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Winter 2022

THE JOURNAL OF Legal Nurse Consulting

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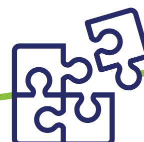

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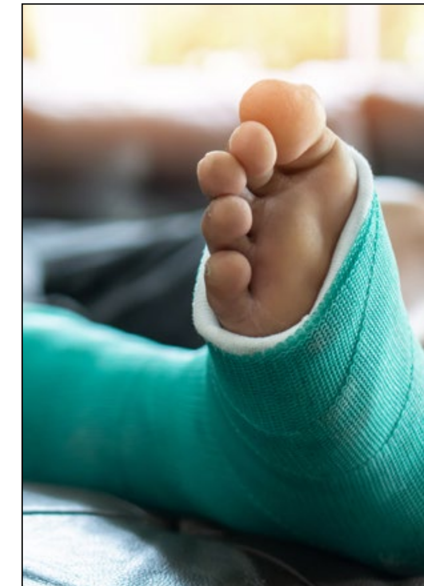

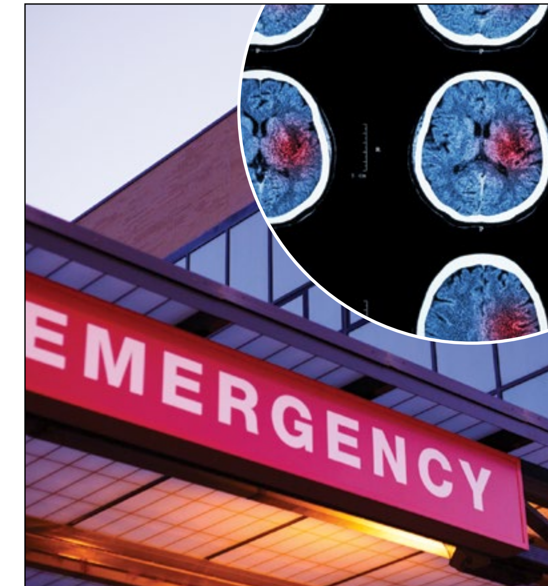

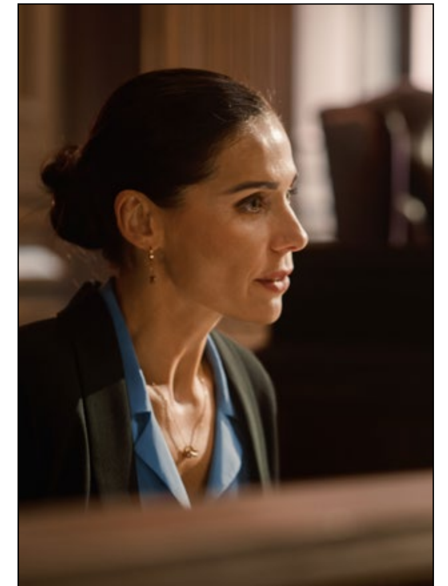

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The purpose of the *Journal* is to promote legal nurse consulting within the medicallegal community; to provide novice and experienced legal nurse consultants (LNCs) with a quality professional publication; and to teach and inform LNCs about clinical practice, current legal issues, and professional development.

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The *Journal* accepts original articles, case studies, letters, and research. Query letters are welcomed but not required. Material must be original and never published before. A manuscript should be submitted with the understanding that it is not being sent to any other journal simultaneously. Manuscripts should be addressed to JLNC@aalnc.org. Please see the next page for Information for Authors before submitting.

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The Journal of Legal Nurse Consulting (JLNC), a peer reviewed publication, is the official journal of the American Association of Legal Nurse Consultants (AALNC). We invite interested nurses and allied professionals to submit article queries or manuscripts that educate and inform our readership about current practice methods, professional development, and the promotion of legal nurse consulting within the medical-legal community. Manuscript submissions are peer-reviewed by professional LNCs with diverse professional backgrounds. The *JLNC* follows the ethical guidelines of COPE, the Committee on Publication Ethics, which may be reviewed at: http://publicationethics.org/resources/code-conduct.

We particularly encourage first-time authors to submit manuscripts. The editor will provide writing and conceptual assistance as needed. Please follow this checklist for articles submitted for consideration.

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Lisa Mancuso, BSN, RN, CCRN, CLCP, LNCC

President, AALNC

President's Update

Dear members and readers,

I am in Utica, NY as I write this message, getting ready to attend my uncle's funeral. Whenever someone close to me passes on, it makes me think about my own life and how fleeting our time here is on this beautiful planet. My uncle's death is coinciding with Autumn, the time of year when the abundance of nature gets ready for a winter nap.

This is a good time to recognize your achievements during 2022. I like to write down everything I accomplished during the year, even if it is the tiniest of triumphs. If you are a newer LNC, connecting with an attorney client, even if you were not retained for a case, is indeed an accomplishment! If you are a seasoned LNC, maybe you have become a mentor and are passing along your skills and experience to the novice.

The end of the year is also a time to identify the areas that did not quite go as expected. I write down the things I didn't accomplish and think about reasons why. Did I plan to do too much? Were my goals unrealistic? I like to think about what I did not make happen and consider whether it's still meaningful to me. If it is, I'll add it to my "to do" list for 2023, with clearer guidelines for achieving my goal.

"Practicing gratitude" is becoming a tired phrase, but this is the perfect time to thank the people in your life who have helped you along the way. Who supported you in reaching your goals? Who made you happier? Remember to send these folks a quick message to let them know they had a positive influence in your life.

You only live once, but if you do it right, once is enough.

– Mae West

At AALNC, we are feeling proud of some of the things we accomplished this year:

1. The launch of our new and improved website—I hope you have spent some time on the new platform and have become familiar with all the new enhancements.
2. With the new website comes the novice LNC shared interest group (SIG), moderated by past-president Mary Flanagan. This is a wonderful spot to ask questions, get answers, and share ideas with other LNCs in the early phases of practice.
3. The much-anticipated Inaugural Mentorship Class. By the time this goes to press, we will be choosing our first class of mentors and mentees. This has been one of our goals for quite a while. To see it come to fruition is very, very exciting. Our headquarters staff has been working hard to accomplish this, so we send out a huge thank you to Melissa Van Fleteren and her team.

We are so thankful to have you as a member of our professional home. Our organization would not exist without you. The community that we are collectively creating, supporting, and empowering is something all of us can be proud of for 2022, 2023, and beyond.

Wishing you all fabulous success,

Lisa A. Mancuso

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Editor's Note

Shawna M. Butler, DNP, JD, RN, CPHRM

Editor, JLNC

Dear readers and colleagues,

I would like to thank the AALNC Board for welcoming me as the new editor in chief of *The Journal of Legal Nurse Consulting.*

Let me introduce myself to the AALNC community - my name is Shawna M. Butler, DNP, JD, RN, CPHRM. As a nurse and attorney, I have always been interested in the intersection of the legal and healthcare systems. What better way to facilitate further dialogue and contribute to the healthcare law community than work as an editor in an area where my passions collide?

My path has not been a traditional one. After receiving my BSN, I worked in an outpatient clinic and then in an acute care telemetry unit at an academic medical center. After exploring future career options, I decided on law school. This was certainly not a typical path for most nurses that I knew. However, I did it to combine it with my nursing experience as opposed to leaving the profession. I wanted to advocate for nurses and patients. I did not know how that would look at the time, but I have thoroughly enjoyed the niche area that I have carved out along the way. I worked as a nurse all through law school. That was no easy task!

After law school and passing the elusive bar exam, I have had the privilege of working in many interesting areas. These include licensure defense, risk management, patient safety, regulatory/compliance and also education. I have worked with many great LNCs along the way. And through all of this I worked per diem as a clinical nurse on a medical unit to maintain my clinical skills. I also did eventually return to school and obtain my DNP degree as well since it opened up options for teaching in nursing programs.

Currently I live in Boston with my spouse and my dog Raven. Professionally, I split my time between patient safety in the hospital setting and teaching Legal, Ethical and Health Policy to nursing and healthcare students at the undergraduate and graduate level at my local University. I enjoy working with my "foot" a little bit in both settings. I have had a legal awareness column in a nursing journal prior to this. And now I am adding editor to that list. I am excited for this latest "leg" of my journey. What could be a more fitting next step than working with authors and journal committee members along with mentoring new authors on related healthcare/legal issues that I have spent my career focused on? I look forward to learning from and collaborating with the LNC community.

I would also like to acknowledge the *Journal's* editorial committee. They have been very welcoming and understanding during this transition. The *Journal* committee is an amazing group that supports the *Journal* in various capacities. They solicit articles, work with the authors, edit articles, engage themselves in the vision of the *Journal* and have certainly guided me in this new role! I would like to thank them for sharing their expertise and patience with me.

Thank you,

Shawna Butler

Shawna M. Butler, DNP, JD, RN, CPHRM

Stroke Management in the Emergency Room:

The Legal Nurse Consultant's Role

Marilyn McCullum, BSN, RN, CEN

Keywords: stroke, code stroke, infarct, nurse-driven protocol, emergency department, neurological assessment, NIHSS, thrombolytic agent, national standards of care, cryptogenic stroke

Time is of the essence when a patient begins to have symptoms of a stroke. Nurse-driven Code Strokes have made advances in getting care and treatment faster. A Code Stroke involves multiple disciplines such as the emergency department, pharmacy, neurology, laboratory, and imaging working seamlessly as a team to provide safe and accurate care for the stroke patient. The skilled legal nurse consultant is able to use the national standards of care to delve into the medical chart to ascertain if the patient's care was true to standards or not.

The hospital operator is heard throughout the building overhead paging, "Code Stroke, Emergency Department. Code Stroke, Emergency Department." The word "code" in the hospital setting strikes up anxiety; however, what exactly does a code stroke entail, and how can the legal nurse consultant successfully review and opine on the management of a stroke patient within the emergency room?

There are multiple categories of stroke. There may be infarcts, where a clot is blocking or limiting blood flow to certain areas of the brain. There may be a hemorrhagic stroke, which is bleeding due to a rupture of the blood vessel (Unnithan, et al, 2022.) There is also what is colloquially known as a "mini stroke," which is a transient ischemic attack (TIA). In TIAs, the symptoms often resolve without intervention, sometimes before the patient reaches the emergency room (within minutes), and with a full resolution of all symptoms within 24 hours (Coutts, 2017). The fourth type of stroke is classified as a cryptogenic stroke. Despite testing, there is no noted cause for a cryptogenic stroke; that is, there is no infarct, no bleed, or other etiology that can be determined (Serhal, 2019). In this article, the author will focus on the most common type of stroke: ischemic strokes (Tsao, et al, 2022).

