SAMPLE CHRONOLOGY EXCERPT

ILLUSTRATIVE DELIVERABLE · FICTIONAL MATTER

In re: Estate of Ronald J. Ashby

Post-Operative Sepsis · Unrecognized Alcohol Withdrawal · Failure to Rescue

Excerpted from a full Case Merit Review of 1,185 pages

PREPARED BY

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WHAT THIS DOCUMENT IS

THIS IS A FICTIONAL MATTER

This excerpt is a marketing sample prepared by TRACE Legal Nurse Consulting, PLLC to demonstrate how a TRACE clinical chronology is constructed and what it is built to show.

The patient, providers, facility, dates, medical record entries, and Bates numbers are entirely fictional. No real person, provider, or institution is depicted. Nothing here constitutes medical advice, legal advice, or an opinion on any live matter.

The chronology below is excerpted from a full Case Merit Review of a 1,185-page record set. It covers the operative window of the admission — the day of surgery through the afternoon of post-operative day three — and reproduces those entries as they appear in the full report, with internal cross-references to sections not included here removed.

The complete chronology in that engagement runs the length of the admission, from the pre-operative history and physical through the autopsy report. Sections of the full review that interpret these entries — the standard of care analysis, the nursing standard of care opinion, the causation analysis, and the cited authorities — are not reproduced here. The physiologic trending is reproduced in full below, because the chronology cannot be read without it.

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Why this reviewer, for this record

Sabrina Ritchie, AGNP-BC, PMHNP-BC, is a dual board-certified nurse practitioner — Adult-Gerontology and Psychiatric-Mental Health — with approximately nineteen years in direct patient care, holding an active, unencumbered registered nurse and advanced practice license.

She practices clinically in addiction medicine concurrently with her consulting work. Records are reviewed personally; analysis is not delegated to a review team and is not produced from a template.

That combination is the reason this record was analyzed the way it was. A reviewer with acute care nursing background alone would identify the sepsis timeline. A reviewer with addiction medicine background alone would identify the withdrawal management failures.

The finding this excerpt is built around — that the two processes were running concurrently, that one supplied a coherent explanation for the other, and that the point at which the record itself separated them is visible in the vital sign trend — requires both.

What a TRACE chronology does

A chronology that lists dated events tells counsel what happened. It does not tell counsel what it means, and it leaves the clinical reading of the record to be done twice — once by the consultant, and again by whoever reads the list.

Every TRACE chronology entry carries a stated clinical significance: what the entry demonstrates about the care delivered, what it contradicts elsewhere in the record, and where the documentation is incomplete. The right-hand column is the deliverable. The left-hand columns are the citation for it.

The practical effect is that a retained testifying expert receives a record already read — the entries identified, the significance stated, and each cited to its Bates number — and reaches the same position in materially fewer hours than a page-by-page review would require.

Three conventions used below

Marked entries. Entries marked ▲ are central to the analysis in the full review. ▲▲ marks the entries on which the strongest findings rest.

Documented absences. Entries sourced to “Records searched” document a searched-for absence rather than an affirmative entry, and are placed at the beginning of the interval they describe. Each reflects a search of the full produced record set for the item described — by flowsheet section, by order type, by result type, and by free-text term — across the stated interval. In a live engagement, the search terms and record ranges searched are provided to counsel on request.

Record citation. Every affirmative entry is cited to its Bates number; documented absences identify the record set searched rather than a page. Nothing in the significance column rests on a source not identified in the source column.

CLINICAL CHRONOLOGY — EXCERPT

The operative day, March 3, through the afternoon of post-operative day three, March 6 at 17:26.

