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THE JOURNAL OF Legal Nurse Consulting

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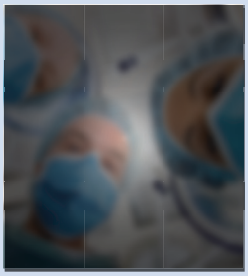
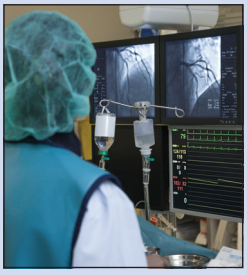
2019 NEW NURSE AUTHOR SUPPLEMENT





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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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ARTICLE SUBMISSION

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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- Put title and page number in a header on each page (using the Header feature in Word)
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GENERAL INFORMATION

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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Elizabeth Murray,
BSN RN LNCC

President, AALNC

President's Update

Dear AALNC Members,

AALNC continues to observe its 30th Anniversary by celebrating the many milestones we achieved this year. Standouts include:

- **AALNC celebrated its first "LNC Awareness Week" July 29 – August 2, 2019**
  - Members submitted videos to discuss what AALNC means to them and lessons learned in this exciting and burgeoning profession, with a free 2020 Annual Forum registration awarded to the winner.
  - Social media highlights posted (#LNCAwarenessWeek) deals for preordering the new Principles & Practice 4th Edition and a flash sale for AALNC's LNCC Review Course. The free webinar "So You Want to Be an LNC" featured successful legal nurse consultants' insights on being an LNC and success stories.
  - We heard from founding members and past presidents, excited to take part in the week. LNCs from every corner of the industry came forward to celebrate, and found their "professional home" in AALNC, joining as new members or renewing old memberships.
- **AALNC published four Principles & Practices Clinical Specialty E-books**, in a series of clinically focused subjects that legal nurses encounter frequently. The editorial team, senior editors Joanne Walker and Karen Wilkinson and associate editors Jodi Beaver, Mandy Bounds, and Dr. Brenda Tousley ably led the first of what we anticipate to be many E-Books focused on clinical specialties. Our authors Deborah Wipf, Dawn Nash, and Sharon S. Kelley showed their clinical expertise and in-depth critical analysis proficiency in these first four.
- **AALNC published the 4th Edition of AALNC's Principles & Practices textbook**, due to the earnest diligence and effort of our senior editors Julie Dickinson and Anne Meyer, and scores of expert authors and associate editors. I am so proud of this Edition and can attest that it genuinely represents the gold standard in legal nurse consulting education and training.

After celebrating this 30th Anniversary year, AALNC members have a lot to look forward to in the coming year. **The 2020 AALNC Annual Forum is in Denver, Colorado April 23 – 25th** at the Embassy Suites by Hilton Denver Downtown Convention Center. As I've heard from the Forum Committee Chair, Susan Point, there is an abundance of intriguing speaker submissions, including a better-than-ever Pre-Forum with even more resources for new LNCs. Besides outstanding continuing education, our Forum continues to be a unique opportunity for legal nurse consulting networking and collegiality. Whether you're just beginning a new career, or attending with experience to share, our Annual Forum offers you new and enduring professional relationships that help our members succeed.

Finish AALNC's 30th Anniversary year by spreading the word to your clients and colleagues about legal nurse consulting, your value, and why belonging to a professional organization matters. I'll close with what is fast becoming my mantra: Your nursing skills and expertise are the bedrock of your legal nurse consulting career. #KnowTheDifference

Elizabeth Murray, BSN RN LNCC

Editor's Note

Wendie Howland
MN, RN-BC, CRRN, CNLCP, LNCC

Editor, JLNC

This is the last issue on our 30th Anniversary Year. Many thanks to all who have made time in their busy lives to contribute their wisdom to our readers. This issue also contains our annual New Nurse Author Supplement. Maybe next year it will be your turn to see your name in print!

As I sit here writing my note, the country's attention is riveted on proceedings following whistleblowers' report of serious concerns. For those not familiar with the related law, in most instances whistleblowers are specifically protected from being identified to prevent retaliation; in many cases, the whistleblower is entitled to a share of any fine levied as a result. Nurses are often the ones who hold the whistle in hospital cases, since they are most likely to see problems' effects and be tuned in to institutional scuttlebutt. The case of Barbara Quillan BSN, RN, a former chief nursing officer at Sparrow Carson Hospital in Caron MI, is instructive. According to the suit filed for damages to her career and reputation, she alleged that she was terminated in retaliation for reporting substandard medical care … including a tubal ligation patient who lost 400cc of blood and a patient with appendicitis who was kept waiting 8 hours while staff searched in vain for a physician to treat him. (https://tinyurl.com/ybssylmz)

Before the hospital fired her they also excluded her from the root cause analysis and the risk management's resolution of the systemic failures. As is common in businesses, she received a confidential settlement some years after she was fired.

This JLNC has a wide range of articles concerned with licensure, standards of care and scope of practice, and confidentiality. This last attracted my attention in 2018 when I got a "Dear Licensee" email blast from one of the states where I am licensed touting a "fabulous new program" to evaluate and treat RNs who wanted help with substance abuse problems. I thought this was interesting, so I tried for about six weeks to contact the company named; when that was fruitless, from the BoN. Turned out that program had been turned over to another provider, so I called them. I specifically wanted to know if nurses who called them would be reported to the BoN. The answer was a qualified "maybe."

> *… Our program and our Board of Directors require that a Board have a "confidential" track for individuals whose condition has not caused their Board to know about them with the agreement that any relapse would require reporting to the Board. We suspect that this was the reason that (our program) didn't get the BoN contract in 2018. The 2019-20 service contract was under the umbrella (State Department of Professional Licensure) and included the BoN with the other 4 Boards with whom we had a long standing relationship and current contract - the Boards of Medicine, Dental Examiners, Pharmacy and Veterinary Medicine. Unfortunately we have very few true "confidential" cases because health care professionals tend to not seek*

(Continued on page 13)

"If you don't stick to your values when they're being tested, they're not values: they're hobbies."

—Jon Stewart

Laws and Rules for Nursing

Protecting the Patient and the Nurse

Judy A. Young, MSN, MHL, RN, LNCC

Keywords: Nurse Practice Act; nursing laws; Boards of Nursing; continuing education

The laws and rules governing nursing practice are established and maintained by state boards of nursing. Yet many if not most nurses have never read these documents. To make nurses more aware of the content and effects of these governing documents, some states have required continuing education training pertaining to the laws and rules and nurse practice acts in place to protect the public and ultimately the nurse. This article aims to make nurses aware of these documents and their importance.

GOVERNING LAWS AND RULES – A FEW DEFINITIONS

Most State Boards of Nursing do a good job of informing nurses of significant changes to statutes and nursing practice; however, anyone with a specific nursing practice question would be wise to go directly to the latest statutes and investigate the issue. Unfortunately, this is not easy in most states. A few definitions may help clarify the web of legal and administrative terms used by state legislatures.

- *Statutes* are a permanent collection of state laws organized by subject area into a code made up of titles, chapters, parts, and sections (Law.com). States generally update state statutes annually by laws that create, amend, transfer, or repeal statutory material. Some "online-savvy" ones even update statutes weekly.
- *Administrative rules* are an agency's statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedure or practice requirement of an agency. In Florida, for example, the "agency" is the Florida Department of Health, and the Division is

the Board of Nursing. The Board of Nursing uses administrative rules to help implement and interpret the laws that affect nursing practice. Administrative rules are generally divided into Codes, Titles, and Chapters. A state's requirements for nursing license renewal, continuing education and the nurse practice act (NPA) are usually in these Titles and Chapters.

NURSE PRACTICE ACT HISTORY

Always remember that statutes governing nursing practice were developed to protect the public and patients, not the nurse. Probably the most significant rule/regulation governing nursing practice, NPAs have been in force in one form or another in every state since 1970 (NCSBN 2019). Practice may differ in each state, and nurses who work in more than one state must be familiar with each state's NPA. The National Council of State Boards of Nursing (NCSB) website has a tool called "Find Your Nurse Practice Act," with links to each state board of nursing's NPA website. Most tell us that the NPA's sole legislative purpose is to ensure that every nurse meets minimum requirements for safe practice. To that end, nurses who fall below minimum competency or who otherwise present a danger to the public shall be prohibited from practicing in the state.

The history of the NPA goes back to the 1890s. According to Corinne Dorsey and Joyce Schowalter (2008), the first law enacted to regulate nursing anywhere was in Cape Town, South Africa, in 1891, followed by New Zealand in 1901. The first state in the U.S. to enact an NPA was North Carolina, in 1903. By 1913, thirty-six states and the District of Columbia had nurse practice acts in effect. These achievements are all the more remarkable since they followed a decade of efforts by a dedicated group of women nurses who could not yet vote.

NPA CONTENTS

Most NPAs are extensive documents covering RN and LPN practice. Unfortunately, most are difficult to navigate or read, and although many rely heavily on the ANA Scope and Standard for Nursing Practice (2015), each state is different. Using the Florida NPA as an example, we will examine what guidance the NPA may or may not provide.

An NPA defines and differentiates the levels of nursing responsibilities for RNs, LPNs, CNSs, and ARNPs, and briefly defines practice of each. For example, the NPA describes practical nursing as the performance of selected acts in the care of the ill, injured, or infirm, and the promotion of wellness and health maintenance under the direction of an RN, a MD, DO, or dentist. The scope of practice of professional nursing is described in a little more detail than practical nursing; however, the description is still very general and includes:

- The observation, assessment, nursing diagnosis, planning, intervention, and evaluation of care;
- Administration of medications and treatments as prescribed or authorized by a licensed practitioner; and
- The supervision and teaching of other personnel in the theory and performance of the above listed acts.

The section on Advance Practice Registered Nurses (APRN) goes into greater detail regarding Certified Registered Nurse Anesthetists (CRNAs) and Certified Nurse Midwives (CNMs) certification process and scope of practice. However, note that additional statutes apply to them: APRNs not only have to be familiar with nursing statutes, but they must also be familiar with statutes relating to their practice specialty. For example, an APRN working in a pain management clinic supervised by an MD must adhere to the requirements established by statutes governing the practice of medicine and nursing. A CRNA providing anesthesia in a dental clinic must adhere to the requirements established by statutes governing the practice of dentistry, nursing, and anesthesiology.

