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From the Editor



Welcome to the JNLCP issue on evidence-based practice. Any registered nurse life care planner who anticipates being grilled on the nursing diagnoses that are the underpinnings of our professional work should take a thoughtful look at the piece by

two of our colleagues from NANDA-I. As you read, imagine how your experience and assessment skills dovetail with the scientifically-validated rationales and derivations in this useful resource. I can tell you from personal experience how powerful this is when opposing counsel tries to position you as "only a nurse." We are direct descendents of the first professional nurse. Our practice derives from hers.

It's timely to remember Nightingale's groundbreaking efforts as a social reformer and advocate for health and sanitation in a wider sense. After her time in the Crimea she wrote an 830-page report on her experiences administering an army hospital there. She developed statistics to analyze mortality rates and causes of death, finding that 16,000 of 18,000 of all the servicemen dead in that war, an astonishing 89%, died of infection, not of war injuries.

This radical work caused a sensation. It helped drive the creation of the Royal Commission for the Health of the Army in 1857; this, in turn, sparked the creation of the Sanitary Commission, whose work spread throughout England and beyond, the real beginnings of what we know as public health. Countless people literally owe their lives and livelihoods to her efforts and example, among them descendants of British soldiers, countless citizens, and every nurse reading these words today.

And now, another huge challenge is upon us. How do nurses respond? I believe it is well past time that the ANA and other nursing organizations make this unambiguous declaration: Donald J. Trump and all

legislators who enable his destructive behavior as a matter of policy are a clear and present danger to national and international health. Full stop.

We all know about their astonishing denial of the reality of communicable disease as evidenced by ongoing lack of leadership, disregard and denigration of experts in the field of epidemiology and public health, and espousing dangerous practices such as unproven medications and ... bleach? At the time of this writing in mid-July, well, the writing is on the wall as incidence is rising, all ICU beds in 21 counties in Florida are full, and death rates are climbing.

What would Florence Nightingale, the founder of evidence-based practices in health, make of their other actions of omission and commission? Contempt for human health needs, women and men, children and elders by blocking safe contraception, mocking immunizations, and advocating for open schools and public meeting places in the face of a surge of infection; steadfast denial of the global warming that threatens populations with rising sea levels, droughts and flooding, and agriculture failures; sowing seeds of distrust of science and evidence-based practices in all spheres; systematic dismantling of environmental protection regulations resulting in increased air, water, and land pollution; defunding and gutting governmental structures designed to protect the general welfare; shocking conditions in service of xenophobic immigration fantasies...need we go on? Now that Médecins Sans Frontières (Doctors Without Borders) condemn our treatment of poor and incarcerated people and other countries ban our citizens from entry, well, there's only one conclusion. We're number one, alright: the premier source of contagion, famine, ignorance, and misery in the world. We need not look further to know why. Now is the time for nursing to make their voices heard, insistently, loudly.

"Nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, facilitation of healing, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, groups, communities, and populations." (ANA, 2015) Read that a few times. That's on all of us. Get on it. Make Florence proud.

Wendie A. Howland

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References

- American Nurses Association Scope and Standards of Practice, 2015
- Florence Nightingale Museum, <https://www.florence-nightingale.co.uk/>
- Médecins Sans Frontières/Doctors Without Borders, <https://www.doctorswithoutborders.org>, July 10, 2020
- Note: It's the 200th Anniversary of Florence Nightingale's birth. The museum of her artifacts and writings at St. Thomas' Hospital in London has been severely affected by the COVID-19 epidemic; they have a minuscule endowment and survive mainly on small admissions fees. Please join me in helping support their work and support of research into her life and times by sending them a donation. At last notice they were just short of half of their goal of £65,000 (about \$82,000). Find out more at <https://www.gofundme.com/f/6ws3a-save-the-florence-nightingale-museum>



Information for Authors

Information for Authors

AANLCP® invites interested nurses and allied professionals to submit article queries or manuscripts that educate and inform the Nurse Life Care Planner about current clinical practice methods, professional development, and the promotion of Nurse Life Care Planning. Submitted material must be original. Manuscripts and queries may be addressed to the Editor. Authors should use the following guidelines for articles to be considered for publication. Please note capitalization of Nurse Life Care Plan, Planning, etc.

Text

- Manuscript length: 1500 – 3000 words
- Use Word© format (.doc, .docx) or Pages (.pages)
- Submit only original manuscript not under consideration by other publications
- Put the title and page number in a header on each page (using the Header feature in Word)
- Place author name, contact information, and article title on a separate title page
- Use APA style (Publication Manual of the American Psychological Assoc. current edition)

Art, Figures, Links

- All photos, figures, and artwork must be in JPG or PDF format (JPG preferred for photos).

- Line art must have a minimum resolution of 1000 dpi, halftone art (photos) a minimum of 300 dpi, and combination art (line/tone) a minimum of 500 dpi.
- Each table, figure, photo, or art must be submitted as a separate file, labeled to match its reference in text, with credits if needed (e.g., Table 1, Common nursing diagnoses in SCI; Figure 3, Time to endpoints by intervention, American Cancer Society, 2019). Graphic elements embedded in a word processing document cannot be used.
- Live links are encouraged. Please include the full URL for each.

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- All accepted manuscripts are subject to editing, which may involve only minor

changes of grammar, punctuation, paragraphing, etc. However, some editing may involve condensing or restructuring the narrative. Authors will be notified of extensive editing. Authors will approve the final revision for submission. The author, not the Journal, is responsible for the views and conclusions of a published manuscript.

- Submit your article as an email attachment, with document title `articlename.doc`, e.g., `wheelchairs.doc`

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Manuscript Review Process

Submitted articles are peer reviewed by Nurse Life Care Planners with diverse backgrounds in life care planning, case management, rehabilitation, and nursing. Acceptance is based on manuscript content, originality, suitability for the intended audience, relevance to Nurse Life Care Planning, and quality of the submitted material. If you would like to review articles for this journal, please contact the Editor.

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A Message from the President



I hope everyone is staying safe and healthy. On the bright side, getting together for our conference in March 2021 in Memphis will be much more exciting, and I look forward to being able to see everyone.

The conference committee is working hard, getting ready for the March 2021 conference. **Victoria Powell** and **Joan Schofield** are the 2021 conference co-chairs. We are always searching for vendors and sponsors for our upcoming conference, so if you have any leads or suggestions, please pass them along.

