Medical Record Analysis

Elements of a Case Review

Case materials can include medical records, depositions of the plaintiff, healthcare providers, opposing expert, and other documents. When performing an analysis, we will look at the records with a critical eye that considers both sides of the case while keeping an open mind.

As we begin the case review process, it will provide additional information that can be helptul in determining what documents may be needed and how to best approach and evaluate the medical records.

Information Extraction

Our familiarity with medical records provides a firm foundation for our review. When applicable sections of the record are examined in detail, we will keep the framework of the nursing process and standard of care in mind to ensure objective evaluation.

Initial Report

After initial case review, we will hold a conversation with you to allow for an opportunity to ask questions, discuss opinions, and review case strategy. This report will provide more details of record analysis to assist you by including suggestions for additional documentation requests, advice about other areas to investigate in the patient's care, and suppletory of literature relevant to the case.

If we believe that no breech occurred, we will convey our opinions to you as soon as possible to allow for you to make a decision about continuing with the case.

Inventory of Documents

Upon receipt of the documents, we will ensure that all files stated sent in the cover letter (if provided) is in fact what we received.

The case review will help us determine if additional records are needed as all applicable records must be present to allow for the development of coherent and complete opinions.

We understand that case development can go on for several years so we will keep the records confidential and safe within an organized filing system that will also aid in rapid retrieval of information.

Chronology Development

With our well-developed timeline of events, the key points and issues can become evident very quickly (as can other challenges) while allowing us to assemble the case facts into an accessible format to help secure a courtroom victory.

Chronologies are also great and effective communication tools that enable everyone on the trial team to share knowledge and brainstorm strategy ideas. To further aid this, we will include disputed facts that opposing counsel may present so that the facts that support or negate the trial strategy are easy to identify.

Medical Record Organization

We will organize the records in a logical manner that:

- Corresponds to the way in which we would expect to find records in a medial chart
- Will allow opinlons to be developed
- Provide easily retrievable data for discussion with the attorney and for testimony

If only abstracts or selected pages from a record are provided for the initial overview, we will clearly express that our opinion is based on limited information and thus subject to change if more information is provided

Documentation Scrutiny

The nursing field has one mantra - *If it wasn't charted, it wasn't done.* We will analyze documentation inadequacies very carefully to look for trends in the documentation that reflect the expected standard of care as it relates to the case as gray area exists in this principle. However, our notice of inadequate or absent documentation can be a reflection of inadequate care - case specific or otherwise. Sometimes the information that is omitted in a medical record is as important, if not more so, than what is documented.

Final Report

Before writing the final report, we will ask if a preferred format and/or style is preferred. All reports will include:

- List of Documents Reviewed
- Description of the Events Prior to Incident
- Definition of the Standard of Care
- Opinion About Whether the Standard of Care was Met or Breached

Our opinions will be supported by specific nursing behaviors identified for each area of concern with an explanation of the standard of care's relationship to the action.

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Author: Miranda Martin, M.B.A, M.S.N, RN