MEDICAL CHART

RED-FLAG CHECKLIST

FOR PLAINTIFF ATTORNEYS · 2026 EDITION

Documentation Patterns That Warrant a Closer Look
Before a Matter Is Declined

Acute Care · Long-Term Care · Emergency · Behavioral Health · Custodial & Correctional

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Contents

Each item is a documentation pattern to look for, followed by why it matters clinically. Sections are independent — review only the settings your matter involves.

About This Checklist

This checklist helps plaintiff attorneys identify documentation patterns in medical records that may indicate a departure from accepted clinical practice — before a matter is declined. Each item is grounded in clinical practice standards, regulatory requirements, and peer-reviewed literature.

It is a triage instrument, not a merit determination. Red flags identify questions for clinical evaluation; they do not establish deviation, causation, or liability. Where they cluster, a full medical-legal record review by a qualified Legal Nurse Consultant is the appropriate next step.

HOW TO USE IT

1. Review the records against the checklist for each applicable care setting.

2. Mark any item that appears present, absent, or inconsistent in the record.

3. As a practical screening convention, three or more marked items in a single setting — or marked items spanning multiple settings — is the threshold at which TRACE recommends a full record review before a matter is declined. This is a triage convention, not a validated scoring instrument.

4. This checklist does not replace a full medical-legal record review. It is a triage tool for prioritizing which files deserve deeper clinical scrutiny.

Why an NP-Led Review

TRACE is led by a nurse practitioner holding dual board certification in Adult-Gerontology (AGNP-BC) and Psychiatric-Mental Health (PMHNP-BC), practicing clinically in addiction medicine concurrently with consulting work. That scope spans both medical and behavioral health complexity, which is why this checklist covers psychiatric documentation at the same depth as acute and long-term care — an area most legal nurse consulting resources treat only in passing.

SCOPE OF THIS DOCUMENT

THIS DOCUMENT DOES: identify documentation patterns in medical records that warrant clinical evaluation, measured against accepted clinical practice standards and applicable regulatory requirements.

THIS DOCUMENT DOES NOT: assess the legal merit, viability, or value of any claim; establish deviation from the standard of care, causation, or liability in any matter; offer opinions on duty, breach, or proximate cause as legal elements; opine on physician standard of care or on medical causation; or recommend whether a matter should be pursued, settled, or declined. Those determinations rest solely with counsel, informed where appropriate by retained testifying experts.

TRACE is retained as a consulting expert. Analysis is prepared at the direction of counsel in anticipation of litigation and is intended to be protected as attorney work product. TRACE does not testify, is not disclosed as a testifying expert, and does not practice law. Where this checklist uses the phrase "standard of care," it refers to accepted clinical practice standards, not the legal standard of care as applied by a court. Clinical guidelines referenced are real and described at a general level; in a live engagement each is pinned to the edition operative on the date of the care at issue.

SECTION 1

ACUTE CARE SETTINGS

Hospital: Medical-Surgical, ICU, Step-Down, Telemetry

WHY THIS SECTION MATTERS

Acute care records are among the most voluminous and most misread documents in medical-legal practice. Documentation issues are estimated to play a role in 10–20% of medical malpractice lawsuits, and the most consequential gaps are often invisible on a first pass — buried in nursing flowsheets, shift-change notes, and medication administration records (Ghaith et al., 2022).

A — NURSING ASSESSMENT DOCUMENTATION

The nursing assessment is the clinical backbone of the acute care record. Its absence, inconsistency, or lack of individualization is frequently the clearest evidence of a monitoring gap.

- **ASSESSMENT TIMING GAPS**

  Nursing assessments are absent or significantly delayed relative to the facility's documented policy for that unit and acuity level. Required intervals vary by unit, patient status, and provider orders, so compare against the facility's own policy rather than a general standard. Missing assessments in the hours preceding an adverse event are among the most clinically significant findings in acute care review.

- **ABSENT OR INCOMPLETE PAIN REASSESSMENT**

  Pain is assessed on admission but not reassessed after intervention, or reassessment timing does not match facility policy or the onset profile of the medication given.

- **FALL RISK ASSESSMENT NOT COMPLETED OR NOT ACTIONED**

  A validated tool (Morse Fall Scale, Hendrich II, or facility equivalent) is absent at admission, not repeated after a change in condition such as new sedation or a procedure, or not acted upon — meaning no documented precautions correspond to an elevated score. Failure to act on a score is as significant as failure to assess.

- **SUBSTANCE WITHDRAWAL RISK NOT SCREENED OR NOT REASSESSED**

  No documented screening for alcohol or sedative-hypnotic use on admission, or a positive history with no subsequent structured withdrawal assessment. Early signs are frequently masked by anesthesia and opioid analgesia, which is a recognized reason withdrawal is identified late in surgical patients. Instrument choice matters as well: CIWA-Ar depends on patient self-report for six of its ten items, was validated in patients who can communicate and cooperate, and has documented validation limitations in patients who cannot — including those who are intubated, sedated, delirious, significantly cognitively impaired, or separated by a language barrier. Autonomic-blunting medications (beta blockers, clonidine, dexmedetomidine) can also depress the score in a patient who is actively withdrawing. Withdrawal and an evolving infection can present with overlapping findings, so an unscreened patient is also one in whom the two were never separated.

- **NEUROLOGICAL ASSESSMENT GAPS**

  Neuro checks (GCS, pupillary response, orientation, motor exam) are required by order or policy but not documented at the required intervals. In stroke, traumatic brain injury, or post-procedure matters these gaps are clinically critical.

