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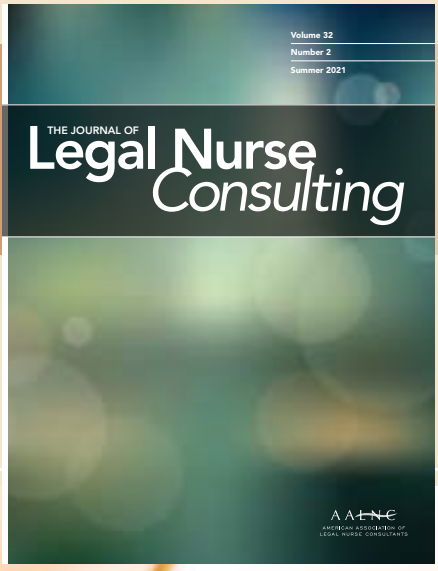

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PURPOSE

The purpose of the *Journal* is to promote legal nurse consulting within the medicallegal community; to provide novice and experienced legal nurse consultants (LNCs) with a quality professional publication; and to teach and inform LNCs about clinical practice, current legal issues, and professional development.

MANUSCRIPT SUBMISSION

The *Journal* accepts original articles, case studies, letters, and research. Query letters are welcomed but not required. Material must be original and never published before. A manuscript should be submitted with the understanding that it is not being sent to any other journal simultaneously. Manuscripts should be addressed to JLNC@aalnc.org. Please see the next page for Information for Authors before submitting.

MANUSCRIPT REVIEW PROCESS

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

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

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

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- Use Word© format only (.doc or .docx)
- Submit only original manuscript not under consideration by other publications
- Put title and page number in a header on each page (using the Header feature in Word)
- Place author name, contact information, and article title on a separate title page, so author name can be blinded for peer review
- Text: Use APA style (Publication Manual of the American Psychological Association, 7th edition) (https://owl.english.purdue.edu/owl/resource/560/01/)
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- Include a 100-word abstract and keywords on the first page
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- 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)

INSTRUCTIONS FOR PERMISSIONS

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

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Lisa Mancuso,
BSN, RN, CCRN, CLCP, LNCC
President, AALNC

President's Update

With a great deal of sadness, I must announce that this quarter's issue of the *JLNC* will be its last. I know I speak for each of the AALNC presidents before me when I say that it has been our honor to publish this peer-reviewed journal for the last 34 years.

At the Fall 2023 Board of Directors meeting, we had to make some challenging decisions. One of those decisions involved *The Journal of Legal Nurse Consulting*. While the *JLNC* has never been a money maker for our organization, recent data indicates it is no longer cost-effective to continue to produce it. We monitor such things as page views and click rates. Only 7% of our membership reads the *JLNC* each quarter. The BOD recognizes that continuing to spend money on publishing the *JLNC* is a poor way to use our resources.

As proud as we are of the *JLNC* and the authors who have contributed over the years, the data doesn't lie—it's obvious that AALNC members are less interested in the *JLNC* than they are in our educational content, including Jumpstart and the LNC Professional Course. We know from our annual needs assessment survey and the emails and phone calls we receive that our members are looking for mentorship, connection, and networking.

To serve those needs, please be on the lookout for information about our new, informal networking opportunity called the LNC Lounge. This is a monthly Zoom meeting hosted by different members of the BOD with guest speakers. The topics vary each month, but some of the ideas we are considering covering in the next few months are expert witness tips and techniques, marketing, business development, resume/CV "best practices," and much more. (As I write this message, our first LNC Lounge is taking place on Monday 10/23/2023. I'm very excited about this new event.)

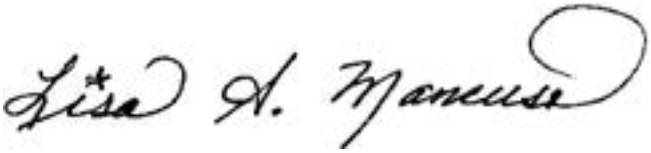
"The feeling is less like an ending than just another starting point."
– Chuck Palahniuk

Meanwhile, please remember to keep the conversations going in our shared interest groups (SIGs). This virtual community is a wonderful, safe place to bring your questions, thoughts, and ideas.

The LNC Jumpstart will continue, and we have plans to offer it more frequently. Forum 2024 is just six months away. It will be held in Pittsburgh, PA April 18-20, 2024, at the Omni Hotel; the education and networking will be amazing.

Although future publications of the *JLNC* will no longer be available, the Journal archives will continue to be available via the website. If you haven't had a chance to go through the archives, the past issues are easily searchable using keywords. I hope you'll take advantage of this important member benefit.

Wishing all of you a healthy, happy, and prosperous New Year and I'm looking forward to connecting with you in Pittsburgh!



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Editor's Note

Shawna M. Butler,
DNP, JD, RN, CPHRM
Editor, JLNC

I hope you all enjoy this final issue of *The Journal of Legal Nurse Consulting*. We have many thought-provoking articles on various topics. It has been such an interesting ride to be in an editorial role for the first time. I am disappointed that the Journal will not be published after this issue, but I encourage you to still peruse the previous volumes of scholarly articles that will remain available and relevant in the archives.

I thoroughly enjoyed working with all the authors, experienced and novice alike. As a nurse attorney with experience at law firms and risk management departments, I had some opportunity to work with LNCs in the past but not to the extent that I did in this role as editor. LNCs are such a valuable resource. In some settings, they may be an untapped talent. They have a role at the intersection of nursing/healthcare and the law and could add tremendous expertise in areas where they are not currently being utilized. I had the pleasure of working with the LNC authors along with all the editorial committee members. LNCs have a lot to offer, and I encourage you to seek roles in areas that may not have traditionally been utilizing LNCs historically. This niche area has much to add to many healthcare, legal and regulatory settings.

It is such a joy to see somebody (usually a nurse or nurse LNC) transition from their daily role as expert practitioner to one that includes being in an additional expert role where they can share their expertise as an author with their peers. At first it can be so intimidating to submit an article (I still remember that), and the potential author may not realize the value they offer to their community of LNCs or other clinicians in a particular field even if they have not written in the past.

If you have ever thought about authoring an article, I encourage you to take the leap and try it. You can usually find somebody that will possibly mentor you from the nursing community (reach out through your networks or a nursing organization along with the members of the AALNC). Try not to allow being intimidated to prevent you from partaking in this milestone if it is something you always thought about or even just considered recently. While this Journal is not accepting articles any longer, there are many nursing or healthcare journals out there that will consider accepting novice authors. The International Academy of Nursing Editors (INANE) is a group that may be able to be utilized for aspiring authors. They have a journal directory on their website: INANE – International Academy of Nursing Editors

Finally, I would like to end by extending my enormous appreciation to the devoted members of the *JLNC* editorial committee. These members use their expertise and support authors (and the editor!) out of kindness, an appreciation for the importance of their profession, and a respect for strong scholarly articles being published. They do this while working full-time in their professional roles. Your support and guidance of me has been invaluable. I could never find the appropriate words to articulate how much your help made this a positive experience that I will always look back on with a smile. Thank you sincerely (and please keep in touch)!

Thank you,

Shawna Butler

Shawna M. Butler, DNP, JD, RN, CPHRM

Consulting with Occupational Therapists

Tori Goldhammer, MS, OTR/L, ATP, CAPS, ECHM, CEAC, CFPS, CLCP

Keywords: occupational therapy, OT, therapy, occupational therapists, rehabilitation therapy, litigation

It is often difficult to fully understand the role of an Occupational Therapist (OT) across settings and populations. OTs work in various settings, from medical rehabilitation facilities to schools and community-based practice. Although the setting, population, and interventions differ significantly, an OT aims to facilitate the client/patient's participation in meaningful occupations. Often, OTs will become experts in their specific field of practice, for example, pediatrics or neurology, by earning board credentials and/or specialty certifications. OTs with this additional level of training can be valuable consultants for Legal Nurse Consultants or Life Care Planners, as they can opine about interventions and recommendations for specific injuries/disabilities to help the client/patient/evaluee achieve a maximized level of performance in their desired occupations.

OVERVIEW

The role of an occupational therapist is varied and diverse across populations and settings. As a result, occupational therapy (OT) is often misunderstood. These misunderstandings exist in the United States (Kuhaneck-Miller, 2019) and worldwide (Wan Yunus, 2022). According to the American Occupational Therapy Association's (AOTA) website, "Occupational therapy enables people of all ages to participate in daily living". It further explains, "Occupational therapy intervention uses everyday life activities (occupations) to promote health, well-being, and your ability to participate in the important activities in your life." This definition remains broad and often doesn't fully explain the role of occupations and occupational therapy on a transdisciplinary healthcare team. This article will explain the role of the OT across settings and the value an OT can add to a cost projection and/or life care plan.

BACKGROUND

Understanding occupational therapy requires an understanding of the word occupations. According to the AOTA 2020 Practice Framework (AJOT, 2020), occupations are "various kinds of life activities in which individuals, groups, or populations engage, including activities of daily living, instrumental activities of daily living, rest and sleep, education, work, play, leisure, and social participation." Occupational therapists provide client-centered, evidence-based evaluations and assessments to help individuals participate in meaningful occupations (Law, 1990). Law (1990) further explains that participation in desired occupations is defined as occupational performance. The specific type of intervention varies tremendously based on the particular setting, age, and situation of the individual receiving the intervention.

This activity is designed to increase understanding of work of occupational therapists and how they can assist in litigation.

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

a. Define the role of the occupational therapist (OT) across settings and populations.
b. Identify what is important for the LNC to note when reviewing OT therapy notes in medical records for litigation.
c. Identify how the OT can assist the LNC in litigation and resources to find the appropriate OT for a case.

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

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For example, in an acute hospital setting, an OT might work with a neonate in the NICU on oral motor skills and educate the parents on handling skills to facilitate development. On the orthopedic floor, an OT would work with an adult post-hip replacement to teach them how to complete their Basic Activities of Daily Living (BADLs) while maintaining hip precautions. In an acute inpatient rehab setting, the OT is part of a transdisciplinary team working on ADLs and Instrumental Activities of Daily Living (IADLs) for return to the community. The OT might work with a patient who suffered a traumatic brain injury (TBI) on visual motor skills and sequencing to prepare a meal or bedside dressing for a patient with a spinal cord injury. An OT in a sub-acute rehab setting often works on the same skills. In contrast, in an assisted living or long-term care setting, they will educate the staff and caregivers on cues, equipment, and positioning for safe participation in meaningful occupations at any level. Once a patient returns home, a home health OT will work on functional transfers, ADLs, and IADLs in the home as part of a transdisciplinary team.

Pediatric OTs work in early intervention, school settings, and facility-based and private clinics. Although the interventions can be markedly different and include managing issues such as sensory integration, handwriting, and organization skills, the foundation of helping children participate in their meaningful occupations remains consistent. Children's occupations include play, school, and basic ADLs.

Occupational therapists provide client-centered, evidence-based evaluations and assessments to help individuals participate in their meaningful occupations

...any OT practitioner using evidence-based practice will focus their interventions and recommendations on helping the patient/client participate in their desired occupations.

OTs have traditionally worked in all of the above healthcare/school-based settings based on typical reimbursement. However, OTs are beginning to work in the community through various funding sources, such as Medicaid Waivers, the Program of All-Inclusive Care for the Elderly (PACE) programs, and grant-funded programs, to ensure that individuals can remain safely in their homes and communities.

OTs are expected to provide client-centered and evidence-based care regardless of the setting. Most funders mandate standardized assessments specific to the population and setting. These assessments, combined with client/family goals, dictate the interventions. The assessments are specific to the population and setting, and the OT often becomes an expert within their area of practice. As is common in most healthcare professions, OTs earn specialty certifications as their careers progress, and they define their unique scope of practice.

OTs can become board-certified through the AOTA in the practice areas of Pediatrics, Gerontology, and Physical Rehabilitation. Outside of the AOTA, OTs earn additional certifications such as Executive Certificate in Home Modification, Assistive Technology Practitioner, USC Chan Sensory Integration Continuing Education Certificate Program, Certified Low Vision Therapist, Certificate in Neurodevelopmental Treatment, and Certified Hand Therapist to name a few. It is important to understand this distinction when consulting with an OT practitioner for litigation cases. Additionally, OTs are earning the Certified Life Care Planning credentials for litigation and care management purposes.

When reviewing medical records for a litigation case, understanding the role of OT during the acute phase or early disease onset is important. Research has demonstrated the efficacy of OT treatment, particularly intensive early intervention, following an injury. For example, in Muhlestein (2023), data revealed that children referred to a specialty clinic within 30 days of birth had better overall recovery of active range of motion for shoulder abduction, forward flexion, and external rotation, and forearm supination, with reduced loss of elbow extension. Early specialized rehabilitation may also help prevent elbow flexion contractures. Frade (2022) corroborates this finding by describing a case study of early, intensive intervention for a child with a brachial plexus injury. The authors credited

> "early intervention, which, in the case of this child, started at 11 days of life, was decisive in increasing the rehabilitation potential of the injured limb, preventing musculoskeletal sequelae, thus stimulating the integration of the injured limb into sensorineural motor development and daily life activities." (p.14)

Studies with children diagnosed with autism also show the benefit of early intervention by a therapist with specialty training. Dawson (2010) conducted a randomized controlled study of children diagnosed with autism. The study group of children aged 18-30 months received intervention using the Early Start Denver Model (ESDM) protocol delivered by a trained therapist. The results versus the control group who received standard community intervention showed "significant improvements in IQ, adaptive behavior, and autism diagnosis."

