TRIFECTA MEDICAL CHRONOLOGY WITH OPINIONS

Referral Date/ Number of pages:	7000 pages
Referral Type:	Medical Chronology
Completed by:	[redacted], MSN, RN, AFN-BC, SANE-A
Report Submission Date:	26Apr21

CLAIMANT DEMOGRAPHICS

Claimant Name:	[redacted]	**Attorney :**	[redacted]
Date of Injury:	26Nov19	**Defendant MD :**	[redacted], MD
Date of Birth:	15Mar52	**Defendant Facility:**	[redacted]

Issue of Focus: Operative negligence resulting in postoperative infection and necrosis requiring two subsequent surgical interventions, ultimately leading to death.

Recommendations:

1. This is a complex case that requires consultation with a bariatric and/or hepatobiliary surgeon to perform a thorough evaluation of the operative and postoperative care and complications of [redacted] to identify deviations from the standard of care and establish causation and extent of damages.
2. An Infectious Disease and/or Internal Medicine Physician should be consulted to analyze the delivery of care in relation to the sepsis that ultimately led to [redacted] death.
3. Thorough analysis of medical records and detailed review of the surgical and hospital stay timeline and patient responses to treatment and condition fluctuations related to complications from the initial surgical procedure.
4. Thorough review of [redacted] outpatient health records to gain a better understanding of her medical history and to identify possible pre-existing condition issues that may be considered contributing factors to the post-operative complications.
5. A complete review of [redacted] hospice medical records indicating her ongoing medical and psycho/emotional status is essential to demonstrate the ongoing adverse effects of the hospital stay and surgical interventions beginning 26Nov19.
6. No obvious nursing errors, deviations from standards of care or breach of duty were identified. A thorough review of the nursing records by an expert RN is recommended to verify the preliminary findings or to identify deviations and deficiencies in nursing care.

Claimant Name: [redacted]
Date of Death: 20Jan20

Missing/ Additional Pertinent Records:

1. Medical records related to Hospice Unit stay.
2. Outpatient medical records relative to chronic/ongoing health conditions
3. [redacted] nursing records.

FORENSIC CASE EVALUATION

Identified Gaps in Care:

1. Identification of iatrogenic CBD (common bile duct) injury which contributed to the development of sepsis.
2. Sepsis prevention standard of care.

Pre-Existing Medical Conditions:

1. Chronic lower back pain
2. Hyperlipidemia
3. Hypertension
4. Diabetes Mellitus II (uncontrolled)
5. Vitamin B12 deficiency

Non-Compliance Issues:

1. Pt reported to have uncontrol DMII; however, the extent of compliance or non-compliance is not included in the records provided. A review of previous medical records related to DMII treatment would be necessary to determine the nature of the uncontrolled status.

CLAIMANT HISTORY AT TIME OF INJURY / EVENT

Height/Weight:	5'3" 150lbs
Pertinent Medical History:	Chronic lower back pain, hyperlipidemia, hypertension, diabetes mellitus II (uncontrolled), vitamin B12 deficiency.
Pertinent Surgical History:	Hemorrhoidectomy, cholecystectomy
Pertinent Injuries:	None

Medications at time of Injury / EVENT:

1. Asper creme 10% topical cream, apply to feet/legs daily
2. Gabapentin 600mg tablet 2 times per day
3. Hydrocodone-acetaminophen 10mg-325mg tab 3 times per day as needed for pain
4. Simvastatin 40mg tablet daily
5. Pantoprazole 40mg delayed release tablet 2 times per day

Co-Morbidities:

1. Chronic lower back pain
2. Hyperlipidemia
3. Hypertension
4. Diabetes Mellitus II (uncontrolled)
5. Vitamin B12 deficiency

Date	Provider	Event	Outcome	Legal Nurse Opinion/ Recommendations	Pg #
26Nov19	[redacted] Medical Center [redacted], MD	**SURGERY:** **PROC:** Gastric antrectomy (excision of lower third of stomach), gastroduodenostomy (surgical connection of stomach to small intestine) **IND:** Dysphasia, continuous nausea/vomiting, gastric & duodenal ulcers **Findings:** Long stricture of proximal duodenum just above the common bile duct (CBD)	**PreOp DX:** Gastric bezoar, duodenal stricture **Op Note (ARH3) indicated NO Complications** **PostOp DX:** Gastric bezoar, duodenal stricture **Plan:** Admitted to Medical Unit	Identified complications of a common bile duct(CBD) injury include progressive post-operative infection and tissue necrosis. Risk factors related to the iatrogenic injury of the CBD injury include, but are not limited to: 1. Anatomical factors. 2. Patient-related factors. 3. Factors related to the disease or presenting condition. 4. Surgical technique. 5. Surgeon.	ARH1 pp 37 ARH3, pp 188 - 189 ARH7 pp 28 - 52

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				Despite the identified risk factors, a CBD injury is an **avoidable** consequence of a surgical procedure. The CBD can rupture spontaneously post-operatively; therefore, the subsequent complications may **not** be related to the initial surgical procedure as noted within the record by other providers. An expert General Surgeon would be able to identify the contributing factors that may have led to the iatrogenic CBD rupture versus a spontaneous postoperative CBD rupture and appropriate	

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				preventative actions that could or should have been employed.	
26Nov19	[redacted] Medical Center [redacted], MD	**ADMISSION TO MEDICAL UNIT:** **Status/Post (S/P):** Gastric antrectomy, gastroduodenostomy **Review of Systems (ROS):** Alert, no distress, nasogastric tube (NG), Oxygen at 2LPM, midepigastric dressing with small amount of drainage	**Assessment & Plan:** 1. Gastric bezoar (impaction/obstruction): - S/P gastric antrectomy, gastroduodenostomy 2. Dysphagia: - Nothing by mouth (NPO) 3. Chronic low back pain: - Pain control 4. Hyperlipidemia: - Restart medications when able 5. Chronic hypertension: - Monitor BP closely		ARH1 Pp 37 -
28Nov19	[redacted] Medical Center [redacted], MD	**GENERAL SURGERY PROGRESS NOTE:** **Subjective:** Pain decreased, NGT with high output, foley catheter removed today. **ROS:** Negative	**ASSESSMENT & PLAN** 1. Duodenal ulcer 2. Dysphagia 3. Gastric bezoar 4. Gastric ulcer 5. Tachycardia 6. Leukocytosis 7. Hx Billroth I operation		[redacted] Medical Center, pp 5 - 8

Date	Provider	Event	Outcome	Legal Nurse Opinion/ Recommendations	Pg #
		Assessment: Tachycardic without acute distress, alert and oriented, elevated WBC, Hb decreased, no bowel function **Labs:** Total bilirubin 0.3 (wnl) ELEVATED: WBC 22.09, Sodium 147, Chloride 117, Glucose 162, Alkaline Phosphatase 122 LOW: RBC 3.06, Hgb 7.9, Creatinine 0.42, Phosphorus 1.8, Total protein 4.8, Albumin 1.7, Amylase 11, Lipase 57	8. Protein calorie malnutrition 9. Acute blood loss anemia - Continue empiric abx (antibiotics), IV fluid - NG to low intermittent suction - Strict NPO - **Low threshold for repeat CT A/P** - Hold metoprolol for tachycardia (high heart rate) - Monitor labs, GI/DV prophylaxis		
28Nov19	[redacted] Medical Center [redacted], MD	**INTERNAL MEDICINE PROGRESS NOTE:** **Subjective:** Pain decreased, pt feeling better	**ASSESSMENT & PLAN** 1. Gastric bezoar - NPO with NGT to LIS (low intermittent suction), able to have ice chips 2. Dysphagia - NPO		[redacted] Medical Center, pp 102 - 105

Date	Provider	Event	Outcome	Legal Nurse Opinion/ Recommendations	Pg #
	[redacted] APRN	**ROS:** Negative, no new complaints **Assessment: Tachycardic 110-120** without acute distress, alert and oriented	3. Chronic low back pain - Pain mgmt 4. Hyperlipidemia - Restart meds when able to take orally 5. Chronic hypertension - Monitor BP (blood pressure) 6. SIRS w/o acute organ dysfunction d/t to non-infectious process - Treated with IVF and IV abx 7. Opiate dependence - Pain management 8. Tachycardia - Lopressor PRN for HR > 110		
28Nov19	[redacted] Medical Center [redacted], MD	**CARDIOLOGY CONSULT:** **Reason for Consult:** Chest pain **History of Present Illness (HPI):** No prior history of coronary disease, 2 days postop, brief episode of mild, non-radiating L sided pain she	**ASSESSMENT & PLAN:** 1. Chest pain: obtain 2d echocardiogram, myocardial infarction (heart attack) ruled out through labs 2. Hypertension: continue with current therapy 3. DM: stable		ARH1, pp 41 - 45

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		believed was different from abdominal pain, lasted only a few minutes & resolved spontaneously. **Assessment:** Alert/oriented did not appear to be in acute distress with negative physical assessment. Lab Results 11/28 @ 1339: Cardiac enzymes: WNL (within normal limits), CBC: ELEVATED: WBC 22.09, Plt count 560, Neut 19.27, Mono 1.27 LOW: RBC 3.06, Hgb 7.9, Hct 26.6, Eos 0.0 CMP: ELEVATED: Sodium 147, Chloride 117, Glucose 162, Alk Phos 122		A normal WBC (white blood cell) count is 4.5-11. An elevated WBC could be a preliminary indicator of infection.	

