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Spring 2021

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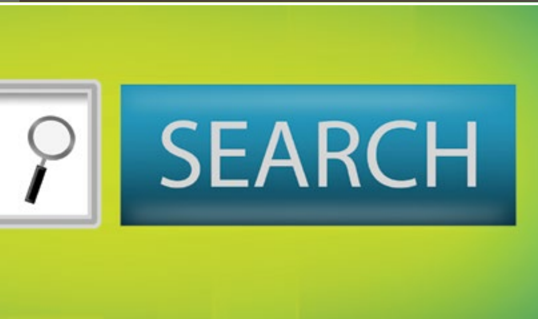

LNC PRACTICE CONTINUUM, NICHE ROLES, LABOR AND DELIVERY SUPPLEMENT

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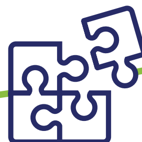

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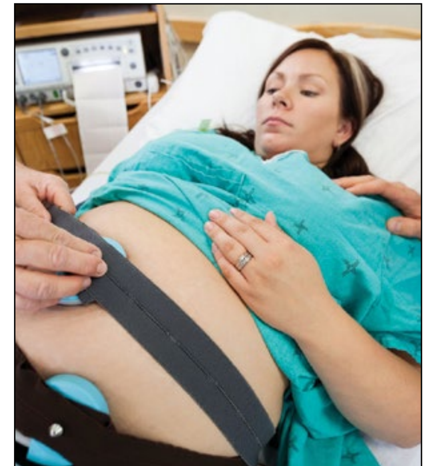

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PURPOSE

The purpose of The Journal is to promote legal nurse consulting within the medicallegal community; to provide 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. Please see the next page for Information for Authors before submitting.

MANUSCRIPT REVIEW PROCESS

We send all submissions blinded to peer reviewers and return their blinded suggestions to the author. The final version may have minor editing for form and authors will have final approval before publication. Acceptance is based on the quality of the material and its importance to the audience.

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ARTICLE SUBMISSION

The *Journal of Legal Nurse Consulting* (JLNC), a peer reviewed publication, is the official journal of the American Association of Legal Nurse Consultants (AALNC). We invite interested nurses and allied professionals to submit article queries or manuscripts that educate and inform our readership about current practice methods, professional development, and the promotion of legal nurse consulting within the medical-legal community. Manuscript submissions are peer-reviewed by professional LNCs with diverse professional backgrounds. The JLNC follows the ethical guidelines of COPE, the Committee on Publication Ethics, which may be reviewed at: http://publicationethics.org/resources/code-conduct.

We particularly encourage first-time authors to submit manuscripts. The editor will provide writing and conceptual assistance as needed. Please follow this checklist for articles submitted for consideration.

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- Manuscript length: 1500 – 4000 words
- Use Word© format only (.doc or .docx)
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- Put title and page number in a header on each page (using the Header feature in Word)
- Place author name, contact information, and article title on a separate title page, so author name can be blinded for peer review
- Text: Use APA style (Publication Manual of the American Psychological Association, 7th edition) (https://owl.english.purdue.edu/owl/resource/560/01/)
- Legal citations: Use The Bluebook: A Uniform System of Citation (15th ed.), Cambridge, MA: The Harvard Law Review Association
- Live links are encouraged. Please include the full URL for each. Be careful that any automatic formatting does not break links and that they are all fully functional.
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- All photos, figures, and artwork must be in JPG or PDF format (JPG preferred for photos). Line art should have a minimum resolution of 1000 dpi, halftone art (photos) a minimum of 300 dpi, and combination art (line/tone) a minimum of 500 dpi.
- Each table, figure, photo, or art should be submitted as a separate file attachment, labeled to match its reference in text, with credits if needed (e.g., Table 1, Common nursing diagnoses in SCI; Figure 3, Time to endpoints by intervention, American Cancer Society, 2003)

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Acceptance will be based on the importance of the material for the audience and the quality of the material, and cannot be guaranteed. All accepted manuscripts are subject to editing, which may involve only minor changes of grammar, punctuation, paragraphing, etc. However, some editing may involve condensing or restructuring the narrative. Authors will be notified of extensive editing. Authors will approve the final revision for submission.

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Laura Grossman Nissim,
RN MS CNS LNCC

President, AALNC

President's Update

Dear Members,

I am writing you in the middle of the holiday season, at the end of a year that none of us have ever imagined or seen before and that I would imagine would not want to see again. I hope when you are reading this we have come through the winter and the promise of the spring includes the decrease of the curve and the success of the vaccination programs that have been approved for emergency administration by the FDA. I wish I had crystal ball that I could view just to have an inkling of where we are as a country and as a world. But that did not come with my Presidency, so for now I will keep all of my fingers crossed.

We had a very successful round-table Ask an LNC webinar in early December. So many new nurses are interested in our field! Our panelists provided great answers to queries from attendees and hopefully encouraged them to join us at the home for all LNCs.

Our Annual Forum is coming up this April 13, 2021-April 16, 2021. The schedule is well thought out, and the speakers are going to be interesting and educational. Though we are not all together, I hope with the assistance of the video platform (and our AALNC HQ Executive Staff) we can enjoy a truly interactive learning experience while also being able to network with fellow LNCs that we cannot see in person.

Though we have had to adjust, change, and rethink so many things, AALNC has remained a vibrant and growing organization. Our membership is higher this year than it was (at this time) for the prior two years. Our educational sales have continued to grow, especially our LNCC Review Course, Professional Course, and our textbook - the 4th edition P&P. Certification revenue has exceeded budget in both certification and recertification.

In a year when we had no play book or strategy to utilize, we used all the tools that nurses have always used; we planned, we researched, and we learned from our efforts. This quarter's Journal looks at niche roles for the Legal Nurse Consultant. Julie, along with the Editorial Committee, has put together a journal that encourages us to look at LNC opportunities outside those most of us think about. Articles are presented about succession planning, mentoring, and working as an expert on Board of Nursing cases. There are also two roundtables planned for this edition as well.

I hope you all enjoy the Spring 2021 issue of the *Journal of Legal Nurse Consulting.* I also hope to 'see' as many of you as possible at the AALNC Educational Forum this April.

Laura Grossman Nissim, RN MS CNS LNCC

"Nothing in life is to be feared, it is only to be understood. Now is the time to understand more, so that we may fear less."

– Marie Curie

Editor's Note

Julie Dickinson
MBA, BSN, RN, LNCC

Editor, JLNC

Dear JLNC Readers,

Spring is a time of transition, and this year is no different. My tenure as the Journal's Interim Editor has drawn to a close, so I want to take this opportunity to express my deepest gratitude for those with whom I have worked during this time. These include the Editorial Committee members and peer reviewers, authors, AALNC Board of Directors, AALNC Staff, and the SmithBucklin production team. It has truly been an honor to work alongside such dedicated and talented individuals. Through collective vision, collaboration, and effort, we have initiated several changes and process improvements.

First, more flexibility has been incorporated into the Journal blueprint to accommodate topics beyond the planned themes and to provide timely content on current trends and contemporary issues. For example, December issues are now "open topic" to welcome authors of any experience level to write on any subject. Another example is the Summer 2021 issue focusing on COVID-19. While COVID litigation, claims, and related case law are still in their infancy, we felt it was important to be on the forefront of providing a resource for LNCs and legal professionals about possible issues and considerations in these cases.

Second, we are pleased to announce the return of the Continuing Education (CE) program in the Journal. Starting with the Summer 2021 issue, readers can earn CE credit(s) on select article(s) by following a few simple steps that will be provided with the article(s).

Third, there has been behind-the-scenes work to strengthen the double-blind peer review process, which is essential to upholding the quality and validity of our Journal's content. I want to thank the AALNC Board for considering these recommendations.

This Spring 2021 issue starts with a focus on transition, too. For newer LNCs or LNCs looking to transition into a different practice area or setting, Davis explores the value of having a mentor or coach. Carlson and DelGrosso introduce a topic that independent LNCs should consider as part of their business strategy – succession planning. Anyiwo and Walker offer prosecution and defense perspectives on serving as an expert witness for a Board of Nursing. In her two roundtable articles, Green synthesizes interviews with nine legal nurse consultants and expert witnesses who share about identifying and developing their niche practices. Finally, in the labor and delivery supplement, Husted discusses trends in obstetrical nursing litigation and provides resources for the analysis of obstetrical nursing care, and Browne reviews current trends in the treatment of postpartum hemorrhage.

I am deeply thankful and humbled to have had the honor of serving you, the readers; our specialty practice; and the Association as the Journal's Interim Editor. Thank you to the AALNC Board of Directors for this opportunity and to the Editorial Committee and authors for making it a wonderful and rewarding experience.

With gratitude,

Julie Dickinson, MBA, BSN, RN, LNCC

AALNC Continuing Education Opportunities

AALNC offers a monthly webinar series, extensive online courses, and an annual Legal Nurse Consulting Educational and Networking Forum. Each educational offering attests to AALNC's commitment to delivering quality education to its members and constituents on diverse and dynamic legal nurse consulting topics.

AALNC Webinar Series presents informative, educational content on clinical issues, legal nurse consultant (LNC) practice issues, and business issues. Individuals can attend live, interactive monthly webinars or access on-demand webinars. Upcoming webinars include:

- May 5, 2021: Case Studies & What Attorneys Look for in LNCs and Expert Witnesses
- June 2, 2021: Research and Medical Literature Review

AALNC members can watch these webinars, as well as those previously offered, on-demand anytime throughout the year.

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- Participate in interactive Q&As in all general and breakout sessions
- Explore subjects relevant to both novice and experienced LNCs, such as clinical topics, practice issues, sedation and rapid response litigation, EMR and audit trails, and business topics
- Receive access to the educational sessions for up to 60 days following the conclusion of the event

Looking for other resources? Check out the publications available to build your library: http://www.aalnc.org/page/aalnc-online-bookstore#complete

To review all of AALNC's continuing education opportunities, click here: http://www.aalnc.org/page/education-and-events

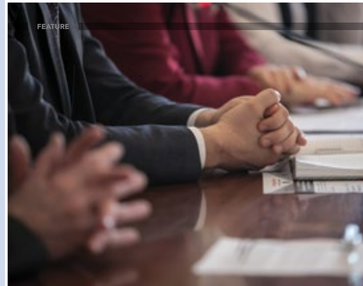
Rewarding Excellence

Every year, the JLNC seeks to recognize excellence by accepting nominations for Article of the Year. In 2020, we published 25 peer-reviewed articles, of which 10 received nominations. Thank you to everyone who voted for the articles that caught their attention, inspired them, or benefited their practice. When the votes were tallied…*there was a tie!*

The co-winners of the 2020 Article of the Year award are:

Deposition 101: Tips for Success

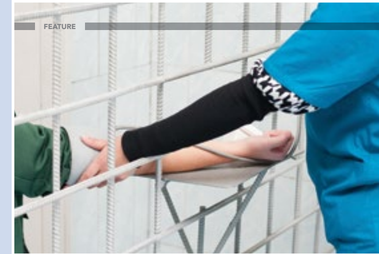
Mary Flannagan
Summer 2020 issue



Deposition 101: Tips for success

Catching the Chain: Working on Correctional Cases

Jane Grametbaur
Fall 2020 issue



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FEATURE

How Mentorship and Coaching Can Unlock One's Full Potential

Natasha E. Davis, MBA-M, BSN-RN, CEME, CSMA

Keywords: Mentorship, Coaching, Mentor, Mentee, Coach, Business Owners, Leaders, Students, Employees, Professional Development, Personal Development, Business Growth

Committing to a mentorship or a coaching relationship, as either the coach or the mentor, is one of the most valuable decisions one can make to unlock their full potential as a leader, business owner, professional, employee, or even student. While there are distinct differences between coaching and mentoring, both serve specific purposes in the growth and development of an individual. No matter the environment or scenario – as a legal nurse consultant, in a collegial environment, or beyond, mentorship and coaching will direct a person towards success, because it provides access to knowledge, strength, and accelerated wisdom.

INTRODUCTION

When looking to grow professionally and personally, or when in need of guidance, one may consider seeking counsel from a mentor or services from a coach to guide them in the right direction. Similar to when a new graduate nurse is paired with a clinical preceptor to mentor them, a new or growing legal nurse consultant should consider a mentor or coach for support and guidance. The legal nurse consulting specialty practice dates back to the late 1970s, and since then, the field has evolved. During this evolution, legal nurse consultants not only ventured into launching their own companies, but they also expanded the areas in which they practice. When new legal nurse consultants are starting their practice or when experienced legal nurse consultants are branching out into a different practice area, accelerated wisdom, guidance, support and accountability is needed.

Committing to either a mentorship or a coaching relationship is possibly one of the most important decisions, personally and professionally, an individual can make to grow themselves and achieve their goals. However, often times, there is much confusion around what mentorship is and what coaching is. Knowing how each will benefit a person and how they differ will guide an individual on when and how to seek one over the other, or even both.

Mentorship is a long-term, deep-rooted relationship requiring total vulnerability and transparency in every relevant area of one's life.

FIRST, WHAT IS MENTORSHIP?

To put it simply, mentorship is a relationship between two individuals: mentor and mentee. According to the Columbia College Alumni Association (n.d.), the sole focus is on the professional and/or personal development of the mentee. Mentorship is a development-driven relationship that can last for many years.

On one side of the relationship, the mentor shares his or her time, knowledge, and expertise to offer ideas or advice to support and direct the mentee towards the mentee's goals. This often includes asking open-ended questions, listening, and drawing from personal experience to give perspective on a situation or dilemma.

In order to be an effective mentor, the mentor must follow both traditional roles and unspoken obligations, such as valuing and respecting the mentee as a person, developing mutual trust, maintaining confidentiality, listening with intention, helping the mentee solve his or her own problems (rather than solving the problems for them), giving perspective, and focusing on the mentee's development while simultaneously resisting the urge to produce a clone, according to the University of Washington (2019). Mentors are not expected to offer employment, provide hands-on support for specific business development, have all the answers, or be responsible for driving the relationship. Mentors are also not expected or required to have any formal training or formal program.

Benefits of mentorship for the mentor can include the opportunity to reflect on and recount their own journey of growth and development, offer accelerated wisdom through past experiences, have a positive effect on the mentee, and grow their personal network. Additionally, as a leader, the mentor leaves the legacy of their knowledge, strength, and wisdom with those they mentor.

On the other side, the Columbia College Alumni Association (n.d.) explains the mentee is typically looking for guidance and support as they navigate their professional and personal journey, often seeking to learn life skills, explore career paths, develop their wisdom, and expand their network.

The mentee is responsible for driving the relationship with the mentor and initiating contact, because mentorship does not typically have structured programming or scheduled session times. The Columbia College Alumni Association (n.d.) also lists that the mentee should be prepared, professional, and respectful; express gratitude; exhibit responsibility; and be punctual. Above all, the mentee should be receptive to insight, feedback, and constructive criticism provided by the mentor. This often includes coming prepared to meetings with thoughtful questions, using the mentor's time wisely, and putting forth effort to stay on track with advice, action steps, or goals agreed upon by both the mentor and mentee.

The mentee will greatly benefit from mentorship by having a resource of knowledge and guidance to help them clarify, define, and reach their personal or professional goals. In the mentor-mentee relationship, the mentee is solely responsible for achieving their goals and finding clarity for the actions they will take and the paths to follow. Mentorship is a long-term, deep-rooted relationship requiring total vulnerability and transparency in every relevant area of one's life. Many times, mentorship relationships just happen to evolve; they are not officially formed and seldom do they have contractual agreements and service fees.

WHAT DOES MENTORSHIP LOOK LIKE IN A PROFESSIONAL COLLEGIAL ENVIRONMENT?

A collegial environment is often described as a place where colleagues work well together and are cooperative, pleasant, and eager to help. According to Freedman (2009), collegiality can also mean a "shared power and authority" among colleagues (p. 378). Professional, collegial environments are harmonious, and all persons are regarded and treated equally, despite their level or role in the organization.

In the corporate environment, such as a traditional work environment, new hires may be paired with mentors who are seasoned within the organization and experienced with how the role or industry functions. This is to help the mentee navigate their new role, understand the organization, stay focused,

and be successful. These pairings are set in place to facilitate a journey for the mentees' transition from being uncomfortable to comfortable. These are short-term relationships that transition from handholding to the mentee's total autonomy within three to six months, as explained in Davis (2016, p. 74-75). However, in order for mentorship to succeed in a collegial environment, and not be seen as financially wasteful, certain expectations must be set in place for both parties. Often, this involves the use of evaluations and questionnaires to understand the mentee's current skill set and goals while creating a timeline of expected growth.

Mentorship that supports a collegial environment involves (Singh, 2013):

- Linking the mentoring to the needs of the broader organization, often by encouraging the mentee to be involved in the company and utilizing training to advance both the mentor and the mentee
- Stressing the importance of self-directed learning and establishing clear, manageable goals and positive expectations for the mentee
- Dedicating time to focus on the training and development of the mentee
- Utilizing a mentor who encourages, maintains, and evaluates the growth and performance of the mentee, emotionally, personally, and professionally (p. 1,552)

This structure is designed to develop the mentee's social and emotional competencies, which can build the trust, cooperation, motivation, and collaboration that are necessary in a harmonious work environment. These competencies also promote a feeling of satisfaction that enhances human connectivity.

