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AN MLP EXCLUSIVE GUIDE

How to Analyze Medical Records

The complete guide for attorneys navigating complex medical documentation

Inside this guide:

- ✓ The 5-step framework for systematic record analysis
- ✓ Complete hospital record checklist
- ✓ Common medical abbreviations reference
- ✓ Red flags that indicate record tampering
- ✓ Real case study showing record review in action

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Why Medical Records Make or Break Your Case

A client has just come to your office to ask for your help. The client has had surgery and has suffered a bad outcome as a result. You believe malpractice to have been the cause of the client's current pain and suffering — but now you have to prove it.

You request the records from the hospital and surgeon's office to determine what happened. When they arrive, you discover thousands of pages of documentation from nursing staff, anesthesia, physicians, consultants, physician assistants, and nurse practitioners.

How do you know where to begin? Is all of this information relevant? Can any of it be sifted through to bring the critical documentation to the surface?

The answer is yes. Follow the framework in this guide to systematically analyze any medical record and determine whether you have a viable case — before you invest significant time and resources.

THE 5-STEP FRAMEWORK

Step 1: Verify Completeness

Go through the record and ensure you have all required and relevant documents. Doctors' offices and hospitals may bury you in volumes of records while leaving damaging evidence out — hoping you won't notice because you're overwhelmed by the sheer volume of what you've been given. Use the checklist on the next page to verify you have everything.

Step 2: Remove the Noise

Once you determine you have all the relevant documents, sift through and remove any pages that are not needed. This includes blank pages, duplicate pages, and documentation unrelated to the event in question. A 4,000-page record may contain only 400 pages that matter.

Step 3: Focus on the Event

Identify all documentation surrounding the timeframe of the incident. In a surgical case, this includes nursing notes, flow charts, anesthesia records, PA/NP notes, surgeon's notes, operative reports, medications given in recovery, and more. These items are often scattered across multiple sections — you may need to search carefully to find them all.

Step 4: Build the Big Picture

Determine what happened. Was there documentation during the procedure that points to negligence by the surgeon, nursing staff, scrub techs, or anesthesia? Does the hospital have protocols in place to prevent this type of injury? If so, were they followed?

Cross-reference the timeline against the standard of care for the procedure in question.

Step 5: Trace the Aftermath

Examine what happened after the mistake was discovered. Was there a second procedure to rectify the problem? Did the surgeon or staff attempt to cover up the mistake? Was appropriate medication administered — or was the patient allowed to suffer and deteriorate? The post-incident response often reveals as much about liability as the incident itself.

Hospital Record Checklist

When you receive medical records, use this checklist to verify you have all the critical documents. Missing items may indicate incomplete production — or deliberate omission.

Admission & Discharge

- ☐ Admission history and physical (H&P;)
- ☐ Discharge summary
- ☐ Consent forms (surgical, anesthesia, blood products)
- ☐ Advance directives / DNR orders
- ☐ Patient identification and demographic sheets

Physician Documentation

- ☐ Attending physician progress notes
- ☐ Consulting physician notes
- ☐ Operative reports (for each procedure)
- ☐ Pre-operative and post-operative notes
- ☐ Physician orders (handwritten and electronic)

Nursing Documentation

- ☐ Nursing admission assessment
- ☐ Nursing progress notes (each shift)
- ☐ Nursing flow sheets / vital signs records
- ☐ Medication administration records (MAR)
- ☐ Intake and output records (I&O;)
- ☐ Incident / occurrence reports (if produced)

Anesthesia

- ☐ Pre-anesthesia evaluation
- ☐ Anesthesia record / intraoperative record
- ☐ Post-anesthesia care unit (PACU) notes

Diagnostic & Lab

- ☐ Laboratory results (blood work, cultures, pathology)
- ☐ Radiology reports (X-ray, CT, MRI, ultrasound)
- ☐ EKG / cardiac monitoring strips
- ☐ Pathology reports

Other Critical Documents

- ☐ Physical therapy / occupational therapy notes
- ☐ Social work notes

- Respiratory therapy records
- Transfer records (if transferred between facilities)
- Pharmacy records
- Code / resuscitation records (if applicable)

Common Medical Abbreviations

Medical records are filled with abbreviations that can be confusing or misleading if misread. Here are the most common abbreviations you'll encounter in litigation records.

