

# Role of Legal Nurse Consultant in Gathering and Analyzing the Nursing Home Record

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### Repository Citation

D'Andrea, Deborah D. (2000) "Role of Legal Nurse Consultant in Gathering and Analyzing the Nursing Home Record," *Marquette Elder's Advisor*: Vol. 2: Iss. 2, Article 6.

Available at: <http://scholarship.law.marquette.edu/elders/vol2/iss2/6>

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# The Role of the Legal Nurse Consultant in Gathering and Analyzing the Nursing Home Record

*The legal nurse consultant (LNC) can be a powerful asset in litigation involving nursing home care. The medical expertise of the nurse is brought to bear on the gathering, organizing, and analyzing of the voluminous records that accompany such cases. The LNC's familiarity with the industry jargon and record standards can help to interpret events and reveal crucial gaps in information.*

**By Deborah D. D'Andrea**

“**M**edical records may appear to be written in English, but reviewing them can be like conducting an archaeological dig—they constitute the only residue of something that happened a long time ago.”<sup>1</sup> When representing an injured or deceased nursing home res-

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ident, it is important to appreciate the timeline of events that precipitated the injury or death. The events leading to the lawsuit often unfold over weeks, months, or years and may involve complex medical issues. These may include behavioral changes, institutional transfers, assessments and reassessments, multiple injuries, and hospitalizations. The legal nurse consultant (LNC)<sup>2</sup> knows what should be in the resident's nursing home record, what may be missing, and what the records really mean.<sup>3</sup> The LNC helps the attorney understand and analyze the nursing home record, which may differ materially in content and organization from hospital or other medical facility records with which the attorney is familiar.

## **Gathering Nursing Home Records**

During the discovery process, the legal nurse consultant assists the attorney in determining what records should be requested. An accurate initial evaluation of the case may be possible without great expense if carefully selected records are obtained in the earliest stages of discovery. Discovery, at least at the beginning of a lawsuit, focuses on record gathering and evaluation. As the claims of deviation from the appropriate standard of care are refined, the specific records become the target of the search.

The following documents are frequently of value.

### **Face sheet**

Locate the face sheet on the front of the resident's chart. It features vital information about the resident, specifically, the resident's treating physician(s), scope of treatment, health insurance, next of kin, and other basic demographic information.<sup>4</sup>

### **Advance Directives**

Advance directives routinely are located in the front of the resident's chart. The document reflects the resident's wishes regarding care. It may address, for example, whether the resident wants tube feedings, pain medications, or any other extraordinary means to extend their life.<sup>5</sup> "The importance of this document, especially in the nursing home setting, is that the defense can use the document to reflect that [the resident] did not want to have his or her life maintained."<sup>6</sup> Conversely, the advance directive may demonstrate that the resident wanted to preserve their life, that they have "not given up and wish to maintain whatever quality of life they had at the time."<sup>7</sup>

### **Consent Forms**

In general, the law accords a nursing home resident the right to receive information about treatment and to choose the health care received.<sup>8</sup> The consent form should be compared with the care rendered. For example, the lack of a signed consent form signals trouble for the nursing home in a case involving the inappropriate physical restraint of a resident.

### **Physician Orders and Progress Notes**

Review verbal, telephonic, or written physician orders to determine medication issues, treatment issues, and other aspects of the care provided. Physician's orders are directed mainly to the nursing staff, but also may be directed to other specialists, such as physical therapists or dietitians. Physician's orders may request particular nursing procedures, such as turning and repositioning a resident at certain intervals, or specify care of wounds as well as medication directions, including dosage, frequency, form, and route of medication to be given to a resident.

The LNC compares the physician's progress notes with the nursing notes and correlates physician progress notes with physician orders. For example, on December 21, the physician's progress notes state that the nursing home resident was in questionable heart failure, evidenced by respiratory readings, fluid retention (shown by the mismatch of the intake and output monitoring), and mildly distended jugular veins.<sup>9</sup> In addition, the progress notes relate that the resident was mildly hypokalemic; that is, a low potassium level.<sup>10</sup> A check of the physician's orders for December 21

reveals that Lasix was ordered to address the heart failure/fluid retention, and that an oral potassium supplement was ordered.<sup>11</sup> The nursing notes reflect that these orders were carried through. Then, on December 22, the physician's progress notes find the potassium problem resolved and the fluid overload situation stable.<sup>12</sup> In this scenario, the physician's orders and progress notes, the nursing notes, and the patient's response indicate that the proper standard of care was observed.