Not all mentors may be equipped to provide high levels of emotional support; however, Singh (2013, p. 1,558) found that emotional connections are vital to the successful mentor-mentee relationship in any setting. The mentor has an obligation to earn the mentee's confidence and trust in the mentor's fair judgment and counsel, especially at the initiation of the relationship. This allows for all in the relationship to flourish with clear expectations and to function amicably.

Overall, mentorship involves a dynamic layer of emotional support that promotes satisfaction for both parties, leading to improved outcomes for the mentee and the mentor.

SO, HOW DOES MENTORSHIP DIFFER FROM COACHING?

While both operate with similar intentions of promoting personal and professional growth, there are a few specific indicators that differentiate mentorships from coaching.

Major indicators of coaching include the formality of the relationship, which is often defined by the structure, focus, cost, and time commitment of the arrangement. The coach is considered the subject matter expert in a particular field who is hired to fix a specific problem.

For example, coaching is often *performance- and result-driven*, typically lasting on a short-term or per-project basis with a specific outcome in mind. Examples of this may be navigating the launch of a brand, increasing company net profit within one year, or becoming a better business owner. Another great example is a coach for professional athletes or professional speakers. This comes with a designated structure of meetings and key performance indicators to keep the coachee on a specific route that is measurable. Often, coaching comes at a price, and the coach is hired to support a specific project, task, or desire.

According to Zust (2017), there are many scenarios in which coaching is beneficial for either a group or individual, including:

- Developing or improving specific skills, such as presenting to large groups, communicating with employees, or increasing sales
- Supporting individuals or groups who are not meeting project or business goals and expectations
- Guiding leaders when navigating new changes in the business, such as a merger, acquisition, or the adoption of new initiatives
- Transitioning or advancing to a new role, such as from employee to entrepreneur and then entrepreneur to chief executive officer
- Improving or developing a specific behavior or preparing for an assignment, such as speaking to the media about a certain topic or speaking at a conference
- Recognizing development gaps and finding solutions to long-standing challenges

The coach will support and guide the coachee to identify and resolve performance and competency gaps by using a combination of hands-on and hands-off approaches. The coach will evaluate the intended or desired end goal and then develop the right coaching program and

Above all, when selecting a mentor or coach, a mentee should first look for an effective leader, because a good leader develops other leaders.

model to help the coachee achieve that pre-outlined goal. Unlike the mentor, the coach is hired to keep the coachee on track, and there is a shared level of accountability. In addition, it is not the coach's responsibility to determine if a desired goal and aspiration is realistic or appropriate — that is what a mentor does. The responsibility of the coach is to support and guide the coachee to achieve the desired goal and aspiration.

The coach tends to ask many open-ended questions to challenge the coachee to go beyond the surface so they can think wider and deeper. These questions often solicit detailed answers filled with intention, and at times, they may be uncomfortable for the coachee. It is the role of the coach to intentionally make the coachee uncomfortable with their status quo thinking and status quo acting.

Another value-added benefit of coaching is the application of the convergence-divergence technique. This technique is applied when the coachee demonstrates "fuzzy brain" or lack of clarity with their goals, actions, and aspirations. The coach listens for vague answers and deflections that consciously or subconsciously put up barriers to achieving goals. When noticed, the coach will support the coachee to breakthrough any such barrier.

In 2019, Forbes magazine released an article about a study they did on executives with and without coaches. The research found that executives and leaders who had coaches were 70% more successful (Sime, 2019). They had better work performance and stronger communication, demonstrated less procrastination, achieved 70% more of their goals, and tended to make less mistakes (Sime, 2019).

The coachee will benefit the most from the coach when there is total, as well as mutual, transparency and trust. The coach must show respect and value to the coachee, and the coachee must do the same for the coach. The coachee must be fully committed to their own success and the coach has to believe the coachee can do it, but the coach is also responsible for outlining the roadmap that will guide the coachee to success.

Coach-coachee relationships must be structured. Without structure, the coachee will not achieve goals on time, and the relationship will morph into an expensive friendship for the coachee. The coach meets with their coachee at a scheduled date and time to transfer knowledge, set the next action steps, address challenges, find solutions, and evaluate the accomplishment of pre-set goals.

In fact, truth be told, using both a mentor and a coach is a smart move to keep an individual working on goals and unlocking their fullest potential.

FINDING THE RIGHT COACH OR MENTOR

Above all, when selecting a mentor or coach, a mentee should first look for an effective leader, because a good leader develops other leaders. Another requirement to look for is that the mentor or coach for consideration has already surpassed where the mentee aspires to be and is actively operating in the place the mentee wants to be in. The final general requirement for both mentor and coach alike is making sure there is mutual respect and trust. Where there is no trust and no respect, there will be no progress or growth. Mentors and coaches do not help people by using intimidation and belittling tactics.

FINDING THE RIGHT COACH

The right coach will hold the coachee accountable to achieve the goals set in place. Without accountability, it can be easy to stay stuck in time and experience a lack of progress, due to fear, arrogance, or complacency. These negative thoughts and behaviors can paralyze a person from making the necessary, yet hard, decisions to maintain forward movement. A coach will help minimize distractions, eliminate complacency, think deeper, and perform higher. It is about reaching one's fullest potential.

It is recommended to ask the coach of interest what their coaching process is and how their program is structured. If they offer a general answer or an unstructured program for coaching, they may be more of a mentor.

The right coach will often not settle for basic excuses. Even at the beginning, they will not accept many excuses. They will push the coachee past their boundaries of comfort to achieve predetermined goals. The coachee will be led into territories they may not realize they are ready to handle. More importantly, a coach will not merely give the coachee the answers but will challenge and guide

There are many differences to understand before committing to a mentorship or a coaching relationship…

the coachee to find the best answers and solutions for themselves.

FINDING THE RIGHT MENTOR

Mentees should be willing to be challenged by and eager to learn from their mentor.

The right mentor will force the mentee to think beyond the surface and even question their desired reason and rationale of thoughts. They will empower the mentee to be fully accountable for their decisions. The mentor may give direct answers to a situation based on past experience, or they may encourage the mentee to express their feelings around the situation to help find the answers the mentee is seeking.

The right mentor will also remind the mentee of their goals, and they will transfer accelerated wisdom over time. Mentorship will empower one to choose their goals over distractions.

The right mentor should also align with and match the mentee's ethical and moral beliefs or have the same faith or values system. Mentorship is typically a much deeper and longer-term relationship than coaching, so this is especially important.

WHERE TO FIND A COACH OR MENTOR

It typically starts within a person's network. Mentors can be former teachers from high school or university. They can be elderly family members or close family friends. Mentors can be local successful individuals or church members.

Coaches are typically sought out professionally via the internet or in a professional network setting. Coaches can also be found on professional coaching association websites or even Chambers of Commerce. One may find the right coach at a business event or in an industry publication.

There is a saying in the coaching world, similar to the education world, "When the student is ready, the coach with appear."

SUMMARY

While there are many differences to understand before committing to a mentorship or a coaching relationship, both are valuable in unlocking one's fullest potential as an employee, leader, business owner, and legal nurse consultant.

Coaching is often a performance- or result-driven relationship that is structured around key goals and measurable outcomes, while mentorship is a development-driven relationship focused on the holistic development of the mentee. Both are ultimately utilized to enhance the mentee or coachee as a whole, and they involve an emotional component to increase the individual's growth and success.

There are many factors to consider when searching for and selecting a coach or a mentor; however, it comes down to one's personal and professional goals, values, and desired relationship outcomes. Committing to a relationship with either a mentor or a coach (or both) is one of the most important decisions an individual can make to move towards a higher level of success, because it provides access and guidance to greater knowledge, strength, and accelerated wisdom.

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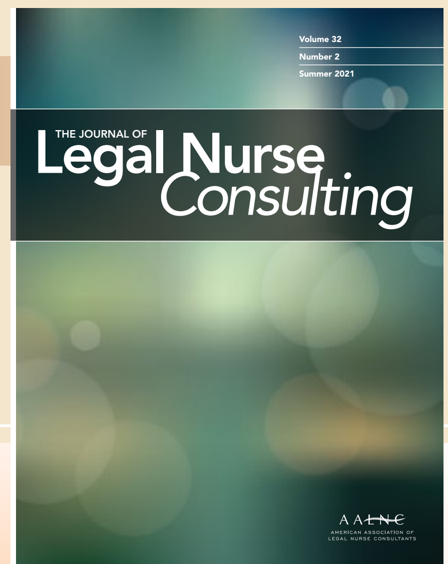

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Succession Planning: An Overlooked Business Strategy

Mila Carlson, PhD, MSHSA, R.N., CNLCP®, CMSP-F
Sherry DelGrosso, DNP, R.N., Legal Nurse Consultant

Keywords: Succession planning, independent legal nurse consultants, business exit strategies, selling a business, retirement, legal nurse consultant demographics, survey results

This article explores the business strategy for solopreneurs to prepare for potential opportunities of selling a business, forming a partnership or joint venture, retiring, or handling an unexpected absence (short-term/long-term/permanent) (Carlson, 2018, para. 1). It serves as an introduction to the topic of succession planning, which is a very detailed process. It also reviews information collected from the 2019 survey, Legal Nurse Consultants: What Are Your Plans?, *that was sent to approximately 1,700 members of the American Association of Legal Nurse Consultants (AALNC).*

"Succession planning is an organized method of documenting the assets and processes of [a] business and determining responsibilities for the business to continue in [the owner's] absence (Carlson, 2018, para. 1). Although each business is individualized to meet the needs of the owner, every business has ***5 categories*** that need to be addressed when planning for succession: Administrative, Financial, Information Technology, Legal, and Professional. "The processes developed, activities performed, and strategies for future growth fall into these categories.

Regardless of how [one] address[es] the specific needs unique to [the] business, there are broad topics within the **5 categories** that need to be considered. For example:

- *Administrative:* daily business operations, maintaining supplies, and office equipment
- *Financial:* billing processes, invoicing, and accounts payable. Insurance policies may be included here or in the legal category.
- *Information Technology:* computer equipment, devices, and any technical needs
- *Legal:* contracts, dispute resolution, and naming a power of attorney to act on [the owner's] behalf [during an] absence
- *Professional:* protection, use, and storage of medical records; attorney-client responsibilities; maintaining client lists; and completing assignments

As entrepreneurs, [owners] focus on starting, then growing a business, networking opportunities, and marketing. Once [these goals have been achieved and successes recognized], it is easy to become comfortable. While this is a common occurrence, complacency is dangerous in business.

Business owners must keep their options open for opportunities of expansion or future growth. If an option to take advantage of a merger or sell the business presents itself, how would [the owner] determine the value of [his/her] contribution or net worth? If an offer to sell [the] business is presented, how would [the owner] know whether the offer is equivalent to the value of [the] business?" (Carlson, 2018, paras. 2-5). Selling the business provides the opportunity for obtaining freedom to pursue other business interests or obtain financial capital for retirement.

"Documenting business processes, assets, and client portfolio offers a means of assessing the value of [a] business. Preparing this information and [updating] it on a regular basis provides the financial appraiser [with information] required to complete this assessment.

Every business has 5 categories that need to be addressed when planning for succession: Administrative, Financial, Information Technology, Legal, and Professional.

Unplanned absences are just that: unplanned. If [the owner] needed to be away from [the] business for an extended period of time, who can or will step in to fulfill [the] contractual obligations, make business decisions on [the owner's] behalf, or close the business if required?

Designating individuals capable of fulfilling the needs within the **5 categories** as part of succession planning allows [the owner] to train the individuals prior to an [unanticipated absence]. It also provides an opportunity to communicate [owner] preferences and direct [the] team on how to act on [behalf of the business] (Carlson, 2018, paras. 6-8). Below is more detailed information about the categories, although it is not an all-inclusive list. Please notice that some roles or processes may fall under more than one category.

Administrative personnel may include an on-site or virtual assistant. These individuals would perform and monitor daily business operations and maintain supplies and office equipment. They would also be responsible for travel accounts, subscriptions and renewals, insurance policies/renewals, and marketing operations. They should have a broad knowledge of and proficiency in office software.

Financial personnel usually include a personal banker, accountant, tax preparer, and power of attorney (POA). Representatives of these services deal with billing processes, invoicing, and accounts payable. Responsibilities related to checking and savings bank accounts, taxes, payroll, and insurance policies fall within this category.

Information technology resources encompass technicians/experts proficient in computers and other devices that connect to the internet, including telephones and mobile devices. These individuals are responsible for any technological needs. A website developer/webmaster may also be part of this team.

Legal team members usually consist of a business attorney, estate/trust attorney, insurance agent, POA, and office manager. Contract reviews, dispute resolution, partnership formation, POA designation, real estate/lease reviews, and company representation in legal matters are delegated to these individuals.

Professional representatives are responsible for protecting, using, and storing medical records; handling attorney-client responsibilities; maintaining client lists; and completing previously accept-

Designating individuals capable of fulfilling the needs within the 5 categories as part of succession planning allows the owner to train the individuals...

ed assignments. They also contribute information for documenting retainer balances and generating invoices. Nurses, employees, subcontractors, and other designated professionals with relevant experience are the types of professionals in this category.

As with every project, determining where to start the process is the most challenging aspect of succession planning. First, identify a key player for each category. Establish the duties and responsibilities for these team members. Develop written policies/procedures of the business practices. Do not hesitate to revise them as needed to improve the business.

For owners planning retirement in the foreseeable future, establish a date and work backwards from that date in closing the business. Determine what kind of cases should be accepted and could be completed in the remaining time frame. Recognize that some types of cases, such as life care plans, may continue over several years. Identify colleagues for referrals for these types of cases. It is advisable not to notify clients too far in advance of the business closing or retirement, as clients may decide to find other consultants, thus impacting the bottom line.

"Succession planning can be an overwhelming project but is a necessary strategy for [a] business. There are many individual actions and details required to develop a realistic succession plan. Starting the process sooner rather than later will bring peace of mind to [the owner], as well as to…clients, colleagues, and family members" (Carlson, 2018, para. 9).

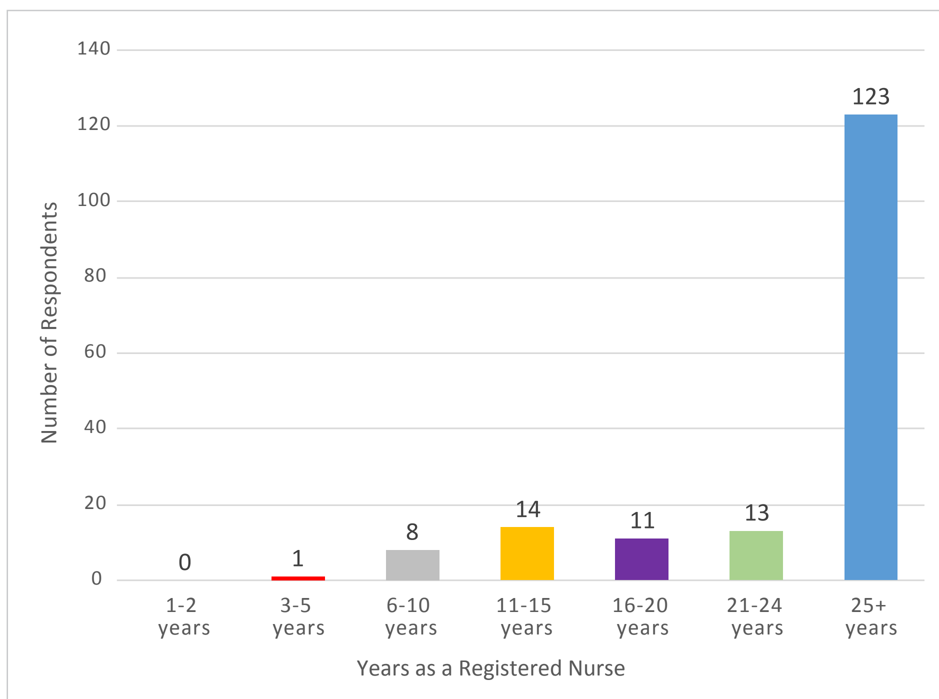

Figure 1: Years Practicing as a Registered Nurse

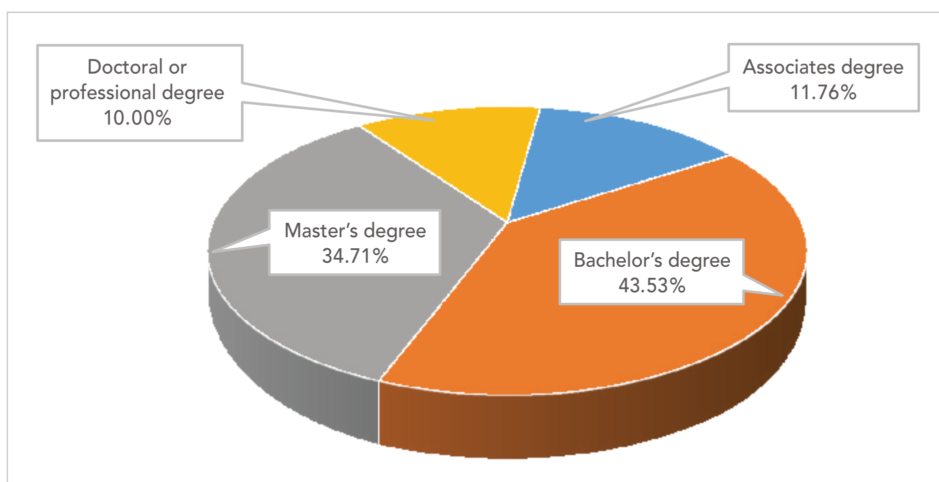

Figure 2: Highest Level of Education

SURVEY RESULTS: *LEGAL NURSE CONSULTANTS: WHAT ARE YOUR PLANS?*

To assess the demographics and proximity to retirement of the current legal nurse consultant generation, *The Journal of Legal Nurse Consulting* and the AALNC Forum Committee requested that members of AALNC complete a 12-question survey. The survey's purpose was to gather demographic information, current practice specialties, future business exit strategies, and other supplemental information.