We have the mentorship program in process, but we are looking for mentors. If you have previously registered for the mentorship program either as a mentor or mentee, please go to the AANLCP website and sign up again. Mentoring is an excellent way to give back to your colleagues, life care planning, and AANLCP, and gives you an opportunity to cheer on our members. Don't sell yourself short! If you are not sure if you would be a great mentor, just remember that you don't have to know all of the answers, and you will learn in the process.

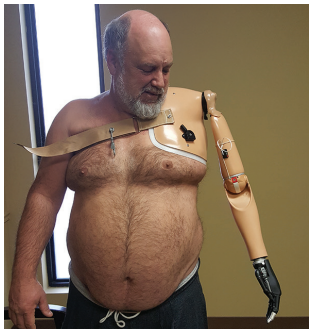
Never forget as Life Care Planners, we have a responsibility to patients and their families, regardless of how we enter their lives.

We value your ideas and can always use a few extra hands. Please don't hesitate to get involved. Getting involved is a great opportunity to make new friends and connections. Join a committee (Education, Conference, or Journal) or serve on the Executive Board! We would love to have you.

A handwritten signature in cursive script that reads "Erin J. OConnell".

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AANLCP President August 2018 - Current
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Letters Page



An update on osseointegration and neurofeedback for amputation information, JNLCP, May 2020, from the New England Journal of Medicine, which see for the full text.

Self-Contained Neuromusculoskeletal Arm Prostheses

April 30, 2020

N Engl J Med 2020; 382:1732-1738
DOI: 10.1056/NEJMoa1917537

Max Ortiz-Catalan, Ph.D., Enzo Mastinu, Ph.D., Paolo Sassu, M.D., Oskar Aszmann, M.D., and Rickard Brånemark, M.D., Ph.D.

Summary

We report the use of a bone-anchored, self-contained robotic arm with both sensory and motor components over 3 to 7 years in four patients after transhumeral amputation. The implant allowed for bidirectional communication between a prosthetic hand and electrodes implanted in the nerves and muscles of the upper arm and was anchored to the humerus through osseointegration, the process in which bone cells attach to an artificial surface without formation of fibrous tissue. Use of the device did not require formal training and depended on the intuitive intent of the user to activate movement and sensory feedback from the prosthesis. Daily use resulted in increasing sensory acuity and effectiveness in work and other activities of daily life. (Funded by the Promobilia Foundation and others.)

To encourage nurses to write for publication, the JNLCP will publish an annual supplement to every Winter (February) issue to be dedicated to NEW NURSE AUTHORS. Topics must be related to nurse life care planning in some way, for example, clinical, procedural, marketing, or communications, and are not limited to the issue topic. Authors must have no prior experience with publishing but will have mentoring to help their submissions shine. Submissions will be eligible for consideration for Article of the Year recognition. Send your questions and ideas to the Editor at whowland1@mac.com.





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Dawn Cook, RN, CNLCP, CLCP

is a licensed Registered Nurse with two certifications in life care planning. Dawn has been practicing as an expert in life care planning and past medical bill review since 2012, creating reports for plaintiff and defense counsel in 28 states. She has testified in Federal and state court and has been deposed more than 80 times. She can be contacted at dawn@cooklifecareplan.com



Susan V. Haibeck, RN, MS, CLNC

is President of Haibeck and Associates Legal Nurse Consultant is a registered nurse with over thirty years of experience, serving attorneys and their clients nationwide. She possesses a graduate degree in adult oncology nursing from Northern Illinois University and has reviewed many cancer related cases (defense and plaintiff) as well as medical records involving nursing home negligence, emergency room incidents and medication errors. She is available to develop pain and suffering reports, compose questions for depositions, coordinate "A Day in the Life" videos and locate medical experts.

Ms. Haibeck was featured as one of the Vickie Milazzo Institute of Legal Nurse Consulting Success Stories in 2017. Her strong nursing background provides needed insight to the 'behind the scenes' story of the institutional nursing culture and organization regarding medical related cases. She is authoring a book to be available by the end of 2020, working title "Cancer Care Malpractice – An Attorney's Guide to Understanding the Issues".



Gera-Lind Kolarik

is the founder and owner of Evidence Video, Inc. Since the company's inception in 1988, she has produced over 30,000 videos and has helped attorneys win in excess of 2 billion dollars in settlements and verdicts. Ms. Kolarik specializes in brain injury, paralysis, birth injury, amputee, and death cases. She graduated from Dominican University and worked at CBS and WBBM as an Assignment Editor and Producer. She then worked in the same capacities at Channel 7 in Chicago where she received an Emmy Award for spot news coverage. Ms. Kolarik was nominated for two more Emmy Awards and an Oscar for an ABC news special. She has also written three successful true crime books with her first book selling over 500,000 copies. She has spoken at numerous legal seminars on the use of video at trial and mediation and how to maximize damages.

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protocols or orders from a physician (Kamitsuru, 2008). Nurse life care planners are singularly placed to put this into action.

Nevertheless, before the last release of the NANDA-I Classification, some diagnoses included related/risk factors that were not modifiable or amenable to independent nursing intervention: gender, age, ethnicity, genetic characteristics, personal or family history, medical diagnoses, pharmaceutical agents, surgical procedures, etc.

In the current (2018-2020, 11th) edition, factors that could be removed or improved by independent nursing interventions were retained.

Factors which were not independently modifiable by the professional nurse, even though they supported clinical reasoning, were reclassified into two new categories: associated conditions and at-risk populations (Herdman & Kamitsuru, 2018). No nursing diagnosis requires either of these categories; however, they may be helpful.

Associated conditions were defined as (Herdman & Kamitsuru, 2018) "... medical diagnoses, injuries, procedures, medical devices, or pharmaceutical agents."

At-risk populations were defined as (Herdman & Kamitsuru, 2018) "... groups of people who share a characteristic that causes each member to be susceptible to a particular human response, such as demographics, health-family history, stages of growth/development, or exposure to certain events/experiences."

Knowing that a patient has a medical diagnosis, for example, chronic kidney failure, may change the way in which nurses work with him to improve fluid balance. However, nursing interventions cannot remove or diminish the chronic kidney failure itself. A nurse must consider how medications might affect care and human responses, and monitor for its effectiveness. However, only licensed prescribers can change a medication.