DATE / TIME	SOURCE	DOCUMENTED EVENT	CLINICAL SIGNIFICANCE
Mar 3 *07:30–10:15*	FRMC 000845	Right total hip arthroplasty. Uncomplicated. Cefazolin given pre-incision.	Prophylaxis appropriate and consistent with accepted practice. Documents that infection risk was recognized at baseline, providing a clinical comparison point for the later omissions. The applicable guideline specifies administration within 60 minutes before incision; the exact administration time should be confirmed against the anesthesia record.
Mar 3 12:00 *– Mar 6 08:14*	Records searched	No CBC, no blood culture, no wound culture, no urinalysis, no chemistry panel, and no imaging ordered or resulted between the post-operative baseline studies and the studies resulting March 6 at 08:14.	▲▲ Nearly three days without any diagnostic study in a patient two to three days from instrumented orthopedic surgery, across which the record documents temperature rising from 98.2°F to 102.4°F and heart rate from 78 to 132. This is the earliest interval in the admission in which accepted practice required a diagnostic response and none is documented.
Mar 3 post-op *– Mar 6 16:40*	Records searched	No nursing entry documenting assessment of the surgical incision, dressing integrity, drainage character, or peri-incisional skin appears in the flowsheets between the immediate post-operative period and the dressing change on March 6 at 16:40.	▲▲ Approximately 78 hours without documented surgical site assessment. Serial incision assessment is a core element of post-operative nursing surveillance for an arthroplasty patient, and is the single assessment most directly capable of identifying the process that caused this death.
Mar 4 19:40	FRMC 000651	Nursing note: “Pt tremulous, anxious, diaphoretic. HR 108. Reassurance given.”	▲ First objective withdrawal signs documented, approximately 48 hours after the last drink. Earlier signs may have been masked by anesthesia and post-operative opioid analgesia — a recognized reason withdrawal is identified late in surgical patients. Charted accurately but not acted on. The observation exists; the assessment does not.
Mar 5 06:20	FRMC 000658	Vitals: HR 118, BP 168/94, T 100.8°F. Charted. No provider notification documented.	▲ Three concurrent abnormal parameters. Under commonly used institutional escalation criteria this threshold triggers provider notification. No notification entry appears in the record. This is also the peak recorded blood pressure of the admission — see the trending table below.

DATE / TIME	SOURCE	DOCUMENTED EVENT	CLINICAL SIGNIFICANCE
Mar 5 14:10	FRMC 000212	Physician progress note: "Post-op delirium, likely multifactorial. Continue current management."	▲ Anchoring begins. A conclusion is recorded without a documented differential. No infectious workup ordered, no withdrawal protocol initiated, no alcohol history revisited.
Mar 5 16:05	FRMC 000721	PRN lorazepam 1 mg ordered. MAR reflects no administration.	▲ Order-to-administration gap. A single PRN benzodiazepine order, entered without a recorded withdrawal diagnosis, scoring instrument, reassessment interval, or escalation parameter, is not a withdrawal regimen — though any administration would be characterized as withdrawal treatment regardless of the recorded indication. Pharmacy dispensing records are outstanding and would determine whether this reflects a documentation failure or a medication omission — clinically distinct findings with different consequences.
Mar 5 19:40	FRMC 000219	Addiction medicine consultation ordered. No consultation note appears in the record.	▲ An ordered consultation with no corresponding note, cancellation, or explanatory entry. Addiction medicine is the service positioned to apply the structured withdrawal assessment and risk stratification absent from this admission, and to recognize where a documented physiologic trend departs from uncomplicated withdrawal. Neither the consultation nor any interim structured assessment appears in the record.
Mar 5 22:15	FRMC 000733	Bilateral soft wrist restraints applied for agitation and line safety.	▲ Restraint applied without a documented underlying diagnostic assessment. Non-violent, non-self-destructive restraint carries its own ordering, monitoring, and reassessment obligations.
Mar 6 05:50	FRMC 000742	Vitals: T 102.4°F, HR 132, RR 28, BP 88/58.	▲▲ The physiologic picture completes a change in character. Blood pressure, which had been declining since 06:20 the previous morning, crosses into frank hypotension — systolic below 90 mmHg, mean arterial pressure 68 mmHg — while fever and tachycardia continue to climb, a divergence inconsistent with uncomplicated withdrawal. See the trending table below.