Utilizing a convenience sample (non-probability sampling method), an electronic link to the survey, *Legal Nurse Consultants: What Are Your Plans?* was sent to approximately 1700 members. Of those, 170 members responded to the survey.

To summarize, the 12 survey questions asked were:

- **1-4:** the participant's years practicing as a nurse, years specializing in legal nurse consulting, educational background, and age;
- **5-7:** business category (independent practice versus in-house), independent practice characteristic (i.e.,

owner/partner, sole practitioner, subcontractor, not applicable), and primary practice specialties (e.g., medical malpractice, government agencies, personal injury, life care planning);

- **8-9:** projected timeframe and reason for exiting legal nurse consulting;
- **10:** plan for the business upon retiring; and
- **11-12 (supplemental):** "Were you surprised by any of the questions asked?" and "Were you not asked something that you wish would have been addressed in the survey?" [Questions such as these afford the Forum Committee the opportunity to modify the scope of future surveys and identify potential educational needs.]

Results revealed the following demographic and practice characteristics of the respondents:

- 72.35% practiced as a Registered Nurses for 25+ years *(See Figure 1: Years Practicing as a Registered Nurse)*
- 43.53% obtained a Bachelor's degrees *(See Figure 2: Highest Level of Education)*
- 85.88% were between 46 – 70 years of age *(See Figure 3: Age of Legal Nurse Consultants)*
- 51.76% have been Legal Nurse Consultants for less than 10 years *(See Figure 4: Length of Time as a Legal Nurse Consultant)*
- 69.41% were employed as independent consultants

The majority of respondents in independent practice were either the single owner or sole practitioner *(See Figure 5: Independent Practice Characteristics)*. Respondents worked primarily in the following specialty areas: medical malpractice, personal injury, healthcare facilities, long term care/elder care, and life care planning *(See Figure 6: Top-Ranked Practice Specialty Areas for Legal Nurse Consultants)*.

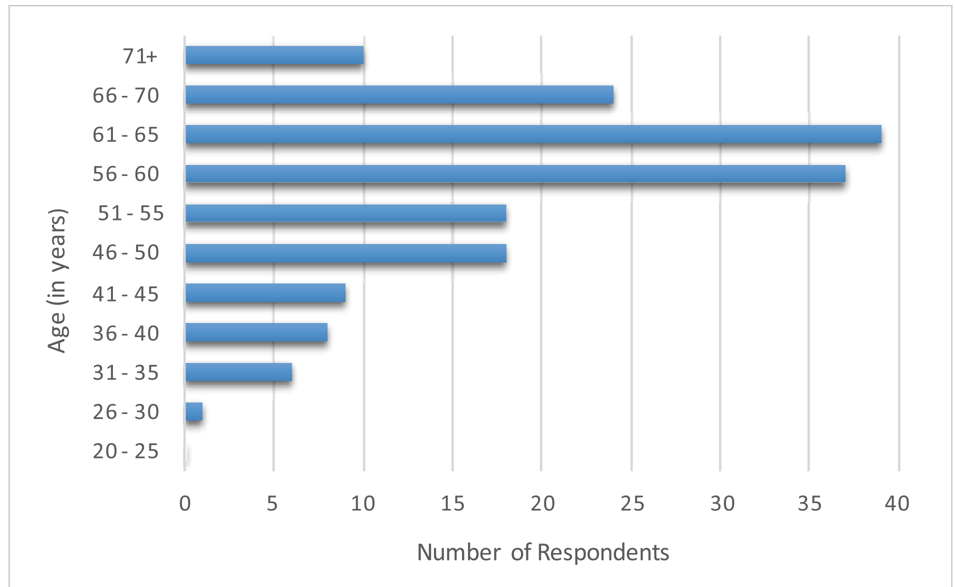

Figure 3: Age of Legal Nurse Consultants

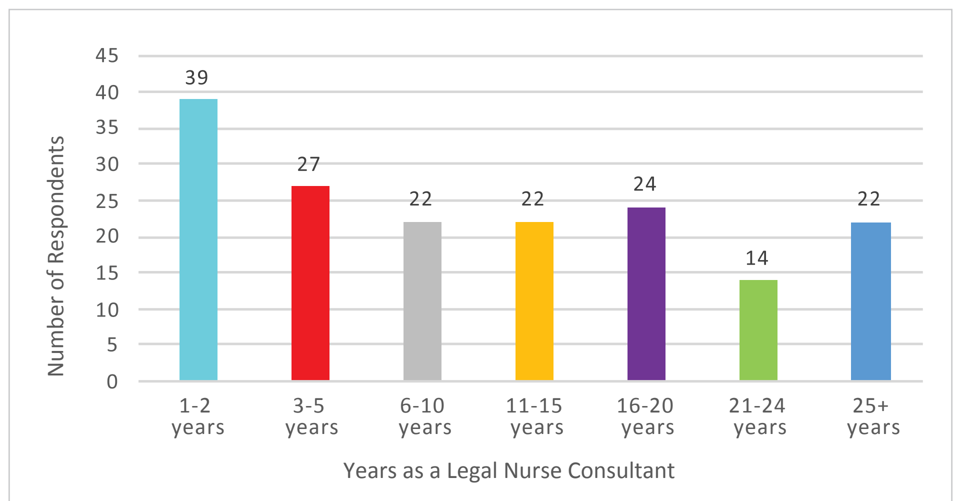

Figure 4: Length of Time as a Legal Nurse Consultant

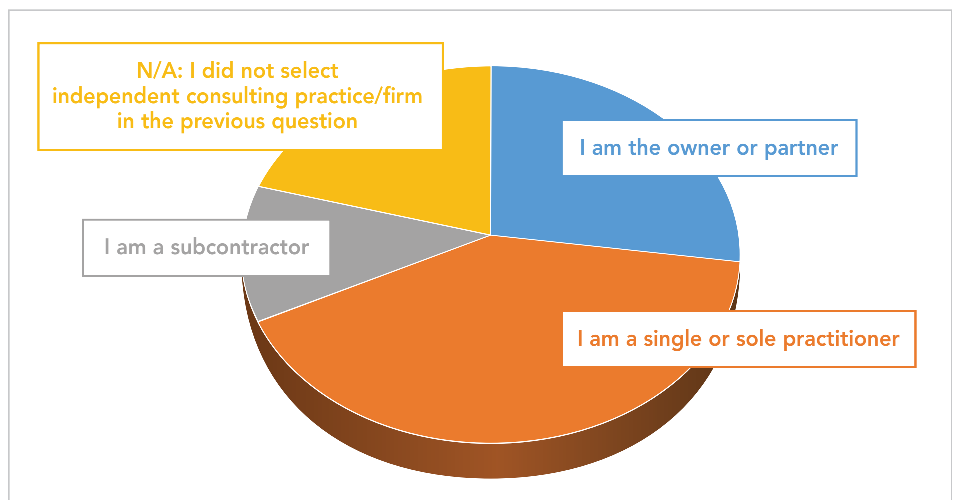

Figure 5: Independent Practice Characteristics

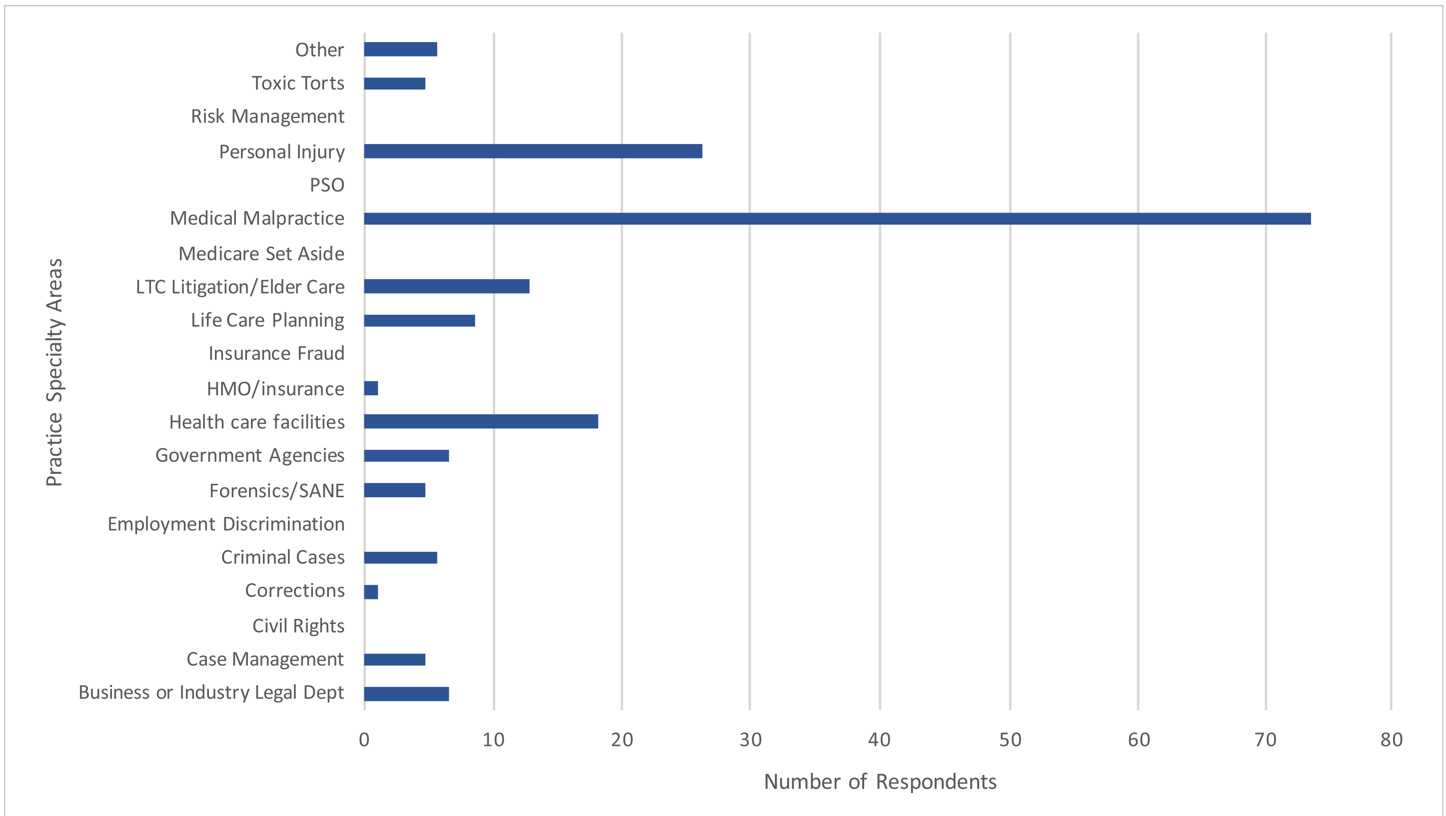

Figure 6: Top-Ranked Practice Specialty Areas for Legal Nurse Consultants

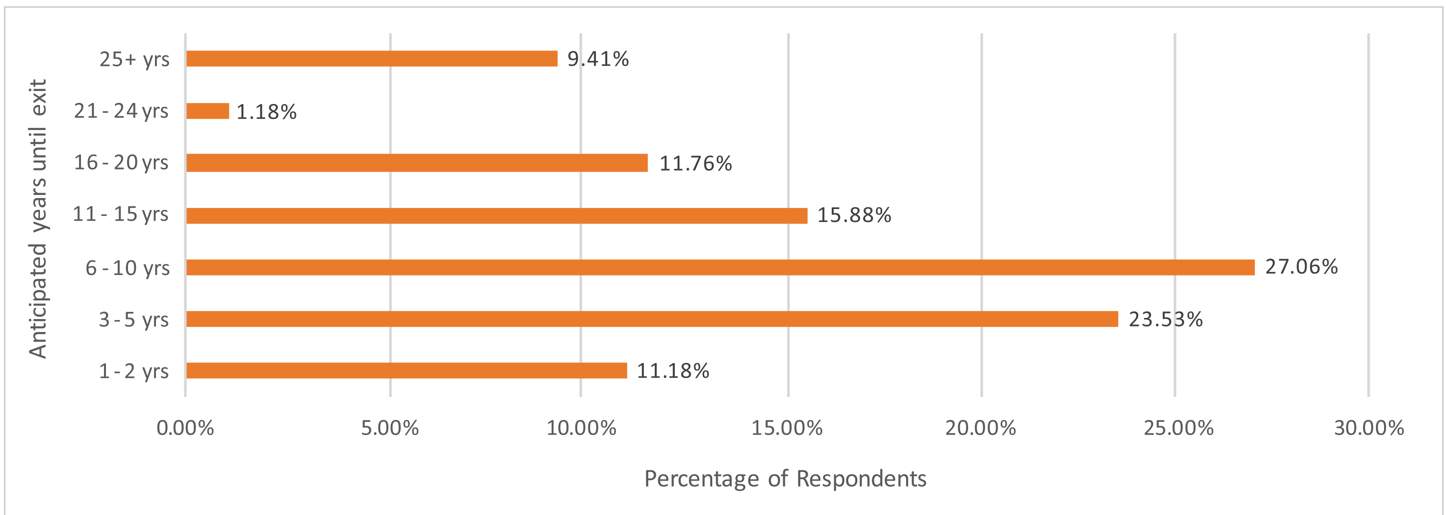

Figure 7: Anticipated Years until Exit Legal Nurse Consulting

Forty-six survey participants chose 6-10 years (from 2019) as the timeframe to exit legal nurse consulting *(See Figure 7: Anticipated Years until Exit Legal Nurse Consulting)*. Thus, between the years 2025-2029, 27.06% of the participants anticipate leaving the specialty. Forty survey participants (23.53%) revealed that they plan to exit legal nurse consulting within the next 3-5 years (i.e., 2022-2024). Remarkably, 90.59% of survey participants chose "Retirement" as the primary reason for exiting legal nurse consulting *(Figure 8: Reason for Leaving Legal Nurse Consulting in the Future)*, and 48.82% plan to close their practice and refer their clients to colleagues (Figure 9: Post-retirement plans).

LEGAL NURSE CONSULTANT IMPLICATIONS

The Forum Committee received valuable baseline data from the survey.

Future research will be considered to explore continued trends as it pertains to demographics, practice specialties, exit strategies, and resources that may be useful for AALNC members to successfully exit the specialty practice. Additional areas for future research may include topics such as mentoring and business support and development. Information obtained from surveys creates value to an organization and its members. Thank you to the members who participated in this survey and thank you in advance for participating in future AALNC member surveys. We truly appreciate you and your contributions to the specialty practice of legal nurse consulting.

