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Improving Documentation & Reducing Risk

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March 25, 2014 – Fairview

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Presented By:

David A. Valent, Esq.

Joseph T. Palcko, Esq.

1400 Midland Building • 101 Prospect Avenue, West • Cleveland, OH 44115 • Telephone (216) 687-1311 • Facsimile (216) 687-1841

Topics / Goals

- Appropriate and effective documentation in the medical record
- How to write up occurrences in the medical record
- What NOT to document in the medical record
- How to document / follow chain of command with patient complaints

What is Documentation?

- Medical Records
- 24 hour reports
- Assignment Sheets
- Incident Reports
- Flow Sheets
- Admitting Notes
- Order Verifications

Purpose of Medical Record

- Memorializes Hx, tests, Dx, Tx
- Communication to other care-givers
- Continuity of care
- Most important witness in court

Purpose of Medical Record, Continued

- Plans Patient's Care
- Communication for the Health Care Team
- Provides Continuity
- Financial Reimbursement
- Used to Assess the Quality of Patient Care
- Mandated to Maintain Accreditation Status

Pitfalls with Documentation

- Patient care is the priority, not charting
- Familiarity with the resident

The record
should paint the
clinical picture

If you remember only two things today….

Documentation Issues

ONE:

- "Not charted it didn't happen, right?"

WRONG!

- All aspects of patient can't always be charted
- Independent memory of case, may supplement record
- Your habit/routine will supplement record

TWO:

Never Ever Alter !

- Do not Obliterate
- Errors: Date, Time, Initial
- Never chart for someone else

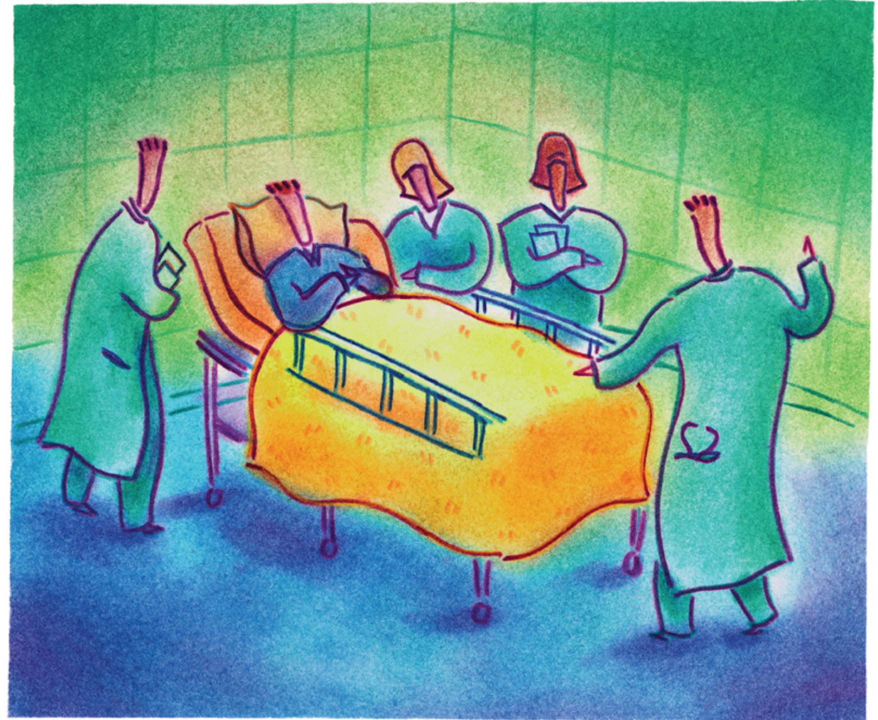
ALTER

Ten Documentation Rules

1. Legible
2. Clear Language
3. Clear Symbols
4. Record Results
5. Be Discrete
6. Be Complete and Thorough
7. Don't Alter Records
8. Never Alter the Medical Record
9. Don't Even Think About It
10. Really, You Won't Get Away With It!!

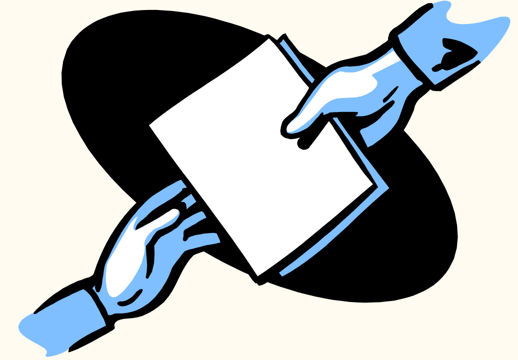
Document Communication

- Doctor – Doctor
- Doctor – Patient
- Doctor – Nurse
- Nurse – Patient
- Patient - family



Document Communication

- Informed Consent – Risks/Benefits
- Lab Results
- Noncompliance
- Family Interaction
- Discharge/follow-up – verbalizes understanding of instructions and follow-up
- Documenting Chain of Command- Positive Approach



Essential Charting Tips

- Pen
- Date & Time
- Sign & Initial
- Be Complete
- Hospital Accepted Abbreviations (JCAHO)
- If not documented, not done – not true!

