# The Legal Nurse Consultant as a Board of Nursing Expert Witness

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*Each state's Board of Nursing is an administrative agency whose mission is to protect consumers through the licensing of registered nurses and through the enforcement of the Nurse Practice Act. Each state's Board of Nursing is responsible for investigations and discipline of registered nurse licensees for violation of the Nursing Practice Act. The primary purpose of the enforcement program is to protect the public from incompetent, negligent, unsafe, dishonest, or impaired RNs. For the purposes of this article, the focus is the California Board of Registered Nursing (BRN). Further information regarding other states' Board of Nursing official titles, scopes of regulation, and enforcement policies can be found at the National Council of State Boards of Nursing Web site at* https://www.ncsbn.org/index.htm.

## INTRODUCTION

The legal nurse consultant (LNC) is well-equipped to assist Boards of Nursing (BRN) enforce Nurse Practice Acts (NPA). According to the American Association of Legal Nurse Consultants (AALNC), legal nurse consulting is the analysis and evaluation of facts and testimony and the rendering of informed opinions related to the delivery of nursing and other healthcare services and outcomes, and the nature and cause of injuries. The LNC is a licensed registered nurse who performs a critical analysis of clinically related issues in a variety of settings in the legal arena. The nurse expert

with strong educational and experiential foundation is qualified to assess adherence to standards and guidelines of practice as applied to nursing practice. (AALNC Scope & Standards of Practice, 2017)

As with any LNC referral, before accepting a BRN case the LNC expert witness must identify any conflict of interest regarding prior knowledge of the accused RN or a current employment relationship with the accused's employer. If upon initial review the LNC finds it impossible to be completely objective, the BRN should be contacted immediately so the case can be reassigned.

## THE PROCESS

The BRN can receive complaints about RN practice from many sources, including a patient or family member, employer, nursing colleague, or another member of the health care team. The LNC will first identify whether the nurse in question deviated from the standard of practice of nursing or committed unprofessional conduct. Secondly, the LNC will serve as an expert witness on behalf of the BRN at any hearing resulting from the investigation, including other experts.

In California, the BRN sends a written notification to the complainant within ten days after receipt of a complaint. They give priority to the most serious allegations, such as gross negligence/incompetence or patient abuse. Next, the Department of Consumer Affairs Division of Investigation (DCADI) does a preliminary investigation and then, if necessary, sends relevant patient records and pertinent information such as interviews conducted during the investigation. on to the LNC for further review and an opinion. If the LNC opines that there is no violation, DCADI closes the case and notifies the complainant.

Evidence that the accused nurse has violated the NPA warranting formal disciplinary action is resolved in informal or formal proceedings. Cases involving unlicensed or criminal activity are referred to the local district attorney for prosecution (CA BRN, Title 16, Chapter 14). If disciplinary action or criminal action is taken, the LNC expert witness may be called to testify at the Administrative Law Hearing. The BRN does not ask the LNC to determine what discipline the BRN should impose, if any.

The written opinion must be based solely on the information provided by the DCADI; however, the LNC should also refer to nursing texts and other practice reference materials that help to define accepted standards of registered nurse practice as part of case research. The final opinion should be based upon the accused RN's adherence to or deviation from the standards of care and what another reasonably prudent nurse with the same education, training, and experience would have done in the same situation.

## TYPES OF VIOLATIONS

Types of violations that RNs are accused of include standard of care issues, substantial relationship criteria issues, sexual misconduct, drug and alcohol violations, and criminal behavior such as dependent adult or elder abuse. The degree of professional misconduct will fall into one of three categories:

1. Gross Negligence: An ***extreme*** departure from the standard of practice.
2. Negligence: A departure from the standard of practice.
3. Incompetence: A lack of knowledge or ability in discharging professional nursing obligations.

When a case involves standard of care issues, the LNC must consider what are known in California as the *Standards of Competent Performance*. These state that an RN shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological, and physical sciences to applying the nursing process as follows:

1. Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team;
2. Formulates a care plan, in collaboration with the client, to ensure comfort, hygiene, and protection, and for disease prevention and restorative measures;
3. Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family, and teaches the client and family how to care for the client's health needs;

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4. Delegates tasks to subordinates based on the legal scopes of practice of the subordinates, and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates;
5. Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed; and
6. Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided (CA Code of Regulations, Title 16, Chapter 14).

The American Nurses Association Code of Ethics for Nurses addresses an LNC's unwillingness to be the one to find fault or negligence in a colleague. Its third provision states, "When nurses become aware of inappropriate or questionable practice, the concern must be expressed to the person involved, focusing on the patient's best interests as well as on the integrity of nursing practice (ANA, 2019)." The RN has a duty to act as a patient advocate, especially if holding oneself out as an LNC to provide case reviews for the BRN. Remember that the LNC may be the one to discover that the subject nurse did indeed conduct him/herself appropriately and that the accusations being investigated are false.

