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Starting an LNC Business From Scratch
Kimberly Flood

Join us on a virtual trip to Australia, a country, with some unique challenges in delivering medical care, where public and private healthcare systems coexist. Kimberly Flood, who has a Master's in Nursing and is a legal nurse consultant, also shares her experiences in building a practice and handling cases.

Check out what Kimberly has to say in this episode of *Legal Nurse Podcast.*

- How is telemedicine in Australia more advanced than in the U.S.?
- What are the main reasons for medical lawsuits in Australia?
- How do standardized practices affect the quality of health care?
- What is an effective answer to the statement: "I already have a paralegal"?
- How has the global pandemic affected LNCs' ability to network?

Patricia: Hi. This is Pat Iyer with *Legal Nurse Podcast*. As I have checked the statistics about the show, one of the things that I realized is that we have a significant number of listeners to our show in other countries. There are listeners in 80 countries right now, and one of the most frequently represented countries is Australia. I brought on to the show with me an Australian nurse, Kimberly Flood, who I met through being connected on LinkedIn, and discovered that she does legal nurse consulting in Australia.

Kimberly has been a registered nurse for 12 years. She is currently based in Victoria and has experience as a nurse in the rural and remote areas of Australia. She is currently working in critical care. She has a Master's in Nursing, and she is building her legal nurse consulting business. Kimberly, welcome to the show.

Kimberly: Thank you for inviting me, Pat.

Patricia: Can you give our listeners a little bit of a sense of how the healthcare system is set up in Australia?

Kimberly: The health care system is a public health care system. That means that there's access for all. The government does encourage us to have private health insurance, and to do that there is a tax offset to encourage public coverage. But, really, the aim is that everybody can

access it without having any additional costs to them, to make sure everyone gets the health care that they need.

A caveat with that, though, is that you can't always pick which hospital you go to and you can't always pick which healthcare provider is going to provide that care to you. Whereas if you do opt to have the private cover and to go under private health, you do have those options of choosing which hospital, choosing which doctors. Obviously, the wait lists aren't as long, so it's a bit more accessible. But just because you come under the public health system doesn't mean that you're going to miss out.

Patricia: I'm thinking that it's probably based, because of the British roots, it's based in the same system as in England and Canada, where I'm familiar with the two parallel tracks of the public and the private health care system.

Kimberly: Definitely. Definitely. Definitely follow on from that to make sure that everybody gets what they need here to keep the country healthy.

Patricia: And I know that Australia has some interesting and some significant challenges. There's a fairly large number of climatic changes in various parts of Australia, some parts are extremely hot. On my trip there several years ago, I learned about the part of Australia where many people live underground, because it is so hot on the surface of the land so that they are actually living under the earth. And then I think there was a lot of mining of minerals in that area as well. And lots of poisonous critters you have in Australia, spiders …

Kimberly: There are a lot of poisonous critters. There are a few snakes you have to watch out for. But with the background in rural and remote regions, it is quite interesting. Because, you know, you can be hours and hours from the nearest capital city. We've got an amazing organization called the Royal Flying Doctor Service, which allows for clinics to occur in our rural and remote areas. So, they'll fly out doctors, nurses, dentists, allied health staff members to provide those services.

Also, telehealth is really coming in with RFDS and other health organizations to make sure that there's a quality of care throughout. But RFDS also do some wonderful work transferring patients from the smaller hospitals or base hospitals into the city to get them to the care

that they need, particularly patients that maybe had a myocardial infarction, and they need to have an angiogram. They're the sorts of patients that will definitely be expedited out of those small towns into a capital city to receive the treatment needed.

Patricia: Yeah, I could see why that would be an issue because of the lack of access to care or, as you mentioned, many hours away. If somebody had an accident in the bush and they were three hours from the nearest town, how do you get that person the medical care that they need? And you see that, I'm sure, from being a critical care nurse working with patients who might have had an extended period of time before they got medical attention.