RESTRICTIONS OR EXCLUSIONS

When reviewing an NPA the LNC will quickly see that many topics are not covered. For example, if you search for specific information about medications that a nurse might administer, you will not find that information in an NPA.

A good example of how this could play out occurred in Florida in 2002. A group of nurses working in a standalone surgical center petitioned the Florida BON for a declaratory statement regarding patient monitoring and propofol administration. The surgical center's anesthesiologist wanted nurses to administer it and monitor the patients. The nurses believed it was outside their scope of practice; however, they could find no support in the NPA.

The BON researched Chapter 464 and agreed that this was lacking in the NPA. The section that related to CRNAs discussed preanesthetic medications, but roles and standards of care were based on protocols to provide guidance. The Board then determined that advanced practice acts could not be performed by RNs not certified as APRNs. Based on these findings, the BON sided with the RNs, finding it was not within the scope of practice for an RN who is not a CRNA to administer propofol in that setting.

Another example of a procedure that required a declaratory statement by the Florida BON involved botulinum (Botox). State regulations regarding botulinum and liposuction vary, and you will not find them in the Florida

NPA-- or in the chapter that discusses medical practice. However, you will find a description of the APRN role in aesthetics and skin care in this Chapter, so the BON has declared that APRNs, but not RNs and LPNs, may administer botulinum.

Many Boards of Nursing have some version of a nursing practice advisory committee of working nurses who research practice issues, help the Board make determinations of this nature, and suggest clarifying language in the Act's online explanations.

DISCIPLINARY PROVISIONS

Because NPAs were developed to protect the public, most contain lengthy sections on criteria for disciplinary action. Some violations of the laws are obvious, such as persons not licensed or certified using the designations RN, LPN, CNS, CRNA, CNM, or ARNP. These actions mislead the public and in Florida, constitute misdemeanors of the first degree, which may be punishable by a term of imprisonment not exceeding one year. Other more serious violations such as using or attempting to use a suspended license or knowingly employing unlicensed persons in the practice of nursing constitute felony of the third degree. These violators may be punishable by a term of imprisonment not exceeding five years.

NPAs may include additional obvious violations that could cause in denial of a license or disciplinary license, such as sexual misconduct in the practice of nursing, having a license revoked, suspended or denied by another state, and being convicted of a crime which directly relates to the practice of nursing. Nursing licensure may also be denied or revoked for persons found guilty of:

- theft
- fraudulent practices
- lewdness and indecent exposure
- assault and battery
- child abuse
- domestic violence
- working while impaired by alcohol, drugs, narcotics, or chemicals
- attempting to engage in possession, sale, or distribution of controlled substances

Less obvious violations should be concerning. For example, the nurse who fails to report another person known to violate the statutes may be subject to disciplinary action. Occasionally nurses are unaware they have violated a statute until they are notified that a complaint has been filed with the BON. Most often these are for failure to meet minimal standards of acceptable and prevailing practice, including engaging in nursing acts for which the nurse was not qualified by training or experience.

MULTI-STATE LICENSURE

Having a Nursing Licensure Compact (multi-state) license can make knowing where and how to search for practice guidance a challenge. Nursing practice is not limited to patient care but includes all nursing practice as defined by the state practice laws of the state in which the patient is located. Nurses who practice in a state other than their home state must comply with the state practice laws of the state where the patient is. The practice of nursing in a party state under a multistate licensure subjects them to the jurisdiction of the licensing board, courts, and laws of that state. Nurses practicing in multiple states must also know the reporting obligations required by their home state, should they be found in violation of rules in a party state.

CONTINUING EDUCATION

In 1975, Dr. Helen Creighton, RN, JD, published "Law Every Nurse Should Know" (Creighton, 1975). Born in 1914, Dr. Creighton was a nurse attorney ahead of her time.

Two quotes from her book helps us understand why we need continuing education regarding the laws and rules that govern our practice today. Dr. Creighton said, "The nurse's right to practice as a practical nurse or as a registered professional nurse with or without specialization, means more to the nurse who understands the purpose and problems of licensure." And probably her most cautionary note: "The nurse who knows her contractual rights, duties and remedies is likely to make better and breach fewer contracts." It is easier to abide by the rules when they are known.

According to Dr. Creighton, early nursing leaders' most important achievement was the promotion of professional licensure. As true then as it is today, "The primary purpose of a licensing law for the control of the practice of nursing is to protect the health of the people by establishing minimum standards which qualified practitioners must meet."

All nurses should be familiar with the laws and rules that govern their practice, but the reality is that most of us do not look at these documents unless we have to, e.g., we're in some kind of trouble or investigating a case involving nursing malpractice. Nurses are being asked to perform more and different interventions and actions than ever before, and often without clearly understanding scope of practice. For example, if you worked for a plastic surgeon who asked you to inject Botox, would you know how to respond? If you were asked to give propofol for conscious sedation in an outpatient surgery center, would you know what to do? To provide answers to these and many other questions regarding nursing practice, the four states mentioned earlier now require continuing education focused on laws and rules that govern nursing.

Thirty-nine states require continuing education (CE) to obtain and renew nursing licensure. Four require nurses to complete training in laws and rules

that govern nursing practice – Alabama, Florida, Ohio, and Texas (Nurse.com) The amount of CE varies greatly from state to state, and some states require other very interesting topics. Some are flexible about how to meet requirements.

- Alaska nurses may choose two of three means of meeting the CE requirement: 1) 30 contact hours; 2) 30 hours professional nursing activities; 3) 320 hours nursing employment.
- Florida requires CE in human trafficking and recognizing impairment in the workplace.
- Massachusetts mandates fifteen hours every twenty-four months.
- Nevada nurses must complete four hours on bioterrorism, and like many other states requires thirty hours of CE every twenty-four months
- New York requires hours in recognizing and reporting abuse of vulnerable citizens
- Texas requirements differ among various nursing specialties: ED nurses must complete two contact hours relevant to forensic evidence collection; geriatric nurses must obtain two contact hours relevant to the geriatric population.

These differences are most significant for nurses who cross state lines to work. Nurses with a Nursing Licensure Compact (multi-state) license must meet the continuing education requirements of their home states.

CONCLUSION

It is the individual responsibility of every licensed nurse to adhere to the laws and rules governing the practice of nursing. It is not the responsibility of employers to ensure that employed nurses know them. Ignorance of the law is not an excuse for actions that lead to or cause harm to a patient. LNCs, whether working as expert witnesses or behind the scenes, are often tasked with offering opinions on standards of care. Knowing the applicable laws and rules is essential to doing so.

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Standards of Care and Standards of Practice

Kathleen C. Ashton, PhD, RN, ACNS-BC

Keywords: Standards of practice, standards of care, legal nurse consulting

Legal nurse consultants (LNCs) are valued for their nursing knowledge and experience. Beyond that, understanding some pertinent legal principles can be an important complement to nursing expertise used in a legal matter. Two common terms with notable differences are standards of practice and standards of care. This article explains the differences to help LNCs use correct terminology

STANDARDS OF PRACTICE

All professions develop their own standards of practice. Commonly, leaders of a specific profession work through a professional association to determine and promulgate them. Nursing has standards generally and for all specialties, established practices and procedures that are accepted as correct within a particular specialty. For example, in 2008 perioperative nurses published their standards of professional performance for perioperative nursing, and then revised them in 2015 (Association of periOperative Registered Nurses, 2019). Similarly, ambulatory care nurses have

Table 1. Standards of Practice	
1.	The RN will be responsible for implementation of the nursing process in caring for each patient.
2.	Assessment must be completed on each patient ASAP, but not to exceed 8 hours of arrival to the inpatient nursing unit.
3.	The RN will develop an individualized plan of care within 24 hours of the patient's admission.
4.	The RN will assess patient readiness to learn and learning needs within 24 hours of admission and ongoing.
5.	The RN or Case Manager will initiate a discharge plan within 24 hours of admission and reevaluate the plan.

published their standards as well (American Academy of Ambulatory Care Nurses, 2017).

See Table 1 for examples of standards of practice.

STANDARDS OF CARE

Standards of care recognize the trusted role that a nurse plays within the profession and in society at large. They form the baseline for measuring quality care and govern the nurse's practice at every level of practice and in every specialty of nursing (SGNA, 2014). Standards of care are developed in consideration of state and federal rules, laws, and regulations that govern the practice of nursing. Therefore, they have legal implications that standards of practice may not reflect. Standards of care are established at the national level and apply to nursing in various settings; thus, they are uniform regardless of venue. Moreover, states and local regions may establish their own set of standards of care. Individual state nurse practice acts are sources for standards of care within each state.

Standards of care are used to delineate professional expectations of nurses, to guide them on proper protocol, and to give them an objective standard with which to evaluate other nurses. They are useful to ensure consistency in practice so that patients and other recipients of nursing care receive quality care and protection.

Legal nurse consultants need to consider standards of practice and standards of care when developing opinions and must be able to point to the source for their opinions. Certain accrediting bodies such as The Joint Commission do not promulgate standards of practice or standards of care. The Joint Commission uses performance standards to evaluate hospitals and other entities and is seldom an appropriate resource for standards. The authoritative professional organizations are the appropriate resources to use in support of opinions regarding professional standards.