DATE / TIME	SOURCE	DOCUMENTED EVENT	CLINICAL SIGNIFICANCE
Mar 6 08:14	FRMC 000903	Labs result: WBC 18.2, lactate 3.8 mmol/L, creatinine 1.9 (baseline 1.0).	▲▲ Elevated lactate with leukocytosis and creatinine at 1.9 times baseline in a post-operative patient indicates hypoperfusion and evolving organ dysfunction. Taken with the mean arterial pressure below 70 mmHg recorded at 05:50, the documented data support a SOFA score of at least 2 — the Sepsis-3 threshold. No documented acknowledgment anywhere in the record.
Mar 6 *08:14–17:26*	Records searched	No repeat lactate, no blood cultures, no antimicrobial order, no documented fluid resuscitation, no rapid response activation, no provider notification entry, and no imaging.	▲▲ Approximately nine hours with no documented clinical response to results requiring immediate action. The longest interval in the admission without response to abnormal findings.
Mar 6 11:30	FRMC 000229	Progress note: “Agitation persists, consistent with withdrawal. Continue supportive care.”	▲ The working diagnosis is restated three hours after the abnormal lactate resulted and more than five hours after the blood pressure crossed into hypotension. Documents that the data was available and the clinical impression did not change.
Mar 6 16:40	FRMC 000751	Wound dressing changed. Nursing note: “moderate serosanguineous drainage, area warm.”	▲ First documented local wound finding of the admission. Warmth with increased drainage on post-operative day three is a recognized early sign of surgical site infection. The finding is recorded but no notification or escalation entry follows it.
Mar 6 17:26	FRMC 000762	Vancomycin and piperacillin-tazobactam initiated. Blood cultures drawn.	▲ Approximately nine hours after the lactate resulted. Cultures were appropriately drawn before antimicrobials, consistent with accepted practice; the interval to administration falls outside the guideline-recommended window.

The excerpt ends here. In the full engagement the chronology continues through ICU transfer at 23:05 on March 6, operative washout and culture results on March 7, death on March 9, and the autopsy report of March 14.

PHYSIOLOGIC TRENDING

Individual vital signs were charted accurately throughout this admission. The deterioration is visible only when they are read as a trend. This table is reproduced in full because the chronology above cannot be read without it — the entry at March 6, 05:50 is a finding only in the context of the seven readings that precede it.

DATE / TIME	TEMP °F	HR	RR	BP	LABS	INTERPRETATION
Mar 3 12:00	98.2	78	14	128/76	WBC 9.8 Creat 1.0	Post-operative baseline. All parameters within normal limits.
Mar 3 20:00	98.6	88	16	134/80		Unremarkable.
Mar 4 08:00	99.1	96	18	142/86	none ordered	Early upward drift across all four parameters. Individually unremarkable; collectively the start of a trend.
Mar 4 19:40	99.4	108	18	152/88	none ordered	First withdrawal signs charted. Rising heart rate and blood pressure consistent with sympathetic hyperactivity.
Mar 5 06:20	100.8	118	20	168/94	none ordered	▲ Three parameters abnormal simultaneously. Highest recorded blood pressure of the admission. From this point the blood pressure declines while fever and heart rate continue to rise.
Mar 5 14:00	101.2	122	22	160/90	none ordered	Respiratory rate now abnormal. Blood pressure falling as temperature rises — the divergence begins. RR is the earliest and most frequently under-documented indicator of deterioration.
Mar 5 22:15	101.6	126	24	158/92	none ordered	Restraints applied. Temperature and heart rate at their highest recorded values to date; blood pressure ten points below its peak sixteen hours earlier.
Mar 6 05:50	102.4	132	28	88/58		▲▲ INVERSION COMPLETE. Systolic pressure below 90 mmHg and mean arterial pressure 68 mmHg — frank hypotension — while fever and tachycardia continue to climb. The direction of the two trends is now fully opposed.
Mar 6 08:14	—	—	—	—	WBC 18.2 Lactate 3.8 Creat 1.9	▲▲ Leukocytosis, hyperlactatemia, and creatinine at 1.9 times baseline — KDIGO Stage 1 acute kidney injury. All four SIRS criteria met (temperature, heart rate, respiratory rate, white blood cell count). First diagnostic studies of any kind since March 3.

DATE / TIME	TEMP °F	HR	RR	BP	LABS	INTERPRETATION
Mar 6 12:00	102.1	130	28	92/54		No documented clinical response. Hypotension sustained; mean arterial pressure 67 mmHg, continuing to fall.
Mar 6 17:26	101.8	128	30	88/52		Antimicrobials initiated. Mean arterial pressure now 64 mmHg, below the 65 mmHg threshold. Respiratory rate continuing to rise.
Mar 6 23:05	100.9	136	32	74/40	MAP 54 (a-line)	ICU transfer. Vasopressor support initiated. Cuff-derived MAP 51; the arterial line value of 54 is the figure recorded in the ICU record.

Mean arterial pressure is calculated from a cuff pressure as the systolic plus twice the diastolic, divided by three. The MAP values above are derived from the charted cuff pressures by that formula, except at 23:05 on March 6, where the ICU record documents an arterial line value and that value is identified as such. Blood pressure is not a SIRS criterion; the four criteria are temperature, heart rate, respiratory rate, and white blood cell count.

