identify other individuals or facilities that may have contributed to the

employee's current problems. The records from all of these sources need to be reviewed to relate the employee's current problems to the work injury.

Another important aspect of the employee's care is the claims management practices. Who performs such claims services, the employer's in-house staff or an outside service? While large employers may provide their own healthcare and claims staff it is far more common to find an outside company providing the oversight and accounting roles. This becomes an important point. The decision to approve or deny recommended treatment requests or expenses must include people who are qualified to analyze the medical issues of the case.

Simple Worker's Comp claims may involve only a claims adjuster. Those involving medical care beyond the date of injury, lost work time, or potential permanent impairment should also involve review by nursing and medical experts. This allows the treatment to be guided by the medical needs of the person, not by financial interest alone. The employer is certainly entitled to protect their financial interests. However, a close review of the medical history can help identify those times that the employee is being denied needed treatment in order to save money.

Worker's Compensation is a unique mix of medicine and the law. In theory, neither can override the other. The LNC can assist the attorney in analyzing

denied requests for treatment. Are the decisions made by healthcare professionals, following a careful consideration of the medical status of the employee? How do they support them? Are there grounds for challenging them medically? Do they follow past decisions of the employer? Do they appear to be in line with the published policies and philosophies of the employer?

Worker's Compensation is a statute-driven program that is supposed to restore an ill or injured employee to health. It is important to compare the employer's actions to the documented needs of the employee in order to judge their appropriateness. If the employer strays too far from this benchmark it can find itself far more vulnerable to employee-driven litigation.

Dental Malpractice

Sarah McLain RN, CLNC

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Though not every complaint or claim will result in a dental malpractice lawsuit, if a patient believes injury has been suffered because of negligence or malpractice under the dentist's care, an attorney specializing in dental malpractice can review the case.

If a strong case exists, the dental malpractice lawyer will be able to advise the patient of his/her legal rights and options.

The Nursing Shortage-What Caused it and How it Impacts Medical Malpractice

Pattie Patterson RN, LNCC, CLCP

(The opinions here are solely my own, based upon my own nursing experience and the experience of nurses I have spoken with, and may not reflect others on the newsletter staff.) This article is different than what I normally write, but I feel the need to write it, so that others may understand some of the influences behind the current nursing crisis.

Not long after I began my nursing career there was a government “issued” nursing shortage. The federal government in its infinite wisdom decided that there was an excess of nurses in the United States so they pulled funding for nursing programs. Within three years there began the first nursing shortage of my practice. By the early 80s hospitals began recruiting nurses from other countries to fill the needs. While many of these nurses that I worked with were quite competent in their nursing skills, their language barrier prohibited many of them to pass state nursing boards, and thus they worked for nursing assistant wages until they were able to pass the boards, although most of them were “allowed” to work as nurses.

Things were never fine, but they were tolerable for the most part until the late 90s, when began the next nursing shortage, the one we are currently into at this point. Although there was no “official” nursing shortage at that time, but having been clinically active at that time, I can tell you, it was beginning at that time.

This time there is no one

clear cut cause of the nursing shortage, but I have some opinions and ideas of the causes, those being:

1. A cut in funding for nursing instructors coupled with an increase in credentials needed to be an instructor. When you expect an instructor to be masters prepared and want to pay them less than their predecessors who were BSN prepared, it just doesn't add up to getting instructors.
2. A lot of BSN programs decreased their clinical parts of their course significantly, and the clinical they had they only had 1-2 patients to care for at any given time. Once they got out into the “real world” of nursing, it wasn't anything like they expected, and many left after only a short time, either by leaving the bedside, or finding positions that did not require bedside nursing or leaving nursing completely.
3. This brings me to the third issue, that of these non-clinical positions. When I first started in nursing, there was a nurse manager and an assistant nurse manager for each unit. The nurse manager worked part of her time in staffing as the charge nurse, and when she was doing administrative duties, the assistant nurse manager was in charge. The director of nursing (DON) was the supervisor for days-Monday through Friday, and there were other supervisors for evenings, nights and

weekends.

- a. In today's nursing set up, there is a nurse manager for several units who NEVER works clinically other than the rare occasional assistance at the desk when ABSOLUTELY needed and only on day shift.
- b. There is still an assistant nurse manager for each unit, but she rarely works as a staff nurse, either, not even as the charge nurse, much like the nurse manager.
- c. As for the DON and the assistant DON, well they have too many meetings, etc, to be bothered with staffing or other day-to-day clinical issues. So this means that there are now supervisors working all shifts, and at most hospitals, there are two on day shift during the weekdays, so that one can attend the infamous meetings. Most of the newer bedside nurses never even meet the DON or the assistant DON much less get any input from them.
4. Along those same lines are the administrative “hats” that have cropped up over that past 10 years or so.
 - a. There's the educational component, those who do the initial education of new employees, that supervise those that do the recertification aspects of current staff, the computer component who teach how to work

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The Nursing Shortage-What Caused it and How it Impacts Medical Malpractice