Time is of the essence during a stroke. For non-hemorrhagic strokes with a last known normal time of 3 to 4.5 hours depending on risk factors, an intravenous thrombolytic agent may be given to preserve brain tissue (Powers, et al, 2019). Around the region of the infarct, also known as the clot, there is a tissue known as the penumbra. After the infarct, the penumbra receives sufficient blood flow to survive but not sufficient blood flow to function (Baron, Moseley, 2000). Giving an intravenous thrombolytic agent can aid in salvaging viable neurons within the penumbra therefore reversing some, and maybe all, symptoms of the stroke.

There are two modes in which a patient may arrive in the Emergency Department (ED): via Emergency Medical Services (EMS) or via private transport (walk-in). When a person arrives via EMS, the ambulance team notifies the ED team of the chief complaint that signals a potential Code Stroke. The ED should have a Code Stroke protocol that runs as efficiently as a Code Blue; in the case of an EMS arrival, the protocol is initiated prior to the patient arriving at the hospital. A gurney with capability to weigh the patient should be prepared and ready, and at least one RN should be at the bedside upon arrival. The goal is to be seen by the ED provider within ten minutes and to have a computed tomography (CT) scan within 25 minutes of arrival.

However, who activates this protocol? Research has shown that standardized, nurse-driven Code Strokes that permit the nurse to order imaging, blood tests, and initiate a neurology consultation greatly improved the door-to-provider time (Olson, et al, 2022) and the time to imaging (Yang, et al, 2019). Therefore, the astute emergency room nurse knows to signal a Code Stroke if the patient fails any of the tests based upon the BE-FAST mnemonic: balance, eyes, face, arms, speech, and time (Aroor, et al, 2017). This algorithm should be initiated in triage when a nurse suspects a possible stroke based on the patient's chief complaints. Once the patient is taken to the designated area for suspected stroke patients (whether that be a room, hallway, or even the interior ambulance bay), a full stroke scale should be performed to determine the extent of the patient's neurological status. The National Institutes of Health Stroke Scale (NIHSS) score is considered the gold standard for assessing the severity of the stroke (Glidden, et al, 2021), and the emergency room nurse should be proficient with these tests and complete their NIHSS certification annually to stay up to date.

If the patient meets the criteria to continue the Code Stroke, then blood tests should be drawn and run stat, a bedside glucose test should be obtained, the neurology provider should assess the patient either in-person or via telemedicine, and the patient should go to imaging with an RN on cardiac monitoring. The CT scan takes priority over all of the other required tasks. The other tasks, such as the neurology consult and a full NIHSS assessment, can wait until the CT scan in order to achieve the goal of CT within 25 minutes of arrival. The pharmacist should be alerted to be ready with the intravenous thrombolytic agent if the provider(s) decides the patient meets the qualifications and none of the absolute exclusion criteria to receive this medication. It should be noted that blood test results should not hinder the administration of this medication, as the goal is to receive the medication within

This activity is designed to increase understanding of emergency patient care when suffering stroke symptoms. Nurses need to be able to identify stroke and when to implement a Code Stroke to involve the multiple disciplines and treatment necessary to provide care for stroke patients.

Upon completion of the learning activity the learner will be able to:

a. Identify national standards of care for stroke management in the emergency room.
b. Recognize the salient points the LNC should look for when doing a medical review on a stroke patient.
c. Identify the importance of nurses calling a Stroke Alert or Code Stroke Protocol and criteria patients must meet.

The author, reviewers, and nurse planners all report no financial relationships that would pose a conflict of interest.

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As a legal nurse consultant (LNC), it is important to be knowledgeable about the national standards of care regarding stroke patients.

60 minutes of arrival (Vanhoucke, et al, 2019). Vital signs should be obtained per hospital protocol, and the patient should be on a telemetry monitor for the duration of the Code Stroke (even in imaging).

As mentioned above, an intravenous thrombolytic agent may be given in certain cases of stroke. If this medication is given, the emergency room nurse should be performing blood pressure checks and neurological assessments every 15 minutes during and after the infusion for the first two hours, then every 30 minutes for six hours, then hourly until 24 hours post-thrombolytic infusion (Philip-Ephraim, 2017). The patient who has received a thrombolytic agent will go to the intensive care unit or be transferred out to a hospital with a higher level of care depending on the facility's protocol.

The patients who do not receive the thrombolytic agent will typically be monitored per the neurologist's recommendation, which includes checking vital signs and performing neurological assessments every two to four hours. If there is any increase in the NIHSS, the emergency room nurse is responsible for reporting this change to the provider, as a second Code Stroke may be called.

As a legal nurse consultant (LNC), it is important to be knowledgeable about the national standards of care regarding stroke patients. Age should not be a deterrent to calling a Code Stroke, nor should assumptions be made without following the protocol (i.e., the ED provider stating the patient has an atypical migraine without consulting neurology or obtaining a CT in a patient with unilateral weakness).

What salient points should the erudite legal nurse consultant look for when doing a medical review on a stroke patient? The following should be considered:

- A BE-FAST score performed by the triage nurse
- The Emergency Severity Index (ESI) score assigned by the triage nurse
- The time the Code Stroke was called (if it was called)
- Time seen by the ED provider
- Time seen by the neurologist
- Time of first set of vital signs (and evaluation of the results)
- Bedside glucose test
- Initial NIHSS
- Intravenous (IV) line placed, preferably at least one large-bore (20G or larger) in the antecubital
- Time labs drawn
- Time patient taken to CT
- RN with patient during imaging
- Vital signs documented during transport to imaging and back to ED per hospital protocol
- Time of IV thrombolytic, if medication given
- Double-check with 2 RNs or with RN and pharmacist of thrombolytic prior to administration
- Time patient back to ED
- Repeat NIHSS per protocol
- Repeat vital signs per protocol
- Swallow screen per protocol
- If any changes in vital signs or NIHSS, documentation that the provider was made aware
- Documentation of patient departure from ED with last set of vital signs
- "Hand-off" NIHSS from bedside RN to receiving RN

This list is not comprehensive, but it may be considered a decent starting point to focus the legal nurse consultant in perusing the small details that may be lost in a mountain of documentation. The LNC knows that these details, though they may seem trivial, can actually steer the course of the patient's entire hospital stay.

When might a patient fall through the cracks? As mentioned above, age should not be a deterrent in calling a stroke alert. A stroke can happen at any age, so ED nurses should be accustomed to and comfortable with calling Code Strokes on young people if they meet the criteria. Patients also get missed when bias comes into play. For example, a person with a history of migraines may arrive in the ED with unilateral weakness. Certain providers may feel justified in diagnosing an atypical migraine without following the Code Stroke protocol; however, without performing imaging and involving neurology, this could be a devastating mistake. Drug abusers may be subject to bias, as well. Other mistakes are seen when the NIHSS isn't performed correctly or on time, when the Glasgow Coma Score or "slim" neurological assessments are performed instead of the complete NIHSS (Nye, et al, 2018), when the NIHSS changes and the provider is not notified, and drastically different neurological assessment scores when a new RN assumes care of the patient (hence why a hand-off NIHSS is pertinent).

Stroke is a diagnosis of exclusion. There are many different wheels in motion during a Code Stroke with multiple disciplines involved; however, the well-trained LNC is able to demystify and detangle potentially messy documentation for the attorney to determine if the Standard of Care was met. By scrutinizing even the smallest details, the LNC can successfully opine the case at hand without compromising their integrity as an expert, because as it is often quoted, "the devil is in the details."

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SUGGESTED LINKS

- Link to Stroke Protocol by AHA https://acls-algorithms.com/adult-stroke-algorithm/acls-stroke-protocol-step-2/
- Link to Image of Stroke Types https://www.cdc.gov/stroke/about.htm
- Image for BE-FAST https://bestcare.org/blog/20210503/it-stroke-time-be-fast
- Thrombolysis Contraindications (have to scroll down) https://emcrit.org/emcrit/acute-ischemic-stroke-1/
- Timeline of Stroke Management (have to scroll down) https://recapem.com/update-on-management-of-acute-ischemic-stroke-in-the-emergency-department-2/
- NIHSS https://pbrainmd.wordpress.com/2015/05/04/nih-stroke-scale-nihss/

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Introduction to Pain and Suffering Reports

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Keywords: Pain, suffering, FRE 1006, injuries, treatments, outcomes, summary, report, expert fact witness

The legal nurse consultant (LNC) prepares several types of work products for the attorney client, including chronologies, case analyses, medical cost projections, and life care plans. Attorneys use the Federal Rules of Evidence (FRE) 1006 report (also known as a "pain and suffering" report) to summarize their client's medical records. The purpose is to highlight the client's injuries, treatments, and outcomes of the medical care in response to their injuries. There are myriad ways to prepare a pain and suffering report; this article is an introduction to the purpose and process of preparing such a report.

WHAT IS PAIN AND SUFFERING?

Cornell Law School defines pain and suffering as "the physical discomfort and emotional distress that are compensable as noneconomic damages. It refers to the pain, discomfort, anguish, inconvenience, and emotional trauma that accompanies an injury" (Cornell Law School, para 1, 2020). In some states, this also includes the loss of enjoyment of life.

Individuals sustain injuries in a variety of ways, including motor vehicle accidents, slip/fall events, recreational misadventure, and medical malpractice. Some studies suggest that medical errors may account for as many as 251,000 deaths per year in the United States (Anderson & Abrahamson, 2017). Personal injury and medical malpractice claims fall under the umbrella of tort law. A tort is "an act or omission that gives rise to injury or harm to another and amounts to a civil wrong for which courts impose liability" (Cornell Law School, para 1, 2020). Tort law protects and compensates people who have been injured by this negligence.

FEDERAL RULES OF EVIDENCE 1006

Frequently, injuries lead to a lifetime of treatment, surgical and interventional procedures, pain, suffering, and even death. Medical records for such cases can be voluminous. Federal Rules of Evidence 1006 recognizes this and states, the "proponent may use a summary, chart, or calculation to prove the content of voluminous writings, recordings, or photographs that cannot be conveniently examined in court" (Federal Rules of Evidence, 2022, para 1). Thus, an attorney will retain the LNC to summarize the plaintiff's medical records in a concise and efficient report. The 1006 report is casually known as a "pain and suffering report."

