Hafernick Legal-Nurse Consulting

Presents a newsletter by legal nurse consultants aimed at educating the community.

Hafernick Perspectives

Volume 1, Issue 2 May 2003

Putting Care Plans to Work for You

Do you consider nursing care plans when reviewing the medical record? Do you really **LOOK** at them or just flip past? Nursing care plans are like a map for healthcare providers, guiding them through the nursing process. They individualize patient care, while providing continuity.

There are five steps in the nursing process:

1. ASSESSMENT: collecting, verifying and organizing data about the patient; data is obtained from report, the patient's chart, assessment, observation, other healthcare personnel, interviews, etc.
2. DIAGNOSING/ANALYZING: forming a nursing diagnosis is a statement of an actual or potential health problem.
3. PLANNING: formulate a "plan" to assist the patient with the identified nursing diagnosis; involves formulating goals/expected outcomes, setting priorities, and identifying nursing interventions to help to help the patient reach the goals.
4. IMPLEMENTING/INTERVENTION: put the nursing care plan into action.
5. EVALUATING: evaluate any interventions, reassess and analyze, etc.

These steps are a part of an ongoing process and it is pertinent to determine whether these steps have been laid out, followed and followed up on.

Various organizations publish standards of care on such issues as preventative care (ie prevention of decubitus ulcers). However, the hospital should also have a policy in place reflecting those current standards.

How can nursing care plans work for you? What if your client has been bed-bound and has ended up with a Stage IV decubitus ulcer on his coccyx? Nursing documentation notes he was rarely turned to offload pressure points. You *could* look to the hospital's policy on the care of bed-bound patients, but you will have to request those documents and wait. *But you already have the nursing care plan*. The nursing care plan should address this issue and specify patient turning and decubitus prevention. Compare what "should have happened" to what was documented. Lack of appropriate care plans and policies may also be an issue.

This is just one of the many finer points involved in medical record review that your **legal nurse consultant** will do for you to nail down your case.

Deborah Hafernick, RN, CLNC

Hafernick Legal-Nurse Consulting

hafernicklnc@ghg.net

www.ghg.net/hafernicklnc

DEALING WITH DRUG SEEKING BEHAVIOR

Drug-seeking behavior is a widely used term that refers to a patient's manipulative, demanding behavior to obtain medication. One of the most challenging situations facing many physicians is recognizing and dealing with patients who present a false picture symptomatically, as a way for obtaining certain prescribed substances. Patients with acute or chronic pain, anxiety disorders and attention-deficit disorders are at increased risk for addiction.

The most common complaints of drug seeking patients include:

- Back pain
- Headache
- Kidney stone
- Dental pain

Drug seekers vary in age, gender and socioeconomic status. They are usually very well informed. They know preferred medication by name, strength, color, price and manufacturer. They may "doctor shop", meaning they are using at least two and often multiple physicians in their attempt to obtain controlled prescription medication. This type of behavior is most common in the ER, where staff may not know the patient. The most sought after controlled substances include narcotic pain medication, benzodiazepines, stimulants, hypnotic, and barbiturates.

There are a variety of reasons for drug-seeking behavior:

- They may be addicted to certain medications
- They may wish to obtain these drugs "legally" versus "illegally-on the street"
- They are obtaining the medication for the purpose of supplying it or selling it to others

Once a physician suspects that is patient is demonstrating drug-seeking behavior, there are a number of risk management strategies that can be used to protect the physician's best interests. All patients need to have an appropriate medical screening examination and stabilization. The examination results should be carefully documented. The best defense against claims of inappropriate prescribing is documenting the indications and rationale for treatment. Any signs of medication dependence or drug-seeking behavior should be charted objectively. If the history doesn't fit, the patient should be asked for a previous practitioner, pharmacist or hospital to confirm the story. The address and telephone number a patient has given should be confirmed. A common practice now in many ER's is requesting a picture ID, photocopying it and including it in the patients record.

Law enforcement and the medical community agree that patient confidentiality is severely jeopardized when a patient "doctor shops" for the purpose of diverting and abusing controlled substances. The physician-patient relationship that ensures patient confidentially no longer exists when a patient provides false information regarding

their symptoms and their medical history. Many states have addressed this issue through statutes and regulations that make doctor shopping a felony conviction.