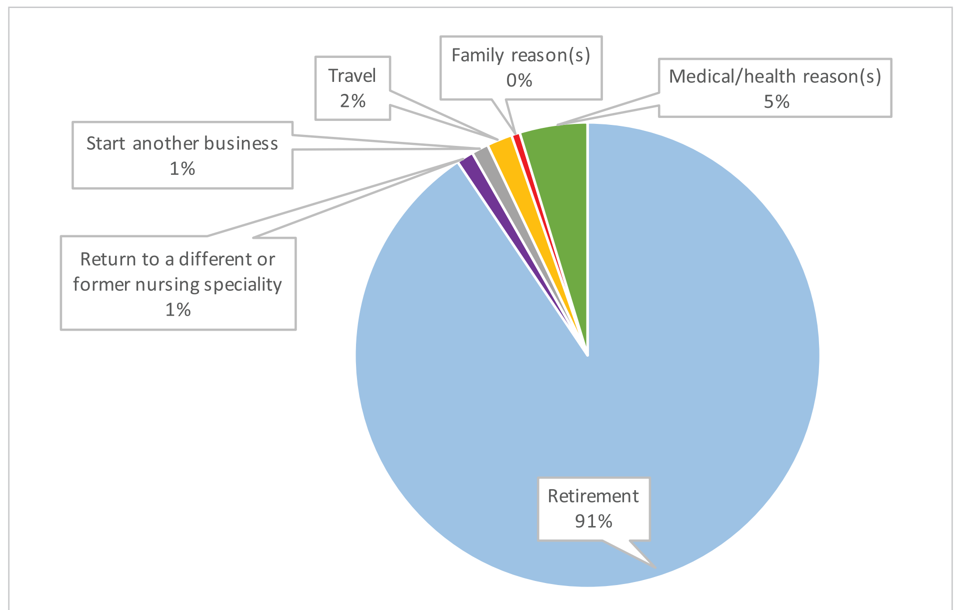

Figure 8: Reason for Leaving Legal Nurse Consulting

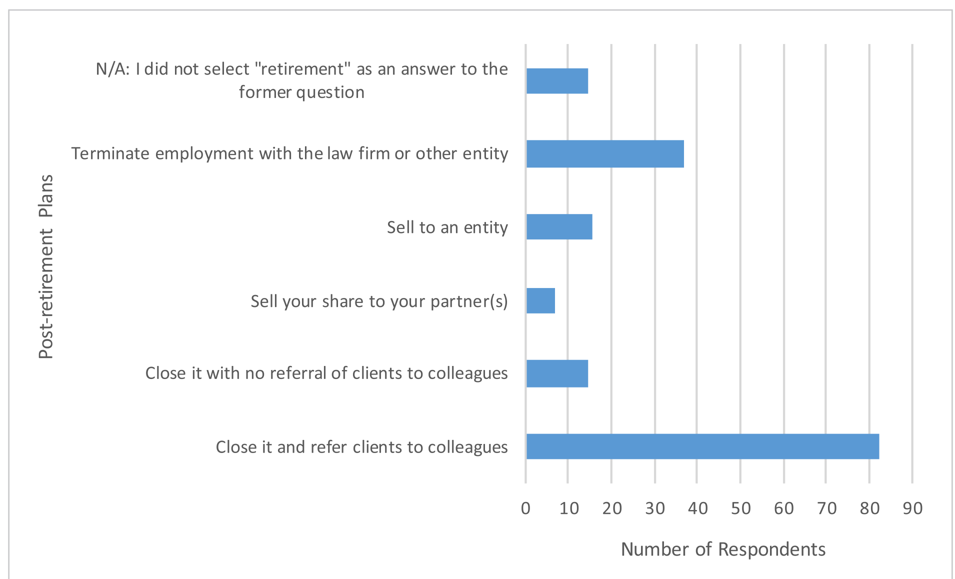

Figure 9: Post-retirement Plans

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Board of Registered Nursing Expert Witness:

A Niche Role for the Legal Nurse Consultant

Eula Anyiwo, MPA, RN, Legal Nurse Consultant
Joanne Walker, BSEd, RN

Keywords: Board of Registered Nursing, expert witness, licensure investigations, possible niche roles

The Legal Nurse Consultant (LNC) can be involved in many niche roles across complementary medicolegal settings. One such role is serving as an expert witness for either the Board of Registered Nursing (BRN) or the defense in a licensure investigation involving a registered nurse. This article describes both sides of this adversarial setting – the oversight body (BRN) and the defense (licensee).

While this article is written about the authors' experience in California, legal nurse consultants across the United States can relate this information to licensure investigations in other states. The rules and regulations governing the process will vary by state. Legal nurse consultants should be familiar with the applicable rules and regulations (especially the Nurse Practice Act) of the state in which they are working.

The California Board of Registered Nursing (CA BRN) depends on a team of qualified subject matter experts in various nursing specialties to opine on allegations of nurse misconduct to determine whether a nurse deviated from the standard of care or the provisions of the Nurse Practice Act (NPA). While it is not required that the expert be a legal nurse consultant (LNC), the expert role can be a niche practice for one who is attracted to the BRN's administrative disciplinary process in nurse licensing issues. This work lends itself to those with a natural curiosity about the dynamics of any case in which things allegedly go wrong, the comparison of the events and nursing care to the alleged violations, and the stipulation of whether there is evidence to support the allegations.

The CA BRN requires interested and qualified Registered Nurses (RNs) to formally apply for the position of expert witness and submit a curriculum vitae. After validating the applicant's credentials in the area(s) of expertise, the CA BRN requires the prospective expert witness to provide a writing sample based on the applicant's review of a real case synopsis. The writing sample must contain sufficient detail of the case evaluation and determination of whether the evidence supports or disputes the allegations based on the applicable standard of care or the NPA. When all requirements are satisfied and the application is approved, the CA BRN sends the expert witness a contract for a specific duration. The initial duration is generally three years, which can be extended by mutual agreement. The contract confirms pay and pay practices, discusses the request and approval processes for additional review time when needed, includes information on invoice processing, etc. The BRN sends the expert a general handbook entitled "Expert Witness Guidelines," which includes such topics as Frequently Asked Questions, Stages of Expert Review, Formulating the Expert's Opinion, etc. When the BRN has an RN misconduct investigation involving the expert witness's area of expertise, it sends the case material for the nurse to review. The nurse expert is ready to launch and occupy the niche role.

The role of the expert witness is to determine whether the RN's conduct and/or treatment met or departed from accepted standards of practice. The Board allows the expert witness to consult some nursing texts and other authoritative reference materials which help define acceptable standards. All sources used should be cited as such. When writing a report, the expert witness must also cite the specific statute or code being referenced. Once the expert witness submits the report, the case is essentially completed. The expert witness does not determine the level of discipline, if any, to be apportioned to the nurse, only whether or not the standard of care was breached and the applicable statute(s).

If the BRN decides to pursue disciplinary action against the RN licensee, an administrative hearing is scheduled. An administrative judge presides over the proceedings and makes the decision on the case. If the BRN and licensee do not reach an agreement before the hearing date, the expert witness may be called to provide testimony at the hearing. In this situation, the expert witness works with the Assistant District Attorney (ADA) on the case. If the subject RN is represented by defense counsel, they have access to case documents, including the BRN's expert witness's report. The ADA generally provides ample notice of the planned hearing and guidance about expectations. These cases generally settle before the hearing – at times, as close as the day before the hearing, resulting in a short notice of cancellation.

FILING A COMPLAINT AND COMMON COMPLAINT CLASSIFICATIONS

Simply put, a complaint can be generated by a variety of people: the patient to whom the alleged misconduct happened, a family member or friend of the patient with firsthand knowledge of the issue(s), staff and colleagues who observed the alleged misconduct, and the institution for whom the subject nurse works. "Anyone who believes a registered nurse has acted in an unsafe or unprofessional manner or that an unlicensed person is illegally providing nursing care should file a complaint as soon as possible" (CA BRN, 2020a, para. 6). Allegations may include:

- Gross negligence or incompetence
- Unsafe actions
- Unprofessional conduct
- License application fraud
- Misrepresentation of role or title
- Substance abuse
- Mental illness
- Unlicensed activity (CA BRN, 2020b, para. 4)

Complaints are submitted to the BRN in writing. The Board then fields the work to an appropriate investigator who obtains all relevant case information, which may include interviewing the nurse and witnesses and obtaining statements (written or digitally recorded) from the identified players (the subject nurse's manager, colleagues, and other staff). These interviews are generally conducted based on the witnesses' proximity to the case. In cases in which the subject nurse or institution has been sued, the investigator will obtain copies of the relevant deposition transcripts and other information. The BRN then provides the case material to the expert witness, who considers all appropriate information in rendering a decision. Depending on the case's nuances, hearsay evidence occasionally may be included in the materials for consideration.

The CA BRN defines departures from accepted standards of practice as:

The expert witness does not determine the level of discipline to be apportioned to the nurse, only whether the standard of care was breached and the applicable statutes.

General Unprofessional Conduct: There are times unprofessional conduct may involve behavior or actions outside the work setting which are not compatible with the professional licensed nurse and not necessarily directed to a patient or a coworker (CA BRN, 2010).

Incompetence: Incompetence means the lack of possession or the failure to exercise the degree of learning and skill, care, and experience ordinarily possessed by a competent registered nurse (CA BRN, 2010).

Gross Negligence: Gross negligence includes an extreme departure from the standard of care which would ordinarily have been exercised by a competent registered nurse under similar circumstances (CA BRN, 2010). An extreme departure means the repeated failure to provide nursing care as required OR the failure to provide care or exercise ordinary precaution in a single situation which the nurse knew or should have known could have jeopardized the patient's health or life (CA BRN, 2010). The expert witness need not show that actual harm was done, only that potential for harm is evident. (This is a distinct difference from medical malpractice tort claims, in which plaintiffs have the burden of proving all four elements of negligence, including causation. In administrative licensure actions, the sole focus is on standard of are.)

Unprofessional Conduct Involving Controlled Substances/Dangerous Drugs/Alcohol: The California Business and Professions Code Section 2762 specifically defines and designates certain conduct involving controlled substances, dangerous drugs, and alcohol as unprofessional conduct. Therefore, expert witness opinions are not absolutely necessary to establish violations.

The expert witness can find departures in more than one of these categories. It is not unusual to find gross negligence and incompetence in the same case. The expert witness is expected to parse these out, citing the violations and connection to the standard (CA BRN, 2010).

CASE EXAMPLES

The expert witness reviewing these cases does so from a consultant perspective using clinical experience and knowledge. Understanding standards of care in clinical practice helps the expert witness to identify any gaps between those standards and the care in question. Cases in which the subject RN deviated from practice standards may involve ***errors of commission or omission, lack of knowledge of standards or scope of practice, poor or inadequate documentation, mental health/burnout, poor or inadequate communication, ineffective leadership, and administrative oversight.*** In the following case examples, specific identifying details and dates have been removed, obscured, or changed to protect the subject nurse's and/or institution's identity.

Incompetence: An error of commission involves performing an action that is improper for the situation. That action/error may be inside or outside one's scope of professional practice. For example, a nurse was reported to the BRN by her own hospital for working outside of her scope of practice. The nurse had inserted an Epistat (a device with anterior and posterior balloons for the control of epistaxis) in a patient's nostril to stop the bleeding and documented her action. There was no order for the Epistat, and in that hospital, only physicians could insert an Epistat. There were no standardized procedures allowing nurses to perform this action on behalf of physicians.

The commission errors here were obvious. This case also involved patterns of ineffective administrative or leadership oversight, including poor staffing that left the nurses to scramble in emergency situations. The nurse wrote in her statement and stated in an interview that she had tried to call the physician, but the physician did not come. The nurse felt she had to insert an Epistat to stop the bleeding in the absence of the doctor she had been trying to call. Regardless, the nurse worked outside her scope of practice, but the BRN expert witness pointed out the culpability of leadership as possible mitigation for the nurse's action.

Errors of omission, on the other hand, are those in which the nurse failed to perform a required duty. Alleged errors of omission are often difficult to dispute due to the lack of documentation supporting that the required action did, in fact, occur. An example includes not documenting discharge instructions, and the patient experienced an untoward event after getting home; the patient or family reports they were never given instructions on what to do after discharge, which may have prevented the untoward event. This speaks to the common adage, if it was not documented, it was not done. Another example is failing to document medications as having been given; another nurse gives the medication, resulting in the patient receiving an additional dose.

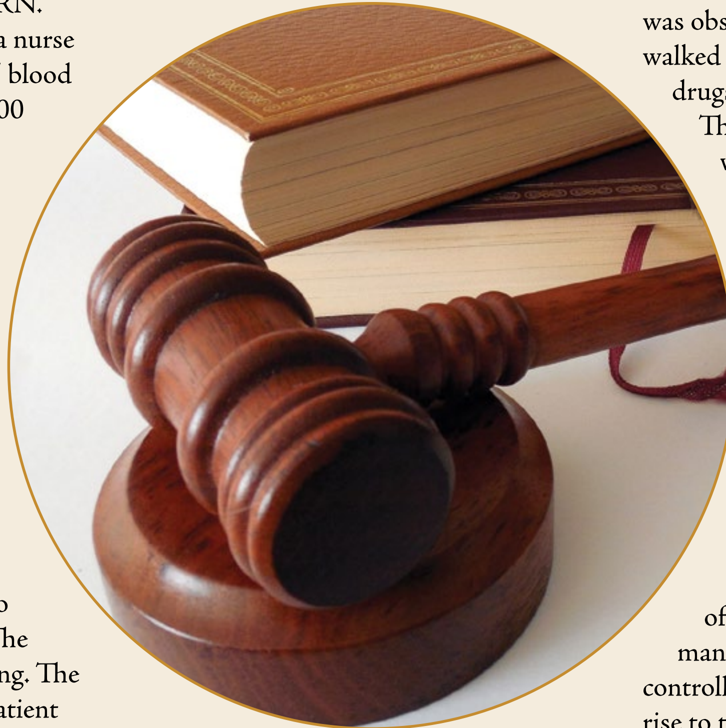
Understanding standards of care in clinical practice helps the expert witness to identify any gaps between those standards and the care in question.

Both commission and omission errors pose safety or risk issues from the nurse's incompetence: *the nurse failed to exercise that degree of learning and skill, care, and experience ordinarily possessed by a competent registered nurse.*

Gross Negligence: Failure to implement orders in a timely manner is an error that may constitute gross negligence, as defined by the CA BRN. For example, one case involved a nurse who failed to implement STAT blood transfusion orders written at 8:00 a.m. for a patient with a hemoglobin (Hgb) of 7.5 g/dl. The nurse's first note was timed at 1:30 p.m. and indicated the patient had been found alert but weak on the bathroom floor after hitting her head. At 2:00 p.m., there was a notation about the first unit of packed red blood cells being transfused without an explanation of the six-hour delay. A 2:25 p.m. note indicated the patient was transferred to ICU for a higher level of care. The patient died at 11:45 that evening. The autopsy report confirmed the patient suffered a subdural hematoma at the base of her skull. In her written statement, the nurse noted she had been extremely busy, had not had a break all day, and had two patients who needed more attention than she could give. In her interview with the investigator, when asked if she had told her manager about her quandary, she stated management was generally not responsive to staffing concerns and this was a chronic problem on this unit.

In reviewing this case, the expert witness listed missing actions and interventions demonstrating this nurse's diminished capacity in the performance of her role. Some of the missing documentation included:

- a reason for the delay in starting the transfusion
- whether blood was not available and why
- what the nurse had done to remedy the situation
- whether she had escalated the situation to a charge nurse
- whether the ordering doctor had been informed about the delay



- any safety instructions given to the patient about requesting help for toileting needs, recognizing a patient with a low Hgb may be dizzy

The expert witness reviewed the policy and procedure for blood transfusion, staffing records, and documentation policy, among other documents. It was determined the nurse had committed gross negligence *by failing to provide care or exercise ordinary precaution in this patient's care which the nurse knew or should have known could jeopardize the patient's health or life.* This nurse also demonstrated a degree of incompetence, in that she *failed to exercise that degree of learning and skill, care, and experience ordinarily possessed by a competent registered nurse.*

Unprofessional Conduct Involving Controlled Substances/Dangerous Drugs/Alcohol: This case involved a nurse who was suspected of diverting controlled drugs for personal use. The nurse was initially observed by a colleague who thought it strange that he had returned to the unit and accessed the Pyxis after clocking out for lunch. The nurse obtained drugs which he was observed placing in his pocket and walked off the unit. The receipts for two drugs were automatically generated. The colleague reported her observations to a manager who then involved the pharmacy department in a narcotic audit. An investigation demonstrated ongoing patterns of irregularities regarding mismanagement of narcotic waste and usage resulting in multiple discrepancies over time by this nurse. This nurse violated several standards of practice and policies regarding the seven rights of medication administration, management of waste of unused controlled substances, etc. which gave rise to this nurse having demonstrated unprofessional conduct.

DEFENDING AN RN AGAINST A BRN ACCUSATION

As stated above, any member of the public (including a coworker or employer) may file a complaint against a nurse. According to the National Council of State Boards of Nursing (NCSBN), complaints to a BRN must be specific to violations of that state's NPA. "Any person who has knowledge of conduct by a licensed nurse that may violate a nursing law or rule or related state or federal law may report the alleged violation to the board of nursing where the conduct occurred. All jurisdictions have specific processes for complaint intake" (NCSBN, 2020a, para. 1).

A mitigating statement must show how circumstances occurred that were misinterpreted or reported in error; hence, hearsay evidence and the RN's narrative of events must be taken into consideration in some cases.

"The first consideration in reviewing a complaint from a member of the public or a health care facility is whether the board of nursing (BON) has jurisdiction or authority to enforce laws or pronounce legal judgments over the particular person and the particular action.

