Medical Record Review

Jane Doe

Chronology

12/9/10	Erin Medical Building/ P.H. CNM	Initial Prenatal Visit Chief Complaint: Pregnancy Weeks of Gest (Gestation)=8.4 BP= 162/94; Weight= 213lbs, Urine Albumin (protein)/Glucose= negative(-)/negative (-), Edema (swelling)= 0 Past history: • High Blood Pressure, treated with Norvasc, took last a few years ago • Tobacco (over 10+ years, stopped once pregnant) • Alcohol (+) social • Varicose Veins (?) • Domestic Violence in past Genetic screening/Teratology Counseling: Patients' age 35 years or older as of estimated date of delivery Physical exam: Height 5.61/2 Weight=213lbs HEENT(Head, eye, ear, nose and throat)-Normal; Fundi(plural for the bottom of an organ, ex: eyes)-def. Normal; Teeth-Normal; Thyroid-Normal; Breasts-Normal; Lungs-Normal; Heart-Normal; Abdomen-Normal; Extremities-Normal; Skin-Normal; Lymph Nodes-Normal; Vulva-Normal; Vagina-Normal; Cervix-cl/3cm long/high; Uterus Size-7-8 weeks; Adnexa (uterine appendages)-Normal; Rectum-def. Normal; Diagonal Conjugate-Reached; Spines-Average; Sacrum-Concave Laboratory and Education: • Blood Type- A	It is important to have one's blood pressure under control especially during pregnancy because "high blood pressure can harm the mother's kidneys and other organs, and it can cause low birth weight and early delivery. In the most serious cases, the mother develops preeclampsia-or 'toxemia of pregnancy'—which can threaten the lives of both the mother and the fetus" (NHLBI). Normal blood pressure is considered less than 120/80. If a person has two consecutive blood pressure readings of 140/90, then they are considered to have high blood pressure. There are 2 types of Preeclampsia: 1 Mild preeclampsia is diagnosed when: • Pregnancy is greater than 20 weeks • Blood pressure is greater than 140 systolic and 90 diastolic • 0.3g of protein is collected in a 24-hour urine sample or persistent 1+ protein measurement on urine dipstick • There are no signs of problems with the mother or the baby (Craig Weber, High Blood Pressure, 2007) 2 Severe preeclampsia is diagnosed when there are additional problems	This is a case about the failure to treat observed signs and symptoms of mild preeclampsia that caused a 40 yr. old African American Female to have complications in her thirty-sixth week of pregnancy. Also, there is failure to follow proper protocol for EMS (Emergency Medical System) transfer of patient with Pre-Eclampsia/Eclampsia. Finally, proper /American Heart Association Guideline for Key Interventions to Prevent Arrest were not followed by both Dr. M and A.W. of Rural Metro Ambulance. Said failures resulted in seizures (eclampsia), anoxic (without oxygen) brain injury and coma, in which the patient remains in a long-term care facility for at this time. Ref 1 National Heart, Lung, and Blood Institute [Internet]. *High Blood Pressure in Pregnancy.* Retrieved on April 28, 2013. www.nhlbi.nih.gov/health/public/heart/hbp/hbp_preg.htm Ref 2 About.com [Internet]. *Are There Different Kinds of Preeclampsia?* By Craig Weber M.D. (2007, April 10). Retrieved on May 24, 2013. www.Highbloodpressure.about.com/od/preeclampsia/f/mild_preclamp.htm **Protocols for Preeclampsia/Eclampsia Prevention during Pregnancy. University Hospitals [Internet]. (Need to use link for High Risk Pregnancy Doctors). (Accessed May 10, 2013). www.uhhospitals.org/macdonald/services/materanl-fetal-medicine/complication-of-pregnancy Ref 3 Weber, Craig, M.D. (2007, April 10). *High Blood Pressure.* Retrieved May 24, 2013, from About.com: www.highbloodpressure.about.com/od/preeclampsia/f/mild-preclamp.htm

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		• D (Rh) Type- Positive • Antibody Screen - Negative • HCT/HGB/MCV- 38% /12.9g/dl • Rubella- Immune • VDRL- Nonreactive • HbsAg- Nonreactive • HIV Counseling/Testing- neg. • Hemoglobin electrophoresis- neg • Chlamydia- negative • Gonorrhea- negative • Vit. D- 5 (low) Jane is a 40yo G (gravida-how many pregnancies) =2 P (how many live births) =0 @ 8+ weeks by sure LMP (last menstrual period) here for NOB (normal Obstetrics). Has been with FOB (Father of baby) X 3 years-decided to electively term (terminate) a pregnancy on7/10 but wishes to keep this pregnancy, has multiple stress factors at home with taking care of sister + FOB. Works full time at light cleaning for the federal building. Remote hx (history) of HTN (hypertension) in past. Was on Norvasc + was taken off secondary to losing weight. C/O (complaints of) headaches. O (objective): see A-log (Antepartum log). BP's high 162/94 +160/98. A (assessment): Hx (history) P (pregnancy) @ 8+ weeks, Hypertensive/CHTN (chronic hypertension, Obese, AMA (advanced maternal age). P (plan): NOB teaching/danger prgns (prognosis) rev (reviewed). Referral to genetics. New revised recommended IOM (Institute of Medicine) wt. gain (15# max). D/W (dealt with) Dr. M re: HTN. Will start Aldomet 500mg 1 PO BID (twice a day) X 30d (day) supply GSUS for 1. NOB labs,	with either mother or baby: • Signs of central nervous system problems (severe headache, blurry vision, altered mental status) • Signs of liver problems (nausea and/or vomiting with abdominal pain) • At least twice the normal measurements of certain liver enzymes on blood test • Very high blood pressure (greater than 160 systolic or 110 diastolic) • Thrombocytopenia (low platelet count) • Greater than 5g of protein in a 24-hour sample • Very low urine output (less than 500ml in 24-hour) • Signs of respiratory problems (pulmonary edema, bluish tint to the skin) • Stroke (Craig Weber, High Blood Pressure, 2007) **The distinction between mild and severe preeclampsia is important because the management strategies are very different. Blood pressure remains elevated and Ms. Doe had a Vitamin D deficiency. Nearly all cases of cervical cancer are caused by infection with oncogenic,	This entry goes back to Reference 3.

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		GC/1, Pap with also HPV (human papillomavirus) + 24hour urine. Follow up 1 week for BP check. Rx (treat) assure given X 12 ref (refills).	or high risk, types of human-papillomavirus, or HPV. There are about 12 high-risk HPV types (Pap-HPV-testing, 2013).	Ref 4 National Cancer Institute. (2013). *Pap and HPV Testing.* Retrieved May 28, 2013, from: www.cancer.gov/cancertopics/factsheet/detection/Pap-HPV-testing
12/16/10	Erin Medical Building/P.H. CNM	Jane returns today states stress level has been "horrible" with FOB. Has been somewhat noncompliant with Aldomet therapy. States "made me so sick I couldn't take my head off the pillow Monday + had to call off sick". Took last dose of Aldomet today at 1200. Also, has not completed 24 hour urine. O-BP 160/102, Vit D 5mg/dl A-Gest 9.4, CHTN-unstable, Vit D deficiency P-D/W Drs Ashby + Duchon. Will have pt take 1000mg Aldomet at bedtime. BP cuff Rx given-to take BID + bring in BP record next week. Will drop off 24 hour urine tomorrow. Discussed maternal + fetal implications of uncontrolled HTN in pregnancy. RTO (return to office) 1 week MD only. Rx Vit D 50,000U Q (every)week.	The risk of preeclampsia with Vit D levels less than 15ng/ml is five times greater (MD, 2009)	Ref 5 MD, J.C. (2009, June 15). Newsletter: *Pregnancy and gestational vitamin D deficiency*. Retrieved May 25, 2013, from Vitamin D Council: www.vitamindcouncil.org/newsletter/newsletter-pregnancy-and-gestational-vitamin-d-deficiency/
12/21/10	Erin Medical Building/Dr. M	Add-on for blood pressure check. S-mild HA-decreased bedrest, C/O nicotine W/D, C/O increased moodiness, 0 VB (vaginal bleeding), 0 cramping-rare O-see ACOG A/P 40yo AAF G2P0- , D/W pt genetics, RTO 2 wks, maintain Aldomet, 24hour T. protein/cr. Clearance off. Will 12/22-12/24 to complete. Info re Vit D Antepartum record: Gest=10.1, Blood Pressure=154/80, Weight-215lbs, Urine (Albumin/Glucose) is -/-.	Dr. M assumes care of Ms. Doe and cares for Ms. Call through 6/15/11 (date of incident). Blood Pressure is still high.	

