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Sharon Scott & Associates
Legal Nurse Consultants

Talking Med

THE LAWYERS GUIDE TO MEDICAL ISSUES

SHARON SCOTT & ASSOCIATES

Detecting Tampering in the Medical Record

Discovering evidence of tampering in the medical record can be a windfall for a plaintiff and the kiss of death for a defendant. Even a marginal case gets better when tampering is brought to light. Juries aren't very sympathetic to these cases and large awards, not proportional to the damages, are often granted. Legal nurse consultants are the best and most cost effective resources you have at your disposal. Nurses are very thorough by nature and will take the time to pick through the records. They are also knowledgeable about the standards for documentation.

Clues to detecting that records may have been altered are:

- Writing that is crowded around existing entries
- Changes in slant, pressure, uniformity or other differences in handwriting
- Erasures or obliterations
- Use of different pens or typewriters to write one entry
- Impressions or lack of impressions from writing instruments on the following pages
- Ink offsets or lack of offsets on the back side of the preceding page
- Additions on different dates written in the same ink while original entries were written in different inks.
- Large discrepancies in charting patterns (Writing a long progress note on a patient when other notes are short and cursory)
- Different handwriting in what appears to be one provider's entry.
- Dictated note that is typed weeks or months after the incident.

Omitting significant information has serious consequences also. Sometimes the old adage "If you didn't chart it, you didn't do it" holds true. It's impossible to remember or prove years later that the care in question was done. When omissions of documentation are detected, the jury begins to wonder what other information was intentionally not recorded.

Clues to substituted or rewritten records are:

- Unnatural order of writing and uniformity of handwriting, ink margins and spacing
- Intersecting fountain pen entries of different dates that

Legal Nurse Consulting Certification

Knowing that your nurse consultant has been certified, gives you peace of mind ...

If you are like most busy law firms, you probably receive information from nurses monthly wanting to help you with your medical cases and you may be wondering how to differentiate one from another. While it is the nurse's experience you are seeking, it is important that they understand legal concepts and how to synthesize complex information, etc. One way to differentiate these nurse consultants is by certification. To obtain the credentials of a Certified Legal Nurse Consultant one must successfully complete a nationally recognized training program developed by the Medical-Legal Consulting Institute, Inc. and master a complex body of specialized knowledge. A written exam is then given to validate the nurses knowledge of legal nurse consulting. The certification is maintained by attending 15 hours of medical-legal related continuing education per year. ***Knowing that your nurse consultant has been certified, gives you the peace of mind that they have demonstrated a level of proficiency and a commitment to continuing education in this specialized field.***

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Organization

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Providing Medical Consulting to Plaintiff & Defense Attorneys Nationwide Since 1993

About Us . . .

- Clinically active
- Over 23 years experience of nursing experience
- Held 2 administrative positions
- Experience with inner workings of hospital
- Experience with hospital, departmental and unit specific committees to write review and approve policies, procedures and patient care standards
- Educated nurses and functioned as unit resource regarding standards of care and legal aspects of documentation
- 14 years as an independent legal nurse consultant, assisting with over cases from all medical fields

Experience

- Medical Surgical
- Cardiac
- Telemetry
- Step-down unit or Sub-acute
- Critical Care
- Coronary Care
- Neurology
- Neurosurgery
- Cardiac Surgery
- Administration

Just a few of our more popular services . . .

- Medical Record Review& Analysis
- Medical Record Summaries, Chronologies & Timelines
- Expert Witness Location
- Medical Research
- **Detecting Tampering**
- Attend IMEs
- Deposition & Trial Support

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bleed together

- Differences between pages as to folds, stains, offsets, impressions, holes, tears and type of paper used
- Use of forms not in use at the time of the timed entry
- Use of a later year, especially if it has been corrected several times

If parts of the medical record are damaged or destroyed, juries will assume that the information on the missing documents was so damaging that the health care provider had to destroy it.

For assistance in reviewing your medical records for tampering, give us a call.

Joint Commission: Sentinel Events

A sentinel event is defined by the Joint Commission as "an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function." Below are the percentages as of June 2006.

- Patient suicide: 13.1%
- Wrong site surgery: 13 %
- Operative/post op complications: 12.4%
- Medication Errors: 9.7 % (decreased since 2005)
- Delay in treatment: 7.5%
- Patient Falls: 5.4%

Also reported but attributed to less than 4 % were: patient deaths from restraints; assault/rape/homicide; transfusion errors; infections related deaths; patient elopement. Source: www.JointCommission.org

Lack of Communication Common After Discharge

There is a growing medical specialty called Hospitalist, where physicians only take care of patients that are admitted to the hospital. Transferring the patient's care back to the primary physician after discharge is very important, but the information provided the primary physcians was often found to be delayed, inaccurate or nonexistent according to an article published in JAMA (The Journal of the American Medical Association) on February 28, 2007.

In this review article, researchers analyzed 55 observational studies investigating communication and information transfer at discharge and 18 controlled studies evaluating the efficacy of interventions to improve information transfer.

What the researchers found was:

- Availability of a discharge summary at the first post discharge visit was low (12-34 %) and remained poor for 4 weeks (51-77 %) affecting the quality of care in about 25% of follow-up visits
- Discharge summaries often lacked important information such as diagnostic test results (missing from 33-63%), treatment or hospital course (7-22%), discharge medications (2-40%), test results pending at discharge (65%), patient/family counseling (90%) and follow-up plans 92-43%).

Source: www.EurekAlert.org