THE LEGAL NURSE CONSULTANT AS A FACT WITNESS

The LNC who prepares a pain and suffering report is considered a fact witness. A fact witness can be anyone who is knowledgeable of the facts of the case through direct participation or observation (Trial Laws, 2019). The LNC's task is to summarize the plaintiff's medical records while educating the jury about the injuries and subsequent treatment.

Typically, a fact witness is not compensated for testimony while an expert witness is entitled to compensation for their participation and work on the case. In the instance of FRE 1006 reports mentioned above, Iyer describes the role of the LNC as an "expert fact witness" (2003). Iyer clarifies that the expert fact witness can testify about the pain and suffering documented in the medical records (2003). In this situation, the LNC is using their expertise to explain the facts of the case with a focus on the plaintiff's injuries and treatment.

It must be stated the expert fact witness is not offering an opinion on standards of care, the delivery of care, or identifying breaches in the standard of care. The role of the expert fact witness is to summarize the medical records without proffering an opinion of the care provided to the plaintiff.

PURPOSE OF A PAIN AND SUFFERING REPORT

By the time the attorney retains the LNC to author a pain and suffering report, the attorney already has a theory for the case and has developed strategies to present the case to the jury. The pain and suffering report can be a significant investment for the attorney because of the amount of time it takes for the expert fact witness to review the records and prepare the report.

The attorney uses the LNC's report to provide the jury with an account of the plaintiff's injuries and subsequent treatment. In essence, the LNC is telling the plaintiff's story because frequently, the plaintiff is unable to speak for themselves because of their injuries. The attorney hopes to persuade the jury to agree with their assessment of the plaintiff's non-economic damages. Pain and suffering reports are especially useful for the plaintiff who has endured a catastrophic injury. Such circumstances often cause the plaintiff to sustain lifelong complications and even death.

The LNC is summarizing the medical records in their entirety. These records are often voluminous. (This author has summarized medical records of more than 30,000 pages.) Thus, the expert fact witness must have excellent verbal and written communication skills. Nurses are known for their ability to educate patients and their families. When preparing a pain and suffering report, the LNC is using the report to educate the jury about frequently complex medical diagnoses and procedures.

ORGANIZATION OF THE PAIN AND SUFFERING REPORT

As stated earlier, there are many ways to approach the preparation of this report. The LNC will want to make sure the contents of the medical record are summarized in a clear and organized manner.

A sensible start to the pain and suffering report begins with a list of all the medical records the LNC reviewed. The list should state the providing entity, dates included in the medical records, and the number of pages in each file.

For example:

1. Community Hospital, May 15, 2020-September 29, 2020 (3,400 pages)
2. Rehabilitation Center, September 29, 2020-December 12, 2020 (7,100 pages)
3. Hospice Home Care, December 12, 2020-January 2, 2021 (450 pages)

Include a list of the plaintiff's past medical history (PMH) and past surgical history (PSH) followed by a paragraph that describes the plaintiff's condition prior to the injury or event. This is an opportunity for the jury to learn about the plaintiff at a more personal level.

Example:

"Mr. George Pepper was a 57-year-old man on May 15, 2020. He was employed full time as a computer software engineer. Mr. Pepper was married to his wife of 31 years, Mary Beth. They lived in a two-story home with a large yard. Mr. Pepper was affectionately known as 'Mr. Fix-it' in their neighborhood. The Peppers had three children and welcomed their first grandchild two weeks before he was injured in the motor vehicle accident."

The attorney uses the LNC's report to provide the jury with an account of the plaintiff 's injuries and subsequent treatment. In essence, the LNC is telling the plaintiff 's story because frequently, the plaintiff is unable to speak for themselves because of their injuries.

Following this introduction, the LNC will want to provide a summary of events in chronological order. Within the contents of the summary, the expert fact witness will explain the injuries and treatments. For example: "Mr. Pepper suffered a cardiac arrest and required cardiopulmonary resuscitation." This is when the expert fact witness explains a cardiac arrest and the activities involved in resuscitation.

> *"The doctor inserted a breathing tube during the Code Blue. (This is known as endotracheal intubation in which the doctor inserted a tube down Mr. Pepper's mouth, into his trachea. The trachea is the large airway from the mouth to the lungs, also known as the "windpipe." The breathing tube is used to establish and maintain an open airway.)*

The LNC may want to use an illustration of intubation to further explain the procedure.

The LNC should explain every injury and procedure in "plain English".

For example:

> *"Because Mr. Pepper was intubated, he required suctioning of his endotracheal tube." (Suctioning involves inserting a catheter into the tube, then withdrawing it while applying suction to remove sputum or other secretions that are in the lungs. Suctioning can cause gagging and coughing.)*

Did the plaintiff require a urinary catheter or arterial blood gases? Did the plaintiff need blood cultures? A PICC line? Dialysis? The LNC should describe these procedures in detail so that the jury understands as laypeople what happened during the course of hospitalization and treatment.

Many times, health care clinicians inflict pain (noxious stimuli) to determine a patient's level of consciousness. This can be a hard concept for the layperson to understand. The LNC must explain to the jury how frequently the plaintiff endured the administration of noxious stimuli.

Date	Pain Medication	Doses per Day	Comments
5/15/2020	Morphine 2 mg IV	8 doses	Pain score 7-10/10
5/16/2020	Dilaudid 0.5 mg IV	9 doses	Pain score 8-10/10; MD notified of frequency of med administration.
5/17/2020	Dilaudid PCA	multiple	Changed delivery method to allow self-administration of pain medication.

Figure 1: Sample Table

Many studies suggest that even when sedated and receiving analgesia, patients still feel pain. Indeed, sedation may mask uncontrolled pain for intubated patients and prevent them from communicating this to a nurse (Clukey, et al., 2014). This is important information for the jury to understand.

COMPELLING DATA TO INCLUDE

While going through the medical records, the expert fact witness will want to search for information that describes the plaintiff's condition. Some things to consider:

4. Pain scores
5. Pain medications
6. Reports of depression or despair
7. Episodes of crying, agitation, or combativeness

Tables and charts can be helpful. It is not necessary to state every administration of morphine, but using a table is a convenient way to inform the jury of the plaintiff's pain.

A PICTURE IS WORTH A THOUSAND WORDS

Photographs can be a powerful way to illustrate the plaintiff's injuries. Family members often take pictures of their loved one during a hospitalization. The LNC should ask the attorney to provide these photographs if they exist. A picture of the plaintiff intubated, on a ventilator with an arterial line, chest tubes, a nasogastric tube, and in wrist restraints will have more of an impact than the words alone.

Hospital photographs are also useful. Wound care providers frequently take pictures. If a pressure injury starts out as a stage one but becomes a stage four, photographs that document the progression of the wound can have a profound impact on the jury's understanding of the plaintiff's suffering.

CONCLUSION OF THE PAIN AND SUFFERING REPORT

If the plaintiff died, a description of their death is necessary. The LNC will want to explain to the jury what occurred.

> *Example:*
>
> *"Mr. Pepper's family decided on comfort care only and the discontinuation of the Impella. Mr. Pepper's nurse medicated him with intravenous Ativan and a fentanyl infusion. At 12:39 p.m., all vasoactive medications (medications for blood pressure) were discontinued and the Impella device was turned off. Mr. Pepper died at 12:54 p.m. with his family at his side. The hospital chaplain was present to provide emotional support for the family."*

The conclusion of the pain and suffering report is an opportunity to review all the plaintiff's injuries and the medical interventions that took place. This list might be extensive; here is a brief example:

1. **Endotracheal intubation:** *Mr. Pepper was intubated for 30 days; even after successful extubation he required a tracheostomy and was never liberated from the ventilator...*
2. **Bilateral wrist restraints:** *The medical record reflected Mr. Pepper's emotional disturbance to his situation by attempting to pull at and remove his medical devices. His wrists were restrained for 68 days. Restricted movement causes both emotional and physical distress. Mr. Pepper was not able to adjust his own position or able to perform something as minor as scratching an itch on his nose. Restraints can be frightening and contribute to a person's loss of control.*
3. **Oral gastric tube: (OGT)** *This tube is inserted into the mouth and passed into the stomach for feeding, delivery of medications, and occasional gastric lavage. In an intubated patient, such as Mr. Pepper, this tube is generally secured to the ETT, creating an object that is approximately 1.5" in diameter within the patient's mouth. An OGT is only meant to be used for a short period of time (generally less than two weeks) because it can cause trauma, infections, and ulcerations of the mouth, throat, esophagus, and stomach. Mr. Pepper's tube remained in place for 33 days. He sustained injuries related to this procedure, including a bleeding ulceration of his esophagus.*

SUMMARY

The LNC prepares several types of reports for the attorney-client. The pain and suffering report is an opportunity for the LNC to bring nursing expertise along with a comprehensive understanding of the plaintiff's condition to inform the jury of the noneconomic damages the plaintiff endured.

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Our First Year as Legal Nurse Consultants (LNC)

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Keywords: New Legal Nurse Consultants, Advice, Mentors, Business Growth, Marketing, Business Startup, Ethics, Networking, Expectations, Legal Nurse, New LNC, Start-up business, SCORE.

At our first annual business earlier this year, we were reflecting on our journey as first-year LNCs; things that went well, things that we wished we knew earlier, and valuable lessons from things that went wrong. We know there is much interest in becoming an LNC, but a lack of information about what to expect in your first year exists. Mustering our courage, we endeavored to write an article sharing some of the most valuable lessons we have learned over the past year.

START-UP

Welcome to the fantastic and never-boring world of legal nurse consulting! Our initial advice for you is to research and vet the program you are thinking of pursuing. Ask people who have attended if they would attend again. Inquire about the pros and cons of the program, cost, and post-completion services available. Do not rely on unknown internet reviews. Unfortunately, we did not do our due diligence and lost considerable time and money.

Our second piece of advice is to figure out your niche as soon as possible. What makes you unique? Where does your passion drive you? What do you have that no one else has? This foundation will allow you to start carving out your little space in the LNC world.