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1/11/11	Erin Medical Building/K. Daniels MA & Dr. M	Flu vaccine Given Left Del. IM Antepartum record: Gest=15.1, Blood pressure=162/80, Weight- 215lbs, Urine (Albumin/Glucose) is -/-.	• There is no note in chart from Dr. M except her initials on Antepartum record.	
2/11/11	Center for Human Genetics- Case Medical Center/Prenatal Screening Lab	Obtained blood serum specimen for open NTD Risk Assessment, Down Syndrome Risk Assessment and Trisomy 18 Risk Assessment. Quad check noted as negative. 8-20 week labs done and checked off by MR (?).	NTD stands for Neural Tube Defects. An example of a NTD is Spina bifida "which is characterized by an incomplete development of the brain, spinal cord, and/or meninges (the protective covering around the brain and spinal cord)" (Neural Tube Defects, 2012). A Trisomy 18 Risk Assessment is an assessment to check for certain chromosomal defects which causes an error in cell division (What is Trisomy 18?, 2013). Quad check is a blood test that can show whether your fetus has signs of some birth defects (Alpha-feto protein (AFP) or MSAFP/Quad screen, 2013)	Ref 6 NIH (National Institute of Child Health and Human Development). (2012, April 16). *Neural Tube Defects*. Retrieved May 25, 2013 from Medline Plus: www.nlm.nih.gov/medlineplus/neuraltubedefects.html Ref 7 *What is Trisomy 18?* (2013). Retrieved May 25, 2015, from Trisomy 18 Foundation: www.trisomy18.org/site/PageServer?pagename=whatisT18_whatis Ref 8 *Alpha-feto protein (AFP) or MSAFP/Quad screen* (2013). Retrieved May 28, 2013, from, Siouxland Obstetrics & Gynecology: www.siouxlandobgyn.com/MSAFP_quad_screening.htm
2/18/11	Erin Medical Building/Dr. M	Antepartum record: Gest=19, FHR=142, + fetal movement, blood pressure=142/78, Weight=220lbs, Urine (Albumin/Glucose) = trace/-. There is also 3+ blood noted in urine clean catch specimen for culture collected on 2/8/11 and the results were given to Dr. M's office on 2/15/11 showing no significant growth. 0 UTI Sx, 0 VB, 0 pain.	A urine specimen for a urine culture takes up to three days for signs of any growth of bacteria and identification of what kind of organism could be causing a urinary tract infection. If there is a result showing no growth in a urine culture usually indicates that the person does not have an infection (AACC, 2012). • No chart note by Dr. M on this day other than what's shown on the Antepartum record.	Ref 9 AACC. (2012, December 6). *Urine Culture.* Retrieved May 27, 2013, from Lab Tests Online: www.labtestonline.org/understanding/analytes/urine-culture/tab/test
3/8/11	Erin Medical Building/Dr. M	0 C/O. RTO 4 wks, to have fetal Echo 2nd degree suboptimal newer assess anatomy US. Antepartum record: Gest=22.4,	The initial blood pressure reading that was recorded on the Antepartum record for this date was 136(?)/88. • The blood pressure was crossed out improperly and on the next line down of the Antepartum record	

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			was entered in as 142/84.	
4/5/11	Erin Medical Building/Dr. M	FHR=146, + fetal movement, blood pressure=142/84, weight=223lbs, Urine (Albumin/Glucose=N/N. C/O carpal tunnel Sx, + ROM, 0 HA. RTO 3-4 wks. Wrist splints. 1 hour GTT, CBC, IgG, TSH. Missed Echo (fetal). Antepartum record: Gest=26.4, Fundal Height (cm)=30, FHR=154. Blood pressure=138/84, Weight=226lbs, Urine (Albumin/Glucose) =30mg/dl/Neg (Glucose)	Ms. Doe's prenatal course also included urine protein dipstick testing. This is a test that can measure the amount of Albumin, which is a type of protein in the urine (normal is 0-8mg/dl). On 4/5/11 the urine protein dipstick test was elevated at 30mg/dl. "0.3g of protein is collected in a 24-hour urine sample, or persistent 1+ protein (30mg/dl - 99mg/dl) measurement on urine dipstick" is considered a symptom of mild preeclampsia (Craig Weber, 2007). • According to the initial history and physical by P.H. CNM on 12/9/10, there was never any mention of Carpal Tunnel or the use of wrist splints to alleviate symptoms of Carpal Tunnel.	This entry goes back to Reference 2.
4/26/11	Erin Medical Building/Dr. M	"Was in argument with FOB BP up". S: excellent ROM, 0 LOF, 0 VB, 0 HA, 0 other preE Sx. O: + FHT. "nl ECHO" per pt. A/P: 29wk INP, + FHT, CHTN. Recheck BP in 3-4d, if still high check labs. Give info re: Reds. Kick counts 6 months. F/U US. Antepartum record: Gest=29.5, Presentation C, FHR=134, + fetal movement, initial blood pressure 150/90, rechecked BP=148/88, weight=226lbs. Urine protein dipstick-30mg/dl. Next appointment in 2 weeks.	Ms. Doe's blood pressure consistently remains above 140/90 except for 2/18/11, 3/8/11, 4/5/11 and 5/10/11. Also, her urine protein dipstick reading is still noted on the Antepartum record as 30mg/dl. Dr. M does not take note of abnormal Urine (Albumin/Glucose) of 30mg/dl. This is a sign of mild preeclampsia. • Also, Dr. M plans to have Ms. Doe return to office and have her blood pressure rechecked in 3-4 days. Who is MLR? Ms. Doe continues to complain of carpal tunnel in her wrists and called off work because of it.	

