Hafernick Legal-Nurse Consulting
Presents a newsletter by legal nurse consultants aimed at educating the community.

Hafernick Perspectives

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Restraint Policies Merit Regular Review

The use of restraints or seclusion (defined as the involuntary confinement of a person in a locked room) is limited to emergencies in which there is an imminent risk of an individual physically harming themselves, staff, or others and non-physical interventions would not be effective. Inappropriate use of restraints is on the list of violations that surveyors characterize as an "immediate and serious threat to the health and safety of patients." But staffing difficulties, especially in hiring and retaining healthcare personnel, may lead to an increase in the improper use of restraints.

In light of the increased HCFA enforcement activities and the new JCAHO standards, nursing homes and other facilities should revisit their restraint policies and consider increasing staff training in this area. At a minimum, the restraint policy should stress the facility's goal to reduce the instances of restraint use and should emphasize the prevention of emergencies that have the potential to lead to the use of restraints. The policy should also incorporate the JCAHO standards and should provide objective criteria as to when restraints should be used and, once initiated, when they should be removed. Because the restraint and seclusion poses an inherent risk to the physical safety and psychological well being of an individual, the facility must provide ongoing staff training to equip personnel with the necessary skills to appropriately implement the facility's restraint policy.

The good news is that much of the HCFA and JCAHO guidelines overlap, but they don't overlap completely -- opening the door to confusion on how to comply with both sets of standards. For now, when in doubt, go with the stricter standards.

One of the more notable differences is that HCFA includes chemical restraints, while JCAHO does not. This means that chemically restrained patients have to be assessed, evaluated, and treated with the same rules and regulations that are applied to mechanically restrained patients. JCAHO does not require deaths to be reported, whereas HCFA does. JCAHO does not require a change in treatment plan if restraints are applied, whereas HCFA requires "restraint to be used in accordance with a written modification to the patient's plan of care." This is only the tip of the iceberg, representing more paperwork for the healthcare provider.

What are the poor outcomes of restraint use? Accidents involving restraints may cause serious injury. Changes in body systems which may include: poor circulation, chronic constipation, incontinence, weak muscles, weakened bone structure, pressure sores, increased agitation, depressed appetite, increased threat of pneumonia, increased urinary infections, or death. Changes in quality of life which may include: reduced social contact, withdrawal from surroundings, loss of autonomy, depression, increased problems with sleep patterns, increased agitation, or loss of mobility.

Has your client suffered or died from the inappropriate use of restraints? **Legal nurse consultants** know current policies and can quickly determine the information you need to prove your case.

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Independent Medical Exams:

How Using Legal Nurses Can Benefit Your Case

Part 1 – This article presents how to benefit from using nurses who objectively assess, observe, monitor and report detailed objective information from a witnessed IME to facilitate the disposition of a case.

A fact of life in legal cases involving medical issues is the independent medical examination. Attorneys, acting on behalf of their clients, often request an IME to obtain a second opinion on the injured party's current clinical and mental condition. A non-treating physician performs the examination and reports back to the defense counsel, insurance carrier or claims adjuster.

In a personal injury or worker's compensation claim, the insurance company providing coverage wants assurance that the alleged injuries are as great as the plaintiff and the plaintiff's attorney claim. In civil matters, the IME is usually requested by the defense on the plaintiff, the injured party. The defendant's attorney will want the examiner to provide a diagnosis, a prognosis and recommendations for treatment. This examiner will likely act as an expert witness for the defense. Clearly the results of this IME are vital to the defense case. Often they are combined with information from the patient's medical record to support preexisting conditions or conflicts in the patient's presentation.

Another frequent use of the IME is for social security medical benefits. Federal and state agencies are responsible for determining disability secondary to physical and mental impairments. Requirements are clearly described in the Manual for Disability Evaluation under Social Security, published by the U.S. Department of Health and Human Services (U.S. Dept. of Health and Human Services, 1990). If it is not clear whether the claimant meets the requirements for severity or duration of an impairment, the agency or the authorized representative of the claimant (often an attorney, but not always) may request an IME. The court has the authority to grant or deny a request. The court may order an exam without a request if

the judge feels that the evidence is insufficient to determine disability status.

IMEs are not only utilized in negligence or personal injury actions but may also be requested in no-fault claims, toxic torts, product liability, medical malpractice and/or worker's compensation cases. Any case where an injury is present may be subject to an IME. They are performed to:

- establish or confirm a diagnosis, a prognosis and/or treatment plan
- determine duration and degree of disability
- estimate present and future physical disabilities
- determine permanency, malingering and causation
- proportion injuries

There are, of course, many other uses for IMEs. They are frequently used in criminal cases such as sexual and physical assaults. An IME may be ordered in custody cases or medical malpractice cases. Whatever the reason, a legal nurse consultant can use the opportunity to further a client's case.