Consider an 80-year-old man with hypertension taking diuretics. It is summer, but he is not thirsty during the day, so he usually drinks only one or two glasses of water a day. These data indicate that he might be at risk for decreased fluid volume. Even though it is helpful to know, nothing can be done to change his age and diuretic prescription. Nevertheless, nurses can intervene on his knowledge about fluid needs.

Continuing with this example, risk factors for the diagnosis Risk for decreased fluid volume (NANDA-I code 00028) were rearranged (Herdman & Kamitsuru, 2018). Extremes of age has been categorized as an at-risk population, pharmaceutical agent has been categorized as an associated condition, while insufficient knowledge about fluid needs remains as a risk factor for this diagnosis. This allows nurses

to tailor the plan more specifically for this elderly male with specific underlying risk factors, rather than providing a general plan for decreased fluid volume that may or may not address his needs.

Missing related or risk factors?

After separating out related/risk factors into the two new categories, several diagnoses had no or very few related or risk factors. In this case, the message "To be developed" was placed under these diagnostic indicator categories. Lack of related or risk factors may be because: 1) these were renamed medical diagnoses, and therefore are not truly within the scope of independent nursing practice; 2) there is evidence for modifiable related/risk factors, but this knowledge has not been added to the NANDA-I terminology; 3) there is no evidence that supports any modifiable related/risk factors for this diagnosis (Herdman, 2019). Further work is required on each of these diagnoses to determine whether NANDA-I will retain them.

Some nurses might argue that a given factor listed as "associated" is in fact "related/causative." Remember that different jurisdictions have distinct practice laws and regulations regarding nursing autonomy. Therefore, some nurses might be able to independently treat an associated condition, while others may not (Herdman & Kamitsuru, 2018). When you see "to be developed" with a diagnosis, or when there are only a few related or risk factors, think critically and consider what a nurse can improve or remove through independent nursing intervention. This deliberation should be based on theories, literature, supporting research, expert opinion, and individual clinical experience (NANDA International, 2018).

During the 2018-2020 cycle, the NANDA-I Diagnosis Development Committee (DDC) has been identifying more useful related/risk factors on which nurses could intervene. If the diagnosis is actually a renaming of a currently existing medical diagnosis, or if no related factors or risk factors are identified that are independently modifiable by the nurse, these diagnoses will be removed from the 13th edition (2024-2026).

Retiring diagnoses, level of evidence

The DDC is also working on updating the LOE, with the assistance of content experts. Users will find that some diagnoses have many related /risk factors that are amenable to independent nursing interventions, but they have been tagged with the message, "This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring up to a level of evidence 2.1 or higher." More than 70 diagnoses have not been updated since at least 2002, when the level of evidence

CLASS (STRENGTH) OF RECOMMENDATION	LEVEL (QUALITY) OF EVIDENCE ‡
CLASS I (STRONG) Benefit >>> Risk Suggested phrases for writing recommendations: <ul style="list-style-type: none"> • Is recommended • Is indicated/useful/effective/beneficial • Should be performed/administered/other • Comparative-Effectiveness Phrases†: <ul style="list-style-type: none"> - Treatment/strategy A is recommended/indicated in preference to treatment B - Treatment A should be chosen over treatment B 	LEVEL A <ul style="list-style-type: none"> • High-quality evidence‡ from more than 1 RCT • Meta-analyses of high-quality RCTs • One or more RCTs corroborated by high quality registry studies
CLASS IIa (MODERATE) Benefit >>> Risk Suggested phrases for writing recommendations: <ul style="list-style-type: none"> • Is reasonable • Can be useful/effective/beneficial • Comparative-Effectiveness Phrases†: <ul style="list-style-type: none"> - Treatment/strategy A is probably recommended/indicated in preference to treatment B - It is reasonable to chose treatment A over treatment B 	LEVEL B-R (Randomized) <ul style="list-style-type: none"> • Moderate-quality evidence‡ from more than 1 RCT • Meta-analyses of moderate-quality RCTs
CLASS IIa (WEAK) Benefit >>> Risk Suggested phrases for writing recommendations: <ul style="list-style-type: none"> • May/might be reasonable • May/might be considered • Usefulness/effectiveness is unknown/unclear/uncertain or not well established 	LEVEL B-NR (Nonrandomized) <ul style="list-style-type: none"> • Moderate-quality evidence‡ from 1 or more well-designed, well executed nonrandomized studies, observational studies, or registry studies • Meta-analyses of such studies
CLASS III: No Benefit (MODERATE) Benefit >>> Risk <i>(Generally, LOE A or B use only)</i> Suggested phrases for writing recommendations: <ul style="list-style-type: none"> • Is not recommended • Is not indicated/useful/effective/beneficial • Should not be performed/administered/other 	LEVEL C-LD (Limited Data) <ul style="list-style-type: none"> • Randomized or nonrandomized observational or registry studies with limitations of design or execution • Meta-analyses of such studies • Physiological or mechanistic studies in human subjects
CLASS III: Harm (STRONG) Benefit >>> Risk Suggested phrases for writing recommendations: <ul style="list-style-type: none"> • Potentially harmful • Causes harm • Associated with excess morbidity/mortality • Should not be performed/administred/other 	LEVEL C-EO (Expert Opinion) <ul style="list-style-type: none"> • Consensus of expert opinion based on clinical experience

COR and LOE are determined independently (any COR may be paired with any LOE.)

A recommendation with LOE C does not imply that the recommendation is weak. Many important clinical questions addressed in guideline do not lend themselves to clinical trials. Although RCTs are unavailable, there may be a very clear clinical consensus that a particular test or therapy is useful or effective.

* The outcome or result of the intervention should be specified (an improved clinical outcome or increased diagnostic accuracy or incremental prognostic information).

† For comparative-effectiveness recommendations (COR I and IIa; LOE A and B only), studies that support the use of comparator verbs should involve direct comparisons of the treatments or strategies being evaluated.

‡ The method of assessing quality is evolving, including the application of standardized, widely used, and preferably validated evidence grading tools; and for systematic reviews, the incorporation of an Evidence Review Committee.

COR indicates Class of Recommendation; EO, expert opinion; LD, limited data; LOE, Level of Evidence; NR, nonrandomized; and RCT, randomized controlled trial.