Establishing your niche will help guide your business plan and operational budget, which will help define your target market, what emails to send, and which conferences will be most beneficial. At the end of the article, we have included some helpful references for finding your niche and mentorship and coaching.

Before marketing, it is beneficial to have an up-to-date resume or Curriculum Vitae (CV). Most attorneys we worked with requested them initially, so now we have the most current CV on all our electronic devices. Many LNCs require them when applying for a contract position. If you are interested in pursuing expert witness work, you must also have a resume or CV. Having an up-to-date resume or CV available will ensure you can quickly respond to LNC opportunities and will significantly reduce your stress. Similarly, ensure your fee schedules are up to date. Dating your resume or CV and fee schedule will help you keep track so that you have a historical record if you choose to increase your fees.

FROM NURSING TO BUSINESS

Running a business is where we see many LNCs getting off track. So many of us were ready to leave the bedside after COVID that many jumped into the LNC world. So here is our first piece of advice about the business side of things – get professional help. Many professional service providers (Certified Public Accountants, Lawyers) offer free consultations. The second piece of advice is to develop a business plan. Your business plan will help you stay on track when things get scary and prevent you from going down the rabbit hole, which will always cost you time and money. You will also need an operating budget. Conference attendance, conference booths, monthly software costs, phone upgrades, gas for site visits, advertisements in magazines, new software, and your salary all cost money and should be included in your operating budget.

Establishing your niche will help guide your business plan and operational budget, which will help define your target market, what emails to send, and which conferences will be most beneficial.

Your business plan and operating budget ensure your business grows and thrives.

Resources available for small business owners include your local chamber of commerce, online support groups, community college classes, and many podcasts and free webinars. Another fantastic resource is the Service Corps of Retired Executives (SCORE) which provides accessible business mentoring. SCORE has local chapters and volunteer entrepreneurs from all industries, which offer a unique perspective on running a small business.

THE ETHICS OF LEGAL NURSE CONSULTING

Unfortunately, as with all careers, some people will take advantage of new LNCs, and we think we should address this, so it does not happen to you. How do we know? It has happened to us. One of the first examples of unethical behavior we saw entering the LNC world was individuals charging substantial amounts of money for LNC mentorship when they were new to the business. Mentorship is free from many outstanding, successful, long-term LNCs. If you choose to pay someone to be your mentor, vet them thoroughly.

The second unethical behavior is being selected for expert work only to find the LNC referring you now wants a percentage of your hours worked after the expert report was submitted to the law firm. If you choose to operate under this business plan, inform the LNC before submitting them for expert consultation. While some companies connect experts to attorneys, these fees are discussed before any work is completed.

The third unethical behavior is stealing other LNCs' work products and presenting them as your own. Unfortunately, there has been an upswing in this behavior in the past several months. Everyone is new at one time or another. Not having sample products is not the end of the world, so rather than put yourself in a compromising position, be honest. Tell the attorney you do not have any samples, or better yet, create one yourself. Most nurses have that one story of negligence or malpractice that changed their practice, so they use that as the inspiration for a case analysis. We think you will surprise yourself with how creative you can be. Remember to redact any protected information.

The final unethical situation we have encountered is independent contractors attempting to hijack work from the hiring LNC. One of our colleagues shared an experience in which one of their independent contractors called their long-time attorney and told the attorney they would be handling all their cases now. Of course, the attorney informed the hiring LNC, who was shocked. Many of us have established relationships with our clients that we have worked long and hard to secure and long and hard to maintain. As tempting as this may be, undermining this relationship is unprofessional, unethical, and potentially financially devastating to your business. The LNC world is small, and it hurts us all when you conduct yourself in this manner.

MARKETING

Social Media – social media is about building relationships and investing in social media platforms comes down to a personal choice based on your business plan. While many LNCs find meaningful professional relationships on social media, others struggle with finding their footing. Only you can decide what is worth your time and money. Having and maintaining a social media presence may be valuable if you are marketing in a large area or want to target specific firms or case types. Ask LNCs you admire if they utilize multiple social media platforms and what the return on their investment has been.

Conferences – Conferences are a considerable investment, but not all of them will break the bank. Looking at your business plan and operating budget, calculate what you can afford each year, then get creative. Start by searching your local area or for something that interests you, such as "spinal cord injury + legal". There are unique conferences all over the world in all price ranges. Push yourself out of your comfort zone, grab your LNC friend, and go to one.

Here is what we learned from attending our first conference and then exhibiting at another: know your audience and be yourself. Although we were dressed professionally at the first conference, we were not dressed to the level of the other attendees, and we ran out of business cards. We were nervous and awkward at the networking events, but we did our best and took plenty of notes. A few brave attorneys gave us their business cards, and we felt on top of the world. When we exhibited at the second conference, our booth and clothes were top-notch but overdressed for the audience. It was difficult at first to engage the attorneys, but we did not give up. And this is the key. Do not give up. Each experience will teach you something. At the third conference, we nailed it – our clothes, our pitch, and our confidence. Keep pushing yourself. You will get there.

Every meeting is an opportunity to hone your skills, represent your business, and buy a new pair of impressive shoes.

As a side note, when attending a conference, it is polite to acknowledge the other LNCs in attendance. The LNC world is small, and you never know when you will need assistance with a question or a case or need to hire contract LNCs. We love meeting and engaging with other LNCs at conferences, and we recommend that you do the same.

Cold emails – Cold emails can be your best friend or your worst enemy. Many states have anti-spam laws, so do your research beforehand. If you decide to send cold emails, ensure they are short, well worded, and appear professional. You will not get a second chance at a first impression.

Site Visits – Site visits are a way for your potential client to see that you are real. Before you go:

1. Think about calling ahead to make an appointment or speaking with the office manager to ensure there will be someone to meet with you. Consider bringing donuts and coffee or a pizza lunch.
2. Make sure you bring plenty of business cards and pens or other marketing material you may have.
3. Consider what makes your business unique and why this firm should hire you.
4. Practice this brief speech in front of the mirror or with your friends and family until it becomes second nature.

Money Saving Ideas – We all love saving money. When we all start, our budgets are small, and our ideas are large. There are a few ways to save money on marketing that you could use for conferences or site visits. We spent a little of our startup money on a high-quality printer and paper. We print our labels for cups, pens, thank you cards, and brochures. We can adjust our cards or pamphlets to fit the seasons and print on demand, reducing costs overall.

Another fabulous idea is to visit your local farmer's market and purchase small local items such as soaps, salsas, or cookies. We always appreciate local specialties; plus, as a small business owner, you contribute to other small business owners. There may also be community events, farmers' markets, health fairs, college fairs, or small business expos where you could set up a booth for little to no cost. All you need is business cards, maybe some pens, and your desire to succeed in this industry. Push yourself to try low-cost new avenues as it will save money and help you develop the confidence to attend more prominent events.

Legal Nurse Consulting is such a unique and exciting profession that it is hard to explain the struggles and challenges we all face to someone outside this world.

YOUR LNC COMMUNITY

Having a successful long-term LNC answer your questions, bounce ideas off, and connect you with the right people exactly when you need it is priceless. As we mentioned earlier, there are many mentors available. Keep in mind that they are volunteering their time and taking time away from their businesses, so come prepared with questions, be approachable, and be willing to learn.

When struggling with a case or a business-related quandary, we reach out to our mentor or LNC colleagues. Legal Nurse Consulting is such a unique and exciting profession that it is hard to explain the struggles and challenges we all face to someone outside this world. There are so many seasoned LNCs in different specialties that are willing to help. One of our goals in the future is mentoring. We would not be the strong, savvy LNCs we are if it were not for our mentor.

EXPECTATIONS

Here is something we struggle with daily. Expectations. How long does it take to get your first client? How many calls to the client are too many calls to the client? How long does it take to get feedback about your reports? Unfortunately, there are no rules or consistency when answering these questions. Your LNC colleagues and mentor can help you navigate these tense, stressful situations. We strongly recommend finding both LNC and business friends. People who emulate the type of business you admire. There is something unique about having someone review your work and give you honest feedback and or being able to ask a sensitive business question. Every successful LNC we know has an LNC friend upon whom they rely. We both can say with certainty that we would not be where we were today if not for the collaboration, support, and encouragement of each other. We challenge each other to be better LNCs and business owners, which has spawned some enormous ideas.

The other expectation that is important to manage is your mindset. A positive attitude is critical to your success because there will be dark days. Days you lose a massive opportunity after spending months planning due to a change in direction. Days that you realize you sent the report with errors instead of the one you stayed up until one am correcting. Understanding that your business is a marathon and not a sprint will be crucial to surviving these days. Everyone makes mistakes. Allowing yourself grace and finding humor in these situations will serve you well.

CONCLUSION

In conclusion, our goal was to provide some insight into our first year as LNCs. We could author a book about what we learned, but we attempted to highlight the concepts we get asked about most frequently for this article. We have learned much over the past year, made terrific connections, made mistakes, and grown from every situation. We are incredibly thankful for our mentor, who pushes us to be better, and the guidance from all the LNCs who freely give their encouragement and assistance when asked. We have included some interesting articles on finding your niche in the LNC world. If you have specific questions, please email us, and we will do our best to help you.

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Who's Next When the Patient Can't Consent?

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Keywords: Informed Consent, Power of Attorney, Surrogate Decision Maker, Supported Decision Making, Capacity,

Healthcare providers are required to obtain medical informed consent from patients to provide services. For a variety of reasons, a patient may lack the capacity to process and respond to information, leaving providers unable to obtain consent. In these cases, the law outlines surrogates who can give medical informed consent on behalf of the patient. Due to variable state laws and the multitude of medical and familial situations that a provider may encounter with a patient, it can be difficult to distinguish how much capacity a patient has, who the surrogate is, and whether the surrogate was appointed legitimately. With a goal of preserving patient autonomy, health care providers and lawyers alike must be well versed in the complex workings of informed consent and capacity. This article outlines the statutory requirements providers should be aware of, best practices for surrogates, and steps prospective patients can take to guard against the loss of autonomy should they become incapacitated.

INFORMED CONSENT

A patient's informed consent has been an important initial consideration for medical care providers as an expression of the patient's self-determination for over 100 years. Also, a substitute decision maker may need to provide that informed consent when a patient lacks the capacity to consent. In some cases, a patient has designated a chosen substitute decision maker, which can give rise to an additional, preliminary question of consent—that is, did the patient give valid consent for the substitute decision maker to act on the patient's behalf. Furthermore, when there is no chosen decision maker for an incapacitated patient, state law may designate someone to decide for the patient. This article explores the range of a patient's capacity to consent to medical care, the patient's capacity to consent to a substitute decision maker, and the types of substitute decisions makers who may be called upon to consent for an incapacitated patient.