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5/3/11	Note in chart at Erin Medical Building/MLR.	"Pt wants a letter for work yesterday. Did not go because her carpal tunnel in her wrist was bothering her really bad". MLR"	Dr. M appears concerned about Ms. Doe's blood pressure. Also, Dr. M appears concerned about the reported carpal tunnel issue and as to whether or not Ms. Doe wore her wrist splints. Who is this provider? Is this person a Registered Nurse or a Medical Doctor?	
5/4/11	Note in chart at Erin Medical Building/Dr. M	Pt needs appt ASAP to F/U her BP checked. Is this pt. wearing her splints daily-24 hr X 7d/wk? We do not typically write notes of this type".		
5/9/11	Note in chart at Erin Medical Building	Provider-M. Lich(k)ua(ll) RN/MD? "Pt has appt tomorrow 5/10. Has not been wearing splints. 'Still have to get them'. I'll see and talk to her tomorrow".	There is never any mention of the urine protein dipstick result being abnormal at 100mg/dl (normal is 0-8mg/dl). Also, this is considered 2+ protein. Finally, there has been a 5lb weight gain since the last doctor's visit on 4/26/11. • On this day, Dr. M has only written on the Antepartum record.	
5/10/11	Erin Medical Building/Dr. M	Antepartum record: Gest=31.5 weeks, Fundal Height 35cm, Presentation C, FHR=141, + fetal movement, blood pressure=142/82, weight=231lbs, Urine protein dipstick-100mg/dl.	Dr. M wrote a doctor's note for missed work due to complaints from Ms. Doe of being sick on 5/18-5/24/11, and return to work on 5/26/11. There has been a weight gain greater than 2lbs in a week noted at this time (staff, 2011). 8lb weight gain since 5/10/11.	
5/24/11	Erin Medical Building/Dr. M	Antepartum record: Gest=33.5 weeks, + fetal movement, blood pressure=162/100, blood pressure recheck =158/88, weight=239lbs, Urine protein dipstick =trace. Noted in chart, "off work since 5/18/11. No HA, no renal change, no RUQ pain, eating hotdogs, potato salad with chips. Compliant with Aldomet. 33 wk INP with CHTN on Aldomet. Plan kick counts.	Ms. Doe's blood pressure=162/100 and recheck=158/88, but there is no change in medication or dosage noted at this time, only that Ms. Doe is "compliant with Aldomet". Kick counts are a way to keep track of the baby's movements in the last trimester of pregnancy. "A common way to do a kick count is to see how	Ref 10 Staff, M.C. (2011, April 21). *Preeclampsia: Symptoms*. Retrieved May24, 2013, from: www.mayoclinic.com/health/preeclampsia/DSECTION=symptoms

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			much time it takes to feel 10 movements. Ten movements (such as kicks, flutters, or rolls) in 1 hour or less are considered normal" (Healthwise, 2010)	
5/26/11	Erin Medical Building/MFW	Antepartum record: Gest=34.1, Fundal Height=35cm, FHR=140, blood pressure=172/92, recheck blood pressure= 160/90, weight=243lbs, urine protein dipstick=30mg/dl, 2+ edema.	Blood pressure still remains elevated with no changes to medication noted. Weight gain of 4lbs in two days. Urine protein dipstick remains elevated. Now there is 2+ edema noted to lower extremities. • There is no note in chart aside from the Antepartum record. Edema is a condition of abnormally large fluid volume in the circulatory systems or tissues between the body's cells (interstitial spaces) (Gale Encyclopedia of Medicine, 2008) There are two types of edema: 1 Non-pitting which means-edema in which pressure does not leave an indentation in the tissues (Saunders, 2003). 2 Pitting-edema in which external pressure leaves a persistent depression in the tissue; it occurs because the pressure pushes the excess fluid out of the intercellular spaces in the tissue (Saunders, 2003). "Your doctor may tell you that it is not uncommon for women to suffer from pitting edema in the ankles during pregnancy. However, there may be cause for concern, in the case of pitting edema in pregnancy if it is accompanied by any of these:	Ref 11Healthwise (2010, November 10). *Pregnancy: Kick Counts-Topic Overview*. Retrieved May 25, 2013, from: www.webmd.com/baby/to/pregnancy-kick-counts-topic-overview Ref 12 Gale Encyclopedia of Medicine. (2008). *Edema*. Retrieved May 25, 2013, from The Free Dictionary: www.medical-dictionary.thefreedictionary.com/edema Ref 13 Saunders. (2003). *Edema.* Retrieved May 25, 2013, from The Free Dictionary: www.medical-dictionary.thefreedictionary.com/nonpitting+edema Ref 14 Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health, Seventh Edition. (2003) by Saunders. Retrieved May 25, 2013, from The Free Dictionary: www.medical-dictionary.thefreedictionary.com/pitting+edema

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			• A rise in blood pressure • Protein in the urine • Reduction in the movements of the baby • Severe headaches or blurred vision • Heartburn, which does not improve in spite of taking an antacid (Pitting Edema During Pregnancy, 2013)	
			• Edema is noted in Antepartum record but not addressed in clinic notes by Dr. M.	Ref 15 *Pitting Edema During Pregnancy.* (2013). Retrieved May 25, 2013, from Pregnancy Baby Care: www.pregnancy-baby-care.com/conditions-during-pregnancy/pitting-edema-during-pregnancy.html
5/31/11 Erin Medical Building/Dr. M		Blood pressure-160/88. Urine protein dipstick-30mg/dl in Antepartum record only. 2+ edema noted in Antepartum record. Sent to lab for lab work and obtained both blood specimens and urine specimen. Weight is 250lbs.	On 5/31/11 Ms. Doe had a urine protein spot check of 123mg/l (normal is 0-10mg/L) and a Total Protein/Creatinine Ratio=397mg/g (normal is < 300mg/g).	
6/1/11 Erin Medical Building/Dr. M		Lab Results from 5/31/11 shows a urine protein spot check of 123mg/L and a T. Protein/Creatinine Ratio=397.	• These lab results were noted on 6/1/11 by Dr. M. • However, once again no treatment was ordered to attempt to correct the abnormal test results (U.S. National Library of Medicine, 2011).	
			• Ms. Doe's blood pressure is still elevated. The blood pressure recorded on the Antepartum record is traced over several times.	Ref 16 U.S. National Library of Medicine. (2011, August 20). *Protein-Urine.* Retrieved May 18, 2013 from MedlinePlus: www.nlb.nih.gov/medlineplus/ency/article/003580.htm
6/7/11 Erin Medical Building/Dr. M		Antepartum record: Gest=35.5, Presentation C, FHR=130, + fetal movement, Cervix exam=cl, pre-term	This is not the acceptable standard of care for correcting an error in the medical record (Toward Improving	

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		labor S/S=BH, Blood pressure 178/78 (hard to read as it is traced over several times), weight= 248, 1+ edema. "Jane has not worked since 5/31/11 due to swollen feet and pregnancy related uncomfortableness".	Outcomes of Pregnancy III, June). Dr. M authorized FMLA (Family Medical Leave of Absence) for Ms. Doe. • However, she still did not change any medication or try to find out medically what she could to do to improve Ms. Doe's health. • Also, there is not an entry in the doctor's notes concerning this FMLA approval. Blood pressure elevated, shortness of breath, and positive results from Group B Strep test which was collected on 6/7/11. Ms. Doe is being sent to the Emergency Room to rule out Preeclampsia.	Ref 17 *Toward Improving the Outcome of Pregnancy III.* (2010, June). Chapter 6, "Quality Improvement Opportunities in Prenatal Care. Retrieved March 26, 2013, from: www.marchofdimes.com
6/15/11	Erin Medical Building/Dr. M	Antepartum record: Gest 36.6, Fundal Height =AO, presentation C, FHR=137, + fetal movement, Blood pressure 192/102, Weight =252lbs, and 1+ edema. Results from 6/7 Genital Perianal Microbiology shows organism as Group B Streptococcus. Complaints of shortness of breath at night. Dr. M noted in chart, "To L. D. for R/O (rule out) Pre E via squad". Call to Rural/Metro. Report from Rural Metro states, "40 y/o/f get MCD ABD signed. IV running. 36 weeks OB. Elevated BP. Transferring for 0B Care. Dr. M".	Dr. M reports at this time that IV was running. However, there was not an IV present according to the EMS note by K.S. Dr. M also requested that the Medicare Coverage Database and Advanced Beneficiary Notice be signed by Rural/Metro Ambulance. Dr. M filled out her part of the insurance claim form for Ms. Doe and changed the date from 6/15/11 to 6/13/11. See Ref 17 for acceptable charting standards.	
7/7/11	Copy of Insurance Claim form	Dr. M filled out her part of the insurance claim form stating on Claim Form that patient was "continuously totally disabled and unable to work since 6/13/11".		

