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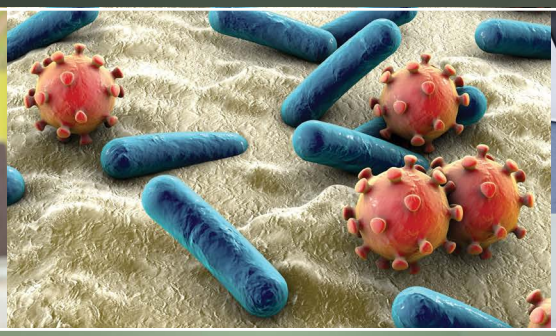


COVID-19

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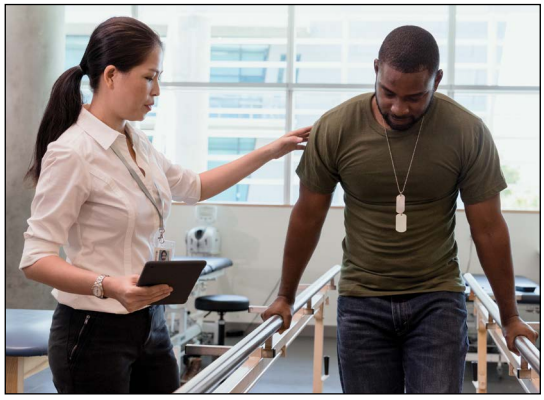



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PURPOSE

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.

The *Journal of Legal Nurse Consulting* is the official publication of the American Association of Legal Nurse Consultants (AALNC) and is a peer reviewed journal. Journal articles express the authors' views only and are not necessarily the official policy of AALNC or the editors of the journal. The association reserves the right to accept, reject or alter all editorial and advertising material submitted for publication.

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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.

INSTRUCTIONS FOR TEXT

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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
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- 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.
- Include a 100-word abstract and keywords on the first page
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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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GENERAL INFORMATION

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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Mary Flanagan,
BSN, RN, CNOR, LNCC

President, AALNC

President's Update

Dear AALNC Members,

As I write this, we have just adjourned our Annual Education and Networking Forum. Every Forum I've had the pleasure of attending was unique in its special way, either for its host city, the quality of its speakers, or enthusiasm of the attendees. This year's Forum was no different in those respects. This year was unique since it was AALNC's first virtual Forum.

The board and I want to recognize the tireless efforts of the Forum Planning Committee led by Sue Point and Susan Carleo in collaboration with our incredible Headquarters team who ensured a world-class virtual experience. Their ability to pivot to a virtual format, while providing LNCs excellence in education and networking opportunities, was inspiring and the Forum had record attendance. Thank you for all the positive feedback, especially from our new attendees and exhibitor partners: it is genuinely appreciated and gratifying.

Another unique AALNC addition is the LNC Ambassador position. We listened to requests for a "go-to" person who can provide answers to questions and offer guidance and support as needed, especially to our newer colleagues. Please join me in welcoming Marjorie Pugatch as our inaugural ambassador-congratulations Margie!

I'm honored to serve as AALNC President this year and follow the many great leader volunteers who preceded me in this important role. Our goal remains the same: to promote your individual growth as a successful LNC no matter when or how you got here. We aim to be your professional home and maintain the highest standards through education, networking, and market visibility. If you are a member, thank you for your continued support of our association. If you're not, come join us! I promise you will not be disappointed.

My call to action: I ask every one of you to promote AALNC in every way you can, whether it be through a conversation with a fellow LNC, attorney colleague, or your own family. Tell them what you do. Tell me what AALNC can do for you! Save the dates for next year's Forum and sock away a little cash to make it happen. If you can dream it, you can do it! We will be right there with you.

I hope you enjoy this latest issue as we introduce Martha Kelso as our new JLNC editor. Martha comes to AALNC with a strong background in writing and publication, and I wish her and our journal committee of devoted volunteers much success. On behalf of the board and staff, welcome Martha! And something else new to this edition- contact hours! You asked, we listened.

I wish everyone reading this a wonderful summer as we all look forward to more halcyon days. And while you enjoy the nice weather, please keep a close eye on your AALNC communications as we roll out our new content hub and information about our second Jumpstart in September.

Don't forget the sunscreen!

Mary Flanagan, BSN, RN, CNOR, LNCC

Editor's Note

Martha R. Kelso
RN, HBOT
Editor, JLNC

Dear Members and Colleagues,

I am honored to be the journal's Editor-In-Chief bringing this groundbreaking issue to print. For my inaugural journal I would like to introduce myself and background. The last few decades of my career have been dedicated to wounds and skin issues .As CEO for a mobile wound care company, I have a relentless devotion to elevate the art and science of wound healing. As a published author, clinical editor for multiple peer reviewed publications, legal expert witness for wound litigation, and a member of several national advisory boards; I cherish being an industry expert bringing new healing modalities to clinical practice. In the wound care arena, I serve as Principal Investigator for clinical research studies working tirelessly to shape the future landscape of healthcare. For those of you involved in wound care, I look forward to connecting soon.

COVID impacted the world like never before and we have yet to see the pandemic's end. The world was sent reeling as our nation fought to understand and get ahead of the most virulent and prolific virus ever known to man. The litigation for plaintiffs and defense is just starting to take shape. The legal side of COVID is a long way from being settled in the outcomes. Court systems are delayed, while state and federal courts continue to determine accountability for employers, healthcare entities, or government agencies, if any, during this unprecedented time. Legal Nurse Consultants (LNCs) are in demand more than ever to help navigate the legal process and current issues surrounding COVID-19. Almost no aspect of the American life went unscathed since the start of the pandemic and those exposed to or affected by COVID are still sifting through protections, or lack thereof. It is why this journal issue is so important to the LNC industry and the manuscripts published inside will help LNCs grasp the complex issues surrounding COVID as it stands thus far.

I want to thank the committee members and the Interim Editor, Julie Dickinson for having the foresight to choose this topic. Our committee's dedication and commitment ensuring the Journal of Legal Nurse Consulting (JLNC) is at the forefront supporting the Legal Nurse Consultant (LNC) as COVID litigation is just commencing is commendable. Another timely addition to this journal issue is the launch of Continuing Education (CE) articles. Readers can earn CEs on selected articles by following the steps listed in this journal and future editions.

Our Fall issue highlighting Forensic Nursing has some interesting articles for our readers. Please email me if you have topics you would like to see considered ifor future journal themes. If you would like to author a manuscript in this peer-reviewed journal, our committee members are happy to help you submit your article. The JNLC Committee is a resource for all aspects of publication for the journal, including mentoring or co-authoring with new authors. Being published in a peer reviewed journal brings credibility to your work. My email address is martha.kelso@aalnc.org. I look forward to hearing from you.

Sincerely,

Martha R Kelso

Martha R. Kelso, RN, HBOT

Considerations When Evaluating COVID-related Medical Malpractice and Personal Injury Cases

Julie Dickinson MBA, BSN, RN, LNCC

Keywords: COVID-19, coronavirus, pandemic, medical malpractice, personal injury

The analysis of medical malpractice and personal injury claims involving the coronavirus pandemic will be exceptionally nuanced given the dynamic medical, advisory, regulatory, and legal factors surrounding this global emergency. While these claims are just starting to be filed and thus state case law is still being established, the considerations discussed in this article may serve as a starting point and a guide for the legal nurse consultant when evaluating medical malpractice and personal injury claims involving incidents arising during the COVID-19 pandemic.

The COVID-19 pandemic will add a significant layer of complexity to the evaluation of legal cases. According to Hunton Andrews Kurth's COVID-19 Complaint Tracker (2021), as of early March 2021, 8,812 COVID-related complaints have been filed since January 30, 2020, which is almost double the 4,744 complaints filed as of September 1, 2020. According to their categorization, 207 of these complaints pertain to health/medical. Of those, 16 are malpractice claims and 138 are wrongful death claims. According to their consumer case

categorization, there have been 30 personal injury and seven wrongful death complaints stemming from exposure to COVID-19 in a public place. These numbers will continue to grow.

It will take at least several years for the initial wave of COVID-related legal cases to work their way through the judicial system and thus for each state to start to build its COVID-19 case law. While each state will set its own legal precedents for COVID-19 cases, there are some general considerations that legal nurse consultants (LNCs) and legal teams should analyze when evaluating liability and causation in COVID-related medical malpractice and personal injury claims.

It will take at least several years for the initial wave of COVID-related legal cases to work their way through the judicial system and thus for each state to start to build its COVID-19 case law.

MEDICAL MALPRACTICE

As with any medical malpractice case, the first step is understanding what liability, if any, the healthcare providers may have. Liability assessment in pandemic-related claims may include but not be limited to possible immunity, gross negligence, crisis/disaster standards of care, other governmental or authoritative standards or guidelines, the subject healthcare provider's experience and expertise vis-à-vis the specialty in which the care in question was rendered, the provider's normal versus crisis scope of practice, other licensure considerations, the mode of care delivery, and any documentation waivers.

For cases involving care rendered during the COVID-19 pandemic, the LNC should research whether the jurisdiction in question granted immunity for healthcare providers. If so, was it in effect at the time the care in question was rendered? What does it cover, and what are its limits? Does the immunity only cover care provided to patients diagnosed with coronavirus, or does it also cover care rendered to any patient during the pandemic (since scarce resource allocation may have been in effect)? In either case, does a healthcare provider or system have to establish that its financial or human resources were negatively affected by the pandemic? Have the immunity provisions changed over time, and if so, what protections were in effect at the time of the care in question? For example, in April 2020, New York State enacted the Emergency Disaster Treatment Protection Act (EDTPA), which "shields health care facilities and professionals from most forms of civil and criminal liability from March 7, 2020, the date of the Governor's COVID-19 emergency declaration, until the emergency declaration expires" (Bopp & O'Neill, 2020, para. 1). In August 2020, New York revised the EDTPA, allowing health care providers and nursing homes to be prospectively "held liable...in lawsuits and criminal prosecutions for care provided to patients that are not being treated for COVID-19" (Berdzik et al., 2020, para. 2).

The legal nurse consultant should also determine whether the subject healthcare provider was a volunteer and, if so, whether there is liability protection under the Coronavirus Aid, Relief, and Economic Security (CARES) Act. Section 3215(a-b) of the CARES Act (2020) states that, with two exceptions (gross negligence and practicing under the influence), "a health care professional shall not be liable under Federal or State law for any harm caused by an act or omission of the professional in the provision of health care services [as a volunteer] during the public health emergency with respect to COVID–19…if…[the] health care services… are within the scope of the license, registration, or certification of the volunteer…" Once the scope and limitations of any immunity are known, the LNC can then evaluate whether the care in question potentially falls under the immunity.

Consideration should also be given to whether the care in question was so egregious (i.e., gross misconduct or intentional acts) that immunity could be excluded. Does the state's immunity act contain any carve backs to this exclusion? In New York's aforementioned original EDTPA, immunity was excluded for willful misconduct, gross negligence, reckless misconduct, or the intentional infliction of harm (Bopp & O'Neill, 2020). However, "acts, omissions or decisions resulting from a resource or staffing shortage [were] explicitly exempted... Consequently, in the event of an overwhelming surge of COVID-19 patients, the EDTPA … shield[ed] health care facilities and professionals from liability if they are forced to triage their limited resources and staff in a way that adversely impacts some patients to the potential advantage of others" (Bopp & O'Neill, 2020, para. 3). Whether there will be protection for simple negligence and not for intentional or willful conduct "may be a significant consideration, because withholding care is an intentional act, taken with the knowledge that it will diminish the patient's hope of recovery" (West, 2020, p. 31).

The LNC should research whether the jurisdiction published and activated "COVID standards" or other similar disaster or crisis standards that were in effect at the time the care in question was rendered.

When evaluating liability, the LNC should also consider how affected the subject healthcare facility was by the pandemic and how this might alter the standards of care, treatment decision-making, and outcomes. At the time in question, was the facility operating under a patient-centered or population-centered standard of care? Consider whether the situation required scarce resource allocation (SRA) or involved another ethical dilemma (such as universal do not resuscitate orders for patients with COVID-19). Were these difficult care decisions made by the provider or by a SRA or ethics committee? Was the facility operating under a surge plan, and if so, what did the plan entail? Does the documentation reflect "if hospital capacity or concern for the nosocomial transmission of COVID-19 factored into any decisions to discharge or admit a patient" (Pensa, 2020, para. 14)? Were typical nurse-to-patient ratios and acuity-based staffing models waived at the time in question?

The LNC should research whether the jurisdiction published and activated "COVID standards" or other similar disaster or crisis standards that were in effect at the time the care in question was rendered. For example, in 2020, Arizona's Department of Health Services (ADHS) published its 3rd edition "Arizona Crisis Standard of Care Plan," which was designed "to provide clear and consistent guidance for allocating scarce healthcare resources during a catastrophic disaster" (2020a, p. 6). In June 2020, ADHS issued an addendum that "specifies statewide triage protocols for acute care facilities during the COVID-19 pandemic. It corresponds with the Arizona Crisis Standards of Care Plan, 3rd edition but offers further guidance to reflect current best practices and recently published evidence on COVID-19" (2020b, p. 1). The ADHS activated these crisis standards of care in late June 2020 (ADHS, 2020c).

Reconciling the patient-centered and population-centered standards of care will be a challenge for courts and juries. For cases involving withheld care, "[t]he plaintiff's expert will testify that the (patient-centered) standard of care is X; the defendant's expert will testify that the (population-centered) standard of care is Y. X and Y cannot be reconciled, because they are apples and oranges. Without clear guidance from the court, it is manifest that juries will be confused by all of this" (West, 2020, p. 31).

In addition to any standards set forth by the applicable government, the LNC should also research any standards or guidelines published by The Centers for Disease Control and Prevention (CDC) or the applicable professional association that were in effect at the time the care in question was rendered. The LNC will then analyze how the subject care compares to these standards.

Additional consideration should be given to the subject healthcare providers. Were they working within their area of experience and expertise, or were they detailed to a different area to help with the crisis? Were there governmental orders issued that waived or reduced certain training or oversight requirements, expanded the scope of practice for certain providers, or allowed flexible reassignments to maximize provider capacity within the healthcare facility? For instance, Texas issued an order allowing "hospitals and facilities associated with Graduate Medical Education (GME) training programs… to utilize [physicians-in-training] permit holders, with proper physician oversight, in areas outside of their GME training program. For example, under these temporary waivers, residents in a surgery residency program can assist in an Emergency Department if a surge of patients is experienced" (Office of the Texas Governor, 2020, para. 1).

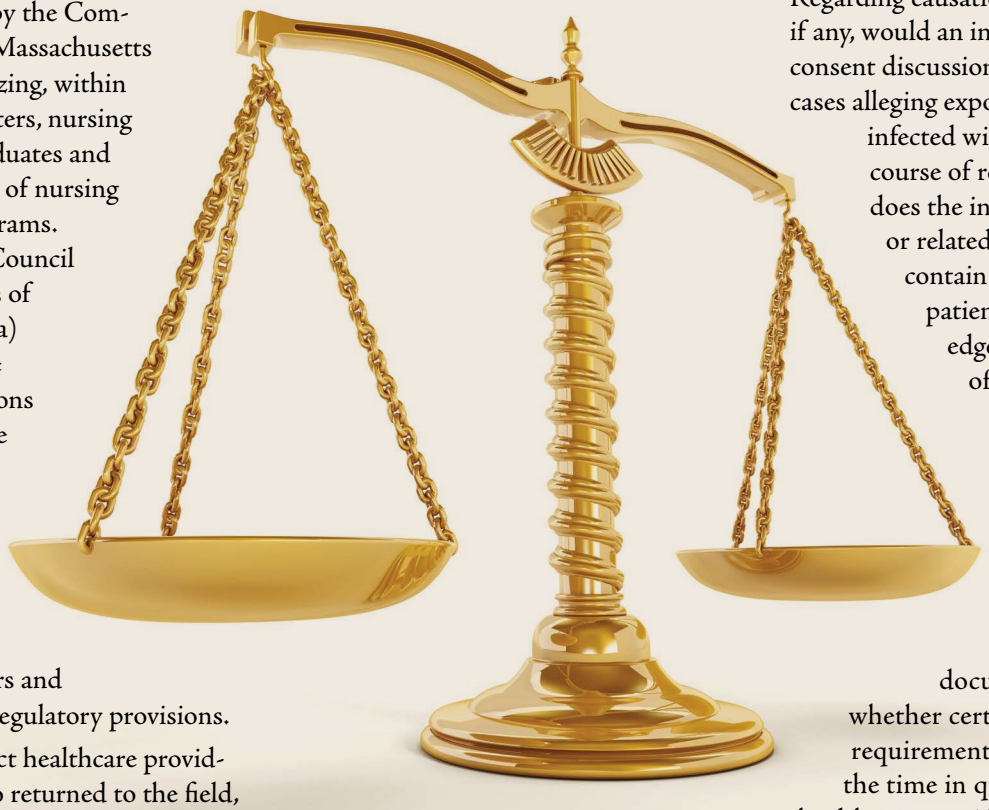
Other healthcare provider licensing considerations include:

- Were the subject healthcare providers licensed to practice in the state in question? If not, did the state have an order in effect at the time the care in question was rendered allowing the individual to provide care in that state? For example, in March 2020, the State of Florida Department of

When reviewing documentation, consider whether certain documentation requirements were waived at the time in question to allow healthcare providers more time to provide more care to more patients.

Health issued Emergency Order 20-002, which stated, "For purposes of preparing for, responding to, and mitigating any effect of COVID-19, health care professionals… holding a valid, unrestricted, and unencumbered license in any state, territory, and/or district may render such services in Florida during a period not to exceed thirty days…" (para. 2). Another example is Order No. 24 issued by the Commonwealth of Massachusetts (2020) authorizing, within certain parameters, nursing practice by graduates and senior students of nursing education programs. The National Council of State Boards of Nursing (2020a) has collated the emergency actions taken across the United States (U.S.), including information about emergency licensing waivers and the applicable regulatory provisions.

- Were the subject healthcare providers retirees who returned to the field, and if so, how long had they been out of the healthcare workforce? What education and re-training, if any, were required by their state's professional regulatory body, and how do those compare to what the provider actually received? Were there any practice limitations or restrictions for these emergency license reinstatements? The National Council of State Boards of Nursing (2020b) compiled exceptions developed by nursing regulatory bodies across the U.S. for inactive/retired licenses in response to the pandemic.
- Did the healthcare provider have an unrestricted professional license or an encumbered license due to disciplinary action? If the latter, did the state's appropriate professional regulatory board (e.g., Board of Nursing) temporarily waive the licensee's disciplinary action during the pandemic? The National Council of State Boards of Nursing (2020c) issued a policy brief on this topic and offered considerations and recommendations for Boards of Nursing when determining whether to waive disciplinary action during the pandemic.



Another liability consideration is whether the care in question was rendered in-person or via chart review, phone call, or video call. If not in-person, was this due to a facility mandate to conserve personal protective equipment (PPE)? What exactly did the mandate state, and is the care in question covered under it? Would the clinical judgment of a similar healthcare provider in a similar circumstance have been to conduct in-person care (i.e., to override the PPE preservation mandate)? These questions also lead to an important causation consideration: What difference in the patient's outcome, if any, may have been possible if the care had been rendered in-person?

There are also considerations when evaluating cases that involve informed consent issues. Was informed consent obtained in-person, via phone call, or via video call? Was it written or verbal? Regarding causation, what difference, if any, would an in-person informed consent discussion have made? For cases alleging exposure to and becoming infected with COVID-19 in the course of receiving healthcare, does the informed consent form or related documentation contain language that the patient/signee acknowledged understanding of and accepted the risk of contracting COVID-19 while under the care of the healthcare entity/provider?

When reviewing documentation, consider whether certain documentation requirements were waived at the time in question to allow healthcare providers more time to provide more care to more patients. For example, the Centers for Medicare and Medicaid Services (CMS) waived one of their usual conditions of participation that requires nursing staff to develop and keep current a nursing care plan for each patient (CMS, 2020, p. 7).

