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

# *Hafernick Perspectives*

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## *NEW* Infection Prevention: Artificial Nail Policy

Recently, artificial nails have come under fire in the healthcare field. Many hospitals are adopting policies placing restrictions related to artificial and natural nails. The hospitals have taken the position that artificial and long natural long nails can harbor an increased amount of pathogens, despite hand washing. Those healthcare workers involved in:

- Direct patient care
- Cleaning and processing of equipment
- Preparation of sterile products
- Handling of food and food products
- Medication preparation

The Association for Professionals in Infection Control and Epidemiology (APIC) recommends that nails be kept short and that the hands, including the nails and surrounding tissue, be free of inflammation. The Centers for Disease Control and Prevention recommends that nails be kept short and surgical team members not wear artificial nails. The draft of the CDC's new Guideline on Hand Hygiene states that healthcare workers should not wear nail or nail extenders when providing patient care. The Association of Operating Room Nurses (AORN) recommends that surgical personnel not wear artificial nails.

Research has shown that the subungal area of the nails contains the highest microbial count on the hand, and thus, the nail is an area of special concern in hand washing. Several recent studies have demonstrated that long and/or artificial fingernails may serve as reservoirs for *Pseudomonas aeruginosa*, Candida and other pathogens.

* Moolenaar 2000: Investigation of an outbreak in a neonatal ICU suggested that long or artificial nails contributed to colonization of healthcare workers' hands with the outbreak strain of *Pseudomonas aeruginosa*. Out of 439 neonates admitted during the study period, 46 (10%) acquired P. aeurginosa and 16 (35%) of those died. Infection was associated with exposure to two nurses; both had hand cultures that yielded strains of P. aeruginosa that were identical by molecular subtyping to strains located from cases. One nurse had natural long nails and on had artificial nails.

* Parry 2001: Three cases of postoperative Candida osteomyelitis and diskitis following laminectomy were epidemiologically linked to an operating technician who wore artificial nails at the time of the procedure.

* McNeil 2001: Investigators studied the effect of hand cleansing with antimicrobial soap or alcohol-based gel among healthcare workers with artificial nails compared to a control group. They found significantly more healthcare workers with artificial nails than controls had pathogens remaining after hand cleansing with soap or gel, suggesting that healthcare workers with artificial nails may serve as reservoirs for transmission of pathogens in the healthcare setting.

This is an issue of growing concern. Expect like policies to go into effect nationwide over the course of the next several months. Has your client experienced setbacks or died as the result of a nosocomial (hospital acquired) infection? **Legal nurse consultants** will help determine the infection's source. This valuable information will give you the edge you need to win your case!
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.

Deborah Hafernick, RN, CLNC
***Hafernick Legal-Nurse Consulting***
League City, Texas
hafernicklnc@ghg.net
www.ghg.net/hafernicklnc

## PAIN: THE ETHICS AND LIABILITY

The International Association for the Study of Pain defines pain as: A*n unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage or both.*

First and foremost, all nurses have a duty to the patient/client that if pain cannot be eliminated, an attempt must be made to reduce suffering. Pain can be defined as acute or chronic: *Acute pain is caused by an injury, illness, or surgery. Chronic pain exists beyond an expected time for healing, typically for six months or more. It is a persistent pain state that may be associated with a long-term incurable or intractable medical condition or disease.*

Proper initial assessment and ongoing assessment of a patient's pain is ultimately the responsibility of the primary care nurse. Ancillary healthcare team members also have the responsibility to report to the nurse a patient's pain and suffering, these team members include but are not limited to the following: physical therapists, nursing assistants, occupational therapists, and any other healthcare professional interacting with the patient.

Many organizations from regulatory, legislative, and professional associations have developed position statements and/or guidelines regarding the assessment, on-going assessment, treatment of the pain, documentation and evaluating effectiveness of treatment rendered. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) developed and published in 2000 the book and guidelines *"Pain Assessment and Management – An Organizational Approach."* Any organization that is accredited by JCAHO must adhere to the guidelines as pain is now considered a critical component in the continuum of care. Hospitals have had to

develop flow sheets as their assessment tools and other forms of documentation specifically related to pain including development of new policies and procedures. Hospitals and other JCAHO accredited organizations have noted that surveyors are spending as much as 50% of their time during a hospital wide survey focusing on pain management. Documentation is the most critical part, if not documented then one must assume it was not done.