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06/15/11 03:52 PM	Erin Medical Building/Rural Metro Ambulance	Rural/Metro Ambulance called by Dr. M for ALS at 3:52pm. En route at 3:55pm and at scene at 4:18pm. Crew members were Crew1: A.W. and Crew2: K.S.. En route to hospital by 4:30pm.	Dr. M requested Advanced Life Support ambulance per preeclampsia protocol. However, oxygen was not administered to Ms. Doe prior to the ambulance's arrival (especially when Ms. Doe had already been complaining of shortness of breath), she was not maintained in the left lateral position (Preeclampsia, 2011) and her vital signs were not re-checked. Instead Ms. Doe was found to be sitting on an exam table when EMS arrived.	Ref 18 *Preeclampsia*. (2011, April 28). Nursing Central. Retrieved May 27, 2013, from: www.unboundmedicine.com/nursingcentral/ub/view/Diseases-and-Disorders/73695/all/Preeclampsia
6/15/11 04:18PM (late entry at 07:43PM)	Rural/ Metro Ambulance /K.S.	"Upon arrival pt was found sitting on exam table. We assisted pt as she walked to cot. Pt states she was coming in today for Dr. apt but she was having SOB. She explained that the baby was positioned high making it difficult to breath and that the baby has settled down + she was able to breathe easier now. Before leaving we asked nurse if IV was started b/c pager noted IV with fluids running. She said no and that UH could do it". (Note written at 07:43PM).	Dr. M claimed that an IV was started and that fluids were running. Although Dr. M and her staff may have attempted to start an IV with fluids, she should have never stated that one was already started and fluids were running when they weren't.	
6/15/11 04:30PM	Rural/Metro Ambulance/A.W.	BP=220/palpation; Pulse =110, strong, regular; capillary refill <2 seconds, Breath rate=8, normal. Lungs normal and clear. O2 saturation=91%. Skin temp=Normal, Skin color=Normal, Skin moisture+Normal. Level of Consciousness: Alert; Pain Scale=0; Arm movement: Left=spontaneous, Right=spontaneous; Leg movement; Left=spontaneous; Right=spontaneous.	No oxygen was administered at this time, even though Ms. Doe's oxygen saturation was 91% on room are. (Normal O2saturation is >92%). Also, Ms. Doe was not put in the left lateral position (Protocol: Pre-Eclampsia (Toxemia), 2002). Blood pressure extremely elevated at this point.	Ref 19 *Protocol: Pre-Eclampsia (Toxemia)* [Internet]. Revised 1/1/2002. Retrieved May 18, 2013, from: www.ems.grmc.org/ems_057.htm
6/15/11 04:33PM	Rural/Metro Ambulance/A.W.	BP=240/140; Pulse 112, stong, regular; cap refill < 2 seconds; Respiratory, BR=20, labored. Left Lung=Normal/C, Right Lung=Normal/Cle; GCS=E4=V5=M6=15; SPO2=91%. Level	Blood pressure remains abnormally high. Ms. Doe is starting to having labored breathing. Oxygen applied. *(see below for full length note-late entry).	

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		of Consciousness: Alert; Pain Scale=0; Arm movement: Left=spontaneous, Right=spontaneous, Leg movement: Left=Spontaneous, Right=Spontaneous.		
6/15/11 04:36PM	Rural/Metro Ambulance/A.W.	BP=palp, Pulse=130, strong, regular, cap refill < 2seconds, Respiratory, BR=24, labored. GCS=E4+V4+M6=14. SPO2=87%; Level of Consciousness-Alert; Arm movement: Left=spontaneous, Right=spontaneous; Leg movement: Left=spontaneous,Right=spontaneous. EKG-3 Lead. Bradycardiac PEA at rate of 37b/m noted at first rhythm check during resuscitation. Bradycardiac PEA at rate of 41 b/m noted at second rhythm check.	At this point A.W. is no longer getting a blood pressure on Ms. Doe and she continues to have labored breathing. Ms. Doe is now only at 87% for her oxygen saturation level. Rhythm-Pulseless Electrical Activity (PEA) is "any organized rhythm without a palpable pulse,…The H's and T's of ACLS is a mnemonic used to help recall the major contributing factors to pulseless arrest including PEA" (H's and T's of ACLS/ACLS Algorithms, 2011-2012) *See initial note above 6/15/11 at 4:36PM	Ref 20 *H's andT's of ACLS/ACLS Algorithms.* (2011-2012). Retrieved May 27, 2013, from All in One ACLS Training: www.acls-algorithms.com/hsandts
6/15/11 *(late entry written for 4:36PM at 7:43PM)	Rural/Metro Ambulance/A.W.	Stated in late entry after initial charting, "positive c/o SOB with semi-fowler's position. Pt moved to full Fowler's position with pt. reporting R/O (relief of) SOB. Pt abdomen palpated with negativeDCAP-BTLS noted. Second set of vitals obtained (BP=240/140, HR=112, RR (Respirations)= 20, O2sat 91% room air). Pt stated positive SOB with Full-Fowler's. I pulled out a nasal cannula (NC) and initiated 6L/M O2 via NC. Pt presented with high anxiety and per pulse ox (HR 130, O2sat 87% room air). I pulled out the 3-lead EKG and began to prepare it to put her on it. When she became extremely anxious, then I told my partner to run lights and sirens when I noticed spontaneous blinking (seizure-like activity), then pt presented with decordicate posturing, then went		

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		unresponsive: All in a matter of 60 seconds. I immediately told K.S., who was driving, to pull over and climb in the back and assist. I listened/looked/felt for breathing and noticed she was apneic and I started setting up the BVM. Hooked it up to 15L/M Hi-flow O2 and started delivering breaths. We both felt for a carotid pulse and agreed we did not feel one and K.S. started chest compressions (30 compressions: 2 ventilations). K.S. applied the 3-lead EKG under my direction. After 2 minutes of CPR (me on vents, K.S. on comps), we halted CPR for a rhythm check which revealed sinus brady at 37 B/M (beats per minute), we checked carotid pulse again which revealed no palpable pulse, so we resumed CPR. In between ventilations, I measured and inserted an appropriately-sized OPA (oral pharyngeal airway) for the pt's mouth. At this point, I called dispatch on the PTT radio and asked for backup, telling them we were on MLK Jr Blvd, and that our location should be on their GPS. At this point, I considered the route of initiating a peripheral IV and pushing epinephrine and atropine according to the ACLS Algorithm, as well as, an advanced airway vs. the route of performing CPR while K.S. commenced rapid transport to the nearest ER, which I opted for the latter. Pt was 36 weeks pregnant. En route I performed 30 chest compressions alternating with 2 ventilations with good compliance noted. Upon arrival, I continued chest compressions into the ER we did not reach 30 compressions necessitating another ventilation when ER staff transferred pt to ER bed and assumed care. I gave a report to ER staff	A.W. did not follow ACLS protocol at this point (American Heart Association, 2005). A.W. did not attempt to place a peripheral IV, in which he could have given epinephrine IV to counteract the PEA. Also, it is not noted in A.W.'s account if he maintained Ms. Doe on "oxygen with a non-rebreather mask and properly pre-filled the reservoir bag at a flow rate of 15 liters per minute of oxygen. Then place mask over face" (MOD-2 Airway, 2010)	Ref 21*"American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiac Care, Part 10.8: Cardiac Arrest Associated With* Pregnancy*"*. (2005). Retrieved May 18, 2013. http://circ.ahajournals.org/content/112/24_suppl/IV150/T1.expansion.html Ref 22 *MOD-2 Airway.* (2010). Retrieved on May 18, 2013, from: www.emt.resources.com/MOD-2.html