Kimberly: That's right. So, a lot of the smaller hospitals remotely, there might be only one or two registered nurses working there with no doctor cover. Some of these towns have specialist ambulance training, where they have volunteers in the town become volunteer ambulance officers to assist the nurses in those rural areas. And they generally have a four-wheel drive or a vehicle with four-wheel drive capacity to be able to go out to the properties or roadside to be able to attend to those sick patients, all the incidents that happen.

And most of the station owners have special chests full of medicine, so they can call the Royal Flying Doctor up, describe their condition, what's going on, and they can tell them exactly which medication they need so that they can start treatment before being in a physical area to receive that health care.

Patricia: Do you ever run into scope of practice issues? The phrase that you shared just now that got my attention was the nurse who has no covering physician. We have nurse practitioners in the United States who are master's level of people who've been taught to be able to treat patients, the less complex patients, without physician supervision, although it varies from state to state, whether that supervision is required. I'm thinking about situations where that nurse is the only trained professional in that geographic area and might be put in a situation of having to make a decision to diagnose and treat somebody without a backup physician. That is curious to me. Can you explain that a little bit more?

Kimberly: Sure. So, depending on which state you're in, in Australia, they all run their own different courses. So, like a first-line emergency course. And they often come with their own clinical practice guidelines that they need to follow. So, they're always available, and they're for most of the common illnesses and injuries that you might come across to at least to get that treatment started.

There is a lot of telehealth involved. A lot of the smaller hospitals actually have cameras set up in their little emergency department rooms. When they call the doctor, that doctor can actually physically see and zoom in onto the patient to be able to make an assessment and then guide the registered nurse to be able to treat that patient accordingly while they're waiting for retrieval to come to pick them up to evacuate them to a more suitable area.

Patricia: In some ways, you're way ahead of us with telehealth. We're just getting used to the concept here because of the pandemic, not being able to see a physician in person. And you've had much more experience with that as a country than we have and worked out some of those kinks that are befuddling us right now.

Kimberly: Well, interestingly, there was a rollout of a project in New South Wales, where everybody got the same defibrillator and monitor. So, what they're able to do through their internet connection is take an ECG, send it through to a receiving doctor, who can then look at that ECG and say, "Yes, that fits a STEMI diagnosis." And the registered nurse is given a check sheet to go through and make sure it's safe to administer thrombolysis to increase that door-to-needle needle time. So, that's one of the projects, which has been out for a few years now, to assist the nurses in providing timely care to those patients.

Patricia: Interesting. We know that healthcare systems are made up of people, and there's always the potential for error, for mistakes to be made. What are some of the common issues that you have seen in working in the patient safety area that plague the healthcare system? And what happens if a patient in Australia believes that a healthcare provider has made a mistake, and that person has been injured? What is the legal system like, first of all, to address those questions, and who pays for all of that?

Kimberly: So, we've got the Health Care Complaints Commission, which is available to anyone make a complaint. It's an independent body which then helps to investigate what the complaint was about, and to come up with a resolution for that complaint.

However, if someone feels that they've been harmed, either psychologically or physically, from a healthcare provider, they have three years to be able to make a claim for that injury. Most of the firms here operate under a no-win no-fee basis. So, they'll take on that case, they'll see if there's merit, if there is, proceed ahead with it. And that client doesn't have to pay until the end of the case. And then there's the payout, the law firm will take their portion of their fees and expenses, and then the rest will then go to the client.

If the case is unsuccessful, and they don't get settlement, or it's unsuccessful in court, then the client will not have to pay any legal fees for that case. In terms of some common issues, unsurprisingly, communication, is a is a big issue. And again, that comes in with the distances that we have, lots of different ways in health care, lots of people talking and passing on messages. So, instructions don't get through, or severity might not be escalated appropriately, or there's a misunderstanding from a senior of the severity because of how it was communicated. That's something that I see quite a lot.

