Screening Test/Interview Questions for Law Group

1. Tell me about your 1+ years of clinical experience. Which of our preferred areas (Pain Management, Interventional Radiology, Orthopedics, Neuro, or ER) is your strongest, and how many years do you have in that specific specialty?
   - Throughout my 12 ½ years of nursing experience I spent 8 years in the Emergency Room (ER) setting throughout various ERs both in inner cities, rural areas and the Veteran Affairs (VA) system. I have worked at Level III to Level II trauma centers encountering a wide array of patient populations. Emergency medicine has always been a passion of mine since entering nursing school and where I feel I am strongest to employ my fast, critical thinking and ability to learn a broader amount due to the mix of medical concerns presented in the ER setting.

2. Have you ever reviewed medical records for legal purposes (personal injury, med-mal, or workers' comp)? If yes, roughly how many cases have you supported?
   - No, I am just starting to work with attorneys as a Certified Legal Nurse Consultant, but I have been reviewing medical records throughout my nursing practice. As a CLNC consultant, I have learned how to use that expertise to help attorneys save time while providing a more thorough record review and solid work product an attorney can rely on.

3. How did you identify if the standard of care was met, and what red flags did you look for in the operative reports and medication histories?
   - To date I have not worked on a case for an attorney to provide a merit review. However, in my training course I worked on sample cases provided. When reviewing a case for standards of care and identifying red flags I look for the following:
     - Documentation consistencies/inconsistencies between medical staff. For an operative concern would be:
       - The surgeon
       - Surgical Assistant(s)
       - Anesthesiologist
       - Circulating Nurse

        - Scrub Nurse and/or Surgical Technologist
        - Preoperative (or pre-op) Nurse
        - Postoperative Nurse
    - Times physician orders are placed compared to being carried out or completed.
    - Patient's documented History and Physical (H&P) with notes to allergies and active outpatient medications.
    - Research and review the authoritative literature for:
        - Diagnosis
        - Recognized clinical and nursing guidelines for treatment during the relevant time period of the incident.
        - Medications: use, mechanism of action (MOA), contraindications, compatibility, and side effects.

4. An anesthesia record shows a patient received Propofol, Fentanyl, and Midazolam during a spinal cord stimulator trial. The patient later developed a hematoma. Explain this procedure and the potential complications to a jury in plain, non-medical language.
    - Two widely accepted and used patient education databases used in the hospital setting, (and all hospitals that I have worked in) are UpToDate and Lexicomp. These databases put medication information, diagnoses, and medical procedures at a 5th to 6th grade reading level to meet the standard health literacy guidelines to accommodate the average adult and patient comprehension limits. They are printed materials typically provided to patients during education by the registered nurse or provider for review. Therefore, I used these resources to compose an explanation of the procedure, medications, and complications that a jury would easily be able to understand. They are as follows:

        - A spinal cord stimulator (SCC) is a small device that is placed inside the body. It can be used to treat serious, long-term pain in some people. It works by sending small electrical signals to the nerves in the painful area. This disrupts the pain signals that normally go to the brain. The goal is to reduce or get rid of the pain. Some people feel a mild tingling sensation instead of pain.
        - There are 2 stages for placing a SCS:

- Trial stage
- Permanent SCS

NOTE: use of anesthesia is typically used for permanent placement of SCS not trial stage. Therefore, since the case is about the use of anesthesia medications for such and possible complications, I will provide the requested information about a procedure that anesthesia was used though not typical for a trial placement procedure.

- Permanent SCS – You will get anesthesia medicines. This is to make sure the patient does not feel pain during the procedure. Types of anesthesia can include:
  - Local – use of local anesthesia medicines to numb the back so you do not feel pain. A patient might also get sedative medicines to make the patient sleepy.
  - General – This makes the patient unconscious so the patient can't feel, see, or hear anything during the procedure. A patient might need a breathing tube to help them breathe.

The doctor will use a continuous medical imaging technique that uses X-rays to display a live, real-time video of internal body structures in motion. Think of it like an X-ray "movie" compared to a standard X-rays' still photograph (fluoroscopy) to place permanent leads in the patient's back. Then the leads are inserted through a needle or by a small cut (incision) in the skin to place the leads. One end of the lead will be near the nerve. The other end will be connected to the stimulator under the skin. The doctor might need to make another small incision to keep the leads in place.

