Expert witness: role and benefits in improving wound care practice

KEY WORDS
- Expert witness
- Litigation
- Medico-legal
- NHS Resolution
- Wound management

Litigation is increasing year on year with an estimated cost of £1.95B in 2017/18, across the whole spectre of NHS care (NHS Resolution, 2017a), with wound prevention and management accounting for some of these costs. Becoming an expert witness can allow healthcare professionals to improve their own practice, particularly in relation to documentation. Shared learning in wound prevention and management can also improve practice and safety for patients. This article discusses the role of the expert witness, and the themes identified in failures regarding wound prevention and management whilst undertaking medico-legal work.

The Academy of Royal Medical Colleges (2019) states: *"The role of an expert witness is to assist the court on matters which are outside the knowledge and experience of the court and which, by virtue of their knowledge, training, or experience, are within the healthcare professional's field of expertise."* Tissue viability expert witnesses are needed to explain the standards of wound care that were applicable at the time to which the case relates and measure them against the practice that was provided by the healthcare professional. In order to establish whether a person with any particular expertise has been negligent, it is necessary to measure those actions against the standard to be expected of a reasonably competent practitioner and not against the best or worse practitioner in that field. This is known as the "Bolam test" (Eyre and Alexander, 2015).

The role of the expert witness provides a wealth of invaluable experiences for the individual and can enable the wider professional group to facilitate improved patient care.

Recent evidence (Guest et al, 2015a) established that there is a lack of holistic assessment of wounds, resulting in poor clinical outcomes with 47% of wounds remaining un-healed after one year. This has a huge impact on the quality of life and wellbeing of patients (Herber et al, 2007), posing a huge financial burden on the NHS together with possible litigation costs. NHS Resolution estimated a cost of £1.95B was spent on litigation in 2017/18 and increasing each year across the whole spectre of NHS care (NHS Resolution, 2017a), with wound prevention and management accounting for some of these costs.

The purpose of NHS Resolution is to provide expertise to the NHS to resolve concerns, ensure shared learning for improvement and preserve resources for patient care. NHS Resolution collect data regarding litigation cases, to ensure learning is obtained to improve patient safety (NHS Resolution 2017a; b; 2018). Case studies, which are available on the NHS Resolution website, are produced based on real claims, and if there are lessons to be learnt these are shared across the NHS, as well as commendation where standards have been met.

Working as an expert witness has recently been endorsed by the Royal College of Nursing (RCN) and Nursing and Midwifery Council (NMC) (Academy of Royal Medical Colleges 2019). The role can enable clinicians to identify persistent failures that occur in wound management, to inform colleagues and managers in order to improve the quality of care of patients.

THE ROLE OF EXPERT WITNESS

The author works as an expert witness for a medico-legal consultancy (Somek & Associates). One of the reasons for commencing work in this

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Box 1. Areas of failures amongst all wound types

Poor documentation
Frequent and inconsistent treatment changes; incorrect and inconsistent record keeping; inaccurate and inconsistent documentation of the anatomical site/s of the wound/s, inaccurate and inconsistent grading of wounds and illegible records.

Poor communication between healthcare professionals
Delays or absence of referrals to the multidisciplinary team, verbal or written communication and poor discharge planning.

Failure to obtain consent appropriately and escalate non-concordance issues
Failure to obtain informed consent, failure to provide the education necessary to understand risks, treatment interventions and/or illness, failure to escalate any non-concordance to the senior nurse, GP and safeguarding team.

Lack of holistic assessment
Absent or incomplete wound assessments, limb and Doppler assessments for lower limb wounds, risk assessments and/or pain assessment.

Failure to examine/investigate reasons for any deterioration of the wound/s, patient and/or pain.
Failures to investigate the possible reasons for any deterioration of the patient or their wound/s, such as infection, pressure, shearing, moisture-associated dermatitis and allergies. Failure to assess level and type of pain.

field, was to learn more about the litigation process and the themes associated with litigation cases in wound prevention and management, in order to improve the author's own practice and share the knowledge with her team and the wider community during educational events.

An expert witness can be involved in writing civil litigation (main area), criminal investigations/court, coroners' inquests and fitness to practice hearings such as those held by the NMC.

The author received the necessary training to write full liability and causation reports, to ensure compliance with the civil procedures rules (CPR). All training was provided by the medico-legal consultancy. Instructions were accepted on behalf of both the Claimant and the Defendant.

The cases involved various aspects of wound care across various settings, ranging from acute care, the community setting, primary care and nursing homes. Themes were collated regarding failures, applying the Bolam legal test, to meet the standard expected of any reasonable and responsible body of registered nurses, working in practice to prevent and/or manage wounds.

AREAS OF FAILURES

An array of issues/failures were noted across all settings of wound management, along with areas of good practice. Several areas were consistent throughout all wound types *(Box 1)*. The remaining issues have been segregated into the main wound types with themes being identified correspondingly *(Box 2)*.

Documentation

Documentation is an important component of wound care. It includes wound assessment, care planning, outlining aims of care, treatment interventions and evaluation, giving the rationale for treatment changes; recording any advice given to the patient/carer/family. Failures included: limited or no documentation regarding holistic and/or wound assessment; frequent and inconsistent treatment changes; incorrect and inconsistent record-keeping regarding bandages/treatment; inaccurate and inconsistent documentation of the anatomical site/s of the wound/s, inaccurate and inconsistent grading of wounds and illegible records.