Research also demonstrates the importance of early and meaningful rehabilitation following acute injuries in adults. In one study, "task-specific motor intervention was most effective within the first 2 to 3 months after stroke" (Dromerick, 2021). Early intervention following a spinal cord injury (SCI) is essential for maximized functional outcomes. A study in Italy concluded that "rehabilitation intervention in patients with SCI should begin as soon as possible, in a specialized setting, because delay may adversely affect functional recovery" (Scivoletto, 2005). Sumida (2001) and Nas (2015) found similar outcomes. The research describes intensive rehabilitation, including OT, beginning when the patient is stabilized to minimize negative consequences such as joint contractures and maximize functional recovery. Nas (2015) describes the acute phase of rehabilitation lasting 6-12 weeks.

The research demonstrates that intervention as soon as the child or patient is stable is essential for maximal recovery. If the child or patient is past the acute stage, an OT can help determine appropriate recommendations to maximize function once discharged home to a community setting. A lawyer and/or life care planner may seek an OT's input in the following scenarios:

1. A child with autism who has sensory issues would benefit from a consul-

tation with a pediatric OT trained in sensory processing or integration. The OT can provide recommendations for equipment and potential interventions.

2. OTs with special training for Cortical Visual Impairments (CVI) at Cincinnati Children's Hospital can advise on potential treatment options and/or referrals to local experts.
3. Upper extremity orthopedic cases can consult a hand therapist regarding future care needs.
4. Patients who have suffered a neurological insult can consult with a neurodevelopmental OT for advice about treatments as well as the ideal environmental setup to maximize function.
5. A practitioner who specializes in assistive technology can advise on wheelchair bases and seating components or adapted computer access and environmental controls.
6. Cases involving adults with visual impairments following a neurological injury may consult with an OT with low vision training.
7. OTs specializing in home modifications can advise on specific home modifications to remove environmental barriers to function.

CASE STUDIES

The following case study illustrates the role of an OT and the use of occupations in rehabilitation.

A 43-year-old man was working on outdoor utility poles when he fell and sustained a severe wrist fracture in his left hand. He underwent surgical repair and wore a cast for 12 weeks. He complained of severe and continuous pain, which continued after the removal of the cast. He was referred to occupational therapy, specifically in the hand therapy clinic, to gain range of motion and resume functional use of his left wrist and hand. This was covered by worker's compensation.

During the initial visit, the OT noted pitting edema and shiny skin with a blue/red appearance from his left wrist distally to his fingers. The patient could not tolerate touch and demonstrated guarding with only minimal active range of motion at his distal phalanges. He kept his left arm flexed and tightly held to his body. He was right-hand dominant and was completing most of his ADLs with his right hand only. His girlfriend assisted with fine motor tasks that required two hands and all IADLs. Eventually, his physician confirmed a diagnosis of Complex Regional Pain Syndrome. His OT treatments began with fluidotherapy (a machine that creates dry thermal heated air streaming and flowing through and over finely granulated Cellex particles in a chamber). While in the fluidotherapy machine, he could actively move his fingers and wrist. Following the treatment, the OT could perform a gentle passive range of motion followed by the patient using his left hand to grasp and release small objects. Although he could move his fingers and wrist, progress was slow, and the patient did not follow through at home.

By the fourth session, the OT incorporated a self-assessment (Baron, 2006), to learn more about the patient's meaningful roles and occupations. The patient shared that he enjoyed cooking his favorite meals and was surprised to learn that the OT had not eaten traditional rice and black beans. A therapy treatment was set up to allow the patient to prepare this meal for the clinic staff. The OT gathered all the supplies, and the patient planned to instruct the OT on preparing the meal. As the preparation began, the patient joined the tasks. He opened the can, moved pots, and set the table. During the activity, he was unaware he was using his left hand. Once the meal was prepared, and the staff sat with the patient to eat, the OT informed him of the functional use of his left hand. He was surprised and grateful. Following this treatment session, the patient made quick progress as he continued to use his left hand in the clinic and at home while participating in meaningful tasks.

DISCUSSION

Occupational therapy has a wide scope of practice across populations and settings. However, any OT practitioner using evidence-based practice will focus their interventions and recommendations on helping the patient/client participate in their desired occupations. This can be a child playing with their friends in school or an older adult cooking a meal for their family at home. In a litigation setting, an OT can assist a practitioner in determining appropriate interventions and recommendations within their specialty area. These recommendations may seek to rehabilitate the patient/client, adapt a task or activity, or modify the environment, all towards the goal of occupational performance. Resources to find an OT within a particular specialty area are provided at the end of the article.

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In a litigation setting, an OT can assist a practitioner in determining appropriate intervention and recommendations within their area of specialty.

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RESOURCES TO FIND OCCUPATIONAL THERAPISTS

American Occupational Therapy Association Board Certification: https://www.aota.org/career/advanced-certification-program

USC Chan Sensory Integration Continuing Education: https://chan.usc.edu/education/ce/sensory-integration

Assistive Technology Practitioner: https://www.resna.org/Certification/Assistive-Technology-Professional-ATP

Executive Certificate in Home Modification: https://homemods.org/echm/

Hand Therapy Certification: https://www.htcc.org/

Low Vision Certification: https://www.acvrep.org/certifications/clvt

Neurodevelopmental Treatment Certification: https://www.ndta.org/NDT-Certification

Tori Goldhammer, MS, OTR/L, ATP, CAPS, ECHM, CEAC, CFPS, CLCP has been an Occupational Therapist for over 20 years with experiences in all clinical settings. Through extensive experience working with older adults and individuals with disabilities in the community, Tori has developed expertise in safe and accessible housing and fall risk management. In 2016, Tori launched the DC Safe at Home program, which as of May 2023 has helped over 6000 residents of Washington DC. She was awarded the 2022 Innovation Award from the National Board for Certification in Occupational Therapy (NBCOT) for her work creating Safe at Home. Tori has taught locally as an adjunct faculty and nationally as a continuing education instructor. She has also partnered as a clinical researcher with Johns Hopkins on various community-based research projects. In addition to teaching and research, Tori has been interviewed by local and national media and has been invited to present at national conferences. Throughout her career, Tori has focused on advocacy, working with local and federal agencies to provide funding for initiatives to help people remain safely in their homes and in the community. Tori is a licensed Occupational Therapist in MD, VA, DC, DE, FL, MA and NY. She has specialty certifications in Assistive Technology, Aging in Place/Environmental Modifications, Fall Prevention and Life Care Planning. You can reach her at tori@lahconsultations.com.

LNC PRACTICE TIP: BEHIND THE SCENES LNC INTERVIEW TIPS

BY *Elizabeth Zorn, RN, BSN, LNCC,* Past President AALNC, Legal Nurse Consultant, Co-Owner/Co-Moderator of LNCExchange

I. Behind-the-scenes LNC interview tips: for positions as an-house law firm employee or volume work with an attorney as an independent LNC.

Do some research about the law firm prior to your interview, including on the firm's website and client/peer feedback submitted to https://www.martindale.com. Identify the firm's primary areas of practice, number of attorneys and awards bestowed on individual attorneys or the firm.

Prior to the interview, provide the attorney with your resume or CV. Come armed to the interview with lots of questions for the attorney or other personnel who will be interviewing you – this allows you to have some control over the interview.

- What will your responsibilities be?
- What is the process for identifying, requesting, following up on and storing medical records?
- Who will be doing your orientation?
- How many LNCs does the firm have?
- How many attorneys will you work with?
- What types of cases will you work on?
- Will you report to anyone besides the attorneys you work with?
- Will you have secretarial and/or paralegal support?
- Is there a written job description for the LNC?
- What computer skills will you need?
- Will you have access to chronology software?
- Will you have access to databases for medical literature searches?
- How does the firm locate experts?
- Are there ways the LNC role could be expanded to better assist attorneys?
- Does the firm utilize a client case management database to store case documents and information?
- Is the firm "paperless?"
- Is there a team philosophy at the firm?
- Is there a firm document which sets forth the responsibilities of each member of the team?
- Are there firm protocols related to the management of different types of cases?

If the firm has never used LNCs in the past, inquire how the interviewer perceives the LNC will be utilized and be prepared to offer your own thoughts about how an LNC can assist the firm in their delivery of high quality legal services.

Take active steps during the interview to indicate the reasons for your interest in the position and the firm. Also, highlight what you perceive to be your strengths (critical thinking, reading, writing, computer and interpersonal skills) and areas of clinical expertise. To demonstrate writing skills, provide samples of prior work products in a medical legal case, especially ones that highlight your analytical ability.

Discussion regarding compensation and benefits is best conducted towards the end of the interview. What a firm is willing to pay a potential hire depends upon firm economics, the pay scale of other professional employees or personnel they contract with, and the interviewers' assessment of the job candidate.

Obtain a business card from the interviewer and follow-up with a thank you note reiterating your interest in the job.

Finally, be patient and persistent; securing a position in a law firm may take a good deal of research and follow-through. Perseverance may be your best attribute when trying to find an in-house job or volume contract work with a firm.

II. Behind-the-scenes LNC interview tips: for independent behind the scenes review of a single case.

Again, as with an in-house interview, come prepared with questions as a means to control the interview:

- What type of case? For example, med mal or PI?
- What is the procedural status of the case? For example, are you screening for merit or is the case already in suit?
- What type of work product does the attorney want? For example, a narrative summary or a chronology?
- How is the attorney planning to use your work product?
- Does the attorney have a complete set of the pertinent medical records?
- Who should you contact if additional medical records are needed?
- When would the attorney like your work product?
- Would the attorney like you to do any medical literature research?

As with any potential LNC work, highlight what you perceive to be your strengths (critical thinking, reading, writing, computer and interpersonal skills), areas of clinical expertise and any prior experience in the legal field.

Discuss your fee structure and any retainer or contract you require, as well as any budget constraints the attorney has.

Be very clear whether you are willing to serve as an expert if your review supports the attorney's claims. If not, consider whether you can assist the attorney to identify clinical experts. ■

The Legal Nurse Consultant and Injury Consistency Analysis

Lisa M. Powers, BSN, RN, CNOR, CAISS, LNCC

Keywords: niche practices, injury consistency analysis, medical record review, biomechanical engineers

Legal Nurse Consultants (LNCs) have a vast array of skills and experiences that allow them to think and work 'outside the box.' LNCs use their knowledge to point out factors that are not obvious or readily apparent to attorneys, adjustors, or even physicians. The nuance of medical-legal work requires a great deal of flexibility regarding the knowledge and expertise of the LNC; this flexibility gives rise to niche practices within the LNC world. This article will explore one of those niches: injury consistency analysis.

This activity is designed to increase the LNC understanding of and skill in assisting in Injury Consistency Analysis.

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

a. Define injury consistency analysis and how it is utilized.
b. Identify what is important for the LNC to note when reviewing medical records for injury consistency analysis.
c. Identify crucial information needed for the biomedical engineer expert to evaluate the motions, forces, and mechanisms required to induce injuries diagnosed.

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 December 1, 2026.

To receive CE credit, read the article and pass the CE test online at https://www.aalnc.org/Resources/The-Journal-of-Legal-Nurse-Consulting

CEs are free to members during the membership year and can be purchased as a 4-issue subscription of $65/year for non-members.

Injury consistency analysis is a complex type of analysis done cohesively by a biomechanical engineer and a legal nurse consultant. The LNC plays a crucial role in the analysis by defining reported injuries that may have occurred during an incident and pre-existing conditions that may alter an individual's propensity to injury. By delving into the medical records, the LNC can provide evidence that may assist in assessing the feasibility of claims made. This is vital to guide the biomechanical expert to the motions, forces, and mechanisms required to induce the injuries diagnosed.

Injury consistency analysis is done by biomechanical engineers using Newton's Laws, other tools of physics, and engineering mechanics in conjunction with knowledge of human biology and physiology to define and explain an injury scenario (Ozkaya et al., 2017). This information is utilized to explain the mechanics associated with a particular condition in the context of an accidental event. Attorneys and insurance adjusters then use this analysis to determine if the injuries claimed were consistent with the mechanics of the incident. Incidents such as motor vehicle accidents (MVAs), slips/trips/falls, or worker's compensation injuries are common occurrences that can benefit from an injury consistency analysis.

Medical records are a vital component to injury consistency analysis. A targeted medical record summary for injury consistency analysis differs from the standard and usual medical record summary done by an LNC. The medical record summary has a specific focus on information needed for the biomechanical engineer. To assist in the analysis, the LNC should focus on finding as much information as possible around the date of injury (DOI). It is important to find as much data as possible on pre-existing history, both medical and surgical, as well as hobbies, occupation, social history, and height and weight.

