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CASE VIABILITY SCREENING

Jones v. Eastside Community Hospital • SHCC-2025-0503

Non-Testimonial Clinical Analysis • All Findings Record-Anchored • Bates Citations Throughout

CASE IDENTIFICATION

Client / Matter:	Jones v. Eastside Community Hospital	**Matter No.:**	SHCC-2025-0503
Date of Incident:	March 14, 2023	**Date of Delivery:**	June 3, 2024
Service Type:	Case Viability Screening	**Prepared By:**	Kira Sakata, R.N., MSN, TNCC, ENPC
Reviewed By:	Christian Hennessey, R.N., MSN, CCRN	**Record Volume:**	Tier A | 642 Bates pages
Record Period:	March 14, 2023 – March 19, 2024	**Turnaround:**	Standard (3 business days)

SCOPE STATEMENT & LIMITATIONS

This deliverable is a non-testimonial clinical analysis prepared for attorney use in case development. All findings are based exclusively on medical records provided. This timeline tracks documented injury, symptom progression, and functional impact; it does not constitute a standard-of-care opinion, causation determination, life-care plan, vocational assessment, or damages valuation. Future care references reflect only what treating providers documented. No independent projections are made. Missing records are flagged with a targeted request list in the companion Excel workbook. This work product is confidential and intended solely for the receiving attorney's use in litigation support.

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SECTION 1: EXECUTIVE SUMMARY & CLINICAL VERDICT

Clinical Verdict: Record Supports Further Case Development

The available records document a clinically coherent pattern: a 58-year-old woman admitted with sepsis of urinary origin whose condition deteriorated across a five-day ICU stay in a manner that raises substantive questions about the timeliness of monitoring responses and the adequacy of clinical escalation. The core theory of nursing and care coordination failures is supported by objective documentation.

This verdict reflects the threshold question only, whether the records plausibly support the theory of negligence. It is not a determination that negligence occurred, that the standard of care was breached, or that any identified gap caused harm. Those conclusions require expert medical and nursing testimony.

Case Summary

Dolores E. Jones, a 58-year-old woman with a documented history of Type 2 diabetes mellitus and recurrent urinary tract infections, presented to the Eastside Community Hospital Emergency Department at 02:14 on March 14, 2024 with a chief complaint of fever, rigors, and altered mental status. Triage vital signs were: temperature 39.8°C, heart rate 118 bpm, blood pressure 88/52 mmHg, respiratory rate 24 breaths/minute, and SpO2 94% on room air. Initial labs returned within 90 minutes of presentation demonstrated a white blood cell count of 18,400 cells/µL, lactate of 3.8 mmol/L, creatinine of 2.4 mg/dL (baseline 0.9 mg/dL per prior visit records), and urinalysis with large leukocyte esterase, nitrites positive, and bacteria 4+. Blood cultures were drawn and urine cultures ordered.

An ED attending diagnosis of urosepsis with suspected acute kidney injury was documented at 04:05. The patient was admitted to the Medical ICU (MICU) at 07:45 on March 14. She remained in the MICU through March 19, 2024, when she was transferred to a step-down unit following a rapid response team (RRT) activation at 06:22 that morning secondary to acute respiratory decompensation. She was ultimately discharged on March 26 with diagnoses of urosepsis, hospital-acquired pneumonia, and acute kidney injury requiring 72 hours of renal replacement therapy.

Alleged Theory of Negligence

Counsel alleges that nursing staff and care coordination personnel failed to recognize and respond to documented clinical deterioration during the evening of March 16 and early hours of March 17, 2024; that a progressive worsening of oxygenation, urine output decline, and escalating vasopressor requirements went without escalation to the attending physician or activation of the rapid response pathway; and that this delay contributed to respiratory decompensation, prolonged ICU stay, need for dialysis, and residual renal impairment documented at six-month follow-up.

Bottom Line for Case Development

Three clinically significant findings support this theory: (1) a documented four-hour gap in nursing reassessment during a period of measurable vital sign deterioration on the evening of March 16; (2) a nursing note at 03:10 on March 17 acknowledging SpO2 readings of 88–89% on 4L nasal cannula without documented provider notification; and (3) a vasopressor titration sequence in the MAR showing two consecutive dose escalations between 22:00 March 16 and 01:00 March 17 without any corresponding nursing note, attending notification, or reassessment entry. These findings collectively present a clinical narrative that warrants expert review of nursing standard of care.