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		LOW: Creatinine 0.42, Total Protein 4.8, Albumin 1.7 **Chest X-ray 11/27:** Suboptimal inspiratory effort with associated borderline central congestion of left basilar discoid (lung area), atelectasis not definite for infiltrate.			
29Nov19	[redacted] [redacted] Medical Center [redacted] [redacted], MD	**INFECTIOUS DISEASE CONSULT:** **Reason for Consult:** Antibiotic management **HPI: 3mo dysphagia, 20lbs weight loss**, food regurgitation, presented to GS clinic few days ago, underwent surgical procedures; did 'relatively well' post, WBC continued to climb and there is a concern for a leak WBC trend: 16 > 5 > 22 >30	**ASSESSMENT & PLAN:** 1. Leukocytosis: - Repeat CT with contrast - Continue abx, - Blood cultures - **Low threshold to return to surgery** **29Nov19 F/U CT A/P @ 1045:** Free intraperitoneal air and fluid, free air evidently postoperative. Fluid somewhat indeterminate larger volume in the RUQ density measurement 5 hounsfield units, no air fluid levels suggest likely fluid rather than definitive abscess.		ARH1, pp 46 - 51

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		Antibiotics: Cefazolin 11/26 - 11/28, Vancomycin & Zosyn initiated on 11/28 **Assessment:** alert & oriented, diminished lung sounds, minimal tenderness to RUQ, surgical staples in place no drainage or erythema **29Nov19 CT A/P @ 0635:** Free intraperitoneal air and small volume of fluid in upper abdomen & pelvis; underlying infectious process or focal loculation of fluid/abscess difficult to exclude particularly in RUQ (right upper quadrant). **Labs:** 11/28 @ 1339 & 11/29 @ 0458 Elevated WBC 22.09 30.69 Plt count 560 757		WBC count jumps dramatically from 22.09 to 30.69 in a little over 12 hours, which is a strong indicator of rapidly	

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		Sodium 147 146 Chloride 117 114 Glucose 162 177 LOW: Hgb 7.9 8.8 Hct 26.6 30.7 Creatinine 0.42 0.49		increasing infection. This lab result, along with the results of the abdominal CT scan on 11/29 at 0635, indicate and active infection vs. abscess.	
29Nov19	[redacted] Medical Center [redacted] MD	**SURGERY:** **PROC:** Open jejunostomy (creation of an external opening to the stomach), Rouen Y bypass (gastric bypass); R hemicolectomy (removal of a portion of the large intestine); partial omentectomy (surgical removal of fatty tissue); 4 quadrant washout (cleansing), T-tube placement **Findings:** Anastomotic leak at gastroduodeneum; injury to common bile duct with bile leak;	**PreOp DX:** Acute abdominal peritonitis, pneumoperitoneum, suspected anastomotic leak **Transferred to ICU** **PostOp DX:** **Anastomotic leak** at gastroduodeneum; injury to common bile duct with bile leak; colon perforation; colon, **common bile duct likely iatrogenic from the previous surgery**, D2, D3 necrosis (cell/tissue death)	**The CBD injury was identified on POD #3.** **Early identification and management of a CBD injury are typically performed within 48HR of a procedure. Identification and management beyond 48H postop is considered to be a delayed diagnosis.**	ARH3, pp 190 - 194 ARH7 pp 2 - 20 [redacted] Medical Center, pp 1

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		colon perforation; colon, common bile duct, D2, D3 necrosis, copious amounts of succus pus in intrabdominal cavity with frank pus and bile observed at the gastroduodenostomy anastomosis.		The cause of an anastomotic leak may be multifactorial to include pt. medical condition, ischemia of the intestine at the suture line, state of sepsis, and others to include faulty surgical technique. **Analysis of the CBD injury and anastomotic leak identification and management by an expert General Surgeon is recommended to determine the potential factors that lead to these complications.**	

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30Nov19	[redacted] Medical Center [redacted], MD	**GENERAL SURGERY PROGRESS NOTE:** **Subjective:** Pt intubated, sedated on versed/fentanyl **ROS:** Unable to obtain d/t intubation **Assessment:** JP with bile other with SSF (serosanguinous fluid), T-Tube with bile, NGT with bilious output, UO ok with foley **Labs:** ELEVATED: WBC 28.99, Plt count 570, Chloride 114, Glucose 194, ABG O2 at pt temp 195 LOW: Hgb 10.2, Hct 32.6, Creatinine 0.5, Calcium 7.6, Magnesium 1.7, ALT 12, Total protein 3.9, Albumin 1.1,	**ASSESSMENT & PLAN** 1. Acute respiratory failure **2. Sepsis** **3. Peritonitis** 4. Pneumoperitoneum 5. Gastrointestinal anastomotic leak 6. Injury of common bile duct during operative procedure 7. Necrosis of duodenum at site of anastomosis 8. Hx of Roux-en-Y gastric bypass 9. S/P R hemicolectomy 10. Jejunostomy tube in situ **11. Severe malnutrition** 12. Hx of Billroth I operation 13. Leukocytosis - Strict NPO - Start octreotide injections, TPN (IV nutrition) - Place midline - Cont empiric abx - Liberate from vent as tolerated,	Peritonitis is the inflammation of the membrane lining the abdominal wall and covering the abdominal organs. It is usually infectious and life-threatening and is caused by leakage/hole in intestines.	[redacted] Medical Center, pp 9 - 12

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		Amylase 11, Lipase 57, ABG pCO2 33	- JP bulb to suction, T-tube to dependent drainage - Trend labs - Maintain foley		
1Dec19	[redacted] Medical Center [redacted], MD [redacted], APRN	**INTERNAL MEDICINE PROGRESS NOTE:** **1DEC** **Subjective:** Remains on vent, VSS, wakes up easily **ROS:** Unable to obtain due to ET tube **Assessment:** Frail and ill appearing, malnourished **Labs:** Blood cultures show candida glabrata and yeast	**1DEC ASSESSMENT & PLAN** 1. Severe malnutrition - NPO, plan for TPN. Because of positive blood cultures, PICC line or midlines are not options, plan for PPN. 2. Acute blood loss anemia - Hgb 7.5, will need PRBCs. (blood transfusion) 3. Protein calorie malnutrition - Start PPN 4. Leukocytosis - Monitor 5. Tachycardia – NSR - Monitor 6. Opioid dependence - Pain management 7. Weight loss - Dietary consult		[redacted] Medical Center, pp 115 - 230

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			8. Chronic hypertension – BP is stable 9. Hypokalemia – potassium 3.5 - Replace as needed 10. Hypomagnesemia - Replace Mg 11. Pneumoperitoneum - Required to go back to surgery 12. Peritonitis - IV abx, IV fluids, monitor labs 13. Acute respiratory failure - Wean vent as tolerated , Pulmonary following 14. Sepsis - **Blood cultures show candida glabrata and yeast, discussed with ID, start Micafungin 100mg IV daily and repeat blood cultures.** - Pt unable to have PICC line or midline because of	Blood cultures show yeast/fungus growing in bloodstream. Life-threatening. Rapid, therapeutic treatment per protocol is necessary.	

