

# Sample Report Template for LNCs

Here are a few tips on writing a professional report and a sample format to follow. Prior to writing, always discuss the content and format of your written opinion with the lawyer.

Format your expert report as a business letter. Key features are your name, title and complete address, the lawyer's address, the date. Address it directly to the lawyer that has requested your nursing opinion. Add a Draft watermark to your preliminary reports. Remove it when the report is finalized.

Jane Jones, RN, BScN  
10 Oak Bay  
Calgary, AB, T2R 6R8

Ms. Beverly A. Martins  
Barrister & Solicitor  
Hutchison Martins  
505 Fisgard Street  
Smithers, BC V8W 1R3

June 29, 2022

**Re: Stan Smith**

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 Ms. Martins,

You have asked me to provide a nursing opinion on the care provided to Mr. Stan Smith (Date of Birth: July 5, 1950) in the Emergency Room (ER) of the Dundee Hospital in Dundee, British Columbia on September 24<sup>th</sup>, September 26<sup>th</sup> and September 28<sup>th</sup> of 2016.

Briefly, Mr. Smith was started on the antibiotic Septra on September 16, 2016 for urinary pain, frequency and hematuria or blood in his urine. On September 24<sup>th</sup> and September 26<sup>th</sup>, 2016 Mr. Smith attended the ER at the Dundee Hospital reporting a headache and fever. On September 28<sup>th</sup>, 2016 he returned to the ER and was diagnosed with Stevens - Johnson Syndrome/Toxic Epidermal Necrolysis. He was admitted to the Intensive Care Unit for a brief period prior to being transferred to the Royal Hospital in Smithers, AB. He died on October 4, 2016.

**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.

# Sample Report Template for LNCs

## **Purpose of This Report**

**Briefly outline what the report will address.**

The purpose of this report will be to provide you with the answers to the questions you have asked of me in your correspondence dated May 22, 2009 and to provide a nursing opinion as to the standards of care provided to Mr. Smith given his diagnosis of Stevens - Johnson Syndrome.

The facts and assumptions on which my opinion is based have been extracted from a review of the documents listed below, provided by the office of Hutchison Martins of Smithers, AB. I confirm that I am the sole person responsible for the evaluation of these documents and for the entire contents and opinion of this written report.

## **Documents Reviewed**

**Provide a detailed list of all the documentation that you have received and reviewed in order to form your nursing opinion. Over the time working on the case, you will receive additional documentation (Discovery/Questioning, Policies, Procedures). Update the list before you finalize and send your written report. Research material is not included in this list, but may be referred to and/or footnoted throughout your report.**

In preparation of writing this opinion, I have reviewed the following information related to this matter provided by Hutchison Martins:

- Statement of Claim dated October 8, 2017
- Emergency Room and Intensive Care records from the Dundee Regional General Hospital dated September 24-28, 2016.
- Questioning of Pamela Smith, Registered Nurse, December 19, 2020

## **Patient History**

**Include past medical history and basic demographic information such as age, sex, height, weight, marital status, employment, and address of the plaintiff. Include relevant information derived from the case documents such as allergies, current medications and past medical and surgical history. Include a synopsis of the events leading up to the date of the incident. This might include information from Doctor's office visits, referrals to specialists, diagnostic testing, and ambulance reports.**

At the time of the original visit to the office of Dr. Theresa Vanes on September 16, 2016, Mr. Smith was a 56 year old married male. Mr. Smith had a past medical history of high cholesterol for which he took the medication Lipitor (atorvastatin calcium). He had no known allergies.

As a reference for the following information, normal vital sign ranges for a male of this age are:

- |                             |                                  |
|-----------------------------|----------------------------------|
| • Systolic Blood Pressure:  | 90 to 140 mmHg                   |
| • Diastolic Blood Pressure: | 60 to 90 mmHg                    |
| • Pulse/heart rate:         | 60 to 100 beats per minute       |
| • Respirations:             | 12 to 20 breaths per minute      |
| • Temperature:              | 36.1 to 37.8 degrees Celsius (C) |
| • Blood Oxygen Saturation:  | 95 to 100% on room air           |

(Lippincott Manual of Nursing Practice, 2010)

## **Chronology of Events**

**Discuss this section with the lawyer as to the extent of the detail required. Include the events for each of the dates or times that form the basis of your opinion.**

## Sample Report Template for LNCs

- Correlate facts such as days, dates, times, lab results, physician orders, medications, shift changes, and staff designations.
- Include names and designations of the doctors and nurses who provided care.
- You may also include aspects of teaching regarding diagnoses, medical terminology, medications and their possible side effects, and normal and expected ranges of laboratory findings.
- If referring to documents that have been poorly photocopied or illegible, note this in the chronology. Do not assume information that you cannot confirm.
- Label each day in the chronology with a date, day of the week, and location.
- End the chronology when you feel nursing responsibility ends. For instance, if you are providing opinion on post operative care, the chronology might end when the client is transferred from the surgical unit to the ICU. Briefly summarize the remainder of the medical records to provide a conclusion.

