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

Hafernick Perspectives

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Writing Expert Reports

First and foremost, I do NOT work as an expert and I am NOT an attorney. ***Hafernick Legal-Nurse Consulting*** consists solely of a 'behind the scenes' practice. However, an integral part of our business is expert location. Although our attorney-clients hire us for our medical expertise, we find it necessary to know a bit about the law and certain requirements in order to serve our attorney-clients more efficiently. This knowledge has proven helpful when securing qualified experts. For instance, Texas does not require experts to be either from Texas or a contingent state, as many do. Though we do require the expert to be either active in the field they are testifying relevant to the claim at the time the testimony is given OR at the time of the incident.

Hafernick Legal-Nurse Consulting may help explain Texas expert report requirements since many of our experts are not from here. On September 1, 2003, many new laws went into effect across Texas affecting our medical malpractice litigation. Expert requirements tightened and many previously qualified experts no longer met our new more stringent guidelines.

Once an expert is retained and said expert has reviewed the records, ***Hafernick Legal-Nurse Consulting*** may act as a liaison for their attorney-clients to get the expert's verbal opinion of the case. If the expert's opinion is not favorable, they may simply be asked to return the medical records along with their final invoice and the relationship is over. But if the expert has a favorable opinion, the attorney will request a written expert report. For the purposes of this article, we will discuss the components of the expert report for the plaintiff attorney in Texas.

The first paragraph should contain a brief introduction; including credentials and that the expert's CV is attached for greater detail. A statement should also be made clarifying that your expert is familiar with the standard of care in the evaluation and treatment of a patient with problems such as the plaintiff. Your expert must be specific here – i.e. 'I am familiar with the standard of care in the evaluation and treatment of the patient that has had a hysterectomy.'

Next, your expert may list the records they reviewed as the basis of their expert opinion. This should be followed with a very brief synopsis of the case. Many experts will go into great detail and this is not necessary. Still, they need to do enough that to be comfortable they conveyed the entire picture.

We encourage experts to use 'bullets' to stay on point. Your expert should list the standard of care for patients with problems such as the plaintiff. Vague words such as 'timely' are not appropriate if they are not defined within the report.

A few terms need to be defined at this point because they should be inserted in the report. These terms are negligence, ordinary care and proximate cause. These definitions should be used – quoting directly from Black's Law Dictionary, for instance – and how they specifically relate to the defendant(s). The defendant(s) should be specifically named – whoever the expert believe was negligent – whenever possible.

At this point, it is necessary to become redundant. The standard of care 'bullets' need to be repeated next. Specifically, your expert needs to state how the defendant(s) fell below the standard of care they just delineated. Your expert will need to follow those bullets by explaining how those failures were the proximate cause of the incident. There may be more than one proximate cause. It is pertinent your expert explain how those deviations from the standard of care were negligent.

As a rule, only a physician can truly address causation, but many times a nurse expert is necessary to successfully pursue litigation against a facility. Therefore, the nurse will usually at least address it. Even if a physician is not believed to be at fault – for instance, only a facility is being sued – a physician will be necessary to successfully address causation.

Many experts will want to include all their resources and this is not necessary – at least in Texas. Remember, if we tell the opposition all of our 'secrets' they will have plenty of time to dissect them prior to deposition. Your expert can expect to elaborate on their resources during deposition and that is soon enough. The reports will always end with something along the lines of 'I reserve the right to amend this report as more information becomes available.'

Again, these are only guidelines and are specific to Texas. These are just more ways ***Hafernick Legal-Nurse Consulting*** can help save YOU time and money!

Hafernick Legal-Nurse Consulting will also be able to assist you prepare your experts for deposition. We will assist you in researching opposing witnesses and in composing deposition questions. Be sure you are utilizing ALL the services and talents ***Hafernick Legal-Nurse Consulting*** offers!

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Pain Management: Medical Record Documentation

Medical record documentation is very important to determine if there has proper pain assessment and management. Both the documentation and assessment have an important connection because if pain is not perceived enough to be documented, it probably is not being accurately assessed. This in itself would be a breach in the standard of care for nursing and can lead to liability if other elements of negligence and malpractice are found. Inadequate documentation can seriously interfere with care and have legal implications for all physicians and nurses in any type of healthcare setting.

It would be safe to say that in any case involving a medical issue that you would expect to see some type of pain or discomfort. Was this pain/discomfort adequately assessed and treated? That is when proper documentation becomes very important and has to be done accurately and adequately.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) now requires that pain be assessed and documented as January 1, 2001, according to their newly revised standards. These standards address the assessment and management of pain in all care settings of healthcare institutions; the revised standards were available to all JCAHO accredited facilities on January 1, 2000. The only way to be in compliance is for the facility to demonstrate that processes are in place to assess and manage pain appropriately in all patients.

Pain and suffering is included in the complaints filed for lawsuits; if it is not, we as legal nurse consultants need to educate our attorney clients to add this to all appropriate complaints.

When reviewing the medical record, the legal nurse consultant needs to determine how the facility or facilities have documented the pain assessments and subsequent pain management. Most healthcare facilities are utilizing pain flow sheets; these flow sheets encompass all of the information necessary for an adequate and accurate pain assessment while also providing an area for medication administered and the effect of medication on the pain.

Pain has been regarded as the Fifth Vital Sign for quite a few years by many of the different pain management organizations including the American Pain Society, American Society of Pain Management Nurses and the American Academy of Pain Management. If the pain assessment is done with the vital signs, then is not difficult for the healthcare professional to remember to do the assessment and documentation.

JCAHO requires facilities to the following for pain management documentation:

- Assess the existence of pain and its intensity in all patients
  - Included must be pain location, radiation, onset, duration, other associated symptoms, characteristics, environment, timing, aggravating/alleviating factors, treatments, medications, effect on functionality, past history, physical examination, and severity as measured by a valid scale.
- Document the medication given for the symptoms and the effectiveness of the medication given.
- Record the pain assessment in a way that facilitates regular reassessment and follow-up.

All the above elements must be documented and tracked over time. If there is more than one site of pain, each site needs this documentation.

The next medical record you review, consider the pain and suffering the patient had to endure. We have learned as registered nurses about assessment, planning, intervention, evaluation and re-evaluation while in nursing school. Should we not expect the same of all nurses and other healthcare providers to put these skills to use, especially as patient advocates, to provide adequate pain assessment and treatment? If the healthcare provider such as a physical therapist is not licensed to do so, at least they can notify the registered nurse, who is able to provide the necessary treatment. Legal nurse consultants are trained in these areas and know where to look for the accurate and appropriate documentation.

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"Call me now, you cannot afford not to!"

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Hafernick Legal-Nurse Consulting is locally owned by Deborah Hafernick, RN. Her company has been providing quality services nation-wide since 2002. Deborah has been a registered nurse for over twelve years with experience including:

- Critiquing medical records
- Creating programs for continuing education
- Quality assurance and performance improvement
- Developing and revising policies and procedures
- Nursing and patient education