Example
Brief Narrative Report

Re:

Dear Attorney-Client,

26-year-old female, Mrs. J., who was approximately 36-37 weeks gestation, ruptured her membranes at approximately 1500, on October 1, 0000. She presented to the labor and delivery unit, ambulatory at approximately 1430, on October 2, 0000.

Mrs. J. had a history of herpes, but her cultures were negative (note, stat culture on October 2, 0000 at 1800 was negative), and was appropriately allowed to go into labor.

On October 3, induction was instituted at 0055. Induction was not successful and cesarean section was performed on October 3 for failure to progress. The infant's Apgar was 8 and 9 for one and five minutes, respectively. This is within high normal limits.

A review of the fetal monitor strip reveals that there is nothing ominous which would necessitate a stat cesarean section. The strip demonstrates a large amount of artifacts, some acceleration, some tachycardia, some periods of decreased variability and two possible late decelerations which were resolved.

The neonatal period was uneventful for a premature infant. The infant presented as a slow feeder which is normal in premature infants. The sepsis workup (done because of prolonged rupture of membranes) was negative and prophylactic antibiotics which had been instituted were discontinued on the third day after birth. The infant had an anal fissure; this is not significant.

The infant was discharged at two and one half weeks which is longer than average stay, but within normal limits for that gestational age.

In conclusion, there has not been any significant deviations from the standard of care and it would be very difficult to establish causation, i.e., that the labor and delivery events caused the seizures in this infant.

If I can assist you further in this case or any other matter, please do not hesitate to contact me.

Best,

Megan Cappuccio, BSN, RN, CLNC

Example
Brief Narrative Report

August 20, 0000

Attorney name
Attorney address

Dear Attorney-Client,

Pursuant to your request that our office screen the case of Mr. A.C., it is our opinion that there are deviations from the standard of care that directly contributed to Mr. C's injuries. Specifically, Dr. R failed to thoroughly examine Mr. C. pre-operatively, and to implement other interventions prior to surgery. These deviations contributed to the performance of a surgical procedure that was not indicted.

An obvious weakness in the case is the damages issue. Additionally, the defense may attempt to relate the ongoing post-operative pain to the fact that Mr. C. was on his feet frequently, was driving a standard transmission automobile and was not elevating foot post-op. They will also probably bring in the fact that Mr. C. came for an office visit on 7/14/0000 without the proper bandage; stating it came off the day before and that he replaced the bandage over the wound and covered it with a sock. This incident has no bearing on the case since there is no evidence of wound infection or wound dehiscence.

If you would like additional assistance in further developing the case or in locating an expert podiatrist and/or orthopedic surgeon, please contact our office at 508.367.9065.

Thank you very much for the opportunity to consult on this matter.

Best,

Megan Cappuccio, BSN, RN, CLNC

Example
Chronological Timeline Without Comments

Mrs. L. a 33 year-old female, Gravida 2, Para 0, Ab 2, was admitted to A General Hospital at 0700 on 10/20/0000 for induction of labor. Mrs. L. was known to be a Class A (gestational) diabetic. However there was no apparent difficulty in maintaining glucose control throughout the pregnancy and Mrs. L. was without prognostically bad signs during pregnancy. Dr. P. classified Mrs. L. as having a borderline pelvis. The summary of course of hospital events, indications for close surveillance of the fetus, summary of birth injuries and deviations from standard of care are as follows.