- **SKIN AND WOUND ASSESSMENT ABSENT OR INCOMPLETE**
  No documented head-to-toe skin inspection on admission, or wound and surgical site assessments lack staging, measurement, and tissue description. Undocumented skin or incision condition makes it difficult to establish when a finding first became observable.
- **RESPIRATORY ASSESSMENT ABSENT**
  Lung sounds, respiratory rate, oxygen saturation, and work of breathing are not documented at required intervals for a patient with known respiratory compromise or receiving respiratory-depressant medications such as opioids or benzodiazepines.
- **VITAL SIGN GAPS OR CLUSTERED ENTRY**
  Vital signs are absent, entered in a single cluster at end of shift, or implausibly uniform across an extended period. Batch entry is inconsistent with contemporaneous documentation and warrants comparison against the EHR audit trail.

B — RECOGNITION AND ESCALATION

The obligation to recognize clinical deterioration and escalate it to a provider is central to acute care nursing practice. Documentation of that communication carries the same weight as the communication itself.

- **NO DOCUMENTED PROVIDER NOTIFICATION DESPITE ABNORMAL FINDINGS**
  Nursing notes reflect abnormal vital signs, significant lab values, or clinical deterioration, but no corresponding provider notification is documented.
- **PROVIDER NOTIFICATION WITHOUT DOCUMENTED RESPONSE**
  A provider was notified, but no order, acknowledgment, or change in plan of care follows. When a nurse escalates and receives an inadequate response, documenting that response and the follow-up action taken is expected practice; its absence is clinically significant.
- **SEPSIS SCREENING OR EARLY WARNING ALERT NOT ACTED UPON**
  The EHR generated a sepsis advisory, SIRS alert, or early warning score threshold notification, but no assessment, provider notification, or order follows. Advisory firing logs are typically retained separately from the clinical chart and should be requested by name — they record what the system told the clinical team and when.
- **STRUCTURED COMMUNICATION TOOL NOT USED**
  The facility requires SBAR or an equivalent structured escalation format, but no structured documentation appears where escalation was clinically indicated.
- **RAPID RESPONSE OR CODE TEAM ACTIVATION DELAYED**
  Objective indicators — early warning score thresholds, specific vital sign parameters, or facility activation criteria — were met, but activation is undocumented or delayed without documented clinical justification.
- **CONFLICTING NURSING AND PROVIDER DOCUMENTATION**
  Nursing notes describe the patient as stable or resting comfortably during the same window in which provider notes reflect acute deterioration or urgent intervention. Cross-disciplinary inconsistency suggests either a communication breakdown or non-contemporaneous documentation.

C — MEDICATION ADMINISTRATION

The medication administration record (MAR) is frequently the most informative document in an acute care file. Across malpractice claims involving documentation, the most common issue is missing documentation — roughly 70% — ahead of inaccurate content and poor mechanics (Ghaith et al., 2022).

- **MAR GAPS — OMITTED DOSES WITHOUT DOCUMENTED REASON**

  Scheduled medications are absent from the MAR with no held, refused, or unavailable notation. Unexplained omissions of time-sensitive medications — antibiotics in suspected sepsis, anticoagulants, insulin, antiarrhythmics — are the highest-yield MAR findings. Compare against pharmacy dispensing records, which distinguish a documentation failure from a medication omission.

- **HIGH-ALERT MEDICATION MONITORING NOT DOCUMENTED**

  High-alert medications (insulin, heparin, warfarin, opioids, vasopressors, chemotherapy) were administered, but required monitoring parameters — blood glucose, aPTT or anti-Xa, INR, sedation and pain scales, hemodynamics — are not documented at the required intervals.

- **ALLERGY OVERRIDE WITHOUT DOCUMENTED JUSTIFICATION**

  A medication contraindicated by a documented allergy was administered with no clinical rationale, prescriber override note, or risk-benefit discussion in the record.

- **MAR CORRECTIONS, OVERWRITING, OR LATE ENTRIES**

  The MAR contains visible corrections, overwritten entries, or late-entry notations added well after the documented administration time. Late entries made after an adverse event or a complaint warrant audit trail comparison.

- **PRN ORDER WITHOUT INDICATION, PARAMETERS, OR REASSESSMENT**

  A PRN order is entered without a recorded indication, dosing parameters, or reassessment interval, or is administered with no documented effect. A single PRN order is not a treatment regimen, and the record should show what it was given for and what followed.

D — RECORD INTEGRITY

Documentation integrity findings can surface the most important facts in an otherwise ambiguous record. Where these patterns appear, the EHR audit trail becomes a priority discovery target.

- **LATE ENTRIES CLUSTERED AROUND AN ADVERSE EVENT**

  Multiple notes, assessments, or orders were entered hours or days after the documented clinical event, with timing that correlates to an adverse outcome, a complaint, or a preservation letter.

- **COPY-FORWARD DOCUMENTATION**

  Nursing notes across multiple shifts contain identical or near-identical language, indicating templated carry-forward rather than individualized assessment. This obscures the patient's actual trajectory and makes it difficult to determine when a change in condition first became observable.

- **VAGUE, GENERIC, OR NON-INDIVIDUALIZED NOTES**

  Documentation relies on templated phrasing — resting comfortably, no complaints, care provided — without individualized clinical detail.

- **MISSING NURSING SHIFT NOTES**

  One or more full shift notes are absent from the record for a high-acuity patient. Complete absence of shift documentation for a critically ill patient raises both documentation and record-completeness questions.

- **EHR AUDIT TRAIL DISCREPANCIES**

Where audit trail data has been obtained, entries show creation or modification timestamps that postdate the clinical event, the adverse outcome, or receipt of a preservation letter. Audit trail metadata is the most objective record of when documentation was actually created.

What This Means for Your Case — Acute Care

These patterns bear directly on nursing assessment, monitoring, and escalation obligations. An assessment gap in the hours before a code, clustered vital signs on the morning of a fall, or an unexplained MAR omission for a time-sensitive antibiotic each describe something the record does not show. Whether that absence reflects a departure from accepted practice depends on facility policy, patient acuity, and the full clinical context — which is what a complete record review evaluates.