Questions that should be considered by the LNC during injury-consistency analysis:

- Did the claimant have prior accidents or injuries that could explain current stated reported injuries?
- Does the claimant have medical conditions that could contribute to the stated reported injuries, such as osteoarthritis, rheumatoid arthritis, or auto-immune conditions, etc.?
  - These pre-existing conditions or lack thereof can be used to explain alleged reported injuries.
  - Any reports of completed imaging can be important in the discovery of what is degenerative and what is acute. For example, is the intervertebral disc bulge found on the CT scan consistent with the mechanisms of the noted accident?
- Does the claimant have an occupation that requires heavy lifting, such as work in construction or an oilfield?

- Is the claimant sedentary in their activities?
- Do they smoke or use e-cigarettes/vape?

All this information is taken into consideration when determining body conditioning prior to the incident and the possible incidence of degenerative changes versus acute changes.

Another element that affects injury analysis is the written account of the incident. Memories can be tricky, complex, and fragmented. Under stressful situations, recollections can change in even the most conscientious person. This makes the notation of the incident's description especially important. Many times, facts are forgotten or misremembered, misinterpreted, or fabricated. There are times when others influence and distort memories with conflicting information. And as time passes, memories get less clear, and imaginations can create an entirely different scenario. For this reason, it is especially important to make a word-for-word notation of what the claimant said during the first medical visit. This description is the most accurate, reliable, and least likely to be tainted by outside influences. Utilizing a combination of medical knowledge and clinical experience, LNCs can review incident reports to determine which claims are supported and which may be inaccurate.

As most injuries that occur or are claimed with MVAs are structural, it is important to have an extensive working knowledge of orthopedics, neurology, and neurosurgery. To delineate potential inconsistencies, it is important to know what is normal and what are the practical and functional implications of pathologic conditions. Having a strong background in orthopedics and neurosurgery will be an asset to the LNC. Being able to draw from prior knowledge and experience allows the LNC to give knowledge-based, insightful comments to help the biomechanical engineer and the client understand the injuries.

Another aspect of the LNC's summary that is of importance to the biomechanical engineer is maintaining simplicity. LNCs must eliminate as much extraneous information as possible within the summary. Taking out superfluous prepositions, such as 'the,' 'an,' and 'a,' allows a condensation of verbiage, and thus, the information noted to have the most importance. Having a contextual understanding of when to take out prepositions or when to keep them for easier understanding, is also important. The medical record summary or grid should be clear, concise, and quick to read for both the biomechanical engineer and the client. The summary can be added to the analysis report given to the client, as requested. It is also important that the comments made within the grid are neutral and fact-based, as the client may be able discover the comments even when deleted.

Medical records are a vital component to injury consistency analysis. A targeted medical record summary for injury consistency analysis differs from the standard and usual medical record summary done by an LNC.

CASE STUDY:

RC is a 65-year-old female restrained driver who was at a stop, waiting to turn right at an intersection. As the traffic cleared, she eased ahead but saw another car coming from her left and stopped quickly. The car behind her did not see that she had stopped and rear-ended her. The airbags did not deploy; there was no head strike within the car, and no loss of consciousness (LOC). Police arrived, and a citation was given to the other driver for failure to stop and following too close. RC declined EMS transfer, as she said she was fine and without pain. She drove herself home and went to sleep. RC's pain increased overnight, and she presented in the Emergency Department (ED) with reported injuries of neck pain, radiating to the bilateral shoulders, and low back pain, radiating to the bilateral buttocks. She is a retired schoolteacher and enjoys gardening and walking for exercise. She admits to smoking a ½-pack of cigarettes daily for the past 45 years, with no desire to stop. She has a history of asthma, two heart attacks with a stent placement, and anxiety/depression. She had one prior MVA, 10 years ago, with slight residual pain in neck and low back.

- **Radiology:**
  - CT scan C-spine showed multilevel degenerative disc disease with disc herniation at C4-5, C5-6, and C6-7.
  - CT scan L-spine showed multilevel degenerative disc disease with disc herniation at L3-4, L4-5, and L5-S1.

  Diagnosis: C-spine sprain, cervicalgia, C-spine radiculopathy, L-spine sprain, lumbago, L-spine radiculopathy

Points of interest for the LNC:

- Restrained
- No airbag deployment
- Rear-ended
- No head strike or LOC
- No pain immediately after impact
- Walks for exercise
- Smoker without desire to quit
- Asthma
- Heart attack with stent placement
- Anxiety/depression
- Prior MVA with prior injury to neck and low back with residual pain
- Radiology imaging showed both C-spine and L-spine multilevel degenerative disc disease. C-spine has disc herniations at C4-5, C5-6, and C6-7. L-spine has disc herniations at L3-4, L4-5, and L5-S1.

  Diagnosis from ER provider: C-spine and L-spine radiculopathy

What does this all mean?

- RC was restrained with modern seatbelts equipped with pretensioners and inertial-locking retractors. As the pretensioners do not fire in a rear-end impact, the retractors will prevent the person from striking the steering wheel.
- No airbag deployment, so there were no airbag injuries.
- No pain immediately after impact. This is common, as most often pain is due to muscle strain.
- RC admits to smoking a ½-pack of cigarettes per day. Many people understate how much they truly smoke.
- "Depression and anxiety are associated with increased perception of pain severity" (Michaelides, 2019).
- A prior MVA caused prior injury to RC's neck and low back.
- CT scans showed degenerative changes and disc herniations on both C-spine and L-spines. The degenerative changes are age-related, and the disc herniations have no causal link to rear-end impact or any type of low-speed, low-velocity impact. (Wood, Grrenston, Charles, & Charles, 2018)
- Because of the low speed of this MVA, it is expected that the pain experienced to resolve within six weeks (about one and a half months) with physical therapy and rest (Karlsson et al., 2020).

OUTCOME

- A verbal report was made to the client with all the facts given. As this was pre-trial, no written report was requested. The

accident was at low speed, and the pain was assessed as acute muscular pain that would resolve within a few months. No further treatment would be needed. Acute muscular pain should resolve in seven days to three months (Delaney et al., 2020)

Legal nurse consultants are highly valued for their vast array of skills and experiences, allowing each LNC the opportunity for niche practices. One such niche is a targeted medical record review used in conjunction with a biomechanical engineer to provide injury consistency analysis. The medical record review and summary point out areas that are vital facts needed for the injury analysis, allowing the client to use them for legal proceedings or insurance investigations. The LNC, with the appropriate knowledge and experience, provides the crucial information needed for the biomechanical engineer and the client.

...this information is taken into consideration when determining body conditioning prior to the incident and the possible incidence of degenerative changes versus acute changes.

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LNC PRACTICE TIP: SOME ETIQUETTE TIPS

BY *Mary K. Flanagan, BSN, RN, CNOR(E), LNCC,* Certified Perioperative Nurse Emeritus, Legal Nurse Consultant Certified AND *Lisa Mancuso, BSN, RN, CCRN, CLCP, LNCC* , President, AALNC 2022-2024

SOME ETIQUETTE TIPS

Credentials:

Let's start with an easy one: Using "**LNC**" after your name. We are all proud to be legal nurse consultants, but using LNC after your name is improper. LNC is a job description, not a designation or credential. What is acceptable is spelling out legal nurse consultant under your name on your business card, email signature, and correspondence. And speaking of credentials, did you know that the correct way to list those titles is to start with the highest level of education, not the order in which you achieved them? Your state can strip no degrees from you, but they can revoke your nursing license.

Email Etiquette:

When replying to an email from a potential client you have not met or do not know, always address them by their proper name, pronoun(s), and designation. If you answer an email request from attorney Mary J. Blige, Esq., you reply, "Dear Ms. Blige". If attorney Blige says, "Please call me Mary J", you may choose to or not, but we suggest sticking with Ms. Blige in any discoverable correspondence. Formality is essential when working as an expert. When it's time for your deposition, often in a subpoena duces tecum (Latin for under penalty, you shall bring it with you), the opposing counsel (OC) will ask for every email you and Ms. Blige exchanged. As testifying experts, our first line of communication with our clients should be by telephone or text message. Remember when composing any discoverable correspondence, write as if the other side is reading it because they are. If your client told you they would send the medical records when they return from a family trip to Disney World, do not begin or end your email with *I hope you had a great time in Orlando.*

Signature:

Now that you have dropped LNC and arranged your degrees and designations properly, let's look closely at your signature line. Is it easy to read? Does the reader or potential client know how to contact you? Does it reflect what you do as an LNC? Start with the font you use. It should be easy to read. Is it big enough to read easily? Or is it so big that it screams? Choose one you like, play around with it, and ask a trusted friend or colleague for constructive feedback. Consider adding your address or location to your signature block. As an LNC, work is unlimited based on your geographic location, but some attorneys prefer someone closer to the firm to save travel expenses. Keep the page manageable if you have a logo or brand image. If you use a tagline, keep it short and sweet. And, as much as we enjoy a touch of whimsy, professional writing and communication is not the place to express yourself in that way. Add a photograph? Sure, but a professional headshot, not one from your recent Caribbean cruise. And a gentle reminder: political or religious affirmations have no place in professional correspondence.

"Anonymous attachments":

When any potential client asks for your CV and fee schedule, which they often do, be prepared, and give them memorable file names. Don't send "my CV", "CV23", or "CV". Use something like "Jane Doe ICU RN CV". You want to be easily recognized especially in securing future work from the firm or LNC.

Manners:

When you see a posting for a potential job on a listserv, email, or shared interest group (SIG), read and follow the poster's instructions carefully. We cannot overstate this. If the hiring LNC asks that you respond with XYZ documents to a specific email address, do that! Do not send text messages, LinkedIn messages, Facebook messages, etc. Don't respond with: "PM me if you're interested in seeing my work." The hiring LNC has invited you to share your work—follow their instructions. Truth can be hard to hear, but many experienced LNCs will agree: If you can't follow our directions, why would we trust you to follow an attorney's request?

And when you are the poster, especially when seeking an expert, do not post specifics about the case. Poor: *My renowned plaintiff attorney is looking for an OR nurse from Atlanta to opine on a case where at a large well-known medical center the patient was in high lithotomy and the surgeon perforated the colon and leaned on the leg and caused a nerve injury and then the anesthesiologist caught the patient from falling off the bed. Better: ISO OR Circulator,* (ISO= in search of). Why? 2 reasons: First, unnecessarily verbose, and second, TMI, as someone on the defense side might recognize and use to their advantage. Details of any case should be discussed only between the client and the hired LNC.

Social media has made us all less conscious of correct grammar and spelling. We have become so used to abbreviations and slang we almost don't recognize them in our professional communication. It is NEVER appropriate to address a potential client with "Hey girl!" (True story, this actually happened!) ■

Transitional Care Management:

Best Practices and Legal Pitfalls

Rachel Ruby, MSN, MPH

Keywords: Transitional care management, quality improvement, care coordination, discharge planning, hospital readmission rates, continuity, primary care, skilled nursing facility

Transitional care management (TCM) is a critical component of healthcare that aims to provide seamless transitions for patients from acute care settings to the community. It involves a series of coordinated activities and interventions to ensure continuity of care, prevent hospital readmissions, and optimize patient outcomes. This article examines the elements of TCM, presents a case study to illustrate its application, discusses legal issues and malpractice risks, and emphasizes the importance of thorough assessment and follow-up in community living situations.

OVERVIEW

Transitional care management (TCM) services are designed to support patient care and promote thorough and timely follow-up for medical issues identified or treated during a stay in a hospital or skilled nursing facility as patients transition to a community setting. It is a "warm handoff" that is initiated by the acute care facility by alerting the primary care provider that their patient is being discharged and by providing a hospital discharge summary. The TCM visit takes place at the patient's primary care provider's office. The intent of this visit is to prevent care gaps that can occur when an acute care facility does not fully communicate a patient's medical disposition to the primary care provider.

During the period when a patient with complex medical needs transitions to a home-based environment, there is an elevated risk of medical errors and adverse events if communication is fragmented between tertiary care and primary care. TCM visits are on the rise as a result of an aging population with more complex medical needs, a shift toward earlier hospital discharges, and payment models that incentivize improving quality of care while reducing costs across the care continuum (Marcotte, 2020). Some studies

have shown a significant reduction in hospital readmissions for patients who attend TCM visits (Rockafellow, 2023; Van De Graff, 2021). Medicare, with a predominantly elderly subscriber population, is the country's largest health insurer. It is a major payor of TCM services, driven by the goal of reducing 30-day hospital readmission rates. The addition of Current Procedural Terminology (CPT) codes 99495 and 99496 to the 2013 CPT manual has added a financial incentive for primary care providers to adhere to the TCM guidelines (Bloink, 2013).

TCM visits are on the rise as a result of an aging population with more complex medical needs, a shift toward earlier hospital discharges, and payment models that incentivize improving quality of care while reducing costs across the care continuum.