### **Care Plan**

Each resident must have an individualized short-term and long-term care plan prepared by an interdisciplinary team that reflects the resident's needs and preferences. For example, the care plan should note a resident's risk for falls, dehydration, weight loss, or malnutrition and should detail steps or interventions to prevent a negative outcome. The attorney relies on the care plan to demonstrate the foreseeability of a negative outcome such as the fall-related injury.

### **Minimum Data Set**

A nursing home must complete a full assessment of a resident's condition within fourteen days after admission, at least once every twelve months thereafter, and "promptly after a significant change in the resident's physical or mental condition."<sup>13</sup> This information is referred to as the Minimum Data Set (MDS).<sup>14</sup> Federal regulations list eighteen topics that must be included in the MDS, including a resident's customary routine, cognitive patterns, communication, mood and behavior patterns, psychosocial well-being, physical function, skin condition, and discharge potential.<sup>15</sup>

### **Resident Assessment Protocols**

The Resident Assessment Protocols (RAP) highlight potential problems identified by the MDS and provide suggestions for care planning.<sup>16</sup> For example, one of the questions on the MDS is whether the resident is easily distracted.<sup>17</sup> If the resident is easily distracted and this behavior appeared or worsened in the preceding seven days, the RAP triggers an examination as to whether the resident suffers from delirium and how the care plan can best address the condition.<sup>18</sup> The MDS and RAP are federally mandated assessment tools that create a blueprint for resident care and trigger the at-risk conditions that should be care planned.<sup>19</sup>

### ***Intake and Output Records***

Intake and output (I&O) records are vital to the nursing home case that involves malnutrition or pressure sores. The I&O reports should be compared with the resident's care plan. The care plan may identify the resident as being at risk for dehydration, weight loss, or malnutrition. In addition, attention to nutritional status is critical in both the prevention and treatment of pressure ulcers. The I&O records provide the volume measurements of all solids and fluids taken in and eliminated by the resident. For example, all oral and tube feedings, including intravenous fluids, blood products, and fluid medications, should be monitored as intake. Output may consist of urine, emesis, diarrhea, blood loss, or drainage from tubes. "[I]t is to the physician's disadvantage to find out only in pre-trial testimony that nurses were charting a nourishment intake of only fifty percent."<sup>20</sup>

### ***Laboratory Values***

Many lab forms provide information about normal lab values, making it easy to determine at a glance whether a resident is outside normal levels. While this comparison is offered for staff convenience, it is also convenient when investigating records for possible negligence. For example, laboratory abnormalities such as low serum albumin accompanied by weight loss and poor oral intake should signal the presence of malnutrition.

### ***Medication Administration Records***

The medication administration record (MAR) details current medications being administered to the resident as well as their dosage, frequency, form, route of administration, time of administration, and to what extent they are effective in treating the specific issue involved. These records are significant in cases alleging medication error or chemical restraint employed for staff convenience or discipline. In addition, in cases alleging malnutrition, a review of the MAR might reveal that the resident was taking psychotropic medications (such as Haldol) that affect one's appetite. The resident's response to the medication is noted as is staff monitoring of the medicated resident.

The LNC will compare the MAR against the physicians' orders to determine if the orders were carried out as requested. In addition, the LNC reviews medication cards (also known as Kardex),

physician progress notes, and facility policy and procedures for information concerning the medication.

### ***Speech Therapy Records***

A swallowing disorder may necessitate examination of the resident by a speech pathologist, gastroenterologist, or ear, nose, and throat specialist.<sup>21</sup> A resident observed drooling and coughing while taking meals may require prompt attention from a speech pathologist.<sup>22</sup> Review the records maintained by these professionals for information and recommendations regarding resident care. For example, dehydration and malnutrition may result if the resident has some degree of dysphagia (an inability to swallow or difficulty in swallowing) that goes unnoticed or untreated.

### ***Physical and Occupational Therapy Records***

"The physical therapist is responsible for providing rehabilitative and restorative services to major muscle groups to restore function, strength and mobility. The occupational therapist works mainly with the muscles and nerves of the upper extremities (hands, arms, shoulders) to improve strength, mobility and dexterity."<sup>23</sup> These records will show, for example, whether the resident was taught how to use adaptive equipment.