SECTION 2

LONG-TERM CARE SETTINGS

Skilled Nursing Facilities, Nursing Homes, Memory Care

WHY THIS SECTION MATTERS

Long-term care sits at the intersection of clinical nursing practice and a dense federal regulatory framework. CMS F-tag citations — particularly F686 (Treatment/Services to Prevent or Heal Pressure Ulcers), F689 (Free of Accident Hazards/Supervision/Devices), F600 (Free from Abuse and Neglect), F604 (Right to be Free from Physical Restraints), and F552 (Right to be Informed/Make Treatment Decisions) — provide a documented regulatory history that sits alongside the clinical record.

Where licensed and unlicensed nursing staff constitute the primary clinical team, the nursing record is substantially the care record.

A — PRESSURE INJURY AND WOUND CARE

- **ADMISSION SKIN ASSESSMENT ABSENT OR INCOMPLETE**

  No documented head-to-toe skin inspection on admission. Skin inspection and risk assessment are two distinct requirements — a Braden score alone does not document skin condition, and a skin inspection alone does not document risk. Both should be present.

- **BRADEN SCORE NOT ACTIONED**

  A Braden score indicating risk is documented at admission or reassessment, but no corresponding individualized prevention care plan follows. Braden bands: 15–18 mild risk, 13–14 moderate, 10–12 high, 9 or below very high. Any score of 18 or under places the resident in an at-risk category requiring documented preventive intervention.

- **WOUND ASSESSMENTS LACKING CLINICAL SPECIFICITY**

  Wound notes omit stage or category (NPIAP staging), dimensions in centimeters, wound bed and periwound description, exudate type and amount, and odor. Without these elements it is not possible to determine whether the wound was progressing, healing, or being treated as ordered.

- **REPOSITIONING DOCUMENTATION ABSENT OR IMPLAUSIBLE**

  The care plan specifies a repositioning schedule, but turning logs are absent, incomplete, or record the same position repeatedly. Logs showing exclusively supine entries for a bed-bound resident are internally inconsistent with the intervention they purport to document. Current guidelines call for individualized repositioning frequency rather than a fixed universal interval, so compare the log against the facility's own care plan.

- **WOUND CARE INCONSISTENT WITH ORDERS**

  The wound order specifies a dressing type, frequency, and technique, but nursing notes document a different product, a different interval, or no wound care during the relevant period.

B — FALL PREVENTION AND POST-FALL RESPONSE

- **FALL RISK ASSESSMENT NOT COMPLETED AT REQUIRED INTERVALS**
  Facility fall risk screening is not completed at admission, following a fall, or at the required reassessment interval. The MDS captures fall history (Section J) rather than functioning as a fall risk screening tool — review both the MDS and the facility's own instrument.
- **POST-FALL ASSESSMENT INCOMPLETE OR DELAYED**
  Following a documented fall, the post-fall assessment is absent, delayed beyond facility policy, or missing required components: vital signs, neurological check, pain and injury assessment, provider notification, and family or representative notification. An incomplete post-fall assessment often indicates the fall was unwitnessed.
- **FALL PREVENTION INTERVENTIONS NOT INDIVIDUALIZED**
  The care plan lists generic precautions — call light in reach, non-slip footwear — without interventions tied to the resident's specific documented risk factors such as orthostatic hypotension, psychotropic medication burden, cognitive impairment, or gait instability.
- **REPEATED FALLS WITHOUT CARE PLAN REVISION**
  Two or more falls are documented during a single admission with no care plan revision, no interdisciplinary review, and no documented change in prevention strategy after each event. A static care plan following repeated falls is a documented departure from care planning requirements.

C — CARE PLANNING AND MDS

- **MDS DOES NOT REFLECT THE CLINICAL RECORD**
  The MDS documents a higher functional or cognitive level than nursing daily notes, therapy notes, or provider documentation from the same assessment window.
- **CARE PLAN NOT UPDATED AFTER A CHANGE IN CONDITION**
  A significant change — a fall, a new pressure injury, behavioral escalation, a medication change, a hospitalization — is not reflected in a care plan update within the required timeframe.
- **CARE PLAN GOALS ARE GENERIC AND UNMEASURABLE**
  Goals use non-individualized, non-measurable language ("resident will remain safe," "resident will not fall") rather than measurable, time-limited goals tied to the resident's clinical profile.

D — RESTRAINTS AND PSYCHOTROPIC MEDICATION

- **RESTRAINT APPLIED WITHOUT DOCUMENTED ASSESSMENT AND ALTERNATIVES**
  A physical restraint, or a medication used to manage behavior, was applied without a documented assessment of the underlying cause, less-restrictive alternatives attempted and failed, a physician order stating the clinical indication, or documented consent. F604 addresses physical restraints and F605 chemical restraints. A medication given to control behavior rather than to treat a diagnosed condition may meet the definition of a chemical restraint regardless of how the order was written.
- **PSYCHOTROPIC INITIATED OR INCREASED WITHOUT DOCUMENTED CONSENT**
  A psychotropic medication was started or its dose increased with no documentation that the resident or representative was informed in advance of the risks, benefits, and alternatives, and chose among them. Missing psychotropic consent documentation is a recurring citation area under F552.

- **BEHAVIORAL SYMPTOMS NOT ASSESSED FOR A MEDICAL CAUSE**
  A change in behavior was managed pharmacologically with no documented evaluation for reversible medical contributors — infection, pain, dehydration, constipation, medication effect, or delirium. Treating the behavior without assessing its cause is both a clinical and a care planning gap.