Another small incision to make a pocket for the stimulator. This is usually placed on the patient's belly, hip, or upper buttock.

A small tunnel under your skin to connect the leads to the stimulator.

The stimulator will be turned on to make sure everything is working correctly. Then, the doctor will close the patient's incisions and cover them with clean bandages.

This procedure takes 1 to 2 hours.

- Most Probable Possible Complications of Procedure:
  - Infection

- The lead moving out of place or breaking
- A collection of fluid between layers of tissue in the body. (Seroma)
- Spinal fluid leakage
- Injury to the nerves or spinal cord.
- The SCS not helping to relieve pain.

- Hematoma – is a localized collection of blood outside the blood vessels resulting from bleeding. This is a frequent postoperative wound complication.
  - Possible Complications of Hematoma:
    - Pain
    - Swelling
    - Incision separation
    - Increased risk of infection
- Medications: Propofol, Fentanyl, and Midazolam

NOTE: To better understand the complications in this such case that may have arose from the anesthesia; the dose, route, and time of each medication administered, along with documentation for reason of use. This information would be beneficial to know to review if there is a standard of care deviation and if medications were properly administered.

Medication	Use	Potential Side Effects
Propofol	Common medication used for anesthesia before or during some procedures or surgery. Used to cause sleep while on a ventilator. Given as a shot into a vein or as a continuous IV infusion. Given as needed in a healthcare setting; not prescribed for home use.	Minor: feeling sleepy, trouble sleeping, cough after waking up. Severe: allergic reaction; pancreatitis; high or low blood pressure; trouble breathing; fast or slow heartbeat; trouble controlling body movements, swallowing, or speaking; abnormal burning, numbness, or tingling. Rare severe risk: propofol infusion syndrome (PRIS), more likely with high doses or long-term use. Tissue damage may occur if medication leaks from the vein.
Fentanyl (Opioid drug class)	Used to manage pain. Commonly used to assist medications that induce general anesthesia. Usually given into a vein at the beginning of general anesthesia to lessen stress response and cough reflex.	Low blood pressure; low heart rate; trouble breathing, slow breathing, or shallow breathing. Post-surgery effects may include nausea and vomiting, urinary retention, delirium, increased sensitivity to pain, and itchy skin.

Midazolam (Benzodiazepine drug class)	Used to relax muscles, treat anxiety, and help control certain seizures. Sometimes given shortly before or after the patient goes to the operating room.	Low blood pressure; trouble breathing, slow breathing, or shallow breathing. Post-surgery amnesia, prolonged drowsiness, confusion, and increased risk of falling.

NOTE: Use of benzodiazepine drugs along with opioid drugs can lead to very bad side effects that include slowed or trouble breathing and death.

5. You receive 2,000 pages of records but discover that the EMG/NCV studies and the day-of-surgery nursing notes are missing. What is your step-by-step process to obtain these and flag the gap for the attorney?
   I will ask the attorney if they have any preferences in how they prefer a notation of missing documentation in the chronology to meet the needs of the attorney. If a preference is not provided and construction is left up to me, I would do the following:

   Step 1: Ensure all 2,000 pages of record have been thoroughly gone through and organized appropriately to ensure "missing" documentation has not been overlooked or misplaced in the file.

   Step 2: Immediately notify the attorney upon realization of the missing relevant records to be requested for discovery.

   Step 3: Continue to compose chronology with currently provided documentation.

   Step 4: Make rows within the chronology highlighted with written indication of missing documentation that needs to be added according to timeline of events.

   Step 5: While continuing to compose chronology of events, note and immediately notify attorney of any other relevant documents that are missing and indicate any other missing relevant documentation within chronology as in step 4.
   Step 6: Once missing documents have been acquired, transcribe information in highlighted missing documentation spots accordingly.

NOTE: maintaining good communication to effectively collaborate with the attorney is important to provide the best-case analysis and outcome for the client.

