



The Medical-Legal Insight Brief

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Reading the Emergency Department Record: Looking Beyond Individual Notes

WHY THIS MATTERS

Emergency Department records often contain hundreds of individual documentation entries created by multiple clinicians over a relatively short period of time. Rather than reviewing each note in isolation, experienced medical record review focuses on how the documentation fits together to tell the patient's clinical story. Understanding that progression may help attorneys identify important questions regarding liability, causation, damages, and overall case strategy.

INSIGHT #1

Every Emergency Department Record Tells One Clinical Story

Triage, nursing assessments, provider documentation, diagnostic testing, treatments, reassessments, and discharge documentation should all be interpreted together, not as separate pieces of information. The strongest case evaluations often come from understanding how these individual entries connect throughout the patient's Emergency Department course.

INSIGHT #2

Look for the Clinical Progression

Patients rarely leave the Emergency Department in exactly the same condition in which they arrived. As you review the record, ask:

- How did the patient's condition change?
- How did the clinical team respond?
- Does the documentation explain how the patient's presentation evolved?

Understanding that progression often provides valuable context when evaluating the medical record.

INSIGHT #3

Clinical Decisions Should Be Supported by the Documentation

Whether reviewing diagnostic testing, treatment decisions, consultations, or discharge planning, one important question remains: Does the surrounding documentation explain the clinical reasoning behind the decision? Reviewing the documentation within its full clinical context often provides a clearer understanding of the patient's Emergency Department course.

INSIGHT #4

Small Details Often Complete the Story

Some of the most valuable clinical information is found in documentation that is easy to overlook:

- Repeat vital signs
- Response to treatment
- Nursing reassessments
- Shift handoffs
- Discharge instructions

Individually, these entries may seem routine. Together, they often provide important context for understanding the patient's overall clinical course.

QUESTION OF THE MONTH

When you review an Emergency Department record, what part of the chart do you read first?

As a nurse, I begin with the triage assessment and then reconstruct the patient's clinical story from beginning to end. That perspective often reveals details that are easy to miss when reviewing individual notes separately.

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