### ***Dietary/Meal Forms***

If the case involves the nutrition and feeding of a resident, the LNC will compare several forms of documentation to confirm abuse or neglect. For a review of weight loss and/or nutritional problems, the following forms will be reviewed: dietary/meal forms, registered dietician/nutritional consultant forms and progress notes (many times recommendations made by this consultant are not followed by the nursing staff), I&O records, physician orders and physician progress reports, and nurses' notes.

### ***Policy and Procedure Manuals***

Policy and procedure manuals including, but not limited to, the Nursing Policy and Procedure Manual, Administrative Policy and Procedure Manual, Infection Control Policy and Procedure Manual, and Laboratory Policy and Procedure Manual are created by the nursing home and dictate a standard of care to follow. Request the table of contents for

each of the manuals. The LNC will review this information and suggest which manuals apply to the case issues. (A sample table of contents is shown in Exhibit 1.)

### **Personnel Files**

A nursing home has a duty to exercise reasonable care in the selection of its staff.<sup>24</sup> Thus, for example, if a home hires and retains an employee even

## **Exhibit 1. Pine Crest Nursing Home Nursing Home Policy and Procedure Manual**

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ISSUE DATE: October 1985

REVIEW DATE:

REVISE DATE: March 1999

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though a properly conducted background check would have revealed a criminal record, the home can be held liable for a battery committed against a resident<sup>25</sup> or a visitor.<sup>26</sup> The facility's personnel files should contain information about pre-hiring screening (criminal background checks), proof of state licensure, satisfaction of continuing education requirements, and letters of accomplishment or reprimands.

In addition, the personnel files should contain performance reviews. "Each facility must complete performance review of every nurse aide at least once every twelve months, and must provide regular in-service education based on the outcome of those reviews."<sup>27</sup> The education must consist of at least twelve hours per year<sup>28</sup> and address areas of weakness in a nurse's aide's performance reviews, and, if a nurse's aide cares for residents with cognitive impairments, the care of the cognitively impaired.<sup>29</sup>

#### **Log or Report Books**

The LNC reminds the attorney to undertake a review of log or report books which have been maintained by the individual facilities for internal communication, for useful information about the resident that does not appear in the resident's nursing home record. Attorneys frequently overlook this information during discovery.

#### **Staffing Documents**

To determine how many staff members were working on the date and time of an alleged incident, staffing documents, such as time sheets or work schedules, should be requested. This data allows the LNC to calculate a staff-to-resident ratio. Did the facility hire enough staff to deliver the necessary care to their residents? If not, "residents may not be fed, hydrated or repositioned adequately. Chemical and physical restraints are used in lieu of activities and exercise. Negative outcomes, including pressure sores, are the result."<sup>30</sup>

#### **Quality Assessment and Assurance Committee Minutes**

Most nursing homes have a Quality Assessment and Assurance Committee that meets to consider issues such as falls, pressure sores, skin tears, and other incidents related to facility residents. The minutes from these meetings are useful in demonstrating a pattern of abuse or neglect. In some

states, this information is privileged and unavailable through the discovery process. In other states, this material may be disclosed if requested in the proper format.

#### **Organizing Nursing Home Records**

The sheer number of nursing home records, some of which exceed hundreds of pages, is daunting. Appropriate organization of the nursing home records is extremely helpful and cost-effective when the attorney and expert are discussing the facts of a case. In addition, for cases involving a significant volume of records, organization of the records is essential. Otherwise, the LNC will be unable to reconstruct the sequence of events that led to the resident's injury or death.

#### **Order and Pagination**

The LNC makes sure that nursing home and other medical records are in proper order and correctly paginated. When ordering copies of such records, do not allow the record retrieval company to paginate them. Confusion will result if the records are paginated before the LNC arranges them in a chronological or medically appropriate order. Only after the LNC has accomplished this should the file clerk or the LNC consecutively number or paginate the records.

#### **Labeling Groups of Records**

If dealing with records from more than one source, such as the nursing home and hospital, label each group according to source. For example, all records from Oak Lawn Nursing Home are labeled "O." All records from the resident's subsequent hospitalizations at Mercy Hospital are labeled "M."