Consumers are becoming more aware of their right to appropriate pain management, therefore placing societal demands for decreased or total elimination of pain and suffering. It is time for all to be aware of their right to pain management, it is a patient's right to receive appropriate treatment and stop the pain and suffering that so many have.

Lack of proper pain management by clinicians meets all of the four elements for negligence and malpractice:

1. **Duty** is established when a patient to clinician relationship exists.
2. **Breach of duty** occurs when the clinician fails to exercise reasonable care including failure to implement appropriate pain management policies, procedures and protocols; failure to report changes in a patient's condition and negligent administration of pain medications.
3. **Causation** due to the negligent conduct of the clinician resulting in injury to the patient, ex: when a patient reports numbness in the lower extremity while receiving epidural pain management and the patient ambulates without assistance and falls, breaking their hip
4. **Damages** as in the above example, the patient has to undergo unnecessary surgery and anesthesia, therefore the risk of anesthesia and possible infection post-operatively. The patient will undergo rehabilitation (hopefully back to the prior level of functioning) along with the additional pain and suffering.

Liability can and does result from improper pain management due to the failure to adhere to good and accepted practice by clinicians. The healthcare provider's legal duty may extend to the driving public when the provider administers drugs or treatments that can induce drowsiness or comprise judgment. There have been lawsuits against the healthcare provider when the patient drives after receiving medication which affects their mental alertness, leaves the healthcare facility, and has a motor vehicle accident seriously injuring the other driver and passengers for example (there are many other situations that could also occur.)

It is the responsibility of the clinician to:

1. First and foremost: to explain and document information provided to the patient regarding risks and side effects that can impair mental alertness or dexterity.
2. Provide written and verbal warnings to the patient and family members regarding potential adverse complications of invasive pain management procedures and when to seek medical attention.
3. Arrange for alternative transportation if the patient is alone.

Cindy Brooke, RN, CLNC
**Medical Legal Strategies**
Hendersonville, North Carolina
CBrooke58@msn.com

**Legal nurse consultants** are very familiar with adhering to good and accepted practices related to pain management. Please contact us to help you determine whether the appropriate Standards of Care have been adhered to. **No patient/client should have to bear unnecessary pain and suffering at any time in their life, it is treatable.**

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## WITNESS TAMPERING OR PEER SCRUTINY?

One of the necessary components in most medical malpractice lawsuits is to have a medical opinion by a physician. Not only is it crucial to have a physician that knows the medical components of the case, they also need to be believable. Numerous cases hinge on the expert's opinion as it clearly becomes a battle of the experts.

Physician groups around the country, with the support of the American Medical Association, are increasing the pressure and scrutiny of their colleagues who testify in medical malpractice cases. Their focus appears to be on plaintiff witnesses. Some groups are even taking disciplinary action against these witnesses.

The Florida Medical Association has implemented a system to track physicians who testify for the plaintiff. Florida also publishes a list of physicians who testify for the plaintiff. The Association does argue that physicians that give truthful and competent testimony have nothing to fear. The other side of the argument, from the plaintiffs' attorneys, fear the goal is to discourage doctors from testifying altogether.

The Association equates the increased insurance premiums and unmerited, excessive awards for plaintiffs to uncensored physician testimony. They also feel that the courts have failed to eliminate bogus testimony and now the job is theirs. According to Florida Medical Association Secretary, Dr. Dennis Agliano, "Experienced testifiers are real smooth on the stand-too smooth for judges and juries to discriminate the truth". He does stipulate that plaintiffs' and defense experts will be scrutinized equally. Dr. Agliano also contends that they are not out to change the jury system but to evaluate testimony and when falsehoods appear, it leaves it to other doctors to deal with them. Within the peer review system of the Florida Medical Association, complaints about members' expert witness testimony are brought to a committee on ethical and judicial affairs, who then assign an expert in the same field to evaluate the complaint. After the investigating expert has submitted a report to the committee, a hearing may be called. Disciplinary action may range from letters of concern to suspension or expulsion from the medical society. As of this writing no sanctions have been issued although many investigations are said to be in progress.

If the various medical groups can monitor, warn, chastise and even regulate what a physician can and cannot do with their mouth, then why do they not do the same for those physicians whom have multiple litigation allegations cases against them? Why are they so protective of the physicians who make the most serious and multiple mistakes?

Shirley A. Andrews RN
**Andrews, Smith and Zurenda, LLC**
Largo, Florida
ShirlRN@aol.com

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