FIGURE 1. Applying Class of Recommendation and Level of Evidence to clinical strategies, interventions, treatments, or diagnostic testing in patient care. (Halperin et al. Circulation 2016;133:1426-1428).

(LOE) criteria for nursing diagnoses were introduced (Herdman & Kamitsuru, 2018). It is possible, and in fact likely, that there is evidence for updated definitions and indicators, but it has not been submitted to NANDA-I.

Diagnoses that were accepted into the taxonomy prior to 2002 do not show LOE criteria, because none were identified when they were submitted (NANDA International, ND). One example is Risk for falls (00155), accepted into the taxonomy in 2000. There are certainly high-quality clinical studies providing evidence on the definition and risk factors for this diagnosis, but there has been no revision since 2000. In 2013 and 2017, revisions were completed for phrase adjustments and separation of risk factors into associated conditions and at-risk populations, respectively. This diagnosis is currently being revised to reflect the latest evidence.

The NANDA-I Research Committee reviews (and revises, as appropriate) these criteria. There is ongoing work to better reflect current evidence-based nursing. Current LOE criteria can be found in the NANDA-I website (<https://www.nanda.org/nanda-i-resources/level-of-evidence-criteria/>) and in the NANDA-I classification itself (Herdman & Kamitsuru, 2018). (Excerpt, Table 1)

The minimum LOE for publication in NANDA-I is 2.1 (Label, Definition, Defining Characteristics and Related Factors or Risk Factors, and References), with references for each. Nursing outcomes and nursing interventions are required; these must come from a standardized nursing terminology (e.g., NOC, NIC). The next levels include concept analysis, consensus studies with content experts and validation & testing through systematic literature synthesis, and clinical studies (Herdman & Kamitsuru, 2018).

Some diagnoses currently at a LOE 2.1 could be leveled higher. For example, Risk for decreased cardiac output (00240) was approved in 2015 at a LOE 2.1, based on cited references. There are no submissions to update it yet, although a concept analysis (Santos, Souza, Gutiérrez, Maria & Barros, 2013) and a clinical study (Santos, Lopes, Maria, & Barros, 2016) can be found in a quick literature search.

Nurses are encouraged to participate in the DDC process by conducting literature syntheses or clinical research to recommend evidence-based factors which are amenable to independent nursing interventions, or new levels of evidence for current diagnoses in order to better reflect the current state of nursing science.

Editor's note: Most nursing diagnosis work and development is based in hospital care and nursing education. However, two experienced CNLCPs attended the NANDA-I international conference in 2018 to present examples of how they used nursing diagnosis in life care planning and litigation. What are your thoughts?

Table 1. Level of evidence for nursing diagnosis, excerpt. NANDA-I, 2018.
<https://www.nanda.org/nanda-i-resources/level-of-evidence-criteria/>

2.0 Accepted for Publication and Inclusion in the NANDA-I Taxonomy

2.1 Label, Definition, Defining Characteristics and Related Factors, or Risk Factors, and References

References are cited for the definition, each defining characteristic and each related factor, or for each risk factor. In addition, it is required that nursing outcomes and nursing interventions from a standardized nursing terminology (e.g., NOC, NIC) be provided for each diagnosis.

2.2 Concept Analysis

The criteria in 2.1 are met. In addition, a narrative review of relevant literature, culminating in a written concept analysis, is required to demonstrate the existence of a substantive body of knowledge underlying the diagnosis. The literature review/ concept analysis supports the label and definition, and includes discussion and support of the defining characteristics and related factors (for problem-focused diagnoses), risk factors (for risk diagnoses), or defining characteristics (for health-promotion diagnoses).

2.3 Consensus Studies Related to Diagnosis Using Experts

The criteria in 2.1 are met. Studies include those soliciting expert opinion, Delphi, and similar studies of diagnostic components in which nurses are the subjects.

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REQUIRED ELEMENTS FOR NURSE LIFE CARE PLANNING TESTIMONY



Dawn L. Cook RN, CLCP, CLNC

Keywords: Nurse life care planning, testimony, foundation, Federal Rules of Evidence, Daubert, Frye

Introduction

The nurse life care planner (NLCP) should understand the circumstances and requirements for qualifications and plan foundation in litigation.

What is nurse life care planning?

"Nurse life care planners develop long-term or lifetime plans of care, including the costs associated with all of a plan's components. Care plan development is based on nursing assessment and collaboration with the affected individual, family, community, and care providers." (AANLCP, 2015).

What is a nurse life care planner expert witness?

In litigation, the nurse life care planner may serve as a testifying expert, providing testimony on disability and function, safety, nursing care, reasonable and necessary future care, and associated costs ... provides evidence regarding the plan's foundation, contents, recommendations, methodology, and conclusions. (AANLCP, 2015).

All life care planners must practice within the scope of their licensure and/or certification. A LCP who is not qualified to make a given recommendation must provide evidence or foundation for it (Weed, Berens, 2010). For example, only a NLCP may opine on assessment and nursing care for scientifically-validated nursing diagnoses (NANDA-I, 2018). A NLCP is generally not qualified to recommend spinal fusion surgery but may find evidence or foundation for including

it in a plan in authoritative texts, medical records, expert reports, physician deposition testimony, or collaboration with the physician (Shahnasarian, 2017).

The NLCP process will produce both a plan based on principles and evidence, and subsequent testimony to defend it. Each needs to demonstrate foundation.

Qualifications and Methodology

Before testimony, the life care planner will submit a written life care plan, a CV (curriculum vitae), a fee schedule, and a testimony log detailing all cases in which testimony has been provided via deposition, arbitration, and trial in the past four years. A list of all publications in the past ten years may also be required (Albee, Cosby, Beach, 2020).

Federal law has rules or standards specifying what is required when providing testimony. Expert witness rules vary by jurisdiction, and each state has civil procedure rules. If not a federal case, different rules may apply. Always check with the retaining attorney to be sure.

Understanding the federal rules will benefit the NLCP prepare for both federal and state trials. Once the judge determines the NLCP can testify then the jury or other trier of fact will then decide.

These two federal rules generally refer to the life care planner's qualifications and the methodology used in their report to substantiate the plan of care:

- **Rule 26 of the Federal Rules of Evidence** "(2) Disclosure of Expert Testimony. (v) a list of all other cases in which, during the previous 4 years, the witness testified as an expert at trial or by deposition" (Cornell, 2018).

