

**You got your first case!
Now what?**

LNctips®

YOUR ASSIGNMENT: REVIEW A POTENTIAL DEFENDANT'S MEDICAL RECORDS AND WRITE A REPORT FOR THE ATTORNEY

If you're like most new Legal Nurse Consultants, it goes something like this:

- You dive into the records to “get a feel for the case.”
- You get excited when you spot a late medication and jot it on a notepad.
- You keep writing observations as you go.
- Near the end, you realize you don't have a firm grasp of the allegations—so you go back to reread them.
- Then you spend hours online researching conditions and standards of care.
- You re-review the records to “see what you missed.”
- Finally, you handwrite or type a rough report...then retype it to make it look tidy.

You finish the case—but you're not sure how long anything took. When you retroactively add up your time, it feels excessive. You ask colleagues if this is “normal.”

You did some things right—but in an inefficient order.

Here are common mistakes I saw when I supervised new LNCs, and how to fix them.

Mistake #1 – Not using a timer

Track your time as you go—on paper or with a tool like Clockify or Toggl Track. You can't bill accurately if you're guessing.

Mistake #2 – Not locking in the allegations

Type the allegations into a Word document. They're the backbone of your report. Not knowing them is like stumbling around in a dark room.

Mistake #3 – “Getting a feel” for the records

Never review just to wander. Your review should always be tied to the allegations.

Mistake #4 – Researching at the wrong time

Do focused research *right after* you review the allegations, not after you've already gone through the records once.

Mistake #5 – Researching too broadly

Stick to standards of care for the time period in the allegations. You don't need to study every condition the patient ever had.

Mistake #6 – Doing the work twice

As you review, type pertinent information directly into the document that will become your report. Don't write it on paper and then retype it later.

Mistake #7 – Re-reviewing the records

Aim for one thorough, allegation-focused review. Look for what supports or contradicts the allegations and move on.

And that late medication you were excited about? If it didn't cause damages—or there's a reasonable explanation—it's not malpractice.

Bottom line: Your job isn't to spot every tiny imperfection. It's to connect the records to the allegations, the standard of care, and the damages (if any).

Start your timer. Lock in the allegations first. Do focused research up front. Build the report as you review.

You'll produce a cleaner work product, bill accurately, and finish your next case faster—with far less rework.

FROM RN TO LNC – HOW TO REVIEW MEDICAL RECORDS

By Katy Jones, MSN, RN

One of the reasons you were hired to review a case and draft a report is because you're a nurse. But not every RN can review legal cases effectively.

Without legal training, RNs default to **reading the chart like a nurse**, which often means:

- **Following the story** instead of the allegations
- **Getting distracted** by interesting clinical details
- **Missing key timestamps**
- **Over-researching**
- **Re-reviewing** because they didn't capture what they needed the first time

LNC work uses your clinical strengths, then adds a legal framework so you can analyze records with purpose and precision.

To do that, you need a method that helps you:

- Lock in the allegations
- Do focused research

- Review the records with purpose
 - Build the report as you go
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How to build your report

Seasoned LNCs often take mental shortcuts they don't even notice. The method below is designed specifically for **new LNCs**, so you can build on your clinical strengths and learn how to apply them through a legal framework, step by step.

First rule:

Don't look at the medical records yet.

1. Clarify the report format

Ask the attorney if they have a preferred format:

- Medical summary
- Chronology
- No preference

If they have a preference, ask whether the firm has a **sample** you can follow. If you still need a format, [AALNC](#) has samples you can use as a starting point.

2. Set up your report document

Start your report **before** you review the medical records.

Use a timer at the start and end of each step. Some steps are longer than others; you may need to start and stop your timer as you take breaks.

1. **Open a blank Word document.** At the top, type:
CONFIDENTIAL ATTORNEY WORK PRODUCT
2. In the body, type the **case name**. If there's no case name, type the **plaintiff's name** and the **potential defendants' names**.
3. Identify the **medical records** you're reviewing (for example, "Ridge Surgery Center records, Dr. Garrison's office records, Community Hospital records").
4. Type the **allegations** into your document.
These should be front and center—they're the reason you're reviewing the records. Allegations may be summarized verbally or in writing by the attorney

3. Research the standards of care

For **each allegation**, research and identify the **standard of care** that supports or contradicts it. Include:

- the standard itself
- the **source**
- the **web address** so you and the attorney can validate your findings later

You'll also be looking for:

- **Damages:** What harm did the patient suffer?
- **Causation:** Did the alleged actions cause those damages?

Do this **before** you look at the records. It gives you a legal framework for your review.

4. Begin reviewing the medical records

Now that you understand the **allegations** and the **standards of care**, you're ready to review the records.

You'll eventually review **all** records provided by the attorney, but a good approach is to:

- start with the records most pertinent to the allegations, then
 - spread outward to less central records
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5. Build the report as you review

As you locate pertinent information, **type it directly into your report**. At this stage, it does **not** need to be in complete sentences.

Include:

- Timestamps
- Facility names
- Staff names and roles
- Pertinent clinical information
- Name of the record and page number where you found it

This helps both you and the attorney locate the information later and prevents you from doing the work twice.