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			infection potential, will need PPN. 15. S/P R hemicolectomy 16. Jejunostomy tube in situ 17. Gastrointestinal anastomotic leak - POD 2, monitor - Cont empiric abx, NG to low, intermittent suction, strict NPO, low threshold for repeat CT A/P, hold metoprolol for tachycardia, cont IV fluid, monitor labs, GI/DV prophylaxis.		
		2December: **Subjective:** Pt moaning, indicating her abdomen; nursing staff indicate great deal of pain last night with elevated BP,			

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		patient is not interactive other than holding abdominal area. **3Dec** **Subjective:** Nursing staff report **pt was restless overnight and pulled out NGT and IV** – both had been replaced. Pt is non-communicative, continues to have pain – currently receiving IV Dilaudid and fentanyl patch for pain. **4Dec** Subjective: Pt more alert, better pain control, asking to go home. **6Dec** **Subjective:** Intermittently confused and uncooperative,			

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		unwilling or unable to understand she remails quite ill. WBC elevated at 21 – continue antibiotics. **9Dec** Subjective: Pt has continued with fluctuating confusion and/or restless. WBC 35, will obtain blood cultures. **13Dec** **Subjective:** Pt has remained with fluctuating confusion and restlessness and minimal activity and has had urine incontinence since removal of foley catheter **WBC beginning to come down at 32.74**	**13Dec PLAN** - Start half-normal saline with amp of bicarb d/t elevated sodium - Broaden abx coverage	**Rapid increase in WBC count on once again can indicate that infection is worsening. A blood culture was obtained on 9Dec, yet antibiotic coverage was not broadened until 4 days later on 13Dec. Pt confusion and restlessness are also indicators of sepsis and worsening**	

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		Sodium elevated at 156 **14Dec** **Subjective:** Pt sitting up, talking, but still very weak Labs ELEVATED WBC 20, Procalcitonin 36 **17Dec19**	**14Dec ASSESSMENT & PLAN** 1. Metabolic acidosis: Slowly improving - Cont current treatment and bicarbonate drip per nephrology 2. Acute kidney injury: slowly improving - Cont current treatment 3. Acute pancreatitis 4. Bile leak 5. Sepsis: Improving with abx, ID to follow 6. Severe malnutrition - Dietary consultation 7. Acute blood loss anemia - Monitor, transfuse as needed 8. Hypoglycemia - Monitor	**infection. Potential delay in care.**	

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		Subjective: Pt remains somewhat disoriented and manipulative with no insight to her ongoing issues, discussed with pt's husband that pt is not ready for discharge. **18Dec19** **Subjective:** Pt reports feeling well, tolerating 1 pop every day; somewhat non-compliant at times – discussed with husband present.			
30Nov19	[redacted] Medical Center [redacted], MD	**PULMONOLOGY CONSULT:** **Reason for consult:** ventilator management **HIP:** S/P multiple surgeries, transferred to ICU intubated, on versed & fentanyl	**ASSESSMENT & PLAN:** 1. Sepsis secondary to pneumoperitoneum, anastomotic leak, necrotic bile and colon with perforation: - Cont fluids, abx, - Blood cultures, - Monitor intake/output 2. Peritonitis: s/p repeat exlap (exploratory laparotomy)		AHR1, pp 58 - 74

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		Assessment: intubated, sedated, otherwise negative	3. Hypokalemia: supplement potassium aggressively 4. Acute respiratory failure: pt intubated post surgery, metabolic acidosis: - Cont vent on current settings, spontaneous awakening and breathing trials tomorrow - DVT & GI prophylaxis		
2Dec19	[redacted] Medical Center [redacted], MD [redacted], APRN	**INFECTIOUS DISEASE PROGRESS NOTE:** **Subjective:** S/P exlap on 11/29, leak was found with necrosis, R hemicolectomy and partial omentectomy performed. Extubated on 12/1; fever 100.9 on 11/30 – today Tmax 99.2 **Assessment:** Pt resting, alert, no acute distress, reports abdominal pain, NG tube in place with PPN	**ASSESSMENT & PLAN:** 1. Fungemia – candida glabrata, source - abdomen: - Cont Van, Zosyn, Micafungin - Repeat blood cultures today/tomorrow, 2. Gastrointestinal anastomotic leak 3. Necrosis of duodenum at site of anastomosis 4. Leukocytosis 5. DM II 6. Hyperlipidemia		ARH5, pp 107 - 115

Date	Provider	Event	Outcome	Legal Nurse Opinion/ Recommendations	Pg #
		Labs: Elevated: WBC 26.3 Blood Cultures: 11/29 – blood candida glabrata 12/1 – results pending ABX: Cefazolin 11/29 – 11/28 Vanco initiated 11/28 Zosyn, initiated 11/28 Micafungin, initiated 12/1	7. Chronic hypertension 8. Severe malnutrition 9. Obesity		
2Dec19	[redacted] Medical Center [redacted] MD	**GENERAL SURGERY PROGRESS NOTE:** **Subjective:** extubated, but confused **ROS:** negative except as noted **Assessment:** ill appearing and disheveled, JP drain – bilious output, other JP drain SSF	**ASSESSMENT & PLAN** 1. Fungemia 2. Jejunostomy tube in situ 3. S/P R hemicolectomy 4. Gastrointestinal anastomotic leak 5. Injury of common bile duct during operative procedure 6. Necrosis of duodenum at site of anastomosis 7. Hx of Roux-en-Y gastric bypass 8. Sever malnutrition 9. Bile leak		[redacted] Medical Center, pp 13 - 16

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		Pt with fungemia prior to surgery & PICC insertion **Labs:** ELEVATED: WBC 26.39, Plt count 424, ABG pO2 at pt temp 195, Chloride 109, Glucose 164, Alkaline Phosphatase 139Triglycerides 695, Procalcitonin 0.85 LOW: RBC 3.29, Hgb 8.4, Hct 27.8, ABG pCO2 at pt temp 33, Creatinine 0.3, Calcium 8, Phosphorus 2.5, Total protein 4.4, Albumin 1., Amylase 11, Vancomycin Trough 7.4	- Check cholangiogram tomorrow - Cont octreotide injections - TPN critical for pts at current - needs for 5 D then reassess - NG to LIS		
2Dec19	[redacted] Medical Center	**CHEST X-RAY:** **Impression:** Poor inspiratory effort without definitive active cardiopulmonary process when compared to exam of 11/30			

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3Dec19	[redacted] Medical Center [redacted], MD	**GENERAL SURGERY PROGRESS NOTE:** **Subjective:** No new complaints, afebrile, **pt removed NGT last evening** – replaced, more lucid intervals today **ROS:** Unobtainable d/t mental status **Assessment:** Disheveled, frail and ill appearing, T-tube & JP tube in RUQ with bile, JP in RLQ with SSF, **WBC downtrending**, no bowel movement, BGT with bilious output, foley with adequate output Labs: ELEVATED: WBC 23.11, Plt count 430, Total bilirubin 1.3, AST 41, Alkaline phosphatase 217, Triglycerides 779	**ASSESSMENT & PLAN:** 1. Fungemia 2. Jejunostomy tube in situ 3. S/P R hemicolectomy 4. Gastrointestinal anastomotic leak 5. Injury of common bile duct during operative procedure 6. Necrosis of duodenum at site of anastomosis 7. Hx of Roux-en-Y gastric bypass 8. Severe malnutrition 9. Protein calorie malnutrition 10. Acute blood loss anemia 11. Bile leak 12. History of Billroth I operation 13. Delirium - Cont octreotide injection, TPN – pt's caloric needs and bowel rest outweigh PICC removal - Anticipate staged repair of CBD in 6-8W if bile leak doesn't resolve with		[redacted] Medical Center, pp 17 - 20 ARH7, pp 102

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		LOW: RBC 3.27, Hgb 8.3, Hct 26.1, Potassium 3.2, Creatinine 0.32, Calcium 7.9, Phosphorus 2.3, Magnesium 1.7, Total protein 4.4, Albumin 1.3, Amylase 11, Lipase 57, Vancomycin trough 7.4 **CHOLANGIOGRAM, T-TUBE:** **Impression:** T-tube placed in an unusually distal common duct location, minimal contrast exiting common bile duct into small bowel – could be due to mechanical obstruction or ampullary spasm/dysfunction; contrast leaks from common duct about the entry of T-tube into periductal biloma which is drained by JP drain.	choledocoduodenostomy versus hepatico- J to allow acute inflammation and infection to resolve and nutrition to improve - Drains to dependent drainage - Empiric abx - Strict NPO, NGT to LIS (low intermittent suction).		
6Dec19 – 12Dec19	[redacted] Medical Center	**GENERAL SURGERY PROGRESS NOTE:**	**ASSESSMENT & PLAN** 1. Delirium – Resolved 2. Bile leak 3. Fungemia		[redacted] Medical Center, pp 25 – 28, 30, 34