NLCPs satisfy this rule providing a list all cases in which they have given testimony.

- **Federal Rules of Evidence Rule 702 – Testimony by Expert Witnesses** A witness who is qualified as an expert by knowledge, skill, experience, training, or education may testify in the form of an opinion or otherwise if:

(a) the expert's scientific, technical, or other specialized knowledge will help the trier of fact to understand the evidence or to determine a fact in issue;

(b) the testimony is based on sufficient facts or data;

(c) the testimony is the product of reliable principles and methods; and

(d) the expert has reliably applied the principles and methods to the facts of the case" (Michigan Legal, 2020).

NLCPs satisfy this rule with reports or testimony showing sufficient facts or data, such as medical records review, expert reports, possible communication with the individual and treating physicians, and other data.

- **Federal Rules of Evidence Rule 703 – Bases of an Expert** "An expert may base an opinion on facts or data in the case that the expert has been made aware of or personally observed. If experts in the particular field would reasonably rely on those kinds of facts or data in forming an opinion on the subject, they need not be admissible for the opinion to be admitted. But if the facts or data would otherwise be inadmissible, the proponent of the opinion may disclose them to the jury only if their probative value in helping the jury evaluate the opinion substantially outweighs their prejudicial effect" (Michigan Legal, 2020).

NLCPs satisfy this rule by producing a report or testimony showing supportive methods applied to the facts. The method is described by the American Association of Nurse Life Care Planners (AANLCP, 2013).

Scientific Methodology of Nurses and Nurse Life Care Planners

The nursing process is a recognized scientific methodology. The American Nurses Association defines the nursing process as assessment, diagnosis, outcomes identification, planning, implementation and evaluation of the plan of care (2015).

Assessment:

- reviewing medical records
- interviewing the individual/family if possible
- communicating with providers and/or experts
- researching literature, cost sources, etc.

Be prepared to describe assessment in detail to demonstrate how you followed the generally accepted process for life care planning. Be able to explain any deviation from the standard steps, such as denied permission to interview the plaintiff. Be prepared to explain how costs were obtained and why the sources of these data are reliable.

Nursing Diagnoses: NLCPs address individual/family responses to health problems and life processes. Nursing diagnoses are clinical judgments and may be

- problem-focused, i.e., concerning an undesirable human response
- risk related, i.e., related to an individual/family susceptibility to an undesirable response

- health promotion related, i.e., about the motivation or desire to improve health status

Nursing diagnoses guide the plan of care. The definitive source of lists, definitions, and defining characteristics of scientifically-validated nursing diagnoses is NANDA-I (NANDA-I, 2018). The NLCP should be familiar with this work and its strengths.

Interventions: These are related to achieving optimal outcomes, collaboratively determined by scope of practice. Examples include evaluations, interventions, health maintenance, health promotion, and optimization of physical and psychological abilities by appropriate actions or equipment. (AANLCP, 2015) The NLCP should be prepared to explain the rationales for these.

Implementation and Evaluation: It is unlikely that the full plan of care for the plaintiff will be implemented until after the case settles. Therefore, the implementation and evaluation components of the nursing process will be in the hands of future case managers and the individual/family. (American Nurses Association, 2015). The NLCP will explain that a well-constructed life care plan serves as a roadmap for care.

What Happens When You Testify

Qualifications: An expert witness must demonstrate qualifications to opine. At testimony the retaining attorney may spend 10-15 minutes asking the NLCP to describe relevant education, experience, certifications, and degrees and discussing past employment, including life care planning experience (Bate, 2018). The attorney may ask for a description of publications, professional presentations, and attendance at conferences, service or related committees, and awards or honors (Powell, 2013).

Methodology: Next, the retaining attorney will ask the life care planner about the methodology used in the report. This should include an explanation of what nursing and life care planning are, what processes the life care planner applied in developing the written report, and showing that generally-accepted practices were followed.

Opinions: After the retaining attorney has walked through qualifications and methodology, discussion of the NLCP opinions and conclusions will follow. The NLCP will show how applying qualifications and methodology resulted in a justifiable list of interventions and their costs.

Challenges to the Nurse Life Care Planner's Report and/or Testimony. There may be challenges to the life care planner's report or testimony, before or even during a trial. This may come in a motion in limine, Daubert, or Frye motion (Cornell, 2018) to have all or part of the life care planner's testimony excluded based on deficiencies in qualifications, methodology, or opinions.

Common challenges: The NLCP

- is not qualified or exceeded scope of practice (professional licensure, education, knowledge, training, and skill)
- did not follow a standard methodology or did not follow the methodology described in the life care plan
- relied upon a provider or expert who has now changed opinion
- did not apply the principles and facts in a reliable method
- did not submit the plan timely for discovery or other court deadline

Follow the Rules of Evidence to Rebut Challenges to a Plan

- Include the NLCP's qualifications in the CV and the written plan of care report. Elaborate on specific uncommon qualifications; for example, relevant strong nursing background, additional coursework, or presentations or publishing.
- Describe the general methodology. Adjust it based on the specifics of the case.
- Describe adherence to licensed scope and practice and association(s) standards. Clarify any deviations and explain them, e.g., plaintiff interviews, physician communications, research used, or how costing analysis.
- Use a section called "Opinions and Basis of Opinions" to describe each component in the report and support the opinion. For example, to support a recommendation for domestic services, the NLCP could list medical and nursing diagnoses, assessment data from the plaintiff interview or home visit, and evidence in depositions. For a recommendation for shoulder surgery, the NLCP could describe the injuries, recommendations from physicians, standard pricing methodologies to include surgeon charges, pre- and post-operative care, facility, and anesthesia needs.
- List services, codes and descriptions, reasonable charges, and sources.

Conclusion

Creating a life care plan that will survive challenges to testimony can be challenging yet rewarding. To meet the federal or state rules of evidence and rules, the NLCP must demonstrate adherence to all the required criteria: being qualified, using a validated methodology, reliably applying principles of life care planning, and having an adequate foundation to every recommendation in the life care plan.

Note: The author is not an attorney and this is not legal advice. An NLCP must communicate clearly with the retaining attorney to ensure that all components of the report will meet with state or federal law.