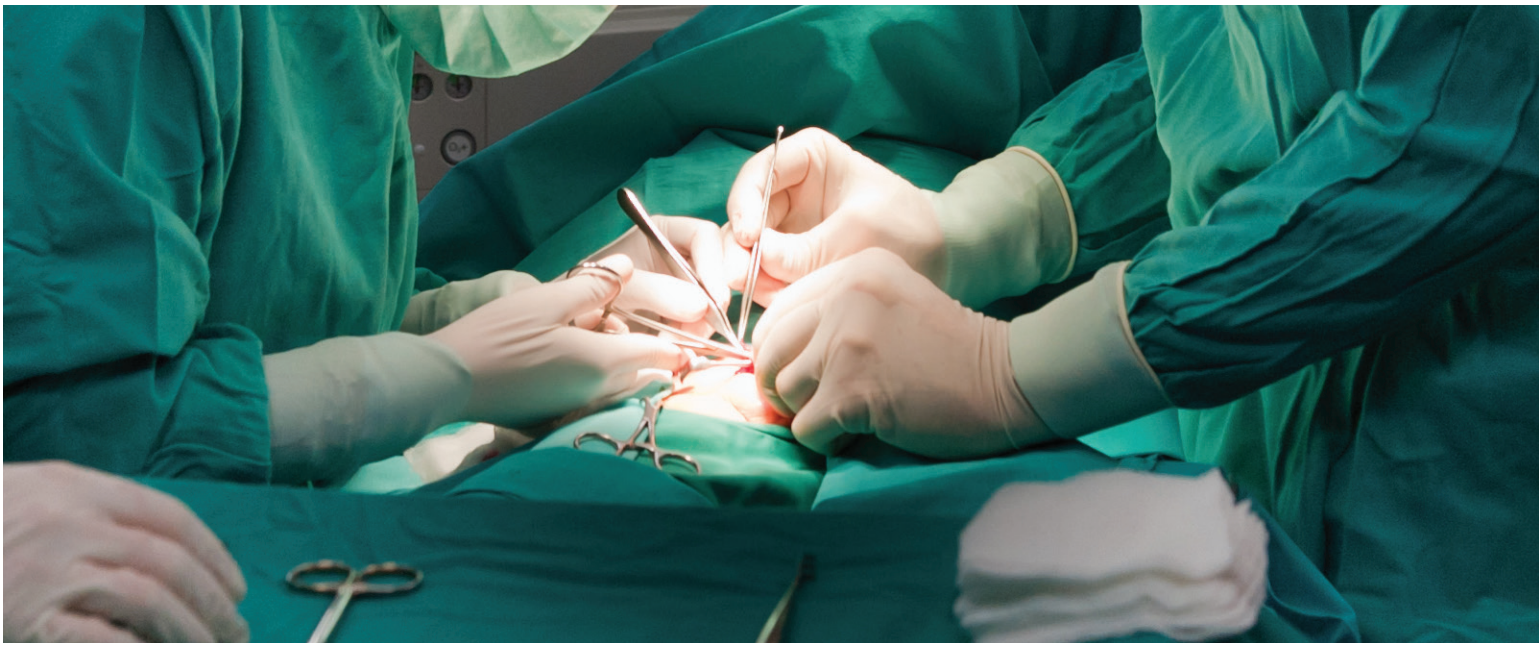
See Table 2 for examples of standards of care.

NEGLIGENCE

A nurse who does not meet the accepted standards of care may be charged with negligence and be the target of a malpractice lawsuit, liable if failure to meet the standard of care results in harm to the patient. A violation of the standard of care occurs when the nurse, or one to whom a nurse has delegated care, fails to comply with the standard of care. A nurse is held liable for failure to monitor a patient's condition or equipment, administer medication appropriately, warn a patient about known harms or dangers, or completely and accurately report patient assessment and observations in a timely manner.

Nurses have a duty to communicate changes in patient condition to a medical professional to avoid harm and ensure that patient can receive medical intervention. Inappropriate management of patient identification and private data can result in HIPAA (Health Insurance Portability and Accountability Act) violations as well as incur legal liability. Nurses must comply with state rules regulating the practice

Table 2. Standards of Care	
1.	The patient can expect the RN to provide appropriate quality nursing care through the use of the nursing process.
2.	The patient can expect to be assessed by an RN on admission and re-assessed throughout their stay.
3.	The patient can expect to have an initial plan of care developed that identifies their individual needs, outlines nursing interventions, and the patient outcomes.
4.	The patient can expect to have learning needs assessed and evaluated.
5.	The patient can expect to have a discharge plan that identifies their individual needs



of nursing including delegation of certain tasks to unlicensed personnel.

SPECIAL KNOWLEDGE OR SKILL

In cases where a nurse possesses special knowledge or skill, that nurse will be judged against that special knowledge and skill. Depending on how this is interpreted, a nurse may be compared with how a reasonably prudent nurse with the same special knowledge or skill would have acted in the same or similar circumstances. This is why some institutions refuse to hire nurses into nursing assistant and other positions for which the professional nurse is considered overqualified; an RN is held to RN standards for nursing practice regardless of job description.

LEGAL DEFINITION

The legal definition of the standard of care for nurses differs from other guidelines or policies set by individuals or institutions and is broad in its scope. It is the embodiment of collective knowledge of the requirement for an average nurse delivering nursing care and sets the minimum criteria for proficiency (WOCNS, 2019).

It has only been since 1975 that nurses were finally recognized as professionals worthy of protection of law afforded to other medical professionals. Before that time, nurses were judged by the standard of an ordinary man or woman, indicating a lack of understanding or acceptance of nursing as a profession.

Standards of care are developed in consideration of state and federal rules, laws, and regulations that govern the practice of nursing. Therefore, they have legal implications that standards of practice may not reflect.

Similarly, at one time it was acceptable for a physician to opine on the standard of care for nursing. No longer can a physician without a nursing degree offer testimony about the standard of care for a nurse. Nurses are now recognized as the appropriate experts to testify and opine on the standard of nursing care. The accepted standard of care is that of an average nurse practicing in a similar area and delivering nursing care to a same or similar patient under the same or similar circumstances (WOCNS, 2019)

In cases of alleged malpractice or a breach of the standards of nursing care, nurses are protected by the statutes in each individual state. The Nurse Practice Act is the legislation that provides authority for nursing practice in each state and the individual state determines and interprets the law.

THE ROLE OF THE LNC

An LNC is the appropriate choice to educate the attorney, the jury, and other individuals concerning the practice of nursing. The nurse opines whether the nurse in question has met the standards of care, so the opinion must be

in accordance with accepted standards of care. Understanding the difference between standards of practice and standards of care is important and the foundation for the LNC's opinion. Being in active nursing practice is the most acceptable way for the LNC to demonstrate current expertise. The legal profession needs credible LNCs in active clinical practice who can opine on nursing actions by applying accepted and applicable standards of care and standards of practice.

No longer can a physician without a nursing degree offer testimony about the standard of care for a nurse. Nurses are now recognized as the appropriate experts to testify and opine on the standard of nursing care.

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EDITOR'S NOTE *(Continued from page 5)*

> *any help when they are sick … We currently do have (a few) confidential nurse cases under monitoring.*

Another tipster in Texas reported that a University of TX hospital had two — two— nurses die of fentanyl overdoses in hospital bathrooms; the feds came down on the hospital for not having done a very good job monitoring incomplete lost/misappropriated medication reports. Upon further review, as they say euphemistically, the hospital then reported about thirty such incidents over the previous few years (https://tinyurl.com/yxj36kyk). It looks like the public wouldn't have known any of this without a whistleblower tip, and perhaps the hospitals wouldn't have protected patients, either.

We have an article on confidentiality of substance abuse records referencing Department of Health and Human Services regulations. You'll be interested to see how these could affect employment law cases as well as others involving inappropriate private health information (PHI) release.

What would you do? Is there whistleblowing in your future? We'd like to hear your thoughts.

Wendie A. Howland

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Editor

42 CFR Part 2: Confidentiality of Substance Use Disorder Records

Elizabeth Murray BSN, RN, LNCC

Keywords: Substance Abuse; medical records; confidentiality; SAMHSA; mental health; 42 CFR Part 2

Anyone working in the healthcare field is familiar with HIPAA legislation guiding medical data privacy and security. However, there are also federal regulations pertaining to medical records about substance use disorder. Legal Nurse Consultants working on cases involving these records, particularly the burgeoning number of cases related to opiate abuse, should know about these regulations.

In 2017, the Department of Health and Human Services (HHS) updated its regulations for substance use disorder record confidentiality. The final rule aligns more closely with the Health Insurance Portability and Accountability Act (HIPAA) than the 1987 version. It also promotes better information sharing between practitioners while still protecting patient privacy in a sector of care that carries a stigma and potential adverse outcomes for personal relationships and employment. 42 CFR Part 2, or "Part 2" among practitioners in this field, was "written out of great concern about the potential use of substance use disorder information against individuals, causing individuals with

substance use disorders not to seek needed treatment" (42 CFR Part 2, 2017). Part 2 imposes more stringent requirements to obtain an individual's treatment records. The American Psychiatric Association (APA) published a comparison of the 1987 42 CFR Part 2 Rule, the updated Final Rule of Part 2, and HIPAA, which appears on the APA website (American Psychiatry Association, 2017).

From medical malpractice and wrongful death cases related to opioid prescription to DOJ/OIG investigation and proceedings against practitioners and facilities, legal nurse consultants potentially see cases impacted by 42 CFR Part 2 daily.

APPLICATION OF FEDERAL REGULATION

42 CFR Part 2 applies to a patient, or "any individual who has applied for or been given diagnosis, treatment, or referral for treatment for a substance use disorder at a part 2 program" and includes any individual who, "after arrest on a criminal charge, is identified as an individual with a substance use disorder" (42 CFR Part 2, 2017). Programs under this federal regulation include any individual, entity, general medical facility, or medical personnel or other staff who holds itself out as providing and provides, substance use disorder diagnosis, treatment, or referral for treatment. Part 2 does not apply to entire hospitals, trauma centers, Federally Qualified Health Centers (FQHC), or Community Mental Health Centers (CMHCs). It also may or may not apply to buprenorphine prescribers and is "fact-specific" (42 CFR Part 2, 2017). The Part 2 program must have formal policies and procedures in place to reasonably ensure privacy of patient information regarding substance use disorder records.

Written consent to share substance use disorder records (paper or electronic) must include:

1. The name of the patient.
2. The specific name(s) of the Part 2 program, or individuals permitted to make the disclosure.
3. How much and what kind of information is to be disclosed, including an explicit description of the substance use disorder information that may be disclosed.
4. The name(s) of the individual(s) to whom a disclosure is to be made. (42 CFR Part 2, 2017)

The regulation describes further requirements if the recipient entity does not have a treating provider relationship with the patient whose information is being disclosed. In addition, a patient who has signed a consent form can revoke consent; and in the case of a disclosure to multiple parties can revoke consent to one or more of the parties while leaving the rest of the consent in force. (42 CFR Part 2, 2017)

Programs include any individual, entity, general medical facility, or medical personnel or other staff who holds itself out as providing and provides, substance use disorder diagnosis, treatment, or referral for treatment.