### **Saturday, September 16, 2016 (First day of Antibiotic Therapy)**

Mr. Smith attended the clinic of Dr. Theresa Vanes with frequent, painful and bloody urination. A urine culture was sent and Mr. Smith was commenced on the antibiotic Septra (trimethoprim – sulfamethoxazole).

### **Tuesday, September 19, 2016 (Day 4 of Antibiotic Treatment)**

The Dundee Regional General Hospital Urine Culture Laboratory Report noted that the urine culture sent by Dr. Vanes had no growth after 1 day of incubation. There was a note written by an unknown writer to “follow up with own MD please”. Dr. B. White was listed in brackets with a fax number. There was a “Faxed” stamp on the culture report. It is unknown if Dr. White ever received or viewed this culture report

### **Friday, September 22, 2016 (Day 7 of Antibiotic therapy)**

Documentation in the Emergency Room records from the Dundee Regional General Hospital indicated that Mr. Smith developed a frontal headache and fever.

### **Sunday, September 24, 2016 (Day 9 of Antibiotic Therapy)**

At 9:20 p.m. Mr. Smith attended the Emergency Department of the Dundee Regional General Hospital.

Mr. Smith was assessed by a triage nurse (name not legible) who documented a history of fever since Friday and that he was being treated for a urinary tract infection (UTI). He described a headache and of feeling “plugged up”. Mr. Smith had taken 1 gram of Tylenol (acetaminophen) prior to attending the ER. Vital signs on arrival were:

Temperature (Celsius)	Pulse	Respirations	Blood Pressure	Oxygen Saturations
37.6	98	20	146/82	99% on Room Air

All the vital signs except the blood pressure are within normal limits. The temperature was within normal limits. If Mr. Smith had a fever prior to taking Tylenol, it had been lowered by Tylenol. The blood pressure was slightly elevated, but this could be attributed to many things including his headache pain. There was no further recheck of his vital signs during this visit.

At 9:45 p.m. Mr. Smith was assessed by an ER physician (name not legible). A complete systems review was documented by the physician. The doctor acknowledged that Mr. Smith was on Septra for a UTI and that he had no further urinary symptoms. Examination of head, neck, ears, mouth, chest and abdomen were all within normal limits. A urine sample was tested in the ER and documented as negative. Mr. Smith was given the anti-

## Sample Report Template for LNCs

inflammatory medication ibuprofen and diagnosed with a viral illness. The physician's plan was symptomatic treatment and Mr. Smith was to follow up with his GP as needed.

At 10:05 pm Mr. Smith was discharged.

### Monday, September 25, 2016 (Day 10 of Antibiotic Treatment)

Mr. Smith completed his course of antibiotic treatment.

### Tuesday, September 26, 2016

At 8:12 a.m. Mr. Smith returned to the ER of the Dundee Regional General Hospital. Triage nurse R. Reeves noted his previous ER visit and that he continued to have a fever and headache. He had no urinary complaints. Vital signs initially were documented as:

Temperature	Pulse	Respirations	Blood Pressure	Oxygen Saturations
37.2 C	114	18	91/59	94% on room air

Of concern in the vital signs was the elevated heart rate and decreased blood pressure. However, repeated vital signs by the nursing staff at 9:15 a.m., 11:00 a.m., 12:30 p.m., and 2:00 p.m. were all within normal limits. A nursing physical assessment of Mr. Smith was completed by Nurse Jo-Ann (no last name is documented). Mr. Smith was alert and oriented to person place and time. He reported a constant central non-radiating headache between his eyes rated on a pain scale at 7 or 8/10 (0/10 would be no pain, 10/10 the worst imaginable perceived by the patient). A system by system assessment by the nurse revealed no abnormalities of the chest/lungs, heart sounds were regular and strong and there were no abdominal or urinary concerns. Mr. Smith's skin was described as hot and dry and appeared very flushed. His recent antibiotic use for a UTI was documented.