ELEMENTS OF TRANSITIONAL CARE MANAGEMENT

TCM services should follow the framework established by the Center for Medicare and Medicaid Services (CMS) (Bloink, 2013). TCM services begin within two business days of discharge with a phone call from the primary care provider's office to the patient. The initial assessment questions must be completed by someone with medical knowledge, typically either a medical assistant or a nurse. During this call, the patient's overall well-being and immediate medical needs are assessed. Prompts for this call include:

- How is the patient doing generally?
- Have any home services been set up for the patient?
- Has the patient completed any labs requested upon discharge?
- Does the patient have any immediate needs to be addressed before seeing the clinician?
- Has the TCM visit been scheduled?
- Review medication list and confirm that the patient is taking medications as prescribed.
- Remind the patient to bring all medications with them to the TCM visit.

The TCM visit will be scheduled at the phone follow-up if not already scheduled by the hospital discharge planner. It must occur within either seven or fourteen calendar days, depending on the complexity of the medical decision-making and stability of the patient.

The TCM visit focuses solely on the hospitalization and includes the following elements:

- Review of the discharge information.
- Follow-up on diagnostic tests and treatments pending at the time of discharge.
- Order any necessary services (i.e., VNA) or specialist referrals.
- Reconcile any medications provided on discharge with the medications the patient may have been taking previously. (It is helpful if the patient brings all their medications to the appointment to confirm that they are taking all of them and doing so correctly.)

CASE STUDY

To illustrate the elements of the TCM exam, let us consider the case of Mr. T. Mr. T is an 84-year-old man who presented to his primary care provider five days after being released from the hospital for an acute cerebral vascular accident (CVA). As this case will illustrate, it is essential for the provider to review all relevant records and not rely solely on the discharge summary. Relevant records would include those which require follow-up, such as imaging, labs, and specialty consults. In addition, complicating social and economic factors that can impact the patient's health and recovery may first be identified post-hospitalization. Mr. T had received no medical care for the 10 years prior to the hospitalization. He and his wife were healthy and active prior to the incident. He was watching television when he experienced weakness on the left side of his face and slurring of his words. His wife immediately called 911 and he was taken to the local emergency room by ambulance. His hospital course included thrombolytic therapy in the emergency room followed by hospitalization. During his hospital-

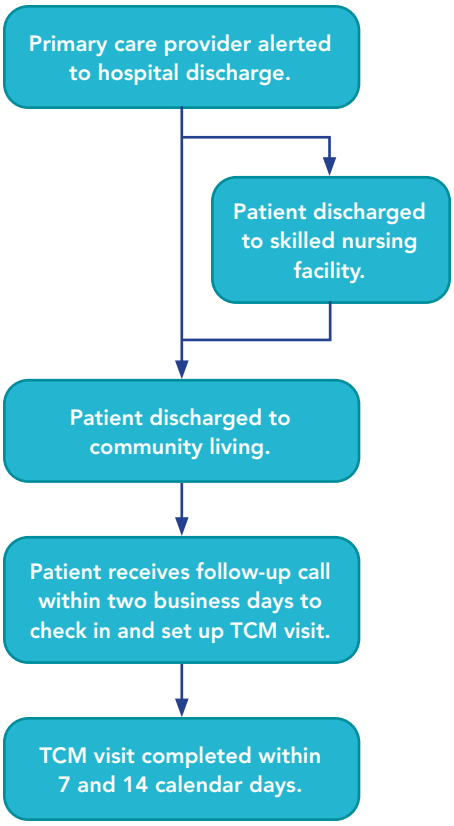

Figure 1: Elements of Transitional Care Management

ization, a series of tests were performed to identify the source of the blood clot, risk factors for clot formation, and any preexisting conditions. Discharge diagnoses included hypertension, cerebral vascular accident, and hyperlipidemia. He was discharged home under the care of his 81-year-old wife.

Additional items were identified during the TCM that were not identified in the hospital discharge summary:

1. A reading of a computerized tomography (CT) scan of the patient's chest noted a pulmonary embolism and right tracheal mass, neither of which had been addressed in the hospital discharge summary. The nurse practitioner who was completing the TCM visit called the radiologist to confirm the reading. Upon review, the radiologist stated that the pulmonary embolism was a transcription error, but the tracheal mass should have a follow-up imaging by ultrasound. This need for follow-up had not been included in the discharge summary.
2. At hospital discharge, the wife felt she could provide for her husband's needs in completing the activities of daily living. However, after several exhausting days, she recognized that she did not have the physical strength to assist safely and that his needs were greater than predicted. The nurse practitioner sent a referral for in-home support services. Additional items that needed to be followed up on included ordering visiting nurse agency (VNA) services, so the patient had access to occupational/physical therapy, nutritional consult, and a full assessment of home safety.
3. The patient became teary during the exam when talking about his music and not being able to play the guitar. The nurse practitioner engaged in a discussion of grief, loss, the recovery process, and brain changes that can lead to depression after a CVA. Accordingly, the nurse practitioner placed a referral for behavioral health services.

BILLING AND TRANSITIONAL CARE MANAGEMENT

The transition of the hospitalized patient back to home and community care requires close communication between hospital discharge planners and the primary care team and is time intensive. In 2013, the Centers for Medicare & Medicaid Services began offering payment to ambulatory care practices for TCM services. These services include contacting patients within 48 hours of their discharge, scheduling an office visit to occur within seven to fourteen days, and discussing the care plan with the patient or caregivers (Patel, N. 2019). It should be noted that specialists can also bill TCM visits; if a patient is seen for an acute cardiac event, it is likely that their initial outpatient visit will be with a cardiologist. Only one provider can bill for a TCM visit within the 30-day post-hospitalization window. The addition of CPT codes 99495 and 99496 for transitional care management encourages infrastructure that supports primary care providers to address these challenges. To bill for TCM services, a provider must meet the following criteria:

- Interactive contact (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge,
- Moderate to high medical decision-making,
- A face-to-face visit within seven or fourteen calendar days of discharge (depending on the complexity of medical decision-making) (Bloink, 2013).

LEGAL ISSUES AND MALPRACTICE

The transitional care management visit is an essential tool in supporting a patient's recovery post-hospitalization and in reducing readmissions. It is a complex visit addressing new or worsened health issues post-discharge and can make a provider vulnerable to liability concerns. Areas that may come under scrutiny from a medical-legal standpoint include:

1. Communication breakdowns: Communication failures between healthcare providers, patients, and caregivers can result in missed or delayed diagnoses, medication errors, and other adverse events that could lead to malpractice claims.
2. Inadequate follow-up: Providers who fail to provide appropriate follow-up care may be liable for malpractice claims if a patient experiences complications or adverse events due to the lack of follow-up care.
3. Medication errors: Medication errors are a common cause of malpractice claims involving TCM services and may include errors in prescribing, administering, or monitoring medications during the transition period.
4. Failure to address risk factors: Providers may face malpractice claims if they neglect known risk factors such as fall risk, wound care, or medication non-compliance during the transition period.
5. Inadequate documentation: Providers who fail to document the care they provide during the transition period may be liable for malpractice claims. This may include failure to document medication changes, care plans, and other important information related to the patient's care.
6. Failure to coordinate care: Providers who fail to coordinate care with other healthcare providers and caregivers may be liable if the lack of coordination results in harm to the patient.
7. Duplicate billing: Duplicate billing occurs when a healthcare provider bills for the same service multiple times. For example, a provider may not bill for both a face-to-face visit and a non-face-to-face service on the

same day, resulting in overpayment by Medicare or other payers. This would also apply if both the specialist and the primary care provider billed for TCM services for the same hospitalization.

8. Failure to meet the requirements for TCM services: To bill for TCM services, providers must meet specific requirements related to the timing and content of the services provided. Providers who fail to meet these requirements may be engaging in fraudulent activity if they bill for TCM services anyway.

CONCLUSION

Patients are being discharged back into the community from hospitals and skilled nursing facilities with higher levels of acuity and more complex disease conditions. This requires seamless transitions to primary care and thorough evaluation of ongoing needs. Appropriate levels of support in community living situations (i.e., nursing, occupational therapy, physical therapy, and nursing aides) are dependent on the thorough assessment, follow-up, and ordering of goods and services by the transitional care management team.

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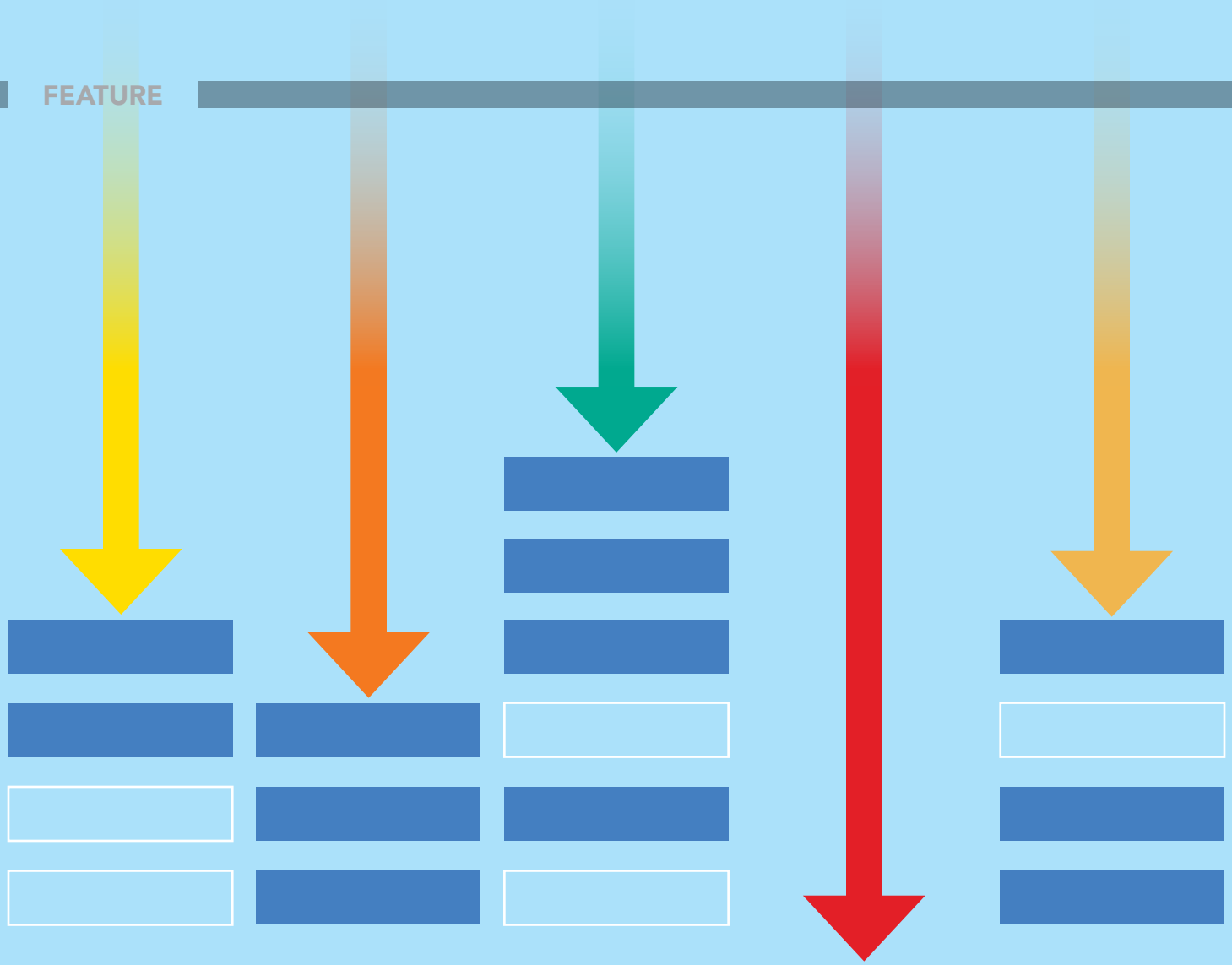

Anatomy of Systemic Errors:

Reducing Gaps in Healthcare

Kayur V. Patel, MD, MRO, FACP, FACHE, FAAPL, FACEP and Kush Patel

Keywords: medical errors, root cause analysis, healthcare administration, healthcare systemic issues

Medical errors rank as the third leading cause of death in the United States. It is imperative to recognize that the majority of these errors stem from flawed systems rather than the actions of individual healthcare personnel. To proactively address this issue, healthcare professionals must collaboratively strive to foster a culture of safety within their ecosystem.

Effectively tackling and remedying these problems necessitates a comprehensive understanding of their root causes. In this discussion, we will delve into an approach for root cause analysis, examining the systemic issues that contribute to medical errors, and proposing strategies to cultivate a culture of safety within your healthcare system.

Medical Errors are the 3rd leading cause of death in the United States, accounting for over 250,000 deaths each year (Johns Hopkins Medicine, 2016). Medical errors do not necessarily result from mistakes made by individuals considered incompetent; rather, they stem from well-intentioned individuals operating within flawed systems. Despite the considerable financial resources invested in the U.S. healthcare system, the consistent delivery of safe care remains elusive. The system's persisting broken, and fragmented nature can be attributed to the absence of open discussions and the sharing of mistakes. Alternatively, there are some who dispute that medical errors are actually the third cause of death due to the fact that medical errors are not typically listed as a cause of death on a formal death certificate (Jarry, 2019).