E — STAFFING AND REGULATORY HISTORY

- **STAFFING RECORDS SHOW DEFICIENT RATIOS**
  Staffing sheets, Payroll-Based Journal submissions, payroll records, or daily assignment sheets reflect levels below state minimums or below the facility's own staffing plan during the relevant period.
- **SURVEY HISTORY SHOWS REPEATED CITATIONS IN RELEVANT AREAS**
  Publicly available CMS survey data shows citations under F686, F689, F600, F604, F552, or other directly relevant tags within the preceding survey cycles. Repeat citations in the same deficiency area document that the facility had notice of the problem.
- **INCIDENT REPORTS MISSING OR INCONSISTENT WITH NURSING NOTES**
  The facility's internal incident report for a fall, pressure injury, or other adverse event is absent from the produced record, or its content conflicts with nursing notes from the same period. This raises record-completeness questions worth pursuing in discovery.

What This Means for Your Case — Long-Term Care

A missing repositioning log, a care plan unchanged after a third fall, or a Braden score with no corresponding prevention interventions each describe a gap between assessed risk and documented response. Where the facility's survey history shows citations in the same deficiency areas, the clinical question shifts from whether a single lapse occurred to whether the gaps were isolated or systemic — a distinction a full record review, read against the regulatory history, is built to answer.

SECTION 3

EMERGENCY DEPARTMENT SETTINGS

Hospital ED, Freestanding Emergency Centers

WHY THIS SECTION MATTERS

More than 75% of emergency physicians will be named in a malpractice lawsuit at least once during their careers, and documentation issues are estimated to contribute to 10–20% of such claims (Ghaith et al., 2022).

ED nursing documentation is uniquely time-sensitive: triage acuity, reassessment timing, and escalation are measured in minutes, and the record either supports the timeline or it does not.

A — TRIAGE DOCUMENTATION

- **ESI LEVEL INCONSISTENT WITH PRESENTATION**

  The Emergency Severity Index level assigned at triage does not align with the documented chief complaint, presenting vital signs, or clinical presentation. Under-triage is among the most consequential triage findings, because the assigned acuity drives reassessment frequency and provider contact timing downstream.

- **TRIAGE ASSESSMENT INCOMPLETE**

  The triage note omits one or more required elements: chief complaint, pain score, vital signs, pertinent history, allergies, current medications, or acuity-appropriate assessment.

- **TRIAGE-TO-ASSESSMENT INTERVAL NOT DOCUMENTED OR EXCESSIVE**

  Time from triage to initial nursing reassessment or provider contact is undocumented, or exceeds the facility's own policy for the assigned ESI level. Intervals are not uniform across institutions, so facility policy governs.

B — REASSESSMENT AND MONITORING

- **REASSESSMENTS ABSENT DURING AN EXTENDED ED STAY**

  A patient with a high-acuity presentation — chest pain, stroke symptoms, sepsis criteria, respiratory compromise — has extended gaps with no documented nursing reassessment. Reassessment intervals should correspond to assigned acuity and facility policy, not to triage alone.

- **DETERIORATION PRESENT BUT NOT ESCALATED**

  Documentation reflects worsening vital signs, increasing pain, new symptoms, or abnormal findings, but no provider notification, order change, or increase in monitoring frequency appears in the subsequent record.

- **AMA DEPARTURE WITHOUT COMPLETE DOCUMENTATION**

  A patient who left against medical advice, or was discharged with an unresolved high-risk presentation, has no documented capacity assessment, informed refusal discussion, risks-explained notation, or provider signature.

C — HANDOFF AND COMMUNICATION

- **HANDOFF DOCUMENTATION ABSENT OR INCOMPLETE**
  Shift change or transfer handoff is not documented using the facility's required tool. Transitions are the periods during which changes in condition are most likely to go unobserved.
- **PROVIDER COMMUNICATION NOT DOCUMENTED**
  A nursing assessment identifies a change in condition, an abnormal finding, or a patient report requiring clinical action, but no provider notification or response appears.
- **DISCHARGE INSTRUCTIONS ABSENT OR INCOMPLETE FOR A HIGH-RISK PRESENTATION**
  A patient discharged with a high-risk complaint — chest pain, headache, abdominal pain, fever — has no documented discharge instructions, return precautions, or follow-up plan.

D — DOCUMENTATION INTEGRITY (ED-SPECIFIC)

- **NOTES ENTERED AFTER PATIENT DEPARTURE**
  Nursing documentation timestamped after discharge or AMA departure indicates non-contemporaneous charting. In ED matters, note entry time relative to patient departure is a priority audit trail item.
- **TEMPLATE LANGUAGE CONTRADICTS DOCUMENTED FINDINGS**
  Notes use templated phrasing — ambulatory, in no acute distress — that conflicts with other documented findings in the same encounter, such as a 9/10 pain score or documented inability to ambulate.

What This Means for Your Case — Emergency Department

In the ED, intervals matter. A triage acuity level that does not match the documented presentation, a multi-hour gap in reassessment for a patient with chest pain, or nursing documentation timestamped after the patient left each describe what the record's timeline can and cannot support. Reconstructing that timeline against facility policy and the audit trail is a threshold step before a matter is declined.

SECTION 4

BEHAVIORAL HEALTH SETTINGS

Inpatient Psychiatric, Outpatient Behavioral Health, Dual-Diagnosis, LTC Behavioral Units

WHY THIS SECTION MATTERS

Behavioral health matters are among the most clinically complex in medical-legal practice. In a 30-year dataset from a major professional liability insurer, suicide or attempted suicide accounted for 27% of malpractice claims brought against psychiatrists (Frierson & Joshi, 2019).

Documentation quality is a recognized concern in its own right: a clinical audit of inpatient psychiatric records found progress and outcome evaluated only sporadically in 86% of records reviewed (Instefjord et al., 2014), and an audit of post-self-harm care in patients aged 65 and over found comprehensive safety plans documented in fewer than 7% of cases (Tariq et al., 2024). Both are small audits of single services outside the United States, but they are consistent with what practitioners encounter: these records are frequently thin before any clinical failure is considered.