MANDATORY AND PERMITTED DISCLOSURES

Certain situations allow for disclosure, such as state-mandated child abuse and neglect reporting; during cause-of-death reports; or with the existence of a valid court order. Programs are also permitted to disclose certain patient information in cases of a medical emergency; to report crimes occurring on program premises or against staff; to entities having administrative control, qualified service organizations, and outside auditors. (42 CFR Part 2, 2017)

PERCEIVED BARRIERS TO CARE

In March 2018, a coalition of more than 40 health care stakeholder organizations, including the APA, the American Health Information Management Association, the American Hospital Association, the American Society of Addiction Medicine, Blue Cross Blue Shield Association, Hazelden Betty Ford Foundation; and the Joint Commission penned a letter to lawmakers regarding the Final Rule. Recommendations included better alignment of 42 CFR Part 2 with HIPAA to "allow appropriate access to patient information that is essential for providing whole-person care." Perceived barriers to care included the challenge of obtaining multiple consents from the patient, the possibility of a doctor

Table 1

Provision	What Is the Proposed Change?	Why Is This Being Changed?
Applicability and Re-Disclosure	Treatment records created by non-part 2 providers based on their own patient encounter(s) will not be covered by part 2, unless any SUD records previously received from a part 2 program are incorporated into such records. Segmentation or holding apart of any part 2 patient record previously received can be used to ensure that new records created by non-part 2 providers will not become subject to part 2.	To facilitate coordination of care activities by non part-2 providers.
Disposition of Records	When an SUD patient sends an incidental message to the personal device of an employee of a part 2 program, the employee will be able to fulfill the part 2 requirement for "sanitizing" the device by deleting that message.	To ensure that the personal devices of employees will not need to be confiscated or destroyed, in order to sanitize per part 2.
Consent Requirements	An SUD patient may consent to disclosure of his part 2 treatment records to an entity (e.g., the Social Security Administration), without naming a specific person as the recipient for the disclosure.	To allow patients to apply for benefits and resources more easily, for example, when using online applications that do not identify a specific person as the recipient for a disclosure of part 2 records.
Disclosures Permitted w/ Written Consent	Disclosures for the purpose of "payment and health care operations" are permitted with written consent, in connection with an illustrative list of 17 example activities.	In order to resolve lingering confusion under part 2 about what activities count as "payment and health care operations," the list of examples will be moved into the reg text from the preamble.
Disclosures to Central Registries and PDMPs	Non-OTP (opioid treatment program) providers will become eligible to query a central registry, in order to determine whether their patients are already receiving opioid treatment through a member program. OTPs will be permitted to enroll in a state prescription drug monitoring program (PDMP), and permitted to report data into the PDMP when prescribing or dispensing medications on Schedules II to V, consistent with applicable state law.	The revised central registry and PDMP provisions will help to prevent duplicative enrollments in SUD care, duplicative prescriptions for SUD treatment, and adverse drug events related to SUD treatment.
Medical Emergencies	Declared emergencies resulting from natural disasters (e.g., hurricanes) that disrupt treatment facilities and services will meet the definition for a "bona fide medical emergency," for the purpose of disclosing SUD records without patient consent under part 2.	To ensure clinically appropriate communications and access to SUD care, in the context of declared emergencies resulting from natural disasters.
Research	Disclosures for research under part 2 will be permitted by a HIPAA covered entity or business associate to individuals and organizations who are neither HIPAA covered entities, nor subject to the Common Rule (re: Research on Human Subjects).	To facilitate appropriate disclosures for research, by streamlining overlapping requirements under part 2, the Privacy Rule and the Common Rule.
Audit and Evaluation	Part 2 will be revised to clarify that some specific situations fall within the scope of permitted disclosures for audits and/or program evaluation.	To resolve current ambiguity under part 2 about what activities are covered by the audit and evaluation provision.
Confidential Communications	The standard for court ordered disclosures of SUD records for the purpose of investigating "an extremely serious crime" will be revised, by dropping the phrase "allegedly committed by the patient."	To correct an earlier technical error from the 2017 rule-making, in which this phrase was inadvertently added to regulatory text without notice or public comment.
Undercover Agents and Informants	Court-ordered placement of an undercover agent or informant within a part 2 program will be extended to a period of 12 months, and courts will be authorized to further extend the period of placement through a new court order.	To address DOJ concerns that the current policy is overly restrictive to some ongoing investigations of part 2 programs.

Information on proposed changes to 42 CFR part 2 can also be found at the HHS.gov website at https://www.hhs.gov/about/news/2019/08/22/hhs-42-cfr-part-2-proposed-rule-fact-sheet.html

treating a patient and writing prescriptions for opioid pain medication without knowing the patient has a substance use disorder, and separation of a patient's addiction record from the rest of the medical record. (Partnership to Amend 42 CFR Part 2, 2018) In response, the House passed a bill, H.R. 3545 the "Overdose Prevention and Patient Safety Act" with bipartisan support in June 2018. The bill would align the federal privacy standards for substance use disorder patient records more closely with the standards under HIPAA, and also would repeal and replace criminal penalties for certain violations involving substance use disorder patient records with the HIPAA civil penalty structure. (Library of Congress, 2018) In November 2018 more than 220 organizations urged Senate committee leaders to consider the Overdose Prevention and Patient Safety Act. (American Hospital Association, 2018)

IMPLICATIONS FOR THE LEGAL NURSE CONSULTANT

From medical malpractice and wrongful death cases related to opioid prescription to DOJ/OIG investigation and proceedings against practitioners and facilities, legal nurse consultants potentially see cases impacted by 42 CFR Part 2 daily. Legal nurse consultants advising attorney clients to request and subpoena patient medical records should be aware of the additional written consents and requirements to obtain records regarding substance use disorder diagnosis, treatment, and management. These regulations, while fairly new, could still change soon. Updated legislation is pending. In August 2019, the National Association of Attorneys General sent congressional leaders a letter asking to end "regulations that prevent doctors from sharing information about their patients' addiction treatment histories (Anson, 2019).

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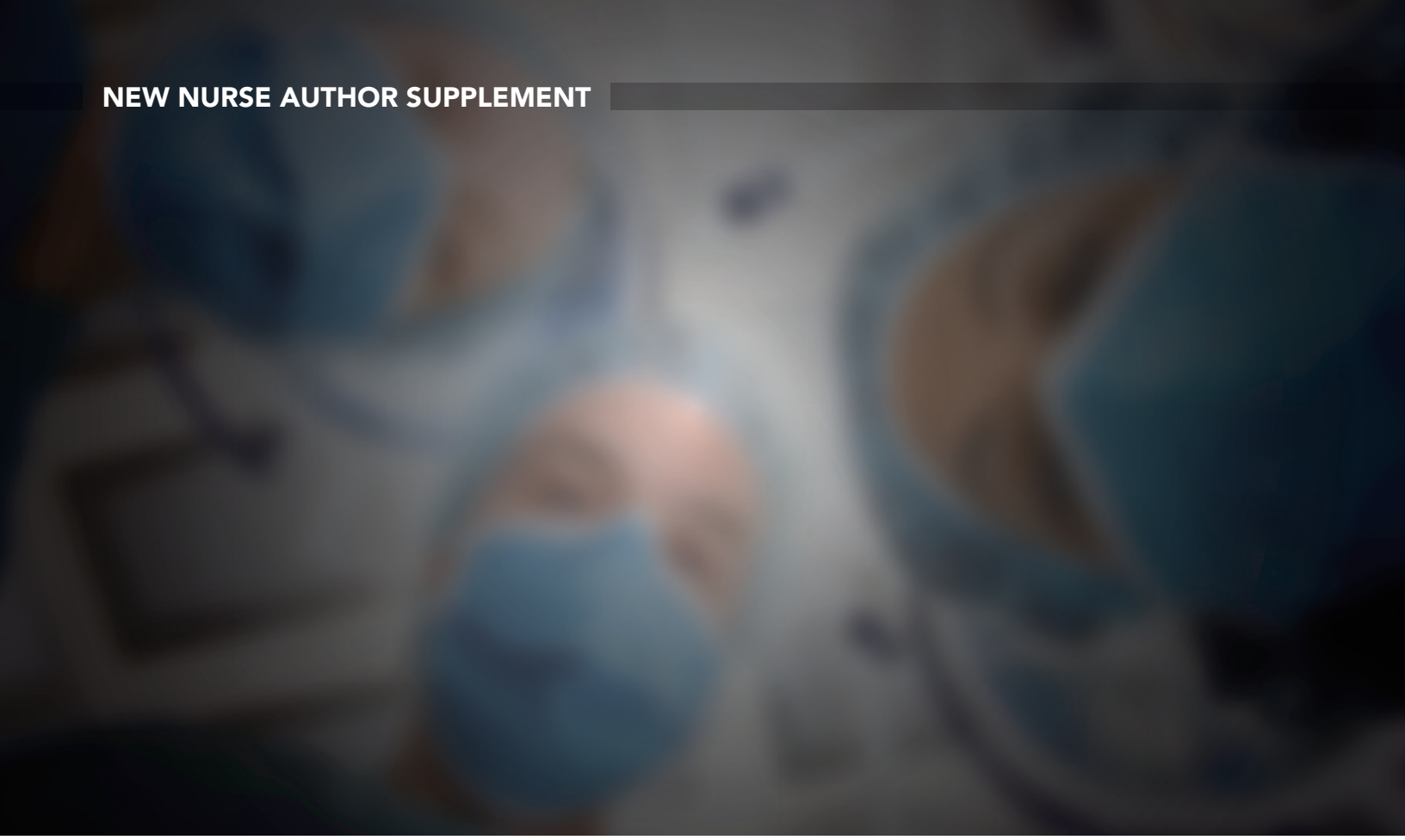

Suddenly Blind: Postoperative Vision Loss

Sandra Krug, CRNA, APRN, RRT

Keywords: POVL, postoperative vision loss, postoperative complications, surgical positioning, Trendelenburg

Postoperative vision loss (POVL) is an uncommon but devastating complication caused by retinal and optic nerve ischemia from prolonged intraocular pressure, related to head-down, prone positioning during anesthesia. LNCs should be aware of this, risk factors, optimal monitoring, and potential treatments when reviewing a case of postoperative blindness.

INTRODUCTION

The plaintiff attorney interviews a woman who wants to sue her surgeon. The patient underwent a posterior cervical disc fusion with instrumentation and was in the operating room for 6 hours. Instrumentation means that metal hardware was attached to the spine. The patient woke up from surgery unable to see. "Does she have a case?" the attorney asks you.