Lastly, for cases alleging negligence in the diagnosis, care, and treatment of COVID, the LNC's medical literature research will need to focus on what information was known, available, and accepted in the medical community at the time the care in question was rendered. The standard of care for the

treatment of COVID evolved as the pandemic continued, as more research was conducted, and as more was known about the virus. The standard of care for treating a COVID (+) patient in March 2020 was very different from now. In these cases, the LNC's causation analysis must include the usual considerations, such as how the patient's other comorbidities played into the outcome and whether the alleged deviation from the standard of care was a proximate cause of the alleged harm.

PERSONAL INJURY

Personal injury cases related to COVID-19 are likely to center around allegations that a business failed to enforce (or improperly enforced) safety rules to minimize the risk of transmission and, thus, the plaintiff contracted coronavirus at the defendant business.

The legal team's evaluation of liability will begin with research on whether the jurisdiction or Federal government granted immunity for businesses from COVID-related litigation. If so, was it in effect at the time of the incident in question? What does it cover, and what are its limits? Does the incident and/or business in question fall under the immunity provisions? Further, did the defendant business's actions rise to the level of gross negligence or willful misconduct such that it would not be covered by the immunity?

The research will also include whether there were any local, state, federal, CDC, or other relevant safety mandates or guidelines in effect for businesses at the time in question. These may include but not be limited to restricting the number of people physically in the business at any one time, engaging in and encouraging social distancing, posting warning signs, and requiring and/or offering face masks (for both employees and customers). How were these guidelines to be enforced? Did the business comply with these rules or guidelines at the time in question?

Another liability consideration is whether the business required those entering the premises to sign a liability waiver (agreeing to waive their right to bring any claims against the business for COVID-related injuries). If so, what are its conditions? Is the subject incident covered under the waiver? The legal team will also need to research whether such waivers are enforceable, as some states will not enforce such prospective liability waivers (Hoffman & Johnson, 2020). "While liability waivers may not provide an absolute defense, other language in the agreement can be used as evidence that the injured party assumed the risk of a COVID-19-related injury — and assumption of risk [may be] a valid defense…" (Hoffman & Johnson, 2020, para. 4). If the defendant business was grossly negligent or acted intentionally, the waiver may not protect the business from being held liable.

A unique issue arising from this unprecedented pandemic is whether Workers' Compensation (WC) will be the sole remedy for employees who allege a workplace exposure resulted in a COVID infection or whether these employees can file a personal injury tort claim against the employer for damages. "Workers' compensation coverage does not necessarily bar lawsuits filed by employees alleging damages arising from workplace exposure to COVID-19" (McKeeby et al., 2020, para. 2). Such tort claims have already been filed, such as Evans v. Walmart, Inc. et al. (2020), which is a wrongful death lawsuit filed in Illinois that alleges an employee contracted COVID while working at the store and died from complications thereof. There are state-specific exceptions to WC being the exclusive remedy for injured workers. Such exceptions may include intentional or deliberate acts by an employer, when an employee waives the right to WC payments upon hire, or when an injury is considered non-compensable under the WC program (McKeeby et al., 2020). Each state will determine these issues through case law or legislation (declaring whether COVID is a compensable injury under WC).

The monumental challenge for plaintiffs bringing COVID infection personal injury suits against defendant businesses will be proving causation. These plaintiffs will have the burden of proving the defendant businesses were the source of their infection, i.e., that they contracted coronavirus at the defendant business on a specific date. To meet this burden, plaintiffs may use contact tracing, which includes identifying those who have had close contact with a person infected with COVID and thus who have had exposure to the virus (CDC, 2020).

A unique issue arising from this unprecedented pandemic is whether Workers' Compensation (WC) will be the sole remedy for employees who allege a workplace exposure resulted in a COVID infection or whether these employees can file a personal injury tort claim against the employer for damages.

SUMMARY

The thorough and effective analysis of medical malpractice and personal injury claims involving the coronavirus pandemic will be exceptionally nuanced given the dynamic medical, advisory, regulatory, and legal factors surrounding this global emergency. Given this rapidly changing environment, it is imperative when evaluating liability that the legal team identify the applicable regulations, guidelines, and other information in effect at the time of the incident in question. While not exhaustive, the considerations discussed in this article may serve as a starting point and a guide for the legal nurse consultant when evaluating medical malpractice and personal injury claims involving incidents that arose during the COVID-19 pandemic.

REFERENCES

Arizona Department of Health Services. (2020a). *Arizona crisis standards of care plan: A comprehensive and compassionate response* (3rd ed.). https://www.azdhs.gov/documents/preparedness/emergency-preparedness/response-plans/azcsc-plan.pdf

Arizona Department of Health Services. (2020b, June 12). *COVID-19 addendum: Allocation of scarce resources in acute care facilities recommended for approval by state disaster medical advisory committee.* https://azdhs.gov/documents/preparedness/epidemiology-disease-control/infectious-disease-epidemiology/novel-coronavirus/sdmac/covid-19-addendum.pdf

Arizona Department of Health Services. (2020c, June 26). *COVID-19 pandemic: Crisis standards of care activation recommendation from state disaster medical advisory committee (SDMAC) and ADHS final determination.* https://www.azdhs.gov/documents/preparedness/epidemiology-disease-control/infectious-disease-epidemiology/novel-coronavirus/sdmac/sdmac-crisis-standards-activation.pdf

Berdzik, C. J., Robinson, L. M., & Berkowitz, J. L. (2020, August 6). *New York rolls back immunity to nursing homes and health care service providers.* Goldberg Segalla. https://www.goldbergsegalla.com/news-and-knowledge/knowledge/new-york-rolls-back-immunity-to-nursing-homes-and-health-care-service-providers

Bopp, C. G., & O'Neill, J. M. C. (2020, April 6). *Emergency disaster treatment protection act lowers the risk to health care facilities and professionals.* Bond Schoeneck & King. https://www.bsk.com/news-events-videos/emergency-disaster-treatment-protection-act-lowers-the-risk-to-health-care-facilities-and-professionals

Centers for Disease Control and Prevention. (2020). *Contact tracing: Frequently asked questions.* https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing-faq.html

Centers for Medicare and Medicaid Services. (2020, December 1). *COVID-19 emergency declaration blanket waivers for health care providers.* https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf

Commonwealth of Massachusetts. (2020). *Order authorizing nursing practice by graduates and senior students of nursing education programs: COVID-19 order no. 24.* https://www.mass.gov/doc/april-9-2020-nursing-school-students/download

Coronavirus Aid, Relief, and Economic Security Act (Public Law 116-136), 134 Stat. 281 (2020).

Evans v. Walmart, Inc. and J2M – Evergreen LLC, Case No. 2020L003938, Cook County, IL (2020). https://www.crowell.com/files/20200406-Compl-Evans-v-Walmart.pdf

Hoffman, I., & Johnson, A. (2020, September 22). *Va. cos. must know the limits of COVID-19 liability waivers.* Law360. https://www.law360.com/personal-injury-medical-malpractice/articles/1312668/va-cos-must-know-the-limits-of-covid-19-liability-waivers?nl_pk=0e32de61-0acd-4a94-ab6b-1ed472a12f51&utm_source=newsletter&utm_medium=email&utm_campaign=personal-injury-medical-malpractice

Hunton Andrews Kurth. (2021). *COVID-19 complaint tracker.* https://www.huntonak.com/en/covid-19-tracker.html

McKeeby, P., Correll, M., Lombardino, M., & Mammone, J. J. (2020, April 30). *Does workers' compensation protect employers from liability arising from workplace transmission of COVID-19?*. Reed Smith. https://www.employmentlawwatch.com/2020/04/articles/employment-us/does-workers-compensation-protect-employers-from-liability-arising-from-workplace-transmission-of-covid-19/

National Council of State Boards of Nursing. (2020a). *State response to COVID-19.* https://www.ncsbn.org/State_COVID-19_Response.pdf

National Council of State Boards of Nursing. (2020b). *NRB exceptions for inactive and retired licenses in relation to COVID-19.* https://www.ncsbn.org/Inactive-and-Retired-License-Changes_COVID-19.pdf

National Council of State Boards of Nursing. (2020c). *Policy brief: Evaluating board of nursing discipline during the COVID-19 pandemic.* https://www.ncsbn.org/Policy-Brief-US-Nursing-Discipline_COVID19.pdf

Office of the Texas Governor. (2020, April 11). *Governor Abbott eases regulations on physicians-in-training to increase health care capacity in Texas.* https://gov.texas.gov/news/post/governor-abbott-eases-regulations-on-physicians-in-training-to-increase-health-care-capacity-in-texas

Pensa, G. (2020, October 23). *Malpractice litigation in the era of COVID-19.* ACEP Now. https://www.acepnow.com/article/malpractice-litigation-in-the-era-of-covid-19/2/?singlepage=1

State of Florida Department of Health. (2020, March 16). *Emergency order 20-002.* https://s33330.pcdn.co/wp-content/uploads/2020/03/filed-eo-doh-no.-20-002-medical-professionals-03.16.2020.pdf

West, J. C. (2020). The crisis standard of care: Considerations for risk management. *Journal of Healthcare Risk Management, 40*(2), 28-33. DOI: 10.1002/jhrm.21441

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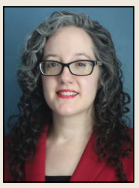

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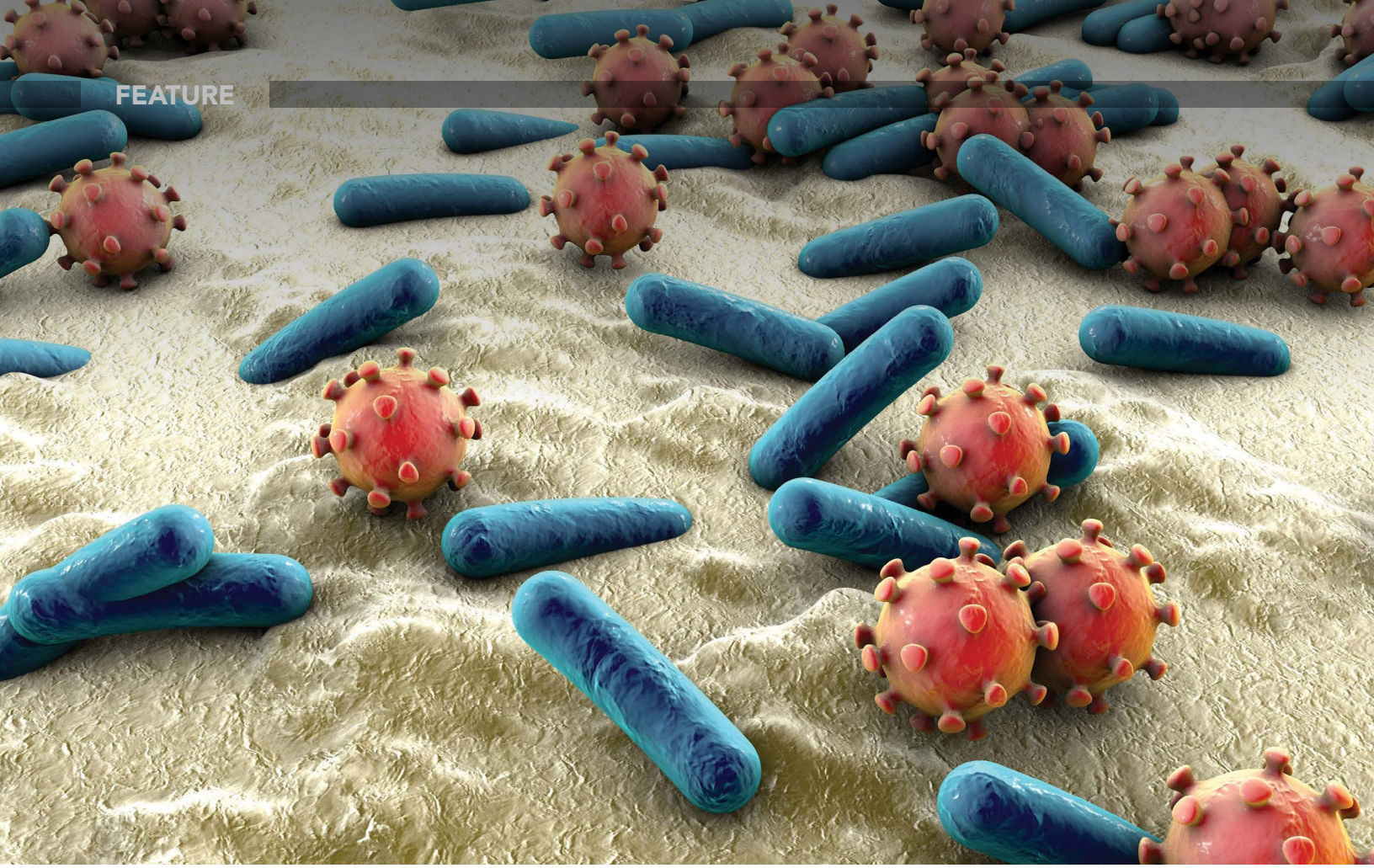

COVID-19-Related Nursing License Complaints

Considerations for LNCs

Hahnah Williams, Esq, RN

Keywords: COVID-19, Nursing License Complaints, Legal Nurse Consultants, Nurse Attorney, License Defense Attorney, Board of Nursing

The COVID-19 pandemic has transformed the nursing profession. It is widely reported that nurses are working longer, unpredictable hours causing burnout, stress, and exhaustion. In addition, some nurses have faced novel practice issues while fighting on the frontline. In some cases, these COVID-19 issues have resulted in complaints being filed against a nurse's license. Legal Nurse Consultants (LNCs) assist with professional license matters in a variety of ways including, serving as expert witnesses, assisting professional license defense attorneys, or working for state boards of nursing. The purpose of this article is to present general information that can be considered by LNCs when assisting with COVID-19 related nursing complaints. This article is not intended to be all-inclusive as there are many factors that should be considered when assessing these issues. No endorsement of any legal strategy is to be inferred from this article.

INTRODUCTION

The rules and regulations governing nursing practice vary by state. There are 59 nursing regulatory bodies in the United States (U.S.) and its territories (NCSBN, 2020). In general, these nursing regulatory bodies are tasked with ensuring public protection by allowing only nurses who are competent and safe to practice in the workforce (Russell, 2017). In doing so, they investigate complaints filed against nurses by employers, patients, consumers, and members of the public. LNCs serve as expert witnesses on behalf of nursing regulatory bodies and nurse defense attorneys by testifying at administrative hearings. Nurse defense attorneys and nursing regulatory bodies also employ LNCs to analyze and evaluate healthcare records and nursing practice guidelines. LNCs who specialize in license matters are uniquely positioned to spot issues, analyze extenuating factors, and evaluate special circumstances when assessing COVID-19 related license complaints.

A COVID-19 related license complaint arises when a complaint is submitted to a nursing regulatory body stemming from a COVID-19 related incident. The legal landscape regarding COVID-19 related license complaints is currently in a state of flux because the U.S. is only one year into the pandemic and many of these issues have not been publicly adjudicated. In addition, there is a dearth of published information regarding these matters. This is largely due to the confidential nature of the regulatory body's investigative file, which generally includes the complaint, the investigative findings, and the nurse's statement. Some state regulatory bodies are required by law to keep their investigative files confidential. For example, Georgia law requires investigative files to be kept confidential for any purpose other than a hearing before the board, and the file may not be released to anyone except for another enforcement agency or lawful licensing authority (Rules of Georgia Board of Nursing, 2021). Given this background, the information presented in this article is largely informed by press releases, news articles, and analysis from professional nursing associations.

COVID-19 RELATED NURSING LICENSE COMPLAINTS

Healthcare professionals have been grappling with a myriad of professional license concerns since the first COVID-19 infection was detected in the United States in January 2020 (TAANA, 2020). According to a recent news article, some of these concerns have culminated into license complaints stemming from COVID-19 related incidents (Basen, 2021). Based on published studies and news reports, COVID-19 related nursing complaints can fall into two categories: Substance or Alcohol Abuse Disorder and Unprofessional Conduct (Brodsky, 2020; National Institute on Drug Abuse, 2020; Basen, 2021).

SUBSTANCE OR ALCOHOL ABUSE DISORDER

It is estimated that approximately ten percent of nurses will develop drug or alcohol dependence; a statistic which falls in line with the general population (Kunyk, 2013). As COVID-19 cases surge across the country, nurses reported burnout, fatigue, and exhaustion. In addition to the stress of frontline work, nurses may experience anxiety, grief, and worry related to their personal experience of coping with the pandemic. Consequently, pandemic-related stress may cause some nurses to experience new-onset drug or alcohol use disorder (McCormick, 2020). Additionally, nurses with existing substance or alcohol use disorders may be vulnerable to relapse during the pandemic (Brodsky, 2020; National Institute on Drug Abuse, 2020). Many nursing boards have "Alternative to Discipline" (ATD) programs for nurses with substance or alcohol use disorders. In general, ATD programs allow nurses to remain licensed while being closely monitored through a variety of license restrictions and parameters. ATD programs have had success with assuring public protection while allowing nurses to maintain their license as they undergo rehabilitation (NCSBN, 2011).

In the face of the pandemic, questions have arisen regarding whether special consideration should be given to addicted nurses who relapse due to frontline work or pandemic-triggered stress. There are also questions about the level of consideration that should be given to nurses who develop addictions triggered by pandemic stress. Some nursing boards rely on board certified addictionologists to make these determinations. Nevertheless, LNCs play an essential role in identifying and analyzing issues that can be further considered by the state regulatory body while assessing these matters. The following are some key factors the LNC can consider when analyzing pandemic-related drug/alcohol abuse claims:

1. The timing of the drug/alcohol abuse disorder; e.g., did the disorder develop during the pandemic?

LNCs who specialize in license matters are uniquely positioned to spot issues, analyze extenuating factors, and evaluate special circumstances when assessing COVID-19 related license complaints.

Nurses can be accused of substandard care after providing nursing care to a COVID-19 patient. The American Nurses Association (ANA) surveyed more than 30,000 nurses across the country and 32% reported that they are not prepared to provide care for a COVID-19 patient (ANA, 2020).

2. Experience as a frontline worker; e.g., has the nurse experienced any psychological trauma related to frontline work?
3. The extent of the drug/alcohol abuse disorder; e.g., did the nurse divert medications from an employer or report to work while impaired?
4. The scope of treatment; e.g., did the nurse voluntary seek and successfully complete treatment?
5. Participation in addiction counseling; e.g., did the nurse voluntary seek and successfully complete addiction counseling?
6. Re-triggering addiction; e.g., was the nurse previously diagnosed with drug/alcohol addiction in the past and experienced a long period of abstinence prior to the pandemic?
7. Availability of resources; e.g., was the nurse's aftercare treatment or psychotherapy counseling disrupted due to pandemic-related administrative issues?
8. Support from superiors and colleagues; e.g., did the nurse's superiors and/or colleagues submit written letters of support attesting to the nurse's ability to practice safely while receiving drug or alcohol treatment?
9. Self-reporting and personal accountability; e.g., did the nurse self-report the drug or alcohol abuse disorder or otherwise take personal accountability?
10. Board certified addictionologist report; e.g., should the nurse be evaluated by a board certified addictionologist to assess the nurse's ability to practice safely?

UNPROFESSIONAL CONDUCT

The Georgia Board of Nursing defines unprofessional conduct as "nursing conduct failing to meet the minimal standards of acceptable and prevailing nursing practice, which could jeopardize the health, safety, and welfare of the public" (Rules of Georgia Board of Nursing, 2021). Other state nursing boards have similar definitions. There are several examples of unprofessional conduct. This article focuses on COVID-19 related nursing complaints that allege substandard care or patient abandonment as unprofessional conduct.