#### **Multiple Copies of the Same Record**

If a page of the nursing home record also refers, in a significant degree, to events that occurred at a different date or time, it should be photocopied twice. Clearly mark the second photocopy as to the date or time of the reference. For example, if a record dated September 4 describes a resident's fall from her wheelchair which caused an injury fall incident on August 4, there should be two copies of this report in the record. One copy should be marked "Sept. 4: duplicate to Aug. 4" and placed in the record chronologically at the September 4 date. The other copy should be marked "Aug. 4: duplicate from Sept. 4 and placed directly follow-

ing the initial injury fall incident report dated August 4.” This procedure allows the attorney to locate and relate significant references that would otherwise appear only in distant parts of the chronology.

### **Preparing Bound File of Medical Records**

The LNC makes accessing resident nursing home and other medical records user-friendly by placing the records into a bound file with dividers between the key elements, such as autopsy, consents, consultations, laboratory reports, medications, nurses’ notes, orders, progress notes, and x-rays. The attorney attending a deposition where parts of the record will be introduced as exhibits brings along the bound record as well as a clean, numbered record—an exhibit file from which to select pages for evidentiary purposes.<sup>31</sup>

### **Charting or Graphing Data**

The LNC may chart or graph data and correlate it to other clinical events to make it easier for the attorney to understand what happened in a complex case.<sup>32</sup> Experience demonstrates that such items as blood values, antibiotics, drug doses, and drug administration become easier to follow when displayed graphically.<sup>33</sup>

### **Analyzing the Nursing Home Record**

Making sense of a mountain of records seems insurmountable without the efforts of the LNC. There are many ways to approach nursing home record analysis, depending on the volume of records, the type of information being sought, and the attorney’s experience. In the ideal world, all relevant observations and interventions are documented on the proper forms and in the proper sequence of events. In the real world, documentation errors are inevitable and, in practice, the number of errors increases with the length of a resident’s stay in the facility. These documentation errors are usually insignificant; however, at other times they are very important. The LNC sifts through voluminous medical records in search of these significant errors. The LNC also reviews the records for completeness, determining if any documents are missing.

### **Learning the Lingo**

Unless the attorney possesses a formal education in medicine or nursing, the terminology found in a

nursing home record can be perplexing. The LNC can advance the attorney’s understanding of the clinical issues and medical terminology essential to developing a strong case or defense. Even when words are legible, medicine, like other professions, has developed its own technical language and its own shorthand.<sup>34</sup> Consequently, unless the attorney knows what to look for and what it means, the record can be intimidating.

### **Interpreting Abbreviations, Symbols, and Measurements**

The LNC interprets abbreviations, signs or symbols, and measurements (English, metric, or other systems) that appear in each type of nursing home record. Casual review of the record by the attorney will underscore the high incidence of medical abbreviations. A misunderstanding of an abbreviation’s meaning may lead to misinformation and confusion.

### **Understanding Anatomical Descriptions**

Anatomical terms and descriptions are found throughout nursing home records and other medical (such as hospital or family physician) records related to the resident’s care. The reviewing attorney who does not understand them is quickly lost. For example, records repeatedly use anatomical direction terminology such as proximal, caudal, sagittal, frontal, palmar, and ulnar, among others. An anatomical discussion might involve joints and their motions, or refer to nerves, spinal nerve roots, dermatomes, muscles, or muscle innervation. The LNC assists the attorney in understanding these terms, for example, by using a diagram of surface anatomy or illustrated cross sections through the body. These demonstrative aides may later be used during trial to similarly explain the material to jurors.

### **Diagnostic, Orthopedic, Neurological, and Psychiatric Findings**

Attorneys do not always recognize which diagnostic procedures or test findings contribute to a specific diagnosis or to the determination of the severity or treatability of a nursing home resident’s particular medical disorder. Thorough case preparation means having the LNC explain the techniques and diagnostic scope of special diagnostic procedures such as paracentesis, cardiac catheterization, electromyography, or magnetic resonance imaging.

Resonance imaging is useful in evaluating soft tissue injuries because it images the hydrogen atoms or water in the soft tissue areas, which indicates swelling and injury.