It is not unusual for third opinions to be available in the records without scheduling an IME. It is reasonable to assume that both the plaintiff and the defense have documentation in the file to support their positions. For instance, a neurologist treating a patient for post-traumatic headache may note symptoms of mild traumatic brain injury. A referral from the neurologist to a neuropsychologist might result in a report confirming the TBI. This report, combined with the neurologist's observations, would be difficult for the defense to refute. On the other hand, a patient whose lower back pain is reported by his or her general practitioner to be secondary to a motor vehicle accident may have a report from a referral to physical medicine and rehabilitation describing a degenerative basis for pain. When a third opinion is available, don't hesitate to use the assenting opinion to substantiate your position.

Counsel should avoid, however, the possibility of putting himself or herself in the position of having to testify as a witness to impeach the credibility of the physician. It is better to have someone else attend the exam — such as a **Legal nurse consultant** — and for that person to tape-record or take contemporaneous but discreet notes. If required, the LNC could testify to impeach a dishonest physician's account of an examination.

Look for Part 2 of this article in the upcoming newsletters.

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JUST THE FACTS ABOUT DECUBITI

We've all heard horror stories about them or seen graphic pictures of them---decubiti. What are they and where do they come from? What causes them and can they be prevented? Do you know the difference in the staging of these ulcers? Can you be sure that appropriate, timely action was taken with the cases you review involving a decubitus? Let's take a look at the basics of decubitus ulcers.

Decubitus ulcers (also known as pressure sores, pressure ulcers, or bed sores) are traumas that occur, initially on the skin, due to a prolonged pressure against areas of the skin. Most commonly, decubiti develop over bony prominences of the body, such as heels, elbows, tailbone, spine, hips, and ankles. Patients who are at high risk for developing decubiti include those with decreased mobility, poor circulation, the elderly, patients who are incontinent, and patients with poor nutrition or dehydration. Decubitus ulcers can vary from a slight, pink discoloration of the skin to deep, open wounds that extend to the bone, and in severe instances, through the bone into internal organs. Once a decubitus is formed, it is slow to heal and requires weeks to years, resulting in an increased morbidity rate, increased lengths of stay, and increased health care costs.

Mechanical forces-pressure, friction and shear-that are exerted on the skin lead to the formation of decubiti. Pressure is a result of the force of gravity. The weight of a person's body, when in bed or sitting in a wheelchair, compresses blood supply leading to inflammation, tissue damage, and eventually, tissue death. Friction, such as that caused by a patient being pulled across bed linens during repositioning, occurs when something (e.g. bed linens, a brace, a cast) rubs the skin to the point of irritation or a direct pulling off of the skin's first layer. Shear occurs when the skin itself remains still and the tissues below, such as fat or muscle, move. This force causes a cut-off of the tissue's oxygen supply, inflammation, and ultimately, tissue damage or death.

Decubitus ulcers are described by "staging." A Stage I decubitus means the skin is intact and the area is red and does not blanche when touched. An open area of skin that is superficial and may present as an abrasion, blister, or shallow crater characterizes a Stage II decubitus. Stage III decubiti involve damage that extends through each layer of the skin. This extension of tissue damage can be a primary site for infection to occur. Stage IV decubiti extend completely through the layers of the skin and into the muscles, tendons, and bone that lie beneath. Without prompt, aggressive treatment by a skilled wound care medical professional, these extensive wounds will not heal and can cause life-threatening infections.

Prevention is the first line of defense in combating decubiti. This includes changing the patient's position every two hours or more, protecting and padding to prevent pressure, and maintaining adequate hygiene, nutrition, and hydration. Patients who are at high risk for decubitus formation and those who have histories of chronic decubitus ulcers should be identified during the initial nursing assessment and interventions should immediately be placed into action in the patient's plan of care. Treatment once a decubitus forms consists of keeping the area clean, removing the source of pressure, friction, or shear, and removing necrotic (dead) tissue. Some deep wounds require surgical removal or debridement of damaged or dead tissue, or amputation of the affected extremity.

The formation of decubiti and decubitus prevention is a basic nursing principle that is a basic focus in nursing schools (LVN, LPN, and RN) and most nursing assistant programs. Decubitus ulcers are generally considered as occurrences that are preventable and that development of these wounds is often thought to be evidence of some form of neglect. However, by providing diligent patient care and astute assessments, even the most compromised patient can remain free of decubitus ulcers.

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