6. "L4-L5 disc extrusion with moderate central canal stenosis." The patient was on Gabapentin 900mg/day and Oxycodone 30mg/day. How would you screen this for causation in a workers' comp slip-and-fall case?
   - Research the diagnosis definition, causation, diagnostic and assessment confirmation. Clinical guidelines for treatment.
   - Review patients' medical documentation for presentation of symptoms and time elapsed for when patient sought medical intervention in relation to the date and time of the incident.
   - Review patients' medical history. Specifically for all previous diagnosed injuries, dates of occurrence, and subsequent treatment and if full recovery from historical injuries were ever obtained.
   - Review the patients report of the event of the fall to compare to research for supported/unsupported findings related to alleged injury.
   - Review patients' medications, indications for use, time patient takes medications, duration of use, reported side effects patient has experienced since taking medications, any medications taken and at what time prior to relevant incident.
   - Research prescribed medications for indicated use, dosages, duration of effects, and potential side effects.

   NOTE: Patients' past medical history and prescribed medications can be used as causation for the defense. It is important to know how contributory they were/weren't to the incident.

7. You have operative reports, PT notes, and a deposition summary from a treating physiatrist. How would you structure a medical chronology to highlight the causal link between an accident and a subsequent SI joint fusion?
   I will ask the attorney if they have any preferences in how they prefer a chronology to be constructed to best meet the needs of the attorney. If a preference is not provided and construction is left up to me, I would do the following:
   - I would construct the chronology in correct timeline order according to all the provided documentation.

- Within a relevant transcription, that provides linkage between the accident and subsequent SI joint fusion, I would insert a footnote notation. The footnote would elaborate on the relevant linking information for easy reference.

8. An attorney asks you to prepare questions for a defense expert who claims a patient's failed back surgery was due to "non-compliance." What key medical record findings would you pull to challenge or support that assertion?
   - What specifically in the medical record made you conclude that the patients' failed back surgery was due to "non-compliance?" (This is a broad question for cross-examination)

   For more detailed questions to get the witness to develop facts and proof of theories would be:

   - What are the causes of this back surgery failing?
   - What are the appropriate discharge instructions for a patient post-surgery for this procedure?
   - Were the appropriate discharge instructions provided for this patient upon discharge according to the medical record?
     - Such as appropriate intervals of follow-up appointments with the surgeon?
     - Incision/wound care?
     - Pain control?
     - Signs and symptoms to monitor for that warrant contacting the surgeon?
     - Signs and symptoms to monitor that warrant immediate medical attention?
     - Any weight-bearing restrictions?
     - Any lifting restrictions?
     - Range of motion restrictions?
     - Ordered prosthetic equipment needs placed?
     - Physical therapy (PT)/Rehabilitation consults?
   - Was there documentation in the medical record that the patient understood the discharge instructions provided and all questions were answered?
   - When reviewing the medical record what specific parts of the discharge instructions did the patient not follow that would have contributed to this back surgery to failing?

- What recommendations were made by the surgeon/PT/primary care provider, in any follow-up appointments of the procedure, that were not completed by the patient?
- Any actions testified to by the expert that the patient did not comply with:
    - What is the level of contribution of (non-complied act) on the failure of this back surgery?

9. You need to create an exhibit showing a patient's progression from an initial epidural steroid injection to a Radiofrequency Ablation (RFA) to a discectomy. How would you visually present this timeline for settlement negotiations?
    - Creating an enlarged calendar with progressive evidence marked/noted with the most relevant information from the medical record. Such as:
        - Initial complaint of medical condition.
        - Imaging study reading and/or image (if any).
        - Initial intervention noted on the calendar of the date of the epidural steroid injection. Having a simple 3-4 frame picture depiction of the procedure enlarged on a separate slide.
            - Clinical guidelines for current state of diagnosis. Concurrent/not concurrent with course of treatment decided.
        - Continued notation on the calendar of patients continued medical outreach due to lack of relief. Noting pain control issues, ordered imaging study readings and/or actual images (if any), and other interventions recommended/ordered (if any).
        - (RFA) notation on calendar. Again, with a simple 3-4 frame picture depiction of the procedure enlarged on separate slide. Any imaging studies readings and/or images per/post-procedure.
            - Clinical guidelines for current state of diagnosis. Concurrent/not concurrent with course of treatment decided.
        - Continued notation on the calendar of patients continued medical outreach due to lack of relief. Noting pain control issues, ordered imaging study readings and/or actual images (if any), and other interventions recommended/ordered (if any).
            - Clinical guidelines for current state of diagnosis. Concurrent/not concurrent with course of treatment decided.