SUBSTANDARD CARE

Nurses can be accused of substandard care after providing nursing care to a COVID-19 patient. The American Nurses Association (ANA) surveyed more than 30,000 nurses across the country and 32% reported that they are not prepared to provide care for a COVID-19 patient (ANA, 2020). While this issue may seem to fall on the employer for ineffectively training the nurse, some state nursing laws require nurses to ensure they are competent to accept a patient assignment. For example, Georgia law lists the following as acceptable standards of practice for RNs:

- Accept responsibility for individual nursing actions and continued competence
- Seek education and supervision as necessary when implementing nursing practice techniques
- Seek educational resources and create learning experiences to enhance and maintain current knowledge and skills appropriate to her/his area of practice
- Assign and supervise only those nursing measures which the nurse knows, or should know, that another person is prepared, qualified, or licensed to perform
- Retain professional accountability for nursing care when delegating nursing intervention

(Rules of Georgia Board of Nursing, 2021). In addition, Georgia law defines "unprofessional conduct" to include:

- Assuming patient care responsibilities that the nurse lacks the education to perform, for which the nurse has failed to maintain nursing competence, or that are outside the scope of practice of the nurse
- Accepting the assignment of nursing functions or a prescribed health function when the acceptance of the assignment could be reasonably expected to result in unsafe or ineffective client care
- Making assignments and delegations that are beyond the scope of the abilities of the person to whom the task is assigned
- Failing to properly supervise a nurse to whom a task was assigned, particularly if the nurse manager was aware or should have been aware, that the employee was not competent to perform the task

(Rules of Georgia Board of Nursing, 2021). These Georgia laws exemplify how nurses can face license complaints for substandard care while caring for COVID-19 patients in unfamiliar or emergent settings. There has been a push for states to adopt laws that protect healthcare professionals from medical malpractice liability associated with COVID-19 care (AMA, 2020). In response, some states promulgated immunity laws or released executive orders, including but not limited to New York, New Jersey, Michigan, Massachusetts, Illinois, and Connecticut (Kang, 2020). Notwithstanding, there appears to be no published information on whether any nursing regulatory bodies have promulgated regulations or released guidance granting license immunity for nurses who face license complaints for substandard care related to the care of a COVID-19 patient.

PATIENT ABANDONMENT

Complaints of patient abandonment typically allege that the nurse deserted a patient with whom the nurse established a provider-patient relationship without making reasonable arrangements for continuing care (NSO, 2017). Seventy-two percent of the nurses surveyed by ANA reported that they were either extremely concerned or moderately concerned about staffing and 64% reported that they were working short or without necessary staff (ANA, 2020). In these cases, the nurse may refuse a staffing assignment that they believe is unsafe. Consequently, the nurse can be accused of patient abandonment and reported to their licensing board.

Some may argue that the nurse should not be subject to a license complaint unless a patient-provider duty was established prior to the nurse refusing the assignment. However, it is important to recognize that a nursing complaint can be filed against any nurse regardless of merit. Specifically, nursing regulatory boards investigate complaints to determine if they have merit. And the nurse must defend themselves in the investigation by hiring a defense attorney or defending themselves pro se. In the case of patient abandonment, some nursing regulatory boards have defined "patient abandonment" in their state laws or published guidance documents. For example, the New York State Education Department (NYSED) released guidance describing patient abandonment as when:

- A nurse, who has accepted a patient care assignment and is responsible for patient care, abandons or neglects a patient needing immediate professional care without making reasonable arrangements for the continuation of such care

- A nurse abandons nursing employment without providing reasonable notice and under circumstances that seriously impair the delivery of professional care to patients

NYSED states that the following are key considerations for determining whether a nurse has "abandoned" a patient:

- Whether the nurse accepted the patient assignment, which established a nurse-patient relationship
- Whether the nurse provided reasonable notice when severing the nurse-patient relationship
- Whether reasonable arrangements have been made for the continuation of nursing care by others when proper notification is given (NYSED, 2015).

CONSIDERATIONS FOR LNCS

Given the dynamic challenges presented by the pandemic, there are several factors that should be considered when assessing COVID-19 related nursing license complaints, including but not limited to ethical dilemmas such as rationing care, involuntary resignations/terminations, reasonable accommodation requests, Personal Protective Equipment (PPE) concerns, personal safety concerns, Health Insurance Portability and Accountability Act of 1996 (HIPAA) concerns, and mental health issues (TAANA, 2020). The following are some considerations that the LNC can consider when assisting with a COVID-19 related nursing license complaint:

- For allegations of drug/alcohol use disorder or relapses, the LNC should assess whether the incident occurred during the early stages of the pandemic (April 2020 to September 2020). The LNC should also evaluate the extent to which drug treatment programs were available to the nurse. During the pandemic, some drug treatment and monitoring programs have been modified or limited in many states due to infection control policies, shelter-in-place periods, and limited scheduling availability.
- For allegations of substandard care, the LNC should also assess whether the incident involves a nurse who was asked to care for a patient outside of the nurse's specialty. It has been reported that nurses are being floated

to units outside their specialties to cover staffing shortages. The LNC should also note whether the nurse accepted the assignment despite their concerns about competency due to fear of retaliation.

- Nurses may be accused of failing to maintain a patient record that accurately reflects the nursing assessment, care, treatment, and other nursing services provided to the patient. In these cases, the LNC should consider whether the facility instituted any new practice policies related to documentation, medication handling, and PPE preservation. These new policies or practices may be unwritten but are evident in the unit's culture or informal directives given to nurses by their superiors.
- For allegations of patient abandonment, the LNC should first review the state's law or guidance on patient abandonment. Next, the LNC should analyze special considerations such as whether the complaint involves a nurse who refused an assignment due to patient safety concerns, such as a higher than typical patient-to-nurse ratio or being asked to care for a patient that the nurse lacked competency to care for. Another factor that can be assessed is whether the nurse informed a superior that the nurse was leaving before leaving the patient care area.

CONCLUSION

The LNC can play a critical role in assisting with COVID-19 related license complaints. These issues can ultimately assist state nursing regulatory boards with disseminating guidance related to a nurse's professional responsibility during the pandemic. In addition, the LNC can assist the professional license defense attorney with defending these matters. Indeed, the LNC's work can help find an appropriate resolution to these complaints that reasonably and legally balances all interests.

REFERENCES

American Medical Association. (2020). Liability protections for healthcare professionals during COVID-19. https://www.ama-assn.org/practice-management/sustainability/liability-protections-health-care-professionals-during-covid-19

American Nurses Association. (2020). COVID-19 Survey, March 20-April 10. https://app.powerbi.com/view?r=eyJrIjoiNTY0YjRmOGEtMThmZC00NDQwLWFlMWMtMWE5YmJkMmM2ODNiIiwidCI6ImI3MTQ5MGE1LTc1MjUtNDRhOS1iYjIxLTYyZTg5ZjhkYjY1MCIsImMiOjF9

Basen, R. (2021). Is nursing board discipline getting more aggressive? Texas Board epitomizes national trend, with nurses seeing campaign of intimidation. *MedPage Today*. https://www.medpagetoday.com/special-reports/exclusives/91322?vpass=1

Brodsky, R. (2020). Experts fear coronavirus crisis putting those recovering from addictions at risk. *Newsday*. https://www.newsday.com/news/health/coronavirus/coronavirus-addictionrecovery-1.43321190

Kang, Y. Peter. (2020). 6 States with COVID-19 medical immunity and 2 without. *Law360*. https://www.law360.com/articles/1264964/6-states-with-covid-19-medical-immunity-and-2-without

Kunyk, D. (2015). Substance use disorders among registered nurses: prevalence, risks and perceptions in a disciplinary jurisdiction. *Journal of Nursing Management, 22*(1), 54–64.

McCormick, M. (2020). COVID-19 fuels anxiety and substance use disorder among healthcare professionals. *Caron*. https://www.caron.org/blog/covid19-fuels-anxiety-and-substance-use-disorder-among-healthcare-professionals

National Council of State Boards of Nursing. (2011). Substance use disorder in nursing: A resource manual and guidelines for alternative and disciplinary monitoring programs. https://www.ncsbn.org/770.htm

National Council of State Boards of Nursing. (2020). U.S. Members. https://www.ncsbn.org/member-boards.htm

National Institute on Drug Abuse. (2020). COVID-19: Potential implications for individuals with substance use disorders. https://www.drugabuse.gov/about-nida/noras-blog/2020/04/Covid-19-potential-implications-individuals-substance-use-disorders

New York State Education Department (NYSED). (2015). Practice Information. Abandonment of patients who need care. http://www.op.nysed.gov/prof/nurse/nurse-patientabandonment.htm#

Nurses Service Organization. (2017). *The Ins and Outs of Patient Abandonment*. https://www.nso.com/Learning/Artifacts/Articles/the-ins-and-outs-of-patient-abandonment

Ulrich, C.M., Rushton, C.H., & Grady, C. (2020, November/December). Nurses confronting the coronavirus: Challenges met and lessons learned to date. *Nurs Outlook, 68*(6), 838-844. https://doi.org/10.1016/j.outlook.2020.08.018

Rules of Georgia Board of Nursing, 410-10-.01(2)(b) (2021); 410-10-.03 (2021); 410-10-.03(2) (2021).

Russell, K.A. (2017). Nurse practice acts guide and govern: Update 2017. *Journal of Nursing Regulation, 8*(3) 18-25.

Williams, H., Grant, P., and Kent, K. (2020). TAANA's Position Paper on COVID-19; Advocating for NURSES and other Healthcare Professionals licensed throughout the United States of America. *TAANA*. https://www.taana.org/resource/papers/8875590

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Nursing Home COVID-19 Litigation:

Regulation vs. Reality

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Keywords: Nursing Homes, COVID-19, Nursing Home Liability

The COVID-19 pandemic disproportionately impacted the elderly population. This is especially true of elderly in congregate living communities such as nursing homes or long-term care facilities. Nursing homes have long-standing requirements for infection control programs and emergency preparedness plans. Despite these regulations, the United States has seen staggering death tolls among elderly people in nursing homes. This article will provide a broad overview of pre-pandemic regulations, a glimpse into nursing home care's reality during the pandemic, and implications for legal nurse consultants.

INTRODUCTION

As the COVID-19 pandemic swept through the United States in early 2020, one fact became increasingly clear: the elderly population was disproportionately affected. In our country's nursing homes, the death toll quickly skyrocketed in this vulnerable population due to congregate living. As the death numbers rose, so did the number of potential lawsuits against these facilities.

This article will offer a brief overview of the pre-pandemic regulatory landscape for nursing facilities, a glimpse of COVID-19 reality in nursing facilities, and implications for legal nurse consultants.

PRE-PANDEMIC REGULATORY LANDSCAPE

The details of all state and federal nursing home regulations are beyond the scope of this article. Rather, a few regulations which are commonly discussed when analyzing nursing home standards as they relate to the COVID-19 pandemic are reviewed. These regula-

tions apply to facilities licensed by and receive reimbursement from Medicare and Medicaid.

At the federal level, nursing facilities are governed by statute 42 CFR § 483. Among the regulations, 42 CFR § 483.80 sets forth requirements for infection prevention and control. In part, this regulation states: "The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections" (42 CFR § 483.80, para 1). The implications for COVID-19 related litigation maintain a facility retain responsibility for ensuring the development and implementation of an infection control program to decrease risk of disease transmission.

In 2016, the federal government issued a Final Rule to improve quality of care in our nation's nursing homes. The 2016 Final Rule was broad and new regulations were rolled out in three phases-Phase 1 (2016), Phase 2 (2018), and Phase 3 (2019). One of the new regulations in Phase 3, require an Infection Preventionist (IP) be designated at each facility (42 CFR 483.80(a)). The regulation requires the facility designate "one or more individual(s)" with "specialized training in infection prevention and control" (42 CFR 483.80 (b)). This regulation was to enhance already existing infection control requirements. Again, the implications for nursing home COVID litigation are apparent. With the enactment of the IP regulation, nursing homes are expected to have the most robust infection control program ever required by the Centers for Medicare and Medicaid Services (CMS). The nursing homes' deadline to meet this standard was November 2019, just a few months before the COVID-19 pandemic started to sweep across the nation.

Nursing facilities are also subject to Emergency Preparedness Program regulations, requiring the facility to develop and implement a plan with strategies to address emergency events using an "all hazards approach" (42 CFR 483.73(a)(1)). To assist nursing facilities with implementation of Emergency Preparedness Program requirements, CMS issued Appendix Z of the State Operations Manual (SOM), which details implementation guidance. Furthermore, Appendix Z defines an emergency preparedness program as "a facility's comprehensive approach to meeting the health, safety and security needs of the facility, its staff, their patient population, and community prior to, during, and after an emergency or disaster" (CMS SOM Appendix Z, definitions).

In February of 2019, almost one year before the COVID-19 pandemic, CMS issued a memo advising providers of updates to Appendix Z. One of these updates expanded the definition of an "all hazards" approach to include "emerging infectious diseases" (CMS QSO, February 1, 2019, para 2). In the memo, CMS gave providers examples of emerging infectious diseases (EID) which included Zika Virus and Ebola, and further stated, "…we believe that facilities should consider preparedness and infection prevention within their all-hazards approach, which covers both natural and man-made disasters" (CMS QSO, February 1, 2019, para 2). Again, this was nearly one year before the beginning of the COVID-19 pandemic; therefore, the implication for COVID-19 related litigation is simple: facilities had months to prepare for the pandemic after being specifically required to develop a plan for EIDs.

COVID-19 REALITY

It is not possible to discuss every aspect of COVID-19 reality in the nursing home setting during the pandemic. Instead, we will examine three areas which present particular challenges for facility operations. These areas include changing guidance from CMS, shortages of personal protective equipment (PPE) and staff, and cross-traffic transmission issues. Many other factors have complicated operations of nursing homes during the pandemic but are too numerous to mention here.

CMS first issued a provider memo about COVID-19 on February 6, 2020 (CMS QSO, February 6, 2020). This memo advised providers about the "emerging 2019 Novel Coronavirus" threat and encouraged facilities to review the Centers for Disease Control and Prevention (CDC) information about the virus (CMS QSO, February 6, 2020, para 1). CMS advised facilities to "take steps to prepare" due to concerns the coronavirus would rapidly appear and spread (CMS QSO, February 6, 2020, para 1). Then, on March 4, 2020, CMS notified all providers they would suspend all non-emergency survey activities across the country to allow inspectors to "turn their focus on the most serious health and safety threats like infectious diseases and abuse" (CMS QSO, March 4, 2020, para 2). A nursing home-specific memo also went out on March 4, 2020, which advised facilities to adopt CDC guidelines, limit visitors, screen staff members, and when to transfer residents to the hospital (CMS QSO, March 4, 2020, pages 1-3). Although necessary, CMS's guidance presented operational challenges for nursing homes including how to implement visitor screening processes, as well as screening employees for potential respiratory infections. On March 10, 2020, CMS recommended patients with known or suspected COVID-19 be cared for in a single person room with the door closed (CMS QSO, March 10, 2020, page 2, bullet 3). Again, this presented an operational challenge for facilities with high occupancy and few empty rooms. Facilities had to develop plans to separate posi-

tive and suspected positives from other residents within the facility.

Then, on March 13, 2020, CMS issued yet another provider memo instructing facilities to restrict all visitors and non-essential health care personnel (CMS QSO, March 13, 2020, page 2, para 5). Facilities were also instructed to cancel communal dining and group activities as well as implement a system for screening all residents and staff for fever and respiratory symptoms (CMS QSO, March 13, 2020, page 3, Additional Guidance). Once again, these requirements presented operational challenges for facilities. With the cancelation of communal dining, facilities were no longer able to supervise a dining room full of residents with just a few staff members. Instead, the facility had to develop a system to ensure adequate supervision to all residents who were now eating in their rooms. This included residents at high risk for aspiration and those functionally dependent on staff for eating assistance. With the cancelation of group activities came additional work for activity staff to ensure residents were provided with 1:1 activity to promote mental stimulation and recreation. With the restriction of visitors, social services had to develop and implement systems to ensure residents could still engage in meaningful interaction with their loved ones. Operationally, these challenges required increased manpower and resources to develop and implement new systems to meet new requirements, all while screening residents and employees for respiratory symptoms. With every suspected employee respiratory infection came challenges for the staffing schedule.

As if all of that was not enough, on March 20, 2020, CMS announced the rollout of "infection control surveys" subjecting facilities to department of health inspectors evaluating the adequacy of infection control procedures (CMS QSO, March 20, 2020, page 1, bullet 5). These surveys placed further strain on nursing facilities around the country. One of the most widely reported outbreaks in a nursing facility was at Life Care Center of Kirkland, Washington. In fact, this is the first known nursing facility outbreak. In a November 2020 interview with 60 Minutes, the Vice President of Life Care Centers of America stated over 400 hours of staff time were diverted when CMS came to investigate the outbreak (CBS News, 2020, para 60).

The perpetual changes from CMS did not stop in March 2020. These provider memos routinely came to facility leadership with more and more requirements which created challenges for an already strained nursing home industry.

Another crisis impacting many nursing facilities was shortage of staff and personal protective equipment (PPE). In an August 2020 article published by Health Affairs, McGarry et al. found "one in five facilities faced a staff shortage or a severe shortage of PPE in early July 2020" (McGarry. Grabowski & Barnett, 2020, Discussion, para 1). This same article concluded "many" nursing facilities in the United States are "poorly prepared to prevent and manage COVID-19 outbreaks, given a lack of essential PPE and staff" (McGarry. Grabowski & Barnett, 2020, Conclusion). Even after months of actively battling the pandemic, many nursing facilities were still facing critical staffing and PPE shortages.

In a letter published in Infection Control and Hospital Epidemiology, Seshadri et al. discussed research showing nursing home workers "felt their workplaces had failed them" (Seshadri et al., 2020, para 4). The same publication discussed inadequate amounts of PPE among the frontline staff feeling their employers did not protect them (Seshadri et al., 2020, para 3).

In September 2020, the Senate Finance Committee published a report entitled, "COVID-19 and Nursing Homes: What Went Wrong and Next Steps" (Senate Finance Committee, September 2020). This publication highlighted reports of nursing home staff "having to purchase their own personal protective equipment, or reuse the same isolation gown throughout their shifts" (Senate Finance Committee, September 2020, page 33, para 2). The same report noted some nursing home staff members were relying on "rain ponchos" instead of isolation gowns (Senate Finance Committee, September 2020, page 33, para 2). Widespread reports of PPE and staffing shortages have plagued the media coverage of COVID-19 in nursing homes.

Another issue contributing to the transmission of COVID-19 in nursing homes was "cross-traffic." Cross-traffic is essentially the sharing of staff between multiple facilities. This is a very common practice in the nursing home industry. The March 13, 2020 CMS provider memo instructed facilities to identify staff working at multiple facilities and restrict them as appropriate to reduce the spread of COVID-19 (CMS QSO, March 13, 2020, page 3, Additional Guidance). In an article published in July 2020, researchers used smartphone location data to analyze COVID-19 transmission and found "individuals moving between nursing homes is a significant predictor" of COVD-19 infections (Chen, Chevalier & Long, 2020, page 13, para 1). A New England Journal of Medicine article cited "staff who worked in more than one facility" as a contributing factor in the spread of COVID-19 (McMichael et al., 2020, Results, para 2).

Nursing homes have faced multiple operational challenges during the COVID-19 pandemic which include CMS guidance changes, PPE and staffing shortages, and cross-traffic transmission from staff members working at multiple facilities. The myriad of

operational challenges detailed above added more strain to a nursing home industry already in crisis.

IMPLICATIONS FOR LEGAL NURSE CONSULTANTS (LNCS)

As the pandemic swept the nation, so did negligence lawsuits against nursing homes. An October 2020 ABA Journal article noted a "major theme" of COVID-19 lawsuits is "families are angry about what they see as a lack of transparency and honesty by nursing homes in the days leading up to their loved one's death" (Meyer, 2020, Key Strategy Qualifiers, para 5).