Eighteen states have implemented legislation or statutory regulations for prescription monitoring programs. This program collects electronic data from community and hospital outpatient pharmacies on the prescribing and dispensing of controlled drugs. It provides educational information on prescribing and dispensing trends as well as case information to regulatory and law enforcement agencies concerning drug distribution and diversion. State monitoring programs provide greater confidentiality protection because it limits access to controlled substance prescription information to only those few individuals and agencies that require use of the data.

Reports from state medical boards indicate that allegations of controlled substance overprescribing is the leading cause of investigation of physicians and of actions against physicians' license. This sets up an unfortunate paradox for physicians. The desire to relieve pain, anxiety and other discomfort must be weighed against the fear of creating addiction and of being investigated by law enforcement or licensing authorities. These concerns often leave physicians feeling ambivalent and uncomfortable about prescribing controlled substances. Unfortunately, this affects the majority of patients who suffer legitimate illnesses and are often left under treated.

Gail Hendrickson RN, CEN, LNC
Northeast Legal Nurse Consultants
Kittery Point, Maine
northeastlnc@aol.com

Informed Consent In a Nutshell

Informed consent is a method of communication between a patient and health care provider prior to undergoing a medical procedure that carries a greater than usual risk. Consent is a legal obligation in every state. The doctrine of informed consent is based on the prevention of battery and the right of self-determination (a person's right to control what is done to his/her body). This process is not simply getting the patient to sign a written consent form, it is educating the patient and allowing him or her to make a decision of free will and free from coercion. Failing to obtain informed consent from a patient or a patient's legal guardian can result in charges of battery or negligence.

State laws require a provider to disclose all information regarding the procedure or treatment in language that is comprehensible to the patient. Elements of informed consent should include:

- Informing the patient of his/her diagnosis
- The nature and purpose of a procedure or treatment, as well as expected outcomes or benefits of the procedure or treatment
- The risks and complications of a procedure or treatment
- Reasonable alternatives, including risks and benefits
- The risks and benefits of not undergoing the procedure or treatment

In addition, most state medical practice acts hold the provider who will be performing the procedure or treatment responsible for obtaining the consent. A provider can be legally liable by delegating a nurse, for example, to inform the patient of the procedure being done and obtain a patient's signature on a consent form for a procedure the provider will be performing. When the provider takes the time to educate the patient and obtain consent, he or she allows for questions to be answered and a better understanding by the patient. There are situations when the duty to obtain informed consent is waived such as when there is no need for treatment, in emergencies where there is imminent danger from failing to treat, or when the provider believes that disclosing the risks would result in a psychological threat that would be harmful to the patient (therapeutic privilege).

It is important that a provider not rely solely on the signed consent form as evidence that an informed discussion took place. The provider should document in the patient's chart that risks, benefits and alternatives of a procedure or treatment have been provided to the patient; and that the patient expresses understanding and agrees to it.

Informed consent is important both legally and ethically. It is in the best interest of the patient to make his or her own determination regarding a procedure or treatment after the medical facts and recommendations have been made by the provider. According to the American Medical Association (www.ama-assn.org) "The physician's obligation is to present the medical facts accurately to the patient or to the individual responsible for the patient's care and to make recommendations for management in accordance with good medical practice. The physician has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice."

Michelle Kinney, RN, MSN, FNP, CLNC
Kinney Legal Nurse Consulting
Wiscassset, Maine
mklnc@midcoast.com

What ***do*** Legal Nurse Consultants ***DO*****?**

- Identify standards of care, causation and damage issues
- Conduct research and summarize medical literature
- Prepare chronologies of medical events and comparing and correlating them to the allegations
- Educate attorneys regarding medical facts and issues relevant to the case
- Assist with depositions, mediations and trials
- Develop and prepare exhibits
- Organize medical records and other medically related litigation materials
- Collaborate with attorneys in preparing or analyzing complaints, answers, and motions for summary judgment, interrogatories, deposition and trial outlines, queries for direct and cross examination, document production request, trial briefs, demand letters, and status reports
- Identify and retain expert witnesses
- Act as a liaison among attorneys, physicians, and clients
- Provide initial case screenings for merit
- And much, much more!!