Abbreviation	Meaning
H&P;	History and Physical
HPI	History of Present Illness
PMH	Past Medical History
ROS	Review of Systems
SOC	Standard of Care
Dx	Diagnosis
DDx	Differential Diagnosis
Tx	Treatment
Rx	Prescription / Medication
Sx	Symptoms
Hx	History
Px	Prognosis
PRN	As Needed
BID / TID / QID	Twice / Three Times / Four Times Daily
PO	By Mouth (per os)
IV	Intravenous
IM	Intramuscular
NPO	Nothing by Mouth
DNR	Do Not Resuscitate
I&O;	Intake and Output
VS	Vital Signs
BP	Blood Pressure
HR	Heart Rate
RR	Respiratory Rate
O2 Sat	Oxygen Saturation
WNL	Within Normal Limits
NAD	No Acute Distress
A&O;	Alert and Oriented

c/o	Complains of
s/p	Status Post (after a procedure)
r/o	Rule Out
AMA	Against Medical Advice
OR	Operating Room
PACU	Post-Anesthesia Care Unit
ICU	Intensive Care Unit
ER / ED	Emergency Room / Emergency Department
LOS	Length of Stay
D/C	Discharge (or Discontinue)

Red Flags: Signs of Record Tampering or Alteration

Not all critical evidence is in what the records say. Sometimes the most damaging evidence is in what the records *don't* say — or in signs that they've been altered after the fact. Watch for these red flags:

■ Unexplained Time Gaps

Periods where no documentation exists despite the patient being under active care. A 6-hour gap in ICU nursing notes, for example, is a significant red flag.

■ Late Entries and Addendums

Notes added hours or days after the event, especially if they differ in tone or detail from contemporaneous entries. Pay close attention to the timestamp vs. the date of the event.

■ White-Out, Strikethroughs, or Overwriting

Physical alterations to handwritten records. Proper corrections in medical records should use a single line through the error with initials and date — not white-out or obliteration.

■ Inconsistencies Between Providers

When the surgeon's note describes a "routine procedure" but the anesthesia record shows hemodynamic instability, or nursing notes document patient distress that physicians never address.

■ Missing Pages or Sections

Particularly suspicious if the missing documentation covers the timeframe of the incident. Compare the total page count against the table of contents or index if one exists.

■ Identical or Templated Language

Copy-paste documentation where every assessment reads identically shift after shift. This suggests the nurse or provider wasn't actually assessing the patient — they were cloning notes.

■ Metadata Discrepancies (Electronic Records)

In EHR systems, audit trails can reveal when entries were created vs. when they claim to have been authored. Request audit logs when you suspect backdated entries.

Case Study: How Record Analysis Changed the Outcome

The Situation

An attorney retained Med Legal Pro to review medical records in a post-surgical complication case. The patient underwent a routine abdominal procedure and developed a serious infection 48 hours later, resulting in sepsis, a prolonged ICU stay, and permanent organ damage.

What the Attorney Saw

The attorney had reviewed the operative report and discharge summary, which described the surgery as uncomplicated and the infection as an "unfortunate but known risk." The initial assessment was that the case lacked merit.

What Med Legal Pro Found

Our clinical review uncovered three critical findings the attorney had missed:

1. A **6-hour gap** in nursing documentation during the first post-operative night — the exact window when the patient's vital signs would have first shown signs of infection.

2. **Inconsistencies** between the surgeon's note (describing "no complications") and the anesthesia record, which documented an episode of intraoperative hypotension that was never addressed in the post-op plan.

3. A **late addendum** added to the nursing record 72 hours after the infection was diagnosed, documenting vital signs that conveniently fell within normal ranges — but the original flow sheet for that shift was missing.

The Result

Armed with these findings, the attorney's expert was able to establish that the standard of care had been breached in monitoring, documentation, and timely intervention. The case, initially considered meritless, settled for a significant amount prior to trial.

This case illustrates why clinical expertise matters. The attorney had the same records — but without a trained clinical eye, the critical details remained hidden in thousands of pages.

The Bottom Line

Following the framework in this guide should allow you to systematically work through any medical record, determine what happened to the patient, and assess whether there is a viable case.

The more significant the damages and the higher the culpability, the more likely the surgeon or hospital will want to settle out of court to avoid the publicity of a trial.

However, real-world experience is not something that can be taught in a guide. Complex medical records require a trained clinical eye — someone who knows not only what to look for, but what *should* be there and isn't.

Ready for Expert Support?

Med Legal Pro combines clinical expertise with legal knowledge to analyze medical records, build chronologies, conduct merit reviews, manage expert witnesses, and support your litigation strategy from start to finish.

Call us: (844) 633-5345
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Here's to your success!

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