And also, the recognition of the deteriorating patient is another factor, and how to manage that. There's lots of systems that are being brought into the hospital systems to improve nurses' abilities to recognize deterioration, and to help them with the escalation, but sometimes things get missed. Whether that's inexperience or something else that's happening on the ward, I'm not quite sure. But, definitely, those two areas of communication and deteriorating patient are big factors for harm to patients.

Patricia: I went to a conference, many years ago, in Melbourne when I was giving a patient education patient safety talk. And I remember sitting in the back of the room when a nurse from New Zealand was there. And she described how in her hospital, she was a Master's-prepared nurse who recognized the need for a rapid response team and worked with her hospital to implement this. And I believe that it was implemented in Australia fairly soon after that, even before other

countries picked up the concept. Are you seeing in the larger cities that concept of a rapid response team being in existence now?

Kimberly: There are rapid response teams, New South Wales Health rolled out a massive program, I think it was about 2012, on detecting the deteriorating patient with a color-coded observation chart, which basically said if the patient was in a yellow zone for their observations, they needed to be seen by a medical officer within a half an hour. If they're in the red zone, you need to call rapid response. And that was rolled out across the whole state. And that was standardized, which is great because it assists nurses when they move between facilities that the systems are exactly the same, the exact same process. So, there's less risk of deviation of the standards, and they know exactly what's expected of them.

Having recently moved to Victoria, it's a different system, and the hospitals are more siloed. And the government doesn't have as much oversight or direction for the health services of how they need to roll different programs out or how to do things. So, the hospital I'm currently at has a rapid response system in place which is quite robust. However, if I moved to another hospital in Victoria, I can't be guaranteed that it will be the exact same sort of system.

Patricia: The parallel arrangement here is that there are hospitals in the States that are owned by the same corporation. So, they will have uniformity within themselves. But they could be next to a hospital that is owned by a religious group, and that religious group, well, for example, the Catholic health system is very large in the United States, they can have a completely different system. So, that's more of the silo arrangement that you're describing.

And the challenge, from a patient safety perspective, is that if there's an incident that results in patient harm in a hospital that's part of the health system, then the risk management team will provide education after the fact, saying, "Hey, here's what happened. Here's what we need to do differently. Here's why we're changing this procedure." But that change and that knowledge stays in that hospital system. They don't share that information, necessarily, with the hospital next door that could be dealing with the same issue. And that fragmentation leads to a lot of lessons that are learned not being shared so that we can avoid those same incidents occurring to other people, even though

those patients may not be part of the same hospital system as where the incident took place.

Kimberly: I know that in New South Wales Health they have the Clinical Excellence Commission, which is part of the health system that covers patient safety and quality programs. All the root cause analysis investigations that occur at all the hospitals throughout the state need to be submitted through to them. And they have a system of collating all that information and putting it together. If they start to see trends, they'll actually issue out a patient safety alert or a newsletter for some incidents, and they highlight different cases that occurred to be released to the staff across the whole state, so that they're aware of the issues that are going on, which I think is a really excellent initiative.

And another initiative that they've come up with in their new incident investigation management system is the ability for clinicians to enter in information about issues that they've had and programs that they've created to be able to rectify those issues and share them on that platform across the whole state so people can learn from other places of what they've been doing to help improve patient safety, which is pretty impressive.

Patricia: It is the kind of knowledge that we do need to share so that individuals who encountered the same type of scenario know the preferred route, the standard of care, the method that has been identified as being much safer. Do you have widespread electronic medical records in Australia?

Kimberly: Again, it's state by state. New South Wales rolled out electronic medical records few years ago. Here in Victoria, however, I believe it's only a few of the big tertiary hospitals in Melbourne which have electronic medical records. But most of the hospitals are still operating on paper-based records, which has its pros and cons. But, again, you're still having problems with communication, particularly with that legibility side of things and being able to find the documents that you need when it's all paper based. And again, bits of paper go missing sometimes. It's not intentional, but crucial information can be misplaced.

Patricia: Is there any government push behind having everybody be on an electronic medical record?

