LNP 48
From Prison Walls to Hospital Wards: An LNC's Journey
Valerie Lane

Pat: Welcome to Legal Nurse Podcasts. This is Pat Iyer and this is another episode of our show. I welcome the opportunity to talk with legal nurse consultants about their roles, how they got started and what has made them successful. I'm talking today with Valerie Lane who has been a registered nurse for 23 years. She has specialties in surgery and corrections. She is a legal nurse consultant who is certified and established Lane & Associates in the Central Valley of California.

Valerie has experience as a full time correctional nurse for the California State Prison System. She established her reputation through hard work and perseverance. She's an expert in correctional nursing. She was successful in assisting clients through her experience and knowledge of the prison system.

I think the expression, Valerie, is that you came out from behind the walls in 2010. She got full time employment as a legal nurse consultant for a major healthcare system, which has facilities in California, Nevada and Arizona. She is a member of the Risk Services Team. She has that interesting background of doing some independent work, some corrections work and now risk management work.

I believe that Valerie and I met at a conference for legal nurse consultants about the time that she left the correctional system. Valerie has also presented a program for me through the Pat Iyer Group called "Hospital Acquired Infections: Whose Fault Are They".

I've been talking with Valerie as we've been ready to get started and found out that she is working on an online course, an RN to BSN program and has ambitions to continue on for her masters. She's juggling going to school, family and work.

Let's take you back Valerie and get you to the point of when you first got started in legal nurse consulting. How did that happen?

Valerie: Thank you for taking the time to interview me, first of all. I appreciate that. I became interested in legal nurse consulting right after I went out to work in the correctional system for the California State Prison approximately in 2007. I'm not sure whether I started seeing advertisements for the education available that we received through the mail through flyers. Somehow my interest was piqued and I decided to get my certification through that program and just started from there.

I opened up Lane & Associates. I did the basic groundwork to establish my business, which was an education in itself and began to market to attorneys in my spare time while I continued my full time work in correctional nursing. I just kept pursuing that as an independent legal nurse consultant.

Pat: When you were doing independent legal nurse consulting were you working specifically on correctional cases or did you have a broader practice?

Valerie: It was broader. At that I was trying to break through and just trying to get in and talk to attorneys, and convince them of what a legal nurse consultant could do for them. It was mainly medical malpractice for the plaintiff side. It was later on that I was able to work on correctional cases once I established my business and then had done some work for previous attorneys. I actually was contacted through I believe my website for my correctional cases.

Pat: Then when you were working in correctional nursing were you in a risk management position or was it a clinical position?

Valerie: Actually I had worked in most of the positions in a prison. So for a clear understanding, the California State Prison system have clinics. There are yard clinics for the different yards, general population, and enhanced outpatient clinic. There are the yards that are under a stricter security clearance such as a protected housing unit where maybe a more infamous inmate would be housed. There are opportunities out in the yard to work in those nursing clinics.

My initial position was in the OR there, which is actually how I went

out to the prison system. They actually have an acute care hospital at Corcoran State Prison, so I started in the OR there. We mainly did a lot of urology and liver biopsies. It wasn't a full OR and then I transitioned out to the yard to the CID clinic, which was a building where all the HIV positive inmates were housed and that eventually transitioned. All those patients or inmates were moved up north to have access to physicians at Stanford and UC San Francisco.

I then actually took another position coordinator of an involuntary medication program where inmates are medicated involuntary due to danger to the self, danger to others or grave disability. I actually would not write investigation reports. I made sure that all the documentation was in order for the administrative hearings where a judge would come in and each side, both plaintiff and defense, would have their opportunity to speak. Then the administrative law judge would make a decision of whether that medication was to continue or not.

That was very interesting and because of my LNC certification that qualified me for that job, which was very autonomous. I ran the program as far as coordinating the doctors and security, and actually attending the administrative hearing. That was very interesting and I did that for about a year. Then I ended up going into a supervisory capacity until this job became available that I'm in now.

Pat: Now I mentioned before that you're in a risk services position. I've been a member of the American Society for Healthcare Risk Managers for quite a few years and attended the New Jersey chapters when I was living full time in New Jersey. What struck me about what I learned about risk managers is that I thought of risk managers as people who primarily investigated potential claims, but I've discovered that there are all other aspects associated with the job.

I wonder if you could share with the members of our audience, probably many of whom have not been in a risk management position, what are the other pieces of your role besides looking at potential claims.