Stop Poor Documentation

- Incorrect Spelling
- Writing in the Margin
- Incomplete
- Inaccurate
- Illegible

Documentation Dont's

- Speculate as to cause of injury or accident
- Give advice as to what measures could have prevented accident in medical record
- Use record to vent frustrations against resident, family, physician or employee

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Documentation Do's

- Remove record upon discharge
- When necessary, quote conversations with resident and family verbatim
- Document and follow-up on risk issues
- Refer to Care Plan
- Remove forms which are not being used

Examples of Poor/Good Documentation & Documentation Issues

Poor

THE NEWS & OBSERVER

Trial on hold 3 years

17 REMAIN DEAD IN MORGUE SHOOTING SPREE

Microsoft breakup won't be pursued

Actual Sentences Found in Patient's Charts

- She Has No Rigors or Shaking Chills, but her Husband States She was Very Hot in Bed Last Night.
- Discharge Status: Alive but Without My Permission.
- The Patient Refused Autopsy.

Actual Sentences Found in Patient's Charts
(cont'd)

- Patient Had Waffles for Breakfast and Anorexia for Lunch.
- Occasional, Constant, Infrequent Headaches.
- Patient was Alert and Unresponsive.
- Large Brown Stool Ambulating in the Hall.

Actual Sentences Found in Patient's Charts

(cont'd)

- Patient has Two Teenage Children, but No Other Abnormalities.
- She Stated that She Had Been Constipated for Most of her Life, Until She Got a Divorce.

Essential Charting Tips

- Abbreviations can lead to poor documentation.

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DO NOT USE Abbreviations

Abbreviation	Problem	Preferred
U for unit	Mistaken as a zero or cc	Write “unit”
Q.D. or Q.O.D.	Mistaken for each other	Write “daily” or “Every other day”
H.S.	2 meanings:half strength or at bedtime	Write out “half strength” or “at bedtime”

Writing Samples

6 units or 60 ?

60 Regular Insulin Now

Writing Samples

q.d. or qid ?

Digoxin 0.25mg q.d.

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DO NOT USE Abbreviations

Abbreviation	Problem	Preferred
x3d	Mistaken for "3 doses" or for "3 days"	Write "for three days" "for three doses"
.5 mg	Mistaken for 5 mg	Write "0.5 mg"
1.0 mg	Mistaken for 10 mg	Write "1 mg"

Writing Samples

80 or 8.0 mg ?

Gentamicin 8.0 mg IV [illegible]

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PREOPERATIVE

ALLERGIES

HEIGHT	WEIGHT	PULSE	B/P	TEMP	SpO2
5'6	245 lb	64	145/66	97.5	97

MEDICAL EVALUATION

Procedure _______ Status _______

Medical History _______

Present Drug Therapy _______

Previous Anesthetics _______

AIRWAY EVALUATION

MP Evaluation 1 2 3 4 Dentition _______

Smoking _______

LAB DATA

Hgb/Hct _______

ytes _______

EKG _______

Other Lab: _______

9/11/07

ANESTHESIA OPTIONS & RISKS DISCUSSED: ☑ YES

PLAN: _______

Date 9-11-07

X _______ Date _______

POSTOPERATIVE

POST - ANESTHESIA NOTES

Awake & Exch well

Report RN

CRNA 09.11.07 Time

POST - ANESTHESIA VISIT

DATE TIME

COMPLICATIONS ☐ NO ☐ YES, EXPLAIN

X

OPERATION Amputation (L) toes #2-5 | CPT #1 | CPT #2 | M + | PCA:

Dx Ulceration Gangrene (L) Foot | ICD 9#

ANESTHETISTS | DATE 1/20/03

SURGEONS | DEPT.: ☑ SURG ☐ OB

ASA risk 1 2 3 (4) 5 E reason:

TIME 1700 30

O₂ L/MIN / Mask 8 8 X

N₂O L/MIN

AGENTS: Fentanyl 2 1 — 4ml; Versed 2 1 — 3mg; Propofal 50 - - - X — 200mg

FLUIDS: D5LR 500 — 700ml

Urine Output

Est. Blood Loss

TEMP 36° 36° 36° 36°

ET CO₂

FI O₂

Cardiac Rhythm SR SR SR SR

PULSE, RESP., B.P., ANES., OPER., TOURN

TIDAL VOL. / PRES. / CYCLES/MIN.