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	[redacted], MD	**6DEC19** **Subjective:** +flatus, BM, afebrile, alert and oriented **ROS:** JP & T-tube with bile Labs: WBC 21.79 – H **7DEC19** **Subjective:** more confused, disheveled, frail and ill appearing	4. Jejunostomy tube in situ 5. S/P R hemicolectomy 6. Hx of Roux-en-Y gastric bypass 7. Necrosis of duodenum at anastomosis site **8. Injury of common bile duct during operative procedure** 9. Gastrointestinal anastomotic leak. **6DEC - PLAN** - Clamp NGT & remove if pt remains nausea and emesis free for 8hrs, 1C water every 24hrs, continue TPN, pt to ambulation w/PT/OT, empiric abx, GI/DVT prophylaxis. **7Dec – PLAN** - CT A/P tomorrow if pt cont to be altered		

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6Dec19 – 24 Dec19	[redacted] Medical Center	**6DEC19** **CHEST X-RAY:** **Impression:** Poor inspiration R basilar discoid atelectasis, borderline central congestion no marked interval change from 12/2. **UPPER QUADRANT ULTRASOUND:** **Impression:** No evidence of mass lesions or drainable fluid collection. **7DEC19** **KUB X-RAY** **Impression:** Contrast material noted within small bowel loops at RLQ; no evidence of contrast material leaking; some contrast within the rectal vault; ne definite evidence of bowel obstruction or ileus; no obvious			ARH7, pp 102 - 104

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		masses or organomegaly; mild DJD lumbar spine. **8DEC19** **CT A/P** **Impression:** No free air or fluid; no organized/drainable fluid collections; no bowel obstruction, nonspecific mild adynamic ileus, hepatomegaly, possible gastrectomy with gastrojejunostomy; posttreatment changes noted at the subhepatic and pancreaticoduodenal regions. **12DEC19** **HEAD CT** **Impression:** No evidence of acute hemorrhage or acute infarction, motion artifact limits evaluation, correlate for central atrophy/chronic subdural			

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		collection in frontal area image #23 **13DEC19** **CHEST CT** **Impression:** RLL infiltrate and small pleural effusion cannot be excluded **18DEC19** **BONE SCAN NUCLEAR MEDICINE** **Impression:** Uptake in axial and appendicular skeleton, likely degenerative; uptake in bilateral metatarsals and calcanei, likely related to inactivity **24DEC19** **CT A/P**			

Date	Provider	Event	Outcome	Legal Nurse Opinion/ Recommendations	Pg #
		Impression: Previous cholecystectomy with drainage tube in gallbladder fossa area persistent free air at this level along with fluid and debris no marked interval change from 12/12; colonic constipation, degenerative disc findings L4-S1			
11Dec19	[redacted] Medical Center [redacted], MD [redacted], APRN	**INFECTIOUS DISEASE PROGRESS NOTE:** **Subjective: WBC elevated to 34.8 on 12/9, down to 23.9 today**, remains afebrile **Assessment:** No acute distress, alert and awake, NGT in place, TPN via PICC, one of the drains has mild amount of induration at site **Labs:** Elevated: WBC 23.9 (WBC on 12/9 – 34.81)	**ASSESSMENT & PLAN:** 1. Fungemia – candida glabrata: - Cont Micafungin plan to complete 2wks - Repeat blood cultures today d/t increase in WBC - Monitor induration (localized hardening of soft tissue) at drain site. 2. Gastrointestinal anastomotic leak 3. Necrosis (death of tissue) of duodenum at site of anastomosis. 4. Leukocytosis		ARH5, pp 134 - 140

Date	Provider	Event	Outcome	Legal Nurse Opinion/ Recommendations	Pg #
		Blood Cultures: 11/29 – blood candida glabrata 12/1; 12/2; 12/4; 12/9 – NGTD (no growth to date) Urine Culture: 12/9: NGTD ABX: Cefazolin 11/29 – 11/28 Vanco 11/28 – 12/9 Zosyn 11/28 – 12/9 Micafungin, initiated 12/1 **9DEC19** **CT ABD/Pelvis:** No free air or fluid, no organized/drainable fluid collections; no bowel obstruction, nonspecific mild adynamic ileus, hepatomegaly, possible partial gastrectomy with gastrojejunostomy; posttreatment changes noted at the subhepatic and pancreaticoduodenal regions	5. DM II 6. Hyperlipidemia 7. Chronic hypertension 8. Severe malnutrition 9. Obesity		

Date	Provider	Event	Outcome	Legal Nurse Opinion/ Recommendations	Pg #
13Dec19	[redacted] Medical Center [redacted], MD [redacted], APRN	**INFECTIOUS DISEASE PROGRESS NOTE:** **Subjective:** Remains afebrile, pt awake and less agitated but did not answer questions, TPN was stopped, lipase elevated; per RN staff – a lot of drainage noted around one of the JP drains **Assessment:** No acute distress, alert and awake, NGT & PICC in place, one of the drains has mild amount of induration, 4x5cm with yellow/brown material expressed around it upon palpation. **Labs:** Blood Cultures: 11/29 – blood candida glabrata 12/1; 12/2; 12/4; 12/9; 12/11 – NGTD (no growth to date)	**ASSESSMENT & PLAN:** 1. Fungemia: - Zosyn restarted by primary presumably d/t WBC and CT chest findings of RLL. Stop Zosyn and start Mero for lower salt load and resistant organisms - Start linezolid – will discuss with GS (general surgeon) - TPN was stopped – remove PICC, which is always a potential infectious source, insert PIV - 2 more days of micafungin 2. Bile leak 3. Jejunostomy tube in situ 4. S/P R hemicolectomy 5. Delirium – resolved 6. Hypernatremia 7. Acute pancreatitis 8. DM with hyperglycemia	**The ability to express yellow/brown material from around the drain indicates a high probability of either leaking or infection at the site of the drain.**	ARH5, pp 146 - 151

Date	Provider	Event	Outcome	Legal Nurse Opinion/ Recommendations	Pg #
		Urine Culture: 12/9: NGTD ABX: Cefazolin 11/29 – 11/28 Vanco 11/28 – 12/9 Zosyn 11/28 – 12/9, 12/13x1dose Micafungin, initiated 12/1 Mero initiated 12/13 Linezolid initiated 12/13 **12DEC19** **CT Head:** No evidence of acute hemorrhage or acute infarction, correlate for central atrophy/chronic subdural collection in frontal area image **CT A/P:** Stable postoperative changes and indwelling catheters, persistent trace pneumoperitoneum in gallbladder fossa, suspect mild pancreatitis (inflammation of the pancreas).			

Date	Provider	Event	Outcome	Legal Nurse Opinion/ Recommendations	Pg #
		13DEC19 CT Chest: RLL (right lower lobe) infiltrate and small pleural effusion cannot be excluded.			
13 - Dec19	[redacted] Medical Center [redacted]	**GENERAL SURGERY PROGRESS NOTES:** **13DEC19** **Subjective:** Discussed with family worsening lab values and clinical setting. Pt cont to be confused and lethargic. **ROS:** Negative except noted in assessment **Assessment:** Disheveled, frail and ill appearing, Postop changed on CT from 12Dec, **JP drain continuing to have copious amounts of bilious output** – that was cultured, TPN	**ASSESSMENT & PLAN** 1. Hypernatremia 2. Acute pancreatitis 3. DM with hyperglycemia 4. Bile leak 5. S/P R hemicolectomy 6. Jejunostomy tube in situ 7. Hx of Roux-en-Y gastric bypass 8. Necrosis of duodenum at anastomosis 9. Injury of common bile duct during operative procedure 10. Gastrointestinal anastomotic leak 11. Sepsis 12. Acute kidney injury	Copious amounts of draining bile could indicate a worsening bile leak.	[redacted] Medical Center, pp 38 – 72; 79 – 83

Date	Provider	Event	Outcome	Legal Nurse Opinion/ Recommendations	Pg #
		likely induced pancreatitis secondary to high lipid content – discontinued today **Labs:** ELEVATED: WBC 32.74, Plt count 939, PT 11.9, Sodium 148, Potassium 5.3, Chloride 116, BUN 139, Creatinine 3.61, Glucose 182, Lactic acid 2.1, AST 80, ALT 92, Alkaline Phosphatase 555 LOW: RBC 3.87, Carbon dioxide 18, Hgb 9.6, Hct 33, Total protein 5.9, Albumin 2.1, ABG pCO2 at pt temp 24.8, ABG pO2 at pt temp 58, ABG HCO3 15.3, ABG total CO2 16, ABG O2 saturation 90	- Hypernatremia improved after free water flushes - Creatinine has worsened – consult nephrology, suspect continued - Deterioration or necrosis of duodenal sweep versus deterioration and necrosis of common bile duct due to copious bilious bile leak output - CT showed RLL infiltrate, but concerned about intra-abdominal process despite recent CT was negative for fluid collection - 'If pt deteriorates further clinically with worsening labs, may have to have a 2nd – look lap for stage procedure - Strict NPO and IV fluids	Worsening Creatinine indicates potential kidney failure.	