Root cause analysis is a systematic process designed to identify the fundamental causes of a problem. In the realm of medical errors, this analytical approach proves invaluable for healthcare organizations as it enables the identification of systemic issues that contribute to such errors. By pinpointing these root causes, organizations can enact essential changes, thereby preventing the recurrence of similar errors in the future.

SYSTEMS THINKING

All entities coexist within systems. Within the healthcare domain, key system elements encompass the patient, healthcare professionals, equipment, and the care environment. Systems thinking involves comprehending the interconnected nature of these components within a shared process and purpose. In numerous public services, healthcare included, this necessitates concentrating on the well-being of the service user and addressing the multiple systems supporting clinical care.

When problems arise for a patient, especially in instances of perceived professional lapses or oversight, adopting a systems-oriented perspective can be challenging. Traditionally, various industries have often attributed personal blame to individuals directly involved in critical situations — be it the last person handling aircraft controls or, in healthcare scenarios, the last healthcare provider attending to the patient.

SYSTEMIC ISSUES IN HEALTHCARE

One of the main conclusions of the Institute of Medicine (IOM)'s first report, 'To Err is Human' in 1999, is that the majority of medical errors do not result from individual recklessness or the actions of a particular group – this is not a "bad apple" problem (2000). It is good people working in inadequate systems!

The majority of medical errors originate from systemic failures rather than human errors, a concept underscored by the adage "To Err is Human." To address this, the leadership of a healthcare system must actively cultivate a culture that encourages reporting from both medical staff and patients. This open reporting framework allows individuals to express concerns about potential lapses in care delivery or issues related to patient safety. Subsequently, systematically reviewing these reported concerns becomes imperative to discern their root causes. The anatomy of systemic failure can be dissected into the following eight categories.

1. Communication

Communication breakdowns stand out as a pervasive and multifaceted contributor to medical errors, manifesting at different junctures in the intricate web of healthcare delivery. Whether through verbal exchanges or written interactions, these breakdowns can sow misunderstandings among healthcare providers, patients, and their families, as well as between disparate healthcare settings. To address and mitigate these challenges, healthcare organizations play a pivotal role in instituting protocols that systematically promote effective communication.

One strategic measure involves the implementation of standardized handoff procedures, particularly during critical transitions of care such as shift changes. Standardization in handoff protocols ensures that crucial patient information is conveyed consistently, reducing the risk of oversight or miscommunication. Additionally, the adoption of clear documentation practices becomes paramount, enhancing the accuracy and accessibility of patient information across the continuum of care. This meticulous approach not only aids in maintaining the continuity of care but also acts as a safeguard against potential errors stemming from ambiguous or incomplete information.

In essence, a proactive focus on communication protocols represents a linchpin in the efforts to enhance patient safety. By addressing breakdowns through standardized handoffs and clear documentation practices healthcare organizations can contribute significantly to the creation of an environment where information flows seamlessly, fostering a culture of clarity, collaboration, and ultimately, safer patient care.

2. Inadequate Information Flow

The inadequacy of information flow in healthcare poses a substantial risk, as it may compel healthcare providers to make critical decisions based on incomplete or inaccurate data. This heightened risk translates into potential medical errors, ranging from administering incorrect medications to performing improper medical procedures. To address and mitigate these challenges, healthcare organizations are increasingly adopting technological solutions, such as electronic health records (EHRs), to enhance the seamless flow of information.

The majority of medical errors originate from systemic failures rather than human errors, a concept underscored by the adage "To Err is Human." To address this, the leadership of a healthcare system must actively cultivate a culture that encourages reporting from both medical staff and patients.

Electronic health records serve as a comprehensive and centralized repository of patient information, facilitating real-time access to critical data by authorized healthcare professionals. This reduces the likelihood of errors resulting from incomplete information and enhances the accuracy of decision-making processes. Furthermore, leveraging other technologies, such as integrated communication platforms and decision support systems, can further streamline information flow, fostering collaboration among healthcare teams and ensuring that providers have the necessary data to make informed and accurate decisions.

In summary, the integration of electronic health records and other advanced technologies represents a strategic response to the challenges posed by insufficient information flow in healthcare. By embracing these solutions, healthcare organizations fortify the foundation of patient care and contribute to a culture of precision, where decisions are grounded in comprehensive and up-to-date information, ultimately minimizing the risk of medical errors.

3. Human Factors

Human-related challenges in healthcare encapsulate a spectrum of factors, including insufficient training and knowledge, mislabeling of specimens, as well as issues stemming from fatigue, burnout, and stress among healthcare providers. These multifaceted elements pose a considerable risk, potentially leading to errors by healthcare professionals or a failure to adhere to established protocols critical for patient safety. Addressing these challenges necessitates proactive strategies implemented by healthcare organizations, with a focus on mitigating burnout and promoting an improved work-life balance for healthcare providers.

Instituting initiatives to mitigate burnout involves recognizing and addressing the systemic factors contributing to stress among healthcare professionals. This may include restructuring work schedules, providing mental health resources, and fostering a supportive organizational culture that values the well-being of its staff. Additionally, offering comprehensive training programs and continuous professional development opportunities ensures that healthcare providers stay abreast of the latest medical advancements, reducing the likelihood of errors due to insufficient knowledge.

Ultimately, healthcare organizations play a pivotal role in cultivating an environment that empowers healthcare providers to deliver optimal care. By proactively addressing human-related challenges through targeted strategies, organizations contribute to the individual well-being of healthcare professionals and the broader goal of enhancing patient safety and the overall effectiveness of healthcare delivery.

4. Patient-Related Issues

Patient-related challenges in healthcare encompass a range of factors, including non-compliance and insufficient patient education, which can contribute to medical errors, such as patients failing to adhere to prescribed medication regimens. Addressing these challenges requires a multifaceted approach from healthcare organizations, emphasizing the importance of patient education programs and strategies aimed at enhancing patient engagement.

Implementing robust patient education programs is crucial to ensuring that individuals possess the necessary information to make informed decisions about their healthcare. This includes educating patients about their medical conditions, treatment options, and the significance of following prescribed regimens. Health literacy initiatives can play a vital role in empowering patients to participate in their care actively, reducing the risk of errors associated with lack of understanding or non-compliance.

Furthermore, strategies aimed at enhancing patient engagement involve fostering open communication channels between healthcare providers and patients. This may include the use of technology, such as patient portals, to facilitate easy access to health information and encourage active involvement in the decision-making process. Shared decision-making

models, where healthcare providers collaborate with patients to develop personalized care plans, can also contribute to improved adherence and reduced likelihood of errors.

In conclusion, mitigating patient-related challenges requires a proactive and patient-centered approach. Healthcare organizations, by implementing comprehensive patient education programs and strategies to enhance engagement, not only empower individuals to take charge of their health but also contribute significantly to the prevention of medical errors associated with non-compliance and insufficient understanding of prescribed treatments.

5. Organizational Transfer of Knowledge

The organizational transfer of knowledge in healthcare addresses critical challenges pertaining to training and education within healthcare institutions. Inadequacies in these areas can lead to healthcare providers lacking the essential skills and knowledge necessary to execute their duties effectively, potentially compromising patient care and safety. To rectify these challenges, healthcare organizations must proactively institute comprehensive training and education programs tailored to the specific needs of their healthcare providers.

Effective training programs should not only cover the foundational skills required for medical tasks but also stay abreast of the latest advancements in medical practices, technology, and patient care methodologies. Incorporating continuous education into the professional development of healthcare providers ensures that they remain competent and adaptable in a rapidly evolving healthcare landscape. This includes initiatives such as workshops, seminars, and online courses, fostering a culture of lifelong learning within the healthcare workforce.

Moreover, organizational commitment to the transfer of knowledge involves creating a supportive environment where healthcare providers feel encouraged to seek further education and training. Allocating resources for professional development, mentorship programs, and knowledge-sharing platforms can enhance the overall competency and expertise of the healthcare workforce. Ultimately, by addressing challenges in the transfer of knowledge through comprehensive training and education initiatives, healthcare organizations contribute to the continuous improvement of patient care standards and the overall effectiveness of healthcare delivery.

6. Staffing Patterns and Workflow

The critical challenges associated with staffing patterns and workflow in healthcare organizations revolve around the delicate balance of staffing levels and resource allocation. Insufficient attention to these factors can lead to healthcare providers being overworked and overstressed, significantly heightening the risk of medical errors. To address these challenges effectively, healthcare organizations must adopt staffing models and resource allocation strategies that prioritize patient safety as a paramount consideration.

Ensuring optimal staffing levels involves quantifying the number of healthcare professionals and considering their skill mix and distribution across different roles and responsibilities. Adequate staffing enables healthcare providers to manage their workload effectively, reducing the likelihood of fatigue-induced errors and ensuring that patients receive high-quality care. Moreover, thoughtful resource allocation, including the provision of necessary equipment and technology, further supports healthcare providers in delivering safe and efficient patient care.

Adopting patient safety-centered staffing models goes beyond meeting regulatory requirements; it becomes a strategic imperative for healthcare organizations to safeguard the well-being of patients and healthcare professionals. This may involve implementing innovative scheduling practices, utilizing technology to optimize workflow, and regularly evaluating and adjusting staffing levels based on patient acuity and organizational needs. In doing so, healthcare organizations contribute to the creation of an environment where patient safety is not compromised by systemic issues related to staffing and resource allocation.

7. Technical Failures

Technical failures in healthcare, encompassing challenges associated with medical equipment and technology, present a considerable risk, potentially leading to medical errors such as inaccurate readings or incorrect medication dosages. Recognizing the critical role that technology plays in patient care, healthcare organizations must proactively address these challenges. One effective strategy involves the establishment of rigorous equipment maintenance and testing protocols to ensure the proper functioning and accuracy of medical devices.

These protocols should encompass regular inspections, calibration checks, and preventive maintenance routines, conducted by qualified personnel. Implementing a comprehensive schedule for equipment upkeep not only minimizes the risk of technical failures but also enhances the longevity and reliability of essential medical tools. Additionally, healthcare organizations should prioritize investing in state-of-the-art technologies that come equipped with built-in safety features and redundancies, further reducing the likelihood of technical errors.

Furthermore, fostering a culture of technological literacy among healthcare professionals is crucial. Training programs and continuous education initiatives can empower staff to understand, operate, and troubleshoot medical equipment effectively, contributing to early detection and resolution of technical issues. In essence, by instituting robust maintenance protocols and promoting technological proficiency, healthcare organizations fortify their capacity to deliver safe and precise care while mitigating the inherent risks associated with technical failures in healthcare settings.

8. Inadequate Policies

Issues stemming from insufficient policies within healthcare organizations underscore challenges related to the formulation and implementation of policies and procedures. These challenges can lead to confusion and inconsistencies in practice, thereby increasing the likelihood of medical errors. To address and rectify these concerns, healthcare organizations must adopt a strategic approach by instituting evidence-based policies and procedures that undergo regular and systematic review and updating.

The development of policies and procedures grounded in evidence-based practices ensures that healthcare providers follow guidelines founded on the latest scientific knowledge and best practices. Regular reviews of these policies are essential, considering the dynamic nature of the healthcare landscape, technological advancements, and evolving patient care methodologies. Such a proactive approach guarantees that policies remain current, relevant, and aligned with the highest standards of patient safety and quality care.

Additionally, healthcare organizations should foster a culture of continuous improvement where feedback from healthcare professionals is actively sought and considered in policy refinement. Transparent communication channels and a collaborative approach to policy development contribute to a shared understanding and adherence to established guidelines. In essence, by instituting evidence-based policies that undergo regular scrutiny and refinement, healthcare organizations demonstrate a commitment to minimizing errors, fostering consistency in practice, and ensuring the highest standards of patient care.

PROMOTING A CULTURE OF SAFETY

Promoting a culture of safety within the healthcare industry is of paramount importance as it directly impacts patient well-being and organizational effectiveness. By prioritizing safety, healthcare providers mitigate the risk of medical errors and enhance the overall quality of care delivered to patients. This cultural emphasis on safety encourages healthcare professionals to be vigilant, proactive, and committed to upholding the highest standards in patient safety protocols.

The ethical imperative of patient safety and promoting a culture of safety has tangible benefits for healthcare organizations. Reduced medical errors lead to lower rates of malpractice claims and legal liabilities, safeguarding the institution's reputation and financial stability. Furthermore, a safety-oriented culture attracts and retains high-caliber healthcare professionals who are drawn to environments that prioritize their well-being and emphasize continuous improvement in safety practices.

Fostering a safety culture in the healthcare industry is indispensable for safeguarding patients, promoting organizational resilience, and attracting and retaining top talent. It is a holistic approach that integrates ethical considerations, organizational efficiency, and the well-being of patients and healthcare professionals.

