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June 2, 2006

Dear Mr. Attorney:

I am a registered nurse licensed to practice in Virginia and New Mexico. I have over 16 years of nursing experience, 15 of those years in a large teaching institution, with 11 ½ years in critical care. My experience has been with medical-surgical, neurosurgical, cardiology and cardio-thoracic surgery patients. I have been on hospital and departmental committees to write, review and approve policies, procedures and standards of care. I have also educated other nurses about standards of care and legal aspects of documentation.

Per your request, I reviewed Barbara Perry's medical records from ABC Hospital from 12/6/95 to 12/7/95, the complaint, interrogatories, expert reports from Drs. A. and B., transcripts from the medical-legal review panel and the deposition of Mr. Perry. My opinion regarding the nursing care for the time in question is as follows.

Upon reviewing the nursing documentation from 12/6/95 to 12/7/95, I could not find any deviations in the nursing standard of care, however there are discrepancies between the nursing documentation and Mr. Perry's testimony at the medical-legal panel and his deposition.

Mr. Perry states in his deposition that he arrived at the hospital around 0700 or 0730 on the morning of 12/7/95, and stayed for approximately 1 ½ hours. This would mean he left between 0830 and 0900. He testified that his wife was not very coherent or as sharp as she normally was. He further states in his deposition that he had to give Mrs. Perry her DDAVP that morning because of this. It was stated that she normally administered her own DDAVP. It is charted in the medical records that this medication was given around 0900.

The nurse documented an assessment at 0800 on 12/7/95. In this assessment, she documented that Mrs. Perry's neurological assessment was unchanged. This means there is no change from the previous assessment, which was recorded as normal. A normal neurological assessment, as seen on the Presbyterian flowsheet, means that she is alert and oriented to person, place and time. Her behavior is appropriate to the situation. Pupils are equal and reactive to light. She has active range of motion of all extremities with symmetrical strength, and she denies numbness or tingling. Verbalizations are clear and understandable. She is able to swallow without coughing or choking. This normal assessment is significantly different from how Mr. Perry described his wife during his visit that morning. If I assume that what Mr. Perry says regarding his wife's mental status on the morning of 12/7 is correct, then either the nurse either did not document an accurate assessment of the patient or she did not document the correct time the assessment was performed. Both would be a deviation in the standard of care.

Mr. Perry also testified that when he called his wife around 1230 she was "very incoherent, and mumbling". She didn't make any sense and did not know who he was. He testified that he was very concerned about her, but could not get away from work at that time. Nursing documentation during the day shift of 12/7/95 was scant and cursory. There is no nursing documentation after 1110. The nurse documents that medications were given at 0900, 1000 and 1110, so she had contact with Mrs.

8105 Rancho Sueno Ct NW
Albuquerque, NM 87120
Email: sharonscottrn@mindspring.com
Http://firms.findlaw.com/sda

(505) 898-5854
Toll Free (888) 732-7779
Fax (505) 898-8847

(505) 898-5854
fax (505) 898-8847
email: sharonscottrn@mindspring.com

Perry at these times, but it is not clear if she had any contact with her after this. **It will be helpful to request the hospital policy for nursing documentation.**

If I assume that Mr. Perry's observations are correct, and she was incoherent in the morning and afternoon of 12/7/95, and the nurse failed to document a change in her condition, this is a deviation in the standard of care. If she did not notify the doctor of this change, this is a deviation in the standard of care.

Dr. Fine stated in the medical-legal panel that he told Mrs. Perry's nurse to notify him of any change in her mental status. The nurse's failure to write this as a verbal order is a deviation in the standard of care. If the nurse did not monitor this patient for a change in mental status and document that she was monitoring her frequently for this, even if unchanged, this is a deviation in the standard of care.

In summary, although there does not seem to be any deviation in the standard of care based on the medical records reviewed, there are discrepancies between the medical records and Mr. Perry's testimony. If I assume Mr. Perry's accounts to be correct, then there are several deviations in the nursing standard of care, which caused Mrs. Perry's delay in treatment and eventual seizures due to severe hyponatremia.

Thank you for allowing me to participate in this very interesting case.

Respectfully,

Sharon A. Scott, RN, B.S.N.