Date	Provider	Event	Outcome	Legal Nurse Opinion/ Recommendations	Pg #
		14DEC19 Hypernatremia has improved – Sodium 147, improved mentation **WBCs down – 20.7** Thrombocytosis improved - Plt Count 543 Bile culture + for GNR (gram negative rods). **16DEC1** Pt with more energetic, wants to go home, labs improving Labs – 12/15 WBC 12.01, Plt count 464, Sodium 147	**14DEC19 PLAN** - Cont empiric abx for +bile culture. - Optimize pt from nutritional standpoint for bile leak repair – will check micronutrients - Cont IV fluid for pancreatitis **16DEC19 PLAN** - Cont octreotide and empiric abx - Cont JP & T-tube drainage - Attempt to maximize pt for reoperation – trickle tube feeds via J tube	Pt has positive bile culture of *gram negative rods.* More than half of the organisms isolated from bile, especially gram positive organisms, are not likely to be true pathogens. But single organism (like *gram negative rods)* cultured from bile has clinical significance especially in patients not showing clinical improvement.	

Date	Provider	Event	Outcome	Legal Nurse Opinion/ Recommendations	Pg #
		17DEC19 No new complaints, tolerating PO (oral) fluids. Labs ELEVATED: ALT 123, AST 71, Alkaline Phosphatase 639, Albumin 1.9, Total protein 5.4, Bilirubin 0.4 **23DEC19** No new complaints, pt on liquid diet with mild nausea and diarrhea WBC 20.91	**17DEC19 ASSESMENT & PLAN** 1. Ecoli bacteremia 2. Elevated LFTs 3. Acute kidney injury - Water or 1 can of pop every other day, primary nutrition from TF - Pt needs bile leak repair at 4-5wks after repair of anastomotic leak - Continue PT/OT – ok to go to the floor **23DEC19 PLAN** - Tolerating CDL (clear liquid diet)with some nausea, will add Reglan. - Ideally to give pt TF until staged biliary surgery - If strong enough to go home and can tolerate TF		

Date	Provider	Event	Outcome	Legal Nurse Opinion/ Recommendations	Pg #
			goals, ok to DC and F/U for outpatient surgery after 8wks. **24DEC19 PLAN** - Pt medically stable - Will need cardiac & pulmonary clearance prior to operative intervention - **High risk for complication for more urgent intervention** – discussed with family & PCP; call surgery if deteriorates.		
		24DEC19 Pt removed T-tube last night, more somnolent today, some purulence (pus) from previous T-tube site.			
14Dec19	[redacted] Medical Center [redacted], MD	**NEPHROLOGY CONSULT** **Reason for consult**: Acute renal failure (ARF) **HPI**: S/P exploratory lap, open jejunostomy tube, open Roux-en-y bypass, duodenectomy, repair bile leak with T-tube placement, 4 quad abd washout,	**ASSESSMENT & PLAN** 1. Acute kidney injury: Likely ATN, no hydronephrosis on CT, Last Creatinine 3.2 – improved from 3.6, BUN down to 121 - Adjust NaHCO3 drip - Avoid nephrotoxic agents - Renally dose meds - Monitor BMP		ARH1, pp 52 - 58

Date	Provider	Event	Outcome	Legal Nurse Opinion/ Recommendations	Pg #
		R hemocolectomy with colo-enteric side-to-side stapled anastomosis, placement of drains, partial omenomectomy; found to have pancreatitis and fungemia. **Assessment:** NPO, altered mental status, no acute distress, limited assessment due to mental status	2. Hypernatremia: SNa down form 156 to 147 - Change NaHCO3 drip to D5 NSS 3. Metabolic acidosis: HCO3 was 22, improved - D/C NaHCO3 4. Fungemia: ID following 5. Acute pancreatitis: Attending following 6. Bile leak: s/p repair – surgeon following		
24Dec19	[redacted] Medical Center [redacted], MD	**INTERNAL MEDICINE PROGRESS NOTE:** **Subjective:** Drowsy but arousable with altered mental status, WBC Elevated at 20, Pt inadvertently pulled out T-tube with a great deal of bloody and purulent drainage. **ROS:** unable to obtain d/d mental status	**No Plan Noted**	The pt pulling out her T-tube, albeit inadvertently as her mental status was altered, could be seen as a contributing factor to the ongoing surgical complications and sepsis. However, there was a great deal of purulent drainage when she pulled it out,	ARH5, pp. 1 - 5

Date	Provider	Event	Outcome	Legal Nurse Opinion/ Recommendations	Pg #
		Assessment: frail appearing.		which indicates that there was a high degree of localized infection at that time. This was not the first incidence of the pt. pulling out medical devices in an altered mental status. In the evening between 2 & 3Dec19, the pt. was in a restless state and pulled out both the NG tube and IV catheter. Based on this incidence and considering the ongoing altered mental status / delirium, intermittent soft restraints may have been an option to	

Date	Provider	Event	Outcome	Legal Nurse Opinion/ Recommendations	Pg #
				ensure inserted medical devices remained intact so as to limit ongoing complications. **The facility's Restraint Policy & Procedures should be reviewed to determine if the pt. would have met the criteria for restraint.**	
25Dec19	[redacted] Medical Center [redacted], MD	**INTERNAL MEDICINE PROGRESS NOTE:** **Subjective:** Pt feeling better **ROS:** no new complaints **Assessment:** well-developed but frail appearing, malnourished, alert and oriented.	**ASSESSMENT & PLAN** 1. Severe malnutrition: cont tube feeding. 2. Acute blood loss anemia, hema globin 5.9: transfuse 2U PRBC's 3. Protein calorie malnutrition: cont to monitor 4. Leukocytosis: cont to monitor 5. Tachycardia, NSR 6. Opiate dependence, continuous: cont pain medicine		ARH5, pp 6 - 11

Date	Provider	Event	Outcome	Legal Nurse Opinion/ Recommendations	Pg #
			7. Weight loss: dietary consult 8. Chronic hypertension: BP is stable 9. Hypokalemia: replace K+ as needed 10. Hypomangesemia: replace as needed 11. Acute respiratory failure: wean vent as tolerated, pulmonology following 12. Sepsis: ID following 13. Diarrhea: check stools, replace electrolytes 14. S/P R hemicolectomy, J-tube in situ, Gastrointestinal anastomotic leak repair: cont to monitor		
12/27/19	[redacted] Medical Center [redacted], MD	**INTERNAL MEDICINE PROGRESS NOTE:** **Subjective:** Scheduled for surgery that morning **ROS:** no new complaints	**ASSESSMENT** 1. Fungemia 2. Hypernatremia 3. Acute pancreatitis 4. DM with hyperglycemia 5. Peritonitis		ARH5, pp 19 - 23

Date	Provider	Event	Outcome	Legal Nurse Opinion/ Recommendations	Pg #
		Assessment: Frail appearing, appears malnourished.			
27Dec19	[redacted] Medical Center [redacted], MD	**SURGERY:** **PROC:** Open choledocojejunostomy, J-tube removal; adhesion lysis; mesenteric abscess drainage; abscess/hematoma drainage; small bowel resection with anastomosis; 4 quad washout **IND:** persistent bile leak, peritonitis, developed bile peritonitis encephalopathy and signs of sepsis, **pt removed own T-Tube approx. 3-4 days prior.** **Findings:** Frank bile and pus along RUQ subhepatic space, tear along distal common bile duct where T-tube was placed and forcibly removed	**PreOp DX:** Persistent bile leak, bile peritonitis, dislodged T-tube. **PostOp DX:** Chronic perforation of common bile duct/duodenal stump with abscess, hematoma, mesenteric abscess, hostile abdomen Pt transferred, intubated, to ICU post-op. (Why was there a 3-4 day delay with surgery to replace the drain, especially since pt. was having a high degree of bile coming out of the drain on a daily basis? Without a drain, the bile was leaking into her abdomen, which is a life-threatening situation and requires urgent replacement of drain.)	**Possible delay in care between second (29Nov19) and third (27Dec19) surgical interventions leading to septic conditions, verified with blood culture testing, displayed by fluctuating trend of white blood cells (WBCs), changes in mentation and nutritional status identified on or about 11Dec19.** **A review of the provision of care between the 2nd and 3rd surgical interventions by an expert General**	ARH3, pp 195 - 204 ARH 7 pp 53 - 82