One important aspect of record reviews LNCs must consider is where the incident date fits into the overall COVID-19 timeline, i.e., reported novel coronavirus transmission across the United States as well as federal and state regulatory guidance. Here are some factors to consider:

- What was known about the transmission of COVID-19 at the time of the incident?
- Was the virus known to be in the relevant geographical region at the time?
- What guidance had been issued by CMS, CDC, and state level departments of health at the time of the incident?
- How do the facts of the patient's case fit into the bigger picture?

Another important consideration is to determine how widespread the COVID-19 outbreak was in a particular nursing home. Is it an issue of a few cases or deaths versus widespread outbreak with many cases or deaths? Along these same lines, it is also important to look at the facility's regulatory citation history. Has the facility been subject to recent infection control citations? Does the facility have repeated history of failing to meet regulatory requirements for infection prevention? Alternatively, does the facility have a clean regulatory history with little to no infection control compliance issues?

One of the most important aspects of these cases will be to examine the measures taken (or not) by the facility to prepare prior to their first COVID-19 case. This will be a major point of examination by both plaintiff and defense teams. As in all negligence lawsuits, documentation will be key. Facilities need to demonstrate compliance with infection control and emergency preparedness regulations. Readiness plans should have been in place years before the pandemic. Next, facilities should demonstrate revisions to emergency preparedness policies and procedures after the February 1, 2019 CMS memo advising facilities to include EIDs. Finally, once the pandemic hit, facilities must show due diligence with attempts to acquire adequate staff, adequate PPE levels, compliance with CMS guidance, as well as compliance with CDC recommendations. LNCs can support their attorney clients by assisting in the analysis of this documentation.

Discussion of the LNCs role in nursing home COVID litigation would not be complete without referring to the many immunity declarations which have been issued to protect providers. On the federal level, the Department of Health and Human Services (DHHS) issued a 2020 PREP Act which provides immunity for "activities related to medical countermeasures against COVID-19" (DHHS, 2020, para 1). From the outset, there are questions as to the scope and applicability of the COVID-19 PREP Act (Przymusinski, 2020, para 2). Some nursing home defense teams claim liability protections under the federal Public Readiness and Emergency Preparedness Act. These claims come with requests to remove cases to federal courts where defense teams hope to achieve more favorable outcomes for

their nursing home clients. Courts are beginning to weigh in on the scope and applicability of the 2020 PREP Act.

In a September 2020 decision, the United States District Court of Central California remanded a nursing home case back to state courts stating: "Defendants argue that they meet this standard for basically the same reasons that they think there is complete preemption. But the raised federal issue is Defendants' defense, not the actual claims made by Plaintiffs. Defendants also make no attempt to show that this particular case raises substantial questions important to 'the federal system as a whole,' and it is clear that it does not" (Martin v. Serrano, 2020).

In a Pennsylvania case, Gill et al. v. Comprehensive Health Care Management Services LLC, the defense argued the following in a January 4, 2021 brief to the court: "Plaintiffs cannot 'plead around' immunity simply by inserting the word 'failure'. If the decision not to provide certain care (even if true) is the decision, it is still protected under the PREP Act as a matter of law." The defense brief continues, "The reasonableness of this discretionary authority is underscored by the fact that experts from the WHO, CDC, and other public and private

organizations issue constantly evolving recommendations, guidance, and advice based on the science of the moment. In fact, expert advice concerning when to provide countermeasures and whether to 'use' covered countermeasures is often conflicted, and program planners must make the best decisions they can using the best available information" (Gill et al. v. Comprehensive Health Care Management Services LLC, 2021).

States across the country have also enacted immunity provisions to protect providers from the threats of lawsuits. One example of a state level immunity provision is that of New York. New York Article 30-D was enacted to "promote public health" by "…broadly protecting the health care facilities and health care professionals in this state from liability that may result from the treatment of individuals with COVID-19" (New York Article 30-D, 2020, Declaration of Purpose). This immunity declaration was issued at the beginning of March 2020 with an executive order which provided additional immunity provisions. One of the many provisions provided by the governor's executive order stated, "health care providers are relieved of recordkeeping requirements to the extent necessary for health care providers to perform tasks as may be necessary to respond to the COVID-19 outbreak…" (State of New York Executive Order, 2020, Number 202.10, para 16). On February 25, 2021, the New York Assembly proposed legislation which would repeal Article 30-D (New York, Senate Bill S5177, 2020). This bill was signed into law on April 6, 2021 (Y. Peter Kang, 2020, para 5). The implication of this type of immunity provision is obvious for LNCs analyzing New York nursing home claims. The LNC might very well encounter issues reviewing records because providers were "relieved" of recordkeeping obligations. As of September 2020, more than a dozen states had passed legislation which protect healthcare providers (Dowdell, 2020, Current Legislation, para 1).

CONCLUSION

The COVID-19 Pandemic is unlike anything ever experienced by nursing homes across the United States. Legal teams will be discerning which cases meet the criteria of "negligence" and/or "gross negligence" depending on the state's immunity provisions. Defense teams will rely heavily on the unprecedented nature of the pandemic as well as overwhelming amounts of CMS and CDC guidance to explain negative patient outcomes. Alternatively, plaintiff teams will likely attempt to show nursing facilities had ample time to prepare for the pandemic but chose not to devote adequate resources to the preparation resulting in negative patient outcomes. LNCs must review the available documentation, analyze the facts, and make determinations about whether these nursing facilities adhered to or deviated from recognized standards of care.

REFERENCES

CBS News. (2020,11.); *Lack of Readiness, Questionable Federal Inspection Helped Fuel First U.S. COVID-19 Outbreak.* https://www.cbsnews.com/news/covid-19-outbreak-nursing-facility-kirkland-washington-60-minutes-2020-11-01/

Centers for Medicare and Medicaid Services, C. M. S. (2019). *State Operations Manual Appendix Z Emergency Preparedness for All Provider and Certified Supplier Types.* Centers for Medicare and Medicaid Services. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/Advanced-Copy-SOM-Appendix-Z-EP-IGs.pdf

Chen, M. K., Chevalier, J. A., & Long, E. F. (2020). *Nursing home staff networks and COVID-19* (No. w27608). National Bureau of Economic Research.

CMS QSO. (2019, 2) https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO19-06-ALL.pdf

CMS QSO. (2020, 2) https://www.cms.gov/files/document/qso-20-09-all.pdf

CMS QSO. (2020, March 4-All Providers) https://www.cms.gov/files/document/qso-20-12-all.pdf

CMS QSO. (2020, March 4-Nursing Homes) https://www.cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and/qso-20-14-nh.pdf

CMS QSO. (2020, March 10) https://www.cms.gov/files/document/qso-20-17-all.pdf

CMS QSO. (2020, March 13) https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf

CMS QSO. (2020, March 20) https://www.cms.gov/files/document/qso-20-20-all.pdf

Code of Federal Regulations. (2019) *42 CFR 483.73-Emergency Preparedness.* https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol5/xml/CFR-2019-title42-vol5-sec483-73.xml

Code of Federal Regulations. (2019) *42 CFR 483.80-Infection Control.* https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol5/xml/CFR-2019-title42-vol5-sec483-80.xml

Code of Federal Regulations. (2019) *42 CFR 483.80(b)-Infection Preventionist.* https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol5/xml/CFR-2019-title42-vol5-sec483-80.xml

Department of Health and Human Services. (2020) *Declaration Under the Public Readiness and Emergency Preparedness Act for Medical Countermeasures Against COVID-19.* https://www.federalregister.gov/documents/2020/03/17/2020-05484/declaration-under-the-public-readiness-and-emergency-preparedness-act-for-medical-countermeasures

Dowdell, Paul (2020) Immunity from Liability in the Age of COVID-19: A New Reality of Trial Lawyers?; ABA Journal; available at: https://www.americanbar.org/groups/litigation/committees/trial-practice/articles/2020/immunity-from-liability-covid-19-trial-lawyers/

Federal Register. (2016) *Final Rule for Long Term Care Facilities.* https://www.federalregister.gov/documents/2016/10/04/2016-23503/medicare-and-medicaid-programs-reform-of-requirements-for-long-term-care-facilities

Gill et al. v. Comprehensive Health Care Management Services LLC, case number 2:20-cv-01754, in the U.S. District Court for the Western District of Pennsylvania. As discussed in Law360 (2021) https://www.law360.com/articles/1341506/pa-nursing-home-seeks-fed-immunity-from-covid-19-suit

Martin v. Serrano Post Acute LLC, 2020 BL 346502, C.D. Cal., No. 20-cv-5937, 9/10/20 https://www.courtlistener.com/recap/gov.uscourts.cacd.787177/gov.uscourts.cacd.787177.34.0.pdf

McGarry, B. E., Grabowski, D. C., & Barnett, M. L. (2020). Severe staffing and personal protective equipment shortages faced by nursing homes during the COVID-19 pandemic: Study examines staffing and personal protective equipment shortages faced by nursing homes during the COVID-19 pandemic. *Health Affairs*, 39(10), 1812-1821. https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.01269

McMichael, T. M., Currie, D. W., Clark, S., Pogosjans, S., Kay, M., Schwartz, N. G., ... & Ferro, J. (2020). Epidemiology of Covid-19 in a long-term care facility in King County, Washington. *New England Journal of Medicine*, 382(21), 2005-2011.

Meyer, Harris (2020) *Coronavirus-related deaths in Nursing Homes prompt Lawsuits and Questions about who's Responsible.* https://www.abajournal.com/magazine/article/coronavirus-related-deaths-in-nursing-homes-seed-lawsuits-and-questions-about-whos-responsible

New York Article 30-D: Emergency or Disaster Treatment Protection Action. (2020) https://www.nysenate.gov/legislation/laws/PBH/A30-D

New York Senate Bill S5177: Act to Repeal Article 30-D (2020); https://www.nysenate.gov/legislation/bills/2021/s5177

Senate Finance Committee Majority Staff Report (September 2020); https://www.finance.senate.gov/imo/media/doc/SFCNursingHomesCOVIDMajorityStaffSFCReport23Sep2020FINAL.pdf

Seshadri, S., Concannon, C., Woods, J., McCullough, K., & Dumvati, G. (2020). "It's like fighting a war with rocks". Nursing home healthcare workers' experiences during the COVID-19 Pandemic. *Infection Control & Hospital Epidemiology*, 1-2. doi: 10.117/ice.2020.393

State of New York Executive Order Number 202.10; (2020) "Continuing Temporary Suspension and Modification of Laws Related to the Disaster Emergency." https://www.governor.ny.gov/news/no-20210-continuing-temporary-suspension-and-modification-laws-relating-disaster-emergency

Przymusinski, L.P., Phillips, S.R., Carr, A.A. (2020) *HHS Clarifies PREP Act Immunity for COVID-19-Related Activities.* https://www.dlapiper.com/en/us/insights/publications/2020/04/hhs-clarifies-prep-act-immunity-for-covid-19-related-activities/

Y. Peter Kang (2020) *NY Repeals COVID-19 Liability Shield for Nursing Homes.* https://www.law360.com/articles/1373074/ny-repeals-covid-19-liability-shield-for-nursing-homes

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Overview of Federal and State Whistleblower Protections

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

Whistleblowers are private citizens who report practices that endanger health and safety, violate the law, or include fraudulent actions. Whistleblowers can be but are not limited to: employees of a federal or state agency; an employee of a company; or anyone who sees wrongdoing (National Whistleblower Center, 2020). The Occupational Health and Safety Administration (OSHA) administers The Occupational Safety and Health Act of 1970, which authorizes the federal government the authority to enforce safety and health standards (Government Accountability Project, 2020). An employee can disclose unsafe occupational conditions (or "blow the whistle") by making an official claim to OSHA or the media or reporting the condition to a supervisor, Board of Medicine, or Board of Nursing. Other protected actions include simply refusing to participate in the hazardous activity and filing a formal "Safety and Health Complaint" to OSHA.

REPORTING UNSAFE WORKING CONDITIONS TO OSHA

OSHA suggests that an employee who believes a working condition is unsafe should, if possible, tell the employer

Whistleblower investigations by OSHA involve both parties providing discovery to all related submissions, including witness contact information to support or defend the allegation. If the investigator finds merit in the claim, it may proceed to a hearing by an administrative law judge of the Department of Labor.

about their concerns. However, the employee may also file a complaint directly to OSHA to perform an inspection. Employees can file a Safety and Health complaint online, telephonic, mail, or in-person (www.osha.gov/workers/file-complaint).

OSHA Workers Rights and Protections entitle employees to:

- a workplace free of known health and safety hazards
- the right to speak up about hazards without fear of retaliation
- receive workplace safety and health training in a language the employee understands
- work on machines that are safe
- receive required safety equipment, such as gloves or a harness and lifeline for falls
- be protected from toxic chemicals
- request an OSHA inspection, and speak to the inspector
- report an injury or illness, and get copies of your medical records
- review records of work-related injuries and illnesses
- see results of tests taken to find workplace hazards (United States Department of Labor, 2020)

PROTECTIONS AFFORDED WHISTLEBLOWERS

The Occupational Safety and Health Act of 1970 prohibits the employer from retaliation against the employee for disclosing a violation of an occupational safety and health condition. In addition to federal whistleblower protections, all states have varying whistleblower protection laws, and many of the state laws also protect employees who raise issues of public policy related to health and safety (National Nurses United, 2020).

Whistleblower protection laws prohibit certain retaliation against the employee, including:

- Firing or laying off
- Blacklisting
- Demoting
- Denying overtime or promotion
- Disciplining
- Denying benefits
- Failure to hire or rehire
- Intimidation
- Reassignment affecting promotion prospects
- Reducing pay or hours
- Making threats (OSHA, 2017)

An employee who complains about a safety issue to their employer or OSHA and then feels the employer is retaliating against them for the disclosure can file a whistleblower complaint with OSHA. Healthcare workers, including doctors, nurses, therapists, and also janitors, receptionists, and other public-facing employees in healthcare, do not need to retain counsel to file a whistleblower complaint under the Occupational Safety and Health Act. OHSA whistleblowers can file a complaint online (www.whistleblowers.gov/complaint_page), orally by telephone or at an OSHA office, or in writing in any language. The filing deadline of the more than twenty whistleblower protection laws administered by OSHA varies from 30-180 days after perceived retaliation by the employer (United States Department of Labor, 2017). OSHA investigates whistleblower claims, which include allegations with these four key elements:

1. The employee engaged in activity protected by the whistleblower protection laws(s) (such as reporting a violation of law);
2. The employer knew about, or suspected, that the employee engaged in the protected activity;
3. The employer took an adverse action against the employee;
4. The employee's protected activity motivated or contributed to the adverse action (United States Department of Labor, 2017).

OSHA WHISTLEBLOWER CLAIMS IN THE COVID-19 ERA

As businesses across the country return to in-person operations, OSHA has been actively enforcing workplace safety related to COVID-19. According to OSHA data, as of January 21, 2021, there were 4,548 whistleblower complaints filed for Coronavirus SARS-CoV-2 (COVID-19) issues, 1,159 docketed for investigation, and 539 investigations completed. Some of these claims involve the lack of personal protective equipment (PPE) available for healthcare providers since the start of the COVID-19 pandemic. Many of the claims involve the short supply

of N95 respirator face masks, which, if appropriately used, filter out small particles in the air and protect nurses, doctors, respiratory therapists, and other providers working closely with the general public from the transmission of the virus.

In some cases, employees report in social media retaliation by hospital employers for talking to the media about the lack of PPE. Many employers require nurses and doctors to sign non-disclosure agreements (or "gag orders")

agreeing to refrain from speaking to the media as a condition of employment. However, the OSHA Whistleblower Investigations Manual categorizes "communicating with the media about an unsafe or unhealthful workplace condition" as protected (OSHA, 2016). Under this protection, the non-disclosure agreement is unenforceable when the employee discloses specific unsafe or unhealthful practices defined by OSHA to the media (OSHA, 2016). At least one federal court upheld this principle in 2015. In that case, King v. Lear Corp., the court granted OSHA's preliminary injunction prohibiting the employer from enforcing the agreement, with a broad decision that recognized "the scope of protected whistleblower includes disclosures to the media" (National Law Review, 2015).

While the above OSHA protections apply to all healthcare employees, the number of healthcare professionals speaking out in the press and social media indicates the number of unsafe working conditions likely far exceeds the number of complaints in 2020. Some employees who should have reported unsafe conditions to their supervisors, medicine and nursing boards, or OSHA during the pandemic did not. Healthcare workers reported numerous disclosures to the press or social media that their deep sense of duty to patients provoked them to continue providing care despite the lack of PPE and other medical supplies and inadequate staffing required for increased patient loads. Additionally, since September 2020, OSHA has come under increased scrutiny by the Department of Labor in handling workplace complaints and violations and the rise in complaints due to the pandemic (Whistleblower Network News, 2020).

A recent high-profile example of whistleblower actions against governmental and healthcare entities by nurses or healthcare staff include the following: a nurse at a Georgia detention center under the purview of Immigration and Customs Enforcement (ICE) accused the facility and staff of unhealthy conditions, ignoring COVID-19 protections and protocols, and worst of all made to have hysterectomies without any informed consent. The twenty-seven-page complaint again brought attention to the "absence of adequate protection against detained immigrants against COVID-19" that the Irwin County Detention facility is under investigation by several Federal and State agencies and that they violated Performance-Based National Detention Standards (PBNDS), Centers for Disease Control and Prevention (CDC) guidelines for correctional facilities, and OSHA standards for training their employees on a workplace hazard assessment (CDC, 2021). This case highlights the issues faced in a particular workplace-correctional facility, but also gives general basic guidelines for workplace safety for both the employer, employees, and general well-being of the inmates.

Another example, though not a direct OSHA claim, is one brought by Dr. Rick Bright against the Trump Administration's response in the handling of COVID-19. Dr. Bright worked for the Department of Health and Human Services, and as outlined in his complaint, was retaliated against by the Trump Administration and demoted to a significantly lesser position because of these critiques, suggestions, and comments on the ineffective handling of the response to the Coronavirus (Popovich, 2020).

LEGAL NURSE CONSULTANT'S ROLE IN WHISTLEBLOWER CLAIMS OF UNLAWFUL RETALIATION

A legal nurse consultant working for a whistleblower's attorney can strengthen the claim by interviewing potential claimants to determine the allegations and identify dates the attorney can use to determine if they meet the varying time limits for filing. The legal nurse consultant can also help identify necessary documentation and review the items to determine the claim's support. This documentation could include:

- Work orders or memorandum from employers
- Hiring or termination letters
- Policies and procedures
- Disciplinary actions
- Job descriptions
- Witness statements

- Medical or workers' compensation records showing damages

Legal nurse consultants working in defense of OSHA safety or retaliatory claims may also conduct interviews of potential witnesses, including former and current employees, and assist with collecting documents. Legal nurse consultants may conduct a clinical review of claims. While defendants may choose to have in-house risk managers review the claims, a third-party clinical review is considered best practice (Gibson & Russo, 2018).

Whistleblower investigations by OSHA involve both parties providing discovery to all related submissions, including witness contact information to support or defend the allegation. If the investigator finds merit in the claim, it may proceed to a hearing by an administrative law judge of the Department of Labor. Then the employee can file a retaliation in federal district court if warranted (United States Department of Labor, 2020).