To foster a safety-oriented culture within the healthcare industry, healthcare organizations can undertake the following measures:

1. Foster Open Communication

In the healthcare industry, fostering open communication is an indispensable element in cultivating a safety-oriented culture. Establishing transparent channels of communication is pivotal for the timely identification and resolution of systemic issues that may contribute to medical errors. To achieve this, healthcare organizations can implement robust protocols designed to facilitate effective interaction among their teams. These protocols may encompass standardized handoff procedures during shift changes, ensuring that critical information is conveyed seamlessly, and clear documentation practices to enhance the accuracy and accessibility of patient information.

By prioritizing open communication, healthcare professionals are empowered to share concerns, report incidents, and engage in collaborative problem-solving. This proactive approach enables the identification of potential risks at an early stage, facilitating the implementation of preventive measures to enhance patient safety. Moreover, a culture that values open communication contributes to the continuous learning and improvement of healthcare practices, creating an environment where lessons from adverse events are shared constructively to prevent recurrence.

In essence, establishing open communication protocols is a strategic initiative for healthcare organizations, serving as a linchpin in creating a culture that prioritizes safety, efficiency, and ongoing improvement in patient care.

2. Encourage Learning from Mistakes

Encouraging the process of learning from mistakes is a critical component in advancing the quality and safety of healthcare delivery. Gleaning insights from errors serves as a powerful mechanism for identifying gaps within healthcare systems and catalyzing essential improvements. To achieve this, healthcare organizations should actively promote a culture that not only acknowledges the inevitability of mistakes but also prioritizes continuous improvement and professional development.

In cultivating an environment conducive to learning from mistakes, healthcare institutions can establish structured mechanisms for incident reporting and analysis. This involves creating confidential reporting systems where healthcare professionals feel secure in sharing their experiences without fear of retribution. Additionally, organizations can institute regular reviews of adverse events, employing a non-punitive approach that focuses on understanding the root causes of errors rather than assigning blame.

By emphasizing continuous improvement and professional development, healthcare professionals are encouraged to engage in reflective practices that enhance their skills and knowledge. This proactive approach not only mitigates the recurrence of errors but also contributes to the overall resilience of the healthcare system. Ultimately, a culture that values learning from mistakes fosters a dynamic and adaptive healthcare environment, where insights gained from errors serve as catalysts for positive change and the continuous enhancement of patient care practices.

3. Implement Root Cause Analysis

Implementing root cause analysis is a crucial procedural step for healthcare organizations seeking to enhance patient safety by delving into the intricate layers of medical errors. This systematic approach serves as a structured investigative process, allowing healthcare institutions to pinpoint the fundamental causes and contributing factors behind adverse events. By engaging in root cause analysis, organizations move beyond surface-level identification of errors and delve into the systemic issues that underlie them, fostering a comprehensive understanding of the complexities involved.

The process involves a meticulous examination of events, employing tools such as the "5 Whys" technique to iteratively explore the deeper layers of causation. This methodical inquiry allows healthcare professionals to move beyond immediate, observable causes and address the underlying factors that create an environment conducive to errors. Additionally, root cause analysis serves as a preventive strategy, enabling organizations to implement targeted interventions and systemic improvements to avert similar incidents in the future.

Through the implementation of root cause analysis, healthcare organizations demonstrate a commitment to a culture of continuous improvement. This analytical approach not only aids in the resolution of specific incidents but also contributes to the development of proactive strategies to mitigate risks and enhance overall patient safety. In essence, root cause analysis is an invaluable tool for healthcare institutions striving to cultivate a learning culture that evolves in response to the insights gained from thorough and systematic analysis of medical errors.

4. Prioritize Patient Safety

Prioritizing patient safety is the cornerstone of exemplary healthcare delivery, demanding a holistic commitment that permeates every facet of organizational strategy and practice. Healthcare organizations underscore this commitment by integrating staffing models and resource allocation strategies explicitly designed to prioritize patient safety. This involves ensuring adequate staffing levels and resources to respond effectively to patient needs, fostering an environment where the well-being and safety of patients are paramount considerations in decision-making.

Moreover, the commitment to patient safety extends to the implementation of evidence-based policies and procedures. By anchoring practices in the latest scientific knowledge and best practices, healthcare organizations create a framework that aligns with the highest standards of safety and quality care. These policies should not be static but subject to regular review and updates to incorporate emerging research findings, technological advancements, and lessons learned from internal assessments.

In essence, a steadfast dedication to patient safety requires a proactive

...a safety-oriented culture attracts and retains high-caliber healthcare professionals who are drawn to environments that prioritize their well-being and emphasize continuous improvement in safety practices.

and dynamic approach. It involves a continuous evaluation of systems, policies, and procedures to ensure their alignment with the evolving landscape of healthcare knowledge and the unique needs of patients. By consistently prioritizing patient safety in staffing, resource allocation, and the implementation of evidence-based practices, healthcare organizations demonstrate a commitment to delivering care that is not only effective but fundamentally safe. This commitment becomes a driving force in cultivating a culture where patients can trust in the quality and safety of the healthcare they receive.

CONCLUSION

The prevalence of medical errors in the United States is an ongoing challenge that demands our attention and action. Shockingly, these errors have persistently remained at high levels over the past three decades. This raises crucial questions: Have we become desensitized to these statistics over time? Have we accepted them as the norm in the healthcare industry? Or perhaps our culture has improved, and we are reporting these events more diligently?

Regardless of the reasons behind these persistently high numbers, one thing remains undeniable: we have an issue that has persisted for far too long, and we have yet to make significant improvements.

Addressing the root causes of medical errors is paramount, especially when 80% of these errors are linked to systemic factors rather than individual errors. Shifting our focus towards a systematic approach to error assessment and prevention can be the catalyst for change that we desperately need. Currently ranked as the third leading cause of death in the United States, medical errors demand our utmost attention.

To effect change, we must foster an environment where healthcare professionals feel empowered to identify and openly discuss the root causes of errors. Open communication channels, a culture that encourages learning from mistakes, rigorous root cause analysis, and an unwavering commitment to patient safety are all essential components of this transformation.

Every near-miss and adverse event should trigger a systematic response, driving us to comprehensively address the underlying issues. In this collective effort, healthcare professionals and organizations play pivotal roles in shaping a culture where safety is not merely a goal but an ingrained ethos. Through this commitment, we can work towards reducing the incidence of medical errors, continually improving patient care, and ultimately achieving better healthcare outcomes for all.

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His experience working as an Emergency Room Medical Scribe and EMT allowed him to witness the healthcare system from a different lens.

As a former Firefighter, Kush understands the importance of a team approach within an organized system in improving outcomes.

Kush's vision is to use his background and education to implement changes in how healthcare is delivered in his community and globally.

LNC PRACTICE TIP: POTENTIAL CAREER BUSTERS

BY *Mary K. Flanagan, BSN, RN, CNOR(E), LNCC,* Certified Perioperative Nurse Emeritus, Legal Nurse Consultant Certified AND *Lisa Mancuso, BSN, RN, CCRN, CLCP, LNCC* , President, AALNC 2022-2024

1. Failure to meet deadlines:
Your attorney-client or retaining LNC client has their deadline: if you are late, you will make your client late. Before accepting an assignment, ensure you have all the information you need (i.e., the volume of records, asked-for work products, written report v. verbal report) to know if you can meet a deadline. Refusing a project is better than delivering work products past the due date.

2. Failure to respond:
Neglecting to respond promptly to your clients will tarnish your reputation. And in the legal world, reputation is everything. Is the paralegal asking for your updated CV and fee schedule? Provide it promptly. Does your retaining LNC need edits on your report? Take care of it immediately. We all have different definitions of "prompt", so if you can't produce something timely, make sure you at least acknowledge the phone call or email within 24-48 hours. If you will be away and not checking your messages, set your voicemail greeting and automatic email reply to reflect this.

3. Lack of flexibility:
Many LNCs are balancing clinical, business, and family responsibilities. Most attorneys keep regular business hours. It's up to you, the retained LNC, to accommodate the client. Have protected time set aside during the week to be available to that client, whether an attorney or fellow LNC.

4. Inappropriate email addresses:
Consider having a dedicated appropriate/professional email address for your business when you start. If your email address is "tiredmom", "hotnurse" or "bunnylove," (we've seen these!), a potential client might pass you by.

Attorney clients and hiring LNCs may not remember your work products, but they will remember your professionalism. You want to avoid being the LNC who does not get hired again because the assistant or paralegal found you nonresponsive and had to hunt you down. Equally, a hiring LNC could find themselves in a difficult position when negotiating a new deadline for their attorney due to your delay. While having excellent technical skills as an LNC is crucial, if you are challenging to work with, those skills won't matter.

As we were all green clinical nurses once, we were also novice LNCs. It's never comfortable to be "green." Learning how we fit into a new industry can be exhausting and stressful. We hope these tips answers questions and, ideally, generate more! We would love to hear from you in the Novice LNC Shared Interest Group at AALNC.org—let's keep the conversation going! ■

Need Content

For this article we will focus primarily on the laws in the Commonwealth of Massachusetts, please check the jurisdiction for specifics in your state. Gun and firearm are used interchangeably.

Gun Violence:

What if we don't ask?

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Guns are prevalent in the United States of America, for a variety of reasons. Americans frequently cite self-defense as their reason to own firearms in the available research. Guns can cause rapid and irreversible fatal injuries and therefore there is inherent liability in their storage and use. Nurses are treating patients with direct and indirect injuries from gun violence and have a significant preventative role in gun violence prevention. Specific populations are at increased risk of death due to firearms, including older adults, adolescents, and children. Nurses provide screenings and education related to intentional and accidental self-injury, suicide, and homicide and can include questions about gun access and storage. While there is some concern that nurses may be reluctant to assess gun ownership and storage, seeing gun ownership as a private matter and fearing conflict, research demonstrates that most patients are willing to have assessments of gun storage as part of their care. Hospitals and healthcare professionals, including nurses, may face legal consequences if there is a negative outcome related to gun ownership or storage and professionals did not assess for this unique risk that is well-established in healthcare literature. Nurse legal consultants may be called upon to weigh in on these issues in the aftermath of accidental or intentional self-injury or death related to firearms.

Gun ownership is a reality in the United States of America (U.S.). Approximately one third of American households report a gun at home (Pew Research Center, 2017). Guns may be in the home to supplement food sources, for recreation, sports, pest control, as gifted heirlooms, or part of a job, though most Americans cite personal defense as the reason for gun ownership (Cleveland et al., 2017; Pew Research Center, 2017). Guns carry inherent risk due to the potential for serious injury and death. Owning and operating a gun can create liabilities. Prevalence of guns in the community confers an increased risk for every member of the community. The Centers for Disease Control and Prevention (CDC) estimates that in 2020 the combined cost of medical expense and statistical value of lives lost from gun violence at 483.89 billion dollars (2020). Injury and death due to guns can be intentional or unintentional. There are identified populations and situations where ready access to a gun results in an increased risk of harm. Children and adolescents, older adults, individuals at risk for suicidal actions and those at risk for domestic violence are all at a greater risk for injury or death related to guns when accessible (Lee et al., 2022; Studdert, et al., 2020; Anglemyer, et al., 2015). Nurses are treating patients impacted by gun violence, seeing the effects, and being affected themselves by gun violence. Healthcare clinicians, especially nurses, can act by educating about safe gun storage to mitigate gun ownership risks.

An unsecured gun is accessible to anyone living or visiting the home, increasing risk and liabilities. The Bureau of Alcohol, Firearms, and Explosives (ATF) defines safe gun storage as: "A device that, when installed on a firearm, is designed to prevent the firearm from being operated without first deactivating the device; 2. A device incorporated into the firearm's design designed to prevent its operation by anyone not having access to the device; or 3. A safe, gun safe, gun case, lock box, or other device that is designed to be or can be used to store a firearm and that is designed to be unlocked only by means of a key, a combination, or other similar means" (para 1, 2023). Unsecured guns are available for more impulsive use.

ACCIDENTAL INJURIES AND DEATH

Vignette

The Wilson family lived in a quiet suburban town. Mr. Wilson was a long-time gun owner and had several firearms, passed down to him from his father. All his firearms and ammunition were locked in a gun safe except for a loaded handgun kept in his bedside table, tucked under some books. The Wilsons had three children aged 12, 10 and 8. One day 8-year-old Edward had two neighborhood friends over to play. During backyard play Edward fell and scraped his knee. The boys ran up to the Wilsons' bedroom to find a Band-Aid. Edward looked in his father's bedside table and found the handgun. The boys, assuming the gun was a toy, started playing with the weapon and pointing it at each other. During the play, the gun went off and one of the boys was fatally shot. The parents of the child who was shot made the decision to sue the Wilsons for the irresponsible storage resulting in their child's death.