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- with the computer documentation on an ongoing basis. These are groups of nurses for each component, not just one nurse and none of these actually work in the clinical arena but they do attend many meetings.
- b. Then there are the wound care nurses. They do see patients, but only to assess and advise on proper wound care, not to actually do the care. Again, there is more than one per institution. This is so they can also attend the meetings.
 - c. There are probably other “hats” that I am not aware of, but suffice to say, were some of these hats eliminated there might actually be clinical bedside nurses to take care of the patients. I know it’s a radically idea, but certainly one for thought.
5. They used to work 8 hours shifts, and then they instrumented 12 hour shifts, but allowed the nurse to choose between the two. Now, they are no longer given a choice of shifts and must either work 12 hour days or nights in most facilities across the nation. Even though the 12 hour shifts allow the nurse to have 4 days off per week, there are often mandatory meetings that they must attend on their off days. These are not counted in their 40 hour week for overtime, but they do get paid at base salary for most of these meetings. Many of the nurses find that the 12 hours shifts are simply too demanding on their physical well-being to be safe.
 6. Another issue that I think is a big contributor to the nursing shortage is the way that the nurses are being treated by these “hats”, administration and the corporations that own the hospitals.
 - a. First, instead of cherishing the nurses that have stuck it out, they threaten them, telling them they are expendable. Get real, how are they going to replace them and with whom? Get a clue; we’re in a nursing shortage, HUH!!!
 - i. They threaten them with abandonment to make them stay over if staffing is short, even though they have already worked 12 hours. (Btw, it is NOT abandonment if the nurse has served her preassigned shift.)
 - ii. They threaten them with termination if they don’t come in extra when needed, making overtime almost mandatory.
 - iii. If they complain about the lack of staff, they tell them to do the best they can with what they have as the patients are now their responsibility.
 - iv. Should they make a mistake, they are told they are written up for it and it goes in their permanent file and if it happens again they can be terminated.
 7. New graduates are often placed in areas of practice they are not experienced enough to handle or have enough knowledge base to perform. They often get very little, if any on the job training, and due to the shortage often do not have any back up support should they have questions or concerns.

Now that you understand some of the mechanics that brought us to this nursing shortage, let’s look at who is really responsible for most of the nursing malpractice. Let’s look at scenarios in which a malpractice may be committed.

 1. Due to being short staffed, even though the nursing supervisor was informed of a potential situation, a patient called for a nurse, and no one responded in a timely manner due to being tied up with other patients and the patient had a heart attack and died. Is the nurse responsible? Yes, as the nurse accepted the assignment knowing it was not safe. This makes the nurse culpable, even though it was the hospital that did not alleviate the situation. Until nurses start standing up for the patients and themselves, these types of situations will continue.

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2. The nurse is just finishing her 12 hour shift when the supervisor approaches her, stating that 2 of the night nurses just called in sick (they left early the night before due to illness) and telling her that it is her "turn" to stay over so she has to stay to assist night shift with the beginning of their shift until additional help can be found. The nurse stays, even though she is not feeling well and is very tired, for fear of being charged with abandonment. While doing her medications she inadvertently gives a patient the wrong medication which causes the patient to have a reaction and a stroke. Is the nurse responsible? Yes, she knew she should not stay as she was not at her peak, but allowed the supervisor to intimidate her into staying. The nurse had every right to say no, and should have, as her duty to her patients ended at the end of her shift.
1. A new graduate has only been working as a nurse for 2 weeks, and is told that she must give Dilantin IV push to a patient, as she is the only RN on the unit and it is policy for the RN to do it. She reports that she has never given the medication before and is instructed verbally how to do it. The nurse gives the Dilantin, but does not realize the patient is having a reaction, and has a grand mal seizure and ends up in a persistent vegetative state. Is the nurse responsible? Yes

because she should have refused to give the Dilantin and had the supervisor come to the unit and administer and asked for some sort of training before she accepted responsibility for giving the Dilantin.

The bottom line here is until nurses stand up and are heard they will continue to be set up to commit malpractice by their employers. And until they make a difference for all nurses the nursing shortage will continue to be a problem of monumental proportions. Until this is accomplished, nurses will continue to leave the bedside either to go into administrative positions, to go into other areas of nursing such as we have done, or to leave nursing altogether. If all of the nurses who are actually licensed were working at the bedside, I suspect that there would no longer be a nursing shortage.

As long as there is a nursing shortage and nurses accept unsafe assignments or are coerced into working in unsafe conditions there will be more and more medical errors and more and more malpractice claims.

JCAHO Update

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) issued a call to action to reform the nation's medical liability system, urging that the current proposal for caps on non-economic damages be expanded to pursue intermediate and long-term system changes

which truly facilitate improvements in patient safety. By its basic design, the current medical liability system chills the identification and reporting of adverse events in health care and thus, undermines opportunities for learning that could provide the basis for significant safety improvements.

The current medical liability system, the Joint Commission suggests, fails patients because it does not effectively deter negligence, truly offer corrective justice, or provide fair compensation to those who have been injured through the care process. It is also accurate to say that too little progress has been made in improving patient safety since the release of the Institute of Medicine's groundbreaking report on medical error five years ago. Finally, it is a simple fact that a very small proportion – two to three percent – of injured patients receive compensation through the medical liability system, and those who do, receive highly variable recompense for similar injuries.

Their recommendations are:

- Actively pursue patient safety initiatives that prevent medical injury.
- Promote open communication between patients and practitioners.
- Create a patient-centered injury compensation system.

For their complete position go to:

http://www.jcaho.org/about+us/public+policy+initiatives/medical_liability.pdf

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