At 10:10 a.m. Mr. Smith was assessed by Dr. L. Dennis. His recent UTI and Septra use was acknowledged in the notes along with his recent ER visit. Dr. Dennis's system by system assessment noted that Mr. Smith had no abnormal head, neck, mouth, chest, or abdominal findings and he had no urinary concerns. Dr. Dennis did note that Mr. Smith had a fine diffuse erythema or skin rash. Though no allergies were noted, Dr. Dennis did question whether or not this was an allergic reaction to Sulfa (referring to the Septra). The physician ordered the following tests:

- Chest x-ray: Reported as normal except for a nodular density or mass on the right side. Reporting radiologist Dr. K. Matsuo felt this may represent a shadow from Mr. Smith's nipple.
- Complete blood count: Reported as normal except for a slightly low white cell blood count of 2.9 (normal range 4.2 – 10.8  $10^9/L$ ). White blood cells (WBCs) defend the body against both infectious disease and foreign materials. The number and type of WABs in the blood are often an indicator of disease.
- Chemistry panel: Results were within normal limits except an elevated creatinine level of 115 (normal 60-110 mmol/L) and a low glomerular filtration rate at 57 (normal 60-120 mL/min/\*). These values look at how well the kidneys are functioning.
- Blood Cultures: No results on the chart.
- Urinalysis: Normal.
- Lumbar puncture with cerebral spinal fluid analysis. All results within normal limits.

Based on the above findings Dr. Dennis made a diagnosis of a viral syndrome, but did question an allergy to Sulfa. Mr. Smith was given Percocet (oxycodone with acetaminophen), a narcotic pain reliever and Benadryl (diphenhydramine), an anti-histamine medication for allergic reactions.

At 2:25 p.m. Mr. Smith reported that he was pain free.

## Sample Report Template for LNCs

At 4:15 p.m. Mr. Smith was reassessed by Dr. Dennis and discharged home with a prescription for Percocet and Benadryl. He was advised to follow up with his GP in 2 days or return to the ER if needed.

### Thursday, September 28, 2016

At 3:22 a.m. Mr. Smith returned by ambulance to the ER of the Dundee Regional General Hospital. Triage notes indicated he had fever; his tongue was bleeding and peeling. He appeared “dry”, or dehydrated, and looked “terrible”. He was brought to an assessment area. The bedside nurse documented vital signs as:

Temperature	Pulse	Respirations	Blood Pressure	Oxygen Saturations
38.1C	95	14	120/72	98% on room air

Mr. Smith was assessed by the emergency room physician who noted Mr. Smith’s recent history of UTI, Septra course and ER visits. On examination there was significant erythema or rash noted to his trunk and extremities. Skin was sloughing from the tongue with further lesions in the throat, right shoulder and upper arm. There was a bullae or large fluid filled blister was on the right chest. The physician noted there was no erythema multiforme likely referring to the appearance of the lesions. Erythema multiforme lesions often have discolorations in the middle giving them a target like appearance. Mr. Smith did not have any swollen lymph nodes, his lungs sounded clear to auscultation; he had no abdominal tenderness or enlarged liver or spleen. He was noted to have some infection in his eyes. A diagnosis of Stevens-Johnson Syndrome or Toxic Epidermal Necrolysis was made and orders were given for blood work, urine and throat cultures, intravenous rehydration, morphine (narcotic analgesic) and Gravol (dimenhydrinate for nausea) and Polysporin dressings to open wounds.

At 4:35 a.m. Mr. Smith was consulted to Dr. Ronald of the Intensive Care Service (ICU).

He was later admitted by Dr. McLaren to the ICU. While in the ER his vital signs remained within normal limits on hourly or more frequent assessments.

At 5:50 a.m. Mr. Smith was transferred to the ICU. In the ICU attending note Mr. Smith was noted to have and estimated 54% of his body surface area that was sloughing.

At 3:50 p.m. he was transferred to the Royal Star Hospital in Smithers, AB to the burn unit for further treatment.

### Discussion: Stevens-Johnson Syndrome/Toxic Epidermal Necrolysis

A discussion section in your report may be included if:

- a) the lawyer requests research on the medical issues of the case, or
- b) you feel it would provide educational value to your report.

Include a summary of your research findings and reference the articles, journals or textbooks that you have referred to. Only include research information from the year that the incident occurred and relevant to nursing practice.