In the U.S., the District of Columbia and eight states have laws mandating owners to appropriately secure their firearms. Additionally, there are 15 states that have child access prevention (CAP) laws. The CAP laws impose criminal liability on persons who did not adequately secure the firearm if a minor gains access to the firearm (Gifford, 2023). The American Academy of Pediatrics (AAP) recommends that in households with children all firearms should be unloaded and maintained in locked storage, with ammunition stored separately (2023). The AAP also suggests storing firearms safely outside of the home (2023). Firearms are the leading cause of death in children, adolescents, and young adults, since 2017 surpassing motor vehicle crashes (CDC, 2020; Lee, 2022).

Specific actions and inactions around possession of a gun have inherent risks and known dangers. Safe gun storage can mitigate some of these potential risks and prevent injury. Keeping a gun locked, unloaded with ammunition locked in a separate location has demonstrated protective effects towards injury reduction in homes with children and teenagers (Grossman, 2015; Johnson et al., 2010; Monuteaux, et al. 2019). There are about 4.6 million minors in the U.S. living in homes with a loaded and unlocked gun (Azrael, 2018). Access to an unsecured firearm increases the risk of accidental deaths in children and adolescents (Feigelman, 2020). Children may mistake a gun for toy, or intentionally pull a trigger on a gun. Adolescents are more impulsive due to evolving brain development, and many who completed suicide in this age group did not exhibit explicit suicidal ideation but had emotional reactivity or impulsivity. Due to the increase in impulsivity in this age group they may engage in more impulsive acts of self-harm or other reactively violent activities, such as gang-associated and retributive violence (Auerbach, 2017). Therefore, screening for access, and ensuring guns are secured in the home should be part of safe patient care. The more safety awareness and best practices on gun storage within the community, the safer the community will be. As in the tragic case of the Wilson family, even though there was no death within their family, the grief, loss, and resulting legal involvement will affect their lives extensively along with the family who lost their child.

SUICIDE RISK AND SUICIDE SCREENING

There were nearly 25,000 deaths in 2020 from gun violence, and more than half of these were due to suicide (CDC, 2020). Firearm deaths in the home continue to be more often deaths by suicide or criminal homicide than the death of an intruder due to self-defense (Butler, 2020). Suicides are not always planned, they are often an impulsive decision due to an acute stressor (Paashaus, 2021). There are situational and static risk factors, and often a major depressive disorder and hopelessness are present, but not always. Situations such as terminal illness, bullying, or interpersonal stressors can also lead to a decision to take one's own life. Access to a rapid and irreversible method such as a firearm causes a higher risk of death (Strobe, 2023). A large-scale study tracking firearm ownership over more than 12 years analyzed all fatalities of adults in California and found handgun ownership is associated with a higher risk of completed suicide (Studdert, 2020).

Preventative suicide risk screening is one of The Joint Commission National Patient Safety Goals (Joint Commission, 2023). If nurses are assessing suicidal ideation at all, there should be assessments in place to determine the level of risk. This includes inquiring about plans and access to means, including the most lethal means for ending one's life, a firearm (Anglemyer, 2015). Psychiatric nurses have a particular responsibility to assess due to the frequency of suicidal ideation, increased risk factors and actions in this specialty practice area. The American Psychiatric Nurses Association (APNA) outlines screening for firearm access in their Essential Competencies (2015). The Massachusetts Nurse Practice Act states that it is the duty of all nurses to assess, analyze and make informed judgements, and implement nursing interventions mandated by the situation and current knowledge in the field (MNA, 2021). Current knowledge in the field supports assessing risk, and thus incorporating firearm access screening into safety assessment and education on safe gun storage.

The significant likelihood of death from a firearm injury, combined with the almost instantaneous action once a trigger is pulled and the often-impulsive nature of a suicide attempt are a deadly combination. In states where nurses are practicing to the fullest extent of their licensure by screening, assessing, and implementing public health measures, suicide and homicide rates are lower (Choi et al., 2020). Screening, and providing education on safe gun storage is an important practice because there may be individuals, especially adolescents, who do not express their suicidal thoughts (Anglemyer, et al. 2015; Monuteaux, et al. 2019).

HEALTHCARE PROVIDER/ CLINICIAN RESPONSIBILITIES

Healthcare clinicians have specific responsibilities and additional liabilities to consider. The California court ruling in the Tarasoff case of 1976 determined that there is a duty to protect and act to reduce possible harm (National Conference of State Legislatures [NCSL], 2022). This ruling determined that clinicians have a duty to warn an identifiable individual who is likely to be the target of violent behavior (NCSL, 2022). Therefore, the clinician's duty is to reduce the risk of harm when there is foreseen violent behavior. Duty to warn laws were enacted at the state level in all 50 states, though some permit and some mandate (NCSL, 2022). Assessing weapons and means would fall into this scope when there is a concern for violent action.

As of this writing, in all jurisdictions in the U.S., asking about firearms in the home is within scope of practice and lawful (AMA, 2018). Medical and professional ethics support clinicians counseling patients about firearms (McCourt, 2018). The American Hospital Association (AHA) supports asking patients about guns in the home and has joined with over 1,000 hospitals and healthcare associations in a public awareness campaign encouraging parents to ask about unlocked firearms, and many hospitals have programs on site to provide gun locks to patients and families (AHA, 2023; Becker's Healthcare, 2023; Tucker, 2023). The AAP, the Association of Emergency Nurses, APNA and multiple other organizations have position statements backing healthcare clinicians' involvement in gun violence prevention, including assessing patients and providing education. St. Louis Children's Hospital in Missouri is providing free gun locks, no questions asked, by making them available in a bin in a waiting area (Tucker, 2023). With the backing of numerous national and local medical groups, along with many local supports there is support of engaging in conversation and providing the resources in the clinical settings.

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WHY HEALTHCARE? WHY NURSES?

Healthcare clinicians are in a unique position to address this potential safety risk to their patients by assessing general risks, providing resources, and education. Nurses are bound by practice standards to follow federal and state laws, current evidence, guidelines, and what a reasonable nurse would do in the same situation. Healthcare clinicians can assess risks and provide resources regarding safe gun storage to reduce harm. There may be liability for healthcare clinicians or their agencies if they do not assess patients for gun ownership and gun storage habits in the post-Tarasoff ruling era.

Asking about guns in the home as part of a healthcare clinician's safety assessment is like asking about helmets, seatbelts, or ungated pools. Nurses routinely assess safety and health related risks and provide education on these topics. Starting the dialogue creates an opportunity to share information, educate on best practices, and provide resources to help increase safety. Nurses are in an especially promising role to be asking, as nurses routinely perform patient and family teaching, and often have more contact in inpatient settings. Nurses are trained to perform non-judgmental assessments like assessing sexual orientation, diet, or activity choices, because the highest professional priority is placed on patient safety and outcomes. Nurses are already skilled in conducting safety assessments, and gun violence prevention is simply another appropriate assessment (Wolfe, 2019). Discussing gun ownership with patients does not imply a value judgement. Assessing access is not about the patient's right to have a gun, but about assessing the risks and providing information regarding safety. We do not "ban" certain foods or habits, we provide the education to aid the individual in making choices that reduce risk for harm. In the end any patient with capacity has free will to make their informed choices with our education to guide them. Nurses can and should engage patients in discussions about gun safety and storage, without shame or blame. Evidence based interventions, such as safe gun storage, are part of harm reduction.

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TRAINING AND READINESS

A study of Emergency Department (ED) nurses supported routine and standardized screening for guns in the home by ED nurses (Wolf, et al 2019). A study conducted at a large academic medical center in New England surveyed nurses in inpatient medical and inpatient psychiatric units regarding comfort with discussing safe gun storage with patients. The results showed that 96% of the nurses surveyed felt there was a need to provide education to their patients regarding safe gun storage and that they would feel comfortable providing this education if resources were provided. The nurses identified this work as important, they wanted to do this, and that training sessions would be helpful to increase comfort level providing education to patients and families (Sheppard et al 2020).

While nurses and physicians may not have had any specific training on gun handling or safety (some do), they do see the outcomes of gun violence, must treat wounds and comfort loved ones after a shooting, can speak to the harm, and can provide evidence-based information regarding risks and safe gun storage (Khubchandani et al., 2011). Nurses do not need to have full training on gun use and storage, but access to patient and family resources is important. Nurses do not need to know specifics regarding guns to provide the appropriate information regarding safe gun storage, with many publicly available resources and institutions making standardized patient information sheets, the nurse can provide these resources or direct the patient or family to the sites (AAP, 2023 ATF, 2023). Many nurses do report they would welcome additional training to improve their confidence around asking patients about firearms (Sheppard, et al. 2020). There is opportunity to model these trainings after physician trainings such as the program implemented by Rickert (et al, 2022) with a didactic and interactive session teaching about gun violence prevention.

Healthcare clinicians are on-the-ground witnesses to the worst of gun violence; violence that continued to escalate even throughout the Covid 19 emergency and lockdown measures (Zwald, 2023). A trauma surgeon in a city hospital, Rogers (2023) speaks to the immense emotional burden of gun violence, seeing the direct impact of gunshot injuries, the gruesome trauma as well as the devastation he must convey to the families of the victims in a perspective piece. Healthcare workers are also some of the individuals most at risk from workplace violence, with a vested interest in protecting their patients, colleagues, and themselves (OSHA 2016). Surveys of Social Workers and Registered Nurses established that in these professionals' opinions, incorporating structured

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questions and dialogue without stigma with the patient, along with resources intended for non-clinicians were effective and appropriate interventions. Patients and clinicians surveyed were generally positive about the firearm access questions and voiced understanding of the value to safety and reducing risk (Richards, 2022). If hospitals do not provide training about this common cause of injury and death to nurses they employ, they may be incurring legal risk.

MODELS TO FOLLOW

Massachusetts State Gun Laws

Massachusetts has a safe gun storage law that requires individuals who hold a license to carry to purchase and have a firearm safely stored separately from ammunition. Having a safe gun storage law in our jurisdiction makes it easier to reinforce this behavior, as there is a state law to reference, as well as resources to share with patients and families. While gun violence prevention laws are in place in our jurisdiction, dissemination of this information is not ensured. A survey of gun owners in 2018 found most gun owners in the U.S. had at least one gun stored loaded or unlocked (Wertz et al.). It is important to know your own state's laws. There are many responsible gun owners who are familiar with local, state, and federal regulations. Even the most conscientious individuals, however, may find themselves surprised by the differing restrictions and laws across the U.S.

In Massachusetts there is also an Extreme Risk Protection Order (ERPO), often referred to as a Red Flag Law, which permits a judge to consider, based on a petition and evidence, the surrendering of firearms and ammunition. In Massachusetts, a healthcare clinician can ask about guns, but cannot be the petitioner. The clinician can educate patients and families so that they are informed about ERPO and have this resource. Some states are considering expansion of Red Flag Laws, such as New York. Even if there is no information provided regarding ownership of or access to firearms, the information regarding ERPO can be given out. Patients maintain their privacy rights; they are not required to respond. Even in the pursuit of an ERPO in Massachusetts, the identified individual has a right to representation, and to present their side of the story.

Veteran's Administration

The Veteran's Administration (VA) has taken a clear stance on the importance of safe gun storage. The VA has developed evidence-based toolkits for their clinicians to assess and educate around safe gun storage, a valuable resource for many settings, cited by the CDC (CDC, 2023). Assessment of gun ownership is a priority for those working with veterans, due to the high proportion of veterans who own guns, and the fact that, much like risk of completed suicide, gun ownership increases with age in the veteran population (Cleveland et al., 2017). It is part of the role of most military servicemembers to be comfortable with guns, and thus the VA takes a pragmatic and hands-on approach to gun screenings.

Limitations

While there is a large body of evidence to support nurses asking patients and families about guns ownership and storage, there are barriers. Nurses are threatened on the job more than other professions, and they are victims of patient and family violence and thus may not want to engage in a topic that could be controversial. A study conducted by Sheppard et al. (2023) highlighted that some nurses worry that conversations regarding safe gun storage may be contentious, and a patient could react negatively. Respondents also stated that patients may not be truthful as this is a sensitive topic. As it involves opinion and political beliefs, nurse participants indicated firearm storage was an intimidating area to discuss. Another theme identified in Sheppard's (2023) study was the need for education for nurses regarding safe gun storage. While this study revealed that nurses felt it was an important topic, nurses wanted more education. Nurses lacked confidence that they could provide accurate information for the patients after the initial assessment if there were follow up questions or requests for resources. Other works noted concerns that dialogue about guns could negatively affect patient rapport, and clinicians were hesitant to alienate patients (Abrams, 2022). Another identified concern is the complexity of laws surrounding relinquishing firearms. Even if a client with suicidal or homicidal ideation were willing, there are barriers to relinquishing guns if there is not a place or way to effectively store them, and the ability to retrieve them in future (Bolton, 2023).

Many action groups that focus on protecting the rights of gun owners and advocacy also support education on safe gun storage. The Second Amendment Foundation (SAF), a group focused on increasing understanding of the constitutional right to own and possess firearms, promotes increasing education

and knowledge regarding gun safety. "Families that own guns have a responsibility to keep them safely stored, so that only the intended users can actually use them" (SAF, 2023). The National Rifle Association (NRA), founded to support 2nd amendment rights, holds a strong position supporting firearm education and offers multiple programs on firearm safety including age-appropriate options for children. "At the NRA, firearm education and safety is paramount—that's why we offer a variety of programs and services to promote the safe handling, use and storage of firearms" (NRA, para 1, 2023).