Kimberly: Not that I'm aware of at this point in time nationally. I know that it was a priority for New South Wales to roll out, to have electronic medical records. But there's sort of a lot of discussion about how that's going to be funded and making sure that our technology is adequate to be able to have electronic medical records and to be able to store that data safely.

Patricia: I'm thinking about the benefits with providers being so widely dispersed in rural areas, how great it would be to be able to pull up a patient's medical record on a computer just as additional information for the providers who are making decisions on treatment.

Kimberly: It would make such a difference.

Patricia: You mentioned the legal system, and it sounds like it's operating on a contingency fee system. You also mentioned there was a commission or an agency that does, it sounds like, decision making on the validity of the case. Can you explain that a little bit more?

Kimberly: So, the commission, it doesn't affect the legal side of the complaint so much. It's more about trying to work out and establish what happens between the patient and the care provider, and like what outcome does that patient or the person who was harmed, what they want, like sometimes, it's as simple as being recognized that this happened and have an apology. Or they would like to see different processes changed within the hospital, that they can also, while they've got this complaint in with the Health Care Complaints Commission, they can also, concurrently, be seeking legal advice from a law firm to have legal proceedings to be able to claim for damages.

Patricia: So, you're a nurse who's interested in working in this field, and how do you connect with the attorneys who are handling the cases? I know you've done some work, and I know that it must not have been easy to get started, or maybe it was. Tell us about how you got involved in that first case.

Kimberly: Sure. So, it hasn't been easy. Something that I've come across quite a bit is we've got paralegals that can do this work for us, or we've got medical officers which review our documents for us. I sent a lot of cold emails and phone calls going out to explain exactly what I can do and how I can benefit their cases to be able to build a claim.

The first case that I managed to get was quite a lengthy set of records, spanning multiple hospitals, over about five years. And I was requested to do a chronology for that patient, to be able to say exactly what happened with his care throughout all those years, which I was able to do successfully and submitted it to the solicitor.

The feedback that I received from her was that it was very beneficial, and it definitely was helping with their case. And that it was really good, because they don't get the time to be able to look through and read through all of the documents. And they found it very helpful to have someone who knew what they were looking at, to be able to read through and pick out different bits and pieces that a paralegal might not have been able to do, or a medical officer might not have been able to look through, because they tend to look at the medical side of things and not so much as the policies, procedures, nursing, allied health care that's provided.

Patricia: I'm thinking five years' worth of records, that must have been an enormous amount of documentation.

Kimberly: It was enormous.

Patricia: You have to think you'd have to understand what the issues were to avoid getting bogged down into rabbit trails, because there would be so much documentation to go through.

Kimberly: Yes, I needed quite a lot of focus to pick out what the main issues were and where we were heading with this case, because there was a lot of social issues happening as well. And like you say, it's quite easy to fall down rabbit holes, which do chew up a bit of time when you could be focusing that on the actual facts that are needed for the case to be productive.

Patricia: Now, I'm assuming that you have, in Australia, the ability for patients to sue for medical malpractice as well as for personal injury cases, is that correct?

Kimberly: Correct. That's correct.

Patricia: If they get injured on the job, is there a way for them to recover for the injuries that they sustained while they were working?

Kimberly: There certainly is. There's a big area of workers' compensation] injury. I haven't done very much in that area. And that's something that I'm starting to look into and expand out into, to be able to get more clients. But that's certainly a big area in Australia for work.

Patricia: Tell us a little bit more about the resistance that you encountered, about, "Oh, we have medical officers or paralegals who can do that kind of work." How do you respond to that? And it's something that happens to nurses in other countries as well. It seems that many people equate paralegals and legal nurse consultants, many attorneys equate them. And if I've got a paralegal that I don't need a nurse. Can you talk with us a little bit about how you responded or how you see that as an issue and how you got around it?

Kimberly: After the first few phone calls, I realized that this was a trend developing, of speaking to solicitors and getting the response, "Oh, we've got paralegals that can do that for us." So, I really needed to go away and sit down and have a think about, this is something I'm going to keep encountering, so how am I going to respond when I'm approaching potential new clients to get them to engage with me and consider the services that I provide?