Valerie: The way it's set up for the health system that I work for I am actually a

corporate employee and I work closely with the risk managers. The risk managers mainly file complaints. They take care of the compliance and regulatory aspects or in other words reportable incidents or events to the state, sentinel events, and things of that nature.

What happens at our facilities is that we have a computer system where people enter incident reports and then that goes to the risk manager. They decide whether that event or incident needs to be reported or forwarded to me. I then get the medical record. I write up a report and do investigative work as far as interviewing staff, documentation, anything that might pertain to the claim. Should the claim be asserted then that goes to another individual and they actually handle that legal aspect of it.

Pat: Take us to the bedside and let's talk about what happens when the risk manager gets a phone call. I know you've talked about how they reported up the system, but the majority of the people listening to the call are involved in a case *after* they've been notified that there's a claim. They might do a little bit of pre-suit investigation if they're working with an insurance company, but the majority of our people are brought in when there's a plaintiff attorney who gets involved or a defense attorney who's notified of the suit.

What happens right at the bedside if there's an incident and then how does the risk manager become involved at that point?

Valerie: I'm going to use my background in surgery, so for example a retained foreign body.

The patient obviously has a procedure. The counts are supposedly correct. The patient leaves the OR. Once the patient leaves the OR with a retained foreign body that's when it's got to be reported at least here in California. I'm would like to say that is more than likely the standard nationally.

The risk manager is notified of the event. It could be from the medical staff. It could be from the nursing staff. It just depends on how that information is communicated to them and then they usually do what is

called a "Root Cause Analysis". That's a process where they gather all of the witnesses involved and they attempt to figure out what happened, if there are processes that need to be changed and what the human factors were that were involved. They actually go through that whole process with a fine tooth comb. That's internal documentation, so that is not available to everybody.

That's usually what happens and then the LNCs come in afterwards and do their own investigation. They then go out and interview staff and also attempt to figure out what processes or what standard of care was not followed. As LNCs usually we're able to glean more information, which is what we're looking for because not everything can be documented in the record (obviously) but there are other aspects. For example, body language or staff conflict that may not be readily noticeable at an internal process meeting.

That's really where the LNC is invaluable because they come in as a third party. That interview is conducted one-on-one and so they're usually a little bit more relaxed. You're able to develop a rapport with them and a trust factor, so if there are things that were not necessarily revealed before then that is the opportunity you should glean additional information for that claim.

Once the risk manager is finished with that internal documentation they monitor. They are the liaison, of course, between the public health department and the facility. They're the ones that actually go in and put the processes in place that maybe are not there to begin with or that should be changed. As an LNC, of course, I would also corroborate with the risk manager. I'll bring to their attention information that I would be made aware of so I know that *they* know that these processes are going on that are not within standard of care, need to be improved or maybe revised.

Pat: It sounds to me from what you're describing that there can be a number of internal changes that may result from an incident. Those are changes that an outside legal nurse consultant working with a plaintiff attorney, for example, or maybe even a defense attorney would really not have any knowledge about in regards to what went

on in the facility as a *result* of an incident.

Sometimes when legal nurse consultants are reading depositions they may get wind of a defendant who says, "That's not the way that we do it anymore. We've changed our practice." Usually that's not germane to the lawsuit and can't be used as evidence of that person's guilt. I'm not phrasing this in the most elegant way, but it's not significant to the lawsuit what changes the facility made afterwards.

There's a lot of mystery in the minds of legal nurse consultants like, "What did happen? Did they (they being the defendants) learn their lesson?" Could you give us a sense of what you've seen over the years in terms of changes that can result from litigation?

Valerie: It can be as simple as checking an oxygen tank volume and process that are changed because of an incident that happened with lack of volume in an oxygen tank. It could be going back to the OR, the process when staff goes on a break whether they counted that time or how involved the count is when somebody leaves the room. What is opened onto the back table that may not be accounted for? They could change the whiteboard line up of the items that are opened and placed on the field in order of items that are most used.

It could really be anything. And that is one thing as an LNC when you see those changes that are made and actually assist in recommending changes that are made - that is a good thing and makes you feel like you are effecting change. Usually in my experience I don't always see the changes that happen due to investigations, but with feedback through your risk manager and good corroboration at times I will be able to see that change.

Pat: Have you had an ah-ha moment in your career?

Valerie: In my current position or just generally?

Pat: Just generally, like a revelation that really struck you about what you're doing or how the healthcare system works.

Valerie: Actually I have. It's very surprising to me when I interview staff and there's a lack of critical thinking skills. I think, "Should I try to

educate them on that?"