REFERENCES

CDC. (2021, 01 11). *Correctional and Detention Facilities Plan, Prepare, and Respond.* Retrieved 01 26, 2021, from CDC Covid-19: https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/

Department of Justice. (2011, February 22). *The False Claims Act: A Primer.* Retrieved 01 23, 2021, from DOJ: https://www.justice.gov/sites/default/files/civil/legacy/2011/04/22/C-FRAUDS_FCA_Primer.pdf

Gibson, J., & Russo, G. (2018, April). False Claims Act - Investigative Tools of the Trade. *ABA Health eSource,* 1-6. Retrieved 01 23, 2021, from https://www.americanbar.org/groups/health_law/publications/aba_health_esource/2017-2018/april2018/fca/#:~:text=False%20Claims%20Act%20--%20Investigative%20Tools%20of%20the,to%20repay%20an%20amount%20owed%20to%20the%20

Government Accountability Project. (2020). *What Is a Whistleblower.* Washington DC: DESIGN & DEVELOPMENT CAUSE INSPIRED MEDIA. Retrieved 01 23, 2021, from https://whistleblower.org/what-is-a-whistleblower/

National Law Review. (2015, 05 11). OSHA Secures Robust Injunctive Relief for Whistleblower. *National Law Review eNews Bulletin,* Volume V, No. 131. Retrieved 01 24, 2021, from Volume XI, Number 24: https://www.natlawreview.com/article/osha-secures-robust-injunctive-relief-whistleblower#google_vignette

National Nurses United. (2020, 01 01). *Whistleblower Protection Laws for Healthcare Workers.* Retrieved 01 23, 2021, from NNU: https://www.nationalnursesunited.org/whistleblower-protection-laws-for-healthcare-workers

National Whistleblower Center. (2020). *National Whistleblower Center Law Library.* Retrieved 01 24, 2021, from https://www.whistleblowers.org/law-library/

OSHA. (2016, 01 28). *Whistleblower Investigations Manual.* Retrieved 01 23, 2021, from OSHA.gov: https://www.osha.gov/OshDoc/Directive_pdf/CPL_02-03-007.pdf

OSHA. (2016, 01 28). *Whistleblower Investigations Manual.* Retrieved 0124 2021, from OSHA: https://www.osha.gov/sites/default/files/enforcement/directives/CPL_02-03-007.pdf

OSHA. (2017). *OSHA Fact Sheet.* Retrieved 01 24, 2021, from OSHA's Whistleblower Protection Program: https://www.osha.gov/Publications/OSHA3638.pdf

Popovich, A. (2020, 10 09). Covid-19 Whistleblower Dr. Rick Bright Has Resigned. *Whistleblower Network News.* Retrieved 01 26, 2021, from https://whistleblowersblog.org/2020/10/articles/whistleblower-news/government-whistleblowers/covid-19-whistleblower-dr-rick-bright-has-resigned/

United States Department of Labor. (2017, 06). *OSHA Online Whistleblower Complaint Form.* Retrieved from Occupational Safety and Health Administration: https://www.osha.gov/whistleblower/WBComplaint.html

United States Department of Labor. (2020, 01 01). *OSHA Workers Rights and Protections.* Retrieved 01 23, 2021, from Occupational Safety and Health Administration: https://www.osha.gov/workers/

United States Department of Labor. (2020, 01 01). *What to Expect During a Whistleblower Investigation.* Retrieved 01 23, 2021, from Occupational Safety and Health Administration: https://www.whistleblowers.gov/whattoexpect

Whistleblower Network News. (2020, 09 10). Department of Labor Report Finds OSHA Must Improve Handling of Whistleblower Complaints. Retrieved 01 26, 2021, from https://whistleblowersblog.org/2020/09/articles/whistleblower-news/osha-whistleblowers/department-of-labor-report-finds-osha-must-improve-handling-of-whistleblower-complaints/

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Screening and Evaluating COVID-19 Correctional Healthcare Cases:

What are the Standards?

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Keywords: COVID-19, Correctional Healthcare, Correctional Nursing

Over the past year, the Coronavirus Disease 2019 (COVID-19) pandemic has impacted numerous aspects of society. The delivery of correctional healthcare services within the closed environment of our nation's prisons and jails was no exception. Although correctional leaders were accustomed to planning for and weathering emergencies such as riots, fires, and other disasters; the spread of the novel coronavirus presented additional challenges. The management of an infectious disease outbreak in correctional facilities was and still is compounded by the inherent close quarters, and the dynamics of daily influx and movement of large numbers of people contributing to opportunities for it to spread (Spaulding & Granner, 2020).

Although the complexities of prevention and treatment of the COVID-19 were and still are ever changing and evolving, the aim of this article is to provide a brief overview of the challenges unique to correctional healthcare that are related to the pandemic, sources of standards, and to provide literature and resources that targeted COVID-19 management in correctional healthcare over the last year. The intent is to provide information that may assist the legal nurse consultant (LNC) with screening and evaluating potential COVID-19 correctional healthcare cases.

CHALLENGES UNIQUE TO CORRECTIONAL HEALTHCARE

For the LNC unfamiliar with the various challenges unique to correctional healthcare such as the differences between jails and prisons, inmate/patient's constitutional rights to health care, and the security dynamics that are integrated into the health care delivery system; the LNC is referred to the appendix/additional reading section (Danahy, 2017; Eckenrode et al., 2020).

Regardless of LNCs familiarity, what is important to keep at the forefront for potential COVID-19 correctional lawsuit cases is in addition to the issues

related to being a closed environment, the correctional safety and security mission confounds and compounds the ability of healthcare providers to deliver healthcare services equivalent to community standards (Eckenrode et al., 2020). What this means is that security issues often take precedence. Hence healthcare staff and security staff should work together in multidisciplinary teams or groups to mitigate conflicts and complications.

While this can be challenging just by the very nature of the two disciplines: security and healthcare, there is another compounding factor rooted in who provides the healthcare services. Are the healthcare services provided by healthcare professionals who are employed directly by the facility or state or local government operating the facility? Or as is becoming more common, are the healthcare services contracted out to private companies who in turn employ the healthcare professionals (Eckenrode et al., 2020)?

In the later situation, the privatized contracted employees may be often viewed as a guest in the institution. Rather than the integrated policies and procedures that are present when security and healthcare are unified by the same employer such as the Department of Corrections, in the privatized situation there are clearly two sets: one generated by Corrections for security/correctional staff and one provided by the contracted correctional healthcare company. When the two sets contradict one another, an impasse may develop.

For instance, the facility correctional staff may be instructed to move offenders or patients — as medical refers to them— from one facility to another facility, change the patient's room assignment, or partake in excessive movements of the patient around the facility. It is the responsibility of the healthcare professionals to promote the discontinuance of this practice in light of the COVID-19 and the corresponding infection control policies and standards.

STANDARDS FOR CORRECTIONAL HEALTHCARE

Standards for correctional healthcare come from a variety of sources. Two examples of global standards sources include those produced by the Federal Bureau of Prisons and the National Commission on Correctional Health Care (NCCHC). The Federal Bureau of Prisons (n.d.a; n.d.c) offers a multitude of standards including access to clinical practice guidelines, national medication formulary, and other various reports specific to correctional care.

The NCCHC is a not-for-profit accreditation organization that provides recommendations for correctional healthcare services systems management (NCCHC, 2021a). The NCCHC provides separate standard volumes for juvenile facilities, mental health, opioid treatment, jails, and prisons (2015a, 2015b, 2016, 2018a, 2018b). The standards cover a wide array of areas such as care and treatment, health records, administration, personnel, and medical-legal issues. The NCCHC reports that one benefit of their accreditation status is that when there is adherence to the standards, it helps "protect against adverse events and reduce liability" (NCCHC, 2018b, p. 141).

Both types of standards are not meant to be mandatory but instead constitute guidelines (Eckenrode et al., 2020). However, court systems in the U.S. tend to recognize them as the embodiment of standards for correctional healthcare as part of the adjudication process. Hence the standards should be carefully reviewed for issues germane to the case at hand.

STANDARDS SPECIFIC TO THE COVID-19 PANDEMIC

Standards specific to the COVID-19 in the correctional setting emerged in March 2020. From March through May 2020, the NCCHC (2020) provided weekly COVID-19 roundtables with updates that addressed both security and healthcare practices. Topics included correctional pandemic response plan sample, quarantine verses isolation, handling ill staff members, entry of new offenders into the facility, guidelines for personal protective equipment, masks verses respirators, and so forth.

In addition to the plethora of pandemic resources found on the NCCHC (2021b) website, various NCCHC publications provided updates regarding the evolving information on mitigation efforts and standards guidance. In spring of 2020, Spaulding and Granner recommended that institutions and healthcare staff prepare for the spread of the virus through prevention efforts that minimize opportunities for introduction of the virus into facilities. Referencing NCCHC (n.d.) infection disease prevention and control standards, suggestions were provided that aligned emergency response plans and exposure control. Examples included conducting intake screening in the sally port and evaluating new entrants before they moved to other parts of the facility. Masks, standard precautions, and the importance of handwashing were also highlighted as a means to control the number of cases among inmates and spread to institutional staff.

In the fall of 2020, Grigg and Bedard provided guidance on the clinical care of correctional patients with COVID-19. In addition to the specifics of how to best monitor and manage these patients, they emphasized that protocols should be developed that includes monitoring and minimizing transmission of the disease both at the institution and when transferring patients to the hospital.

Similarly, in March of 2020 the Federal Bureau of Prisons provided information on the COVID-19 Action Plan. The action plan addressed guidance on visitation, inmate movement, staff training, screening of inmates, and other aspects

VitalCore Elements

Box A: Pandemic Response Plan Elements

1. Administration/Coordination
2. Communication
3. General Prevention Measures
4. Visitors/Volunteers/ Contractors/Lawyers
5. Employee Screening
6. New Intake Screening
7. Initial Management and Testing of Cases of Respiratory Illness
8. Personal Protective Equipment (PPE) and Other Supplies
9. Transport
10. Isolation (Symptomatic Persons)
11. Care for the Sick
12. Quarantine (Asymptomatic Exposed Persons)
13. Data Collection, Analysis & Reporting
14. Summary, Evaluation and Continuous Quality Improvement

related to the operational adjustments specific to the pandemic. The plan was updated in November 2020. Additionally, the Federal Bureau of Prisons (n.d. b) provided COVID-19 specific operations plans and screening resources.

Simultaneously, in March 2020, VitalCore Health Strategies (2020a; 2020b) developed and disseminated a COVID-19 Pandemic Response Plan, and provided updates disseminated in October and November 2020. The plan documents were comprehensive and contained guidance on 14 pandemic response elements and various screening forms. (See Box A)

VitalCore Elements

Box B: Screening Forms

COVID-19 Visitor Screening Form

COVID-19 Employee Screening Form

COVID-19 New Intake Screening Form

Respiratory Infection Isolation Room Sign

Quarantine Room Sign

COVID-19 Personal Protective Equipment Recommendations

https://www.ncchc.org/other-resources

The Centers for Disease Control and Prevention (CDC) (2021) also published COVID-19 guidance on the management of COVID-19, providing periodic updates in the summer and fall of 2020, and the most recent update on February 19, 2021. These comprehensive guidelines cover a multitude of COVID-19 clinical issues and include operational and communications preparations, enhanced cleaning and hygiene practices, strategies to limit transmissions, testing, and isolation/quarantine.

LNC CONSIDERATIONS: SCREENING COVID-19 CASES FOR MERIT

A few examples of allegations that might come across the LNCs desk for screening include:

- My incarcerated family member caught COVID-19 because the facility staff did not wear masks or practice social distancing.
- My family member died because of negligent care.

A best practice preparation for screening these types of cases includes the LNC review and become familiar with the COVID-19 standards that were pertinent at the time of the allegations. This includes not only what were the national correctional healthcare COVID-19 standards, but if available what procedures and protocols did the facility implement and integrate into practice to mitigate spread and promote containment of the virus. Additionally, the LNC may consider the following questions to help focus and address the circumstances that may be relevant to the allegations:

1. What evidence supports that the staff followed or deviated from their infection control policy and procedures when treating the patients?
   - The facility should have a procedure for handling contagious diseases and how to contain the spread throughout the facility. Practices and protocols specific to COVID-19 should be evident including CDC spacing considerations that mimic community social distancing practices.
2. What evidence supports and reflects that personal protection equipment was made available and accessible to security and healthcare staff, patients, and other inmates?
   - Although dependent in part upon facility specific purchasing and stocking operations, personal protection equipment (PPE) such as masks and gloves should have been made available as recommended by the CDC. Whomever (security or healthcare) was responsible for the obtaining/purchasing the PPE, what is the evidence that supports that the proper PPE was obtained and made accessible for the staff

and the patients? Note that in some cases, the inmates may have had to purchase gloves and masks from the facility's inmate store if they had money on their books. For those inmates without money on their books, the facility should have provided the supplies to the inmate.

3. What evidence supports that security adjusted their visitor, intra and inter-transfer, and housing polices to reflect mitigation of practices that could spread the virus?
   - What changes were made to the visitor/visitation policies to mitigate spread or exposure to COVID-19?
   - Were there housing/cell assignment practice changes or accommodations implemented to curtail spread of and exposure to the virus?
   - What is the evidence that the security side of the institution curtailed the transfer of inmates from one institution to another during the height of the pandemic?
   - If an infected inmate was transferred to an outside resource for treatment, were any extra precautions implemented to mitigate spread of the virus and cross contamination?
4. What evidence supports that procedures were put in place to safely carry out the daily medical activities that involve the patient's medical regime?
   - Inmates have access to the healthcare services through requests for care, medication call, and assigned clinic appointments for chronic medical issues such as diabetes, HIV, Hepatitis C, etc. Is there evidence that security staff were instructed on the need to develop plans, and implemented corresponding practices that reflect limiting the number of inmates allowed to be in the area that mimics social distancing?
5. What evidence conveys that protocols and procedures were developed and implemented to identify inmates with COVID-19 and to safely care for those patients who tested positive?
   - Some facilities may have an infirmary and others do not. For those with an infirmary, what were their treatment protocols?
   - For those that did not have an infirmary or needed to transport the patient for care, what precautions were utilized to avoid cross contamination?
6. Is there evidence that adverse events occurred due to staff non-compliance or facility deviations from practices and protocols that were put into place to prevent the spread of COVID-19?

CONCLUSION

Many obstacles have arisen during the pandemic that has turned the world upside down including the delivery of correctional healthcare within correctional facilities. The management of COVID-19 pandemic in correctional facilities has had unique challenges compounded by the inherent close quarters and security dynamics. This article provided a brief background of the challenges that are unique to correctional healthcare. Sources of standards for correctional healthcare and standards specific to the COVID-19 pandemic were outlined and discussed with the intent to provide information and questions to consider that might be useful to LNCs who screen or evaluate a correctional case involving the pandemic. The references and information provided regarding COVID-19 correctional healthcare standards should also benefit research efforts for those LNCs consulting or

nurses functioning as an expert on these type of cases.

REFERENCES

Centers for Disease Control and Prevention (CDC). (2021). *Interim Guidance on management of Coronavirus Disease 2019 (COVID-19) in correctional and detention facilities. COVID-19, Work & School, Correctional and Detention Facilities, Guidance for Correctional & Detention Facilities.* Retrieved from https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html

Eckenrode, J. T., Maag, C. A., & Cosby, M. F. (2020). Correctional healthcare and civil rights. In J. Dickinson & A. Meyer (Eds.), *Legal nurse consulting: Principles and practices* (4th ed. pp.401 - 432). New York: NY: Routledge.

Federal Bureau of Prisons. (n.d.a) Retrieved March 15, 2021 from https://www.bop.gov/

Federal Bureau of Prisons. (n.d.b). *COVID-19 Coronavirus.* Retrieved March 15, 2021 from https://www.bop.gov/coronavirus/index.jsp

Federal Bureau of Prisons. (n.d.c) Health management resources. Retrieved March 15, 2021 from https://www.bop.gov/resources/health_care_mngmt.jsp

Federal Bureau of Prisons (2020, March 13). *Federal Bureau of Prisons COVID-19 Action Plan.* Retrieved from https://www.bop.gov/resources/news/20200313_covid-19.jsp

Federal Bureau of Prisons. (2020, November). *Federal Bureau of Prisons COVID-19 Action Plan.* Retrieved from https://www.bop.gov/coronavirus/covid19_status.jsp

Grigg, J., & Bedard, R. (2020). Clinical care of COVID-19 patients: Monitor, manage, and move out. *CorrectCare, 34*(4), 14- 15. Retrieved from https://www.ncchc.org/correctcare-archive

National Commission on Correctional Healthcare. (n.d.). *NCCHC standard on infectious disease and prevention and control available for download to help you formulate policies and procedures for reducing the risk of infectious disease transmission, including COVID-19.* Standards and resources, downloadable materials/videos. Retrieved March 15, 2021 from https://www.ncchc.org/downloadable-materials

National Commission on Correctional Healthcare. (2015a). *Standards for health services in juvenile detention and confinement facilities.* Chicago, IL. Author.

National Commission on Correctional Healthcare. (2015b). *Standards for mental health services in correctional facilities.* Chicago, IL. Author.

National Commission on Correctional Healthcare. (2016). *Standards for opioid treatment program in correctional facilities.* Chicago, IL. Author.

National Commission on Correctional Healthcare. (2018a). *Standards for health services in jails.* Chicago, IL. Author.

National Commission on Correctional Healthcare. (2018b). *Standards for health services in prisons.* Chicago, IL. Author.

National Commission on Correctional Healthcare. (2020, May 15). *Weekly roundtable for law enforcement and correctional health care.* Standards and resources, downloadable materials/videos, All COVID-19 recorded webinars and slides: Retrieved March 15, 2021 from https://www.ncchc.org/blog/covid-19-weekly-roundtable-for-law-enforcement-correctional-health-care-webinar

National Commission on Correctional Healthcare. (2021a). *About us.* Retrieved from https://www.ncchc.org/about

National Commission on Correctional Healthcare. (2021b). *COVID-19 Coronavirus: What you need to know in corrections.* https://www.ncchc.org/COVID-Resources

Spaulding, A., & Granner, B. 2020. Pandemic: Prepare, prevent, respond, repeat. *CorrectCare, 34*(2), 8- 10. Retrieved from https://www.ncchc.org/correctcare-archive

VitalCore Health Strategies. (2020a, March). *COVID-19 pandemic response plan.* Prison Legal News. Retrieved from https://www.prisonlegalnews.org/news/publications/covid-19-correctional-pandemic-response-plan-vitalcore-health-strategies-2020/

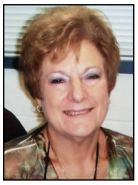
VitalCore Health Strategies. (2020b, November). *COVID-19 pandemic response 11.28.20. NCCHC, COVID-19 Coronavirus what you need to know in corrections.* National Commission on Correctional Healthcare, From the Field. Retrieved from https://www.ncchc.org/other-resources

ADDITIONAL READING

Danahy, L. (2017). Nursing behind bars: The differences between jail and prison. *The Journal of Legal Nurse Consulting, 28*(1), 22 – 25. Retrieved from http://www.aalnc.org/page/journal-v2.0

Eckenrode, J. T., Maag, C. A., & Cosby, M. F. (2020). Correctional healthcare and civil rights. In J. Dickinson & A. Meyer (Eds.), *Legal nurse consulting: Principles and practices* (4th ed. pp.401 - 432). New York: NY: Routledge.

Dr. Mariann F. Cosby's nursing career spans 41 years. It is woven with an overlap of 25 years of traditional emergency department stretcher-side and nursing manager roles, and 31 years of non-traditional emergency practice settings including school nursing, public health, and 10 years of correctional healthcare. Although recently semi-retired, she continues her 30 year legal nurse consultant practice as a retained expert witness, consultant, and life care planner. Mariann holds several national certifications. In 2020 she was inducted as a Fellow into the Academy of Emergency Nursing for her enduring contributions to emergency nursing. Dr. Cosby publications include journal articles, and chapters in several nursing textbooks. One of her most recent contributions was a co-author of the new chapter: Correctional Healthcare and Civil Rights, in the fourth edition of the American Association of Legal Nurse Consultant's *Principles and Practices.*



Betty Rogers, RN, CCHP, LNC, has a career that spans over 48 years with extensive experience. Her experience began with ICU, CCU, ER expanding to Nursing home, oncology, and home care. She is semi-retired after 13 years as an administrator of a medical unit in a state women's correctional facility. Her management experience of 30 plus years has been in the various positions. Since retiring she has been a surveyor with the Medical Association of Ga doing surveys in prisons and jails for accreditation with the National Commission on Correctional Healthcare (NCCHC) since 2015. Ms. Rogers acquired her Certification as a Correctional Health care professional in 2015 and is an expert witness for correctional health cases after becoming a LNC in 2008. Ms. Rogers has given a webinar on correctional cases with an AALNC chapter and a presentation to a group of correctional professionals on correctional lawsuits.