So, now when I speak to them, I say, "I understand that you probably have paralegals that do this kind of work for you," to be on the front foot. And then I explain that I'm a nurse. I'm medical, I'm not legal. I know the medical system. I know how it works. I can have a look through the notes, and I know exactly what I'm looking at. I know about the policies and procedures and the standards that need to be adhered to. Can you guarantee that your paralegals have that same sort of knowledge and can provide those details to you? And quite often my response to that is, "Huh."

Patricia: Very interesting.

Kimberly: S, I think that gets them thinking about what I can provide, in addition to what their paralegals can do for them, trying to sell that I'm the medical expert, and the paralegals are great with the law aspect of it. So, how can we work together and be a team to get the right outcome for their client?

Patricia: When I had those conversations with the attorneys, sometimes, I would say the paralegal is reading the medical record but might not understand the implications of what's in the record. Whereas, as a nurse, working behind the scenes, working in that clinical area, I can spot the fact or the phrase or the reference that might not be understandable to a paralegal.

Kimberly: Or what's missing as well.

Patricia: Yes.

Kimberly: A paralegal might not always know what's missing.

Patricia: And I've taught some courses, over the years, to paralegals when I've been at conferences, and they've talked with me about how frustrating it is trying to interpret medical records, because they could be sitting there looking up medical abbreviations every other sentence trying to put the pieces together. And you know when you look up medical abbreviations, there might be seven different interpretations of what those three letters mean. You've got to be able to put it in the right context to say, "Oh, yes, that's what that means." And the paralegal may not have that context and, therefore, spends a lot more time wading through records that you, as a critical care nurse, would look at and say, "Oh, yeah, that means blah, blah, blah, blah, blah," and you're done with interpreting that sentence.

Kimberly: Definitely, yep. So, that's the angle that I'm trying to go with to engage potential clients to take me on.

Patricia: What advice would you give to somebody who is going through the process that you're going through in terms of building your business and communicating with attorneys?

Kimberly: A big thing for me was to be able to have the confidence to be able to even reach out to make that call and answer that phone call. Have a bit of an idea in your head of common questions that they might ask you, and how you're going to respond to that so that you're prepared, so that you're not caught on the back foot is probably the biggest thing for me when I'm reaching out and trying to create some LNC work. I use, or I've been online quite a lot, looking at what other people are doing, particularly in America, because it seems to be a lot more

established. Looking at other people's websites, how they're set out, what sort of work they're doing.

I reached out to the American Association of Legal Nurse Consultants, which were lovely and were able to provide me with some resources, some webinars to watch to increase my level of knowledge. And also, on Facebook, I'm part of a Legal Nurse Consulting Facebook group, where people can jump on, ask questions, and people with experience can provide answers or give advice, which I think is really nice to be able to share. And if you are stuck, you know that it's not just you, there's other people out there that are having the same issues as you, and you can work through them together, which is really lovely.

Patricia: I think you're describing the value of a community and a source of information.

Kimberly: Definitely, definitely. It's really handy to have that being in Australia and finding it difficult to find other nurses doing the same type of work has been very difficult. But at least having that group on Facebook of people from the UK, and America, and Canada, it doesn't feel so isolating and it's lonely out there, knowing that you do have other people that you can bounce some ideas off that also have experience, that have been through what you've been through.

Patricia: And you said something in the beginning of this, about the confidence. You were making cold calls and cold visits to be able to connect with attorneys. That's probably one of the most difficult, soul-sucking activities you can get involved in, trying to connect with people who don't know you, who are a little suspicious, who are busy, who don't want to be bothered. You have to be able to take rejection in order to make those connections. I can remember one time I sat down to do some cold calls. And I remember my hand sweating as I was holding the phone, thinking, "How many of these calls am I going to have to make?" "No, we don't need you. "No, we don't want you."