I'm not sure if that's what you're talking about, but as far as legal nurse consulting and getting into this specialty I love it when I go through a record and I'm able to point out the things that are patterns or just the whole investigative process. Especially when I discuss the case with somebody else, for example, a risk manager and they corroborate what I've found. I of course do all my investigating independently and then when somebody corroborates that that's very nice. I feel like I'm on the right track and to me that's an ah-ha moment. I always appreciate that or we come up with the same synopsis or the same view of the claim independently. That's probably my favorite part I would think.

Pat: I've heard LNCs talk about that moment when they find the one word in the medical record that changes the whole complexion of the case.

Valerie: Yes and actually I did have one of those in a perinatal claim. The doctor was supposedly in the room at a certain time and then Anesthesia was so nice to say, "No, he wasn't. He didn't get here until after that." I looked at where he lived and I thought, "He's stuck in traffic." That was an ah-ha moment.

Once I asked where the physician lived that corroborated that impression that I had that. There wasn't really anything in the record. It was just putting things together, putting information together and looking at it thinking, "He was stuck in traffic. There's no way he could have got to the hospital in less than 30 minutes from where he lived, not in Los Angeles, California".

Pat: I have been in Los Angeles. I think we went from West Hollywood to the Santa Monica Beach, (which is 11 miles) when my son lived out there. It took an hour and a half to drive 11 miles. Yes, that's an important frame of reference to keep in mind in terms of the geography.

Valerie: I guess another one was a correctional case that I had and it's already been settled so I can talk about it. This RN was being sanctioned by the Board of Registered Nursing from a letter that they had received

that was on plain typing paper. In other words it didn't have any letterhead on it and if you work for the state or any corporation, people don't usually send out type written letters without their company letterhead. That's your branding.

Supposedly it was the DON of a state prison in northern California, Sacramento State Prison that they had supposedly written this letter about this nurse. The board was sanctioning him and the DA was prosecuting. I said that there's no way that a DON for a state prison here in California would not use a letterhead and so that was an ah-ha moment. He would never had known that and having worked in the prison system there are templates in the computer system that anybody can pull up and it's just not very professional. That was another ah-ha moment. That case ended up being dropped. That was good.

Pat: Clearly Valerie you've had a long career in working in legal nurse consulting and have achieved a high level of success being in a corporate position. What do you think are the personal qualities that most contributed to your success?

Valerie: I think that perseverance is one of them and persistence, and that even though I wasn't sure exactly the path specially that I was headed down I knew generally that this is what I wanted to do, especially as I transitioned to a seasoned clinician that I would just look for opportunities to continue to get out there and build my reputation. In fact one of those was when we first met.

You and I both spoke at that first legal nurse conference in 2010. That was right before I started my current position. When I saw *you* on the program I thought, "Hm that's not too bad." I've just always looked for what's next, what's down the road and what am I going to do right after I finish my undergrad degree. I think I'm going to finish my masters and continue to just keep busy and move forward, and I think that that's key also.

Pat: I know that I get asked this question a lot from legal nurse consultants. They want to know how they can be successful, how they can do well in this field. What do you think are the skills that are critical to being a

successful legal nurse consultant?

Valerie: Again I think it is perseverance, in looking for opportunities that will help you to grow and develop. For example, when we met it was an inaugural conference and I submitted a topic and low and behold that topic was accepted. I wrote a PowerPoint. I have a lot of experience in public speaking, so that really wasn't an issue. There are other conferences that I would like to speak at eventually maybe one day, but just always looking for what you can do to develop and hone your skills, such as report writing and getting example reports written.

I would always have a portfolio that I would take with me when I interviewed with perspective clients. Develop those small business strategies if you can. Now that's where I thought I would start and I would continue, but then my path took a different road. I did not realize that this healthcare system hired legal nurse consultants. There are not very many healthcare systems that do, but once I found out and I knew they were hiring I certainly put in my application, continued to pursue that and was able to gain employment that way.

There are other avenues besides just being an independent consultant. I know there are other companies out there that do hire legal nurse consultants. I think that we hear that the independent consultant is the only way to go and that's not necessarily true. I would encourage especially as people become more aware of what legal nurse consultants can do in a corporate setting I think that they are going to become more commonplace then they have been in the past.

Pat: It's certainly a place that you have found as a home with a busy job, lots of responsibility and the capability of taking what you know from your prior experiences as a nurse and legal nurse consultant. And bring them into a different setting using skills involving analysis, communication, probably a fair degree of education and persuasion to make changes after recognizing that there are risks.