200 180 160 140 120 100 80 60 40 20

REMARKS: T 1 250 MMHG 1659 ↓ 1735

TYPE OF ANESTHESIA: GENERAL, SPINAL, EPIDURAL, ☑ MONITORED ANESTHESIA CARE, NERVE BLOCK

TOTALS | MONITORING: ART LINE, CVP CATH, PA CATH, DOUBLE LUMEN ENDO TUBE, ☑ PULSE OXIMETRY, ☑ E.CO₂, ☑ EKG, ☑ DINAMAP, ☑ TEMP, C.ANAL, STETH, ☑ SAFETY CHECK

ANESTHESIA TIME: START 1638 A.M. (P.M.) FINISH 1743 A.M. (P.M.)

POSITION OF PATIENT: SITTING, PRONE, ☑ SUPINE, LITHOTOMY, LATERAL DECUBITUS R L

AIRWAY: ☑ MASK O₂, ☑ AIRWAY ☐ ORAL ☑ NASAL, E.T. TUBE BLADE, SIZE ☐ ORAL ☐ NASAL ☐ R, BREATH SOUNDS ☐ EASY ☐ DIFFICULT

REMARKS:

BIRTH TIME A.M. P.M.

PLACENTA TIME A.M. P.M.

SEX OF CHILD ☐ M ☐ F

APGARS 1 MIN. 5 MIN.

208 G F 50
13821109 12/13/1942

START A.M. (P.M.) 1638 FINISH A.M. (P.M.) 1743

Good

Objective v. Subjective

- Objective: Surgical incision healing- No signs of infection
- Subjective: Wound OK
- Objective: IV site clear and infusing at 40 drops per minute
- Subjective: IV running well

Objective v. Subjective

(Cont'd)

- Objective: Pain of 3 out of 10
- Subjective: moderate pain
- Objective: Patient's home called 3 times regarding appointment, with no response.
- Subjective: Patient refused to come in

Objective v. Subjective

- Objective:
  - Plan: recommended follow up in one month with Dr. Patouhas
- Subjective: Instructions given

Objective v. Subjective

- Objective: Patient ate half of hamburger and half of bun
- Subjective: Diet taken fairly

Document Communication = Good

- Lab Results
- Noncompliance
- Family Visits and Social Documentation
  - Wife tearful at bedside
  - Patient Quotes

How can poor documentation lead to problems?

Q: Doctor, can you tell me what the purpose of a medical record is?

A: It's the method we use to capture the chronology of the events. It has nothing to do with patient care, just documents the care rendered.

Q: Doesn't the medical record serve the purpose of the conduit of communication between physicians.

A: Yes.

Q: I mean, you don't speak with every other consulting physician or the attending physician, do you? You rely on what is written in the patient's chart.

A: I would agree with that.

Q: And if you can't read a colleagues writing, that note is futile.

A: I wouldn't say the whole note is futile.

Q: Here's my point. If the physician writes something important in the record, and you can't read it, and you haven't personally spoken with the physician, important information may be missed.

A: Yes. That can happen.

Q: Can you turn Dr. _____'s progress note dated August 29, 2006?

A: I'm there.

Q: Can you read the writing after impression. By the way, impression is another word for diagnosis.

A: It what the physician believes what may be causing the patient's presentation.

Q: Is that different than diagnosis?
A: No.

Q: <u>What is written after impression.</u>

A: <u>I'm sorry. I can't decipher that writing.</u>

Q: Did you speak to Dr. ____ about that note?
A: I don't recall doing so.

Q: And that wouldn't have been your practice either, would it?
A: Generally not.

Q: <u>So can you and I agree that that particular writing, following impression, that information which should communicate Dr. ______'s diagnosis is futile.</u>

A: I <u>can't read it.</u>

Q: And if you can't read it, you can't get the benefit of his impressions.

A: True.
Q: <u>So it's futile.</u>

A: <u>I can't disagree with that.</u>

As you can see…

- Better documentation would lead to better defenses during litigation, and better proof of quality care provided.
- This includes better proof of patient's non-compliance. Which, as you know, often contributes to "bad outcomes."
- Important when arguing contributory negligence.

Occurrence Reporting

- Within the Chart v. Incident Reports

In General…

Avoid finger pointing

5-25-06 RI Prog note

0100 Labs ordered yesterday for Today were not drawn per PIN records. No notes in chart addressing issue. Nurse asked about labs this AM @ 700 am. Nurse reported No Knowledge about check out from Last Pm Nurse. Labs still not drawn per PIN records. Nurse instructed personally by me to get labs drawn. Nurse requested Labs be re-ordered for today. Labs were reordered MD to Nurse ordered to get labs drawn. Will Follow up.

MD.