THE BLOOD PRESSURE INVERSION

From March 4 through the early morning of March 5, the blood pressure climbed steadily, reaching its highest recorded value of 168/94 at 06:20 on March 5. That pattern is consistent with alcohol withdrawal, in which sympathetic hyperactivity characteristically produces hypertension together with tachycardia and fever. Through the morning of March 5, the clinical impression recorded in the chart fit the data then available.

From 06:20 on March 5, the trends separate. Blood pressure declines — 168/94, then 160/90, then 158/92 — while temperature rises from 100.8°F to 101.6°F and heart rate from 118 to 126. By 05:50 on March 6 the separation is complete: the blood pressure has crossed into frank hypotension at 88/58 while the temperature has reached 102.4°F and the heart rate 132.

That is not withdrawal worsening. In escalating sympathetic hyperactivity, blood pressure, heart rate, and temperature move together. A patient whose fever and heart rate are climbing while his blood pressure falls is not following the trajectory the working diagnosis predicts.

The clinical significance is one of character rather than degree. Had the working diagnosis been correct, all four parameters would have continued in the same direction. They did not. The point at which the record itself began to contradict the working diagnosis is the morning of March 5 — approximately twenty-six hours before the first laboratory study was drawn, and roughly eight hours before the progress note recording an unchanged clinical impression.

SCOPE AND LIMITATIONS

TRACE is retained as a consulting expert. Analysis is prepared at the direction of counsel in anticipation of litigation and is intended to be protected as attorney work product. TRACE does not testify, is not disclosed as a testifying expert, and does not practice law.

This document DOES: analyze the medical record and state the clinical significance of each entry, measured against accepted clinical practice standards.

This document DOES NOT: assess the legal merit, viability, or value of any claim; offer opinions on duty, breach, proximate cause, or liability as legal elements; opine on physician standard of care or on medical causation; recommend whether a matter should be pursued, settled, or declined; or advise on litigation strategy. Those determinations rest solely with counsel, informed where appropriate by retained testifying experts.

Where this document uses the phrase "standard of care," it refers to accepted clinical practice standards, not to the legal standard of care as applied by a court. Clinical guidelines referenced are real and described at a general level; in a live engagement each is pinned to the edition operative on the date of the care at issue and produced as an exhibit.

Opinions on nursing and advanced practice nursing standards of care are rendered within this consultant's own licensure and board certification. No opinion is rendered on physician standard of care or on medical causation.

WHAT THE FULL CASE MERIT REVIEW ADDS

The chronology is one section of the deliverable. The full Case Merit Review of this record comprised the following:

SECTION	CONTENTS
Engagement summary	Matter details, scope of analysis requested, and the findings most supported by the record
Records reviewed	Source, date range, Bates range, and page count; records requested but not produced
Clinical chronology	The full admission, from pre-operative history through autopsy — excerpted above
Physiologic trending	Reproduced above
Clinical issues identified	Each issue ranked by strength of documentary support
Standard of care analysis	Sepsis recognition, withdrawal management, and diagnostic reasoning, each stated with the standard applied, the record evidence, and the analytical basis
Nursing standard of care	Findings within this consultant's own scope of practice, cited to published nursing standards, with a stated consultant opinion and its limits
Clinical causation analysis	The documented sequence, what requires physician expert opinion, and alternative clinical explanations considered

SECTION	CONTENTS
Findings relevant to damages	Clinical observations bearing on damages development
Missing records and discovery	Outstanding items ranked by expected impact, including EMR audit trail and sepsis advisory firing and dismissal logs
Recommended expert specialties	Which experts to consider and the scope of opinion needed from each
Outstanding clinical questions	What the review cannot yet resolve, and what would resolve it
Questions for the retained expert	Prepared so counsel can direct expert engagement efficiently
Abbreviations	Clinical terms and instruments referenced in the report
Authorities and sources	Full citations, the section each supports, and production status — prepared for transmission to the retained expert

THE TRACE METHOD

TIMELINE · RECOGNITION · ACTION · CAUSATION · EVIDENCE

NEXT STEP

Case screening: from $850, fixed fee quoted before any work begins. The screening fee is credited in full toward a case merit review commenced within 60 days.

Case merit review, as excerpted here: from $6,000, fixed fee quoted before any work begins, scoped to record volume. Every proposal states a record cap.

Confidential case inquiries receive a conflict check within one business day.

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