Sally Ann Cullen is a New York State Registered Nurse and Certified Legal Nurse Consultant™. While attending high school, she began her nursing career upon attending and graduating from the LPN program at Southern Westchester BOCES in 1997. As an LPN employed at St. Cabrini Nursing Home in Dobbs Ferry, NY, she attended Rockland Community College in Suffern, NY and received an Associate degree in Nursing in 2000.

As a Registered Nurse, Sally Ann relocated to Tulsa, Oklahoma to spend time with family and was employed St. Francis Hospital, working on a Step-Down ICU Trauma/

Telemetry/Thoracic Surgery/Urology/Bariatric and Medical Surgical patients.

In 2002, she returned to New York as a travel nurse, accepting a 13 week assignment on a Medical Surgical/Telemetry unit in Beth Israel Hospital: Herbert and Nell Singer Division in New York City. After completing the travel assignment, she began her ten-year employment at Westchester Medical Center in Valhalla, NY as a Neonatal ICU nurse in October 2002. There, she attended high-risk obstetric deliveries, cared for premature babies and neonates who required specialized care and surgeries. In December 2012, Sally Ann received her Certified Legal Nurse Consultant certification and founded WestRock Legal Nurse Consulting, which provides meticulous review of medical records for attorneys and paralegals in areas of medical malpractice, personal injury and product liability.

 “As a nurse, it’s second nature to want to help others- and we do it with a smile!”

Medical Records

Sally Ann Cullen, RN, CLNC®

# Introduction (5 Minutes)

A. Brief background of my experience

B. Paralegals and nurses working together

C. Topics

1. Formulating a plan

2. Compiling a complete set of medical records

3. Breakdown of hospital record sections

4. Other records to consider

5. EMR (brief overview and a few pearls)

6. Tips on working with a LNC

7. Resources

# Formulating a Plan (15 minutes)

A. Know the allegation before you search the medical records

1. Interrogatories

a. Review questions and answers

b. Write down any immediate questions that come to mind

c. Gather information for preliminary research: medical diagnosis, injury, and medications (Medscape…)

2. Make a list of current injuries/allegation and stated pre-existing medical history

a. Recognize a possible relationship

b. Consider pre-existing conditions and what is physically, mentally, and psychosocially involved (i.e. diabetes) and its potential impact on the allegation

B. Consider potential locations of the information needed to answer your preliminary questions (this will also be helpful when compiling complete medical records)

1. EMS documents, ER documents, consults, lab, nursing assessment documentation, etc.

2. Note: each time a patient is transferred to another unit within the hospital or post-operatively, a new initial assessment form will most likely be filled out and physician orders regarding diagnoses, medication, diagnostic tests, diet and activities will be re-ordered

3. Other treating physicians or physical therapy notes

C. Medical Malpractice/ Personal Injury Cases

1. Preliminary research will help you:

a. Recognize early signs and symptoms of the injury that were exhibited in the record but may have been overlooked by healthcare staff

b. Note acts of omission and commission

c. Helps determine the possibility of pre-existing conditions that may have contributed or caused the alleged injury

D. Product Liability Cases

1. Preliminary research will help you:

a. Determine which pre-existing medical conditions may have affected the way the operator handled the product (i.e. arthritis, newly diagnosed trigger finger, medications)

E. Preliminary research

1. A good foundation is essential

a. Saves you time, your client money, and will prevent subtle information from being overlooked

2. Perform a search of each injury or claim

a. Definition, cause, incidence, how it’s diagnosed, treatments, medications, and prognosis (note knowing what tests should be done to diagnose the condition is helpful in determining whether you have a complete set of medical records)

b. Print the information and keep it handy for a quick reference for when you review the medical records

# Compiling a Complete Set of Medical Record (hopefully) (15 minutes)

A. First determine what is/are the specific allegation(s) of the complaint

1. Formulate which medical records will be necessary to review based on the cases medical-legal issues

a. Hospital

b. Primary Care Physician

c. Consulting/ specialty physicians

d. Other records: Nursing Home, Rehabilitation Facility, Out- patient Physical Therapy Centers, Mental Health or Substance Abuse

2. Always request for the certified copy of each medical record

3. Never assume it’s complete

a. Portions of the record may have been removed or not included at the time of request

b. Copies of two-sided forms may not have been included in the record (Note the number of pages in the typical nursing assessment form, is it consistent or are some pages missing, especially during a questionable incident)

c. Keep a list of all suspected missing documents

4. Joint Commission on Accreditation of Healthcare Organization (JCAHO) has strict regulations that the completion medical records can’t exceed 30 days after a patient’s discharge.