Update Article: Active Military Achieve New Limited Waiver to *Feres* Doctrine

Marjorie Berg Pugatch BSN MA RN LNCC

Keywords: Legal, active military, medical malpractice, limited waiver to Feres doctrine

The author wrote an article for the Journal of Legal Nurse Consulting in 2008 entitled Federal Tort Claims and Military Medical Malpractice that reviewed the history, laws, and processes for making a claim. The goal was to educate and inform LNCs of another area they can be involved in. In 2019, a new bill was signed into law that changed tort claims for active military medical malpractice. This update discusses the new law and how LNCs practicing in this area are affected.

In 2008, the author wrote an article on military medical malpractice for the Journal of Legal Nurse Consulting (Pugatch, 2008). The 2008 article provided a history of claims against the government (claims barred due to sovereign immunity), discussed Federal Tort Claims Act of 1946 (Federal Tort Claims Act, §§ 1346) that curtailed the Federal government's right to sovereign immunity and described the *Feres* Doctrine decided in 1950 by the Supreme Court (*Feres v United States*, 1950). That doctrine carved out an exception whereby **active-duty military** were barred from making claims for personal injury including medical malpractice against government entities and gov-

This bill carried a 3-year statute of limitations beginning on the date the injury was discovered or should have been discovered. If the negligent act occurred outside of the United States, the law in place at that location would prevail.

ernment employees. It should be noted, service members are eligible for military disability without resorting to litigation. Military disability is a no-fault compensation system but pays out only a small amount when compared to what might be provided by making a claim or from winning or settling a lawsuit. The original article also described the process of making a claim by **non-active military** against the government and described the litigation process should a claim be denied.

After *Feres* was decided, court challenges (*Chappell v Wallace*, 1983; *U.S. v Shearer*, 1985; *U.S. v Johnson*, 1987; *Witt v U.S.* 2009) and senate judiciary committee hearings in 1986 and 2002 ensued to permit **active military** negligence claims. The goal was to amend the Federal Tort Claims Act (FTCA) by legislation or to overturn the Supreme Court *Feres* Doctrine. Ultimately, those attempts to change *Feres* failed, that is, until now.

NEW SOLUTION TO AN OLD PROBLEM FOR ACTIVE MILITARY

On April 30, 2019 H.R. 2422 was introduced to the 116th Congress by Representative Jackie Speier (D-CA-14), the Chair of the House Armed Services Military Personnel Subcommittee. This was referred to as the SFC Richard Stayskal[1] Military Medical Accountability Act of 2019:

> A claim may be brought against the United States under this chapter for damages relating to the personal injury or death of a member of the Armed Forces of the United States arising out of a negligent or wrongful act or omission in the performance of medical, dental, or related health care functions (including clinical studies and investigations) that is provided at a covered military medical treatment facility by a person acting within the scope of the office or employment of that person by or at the direction of the Government of the United States. (SFC Richard Stayskal Military Medical Accountability Act of 2019, H.R.2422, 116th Cong. (2019) Sec. 2. Chapter 171 of title 28, USC, § 2681 p.2)

This bill carried a 3-year statute of limitations beginning on the date the injury was discovered or should have been discovered. If the negligent act occurred outside of the United States, the law in place at that location would prevail. The bill would not cover battalion aid stations or other medical treatment locations deployed in a combat area. The bill provided for a report to Congress every two years on the number of claims filed. (H.R. 2422 116th Congress 2019)

Eventually, this bill appeared in the House of Representatives version of the National Defense Authorization Act for Fiscal Year 2020 (NDAA FY 2020; H.R. 2500) on July 12, 2019 while the Senate passed its version of the NDAA (S. 1790) on June 27, 2019. In Senate and House conference committee meetings, the differences were resolved and a final bill was signed into law by the President on December 20, 2019 and became Public Law 116-92 sec.731 of the NDAA. The signed bill allowed for an **administrative claims process. It did not allow for filing a civil suit in federal court rather it created a limited waiver[2] to *Feres for active duty military***, by authorizing "the Secretary [of Defense to] allow, settle and pay a claim against the United States for personal injury or death incident to the service of a member of the uniformed services that was caused by the medical malpractice of a Department of Defense health care provider" (NDAA for FY 2020: P.L. 116-92 [H.R. 2500, S. 1790] Sec. 731 p. 261). Claims were initially allowed from events that occurred from January 2017[3] and then provided victims two years to file a claim thereafter (statute of limitations). The new law designates $400 million to the Pentagon to investigate claims and award compensation. The Department of Defense (DoD) may offer up to $100,000 in direct compensation for a substantiated claim and if a referral were to be made to the Secretary of the Treasury by the DoD then additional compensation could be made. (NDAA for FY 2020: P.L. 116-92 [H.R. 2500, S. 1790] Selected Military Personnel Issues.) There is no recourse if a claim is denied. Claims cannot be filed for medical malpractice occurring in an active combat zone or for future loss of income. Payouts would not include separate attorney's fees and the maximum the attorney could be compensated would be 20% of the claim. Annual reports from the Secretary of Defense to Congress were mandated for five years to include the number of claims and the resolution of each claim.[4] The Secretary of Defense was to brief the Committees on Armed Services from both houses of congress on the development of regulations not later than 180 days after the date of the enactment of the act. (NDAA for FY 2020 (P.L. 116-92).

HOW A NEW SOLUTION TO AN OLD PROBLEM AFFECTS LEGAL NURSE CONSULTANTS

Laws and processes governing medical malpractice cases in the military are different than civilian laws and processes. LNCs need some basic knowledge of how these cases move through the claims process. Medical malpractice administrative claims and lawsuits for **non-active duty military** and their families have existed for decades as described in the original 2008 article. Now that **active duty** soldiers are no longer barred from making a claim, LNCs need to appreciate the changes to assist with these cases.

There are many law firms that advertise on the internet their willingness to assist with the process for filing active duty and non-active duty military medical malpractice claims. Thus far *Standard Form 95* (See "References of Interest") will be used for both types of claimants by all service branches though the form is submitted to the service member's specific branch.

The limited waiver to *Feres* will likely create additional opportunities for LNCs. LNC work on such cases may include interviewing the claimant or family members, requesting and reviewing pertinent medical records, investigating military medical facilities where care was provided and of the military healthcare employees that provided the care to the injured party, assessing the claim's value and assisting with filling out and filing of the claim and follow-up until the claim is resolved or denied.

As of the writing of this article (February 2021), no claims have been paid although in excess of 200 medical malpractice claims have been submitted with a reported value of $845 million. The DoD has not issued a federal interim final rule. That rule would spell out the process of how DoD would handle the claims. Although the Pentagon indicated in June 2020 they would publish their policy by September, no procedures have been forthcoming. With the change-over in administrations, it is likely that further delays will ensue. (Tiron, 2021 no page number)

REFERENCES

Chappell v Wallace, 462 U.S. 296 (1983). https://supreme.justia.com/cases/federal/us/462/296/

Dewar, C.D., Boulter, J.H., Curry, B.P., Bowers, D.M., & Bell, R.S. (2020). The changing landscape of military medical malpractice from the *Feres* Doctrine to present. *Neurosurgical Focus,* 49 (5): E7. Doi: 10.3171/2020.8.FOCUS20594

Federal Tort Claims Act. 28 USC §§ 1346(b)(1), 2401(b), 2671-2680 (1946).

Feres v United States 340 US 135 (1950). https://law.justia.com/codes/us/2011/title-28/part-vi/chapter-171/section-2671/

National Defense Authorization Act for Fiscal Year 2020. S. 1790 116th Congress (2019): https://www.govtrack.us/congress/bills/116/s1790

National Defense Authorization Act for Fiscal Year 2020. P.L. 116-92. Sec. 731 (December 20, 2019) https://www.congress.gov/116/plaws/publ92/PLAW-116publ92.pdf

National Defense Authorization Act for Fiscal Year 2020: P.L. 116-92 (H.R. 2500, S. 1790) (January 2, 2020). https://congress.gov/116/plaws/publ92/PLAW-116publ92.pdf

National Defense Authorization Act for Fiscal Year 2020: P.L. 116-92 (H.R. 2500, S. 1790) Selected Military Personnel Issues. (Updated September 18, 2020). https://fas.org/sgp/crs/natsec/R46107.pdf

Pugatch, M.B. (2008). Federal Tort Claims and Military Medical Malpractice. *The Journal of Legal Nurse Consulting, 19*(2), (3-6). http://www.aalnc.org/pag/journal-v2.0

SFC Richard Stayskal Military Accountability Act of 2019. H.R. 2422 116th Congress (2019). https://www.congress.gov/116/bills/hr2422/BILLS-116hr2422ih.pdf

Simkins, J.D. (2018, November 7). This Green Beret is battling cancer-and the government-after Army medical's "gross malpractice." *Army Times.* https://www.armytimes.com/news

The Feres Doctrine and Military Medical Malpractice, 99th Cong. (1986). Hearing before the Subcommittee on Administrative Practice and Procedure of the Committee on the Judiciary United States Senate. https://lawcat.berkeley.edu/record/407435

The Feres Doctrine; an Examination of this Military Exception to the Federal Tort Claims Act. 107th Cong. (2002). Hearing before the Committee on the Judiciary United States Senate. https://www.judiciary.senate.gov/meetings/the-feres-doctrine-an-examination-of-this-military-exception-to-the-federal-tort-claims-act

Tiron, R, (2021, January 27). Pentagon Slows $900 Million Malpractice Claims as Congress Fumes. *Bloomberg Health Law & Business News.* https://news.bloomberglaw.com/health-law-and-business

United States v Shearer, 473 U.S. 52 (1985). https://supreme.justia.com/cases/federal/us/473/52/

United States v Johnson, 481 U.S. 681 (1987). https://supreme.justia.com/cases/federal/us/481/681/

Witt v United States U.S. Dist, E.D. Cal (2009). https://www.casemine.com/judgement/us/5914683dadd7b049342c129e

REFERENCES OF INTEREST

Department of the Navy, Federal Tort Claims Act, Claims Procedures. https://www.jag.navy.mil/organization/documents/SF95_Packet.pdf

Department of the Navy, Federal Tort Claims Act, Fillable Standard Form 95, Federal Tort Claims Act. https://www.jag.navy.mil/organization/documents/SF95_07a.pdf

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Case Series for the LNC: Assessing Risk for Elder Abuse Using DMES©

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Keywords: Elder Abuse, Elder Maltreatment, DMST, Decision Matrix for Elder Safety, Elder Capacity, Elder Competence, Cognitive Decline, Health Decline

There are predictable declines associated with the aging process. The elder with cognitive or health declines experiences increasing vulnerability to others' predatory behaviors, including family and neighbors. The purpose of the case series is to provide Legal Nurse Consultants demonstration for a classification system designed to document cognitive and health decline patterns over time using caregiver reports or medical/social records. When detected, the increased risk for the elder is an opportunity to determine liability with the level of decline and identify interventions to mitigate maltreatment risk.

INTRODUCTION

Multiple systems are triggered to respond to suspected cases of elder abuse (Administration for Community Living, 2016, 2017; Jin, 2018). The Legal Nurse Consultant (LNC) is often the only one able to unwind the complex medical and neurocognitive presentations in elder abuse case analysis. The LNC has a foundation in liberal arts education, required before entering nursing school. Nursing schools integrate the initial education with nursing theory, frameworks, core concepts, and general practice (American Association of Colleges of Nursing, 1998, 2006, 2011, 2020, November 11). The practice applies the nursing process, which is a cyclic approach to ADPIE (assessment, nursing diagnosis, planning, intervention, and evaluation) (American Nurses Association, 2018). The practice is not static but a dynamic approach to patients and population health and well-being (American Association of Colleges of Nursing, 2020, November 11). As developmental specialists, registered nurses and nurses with advanced degrees all possess core competencies in the approach to patient problems (American Association of Colleges of Nursing, 2020, November 11). However, when the patient is older, the dynamic approach to the elder's experience and life trajectory requires unique gerontologic education to monitor progress and create interventions that promote continued independence and health. Recognizing that the older population has varying degrees of support systems and people who care for them, the medical model is reactionary and without a mechanism to predict dependency and impairment from health co-morbidities and neurocognitive decline. The purpose of this article is to provide a mechanism for LNCs to evaluate dependency and impairment of an older person over time from available records and caretaker reflections. With logarithmic documentation (e.g., over

time and/or through reflections), the method exposes a pattern of decline or improvement, and with the knowledge, provides opportunities for intervention, prevention, and mitigation. When faced with loss of independence performing activities, elders become vulnerable to predators (Center for Disease Control and Prevention, 2020, May 12; Van Den Bruele et al., 2019). The complexity of identifying serious impairments and levels of dependency that place the elder at risk for abuse also includes measuring the elder's awareness AND the initial expected denial of early neurocognitive decline and/or loss of health and function. This article helps LNCs develop a systematic approach to assessing vulnerability of an elder when reviewing a case with allegations of elder abuse or harm.

BACKGROUND

Elder abuse is a societal problem that is frequently undetected, underreported and poorly defined (Administration for Community Living, 2017, September; Van Den Bruele et al., 2019; Young, 2014; Ziminski Pickering & Rempusheski, 2014). The majority of reported elder abuse episodes come from emergency departments, often excluding clinician encounters in outpatient clinics and institutional care settings (Baker & Kim, 2019; Center for Disease Control and Prevention, 2020, May 12). Signs of elder abuse are often missed by clinicians and elders alike, compounding the problem of accurate reporting and protection of this vulnerable population (Baker & Kim, 2019; Mion & Momeyer, 2019; Ziminski Pickering & Rempusheski, 2014). The World Health Organization (WHO) defines elder abuse as "a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person" (n.d., para. 1). Elder abuse may be intentional or unintentional and can be classified as physical, sexual, financial, psychological and neglect (Center for Disease Control and Prevention, 2020, May 12; World Health Organization, 2020), defined in Table 1.

An estimated 15.7% of adults aged 60 and older are at risk to becoming a victim of elder abuse (World Health Organization, 2020). Regardless of evidence, the older person is vulnerable only when there is a predator with intent and access to them (Speck et al., 2014), who uses the elder's vulnerability of declining health or cognition (Van Den Bruele et al., 2019) to commit a crime. After the crime, the elder is often embarrassed and ashamed, often making excuses (e.g., I often misplace my jewelry); or taking up for the family member (Ziminski Pickering & Rempusheski, 2014) or neighbor who committed the crime (e.g., they are nice people and wouldn't do that to me).

The prevalence of elder abuse transcends all socioeconomic, ethnic, race and gender domains (Baker & Kim, 2019; Dong, 2012; Mion & Momeyer, 2019). Older adults with cognitive, functional, psychological, and physical impairments experience an increased risk for abuse globally (World Health Organization, 2020; Yon et al., 2017). While physical dependency increases risk for abuse, cognitive impairment appears to place the elder the greatest risk of abuse (Dong & Simon, 2015; Lachs et al., 1998; VandeWeerd et al., 2013).

Civil cases arise when competence or capacity is questioned (Darby & Dickerson, 2017; Filaković et al., 2011). Intentional or unintentional injury often focus on competence and capacity (Speck et al., 2014). Medical teams often evaluate competence and capacities when there is sudden change in the elder's function. Often the report is a "slice in time" and may not be reflective of decline over time. Regardless, the medical team informs the court regarding the findings about cognitive and health capacities during the evaluation; and the court uses the medical report to form a legal plan of care to determine competence (Darby & Dickerson, 2017).

Functional decline, as well as cognitive decline, determines the elder's ability to function independently. Once there is evidence of medical co-morbidities with cognitive decline, the functional behaviors associated with the health decline become problematic for caregivers and the community at large. There is also evidence once cognitive decline is diagnosed, the expectation is that it can only be slowed (Karr et al., 2018; Kluger et al., 1999). Therefore, there is increasing vulnerability to elder maltreatment when there is cognitive and health decline.

Table 1: Types of Abuse

Types of Elder Abuse	Definition
Physical	Physical force resulting in pain, injury, functional impairment, illness, distress, or death
Sexual	Forced or unwanted sexual interaction of any kind, including non-penetration sexual activity or sexual harassment
Financial	Illegal, unauthorized, or improper use of an elder's financial assets or belongings for the benefit of someone other than the older adult
Psychological	Verbal or nonverbal behaviors that inflict fear or distress
Neglect	Failure to meet an elder's basic needs, such as food, water, shelter, clothing, hygiene, and essential medical care

Center for Disease Control and Prevention, 2020, May 12
Found at https://www.cdc.gov/violenceprevention/elderabuse/fastfact.html

PURPOSE

The purpose of this article is to introduce a mechanism to serially evaluate function and cognition, with a focus on decision-making about dependency and impairment of an older person over time. The information is valuable and contributes to criminal justice and support services understanding of the complexity of an older persons' vulnerability. With repeated use, another purpose is to validate experiences of persons (such as family, health care providers) charged with care of the elder who experiences the elder's increasing care activities related to declining health and cognition. The tool proposed helps quantify the elements associated with declining health or cognition. When decline is detected whether from serial documentation or "slice in time" medical evaluation, recognition of need for additional support occurs, and assists in the planning for the older person who needs help with their increasing dependency. The beneficiaries include family and neighbors, along with external support systems and professionals who care for them. However, a complexity is the elder's liberty, where awareness AND denial of early neurocognitive decline and physical abilities, make the management of serious impairments and estimating levels of dependency difficult. The tool proposed plans to quantify health needs and cognition. Regardless, when the elder remains competent, regardless of their capacities, it is necessary to gain their trust before intervention implementation for the elder's protection. When faced with loss of independence performing activities, particularly if the elder is unaware or in denial, elders become vulnerable to predators. Again, the most vulnerable elder is one without capacity and/or competence. This article helps LNCs develop a systematic approach to serially assessing categorical areas to determine vulnerability of an elder when faced with health status decline and/or growing neurocognitive deficits.

AIM

This publication aims to provide a classification schema using pseudo case series to train the elder abuse LNC to evaluate neurocognition and health status using the Decision Matrix for Elder Safety (DMES) classification system below.

LNC Case Evaluation of Physical and Cognitive Status

The role of the LNC nurse expert is to identify, collect and evaluate evidence in a particular case. The LNC role differs from the health care provider in a civil and criminal cases, as does the proof. The LNC is working behind the scenes as a consultant or as a nurse subject matter expert in elder abuse cases and whether the LNC was retained by the plaintiff's attorney or prosecutor, or defense attorney, they evaluate the records provided by the attorney. While reviewing records, LNC understands that health providers implement an evaluation to determine capacities and competence of an older person. Often providers must consider the health status and management functional and cognitive decline in their calculations. Validated tools measuring different aspects of activities of daily living include Katz Index of Independence in Activities of Daily Living (ADLs) and Lawton Instrumental Activities of Daily Living Scale. Katz identifies bathing, dressing, toileting, transferring, continence, and feeding (Graf, 2006; Katz, 1983; Noelker & Browdie, 2014) Katz, 2007, (Permission to post URL for Lawton Brody tool, Found at https://www.alz.org/careplanning/downloads/katz-adl.pdf) and Lawton identifies 8 areas of function including management of their mode of transportation, ability to use the phone, shopping for self, managing own medication, managing own finances; note there are differences between women and men, where men may not participate in food preparation, housekeeping, and laundering (Graf, 2006; Lawton & Brody, 1969) (Permission to post URL for Katz tool, Found at https://www.alz.org/careplanning/downloads/lawton-iadl.pdf). These tools, used for decades with significant supporting evidence, are best practice and supplied a foundation for use of the DMES in counting the ADLs in health status.