Stevens-Johnson Syndrome (SJS) is a rare skin disorder first described in 1922. It is thought to be hypersensitivity involving the patient’s own immune system, though there may be a genetic predisposition as well. SJS may be caused by drugs such as sulfa, phenytoin (used for seizures) or penicillin.... (Brady, Perron, DeBehnke, 2004, p. 1513-1515)

### Nursing Opinion

The opinion is the most important part of your written report. Clearly identify:

- What happened in this case
- The expected standard of care
- The ways in which the nurses did (or did not) meet the expected standard of care

## Sample Report Template for LNCs

If there are several areas where the Standard of Care is in question, identify the issues that are related to the outcome. You can categorize your opinions under broad standards of care such as Patient Monitoring/Frequency of Nurse/Physician Communication, Nursing Documentation.

I am of the opinion that the nursing care provide to Mr. Smith met the expected standards of care. Without the benefit of the policies and procedures related to documentation and assessment of the Dundee Hospital, typically once a patient is brought into the Emergency Department the responsible nurse will complete a complete physical assessment and vital signs. This forms a baseline assessment upon which further assessments can be compared to. With patients such as Mr. Smith the physical assessment should have included:

- Assessment of his neurological status to determine if he was alert and oriented to his surroundings. Any signs of increasing fatigue or decreasing level of consciousness or reponsiveness would be concerning findings.
- Assessment of his respiratory status including observing his rate and efforts to breath, shortness of breath, the use of accessory muscles of the chest to breathe, listening to the chest for crackles or wheezes.....

With regard to the first Emergency Room visit on September 24, 2016, it is my opinion that the nursing standards of care were met. Mr. Smith had a thorough review of body systems, appropriate reassessments and there were no alarming findings. The physician knew Mr. Smith was on Septra and appropriately re-tested the urine. By day nine of antibiotic treatment, it would be expected that the urine would test normally. This would indicate that the antibiotic was working. Had the urine tested positive further workup would have been warranted. Mr. Smith had no skin rash or lesions which would be suggestive of erythema multiforme or SJS/TEN.

With regard to the Emergency Room visit on September 26, 2016, it is my opinion that the nursing standards of care were met again. Assessments and vital signs were completed. Mr. Smith's most significant physical finding at this point was the rash along with the ongoing fever and headache. Based on the generally normal lab results, the vital signs being within normal limits, and that Mr. Smith was feeling better, he was discharged home. There was no obvious need for admission to hospital. Even if the physician had considered that the rash was erythema multiforme, or early SJS, treatment would still have been symptomatic as there were no lesions on the skin. Mr. Smith was advised to follow up with his GP or return to the ER if needed.

With regard to the visit on September 28, 2016, I am again of the opinion that standards of nursing care were met by the hospital staff. Unfortunately, Mr. Smith had significant skin involvement by this point in time. It was unclear from the records when the skin breakdown began to occur. Treatment at this point was supportive. He was given intravenous rehydration and appropriate lab tests were ordered to look for electrolyte abnormalities and secondary infections. Ultimately Mr. Smith was appropriately transferred to the Burn Unit at the Royal Star Hospital in Smithers with extensive sloughing of his skin (estimated at 54% of his body surface area) which significantly increased his risk of complications and death.

### Closing

**End your report. Some lawyers may request a summary of your opinion. Do add in a date as reports are often updated as more information becomes available.**

Thank you very much for asking my opinion in this matter. I have done my best, in preparing my opinion, to be accurate and complete. This information is based on documents reviewed as of June 29, 2022. I reserve the right to amend my opinion as more information comes available at a later date. Please do not hesitate to contact me if I can be of further assistance.

Sincerely,

Jane Jones, RN, BScN

# Sample Report Template for LNCs

## References

Brady, W. J., Perron, A.D., DeBehnke, D.J. (2004) Serious Generalized Skin Disorders. In J. Tintinalli, G. Kelen, S. Stapczynski (Eds.) *Emergency Medicine: A Comprehensive Study Guide for Nurses (6<sup>th</sup> edition)* (pp. 1513-1515). New York, NY: McGraw-Hill

High, W.A., Nirken, M.H. (2009) *Stevens-Johnson Syndrome and toxic epidermal Necrolysis: Management, prognosis and long term sequelae*. Retrieved from [www.uptodate.com](http://www.uptodate.com)

Parrillo, S.J., Parrillo, C.V. (2009) *Stevens-Johnson Syndrome*. Retrieved from <http://emedicine.medscape.com>

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