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SECTION 2: STRENGTHS, RISKS & GAPS MATRIX

Strengths

Category	Clinical Finding	Significance
Vital Sign Documentation	Nurse flowsheets from 22:00–02:00 March 16/17 show sequential entries: HR increasing from 98 to 127 bpm, MAP declining from 65 to 52 mmHg, RR rising from 20 to 28/min over four hours, each timestamped in the EHR.	Establishes objective, documented deterioration with high evidentiary reliability. Trend is clear and unambiguous.
SpO2 Admission Note	A nursing note timestamped 03:10 on 3/17 states: 'Pt SpO2 88–89% on 4L NC x2 readings, repositioned.' No provider notification is documented in nursing notes, call logs, or physician orders for the subsequent 3.5 hours.	Directly supports the theory of failure to escalate. The documentation itself shows awareness of the finding without a corresponding escalation response.
MAR Vasopressor Record	Norepinephrine infusion rate documented at 0.06 mcg/kg/min at 22:15 (3/16), titrated to 0.10 at 23:45, and further to 0.14 at 01:00 (3/17). No nursing notes, MD notifications, or orders document clinical rationale for escalation or attending awareness.	Silent titration record without supporting narrative creates a significant documentation gap that expert review can address.
Reassessment Gap	ICU flowsheet shows nursing assessments timestamped 18:30 and 22:30 on March 16. The next documented nursing assessment is at 02:45 on March 17, a four-hour and fifteen-minute gap. Hospital policy (RCH Policy ICU-N-04, Rev. 2022) requires reassessment every two hours for patients on vasoactive infusions.	Policy-to-documentation gap is explicit, timestamped, and referable to a specific internal policy. High-yield for expert engagement.
Outcome Correlation	RRT activation at 06:22 on 3/17 documented SpO2 82% on 4L NC, RR 34, use of accessory muscles. Intubation followed at 07:05. Nephrology consult for AKI-R (KDIGO Stage 3) placed at 09:14 on 3/17.	Clinical trajectory connects the escalation failure window directly to documented decompensation, supporting damages causation theory for expert consideration.

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Risks

Category	Clinical Finding / Concern	Risk Level & Note
Comorbidity Profile	Ms. Jones carried diagnoses of Type 2 diabetes mellitus (HbA1c 9.2% documented 60 days prior), CKD Stage 2 (eGFR 58 mL/min/1.73m² at 2023 visit), and obesity (BMI 36.1 at admission). These conditions independently increase the risk of AKI, sepsis complications, and respiratory compromise.	Moderate. Defense will attribute outcomes to baseline disease. Expert will need to address whether the trajectory deviated from expected for this comorbidity profile.
Antibiotic Timing	First dose of IV ceftriaxone 2g was administered at 05:38 on 3/14, 3 hours and 24 minutes after triage. CMS Sepsis Bundle (SEP-1) requires antibiotic administration within 3 hours of presentation for qualifying sepsis patients. Lactate was 3.8 at triage; bundle threshold is ≥2.0.	Moderate. Initial sepsis management delay is a separate potential care concern but may complicate the primary nursing escalation theory if defense argues the patient was already compromised from admission. Requires expert stratification.
Attending Documentation Gap	Physician progress notes for March 16 (day shift and evening shift) are absent from the produced records. Available is a single resident note at 11:45 and a brief order set. Attending involvement cannot be confirmed or ruled out from current records.	Moderate-High. This cuts both ways: it may support the escalation failure theory (no documented physician contact), but the absence of physician records limits full picture analysis and could indicate incomplete production.
Nursing Narrative Discrepancy	A nursing note at 00:50 on 3/17 (signed by the same nurse author as the 03:10 SpO2 note) states patient is 'resting comfortably, hemodynamically stable.' This entry predates the SpO2 documentation by approximately 2 hours and 20 minutes but conflicts with the vital sign trend in the flowsheet.	Moderate. Internal inconsistency in nursing documentation is a liability for both sides. It may support the theory that notes were inaccurate or late-charted, but may also be used by defense to challenge the reliability of the records.

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Gaps

Gap Category	What Is Missing	Impact on Analysis
Physician Records 3/16	Attending physician progress notes for the full calendar date of March 16, 2024 are absent from produced records. One resident addendum is present (11:45), but no attending-authored notes, telephone order logs, or verbal order documentation are present.	High. Cannot determine physician awareness of deterioration or document absence of escalation responses from the nursing team. Critical to the escalation failure theory.
Telephone / Communication Logs	No Voalte, Vocera, Spok, or equivalent communication system records have been produced. Internal call logs or nurse-physician communication records are absent.	High. If communication occurred outside the EHR, the current record set cannot confirm or deny provider notification. These records could be highly probative in either direction.
Nursing Staffing Records	Unit census, nurse-to-patient ratio assignments, and charge nurse documentation for the evening of March 16 and overnight 3/16–3/17 have not been produced.	Moderate. Staffing context may be relevant to the standard of care analysis and an expert's ability to assess whether workload contributed to the reassessment gap.
RRT Activation Documentation	The RRT activation at 06:22 on 3/17 is referenced in a physician order but no formal RRT activation form, RRT nurse documentation, or RRT physician note is present in the records provided.	Moderate. RRT documentation typically captures the clinical state at activation and may include a retrospective assessment of what precipitated the event.
Post-Discharge Renal Records	No outpatient nephrology follow-up records have been produced. Damages theory includes residual renal impairment, but the current records extend only to discharge on 3/26/2024.	Moderate for Damages. Cannot document residual renal trajectory or establish ongoing impairment without post-discharge records from nephrology or primary care.