1. If a staff member consistently exceeds this time constraint, they may be suspended

B. Records that may not be included in a response to a copy of the medical records and therefore may have to be requested by name.

1. Autopsy report

2. Billing records

3. EMS transport records

4. Fetal Heart Monitoring Strips

5. Radiographic Films

6. Videotapes or photographs taken during surgical procedure or delivery

a. Note that if a difficulty was encountered during the procedure, the surgeon may have requested the video to be stopped

7. Lab results from an outside laboratory

a. Results may not have come back before the patient was discharged and therefore may not have been included in the chart

8. Drug store pharmaceutical records

9. Operating Room logs

a. This will provide information as to what the case schedule was like on a certain day and what was the previous case in the operating room

10. Emergency Room logs

a. This will provide the information on the acuity of the ER

b. Emergency Room records may have to be requested separately; it may be considered outpatient records

11. Laboratory logs

a. Provides information that includes what test was drawn, who ordered the test, who drew the lab specimen, the date and time it was drawn, when the test was performed, when the results were entered in the system, and if needed who was notified of critical results

12. Hospital Pharmaceutical records

13. HIV testing records

14. Monitor tapes- EKG

15. Specialty procedures reports and films that are not a part of the medical records department

a. Cardiology

b. Radiology

16. Neonatal transfer reports

17. Specialty testing

a. Neuropsychology, hearing, speech, language testing

18. Biomedical equipment records and logs

19. Medical record dictation logs

20. Miscellaneous special records

a. Resuscitation records, critical care flow sheets, hemodialysis records)

21. Nursing home records you may have to specifically request:

a. Skin assessment/ wound care logs

b. Treatment Administration Record (TAR)

c. Medication Administration Record (MAR)

22. Incident Reports filed within the facility

 a. May not produce it since it’s an internal record for quality improvement, but it’s worth a try

b. May be created in response to an incident within the facility, such as a fall, medication error, equipment malfunction

23. Telephonic communications (doctors office call log)

# Breakdown of Patients Hospital Medical Chart (10 minutes)

A. Software programs for EMR may differ in the organizational format and may vary within the facility’s different specialty units, however this is a general example of what may be expected.

1. Advance directives

2. Medication administration

3. VTE assessment (Venous Thromboembolism)

4. Clinical procedure notes

5. Order sheets

6. Restraints

7. Skin/wound care

8. Radiology

9. Lab reports

10. OR permits and/or sheets

11. Respiratory care

12. Social work/ discharge planning

13. Nurses notes

14. Patient education

15. Nursing care plan

16. Consults

B. Manual charts

1. Face sheet- general information about the patient

2. Transfer forms, EMS forms (if included in the requested copy)

3. Physician notes/ progress notes

4. Physician orders

5. Nurses notes

6. Consults

7. Labs

8. Respiratory care

a. Blood gas results

b. Oxygen therapy

c. Respiratory treatments

d. Ventilator, CPAP (continuous positive airway pressure), and or nasal cannula therapy

9. Advanced Directives

10. Social work

11. Discharge Planning/ Summary

12. Medication administration record

13. Consents/ Operating Room records

# Electronic Medical Record (EMR)- A few pearls to know (10 minutes)

A. Know the vendor/ system being used

1. Each vendor is different

2. A vendor may use different software systems within the same facility depending on the department’s needs

a. Pharmacy vs. ER vs. Med-Surg floor

3. IT support and training vary depending on the “package” the facility opted to pay for

4. Vendors have a list of known bugs/ fixes (can ask for this)

5. Software implementation varies state to state

6. Some software do not have the capability to audit, some may document the complete list of medication allergy information in the pharmacy area and truncate the list with one medication in the nursing area-so important to look at the facility’s training policies and how updates and fixes are communicated to staff