As you continue to review, keep adding information and **slot it into chronological order**. For example:

- If you already have entries for **February 25, 2025**, and **March 1, 2025**, and you find something from **February 27, 2025**, insert it between those dates.
- Do the same for entries on the **same date** but different times.

6. Clean up and finalize your report

After you've finished your review:

1. **Remove irrelevant information** that doesn't relate to the allegations, standards of care, causation, or damages.
2. Convert your notes into **complete sentences**.
3. Add your **conclusions**.
4. Add an **introduction** that orients the attorney to the case and your role.

I walk through this part of the process step-by-step in [Legal Nurse Consultant Procedure Manual \(and More\)](#)

SAMPLE CASE

An attorney hires you for a case involving **sepsis after a colonoscopy**.

You're told:

- **Physician:** Alistair Garrison, MD
- **Patient:** Syed Curry
- **Procedure:** Colonoscopy with polyp removal
- **Date/Place:** February 21, 2025, at Ridge Surgery Center

At discharge, as Mr. Curry is being helped from the bed, he reports a **“pop”** in his left lower abdomen to the nurse assisting him. She takes no action.

A few hours later, Mr. Curry develops pain in the area of the **“pop.”** He contacts Dr. Garrison's answering service but doesn't receive a call back. By evening, he has a fever and severe pain. He calls again. Dr. Garrison returns the call and tells him to take Tylenol and call in the morning if there's no change.

At **3 a.m. on February 22, 2025**, Mr. Curry presents to the Emergency Department at Community Hospital and is diagnosed with **sepsis**. He is admitted and treated with antibiotics and a **bowel resection**.

You type this information into your report. You will also type any demographic and other information you find later in the medical records.

At this point, most new LNCs are **dying to review the medical records**—but that’s simply the clinical instinct kicking in. As an LNC, you’ll review the allegations and research the standards of care next, so your record review has purpose and direction.

Turning the summary into allegations

From the attorney’s summary, you might create allegations like:

1. **Allegation #1** – Failure of Alistair Garrison, MD on February 21, 2025, to properly perform a colonoscopy on Syed Curry, resulting in a colon perforation which in turn caused severe pain, infection, and sepsis.
2. **Allegation #2** – Failure of nursing staff at Ridge Surgery Center to appropriately monitor and assess Syed Curry after a colonoscopy with polyp removal.

The attorney didn’t provide the nurse’s name. That could indicate:

- It didn’t happen, contradicting the plaintiff’s account.
 - The name is in the records, but the attorney couldn’t find it at first glance.
 - The nurse didn’t document the encounter, which may be a deviation from documentation standards of care as well.
3. **Allegation #3** – Failure of nursing staff to report a change in patient status to Dr. Garrison, resulting in lack of timely treatment of a colon perforation.
 4. **Allegation #4** – Failure of Dr. Garrison to timely diagnose and treat Mr. Curry’s perforated colon, resulting in continuing pain, infection, sepsis, hospitalization, and emergency surgery for a bowel resection.

If a Complaint is filed, the attorney will use the correct legal wording and may add any employers/legal entities of the physician and nursing staff.

Researching standards of care for an allegation

For each allegation, identify:

- the standard of care, and
- the source, including the webpage for easy reference later.

For example, focusing on **Allegation #4**:

Allegation #4 – Failure of Dr. Garrison to timely diagnose and treat Mr. Curry’s perforated colon, resulting in continuing pain, infection, sepsis, hospitalization, and emergency surgery for a bowel resection.

You might search for:
gastroenterology “standards of care” perforation colonoscopy

From that, you could note:

- Colonic perforation is a **rare but well-known complication** of colonoscopy. Early diagnosis and treatment are necessary to decrease complications. ([NIH](#))
 - The incidence is rare but can be deadly, with mortality ranging up to **25%**. ([WSES](#))
 - Repeat for Allegations #1-3. Now you know what **should** have happened, you can review the records to see what **did** happen.
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Focusing your review

Knowing the standards lets you focus your review on **supporting and/or contradicting evidence**.

For each piece of evidence, type:

- what happened
- how it relates to the allegation and standard of care
- whether it supports or contradicts the allegation
- the **page number(s)** in the records where you found it

Also look for **damages** (if any) resulting from deviations in standards (causation), and document those with page numbers as well.

You’ll review all records, but you might start with:

Ridge Surgery Center

- **All records**, with emphasis on:
 - Operative/Procedure Report (indications for the procedure, inspection of the colon after polypectomy)
 - Postoperative nursing care, including names of personnel and timeline of events

Dr. Garrison’s office

- Any records of information from the answering service

- If none are present, it may be helpful for the attorney to obtain them if the case proceeds.
- All records, with emphasis on:
 - Documentation of phone calls from the patient or Ridge Surgery Center
 - Exams and pre-/post-procedure visits
 - Consent forms (which likely list colon perforation as a complication)

Community Hospital

- ER records and hospital admission(s) for **sepsis** and **bowel resection**
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The payoff for new LNCs

By following this process, new Legal Nurse Consultants can:

- review records with **purpose**, not just curiosity
- connect findings to **allegations, standards of care, causation, and damages**
- avoid unnecessary re-review
- build the report as they go
- provide knowledgeable, thorough reviews with **confidence**

This is how you move from simply reading the chart to applying your clinical expertise through a legal lens—**thinking and working like a Legal Nurse Consultant**.