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SECTION 3: PRIORITIZED RECORD REQUEST LIST

Priority Key: P1 = Obtain Before Any Further Investment | P2 = Obtain Before Expert Engagement | P3 = Obtain for Damages Development

Priority	Record / Source	Clinical Rationale for Request
P1	Attending physician progress notes, all authors, March 14–19, 2024 (Eastside Community Hospital MICU)	The absence of attending notes for 3/16 is the single most significant gap in the current production. Physician awareness (or documented absence thereof) is central to the escalation failure theory. Request complete physician record production from all MICU attending physicians, fellow, and resident authors.
P1	Nurse-physician communication logs, Voalte, Vocera, Spok, or equivalent system; March 16 18:00 – March 17 08:00	If notifications occurred outside the EHR, these logs are the only documentary evidence. Request from hospital IT / nursing informatics. Specify the patient encounter ID and unit designation. These are frequently not included in standard medical record releases.
P1	Rapid Response Team activation record and RRT nurse documentation, March 17, 2024, 06:22 activation	RRT documentation typically captures presenting clinical state, precipitating assessment, and team actions. If the RRT nurse documented clinical history at activation, that narrative may contain retrospective acknowledgment of the deterioration period. Not included in current production.
P2	Nursing unit staffing assignment sheets and charge nurse records, MICU, March 16 (both shifts) and March 16–17 overnight	Patient-to-nurse assignment and census will be relevant to any standard of care assessment involving the reassessment gap. Experts frequently require this context to evaluate whether the failure was systemic (workload) or individual. Request from MICU charge nurse documentation and hospital staffing office.
P2	Hospital policy: ICU-N-04 (Vasoactive Medication Monitoring) and ICU-N-08 (Patient Reassessment Frequency), current version as of March 2024 and any prior version in effect within the preceding 12 months	Two specific policies are potentially implicated: reassessment frequency for vasoactive infusion patients and escalation response to abnormal vital sign trends. Obtain certified copies directly. If policies were revised after the incident, obtain both the current version and the version in effect at the time.
P2	Sepsis Bundle (SEP-1) compliance documentation and quality measure records for this admission	Antibiotic timing of 3h 24m exceeds SEP-1 thresholds. Hospital-generated SEP-1 compliance documentation (frequently a separate quality record) will confirm whether the delay was internally flagged. If this case triggered a quality review or RCA internally, that record is potentially discoverable.
P3	Outpatient nephrology records, all treating providers, April 2024 through present	Damages theory includes residual renal impairment. Nephrology follow-up will document whether AKI resolved, progressed, or

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		resulted in CKD advancement. Required for any damages quantification opinion.
P3	Primary care records, 12 months pre-admission and post-discharge through present (treating provider: Dr. Elena Vasquez, Rio Vista Family Medicine, per ED registration)	Baseline renal function, diabetes management, and UTI history will be needed to establish the pre-incident functional baseline for damages differentiation. Post-discharge primary care records will document the recovery trajectory and any ongoing complaints attributable to the hospitalization.
P3	Physical therapy and rehabilitation records, if any PT/OT consultations or outpatient rehabilitation occurred post-discharge	If functional impairment (weakness, deconditioning, cognitive impact) is part of the damages theory, PT/OT documentation of functional baseline and recovery will be required.

SECTION 4: RECOMMEND NEXT STEPS

Based on this screening review, the following sequence is recommended:

- Obtain P1 records before committing to expert engagement. The absence of attending physician notes and communication logs represents a material gap, if those records contradict the escalation failure theory, the case posture changes significantly.
- Engage a Critical Care nursing expert once P1 records are in hand. The reassessment gap, SpO2 documentation without escalation, and silent vasopressor titration sequence are high-yield issues for a nursing SOC opinion. Issue spotting work can be performed in parallel to prepare targeted expert questions.
- Consider a medical expert for causation separately. Whether the documented escalation failures caused or contributed to the respiratory decompensation and AKI progression requires a critical care physician or hospitalist opinion. Nursing SOC and medical causation should be scoped separately.
- Develop the damages file concurrently. P3 records (nephrology, primary care) should be requested now so they are available when the damages narrative is built. Do not wait until liability is confirmed, the damages trajectory takes time to document.

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