POSTOPERATIVE VISION LOSS

The Centers for Disease Control and Prevention reports vision loss as among the top ten causes of disability in the United States. It is a condition feared by many. People with vision loss are more likely to report depression, diabetes, hearing impairment, stroke, falls, cognitive decline, and premature death. Vision loss often leads to an inability to drive, read, keep accounts, or travel in unfamiliar places, substantially compromising the quality of life. Postoperative vision loss (POVL) not only has profound

implications for emotional well-being and return to preoperative function level but also increases the length of stay postoperatively and leads to higher medical bills. Patients who experience POVL incur an average of 8.6 hospital days versus 4.1 days for those unaffected. The average cost of stay more than doubles: $49,532 compared with $22,697 for those without POVL.[1]

The first documented report of POVL was in 1948 and was attributed to improper head positioning during a procedure with the patient in the prone position.[2] In 2006 an anesthesiologist, Dr. Anthony D. Lehner, experienced POVL following prolonged (7.5 hours) lumbar spine surgery in prone Trendelenburg position. (Figure 1) He stated that he was not able to open his eyes until noon the day after surgery due to edema. His vision loss was permanent, ending his career. Dr. Lehner then advocated for patient education, highlighting the potential risk of POVL. He recommended disclosing the risk of POVL to each patient undergoing a procedure at potential risk at the time of informed consent. Clearly stating the risk of POVL also helps patients and their family members understand this is a complication of positioning, not of the anesthetic itself.[3] *(Ed. note: See also N. Radoslovich, OR positioning for the LNC, JLNC Spring 2019, p. 24)*

INTRAOCULAR PRESSURE (IOP)

Increased intraocular pressure (IOP) of the aqueous humor (fluid) inside the eye can have serious effects. Studies show steep Trendelenburg and prone positions, as well as excessive fluid replacement, influence IOP, and contribute to POVL.[4] The first controlled study of IOP in prone anesthetized patients was by Cheng et al. in 2001. IOP initially decreased at anesthesia induction. However, when the patient was prone versus supine positions under general anesthesia, Cheng et al. found IOP doubled. There was a direct correlation between time spent prone and severity of IOP. They suggest a linear relationship between time spent in the prone position and IOP. Increased IOP associated with periorbital edema, venous hypertension, and abnormal eye fluid mechanics contributes to orbit hypoperfusion by decreasing the pressure gradient below a critical level at the optic nerve and retina[5] resulting in hpoperfusion and anoxic injury to these delicate structures.

When surgery requires steep Trendelenburg or prone position, venous pressure rises from increased intraabdominal and intrathoracic pressure, creating increased IOP. Think how you would feel lying on your face or standing on

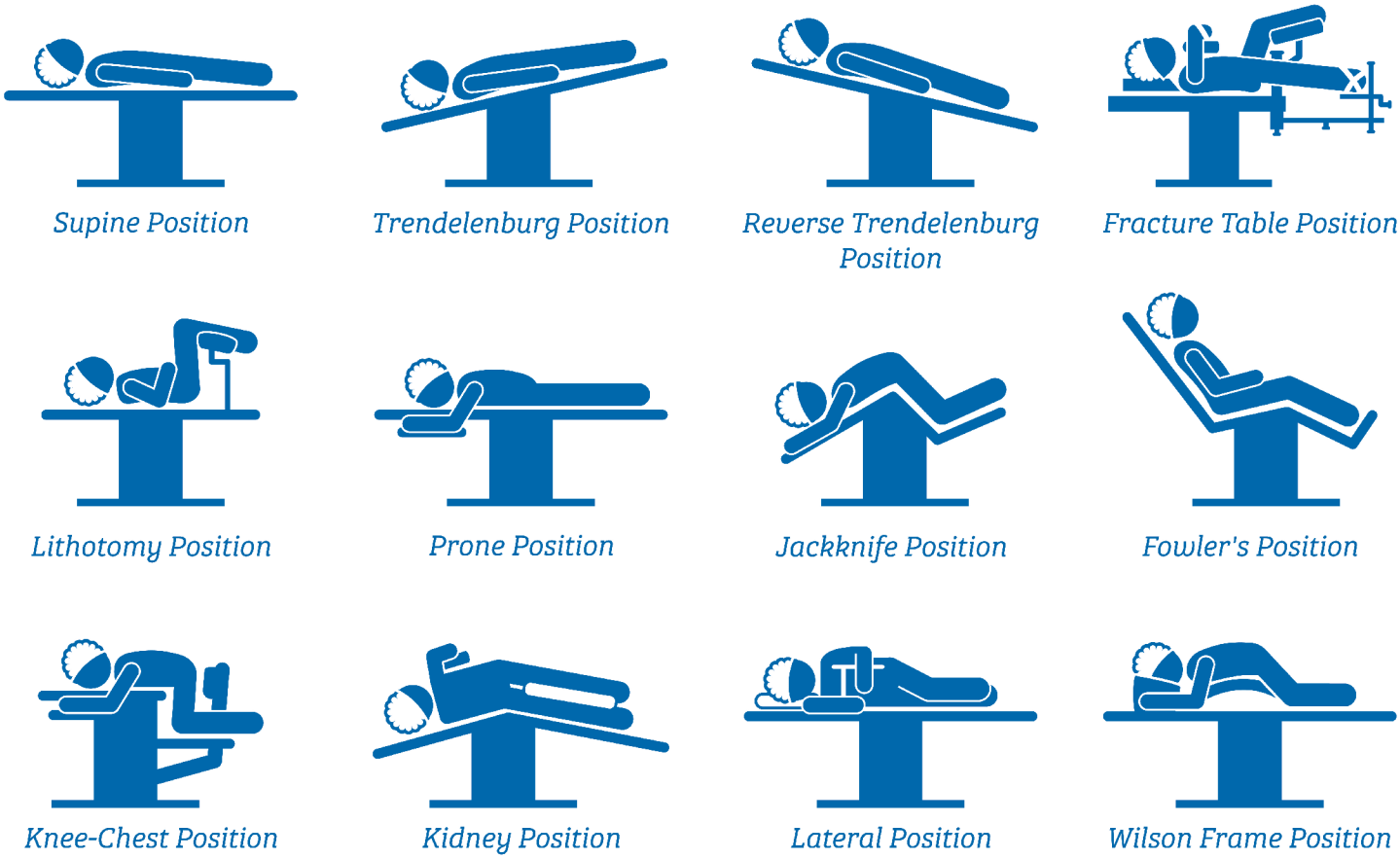

Figure 1. Surgical positioning

your head for long periods of time. As venous pressure increases in the head and neck, higher hydrostatic pressure causes capillary leakage. This forces fluid to accumulate in the interstitial space, further constricting venous return and limiting perfusion to the optic nerve. Most cases of ischemic optic neuropathy (ION) occur in the posterior region of the optic nerve, where collateral branches of the pial plexus arteries supply flow. The optic nerve travels through the optic canal and an enclosed space constructed of collagen and bone in the sclera called the lamina cribrosa (Figure 2). Edema in the area compresses the optic nerve, leading to the ischemia.[6]

Ischemic optic neuropathy can lead to permanent optic nerve atrophy. However, vision may be preserved with timely correction of underlying causes (such as perioperative anemia and hypotension), and suitable treatment.

ISCHEMIC OPTIC NEUROPATHY (ION)

Blood supply to the optic nerve originates from the internal carotid artery, which branches into the ophthalmic artery and thence to the central retinal artery. The most common cause for POVL is ION, encompassing approximately 89% of documented POVL cases. As blood supply becomes disrupted in either the anterior or posterior segment, it results in anterior ischemic optic neuropathy (AION) or posterior ischemic optic neuropathy (PION), respectively.[8]

AION is characterized by sudden, painless, bilateral visual deficit ranging from a minor decrease in visual acuity to blindness, unilaterally, or bilaterally.[7] PION in the postoperative period presents as a sudden painless loss of visual acuity, and it may continue to degenerate but typically does not improve.[8]

Unilateral optic nerve dysfunction, visual field deficits, and absence of other causes of decreased vision are indicative of afferent pupillary defect and are diagnostic indicators of ION.

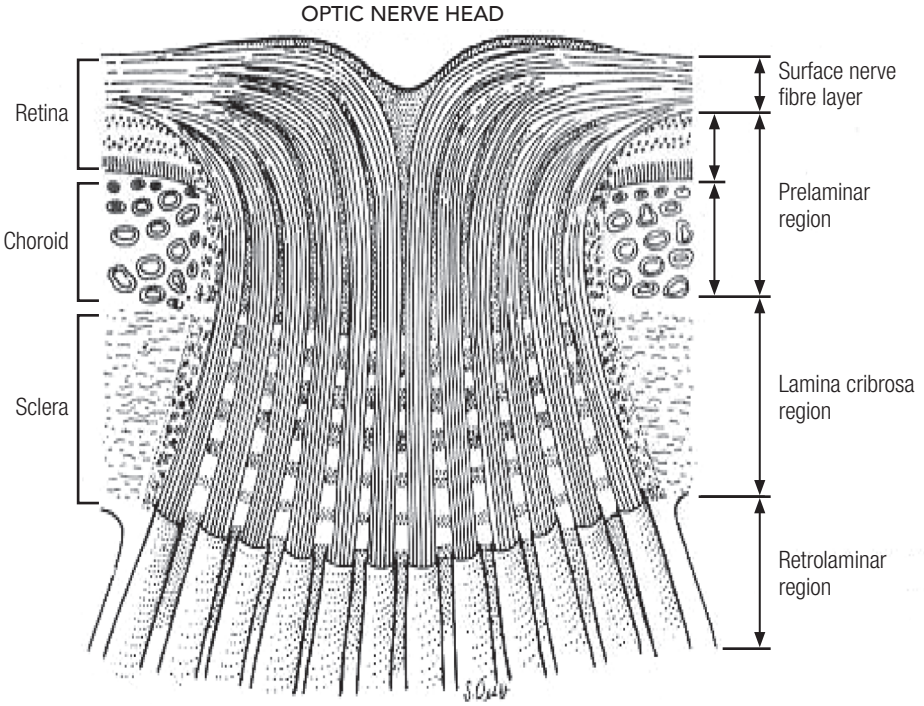

Figure 2

Blood supply determines the extent of the visual loss of the optic nerve. In anemic patients, whose blood has decreased oxygen-carrying capacity, hypotension may lead to an infarction of the optic nerve head where blood supply is vulnerable to compression.