Date	Location	Chart Documentation	Review Note	Comments/References
		regarding pt vitals, C/C, progress of pt presentation, and care delivered". Arrived at ER and maintaining CPR. ER staff transferred patient to ER bed and assumed care. Report given to ER staff.		
6/15/11 4:51PM	ER/Dr. C	ER (emergency room) approximately 4:40pm 6/15/11. Full arrest/eclampsia. Jane Doe is a 40-year-old female, 36 weeks' pregnant, who has a history of chronic hypertension and obesity, who was seen by her primary care physician earlier today for shortness of breath. She was sent in by EMS and en route had an eclamptic seizure. She was brought into the UH emergency department with active chest compressions and oral airway placed. An ACLS protocol was initiated, OB arrives at the bedside with Anesthesiology. The patient initially had no IV access. ROS (Review of Systems)-unstable PMH (Past Medical History) 1. Chronic hypertension 2. Gravida 1, para 0 PSH (Past Surgical History)-unknown Allergies-unknown Medications-Maxzide SH (Social History)-unknown PE (Physical Exam) Hospital Course: ED course summary:	Actual time of arrival to ER was 4:51pm per both EMS notes and initial ER note. Eclampsia-is seizures (convulsions) in a pregnant woman that are not related to a preexisting brain condition. Eclampsia follows preeclampsia, a serious condition of pregnancy that includes high blood pressure and excess weight gain (Eclampsia, 2012). Ms. Doe was on Aldomet, not Maxzide.	Ref 23 *Eclampsia.* (2012, February 26). Retrieved May 28, 2013, from MedlinePlus: www.nlm.nih.gov/medlineplus/ency/article/000899.htm

Date	Location	Chart Documentation	Review Note	Comments/References
		The patient's initial rhythm was noted to be a PEA and chest compressions were continued. We were able to get an ET (endotracheal)-tube initially, which 2mg of epinephrine were put down and then, an IO (Intraosseous-between the bones) was obtained for further intravenous access. The OB team performed an emergent C-section delivery of the baby with an estimated blood loss per their report of 1.5L. There was abruption noted per their report. This was sutured and Pitocin 30mg was placed in the IV. Meanwhile, chest compressions were continued and a total of 6mg of epinephrine was given IO and circulated. Three liters of normal saline were given. One amp (ampule) of bicarb was given. The initial ABG (arterial blood gas) did show a pH of 6.9 with a pCO2 of 90 and a PaO2 of 60. This gradually improved to a pH of 7.02 and a pCO2, load was lowering and a PaO2 of 131. The patient was continued to be hyperventilated given her elevated pCO2 and this was determined to likely be a respiratory arrest secondary to seizure causing the PEA. This was thought to be the etiology of her PEA arrest. We did eventually retrieve a pulse, which was subsequently lost and then regained after chest compressions were initiated. It lost again and then regained after chest compressions were initiated. Additional epinephrine X 1 were given with each of these losses of pulses. The patient eventually did regain a pulse with a good pressure in the 90s. Dopaminewas started at 5 and titrated to 20. Magnesium was given 4g initially, then 2 g, and then a drip started at 2g an hour. The patient was then	Ms. Doe's blood gases were abnormal. "An arterial blood gas measures a patient's oxygen and carbon dioxide status in the blood. It also measures the acidity (pH) of your blood. A true arterial blood gas measures three data points: • PaO2-partial pressure oxygen-normal 60-90mmHg. • PaCO2-partial pressure carbon dioxide-normal 36-44mmHg. • pH-normal 7.35-7.45." (Blood gases, 2012)	Ref 24 *Blood gases.* (2012, September 1). Retrieved on May 27, 2013, from: MedlinePlus. www.nlm.nih.gov/medlineplus/ency/article/003855.htm

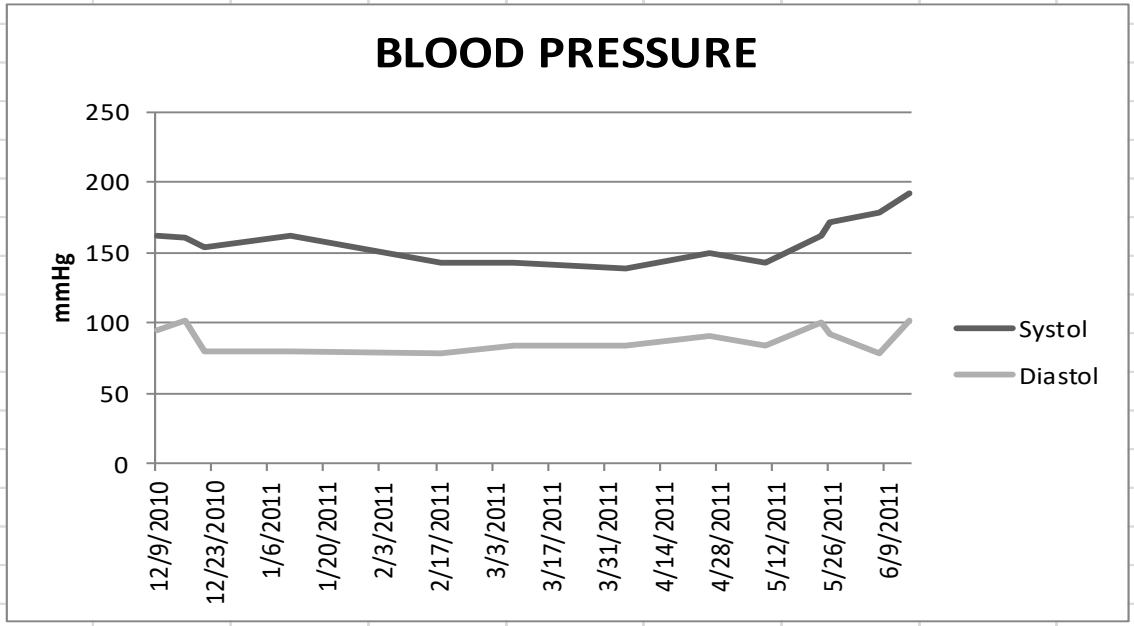
Date	Location	Chart Documentation	Review Note	Comments/References
		paralyzed using pancuronium, 7mg was given of this as the patient started to breathe against the bag. She was put on the ventilator and put on PEEP (positive end-expiratory pressure), stabilized, and taken to the CT scanner where she did not have any evidence of a head bleed. Labs are pending at the time of this dictation. The patient was transferred immediately up to the care of the ICU where the patient was stable. The IO in the right anterior tibia was removed without difficulty. Report was given to the MICU team and the family. The patient's condition was discussed with the OB team and the ER team present with the family. The baby was resuscitated and was taken to the Neonatal Intensive Care Unit and at the time of this dictation, was stable, but critical condition.	"PEEP is the abbreviation for positive end expiratory pressure. The purpose of PEEP is to increase the volume of gas remaining in the lungs at the end of expiration in order to decrease the shunting of blood through the lungs and improve gas exchange (Definition of PEEP, 2012)	Ref 25 *Definition of PEEP.* (2012, October 9). Retrieved on May 27, 2013, from: Medterms.com www.medterms.com/script/main/art.asp?articlekey=31845
6/15/11	ER notes/Dr. P	Patient is a 40y/o AAF. G2P1 with PMH notable only for HTN, who was 36w6d pregnant who presented to ED in cardio-pulmonary arrest. Per the family, the patient has been complaining of SOB x 1 month, which is progressively worsening. Initially, it was noted with activity, but it progressed to being noted at rest. No assc sx (associated symptoms): no chest pain, lightheadedness, dizziness, abd pain. No fevers, chills, nausea, vomiting. No sick contacts. No complications during her pregnancy (this is her first pregnancy). She presented to her OB's office for a regular check-up and complained of SOB. Her BP was noted to be 202/100 (192/102). She then was sent by EMS to ED. In the EMS, she had a seizure with continued BPs 220s. She did lose her	Dr. P's notes are confirming Dr. C's notes from above. As well as, she is showing from an OB/Gyn stand point what transpired.	

