Sample Merit Screening

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CONSULTING

This sample is for marketing and demonstration purposes only. All reports will meet all standards set by client at time of consultation.

Screening Report of Client: John Doe

As requested, I have reviewed the following case covering hospital records from February 2nd, 2021, through February 21st, 2021. John Doe was transported from Rest Haven nursing home for a low blood pressure of 80/50. Upon reaching the hospital, he received blood work and a chest x-ray which indicated that fluid was present in both of his lungs. Once Mr. Doe's blood pressure began to improve (95/66), he was diagnosed with pneumonia and sent to a medical surgical floor for further evaluation. 95/66 is the last recorded blood pressure measurement until 23:45. According to documentation by *** RN, Doe became increasingly combative, which she attributed to his medication and the late hour. *** RN documented finding Doe on the floor, at 23:15. There is no documentation of physician, or family notification after the fall occurred. The patient was rushed to a CT of the head at 05:30, due to decreased mental status. Imaging showed an acute, subdural hematoma, which resulted in severe brain damage. On February 21st, 2021, John Doe ultimately passed away from complications of the sustained fall. It is my professional nursing opinion that deviations from appropriate standard of care caused John Doe to rapidly decline, and ultimately pass away. I believe this case is meritorious and should receive further, thorough review.

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Merit based on the following deviations of care:

1. Failure of staff to assess blood pressures' following a reading of 95/66, which occurred 22 minutes after arriving to the emergency department
2. Failure of staff to prevent the traumatic fall
3. Failure of staff to complete/document assessments throughout the night, after the fall occurred

Items that need further investigation and attention:

1. Research on SOC for assessing vital signs, specifically related to frequency following abnormal blood pressure readings
2. Review of orders given by the hospitalist, compared to nursing actions performed throughout the night
3. Timeline showing deterioration of John Doe
4. Research on SOC related to deteriorating patient mental status
5. Research into nursing documentation to identify if fall risk preventions were implemented, in accordance with unit policy
4. Development of a chronology demonstrating substandard nursing care
5. Location of a medical intensivist (ICU doctor) to testify on the importance of early subdural hematoma recognition, related to survival chances
6. Locate a nurse expert to testify on deviation from standards of care, related to patient assessments, deteriorating mental status, obtaining vital signs, and proper handling of falls

Analysis

This case will require a thorough and clear understanding of SOC related to falls, vital sign assessments, and managing deteriorating patient mental status. I plan to show that *** RN deviated from standard of care in all the above listed categories. I believe that we can make a strong argument that links mishandling of the fall (and period after) with the development of a subdural hematoma, and eventual demise of Mr. Doe.

Thank you for referring this case to me. Please don't hesitate to reach out if there is anything more I can do to help. I look forward to working with you and your staff in planning and implementing the necessary investigation for successful case conclusion.

Sincerely,

Mariah Ferry, RN, BSN, LNC 12/22/2021