Date	Provider	Event	Outcome	Legal Nurse Opinion/ Recommendations	Pg #
				Surgeon may be able to distinguish a breach of care versus complications resulting from pt-related issues, such as advanced age and pre-existing co-morbidities.	
28Dec19	[redacted] Medical Center [redacted], MD	**GENERAL SURGERY PROGRESS NOTE:** **Subjective:** still having pain, no flatus or bm, afebrile **ROS:** Negative Labs: WBC 6.96	**ASSESSMENT** 1. -S/P biliary surgery 2. Bile leak 3. Mesenteric abscess 4. S/P R hemicolectomy 5. HX of Roux-en-Y gastric bypass 6. Injury of common bile duct during operative procedure 7. Necrosis of duodenum at anastomosis site 8. Gastrointestinal anastomotic leak 9. Obesity 10. Tacycardia 11. Intra-abdominal abscess		[redacted] Medical Center, pp 73 - 78

Date	Provider	Event	Outcome	Legal Nurse Opinion/ Recommendations	Pg #
			- **Bile leak not unanticipated given extensive surgery, friability of tissue and damage caused by patient removing T-tube.** - Pt is stable without signs of overt sepsis, shock or peritonitis - Keep NGT to LIS, Strict NPO - Switch octreotide injections to continuous infusion - Anticipate hospital stay of 2-4wks for bile leak - If pt has significant improvement over next 2-3wks with decreased bile output and overall progression will transfer to hepatobiliary surgical evaluation	Regardless of damage caused by T-tube removal on 24Dec, surgery was not performed until 27Dec. Bile was leaking into the abdomen during this time, causing increased probability for acute complications.	

Date	Provider	Event	Outcome	Legal Nurse Opinion/ Recommendations	Pg #
28DEC19	[redacted] Medical Center [redacted], MD	**INTERNAL MEDICINE PROGRESS NOTE:** **Subjective:** Confused more than usual, NG removed **ROS:** unobtainable d/t altered mental status **Assessment: Well-developed, frail looking**	**ASSESSMENT** 1. Gram-negative bacteremia 2. Hypernatremia 3. DM with hyperglycemia 4. Delirium		ARH5, pp 24 - 28
29DEC19	[redacted] Medical Center [redacted], MD	**INTERNAL MEDICINE PROGRESS NOTE:** **Subjective:** Agitated and restless, not oriented **ROS:** unobtainable d/t altered mental status **Assessment:** Frail appearing	**ASSESSMENT** 1. S/P biliary surgery 2. Mesenteric abscess 3. Intra-abdominal abscess 4. Gram-negative bacteremia 5. Elevated LFTs (liver function tests)		ARH5, pp 29 - 33
31DEC19	[redacted]	**INTERNAL MEDICINE PROGRESS NOTE:**	**ASSESSMENT** 1. S/P biliary surgery		ARH5, pp 34 - 38

Date	Provider	Event	Outcome	Legal Nurse Opinion/ Recommendations	Pg #
	Medical Center [redacted], MD	**Subjective:** Remains slightly confused **ROS:** unobtainable d/t altered mental status **Assessment:** frail appearing, altered mental status, low-grade fever	2. Mesenteric abscess 3. Encephalopathy 4. Acute kidney injury 5. Acute pancreatitis 6. DM with hyperglycemia 7. Delirium - resolved		
31DEC19	[redacted] Medical Center [redacted], MD	**INTERNAL MEDICINE PROGRESS NOTE:** **Subjective:** Pt moaning c/o abd pain, confused, still with much bilious drainage from R abdomen around JP drain, **pt pulled PICC line** – new one placed for TPN, on Merrem, getting Mag replaced, Ativan given for sleep. **ROS:** unobtainable d/t altered mental status	**ASSESSMENT & PLAN:** 1. Intra-abdominal abscess: cont Merrem per ID, supportive care 2. Metabolic acidosis: improved, cont to monitor 3. Encephalopathy, multifactorial due to sepsis, medications, ICU 4. DM with hyperglycemia: Monitor, FSBS, SSI 5. Bile leak, persistend as per surgery 6. S/P R hemicolectomy 7. Sepsis: cont Merrem per ID	**Pt continues to pull out important medical lines. Restraints?**	ARH5, pp 39 - 44

Date	Provider	Event	Outcome	Legal Nurse Opinion/ Recommendations	Pg #
		Assessment: Ill appearing, chronically, abdominal dressing saturated with bile, JP drain with bile drainage, low-grade fever			
1Jan21	[redacted] Medical Center [redacted], MD	**INTERNAL MEDICINE PROGRESS NOTE:** **Subjective:** Pt still moaning d/t pain around bile drain, continues to have much bile drainage, most recent blood cultures showed no growth **ROS:** unobtainable d/t altered mental status **Assessment:** chronically ill looking, **drainage leaking onto skin around JP drain site, abdominal packing saturated, abdominal tender around JP drain in RUQ,**	**ASSESSMENT & PLAN** 1. Intra-abdominal abscess: - Cont Merrem per ID - Supportive care 2. Metabolic acidosis, improved: - Cont to monitor 3. Encephalopathy, multifactorial due to sepsis, medications, ICU 4. DM with hyperglycemia: monitor GSBS, SSI 5. Bile leak, persistent as per surgery still draining significant amount around bile drain: -Transfer to UK Medical Center for 2nd opinion and further care 6. S/P R hemicolectomy 7. Sepsis: - Cont Merrem per ID		ARH5, pp 45 - 50

Claimant Name: [redacted]
Date of Death: 20Jan20

Date	Provider	Event	Outcome	Legal Nurse Opinion/ Recommendations	Pg #
1Jan20	[redacted] Medical Center [redacted], MD	**GENERAL SURGERY PROGRESS NOTE:** **Subjective:** worsening drainage, pt remains confused **ROS:** unobtainable d/t altered mental status **Assessment:** frail and ill appearing , drainage increasing and now with bile coming from subcostal incision.	**ASSESSMENT & PLAN** 1. Tachycardia 2. S/P biliary surgery 3. Mesenteric abscess 4. Intra-abdominal abscess 5. Pre-operative clearance 6. Diarrhea - Cont NPO and NG tube to LIS - Low threshold for transfer to tertiary care for hepato-biliary for persistent worsening bile leak.		[redacted] Medical Center, pp 89 - 93
1Jan20	[redacted] Medical Center [redacted], MD	**TRANSFERRED FROM HAZARD RMC TO UK HEALTHCARE:** **Reason for transfer:** Extensive worsening of bile leak and subsequent possible reoperation versus drain			ARH3, pp 183 - 187

Date	Provider	Event	Outcome	Legal Nurse Opinion/ Recommendations	Pg #
		placement. HRMC did not have the capabilities required.			
2Jan20	[redacted] Medical Center [redacted], MD [redacted], MD [redacted], MD	**SURGERY HISTORY & PHYSICAL NOTE:** **HPI:** 67yo female with PMH significant for poorly controlled T2DM, presented to OSH in Nov with intractable nausea and inability to tolerate PO intake. From OSH reports, pt may have had gastroparesis resulting in bezoar or impacted food bolus. Details of the primary operations are unclear per OSH reports. Pt required distal gastrectomy with partial duodenectomy and Billroth I reconstruction. Unfortunately, she developed a bile leak from her CBD and was taken back to be managed conservatively with a T-Tube and J tube placed for feeding. She became delirious	**ASSESSMENT & PLAN:** 1. CBD injury 2. Biliary peritonitis - Admit to SGO - IVF D10LR - NPO, restart TPN in am - NGT for PO contrast then to LWS after scan - CT A/P - IV pain, agitation, nausea control - Less concerning for biliary peritonitis given normal Tbili and lack of bilious output to LLQ - Based on exam & imaging, concern for mor than an isolated CBD leak; appears to have a leak from bowel as well, sit it unclear but consistent with something in the proximal GI tract	The pt was transferred to UK Healthcare for concern of postoperative biliary peritonitis. CT imaging performed at UK Healthcare suggested more extensive damage than CBD leakage. Upon surgical intervention, succus through the abdomen with complete dehiscence (splitting) of the loop choledochejejunostomy (new opening of the bile duct and middle intestine) with duodenal stump (dilated section of the first part of the small intestine) leak and possible leak at site of entry of common bile duct into duodenum	[redacted], pp 15 – 20, 25 - 28