An orthopedic injury may be the cause of litigation if a resident's joint is injured, or if the resident experiences a loss of the joint's range of motion and disability results. The LNC describes bone fractures and dislocations and explains the terminology used to describe orthopedic trauma and fractures.

The resident's mental status may be extremely important to a variety of legal matters. The LNC evaluates neurological and psychiatric findings that appear in the medical records. In addition, the LNC considers whether prescription medications are relevant to the resident's mental status.

### **Comparing Records**

Disagreement between different parts of a medical record is common. For example, the physician may have failed to read the nurses' notes before recording that the resident is doing well with minimal pain. In sharp contrast, the nurses' notes describe the resident's agony and need for considerable pain medication. The physician may have examined the resident when the pain medication was at its peak effectiveness, and the resident wrongfully assumed

the physician knew of the pain and, therefore, did not mention it. Sometimes an apparent disagreement has a logical explanation. For example, the nurses' notes from the evening shift describe a confused and uncooperative resident while the notes of other nurses and physicians describe the same resident as alert and cooperative. The explanation is that residents with certain brain disorders have cyclic periods of confusion that are present at one time of day.

Other useful comparisons involve comparing physician orders for drugs with the medication records (or nurses' notes) and comparing nurses' notes with physicians' notes. Although the nursing notes and physician notes are concerned with somewhat different aspects of resident care, they complement one another. For example, compare order sheets with medication sheets and other nursing records to determine that all ordered medications and treatments were carried out.<sup>35</sup>

### **Constructing Event Chronology**

The LNC prepares an event chronology that distills potentially hundreds of pages of nursing home records into several pages of readable, accessible information. A comprehensive chronology includes all care rendered within a specific time period. (see Exhibit 2.) In contrast, a specific chronology con-

## **Exhibit 2. Comprehensive Chronology**

<b>1997</b>	Admission to Rest Haven Nursing Home
	<b>Diagnosis:</b> S/P Right CVA w/ L side Paralysis; HX Coronary Artery Disease
	<b>Physical Exam:</b> Alert & oriented; ambulates w/ cane
	<b>Plan:</b> Assistance w/ activities daily living (ADLs) due to stroke deficits. Monitor cardiac condition.
<b>1998</b>	No change in physical condition. Alert & active, ambulating w/ cane, no cardiac problems
<b>1999</b>	<b>March:</b> Experienced New CVA. Hospitalized 5 days @ St. Joseph's Hospital. Needs additional physical therapy for strengthening exercises. Ambulating w/ walker. Some confusion due to CVA. No cardiac problems.
	<b>April:</b> Experienced 2 fall incidents. No injuries due to falls. No cardiac problems.
	<b>May:</b> Fell out of bed on 5/5/99 when attempting to go to bathroom. Two other fall incidents while ambulating in hall and day-room w/ walker. Gait very unsteady, needs 1 to 2 person assistance w/ ambulation at times.
	<b>June:</b> Confusion increasing. Requires increased assistance w/ ADLs. Gait unsteady at times; usually requires 1 to 2 person assistance as resident leans to the right side and forgets left side. 6/10/99, while attempting to walk in day-room w/ assistance of walker & 1 PCA, fell. Complained of right hip pain. Transported to St. Joseph's hospital. Diagnosis fractured right hip



siders a particular aspect of care such as that provided by a particular caregiver minute-by-minute or day-by-day. (See Exhibit 3.)

A properly constructed chronology navigates the attorney through the discovery process, including the formulation of deposition questions. In