## CASE EXAMPLES

The following two cases are examples of BRN reviews. Not only do Boards of Nursing protect the public, but the Boards of Nursing can also rule in favor of nurses.

***Case #1:*** The BRN received an allegation that RN Maria was suspected of fiduciary abuse of an elderly patient, Ms. Kate. The allegation stated that RN Maria withheld funds from a check she cashed for her patient. The initial relationship between this RN and the patient is one whereby this RN was providing home health nursing services to the patient as a paid employee of Acme Home Health Services under a physician's order. The LNC expert witness reviewed the complete home health records in regard to Ms. Kate and the statements made to the BRN Investigator by RN Maria, Ms. Kate, and Ms. Kate's daughter.

On January 31, the patient began to receive skilled nursing services through Acme under a physician's order. The plan of treatment included RN visits two times per week to perform nursing assessments, blood glucose monitoring, and medication management. RN Maria made eleven of the twelve skilled nursing visits as ordered by the physician between the dates of January 31 and March 21. Medicare was appropriately billed by Acme for each visit.

*Remember: the LNC may discover that the nurse did indeed conduct him/herself appropriately and that the accusations being investigated are false.*

According to the numerous documented interviews by the police department, the California Department of Health Services (CDHS) investigator, the Acme supervisors, and the BRN investigator, some of the facts were consistent from both the accused RN and the patient, e.g., the amount of money in question. However, there were differences of opinions on the actual events, how they occurred, and what consisted of the verbal contract or lack thereof.

Ms. Kate stated that RN Maria was her home health nurse for the confirmed period of time and that, in February, she became bedbound due to illness. Ms. Kate needed cash in order to pay for some home repairs, so she asked RN Maria to cash a check for her. Ms. Kate wrote a personal check to RN Maria for $5,000. When RN Maria returned from cashing the check, she told Ms. Kate she needed to borrow $1,500, which she would repay. She then gave Ms. Kate $3,500. Ms. Kate stated she was scared to death and didn't want to fight with RN Maria. Ms. Kate denied ever having requested RN Maria to provide private duty care to her outside of the hours that Acme was contracted. Ms. Kate's daughter denied having been contacted by RN Maria for approval to provide private duty nursing to her mother for additional payment. There was no formal contract entered into by RN Maria and Ms. Kate for either private duty services to be rendered or for a personal loan. Ms. Kate had no recollection of RN Maria ever actually making any visits to her home outside of the expected skilled nursing visits arranged by Acme.

RN Maria agreed that she made visits to Ms. Kate as an employee of Acme for the confirmed period of time. Aside from her visits to the patient as an Acme employee, she also visited Ms. Kate as an "independent caregiver" but kept no record or documentation of the time spent in this private capacity. RN Maria reported that Ms. Kate asked her to provide the private duty services and that she checked around first to be sure that it was all right to provide private duty services to an Acme patient and that "some people" told her she was allowed to do this outside of normal Acme business hours. RN Maria also reported asking Ms. Kate's daughter if this private duty arrangement would be all right and that the daughter did not care how her mother spent her money. RN Maria stated that she cashed Ms. Kate's $5,000 check and that she not only gave her the money but had the patient sign a receipt to document the event (there was no such receipt submitted as evidence during any of the investigations). After Ms. Kate received the $5,000, RN Maria stated that the patient turned around and offered to give her back $1,500 as payment for caregiver services that were to begin on March 1. RN Maria stated that she made a few 15-minute visits in early March, during which she encouraged Ms. Kate to eat and checked her blood sugar. RN Maria reportedly called Ms. Kate a couple of times per day to check on her. At some time later, Ms. Kate called and asked for her money back and then reported RN Maria to her physician as having stolen the money.

It appears that, at some point after the police, employer, and CDHS investigations began, RN Maria delivered $1,000 to Ms. Kate in the form of a money order and reportedly chose to keep $500 as payment for private caregiver services that she felt she had rendered. Later, before a criminal prosecution hearing, RN Maria mailed a cashier's check in the amount of $500 to Ms. Kate.

The evidence presented during several investigations led the LNC expert witness to the opinion that RN Maria coerced Ms. Kate into either giving her or loaning her $1,500, with no formal agreement to render private duty services or to repay the money. RN Maria deviated from what the ordinarily responsible and prudent RN would have done when she:

- Handled a patient's funds while working as an employee for a home health agency. This was not within her scope of practice as an Acme employee.

- Entered into an informal agreement to provide private duty services outside of her employment with Acme, and if she did so, without any type of written agreement with the patient as to what services would be rendered and at what rate of pay would be compensated. Ms. Kate denied that this informal agreement ever occurred.
- Borrowed money from a patient, regardless of intent to pay it back or not.

> permits the elder or dependent adult to be placed in a situation in which his or her person or health may be endangered, is guilty of a misdemeanor.