Date	Location	Chart Documentation	Review Note	Comments/References
		pulse and stop breathing. CPR was initiated. This was continued on arrival to the ED. ACLS protocol was followed.		
6/15/11	5:36PM	Transferred to MICU per Dr. C.	Ms. Doe was transferred to the Medical Intensive Care Unit for further treatment and stabilization on 6/15/11.	
6/17/11 1911	MICU/RES (Resident) R	MRI brain w (with)/and w/out contrast to r/o (rule out) any pathology. (Previous EEG on this admission showed no seizure activity, more likely related to anoxic brain injury).	Testing that confirmed brain activity in Ms. Doe and to confirm her anoxic brain injury. The EEG showed the electrical activity of Ms. Doe's brain and the MRI was to see if there was another cause for her brain injury.	
6/18/11 1302	MICU/RES Ma	MRI results show: diffuse anoxic injury throughout entire gray matter including basal ganglia and candate bilaterally.	Anoxic/ anoxia meant that Ms. Doe did not have any oxygen to her brain for an unspecified amount of time and this is what caused her brain injury.	
6/29/11	Operative Report/Dr. Z	#7 Shiley placed tracheostomy tube placed today. A percutaneous endoscopic gastrostomy (PEG) tube placed today as well.	For Ms. Doe to remain on mechanical ventilation it is customary to surgically place a tracheostomy tube. Also, to insure that one is getting nutrition while they have a tracheostomy tube in place, a feeding tube is also the treatment of choice.	
7/11/11	Discharge Instructions/Dr. S	Admitting Diagnosis: • Respiratory Arrest • Anoxic encephalopathy • Anoxic brain damage complication Post-anoxic coma Discharged to Kindred LTAC (Long-term Acute Care) Hospital	Ms. Doe was discharged to Kindred Hospital on this day and one of their specialties is to wean patients from mechanical ventilation.	

Date	Location	Chart Documentation	Review Note	Comments/References
7/11/11 6:38PM	Kindred Hospital/Dr. P2	Admitted to Kindred Hospital Admission Diagnoses is Respiratory Failure	Admitted to Kindred Hospital.	
7/12/11	Pulmonary Consultation/B.A.	Reason for Consultation: Respiratory Failure, status post trach. Failure to wean. Mechanical ventilation. History of Present Illness: this is a 40-year-old female who had a history of hypertension and was 36 weeks pregnant. She went to her OB-Gyn office complaining of shortness of breath for one month with progressive worsening. During the office visit her blood pressure was noted to be 190/100 (192/102). She was transported to the nearest hospital by EMS. She started to have seizures while in the squad. She went into full cardiopulmonary arrest, ACLS protocol was initiated. On admission to the emergency room, she was started on vasoactive drugs as well as epi. She was intubated and her rhythm continued to be in PEA. An emergency C-section was completed. A baby boy was delivered. She had a considerable amount of bleeding, as the placenta abrupted. Clots were evacuated. She was transferred to the MICU and intubated on a drip. She failed to wean from mechanical ventilation and a tracheostomy was completed. She was transferred to Kindred Hospital on mechanical ventilation with tidal volume of 400, rate of 18, and 5 of PEEP. Laboratory Data: Diagnostic information from the 12th: WBCs are 21, hemoglobin 10.1, hematocrit 31. BUN 35, creatinine 0.8. ABG's on admission: Her pH was 7.46,	Consultation to Pulmonary concerning Mechanical Ventilation.	

Date	Location	Chart Documentation	Review Note	Comments/References
		pCO2 of 40, pO2 of 135, bicarb 28. Imaging: Chest x-ray is pending. Plan: Chest x-ray is pending. Continue current vent settings. Measure spontaneous parameters. Will trial step. 1. Continue DVT and GI prophylaxis. Avoid sedation. Aspiration precautions. ABGs completed. Continue pulse oximetry. Sputum C and S. Albuterol every 4 hours p.r.n., if needed.	Pulse oximetry is a method to record the level of oxygenation a person is receiving by either placing the pulse ox (oximetry) on the finger or forehead of an individual.	
7/24/11	Pulmonary Progress Report	Vent/O2: FIO2 30%, Mode SIMV, Trach 7 Portex, Step 14 completed today. Tol trach collar. Increase wean time on T.C (trach collar).	Will use a 21 step method to aide in mechanical ventilation weaning.	
7/30/11	Pulmonary Progress Report	Trach collar all day. Completed step 20.	At this point, Ms. Doe has been weaned from the ventilator.	
8/19/11	Partial Discharge Summary/Dr. P2	Date of discharge. Discharge Planned: She will be discharged to_____. She had a UTI when she came, this is resolved. Dietary on case. Assessment and plan as above. Anoxic encephalopathy, hypertension, tracheostomy care, PEG tube care. Dietary insufficiency and DVT prophylaxis to be monitored.	Ms. Doe has been successfully weaned from the ventilator and is now ready for her next stage of recovery.	
8/19/11	Admission notes/Park East	Diagnosis Information: • Chronic respiratory failure • Attention to tracheostomy • Unspecified protein-calorie malnutrition • Attention to gastrostomy • Pneumonitis due to inhalation of vomitus or food • Other, convulsions • Unspecified essential hypertension	Ms. Doe was admitted on this date. She has remained at Park East since this time except for at least one occasion when she went to St. Vincent/St. Mary hospital for sepsis (Sepsis, 2012)	Ref 26 *Sepsis.* (2012, August 23). Retrieved on May 27, 2013, from: Medline Plus. www.nlm.nih.gov/medlineplus/ency/article/000666.htm

Date	Location	Chart Documentation	Review Note	Comments/References
		• Obesity, unspecified • Anoxic brain damage		
8/19/11	Admission Vitals/D. C. LPN	BP 162/86, Temp 98.1 Axillary, Pulse 84 Respirations 20		
10/24/11	W. S. RN Park East/nursing staff	Completed Admission Assessment. Temperatures had not been charted since 10/19/11.	Nurse discontinued temperatures on temperature log without a doctor's order. Standards of Care for charting were not followed (Underwood, 2008) • Please see key player list for reasons why Park East is a key player. There are quite a few nurses' notes that have gaps in them. • Recommendation to perform separate review of Park East for further investigation as this appears that it could be a separate case. However, the decision is left up to your firm.	Underwood, R.A., *"Demystifying documentation".* (2008, December 12). Retrieved on May 28, 2013, from: Nursing homes at www.FindArticles.com