As a starting point, it is useful to define some terms for the purposes of this article. In the United States, state statutes provide for patients to prepare advance directives regarding their medical care. The most notable advance directive, and the one discussed in this article, is a *health care power of attorney*. This article uses the term *health care power of attorney*, or power of attorney (POA) for short, although some states use the term *health care proxy* or another similar term. In legal terms, a POA operates under laws of agency, where the person making the POA is the *principal*, and the one who may act on the principal's behalf is the agent. This article uses *principal* and *agent*, although some states use alternative terms, such as *proxy* or *attorney in fact*, for the agent. In cases where a substitute decision maker may be invoked—whether an agent, someone designated by state statute, or someone appointed by a court —this article uses the term *surrogate* as a general term for any substitute decision maker. Finally, the term *capacity* refers to a patient's ability to receive and process information and to give a meaningful response. In contrast, the concept of competence in many jurisdictions refers to a court determination of an individual's capacity in a particular context.

MEDICAL INFORMED CONSENT

A patient's informed consent to receive medical care has been recognized since 1914, when the renowned judge Benjamin Cardozo, declared in *Schloendorff v. The Society of the New York Hospital*, "[e]very human being of adult years and sound mind has a right to determine what shall be done with his [or her] body" (*Schloendorff*, p. 129). Over the past century, medical providers have become accustomed to obtaining a patient's consent before providing care or treatment. In obtaining informed consent, medical providers are required "to disclose all pertinent information about risks and benefits of the procedure to the patient" (Paterick, et al., 2008, p. 313). More specifically, the American Medical Association (AMA) ethics opinion states that physicians should follow the following process in obtaining a patient's informed consent:

1. Assess the patient's ability to understand medical information relevant to them and to make a decision;
2. Present relevant information, including diagnosis, if known, details of recommended interventions, and burdens, risks, and benefits of receiving or forgoing such interventions; and
3. Document the conversation and the patient's decision. (AMA, 2000, 2.1.1)

In cases when a patient is totally incapacitated, medical providers routinely recognize a surrogate to give informed consent for the patient. The AMA ethics opinion further elaborates on the efforts necessary to identify and engage a surrogate in giving informed consent for a patient. (AMA, 2000, 2.1.2)

When a patient has diminished capacity, but perhaps is not incapacitated, the question arises as to whether the patient can consent or whether a surrogate is the proper party to consent. In addition, in cases where an agent is appointed by the patient, a further question may arise as to whether the patient had sufficient capacity to appoint the agent in the first place.

CAPACITY TO MAKE MEDICAL DECISIONS

For legal purposes, there is a range of capacities, depending on the decision to be made or the legal document to be signed. This is why, when asked whether an individual has sufficient capacity, the immediate response before answering should be "capacity to do what?" One resource for evaluating an individual's capacity is Assessment of Older Adults with Diminished Capacities, a joint publication of the American Bar Association and the American Psychological Association (ABA, 2021). Similar resources are published by medical and social services professional organizations, such as the Interview for Decisional Abilities (IDA) tool developed for adult protective services agencies. In most cases, assessing capacity involves some subjectivity, except in cases where an extensive professional medical or psychological evaluation is conducted (ABA, 2021).

The ABA recognizes the range of capacities for various purposes, such as making a contract, executing a will, and making financial decisions (ABA, 2021). Regarding the capacity to make medical decisions, *Assessment of Older Adults with Diminished Capacities* refers to the definition used by the model law, Uniform Health-Care Decisions Act: "an individual's ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate health-care decisions" (ABA, 2021, p. 19). This decisional capacity is parallel to the standard for informed consent in the AMA code of ethics.

As Robert P. Roca describes in *Determining Decisional Capacity: A Medical Perspective*, evaluating a patient's capacity involves the progressive analysis of diagnosis, impairment of decision-making ability, and dangerousness of potential decisions (Roca, 1994). Figure 1 provides a flowchart of Roca's recommended process.

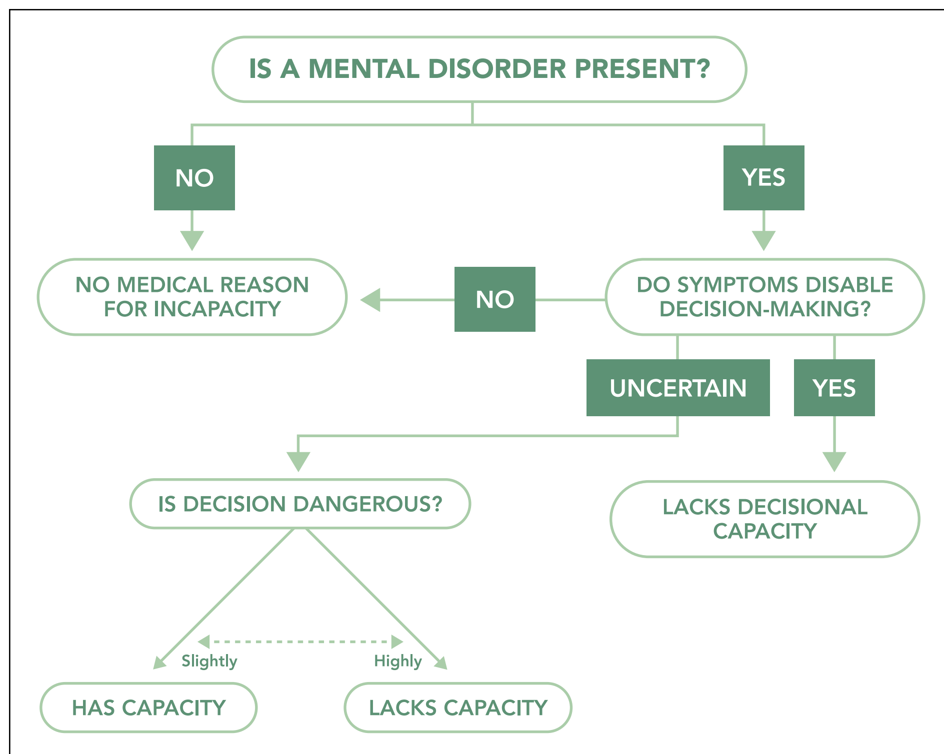

Figure 1. Evaluating Decisional Capacity

Note. From "Determining Decisional Capacity: A Medical Perspective," by R. Roca, 1994, *Fordham Law Review*, 62(5), p. 1190.

SUPPORTED DECISION MAKING

In cases when a patient has diminished capacity but is not incapacitated medical providers, social services, and legal professionals are well-advised to understand and engage supported decision-making. The ABA describes supported decision-making as a series of informal or formal relationships and arrangements designed to assist an individual with an impairment to make and communicate decisions about the individual's life (ABA, 2021). In practice, supported decision-making avoids a leap from autonomy of an individual with full capacity to an assumption of incapacity and immediate reliance on a surrogate decision maker. Supported decision-making is not a new concept—everyone relies on advice and support of others at various times. But, in recent years, supported decision-making has become a term to represent an individual's supported autonomy, sometimes with formalized agreements and releases. A growing number of states have enacted statutes that provide for supported decision-making agreements as a way to formalize an individual's choice of supporters and the areas of the person's life where support is provided (ABA, 2021). In instances of cognitive disability, an individual may not be able to make decisions entirely on their own, but that does not necessarily warrant relying exclusively on a surrogate. If an individual has some decision-making capacity, and that capacity can be increased or sustained with certain support, such support should be provided with the goal of enabling individuals to make decisions for themselves when at all possible.

As such, when a professional—whether medical, legal, or financial—deals with someone who may need support in making decisions, they should inquire whether there are supporters who may be able to assist with receiving and processing information. For a patient dealing with medical decisions, supporters may be close family members, such as a spouse or adult children. In other cases, supporters may be friends or volunteer or paid assistants.

In addition to individual supporters, in Assessing Legal Capacity, David Godfrey recommends providers of legal services help maximize a client's capacity with supportive arrangements such as the following:

1. Arrange for assistance when a client has difficulty hearing, seeing, writing, or speaking.
2. Simplify the discussion as much as possible by conducting business at a slower pace, addressing one topic at a time, and allowing extra time for the client's response.
3. Confirm the client's understanding by repeating or paraphrasing information as needed, and by providing written summaries and information.
4. Pay attention to issues of timing for the client. Some clients are at their best in the morning and "sundown" in the afternoon. Shorter meetings prevent a client from becoming overwhelmed or tired. Breaks to rest or use the bathroom may assist the client to maintain focus and comfort. (Godfrey, 2021)

POWER OF ATTORNEY LAW AND APPLICABLE CAPACITY

A POA for health care is a creation of state law, which is a development from the broader subject of agency law. To understand a principal's autonomy and delegated authority under a POA, one must take into account the principal's capacity – whether it is the capacity to act for oneself, to execute a POA, or to revoke a POA (ABA, 2021).

In addition to applying state statutes and case law, courts that are asked to resolve issues with POA's often turn to treatises, such as restatements of law, published by the American Law Institute. The Restatement (Third) of Agency is frequently cited by courts for financial agency, and the general concepts extend to delegated authority in a health care POA too (See, e.g., *Heaphy v. Willow Canyon Healthcare, Inc.*).

According to the Restatement, actual authority is created when the principal assents to the agent taking action on the principal's behalf (Restatement (Third) of Agency, 2006). Furthermore, many states require a health care POA to be "activated" by a certain event. For example, Wisconsin statute provides for activation by a statement from medical providers that the patient has become incapacitated, unless the POA designates a different method (Wis. Stat., 2020, sec. 155.05). Correspondingly, Wisconsin statute states that a health-care agent cannot contradict a principal who is not incapacitated (Wis. Sta., 2020). These concepts of the primacy of the patient's decisions over an agent's decisions reflect the bedrock of the principal's authority—the agent answers to the principal because the principal's assent is the sole source of the agent's authority (Restatement (Third) of Agency, 2006).