### Exhibit 3. Specific Chronology

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- 12-1-98 Admitted for 2 week stay while brother in Florida  
Medical Diagnosis: Periodic confusion, forgetfulness, constipation, dementia related to alcoholism  
Medication: FiberCon & Phazyme 95  
Physical Examination: Alert with intermittent confusion; gait steady without assistance  
ADMISSION NOTE PER DR. KIM:  
“Mr. Bogart will be here until after Christmas . . . needs assistance with bathing & a reminder to change clothes . . . enjoys people . . . encourage participation in activities . . . no medical problems except constipation, general diet, medications include FiberCon & Phazyme.”
- 12-1-98 NURSING NOTE:  
Arrived on unit, ate well at dinner . . . oriented to unit . . . no complaints . . . VSS
- 12-2-98 NURSING NOTE:  
Assisted with activities of daily living (ADLs) minimal. Needs reminder to pick up clothing & possessions. Out on unit most of day. No complaints.
- 12-3-98 NURSING NOTE:  
No complaints, minimal confusion noted but only when asked what the date was.
- 12-4-98 NURSING NOTE:  
Relaxing in his room, no complaints, minimal assistance with ADLs
- 12-5-98 NURSING NOTE:  
Minimal assistance with ADLs, appetite good, no complaints. 2:00 pm wandering in and out of various rooms, when questioned, stated he was “lost and could not find his bedroom.” Appears to be more confused than normal, responds appropriately to verbal interventions and redirection.
- 12-6-98 NURSING NOTE:  
Up and about, no complaints.
- 12-7-98 NURSING NOTE:  
No complaints, minimal assistance with ADLs, appetite good.
- 12-8-98 NURSING NOTE:  
Minimal confusion in am, however became more confused as day progressed . . . appears more confused than normal . . . found taking nap in another resident’s room . . . responds appropriately to verbal redirection.
- 12-9-98 NURSING NOTE:  
Minimal confusion, minimal assistance with ADLs, appetite good.
- 12-10-98 NURSING NOTE:  
9:00 am minimal confusion and assistance required with ADLs  
5:00 pm unable to find resident on unit, not in room, not in day-room, searched all other patient’s rooms. Call to security found Mr. Bogart on 5th floor in day room watching TV. Unable to relate how he got off floor and onto 5th floor.

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**Exhibit 3. Specific Chronology (continued)**

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- 12-11-98 NURSING NOTE:  
Alert but intermittently confused . . . assisted with ADLs.
- 12-12-98 NURSING NOTE:  
No complaints, uneventful day.
- 12-13-98 NURSING NOTE:  
Assistance with ADLs . . . appetite good, no complaints.
- 12-14-98 NURSING NOTE:  
Resident relaxing in room, no complaints . . . active in activities.
- 12-15-98 NURSING NOTE:  
Appears to have slept well . . . minimal assistance with ADLs.
- 12-16-98 NURSING NOTE:  
Confused today . . . redirected easily . . . no complaints.
- 12-17-98 NURSING NOTE:  
Up and about on unit, active, no complaints.
- 12-18-98 NURSING NOTE:  
Minimal assistance with ADLs, needs reminder to pick up things . . . appetite good.
- 12-19-98 NURSING NOTE:  
Up and about  
12:30 pm: escorted onto unit by security staff that states resident "found wandering around the parking lot by a visitor, appearing lost and confused." Assessment reveals increased confusion, no complaints. Supervisor advised of past events.
- 12-20-98 NURSING NOTE:  
No complaints, appeared to sleep well, appetite good.
- 12-21-98 NURSING NOTE:  
Resident relaxing in room . . . watching TV & participating in activities.
- 12-22-98 NURSING NOTE:  
Confused intermittently . . . no complaints.
- 12-23-98 NURSING NOTE:  
9:00 am no complaints, up and about unit.  
9:00 pm resident was not on unit at bedtime. Security out searching grounds... Nursing Supervisor notified of situation. Dr. Kim called and notified of situation. Nursing Supervisor placed call to local police department listing resident as possible missing person.
- 12-28-98 NURSING SUPERVISOR NOTE:  
Received call from St. Ann's Hospital. Resident admitted to ICU on 12-23-98 after paramedics found him wandering in the streets. Resident died on 12-28-98 of respiratory failure.
-

addition, the chronology assists throughout settlement negotiation and during trial. If the case goes to trial, a detailed chronology introduces the jury to the events that led to the resident injury or death.

Expert witnesses appreciate the time saved by using the chronology and "are greatly impressed by the attorney or firm that can present such massive material in such a succinct, cogent and efficient manner."<sup>36</sup> Of course, in jurisdictions that allow or require opposing counsel to discover all records and information reviewed by expert witnesses, the attorney must decide whether to risk turning over the chronology to opposing counsel.<sup>37</sup>

### Searching the Literature

Analysis of the nursing home record may require the LNC to identify, locate, and read medical literature specific to the issues presented by the case. The consultant may review, for example, *Gray's Anatomy*, *Merck Manual of Diagnosis and Treatment*, *Current Medical Diagnosis & Treatment*, *Mosby's Drug Guide for Nurses*, *Cecil Textbook of Medicine*, *Merritts' Textbook of Neurology*, *Physician's Desk Reference*, *Stedman's Medical Dictionary*, *Taber's Cyclopedic Medical Dictionary*, or *The Lippincott Manual of Nursing Practice*. In addition, the LNC's search may use resources available on the Internet including Grateful Med or MEDLINE. The LNC provides a written summary of the literature for attorney review. If the expert witness requires research of the medical literature, it is cost-effective to employ the LNC to work with the expert concerning this research.