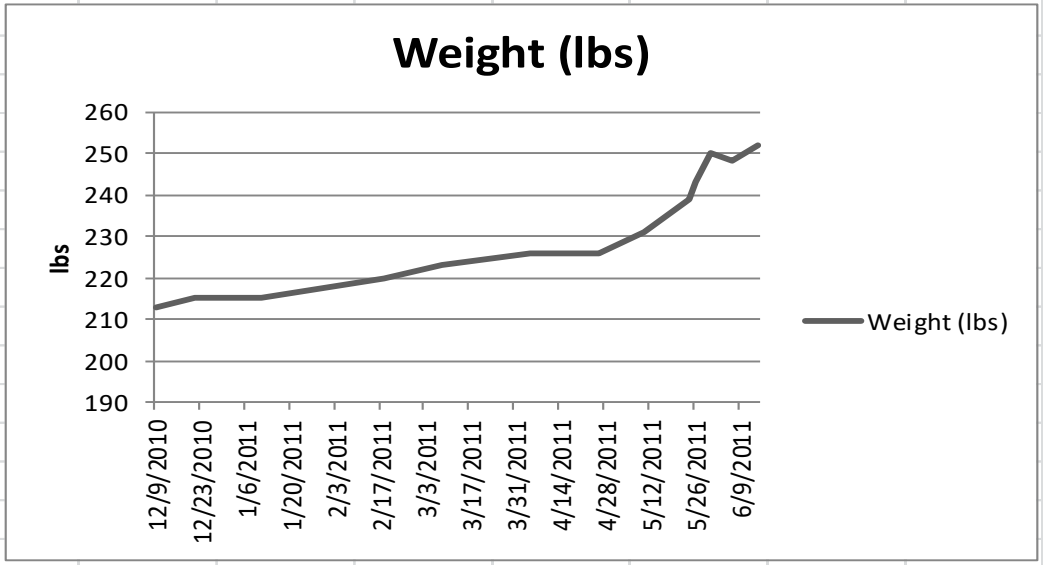


Date	Systol	Diastol
12/9/2010	162	94
12/16/2010	160	102
12/21/2010	154	80
1/11/2011	162	80
2/18/2011	142	78
3/8/2011	142	84
4/5/2011	138	84
4/26/2011	150	90
5/10/2011	142	84
5/24/2011	162	100
5/26/2011	172	92
6/7/2011	178	78
6/15/2011	192	102

NOTES

**List of all initial blood pressures taken at Erin Medical Building

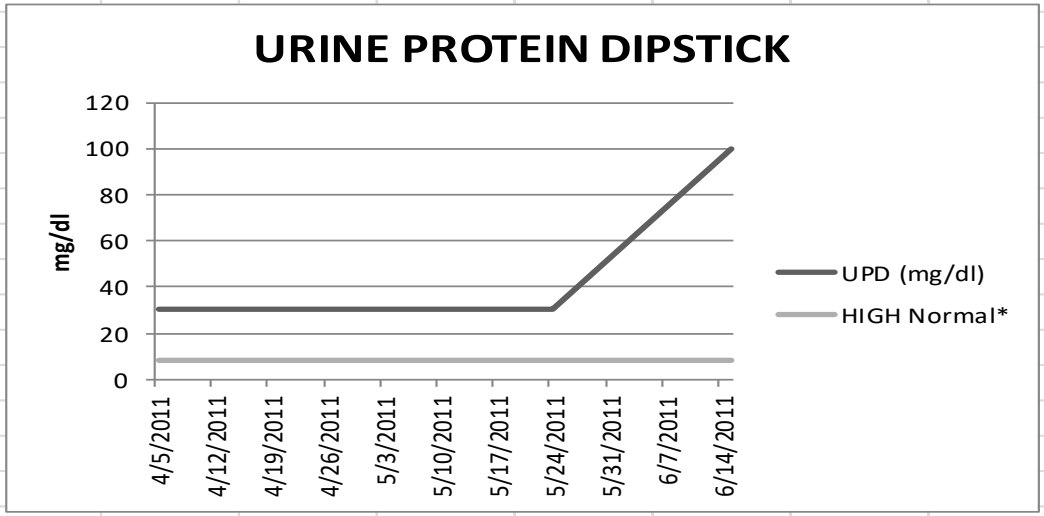
***Two consecutive blood pressures of 140/90 are considered high blood pressure. (Refer back to reference 1).



Date	Weight (lbs)
12/9/2010	213
12/21/2010	215
1/11/2011	215
2/18/2011	220
3/8/2011	223
4/5/2011	226
4/26/2011	226
5/10/2011	231
5/24/2011	239
5/26/2011	243
5/31/2011	250
6/7/2011	248
6/15/2011	252

NOTES

**List of all weights taken at Erin Medical Building

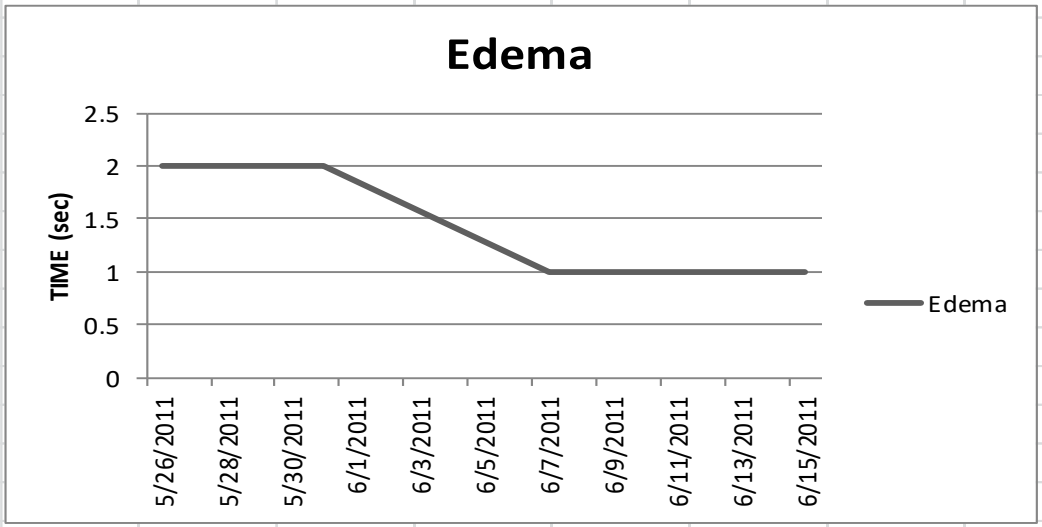


Date	UPD (mg/dl)	HIGH Normal*
4/5/2011	30	8
4/26/2011	30	8
5/24/2011	30	8
6/15/2011	100	8

NOTES

**List of all urine protein (albumin) dipstick readings taken at Erin Medical Building

*Normal is 0 to 8mg/dl.



Date	Edema
5/26/2011	2
5/31/2011	2
6/7/2011	1
6/15/2011	1

NOTES

**List of all the times that Ms. Doe was noted as having edema at Erin Medical Building

Key Players:

Dr. M did not follow up on abnormal blood pressure readings after 12/21/11 through 6/7/11, abnormal urine protein dipstick test results starting on 4/5/11 to 6/1/11 and complaints of swelling starting in April/May 2011.