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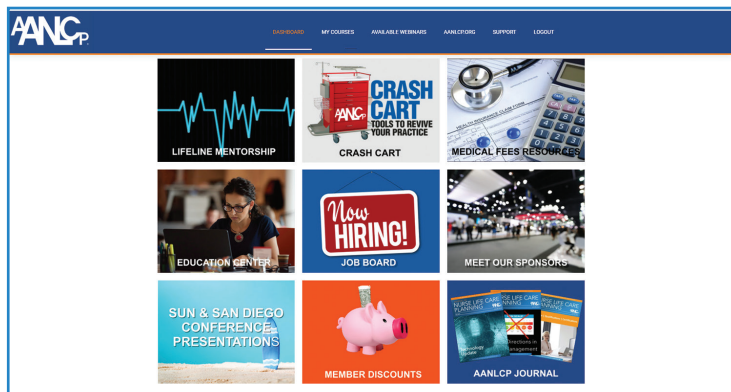
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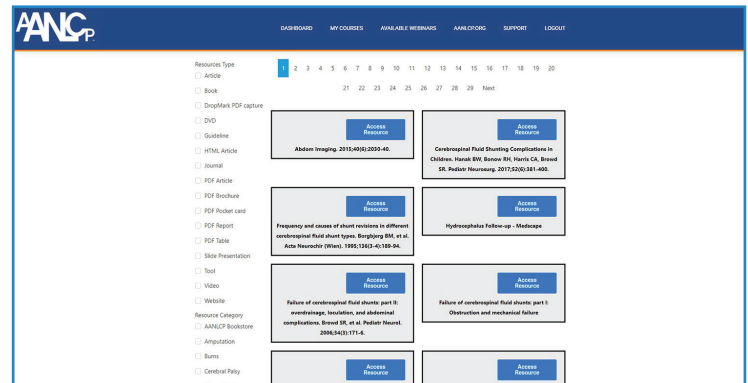
- Click on the "forgot password" if you need a new password
- At the bottom, click on support if you are not a member trying to log in

3. This is what the website looks like when you are logged in!

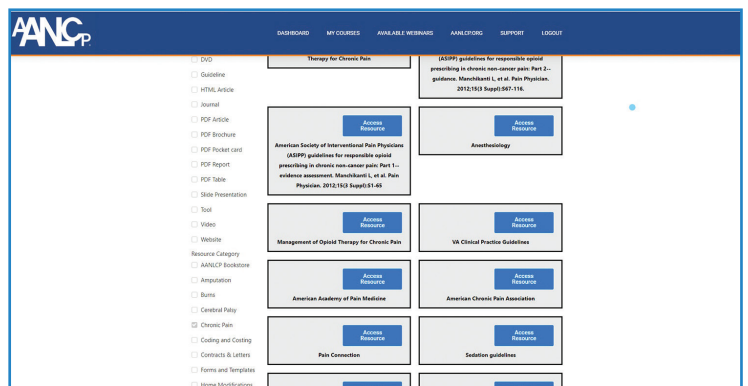


4. Click on the Crash Cart

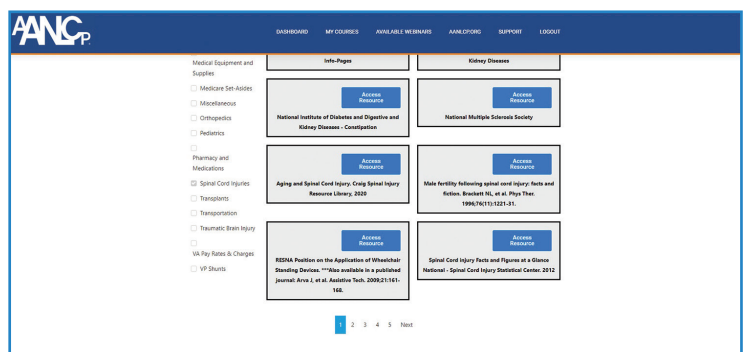
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- To get the best results, use "Resource Category" Scroll to the middle of the section
- Start your search by clicking on the broadest category, for example "Amputation," "SCI," or "Chronic Pain." This will automatically return the resources that are in this category. If this search gives you too many results, add another category to filter the returns further.



- Always look at the bottom for more resources



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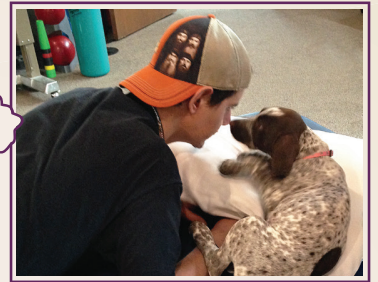
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SEEING IS BELIEVING:

Use of Video for Nurse Life Care Planning



Susan Haibeck RN MS CLNC
Gera-Lind Kolarik
Laura Lamar RN JD

Keywords: Day in the life video, demonstrative evidence, videography

Introduction

In our society, video images are a powerful, integral part of daily routines. Nurse life care planners and legal nurse consultants use videos to reinforce their assessments and nurse life care plans to demonstrate financial need for equipment, aids, nurses and supplies by helping the viewer to understand the injury's effect on a family or a client. A Day in the Life Video demonstrates injuries and can lead to increased damages recovered.

Video in use

According to the Illinois Trial Lawyers Association CLE Program, attorneys throughout the United States have increasingly discovered the value of using video as demonstrative evidence. Video instantly demonstrates in a few frames what otherwise would take several paragraphs of written text or minutes of spoken words. We more readily identify with people in a video even if they are complete strangers. Demonstrative evidence also provides break periods for the juries from verbal testimony.

Furthermore, we are persuaded by what we see more than by what we read or hear. Studies have shown that most human learning is based on sight; people who have seen and heard evidence remember it better. Increased retention is based in part on how much video information can be accurately

communicated. If a picture is worth a thousand words, a video can be worth millions. **Seeing is believing.**

Not surprisingly, attorneys have discovered the value of using video at trial and for out of court mediation to maintain a competitive advantage. However, they must understand and master the effects of visual tools on the viewer's perceptions, thoughts, beliefs, and emotions.

Purposes of a Professionally Produced Video

Why would plaintiff and defense want to use a professionally produced video?