- Discectomy noted on calendar. Again, with a simple 3-4 frame picture depiction of the procedure enlarged on a separate slide. Any imaging studies readings and/or images pre/post-surgery.

10. The attorney needs an interventional pain physician to review a case involving a spinal cord stimulator malfunction. Where do you search for qualified experts, and what criteria do you use to vet them before recommending them to the legal team?
    - Having obtained my certification from Legal Nurse I am a member of the National Alliance of Certified Legal Nurse Consultants (NACLNC ®) where I can access a database of other CLNC ® consultant's and their pool of expert witnesses. Also, research for experts on LinkedIn, through professional associations, and authoritative literature publications.
    - My vetting process includes:
        - Assessing credentials, including education, training, certifications and current license to practice. Request CV.
        - Professional experience and specialty.
        - Publications and presentations.
        - Professional memberships.
        - Reputation.
        - Communication skills.
        - Positive attitude and willingness to commit to the case.
        - Personality.
        - Number of years of experience as a testifying expert or consulting expert.
        - Percentage of income from consulting and from testifying.
        - Types and frequency of testifying experiences.
        - Opinions, verdicts and outcomes of past cases in which the expert was involved.

11. An attorney wants to ague that a specific pain pump medication was used "off-label" against FDA guidelines. Walk me through your process for conducting a peer-reviewed literature search to support this strategy.
    - I use a Search Strategy Form:

Sequence	Subject Search
Simple Topic Search	(Medication)
Databases	PubMed, UpToDate, MedLine
Keyword/Concepts or Conceptual Phrases	Off-label use; pain pump
Relevant Related Terms	Side effects of (medication); black box warning of (medication); complications (medication); incompatibilities with (medication)
Specific Date Range(s)	2 years prior and subsequent to the incident
Revised or Additional Search Terms	Based on search results
Notes/Comments	

12. We use Zoom, Microsoft Teams, and shared drives. Describe your experience with these. How do you organize your digital case files so a senior attorney can instantly find the operative note they need during a lastominute trial prep?
    - When starting a attorney-client relationship I prefer to ask the attorney-client how they prefer communication, reports, chronologies, research, file organizations done. This is to ensure that I am being efficient for the attorney's preferences and workflow.
    - If the attorney does not provide specifications and/or leaves those details up to me, then I like to organize files as such:
        - File with Case name
            - Files within with clear subject titles:
                - Reports/Chronologies: with clear name titles of author and type of report.
                - Medical Report: with clear name titles of the author, specialty, and date (if applicable); medication administration record (MAR); orders; imaging reports; and anything else contained in the medical file that may be needed to subcategorize.
                - Hospital Policies with clear name titles.
                - Authoritative literature
                - Demonstrate Evidence
                - And any other files with clear name titles (for files and documents within) that require a subcategory for quick and easy accessibility.

13. You notice the hospital's discharge summary lists "Morphine 15mg ER," by the inpatient MAR shows "Oxycodone 10mg" and the patient's home med list shows "Tramadol." How do you reconcile this discrepancy in your summary, and why is this important for a malpractice case?
    - Review ordered medications and prescribers.
    - Review documented medication reconciliation completed by (each) prescribing physician, as this is a standard of practice to be done by every prescribing physician. Note this was completed/or not. [Most important aspect of the summary]
    - Review the prescribing physician's plan of care/treatment sections of documentation to find supporting reason for medications prescribing. Note that this aligns with ordered medications/or not.

    Medication reconciliation discrepancies are important in a med-mal case because it proves negligence; breach of duty; can establish causation and damages; and weakens a defense case. If standards of care (SOC) were not carried out, then it can expose errors such as wrong dosages or dangerous drug interactions directly to patient harm. Therefore, establishing a critical legal cause and effect is needed to prove negligence.