MacDonald's Physician Group (Dr. M's Physician Group)

Rural/Metro Corporation (EMS group called for transport of patient from clinic to hospital).

A.W.-He was the EMT treating patient on the way to the hospital. A.W. also was in charge of making the decisions during transport to the hospital. Per A.W.'s notes, he chose to hurry to the hospital after CPR had been performed, rather than place an artificial airway, peripheral IV line or give patient medications per ACLS (Advanced Cardiac Life Support) Algorithm. Also, rather than waiting for backup or calling the hospital to talk to a doctor for further instructions, he again opted to hurry to the hospital. Following these procedures could have prevented or minimized the loss of oxygen to the brain that this patient experienced and is now in a coma as a possible result of the decisions of this EMT.

Park East nurses did not chart as they should have in the nurses notes. In fact, there were quite a few gaps in care as listed for example:

- October 24, 2011 shows that physician's orders to monitor temp every shift, if temp greater than 100.0 then notify MD. Nurses have a discontinue note for temps on 10/19/11. There is no doctor's note that concurs with this documented discontinue note.
- February 15, 2012 to March 15, 2012, in this case there is not even a note on March 15 from Park East stating that resident was sent to ER. ER notes states that RN from Park East called to report that patient had "hematuria, fever 103.8 and unstable pulse ox".
- August 22, 2012 to September 4, 2012, no nurses notes.
- September 15, 2012 to September 27, 2012, no nurses notes. Then on September 28, 2012 "resident's right eye crusty and red with yellow/green drainage" noted.
- Other disruptions in charting are noted on 3/27/12-5/24/12, notes nurses notes; 5/24/12-6/11/12, 6/11/12-6/27/12, 6/27/12-7/10/12, all with nurses notes during these times. Also, 1/25-2/11/13, 2/11-3/1/13 and finally 4/22-5/1/13 there are no nurse's notes. Though there are other gaps in the nurse's notes throughout Ms. Doe's stay at Park East, the ones that have been listed here are the most significant.

Date	Location	Chart Documentation	Review Note	Comments/References

Itemized List of Sparse Records for Dr. M's Deposition

- 1/11/11 Dr. M charted on the Antepartum record and nowhere else in the chart. Ms. Doe's blood pressure was never acknowledged to be "high".
- 2/11/11 Quad check noted as negative. 8-20week labs done and checked off by MR (?), no further notes in chart by either MR or Dr. M.
- 2/18/11. Dr. M charted in the Antepartum record, which included Jane's blood pressure, weight, urine Albumin/Glucose results, Jane had +3 blood in her urine and stated that there was no signs of Urinary Tract Infection, no vaginal bleeding and no pain. However, there was no note charted in the actual note section of the chart.
- 3/8/11 Dr. M crossed out the initial blood pressure inappropriately and then she entered a totally different blood pressure on the next line.
- 4/5/11 Complaints of Carpal Tunnel symptoms, Urine dipstick protein reads 30mg/dl (normal is 0-8mg/dl). No mention of urine dipstick protein in charting or further questioning about Carpal Tunnel symptoms. There was not a history of Carpal Tunnel noted in the initial history and physical 12/9/10.
- 4/26/11 Blood pressure on initial check is 150/90 and on recheck by Dr. M is 148/88. Dr. M writes in her notes "Recheck blood pressure in 3-4 days, if still high check labs. Ms. Doe did not return to the clinic until 5/10/11 according to clinic notes. No labs were ordered until 5/10/11 and 5/31/11. On 5/10/11 all that was ordered was a urine culture to check for a urinary tract infection. Actual lab work that would coincide with blood pressure checks were not completed until 5/31/11 and initialed on 6/1/11 by Dr. M. Urine dipstick protein reads 30mg/dl, which is considered high. No further mention of urine protein in chart other than that Dr. M checked the lab result.
- 5/4/11 Ms. Doe complained of missing work on 5/3/11 and requested a doctor's note stating that her wrists were hurting too much to go to work. According to Dr. M's note on 5/4/11 she needed Ms. Doe to come in to have her blood pressure checked. Dr. M also wrote in her notes as to whether or not Ms. Doe was wearing her wrist splints daily. However, there was never any mention of questioning Ms. Doe further about possibly having signs of swelling or not.
- 5/24/11 A doctor's note for missing work 5/18-5/24 was written by Dr. M because Ms. Doe claimed to be sick at home during this period. Dr. M also wrote on the note that Ms. Doe was able to return to work on 5/26/11. Again, there was no line of questioning noted in the chart as to why Ms. Doe was sick from work, only the doctor's note. Again, urine dipstick protein is 30mg/dl and again there is nothing mentioned in the chart besides the test result itself.
- 5/26/11 Blood pressure check was 172/92 and on recheck it was 160/90. The Antepartum record also indicated that Ms. Doe had 2+ edema (swelling) charted by MLR(?). Otherwise, there is no further charting on this date.
- 5/31/11 Blood pressure 160/88, 2+ edema noted in the Antepartum record, otherwise, the edema (swelling) is not addressed in clinic notes.
- 6/1/11 Labs from 5/31/11 checked by Dr. M as having seen results. However, Total protein, urine spot=123mg/l (normal 0-10mg/l). No follow up by Dr. M regarding this lab result and nothing noted in chart.
- 6/7/11 Blood pressure 170/78 (?) Unable to clearly read value as it appears to have been changed by Dr. M inappropriately.
- 6/10/11 Dr. M signed FMLA (Family Medical Leave of Absence) paperwork on this date explaining that Ms. Doe, "has not worked since 5/31/11 due to swollen feet and pregnancy related uncomfortableness . Patient states cannot complete job functions daily due to pregnancy". Also, 32-36 week labs showed Group B Strep test positive, but there was no treatment ordered or any further notes concerning this lab result.
- 6/15/11 Blood pressure 192/102, Urine protein (dipstick) = 100mg/dl, complaints of shortness of breath at night so Dr. M charted to L.D. for rule out pre-E via squad. The note for sending Ms. Doe to the ER only mentioned her blood pressure as the symptom for being sent to the ER.
- 7/7/11 Dr. M filled out the insurance information form and inappropriately changed the date from 6/15/11 to 6/13/11 for Ms. Doe being "continually and totally disabled and unable to works since"_____.

Protocols according to Maternal Fetal Medicine at University Hospitals MacDonald Women's Hospital

For Preeclampsia/Eclampsia Prevention during Pregnancy:

- Hospitalization
- Bed Rest
- Medication to lower blood pressure
- Close monitoring of both the fetus and the mother

According to the University Hospitals website, "Preeclampsia, also called toxemia, is a condition characterized by pregnancy induced high blood pressure, protein in the urine, and swelling due to fluid retention. Eclampsia is the more severe form of this condition, which can lead to seizures, coma, or death.

The cause of preeclampsia is unknown, but it is more common in first pregnancies. It affects about seven to 10 percent of all pregnant women. Other risk factors for preeclampsia include the following:

- A woman carrying multiple fetuses
- A teenage mother
- A woman older than 40
- A woman with pre-existing high blood pressure, diabetes, and/or kidney disease."

** Link for High Risk Pregnancy Doctors from University Hospitals

www.uhhospitals.org/macdonald/services/maternal-fetal-medicine

Date	Location	Chart Documentation	Review Note	Comments/References