Issues which are not within the authority of the BON include the following: interpersonal conflicts, rudeness or impolite behavior, employee-employer relations, labor issues, fee or billing disputes, complaints against health care practitioners who are not nurses, complaints against health care facilities, clinics, or agency operations" (NCSBN, 2020b, para. 1-2)

When the BRN receives a complaint against an RN alleging a breach of the NPA, the Board notifies the RN of the complaint. There are attorneys who specialize in defending nurses when they are at risk of losing their nursing license. Engaging their services should be the first avenue of reaction for the RN upon notification of a BRN complaint. The RN may have a professional liability insurance carrier that will retain an attorney to defend the RN; if not, the RN should hire an attorney. The RN and defense team gather their own information to defend against the allegations. This may include testimonials from the RN's colleagues, certificates of in-service programs or other continuing education attended by the RN to prove compliance with competency requirements, and the RN's own version of the events in question. Any relevant emails the RN may have received from a manager or Human Resources should also be included in this material.

If the complaint involves a specific patient or patients, the portions of the medical records related to the allegations of negligence or incompetence are requested by the attorney for the defense nurse expert witness to review. If the allegation is drug diversion, the expert witness should request the attorney obtain the Pyxis logs (or other medications cabinet data) and the records of the patient(s) from whom the medication(s) are alleged to have been diverted. The defense will also request all information obtained by the BRN, including the RN's personnel records, prior facility-level disciplinary issues and their resolution, and any audio recordings of witness interviews by the BRN investigators.

The expert witness then reviews all the information, refers to the complaint, and writes a mitigation statement or rebuttal, according to the attorney's needs. Some attorneys have a template for these reports so the expert witness should ensure access to this. The approach to defending the RN depends on the specifics of the case. Each case is unique and must be reviewed with a clear knowledge of the allegations. A mitigating statement must show how circumstances occurred that were misinterpreted or reported in error; hence, hearsay evidence and the RN's narrative of events must be taken into consideration in some cases. A rebuttal, on the other hand, will use specifics to detail how each allegation is untrue.

Sometimes the RN's actions are indefensible, and the defense expert witness must tell the attorney the RN violated the scope of nursing practice. For example, an RN was purchasing Botox from a compounding pharmacy and running a 'clinic' where she injected this substance into clients without any prescription or medical supervision. An expert consulted by the defense advised the attorney this was outside the RN's scope of practice per that state's NPA.

Once the BRN's investigation is complete and the allegations are addressed by the BRN expert witness in a report, the Accusation is filed. "An Accusation is a legal document formally charging a registered nurse with a violation(s) of the Nursing Practice Act, and notifying the public that a disciplinary action is pending against that nurse" (CA BRN, 2020c, para. 4). "The accusation contains all of the factual allegations in support of the adverse nursing license action and citations to the Nursing Practice Act the BRN claims have been violated" (Rose Law, 2018, para. 6). See Appendix A for a portion of a redacted exemplar Accusation. As detailed above, an administrative hearing is then scheduled, and the case (including any disciplinary action) is decided by an administrative judge after hearing witness and expert witness testimony.

EXAMPLE OF ATTORNEY INSTRUCTIONS IN DEFENSE OF A BRN INVESTIGATION

The following is a hypothetical example of an attorney's instructions to a defense expert witness.

Appendix A

Attorney General of California

Supervising Deputy Attorney General

Deputy Attorney General

State Bar No.

Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	Case No.
Respondent.	**ACCUSATION**

Complainant alleges:

PARTIES...
JURISDI CTION...
STATUTORY PROVISIONS...
REGULATORY PROVISIONS...
FACTS

15. At all times mentioned herein, Respondent was employed as a registered nurse at alifornia.

16. On Respondent was assigned to perform stress tests[1] simultaneously on three patients. As part of the test, one patient was walking on a treadmill. The patient told

[1] A stress test is done to identify lack of circulation to the heart muscle, which is caused by plaque buildup in the arteries of the heart. When a person exercises, the heart muscle needs more oxygen, and if there is inadequate blood flow to the heart muscle it often will show up on the stress test, as chest pain or EKG changes.

1 Accusation

Respondent that the treadmill was going too fast for her and Respondent told the patient "you have long legs walk faster." The patient almost fell off the treadmill. Another nurse saw that the patient was going to fall and had to step in and assist the patient off the treadmill.

17. On , while Respondent was performing a Dobutamine Stress Echocardiogram[2] (DSE), Respondent was rude and unprofessional to the patient, which made the patient cry and upset. Upon investigation by a manager, Respondent said the manager could perform the stress test herself and that "maybe some dirty jokes would help" the patient. The patient had recently had plastic surgery and Respondent made demeaning and inappropriate remarks about the patient's surgery.

18. On or about , Respondent administered a bolus of Dobutamine, via IV push, to two patients while she conducted a DSE. The patients did not have physician's orders for Dobutamine. The patients did not have any physical limitations or impairments that would prevent them from exercising to bring their heart rates up on their own, and without the assistance of medication. policy on administering Dobutamine, and drug studies for Dobutamine, provide that Dobutamine is to be given into an IV drip with specific doses and at specific times, not via IV push, as Respondent had administered.

19. On , Respondent administer Aminophylline to four patients that had previously received Lexiscan. All four patients were non-symptomatic and free of any reaction from the Lexiscan. There were no physician's orders or protocol in place to give the patients Aminophylline. Respondent admitted giving all of her Lexiscan patients Aminophylline.

20. On , while Respondent was working in the , she left a voice mail message for a patient who was over 18 years old to return the call for her test results. The patient's mother retrieved the message and called and spoke with Respondent. Respondent gave the mother the patient's test results without the patient's consent. The patient complained to .

[2] A Dobutamine Stress Echocardiogram is a diagnostic procedure that may be used when a doctor wants to assess the heart muscle under stress. If exercise on a treadmill is not an option due to a person's medical condition, a doctor may use Dobutamine IV, which will mimic the effects of exercise on the heart.

5 Accusation

21. On , Respondent provided nursing care for several patients, but did not document on any of her patient charts for the day.

22. On , while Respondent was working in the , a patient came in complaining of chest pain. An LVN asked Respondent to assess the patient, but Respondent would not assess the patient and said it was not chest pain and that the patient was fine. Respondent did not document that she evaluated the patient before turning her away. The LVN was not comfortable with Respondent's opinion and took the patient to see another registered nurse in the .

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Incompetence)

23. Respondent is subject to disciplinary action for unprofessional conduct under Code section 2761 subdivision (a)(1) in that she was incompetent in the nursing care she provided to patients at as more specifically set forth in paragraphs 15 through 22 and as follows:

a. On Respondent failed to exercise prudent judgment of her limitations and failed to request assistance in performing procedures when she felt overwhelmed in having 3 patients for stress testing at the same time.

b. On Respondent failed to treat a patient with dignity, respect and compassion, in order to foster comfort and security during a cardiac procedure, when she spoke to the patient unprofessionally and disrespectfully about her plastic surgery, causing the patient undue stress and making her cry.

c. On Respondent violated patient confidentiality when she disclosed an adult patient's test results to the patient's mother without the patient's permission.

d. On , Respondent failed to document in patient charts for the stress test patients that she saw that day regarding the care she provided and the medications she administered.

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///

///

6 Accusation

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Gross Negligence)

24. Respondent is subject to disciplinary action for unprofessional conduct under Code section 2761 subdivision (a)(1) in that she was grossly negligent in the nursing care she provided to patients at as follows and as more specifically set forth in paragraphs 15 through 22:

a. Respondent administered Dobutamine to two patients without a physician's order.

b. Respondent administered Dobutamine via the wrong method by flushing two patients' IV lines in violation of protocol.

c. Respondent administered Dobutamine to two patients when there was no medical indication for the administration of the medication.

d. Respondent went beyond the scope of practice as a registered nurse by giving patients Aminophylline prior to the start of Lexiscan scanning and before identifying a need for such medication. Respondent failed to obtain a physician's order each time she gave Aminophylline to the Lexiscan patients.

e. Respondent failed to assess a patient complaining of chest pain in the urgent care and failed to obtain an order for an EKG and blood tests to make sure the patient was not having a cardiac or pulmonary event.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

25. Respondent is subject to disciplinary action for unprofessional conduct under Code section 2761 subdivision (a) in that she violated patient confidentiality when she disclosed an adult patient's test results to the patient's mother without the patient's permission as set forth in paragraph 20 above, and incorporated herein, as though fully set forth.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number

Signed: ____________
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California *Complainant*

7 Accusation

An administrative hearing is scheduled, and the case (incl. any disciplinary action) is decided by an administrative judge after hearing witness and expert witness testimony.

"Our office represents an RN who has been a conscious sedation RN for a surgery center for six years. She has spent most of her 25-year career as an RN in PACU. The majority of cases she assists with are epidural steroid injections (pain management).

The BRN has initiated an investigation against our client regarding incidents of pre-charting in pain management in anticipation of the daily procedures. The following are issues we will need to have an expert address for purposes of responding to this investigation.

Expert issues:

- California guidelines vs. other states
- If only guidelines, is there scientific evidence to support the guidelines?
- Standard of care in California or variation in patterns of patient care
- Mitigation used before and since incidents such as: other credible mechanisms & safeguards; no one injured and no harm caused to any patient; impact on affordable care.

Our client believed her pre-charting the pain cases was 'charting by exception.' She only pre-charted for this particular physician in these types of cases. She was filling out administrative information. Her director and her manager knew this was her routine. Once our client became aware there was any concern about pre-charting, she immediately ceased doing so."

As can be seen in this example, the attorney requires specific issues to be addressed in the expert's report. This guidance is essential information for the expert to ensure a thorough report that meets the attorney-client's needs.

EXAMPLES OF MITIGATION AND REBUTTAL ARGUMENTS

Mitigation: An RN was alleged to have diverted opioids and not wasted the drugs per facility policy, which stated all opioid wastes must be done by two RNs. The defense expert witness mitigation statement cited an email from the RN's direct nurse manager to other managers reminding them of the policy. This email included details of other instances when the policy was observed to have been flouted, e.g., when the unit was very busy and when RNs used a second RN's Pyxis login as a 'workaround' when the second RN was not actually at the Pyxis for the waste. The defense expert argued this email proved the practice was known to management, was tacitly 'accepted' by the nurse managers, and was not proof of diversion as alleged.

Rebuttal: It was alleged an RN did not report the bladder scan results on a patient who had not voided post-operatively for over 12 hours after a Foley was removed per physician order. The expert's rebuttal of the claim of gross negligence included:

- entries from the patient's medical record of timed calls to the physician stating the results (and phone company records of these calls);
- timed entries notifying the physician of the imbalance of input and output during the 12 hours; and
- other follow-up actions taken by the RN, such as going up the chain of command when escalation was required due to lack of physician response.

The defense expert was able to refute this allegation through the medical record review, uncovering facts missed by the BRN expert.

The attorney requires specific issues to be addressed... This guidance is essential… to ensure a thorough report that meets the attorney-client's needs.

SUMMARY

The review of cases for the BRN or the defense involves the expert witness in a type of 'detective' work many may find enjoyable. Regardless of whether retained by the prosecution or defense, the expert witness must decipher the facts. For the LNC who is inclined to wear multiple but complementary hats, this might be a great niche.

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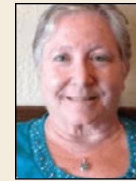
Eula Anyiwo, MPA, RN, Legal Nurse Consultant, started her nursing career in the United Kingdom over 40 years ago. She concentrated her clinical practice in med/surg, oncology, and bone marrow transplant units. Most of her career was spent in progressive leadership positions in ambulatory care, regulatory compliance in service and access issues, and clinical quality and risk oversight. She launched Danasys Legal Nurse Consulting in 2013. In 2016, she started expert witness work with the California Board of Registered Nursing, which complemented her legal nurse consulting work vis-à-vis nursing standards and statutory requirements. Eula may be reached at eranyiwo@danasys.com.



Joanne Walker, BSEd, RN, has been a nurse for over 40 years and has extensive clinical experience in the perioperative area. She has worked as a Legal Nurse Consultant since 2007 and has testified as an expert witness at trial. She founded Clarity Medical Legal Consulting in 2009. Joanne's interest in Nursing Research has developed over her career, both in the OR and as a Legal Nurse Consultant. Her goal is to de-mystify the science of research for other LNCs. Joanne is a member of several professional organizations, keeping up to date in clinical advances to retain her RN license and assist her clients with their research needs. Joanne may be contacted at Joanne@ClarityMedicalLegal.com.

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Roundtable: Developing a Unique Focused-Interest Niche Practice

Curated by Patricia Ann "Stormy" Green, RN, BSHS, RNFA

Keywords: niche practice, focused practice, strangulation, electronic health record, health information technology, root cause analysis, tobacco litigation

INTRODUCTION

Most legal nurse consultants (LNCs) have an area of expertise when they choose to enter the legal sphere. This area of expertise is typically a specialty practice in which the nurse has experience and has attained a level of proficiency to competently execute the required skills. The area of expertise is generally broad. Some examples include surgery, labor and delivery, risk management, emergency nursing, corrections, or interventional radiology.

A niche practice is narrower in its focus. Most LNCs who have a niche practice started in their given area of expertise. As opportunities presented, these innovative LNCs recognized that a particular skill from their past experiences positioned them to offer a unique service to attorneys. As a result of this focused interest and service, a niche practice was born. None of the LNCs interviewed for this article work solely within their niche. Rather, the niche comprises a portion of their overall legal nurse consultant practice.

Four LNCs with niche practices were interviewed for this article. First, they talked about how they recognized they had a niche in addition to their area of expertise. They then offered suggestions about how a niche can be developed by

fellow LNCs. The goal of this article is to help LNCs evaluate their own practices for opportunities to develop a niche. The author would like to thank the interviewees for their thoughtful contributions to this roundtable.

This author noticed one thing in common about the interviewees: They love their niche! They are passionate about the topic, they love to talk about it, they know it inside-out, they love to teach the subject matter, and they never stop learning about their chosen niche. Remember, "Developing a niche can set [one]self apart from the pack. It can also expand [one's] market both nationally and internationally" (Powell, 2017, p. 18).

As opportunities presented, these innovative LNCs recognized that a particular skill from their past experiences positioned them to offer a unique service to attorneys. As a result…, a niche practice was born.

NICHE PRACTICE: STRANGULATIONS

Lori Combs, BS, RN, had a background in forensic nursing that dated back to the 1990s. When she started her legal nurse consulting journey, Lori had no idea she would become an expert on strangulations. Her goal was to simply develop a successful legal nurse consulting business. About five years ago, she started reviewing criminal cases. Through working in the criminal arena, Lori's practice progressed to include the evaluation of strangulation cases.

Lori's forensic experience has also allowed her to branch into the area of family law to assist attorneys in cases of domestic violence and strangulation. Strangulation in criminal and family law cases can be difficult to recognize. The evaluation of these cases requires a medical professional trained in the signs and symptoms and in interpreting the subtle verbal cues of the reported victim, as these cases are not overtly obvious.

To prepare herself for this area of evaluation, Lori obtained specific education on strangulation mechanisms, victimology, signs and symptoms of strangulation, offender profiles, and treatment protocols. As a result, Lori has become successful working on strangulation cases in the areas of family and criminal law.

Lori does not market only for this niche, but her reputation as a strangulation expert has grown significantly. Her work in both family law and criminal law has leveraged her business, presenting unexpected opportunities for growth.

For LNCs wanting to develop a niche practice, Lori recommends:

- Determining the area of your highest interest. It may be within your area of expertise.
- Sharing that expertise with those who would most benefit from your knowledge and skills.

NICHE PRACTICE: ELECTRONIC HEALTH RECORD EXPERT/ HEALTHCARE INFORMATION TECHNOLOGY EXPERT

A lifelong proponent of getting technology into the hands of clinicians, Michael Seaver, RN, BA, made the switch from working clinically to working with and on electronic health record (EHR) systems after sustaining a significant back injury. As a result, over half of his 30-year nursing career has been spent specializing in clinical informatics. With a dual background in nursing and EHR implementation, Michael recognized his unique niche.

Michael assists attorneys with identifying, obtaining, and analyzing data available from technologies associated with, but not directly a part of, the medical record. The printout of the medical record is actually a series of reports of data that are combined in various ways. This is the reason there seems to be so many redundancies in EHRs. All of the data serves to support or refute the "theory of the case" and can literally make or break the case. Michael provides clients with an "insider's" look at what is produced as a medical record and what can be produced as additional data related to the origin and history of elements of the medical record through the utilization of audit trails.

Michael likes to explain he did not seek this niche out; rather, he was "pulled" into it. A friend who was serving as a pediatric nurse testifying expert asked Michael to explain what something meant in a hard copy of the EHR. Michael explained what it meant and why it looked so different to the end-user. The friend shared Michael's skill with the attorney and also encouraged Michael to begin networking with other LNCs. Michael found he had an exceptional ability to answer EHR-related questions on listservs, and people began to notice and seek him out for his expertise. Michael believes he was at the right place at the right time with the right skills and knowledge. He is committed to helping others in the pursuit of truth.