### Identifying the Standard of Care

Litigating the nursing home case is a battle over standard of care, and nursing home records are all that remain of the caregiving.<sup>38</sup> These records more or less reflect what was done on the resident's behalf and often constitute the best evidence of departures from the standard of care.<sup>39</sup> The LNC will offer her impression of the resident's care.<sup>40</sup> (See Exhibit 4.)

### Protected Work Product

All work produced by the LNC is considered attorney work product and, therefore, is protected against discovery. In contrast, any report produced by a testifying expert witness is discoverable. Thus,

the attorney should consider using the LNC to evaluate and provide opinions on the liability of all health care providers including physicians, nurses, facility administration, and various therapists and other technicians.

### Final Thoughts

Teaming an attorney with a LNC makes for a powerful, effective litigation team. The medical training and expertise of the LNC provides the attorney with an indispensable tool when entering the unfamiliar realm of the medical profession. Like an interpreter of a foreign language, the LNC translates the language of the nursing home into a language that the attorney can understand.

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### Endnotes

1. Elliott B. Oppenheim, *Examining Medical Records: How to Know What Is Said When You Read What the Doctor Wrote*, 82 A.B.A. J. 88, 88 (Mar. 1996) [hereinafter *Examining Medical Records*].
2. See generally Patricia W. Iyer & Deborah D. D'Andrea, *The Legal Nurse Consultant: An Essential Team Member*, in NURSING HOME LITIGATION: INVESTIGATION AND CASE PREPARATION 415-77 (Patricia W. Iyer ed., 1999) [hereinafter Iyer & D'Andrea 1999]; Patricia W. Iyer & Deborah D. D'Andrea, *The Legal Nurse Consultant: An Essential Team Member*, in NURSING MALPRACTICE 725-96 (Patricia W. Iyer ed., 1996); Bonnie Faherty, *Legal Nurse Consultants: Who Are They?*, 1 J. NURSE L. 37 (1995).
3. See Deborah D. D'Andrea, *Role of the Legal Nurse Consultant in Nursing Home Litigation*, 12 NAELA Q. 12, 12 (Fall 1999) ("The [legal nurse consultant] is able to interpret what is, as well as what is not, documented within the medical record.").
4. See Jeff E. Rusk, *The Truth Is Out There: Discovery from a Plaintiff's Perspective*, ANATOMY OF NURSING HOME MALPRACTICE (ABA Mar. 13, 1999) (unpublished manuscript on file with author).
5. All federally certified health care providers, including nursing homes, must inform each resident of their right under state law to execute an advance directive. See 42 U.S.C. §§ 1395cc(f)(1)(A)(i), 1396a(w)(1)(A)(i); 42 C.F.R. § 489.102(a)(1)(i).

