Sample Rebuttal Report Template for LNCs

Before writing your rebuttal opinion always discuss the report first with the lawyer you are working with.

Jane Saundare, RN, BScN
123 Wallabee Way
Donnar, AB, T2M X9P

Mr. Jason Whyte
Whyte Law
1801 Summer Street
Halifax, Nova Scotia
B3X 3M4

www.whytelaw.ca
hWhyte@pattersonlaw.ca
Tel: 928-426-5050
Fax: 928-426-5051

Re: James Smith v. Capital Health et al.
Your File Number: 8679305

June 1, 2022

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Start the report by stating what you have been asked to do. Follow this with a brief synopsis of the case events and outcome.

Dear Mr. Whyte,

You have asked me to review the nursing opinion of Registered Nurse Sandra Costo related to the above matter, and I am writing to respond to specific issues raised in that report. In preparation of this letter, I have reviewed the following documents provided by your office:

1. Nursing Opinion Report of Sandra Costo, RN dated August 11, 2021
2. Emergency Department Medical Records for James Smith from Capital Health dated May 13 and May 16, 2011
3. Printout for EDIS for May 12-16,2011
4. Transcript of Discovery of Paramedic Jodi Coombs, dated January 23, 2020
5. Transcript of Discovery of Paramedic Eric Le Due, dated January 23,2020
6. Transcript of Discovery of Registered Nurse Eliza Hunter dated May 10, 2020

I confirm that I am the sole person responsible for evaluation of these documents and for the entire contents and opinion of this written report. I have made every effort to be as complete and accurate as possible in my review and in my rebuttal comments.

Statement of Qualifications

Inform why you are qualified to provide expert opinion on this case. Define which of your qualifications are relevant. Summarize your qualifications as you will also attach a recent copy of your CV to the final report.

I am a Registered Nurse licensed in the province of Alberta with the College of Registered Nurses of Alberta. I graduated from the University of Alberta with a Bachelor of Science in Nursing in 1988. I have been employed in the nursing profession since that time. Currently I am employed by Safe Harbour

Hospital as a clinical instructor at the Emergency Department. This has been my field of expertise for the past 26 years.

I have completed a Critical Care Nursing Program specializing in emergency nursing. My certifications include Neonatal, Pediatric and Advanced Cardiac Life Support, the Trauma Nurse Core Course and the Emergency Nurse Pediatric Course. My current responsibilities include the orientation of registered nurses to the emergency department and their ongoing in-servicing and training to all areas of the department. I am directly involved in department and hospital quality assurance. I am an active member of the Canadian Nurses Association (CNA), the National Emergency Nurses Affiliate (NENA), and the Emergency Nurses Association (ENA). My attached Curriculum Vitae further details my clinical and educational background.

Rebuttal to the Expert Opinion of Registered Nurse Sandra Costo

Respond to the other expert's opinion. Identify where you might agree and specifically where you do not and why.

1. **In response to Nurse Costo's opinion that Nurse Eliza Hunter *"who oversaw the ED as well as the EMS Triage nurse met the standard of care"*. (Page 2)**

Emergency departments across Canada deal with large volumes of patients with a variety of conditions and varying acuity levels. The first health care professional a patient is likely to encounter on arrival to emergency is a triage nurse. The role of the triage nurse …

In this matter patients were being triaged using the Canadian Triage and Acuity Scale (CTAS). This nationally accepted scale was developed by the Canadian Association of Emergency Physicians and the National Emergency Nurses Association in 1998. CTAS is used across Canada and provides a valJodited method for sorting and prioritizing patients in Emergency Departments. (Beveridge, 1998) (Murray, 2004).

There are five triage levels in Canadian Emergency Department Triage and Acuity Scale…

In order to meet the standard of care, the triage assessment of each patient must include documented evidence of both subjective and objective assessment findings. The subjective assessment includes questioning ……

Upon review of Nurse Hunter's triage assessment subjective and objective assessments were completed with the exception of a temperature and pain score. While not completing a temperature or pain score was below the expected standard of care, Nurse Hunter did change the CTAS score from and 4 to a 3 in light of the second visit to Emergency (Discovery of Eliza Hunter, page 110) which was reasonable. Ms. Smith was then transferred shortly after to Pod 5. Overall, I would agree with Nurse Costo that Nurse Hunter did meet the expected standard of care by assigning Ms. Smith a CTAS 3. I hold this opinion with a high degree of certainty.