WHICH SUICIDE RISK REQUIREMENT APPLIES DEPENDS ON THE DATE AND THE ORGANIZATION

Effective January 1, 2026, The Joint Commission moved its suicide risk requirements for hospitals and critical access hospitals out of the National Patient Safety Goals chapter into a new National Performance Goals chapter, as NPG 8 — "The hospital reduces the risk for suicide" (NPG.08.01.01).

Behavioral health care and human services organizations remain under NPSG 15.01.01.

No new requirements were introduced; the content was reorganized. The elements below — environmental risk assessment, validated screening, evidence-based assessment, a documented risk level and mitigation plan, reassessment, and discharge counseling and follow-up — are common to both. Cite whichever framework governed the organization on the dates at issue, and expect records and policy sets spanning the change to reference both.

A — SUICIDE RISK ASSESSMENT

- **RISK ASSESSMENT TOOL NOT DOCUMENTED OR INCORRECTLY APPLIED**

  The record contains no documented suicide risk assessment using a validated instrument such as the Columbia-Suicide Severity Rating Scale (C-SSRS) or the Beck Scale for Suicide Ideation. A facility-generated checklist without supporting clinical narrative is also a significant finding. Note that screening and assessment are separate required steps: a completed screening instrument does not satisfy the assessment requirement.

- **RISK STRATIFICATION NOT DOCUMENTED**

  A note states that a risk assessment was completed but records no risk level and no clinical rationale for the level assigned. Documenting the patient's overall level of risk and the plan to mitigate it are two distinct required elements, and risk stratification without documented reasoning cannot drive the interventions that are supposed to follow from it.

- **SAFETY PLANNING ABSENT OR NON-INDIVIDUALIZED**
  A safety plan is absent, consists of pre-printed language without documented patient participation, or does not address the patient's specific identified risk factors, warning signs, coping strategies, and support contacts.
- **SAFETY PLAN NOT UPDATED AFTER A CHANGE IN STATUS**
  Clinical status changed — new ideation expressed, behavioral escalation, medication change, a disclosed stressor — but the safety plan was not revised to reflect the new risk profile.
- **MEANS RESTRICTION COUNSELING NOT DOCUMENTED**
  No documentation that access to lethal means was discussed and addressed as part of safety planning. Means restriction counseling is an evidence-based component of suicide risk management and is consistently under-documented.

B — OBSERVATION LEVEL

- **OBSERVATION LEVEL INCONSISTENT WITH DOCUMENTED RISK**
  The assigned observation level does not align with the documented risk level, presentation acuity, or clinical rationale in the note. For patients identified as high risk for suicide, Joint Commission expectations are continuous one-to-one visual observation, and this applies on non-psychiatric units as well.
- **OBSERVATION LOGS SHOW IMPLAUSIBLE INTERVALS**
  The check log shows exact, unvarying intervals across an entire shift — a pattern inconsistent with real-time documentation — or contains gaps exceeding the ordered interval.
- **OBSERVATION LEVEL REDUCED WITHOUT DOCUMENTED RATIONALE**
  The observation level was downgraded with no documented reassessment, clinical rationale, or provider order. Unexplained reductions preceding an adverse event are a priority review item.

C — ELOPEMENT RISK

- **ELOPEMENT RISK ASSESSMENT NOT COMPLETED OR NOT ACTIONED**
  An elopement risk assessment is absent, was not completed at admission, or documents elevated risk with no corresponding individualized prevention interventions in the care plan.
- **ENVIRONMENTAL SAFETY DOCUMENTATION ABSENT**
  No documented ligature risk assessment, environmental safety rounds, or belongings search consistent with facility policy for a patient on psychiatric hold or with documented suicidal ideation. Environmental risk assessment is an explicit element of The Joint Commission's suicide risk reduction requirements — NPSG 15.01.01 for behavioral health care and human services organizations, and NPG.08.01.01 for hospitals and critical access hospitals as of January 1, 2026.
- **ELOPEMENT EVENT DOCUMENTATION INCOMPLETE**
  Following an elopement, documentation omits required elements: time discovered, search conducted, notifications made to provider, family, and law enforcement, and post-event risk reassessment.

D — PSYCHIATRIC MEDICATION

- **INFORMED CONSENT FOR PSYCHOTROPICS NOT DOCUMENTED**

  A psychotropic medication was initiated or changed without documented informed consent covering risks, benefits, alternatives, and patient understanding.

- **REQUIRED MONITORING NOT DOCUMENTED**

  Medications requiring specific monitoring — lithium levels, QTc for QT-prolonging antipsychotics, metabolic panels for second-generation antipsychotics, absolute neutrophil count for clozapine — were administered without documented monitoring results during the relevant period.

- **SIDE EFFECT ASSESSMENT ABSENT**

  No documented assessment for medication side effects such as extrapyramidal symptoms, akathisia, or serotonin syndrome findings in a patient receiving high-risk psychotropics. Structured surveillance instruments — the AIMS for tardive dyskinesia and the Barnes Akathisia Rating Scale — are the conventional documentation of that assessment.

- **PRN PSYCHOTROPIC USE NOT CLINICALLY DOCUMENTED**

  PRN psychotropics were administered with no documented indication, no documented precipitating behavior, and no post-administration assessment. Undocumented PRN use raises questions about clinical justification and about whether the medication functioned as a chemical restraint.