6. Rusk, *supra* note 4, at 2.
7. *Id.*
8. See 42 U.S.C. §§ 1395i-3(c)(1)(A)(i), 1396r(c)(1)(A)(i); 42 C.F.R. §483.10(b)(3) (corresponding regulations to the federal Nursing Home Reform Law reiterate the right to be informed about treatment).
9. See WANDA L. HURR, ATTORNEYS' GUIDE TO MEDICAL RECORDS § 207 (Debra Tillinghast ed., 1993) (detailing what to look for in physician's order).
10. *See id.*
11. *See id.*
12. *See id.*
13. 42 U.S.C. §§ 1395i-3(b)(3)(C)(i)(II), 1396r(b)(3)(C)(i)(II).
14. See 42 U.S.C. §§ 1395i-3(b)(3)(A)(ii), (f)(6)(A), 1396r(b)(3)(A)(ii), (f)(6)(A).
15. See 42 C.F.R. § 483.315(e).
16. See HEALTH CARE FINANCING ADMIN. STATE OPERATIONS MANUAL § 4145.2 (defining Resident Assessment Protocols).
17. See ERIC M. CARLSON, LONG-TERM CARE ADVOCACY § 2.08[1] (1999).
18. *See id.*
19. See Lesley Ann Clement, *Litigating the Pressure Sore Case Against a Nursing Home*, 12 NAELA Q. 8, 10 (1999).
20. Jeffrey M. Levine, *Pressure Ulcers in the Nursing Facility: Medicolegal Considerations for Physicians*, NURSING HOME MED., May 1994, at 32, 36.
21. *See id.*
22. *See id.* at 38.
23. Mary L. Lubin, *Inside the Nursing Home: The Structure*, in NURSING HOME LITIGATION INVESTIGATION AND CASE PREPARATION 13, 19 (Patricia W. Iyer ed., 1999).
24. See Ralph Gerstein, *Nursing Home Litigation*, THE ELDER LAW PORTFOLIO SERIES, Feb. 1996, at §13-7.1(b).
25. See *id.* (citing *Rodebush v. Oklahoma Nursing Homes*, 867 P.2d 1241 (Okla. 1993)) (offending employee with criminal conviction for attempted murder slapped a nursing home resident).
26. See *id.* (citing *Deerings West Nursing Ctr. v. Scott*, 787 S.W.2d 494 (Tex. Ct. App. 1990) (finding nursing home liable for a battery committed by an employee with a long record of criminal convictions for theft).
27. 42 C.F.R. § 483.75(e)(8); 42 U.S.C. §§ 1395i-3(b)(5)(E), 1396r(b)(5)(E).
28. See 42 C.F.R. § 483.75(e)(8)(i).
29. See 42 U.S.C. §§ 1395i-3(b)(5)(E), 1396r(b)(5)(E); 42 C.F.R. § 483.75(e)(8)(ii), (iii).
30. Clement, *supra* note 19, at 10.
31. See Oppenheim, *supra* note 1, at 88.
32. *See id.*
33. *See id.*
34. See Elliott B. Oppenheim, *A Trial Lawyer's Guide to the Medical Record*, 84 ILL. B.J. 637, 637 (Dec. 1996) [hereinafter Oppenheim].
35. See HURR, *supra* note 9, at § 313.1 (comparing the treatment and responsiveness of one discipline with another).
36. *Id.* at § 313.3 (using an event chronology to prepare expert witnesses).
37. *See id.*
38. See Oppenheim, *supra* note 34, at 637.
39. *See id.*
40. See generally Iyer & D'Andrea 1999, *supra* note 2, at 430-33 (highlighting deviations from the standard of care in a nursing home case).

**Exhibit 4. Nursing Deviations Policy & Procedures JCAHO Standards**

NURSING DEVIATIONS	POLICY & PROCEDURE	JCAHO STANDARDS
<p>Nursing staff failed to perform ongoing assessments and evaluations.</p>	<p><b>PRESSURE SORE PREVENTION &amp; CARE #1406 C</b></p> <p>Assessment for the potential formation of pressure sores:</p>	<p>PE .3 The assessment process for each patient includes assessment of nursing status and needs:</p>
<p>The chart contains a Nursing Observation Form that is dated with the admission date. However, this form is only partially completed.</p>	<p>Nursing Observation Form will be included within the medical records and completed at the time of admission.</p>	<p>PE.3.1 This assessment includes at least the following:</p>
<p>For the entire 3-month stay within the Wellbeing Nursing Home, there are no weekly Nursing Observation Forms contained within the medical records.</p>	<p>Nursing Observation Form will be updated on a weekly basis if ulcers are present.</p>	<p>PE.3.1.1 Physical status and needs including:</p>
<p>There are no Monthly Summary Forms contained within the medical records.</p>	<p>Monthly Summary Form will be completed for all residents on a monthly basis.</p>	<p>PE.3.1.1.1 Current Medications and treatments</p>
<p>There is no documentation within the various graph forms or on the nursing progress notes that are relative to the performance of any pressure sore assessment</p>		<p>PE.3.1.1.2 Skin Integrity</p>
		<p>PE.3.1.1.4 Musculoskeletal status</p>
		<p>PE.3.3 Patient care policies and procedures serve as a guide to assessment of patient's nursing needs and of nursing participation in the patient care management system</p>