Evidence to support the efficacy of harm reduction through nurses incorporating assessment of access to guns and providing education is difficult to provide. Predicting the future or understanding the impact of prevention is challenging to prove. Providing information on safe gun storage or red flag laws may lead a patient or family to make a change or take action that prevents an event of gun violence. But determining what did not happen, what mass shooting plot was never acted on, or which suicide plan was not attempted is far more challenging to capture.

Freedoms and Restrictions

Despite clinicians' thoughtful concerns about upsetting patients, unbalancing the rapport, or creating uncomfortable conversations, the fact remains that asking about firearms may prevent many different forms of gun violence. Although some nurses expressed concerns, Sheppard et al. (2023) found that most nurses who were interviewed regarding their opinion regarding assessing firearm access and providing safe gun storage indicated that nurses should be involved in assessment and education (2023). All the data we have supports that most of conversations about gun violence prevention are friendly. Even in instances of an uncomfortable interaction, Healthcare clinicians offering education may still have an impact on patient attitudes and behavior, even if a rare uncomfortable interaction occurs (Abrams, 2022).

Liability of Healthcare Clinicians

If the nurse determines the patient is at increased risk for harm due to gun ownership, access, or storage but this risk is not appropriately documented or addressed, legal liability could be significant. The risk of fatality in a suicide attempt is 80-90% greater when a gun is used. If access to means to carry out the suicide attempt is not assessed, failure to ask or document may represent a missed opportunity or negligence. Asking about guns and safe storage as part of the risk assessment also provides an opportunity to share information on safe gun storage and red flag laws. Unintentional injuries with children in the home, a self-inflicted gunshot wound leading to death as a suicide attempt, or a heated argument in a household leading to an impulsive use of a gun are all times when safe gun storage can reasonably be expected to reduce fatalities and negative outcomes, based on the data we have and investigations into gun behavior.

When intentional or unintentional death or injury due to a firearm occurs, litigants will be seeking responsible parties. If a parent is asked about gun accessibility at the pediatrician's office but no follow-up recommendations are given, the lack of education could present a risk to the child living with an unsecured gun. Questions about clinicians and practice liability may be raised in this scenario, and more importantly there is an opportunity to prevent harm. If the older adult with intense caregiving responsibilities and access to a firearm is overheard alluding to suicide in the Emergency Department on an unrelated matter, having clarity about which staff member most appropriately intervenes to assess and educate could prevent a missed opportunity and a tragedy.

CONCLUSIONS AND NEXT STEPS

Nurses are expected to follow standards of practice and the current evidence, and there is support for asking about gun ownership and storage in the available evidence. Nurses have an obligation to provide this education and could be held liable for not addressing identified risks. By asking about guns in the home, access to guns, and providing resources to interested patients, there is potential for nurses to reduce access to guns and liability and harm arising from gun violence. First, nurses must be educated regarding safe gun storage, local laws and available resources. Nurses could play a significant role in reducing injuries and fatalities due to gun violence. Nurses must follow best practices to reduce liability.

The role of the legal nurse consultant in assessing a case would be to determine if there was a known risk, and if there is a risk was there an opportunity to inquire about access to guns and provide follow-up. It is the responsibility of the nurse to provide reasonable care and follow the best recommendations of governing and regulatory bodies, and adherence to this must be established in any potential case. There could be role for legal nurse consultants to develop training programs that address safety as well as the legal aspects related to assessing for gun ownership and providing appropriate education, especially as there are differing laws in each jurisdiction. They can also provide attorneys with rationale for this practice as a patient safety mechanism.

It is legal in all states in the U.S. to inquire about guns, and multiple healthcare organizations support nurses playing an active role in reducing potential risks by assessing gun access and providing education regarding safe gun storage. Therefore, it is the duty of nurses to assess these lethal means in situations of higher risk, such as homes

with children, when people express thoughts of harming themselves or others, and in situations where domestic violence is an identified concern. Safe gun storage and education about gun resources, such as ERPO, can decrease the risk of harm, and healthcare clinicians are positioned to provide this information when assessing these risks.

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Artificial Intelligence in the Healthcare, Legal and Medical Professional Liability Insurance Communities

Ashley Weber BSN, RN, LNCC

Keywords: artificial intelligence, medical professional liability, legal, healthcare

Artificial intelligence (AI) across the world has high implications for increased efficiencies as well as the potential for both an increase and decrease in risks associated with its use. In this article, discussion occurs within the communities of healthcare, legal, and medical professional liability insurance. A brief review of available literature was conducted. It was concluded that even though AI has been around for decades its' advancing technology highlights the interrelation between the three industries. Further research is required to ascertain the potential risks and benefits as it applies to each individual industry and to the community as a whole.

Artificial intelligence (AI) is currently one of the most discussed topics across the globe. It is capable of mimicking human cognitive functions, improving efficiency and has unrealized potentials that could exponentially revolutionize industries such as healthcare, finance, agriculture, education, social media, data security, and law (Poalelungi, et al., 2023). This exponential growth will require collaboration between stakeholders from every profession, across the world, to ensure the responsible, ethical, safe, secure, unbiased, trusted, equitable, and accountable regulation and implementation of advancing artificial intelligence. This article will focus on the interconnectedness and impact of artificial intelligence on the professions of healthcare, legal and medical professional

liability insurance, and the community as a whole.

AI AND HEALTHCARE

Healthcare is not naïve to AI. AI can already perform impressively at discrete tasks, such as interpretating medical images (Lancet, 2023). AI has a decades long history of use in the healthcare field. The 1990's began the era of computer read electrocardiograms, white-cell differential counts, and image processing tasks. These required and still require a skilled professional to oversee the process (Drazen, Kohane, & Leong, 2023). Current AI is proving to be a valuable tool and is increasingly being used for disease detection and diagnosis, medical imaging and analysis, treatment planning and personalized medicine, drug discovery and development, predictive analytics, and risk assessment (Poalelungi, et al., 2023). The advancement of AI in healthcare is being rapidly implemented in areas such as diagnostics and clinical trials (Drazen, Kohane, & Leong, 2023). AI performs best with well-defined tasks, and when it can, easily augment rather than replace human judgement. AI can make mistakes easily missed by humans or "hallucinate" non-existent sources (Lancet, 2023).

The American Nurses Association (ANA) stated the use of AI in nursing practice should support and enhance the core values and ethics of nursing (ANA Center for Ethics and Human, 2022). We as a healthcare industry are responsible for questioning a variety of points. How will the implementation of AI affect personal privacy data now and in the future? How do deep rooted healthcare dataset biases affect the algorithms used in the building of AI and the results they produce? Is there equitable representation of unbiased data available? The ANA Position Statement on *The Ethical Use of Artificial Intelligence in Nursing Practice* states that nurses must ensure that advanced technologies do not compromise the nature of human interactions and relationships central to the nursing profession. Users of an AI system like a chatbot, that provides a diagnosis or treatment recommendation, may not be able to differentiate between fact and fiction which is of great concern (Drazen, Kohane, & Leong, 2023). Li, et al., 2023 stated that large language models (a form of AI) do not exactly know what it is doing and does not have intentionality. "AI does not replace good nursing care, or the care provided by other members of the interprofessional team. AI augments, supports, and streamlines expert clinical practice. An exploration of AI requires moral/ethical consideration of four key aspects of AI: methodological elements; justice, fairness, and equity; data and informatics; and regulatory principles" (ANA Center for Ethics and Human, 2022, p. 3).

Legal practitioners must adapt to the rapidly changing AI landscape by embracing technological advancements while remaining aware of the associated risks.

AI AND THE LEGAL LANDSCAPE

The rapid evolution of AI and related technologies has reshaped the legal landscape as legal services are streamlined ultimately changing the way legal professionals work (Ruslan, 2023). Legal practitioners must adapt to the rapidly changing AI landscape by embracing technological advancements while remaining aware of the associated risks. The balance between technology adoptions and ethical obligations in the legal profession as well as the challenges of maintaining the attorney-client relationship while also ensuring access to equitable justice can pose quite the challenge (Ruslan, 2023). According to Said, Azamat, Ravshan, & Bokhadir in 2023, maintaining human oversight and control in litigation using AI is globally essential, developing ethical guidelines for AI in litigation can be challenging due to the multifaceted and ever evolving nature of advancing AI. They go on to state that effective training and enforcement mechanisms may be required to ensure that those guidelines are widely accepted and followed by legal professionals.

The possibility of attorneys over-relying on AI or being hesitant to overrule an AI generated opinion can pose a threat to the integrity and fairness of the litigation process. "Ethical principles development, robust algorithmic transparency and explainability, data governance, human oversight, continuing education and training, and international collaboration have been identified as key strategies for AI-enabled fairness and accountability in litigation" (Said, Azamat, Ravshan, & Bokhadir, 2023, p. 13). Explainability in the medicolegal realm can be defined as being able to explain how AI came to the conclusion for the task at hand. Medical malpractice defense largely surrounds the ability for the practitioner to explain how and why they made the decisions they made, essentially supporting the standard of care. Without a person to depose how will AI products explainability be litigated? Is it the responsibility of the practitioner using the AI to know how its algorithms work? Who can fault be attributed to if a mistake in the AI algorithm is the cause of the deviation of standard of care?

AI AND MPL

Medical professional liability (MPL) cases affect nearly one-third of practicing physicians each year and costs are estimated at $60 billion a year. A small percentage of claims are litigated in court with 80-85% in favor of the defendant (Buttell, 2023). In the MPL industry it is widely known that the time from open to close on a claim has correlation to the overall cost of the claim. Throughout the MPL industry AI has been an innovation in the way claims are managed from robotic process automation to underwriting risk assessments. AI can be used to generate reports and highlight high risk claims. Through AI the MPL industry has the opportunity to improve efficiencies without changing staffing levels, as well as improve outcomes for their insureds utilizing AI to streamline processes across all departments potentially decreasing the time from open to close on a claim.

DISCUSSION

This article was intended to discuss the impacts of AI on healthcare, legal and medical professional liability communities individually and as a whole. The volume of research into the various aspects of the use of AI across these three industries is rapidly growing. As healthcare costs continue to rise, which includes MPL insurance policy premiums and legal fees related to non-covered services under those MPL policies, the community as a whole has the opportunity through the use of advancing AI to mitigate risks, decrease costs and become more efficient. Buttell in 2023 stated that the potential for major reassessment of risk by MPL insurers and reinsurers could potentially increase rates and affect policy terms as the adoption of the use of AI technology could bring about a larger reckoning of risk by a wide variety of healthcare stakeholders. Commonalities sweeping across all three communities includes cybersecurity risk, privacy risk,

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informed consent risk, litigation risk, safety concerns, equitability of access and use of AI, potential for biases in AI algorithms, and end user education with high levels of human oversight for accuracy, validity, and accountability.

As the healthcare industry adapts to the use of AI, patient care should benefit significantly, and the medical professional liability risk should be reduced. However, AI will also create new MPL risks to be managed and underwritten (Greve, September). Greve's indicates one of the best and most important ways that AI can reduce malpractice risk is by improving error rates from diagnostics to pathology. Diagnostic error has consistently resulted in a large percentage of all malpractice litigation for many decades. He further states that the potential for harm exists if an AI system is poorly designed or the data is not kept current. This is applicable across all three industries as healthcare, legal, and MPL regulatory, standard of care, and guidelines are ever evolving. All three industries are responsible for reporting to at least one regulatory body. This means that real time data must be updated in the systems utilizing AI that are used in the support of healthcare, legal/judicial, and insurance.

CONCLUSION

In conclusion, the use of AI across all three industries has the great potential to increase the efficiency of employees' time, in an era where the current staff must be as efficient as possible, reducing costs and increasing revenue. It has the great potential to streamline healthcare and improve patient outcomes while lowering medical malpractice risks. At the very same time it has the potential to increase risks due to the uncharted and largely unregulated use of artificial intelligence across all industries. Will medical malpractice and legal malpractice insurance policies begin including language about coverage determination in regard to the use of AI? Will the legal system consider the manufacturer of the software or the end user as the entity held accountable when an error has occurred that is actionable? The interconnectedness of the three industries highlights the need for further research on the implications and impact of advancing artificial intelligence and its use. As a registered nurse who holds a Legal Nurse Consultant Certified (LNCC) certification regulated by the American Legal Nurse Consultant Certification Board (ALNCCB) accredited by the Accreditation Board for Specialty Nursing Certification (ABSNC), and works in medical professional liability insurance, I am intrigued by the vast applications that AI has pertaining to the processing of cases/claims. AI has the potential to reduce typist time, make processing medical records more efficient, and improve the overall processing of claims. Moreover, advancing AI has the potential to read medical records and create working documents for the legal team who support healthcare providers during the medical professional liability insurance claims process. This portends increased revenue through the shortening of the time a claim is opened to its closing.

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