When an error is made, there may be a tendency to cover it up. Michael knows that, with EHR systems, every action taken on every element of documentation is retrievable. In one case, Michael was able to prove a record had been altered 25 times after the patient had expired. In addition, because of his clinical background, Michael was able to identify the significance of these types of changes.

Nearly 50% of Michael's cases go beyond the EHR itself. There are many potential audit reports (e.g., pharmacy, labs, bed management, etc.) that Michael accesses in order to paint a clear picture of events. For example, in a compartment syndrome case that had no demonstrable evidence on its surface, Michael's advice enabled the attorney to identify an eyewitness to specific events that were crucial to the success of the case. The eyewitness, a hospital roommate who had been moved due to the plaintiff's intense pain, was willing to testify about events that transpired during his time as the plaintiff's roommate. In another case, Michael was able to combine different audit trails and prove blood was drawn after a patient coded.

Michael advises attorneys on the correct verbiage to request exactly what they need during discovery, and he assists them when faced with defense responses suggesting the request for production is "overly broad" and "exceedingly burdensome." He especially likes to explain that mysterious and isolated "glitches" cannot account for alterations in documentation and data entry times.

Michael says that, while it is appealing to consider retiring from his "real job" in order to focus on legal work, remaining employed as a clinical informaticist and EHR analyst allows him to continuously increase his knowledge and maintain technical and analytical skills – giving him an edge.

Knowing that his skill set is unique, Michael has marketed his niche by helping and teaching others. He presented at the 2014 American Association of Legal Nurse Consultants (AALNC) Forum and other conferences. His webinar, "The Case of the Elusive EMR: Discovering the Truth," was presented to an AALNC Chapter (Seaver, 2018a). Furthermore, Michael authored an article, "The EHR Files: The Truth is Out There," that was published in the *Journal of Legal Nurse Consulting* (Seaver, 2018b).

Michael's advice for LNCs interested in developing a niche practice is to:

- Make your skill set known by helping others.
- Be prepared to create your own tools.
- If you have the skills, say so. Know that you have to "toot your own horn."
- Have a tag line and use it (i.e., "EHR Expert").

NICHE PRACTICE: ROOT CAUSE ANALYSIS

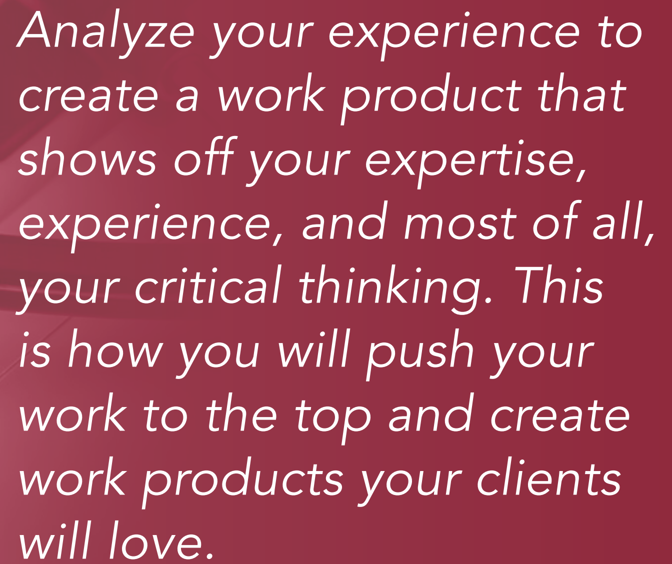
Prior to becoming an LNC, Katie Haney, MSN, RN-BC's area of expertise was in Risk Management. One of her duties in this role was to conduct root cause analyses (RCAs) for the facility when adverse events occurred. The Joint Commission (2015, p. 1) defines RCA as "a process for identifying the basic or causal factor(s) underlying variation in performance. Variation in performance can (and often does) produce unexpected and undesired adverse outcomes." Root cause analyses performed by facilities are typically peer review protected during litigation.

Like other interviewees, Katie did not set out to develop a niche when she started her legal nurse consulting business. Initially, she worked behind-the-scenes as an LNC. Then, attorneys who hired her asked if she was able to conduct RCAs on their cases. As it turns out, it can be done, so she jumped in. Katie took what she learned in the hospital and applied that knowledge to medical malpractice cases. As Katie puts it, she "married them together for a new product" that she offers attorneys. As a result, Katie now acts as a fact expert, testifying about the findings of the RCA she conducts based on documents, interrogatories, and depositions provided in discovery.

To establish this expertise, Katie has presented talks and given demonstrations on RCAs. She also has a website where she writes articles that showcase RCAs as her specialty. It is rewarding to have an attorney say, "I had no idea RCAs even existed. That's why I'm glad I hired you."

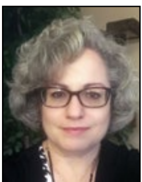
To stay up-to-date on the advances and best practice related to RCA and patient safety, Katie continues to maintain her position as a full-time risk manager. She is also a member of Southern California Association for Healthcare Risk Management (https://scahrm.org/). In addition, Katie recommends the Institute for Healthcare Improvement (http://www.ihi.org/) as a source for best practice in the performance of RCAs.

Make your skill set known by helping others. Be prepared to create your own tools… Know that you have to "toot your own horn." Have a tag line and use it.



Katie's recommendation to LNCs who wish to develop a niche practice to set themselves apart is: Go with what you already know. Most nurses are experts in their area; just focus on a specific topic within your own area of expertise.

NICHE PRACTICE: TOBACCO LITIGATION – PLAINTIFF



Audrey Friedman, RN, CLNC, did not have a specific area of interest when she started her legal nurse consulting business. She knew she would be comfortable working in the areas of oncology, bone marrow transplant, or intensive care. She had worked in oncology as well as inpatient and outpatient bone marrow transplant for approximately 14 years as a staff nurse, educator, and case manager. She then worked the next 15 years in medical and trauma intensive care.

Audrey did not seek tobacco litigation cases; however, this area of litigation primarily focuses on tobacco causation of cancer diagnoses. Ultimately, it turned out to relate intimately to Audrey's clinical experience and became a primary niche for her work. After the first few cases, she really fell in love with the cases and her work with them.

To develop this niche, Audrey included oncology practice guidelines, issues, and assessment scopes in her evaluations of the tobacco litigation. For example, in reviewing tobacco causation of cancers, she incorporated evaluation of other potential oncology-causing issues including history, family history, environment, military exposure, hobby exposure, etc. This gave a comprehensive analysis of all possible cancer causation in order to identify whether tobacco was the cause or whether there were other possible alternative causes.

Additionally, Audrey always included evidence-based research related to the diagnosis, related diagnoses, alternative causes, or anything else she could find in the records; this clinical research gave a solid foundation of information to support or refute any issue in the case. Audrey wanted to educate her clients on the issues of the case so they could answer as many questions as possible when needed. It also provided them with the information to build their clinical library.

Audrey does not market specifically to a tobacco or an oncology niche. However, this niche has been successful in maintaining a consistent client group who handles these types of cases. Audrey also offers classes to health care providers to show how and why their documentation matters. It is important for them to understand how their documentation can affect cases in litigation.

Audrey has developed her skills in report writing, research, and education. The quality of her process and work product has become her reputation. Audrey cites a discussion with a new client about the options for casework and report options. As she described

the options she could offer the client, he stopped her and said, "I saw what you did for my co-counsel. Please do for me what you did for him."

Audrey's advice to LNCs with a desire to establish a niche practice consists of:

- Think about and work through what your intended niche area of expertise really taught you. Do not simply think, "I worked in oncology – or NICU – or cardiology." Consider the comprehensive nature and depth of your experience. Really pull it apart and look at:
  - Knowledge: Consider all the knowledge for your niche – physiology, pathophysiology, medications, tests, procedures, informed consents, patient and family education, research, etc. What are the standard resources? What is the current research in this area? What is considered first, second, and past treatments? What has your clinical experience with all of this been? How long does it take for someone to become competent in this area? Is this an area for new graduates or experienced nurses? What other areas of nursing can this knowledge apply? Can you teach it?
  - Skills: Consider all the skills you have learned and what is required to work in this niche. What clinical assessment skills are required in this area? How do you analyze your shift report? How do you analyze a new admission? How did you learn them? How does anyone learn them? How do you teach them? What are the standard resources, policies, and procedures that would be source documents for standard practice? How long does it take for someone to become competent in these skills? To what other areas of nursing can these skills apply? Can you teach them?
  - Social Skills: We often forget this part or take it for granted; however, there are social skills you know on your unit or in your niche – not only with patients but with colleagues, support staff, physicians, administration, other departments or units, medical equipment representatives, and associated providers such as ambulance, transport, etc.
- Use these skills to get past the surface of the case review into the real core. Consider all angles as you would when you are taking report and planning your care.
  - What are the specific issues you need to understand in your area of expertise?
  - Now consider how you can apply that workup to a report and analysis of a case.
  - Bring the uniqueness of that niche area to your analysis and report.
- Create something that is more than just a chronology and summary – something that brings out the heart of your niche area of expertise.
- Use these steps to create a process and system you can replicate for structure and adjust for the specifics of each case.
- Really look at and analyze your experience to create a work product that shows off your expertise, experience, and most of all, your critical thinking. This is how you will push your work to the top and create work products your clients will love.

SUMMARY

Legal nurse consultants who find that a particular aspect of a topic piques their interest may very well be onto a niche. They should immerse themselves in the topic, learn everything they can, join organizations that provide related education, and network with other experts who share the same or a similar interest. When they have a skill no one else is offering, they should speak up. Opportunities only present themselves to those who make their talents known.

RECOMMENDED READING

This entire issue was devoted to niche roles for LNCs:

Journal of Legal Nurse Consulting, Spring 2017. http://www.aalnc.org/d/do/922

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Patricia Ann "Stormy" Green, RN, BSHS, RNFA, a nurse for well over 40 years, Stormy has extensive involvement in perioperative services, specializing in heart and vascular surgery in addition to orthopedics, general, OB/GYN, urology, plastics, and more. She also has knowledge in PACU, Pre-op, GI Lab, and numerous other areas such as women's health. Stormy functioned in various roles in the OR including clinical nurse, RN first assistant, educator, and administrator. Her company offers services throughout the nation for both plaintiff and defense attorneys. A member of the JLNC Editorial Committee since 2014, Stormy loves teaching and welcomes opportunities to collaborate and share her expertise with others. Stormy@GreenLNC.com (714) 588-2418

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Roundtable: Regulatory and Accreditation Niche Practice Roles and Little Known LNC Niches

Curated by Patricia Ann "Stormy" Green, RN, BSHS, RNFA

Keywords: niche practice, focused practice, regulatory niche practice, accreditation niche practice, peer review, Board of Nursing, clinical investigator, Board of Medicine, ambulatory surgery facility surveyor, injury causation investigation, elder fiduciary abuse

INTRODUCTION

Many innovative legal nurse consultants (LNCs) create opportunities for themselves that are outside the usual realm of legal nurse consulting. Some of these opportunities are found with regulatory and credentialing bodies, and others are developed through a focused interest. The LNCs interviewed for this article secured work in nontraditional settings that they love. The author appreciates the contributions of these LNCs to this article. Here are their intriguing stories.

NICHE PRACTICE: PEER REVIEW FOR STATE NURSING BOARD

Laura Conklin, MSA, MSN, RN, was approached by the Michigan Peer Review Organization to review an allegation against a nurse and opine on the standard of care. Michigan (MI) does not have a Nurse Practice Act but instead references The Public Health Code, Act No. 368 of Public Act of 1978 as its nursing practice guidelines. Laura did not realize this organization is part of the Disciplinary Subcommittee of the Board of Nursing and that it gathers information for possible sanctions against a nurse when an error occurs.

Laura reviewed the case, answered the Organization's questions, and provided her opinion based on the case facts and her determination of what, if anything, the nurse could have done differently. She referred to the scope of practice as

set forth by the American Nurses Association and as delineated in Michigan's Public Health Code. The Disciplinary Subcommittee accepted her review and opinion, which led to additional, and increasingly complex, cases to review. This allowed her to opine as an expert witness when a case proceeded to an Administrative Law Hearing.

Laura says, "The niche for reviewing cases for [Michigan] is based on experience in the nursing process and not a specific nursing area. When a nurse follows the nursing process and uses critical thinking, it doesn't matter where [the nurse] practices because the requirements are the same."

Recommendations from Laura for LNCs include:

- Explore how nursing board allegations are investigated in your state. Being qualified to review or opine for the state nursing board boosts your credibility.
- Find out if other LNCs are reviewing cases for the state nursing board.
- When developing your business plan, show how a particular service would be an asset to the state nursing board.
- Implement your plan, and you will become recognized as an expert in that field.
- Market your specialty, because it will become a very narrow market or niche.
- Find your passion and follow it, and you will never work a day in your life!

NICHE PRACTICE: CLINICAL INVESTIGATOR FOR STATE MEDICAL BOARD

Marian Ead, BSN, RN, has been in the position of Clinical Investigator at the Massachusetts (MA) Board of Registration in Medicine (BORIM) for 12 years. Divisions within BORIM include a Licensing Division (licenses all MA physicians and acupuncturists), a Law & Policy Division (provides legal counsel to the seven-member board), a Quality and Safety Division (assists with improving hospital systems issues), and an Enforcement Division. The Enforcement Division is responsible for investigating complaints made against physicians and acupuncturists; these include allegations of substandard care, misconduct, and impairment. The Enforcement Division has the authority to recommend that action be taken against the license of the physician or acupuncturist.

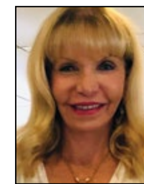
The Enforcement Division team members include investigators (two of whom are registered nurses [RNs]), attorneys, and paralegals. As an RN, Marian is assigned to cases involving allegations of physician substandard care. Cases that involve misconduct or impairment are assigned to non-RN investigators. Some of Marian's duties include requesting and analyzing pertinent medical records; conducting medical research; searching and qualifying physicians to serve as expert witnesses; conducting interviews of complainants, the physicians who are under investigation, and health care staff; assisting the attorneys to prepare for hearings; and attending the hearings.

To maintain her skills, Marian actively attends webinars and participates in training sessions as they are offered by the MA Medical Board. Because of her extensive research experience, she has learned a great deal about different medical specialties, medical standards of care, and administrative law.

Marian offers the following advice to LNCs seeking a nontraditional role:

- Most importantly, join the American Association of Legal Nurse Consultants (AALNC) and a local chapter if one is available.
- Understand that networking is essential. Marian reports that effective networking through AALNC and her local chapter provided her with various LNC opportunities, including her position at BORIM.

NICHE PRACTICE: AMBULATORY SURGERY FACILITY SURVEYOR



Office surgery has become the focus of Cheryl White, MSHL, BS, AS, RN, HRM, LNCC, MSCC, DFSHRMPS's practice. Her background as a health care risk manager for three hospital systems opened doors for Cheryl to inspect and survey surgical practices. Cheryl was a contracted office surgery inspector for the Florida Board of Medicine for 16 years, and she has been a surveyor for the American Association for Accreditation of Ambulatory Surgery Facilities for many years. Cheryl says that each step of her success was the result of an opportunity that she recognized, and she dared to venture into a new arena.

Cheryl's suggestions for LNCs wanting to create a niche practice are to:

- Choose a path early if possible.
- Become board-certified as a Legal Nurse Consultant Certified (LNCC) through the American Legal Nurse Consultant Certification Board.
- Seek out a mentor who can guide you in your desired field.

Choose a path early if possible. Become board-certified as an LNCC. Seek out a mentor who can guide you in your desired field.

- Do not be afraid to try something new if the opportunity presents itself. You may find yourself passionate about an area you never expected.

NICHE PRACTICE: INJURY CAUSATION INVESTIGATION

D. Lee Campbell, RN, BSN, CLNC, started her LNC practice with a background in forensic nursing. Lee feels this provided the foundation for an investigative mindset that requires heightened attention to detail and critical thinking skills. She did not set out to develop a niche but always knew there had to be more opportunities out there for forensic nurses.

Lee was working as an in-house legal nurse consultant on a personal injury case when she developed an excellent rapport with a biomechanical engineering expert. While Lee provided significant assistance to the biomechanical engineer with the medical record analysis, she was intrigued by how much light he was able to shed on the case.

Lee immediately wanted to know more and become involved in this niche. She expressed her interest to the engineer, who then recruited Lee to work for his company. The door opened to a position in which she could use her forensic skills even further. Lee created the role of "forensic nurse" within the company and assists biomechanical engineers with medical record analysis and injury causation investigation. She also reviews, analyzes, and interprets important medical, legal, and governmental documents to identify evidence that may bolster the engineers' opinions in preparation for trial, mediation, or deposition.

Lee has been fortunate to have several mentors at her workplace who continually teach her about biomechanics and human factors analyses on a case-by-case basis. She maintains her education by routinely attending in-house biomechanical meetings and seminars. In addition, Lee maintains her membership with AALNC, and she is involved with the International Association of Forensic Nurses.