Date	Provider	Event	Outcome	Legal Nurse Opinion/ Recommendations	Pg #
		after 2nd surgery and pulled out the T-tube resulting in biliary peritonitis requiring another surgery on 12/27. During the 2nd surgery her J tube was inadvertently ripped out d/t severe scar tissue and a hostile abdomen. She was transferred to the ICU where she had continued delirium and TPN via PICC for nutrition. Over the last 3 days she had had increasing biliary output from JP drain next to the anastomosis and was transferred to UKHM for higher level of care. Since admission, pt has been agitated and confused. She is afebrile and hemodynamically stable with HR from 100-120. Oriented to person only; frequently cries out and appears	- Appears to have severe soft tissue infection to R abdominal wall. - **Emergent surgical intervention is needed.** 3. T2DM - SSI 4. Delirium - Baseline ECG - PRN Haldol - QHS Seroquel - PRN IV Dilaudid for pain 5. Malnutrition - Albumin 1.1 - Prealbumin 6.8 - Restart TPN	from previous operation were identified. **A review of the current standards of practice in relation to the pt's course of care and complications would indicate whether the utilization of diagnostic studies aids in timely identification of complications and infections were utilized.**	

Date	Provider	Event	Outcome	Legal Nurse Opinion/ Recommendations	Pg #
		uncomfortable, but when left along able to rest and sleep Abdomen is very TTP diffusely. Well-healed midline exlap and chevron incision with staples, RUQ JP drain with frank bilious output and some leakage around drain; LLQ JP remains SSF localize peritonitis with marked induration of R abdominal wall, upon deeper palpation in succus began draining from R side of chevron incision. NGT removed inadvertently prior to transport; foley catheter in place, RUE PICC. **Labs:** Leukocytosis to 15.4; Hgb 10.6, Glucose 343, Total bilirubin 0.9, Albumin 1.1.			

Date	Provider	Event	Outcome	Legal Nurse Opinion/ Recommendations	Pg #
		No physician notes or operative reports were sent with the patient, so most information was gleaned from nursing record, nursing report and pt's son. **CT A/P with contrast on 1/2/20** Lower chest bibasilar atelectasis with small bilateral pleural effusions GI tract/Mesentery/Peritoneum: Surgical changes, extraluminal contrast noted to RUQ consistent with bowel leak -- difficult to locate source of leak, but subhepatic contract appears to be extending from the distal gastric anastomosis and is contiguous with the fluid collection located within the			

Date	Provider	Event	Outcome	Legal Nurse Opinion/ Recommendations	Pg #
		anterolateral wall; small free fluid collections within the abdomen and pelvis.			
2Jan20	[redacted] Medical Center [redacted], MD	**SURGERY:** **PROC:** Exploratory laparotomy, abscess drainage, enteroenterostomy (surgical connection of two segments of intestine), temporary abdominal closure, EGD **IND: suspected abdominal peritonitis** **Findings: feculent peritonitis** (fecal matter in abdominal cavity), retrocolic gastrojejunostomy, ileocolic anastomosis & duodenal stump leak with appearance of jejunal serosal patch inter anterior portion of duodenum with free leakage of succus (fluid) from	**PreOp DX:** septic shock, peritonitis, hollow viscus perforation, history of recent gastric & duodenal resection **PostOp DX:** septic shock, peritonitis, hollow viscus perforation, history of recent gastric & duodenal resection		[redacted], pp 11 - 14, 28 - 30

Date	Provider	Event	Outcome	Legal Nurse Opinion/ Recommendations	Pg #
		this portion of jejunum where the patch had separated.		Patch had separated. Poor surgical technique?	
3Jan20	[redacted] Medical Center [redacted], MD [redacted], MD [redacted], MD [redacted], MD	**GENERAL SURGERY CONSULTATION NOTE:** **Subjective data:** overnight required 3L fluid with elevating lactate and low UOP; continues to be hypotensive and was started on levophed this am, blood cultures from1/2 show no growth. **Assessment:** intubated, in bed, ill appearing with follow commands with sedation held **Labs:** WBC 35.01 – increased from 16.15 on 1/2, Hg 10.1, Hct 31.7, Plt 267 **4Jan20** WBC down trending to 18.33	**ASSESSMENT & PLAN** 1. Biliary anastomotic leak - S/P exlap with abdomen left open on 1/3 - NG to LWS - Cont vanc abx/discont flagyl 2. Hypotension - On levophed – wean today - Monitor drain output 3. Oliguria - Foley in place, monitor 4. Agitation - Sedation 5. Sepsis - Elevated lactate - monitor - Source of biliary/duodenal leak - Hypotenstion - Calculate SOFA score today - 8 - Fluid resuscitation	**The entry, *"Inadequately treated for candida at OSH, will treat with micafingin for appropriate course"* included in this GS Consultation Note indicates the candida treatment provided at HRMC did not meet the current standard of care. A detailed review of the treatment provided compared to the current standard is required to determine whether the standards of care were met or fell short as the candida infection contributed significantly to the ongoing** septic	[redacted] 35 – 39, 52 – 59

Date	Provider	Event	Outcome	Legal Nurse Opinion/ Recommendations	Pg #
			- Levophed PRN 6. Hyperkalemia - Calcium 5.2 today - Monitor 7. Leukocytosis - Likely secondary to duodenal leak, plans for drainage by IR today 8. Anemia - Component of dilution 9. DM -SSI 10. Malnutrition -Cont TPN 11. Candidemia - Optho consult – No evidence of fungal ocular invovement - Echo - Inadequately treated for candida at OSH, will treat with micafingin for appropriate course. 12. Respiratory failure -mechanical vent, monitor labs	**condition that progressed through the patient's HRMC hospital stay.**	

Date	Provider	Event	Outcome	Legal Nurse Opinion/ Recommendations	Pg #
			13. TLD - L central line, R A line, foley, JP drains, abthera, PIV, NGT 14. PPX -famotiditne SQH, restart after IR 15. Hyperbilirubinemia -monitor with lab eval 16. Hypernatremia - Cont to monitor		
4Jan20	[redacted] [redacted] [redacted] Medical Center [redacted] [redacted], MD [redacted], MD [redacted], MD	**SURGERY:** **PROC:** Reopening of laparotomy, abdominal washout, enterorrhaphy of duodenal perforations, drain placement, complex abdominal wall closure **IND: abdominal washout and further evaluation of perforations.**	**PreOp DX:** open abdomen & bile leak **PostOp DX:** open abdomen, duodenum perforations – one at site of entry of the common bile duct.		[redacted], pp 48 - 51, 60 – 61.