E — SECLUSION AND RESTRAINT

- **RESTRAINT OR SECLUSION INITIATED WITHOUT REQUIRED DOCUMENTATION**

  Use of seclusion or physical or chemical restraint is not supported by documented clinical justification, less-restrictive alternatives attempted, a provider order, and a time-limited order. In Medicare-participating hospitals, including psychiatric hospitals, 42 C.F.R. § 482.13(e) limits orders for restraint or seclusion used for violent or self-destructive behavior to 4 hours for adults, 2 hours for ages 9–17, and 1 hour for patients under 9, with an in-person evaluation required within 1 hour of initiation. Restraint used for non-violent, non-self-destructive purposes carries its own separate ordering, monitoring, and reassessment obligations; long-term care facilities are governed by separate requirements under F604.

- **RESTRAINT MONITORING DOCUMENTATION ABSENT OR INCOMPLETE**

  A restrained patient's record lacks the required circulation checks, vital signs, range of motion, nutrition and hydration offerings, and toileting documentation at the required intervals.

What This Means for Your Case — Behavioral Health

Behavioral health matters are among the most under-screened in plaintiff practice and among the most demanding to analyze. A risk assessment with no documented risk level, an observation log with unvarying check intervals, or a safety plan with no means restriction counseling each describe a gap between identified risk and documented response. Evaluating those gaps against psychiatric nursing practice standards requires clinical familiarity with the setting — a background that remains uncommon among legal nurse consultants.

SECTION 5

CUSTODIAL AND CORRECTIONAL SETTINGS

Jails, Prisons, Juvenile Detention, Police Lockups, Contracted Correctional Health Vendors

WHY THIS SECTION MATTERS

Custodial matters differ from other settings in a way that changes how the file must be worked. The record is fragmented across separate custodians — the health record, frequently maintained by a private correctional health vendor on its own system; the custody record, including booking, housing, observation logs, and incident reports; and off-site provider records. Producing one is not producing the record.

The applicable clinical benchmarks also come from a different framework: NCCHC's Standards for Health Services in Jails and Prisons, whose 2026 editions took effect January 1, 2026, are an accreditation standard rather than a regulation, and they sit alongside state jail rules and the facility's own written medical plan. In North Carolina, G.S. 153A-225 requires each unit operating a local confinement facility to adopt a written medical plan approved by the local or district health director; 10A NCAC 14J .1001 specifies its required contents and requires a written record of each health complaint and the action taken.

A — INTAKE AND RECEIVING SCREENING

Intake is where the clinical trajectory of a custodial matter is usually set. The screening either identified the condition that caused the outcome, or it did not — and either way the form is in the file.

- **RECEIVING SCREENING ABSENT, LATE, OR NOT CLINICALLY REVIEWED**

  No receiving screening appears, it postdates the required interval, or it was completed by booking or custody staff with no documented review by qualified health care staff. NCCHC's 2026 standards call for receiving screening within six hours of admission; state jail rules and the facility's own medical plan may set a different interval — apply whichever governs the facility.

- **SCREENING POSITIVE BUT NOT ACTIONED**

  The screening documents current prescriptions, substance use, chronic illness, pregnancy, injury, or suicide risk, but no referral, clinician contact, protocol initiation, or housing decision follows. A screening that identifies risk and generates no order is the most common intake failure in this setting.

- **ARRESTING OR TRANSPORTING OFFICER OBSERVATIONS NOT RECONCILED**

  The arrest report, transport paperwork, or booking sheet notes intoxication, injury, or altered mental status that the health screening does not reflect. These are three separate documents generated within the same hour and should be read against one another.

- **INITIAL HEALTH ASSESSMENT ABSENT**

  A detainee held beyond the screening period has no documented initial health assessment or history and physical within the required interval.

- **REPORTED MEDICATIONS NOT VERIFIED**

  Self-reported prescriptions are recorded with no documented attempt to verify them with a pharmacy, outside provider, or family member, and no documented decision about continuation.

B — WITHDRAWAL AND MEDICATION CONTINUITY

Untreated alcohol and sedative-hypnotic withdrawal can be fatal; untreated opioid withdrawal becomes fatal through dehydration, electrolyte derangement, and aspiration. Intake identifies the risk in most matters. What follows the identification is the question.

- **WITHDRAWAL RISK IDENTIFIED WITHOUT PROTOCOL INITIATION**

  Intake documents alcohol, opioid, or benzodiazepine use, but no withdrawal protocol was initiated, no scoring instrument ordered, no reassessment interval set, and no provider notified. Identification without a regimen is the central documentary finding in most custodial withdrawal matters.

- **WITHDRAWAL SCORING ABSENT, INCOMPLETE, OR IMPLAUSIBLE**

  A scoring instrument was ordered but scores are missing at the required intervals, or the log shows identical scores across shifts. Instrument selection also matters: CIWA-Ar depends on patient self-report for six of its ten items and has documented validation limitations in patients who are sedated, delirious, significantly cognitively impaired, or separated by a language barrier — populations in which a predictive or observational instrument (PAWSS, MINDS) is the more appropriate choice. Autonomic-blunting medications can also depress the score in a patient who is actively withdrawing.

- **CHRONIC MEDICATIONS DISCONTINUED WITHOUT A DOCUMENTED DECISION**

  Insulin, anticonvulsants, anticoagulants, antihypertensives, or psychotropics were stopped at intake with no order, no clinical rationale, and no taper where one was indicated.

- **MEDICATION FOR OPIOID USE DISORDER INTERRUPTED**

  Buprenorphine or methadone was discontinued or not continued with no documented clinical rationale, no verification attempt with the treating program, and no transition plan.

- **MONITORING ABSENT DURING A WITHDRAWAL WATCH**

  A detainee on detoxification observation has no documented vital signs, oral intake, output, or mental status assessment at the ordered interval.

- **VOMITING OR REFUSED INTAKE NOT ESCALATED**

  The record repeatedly documents vomiting, refused fluids, or inability to retain medication, with no escalation, no consideration of intravenous access, and no documented decision about transfer to a hospital.