In addition, a principal may withdraw consent by revoking the agent's authority. The Restatement explains that the power to revoke is based in the consensual relationship of the agency: Comment b of section 3.10 of the Restatement states that consent is "a relevant question on an ongoing basis throughout the duration of the relationship," and a "manifestation of nonconsent, or dissent, to the other party [for example, the agent] is determinative" (Restatement (Third) of Agency, 2006)

Regarding capacity to execute a health care agent, the ABA suggests that a principal possesses sufficient capacity if the principal understands (1) what it means to delegate health care decision-making authority to someone else; (2) the use of a legal document to do so; (3) for future or imminent incapacitation; and (4) to consistently designate an appropriate choice as an agent (ABA, 2021). This level of capacity is generally considered to be less than the requisite capacity to make healthcare decisions for oneself—the ability to understand the benefits, risks, and alternatives to proposed health care and to make and communicate a health-care decision (ABA, 2021).

HIERARCHY OF SURROGATES

If a person is deemed incapable of making medical decisions, then a surrogate, whether designated by a POA, state statute, or court appointment, may make decisions for the patient. Most simply, if a patient has a health care POA then the POA dictates who makes any medical decisions for the incapacitated patient. If there is no POA and a patient is incapacitated, a majority of states have enacted statutes, sometimes called "surrogate consent laws," which determine who decides for the patient (Wynn, 2014). There are two types of surrogate consent laws: hierarchy and consensus (Wynn, 2014). Most states with such laws use hierarchy consent laws, which designate family members as surrogates according to the following priority: spouse, adult child, parent, adult sibling (Wynn, 2014). Some states continue with further priority given to more distant family members (Wynn, 2014). Alternatively, in Colorado and Hawaii, consensus surrogate consent laws create "a single class of interested persons" who must come to a consensus on who should be the surrogate (Wynn, 2014, p. 2).

In situations where a patient does not have any identifiable family or interested person, a court proceeding for a guardianship is required (Wynn, 2014). Guardianship is the last resort option because the court proceeding can be time-consuming and can result in a non-related party being appointed, which makes it more difficult to consider what the patient would want. Yet, guardianships are useful in that they establish a clearly identified surrogate. Furthermore, a court-appointed surrogate resolves any disagreement among parties and provides a single individual for care providers to communicate with. Indeed, if the capacity of an individual remains uncertain, if interested parties disagree, or if stakes are high (e.g., a pending life-or-death decision), then a court will need to adjudicate the capacity and competence of the patient to determine who—the patient or a particular surrogate—will make decisions for the patient.

Once a patient has been deemed incapacitated and a surrogate is identified or appointed, the surrogate will need to grapple with the medical situation and the burden of making difficult medical decisions for someone else. Surrogates themselves are often under stress because their loved one is sick, they may be uncomfortable with medical terminology, or they may struggle with making the right choice. Ideally, the surrogate-patient relationship is such that the surrogate has been well informed by the patient of the patient's wishes. If this is the case, the surrogate should use the substituted judgment standard and make decisions based on what the patient would want (ABA Commission on Law and Aging, 2009). When the surrogate knows what the patient would want, the decision is relatively easy – a surrogate should always respect the patient's wishes expressed while the patient had capacity (ABA Commission on Law and Aging, 2009).

However, there are many instances where a surrogate will not know what the patient would want. Perhaps the surrogate is appointed by statute or court order, never anticipated being in a decision-making position, and is not familiar with the patient's wishes. Or maybe the patient did not express their wishes while they had capacity.

In cases where the surrogate does not and cannot know, they should make decisions in the patient's best interest (ABA Commission on Law and Aging, 2009). The best interest is an objective standard used when there is no way to know what a patient may choose (ABA Commission on Law and Aging, 2009). Because the best interest standard does not account for an individual's wishes, it should only be used when there is no possible way to know what the patient would want. If any inferences can be made based on past behavior or comments to make a decision that reflects a patient's wishes, those inferences are considered part of the substituted judgment standard and are preferred to the best interest standard (ABA Commission on Law and Aging, 2009).

While these standards are a useful starting point for surrogates, it is important that a surrogate understand the medical context to apply the standard. Perhaps a surrogate knows that the patient would accept extensive therapy after a surgery if it means the patient could walk again, but the same patient also may not want to live with pain. In some instances, these two wishes could conflict, and it is the surrogate's role to gather and sift through the medical circumstances to make a decision that best fits the patient's desires (ABA Commission on Law and Aging, 2009). As situations become complex, surrogates should seek help. They should ask questions of the medical staff to make sure they fully understand the implications of the choices they will make (ABA Commission on Law and Aging, 2009). Surrogates should consult ethics committees when there are gray areas. (ABA Commission on Law and Aging, 2009). Finally, because being a surrogate can be emotionally and psychologically taxing, surrogates should seek the support that they need to remain able to perform their duties and adhere to the decision-making standards (ABA Commission on Law and Aging, 2009).

Like surrogates, when it comes to consent healthcare providers are often faced with difficult situations. They are required to provide timely care, determine if a patient is incapacitated, identify any acting surrogate, and then follow the direction of the proper party—all while attempting to maximize patient autonomy. From a legal standpoint, patient autonomy is best preserved through care directives and meaningful conversations between the patient and their POA agent. Healthcare providers should ask patients what they want when they have the chance and encourage patients to pursue legal documents that express their wishes.

SUPPORTING DIVERSITY

Although the various surrogate arrangements intend to serve the patient's wishes and best interests, they may fail to account for patient diversity, and POAs may be unfamiliar and out of reach for certain populations.

POAs do not easily accommodate multiple decision makers for families or cultures that would warrant such structure (Wynn, 2014). State surrogate consent laws make assumptions about who might be important to a patient. For example, these assumptions can overlook LGBTQ+ partners or non-familial parties who may be better informed of the patient's desires than a parent or sibling (National Resource Center on LGBT Aging 2020). Similarly, guardianships and the objective best interest standard may be slow to acknowledge and incorporate a patient's religious, ethnic, and racial background as important components of a patient's best interest because they are not equipped to do so. This lack of personal information results in the best interest serving only a hypothetical "blank slate" patient, that is, a patient devoid of religion, ethnicity, or race. As a result, patients who have specific wishes that align with their cultural identity will lose their autonomy if a surrogate must use the best interest standard.

Populations that have faced discrimination, like the LGBTQ+ community and racial minorities, commonly suffer from more health problems because of the social prejudice and hostility they have endured (National Resource Center on LGBT Aging, 2020). As a result, they may need more care, but because of the social ostracization and discrimination they have experienced, they may be less trusting of providers and less inclined to seek services (National Resource Center on LGBT Aging, 2020).

In addition to the apprehension minority populations have in seeking medical care, some minority populations also lack access to legal support for advance care planning. For example, barriers to creating POAs disproportionately affect Black Americans (Koss, 2017). Although it is difficult to pinpoint one reason why elderly Black people are far less likely to create planning documents like POAs than elderly white people, economic disadvantages are likely at the forefront (Koss, 2017). Other possible reasons include mistrust of doctors and healthcare systems, low health literacy, and doubt that planning will be effective (Koss, 2017). Without planning, elderly Black patients are less likely to receive hospice care and less likely to manage pain (Koss, 2017).

In general, low-income households lack adequate access to legal services (Legal Services Corporation, 2017). POAs are often made in conjunction with the creation of an estate plan – something people usually seek if they feel they have a certain net worth. While POAs can be prepared without an attorney, this still requires the time and ability to do it yourself, and it requires an awareness that it needs to be done in the first place. Due to lack of funds, discomfort with medical care, and a mistrust in the viability of POAs, marginalized groups might only receive medical care in emergency situations that are more likely to necessitate a surrogate to make decisions, and yet these same people may not have POAs designating an agent. Without a POA, in situations where an individual lacks capacity, even temporarily, there is no guarantee that decisions will be made according to their wishes.

All in all, minorities are more likely to have suffered trauma and experience social isolation, and these experiences lead to an increase in health issues and a lack of trust in providers and legal professionals. People who are LGBTQ+, low income, a racial minority, or disabled may need planning beyond that of the "blank slate" patient. Yet, they are less likely to seek or receive the help they need to document their wishes. As a result, healthcare providers may have to turn to statutorily designated surrogates, those surrogates may be without the information needed to use the substituted judgment standard, and diverse patients may lose their autonomy. To alleviate the barriers in accessing legal advice, legal professionals should offer reduced cost or free services to low-income individuals who are unable to afford it otherwise, spread awareness about the need for planning documents like POAs, and conduct outreach in the community so that people are aware of the resources available to them and feel comfortable seeking help. Healthcare providers should work to create an environment that recognizes potential disparities, dispense with assumptions (no blank slate patient), use language to make patients feel comfortable, and encourage patients to engage in advance planning. (National Resource Center on LGBT Aging, 2020)

CONCLUSION

This article outlines the statutory requirements providers should be aware of, best practices for surrogates, and steps prospective patients can take to guard against the loss of autonomy should they become incapacitated. With a goal of preserving patient autonomy, health care providers and lawyers alike must be well versed in the various aspects of informed consent, capacity, and advance directives.

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EMR and the Audit Trail

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Keywords: EMR, Audit Trail

There are a lot of ways to approach the topic of audit trails. The topic could be approached by reviewing the data requirements of the audit trail. The various uses of the audit trail within a medically related case by discussing different state, and federal regulations, as well as hospital policies on charting. Then breaking down how each of these regulations or policies play into what data is captured within the audit trail. There are simply too many avenues to explore and discuss in a short article. However, providing the foundational knowledge needed to explore this dynamic topic may be the best option so each legal nurse consultant (LNC) can begin their educational journey. A brief discussion follows on the audit trail, how it relates to the electronic medical record (EMR), and the LNC's role in analyzing them.

This activity is designed to increase understanding of the uses of the audit trail and how it relates to the electronic medical record. Legal nurse consultants need to know when and how to use audit trails when analyzing cases.

Upon completion of the learning activity the learner will be able to:

a. Identify what an audit trail is and how actions are tracked and identified in the healthcare record.
b. Recognize what information the LNC must understand about state, federal, and organizational requirements on charting to use when assessing the audit trail on a case.
c. Identify the various operating systems used by healthcare facilities and how differences can affect the data received in an audit trail.

The author, reviewers, and nurse planners all report no financial relationships that would pose a conflict of interest.

This activity has been awarded 1 Contact Hour of credit. The activity is valid for credit until December 1, 2025.