Date	Provider	Event	Outcome	Legal Nurse Opinion/ Recommendations	Pg #
		Findings: feculent peritonitis, retrocolic gastrojejunostomy, ileocolic anastomosis & duodenal stump leak with appearance of jejunal serosal patch inter anterior portion of duodenum with free leakage of succus from this portion of jejunum where the patch had separated			
5Jan20	[redacted] Medical Center [redacted], MD [redacted], MD [redacted], MD	**SURGERY CONSULTATION FOLLOW-UP:** **Subjective:** no acute events overnight, hemodynamically stable, afebrile, intubated & sedated **Assessment:** no acute distress, sedated and resting, abdomen mildly distended, 3 JP drains in place 1 with SSF, 2 with dark murky drainage	**ASSESSMENT & PLAN** 1. Duodenal stump & CBD leak - S/P ex-lap, drainage of soft tissue & peritoneal abscess, enteroenterostomy, temp abdo closure on 1/2 - PTC placement on 1/3 - S/P relook washout, drainage of abscess, enterorrhaphy of duodenal stump leak, abdominal closure on ¼ - Continue to monitor JP output		[redacted], pp 4 – 7, 62 - 66

Date	Provider	Event	Outcome	Legal Nurse Opinion/ Recommendations	Pg #
		CTA Head: negative	- Monitor PTBD output, keep gravity drainage - Onctreotide - Blood transfusion if needed - Cont TPN - Cont broad-spectrum abx and micafungin 2. Acute Respiratory Failure - Extubation as appropriate 3. Agitation - Haldol PRN 4. Candidemia - Cont mica 5. DM - SSI, increase lantus 6. Leukocytosis - Cont abx 7. Malnutrition - Cont TPN 8. Sepsis - Cont abx & BP mgmt 9. Hypertension - Goal SBP <180 asymptomatic, <160 if sxs present		

Date	Provider	Event	Outcome	Legal Nurse Opinion/ Recommendations	Pg #
			10. Lactic acidosis - Lactate 2.5, PRN fluid boluses		
5Jan20 -	[redacted] Medical Center	**PATIENT PROGRESS THROUGH HOSPITAL STAY**	**5Jan20** – Extubated, R sided weakness observed. **6Jan20** - Neurology Evaluation – no definite persistent focal deficits, remains somewhat encephalopathic may be the result of delirium, no evidence to suggest stroke - Pharm/Nutrition evaluation – recommendations to adjust TPN formula, aggressively replace electrolytes, calcium and phosphorus, will follow and adjust as needed.		[redacted], pp 69, 71, 80-81. 84, 96 – 98, 107, 114, 131 – 134

Date	Provider	Event	Outcome	Legal Nurse Opinion/ Recommendations	Pg #
			7Jan20 - Wound VAC dressing changed by [redacted] – no complications/difficulty - Received 1U blood **8Jan20** - WBCs downtrending – discontinued abx - Increasing bile in FP indicative of disruption of CBD repair – no further surgical options per Surgical Oncology; appears controlled with drains - Wound VAC dressing changed by [redacted] – no complications/difficulties.		

Date	Provider	Event	Outcome	Legal Nurse Opinion/ Recommendations	Pg #
			10Jan20 - TPN cont, added clear diet as tolerated - Continues to mentate - R JP drain draining straight bile, VSS, afebrile, WBC 15. **12Jan20** - Pt pulled out central access place for TPN previous evening, transitioned to IVD with dextrose via PICC, Confused and distressed otherwise asymptomatic. **13Jan20** - Remains confused & distressed, given 2U PRBC for Hgb of 6.8, drains & wound VAC with minimal output.		
9Jan20	[redacted] -	**PALIATIVE CARE CONSULT:**	Discussed sustaining treatments with abdominal drains and permanent TPN		[redacted], pp 103

Date	Provider	Event	Outcome	Legal Nurse Opinion/ Recommendations	Pg #
	[redacted] Medical Center [redacted], MD	**Reason for consult:** Complex medical decision-making Met with patient and husband at her bedside; pt was somnolent and did not participate in conversation other than an occasional nod. [redacted] indicated that he was under the impression his wife was on her way to healing and the information provided by the Palliative Care Physician brought him "down".	if needed; husband did not think she would value that scenario. Husband mentioned [redacted] told him in the past that she would not want to be on machines. Palliative Care Physician explained DNR/DNI status, but husband preferred his wife make that decision.		
14Jan20	[redacted] Medical Center [redacted], MD	**SURGERY:** **PROC:** Incision & drainage of complex postoperative wound infection and negative pressure wound dressing change, negative wound pressure closure placement	**PreOp DX:** duodenal fistula **PostOp DX:** duodenal fistula		[redacted], pp 140 - 141

Date	Provider	Event	Outcome	Legal Nurse Opinion/ Recommendations	Pg #
	[redacted] MD	**IND:** Over the past 24hrs VAC dressing change has turned from relative thin fluid to bile-stained and succus like, need to change VAC and inspect the complex wound given slightly rising WBC. **Findings:** Muliptle pockets of fluid in wound, Strattice to medial portion of wound discinigrated and was freely flapping with multiple pools of drainage coming up from the Strattice, large LUQ fluid collection – discussed with Interventional Radiology for possible percutaneous drainage as pt's frail conditions was not optimal to reopen lap incision.			
14Jan20	[redacted] Medical Center	**INTERVENTIONAL RADIOLOGY CONSULT:**	**ASSESSMENT & RECOMMENDATION:** Pt would benefit from drain placement.		[redacted], pp 142 – 145, 148

Claimant Name: [redacted]
Date of Death: 20Jan20

Date	Provider	Event	Outcome	Legal Nurse Opinion/ Recommendations	Pg #
	[redacted], MD [redacted], MD	**Reason for consult:** Perisplenic fluid drain placement	Percutaneous drain successfully placed to LUQ, approximately 450 bilious fluid initially evaluated Drain care per primary team		
15Jan20	[redacted] Medical Center [redacted], MD	**PALLIATIVE CARE CONSULT FOLLOW-UP:** **Reason for consult:** Speak with [redacted] and family about options of going home or cont life sustaining tx.	Met with pt, husband and 3 children; discussed diagnosis and prognosis. Pt decided to cont hospitalization for TPM and complex wound c.are and elected DNR/DNI status.		[redacted], pp 153 -156
17Jan20	[redacted] Medical Center [redacted], MD	**SURGERY:** **PROC:** Change of abdominal VAC (vacuum assisted closure) dressing, drainage of perforated viscus contents **IND: over previous 5 days abdominal wound increasingly more difficult to control using VAC dressing**	**PreOp DX:** perforated viscus with contamination **PostOp DX:** perforated viscus with contamination		[redacted], Pp 163 - 164

Claimant Name: [redacted]
Date of Death: 20Jan20

Date	Provider	Event	Outcome	Legal Nurse Opinion/ Recommendations	Pg #
		Findings: undigested food product in anterior abdomen, complete breakdown of previously places Strattice mesh, anterior abdominal fascia densely adherent to underlying viscera.			
17Jan20	[redacted] Medical Center [redacted], RN	**WOUND DOCUMENTATION:** MASD (moisture assoc) wound to perirectal area	Dressing: Allevyn dressing in place Plan: Gently cleanse skin, no-sting barrier spray, thick layer of Z guard barrier, turn Q1h.		[redacted], pp 175
18Jan20	[redacted] Medical Center [redacted], MD	**PALLIATIVE CARE FOLLOW-UP:** Discussed diagnosis and prognosis with pt, husband and one child. [redacted] indicated there were no further operative	**PLAN** Pt DNR/DNI status: d/c all non-essential measures and medications that do not provide relief of pain or suffering and TPN.		[redacted], pp 177 - 178

Date	Provider	Event	Outcome	Legal Nurse Opinion/ Recommendations	Pg #
	[redacted]	interventions available and her condition was not survivable. [redacted] stated she just wanted to die comfortably.			
18Jan20	[redacted] Medical Center [redacted], MD	**TRANSFERRED TO HOSPICE UNIT:** **Discharge Diagnoses:** Acute respiratory failure Candidemia Malnutrition Diabetes mellitus Anemia Leukocytosis Hyperkalemia Agitation Oliguria Hypotension Sepsis Biliary anastomotic leak **Hospital Course:**	Discharge condition stable & manageable. Hospice Evaluation performed @ BS prior to transfer to Hospice Unit.		[redacted], pp 181 - 186

Claimant Name: [redacted]
Date of Death: 20Jan20

Date	Provider	Event	Outcome	Legal Nurse Opinion/ Recommendations	Pg #
		Pt admitted to General Surgery for critical care and operative management. Returned to OR multiple times for drainage of abscess, perforation repairs and washouts with further complications for abdominal infection. Remained hemodynamically stable, TPN nutrition, but was delirious and transferred to Surgical Oncology for management. During an OR visit for wound VAC change, perforation with bowel contents was identified.			
20Jan20 @ 0213.	[redacted] Medical Center	**DEATH:** **Cause of death:** Sepsis No autopsy performed.			[redacted], pp 2

Claimant Name: [redacted]
Date of Death: 20Jan20

Date	Provider	Event	Outcome	Legal Nurse Opinion/ Recommendations	Pg #
	[redacted], MD				

Thank you kindly for this referral. These conclusions and recommendations have been based on those documents currently on file and previously submitted. Should further information become available, this should be reviewed by Trifecta Legal Nurse Consulting to determine content and relationship to the case.

Respectfully Submitted,

Trifecta Legal Nurse Consulting [redacted]

Contributing Legal Nurse Specialist: [redacted]