Lee's suggestions to LNCs who would like to develop a niche include:

- Express your interest and passion to others.
- Think about how you can make a difference.
- Keep an eye out for that "someone" who may help open the door for you.

NICHE PRACTICE: ELDER FIDUCIARY ABUSE

Never underestimate the added value of pro bono work. After Cheryl Hobbs, RN, CEN, became an LNC, she heard a local district attorney's (DA's) office in the news discussing efforts and successes in prosecuting different types of cases. She thought this could be an opportunity to give back to the community by donating her time and skills while getting exposure for her business in the process. The DA's office was in a different county, minimizing the risk of any conflict of interest.

Cheryl called the DA's office and offered to volunteer as an assistant to the attorneys. The DA's office traditionally only used law students as volunteers, so it took persistence before Cheryl was introduced to the attorney who coordinated the volunteers. She asked to assist with the abuse cases and explained how a nurse, especially an LNC, could help. She and her business partner were given a child abuse case to review; the case was already in trial, but they were able to offer some helpful suggestions.

The attorney and investigator on the child abuse case also had been reviewing a case in which they felt an elderly woman in a nursing home was being exploited. They were unsure if the LNCs would find anything with the case, but they were overwhelmed by the abundance of medical records. Cheryl and her partner rose to the challenge. From their medical record review, Cheryl and her partner pointed out important information about the woman's medications, vital signs, weight, treatments, group activities, interactions with staff and visitors, facility bills, and pharmacy bills. Together, these told a story that was helpful to the DA. The DA's office decided it needed to have this multi-disciplinary approach to all its elder fiduciary abuse cases and formed a Financial Abuse Specialist Team (FAST team). Ten years later, Cheryl and her team continue to volunteer on the FAST team, and the DA's office continues to be impressed with how helpful LNCs are on the cases.

Cheryl believes maintaining relationships and accepting opportunities to teach, attend meetings, and staying in contact with past colleagues (networking) are great ways to gain exposure for her business and niche practice. She also has gained more confidence by helping people to understand her niche role, so she no longer feels like she is actually trying to "sell" or "market" even though it is what she is doing.

Having the courage to act upon novel ideas is what established these LNCs with nontraditional but exciting roles.

Cheryl offers advice to LNCs:

- Consider if there is something you know that others may not know. For example, in your work setting, was there something that most of your colleagues did not like but you loved? Also, when talking with other nurses, are they often surprised by a skill you have, because they were unaware it was within the scope of practice for a nurse? That could be a window of opportunity to develop a niche.
- Your network is important. Keep the relationships you have and keep making new ones.
- Be persistent. When venturing out of the more traditional LNC role and actively pursuing the DA's office, it was three months before an opportunity arose for Cheryl to talk with the attorney who managed the volunteers. She recommends gentle, polite persistence and not bombarding them. Staying in contact was what got Cheryl in the door.
- Be aware that for some types of volunteer work, such as with a DA's office, background checks and fingerprinting may be required.

Having the courage to act upon novel ideas is what established these LNCs with nontraditional but exciting roles. The author hopes their stories will serve to inspire LNCs who seek steady work in roles that others never dreamed were possible.

RECOMMENDED READING

This entire issue was devoted to niche practices and other roles for the LNC:

Journal of Legal Nurse Consulting, Spring 2017. http://www.aalnc.org/d/do/922

Patricia Ann "Stormy" Green, RN, BSHS, RNFA, a nurse for well over 40 years, Stormy has extensive involvement in perioperative services, specializing in heart and vascular surgery in addition to orthopedics, general, OB/GYN, urology, plastics, and more. She also has knowledge in PACU, Pre-op, GI Lab, and numerous other areas such as women's health. Stormy functioned in various roles in the OR including clinical nurse, RN first assistant, educator, and administrator. Her company offers services throughout the nation for both plaintiff and defense attorneys. A member of the JLNC Editorial Committee since 2014, Stormy loves teaching and welcomes opportunities to collaborate and share her expertise with others. Stormy@GreenLNC.com (714) 588-2418

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Liability and Errors in Labor & Delivery: Analytical Lessons for LNCs

Linda Husted, MPH, RN, CNLCP®, LNCC, CCM, CDMS, CRC

Keywords: obstetrical nursing litigation, nursing malpractice in labor & delivery, maternal mortality, maternal morbidity, perinatal mortality and permanent disability, fetal birth-related brain injury

The focus of this article is to inform the legal nurse consultant on trends in obstetrical nursing litigation and errors in labor and delivery and to provide resources for the analysis of cases involving alleged obstetrical nursing malpractice.

"The difference between harm on the battlefield and harm in our hospitals is that on the battlefield we expect harm..."

Patricia Horoho,
43rd U.S. Army Surgeon General

INTRODUCTION

With the call for improved maternal and infant outcomes, it is anything but business as usual in labor and delivery (L&D) units today. Could the stakes get any higher when maternal and fetal death or injury are the top risks? According to the Institute for Healthcare Improvement (2018), approximately 750 women die each year in the U.S. because of complications of childbirth, and more than 50,000 suffer serious complications. Additionally, there are significant racial and ethnic disparities. The pregnancy-related mortality rate of African American women is estimated to be three to four times higher than that of white women (Institute for Healthcare Improvement, 2018). Although perinatal mortality (late fetal death at 28 weeks or more and early neonatal death under age 7 days) declined 30% from 1990-2011, there has been no further decline from 2012-2014 with 6.00 deaths per 1,000 births and late fetal deaths (Gregory et al., 2018).

By reviewing obstetrical malpractice claim data, the legal nurse consultant (LNC) can learn of the increasing

exposure nurses have in malpractice litigation, frequent nursing errors, and the most severe injuries with the highest paid indemnity. [Indemnity is the "monies paid in the settlement or judgment of a claim" (CNA & Nurses Service Organization [NSO], 2009, p. 51).] Discussion of available safety bundles, safety tools, and two new standards in perinatal safety can assist the LNC to analyze obstetrical nursing care.

SENTINEL EVENT ALERT 30

The Joint Commission maintains a repository of root causes of sentinel events. The Commission notes that reported sentinel events represent only a small portion of actual events as reporting of most sentinel events is voluntary (The Joint Commission, 2020a).

In 2004, The Joint Commission issued Sentinel Event Alert 30: Preventing infant death and injury during delivery. The breakdown of root causes identified in this Alert will help the LNC consider areas of potential concern when conducting a case review. The top five root causes of the reported sentinel events were:

- 72% - communication
- 55% - organization culture as a barrier to effective communication and teamwork, i.e., hierarchy and intimidation, failure to function as a team, and failure to follow the chain-of-communication
- 47% - staff competency
- 40% - orientation and training
- 34% - inadequate fetal monitoring (The Joint Commission, 2004)

MALPRACTICE INSURANCE COMPANIES' REPORTS ON NURSING MALPRACTICE

Claim data compiled by malpractice insurance companies can also be instructive for LNCs to learn the top alleged errors by nurses and the trends therein. Various malpractice insurance companies have published reports on claim data, including claims involving nurses. The analytic findings of these reports can be insightful for the LNC working on obstetrical claims involving maternal and fetal/infant morbidity and mortality. The claims studies and data discussed below pertain to claims involving registered nurses and licensed practical nurses, not advanced practice nurses or midwives.

CNA HealthPro Nurse Claims Study: An Analysis of Claims with Risk Management Recommendations 1997-2007

In a sample of 8,151 professional liability claims, this CNA ten-year study focused on 1,260 claims with paid indemnity of $10,000 or more (CNA & NSO, 2009). This study is important, because it pointed to a developing trend in nursing malpractice as the role of the nurse experienced a paradigm shift in medical malpractice litigation. In the past, nurses were considered "functionaries" or "custodians" playing limited roles in the care and treatment of patients. Nurses were not usually named as defendants in lawsuits. From 1997-2007, however, plaintiff attorneys began to specifically name nurses as defendants based on their role as a clinician responsible for clinical judgments (CNA & NSO, 2009). With the rise of nursing specialties in the nursing profession, so too has the number of nursing malpractice claims risen.

Here is a link to a video excerpt of a plaintiff attorney describing to a jury the role of nurses named in an obstetrical malpractice suit (Courtroom View Network, 2018).

https://cvn.com/proceedings/mitchell-v-south-broward-hospital-district-trial-2018-07-12

Looking at the 1,260 closed claims with paid indemnity of $10,000 or more, CNA found that 10.3% of closed cases involved nurses in the specialty of obstetrics/gynecology (CNA & NSO, 2009). Although there were fewer obstetrics/gynecology nursing claims than claims in other nursing specialties, they had the highest average paid indemnity of all specialties. The most severe of the 1,260 closed claims involved birth-related brain damage, because these birth injuries resulted in either death or costly future medical expenses (CNA & NSO, 2009).

The top alleged nursing errors were:

- "Failure to timely treat symptoms/illness/disease in accordance with established standards/protocols/pathways…
- Failure to timely report complications of pregnancy, labor, or delivery to a physician/licensed independent practitioner…
- Failure to timely implement established treatment protocols or established critical pathways" (CNA & NSO, 2009, p. 19)

CNA HealthPro and Nurses Service Organization: Understanding Nurse Liability, 2006-2010: A Three-part Approach

In this study, closed claims in the nursing specialty of obstetrics involved care that took place in hospitals and other locations and settings. The most severe injuries due to these nursing errors were:

- Fetal/infant birth-related brain injury
- Maternal death
- Maternal obstetrics-related injury (CNA & NSO, 2011)

Nursing errors resulting in fetal/infant birth-related brain injuries included:

- Failure to properly monitor the fetus during labor

"The problem is not that we err. The problem is that we ignore the errors." Today, errors in treatment and care continue to be the most frequent allegation against nurses.

- Failure to recognize signs of fetal distress
- Failure to notify the practitioner of fetal distress
- Failure to invoke the chain of command to obtain appropriate practitioner intervention and care during labor (CNA & NSO, 2011).*

**Half of all closed claims involving allegations of failure to invoke the chain of command occurred in the labor and delivery specialty and resulted in either death or permanent total disability (CNA & NSO, 2011).*

CNA and Nurses Service Organization – Nurse Professional Liability Exposures: 2015 Claim Report

Out of 10,639 adverse incidents and claims that closed during the 5-year period from 2010 to 2015, 549 nursing closed claims were analyzed. Obstetrics was in the top two nursing specialties with the highest claim severity, because those injured required lifelong, one-on-one nursing care (CNA & NSO, 2015).

"Obstetrics-related closed claims involve[d] one or more of the following nursing errors:

- Failure to invoke the chain of command.
- Failure to timely report complication of pregnancy/labor to a practitioner.
- Failure to monitor and timely report the mother's and/or baby's vital signs.
- Failure to identify and report observations, findings, or changes in condition.
- Improper or untimely nursing management of an obstetrical patient/complication."

(CNA & NSO, 2015, p. 33)

Although obstetrical claims may be few, these cases can be high in severity. Take, for example, the $101 million dollar verdict for a baby, Gerald Sallis, who sustained brain damage at birth (Clifford Law Offices, 2019). According to the plaintiffs' attorneys, the "external fetal monitoring strips were ignored for six hours. Experts on behalf of the plaintiff testified that he would have been born a normal baby if hospital nurses and other medical personnel would have alerted doctors to the abnormalities and performed an emergency C-section" (Clifford Law Offices, 2019, para. 2). Plaintiffs' attorneys cited a lack of communication and proper care as the causes of the baby's injuries (Clifford Law Offices, 2019, para. 3). The obstetrical nurse was individually named in the lawsuit, and plaintiffs' obstetrical nurse expert opined that the defendant nurse's negligence involved 14 failures to monitor, recognize, report/communicate, and advocate for her maternal and fetal patients (Sallis v. West Suburban Medical Center et al., 2016, pp. 65-66). This case can be instructive to LNCs, as all of the obstetrical nursing errors identified in the CNA & NSO 2015 report can be seen in this case.

Controlled Risk Insurance Company of Vermont, Inc. (CRICO) Strategies 2015 Annual Benchmarking Report Malpractice Risks in Communication Failures

CRICO, a medical professional liability carrier, insures RNs and LPNs under their employer's policy at Harvard-affiliated medical institutions (CRICO, 2019; CRICO Strategies, 2020).

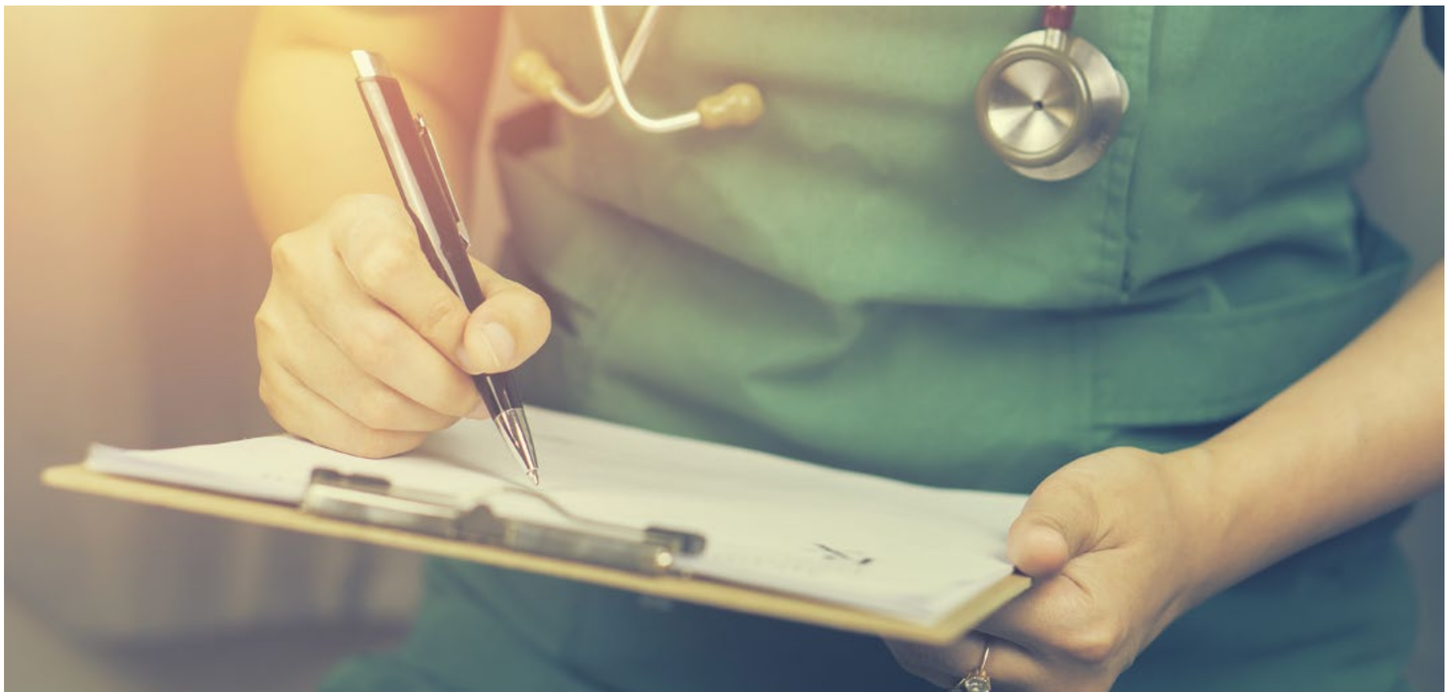
Of more than 23,000 medical malpractice claims analyzed in this report, three out of every 10 cases included at least one specific breakdown in communication, and one third of both nursing and obstetric cases involved a communication failure (CRICO Strategies, 2015).

A communication failure, such as a language barrier, is not the only problem. According to Heather Riah, Assistant Vice President. CRICO Strategies, "Nor is the problem exclusive to communication that is misspoken or misunderstood: errors often occur because information is unrecorded, misdirected, never received, never retrieved, or ignored" (CRICO Strategies, 2015, p.3).

Communication failures in nursing and obstetrics indicate the possible role L&D nurses may have played during these adverse events. During review of the nursing allegations, the LNC might ask some of the following questions: Was the nurse skilled in communication, protocol initiation, teamwork, and documentation? If, for example, the obstetrician made an error in clinical judgment, such as delaying a cesarean section, did the nurse speak up, request a huddle, or invoke the chain of command?

According to Jock Hoffman (2019) in a CRICO newsletter entitled *Taking a Second Look at Nursing Malpractice Cases,* analysis of 60,000 medical professional liability cases from 2007 to 2016 indicated that nurses made

up less than 3% of the 104,000 defendants. In more than 17% of these cases, however, nursing was the primary or secondary service responsible for the patient's care at the time of the event in question. When nursing was identified as the primary responsible service (i.e., the event in question involved bedside skills, clinical assessment, and monitoring activities), liability fell more often to the organization where the nurse practiced (vicarious liability) or to the physician who was involved in the patient's care. "When the nursing service is secondary, i.e., noted as sharing responsibility for the patient at the time of the alleged event, those cases are more likely to be triggered by inadequate patient assessment or provider-provider communication breakdowns…" (Hoffman, 2019, para. 5).