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OVERVIEW

Clear, timely, and accurate charting is essential in healthcare. It could be argued that every healthcare professional from doctors and nurses to the risk management team must understand the importance of charting. By documenting patient assessment, vital signs, and history, the healthcare professional can better promote positive clinical outcomes. Some could even suggest the EMR has become indispensable members of the healthcare team, providing the team with a detailed, organized, and often color-coded view of the patient's current medical status.

Even though the EMR is an important clinical tool, healthcare professionals do not understand all its functions or uses. It is critical to realize that the information captured in the EMR is used not only to assess and audit patient care, perform research on disease processes, and improve care outcomes but is also used in the legal field on medically related cases. More alarming is the fact that healthcare professionals do not realize that the EMR information they see is only one layer of information being captured. There is a whole other system capturing how they are using the EMR, what they are reviewing, from where they are reviewing and using the system, and for how long. This system in turn can be used in the legal field to authenticate the medical record by providing the most accurate timeline of care and the subsequent documentation of that care (Hansen, Pratt, 2020). The audit trail is the obscure and often misunderstood tool working autonomously behind the scenes.

THE SCENARIO

Jane Doe was a 40-year-old female and mother of two. She went to her local emergency department with complaints of fatigue, headache, and shortness of breath for the past two days. The ED nurse discovered Jane had a high-stress job as the accountant for a large manufacturing facility, and she had recently been placed on Lisinopril by her primary care physician (PCP) for increasingly high blood pressure. She was also placed on a smoking cessation program. Vital signs revealed a blood pressure of 220/110. Nursing notes indicated that she relayed vital signs and assessments to the emergency department (ED) physician. An order for hydrochlorothiazide orally 25 mg, one time was entered. An hour after the medication was given the nurse took the second set of vital signs (190/102). The nurse noted Jane appeared to be anxious. The ED physician's notes indicated the discharged diagnosis of "hypertension-uncontrolled" and prescribed hydrochlorothiazide orally 25 mg, once daily. The discharge instructions reinforced Jane should continue the same dose of Lisinopril already prescribed by her primary physician and return to the ED if symptoms persisted. Six hours later, Jane was discharged with the third set of blood pressure readings of 159/100. Less than 24 hours post discharge from the ED, Jane died.

The spouse reported that Jane was exhausted when she got home from the ED. She continued complaining of a headache and went straight to bed. The family alleged the facility, nurse, and ED doctor failed to monitor and provide interventions to treat this prolonged high blood pressure. On the audit trail

> *The audit trail has been described as the who, what, when, where, and action of the EMR. It tracks and identifies all "audible actions" within the healthcare record.*

review, the LNC discovered that the ED physician spent four minutes reviewing Jane's vital signs and assessment before discharging her home. The ED physician's note and discharge documentation were not completed nor signed before Jane's discharge but three weeks after Jane's discharge and death. Showing that the ED physician backdated the note, casting a shadow on the accuracy of the documentation. This was a key fact brought up at trial.

UNDERSTAND EMR CHARTING PRACTICES GUIDELINES

All documentation, clinical reviews, and assessment of care outcomes are based on what has been charted by each member of the healthcare team. The healthcare professional relies on that information to provide competent care to the patient and ensure they have an accurate medical history. With the development of EMR, charting practices have changed. Computer charting has made it easy to update and change records that have been previously documented. Now clinicians can backdate clinical assessments, vital signs, and notes with ease. They can even go as far as copy and pasting previous assessments already conducted, something that could not occur with paper charting.

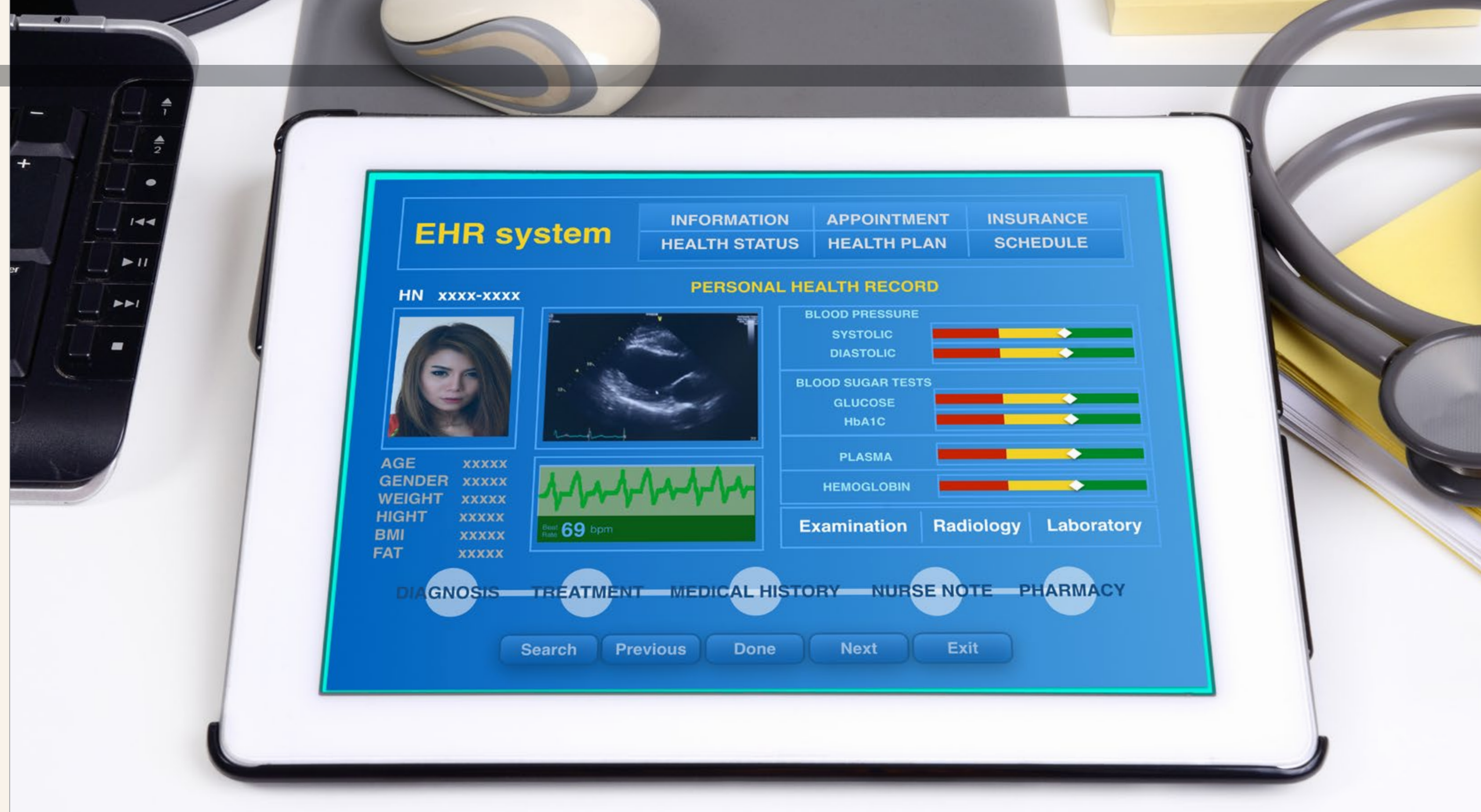
Although the EMR has made it much easier for clinicians to document, it has led to issues in care and injuries to patients. For example, copying and pasting medical information could cause a diagnosis to not be recorded or even overlooked, thus delaying lifesaving measures. Even late entries pose a safety risk because documentation and communication of critical assessment or lab values, for example, could delay lifesaving measures as well. Such as in the case of Jane Doe. It is important to note that not all late entries are a concern. LNCs must be aware of this and communicate it to the attorney-clients. However, it is also important to note that late entries can raise questions about the accuracy, authenticity, and security of medical records. In addition to this, the action of late charting can appear completely self-serving to the healthcare professional doing it, a factor that should be taken into consideration in any type of charting.

It is a sad fact that many healthcare professionals do not realize there are state, federal, and organizational requirements on charting that play role in charting practices. The way the healthcare professional deals with issues such as late entry, corrections to past charting, or pends, can depend on hospital policy based on guidelines taken from regulatory bodies. Understanding these concepts is fundamental for all healthcare professionals but is key for LNCs to know when reviewing medically related cases. Why? Because it would be important knowledge to use when assessing the audit trail as well as providing communications to attorney-clients or even educating peers on charting practices.

WHAT IS THE AUDIT TRAIL?

The audit trail has been described as the who, what, when, where, and action of the EMR. It tracks and identifies all "audible actions" within the healthcare record. Actions such as who accessed the medical record (along with their unique identifier), from where the access occurred (such as what workstation within the hospital or a mobile device outside of the facility), and what information they have accessed (such as laboratory values, operative reports, and clinical summaries), as well as the time spent within the records (ASTM International, 2022). Such as the ED doctor reviewing clinical assessment notes for four minutes in Jane's case.

Why is this data collected? The audit trail is the only way to prove that medical records are trustworthy, authentic, and secure. Think of it this way: the EMR has made it possible to collect copious amounts of data (think mega data or data with meaning) about the healthcare system in almost real-time. The data can be shared with the patient, their representatives, and insurance groups. Healthcare professionals can access records from anywhere within the facility as well as on mobile devices. There are a lot of providers using the EMR. With EMR, healthcare professionals can chart events that took place hours, days, or weeks prior. In other words, late charting along with backdating the information to the time it occurred will give the appearance of timely charting on the printed medical records. The need to ensure the EMR is truly authentic and accurate documentation can only be verified by collecting this data - the audit trail.



WHAT ARE THE LNC'S ROLES AND RESPONSIBILITIES?

Healthcare is not a singular event, nor does it occur in isolation. Instead, it is multifactorial. The healthcare system has recognized standards of care, technological advancements that have changed the ability to provide care over vast distances, making information more easily accessible to those who are providing the care, legal and ethical considerations as well as regulations that affect how the healthcare professional practices. Nurses, doctors, healthcare administrators, regulations, and even legal considerations all have different roles to play in healthcare and affect how the system runs. LNCs are in a unique position to educate attorneys and healthcare professionals about audit trails and accurate charting.