C — ACCESS TO CARE AND EMERGENCY RESPONSE

- **HEALTH REQUEST FORMS MISSING FROM THE PRODUCED RECORD**

  Sick call requests are not produced, or are produced without triage date, disposition, and the action taken. In North Carolina, 10A NCAC 14J .1001(c) requires the jail to maintain a written record of each health complaint and the action taken — an absent request log is itself a finding.

- **REPEATED REQUESTS FOR THE SAME COMPLAINT WITHOUT CHANGE**

  Multiple requests describe the same symptom with no change in assessment, no diagnostic study, and no provider evaluation. A rising volume of requests across days is a documented deterioration curve.

- **REQUEST-TO-ENCOUNTER INTERVAL EXCESSIVE OR UNDOCUMENTED**

  Time from a submitted request to a clinical encounter is not documented, or exceeds the interval set by the facility's medical plan or applicable state rule.

- **EMERGENCY RESPONSE DELAYED OR DECIDED WITHOUT CLINICAL INPUT**
  A medical emergency was managed by custody staff with no documented clinical assessment, or a measurable interval separates the first documented abnormal finding from EMS activation. Identify who made the decision not to transfer and what documented clinical basis supported it.
- **OFF-SITE REFERRAL ORDERED BUT NOT COMPLETED**
  A specialty referral, diagnostic study, or hospital transfer was ordered, but nothing in the record shows it occurred, was denied, or was rescheduled. Utilization review files held by the contracted health vendor are a separate custodian and must be requested separately.

D — SUICIDE RISK AND MENTAL HEALTH IN CUSTODY

- **INTAKE SUICIDE SCREENING ABSENT OR NOT ACTIONED**
  No documented suicide risk screening at booking, or a positive screen with no corresponding watch order, clinician referral, or housing decision.
- **WATCH LEVEL DISCONTINUED WITHOUT CLINICIAN INVOLVEMENT**
  An observation or suicide watch level was reduced or discontinued with no documented clinical assessment, or by custody staff without clinician authorization.
- **OBSERVATION LOGS IMPLAUSIBLE OR CONTRADICTED BY VIDEO**
  Cell check logs show unvarying intervals across an entire shift, contain gaps exceeding the ordered interval, or conflict with surveillance footage timestamps. Where footage exists, log-to-video comparison is the most objective check available in this setting — and footage retention periods are short, so preservation should be addressed early.
- **RESTRICTIVE HOUSING WITHOUT DOCUMENTED HEALTH ROUNDS**
  A detainee in segregation has no documented clinical rounds at the required interval, or rounds are documented cell-front with no assessment content beyond a notation that the person was observed.
- **PSYCHIATRIC MEDICATION CONTINUITY BROKEN**
  Psychotropic medications documented at intake were not continued, or lapsed during the admission, with no documented clinical decision, verification attempt, or reassessment.

E — RECORDS, CUSTODIANS, AND PRODUCTION

What was not produced is often the record that answers the question.

- **HEALTH RECORD PRODUCED WITHOUT CUSTODY RECORDS, OR THE REVERSE**
  Booking sheets, housing and movement histories, observation logs, incident and use-of-force reports, and grievances are maintained separately from the health record. A production containing only one set is incomplete on its face.
- **CONTRACTED VENDOR RECORDS NOT PRODUCED**
  Where health services are provided under contract, the vendor holds its own electronic record and audit trail, staffing and credentialing files, policies and protocols, and utilization review documentation. A subpoena directed only to the county or the facility may not reach any of it.
- **FACILITY MEDICAL PLAN AND PROTOCOLS NOT OBTAINED**
  The written medical plan defines what the facility committed to do, which is the benchmark the record is measured against. In North Carolina it is required by G.S. 153A-225, must be approved by

the local or district health director, is reviewed annually, and its required contents are specified at 10A NCAC 14J .1001.

- **DEATH-IN-CUSTODY NOTIFICATIONS ABSENT**

  Required internal and external notifications following an in-custody death do not appear in the produced record. In North Carolina, G.S. 153A-225(b) requires the facility administrator to report the death in writing to the local or district health director and to the Secretary of Health and Human Services within five days.

- **TRANSFER RECORDS INCOMPLETE**

  A detainee was transferred between facilities without health information accompanying the transfer. In North Carolina, G.S. 153A-225(b1) requires the transferring local confinement facility to provide the receiving facility with the health information and medical records in its possession.

- **STAFFING AND COVERAGE RECORDS NOT OBTAINED**

  Nursing coverage hours, post assignments, vacancy rates, and agency staffing use during the relevant period are not in the production. Where a facility is covered by a single nurse across intake, medication pass, and sick call, coverage records explain what the clinical record does not.

What This Means for Your Case — Custodial and Correctional

Custodial matters are frequently declined on an incomplete production rather than on the clinical picture. A screening form that identified withdrawal risk and generated no protocol, a stack of unanswered health requests, or a cell check log that cannot be reconciled with video each describe a gap between what the facility knew and what it did. Reading the health record against the custody record, the vendor's record, and the facility's own written medical plan is what makes that gap visible — and no single production contains all four.

SECTION 6

CROSS-SETTING RED FLAGS

Universal Patterns Across All Clinical Environments

Each of the following warrants evaluation before a matter is declined, whatever setting the care occurred in.

- **INFORMED CONSENT DOCUMENTATION ABSENT**

  A procedure, surgery, medication initiation, or significant intervention was performed with no documented consent process covering risks, benefits, alternatives, and patient or surrogate acknowledgment.

- **DISCHARGE DOCUMENTATION INCOMPLETE FOR A HIGH-RISK PATIENT**

  A patient with a high-risk diagnosis or unresolved clinical concern was discharged without documented instructions, return precautions, follow-up plan, and evidence that understanding was confirmed.