Similarly, the Mini-Mental State Evaluation (MMSE) consists of 30 items assessing orientation, attention/working memory, short-term memory, language, and visuospatial skills (Folstein et al., 1975). The evaluator measures domains of Orientation (place and time), Repetition (working memory recall), Verbal Recall (specific word recall after activity), Attention and Calculation (serial 7s subtraction from 100), Language (identify common objects, repeat phrases, follow 3-stage command, read and obey written instructions, write sentence) and Visual Construction (draw as shown two pentagons and intersect the shapes) (Folstein et al., 1975). The MMSE is a proprietary tool and widely used instrument to obtain an estimate of global cognitive function and screen for dementia. Another simple tool used is the Mini-Cog, a global screening measurement tool widely used in Medicare Annual Wellness Visits for cognitive impairment by measuring three-words, clock drawing, and 3-word recall (Borson et al., 2000). The tool is not predictive of dementia and has positive association with identifying moderate to severe cognitive impairment (Fage et al., 2015, February), but not the cause of cognitive impairment.

LNC EVALUATION USING DMES

All four tools are useful in identifying the categorical assignment for DMES and are recommended in the LNC evaluation of the elder abuse case records. When the information is absent, the LNC should rely on the best assessment with objective documentation in the record, where deficits are not necessarily a sum but represent the evaluator's best judgment at this time. For instance,

functional dependence with no cognitive decline may be less worrisome than moderate cognitive decline without functional impairment. It is important to remember that most institutions that provide 24-hour care to elders are required by federal and/or state laws to conduct assessments that determine the level of participation in ADLs and their cognitive abilities. In unsupervised community care homes, the only way to assess cognition and health is through deposition of the care providers and/or family members, who may be a person of interest during the investigation of a crime against the elder.

The article's design is to use a case series to inform the LNC to think about the older person as a target for maltreatment based on their vulnerabilities. The method used to introduce the tool described involves pseudo case studies that illustrate specific elements of the cognition and health status to help the LNC in the evaluation of the cases under adjudication, using the records and depositions available from family and neighbors who have access to the knowledge about the older person's cognition and function. When working for the plaintiff (e.g., possibly surviving family members), families often are sources of cognition and health information, useful for attorney strategies addressing the elder's vulnerabilities and all witnesses, including family members would be deposed. The DMES tool is presented here as a categorical assessment option when there are cases involving suspected elder maltreatment.

Pseudo case studies are the challenge to the reader, as they apply the elements of the matrix in determining their level of concern about risk of abuse and capacity to participate in adjudication (for instance, is the elder a reliable witness?). This matrix may be a way to explain to the court the vulnerability and allow the LNC to assist the attorney in identifying and evaluating the evidence. Table 2 is a simple method for assessing and identifying cognitive impairments and dependency in the cases presented.

CASE SERIES FOR THE LNC

Case #1

Charlotte, a retired bookkeeper, lives alone in the home she and her husband built after WWII. Her elder children check in several times a week with phone calls and "drop-ins." Charlotte is independent, mows her own grass and the grass of her neighbor. She schedules her week around church activities and drives to the nearby nursing home to play the piano for the residents. She prepares

Table 2: Decision Matrix for Elder Safety (DMES)©

GREEN = Mild YELLOW = Moderate RED = Severe		CAPACITY			
		Full Cognitive Function	**Obvious Focal Decline**	**Multiple Focal and Partial Global Decline**	**Full Global Decline**
HEALTH	**Full physical health/ function, managed with medication**	CD handling all aspects of life	CD with minor deficits present, requiring assistance with one ADL	CD or ID with identified focal deficits, requiring assistance with one ADL	CD or ID with full global decline deficits; requiring assistance with most ADLs; requiring assistance with all decision-making tasks
	Mild health/function decline, corrected with medications or activity	CD requiring assistance with one ADL	CD or ID requiring assistance with some ADLs	CD or ID with identified focal deficits, requiring assistance with some ADLs; requiring assistance with some decision-making tasks	
	Moderate health/ function decline	CD or ID requiring assistance with some ADLs; has full decision-making capacities	CD or ID requiring assistance with multiple ADLs; requiring assistance with some decision-making tasks	CD or ID with identified focal deficits, requiring assistance with multiple ADLs; requiring assistance with most decision-making tasks	CD or ID with full global decline deficits; requiring assistance with all ADLs; requiring assistance with all decision-making tasks
	Severe health/ function decline	CD or ID requiring assistance with all ADLs; has full decision-making capacities	CD or ID requiring assistance with all ADLs; requiring assistance with some decision-making tasks	CD or ID requiring assistance with all ADLs; requiring assistance with all decision-making tasks	CD or ID with full global decline deficits; requiring assistance with all ADLs; requiring assistance with all decision-making tasks

Legend: CD – Community Dweller; ID – Institutional Dweller; ADLs – activities of daily living

Definitions: Community dweller – lives in community; Institutional dweller – includes assisted living facilities and nursing homes; Assistance – implies needs direction and/or help with ADLs; ADLs – Activities of Daily Living, capacity to navigate their environment including but not limited to dressing, feeding, bathing, medications, but may not include driving, shopping, paying bills

DMES© Speck & Baker, 2020, used by JLNC with permission.

her own meals and delivers for "Meals on Wheels" one day each week. Recently while mowing her grass, she was approached by a repair person in a truck (unknown to her). He tells Charlotte that her roof has a hole in it. Since she can't see it, she allows him to climb on the roof. He returns with phone pictures of damage and states he needs to go into her attic to check for water damage. She takes him to the attic stairs and goes back to her kitchen to wait. She notices that after he left, her wedding ring was missing. After telling her son, he decided to call law enforcement. Charlotte explains that she probably misplaced the ring because it happens all the time and states, "it'll turn up later." She also explains that the repair person will be back next week with the patch for the roof, admitting that she had given him $250 cash to buy the supplies. Her son is very irritated with his mother.

Knowing what you do about Charlotte, complete the four tools to gain insight to Charlotte's functioning and cognition; then place her on the DMES. The LNC notes that Charlotte is in the green zone. She has full capacity and cognition to exercise her liberties without oversight. However, she demonstrated a vulnerability to an outside ploy where she trusted a repair person and was unable to appreciate the potential danger. The LNC uses the tool to advise Charlotte and her son about predatory behaviors and recommends an audit of the expenditures to determine other financial vulnerabilities. The son found that Charlotte made multiple errors in her checkbook documentation and had overdrawn the account, creating additional expenditures she could not afford. The son arranged for Charlotte to stay in her home but provided additional financial oversight and support to assist in decision- making for any spontaneous expenditure.

Case #2

Mary Frances is 75 years old, widowed three times with history of multiple head traumas. She has a sixth-grade education and worked in the cotton fields where she met her future husband. She married at 16 years of age. Her husband died when she was 40, leaving ten children, ranging in age from six weeks to 16 years. She married her second husband, who was an alcoholic within a year. When he died, Mary Frances lived for a time with one of her sons until she married her third husband. After being married for 18 months, her third husband died unexpectedly, and she could not afford the home they bought together. Mary Frances moved to an assisted living facility (ALF) with her son's help, and with her permission, he took all her valuables. Shortly after moving into the ALF, Mary Frances experienced a heart attack and had coronary bypass surgery. Over the last five years, her son had increased responsibility in caring for his mother while residing at the ALF. Mary Frances' "forgetfulness," has required assistance with medication management, occasional transportation, and finances. Since admission to the ALF, Mary Frances has progressed to mild global dementia. She has displayed aggressive behavior, resulting in fights with her neighbors, particularly a male neighbor confined to a wheelchair. This behavior prompted a brief geropsychiatric hospitalization for medication management that improved her functioning, allowing her to return to the ALF. She has remains ambulatory, able to orient to her location and friends' apartments at the ALF. She continues to prepare her meals, feed herself, toilet and bathe without assistance, and she attends many of the facilities group activities. Notably, she has had no recent altercations with neighbors. In addition to the medication, transportation, and finances, the son now washes clothes and cleans her apartment. In this case Mary Frances was the aggressor, hitting the male neighbor confined to the wheelchair. For that she was hospitalized, and her medication adjusted to diminish her angry outbursts. The LNC completed the four tools to gain additional insight to Mary Frances' current functioning and cognition. The attorney also asked the son to help address the decline in the last 6 months by completing a second DMES tool using the four tools to determine vulnerability documenting the decline over time. In this case, the LNC noted that the dementia worsened three months earlier, and it resulted in Mary Frances' hospitalization. While Mary Frances declined in functioning, she then improved in functioning after the medical intervention. Identifying the areas of assessment and responding to her needs for the son charged with caring for his mother was another intervention for the predictable global cognitive decline. Estimating vulnerability using the DMES helps plan for interventions necessary to maintain the remaining independence of the elder. In Mary Frances' case, the elder has progressive global dementia, caused by plaques throughout her body. The LNC notes that Mary Frances is in the yellow zone needing support for several ADLs and for safety. She has diminished capacity and diminished cognition to exercise her liberties without oversight. Her son is counseled on the assessment and encouraged to plan an intervention for increasing care needs and recognize when the next intervention is warranted.

Case #3

Gladys is 89 years old. She was married for 64 years before her husband died. Her son moved in with her several years ago, but her son became more neglectful as her health and cognition declined. The police visited her home because neighbors heard her calling out from the basement, yelling "help me!" The son had previously explained to the neighbors that Gladys had dementia and was going to be yelling periodically. The police found Gladys in her basement on plywood covered with a shower curtain. She was naked and had a soiled blanket beside her. Her son explained that she was not cooperative, kept soiling her bed and chair, so he washes her with a hose connected to the basement sink and

turns her once a day. He reports that he feeds her "when she'll open her mouth," and he says he tries at least three times a day. An ambulance transported Gladys to the hospital, and she was admitted with a diagnosis of failure to thrive and dehydration. She was unable to orient to her environment and did not know her son. Her nursing admission form noted Stage 2 pressure injuries on both sides of her hip bony prominences and bilateral ankle bony prominences. After stabilization, it was determined that she was severely neglected, but no charges were brought. Her progress in the skilled nursing home included self-feeding, talking to the nurses, and alerting the nurses when toileting was needed. She was able to walk with a walker without assistance. It was determined that she had severe dementia and needed full care. Nearing discharge, she had healed pressure injuries noted by scaring. The son was involved in discharge planning, stating he understood the amount of care she required, but he wanted to take her home. The physician discharged Gladys to the care of her son. Six months later, Gladys was back in the hospital with similar decomposition with Stage Four pressure injuries on her sacrum and heels of her feet, severe dehydration, and malnutrition. The son was not charged. After stabilization at the hospital, Gladys was transferred to the skilled nursing facility. Totally dependent and now non-verbal, responding only to pain; on a usual day Gladys lays silently on her bed or sits in her wheelchair on a usual day. She receives total care including help with feeding, dressing, bathing, and medication. She is passively cooperative but does not initiate any action. In evaluating Gladys' records, the LNC focuses on the risk at various points in her life, beginning when her son moved in with her. Neighbors reported that she was self-caring when her son moved in but quickly decompensated and that is why they called the police when they heard her yelling. The assumption is that Gladys was an independent community dweller before the son moved in with her. After authorities became involved, Gladys decompensated quickly. Upon discovery, she had no capacity to care for herself and no awareness of her surroundings, therefore her competence was compromised. In completing the DMES tool using the documentation available, at the various time periods, a picture emerges to document the neglect between home, hospital, and skilled nursing facility recovery. In the pre-discovery, neighbors reported her independent living, caring for all aspects of her life, placing her in the green zone of the DMES. Upon discovery by law enforcement, the LNC graded her to be in the red zone from the record. With discharge from the skilled nursing facility, she achieved a yellow zone designation and significant intervention with the son was initiated to address the deficits. A short time later, law enforcement discovered Gladys in very poor condition, transferring her to the hospital. The LNC placed Gladys back in the red zone and from that event, and unfortunately, she did not exit the red zone again. As a result, and against the protests from the son, she was transferred from the hospital to the nursing home for skilled nursing care.

SUMMARY

The individual elder is vulnerable to predatory behaviors of others. There are predictable declines associated with the aging process. The LNC's job in cases like this is to identify and evaluate the records related to whether there is evidence of actual abuse and what type. There is no method of serial classification of risk or levels of cognition and function. The article proposes a system whereby the LNCs document cognitive function and health capacities over time and demonstrates use of the DMES through a case series. The discussions help the LNC use the proposed classification to estimate risk and identify vulnerabilities related to the elder's cognition and health needs, specifically physical, sexual, financial, psychological and/or neglect, when abuse is suspected or confirmed.

REFERENCES

Administration for Community Living. (2016, September). *Final national voluntary consensus guidelines for state adult protective services systems*. U. S. Department of Health and Human Services. https://acl.gov/sites/default/files/programs/2017-03/APS-Guidelines-Document-2017.pdf

Administration for Community Living. (2017, September). *The elder justice act*. U.S. Department of Health and Human Services, Administration for Community Living. Retrieved November 19 from https://acl.gov/about-acl/elder-justice-act

American Association of Colleges of Nursing. (1998). *Essentials of Baccalaureate education for professional nursing practice*. American Association of Colleges of Nursing. https://www.aacnnursing.org/Portals/42/Publications/BaccEssentials08.pdf

American Association of Colleges of Nursing. (2006). *The essentials of Doctoral education for advanced nursing practice*. American Association of Colleges of Nursing.

American Association of Colleges of Nursing. (2011). *The essentials of Masters education in nursing practice*. https://www.aacnnursing.org/Portals/42/Publications/MastersEssentials11.pdf

American Association of Colleges of Nursing. (2020, November 11). *DRAFT The essentials: Core competencies for professional nursing education* [Consensus Document]. https://www.aacnnursing.org/Portals/42/Downloads/Essentials/Essentials-Draft-Document.pdf

American Nurses Association. (2018). *The Nursing Process*. American Nurses Association. Retrieved January 1 from https://www.nursingworld.org/practice-policy/workforce/what-is-nursing/the-nursing-process/

Baker, N. R., & Kim, J. (2019). Recognizing and Addressing Elder Abuse in the Primary Care Setting. *Advances in Family Practice Nursing, 1*, 99-115. https://doi.org/https://doi.org/10.1016/j.yfpn.2018.12.004

Borson, S., Scanlan, J., Brush, M., Vitaliano, P., & Dokmak, A. (2000). The Mini-Cog: a cognitive 'vital signs' measure for dementia screening in multi-lingual elderly. *International Journal of Geriatric Psychiatry, 15*(11), 1021-1027. https://doi.org/10.1002/1099-1166(200011)15:11<1021::AID-GPS234>3.0.CO;2-6

Center for Disease Control and Prevention. (2020, May 12). *Elder Abuse: Risk and Protective Factors*. U.S. Department of Health & Human Services. https://www.cdc.gov/violenceprevention/elderabuse/fastfact.html

Darby, R. R., & Dickerson, B. C. (2017). Dementia, Decision Making, and Capacity. *Harvard Review of Psychiatry, 25*(6), 270-278. https://doi.org/10.1097/hrp.0000000000000163

Dong, X. (2012). Advancing the field of elder abuse: future directions and policy implications. *Journal of the American Geriatrics Society, 60*(11), 2151-2156. https://doi.org/10.1111/j.1532-5415.2012.04211.x

Dong, X., & Simon, M. A. (2015). Elder self-neglect is associated with an increased rate of 30-day hospital readmission: findings from the Chicago Health and Aging Project. *Gerontology, 61*(1), 41-50. https://doi.org/10.1159/000360698

Fage, B. A., Chan, C. C. H., Gill, S. S., Noel-Storr, A. H., Herrmann, N., Smailagic, N., & Nikolaod, V. (2015, February). Mini-Cog for the diagnosis of Alzheimer's disease dementia and other dementias within a community setting. *Cochrane Systematic Review - Diagnostic*. https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD010860.pub2/full#CD010860-sec1-0005

Filaković, P., Erić, A. P., Mihanović, M., Glavina, T., & Molnar, S. (2011). Dementia and legal competency. *Collegium Antropologicum, 35*(2), 463-469.

Folstein, M. F., Folstein, S. E., & McHugh, P. R. (1975). "Mini-Mental State" A practical method for grading the cognitive state of patients for the clinician. *Journal of Psychiatric Research, 12*(3), 189-193. doi: 10.1016/0022-3956(75)90026-6

Graf, C. (2006). Functional decline in hospitalized older adults. *American Journal of Nursing, 106*(1), 58-67, quiz 67-58. https://doi.org/10.1097/00000446-200601000-00032

Jin, J. (2018). Screening for Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults. *JAMA, 320*(16), 1718-1718. https://doi.org/10.1001/jama.2018.14851

Karr, J. E., Graham, R. B., Hofer, S. M., & Muniz-Terrera, G. (2018). When does cognitive decline begin? A systematic review of change point studies on accelerated decline in cognitive and neurological outcomes preceding mild cognitive impairment, dementia, and death. *Psychology and aging, 33*(2), 195–218. https://doi.org/10.1037/pag0000236

Katz, S. (1983). Assessing self-maintenance: activities of daily living, mobility, and instrumental activities of daily living. *Journal of the American Geriatrics Society 31*(12), 721–727. https://doi.org/10.1111/j.1532-5415.1983.tb03391.x

Kluger, A., Ferris, S. H., Golomb, J., Mittelman, M. S., & Reisberg, B. (1999). Neuropsychological Prediction of Decline to Dementia in Nondemented Elderly. *Journal of Geriatric Psychiatry and Neurology, 12*(4), 168-179. https://doi.org/10.1177/089198879901200402

Lachs, M. S., Williams, C. S., O'Brien, S., Pillemer, K. A., & Charlson, M. E. (1998). The mortality of elder mistreatment. *JAMA, 280*(5), 428-432.

Lawton, M. P., & Brody, E. M. (1969). Assessment of older people: self-maintaining and instrumental activities of daily living. *Gerontologist, 9*(3), 179-186.

Mion, L. C., & Momeyer, M. A. (2019). Elder abuse. *Geriatric nursing* (New York, N.Y.), *40*(6), 640–644. https://doi.org/10.1016/j.gerinurse.2019.11.003

Noelker, L. S., & Browdie, R. (2014). Sidney Katz, MD: A New Paradigm for Chronic Illness and Long-Term Care. *Gerontologist, 54*(1), 13-20. https://doi.org/10.1093/geront/gnt086

Speck, P. M., Hartig, M. T., Likes, W., Bowdre, T., Carney, A. Y., Ekroos, R. A., Haugen, R., Crum, J., & Faugno, D. K. (2014). Case series of sexual assault in older persons. *Clinics in Geriatric Medicine, 30*(4), 779-806. https://doi.org/10.1016/j.cger.2014.08.007

Van Den Bruele, A. B., Dimachk, M., & Crandall, M. (2019). Elder Abuse. *Clinics in Geriatric Medicine, 35*(1), 103-113. https://doi.org/10.1016/j.cger.2018.08.009

VandeWeerd, C., Paveza, G. J., Walsh, M., & Corvin, J. (2013). Physical Mistreatment in Persons with Alzheimer's Disease. *Journal of Aging Research, 2013*, 920324. https://doi.org/10.1155/2013/920324

World Health Organization. (2020). *Elder abuse*. https://www.who.int/ageing/projects/elder_abuse/en/

Yon, Y., Mikton, C. R., Gassoumis, Z. D., & Wilber, K. H. (2017). Elder abuse prevalence in community settings: a systematic review and meta-analysis. *Lancet Glob Health, 5*(2), e147-e156. https://doi.org/10.1016/s2214-109x(17)30006-2

Young, L. M. (2014). Elder physical abuse [Review]. *Clinics in Geriatric Medicine, 30*(4), 761-768. https://doi.org/10.1016/j.cger.2014.08.005

Ziminski Pickering, C. E., & Rempusheski, V. F. (2014). Examining barriers to self-reporting of elder physical abuse in community-dwelling older adults. *Geriatric Nursing (New York, N.Y.), 35*(2), 120-125. https://doi.org/10.1016/j.gerinurse.2013.11.002

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Workers' Compensation Considerations When Reviewing COVID-19 Claims

Maureen T Power, RN MPH LNCC CCM

Keywords: COVID-19, occupational disease, compensability, workers' compensation statute, workers' compensation, scope of employment, accident, work related, pandemic, exposure

When asked to review a workers' compensation claim, the Legal Nurse Consultant (LNC) should proceed in a logical fashion enabling the LNC to obtain a general sense of the claim, most likely receiving records in electronic format. The LNC begins the process with an inventory of what preliminary records are necessary and what has been forwarded. COVID claims may require the LNC to identify other authoritative resources providing additional education necessary to understand the virus itself. It should be noted, there may be few, if any claims to review. Even fewer COVID-related claims may be cited by the courts since courts were closed for a long duration at the beginning of the pandemic and the workers' compensation claim process generally takes months to possibly years to work through the court system. Thus, the most basic information providing value for the nurse will be a comprehensive knowledge of the workers' compensation statute where the claimant has filed the claim. Each state enacts a specific workers' compensation statute or act that is followed, citing state specific rules and regulations that address workers' compensation claims.