Thousands of pieces of data are captured within the audit trail. It can be difficult to understand how this data is important or used by the LNC in their case reviews. Before beginning any review, it would be imperative to reflect on how the healthcare system works and how care is documented within that system. From there, the LNC conducting an audit trail review should keep three important factors in mind:

First, the LNC must be aware that every audit trail will differ because each case is different. Organizations have options for using different operating systems (such as Epic, Meditech, or Cerner). However, facilities within the organization can customize operative systems to suit their patient population. Each operating system has a different glossary of terms and what data they capture can be slightly different as well. Thus, the LNC will have to be familiar with these differences and how it relates to the case at hand.

Second, the LNC must know that an audit trail is a tool, not a magic bullet. The audit trail can only show that an action did occur, not the details of that action. Therefore, it is essential to use the audit trail in conjunction with EHR. For example, the audit trail will show when and from where a healthcare professional created,

The LNC is in a unique position to act as a bridge between the audit trail, medical-related cases, and how the healthcare system uses the EMR.

modified, and maybe subsequently signed a clinical assessment note. But it will not tell you what the note contained or if it is of any significance to the case. The LNC will compare the audit trail to the printed medical record, and then use their critical thinking skills, understanding of how the healthcare system uses the EMR, guidelines outlining charting practice, and assessment skills to analyze it. If data entries or modifications raise questions, then a discussion with the attorney-client needs to take place and additional documentation may need to be requested. For example, when the LNC reviewed the audit trail in Jane's case, she compared the entries made by the ED physician to the EMR. In this way, the LNC could correlate the timestamp within the audit trail to medical records. Though the note could be backdated and timed to fit within the frame of Jane's care; the audit trail would show the exact date and time the entry was input within the EMR.

Third, the LNC may have to assess the need for experts. Similar to any case, the expert must meet the case needs. So, if there are concerns with missing records within the audit trail, and incongruencies with medical records compared to the audit trail, the LNC will need to have a discussion with the attorney-client and suggest having potential experts analyze the audit trail further. Potential experts could be experienced nurse informatics specialists or IT forensic analysts. When it came to Jane Doe, the LNC collaborated with her attorney-client and discussed the importance of having an experienced nurse informatics specialist. One who understood the life cycle of EMR and various uses to talk about the deviation of time-stamped within the audit trail and the printed medical record.

Often it may feel as if falling down a rabbit hole when reviewing the audit trail: thousands of pieces of data need to be reviewed, compared, and assessed for relevance against the clinical records. Keep in mind how the healthcare professional charts, the rules, and regulations coincide with them along with the three tips above, and then use them as a reference point at the start of any audit trail review.

CONCLUSION

Everywhere one looks, data is being captured. Whether using a cell phone, when sending emails, or conducting internet searches, data is being collected, stored and analyzed about how individuals use their devices. The EMR is no different. The information captured by the audit trail helps provide a picture of how the doctors, nurses, and other healthcare professionals are providing clinical care, utilizing the electronic health record, how clinical reference materials are used, and the timeline of documentation. All of these are used to depict a clearer, more accurate picture of care rendered. The audit trail is quickly becoming a standard request in most medical-related cases. Now attorneys can use the audit trail as a resource. The LNC is in a unique position to act as a bridge between the audit trail, medical-related cases, and how the healthcare system uses the EMR. Therefore, it is important to develop an understanding of the basic functions and use of the audit trail and how it relates to the EMR.

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SUGGESTED READINGS

For more on how the audit trail is being used in litigation and for medical research:

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- Paterick, Z. R., Patel, N. J., Ngo, E., Chandrasekaran, K., Jamil Tajik, A., & Paterick, T. E. (2018, September 11). Medical liability in the Electronic Medical Records Era. Proceedings (Baylor University. Medical Center). Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6413973/

For more information on EHR, their implementation, and life cycle:

- Saba, V. K., & McCormick, K. (2015). Essentials of Nursing Informatics (6th ed.). McGraw Hill.

For more information on EHR, CMS Incentive programs, and definitions:

- Electronic Health Records. CMS. (n.d.). Retrieved from https://www.cms.gov/Medicare/E-Health/EHealthRecords
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- Reisman M. (2017). EHRs: The Challenge of Making Electronic Data Usable and Interoperable. P & T: a peer-reviewed journal for formulary management, 42(9), 572–575. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5565131/

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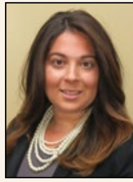
- Tsou, A. Y., Lehmann, C. U., Michel, J., Solomon, R., Possanza, L., & Gandhi, T. (2017, January 11). Safe practices for copy and paste in the EHR. Systematic Review, recommendations, and novel model for Health IT Collaboration. Applied clinical informatics. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5373750/#:~:text=Overall%2C%2066%25%20to%2090%25,to%20seek%20additional%20unplanned%20care

For more information on how software companies and EHR customizability:

- American Hospital Association (2018). How hospitals are customizing their EHRs for Better Patient Care: AHA News. American Hospital Association | AHA News. Retrieved from https://www.aha.org/news/insights-and-analysis/2018-10-18-how-hospitals-are-customizing-their-ehrs-better-patient-care



Mary Ann Seibold is a registered nurse with over 12 years of healthcare experience and an MBA in Healthcare Administration. Her clinical experience includes ICU, cardiac care, and medical surgical nursing. As an administrator for a large insurance company, Mary Ann reviewed documentation of nurses who were auditing hospital records. She participated in CMS and NCQA audits, providing a breakdown of all investigations performed by the insurance company.

Mary Ann then opened her business, Seibold & Associates Consulting Agency, where she analyzes and identifies critical issues in medical cases for her clients, whether med-mal, personal injury, and toxic tort. More recently, Mary Ann became deeply interested in audit trails and invested her time in learning how audit trails affect healthcare medical cases. She has incorporated this new knowledge into her case analyses, thereby enhancing the end product.

If you have additional questions; please reach out to seiboldandassociatesclnc@gmail.com.

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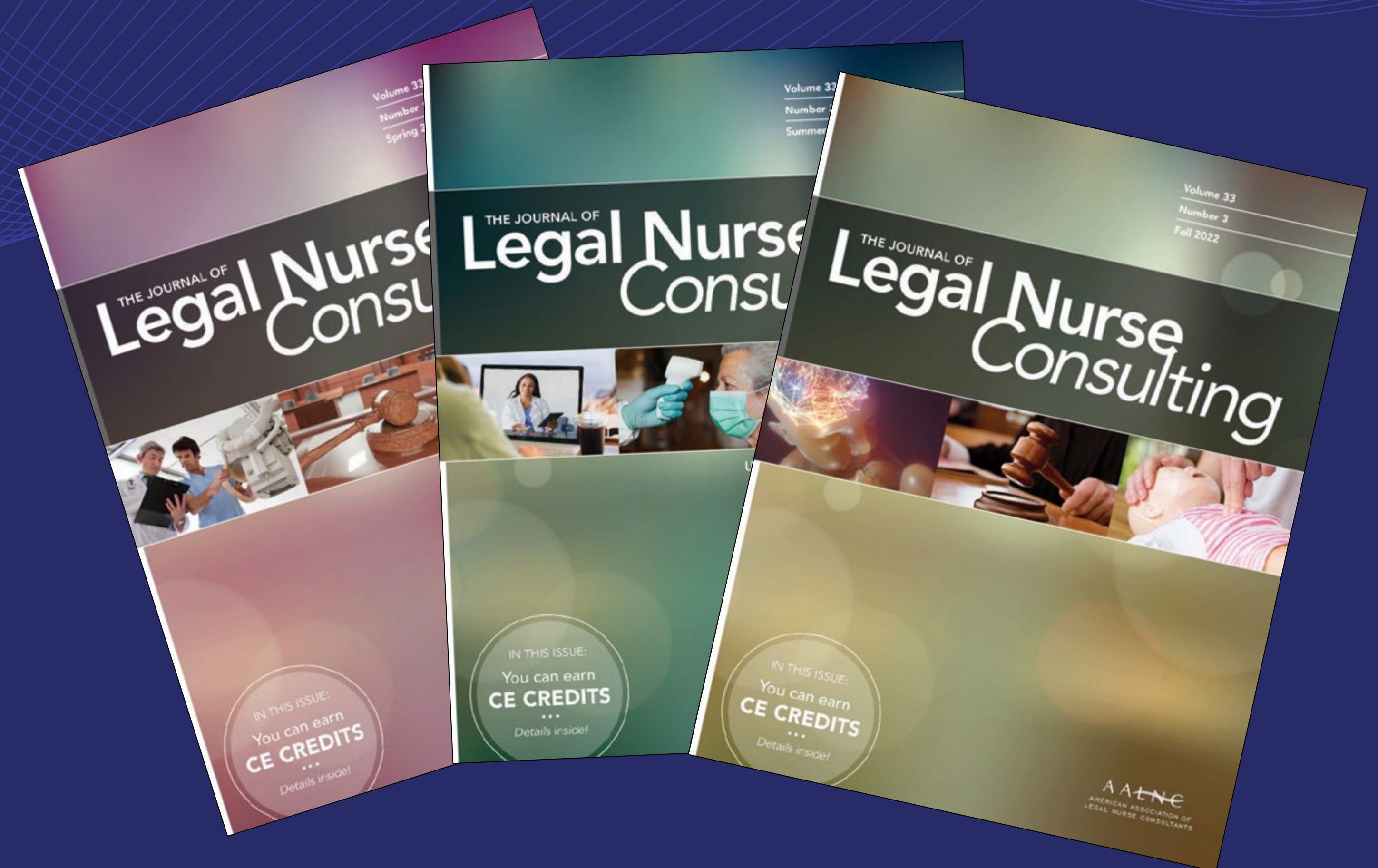

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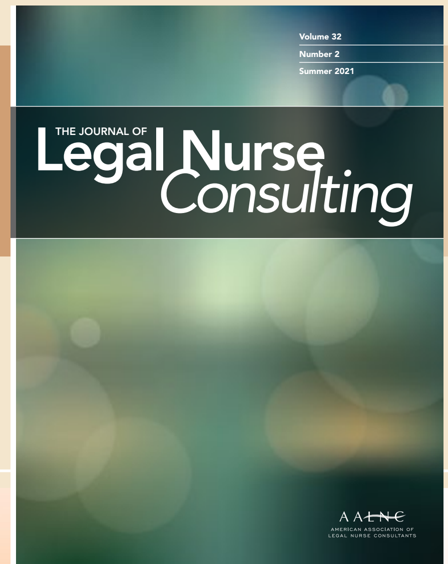

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