DECLARATION
This article was supported by Somek & Associates

Box 2. Areas of failures according to wound type

Leg ulcer management

- Failure to determine a possible aetiology for the leg ulcer
- Failure to follow decisions through, e.g. obtaining swab results, ordering appropriate supplies
- Failure to work with the patient in decision making
- Failure to inspect both limbs
- Application of moderate/high-compression therapy without a limb and Doppler assessment
- Poor supervision of students/healthcare assistants applying support bandages
- Insufficient visits/changes of dressings according to individual need
- Inappropriate dressings
- Inaccurately and inconsistently documenting the anatomical site/s of the wound/s.

Pressure ulcer prevention and management

- Delays in/or failures to undertake risk assessments and review any risks
- Delay in taking preventive measures
- Delay or no documentation of a pressure ulcer prevention care plan
- Failure to increase pressure ulcer prevention vigilance when the individual deteriorated
- Failure to explore reasons for the pressure ulcer development
- Failure to undertake skin inspection consistently
- Failure to adapt a generic care plan to the person's individual needs
- Failure to provide education and regular advice to individual and carer/family
- Unsatisfactory communication with relatives
- Inadequate provision of special mattresses and equipment
- Inappropriate use of equipment such as hoists, slings and sliding sheets
- Inadequate education of staff
- Insufficient visits/changes of dressings according to individual need
- Inappropriate dressings
- Failure to submit a clinical incident form for grade 2 and above pressure ulcers.

Surgical wound management

- Poor observation and recording of developing infection and liaising with the surgical team
- Wound packing such as a fibre dressing remaining in situ
- Negative Pressure Wound Therapy (NPWT) foam/gauze remaining in situ
- Failure and/or delays in commencing NPWT following recommendation by the surgical team
- Omission of antibiotics and/or treatment
- Failure to increase visits/dressing applications when the wound deteriorated and/or increased exudate.

Malignant wound management

- Failure to refer to the specialist despite symptoms and/or failure of wound progression
- Failure to determine a possible aetiology for the wound.

Effective communication between clinicans

Good communication between healthcare professionals results in effective wound management. By contrast, inadequate verbal and written communication between clinicians were found to result in delays or non-referrals to the multidisciplinary team as well as poor discharge planning.

Consent and concordance issues

A recent judgement (UK Supreme Court, 2015) has highlighted the importance of obtaining informed consent, including the provision of advice regarding the risks of the treatment and/or of not having the treatment, ensuring the person is able to understand the medical and individual significance.

Healthcare professionals need to consider this judgement and obtain verbal and written consent for the planned interventions.

There were several litigation cases where education was not provided to the person regarding the risks of a treatment intervention or illness. There were failures to escalate any non-concordance issues to the senior nurse, GP and safeguarding team. Although some trusts do have non-concordance policies, these seem to be in the minority.

Holistic assessment

Inadequacies assessing patients holistically included failing to complete the minimum data set for wound assessment (Coleman et al, 2017), undertake limb and Doppler assessments for lower limb wounds, undertake risk assessments and pain assessments.

Investigating any deterioration of the wound, patient or pain

Failures to investigate the possible reasons for any deterioration of the wound such as infection, pressure, shearing, moisture-associated dermatitis and allergies. In the event of systemic deterioration of the patient, there were delays in determining the possible reasons and escalating to the medical team. Pain was poorly assessed with regard to the level of pain and the type of pain being experienced.

CAUSATION

Damages can only be recovered for the consequences arising from the incident and not for anything that would likely have occurred in any event (Eyre and Alexander, 2015). Examples of causation in the author's cases included: deterioration of infection resulting in sepsis and death; development and deterioration of a pressure ulcer; amputation of a lower digit or limb; deterioration of the wound/s; further surgical intervention; delayed rehabilitation; delayed diagnosis of a malignant wound resulting in metastatic disease and death.

DISCUSSION

The current emphasis on the NHS is to improve wound care assessment and management in the UK with initiatives such as the National Wound Care Strategy (Adderley, 2018a), The Legs Matter Campaign (Adderley, 2018b), and the wound assessment Commissioning for Quality and Innovation (CQUIN) (NHS, 2016).

The author identified areas of documentation and practice, which required improvement within her own clinical role and that of her team. Educational sessions were provided to the team and district nurses in the trust on both the medico-legal process and approaches to improve patient safety with particular emphasis on documentation. The author works independently providing education to clinicians regarding clinical aspects of wound management, the medico-legal process and uses case studies to demonstrate issues regarding liability to improve wound care for patients.

A recent document (Academy of Royal Medical Colleges, 2019), produced by professional medical organisations and endorsed by the RCN, sets out the conduct and standards expected of a clinician acting in the role of a witness. The professional bodies suggest that acting as an expert witness should be acknowledged as part of a healthcare professionals' revalidation and/or professional development plan.

CONCLUSION

Litigation in all aspects of healthcare is increasing every year (NHS Resolution, 2017a). An expert witness helps the legal team, and ultimately the courts or fitness to practice panels, to understand the issues of a case which are outside their knowledge and expertise. Undertaking expert witness work has enabled the author to identify themes regarding failures to meet the standard expected of any reasonable and responsible body of registered nurses, working in practice to prevent and/or manage wounds (Bolam test). These themes assisted the author to improve her own practice and documentation together with ensuring shared learning amongst healthcare professionals and senior management. NHS Resolution resolve concerns, ensure shared learning for improvement and preserve resources for patient care. Case stories can be found on the NHS Resolution website. Becoming an expert witness should be considered by healthcare professionals to identify areas for improvements in quality of care to ensure patient

safety and as part of their professional development plan for revalidation. WUK

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