Valerie: Yes and actually due to my correctional experience that is one of the reasons I'm sure that I gained employment here. We have a guarded care unit at one of our facilities and due to the close proximity of six state prisons in this area we have a tendency to treat a lot of inmates.

Of course where there are people you're going to have events and incidents, and along with that people who want to assert claims. I do see quite a few of those and I know that was influential in getting employment where I'm at.

My background in surgery is another example, like my surgery cases. There are some areas that I've had to learn more about such as perinatal, but that has also provided growth and development. Your specialty background is always valuable.

Pat: How can people find out more about you, Valerie?

Valerie: I have a website, www.ValerieLaneLegalNurse.com and you can contact me there. My email is VLane@ValerieLaneLegalNurse.com. If you're interested in contacting me privately, please, I look forward to those contacts.

Pat: Thank you so much, Valerie for being on the show. This has gone by really quickly and I'm delighted that you've been able to share with us your expertise as a corporate legal nurse consultant.

For our listeners please stay tuned. We'll have another episode next week. We appreciate you being part of this show, listening to our sessions and learning. Thanks so much and thanks for listening.

Related Product: Deciphering Operating Room Liability

You are working on a medical malpractice case involving the operating room. You wonder, “Is this a viable claim?” Do you know how to screen operating room cases for merit? Do you know the roles, responsibilities and special language of the operating room?

In our online training, you will gain insider information from an OR nurse, who will take you behind the OR door into the unique world of the operating room. You will gain confidence in your ability to recognize key operating room safety issues. You will

gain credibility with your attorney clients when you are reviewing operating room cases.

Learn more about operating room nursing liability by purchasing Deciphering Operating Room Nursing Liability at this link: http://lnc.tips/OR. Get a 25% discount on this training by using the code Listened in the coupon code box during check out.

Check out the online training and books at legalnursebusiness.com. Expand your LNC skills with our resources.

Explore coaching with Pat Iyer at LNCAcademy.com to get more clients, make more money and avoid expensive mistakes.

Join our continuing education program and get monthly training at LNCCEU.com. You'll get 2 online trainings each month designed to deepen your knowledge and skills.

LNP 49
Retained Objects After Surgery: Oops!
Pat Iyer

The patient leaves the operating room with a sponge, a clamp, or a towel inside. What is the impact on the patient? We've heard the stories of the patient's clamp that sets off the metal detector in the airport, but many patients find out about the presence of a retained object as a result of a medical change:

- infection (the biggest risk affecting nearly 50 percent of patients),
- a fistula,
- perforation of an organ, or
- a bowel obstruction.

Most commonly, the patient is readmitted to the hospital and has to undergo surgery to remove the retained object.

How do instruments and sponges get left behind? The highest risk is an emergency surgery – there is a *nine-fold risk*. With the focus on the saving the patient's life, counts of instruments can fall by the wayside. There is a *four-fold risk* when there is an unplanned change in surgery based on new findings or changes in the patient's clinical condition. Obese patients have a higher risk of instruments or sponges being lost in the body.

The risk of retained instruments is doubled when more than one surgical team performs surgery at the same time. The risk also increases when there is greater blood loss during the procedure.

There are several patient safety recommendations offered by the American College of Surgeons, The Food and Drug Administration, and the Association of Operating Room Nurses.

Recommendations focus on the methods of counting and reconciling discrepancies, the types of sponges used, the need to thoroughly check the wound before closing, and the documentation of counts.

In my experience hearing about these cases from attorneys, the surgical counts are

ALWAYS recorded as correct.

The Centers for Medicare and Medicaid Services took a stand on this problem by announcing it is no longer providing reimbursement for care necessitated by the retained surgical instruments.

Let's say the patient is fortunate and the retained object is discovered before she is discharged. In LNP 48, Valerie Lane discussed the risk management perspective of handling the situation. Independent LNCs and inhouse LNCs may be unaware of the steps the facility staff took to investigate the incident.

The best time for the facility staff to collect information about the adverse event is immediately after the event occurs and the patient has been stabilized to avoid more harm. Some facilities use techniques called *huddles* and *debriefings*. A huddle is a non-punitive, non-judgmental discussion to analyze the way an individual and team performed. It identifies areas requiring improvement. A huddle takes place immediately after the event occurs and the patient is stable. The huddle may result in identifying the need to secure equipment, materials, documents or other items involved in the incident.