B. Hospital responsibilities

1. The general rule of “If it’s not charted/ documented, it’s considered not done” still applies in EMR, however may want to consider the following:

a. A new employee entered the information and has not been fully trained or updated on

b. User’s may change the computer’s browser (Firefox, Chrome, etc.) and the software may not be “responsive to these changes and may omit parts of the chart without the user being aware

c. There may be a late entry

d. Documentation may be a mix of EMR and manual (paper) charting

e. Someone may be charting under a fellow staff members ID

2. Keep current with upgrades and new versions of the software

a. If not up to date, features and functionalities may be missing to help them do a better job

b. If the hospital did not purchase support or enough hours of support, then it could eventually cause problems with documentation

3. How the facility handles back-ups, downtimes, how the information is processed and where it’s stored, and the training policy for initial use and for updates

a. Some hospitals have more than one data repository

b. Request for production: a copy of the software upgrades education material, how it was upgraded and how it was communicated to the users

 4. Policy and procedures as they relate to the EMR

a. Know what stage the facility was in re: the implementation of converting to EMR at the time of the incident because you may not find what you are looking for since it wasn’t implemented during that time period and request the policy and procedure accordingly

b. Know the downtime policy and procedure specific for the implementation period for downtime charting policies and procedures (1 hour, 2 hour, 3 hour, etc.) and if entering the information in the computer at a later time is required or if the paper is scanned into the EMR

C. Audit Trails

1. Maps information from one system to populate the main record

a. There are no permanent deletes

b. Tracks every change that was made: who made it, what and where

c. Audits can span multiple systems

d. Facilities are required to keep data for 6 years

e. Some systems (Legacy) do not have the capability to audit

f. Auditing slows a system down and if enough complaints from the staff are made, the auditing may stop and you may not find the information needed, so ask what was audited

g. May not track all applications

h. Log on/off information and viewed data within the system

2. Facility is responsible for writing the policy and procedure (P&P) of how auditing is maintained

a. P&P re: addendums and late entries

b. Password changes

3. Request an audit trail if tampering is suspected

D. Metadata

1. Tracks the actual information you are looking for in an audit trail for that particular patient

a. Has to be specific: date, time

b. IT persons have to know exactly what you are looking for so they will know how to pull specific data elements out of that record

2. Tracks every key stroke, deletion, and any changes made to the record is seen

3. Costly, so be specific!

E. Red Flags

1. Missing pages/ gaps in the numbered EMR

a. Determine what information may be missing-was it around the date/ time of the allegation

b. Are the records out of order to begin with?

c. Did another member of the team “pull” the pages to keep for their file

2. Note that EKG and fetal monitoring strips are not included in the EMR and need to be requested specifically

3. Late entries

a. Someone may forget to chart something and enter a late entry

b. May see a second e- signature, which may be a supervisor that had to go in the patient’s EMR and chart on behalf of the staff member

c. Review the facility’s policy and procedure regarding late entry documentation

4. Workarounds

a. Information may have been entered in a section/ box that was not set up for that specific purpose, but a unit may have adopted it as such, which may make it difficult to locate upon review of the EMR

# Tips When Working With a LCN (Legal Nurse Consultant) (5 minutes)

A. Communication

1. Set aside some time to discuss the case objectives and inquiries at the first meeting

a. Discuss file organization

b. Specific formats of reports or tables you or the attorney prefer

c. Clarify the degree of detail you would like the information to be presented

2. Budget expectations

a. Open communication regarding this matter will achieve the most desirable results

3. As the case is reviewed or additional records are obtained, it is helpful to both the paralegal and LNC to continue to discuss case findings and brainstorm together on potential theories

B. Ongoing support

 1. Ask if the LNC will be available after the review is complete to address any concerns or questions that may arise

a. Location of a note/ incident within the medical records

b. Further explanation of medical terminology, injury or disease process

# Resources

A. American Association of Legal Nurse Consultants (AALNC.com)

1. Free online access to the AALNC journal

2. Monthly informative webinars

3. Webinar fees are discounted or sometimes free for members

B. Joint Commission on Accreditation of Healthcare Organizations (JCAHO) jointcommission.org

1. Private, not for profit organization est. in 1951 to evaluate healthcare organizations that voluntarily seek accreditation

2. Provide resources that address quality improvement, performance measurement and assessment, and standards compliance

C. HealthIT.gov

1. Guidelines for implementing and troubleshooting with EMR

a. Use as a reference when determining if guidelines where met

b. May be useful to determine where one can find “hidden” information