This count was dismissed in the interest of justice and because RN Maria repaid the $1,500.00 she received from the patient. The LNC's final opinion was that RN Maria violated the Substantial Relationship Criteria as defined by the California Code of Regulations Section 1444, including subsection (c): theft, dishonesty, fraud, and deceit:

> A conviction or act shall be considered to be substantially related to the qualifications, functions or duties of a registered nurse if to a substantial degree it evidences the present or potential unfitness of a registered nurse to practice in a manner consistent with the public health, safety, or welfare.

The CDHS did its own investigation, substantiated the allegation, and turned over the case to the District Attorney's (DA) office for criminal charges. The criminal prosecution was of one count of Penal Code Section 368(e), which states that any person

> who, under circumstances or conditions other than those likely to produce great bodily harm or death, willfully causes or permits any elder or dependent adult, with knowledge that he or she is an elder or a dependent adult, to suffer, or inflicts thereon unjustifiable physical pain or mental suffering, or having the care or custody of any elder or dependent adult, willfully causes or permits the person or health of the elder or dependent adult to be injured or willfully causes or

***Case #2:*** The BRN received a complaint alleging that on August 1, RN Alison "assaulted" a terminally ill patient, Mr. Jones, under her care. The complaint was made by Mr. Jones' adult son, following Mr. Jones' death. The assault allegedly occurred when RN Alison placed a pain medication patch on the patient after he objected to the use of the patch. Additionally, it was alleged that the pain patch was used to keep the patient excessively sedated.

The LNC expert witness reviewed Mr. Jones' complete home health hospice records, as well as formal statements made during the BRN investigation by several of Mr. Jones' family members, RN Allison, and some of her hospice colleagues who had also been to Mr. Jones' home.

Mr. Jones was admitted into the hospice on July 11, on morphine sulfate-extended release tablets, liquid morphine sulfate, and medicinal marijuana. Several different nurses made home health hospice nursing visits several times per week. On July 18, the physician prescribed an increase in the extended-release morphine and the liquid morphine, and added lorazepam. On July 22, the hospice nurse noted that Mr. Jones was inconsistent with his pill organizer and use of pain medications, and she obtained an order for a fentanyl transdermal patch. On July 28, RN Sue made a visit and noted that the Mr. Jones had not yet begun using his fentanyl patch due to being fearful. However, RN Sue could not pinpoint the source of Mr. Jones' fear, documenting that he would continue to use extended-release morphine tablets until he was ready to use the fentanyl patch.

On August 1, RN Alison made her only visit to Mr. Jones. This weekend visit was requested by Mr. Jones and made by RN Alison who was on call. RN Alison documented that Mr. Jones was experiencing pain that was an 8 to 9 out of 10, yet he was able to ambulate. RN Alison observed that Mr. Jones seemed "spacey" and had difficulty following the conversation or answering questions. RN Alison applied a 25 microgram fentanyl patch per the physician's order, and the patient also took two extended-release morphine tablets during her visit. RN Alison had concerns with Mr. Jones' safety and reported her concerns to her supervisor.

On the August 2 visit, RN Joy documented that Mr. Jones' pain was in his stomach and liver area, and the fentanyl patch relieved severe pain. The fentanyl patch was continued along with oral liquid morphine for breakthrough pain. Mr. Jones continued to deteriorate from his terminal illness and had to be subsequently treated for a urinary tract infection. The hospice team documented their daily attempts to get the family more involved or to hire caregivers due to increasing safety issues. The hospice team documented many dysfunctional family dynamics and eventually made an Adult Protective Services referral. The ongoing problems continued throughout August and included many documented events of nonadherence to the hospice care plan by Mr. Jones and his family. Mr. Jones was noted to continue the use of the fentanyl patch and breakthrough narcotics without any adverse effects. On August 27, the hospice agency discharged Mr. Jones from service due to nonadherence with the hospice care plan.

The LNC expert witness noted that RN Alison had only one direct patient contact with Mr. Jones, on August 1. There was no indication that the patient refused the patch or verbalized any wish on that date to not use this pain medication. There was no evidence of excessive sedation resulting from its administration. As a result of the LNC's opinion that RN Alison's behavior and conduct met the standard of care expected of a competent RN, the investigation file was closed, no formal charges were filed against this nurse.

## CONCLUSION

State Boards of Nursing appreciate the special experience and expertise that LNCs provide when reviewing cases and acting as expert witnesses. They recognize that LNCs can play a vital role in their investigations of alleged professional misconduct and that the objective performance LNCs provide reflect well on the nursing community. For more information on becoming an expert witness in this capacity, contact your state's Board of Nursing and request an application.

## REFERENCES:


American Association of Legal Nurse Consultants (AALNC). Retrieved February 10, 2020 from http://www.aalnc.org

American Nurses Association, Code of Ethics. Retrieved February 2020 from https://www.nursingworld.org/coe-view-only

California Board of Registered Nursing, California Code of Regulations, Title 16, Division 14, Standard 1443.5 and 1444. Retrieved February 2020 from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=IA3A57DF0D48E11DEBC02831C6D6C108E&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)

California Penal Code Section 368(e). Retrieved February 2020 from http://www.harp.org/pc368.htm



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