Some treatments for ION include retrobulbar steroid injections, antiplatelet therapy, anticoagulants, phenytoin, norepinephrine, and blood replacement. Other preventative measures include avoidance of prolonged reduction of oxygen delivery to the eye from hypotension or anemia and minimizing the time a patient is prone.[9] A literature review by Buono and Foroozan reveals the correction of hemodynamic derangements as the only proven valuable treatment modality.[10]

ION can lead to permanent optic nerve atrophy. However, vision may be preserved with timely correction of underlying causes (such as perioperative anemia and hypotension), and initiation of suitable treatment.[11] Although there are no accurate statistics, underlying disease factors contributing to POVL are diabetes, vascular disease, and glaucoma. Lee et al. theorize that hypotensive ION occurs from optic nerve compartment syndrome, suggesting high venous pressure and interstitial tissue edema can compromise blood flow to the optic nerve. They cite increased blood loss and prolonged anesthetic time as factors associated with POVL.

The American Society of Anesthesiologist (ASA) POVL Registry cites

increased blood loss and hemodilution to be prominent in POVL. This Registry provides a mean surgical time of 5.5 hours in reviewed cases of POVL. Members of the ASA POVL Task Force also advocate frequent eye assessments along with proper documentation. Since avoiding pressure on the eyes is essential in preventing central retinal artery occlusion, ocular pressure must be assessed frequently by anesthesia providers in cases with patients in the prone position.[13] In a study by Lee and colleagues, anesthesia providers documented eye checks in only 51% of cases of POVL.[12]

Once established that the patient is experiencing POVL, an ophthalmologist should be contacted urgently for a consultation to determine the cause and to create an interventional plan.[15] However, there is no established treatment, so prevention is key. Pre-existing conditions include cardiovascular disease, long-standing or poorly controlled hypertension, known visual disorders such as glaucoma or end-organ ocular damage. In these patients, it would be practical to sustain systemic blood pressure as close to baseline values as possible and to avoid extended declines in ocular perfusion pressure (OPP).[14]

Fluid management is complicated in a procedure that is associated with substantial blood loss and prolonged anesthesia time; however, the ASA Practice Advisory recommended in 2006 that anesthesia providers should incorporate colloids along with crystalloid in fluid administration. Central venous pressure monitoring may also be useful in high-risk patients.

It is unclear how low the hemoglobin level must drop or the length of time the hemoglobin level must remain low to result in intraocular neuropathy.[16] A literature review by Gilbert, a neuro-ophthalmologist, concludes that any interruption to blood flow autoregulation can lead to POVL.[17] Even more confusing is though case reports suggest hypotension and anemia are factors that cause ION, it can occur in patients without these factors and in patients with blood pressures and hematocrit that anesthesiologists considered to be in acceptable ranges. We do know that after spine surgery risks factors for ION include the lengthy operative procedures in the prone position, hypotension, hemodilution or anemia, blood loss, and infusion of large amounts of intravenous fluids.[18]

IOP AND ION

Remember the two types of ION: AION, anterior ischemic optic neuropathy due to ischemia of the optic disc, and PION, posterior ischemic optic neuropathy due to ischemia of the retrobulbar optic nerve.[19] In AION the optic disc is acutely edematous, whereas in PION the optic disc is acutely healthy but atrophies weeks to months after the event.[20] Hayreh published an in-depth review of retinal blood flow and autoregulation also noting that optic nerve perfusion pressure (OPP) equals carotid arterial pressure or mean blood pressure minus IOP in all position[30] when IOP exceeds jugular venous pressure (JVP). As you might expect, studies show that peak IOP is the principal determinant of functional loss.[21]

Normal IOP ranges between 12 and 20 mmHg, averaging about 15 mmHg; it is regulated to remain constant in the healthy eye, usually +/- 2 mmHg of its baseline. Pressure can be determined by resistance to outflow of aqueous humor from the anterior chamber while reabsorption in the canal of Schlemm occurs, and then goes into the venous circulation. In healthy eyes, autoregulation occurs so that as pressure increases in the eye, the rate of flow into the canal of Schlemm increases, maintaining constant blood flow during changes in perfusion pressure.[22]

Increases in IOP may also be a source of postoperative ION. There are reports of visual loss related to ION in patients without hypertension or anemia. However, patients with chronic hypertension may be intolerant to hypotension since it contributes to a shift in the autoregulatory curve of optic nerve blood flow.

There are also reports of POVL documented in supine patients, but most reported cases follow general anesthesia for spine procedures in the prone position.[23] According to Sappington et al., during surgical procedures with anesthesia, especially those requiring extreme positioning, autoregulatory processes do not respond to increases in IOP by decreasing the production of aqueous humor.[24]

CONSIDERATIONS TO LIMIT EFFECTS OF IOP

A proposed intervention is to administer a topical anhydrase inhibitor and beta-adrenergic receptor blocking agent ophthalmic solution once IOP reaches 40 mmHg. A hand-held tonometer can make contact with the eye and be used to measure IOP in any surgical position. If IOP increases, second doses can be given.[25] These medications reduce IOP by decreasing aqueous humor production through inhibition of carbonic anhydrase II in the ciliary processes and direct action on beta2-adrenergic receptors in the ciliary processes.[26]

A study by Grover et al. of beta-adrenergic blocker eyedrop administration in patients under general anesthesia showed that this protects against increased IOP in patients following tracheal intubation.[27] According to Shemesh et al., large-scale clinical studies demonstrate the importance of early IOP reduction to prevent optic nerve damage and visual loss. Their studies mention that the second and even a third dose of beta-adrenergic eye drops administered per day is shown to lower IOP 25.9% over time.[28]

As shown in Figure 3, chemosis is detected as the white outer coating rises above the iris, appearing gelatinous. The presence of chemosis should alert the anesthesia provider that inflammation is occurring in the eye. Once chemosis is visible, IOP is approaching a critical level, allowing time for the provider to intervene. Because it is not possible in all operating rooms to measure IOP, detecting chemosis is an indicated clinical endpoint at which topical anhydrase inhibitor and beta-adrenergic receptor blocking agent ophthalmic solution would be valuable.[29]

POSITIONING

Pinkney et al. reviewed the relationship of patient positioning and IOP across all surgical specialties and concluded that rising IOP is time-dependent.[31] Porciatti and Nagaraju note benefit in reverse Trendelenburg positioning and illustrate decreased IOP and improved retinal ganglion cell function with this intervention.[32] Linder et al. also suggest that elevation of the head above the level of the heart reverses the effects of gravity-induced orthostatic venous pressure gradient resulting in decreased IOP.[33] However, the need for steep Trendelenburg positioning during lower abdominal robotic and laparoscopic procedures has dramatically increased over the past decade; more than 853 US hospitals were using the system as of 2010, and internationally the numbers doubled from 200 to 400.[34]

Figure 3. Chemosis.

There was a case report of bilateral POVL in a patient undergoing laparoscopic prostatectomy in steep Trendelenburg position, without intraoperative hypertension, hemodilution, extreme blood loss, or perceived metabolic disturbance. But he remained in a steep Trendelenburg position for 7.5 hours. This sentinel event prompted researchers in the institution where it occurred to develop a study investigating the relationship between IOP and steep Trendelenburg position. The study included 36 patients undergoing laparoscopic surgery in the steep Trendelenburg position over three years. IOP was measured using a tonometer at designated times during the surgery. Malloy found a direct correlation between the duration of time in steep Trendelenburg position during surgery and increased IOP.[35]

The surgical and anesthesia team can reduce IOP by unlocking the laparoscopic equipment and leveling the table for 5 minutes after the patient has been in the steep Trendelenburg position for four hours.[36] In a comparison of IOP between patients in a continuous steep Trendelenburg position compared with those who are placed in the supine (flat) position for 5 minutes after four hours of surgery, the patients who received the 5-minute supine rest had decreased IOP immediately following the rest period. They also had a faster return to baseline IOP after completion of the surgery than did patients who did not have a change in position intraoperatively.[37]

The 2003 Anesthesiology Update titled "Preventing blindness" stated that one in every ten neurosurgeons reported having had patients with POVL following lengthy back procedures.[38] It is important to initiate protocols during procedures requiring prolonged steep Trendelenburg or prone positions, in pursuit of providing an optimal level of ophthalmic safety for this patient population.[39]

Baig et al. performed a 2007 literature review citing bypass procedures as having a 4.5% incidence of postoperative vision loss and spine surgery a 2% incidence. Intraoperative factors were hypertension, blood loss, anemia, excessive fluid replacement, and duration of the surgical case.

Baig and colleagues reviewed POVL after spine surgery and suggest that the posterior optic nerve may be susceptible to decreased perfusion caused by increased venous pressure because of the nature of these small end vessels. They note that small pial branches supply the midorbital optic nerve, which is at risk in posterior ischemic optic neuropathy.[40] A 10-year study (between 1996 and 2005) analyzing more than 5.6 million patients in the Nationwide Inpatient Sample, determined that the highest rates of POVL involved cardiac surgery (8.4 events of 10,000 cases) and spinal fusion (3.09 events of 10,000 cases).[41]

AION is often associated with cardiac surgery; PION with spine surgery. There is individual variability in blood supply to optic nerves, so patterns of vision loss vary. Using horseshoe headrests in spine surgery can lead to unilateral vision loss involving periorbital edema, chemosis, ptosis, and corneal abrasion. In nose and sinus procedures, blindness can arise from direct surgical damage to the optic nerve. Using square or circular foam headrests with eye cutouts and a mirror to view the eyes helps prevent central retinal arterial occlusion from direct pressure on the eyes. There are reports

There is no established treatment, so prevention is key. Pre-existing conditions include cardiovascular disease, long-standing or poorly controlled hypertension, known visual disorders such as glaucoma or end-organ ocular damage.

of goggles dislodging and causing direct ocular pressure, resulting in unilateral central retinal arterial occlusion.

Roth suggests ensuring eyes are properly positioned behind eye cutouts on headrests and checking every 20 minutes, by palpation or visualization, to ensure there is no direct external compression to the eyes.[42]

Treatment options for the initial management of vision loss after spine surgery associated with PION consist of correcting volume depletion, correcting blood loss, restoring the blood pressure to normal, and possibly administering corticosteroids intravenously. The worst prognosis for perioperative blindness is with central retinal artery occlusion and PION. The beginning point for prevention is an increased awareness of the possibility of complications in addition to the correction of hypoperfusion to the eyes, particularly in patients with vaso-occlusive conditions, such as chronic essential hypertension and diabetes mellitus.[43]

SUMMARY

In our case study, the plaintiff experienced POVL. What should the LNC look for in chart analysis?