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Write Objectively

Record the details of the incident in objective terms, describing exactly what you say and heard. For example, unless you actually saw a patient fall, write "Found patient lying on the floor." Then describe only the actions you took to provide care at the scene, such as helping the patient get back into bed or assessing him for injuries.

Include Essential Information

Document the time and place of the incident and the name of the practitioner who was notified. Also document witnesses.

Avoid Opinions

Don't commit your opinions to writing in the incident report. Rather, verbally share your suggestions or opinions on how an incident may be avoided with your supervisor and risk manager.

Assign No Blame

Don't admit to liability, and don't blame or point your finger at colleagues or administrators. Steer clear of such statements as "Better staffing would have prevented this incident." State only what happened.

Avoid Hearsay and Assumptions

Each staff member involved in the incident should write a separate incident report.

File the Report Properly

Don't file the incident report with the medical record. Send the report to the person designated to review it according to your facility's policy.

Medical Documentation – Incident Reports

Incident Reports

- Factual
- Deemed Confidential

Incident Report

- 2305.253 Confidentiality of Incident Report or Risk Management Report

"Notwithstanding any contrary provision an incident or risk management report and the contents of an incident report or risk management report are not subject to discovery in, and are not admissible in evidence in the trial, or of a tort action".

➢ Always Utilize The Incident Report for Confidential Subjective Information

➢ Reducing Risk if Giving Testimony – Subpoenas & Depositions

SPECIFIC DOCUMENTATION ISSUES

Putting it all together

Patterns of Malpractice Acute / Long Term Care Nursing Home Setting

- Failure to diagnose / delay in diagnosis
- Failure to follow-up on testing (leads to failure to diagnose)
- Failure to appreciate information provided by other health care providers
- Informed consent
- Falls
- Pressure Sores
- Dehydration/Malnutrtion
- Abuse/Neglect
- Elopement

Falls

- 42 C.F.R. 483.25(h)

  The facility must ensure that --

  (1) The resident environment remains as free of accident hazards as is possible; and

  (2) Each resident receives adequate supervision and assistance devices to prevent accidents.

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Falls (cont.)

- Develop Falls Committee
  - Involved in Quality Assurance
  - Meet weekly
  - Involve all disciplines
  - Evaluate all new admissions
  - Place recommendations on IDT

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If a Fall Occurs

- Document in Resident Record
  - Neuro checks for three days q shift
  - Reinforce prior fall interventions were in place
  - Do not speculate as to cause
  - Discuss new interventions with physician
  - Follow-up documentation for three days q shift

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Falls Documentation

- Specific interventions
- Resident’s awareness of safety risk
- Whether resident is on restorative or therapy programs
- Gains/Progress

Sample Entry

- 4:00 pm – Resident attempting to stand from w/c without assistance. Resident oriented x2, not easily redirected. Lap buddy and alarm in place. Will place resident next to nurses' station to observe.
- 6:00 pm – Resident continues to be assessed. Resident sitting quietly. No further attempts to stand.

Pressure Sores

42 C.F.R. 483.25(c)

Based on the comprehensive assessment of the resident, the facility must ensure that--

(1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates they were unavoidable; and

Pressure Sores

(2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

Pressure Sores

- PICTURES
- Wound Team
  - Meet weekly
  - Identify residents at risk and who have pressure sores
  - Evaluate new admissions

Pressure Sores

- All disciplines in IDT should note pressure areas/ prevention
- Must document non-compliance
  - "interventions per POC"
  - Attending must address risk factors predisposing for pressure sores
  - Address non-compliance with family members
- Weekly monitoring once pressure sore occurs

Sample Documentation

- 3/28/00 10:00 am – Resident assessed by wound team. Resident's treatments, nutrition and activity reviewed and assessed. Resident continues to be non-compliant with turns and repositions. Family informed risks of non-compliance.
- 3/29/00 4:00 pm – Resident's wounds assessed and treated per POC. No change in condition.

Sample Documentation

- 11/24/01 6:00 pm - Resident speaking incoherently. Resident's VSS, mucous membranes moist, skin turgor good. Will continue to monitor.
- 11/24/01 8:00 pm – Resident continues to speak incohrently. Condition as above. Will continue to monitor
- 11/25/01 7:30 am – Resident speaking as per normal. Resident's vss, skin turgor good, mucous membranes moist.

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Elopement

- Be consistent with interventions for other residents at risk at risk for elopement.
- Make sure interventions are measurable and realistic
- Weekly nurses’ note to discuss progress of intervention and any escalation in behavior.

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Resident to Resident Abuse

- Appropriate preadmission screening
- Follow-up on possible resident to resident issues with:
  - Psych services to assess whether new interventions are warranted.
  - Psych services to assess and document whether continued placement is appropriate.

Thank You!

QUESTIONS??