A debriefing occurs within 24 to 72 hours after the event. It is a meeting of all the involved people and their leadership. The goal is to clarify what happened, to determine if there are continued safety risks and to develop plans to attack the immediate risks.

This meeting allows the team to discuss disclosure to the patient and family. They should also determine if the event needs to be reported to an external agency and investigated further with a root cause analysis.

Regulations and ethical standards *require* healthcare providers to inform patients of adverse events. The Joint Commission requires the licensed independent practitioner responsible for managing the patient's care, treatment, and services or his or her designee to inform the patient about unanticipated outcomes of care, treatment and services. This person is typically the attending physician.

The American Medical Association has an ethical code that also addresses this responsibility. It states that in cases in which a patient suffers significant medical

complications that may have resulted from a physician's mistake, the physician is *ethically* required to inform the patient of all the facts necessary to ensure understanding of what occurred. That standard went into effect in 2001.

Despite The Joint Commission's regulation and the American Medical Association's code, some patients do not find out about an error. We *know* as LNCs that disclosure does not occur all of the time. In fact, we know one of the reasons patients and families see a plaintiff attorney is because there was an adverse outcome and they want answers.

Why don't patients and families get explanations? Physicians and other healthcare professionals often chose to not report patient harm cases because they did not believe they were supposed to. They may have seen adverse events as just part of routine care.

There are other reasons why healthcare providers do not report errors:

- A sense of disbelief that a serious error really occurred
- Fear of punishment
- Productivity demands to keep up with the demands of a busy healthcare environment
- Fear of being sued
- Uncertainly of the clinical importance of the adverse event
- Lack of adequate reporting systems
- Lack of changes after reporting an adverse event

Let's get back to the case of the retained object. These are difficult cases to defend – retained instruments and sponges during *emergency procedures* are the most easily defensible cases. Analysis of damages centers around the effects on the patient from the retained instrument or sponge, which can be considerable. During discovery, obtain procedures for surgical counts. Determine if an incident report was completed. Work with attorney clients to develop questions to ask healthcare providers who were in the operating room at the time.

- Were the packages of sponges counted before the surgery to verify the number printed on the outside of the package was correct?
- Did the surgeon dismiss the incorrect count without re-exploring the wound?
- Did the nursing staff accept the incorrect count?

- Was there any sign of breakage of devices after they were removed from the patient?
- Were non-x-ray detectable sponges used?
- Were counts performed in an audible manner?
- When was the count performed in relation to closing the wound?
- Did the radiologist or the surgeon read the x-ray when the count was incorrect?

Make sure that all of the appropriate defendants are involved in the suit. In an interesting case reported in 2016, the plaintiff underwent surgery to remove gallstones. During the surgery, the defendant surgeon had to convert the laparoscopic procedure to an open one. The hospital nurses claimed they counted the sponges three times before the incision was closed. All sponges were allegedly counted and removed.

The plaintiff suffered from intermittent abdominal pain for *years* after surgery. *Seven* years after the surgery, a CT scan revealed a foreign body in her abdomen. She underwent laparotomy and removal of the sponge. It caused a fistula to develop. The plaintiff alleged the nurses were negligent in leaving behind the sponge. The defendant surgeon contended he relied on the sponge count from the nurses. The nurses also contended they diligently counted three times and that even if the count was off, the act of trying to count met the standard of care.

The plaintiff attorney did not name the radiologist as a defendant – the person who read the x-ray. Both defendants pointed blame at a non-party radiology company that reviewed films after the surgery and failed to detect the sponge. The jury found the nurses and surgeon not negligent.

Related Product

You are working on a medical malpractice case involving the operating room. You wonder, “Is this a viable claim?” Do you know how to screen operating room cases for merit? Do you know the roles, responsibilities and special language of the operating

room?

In our online training, you will gain insider information from an OR nurse, who will take you behind the OR door into the unique world of the operating room. You will gain confidence in your ability to recognize key operating room safety issues. You will gain credibility with your attorney clients when you are reviewing operating room cases.

Learn more about operating room nursing liability by purchasing Deciphering Operating Room Nursing Liability at this link: http://lnc.tips/OR. Get a 25% discount on this training by using the code Listened in the coupon code box during check out.

Check out the online training and books at legalnursebusiness.com. Expand your LNC skills with our resources.

Explore coaching with Pat Iyer at LNCAcademy.com to get more clients, make more money and avoid expensive mistakes.

Join our continuing education program and get monthly training at LNCCEU.com. You'll get 2 online trainings each month designed to deepen your knowledge and skills.