Time	Event (Mrs. L.)
0700	Admitted to the labor and delivery unit. FHR baseline range 130s-150s.
0815	IV started; CBS, RPR sent to the lab. External fetal monitor applied.
0830	Induction of labor began with Oxytocin. Dr. P. present.
0920	Artificial Rupture of Membranes (AROM) per Dr. P. probably related to the fact Mrs. L. does not have a successful response to the Oxytocin alone. Small Amount of meconium stained fluid present upon AROM. Internal fetal monitoring began.
0945-1000	Onset of regular contractions following AROM
1100	“FHTs baseline good BTB” (good beat-to-beat variability)
1130	“FHTs as above good BTB good FHT recovery from contraction” (Fetal monitor strip may show some type of deceleration pattern here.)
1200	Demerol 25mg, Phenergan 25mg IV push. Indication for medications not Documented by nurses, however, Mrs. L. described during interview the Presence of significant back pain during labor, which is common to the ROP Position. Ice pack to sacral region. Indication is not documented, however is probably Indicated for back pain.

Example
Chronological Timeline with Comments

V. Specific Deviations from Standard of Care

Date/Time	Event/Source	Comments
11/10/000 1410	Emergency Center Nsg. Assessment and Prog. Record (p.10) Transport in: carries Triage Nurse: D.S., RN Vital Signs: Temp: 98.5 Pulse: 100 Resp.: 20 B/P: 135/70 Chief Complaint: While playing baseball he was struck on the left side of the head near the ear. He has had 3-4 large emesis; c/o [without] [left] neck pain. Pertinent medical surgical history: febrile convulsion at young age. Allergies: NKA Medications: none Last tetanus: Current LMP: N/A Ht: Wt: Private MD: G. Time called: Pt. request: ☐Private MD ☑Emergency Physician Consulting M.D.s: B. S. Nurse: Time:	This is a case about the failure to respond timely and appropriately to an emergency or urgent condition in a 9 year-old child who sustained head injury. Said failure resulted in significant neurological deficits. It will be important to establish the exact time this initial assessment was done, It will be important to establish the specific involvement of both J.L.,LVN and D.S. caring for {Patient}. It will also be important to establish who documented entries in the record. The application of mu comments depends on the provider's specific level of involvement. It is my position that this patient was beyond the scope of an LVN. **The nurses failed to treat {Patient} as a trauma patient and specifically failed to provide Level II capabilities.** I recommend that you consider suing the nurses individually. See ENA Trauma Care ( ) p. 1-2 which states: 1. The optimal care of the trauma patient is best accomplished within a framework in which all members of the trauma teams use a systematic, standardized approach to the care of the injured patient.

Example
Brief Outline Report

Attorney
Attorney Address

Dear Attorney,

Pursuant to our discussion on May 16, 0000, my comments are intended to supplement the opinions of Dr, Dudley and Dr. Fisk.

I. ADDITIONAL POTENTIAL DEFENDANTS

A. Dr. Fisk
1. Failed to arrange for a cardiology consult in January, 0000 following the circumcision.

2. Failed to impress on Mr. S. the importance of seeing a cardiologist in the presence of left ventricular hypertrophy and T-wave abnormality in the anterolateral leads.

Note: I am unable to read Dr. Fisk's progress notes, however it appears that he does not even document the abnormal EKG.

B. The LVN who treated Mr. S. the evening of his death (see comments under Section V. NURSING MANAGEMENT).
C. Possibly the floor RN who responded initially to the code.
D. Dr. Sloan's assistant, if any.

II. MR. S'S HISTORY

A. It will be important to establish how long Mr. S. had been taking Tagamet, who prescribed it and the indication for said Rx (e.g. indigestion). Mrs. S. refers to a history of ulcer, which could account for this prescription.

III. MEDICAL MANAGEMENT

A. H&P dictated on date of death, and appears self-serving, especially with respect to so many comments regarding CXR, EKG, and consult. It would be interesting to compare this rather thorough H&P to others he has dictated.
B. Failed to obtain a cardiology consult prior to surgery or in the alternative failed to admit Mr. S. to the ICU or intermediate care unit (IMU) for observation postoperatively. Mr. S. should have been in the ICU or IMU until he was seen by a cardiologist. The entry "Ans. Machine 6pm. 3/29" (looks like Dr. Sloan's handwriting) was probably added to the record after Mr. S's death.