- **INTERDISCIPLINARY COMMUNICATION GAPS**

  Significant findings documented by one discipline do not appear in the notes of other treating clinicians from the same or immediately following period.

- **ORDERED CONSULTATION WITH NO CORRESPONDING NOTE**

  A consultation was ordered but no consultation note, cancellation, or explanatory entry appears in the record. An unanswered order for the service positioned to identify the process at issue is a documented gap in the diagnostic pathway.

- **ABSENT OR DELAYED INCIDENT REPORT FOR A SIGNIFICANT EVENT**

  A fall, medication error, pressure injury, elopement, or patient-to-patient altercation has no corresponding internal incident report in the produced record.

- **DOCUMENTATION THAT READS DEFENSIVELY**

  Notes contain unusually detailed, self-justifying, or argumentative language inconsistent with the clinical tone of surrounding entries, particularly immediately before or after an adverse event.

- **SIGNATURE OR COUNTERSIGNATURE MISSING**

  Orders, co-signed nursing notes, or advanced practice provider entries lack the required countersignature within the facility's policy timeframe, creating gaps in the chain of clinical authority.

- **RECORD PRODUCED IN LITIGATION DIFFERS FROM AN EARLIER PRODUCTION**

  Comparison of a pre-litigation records request against the discovery production reveals added entries, missing pages, or altered content. Any discrepancy between two productions of the same record warrants immediate further investigation.

SECTION 7

WHEN RED FLAGS ARE PRESENT

Next Steps for Plaintiff Attorneys

Three or more marked items in a single care setting, or marked items spanning multiple settings, is the point at which TRACE recommends a full record review before a matter is declined. The patterns in this checklist are the clinical building blocks a standard of care analysis is constructed from. Declining a file without a qualified clinical review of the chart risks setting aside a matter the record would have supported.

WHAT A TRACE CASE MERIT REVIEW PROVIDES

— Clinical analysis of the complete record against accepted clinical practice standards, facility policy, and applicable regulatory requirements

— A clinical chronology in which every entry carries a stated clinical significance, cited to its Bates number

— Physiologic trending, where the deterioration is visible only when readings are read as a trend rather than individually

— Nursing standard of care findings within this consultant's own scope of practice, with a stated consultant opinion and its limits

— Clinical causation analysis: the documented sequence, what requires physician expert opinion, and alternative clinical explanations considered

— Missing records and discovery items ranked by expected impact, including EHR audit trail and sepsis advisory logs

— Recommended expert specialties and the scope of opinion needed from each

THE TRACE METHOD

TIMELINE · RECOGNITION · ACTION · CAUSATION · EVIDENCE

NEXT STEP

Case screening: from $850, fixed fee quoted before any work begins. The screening fee is credited in full toward a case merit review commenced within 60 days.

Case merit review: fixed fee, scoped to record volume and quoted before any work begins. Every proposal states a record cap.

Confidential case inquiries receive a conflict check within one business day.

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This checklist is updated periodically to reflect emerging clinical standards, regulatory changes, and litigation trends.

References and Clinical Authority

Sources, standards, and regulatory authority cited throughout.

American Society of Addiction Medicine. (2020). ASAM Clinical Practice Guideline on Alcohol Withdrawal Management. Journal of Addiction Medicine.

Centers for Medicare & Medicaid Services. State Operations Manual, Appendix PP — Guidance to Surveyors for Long-Term Care Facilities. U.S. Department of Health & Human Services.

European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel, & Pan Pacific Pressure Injury Alliance. (2019). Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline (3rd ed.).

Frierson, R. L., & Joshi, K. G. (2019). Malpractice law and psychiatry: An overview. Focus: The Journal of Lifelong Learning in Psychiatry, 17(4), 332–336.

Ghaith, S., Moore, G. P., Colbenson, K. M., & Lindor, R. A. (2022). Charting practices to protect against malpractice: Case reviews and learning points. Western Journal of Emergency Medicine, 23(3), 412–417.

Gilboy, N., Tanabe, P., Travers, D., & Rosenau, A. M. Emergency Severity Index: A Triage Tool for Emergency Department Care. Emergency Nurses Association.

Instefjord, M. H., Aasekjær, K., Espehaug, B., & Graverholt, B. (2014). Assessment of quality in psychiatric nursing documentation — a clinical audit. BMC Nursing, 13, 32.

National Commission on Correctional Health Care. (2026). Standards for Health Services in Jails; Standards for Health Services in Prisons. NCCHC.

N.C. Gen. Stat. § 153A-225 — Medical care of prisoners; and 10A N.C. Admin. Code 14J .1001–.1002 — Jails, Local Confinement Facilities: Medical Plan and Screening.

Tariq, S., Prasanna, A., & Lau, R. (2024). Assessment of compliance with NICE guidelines on safety planning following self-harm in elderly patients in a mental health trust. BJPsych Open, 10(S1), S265.

The Joint Commission. (2019). National Patient Safety Goal 15.01.01 — Reduce the risk for suicide. Applicable to behavioral health care and human services organizations; R3 Report Issue 18, updated December 2025.

The Joint Commission. (2026). National Performance Goal 8 — The hospital reduces the risk for suicide (NPG.08.01.01). Effective January 1, 2026 for hospitals and critical access hospitals, replacing NPSG 15.01.01 for those programs.

42 C.F.R. § 482.13(e) — Condition of Participation: Patient's Rights, Restraint or Seclusion.

DISCLAIMER

This checklist is provided for educational and medical-legal consulting purposes only. It does not constitute legal advice, a medical opinion, a standard of care opinion in any specific matter, or an assessment of the merit or likely outcome of any claim. Clinical analysis, causation opinions, and standard of care findings require review of the complete medical record within an established attorney-consultant relationship. TRACE Legal Nurse Consulting, PLLC does not practice law and does not provide legal advice.