Did the healthcare providers:

- Consider risk factors for POVL, potential degree of permanency, and the immediate treatment options?
- Discuss with patients preoperatively about the risk of perioperative vision loss occurring during informed consent?
- Assess and document that the eyes are free of pressure throughout prone and Trendelenburg procedures?
- Incorporate colloids with fluid administration?
- Use 5 to 10° reverse Trendelenburg position during spine procedures performed with the patient in the prone position?
- During steep Trendelenburg procedures, use a 5-minute supine rest stop at the four-hour timeframe. Rest stops require undocking of laparoscopic equipment?
- Use soft foam headrest with cutouts for eyes to prevent direct external compression and a mirror for viewing the eyes?
- Consult an experienced ophthalmologist at first sign that the patient has altered vision after surgical procedure?

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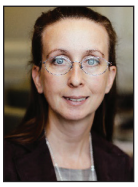

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Lessons Learned in Year One of Business

Adam McKinnon BSN, RN, CCRN

Keywords: Entrepreneurship, Lessons, Business, Nursing, Nurse to business transition.

Many nurses struggle with the transition to entrepreneurship. Transitioning to nurse consulting is not a regression from master nurse to apprentice entrepreneur; it means developing new professional skills to supplement your traditional nursing expertise. This article shares some lessons that he learned in his first year of business, hoping to ease the transition and increasing the odds of successful entrepreneurship. Though they might not pertain to all nurses in the entrepreneurial world, they will be helpful to new legal nurse consultants.

Here is what I learned in my first year of business, although in fairness the term "business" may not describe it accurately. (It was more a haphazard and ineffectual attempt at commerce.) This personal list may not apply to others, but I hope readers will find this useful. Many of these lessons led to lifestyle changes that themselves evolved into better business practices.

Act once your mind is set. Avoid "analysis paralysis," delayed decision-making and inaction due to prolonged over-analysis. As nurses we always want to pick the "most" correct answer from correct answers. In business, if all the answers are correct, pick one and get started! This is useful in situations when you have to complete all the options. The most important factor in any decision is time; in business you must decide and act quickly. Target your actions in relentless pursuit of an objective. Not ruthless or unethical, but relentless. Then complete the task once you make your decision. Every day that goes by without a decision is another day without achievement.

Business is not for the faint of heart. Starting a business can be overwhelming and time-consuming. It requires attention to detail and a strong backbone. Only start a business when you have made a firm decision. Be very clear about your ambition. Do not expect instant and everlasting success; this venture will very likely involve unplanned sacrifices of time and energy. Don't quit your day job; be sure that you have the

time and energy to devote to initiating your business. Anticipate the things that will stress you out:

- developing policies and procedures
- lifestyle changes
- developing workflow patterns
- marketing
- maximizing profits
- cash flow challenges
- health concerns
- difficult clients
- friends and family

There are resources to help you plan to deal with many of these, including the Small Business Administration and the Service Corps of Retired Executives (SCORE). More on them later.

Plan for the bad while it's good. Have a backup plan to tide you over unexpected cash flow problems. It's likely prudent to remain clinically active while your company becomes established. For nurses who cannot pick up a per diem shift with a staffing agency it is vital to have an emergency fund, tight money management skills, or a source of support. To compensate for cashflow problems, it's professional and expected to obtain retainers at the outset. Once an attorney and I become established I might forgo the retainer and bill monthly, but it's because of hard lessons learned that I now charge an initial retainer.

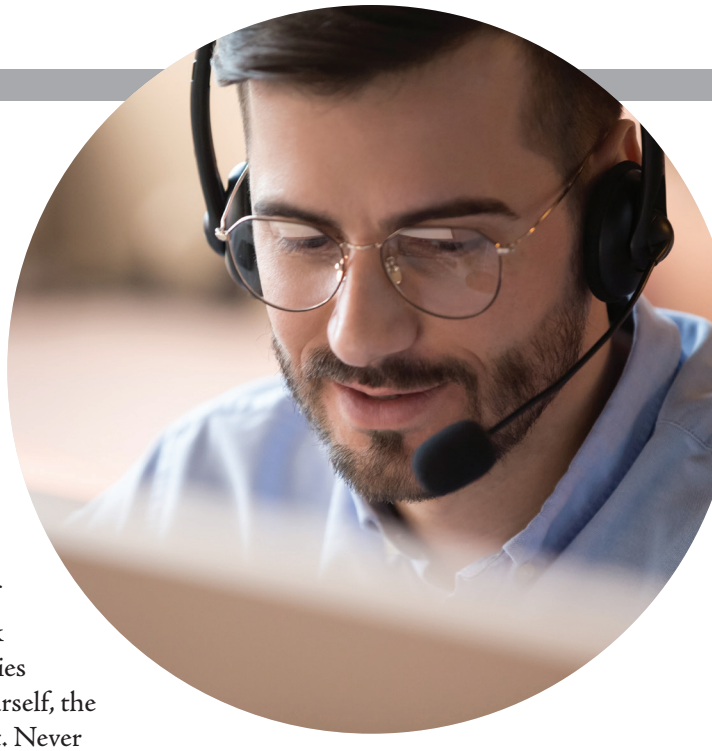
Keep your loved ones involved. It is easy to forget about our loved ones as we pursue our business goals. I encourage new entrepreneurs to plan monthly meetings with their spouse or loved ones to discuss business activities. This will help solidify your relationship and the business will be a blessing instead of a detriment. Your loved one can get involved with the business and understand your time demands and energy expenditures, and act as a buffer against work overload. This will help bring balance and clarity to the maelstrom of entrepreneurship.

Have a process and trust it. Our worst mistakes come from trying to bend the rules that govern business. Establish a process to handle everyday activities and workflow; evolve those into policies and stick to them. Every new LNC should have this one: "No work starts until the retainer check clears." Every LNC has a sad story of what happens when you work without pay. Implement policies that protect the company, yourself, the client, and your work product. Never bow to the temptation to bend or break your policies.

Time management is key to the kingdom. Legal nurse consulting is intellectually draining and detail-oriented. It is easy to mismanage time chasing the proverbial rabbit down the wrong hole. Learn the art of how to read a chart properly and write a report without serendipitous fact checking. Doublecheck your analysis, but remember it's not reasonable to expect attorneys to pay you 40 hours to review a chart for merit. Your learning curve is on you. Finding a happy balance develops naturally with time.

Set a time limit for each task. Look at any that consume more time than they should and rethink your processes. Take time to understand and adjust to delays. Being consistently effective and productive means more opportunities.

Marketing. Think of marketing as increasing your exposure to potential



growth, not looking solely at results. You may meet 100 potential clients without success, but once you make a connection, you'll know it. Never market to land a client on the first attempt. It's a continuous process. It may take several phone calls or meetings to get a first case.

The best marketing strategies involve maximum exposure. This can be intimidating because it involves making yourself vulnerable to criticism and failure. The reward is usually equal to the risk. Your nursing knowledge is exactly what your clients want and value. Many LNCs fail because they fear expressing knowledge and then crumble under scrutiny. When an attorney scrutinizes your work, it's time to market! That's what marketing is, presenting your skills, knowledge, and work product to prospective clients. Never fear to let the world know what you know. Always carry

Act once your mind is set. Avoid "analysis paralysis," delayed decision-making and inaction due to prolonged over-analysis.

your business cards and share them widely. Furthermore …

Help when you can. The best marketing is a word of mouth; the best word of mouth flows from being involved with professional organizations. If you can provide insight or have useful skills, please connect with people that value them. People remember helpful people. Helping might involve a financial gain but should reflect a job well done. One of the best places to find people that value your skills are in the AALNC, in a local chapter, national committee, and other nursing organizations. Take the time to plug into something bigger than yourself and company. You can never tell what opportunities will follow-- and they will.

Perception changes it all. I always thought I was aloof and introverted, but I've learned that I am bold and outspoken.. Anyone that knows me and is reading this article right now is probably having a great chuckle at my expense. Take the time to ask individuals close to you for an honest perception of you—consider a "360-degree evaluation" by people you know well, a little, or peripherally. You may find you are not who you think you are. Knowing who you are and how people perceive you will help you develop professionally and fine-tune how to present yourself to potential clients.

Get connected. This lesson was huge for me. Reach out to like-minded individuals. Find a mentor, join a group of peers, and once established, find a student. My mentor has never failed to encourage me, protect me and my interests, and identify areas of needed growth. During confused and troubling times, a good mentor will give you a roadmap of experience. What may take you hours of agonizing scrutiny and conflict could be resolved with one phone call. Find a peer pursuing similar goals and motivate each other. It is helpful to have someone that understands the lifestyle of entrepreneurship. Sometimes the answers provided in deposition will challenge your sanity and it is helpful to have an anchor to hold you steady in a tide of uncertainty.

Get involved. Join an online community like LNCExchange. Join AALNC, read the JLNC, and connect with your local chapter. They have all the resources you need to get started, stay motivated, and find work. You'll discover collegiality and experienced supportive nurses all around you.

The Small Business Administration is a government agency designed to support small business growth in America. Their resources will help you fund, plan, and grow your company. SCORE connects new entrepreneurs to experienced business mentors. This organization has chapters all over the US that provide workshops, webinars, and access to trained professionals to help a small business survive.

Routine = success. Developing a routine for daily activities will save you a lot of hassle as your business grows. That means have strict hours of operation, keep track of inventory, time to develop new ideas, and time for personal interests. Respect the time of your company as if it is your employer. Do the things that your employer would expect. Arrive on time, be pleasant, dress and answer the phone. This is not an all-inclusive list. Figure out what works for you and do it.

This list isn't everything I learned in the first year but it includes what I deemed the most valuable. I am sure I could have included lessons regarding Limited Liability company (LLC) vs Doing Business As (DBA), taxes, invoicing, finding resources and a slew of other topics, but these are the lessons for another day. I hope this abbreviated list helps you on your way to becoming an established and prosperous legal nurse consultant.

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Just a Routine Cardiac Catheterization

Linda Summers RN, BSN, PHN

I just returned to the Intensive Care Unit (ICU) after transferring out my only patient, when Louise the charge nurse stopped me, "Your cath lab patient may be awhile, so why don't you go to lunch now?" This was unusual. I was going to go to the cafeteria for a real lunch, sit down at a table, and eat with a fork. The small pleasures in life. Best of all, I didn't have any patients to worry about.