C. Apparently performed surgery without reviewing the CXR first or having the benefits of the report.
D. The post-op entry in the Medical Progress Note (p. 12) “suggesting Pulmonary edema/infiltrate” appears to have been added later. Other squeezed-in entries may have been added later as well. It will be important to establish what time Dr. Sloan wrote the admitting note, because it does not mention the EKG and CXR results.
E. The reference to the “abnormal chest X-ray with suggestion of pulmonary edema and or infiltrate” on the OR record (dictated on date of death) seems out of place. I question whether Dr. Sloan was even aware of these abnormal findings before surgery because he seems so intent on communicating that he did indeed have knowledge of these reports. The Pre-Anesthetic Record (p.32) contradicts at least Dr. Sloan’s knowledge of CXR, because the report indicates the CXR is pending. The OR nursing Pre-Op Assessment (p.26) also indicates that the CXR report was not on the chart prior to surgery. It will be important to establish whether the 1317 time on the CXR (p.19) represents the report time or the dictation time. Also, Mrs. S indicates that Dr. Sloan was surprised when she mentioned the problem with Mr. S.’s heart to him after surgery. It would be interesting to compare this rather thorough OR report to others he had dictated.

IV. ANESTHESIA MANAGEMENT: DR. FISK

A. Misclassified anesthesia risk as one.

V. NURSING MANAGEMENT

A. Negligently assigned a patient with significant cardiac risk to a LVN.
B. The late entry on 3/29/0000 (made by the same nurse who was caring for Mr. S. at time of death) regarding consultation was probably written after Mr. S. death.
C. The nurses failed to respond to Mr. S.’s complaints and family requests as describe in the family narrative
D. The second shift (3-11p) notes were probably rewritten. The entries re: chest pain are clearly out of character with the rest of the chart and with the same nurse’s entries on 3/29/0000. Orthopedic nurses don’t assess for chest pain unless there is a clear indication to do so or the patient actually complains of chest pain. It is unlikely that this nurse recognized an indication to assess for chest pain, especially since she had not done so the night before. It will be important to establish from family members and witnesses whether Mr. S. complained of chest pain, indigestion, etc. to which the nurses failed to respond.
E. The record strongly suggests that the nurses failed to initiate CPR prior to the arrival of the code team. This is a significant departure from the standard of care.
    - Mrs. S. states that “at 6:30p until 7:00p they didn’t give CPR or oxygen, just after 7:15p a paramedic went to get a shock machine.”
    - See ER Progress Note (p.13) which states “called to see a patient at 6:45p. On arrival the patient is in bed without resp., pulse, HR or neuroactivity-pupils fixed and dilated. CPR began with ambu and compressions.”

- It will be important to establish with family members and other witnesses who actually started CPR.

F. The nurses failed to maintain a complete and accurate code record (e.g. VS, time CPR started, time intubated, etc.)
G. It will be important to establish the significance, if any, of the blank “Nursing Care and Assessment” records (p. 45 and p.51)
H. VS are not assessed a minimum of every four hours. Also, there should be a policy and procedure which calls for more frequent VS on the floor for the immediate post-op period.

VS were documented:

3/29 (3-11): One time
3/30 (11-7): One time (on graphic sheet only)
3/30 (7-3): Not documented
3/30 (3-11): One time (in nursing notes only)

VI. REQUEST FOR PRODUCTION AND INTERROGATORIES

A. It will be important to obtain all policies and procedures, rules and regulations regarding consults.
B. It will be important to request the code EKG strip, and the name of every individual who responded to the code.
C. It will be important to obtain the Nursing Care Plan.
D. It will be important to establish Dr. Anderson’s arrival time to the code. He apparently intubated the patient.

VII. ADDITIONAL COMMENTS

A. The defense will probably argue that Mr. S. was negligent for failing to see a cardiologist following the circumcision.

If I can assist you further with this case please let me know.

Best,
Megan Cappuccio, BSN, RN, CLNC