For those LNCs familiar with workers' compensation claims, the reviewer has generally developed a style for a review or may be asked by the attorney or the carrier to address specific elements of the file to meet the requestor needs. Reviewing the first COVID-19 claim will be no different for the Legal Nurse Consultant because of the COVID designation. Certain pieces of information may be required to assist in the process of the review or analysis. This article provides an overview for the LNC to establish what information should be included in the file review to help determine compensability for the claimant

and claim. Compensability is always an issue in workers' compensation claims and whether the claimant should be awarded benefits to compensate for time lost from work, medical expenses and any disability that could have resulted from the event causing harm.

Legal Nurse Consultants serve as valuable team members and perform a variety of roles in addressing work related injuries in diverse industries managing workers' compensation claims. This article will only focus on the role of the nurse in reviewing COVID-19 claims. Examples of nursing roles that exist in the workers' compensation marketplace include:

1. **Legal Nurse Consultant** – assisting the attorney or insurance carrier in file analysis, literature review, establishing work related baseline and compensability
2. **Risk Manager/Legal Nurse Consultant** – oversight of all claims within an organization, liaison between organization and carrier in managing claims, corporate exposure, business interruption, oversight in workforce management of safe work practices, liaison with legal/insurance team to mitigate damages, provider management
3. **Occupational Health /Legal Nurse Consultant** – in-house management of all workforce injuries, assisting in development of modified duty or job function, coordinating case management, healthcare provider liaison and reducing exposures in unsafe work practices, monitoring claims activities, collaboration with legal and insurance team. Work related injuries may result in worker's compensation claims and legal nurses utilize their background extensively in occupational health
4. **Infection Control Practitioner/ Legal Nurse Consultant** – managing evolving pandemic healthcare issues related to transmissibility, securing and inventory of personal protective equipment (PPE), developing policy and procedures addressing work related issues specific to prevention or controlling the spread of the COVID-19 virus, development, and review of contact tracers to determining a work-related versus external exposure to COVID-19.

WORKERS' COMPENSATION AND OCCUPATIONAL DISEASE

It is important to understand workers' compensation and occupational disease basics before embarking on the file review assignment. Workers' compensation issues dealing with infectious disease are not new to employee related allegations. Infectious disease and work-related exposures have been alleged in the past for H1N1, Zika, Ebola, SARS and even HIV. As with any issue never seen or dealt with before, the outcome, disposition, impairment, or disability the virus may have caused, may take years to conclude. Healthcare providers do not know the ultimate physical impact or impairment the virus will have on the individual or workers' respiratory, cardiac, or other body system. For this reason, claims deemed "compensable" for COVID-19, will be monitored for long-term residual medical issues related to the virus.

The workplace is not necessarily in the bricks-and-mortar building of the employer but includes the virtual work environment.

Worker's compensation benefits are, in general, available to the worker through the employer. States have enacted workers' compensation statutes that define rules and regulations for processing claims for anyone involved in worker injury. An example of information found in a statute, addresses various entities' responsibilities in the claim process for entities such as: organizations, employers, attorneys, insurance carriers, providers, and employees. The processing of claims and care management will vary from state to state as determined by the state legislature who enacted the workers' compensation statute.

While the definition of what constitutes an injury can vary by state, a few critical concepts are essential distinctions in workers' compensation. A compensable workers' compensation injury is one which: (1) occurred in the course of employment, meaning the alleged injury happened at work; and (2) arose out of, or was proximately caused by, the injured worker's employment. Not all injuries that occur in the workplace are compensable. The workplace is not necessarily in the bricks-and-mortar building of the employer but includes the virtual work environment.

The legal nurse, accepting a workers' compensation file for review should be well-versed in rules and regulations surrounding work related injuries and occupational exposures in the state wherein the claim is filed. Nurse analysis of the claim may also address medical record abstract, definitions, procedures, and benefits. The legal nurse analyzing claims for a national insurance carrier or national law firm will still need to utilize a state specific workers' compensation statute to facilitate an accurate analysis for the claim.

An understanding of occupational disease in the consideration of worker's compensation is important. In general, an occupational disease is not typically caused by one incident or one

event. Many states, by statute require an injured worker to identify a specific patient/person, date or time of exposure and positive testing results in terms of securing coverage for that claim. This requirement alone would rule out COVID-19 as an occupational disease in many states and currently has resulted in a denial of exposure in states wherein the language of occupational disease is defined by identifying one event, one person/patient or one exposure incident. Questions of whether COVID-19 will be deemed an occupational disease will remain unanswered until the state courts have ruled on how COVID-19 will be viewed. In addition, COVID-19 legislation enacted post-pandemic deeming specific job titles or industries will be presumed to be exposed thus negating the argument of occupational injury. Questions regarding the term "employment" in reference to a work-related accident having occurred, and benefit coverage remains debated as well in this COVID-19 disease process. Finally, debate remains ongoing if workers, in the scope of employment, are at greater risk or hazard of contracting COVID-19 when compared to the general public in contracting the virus. The court cases for final disposition, dispute of compensability, disability and citation of precedence remain ongoing in states with outcomes too soon to be referenced.

As the pandemic progressed, with escalation of infections, panic, concerns of increasing transmissions, the need for personal protective equipment for workers became paramount. Employers have a duty, as defined in regulatory language, to provide personal protective equipment to workers. Employees have a responsibility to comply with the education on proper utilization and wearing of the equipment. Employee lack of compliance with wearing of personal protective equipment does not represent a reason for denial of benefits in workers' compensation. Compensability

Questions regarding the term "employment" in reference to a work-related accident having occurred, and benefit coverage remains debated as well in this COVID-19 disease process.

debate will be included in all claims but no more so than in early pandemic claims when workers were not necessarily wearing equipment or had access to equipment when dealing with the public or even a known infected person. The legal nurse will include employer policy statements regarding reporting injury, record of education, employee selection of leave practices as part of the analysis of the record. Front line worker designation and definition remains unclear in many states as the definition of coverage and inclusion of front-line status remains as varied as the number of states. Discussion and debate continues in sectors of insurance, healthcare, legal, and business communities as to how COVID-19 claims will be ruled on and the long term health impact of the alleged injured worker, therefor the nurse analysis will be including information that may impact or assist final disposition of a claim.

States have issued executive orders or laws that created legal presumption of workers' compensation coverage for certain employees who contract COVID-19. Presumption has been tied to specific workplaces or job duties and titles where it is generally considered infection would more easily occur. For instance, first responders were, very early on in the pandemic, deemed at higher risk for contraction of the virus simply because of the job performed and exposure to the general public who could have been infected. Early in the pandemic, it was not unusual for a paramedic /firefighter to claim an exposure to a confirmed/unconfirmed patient. The claim of a possible exposure then resulted in the entire fire house staff claiming exposure to the fellow employee who had possibly been exposed. This resulted in multiple claims being filed by paramedic/firefighters in the municipality and a near immediate reduction in force of a firefighter /paramedic shift because of possible exposure of the individual, all exposed staff quarantined for a duration of up to fourteen days. In many states, the possible exposure also resulted in benefit payment, lost wages, for the quarantine period, based on state statutory language designation resulting from presumption. To date, not all states have adopted presumption and as such the numbers of claims filed is impacted state-to-state.

FILE REVIEW PROCESS

The file analysis process begins with fact-finding and personal scanning of the records initially available to obtain a snapshot determination of what the file is about. The file analysis or abstract might include a review of medical records and information leading to a determination of accident (by definition) or exposure having occurred. What might appear obvious to a worker, "I was at work when I became ill," a common statement voiced by a worker, may not necessarily be deemed a compensable accident or exposure. Secondarily, a determination if the accident occurred within the scope of employment and job duties is another necessary test in determining whether

accident will be accepted by the carrier and the employee compensated.

Workers can become frustrated in working with the employer in the care management of an injury. Likewise, if a claim is filed against the employer by the employee, heightened frustrations by the claimant employee may still take place based on statutory rules and procedures followed once injuries enter the claim designation status. Lastly, workers' compensation claims do not always involve an attorney which is a distinction in this specialty. Attorney involvement is state specific and defined in the workers' compensation statutes for a specific state.

The role of the nurse is to review the file for all elements addressing concerns of accident and scope of employment, secondarily noting information about salary and wages, supplemental employment, investigation information about the accident. In many states, the nurse may work with the legal team in identifying expert medical providers for expert opinion regarding medical care provided, review of expenses in the claim, ability of the worker to return to gainful employment and based on the injury, expectations regarding percent of residual disability expectations post claimant reaching maximal medical improvement.

The following list represents components of the worker's compensation file used to provide a full analysis of the file (some, none, or all items may be available). This writer breaks the components into two categories:

a) File Contents. The legal nurse tracks what information is missing in order to provide a thorough review and analysis of the records

b) Other Resources: Identify what resources or reference material may be helpful for the nurse to assist in understanding the disease process or state workers' compensation requirements

File content examples:

1. Employee Records

Employee statement to adjuster or employer: events surrounding exposure, salary, last date of work, status of employment, date of suspected infection, medical and treatment history, contact tracing, etc.

2. Employer Records

Human Resource Records:

- Report of Injury also known as Employee Statement of Injury – required by employers when an injury occurs- can be verbal or written and is defined in the state workers' compensation statute
- Wage Statement – state requirements identify a specific duration of employment history. This duration of wages leads to securing an average week wage that will represent weekly benefits paid to an injured worker. The legal nurse or attorney may calculate this and will be referred to as average weekly wage (AWW) in the file analysis, in adjuster notations or legal discussions
- Medical & Other Records may include:

  Job description, contact tracer tool, medical records, and occupational health records
- Employment records
- Group health records
- Other miscellaneous forms, communication by the employer disseminated to the employee population throughout the pandemic discussing process for handling COVID-19 patients. Example communication have included:

  Centers for Disease Control and Prevention (CDC) updates or directives, work from home policy, safe work practices, PPE, notification of illness, temperature checks
- State, city, county, or public health updates; travel related instructions; human resources policy; practice updates
- All employer human resource policy information regarding any salary, time loss or pandemic specific communication to employees, any elections an employee has made during time lost as outlined in the state specified language

3. Carrier/Adjuster Records

Carrier communication and adjuster notes, legal communication, medical records, court decisions made regarding claim status, expenses paid, outstanding expenses and reserves available for each claim, hearing outcomes

Other Resources

Consider tools that provide additional value to the reviewer, carrier, attorney in support of understanding issues surrounding virus and occupational injury

- **Center for Disease Control and Prevention (CDC)**

  Point of reference for individuals seeking to understand current medical, scientific, protocols for prevention of spread of disease and information about the virus.
- **Occupational Safety and Health Administration (OSHA)**

  OSHA, part of the United States Department of Labor serves to promote a safe and healthy working

environment, setting and enforcing standards for the employer, providing education and assistance to the worker and employer.

It should be noted, not all organizations come under OSHA jurisdiction, so be sure when citing OSHA regulations, the reference is relevant to the state the workers' compensation claim was filed.

- **Dashboards**

  Dashboards have been created during the pandemic to track numbers of infections, number of deaths, number of hospitalizations, numbers of claims received, number of claims denied, number of individuals tested, conversion rate, vaccine acceptance/declination, workdays lost, and many other variables.

  Dashboard tracking data points are dependent on the entity or industry. Dashboards have been useful in monitoring community spread and have been used to determine probability of exposure or transmission in a specific workplace.

Workers' Compensation State Statute:

- Benchmark state specific resource explaining all aspects of the process of workers' compensation and occupational disease
- Defines how accident, compensability, wages, scope of employment is determined. The factual information to support issues in the claim will be noted in the file review completed by the legal nurse
- All rules, processes, practice of workers' compensation will be explained in the statute

  State Statute Examples (examples can be accessed for every state by searching workers' compensation statutes:

  Illinois Workers' Compensation Act – 820 ILCS 305
  https://www.ilga/gov/legislation/ilcs/ilcs3/actID=2431

  820 ILCS 310/Workers' Occupational Diseases Act
  https://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=2431&ChapterID=6

  Texas Workers' Compensation Act
  https://www.tdi.texas.gov.act

  Wisconsin Workers' Compensation Act
  https://www.dwd.wisconsin.gov

4. **Insurance Carrier Related Resources:**

- NCCI, the National Council on Compensation Insurance, gathers data, analyzes industry trends, and provides information valuable to a wide insurance audience.
- WCRI, Workers' Compensation Research Institute

  Monitors state systems on a regular basis to identify changes in the workers' compensation state systems. Provides feedback to users on all aspects of industry and state specific, for example: medication and cost trending, industry trends, research findings, etc.

SUMMARY

The role of the legal nurse consultant is exciting and will continue to evolve. Experienced LNCs are counted on to provide valuable insight and interpretation regarding course of disease and effects of the injury or exposure on the injured worker. LNCs assisting on a workers' compensation claim, may be involved in a variety of roles including claimant interviews, analyzing records, assisting in researching labor, safety, public health, disease state and state specific workers' compensation laws. The opportunity for full time, regular employment in the workers' compensation marketplace is generally more common when working as an employee for an organization, carrier, or law firm rather than fee-for-service. The work performed as an LNC risk manager is diverse and always a blend of healthcare, legal, claims, safety or other areas and should never be ruled out as a legal nurse career choice.

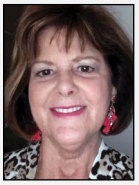
REFERENCES

Center for Disease Control and Prevention. (2020). COVID-19. https://www.cdc.gov

NCCI. (2021). COVID-19 and Worker's Compensation: What You Need to Know Resource Center. https://www.ncci.com/Articles/Pages/COVID-19.aspx?

Occupational Health and Safety. (2020). Coronavirus Disease (COVID-19). https://www.osha.gov/coronavirus

WCRI (2021). The Early Impact of COVID-19 on Workers' Compensation Claim Composition. https://www.wcrinet.org/



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Continuing Education Summer 2021 JLNC62021-1

Considerations When Evaluating COVID-related Medical Malpractice and Personal Injury Cases

Author Julie Dickinson MBA, BSN, RN, LNCC

This activity is designed to augment the knowledge and skills of legal nurse consultants and assist in their understanding of the analysis of medical malpractice and personal injury claims involving the coronavirus pandemic.

Upon completion of the learning activity the learner will be able to:

a. evaluate medical malpractice and personal injury claims involving incidents arising during the COVID-19 pandemic.
b. assess liability in pandemic-related claims for medical malpractice and personal injury cases.
c. identify the focus for their medical literature research and application of the standard of care for treating COVID patients for litigation cases they are involved in.

The author, reviewers, and nurse planners all report no financial relationships that would pose a conflict of interest.

This activity has been awarded 1 Contact Hour of credit. The activity is valid for credit until June 1, 2024.

CE Test and Application

Choose the best answer for each question. Required minimum passing score is 70%.

1. According to the COVID-19 Complaint Tracker (2021), COVID-related complaints have:
   a. stayed about the same in number from January 30, 2020 to September 1, 2020.
   b. almost doubled from January 30, 2020 to September 1, 2020.
   c. decreased by 1/3 from January 30, 2020 to September 1, 2020.

2. When evaluating liability for COVID-related cases, the LNC should consider:
   a. how affected the healthcare facility was by the pandemic and how the standards of care, treatment decision-making, and outcomes may have been altered.
   b. if the facility was operating under a patient-centered or population-centered standard of care.
   c. all of the above.

3. Standard of care research should include any standards or guidelines published by The Centers for Disease Control and Prevention (CDC) that were in effect when the care in question was rendered.
   a. True
   b. False

4. What types of cases are likely to center on allegations that a business failed to enforce or improperly enforced safety rules to minimize the risk of transmission of coronavirus?
   a. Malpractice
   b. Personal injury
   c. Licensure / administrative actions

5. The Act that states "a health care professional shall not be liable under Federal or State law for any harm caused by an act or omission of the professional in the provision of health care services [as a volunteer] during the public health emergency with respect to COVID-19…if... [the] health care services… are within the scope of the license, registration, or certification of the volunteer…" is:
   a. the Coronavirus Aid, Relief, and Economic Security (CARES) Act.
   b. the Emergency Disaster Treatment Protection Act (EDTPA).
   c. the Crisis Standards of Care Act (CSCA).

6. For cases alleging negligence in the diagnosis, care, and treatment of COVID, what will the LNC's medical literature research need to focus on?
   a. the information known, available, and accepted in the medical community at the time this care was rendered
   b. the standard of care that has been established at present for current treatment of COVID
   c. only FDA approved measures in place at the time of care in question

Continuing Education Summer 2021 JLNC62021-2

Case Series for the LNC: Assessing Risk for Elder Abuse Using DMES©

Authors: Natalie R. Baker DNP, CRNP, GS-C, CNE, FAANP and Patricia M. Speck DNS, CRNP, FNP-BC, DF-IAFN, FAAFA, SF-AFN, FAAN

This activity is designed to provide Legal Nurse Consultants with resources and demonstration for a classification system designed to document cognitive and health decline patterns over time using caregiver reports or medical/social records.

Upon completion of the learning activity the learner will be able to:

a. understand use of classification system designed to document cognitive and health decline patterns over time using caregiver reports or medical/social records.
b. determine liability with the level of decline and identify interventions to mitigate the maltreatment risk.
c. apply the DMES system learned to 3 cases provided in the series.

The author, reviewers, and nurse planners all report no financial relationships that would pose a conflict of interest.

This activity has been awarded 1 Contact Hour of credit. The activity is valid for credit until June 1, 2024.

CE Test and Application

Choose the best answer for each question. Required minimum passing score is 70%.

1. The majority of reported elder abuse episodes come from:
   a. nursing homes
   b. emergency departments
   c. primary care providers

2. The Decision Matrix for Elder Safety (DMES) classification system is a:
   a. classification system allowing the LNC to serially evaluate function and cognition.
   b. system to evaluate the risk an elder has for potential abuse.
   c. all of the above.

3. Which evaluation tool consist of 30 items assessing orientation, attention/working memory, short-term memory, language, and visuospatial skills to measure the domains of orientation, repetition, verbal recall, attention and calculation, language, and visual construction to give an estimate of global cognitive function and screen for dementia?
   a. Lawton Instrumental Activities of Daily Living Scale
   b. Mini-Mental State evaluation (MMSE)
   c. Mini-Cog

4. What is the estimated percent of adults aged 60 and older at risk of becoming a victim of elder abuse according to the World Health Organization in 2020?
   a. 4.5%
   b. 15.7%
   c. 22.3%

5. What condition places an individual at the greatest risk of abuse?
   a. Cognitive impairment.
   b. Physical dependence.
   c. Anxiety disorder.

6. A global screening measurement tool used for positive association with identifying moderate to severe cognitive impairment measuring identification of two common objects, clock drawing, and 3 word recall is the:
   a. Lawton Instrumental Activities of Daily Living Scale
   b. Mini-Mental State evaluation (MMSE)
   c. Mini-Cog

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