Upon arrival back at the unit, it was the normal chaos, phones ringing, alarms buzzing, and people talking non stop. The door to my cath lab patient's room was ajar, curtains partially open. "Your cath lab patient got back while you were at lunch," Louise called to me. "I haven't had time to look in on him. It was just a routine PTCA (balloon angioplasty) to the RCA (right coronary artery)," she said, walking away. I felt like sarcastically replying, "Well, then, maybe you could have followed the routine hospital protocol for cath lab patients, and actually assess him." I knew I shouldn't have gone to lunch.

There are over a million cardiac catheterizations performed yearly for both diagnostic reasons or therapeutic procedures (Manda and Baradhi, 2018). During a cardiac catheterization, the cardiologist may perform a balloon angioplasty, stent placement, or both, to open up a blockage in the coronary arteries. The doctor will puncture either the femoral or brachial artery, and advance a flexible catheter up into the coronary arteries where the blockage is. They inflate a balloon in the blocked area of the coronary artery. A stent is mesh wiring that holds the vessel open after the angioplasty is done. The stent may be impregnated with medications (drug-eluding stent) that helps prevent the artery from clotting off (Medline Plus, n.d.). During the procedure the patient receives high doses of anticoagulants so the coronary artery doesn't reocclude. This puts the patient at high risk of bleeding.

After the procedure, they seal the arterial access site and apply manual pressure or a special closure device to seal the arterial site. There are different types of

closure devices, and each works a little differently. For example, the Angio-Seal is a special closure device that works by delivering a collagen plug, designed to create an effective seal (Terumo International Systems, n.d.). The seal is placed in the cath lab, then the patient is transferred to the ICU.

Our hospital protocol is for the cath lab personnel and the receiving nurse to check the femoral artery site together when the patient arrives in ICU, and for the ICU nurse to stay with the patient for at least the first 15 minutes. Local vascular complications are the most common complications following cardiac catheterization (Manda and Baradhi, 2018). The patient can have bleeding from the artery which at the same time leaks out underneath the skin and causes a swollen area called a hematoma. The patient may also have "clandestine" bleeding, a retroperitoneal bleed where blood leaks into the tissues, but without a visible hematoma or bleeding to the outside. Symptoms include back pain (Manda and Baradhi, 2018), difficulty voiding, and hemodynamic changes related to lowered blood pressure.

I enter the room. Mr. Jones is sitting up at a 30-degree angle, moving around, pale, and there is bright red blood on the sheet. Patients should lie flat or with a slight elevation after the procedure to allow the clot to stabilize and to reduce the chance of the collagen plug dislodging. "I think I may have urinated because it feels wet down there," he says, apologetically.

Immediately, I pick up the sheet and see blood pouring out of his femoral artery.

I knew I shouldn't have gone to lunch ... Mr. Jones is sitting up at a 30-degree angle, moving around, pale, and there is bright red blood on the sheet.

I hastily grab some gloves and apply manual pressure approximately 2-3 cm above the puncture site. It is difficult to find because the area is covered in blood. I talk calmly so Mr. Jones does not panic, which would raise his blood pressure, heart rate, and therefore increase bleeding. I call out for help. Louise arrives and guiltily wipes the blood away to make sure that the bleeding has stopped. It is important to visualize the puncture site. The bleeding has slowed but still oozing so I press more firmly.

She hooks up his EKG leads and sets his blood pressure cuff to run automatically every 5 minutes. Mr. Jones is now very anxious, having difficulty lying still, and has a vasovagal response, in which the patient becomes bradycardic and hypotensive, and may lose consciousness. His heart rate drops to 43 (normal is 60 -100), he becomes pale, his blood pressure falls to 70/46, and he loses consciousness. Unlike other arteries, coronary arteries perfuse in diastole; blood pressure this low decreases coronary perfusion. Louise opens the normal saline bag wide and flattens his bed. Mr. Jones wakes up. I also have atropine at the bedside in case it was needed. I reassure him, explain that we have things under control, and ask him questions to distract him. Dave from the cath lab comes back and takes over holding manual pressure. The bleeding slows and stops. As Dave holds pressure I check to make sure that Mr. Jones has pulses in his feet; they are warm to the touch.

About an hour later Mr. Jones begins complaining of chest pain radiating to his left arm, and his blood pressure falls to 90/60. He is diaphoretic and short of breath. We have protocols in place for responding to patients' symptoms and to escalate treatment; I turn his oxygen up to 5 liters per nasal cannula, give him a 250 ml fluid bolus, order a stat EKG, and call the cardiologist. The EKG shows ST elevation in the inferior leads II, III, and aVF indicating myocardial ischemia. He returns to the cath lab emergently.

Mr. Jones was still in the cath lab when I left work that night. The next morning, when I received report from Nancy, the night shift nurse, I found out that Mr. Jones had an iatrogenic coronary artery dissection (torn artery), and got a stent placed in the area of the dissection. Iatrogenic coronary artery dissection is a rare complication and the exact mechanism is unclear (Baghdasaryan & Nazaryan, 2017); it" … results from mechanical injury to the arterial wall during catheter or wire manipulation, passage or deployment of an interventional device, forceful injection of contrast medium, balloon dilatation, or stenting."

This time Nancy and I checked the groin site together per protocol. He had a hematoma at the puncture site. These usually form within 12 hours of a procedure (Kaushal, 2015). Mr. Jones

Local vascular complications are the most common complications following cardiac catheterization.

was at high risk of developing a hematoma because he had greater than one puncture, received low-molecular weight heparin prior to the cath procedure, and had a personnel change during manual compression (Kaushal, 2015). Hematomas resolve over time.

Mr. Jones remained on bedrest until that evening. He was able to get up to the chair for dinner. He was still feeling tired and the right groin site was uncomfortable. I reassured him that this was normal and offered him pain medication. He was transferred to the telemetry unit the next day.

Just a routine cardiac catheterization.

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Why Should You Attend the AALNC 2020 Annual Forum?

Nursing is dynamic; knowledge and skills change constantly. Standard practice supported by evidence-based studies today may no longer apply later. Continuous nursing education (CNE) is a critical professional responsibility we owe to ourselves and our patients.

Therefore, two recommendations from the Institute of Medicine report, *The Future of Nursing: Leading Change, Advancing Health,* are: 1) preparing and enabling nurses to lead change to advance health and 2) ensuring that nurses engage in lifelong learning to gain the knowledge required to do that (IOM, 2010). Continuing nursing education (CNE) should serve as a platform for continued lifelong learning that influences best practices thus contributing to improved quality of patient care and positively influencing innovation and successful implementation of evidence-based practices. (Yost et al, 2015). CNE promotes professional advancement and can open job advancement and professional opportunity for legal nurse consultants (LNC).

Lifelong learning requires a commitment and recommitment by every nurse and the IOM report recommends that nurses should take responsibility for their professional growth by seeking opportunities to gain CNE beyond their initial nursing education programs (IOM, 2010; National Academies of Sciences, 2016). CNE has been shown to increase nurses' professional behavior and improve the knowledge of patient management and nursing practice. The benefits of attending national meetings cannot be overstated. Opportunities for networking and career growth are important reasons for attending AALNC's 2020 Annual Forum in Denver this April. Attending the AALNC Annual Forum allows LNCs to interact and network with LNC colleagues and goes beyond expanding one's knowledge base by reading journals and participating in various on-line LNC learning modules and webinars.

The American Nurses Credentialing Center's (ANCC) Primary Accreditation Program is considered "the gold standard" for CNE and accredits only organizations that demonstrate excellence in CNE. AALNC is an ANCC accredited provider of nursing continuing professional development (NCPD) using evidence-based ANCC criteria to plan, implement and evaluate high quality NCPD activities. While planning for this year's forum the planning committee has used ANCC criteria to identify gaps in LNC practice and is working hard to ensure that evidence is incorporated

HERE IS WHAT IS IN STORE FOR THIS YEAR IN DENVER:

- Pre-Forum Activities on Thursday, April 23
- Welcome Reception and Networking Event on Thursday, April 23
- Forum Sessions, Networking time, and Exhibit/Vendor time on Friday and Saturday, April 24-25

AT THE AALNC ANNUAL FORUM ATTENDEES WILL:

- Engage in educational activities that will address personal learning interests and needs.
- Attain new knowledge and skills to improve LNC work products and client satisfaction and outcomes.
- Interact with colleagues to exchange ideas, explore trends and issues, and consult with other LNCs and legal professionals for assistance in meeting specific practice needs.
- Earn continuing education contact hours.

HERE IS A PREVIEW OF WHAT TO EXPECT AT THE 2020 ANNUAL FORUM:

- Pre-Forum Tracks that can be mixed and matched:
  - "CSI Denver" that will address many of the key principles of LNC practice in forensic evidence investigation, criminal law, and correctional system nursing care with sessions on evaluating issues associated with nursing practice breakdown in correctional settings, forensic nurse expert work, and criminal case consultation.
  - Clinical Issues for Litigation and Mini Mock Trial sessions that will address clinical issues including inflammatory conditions of the colon, ER management of pulmonary emboli, myocardial infarction, cerebral vascular accident, and sepsis for litigation and apply those skills to a mock trial of a case allowing learners to apply their newly learned skills and get instant feedback.
- General Sessions including:
  - Pressure injury and wound care litigation by a well-known expert and board certified wound and ostomy nurse: Heidi Cross.
  - Future role of LNCs in mass tort litigation by a founding member of AALNC: nurse attorney Elise Alpert.
  - Personal injury litigation by local Denver nurse attorney: Penelope Clor.
  - Environment exposure and presumptive diagnosis by firefighter/paramedic: Jim Brown.
- Concurrent Sessions with something for everyone to choose from in various areas including: clinical practice issues, LNC practice issues, and LNC business issues.

into the presentations, that planners and presenters are free from any conflicts of interest, and that no bias exists in the actual presentations. The educational activities for this year's forum are of the highest caliber of education to meet LNCC® certification or licensure requirements and assist LNC's in their quest for relevant and LNC education.

The AALNC Annual Forum creates an environment of continuous learning and opportunities for professional growth. This year's upcoming forum in Denver offers several educational opportunities such as presentations of best practices and new research, pre-forum sessions on particular topics of interest, and networking opportunities for beginning and seasoned LNCs. The ability to open doors to new opportunities makes attending this year's Annual Forum a worthwhile part of any LNC's career development.

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Looking Ahead...

XXVI.1, Spring 2020 — Implantable Devices

XXVI.2, Summer 2020 — Roles in Litigation Support

XXVI.3, Fall 2020 — LNC and Human Rights

XXVI.4, Winter 2020 — Pediatrics and New Nurse Author Supplement

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