RESOURCES FOR REVIEWING OBSTETRICAL NURSING MALPRACTICE CLAIMS

Errors in assessment, clinical judgment, communication, and timeliness of interventions are implicated in nursing malpractice claims. There are numerous resources that can help LNCs determine if the defendant(s) provided timely recognition, evaluation, treatment, and documentation of obstetrical abnormalities and critical conditions. The Council on Patient Safety in Women's Healthcare provides access to patient safety bundles and safety tools to address known causes of preventable maternal mortality and morbidity (Council on Patient Safety in Women's Healthcare, 2020). Most of the bundles have been developed by the Alliance for Innovation on Maternal Health (2020). An important protocol called The Maternal Early Warning Signs Protocol identifies critical changes in the maternal condition which require prompt recognition and response (Heard, 2015). This protocol as well as patient safety bundles on obstetric hemorrhage and severe hypertension in pregnancy can assist the LNC during case review.

Another resource for LNCs is the Agency for Healthcare Research and Quality (AHRQ). This Agency considers L&D to be a high-risk care environment and provides a labor and delivery safety bundle and program for perinatal care (AHRQ, May 2017).

In addition to the above resources, as of January 1, 2021, Joint Commission-accredited hospitals are required to adhere to two new standards to improve the quality and safety of perinatal care (Swinton et al., 2020). These standards are designed to reduce the likelihood of harm related to maternal hemorrhage and severe hypertension/preeclampsia (The Joint Commission, 2020b). These standards specify 13 new elements of performance and align with the recommendations by the Council on Patient Safety in Women's Healthcare, the American College of Obstetricians and Gynecologists, and the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) (Swinton et al., 2020; The Joint Commission, 2020b). Particularly noteworthy is that these two standards apply to multidisciplinary teams within and

outside of the L&D unit, such as in the emergency department (The Joint Commission, 2020b).

For all obstetrical nurses, whether providing direct care or working in supervisory roles, AWHONN's *Standards for Professional Nursing Practice in the Care of Women and Newborns* (2019) serve as a guide for best practice. As the 11th AWHONN standard states, leadership is the responsibility of every L&D nurse (ANA, 2015; AWHONN, 2019).

Using these resources, the LNC might consider the following questions during obstetrical nursing malpractice case reviews: were the L&D nurses vigilant in their watch for maternal vital sign changes or other maternal early warning triggers? Were they decisive in initiating intrauterine fetal resuscitation when patterns of change in the fetal heart rate occurred? Did the L&D nurses speak up and express their assessment and clinical judgment? If issues were unresolved, did the L&D nurses stand their ground and invoke the chain of command? Did they act as leaders while carrying out their professional responsibilities and actualize their role to facilitate the best maternal and fetal outcomes?

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This patient safety podcast is an example of how a lack of situational awareness and distraction can lead to an adverse outcome (Augello & Beatty, 2016).

https://rmf.harvard.edu/Clinician-Resources/Podcast/2016/Case-OB-Distraction

SUMMARY

Patricia Horoho, the 43rd Lieutenant General in the U.S. Army and the first woman and first nurse to serve as the Army's Surgeon General, has spoken about the staggering scale of preventable harm in U.S. hospitals (Horoho, 2014). She stated, "To err is human. The problem is not that we err. The problem is that we ignore the errors" (Horoho, 2014).

Today, errors in treatment and care continue to be the most frequent allegation against nurses, making up 56% of closed nursing malpractice claims (CNA & NSO, 2020). Closed claims involving failure to document or falsification of documentation are increasing (CNA & NSO, 2020). Obstetrical closed claims, while infrequent, continue to be of higher-than-average severity, and the allegations against nurses demon-

strate a failure to fulfill core nursing responsibilities (CNA & NSO, 2020). Communication failures continue to play an important role in nursing malpractice claims. Understanding the failures and errors identified in sentinel event and closed claims reports can help the LNC when analyzing cases involving obstetrical nursing.

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Current Trends in Postpartum Hemorrhage Treatments

Margaret Browne BSN, OB-RNC, Legal Nurse Consultant

Keywords: Postpartum hemorrhage, obstetric hemorrhage, quantification of blood loss, uterine balloon tamponade, uterotonics, patient safety bundles

Postpartum hemorrhage (PPH) represents the most frequent and life-threatening childbirth complication and is the primary cause of morbidity and mortality during childbirth (Wormer et al., 2020). It is defined as a loss of 1,000 or more milliliters of blood with evidence of hypovolemia during the 24 hours after delivery, regardless of delivery method (Wormer et al., 2020). For the experienced or novice clinician, uncontrolled bleeding represents one of the most terrifying scenarios in obstetrics.

Between 1-6% of deliveries are complicated by PPH (Wormer et al., 2020). Prompt recognition and intervention by the obstetrical team may avert a catastrophic event. Postpartum hemorrhage may occur with or without the presence of significant risk factors. Worldwide, 27.1% of maternal deaths are attributed to PPH every year (Sebghati & Chandraharan, 2017). In the US, 12% of yearly maternal deaths are caused by excessive blood loss (Wormer et al., 2020).

INTRODUCTION

The incidence of postpartum hemorrhage (PPH) in the United States rose steadily from 1993 to 2014 (Centers for Disease Control and Prevention, 2019). This increase does not appear to be caused by risk factors such as advanced age, hypertension, or diabetes. Researchers suspect that increased use of labor induction and primary cesarean sections have increased the frequency of uterine atony, which has resulted in a higher incidence of PPH (Callaghan et al., 2010).

Women who survive PPH may experience organ damage, loss of fertility, and post-traumatic stress disorder (Sebghati & Chandraharan, 2017). Improving survival and outcomes requires a swift, coordinated response involving medical, nursing, laboratory, and blood bank staff. Failure to recognize substantial blood loss and quickly implement interventions can lead to loss of life. The non-obstetrical legal nurse consultant may be involved in reviewing cases involving maternal injury or death from PPH.

Postpartum hemorrhage occurs after the delivery of the placenta and is characterized by excessive bleeding and lack of uterine muscle tone… PPH's significant causes [are] Tone, Trauma, Tissue, and Thrombin.

CURRENT TRENDS

Safety bundles improve outcomes in patient care. As defined by the Institute for Healthcare Improvement (2021), a safety bundle "is a structured way of improving the processes of care and patient outcomes: a small, straightforward set of evidence-based practices — generally three to five — that, when performed collectively and reliably, have been proven to improve patient outcomes" (para. 1).

The use of standardized safety bundles is recommended by The Alliance for Innovation on Maternal Health (AIM) within The Council on Patient Safety in Women's Health Care. The AIM is a national maternal safety and quality improvement initiative that is data informed (AIM, 2020, para. 1). The Council is composed of all the major professional organizations involved in women's health care, including but not limited to the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN); the American College of Obstetricians and Gynecologists (ACOG); and the Society for Maternal-Fetal Medicine.

The Obstetric Hemorrhage Patient Safety Bundle published by the Council (2015) includes but is not limited to:

Readiness:

- Immediate access to emergency medications (kit)
- Hemorrhage cart with blood tubing, intrauterine balloons, and instructions
- Establishment of a response team
- Massive transfusion protocol
- Annual drills and debriefing

Recognition and Prevention:

- Assessment of every patient for the risk of excessive bleeding
- Accurate measurement of cumulative blood loss for every delivery
- Active third stage management

Response:

- Standardized emergency management plan with checklists
- Communication with patients and family afterward with a support program

Reporting:

- Huddles (communication) for at-risk women and debriefing
- Outcomes monitoring via process improvement committees

BACKGROUND

Labor is divided into three stages. The first stage involves dilation and thinning of the cervix. The second stage begins with the complete opening of the cervix and ends with the delivery of the baby. The placenta is delivered during the third stage. Postpartum hemorrhage occurs after the delivery of the placenta and is characterized by excessive bleeding and lack of uterine muscle tone. Factors associated with increased PPH risk include prolonged labor or induction, infection, uterine fibroids, obesity, multiple gestations, and previous uterine surgery. A helpful mnemonic for identifying and addressing PPH's significant causes is the four T's: Tone, Trauma, Tissue, and Thrombin.

Tone: Uterine atony, or lack of uterine tone, contributes to 70-80% of PPH cases (ACOG, 2017). Medications commonly used during labor such as magnesium sulfate and nifedipine for hypertension may impair uterine contractility. The ACOG currently recommends active (versus expectant) management of the third stage of labor. Active management measures include prophylactic oxytocin with the delivery of the baby's anterior shoulder, or soon after, and uterine massage (ACOG, 2017). In addition, a full bladder displaces the uterus and interferes with uterine contractility, so the insertion of an indwelling urinary catheter may help improve tone.

A patient's initial hemorrhage risk assessment…may increase over time due to prolonged labor, infection, and extended hours of oxytocin administration. These factors may impair uterine contractility after delivery.

Trauma: The obstetrical (OB) team should consider whether any tissue trauma may be contributing to the PPH. Trauma to the genital tract could be caused by operative delivery via vacuum or forceps or a laceration from fetal delivery.

Tissue: Tissue refers to any retained placental fragments or clots that prevent the uterus from contracting effectively. The uterus will need to be explored manually, preferably with analgesia.

Thrombin: The obstetrical team should consider whether any coagulopathies may be causing the PPH. Clotting alterations may be inherent (e.g., Von Willebrand disease) or acquired. Severe pre-eclampsia with HELLP syndrome (hemolysis, elevated liver enzymes, and low platelet count) is one form of acquired coagulopathy. Massive PPH itself leads to a consumptive type of coagulopathy (i.e., disseminated intravascular coagulation) in which clotting factors are depleted intravascularly (Su & Chong, 2012).

Nursing care of obstetrical patients includes assessing hemorrhage risk upon admission, placing a large-bore intravenous catheter, and obtaining baseline labs including a type and screen or crossmatch for at-risk patients. A patient's initial hemorrhage risk assessment is not fixed and may increase over time due to prolonged labor, infection, and extended hours of oxytocin administration. These factors may impair uterine contractility after delivery. Patient education is needed to illuminate the rationale for having venous access available and drawing lab work. Some clients desire minimal interventions during labor and should be fully informed by their providers of the risks of refusing interventions. Patients who do not wish to receive any blood products for religious or other reasons should be identified upon admission.

For the initial 30 to 45 minutes after delivery until the mother is stable, staffing recommendations are to have one nurse caring for the mother and a separate nurse assigned to the baby. The new mother's vital signs and the height and consistency of her fundus should be evaluated and documented every fifteen minutes. The amount of lochia (vaginal bleeding) should be carefully assessed. Continuous nursing care at the bedside during the first two postpartum hours is considered best practice (Simpson, 2015). Changes in vital signs, tachycardia, and low blood pressure are late signs of PPH (Nathan et al., 2014).

QUANTIFICATION OF BLOOD LOSS

The AWHONN (2015) recommends that blood loss be formally measured after every delivery. Prior practice has been documentation of estimated blood loss. However, most clinicians vastly underestimate blood loss after delivery, and the lack of early recognition of significant blood loss leads to increased morbidity and mortality. Overestimation of blood loss leads to risky interventions and potential exposure to infectious diseases from blood products.

Current practice is the quantification of blood loss (QBL), which requires planning and a group effort. The delivery nurse and provider document dry weights for pads, gauze, and lap sponges. Calibrated drapes (drapes with a calibrated pouch for fluid collection) may be useful. The QBL recording begins immediately after the infant's birth, with amniotic fluid and irrigation fluids subtracted. Blood-soaked materials are weighed, and their dry weight is subtracted. Quantified blood loss is then determined using this ratio: one gram of weight = one milliliter of blood loss (AWHONN, 2015).

TREATMENT OF POSTPARTUM HEMORRHAGE

Medications are an integral part of blood loss mitigation in PPH. Some labor and delivery units have prepared OB hemorrhage kits containing frequently used agents, such as oxytocin, tranexamic acid, misoprostol, methylergonovine, and carboprost. These may be available at the bedside during an at-risk delivery. The use of uterotonics (uterine stimulants) after delivery is a common practice. Tranexamic acid may be used in the first

Image 1

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three hours after delivery and does not appear to increase the risk of thromboembolic events (Shakur et al., 2018).

Uterine balloon tamponade may be useful for addressing bleeding from the placental implantation site. Balloon catheters may be used for women who do not respond to medications and may be used after cesarean or vaginal deliveries. See Images 1 and 2 for an example of a uterine balloon catheter and how it is placed. They are relatively inexpensive devices to purchase and have on hand. Balloon tamponade may work by applying pressure directly to the placental bed and/or lowering uterine artery perfusion pressure (Belfort et al., 2011).

In areas of low resources, the B-Lynch suture may be employed. This method involves uterine compression sutures typically placed during a cesarean section. Both balloon placement and the B-Lynch suture preserve the uterus and are considered fertility-sparing (Kaya et al., 2016).

Facilities with interventional radiology may perform uterine artery embolization to address bleeding while sparing the uterus (Aoki et al., 2018). Hysterectomy is indicated for continued bleeding in patients who do not respond to interventions.

The utilization of a massive transfusion protocol during a severe obstetrical hemorrhage is of value. In the absence of a known blood type, administration of O negative blood is an acceptable practice. The California Maternal Quality Care Collaborative's OB Hemorrhage Toolkit recommends an OB hemorrhage pack consisting of four to six units of packed red blood cells, four units of fresh frozen plasma, and one unit of apheresis platelets (2015). A cooler may be used for storing the blood products before use, minimizing delays from multiple trips to the blood bank to pick up products. Lab values should be evaluated every 30 minutes and should include a complete blood count with platelets, prothrombin time (PT), international normalized ratio (INR), partial thromboplastin time (PTT), fibrinogen, and ionized calcium. The target values for these labs are hematocrit over 24%; platelets over 50,000 µL; international normalized ratio less than 1.5; fibrinogen over 100,000 mg/dL; and ionized calcium levels 4.4 to 5.4 mg/dL (Shields et al., 2015). Care should be taken to maintain blood pH at or above 7.2 and temperature above 95° Fahrenheit. Maintaining lab values at or above these targets is important to avoiding coagulopathy. The use of a blood warmer is recommended when infusing large volumes of blood products (Shields et al., 2015).

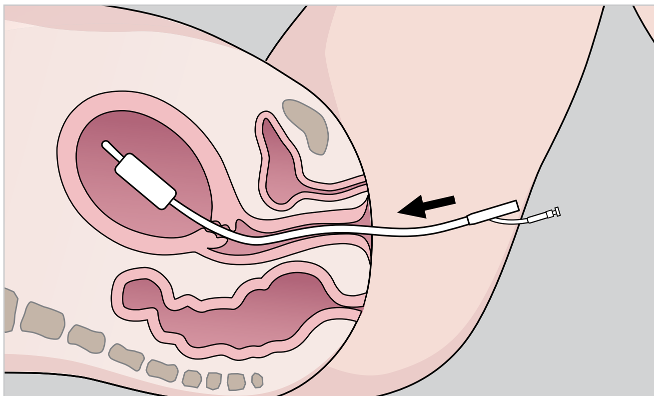

Figure 1: Transvaginal placement, postvaginal delivery

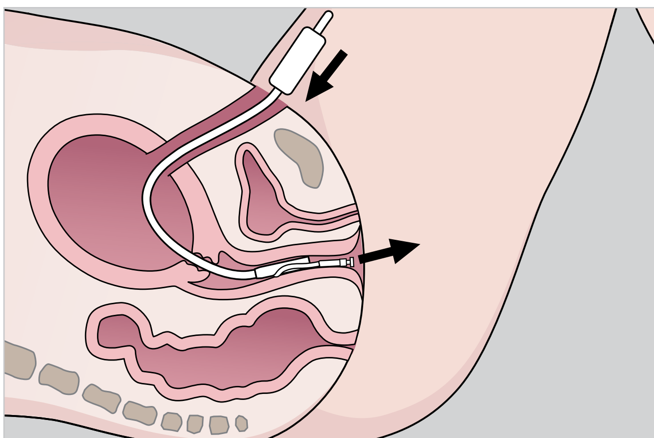

Figure 2: Transabdominal placement, postcesarean delivery

Image 2

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SUMMARY

Postpartum hemorrhage represents a real obstetric emergency and requires a coordinated, skilled response to prevent maternal morbidity or mortality. When reviewing an OB hemorrhage case, the legal nurse consultant should consider the following questions. Was the patient assigned a risk score upon admission? If she was deemed at high risk for bleeding, was a type and screen ordered? Did her risk change during labor? Was she on oxytocin for over 24 hours, or did she become febrile? Were her vital signs and fundus checked frequently? Was the provider notified in a timely manner, or was the chain of command activated? Were uterotonics administered emergently (if part of a standing order) prior to the delivering provider's arrival at the bedside? Was the birth facility compliant with clinical recommendations that were in effect at the time of the incident in question? Understanding postpartum hemorrhage and its treatments and considering these questions will help the legal nurse consultant conduct a thorough analysis of these cases.

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FOR FURTHER INFORMATION

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