I found it to be helpful to build my business by meeting attorneys at conferences when I exhibited, where they would come to me to find out about my services, as opposed to me interrupting them when they were working. And those conferences are now occurring virtually as opposed to in-person at this point. But presumably, we'll get back to

an in-person event at some point in the future. So, I commend you for making those calls.

Kimberly: I had planned to attend some conferences but then, of course, a global pandemic kind of got in the way.

Patricia: Yes.

Kimberly: Which is why I've ended up with the cold calls, cold emails. But now that I've got some work from different firms. They know me, they know the standard of work that I produce. They know the value that I can provide. Hopefully, I can use that. And they can help me with networking and get me in touch with other people who could use the help that I can provide.

Patricia: Have you gotten all those attorney clients through those cold calls, cold emails, cold approaches?

Kimberly: All of them, yeah.

Patricia: So, your activities have certainly paid off, Kimberly.

Kimberly: They have.

Patricia: Even though I talk about cold calls I hated doing it. You persisted, you're far better than I am in terms of being able to stick with that, and you're building your business by doing it.

Kimberly: My husband has now said to me, “High fives when you get paid work, not when you get an email back.” That I say like even if I get an email back at least they’re showing interest. Or if I get a phone call, they've read it and they're curious about what it is that I'm doing. And at the moment, in these really early stages of developing my business, like that's a huge win for me. So, I take that as a positive and that's what gives me energy to keep going.

Patricia: Yes, you do that case, you get repeat business from that attorney, that attorney tells another attorney in the firm about you, “Hey, you had used that nurse, Kimberly, for helping with your case. How can I get in touch with her?” And then that attorney tells a colleague, “You know, I've been working with this nurse and this is what she's done.” “Oh, well, how can I reach her?” And it builds. It doesn't happen

overnight, but it builds, and you're putting in the energy at this critical stage in your business to keep pushing and pushing. It's like pushing a rock up the hill, and at some point, you realize that you're on level ground, and then it becomes fun.

Kimberly: That's good.

Patricia: How can our listeners find out more about your services, Kimberly? Do you have a way that people can connect with you?

Kimberly: Sure. So, my business is called Access LNC Australia. We have a website which is www.accesslnc.com.au. And you can also find me on LinkedIn. My name's Kimberly Flood, so if you search me, I should be able to come up there. And I'm currently in the process of developing an Access LNC page on LinkedIn for people to be able to connect.

Patricia: Perfect. And Kimberly's last name is Flood, F-L-O-O-D. We've been talking with Kimberly Flood in Victoria, Australia about building her business. Be sure to come back next week, we'll have a new show, a new guest. Tell your Legal Nurse Consultant colleagues about *Legal Nurse Podcast.*

And be sure to sign up to receive the transcripts for these programs, so that you are able to go back and check out details and look up information that you want to refer to again.

Thank you so much, Kimberly, for being a guest on the show. I appreciate you staying up late. It's close to midnight for Kimberly, and we're recording this at 8:30 in the morning, Eastern time. And she's been gracious to be able to adjust her schedule so that she could talk with me and share her knowledge about legal nurse consulting in Australia.

Kimberly: Thank you so much for having me today, Pat.

Patricia: You're most welcome. It's been fun.

Patricia: This is Pat Iyer with Legal Nurse Podcast. I have just spent half an hour with Janice McIntosh talking about home health care cases. Janice is an expert witness in this area. Janice, can you tell our listener what are some of the key topics that we covered in your podcast?

Janice: So Pat, in the podcast, we talked about how I got started with homecare, and also about how I got started being an expert in home health care. And then we discussed the challenges of why homecare cases are different than regular med mal cases in hospitals or other settings, and also I shared some of my more challenging cases that I've seen.

Patricia: There's an infinite number of ways that people can get injured in life and behind the closed doors of your home, and Janice has seen a lot of things that have gone on behind those doors. Be sure to look for Janice McIntosh, her podcast on home health care, medical malpractice, or nursing malpractice issues. And we'll see you then.