2. **In response to Nurse Costo's opinion that Paramedic Eric LeDue met the standard of care. "*Paramedic LeDue stated he recognized Ms. Smith to have a low-grade fever with a little elevated HR (P. 12, Lines 6-16). She also believed the BP of 94/50 was normal for women (P. 12, Lines 7-19). In my opinion, Paramedic LeDue's thinking is reasonable, as some women present with lower blood pressure than men. Ms. Smith's temperature was low grade and not alarming, and her elevated heart rate could have been related to pain. In her Examination for Discovery, Paramedic LeDue demonstrated a good knowledge base regarding Triage scoring and how not only presentation of physical appearance can affect the CTAS so can abnormal Vital Signs (Questioning for Discovery, P. 26, Lines 19-20, P. 17, Lines 1-4).***

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> ***When using ECTAS/Edis, the Triage chooses certain modifiers from the system that will automatically assign a CTAS score. Paramedic LeDue chose Acute peripheral Moderate Pain 4-7/10 using his observation of Ms. Smith. It is up to the user to increase or decrease the CTAS score if they feel it is necessary.***
>
> ***According to the Triage performed on Ms. Smith a CTAS 4 was appropriate." (Page 7)***

Ms. Smith's second visit to the Emergency on May 16, 2011, should have been recognized by Paramedic LeDue as concerning. Prior to sending any patient to the waiting room, CTAS requires review the subjective and objective assessments in context with vital signs and demonstrate critical thinking and investigation into the patient's presenting complaint in order to prioritize their care. Paramedic LeDue's assessment did not meet the expected standard of care at triage…

Applying critical thinking, given the second presentation to the emergency with worsening symptoms, abnormal vital signs, swelling of the knee and inability to weight bear, the prudent approach would have been a CTAS 2 recognizing the risk for potential infection or more serious condition. I hold this opinion with a high degree of certainty given the documents reviewed.

3. **In response to Nurse Costo's opinion that Advanced Care Paramedic Jodi Coombs met the standard of care: "*Although there were VS documentation gaps, in my opinion, Paramedic Coombs provided a reasonable standard of care taking into consideration Ms. Smith was in severe pain and that her condition was concerning. She appropriately responded by bringing Ms. Smith to a room, calling for assistance by Paramedic Jim Blocker and by retrieving a Medical Resident to come and assess Ms. Smith." (Page 7)***

As previously mentioned, patient assessments and documentations must reflect the degree of risk to the patient. Without information as to the patient volume and acuity in the emergency that night, I am unable to comment on the almost two-hour delay from time of triage to Ms. Smith's transfer into a bed in Pod 5.

In the Transcript of Discovery Paramedic Coombs did initially see Ms. Smith in the waiting room when she heard Ms. Smith yelling (Page 43). It was unclear from the medical records and Discovery provided the time frame between this interaction and when the second interaction at 11:15 pm.

I agree with Nurse Costo that Paramedic Coombs recognized Ms. Smith's condition was concerning upon bringing her into the department at 11:15 pm. She appropriately sought assistance from another paramedic and got a resident physician in to see Ms. Smith. An intravenous was started, pain medications were given and lab tests including blood cultures were drawn at 0:50 am. It is unclear from the documents provided when the antibiotics were ordered. The first dose was given at 2:30 am which is a significant delay from when Ms. Smith was seen by the physician and the blood work was drawn. When a potential infection is identified it is imperative to initiate antibiotics as soon as possible after being ordered.

While the initial care was reasonable upon realizing Ms. Smith was unwell, once settled there should have been ongoing assessments documented of her physical status and vital signs. A limited initial assessment was documented of the appearance of the leg, that pulses were present and there was decreased sensation to the leg. A further initial assessment should have included……

The physician assessment indicated Ms. Smith looked unwell, her leg was swollen, warm, she was sweaty and had chills. As previously mentioned, the initial assessment would be used as a baseline for ongoing assessments. Minimally Ms. Smith should have been reassessed hourly and/or after medications and procedures. These assessments should have included:

- Vital signs. ……

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It was concerning that vital signs noted at 1:00 am indicated a blood pressure of 80/(illegible). This is a low blood pressure which should have been brought to the attention of the physician and repeated minimally hourly as fluids and medications were given.

While tasks and medications given were documented, there were no reassessments of Ms. Smith's vital signs, physical status or response to the medications and intravenous fluids. Paramedic Coombs indicated in Discovery that vital signs were generally taken every three to four hours or more frequently dependent on the patient complaint (Page 68). The next vital signs were not completed until 5:35 am which indicated a blood pressure of 152/105 and a heart rate between 120-130 beats per minute. …… Failure to perform a more comprehensive initial assessment and then to continue to monitor Ms. Smith was below the expected standard of care. I hold this opinion with a high degree of certainty.

This report is based on information made available to me as of June 1, 2022. I have done my best to be objective, accurate and complete. If my opinion changes after further consideration of these facts or through a review of additional information provided in the future, I will notify you in writing as soon as possible. Thank you very much for asking my opinion in this matter. If I can be or any further assistance to you, please do not hesitate to contact me.

Sincerely,

Jane Saundare, RN, BScN

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References

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