- A. Demonstrate or refute damages or liability
- B. Desensitize the viewer to the subject or content
- C. Present evidence that otherwise could not be explained or admitted
- D. Length can be tailored to the viewers' interest level
- E. Support a life care plan
 - 1. Captures pain, physical and psychological disability, and rehabilitation over an extended period; brings subjects, equipment and devices into the courtroom
 - 2. Formats include still photographs, Progressive Video, Day in the Life Video, and Settlement Brochures
- F. Deposition
- G. Document an Independent Medical Examination

Video Formats

A jury trial may involve evidentiary restrictions for aspects of a Progressive Video or Day in the Life Video. Courts allow more latitude where the video is used as demonstrative evidence, such as a visual aid or context to an expert's testimony. If there are no legal restrictions to limit a video as a settlement tool, certain common-sense restrictions apply.

- A. Day in the Life Video** features the plaintiff in a variety of everyday situations that the non-injured person takes for granted: bathing, eating, dressing, ambulating, and interacting with family members and other activities of daily living. If appropriate, video may be taken of the plaintiff undergoing dressing changes, physical and occupational therapy or other treatments. Video helps the plaintiff convey to the judge and jury the struggles of his and his family's post-injury life. It demonstrates their courage and determination as they confront everyday challenges and obstacles. (Fig. 1a, b)



Fig. 1 a, b Medical malpractice case where the client was left brain-damaged. The video was used to show his condition and necessary constant care. Photo by Traci Ference

Sometimes it is advisable to have a short lead-in, depicting the plaintiff in a healthy, pre-injured, active state. It is highly unlikely that a person with the same or similar injury/disability as the plaintiff will be chosen to be a juror. Jurors have a natural inclination to take health and mobility for granted. Additionally, a plaintiff often has a tendency to be stoic and avoid the appearance of self-pity. This has a dramatic effect when the viewer compares the plaintiff's former life to his daily struggles now. After a month-long trial, a jury of six men and six women returned a verdict of \$101 million in the case



Fig. 2. A progressive video shows the care that this child's mother gives him with a G-tube feeding. (\$100M verdict.) Photo by Traci Ference

of this now 5-year-old child. He was born brain-damaged after hospital staff ignored abnormalities on external fetal monitoring strips for 6 hours. He has a normal life expectancy and is completely dependent on others for all aspects of his care. At the time of the trial, he was in a facility where he received excellent care. His mother will now be able to obtain care for him at home. Pictures used by permission of the attorney and mother. (Fig. 2)

B. Progressive Video is a series of Day in the Life films taken over an extended period. It is well-suited to demonstrate pain and suffering over the course of treatment and the stages of recovery. Videotaping begins as soon after the injury as feasible and continues at intervals to capture each stage of recovery, such as acute hospitalization and therapy, rehabilitation, in-home care, and outpatient follow up.



Fig. 3. Man who lost both legs in an accident, learning how to walk again. Photo by Traci Ference

It may be several years before a case reaches trial and the plaintiff may have adapted to (amputee with a prosthesis) or recovered from the injury after extensive therapy. A Progressive Video is very effective at conveying the plaintiff's potential for reaching his maximum function. For example, the expense for a more technologically advanced and expensive prosthesis can be justified by a video showing how much more independent the client could be with an upgraded prosthesis, compared with the prosthesis two years prior (Fig. 3).

C. Living Plaintiff Documentary/Wrongful Death Documentary (Settlement Brochure) This is a narrated presentation to build the plaintiff/decedent's life story. The Living Plaintiff Documentary compares and contrasts the plaintiff's level of functioning pre- and postinjury and the finished product shows current condition and level of function. Its visual impact is highly effective in settlement negotiations because it personalizes the plaintiff /decedent. These often use co-workers, family and friends interviews, home video, and photographs for maximum effect.

Cost

Cost varies with the complexity and length. Cost for taping and editing will typically be \$4000 to \$7500. If including evening care and the following day morning care, the cost could be approximately \$6000.00. Four hours of morning care will cost approximately \$4000. Video of a child, recording home care, therapy at school, and outpatient therapy could be approximately \$7500. Every effort is made to work within a client's budgetary constraints.

Review of Applicable Case Law

A case frequently cited in Federal and State Court is the 1991 Illinois Supreme Court case, *Cisarik v. Palos Community Hospital*, 144 Ill. 2d 339, 579 N.E. 2d 873 (1991), established a two-pronged admissibility test for video:

- i. Proper foundation must be laid by the person having personal knowledge of the filmed object, who can attest that the videotape accurately depicts what it purports to show; and
- ii. The probative value of the videotape must outweigh the danger of unfair prejudice.

Additionally, *Cisarik* set parameters regarding discovery rules:

- Materials generated during preparation of a video, such as schedules or storyboards are not discoverable because such material is attorney work product.
- Outtakes or unused videotape, that is scenes which were taped but not included in the final edited version, are privileged as attorney work product.
- Opposing counsel has no right to be present at the time of videotaping.

Examples: Illinois Caselaw

The first Illinois case to examine the use of video was *Barenbrugge v. Rich*, 141 Ill. App. 3d 1046, 490 N.E. 1368 (1st Dist. 1986). *Barenbrugge* holds that a videotape of a

Day in the Life of a plaintiff in a medical malpractice action, which was an accurate portrayal of plaintiff's condition and circumstances and whose probative value was not questioned, was properly admitted.

In Georgacopolous v. University of Chicago Hospitals and Clinics, 152 Ill. App. 3d 596, 504 N. E. 2d 830 (1st Dist. 1987), the court upheld the admissibility of a Day in the Life video which demonstrated a medical malpractice plaintiff undergoing painful physical therapy sessions. The defendants' objections that the videotape was both prejudicial and cumulative were unavailing. The court reasoned that no objection had been made that the videotape was not an accurate portrayal of the plaintiff's condition and circumstances. Furthermore, the judge described the tape as "tasteful" and the objectionable therapy session amounted to only a few minutes out of a nineteen-minute tape.

In a personal injury action resulting from a motor vehicle accident, testimony from the plaintiff's wife provided the proper foundation for the admission of the Day in the Life film. She testified that she had personal knowledge of the contents of the film, she had attended two physical therapy sessions, and the film accurately depicted how the plaintiff ambulated and how his therapy was administered. The film did not focus on plaintiff's pain and discomfort to the exclusion of anything else. While he did wince and grimace in various parts of the film, the plaintiff also smiled and talked with the therapist. The film focused on the therapy sessions that would be required for the rest of his life, rather than focusing on his pain. *Donnellan v. First Student, Inc.*, 383 Ill. App. 3d 1040, 891 N.E. 2d (1st Dist. 2008).

Google Scholar can help you locate Federal and state case law. This resource also has articles on the subject of Day in the Life videos. Laws regarding video at trial vary from state to state. The nurse life care planner and videographer should consult with the retaining attorney regarding applicable regulations.

Role of the Nurse Life Care Planner

Nursing Diagnosis Video can educate the jury on foundational bases for the NLCP's nursing diagnoses. A few examples:

- Alteration in physical mobility
- Imbalanced nutrition, weight loss
- Self-care deficit
- Social isolation
- Compromised human dignity
- Incontinence
- Caregiver role strain

Counsel may show parts of the video during NLCP testimony on line items in the plan, justifying the expense of equipment to increase independence and mobility. The video helps reinforce the written plan by showing:

- medical equipment and supplies, size, and storage
- intravenous tubing
- feeding tube
- various pumps
- injuries and scars
- surgical openings and dressings
- prostheses
- customized motor vehicles
- ramps
- architectural modifications
- space restrictions
- bowel and bladder programs
- functional deficits requiring therapies and adaptive technology
- condition and function of DME

Coordination The NLCP is ideally involved with the coordination and preparation of the video from the beginning of the case, perhaps recommending the use of video to the attorney, identifying a videographer, and coordinating the video. Prepare the family and patient for what will happen. Preparing the videographer for the expected activity is appropriate, such as saying, "Be sure to show how the mother handles this child in the bathroom." However, the NLCP should never act as a director or stage manager; the video should show actual activity as it occurs naturally.

Identifying an appropriate provider Cases commonly benefiting by video are brain injury, paralysis, and limb loss.

Hiring the right person is critically important. The video company must be familiar with the use of legal video with courtroom restrictions. Refrain from using a family member, friend, or videographer who films weddings and parties; experience and credibility with catastrophic cases are critical.

Ask for referrals and screen them. How often has their work been used in litigation? Speak with references to determine if their videos were effective. Review their work samples. Professional legal videos and non-professional legal videos are of vastly different quality and usefulness; nothing but a clear, well-lit, and properly-sequenced video will effectively tell the patient's story.

Preparation Before taping begins, the NLCP should pay attention to several important items. These include:

- Basic demographics
- Date of incident
- Date finished product needed
- Notification/Cooperation of plaintiff/family
- Type of case (e.g., car accident, medical malpractice, construction case)
- Type of injury
- Patient location and special equipment (walker, commode, hospital bed, ventilator, etc.)
- Contact administrator to coordinate if client is in a facility
- Facility release form

Each facility's response to a crew videotaping is different. Some will do anything to help the patient as long as releases are signed and the family initiates and is present throughout the filming. If the facility is uncooperative the retaining attorney may need to obtain a court order.

The NLCP may need to locate therapy experts to provide therapy in the video if the facility does not wish their staff to participate. The NLCP may need to demonstrate nursing care as determined. Original or follow-up tapings at the patient's home will document the home assessment and the family's involvement. (Fig. 4)

CONCLUSION

A well-made video showing morning, afternoon, and evening routine care and other activities of daily life will make the plaintiff's story come alive and support the economic and noneconomic damages sought. Seeing is believing.

Fig. 4 A 23-year old-quadruplegic in a standing device at home. Photo by Traci Ference



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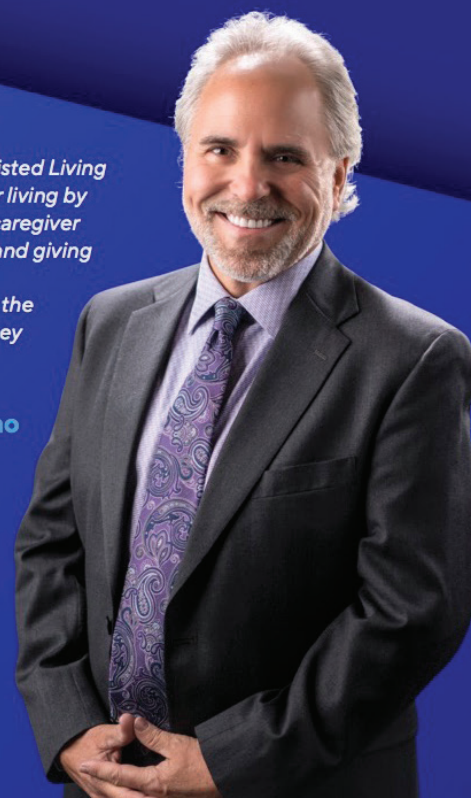
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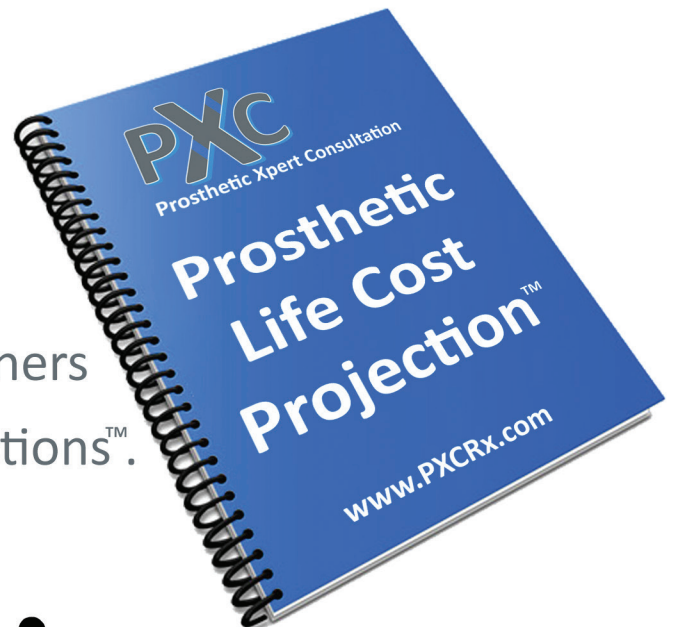
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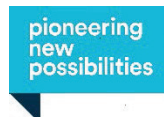




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